



## MORE CHOICES FOR MEDICAL AND DENTAL COVERAGE

### MEDICAL

In the December 2004 issue of *HealthLine* the State announced its intent to award the contract to administer the State's self-funded medical plans to Great-West Healthcare, beginning July 1, 2005. In this issue we begin the countdown to open enrollment in the Spring of 2005 with additional information about what's in store. You will be able to choose from among five new plans covering the entire state. Although detailed descriptions of the five new self-insured medical plan options and their premiums will not be available until much closer to open enrollment, we can provide a basic overview of the plan options that will be offered to state employees for July.

All five plan options will use the Great-West Healthcare national PPO provider network and will be available statewide. Two of the options will be In-Network Only (INO) plans with fixed dollar co-pays for most services. Three of the options will be Preferred Provider Organizations or PPO plans. Each of the three PPO options will have a different deductible, co-insurance percentage, and out-of-pocket maximum. The PPO options also offer out-of-network coverage. If keeping the same doctor is the most important consideration for you, you may want to choose one of the PPO plans because you will have the flexibility to use out-of-network benefits if your doctor is not in the PPO network.

It is important to note that all five plans offer the same covered services. The only differences among the plans are in the balance between monthly premiums and out-of-pocket costs. The greater the potential out-of-pocket costs for you, the lower the monthly premium because you have taken on more cost risk.

Through an INO, you can pay more each month in premium in exchange for less cost at the time services are rendered (i.e., fixed co-pays and no deductible). These INO choices provide more predictability of costs but you can overpay if you rarely or never visit the doctor. Also you must use in-network providers.

Alternatively, you may prefer a lower monthly premium in one of the PPO plans and pay more only when you actually use services (i.e., higher deductibles along with co-pays). This approach provides less predictability of costs and could cost more overall if you have major health care needs, but it allows you to retain the money until you need the service and also gives you the flexibility to use out-of-network doctors if you so desire.

We are also pleased to report that one of the PPOs will be an HSA-qualified plan, meaning that it will enable employees to take

### PLAN OPTIONS FOR JULY 1, 2005

- Five Self-Funded Plans Under Great-West Healthcare
  - 3 PPOs with both in-network and out-of-network coverage
    - The 3 PPOs will have different deductible and co-insurance amounts
    - One of the PPOs will be an HSA-qualified plan
  - 2 In-Network Only (INO) coverage options
    - The 2 In-Network Only options will have different co-pay amounts
- The Kaiser and San Luis Valley HMO Plans will remain in place for the geographic areas they serve.
- Delta Dental continues Basic and Basic Plus plans
- Direct Reimbursement (DR) plan added to dental choices

advantage of Health Savings Accounts. Under the HSA-qualified plan, prescriptions are treated the same as other covered medical services, meaning they are both subject to a common deductible, co-insurance percentage, and out-of-pocket maximum. The other four plans include a prescription card benefit, which means the costs for prescriptions are separate from the costs for medical services. Employees who choose this HSA-qualified plan must satisfy the deductible before benefits begin although there is an exception for preventive medical services. To qualify as an HSA-qualified plan, the plan design had to meet federal specifications for minimum deductibles and out-of-pocket maximums.

In addition to the five plans offered by the State through Great West, Kaiser Permanente and San Luis Valley HMOs will still be offered in those areas where they are available.

### DENTAL

In the last *HealthLine* we also reported that the State will continue its relationship with Delta Dental. The two plans that have been available for some time now, Basic and Basic Plus, will continue. Starting July 1, 2005, you will also have the choice of enrolling in a dental direct reimbursement (DR) plan (please see the article "*What Is Direct Reimbursement For Dental?*").

Another important change is the elimination of free dental. We concluded that many people enrolled in free dental (Basic, employee only) were not using the benefit, which resulted in wasting the State's contribution. In order to put those dollars to better use, we have added a modest employee contribution to the

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# UPCOMING OPEN ENROLLMENT

The next open enrollment for the plan year beginning July 1, 2005, will take place in the Spring of 2005. **It will be a positive open enrollment, meaning that all employees MUST participate in the process, even if they do not want the State's coverage.**

This open enrollment will be the first major step in the partnership we wish to cultivate in the area of benefits between the State and its employees. The course we are charting is an attempt to put more decision-making power in your hands. With decisions come responsibility. In the upcoming open enrollment, **there WILL NOT be the option of doing nothing, meaning your current coverage will not roll forward into the next plan year.** The options available will be so different from the current choices that this type of passive open enrollment simply will not work.

