STATE OF NEW HAMPSHIRE
EMPLOYEE BENEFIT FUND

FINANCIAL AND COMPLIANCE
AUDIT REPORT
FOR THE FISCAL YEAR ENDED
JUNE 30, 2004

STATE OF NEW HAMPSHIRE
EMPLOYEE BENEFIT FUND

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STATE OF NEW HAMPSHIRE
EMPLOYEE BENEFIT FUND

Reporting Entity And Scope

The reporting entity and scope of this audit and audit report is the New Hampshire Employee Benefit Fund (the Fund) as of and for the fiscal year ended June 30, 2004. During this period, the Employee Benefit Fund primarily reported the nine months of operation of the State's self-funded employee and retiree health benefits plan and the twelve months of operation of the State's insured dental benefits plan. The health benefit plan covered employees, their spouses, and dependents and retirees and their spouses of New Hampshire State agencies and related organizations. Only active employees and their families are provided paid dental plan coverage.

The following report describes the financial activity reported in the Employee Benefit Fund, as it existed during the period under audit. Unless otherwise indicated, reference to the Department refers to the Department of Administrative Services, the State organization primarily responsible for the operations recorded and reported in the Fund. Reference to the administrator refers to the firm hired by the Department to administer the State's employee and retiree health benefits plan under an administrative services only plan agreement. Unless otherwise noted, the Department of Administrative Services provided the auditee responses, comments on observations, and action to be taken statements included in this report.

Organization And Responsibilities

The Employee Benefit Fund was created in fiscal year 2004 pursuant to RSA 21-I:30-d, which directed the Commissioner of the Department of Administrative Services to "implement a self-insured health plan for all State employees and their families and retired State employees and their spouses."

RSA 21-I:30 provides for a health benefits plan for State employees and retirees meeting certain criteria. Prior to October 1, 2003, the State had provided insured plans for its employees and retirees. RSA 21-I:30-d, effective July 1, 2003, mandated the Department to implement a self-funded plan for State employee and retiree health benefits. The plan, effective October 1, 2003 and administered by a contracted insurance company, included specific and aggregate reinsurance (stop loss) protection for the State. Specific stop loss insurance coverage capped State costs at $500,000 per employee per contract year and aggregate insurance coverage capped total State costs at 125% of the State's expected medical and pharmacy claims.

For the year ended June 30, 2004, the Department's administration of the medical and dental plans was centered in the Department's Bureau of Risk Management. Other functional areas of the Department assisted the Bureau in the financial reporting and other aspects of the plan.

At June 30, 2004, the Bureau of Risk Management employed four full-time classified employees, three of whom were primarily responsible for the operation of the State's health benefit plans, as well as their other responsibilities.

Funding

The Employee Benefit Fund, an internal service fund, was established by the Department of Administrative Services to clearly track and allow for the close analysis of the financial activity of the self-funded State employee and retiree health plan and to meet the requirements of RSA 21-I:30-c. This statute required the establishment of a nonlapsing reserve fund, administered by the Commissioner of the Department, to protect the State from unexpected losses incurred in the provision of a self-funded employee and retiree health benefit plan.

Expenses from the Fund include payments for medical services provided to covered employees, retirees, and dependents; dental insurance premiums; administrative costs; enrollment costs; and anciliary benefits such as health club memberships and health-related education classes. The contracted administrator receives, accumulates, and processes claims for services provided to covered employees, retirees, and dependents and the State provides funding for the payment checks produced and disbursed by the administrator.

Fund revenues include State agency contributions for active employees, retired judges, and constitutional officers; and State agency, State General Fund, and New Hampshire Retirement System (System) contributions for retired State employees. Contributions for employees and retirees of other participating employers and participant contributions from employees and retirees not meeting criteria for fully paid coverage and terminated employees allowed to extend coverage for limited periods under federal laws and regulations are also recorded as revenues to the Fund.

Active employee benefit costs are budgeted in the State's various agencies class 060 benefits accounts based upon an overall percentage of payroll. Agencies' benefits accounts are charged on the biweekly pay schedules at a contribution rate intended to cover all of the costs, including administrative costs, associated with the health benefits plan. Fiscal year 2005 contribution rates are also intended to be sufficient to build a statutorily required reserve. The contribution rates are based on the employee's coverage type, either health maintenance organization (HMO) or point of service (POS), and family composition. The contribution rates for retirees are based on either a POS or medicomp coverage plan, depending upon the retiree's age.

RSA 21-I:30-b directs that the State shall maintain a health benefits reserve at least equal to the sum of:

(a) An amount estimated to be necessary to pay claims and administrative costs for the assumed risk for 3 months; and
(b) The amount determined annually by a qualified actuary to be necessary to fund the unpaid portion of ultimate expected expenses for incurred but not reported claims, and related expenses incurred in the provision of benefits for eligible participants, less any credit, as determined by a qualified actuary, for excess or stop-loss insurance. The reserve amount shall be maintained in the fund established under RSA 21-I:30-c. If the State self-insures for more than one employee group plan, a reserve meeting the requirements of this paragraph must be maintained for each plan.

During fiscal year 2004, the Department established the contribution rates at the prior insured premium rates with the expectation that these rates would be sufficient to fund the plan until a

study of plan experience would provide sufficient data to establish rates that would allow funding of the statutory reserve.

The insured dental program also is accounted for in the Employee Benefit Fund. Contributions are deducted from agency benefits accounts in the biweekly payrolls at rates established to ensure appropriate funding of the insurance premiums for the provided dental benefits.

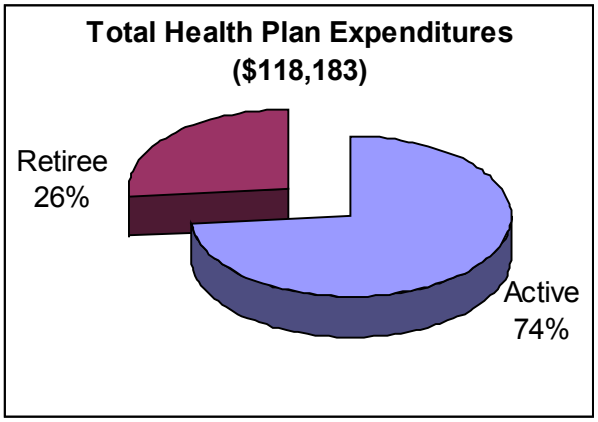
The following schedule summarizes the financial activity in the Employee Benefit Fund for the fiscal year ended June 30, 2004. (Amounts expressed in thousands.)

