MANAGEMENT BOARD SECRETARIAT

Employee Health Care Benefits

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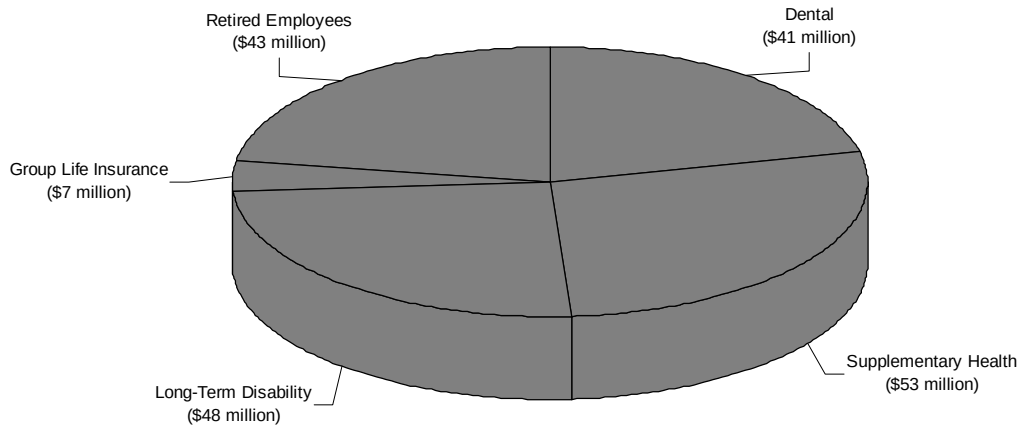
The Ontario government provides employee health care benefits for its employees and their eligible dependants similar to those of many other large private and public sector employers. These benefits fall under four main categories: supplementary health which covers expenses for such items as drugs and vision care; dental care; long-term disability protection; and group life insurance. Approximately 71,000 current employees are entitled to these benefits along with another 45,000 retired employees who qualify for all benefits except long-term disability. For the year ending July 31,1996, the reporting year of the insurance carriers (processors and payers of employee health care claims), the cost of providing these benefits was $192 million, as shown in the following chart.

Cost of Employer's Share of Health Care Benefits



Source: Management Board Secretariat

Similar to most employers who manage benefit programs for a large number of employees, the Ontario government is self-insured and uses insurance carriers to process and adjudicate employee benefit claims. This means that the government reimburses the insurance carriers for the actual benefit claims paid to employees and pays an administrative fee for their processing and adjudication services. The government currently divides the administration of its various benefit plans among three insurance carriers.

The Compensation Services Branch of Management Board Secretariat (MBS) is responsible for the management of the benefit plans. In addition, the Human Resources Systems Branch within MBS has certain administrative and systems responsibilities for the benefit plans.

OBJECTIVE AND SCOPE

Our audit objective was to assess whether the Secretariat had adequate systems and procedures in place to manage employee benefit plans with due regard for economy and in accordance with the terms of the plans.

As well as reviewing the practices used by MBS in managing its benefit plans, we performed audit work at two of the three insurance carriers which process claims on behalf of the government. We also conducted research into best practices and other initiatives being undertaken in the field of employee benefits management.

We met with benefits specialists from a number of large private and quasi-public sector organizations. Information on benefits management practices followed by three other provinces and the federal government was also obtained. In addition, we engaged the services of a benefits consulting firm to provide advice on selected issues.

This program had never been audited by the MBS Audit and Business Improvement Branch and had not been audited by our Office during the last 20 years.

OVERALL AUDIT OBSERVATIONS

From 1992 to 1996 the cost of providing health care benefits to current and retired employees and their eligible dependants increased from $143 million to $192 million or approximately 35% even though the number of eligible members excluding dependants has remained relatively stable. Our research indicated that during this period other large employers had also experienced similar significant increases in the cost of providing employee health care benefits and have recently initiated cost-containment measures to slow the rate of growth in benefit costs.

MBS has identified a number of possible cost-containment strategies during the past four years. One strategy that has been implemented is the recent retendering and renegotiation of insurance carrier contracts that is expected to save about $2 million annually. However, the other cost-containment strategies have not been implemented because of reduced staffing levels in the employee benefits area, limited systems capabilities and not reaching agreement on such proposals during collective bargaining. We acknowledge that some of these strategies will require negotiation with employee unions and believe that MBS needs to thoroughly research and analyze the various cost-containment options.