Nor will there be any sort of default coverage for those who do not currently participate, but who still want coverage next year. If you want coverage, you will have to actively choose it no matter what medical coverage you have now.

We also want those employees who are not taking the State's coverage to actively waive that coverage by using the online system. We want to know why you are waiving the coverage. This kind of information provides the State with the data as to who is not covered and why, allowing us to refine the plan options in the future. So please help us gather this critical information by taking just a few minutes to actively waive coverage and answer a few simple questions about why you are doing so. We need your help and we are trying to make this as easy as possible.

Remember that in most cases elections made during open enrollment are irrevocable, especially those involving pre-tax selections. They can only be changed in certain circumstances as prescribed by the IRS, which considers financial hardships and employee mistakes insufficient reasons to change. Please consider your choices during open enrollment very carefully.

The online open enrollment in the Fall of 2004 was more successful than our first attempt in 2003. We hope to be even more successful this time around. Watch for other issues of *HealthLine* in the coming weeks for more details on the online enrollment process.

## TRANSITION TO GREAT-WEST HEALTHCARE

The prospect of changing from one provider network to another next July understandably may cause some employees to feel anxious as they wonder, "What if my doctor is not in the Great-West network?" To ease such concerns, it helps to know that there is substantial overlap between the Anthem Blue Cross & Blue Shield and Great-West Healthcare networks. In those areas of the state where the network is lean, Great-West will supplement its own network with providers from another network. This is a temporary solution, since, at the same time, Great-West will increase its provider recruiting efforts, concentrating first on those areas of the state where the network currently has an insufficient number of doctors, including several mountain resort areas.

Employees interested in viewing the Great-West network in advance of open enrollment can begin viewing the network by following the links from [www.mygreatwest.com](http://www.mygreatwest.com). All five new medical plan options will utilize Great-West's PPO network

(please see article "*More Choices for Medical and Dental Coverage*"). More information on providers will be available prior to open enrollment.

In its agreement with Great-West Healthcare, the State will require the maintenance of a network of sufficient size and scope to ensure adequate access to necessary services, but Great-West will not be required to guarantee the participation of any specific provider (please see article "*Doctors, Hospitals and Networks*"). Employees with strong attachments to their healthcare providers should consider enrolling in one of the plan options that provides out-of-network benefits, such as one of the PPO plans. Those who live in areas that have few provider choices may also want to encourage their doctors to consider joining or remaining in the Great-West network. Please bear in mind that Great-West can not create providers where none exist, nor can they force any provider to become part of the network.

## DOCTORS, HOSPITALS & NETWORKS

Healthcare providers who contract with a provider network must submit to a review process called "credentialing". This review generally includes verifying the provider's medical license, education, training, hospital admitting privileges, and whether or not they have adequate malpractice insurance. Credentialing also includes a review of work history, license violations, and malpractice claims. Providers must agree to periodic site visits and audits as well as other requirements of the network. In addition to meeting standards designed to assure patient safety and appropriate care, they often must agree to provide services to covered members at a discount.

Why would a physician or other healthcare provider enter into such an agreement? A variety of business reasons impact this decision. Some do so simply because their patients, like you, request

them to. Others hope to benefit from having more patients - higher volume can mean more money.

Provider contracting involves balancing the need to provide adequate access to insured members with the need to control cost and quality of care. Provider needs must also be taken into consideration, or else there is little to no incentive for them to join the network.

It is unusual and expensive for employers to contract directly with medical providers. Hospitals, physicians and other providers generally contract with an established network organization, which in turn sells their services to employers, either directly or through an insurance company or third-party administrator. An employer has no control over the comings and goings of individual providers, who may leave the network when their contracts expire or if they become dissatisfied with the agreement. If remaining with a doctor of your choosing is important to you regardless of cost, an option that offers out-of-network benefits is probably a better choice for you. Better yet, ask your doctor to join the network.

# RISKS & COSTS

As the cost of healthcare continues to rise faster than wages and all other consumer costs across the nation, it is important for employees to

understand the concept of insurance risk and how it affects healthcare coverage. We all pay the price of choices that increase the cost of healthcare coverage regardless of whether we buy that coverage from an insurance company or take on that risk as a self-funded employer. Yet an understanding of risk becomes increasingly important as we move to self-funding of medical and dental coverage.