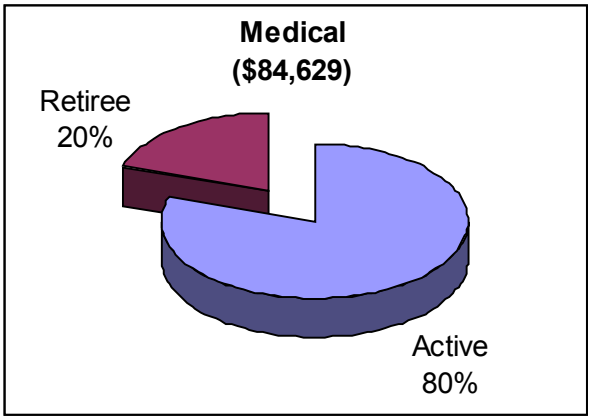
Operating Revenues	
Contributions For Health Benefits	
State Contributions	$ 102,094
Non-State Contributions	10,294
Total Contributions For Health Benefits	112,388
State Contributions For Dental Benefits	6,371
Total Operating Revenues	118,759
Operating Expenses	
Health Care Claims	118,183
Dental Insurance Premiums	6,364
Administration	5,681
Other	662
Total Operating Expenses	130,890
Operating Income (Loss)	(12,131)
Change In Net Assets	(12,131)
Net Assets - July 1, 2003	-0-
Net Assets (Deficit) - June 30, 2004	$ (12,131)

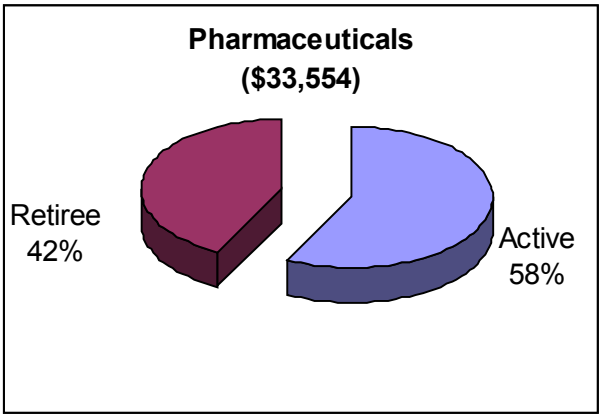
State of New Hampshire
Employee Benefit Fund

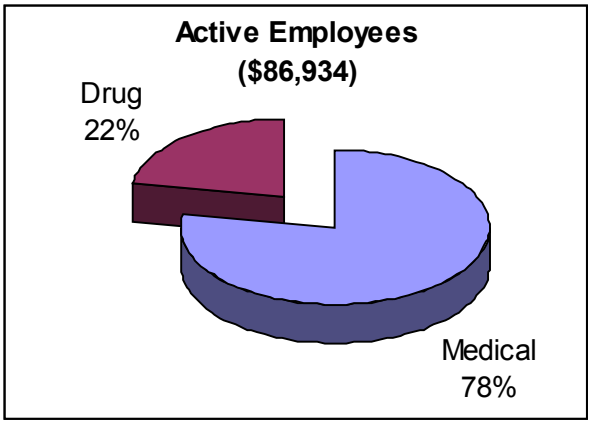
Health Plan Expenditures In Thousands
For The Year Ended June 30, 2004

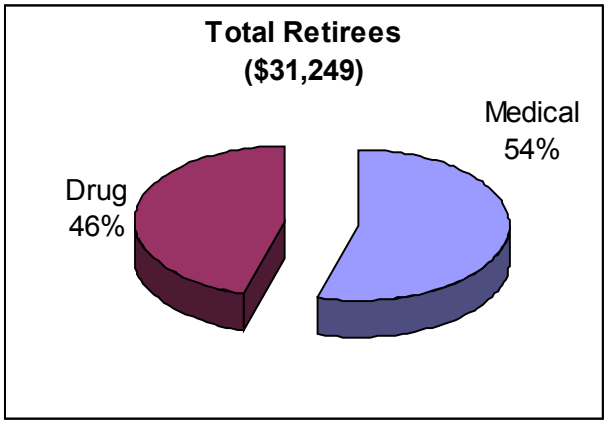
*** Active Employees Versus Retirees**
*** Medical Versus Pharmaceuticals**
*** Retirees Under Versus Age 65 And Over**

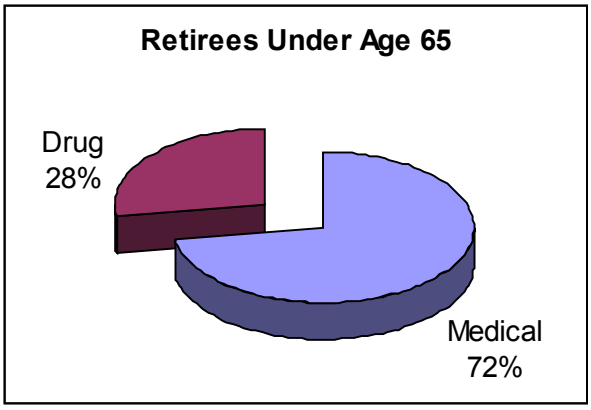


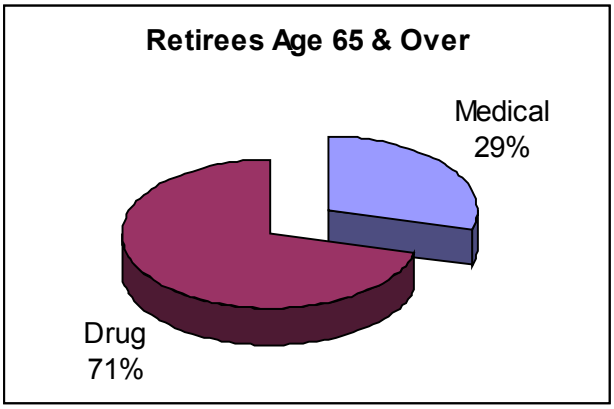






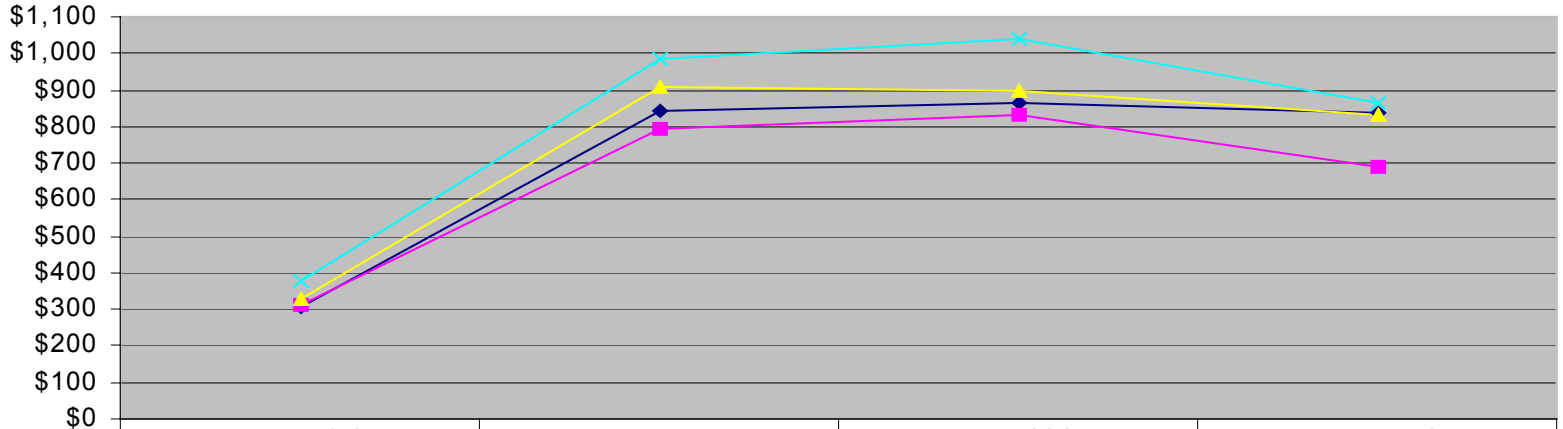






Source: Department of Administrative Services data.