Our report outlines a number of other cost-containment initiatives that are not likely to require union ratification and that can result in significant savings and need to be more actively pursued. We acknowledge that the implementation of any such initiatives may require investment in additional resources. However, we believe that the potential payback will more than justify the

investment. MBS also needs to better monitor its insurance carriers to ensure that claims are being processed accurately.

DETAILED AUDIT OBSERVATIONS

COST-CONTAINMENT STRATEGIES

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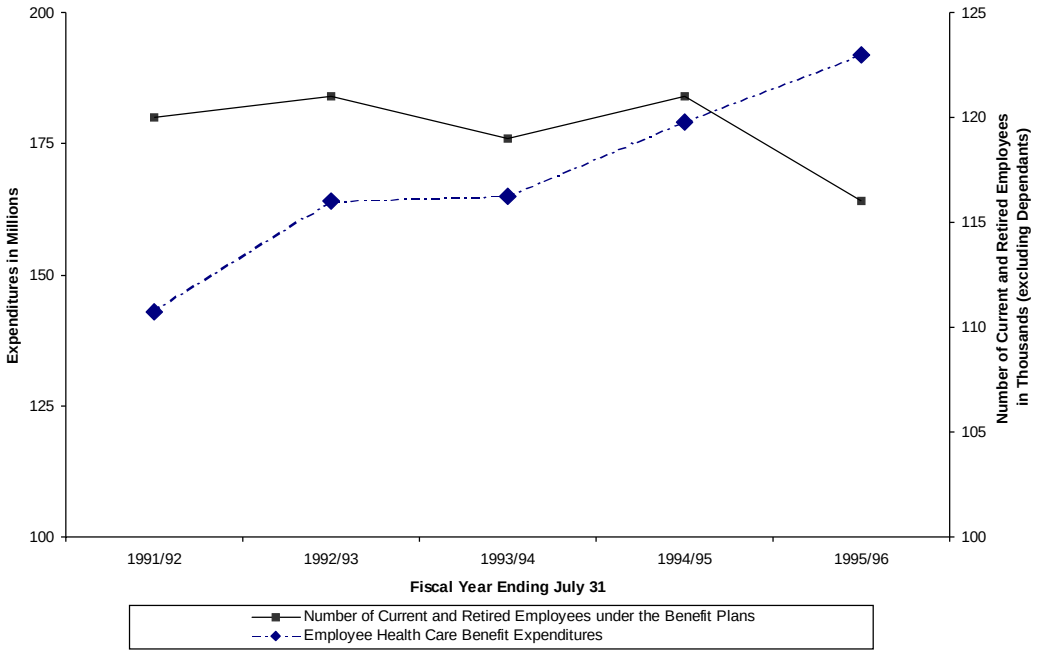
All plan members and their eligible dependants are entitled to partial reimbursement for supplementary health and dental costs incurred. For instance, 90% of the cost of drugs is reimbursed while 40% to 85% of most dental costs is reimbursed. Current employees are also eligible for long-term disability protection whereby they can receive two thirds of their gross salary if they become totally disabled. Under the group life insurance plan, when employees die, the designated beneficiaries are entitled to a benefit of up to one year's salary while the beneficiaries of retired employees are entitled to a $2,000 death benefit.

The cost of providing these benefits has increased from $143 million to $192 million or approximately 35% between 1992 and 1996. The following chart illustrates the annual growth in such benefits received by current and retired employees and their dependants since 1992.

Cost of Employee Health Care Benefits and Number of Eligible Employees



Source: Management Board Secretariat

However, the government is not alone in facing significant increases in employee health care costs. Our research, and the benefits consultant that we engaged, indicated that other large

employers had also experienced similar significant cost increases between 1992 and 1996. Based on our research and discussions with a number of organizations and our benefits consultant, it was apparent that most other large employers, including other provinces and the federal government, had recently implemented selected cost-containment strategies to control this rapid growth in benefit expenditures. For example, one province applied its provincial drug formulary and realized estimated savings of 8% to 10% of its drug costs. According to an MBS analysis, Ontario could save as much as $3.8 million annually by restricting eligible drugs to those covered by the Ontario Drug Benefit Plan.