Self-funding is just another name for self-insuring, but we don't use that term because we are not in the insurance business. What matters most is that both the employer and the employees understand and accept their respective roles in controlling the risk. Under self-funding it is yours and the State's dollars that will pay for claims regardless of how high those claims are. We will no longer be shifting the entire risk to an insurance carrier. But we will have in place what is known as "stop-loss" insurance to cover all claims over \$50,000.

Insurance risk may be defined as "the probability of loss." Experts called "underwriters" and "actuaries" attempt to predict the future by calculating the likelihood of claims occurring and the dollar amount of those claims. Then they add a small cushion for error because predicting the future is never perfect. When the State thought about self-funding your health benefits we hired independent experts to help us quantify the risk we're taking on and set the "premium rates" for the new benefit plans accordingly. It is vital that premium rates be set at the appropriate level to cover the risk.

Assessing risk is something you do every day; whether it is predicting the likelihood that your car will malfunction or estimating how high a deductible you should purchase on your car insurance. The same risk assessment should be done when choosing a health plan. And when you think about assuming risk, you should also be aware of how to eliminate or reduce that risk. You should change your car's oil and get periodic tune-ups. If someone told you that your car was at immediate risk for breaking down, you would not hesitate to do whatever you could to reduce or eliminate that risk. You would try to replace the worn out parts or repair the engine to prevent the inevitable loss of the entire vehicle. Similarly, if your life was at stake due to a health condition, you would do whatever was within your control to increase your chances of staying healthy and living longer. Unlike a car, however, you can't buy a "new you". You can, however, reduce the risk of your body breaking down and paying a lot more down the road trying to fix it by performing appropriate regular "maintenance" on yourself.

As we go forward, the State will increasingly focus on providing you education, disease management programs and other tools to help reduce avoidable health care costs. As a partner in this endeavor, there is much you can do to help reduce the risk and control cost increases for both yourself and the medical and dental plans. First, know what your particular health risks are (heart disease, diabetes, cancer, etc.). Then, follow your physician's advice for reducing those risks (diet, exercise, medication, etc.). And third, avoid unhealthy behaviors (stop smoking, wear seatbelts, don't drink and drive, etc.). Reducing health risks will reduce your health care costs and will ultimately reduce increases to our medical and dental plans, saving money for everyone concerned.

## What is Direct Reimbursement for Dental?

The State will continue to offer the Basic and Basic Plus dental plans. The deductible amounts for the Basic and Basic Plus plans will return to \$50 for 12 months, as the current \$25 deductible was only for the short plan year. In addition, the State will offer a Direct Reimbursement (DR) dental program in July. All three plans will be self-funded and administered by Delta Dental Plan of Colorado. Although it will be more costly than the Basic Plan, DR may appeal to those who prefer to make their own decisions about the appropriateness of care.

Direct Reimbursement allows you the flexibility to choose any dentist and to make your own decisions about the appropriateness of care. DR involves paying for services up front, then filing for reimbursement from the plan. DR has no network of providers, essentially providing out-of-network benefits only. Employees enrolled in the DR plan can expect to pay full price at the dentist's office, although they may want to ask their dentist about a discount for cash payments. Cosmetic procedures and orthodontia will not be covered under DR. All services will be subject to the same deductible and co-insurance percentage.

Remember too that since DR dentists are outside the managed care network, our Third-Party Administrator (TPA), Delta Dental, is not monitoring their credentials or the quality of the care they provide.

### **Fast Facts** about the Direct Reimbursement Dental Program

- **No network is involved. Choose any dentist.**
- **No in-network provider discounts, but few limits on services**
- **Pay full price when visiting the dentist. Discounts, if any, are between the patient and dentist.**
- **Employees file claims and are reimbursed**
- **Maximum annual benefit will be \$850**
- **Participants make own decisions about appropriateness of care**

### **MORE CHOICES** *(continued from page 1)*

previously free coverage and will redirect any savings into a better dental value for everyone enrolled.

We encourage you to read the remainder of this issue for more helpful information, and to stay tuned for future issues of *HealthLine* as we move closer to open enrollment in the spring.

And look to future issues of both *Stateline* and *HealthLine* for informative articles on benefits-related topics from DPA Executive Director Jeff Wells.

A glossary of key terms in healthcare that you should know can be found on page five of this issue (see "*Terms To Know*").