State Of New Hampshire
Employee Benefit Fund
Fiscal Year 2004 And 2005: Average Monthly Health Costs Vs. Rates



	Retirees 65 & Over	Retirees Under 65	Active Point Of Service	Active HMO
FY 04 Costs	$308	$844	$863	$835
FY 04 Rates	$313	$792	$830	$692
FY 05 Costs	$329	$911	$896	$830
FY 05 Rates	$375	$983	$1,038	$866

Source: Department of Administrative Services data.
Monthly costs and rates are total costs and total contributions divided by number of subscribers.
FY 04 Costs: Average for the months of March - June 2004.
FY 05 Costs: Average for the months of July 2004 - March 2005.

Prior Audit

The Employee Benefit Fund was created in fiscal year 2004, and as such, there have been no prior audits of the Employee Benefit Fund.

Audit Objectives And Scope

The primary objective of our audit is to express an opinion on the fairness of the presentation of the financial statements of the Employee Benefit Fund as of and for the fiscal year ended June 30, 2004. As part of obtaining reasonable assurance about whether the financial statements are free of material misstatement, we considered the effectiveness of the internal controls in place affecting the Employee Benefit Fund and tested compliance with certain provisions of applicable State and federal laws, rules, regulations, contracts, and grant agreements related to the Employee Benefit Fund. Major accounts or areas subject to our examination included, but were not limited to, the following:

- Revenues and receivables,
- Expenditures and payables, and
- Cash.

Our reports on internal control over financial reporting and on compliance and other matters, and on management issues, the related observations and recommendations, our independent auditor's report, and the financial statements of the Employee Benefit Fund are contained in the report that follows.

Auditor's Report On Internal Control Over Financial Reporting And On Compliance And Other Matters

To The Fiscal Committee Of The General Court:

We have audited the accompanying financial statements of the Employee Benefit Fund of the State of New Hampshire as of and for the fiscal year ended June 30, 2004, as listed in the table of contents, and have issued our report thereon dated December 23, 2004. We conducted our audit in accordance with auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States.

Internal Control Over Financial Reporting

In planning and performing our audit, we considered the internal control over financial reporting of the Employee Benefit Fund in order to determine our auditing procedures for the purpose of expressing our opinion on the financial statements and not to provide an opinion on the internal control over financial reporting. However, we noted certain matters involving the internal control over financial reporting and its operation that we consider to be reportable conditions. Reportable conditions involve matters coming to our attention relating to significant deficiencies in the design or operation of the internal control over financial reporting that, in our judgment, could adversely affect the Employee Benefit Fund's ability to record, process, summarize, and report financial data consistent with the assertions of management in the financial statements. Reportable conditions are described in Observations No. 1 through No. 18 of this report.

A material weakness is a condition in which the design or operation of one or more of the internal control components does not reduce to a relatively low level the risk that misstatements caused by error or fraud in amounts that would be material in relation to the financial statements being audited may occur and not be detected within a timely period by employees in the normal course of performing their assigned functions. Our consideration of the internal control over financial reporting would not necessarily disclose all matters in the internal control that might be reportable conditions and, accordingly, would not necessarily disclose all reportable conditions that are also considered to be material weaknesses. However, of the reportable conditions noted above, we consider the matters described in Observation No. 1 to be a material weakness.

Compliance And Other Matters

As part of obtaining reasonable assurance about whether the Employee Benefit Fund's financial statements are free of material misstatement, we performed tests of its compliance with certain provisions of laws, rules, regulations, contracts, and grant agreements, noncompliance with which could have a direct and material effect on the determination of financial statement amounts. However, providing an opinion on compliance with those provisions was not an objective of our audit, and accordingly, we do not express such an opinion. The results of our tests disclosed no instances of noncompliance or other matters that are required to be reported under *Government Auditing Standards*.

This auditor's report on compliance and on internal control over financial reporting and other matters is intended solely for the information and use of the management of the Employee Benefit Fund and the Fiscal Committee of the General Court and is not intended to be and should not be used by anyone other than these specified parties.

Office Of Legislative Budget Assistant
Office Of Legislative Budget Assistant

December 23, 2004

Internal Control Comments
Material Weakness

Observation No. 1 : The State's Self-Funded Employee Health Benefits Program Was Not Effectively Administered During Fiscal Year 2004

Observation:

Insufficient resources were applied to effectively establish and administer the State's self-funded employee health benefits program during fiscal year 2004.

The Department of Administrative Services (Department), which was charged with establishing and operating a self-funded health benefits plan for the State's employees and retirees, either did not have or was otherwise unable to assign sufficient capable staff to efficiently and effectively take on this enormous responsibility in the timeframe provided for in State statute and within the State budget. As a result, the plan was poorly conceived, poorly executed, and its performance was poorly monitored during the fiscal year ended June 30, 2004.

The lack of necessary resources, including a sufficient number of trained employees with the ability and resources to obtain and understand relevant data, applied to the establishment and running of the plan resulted in a material weakness in the design and operation of controls. The plan operated in a condition where the Department could not be reasonably confident that material errors or misstatements that might occur would be detected within a timely period by employees in their normal course of performing their assigned functions.

Poorly Conceived
Insufficient resources applied prior to the enactment of the plan made it impossible for the Department to understand the full scope of operating a self-funded health benefits plan. The Department did not have a good grasp of the prior insured plan that had been in place for a number of years including the level and scope of services, the claims experience, and the cost of medical services provided under the prior insured plan. Also, the Department could not effectively obtain that information when it became necessary to understand what to expect under the State's self-funded plan. The lack of understanding, data, and resources necessary to gain and analyze the medical claims experience of the covered population of State employees, retirees and eligible dependents put the Department at a great disadvantage when it undertook the planning for the implementation of its self-funded plan.

Compounding the problems in effectively planning for the conversion to a self-funded plan was the fact that the existing plan design or plan coverage was not fully understood, yet was perceived as being an unalterable condition on the new plan. While the intention was to establish a plan that mirrored the coverage under the prior insured plan, because the Department had historically not actively monitored the coverage under its prior insurance contracts, when the prior insurance carriers provided coverage beyond the contracted coverage there was a defacto increase in plan coverage that was not necessarily understood and agreed to by the Department. As a result, the definitions of what were covered services under the self-funded plan became unclear.