While the Ontario government has been considering a number of cost-containment options, only the retendering and renegotiation of carrier contracts had been fully implemented. In researching the various cost-containment measures and best practices that are being used in employee benefits health care management, we noted there are essentially two types of cost-containment strategies. The first type of strategy requires negotiation with employee unions before being undertaken, whereas the second type can be likely initiated without union approval or negotiation.

Cost-containment strategies that require negotiation with employee unions are generally those that seek to reduce benefits or increase the employees' share of the cost of such benefits. Our research indicated that employers need to recognize that in the short-term restricting health care benefits may be effective in capping costs; however, any potential changes need to be analyzed to ensure that they will not adversely affect the long-term health and productivity of their employees.

The following examples represent cost-containment strategies that would require negotiation with the employee unions.

- Excluding coverage for over-the-counter (OTC) drugs — At present if these drugs have been prescribed by a doctor, they are reimbursable even though they can be purchased without a prescription. MBS estimated that the elimination of OTC drugs from the benefit plan would save approximately $2.6 million annually.
- Excluding benefits or reducing reimbursement levels — For example, reducing drug reimbursement from 90% to 75% or changing certain benefits from being eligible for coverage to being ineligible.
- Using a Preferred Provider Network — Negotiate a reduced drug dispensing fee and/or a maximum drug ingredient cost for widely used drugs with selected pharmacy chains. Employees would be encouraged to use these pharmacies, as only the reduced dispensing fee and/or maximum ingredient cost would be eligible for reimbursement.
- Requiring generic substitution — Brand name drugs would not be reimbursed if a generic substitution exists unless the prescription specifies "no substitution."

We noted that in July 1995 the Ministry prepared a paper on compensation within the Ontario Public Service that identified a number of containment measures. While the paper contained data on the projected savings of selected cost-containment strategies there was no documentation of the potential impact such changes could have on employees' health. MBS informed us that the potential impact of the proposed strategies was considered although it was not documented. MBS told us that some of these cost-containment measures were introduced at the bargaining table with the Ontario Public Service Employees Union (OPSEU) during negotia-

tions for a new contract in 1996, but they were not reflected in the resulting collective agreement.

Recommendation

To ensure that government decision-makers have appropriate information before the next round of union negotiations, the Management Board Secretariat, when updating its analysis of the financial impact of the various cost-containment options, should also document the effect such changes could have on the long-term health and productivity of their employees.

Ministry Response

Management Board Secretariat has traditionally analyzed costs and developed options for cost-saving/improvements in preparation for bargaining, and we will do so for the next round of bargaining in 1998. Appropriate staff resources will be committed to ensure analysis is comprehensive and complete and takes into consideration our new multiple bargaining agent environment.

The analysis will include impacts on employee health and productivity as has been past practice but this analysis will now be documented.

There are also a number of cost-containment strategies that focus on either reducing the demand for health care services or reducing costs by educating plan members to be smart consumers. Such measures lower costs without restricting the current level of benefits provided and therefore are not likely to require negotiation with employee unions. Examples of such cost-containment strategies are indicated below.

- Communication with employees — educate employees through benefit newsletters about the cost of benefits provided, changes in benefit plans and provide "smart shopper" health care advice.
- Positive enrolment — require employees to periodically confirm details of spousal insurance coverage and dependant eligibility information.
- Disability management procedures — more actively manage short-term and potential long-term disability situations.
- Competitive selection of carriers — periodically tender for carrier services to reduce administrative fees and enhance service levels provided by the carriers.
- Carrier performance agreements — ensure that carriers are contractually bound to pay claims accurately, meet performance standards and provide detailed information on claim costs.
- Carrier audits — periodically audit the carriers to assess whether claims are processed in accordance with the various plans.

MBS advised us that one reason only one of the above-noted cost-containment strategies had been fully implemented was because of the significant reduction in the number of staff manag-

ing employee benefits over the past six years. Specifically, the staff had been reduced from six employees to three. While we believe that MBS should more actively pursue these strategies, we acknowledge that, at least initially, additional investment in resources may be needed. However, we believe that there would be good payback from this investment.

Our specific observations and recommendations relating to the various cost-containment strategies that we believe warrant consideration by MBS are included in the remaining part of this report.

COMMUNICATION WITH EMPLOYEES

According to a recent survey conducted by Benefits Canada and a major benefits consulting firm, communication with employees was perceived as one of the most important cost-containment tools by the 203 responding organizations which, in total, had more than 570,000 employees. In addition, our benefits consultant advised us that employers are increasingly recognizing the importance of partnering with employees to reduce costs. The consultant indicated that communication with employees, especially in conjunction with other cost-containment strategies, can be an effective tool in educating employees about the need to work together to ensure the future affordability of the benefit plans, in motivating health care behavioural changes and in communicating plan changes.