# SELF-FUNDING WILL NOT MEAN LOWER PREMIUMS

## *(but it should cost less in the long run)*

When you go the doctor or dentist you should never have to think about how your medical or dental plans are funded. That being said, we are embarking on a partnership with you, the employees, in an effort to control rising health care costs. To that end, we owe you an explanation of what self-funding is and why this route makes sense.

### **Fully insured versus self-funded - what's the difference?**

We currently have only fully insured medical and dental plans, meaning that an insurance company takes the risk that the premiums they collect will cover the claims they pay, as well as their administrative costs. Self-funding, on the other hand, means that we, the State, in effect become the "insurance company." The risk becomes our risk. Claims are paid out of funds that we collect, although we will have stop-loss insurance for claims over \$50,000.

This then begs the question, "Where do Great-West and Delta Dental fit in?" The State has neither the infrastructure nor the market leverage of a health or dental insurance company, and we do not intend to build these capabilities at your expense. The role of Great-West and Delta Dental is to serve as the third-party administrators (TPA), processing medical and dental claims submitted to the State. We will rely on Great-West's vast expertise in the health care and insurance industries to administer the medical program and help minimize the risk we have assumed. Similarly, Delta Dental's experience will ensure quality administration of self-funded dental coverage.

### **How did we decide self-funding was the better choice?**

Self-funding was chosen because it provides for greater flexibility and control at a lower cost than being fully insured. This will enable us to better address rising health care costs while providing improved choices. For dental, this was a relatively easy decision; the risk is low due to benefit caps and claim predictability, and the cost savings are substantial without sacrificing choice or quality. Health care coverage is more complicated.

In health care, factors such as demographics, pharmaceutical costs, expensive new procedures, and even the networks of doctors and hospitals are all contributing to the rising cost of health care. In fact, health care costs are rising faster than any other consumer cost. In addition, unlike dental, many of the benefits have no dollar caps on how much the plans will pay. A single premature baby can easily cost the plans \$1 million. Most of these factors are all beyond the control of employers, including the State. But there are some things we can control.

In the world of insurance, larger groups are typically better than smaller ones because the risk can be spread around. In 2000 we had lots of choices, but this created too many small groups, or risk pools, costing more individually than a single large group. As carriers dropped out of our program over the last four years (e.g. Aetna, Cigna, Rocky Mountain HMO) this helped consolidate the group's negotiating power with fewer carriers, but it also reduced plan choices for you. For these reasons it became obvious early on in our planning for the future that the existing arrangement was not working.

To address these challenges, we brought together a group of experts from inside and outside of the benefits program, including private consultants and representatives from several large state departments. The team asked itself how the State could maximize choice while combining everyone into the power of a larger risk pool. The answers we came up with are what you will soon see for July 1, 2005. We created five new plan choices available statewide and then issued a Request for Proposals asking what the costs would be for either fully insuring the program or administering a

self-funded program. **Self-funding does not mean lower premiums.** The cost of medical care is rising and premiums will be higher than they are now. However, self-funding proved to be significantly less expensive than fully insuring these new plans by about \$4 million a year.

Self-funding allows us to focus on what's important to the State, such as rural access to care, which may not be a priority for an insurance carrier. It affords us the flexibility to maximize our options and manage our costs. We can design, adjust, and improve the types of plans we offer. Under self-funding we can identify some of the best practices and behaviors that can help us to control costs, such as a targeted disease management program. This ability to change and adapt gives us a measure of control over the ever-escalating costs of health care that we do not presently have with fully insured products. A key advantage of self-funding for the State becomes access to critical data not presently available to us. With general information on what services are being used (not who is using them), and even information on those who do not choose coverage from the State, we can design and improve the plans to better match employees' needs.

In partnering with Great-West, a company that has an extensive network of doctors throughout Colorado and vast self-funding experience, coupled with the ability to design our own plans, we are addressing a growing concern. In the past, many employees have felt that their choice of health coverage was limited. We are offering more choices across the whole of the state, so employees will be able to choose a plan that meets both their health and financial needs.

### **What about Kaiser Permanente and San Luis Valley HMO?**

You might well ask if a single group is better than several smaller ones from a risk standpoint, why we still offer Kaiser and San Luis Valley HMO (SLV). The challenge of maximizing choice and buying power was most acute for the 15,000 state employees not in Kaiser or SLV, many of whom live in areas where those choices are unavailable. This is what we set out to address. Then we analyzed whether or not Kaiser or SLV were creating harmful competition for the self-funded group. We found no evidence of that and therefore saw no valid reason to deprive employees of the additional choices of Kaiser or SLV in those areas where they are available. We can still improve the situation for the remaining 15,000 state employees and their families even with Kaiser and SLV.