Another compounding factor in the weakness in the initial planning of the conversion to a self-funded plan was the lack of clear establishment of responsibility for the planning. While elements of the Department were apparently responsible for these activities, the parties were arguably not directly answerable to the Commissioner and the Commissioner did not exert direct authority over them.

Perhaps the premier example of the insufficient planning prior to the implementation of the plan were the difficulties experienced in developing and issuing requests for proposals for a firm to administer the new self-funded plan. The lack of time and data and the inexperience and lack of effective Department oversight of assigned staff led to incomplete and confusing requests for proposals, requiring a re-issuance. As noted in the following section, contracts were not sufficiently detailed and structured to provide a clear understanding of the services to be provided, including the responsibilities of all contracting parties, or otherwise adequately address the expected scope of required services. In addition, State contracting requirements for one contract were not followed. The contract for providing administrative services to the plan was not sufficiently explicit to ensure that the costs of medical services charged to the State were advantageously structured for the State.

Poorly Executed

Insufficient resources were provided to properly administer the State's self-funded employee health benefits. Department employees assigned to administer the State's responsibilities under the plan were not experienced in the operations of health benefits plans, were not provided with access to additional resources to assist with the establishment of the plan, and arguably were overwhelmed with the responsibility.

The most critical early flaw in the Department's involvement in the plan's implementation was the lack of defined plan documents also known as summary plan descriptions (SPDs). An SPD describes the coverage provided by a plan, the methods of plan operation, and how covered members are to interact with the plan. The SPD is critical to the operation of the plan as it describes covered services, how costs are shared, and how members can establish and challenge service coverage decisions of the plan administrator. Generally, an SPD should be available to members immediately upon the enactment of a plan and should be kept current for any subsequent plan revisions.

When the State's self-funded plan was enacted on October 1, 2003, the Department did not have SPDs nor did it have the sufficient understanding of the plans it was responsible for to establish SPDs. While the firm contracted to administer the plan (administrator) requested the Department to provide SPDs soon after October 1, 2003, the Department directed the administrator to draft SPDs according to the administrator's understanding of the specifications of the prior insured plan. It was not until the early summer of 2004 that an SPD document agreed to by the State was in place. The lack of clear SPDs during the first six plus months of the plan's operation contributed to the situation where Department employees made coverage decisions in a near arbitrary manner. Department employees made decisions authorizing or denying coverage for certain medical procedures based on their understandings of whether coverage was provided by the prior insured plans. Because the insurance company administering the State's prior insurance-based plan may have provided some coverage in excess of the prior SPD document, confusion existed as to what services were provided in the prior plan and what should be covered under the new plan.

Many of these coverage decisions are evidenced in Department emails sent between covered employees, the Department, the contractor administrating the plan, and others. Many of these emails contain confidential information including patient names, medical conditions, and other identifiable information that should be held in a confidential manner to preserve patient confidentially and patient rights. In fact, the best documentation of the Department's operations of the self-funded plan exists in the Department's email files. These emails show the extent of the Department being overwhelmed by the responsibility.

Ultimately, the Department determined it lacked the expertise and could not continue to be involved in making plan coverage decisions for State employee, retirees, and their dependents. The Department withdrew from the plan's benefit/coverage decision-making structure and made the administrator fully responsible for essentially all steps of this function.

Poorly Monitored/Reviewed

Insufficient resources were applied by the Department to effectively monitor the operation of the plan. Direct human resources applied by the Department included a Benefits Administrator and three staff. These employees were also responsible for other State insurance activities, including managing the workers' compensation program and obtaining automobile and other insurance coverage for the State. Additionally, other Department employees including staff in the Division of Accounting Services assisted the Benefits Administrator with setting up the accounting procedures for the Employee Benefit Fund and processing and reporting revenue and expenditure transactions. However, there was no structure set up within the Department to provide effective monitoring and oversight of the plan operations. While some data from the administrator was available, the assigned employees did not have the expertise necessary to utilize the data effectively. The Department was reliant upon the administrator to run the program to the best benefit of the State even though the incentives of the administrator were not the same as the Department's.

The Department did take some effective steps toward monitoring the plan's activity. The Department periodically reviewed the account activity; however, the review did not include thorough account reconciliations. In addition, there were efforts to reconcile the enrolled participants in the active employee group between the State's payroll records and the enrollment agent records, however this effort did not also include reconciliation of the retiree group or agreement of the enrollment information to the records of the administrator. In fact, because the retiree group data was maintained outside the State's accounting system at the New Hampshire Retirement System and the Retirement System's records for this data were not available in a database format, there was very little that the Department could do to verify the status of the retiree enrollment data provided to the administrator.

Prior to the start of the audit in the early spring of 2004, the Department had not undertaken a review of the actual enrollment in the plan. Prior to a Department review of the covered groups requested by the auditors, the Department had allowed a small number of non-governmental groups to be covered by the plan. These groups had been covered for varying periods of time under the prior insured health benefits plan. While these groups contributed at the same rate as State departments and agencies for their members' coverage, the Department could not provide statutory or other authority for the continued coverage for some of these groups and could not demonstrate that the contributions from these groups covered the cost of services provided to their covered members.

The Department also did not have a full understanding of many significant provisions of its contract with the administrator including provisions relating to how to calculate the contract's stop-loss provisions, how to measure compliance with performance guarantees, whether the State should share in pharmaceutical rebates collected by the plan administrator, or even who was providing pharmaceutical services under the contract (whether it was the administrator or a subcontractor to the administrator.) In addition, at the start of the audit in the early spring of 2004, the Department apparently was unaware of certain statutory provisions including the requirement that the plan should cover University of New Hampshire (UNH) employees nor had it taken steps to ensure that an actuary would be available to calculate the funding status and establish the contribution rates of the plan as of June 30 as required by statute. Nor had the Department established with federal grantor agencies that federal assistance programs could participate in funding the 90-day reserve required by the statute.

In the course of discussion with the Department about the scope of the audit, the Department, agreeing that up to that point there had been only limited Department monitoring of plan expenditures, concurred that it would be appropriate to have a claims audit of the plan. The Department issued a contract to obtain a claims audit, actuarial work, and plan administration assistance, which was performed for the fiscal year ended June 30, 2004. The Department also received approval from the Fiscal Committee of the General Court at its June 2004 meeting to allow the Department to exclude the UNH employees from coverage.

Recommendation:

1. The Department must assign sufficient, suitably trained staff organized in a clear and well-designed structure to administer the State's employee health benefits plan. As one of the largest programs in the State organization, sufficient resources must be allocated to the administration of the plan to ensure that well-designed controls can be established to provide for reasonable assurance of protecting the State's interests.

2. The Department must take an active role in the administration of the plan. The Department cannot delegate its responsibilities to contracted administrators with divergent incentives and expect that the State's interests will be protected.

3. The Department must undertake efforts to gather and analyze relevant plan data to understand and report plan utilization and detect opportunities to effect savings in the plan.