Most of the organizations that we met with advised us that they are now regularly communicating with employees through periodic health care benefit newsletters which expressed two common themes. Firstly, employees were informed about the recent significant increases in the cost of providing health care benefits. Secondly, the newsletters stressed the need for the employees to help in controlling costs by being smart health care consumers. Included in these newsletters were the following examples:

- advising employees that the price of drug dispensing fees varied widely from $2 to $16 a prescription and providing a list of pharmacies with the lowest dispensing fees;
- explaining the significant savings that could result from substituting generic drugs for brand name drugs where acceptable to the health care provider; and
- including in each employee's newsletter, as one organization did, a statement of the annual cost of health claims paid on behalf of the employee.

As an example of the impact that increased communication with employees can have, our research indicated that one company had reduced the annual increase in its drug costs from 10% to 15% per year to less than 3% per year by providing its employees with information to give to their physicians and pharmacists regarding acceptable generic drug substitutions.

We noted that other than providing employees with notices of changes to their benefit premium rates, MBS had not provided any information to government employees in the past four years advising them of the recent significant increase in the cost of providing health care benefits, nor did MBS request their assistance in controlling costs by providing them with any information for making more cost-effective health care decisions.

Recommendation

To help control rapidly escalating health care benefit costs, the Management Board Secretariat should communicate the mutual benefits of making more cost-effective health care decisions and provide employees with information about becoming smart health care consumers.

Ministry Response

Management Board Secretariat is developing an overall benefits communication strategy based on the "smart shopper" approach to benefits. As a first step, Management Board Secretariat has begun a series of monthly benefit articles in* topical *[the government's employee newsletter] called "Focus on Benefits." The first article appeared in the April 25, 1997 issue. The series is aimed at the responsible use of benefits, the cost of benefits and basic benefit entitlements.

Other elements will include direct employee communication by way of pay inserts, as appropriate, and the intranet. To the extent possible, the strategy will rely on joint employer/employee group communication messages.

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POSITIVE ENROLMENT

When a new employee enrols in the various benefit plans, the only information that is provided to the carriers is whether or not the employee has family coverage. Information on eligible dependants is only entered into the carriers' claims system when the first claim for a particular dependant is submitted.

When claims relate to an employee's spouse, the employee should indicate on the claim form whether the spouse also has employer-provided benefits. If so, the spouse's employer is primarily responsible for paying the spouse's claims. When both spouses have coverage provided by their employers, claims for dependent children are primarily paid for by the employer of the spouse whose birthday comes first in the calendar year.

Accordingly, it is critical that the government's insurance carriers have reliable information regarding the employee's dependants and whether the spouse has other benefits coverage. Otherwise, the risk exists that employees could submit claims for their spouses and dependants that should have been submitted to their spouses' employers or may have already been paid for under their spouses' plans.

To minimize this risk, there is a recent increasing trend by employers to move to a system called positive enrolment. Under positive enrolment the employer periodically requests employees to provide information on dependants and the details of any spousal insurance coverage.

During our work at the two carriers, we reviewed a sample of 92 supplementary health and dental claims for costs incurred by either employees' spouses or their dependants. In 24% of the claims that we examined, the claimants did not complete that part of the claim form which asked whether a spouse had other benefits coverage, yet the claims were still processed by the carriers since the claimant had not previously indicated any spousal coverage. Consequently,

the risk existed that the government could have paid claims in cases where the spouse was employed and had coverage. Moreover, when dependent children's claims were included and the spouse's birth date was earlier in the year than the government employee, the risk also exists that the claims should have been paid primarily by the spouse's employer and not the government.

MBS informed us that both carriers process claims regardless of whether the question on spousal coverage is fully answered by the claimant. However, one carrier restricts processing in these circumstances to claims less than $200. The other carrier informed us that many of their other planholders do require the section of the claim form on spousal coverage to be completed or the claim would not be processed.

Our benefits consultant informed us that the related annual savings due to positive enrolment can be in the range of 2% to 8% of the supplementary health and dental costs. Based on current expenditure levels this could result in annual savings in the range of $1.9 million to $7.5 million excluding any system design and ongoing costs associated with the implementation of positive enrolment.