**How can I help?** We are promoting a partnership with you, the employees. This is a partnership to help control the rising costs of health insurance. The State needs to inform you of your options and must educate you about these choices. We ask that you take the time to understand the plans and to make informed and thoughtful decisions about your benefits choices and the lifestyle issues that impact your healthcare costs. We want you to provide the data we need when you participate in open enrollment, even if you do not choose our coverage. We also hope that those of you who enroll will take advantage of the various new educational, medical management and other tools we are putting into place as part of a concerted effort to control costs for all concerned.

**How will the transition affect me?** The State's move to self-funding should be seamless and invisible for employees. The processes in going to the doctor or the hospital will not be materially different. Some employees may have to change doctors. The biggest change for most of us will be in dealing with a new company, Great-West Healthcare. Even with this monumental shift, we are making every effort to minimize disruptions in care for employees and their families.

It's a big step, but in the end we hope to provide better choices and better value. We need you to join us in this effort.

# TERMS to KNOW

*As we undertake a partnership with you, the employees, there are some basic terms you should know that apply to medical and dental insurance. This information will allow you to make more informed decisions about which plan you choose. The following defines some of the more common terms associated with the health care industry.*

**CO-INSURANCE:** A percentage that the individual is required to pay, often after a deductible is met. For example, a plan might require 20% co-insurance, meaning the employer or insurance company pays 80%, while the individual pays 20%. Co-insurance is applied to covered services only. So, for example, if you had a deductible of \$2,000 with 80-20 co-insurance, and you received covered services in the amount of \$5,000, you would pay the first \$2,000 plus 20% of the remaining \$3,000, or \$600 and the plan would pay \$2400. Note also that such plans have limits on what they will pay for certain services, so you may be responsible for all costs above those limits. Co-insurance is typically associated with PPOs, in which you pay a lower premium and pay more when you actually need services.

**CO-PAYMENT:** A predetermined (flat) fee that an individual pays for health care services, in addition to what the insurance covers, typically at the time service is provided. For example, a plan could require a \$50 co-payment for each office visit or lab service. Co-payments are not specified by percentages and are applied to covered services only. Co-payments are typically associated with HMOs where you pay a higher monthly premium in exchange for no deductibles and less money out of your pocket when you go to the doctor.

**DEDUCTIBLE:** The amount an individual must pay for covered health care expenses before insurance begins to cover costs. Health plans base the deductible amounts on a benefit plan year. Deductibles apply only to services covered by the plan. Deductibles are generally associated with PPO plans.

**EXCLUSIONS:** Services that are not part of the health or dental plan. Chiropractic care, experimental and cosmetic procedures are examples of services that are often not covered by health plans. Individuals are responsible for the charges associated with these exclusions. Excluded services cannot be used to satisfy deductibles or out-of-pocket maximums.

**FLEXIBLE SPENDING ACCOUNT (FSA):** An account that allows you to set aside money on a pre-tax basis, lowering your taxable income. You can then use the money to cover health care or dependent care expenses. Typically, they operate as a reimbursement to the individual once proof of the expense has been provided. An FSA will not directly lower or control your health care or dependent care costs, but instead it puts more money into your pocket to pay for these costs. Money in an FSA that is not spent at the end of a plan year is forfeited; it does not roll forward.

**FORMULARY:** A listing of prescription medications that are covered by a health plan. A formulary often fosters the use of generic medications with equivalent therapeutic value to provide more cost-effective treatment. Medications that fall outside the formulary are typically more expensive.

**HEALTH MAINTENANCE ORGANIZATION (HMO):** A prepaid medical group practice plan that provides a comprehensive, predetermined medical care benefit package. Employees select their primary care physician (PCP) from the HMO network. The PCP provides referrals to specialists within the participating HMO network. Doctors outside of the network are not covered. Kaiser Permanente and San Luis Valley HMO are examples of HMOs.

**HEALTH SAVINGS ACCOUNT (HSA):** A mechanism for saving money to pay for health care. Participants can pay for current health expenses while saving for future qualified medical health expenses on a tax-free basis. HSAs must be used in conjunction with a High Deductible Health Plan (HDHP). Participants control the money in an HSA, deciding how to spend it and how to invest it. Unused funds in an HSA at the end of a plan year may be rolled forward.