4. The Department must increase communications with the New Hampshire Retirement System to ensure the System is providing accurate information related to the enrollment and status of covered retirees. The Department should develop procedures to periodically monitor and test the reliability of the information provided by the System.

5. The Department must increase its contract monitoring efforts to ensure that its service providers are working to the benefit of the State's operations. The Department must require contractors to perform agreed upon activity reviews and report the results of the reviews in a timely manner to the Department.

6. The Department must establish appropriate Health Insurance Portability and Accountability Act (HIPAA) privacy rules to ensure health information about employees and family

members is not used for purposes other than health care. There are a number of requirements placed on covered organizations by HIPAA including establishing business associate agreements, policies and procedures relating to the use, disclosure and access to medical information of employees and family members, the establishment of a privacy official and a contact person.

7. The Department should review the statutes requiring the establishment of a 90-day reserve in addition to an amount for claims that have been incurred but not reported at the fiscal year end. The Department should establish whether federal granting agencies will participate in accumulating a reserve in the amount required by the statute.

Auditee Response:

We concur in part.
Insufficient resources (one new position) were appropriated to the Department to administer the self-funded employee health program, which is approximately a $175 million program. The Department was statutorily required to implement the program with an unrealistic time frame to properly plan for the transition from a fully insured plan to a self-insured environment. The Department concurs with the recommendations, but the legislature must realize that we will only be able to implement them if we receive the requested funding for three new positions in the FY 2006/2007 biennial budget.

Due to the tight time frame, we needed to prioritize our workflow and focused our initial efforts on making sure our members were properly serviced and that member disruption was kept to a minimum. The retirees health insurance program was particularly challenging since this group has always been with Anthem / Blue Cross and the switch to a self-insured environment with a new carrier heightened concerns for this sensitive group. Therefore, some of the desired control functions were delayed until we could ensure that the critical services to our members were being delivered.

When the program was implemented, we needed to resolve a range of issues including whether very specific services that were covered by the previous carrier should still be covered by the State. These coverage issues needed to be resolved before the summary plan descriptions (SPDs) could be finalized. The SPDs are very detailed and the Department went to great lengths to verify the accuracy of these documents. This process took longer than what was originally assumed.

The accounting model that we developed has proved to be very effective and we have been able to generate financial reports for management purposes in a timely manner. The payroll processes we implemented by moving to self-billed environment and transmitting the data to our carriers through Choicelinx, has not only eliminated overcharges but has resulted in tremendous savings of time and paperwork at the agency level. In order to perform the accounting, the work was spread over seven staff members and an Accounting and Procedures Guide was developed. Due to the initial priorities, reconciliations were delayed but were current by year-end.

Membership enrollment reconciliation for a group of 35,000 members on an individual basis has been an ongoing challenge and the Department with the assistance of Choicelinx has improved the process each time. Our next quarterly reconciliation is scheduled for June 1, 2005. Through

the enrollment process, we have identified individuals that should not be covered and we have pursued reversing the charges by our administrator.

We are exploring options with Retirement how best to accomplish this control function. We have not successfully reconciled with Retirement to Cigna on a member-by-member basis.

For the other various participating groups, the Department has reviewed these on a case-by-case basis and has terminated coverage for some groups previously covered.

While the Department did not receive the appropriate level of funding, I am proud of the way my staff took on these duties in a professional manner. While the comment is correct that the specific skill sets were not in place at the time of implementation, our employees collectively pooled their varied insurance, technical and business experiences to manage this program as best as we possibly could. By taking control of our data; automating our business rules; and increasing the transparency of the program, we have been able to eliminate many of the problems that have plagued our insurance program for years.

Internal Control Comments
Other Reportable Conditions

Observation No. 2: Greater Understanding Of Contracted Operations Is Needed

Observation:

The Department during fiscal year 2004 did not sufficiently understand the scope of operations of its contracted administrator to allow for a reasonable review and oversight of the operation of its health benefits plan.

The contract between the Department and the administrator allowed the administrator to assign or subcontract specific obligations pursuant to the contract with prior written notice of such subcontracting/assignment.

The administrator apparently assigned the pharmaceutical obligations under the contract to a pharmacy benefits manager (PBM). While the name of the PBM (a short, nondescript name) was used in naming the drug utilization reports that would be available under the contract with the administrator, based on discussions with Department personnel, there was no understanding that the pharmaceutical obligations under the contract would be performed by anyone other than the administrator.

Because the Department did not constructively know that the pharmaceutical obligations had been assigned, it could not properly consider what effect that fact could have on its controls over the plan including what, if any, additional risks it faced and what additional controls should be applied to mitigate those risks.

A primary risk that the assignment raised was the risk that the eligibility files used by the PBM to determine eligibility for payment of pharmaceutical benefits would not be, and remain, accurate. Generally, a periodic reconciliation of data is used as a control to ensure that parallel systems contain consistent information. Because the Department was unaware of the existence and activity of the PBM during fiscal year 2004, it did not consider the need to require the administrator to document the accuracy of the PBM eligibility data.

The first reconciliation of the administrator and PBM eligibility files occurred during December 2004. The reconciliation performed by the Department was a simple record count comparison, which indicated that, as of the date of the reconciliation, there was a net of 82 additional records in the PBM's file when compared to the administrator's file. The majority of the additional records in the PBM file were reported to be "dummy records" used in data loading procedures.

Our further review of the data indicated inconsistencies in additional data records.

- 26 duplicate records were identified in the PBM's dataset.
- 134 duplicate records were identified in the administrator's dataset.
- 34 records in PBM's dataset did not match any of the administrator's data.
- 6 records in the administrator's dataset did not match any of the PBM's data.

Information on the records noted above was provided to the Department who requested an explanation of the variance from the administrator.

Recommendation:

The Department must gain a better understanding of the scope of operations of the health benefits plan by becoming more involved in the controls of the plan and taking appropriate steps to mitigate risks faced in the plan. The Department must also establish a staffing structure with sufficient knowledge and resources to appropriately oversee and control the activity in the health benefits plan. The Department cannot rely upon its contractor to operate the plan in the best interest of the State; therefore, it must continually review the operation of the plan to ensure that the State's interests are protected. Information provided by the administrator on the plan's operation should be reviewed and periodically verified and risks faced by the State in the operation of the plan should be identified and responded to. Reconciliations and other control procedures should be regularly performed and the results reviewed by management for evidence of problems in the plan.

Auditee Response:

We concur.
Although not prohibited by terms of the contract, the plan administrator did not notify the State of all third party relationships. With limited staff and a new self-insured health program that continues to evolve, the Department has requested three additional positions in the budget process. The Department is firmly committed to develop and address issues of the audit and other, as staffing resources will allow.

Observation No. 3: Summary Plan Descriptions Must Be Current

Observation:

On October 1, 2003 the State transitioned from a fully insured employee health benefits plan to a self-funded health benefits plan with a third-party administrator for retired and active State employees and their dependents. As of May 26, 2004, Summary Plan Descriptions (SPDs) for the State's health plan had not been finalized.