Additionally, two of the organizations that we met with had significantly fewer employees than the Ontario government and they informed us that they had recently implemented positive enrolment and had achieved significant savings or were expecting to do so. One organization estimated savings of $500,000 in the first year while the other expected savings of up to $2 million per year. Both organizations had advised their unions about the introduction of positive enrolment, even though their approval was not required.

We noted that MBS had never implemented positive enrolment. MBS indicated that after the installation of a corporate human resources information system is completed in 1998, positive enrolment will be more feasible and will be actively considered.

Recommendation

To help ensure that supplementary health and dental claims are only paid for eligible recipients, the Management Board Secretariat should implement positive enrolment, whereby employees are periodically required to provide detailed information regarding spousal insurance coverage and the eligibility of family members.

Ministry Response

Management Board Secretariat agrees that we need to be examining new ways of disciplining the cost of benefits. The government is currently preparing to implement a new corporate human resources information system and we agree that positive enrolment should be considered in putting this system in place across the Ontario Public Service.

A cost/benefit analysis will be undertaken to confirm the savings potential of positive enrolment as compared with the development and implementation costs to the employer.

MANAGEMENT OF LONG-TERM DISABILITY

The cost of long-term disability (LTD) claims has risen by approximately 40% from $34 million in 1992 to $48 million in 1996. Employees submitting proof that they have been totally disabled for more than six months are eligible to receive disability income protection benefits. The monthly benefit payment equals 66 2/3% of the employee's gross salary. For the first six months employees are off work, they are covered by the government's short-term sickness plan which provides six days at 100% pay and the balance at 75%.

Two carriers adjudicate and manage LTD claims for the government. Employees initially submit the required LTD application and medical documentation from their physicians directly to the carriers. Additional medical information is often requested by the carrier from the employee's physician and the employee may be required to undergo an independent medical examination. The carrier's medical experts review this information and either approve or deny the claim. If denied, the employee has the right to appeal the decision.

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Our research and discussions with other organizations as well as with our benefits consultant indicated that early intervention is critical in order to succeed in having employees return to work quickly. Such intervention reduces not only short-term absences of less than six months but also potential long-term disability claims. Studies have shown that only 10% to 15% of disabled employees off work for more than one year ever successfully return to work.

Although the government has been researching and piloting various options over the past two years, MBS has not yet implemented a coordinated early intervention program to assist employees at an early stage of their absence and thus reduce the likelihood of a long-term disability claim. MBS informed us that in the meantime individual ministries continue to manage their short-term sickness programs in varying ways, with medical documentation required for absences in excess of five consecutive days as per the terms of the collective agreement with OPSEU.

Several large organizations that had recently instituted early intervention programs informed us that they had contacted absent employees after as little time as a week to discuss the details of their absences and had asked what assistance they could offer. The organizations or their carriers could also request detailed medical and other information from the employee well in advance of when the employee was eligible to file a long-term disability claim. One organization advised us that their LTD management program had resulted in significantly reduced claims.

Rehabilitation such as physiotherapy is another area critical to assisting disabled employees to return to work. Our research and discussions with other organizations indicated that employees are normally required to participate in rehabilitation if a carrier has identified it as being necessary. However, MBS informed us that collective agreements with the bargaining agents do not require an employee to accept rehabilitation to receive long-term income protection benefits. Our review of a sample of LTD claims at the two carriers revealed that some claimants of one carrier had, at one point, declined to participate in rehabilitation programs. In these instances, the carrier continues to monitor and to assess the claimant's condition.

Recommendations

To help reduce short-term absences and identify potential long-term disability claims at an earlier stage, the Management Board Secretariat should implement an early intervention program.

Additionally, the Management Board Secretariat should endeavour to change its long-term disability plan to require disabled employees to participate in rehabilitation programs recommended by its carriers.

Ministry Response

The government agrees and is in the process of implementing an early intervention program across the Ontario Public Service. This is being done on the basis of a successful 1996 pilot project in the Ministry of the Solicitor General and Correctional Services that involved ministry managers and the insurance carriers.

Management Board Secretariat is aware of very recent initiatives by some employers to engage third party assistance at the earliest stages. We plan to compare the results of these initiatives with the results of our new corporate program.