**IN-NETWORK ONLY (INO):** A plan with a group of hospitals and physicians that contract with insurance companies, third-party administrators or employers to provide comprehensive medical coverage for a predetermined package of benefits. INO plans do not provide out-of-network coverage, except in emergencies. INO plans do not use primary care physicians (PCPs).

**LIMITATION:** A limit on the maximum amount payable for a specific benefit. For example a plan might limit the number of visits allowed for physical therapy or the dollar amount paid for durable medical equipment. The individual is then responsible for charges that exceed this maximum benefit.

**PHARMACY BENEFITS MANAGER (PBM):** A third-party administrator of a prescription drug program that manages the prescription drug benefits. A PBM develops and maintains the formulary list of prescription drugs. It also negotiates discounts with drug manufacturers and contracts with pharmacies. Typically, a PBM is contracted in conjunction with a health plan insurance carrier, a third-party administrator or directly with a self-funded plan. PBMs also can provide disease management programs that help control medical costs by providing incentives for patients to take prescribed medication for a particular condition.

**PREFERRED PROVIDER ORGANIZATION (PPO):** A group of hospitals and physicians that contract on a fee-for-service basis with insurance companies, third-party administrators or employers to provide comprehensive medical coverage. Using in-network providers and services allows more of an individual's costs to be covered by the plan because the provider charges are discounted and the plan pays a greater share of those reduced costs. An individual can go out-of-network for care, but usually at a higher cost. PPOs do not use primary care physicians (PCPs).

**REASONABLE AND CUSTOMARY FEES:** The average fee charged by a particular type of health care practitioner within a geographic area. The term is often used by medical plans as the maximum amount of money they will approve for a specific test or procedure. When out-of-network fees are higher than the approved amount, the individual receiving the service is responsible for paying the difference. Sometimes, however, if an individual questions his or her physician about the fee, the physician may reduce the charge to the amount the insurance company has defined as reasonable and customary.

**THIRD-PARTY ADMINISTRATOR (TPA):** An organization that is responsible for claims administration services of a self-insured group's benefits programs. In addition to claims administration, other services may include eligibility management, provider network management, medical management, claims review and claims processing. Unlike an insurance company, a TPA does not assume any risk associated with the programs.

# WHEN WILL I GET MY JULY 2005 RATES?

Paramount in everyone's mind is one burning question - "How much is this going to cost me?" Since most of us working on your benefits are enrolled in medical and dental plans, we're just as curious as you to know how much we'll have to pay. Truth is, though, we won't know the exact rates until we have a better idea of how much money the Colorado General Assembly will make available for next fiscal year's contribution to State employee benefits.

In addition, our actuarial experts must finish crunching the numbers based on current projections of risks and costs. Although we have a pretty good idea what the various plans will cost, it would be a real disservice to publish inaccurate rates and then change them a month from now.

We do know that the new rates will be higher than they are now, but not as high as they would have been had the State selected a fully insured proposal for our new plans. We cannot control the rising cost of health care nationally and no one should be surprised at paying higher rates. In addition, making better choices available to all employees statewide drives the group's costs up. Certain areas of the State have much higher costs. The approach we have taken uses the collective purchasing power and teamwork of the entire group to help mitigate the costs in those areas and make health care coverage more affordable for all. We're all in this together.

Unfortunately, we cannot provide the exact rates until much closer to open enrollment. When determining premiums, it is advantageous to set them as close to the end of the current plan year as possible. Premiums are determined by the utilization of the plans (how many people have had claims and the cost of those

claims) so the more we use real numbers from the existing plan year as opposed to projections, the better premiums could be. Otherwise, by calculating them too soon, a higher margin of utilization risk must be built into the premiums, to account for any potential claims - claims that ultimately may not occur.

Remember that while the Executive Director of DPA makes the recommendations on the employer's contribution, it is the General Assembly that approves that amount. If approved, it is typically done as part of a larger appropriations bill near the end of the legislative session.

Once the rates are set and we have a clearer idea of what the General Assembly will fund, we will provide the premiums along with the amount the State will contribute, giving you the final monthly cost you can expect to come out of your pay.

Please watch for upcoming issues of *HealthLine* for updates on premiums and the employer contribution.

**[www.colorado.gov/dpa/dhr](http://www.colorado.gov/dpa/dhr)**

**or call the Benefits Hotline at:**

**303-866-3434 or 1 800-719-3434**

**or email the DPA Benefits Unit at:**

**[benefits@state.co.us](mailto:benefits@state.co.us)**

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