Common industry practice for health benefits plans dictates the development of appropriate SPDs for all covered groups no later than the implementation date of a health benefits plan. The SPD is a summary of the plan and describes how the plan is structured, what services are covered, and how a covered individual can interact with the plan. Common SPD disclosures include:

- How a covered individual becomes eligible for benefits,
- When a dependent is eligible for coverage,
- What benefits are provided by the plan,
- How the plan pays claims,
- Limitations and exclusions of the plan,

- What respective financial responsibilities are,
- How claims are to be filed, and
- The process for appealing a denied claim.

The State operated its health benefits plan for over eight months without a finalized SPD. According to email documents, at the inception of the plan, the administrator was asked to prepare an SPD based on its understanding of what the State's prior plan had provided. The administrator provided draft SPDs on November 26, 2003 with the request that the State review the documents as soon as possible in order for the administrator to administer the State's health plan. The administrator stated it would administer the State's plan based on the draft documents until the Department provided them with finalized SPDs.

However, the Department's review of the draft SPDs was delayed for over two months as the Department was under the mistaken impression that the draft documents had been forwarded to the Department of Justice (DOJ) for its review. In late January, it was determined that the documents had not been forwarded and the Department requested an additional copy of the documents from the administrator. On January 30, 2004, the Department forwarded the documents to the DOJ, which confirmed that it had not previously received the documents. Poor communication at the Department level resulted in a two month delay of the State's review of draft SPDs sent to them by the administrator in November of 2003.

The apparent review of the SPDs began at the end of January of 2004. Per the Department, in April of 2004 a health plan comparison table was sent to the administrator outlining changes the Department wanted the administrator to make to the SPD. The Department indicated that it was the administrator's responsibility, not the Department's, for making changes to the SPDs, as well as including mandates for coverage contained in State and federal law. The Department also reported it was determined the finalized SPD did not need to be reviewed by the DOJ.

Recommendation:

The Department must develop and implement a formal review process for the SPD to ensure the plan the Department intends to provide is the plan that is administered and the SPDs remain current and relevant to the State's plan, structure, experience, and needs.

The Department must also establish policies and procedures to regularly review the SPDs to ensure that the benefits outlined in the SPDs are those the State wants covered based upon careful analysis of claim experience, contract negotiations, etc. The Department must also monitor the administrator's, service providers', and members' compliance with the plan.

Auditee Response:

We concur.
Although the Summary Plan Descriptions (SPDs) were not finalized immediately, the plan administrator prepared and drafted SPDs shortly after the contract was awarded, and the State operated under the information contained in these documents.

When the Department implemented the self-funded health benefit program, we began a detailed analysis and review process to ensure that all services covered by the previous carrier would still be administered in the same way under the self-funded program managed by the Department. The review process included a thorough examination of the draft SPDs to verify the accuracy of these documents. Due to lack of staffing within the Department, this process took longer than anticipated. The Department recognizes the importance of establishing policies and procedures to review SPDs and is currently developing relevant business practices associated with this process.

Observation No. 4: Organization Structure And Policies And Procedures Should Be Established For Department Involvement In Claims Coverage Determinations

Observation:

The Department, during fiscal year 2004, did not establish the required policies and procedures, including appointing responsible delegates, to adjudicate claims coverage determinations brought to the Department by its administrator and covered members of the plan.

The draft Summary Plan Description (SPD) utilized at the inception of the plan described a multi-stage appeals process for claims denied for payment. The second level of the appeals process involved the Department determining whether a claim initially rejected by the administrator should be paid as a covered service.

During fiscal year 2004, the Commissioner, the Risk and Benefits Administrator, and the former Director of Personnel each, on different occasions, were involved in deciding whether to approve or deny coverage of medical claims in response to inquiries and complaints received from covered participants and service providers. Emails documenting discussions relating to these decisions, which mostly arose early in the transition period from the fully insured to a self-funded plan, illustrate that the decisions were not subject to any formal review process but were essentially made in an ad hoc manner. These Department employees approved or denied plan coverage for procedures such as gastric by-pass surgeries and pharmaceutical-related coverages such as methadone treatments and vaccination administrations without first establishing policies and procedures to provide guidelines for the determination process. As noted in Observation No. 8, often these decisions were documented in emails sent between various parties that unnecessarily contained identifiable patient information, contrary to federal patient privacy (HIPAA) guidelines.

These Department employees decided what claims should or should not be covered under the State's health benefits plan based on their understanding of plan coverage. The understanding of the plan's coverage was greatly hampered by the lack of a comprehensive SPD at the inception of the plan as noted in Observation No. 3. The manner in which coverage questions were resolved during the first months of the plan caused problems for the plan administrator. Emails indicate that in one instance there was disagreement among Department employees that resulted in two separate and conflicting decisions being provided to the administrator on how one specific claim should be handled. In another instance, the administrator received direction from the Department to cover a member's denied claim but the administrator did not follow the direction and maintained the denial. The administrator suggested this claim should be referred to the outside appeals process, normally the next level of appeals in an insured plan. This ultimately

resulted in a letter from the State Employee's Association asking the Department how the administrator could refuse to cover a claim under a self-funded health plan when directed by the Department, and demanded that the plan pay the claim pending resolution of the issue. Emails also indicated that in one instance, the administrator authorized coverage of a claim without receiving prior approval from the Department and stated they would sort out the policy going forward.

As the year progressed, Department officials reportedly grew more uncomfortable in making claims decisions, due to their self-perceived lack of expertise, and removed the Department from the resolution process. All claims were referred back to the administrator for final determinations. However, the SPDs indicate the State has decision authority for second-level appeals. By allowing the administrator to make all payment coverage determinations, including adjudicating appeals, the Department has simply removed itself from the decision process. It has not eliminated the State's and participants' need for accurate, consistent, and compassionate decisions to be made.

Recommendation:

The Department must develop the organizational structure and policies and procedures to allow it to ensure that decisions made to cover or deny payment on claims are made in a consistent manner and as intended by the State's health benefits plan. These policies and procedures must include a clearly defined appeals process, which allows for proper Department representation in the process. The appeals process must be accurately detailed in the SPD.

Auditee Response:

We concur.
Due to lack of trained staff and expertise, the Department has assigned the duty to adjudicate claims to the plan's administrative service organization. This assignment is an acceptable departure from the initial Summary Plan Description (SPD) under the former fully insured plan.

The bureau will detail these changes to the appeals process in the anticipated and revised SPD effective with the new contract at July 1, 2005.

Observation No. 5: Changes To Plan Contracts Should Be Subject To A Formal Review And Approval Process

Observation:

The State's Dental Plan design was changed during fiscal year 2004 via a Memorandum of Agreement between the Department and the vendor and adjusted the covered ages for dependent eligibility from birth to 23 to age two to 25 years.

The Memorandum of Agreement was executed to formalize a change to the plan made by the Department to bring the age criteria for coverage for dependent dental services in line with coverage for dependent medical services. The change, in addition to bringing similarity in dependent coverage for both medical and dental benefits, also recognized that children under the

age of two use very little dental services and coverage for dependent ages 23 though 25 would be a much more practical benefit of the plan.