At the same time, a review by Management Board Secretariat and the carriers of the steps to be taken before long-term insurance benefits are provided will assist ministries and claimants in facilitating an earlier return to work. This review will include access to rehabilitation programs and claimants' participation in such programs.

Requiring disabled employees to participate in rehabilitation programs recommended by carriers requires negotiated changes to the collective agreements with employee groups.

COMPETITIVE SELECTION OF CARRIERS

As the employee benefit plans are self-insured, the government reimburses its insurance carriers for the actual benefit claims paid to employees and also pays the carriers an administrative fee for claims processing and adjudication services. For the carriers' reporting year ended July 31, 1996, the government paid its three carriers administrative fees of approximately $6.5 million, which represented about 3.6% of the $179 million in benefits paid to employees, excluding administrative fees, premium taxes and interest.

For a number of years up to 1994, MBS had used the same insurance carriers to manage the various benefit plans. However, in 1995 MBS tendered the dental plan for unionized employees, and in 1996 all non-union plans were also tendered. All proposals were properly evaluated against predetermined criteria which included administrative costs, service levels and other key performance factors. In 1996 MBS entered into negotiations with its third carrier which administers all union plans except dental care. We were informed that MBS was successful in negotiating a significant reduction of the annual administrative fee paid to this carrier.

As a result of the recent retendering and renegotiation of the carrier contracts, the Ministry anticipates savings in the administrative fees paid to its three carriers of about $2 million annually.

CARRIER PERFORMANCE STANDARDS AGREEMENT

The first step after the completion of an insurance carrier tendering process is the negotiation of a contract with the successful carrier to define the components of the benefit plans, including eligibility criteria, as well as administrative fees. In many cases the next step is the negotiation of a performance standards agreement with the carrier. Such an agreement allows the employer to hold the carrier accountable for the administration of the plan and typically includes performance standards such as error ratios and claims processing turnaround times. Often financial rewards and penalties are included in the performance standards agreement to reward or penalize the carrier depending on the carrier's actual performance. Our research and discussions with other large private and public sector employers indicated that many organizations had negotiated performance standards agreements with their carriers.

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We reviewed the performance standards agreements that MBS has with its three carriers and made the following observations.

- At the time of our audit MBS was finalizing the contracts with the carrier which was awarded the contract in late 1996 to administer all non-union plans. We were informed that the Ministry plans to negotiate performance standards agreements with this carrier.
- MBS does not have performance standards agreements in place for either the carrier which was awarded the union dental care contract in mid-1995, or for the carrier that administers all union plans except dental. MBS advised us that it is in the process of negotiating such agreements with these other carriers.

We will follow up on MBS success in implementing performance standards agreements with its carriers.

MONITORING CARRIER CLAIMS PROCESSING ACTIVITIES

Given the fiduciary nature of insurance carriers, it is not unreasonable for employers to rely on their carriers to process claims in accordance with the terms of the benefit plans. Nevertheless, prudent employers also obtain assurance that their carriers process health care benefit claims accurately.

According to the benefits consultant we engaged, the only way to accurately assess whether a carrier is processing claims in accordance with the terms of the benefit plans is by auditing a sample of claims processed by the carrier. Our consultant also indicated that periodic audits help in determining whether carriers are adhering to the performance standards agreements. Additionally, our discussions with other organizations indicated that it is common practice to periodically conduct such audits. One of the organizations informed us that its carrier is audited because "it is our money they are spending." The three provinces that we contacted also indicated that they conduct audits or test-check carrier claims processing.

MBS had never audited a sample of claims at its carriers or evaluated the adequacy of claims processing controls to ensure that only valid claims were processed. MBS advised us that it relies on the carriers' internal auditors to ensure compliance with the contracts and also to receive some indication of the accuracy of the claims processing through employee complaints

of rejected claims. However, MBS had neither received any reports from the carriers' internal auditors nor any information from the carriers such as error ratios and statistics related to the coordination of benefits or the number of claims disallowed.

As MBS had never audited its carriers, we conducted some limited audit work at two of the three carriers. Although our audit did not include an assessment of the effectiveness of the carriers' rehabilitation departments or claim monitoring procedures, for a small sample of long-term disability (LTD) claims we checked the calculation of the disability payments and reviewed the carriers' ongoing monitoring of the claimants' disabilities. We also tested a small sample of supplementary health and dental claims.

As a result of the samples that we tested at the two carriers, we made the following observations.

- One carrier was ensuring that eligible claimants applied for Canada Pension Plan (CPP) disability benefits and was reducing the amount of LTD benefit payments accordingly. However, at the other carrier we found that 20% of the LTD claims examined appeared to be eligible for a CPP disability benefit payment, or a larger CPP benefit payment due to the birth of an additional dependant. In these cases CPP payments would reduce the amount of LTD benefit paid by the carrier on behalf of MBS. We estimated that the carrier may be able to recover on the government's behalf as much as $65,000 in CPP benefits relating to these claimants.
- When LTD claimants earn employment income from part-time work, the LTD benefits are to be reduced by such income. In 30% of the LTD files that we reviewed at one carrier, the claimant had earned income but the LTD benefits had not been reduced accordingly. We estimated that the carrier had overpaid these claimants by approximately $5,000.
- To ensure that claimants continue to be eligible for LTD benefits, the carriers are responsible for periodically requesting and reviewing updated medical information regarding the claimants' disabilities. We reviewed a sample of LTD claims and noted that the carriers were periodically requesting this information. We also noted that the rehabilitation needs of LTD claimants were being assessed by the carriers' rehabilitation departments.
- There is an inconsistency in the way that unsigned supplementary health and dental claim forms are handled by the two carriers. We noted that in 7% of these claims that we reviewed at one carrier, the claimant had not signed the claim form certifying that the information provided was correct. This carrier informed us that it processed unsigned claim forms as long as the total claim was under $200. At the other carrier, we found that all claim forms that we reviewed were signed by the claimants. This carrier returns all unsigned claim forms to the employees for signature because the absence of a signature on the claim form increases the likelihood of an ineligible claim.

Based on the results of the samples that we tested, we believe that periodic carrier audits will offer good payback including the identification of inconsistencies in claims processing. In our discussions with a number of organizations, we were informed that some of the organizations have their internal auditors conduct an audit of their carriers, while others engage benefits consulting firms to undertake audits on their behalf.

Recommendation

In order to assess whether the carriers are processing claims in accordance with the employee benefit plans, are adhering to performance standards agreements and are calculating long-term disability benefit payments accurately, the Management Board Secretariat should periodically obtain appropriate audit assurance.

Ministry Response

Management Board Secretariat will obtain periodic audits of the carriers and this is reflected in the Management Board Secretariat 1997/98 audit plan. The audit will ensure that claims are paid in accordance with the benefit plan provisions, including the calculation of long-term income protection benefits, and it will measure contract compliance against the standards set in the underwriting agreements.

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MEASURING AND REPORTING RESULTS

The Compensation Services Branch of MBS is responsible for overseeing the management of the health care benefit plans. The Branch informed us that its objective was "to administer the corporate benefits policy, to develop cost-effective benefits program options and to contract for the administration of benefits programs at 'best available in the market place' cost levels." However, this objective was not formally documented in any Branch, Division or corporate business plan or document.

The Branch had developed several mostly qualitative indicators for measuring the achievement of its objective. Having also more quantifiable indicators that demonstrate how cost effective the Branch is in managing health care benefit expenditures will be especially important if the Branch begins to evaluate and implement selected cost-containment strategies. These quantifiable indicators could include:

- the comparison of annual benefit costs per employee by plan perhaps compared against benchmark data from other provinces and large employers;
- the timeliness and accuracy of carrier claims processing, based on both the data provided by the carriers and the results of carrier audits if implemented; and
- the number of claimants on long-term disability broken down by the length of time on disability, for example, as less than two years or more than two years.

We also reviewed the MBS business plan and noted that the management of health care benefits expenditures was not included. As the cost of these benefits is approaching $200 million annually and is escalating at a rapid pace, an indicator tracking the overall rate of per capita growth could be used as a high level indicator in the MBS business plan.

Recommendation

The Management Board Secretariat should clearly define its objective relating to the management of employee health care benefit plans and identify appropriate performance indicators to measure and report on success in achieving the objective.

Ministry Response

Objective and quantifiable performance indicators related to the management of employee health care benefits will be developed and reflected in the next Human Resources Division business plan. As well, Management Board Secretariat will consider incorporating performance indicators in the Ministry Business Plan relating to employee health care benefits.

The activities associated with realizing these measures will be incorporated into the performance contracts of the senior managers accountable for benefits policy and programming.

Results reporting will occur through performance evaluation and reporting on the results of the Business Plan.