The Department did not provide documentation to evidence that the effects of the change in the plan coverage were analyzed prior to the change being made or that the change was formally approved at the appropriate levels of authority prior to the change being implemented. Based on review of the available records, the Memorandum of Agreement appears to have been executed after the change had been put into place.

Recommendation:

Changes to the State's health benefits plan design should be subject to a formal review and approval process. The process should include documenting why the change is appropriate, the benefit the State will realize from the change, and any cost savings or additional costs that will be realized from the change.

All significant plan changes affecting plan coverage should be formalized through an amendment to the contract prior to affecting the change. All changes that significantly affect the plan and affect overall plan benefit levels should be brought before the Governor and Council for approval.

Auditee Response:

We concur in part.
We concur that the change made to the dental plan was not formalized through an amendment to the dental contract prior to affecting the change.

Instead, a Memorandum of Agreement was executed between the State and the State Employee's Association to formalize the plan change. This change was implemented by the Department in an effort to align the dental plan with industry standards for eligibility and was not perceived to be a change that significantly affected the overall plan benefit levels. For this reason, a formal amendment to the dental contract was not made.

The Department concurs that health benefit plan design changes should be subject to a formal review and approval process. However, this process is already in place because dental and other benefits are subject to collective bargaining and plan design changes must be negotiated with the union. As part of the collective bargaining process, both parties analyze plan design changes and identify any cost savings or additional cost. The funding for all plan design changes negotiated as part of the Collective Bargaining Agreement is appropriated by the legislature after a public hearing before the Joint Committee on Employee Relations. Health benefit plan design changes are then incorporated into existing health benefits contracts through contract amendments and are brought before the Governor and Council for approval.

Observation No. 6: Controls Must Be Established For The Reconciliation Of The Disbursement Account

Observation:

The Department did not have sound controls in place over the reconciliation of the benefits fund disbursement account during fiscal year 2004. The lack of policies and procedures and compliance with existing policies and procedures resulted in a situation where the reconciliations could not be regarded as an effective control to ensure that financial activity recorded in the account accurately reflected the financial activity of the plan.

The Department processed approximately $103 million of manual warrants to fund provider payment checks issued by the plan administrator during the nine months the plan operated in fiscal year 2004. The Department prepared the manual warrants based on the check registers provided by the plan administrator supporting the checks issued to pay medical service providers. The funds drawn by the manual warrants were deposited into a local bank account to pay the checks when presented by the banks.

The Department's process outline indicates that a Department employee is to periodically reconcile the bank account with the reconciliation to be reviewed and approved by a second, supervisory person. In practice, during fiscal year 2004 the reconciliations were prepared by the supervisory employee and were not subject to a review and approval control. The lack of an independent review and approval control contributed to the condition where the reconciliations were not consistently and thoroughly performed and also were not prepared in a timely manner. The deficiencies in the reconciliation process hampered the timely detection and resolution of differences including corrections of errors noted by the reconciliations.

Deficiencies noted included:

- A $606.44 refund was reported on the November 2003 bank statement and a $12,759 refund was reported on March 2004 bank statements; however corresponding adjustments were never recorded in the State's accounting records.
- Although the Department developed basic procedures for performing the reconciliations, the procedures only list the reports used for reconciliations in general, not detailed steps required to reconcile the bank statement (i.e., procedure states: "Obtain Bank Statement, Proof of Outstanding Report, Recap of Posted Items and prove to [Self Insurance Fund].") The actual process and reports used in the monthly reconciliations differ from the written procedures. Reports used in the reconciliations are not consistently attached to the reconciliations requiring the reports to be reprinted if the reconciliations are subsequently reviewed. While reviewing the monthly reconciliations, we noted the same reports were not always attached to the monthly reconciliations.
- As noted in the table below, the account reconciliations were not consistently prepared on a timely basis during fiscal year 2004. Generally, account statements should be reconciled in the month following the statement month.

Statement Month	Date Reconciled
October 2003	February 21, 2004
November 2003	February 21, 2004
December 2003	March 10, 2004
January 2004	April 4, 2004
February 2004	April 11, 2004
March 2004	April 11, 2004
April 2004	June 29, 2004
May 2004	June 29, 2004
June 2004	

The Department's experience with the reconciliation process during fiscal year 2004 indicates that the Department was in a reactive rather than a proactive mode with regard to its review of disbursement activity. The Department did not implement its original control of having a supervisory review of the reconciliation of the account activity, the reconciliations performed by the Department changed over the course of the fiscal year in response to unanticipated items appearing on the account statements, and the reconciliations were not performed timely. Each of these conditions indicates that the reconciliation process was not adequately planned or supported.

Recommendation:

The Department must establish and implement appropriate controls over its disbursement account including comprehensive policies and procedures for the timely and complete reconciliation of the activity reported in the account.

Department employees responsible for the reconciliation of the accounts should be trained in the account reconciliation process to ensure that the reconciliations are competently performed. Adequate resources must be applied to ensure the timely reconciliation of the account and an adequate segregation of responsibilities including an independent supervisory review and approval process. Procedures should be adequately detailed to promote the consistent preparation of the reconciliations and require the acquisition and retention of documentation supporting significant reconciling items.

Auditee Response:

We concur.
With the limited staff available, there was one person responsible for the payments and reconciliation of the disbursement account. The Department recognizes the importance of establishing written procedures and enhancing internal controls, but with the limitations placed on the staff our priority was to process the required payments. We have requested additional staff in the current budget to aid in the operations of the self-insured health program.

Observation No. 7: Formal Risk Assessment Policies And Procedures Should Be Established For The Operation Of The Health Benefits Plan

Observation:

As described by a Department employee, given the relatively small allocation of staff and short period of time to implement the State's transition to a self-funded employee health benefits plan, the Department operated in a reactive rather than proactive management mode.

The Department's Bureau of Risk Management, operating with a Risk and Benefits Administrator and three employees, became primarily responsible for overseeing the operation of the self-funded health and workers compensation benefits, the fully insured dental contract, as well as other functions related to obtaining insurance coverage for State operations. While the Bureau had additional assistance from the Divisions of Personnel and Accounting Services, the Department never provided a clear structure for the Department's management of the plan nor provided sufficient resources to give the responsible parties the ability to adequately review operations and design procedures to identify and respond to the risks faced in the operation of the plan.

Management's assessment of risk facing the organization is an integral component of internal control. The purpose of an entity's risk assessment is to identify, analyze, and, where appropriate, respond to risk and thereby manage risks that could affect the entity's ability to reach its objectives. Effective risk assessment practices should be a core element of management's planning activities and should be an ongoing activity.

As noted in several observations, during fiscal year 2004 the Department operated without a clearly defined and adequately staffed organizational structure and policies and procedures to ensure the plan operates in an efficient and effective manner. Because these controls were not present, the Department relied upon the contracted administrator and others to operate the plan in the best interests of the State, even though the plan design did not correlate the State's incentives to the service providers' incentives. The Department's resources allocated to the plan were so consumed with keeping the plan running, they operated in a reactive manner unable to anticipate and react to risks and opportunities facing the plan. By not identifying and managing risk, the State allowed the operation of its self-funded health benefits plan to be ripe for the risk of error, fraud, waste, and abuse that might have been anticipated and mitigated, if not prevented, with a properly implemented risk assessment plan.

Recommendation:

The Department needs to conduct a risk assessment of the health, workers compensation, and dental insurance plans. Given the relatively small size of the Bureau, it is imperative that management recognizes risks and implements strategies to mitigate significant risk. This will enhance the effectiveness of the Bureau and help reduce the risk of the occurrence of fraud, waste, and abuse related to the States' insurance plans.

Auditee Response:

We concur in part.
We recognize the need to adopt a formal comprehensive risk assessment policies and procedures for the benefit plans administered by the Department. As resources are limited the Department researched the possibilities of seeking the services of outside consultants to perform a Department wide risk assessment. However, preliminary research indicates that the costs of obtaining such services are prohibitive (approximately $250,000). As a result, the Department's Internal Audit Unit has begun to research and gather resource materials in an attempt to develop a reasonable Department–wide risk assessment plan that will include the self- insurance fund.

We do not concur with the notion that the operation of the self-funded health benefits plan was *ripe* for the risk of fraud, waste, and abuse. The Bureau of Risk Management was already aware of and in many cases was able to anticipate risks and general procedural deficiencies that needed to be addressed, but was unable to make the necessary changes in a timely manner since the Bureau was in the midst of a radical change in the administration, communication, funding and State oversight of medical benefits to approximately 18,000 members including approximately 7,500 retiree population who were never serviced by any vendor other than our previous insurance carrier and were difficult to communicate with due to the transient nature of this group in the winter months. There were many obstacles that prevented quick, corrective action, some of which included a lack of resources and funding to draw from to support needed actions, the added responsibilities of servicing the retiree population as it related to health coverage, the many layers of leadership and public interest in the process and outcome that had to be continually responded to before any action could be approved or taken and staff time consumed in responding to the on going audit of the program. Despite these limitations, the Department was actively involved in monitoring the program operations including frequent and regular communications with the plan administrator via telephone and personal meetings on a range of issues, periodic management review and analysis of financial reports, reconciliations of member databases between the State's payroll system, plan administrator and the enrollment vendor to ensure that only eligible employees received health benefits. Recognizing the need to further monitor the program and to ensure the State's compliance with statutory requirements, the Department also hired an independent consultant to perform actuarial, claims audit and consulting services for the term of the Plan Administrator's contract.

It should be noted that the independent claims audit conducted by the consultant and the Legislative Budget Assistant's financial audit of the Employee Benefit Fund did not disclose any known instances of fraud or abuse.

The Department will continue to monitor the program for effectiveness and will strive to continuously improve the program operations.

Observation No. 8: HIPAA Compliance Policies And Procedures Must Be Established

Observation:

The Department has not established HIPAA compliance policies and procedures for the State's health benefits plans.

The federal Health Insurance Portability And Accountability Act of 1996 (HIPAA), Public Law 104 – 191, was created in part to protect the privacy of patients' medical records and other health information provided to health plans, doctors, etc. HIPAA represents a uniform standard of privacy protection related to patients' medical records and other health information. HIPAA requires that covered entities:

- Designate a privacy official who is responsible for the development and implementation of the policies and procedures of the entity.
- Have written privacy procedures including a description of staff that has access to protected information, how it will be used, and when it may be disclosed.
- Train their employees in privacy procedures and designate an individual to be responsible for ensuring the procedures are followed.

The federal law provides for civil and criminal penalties to be imposed for certain situations resulting from noncompliance with HIPAA requirements.

The Department has not designated a privacy official, nor has it established written privacy procedures or provided HIPAA training. During our review of Plan documentation we noted medical conditions and treatments of plan members were routinely discussed via email between and among Department and other State management officials and between the administrator and the Department. This communication did not always appear to conform to HIPAA guidelines for patient privacy including the secured transmitting and sharing of confidential patient information.

Recommendation:

The Department must establish policies and procedures to ensure HIPAA compliance. While access to confidential patient information is necessary to properly administer the plan, it is incumbent upon the Department to establish proper guidelines to protect patient information from improper disclosure.

Auditee Response:

We concur.
The Department does not have formal written policies and procedures specific to HIPAA compliance. The Department fully recognizes the importance of formally documenting these policies and procedures, however with limited staff, has not been able to undertake this task. With the addition of new staff, the Department will attempt to bring our program into compliance with HIPAA regulations.

Observation No. 9: Policies And Procedures Should Be Established For COBRA Billings

Observation:

The Department had not established policies and procedures covering the billing of State agencies and others for COBRA-extended benefits.

The federal Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1986 gives workers and their families who lose their health benefits the right to choose to continue group health benefits provided by their group health plan for limited periods of time under certain circumstances such as voluntary or involuntary job loss, reduction in the hours worked, transition between jobs, death, divorce, and other life events. COBRA allows that qualified individuals may be required to pay the entire premium for coverage up to 102 percent of the cost to the plan.

- The Department through its administrator charges the 102 percent maximum allowed by COBRA for the extension of benefits for terminated employees and others covered by COBRA. The Department could not document that the rate charged was the result of a deliberate Department decision. It is not clear the Department understood the 102 percent rate charged by the administrator was the maximum allowed by law and was not necessarily an amount required to be charged.
- Chapter 319:7, Laws 2003, effective July 1, 2003, provides that any full-time State employee laid off between January 1, 2003 and July 1, 2005 who before the lay off received state-paid medical benefits pursuant to RSA 21-I:26-36, who is not eligible to retire and receive post-retirement medical benefits, and is not eligible for employer paid coverage under the plan of another employer, or as a spouse of a person covered under the plan of any other plan or the State plan, can receive State paid benefits for a period not to exceed six months. The State would pay the full cost for the first three months and half the cost for the second three months.
    1. The Department does not have policies and procedures in place to ensure that individuals receiving benefits pursuant to Chapter 319:7 are eligible. The Department reported it had no means to determine whether a prior employee subject to the benefits provision of Chapter 319:7 was eligible for employer paid coverage under the plan of another employer, or as a spouse of a person covered under another plan.
    2. During fiscal year 2004, the Department did not consistently charge agencies for the cost of the continuation of COBRA benefit for employees laid off from those agencies. Except as noted in No. 3 below, State agencies were not charged for the costs of COBRA benefits provided to their prior employees who were laid off pursuant to Chapter 319:7.
    3. There were seven employees of the Pease Development Authority (PDA) who were laid off during March and April 2004 and participated in COBRA continuation of State-paid benefits pursuant to Chapter 319. The Department did bill the PDA for premiums for the laid off PDA employees; however, the bill for the period March through May 2004 was not submitted until June 2004 and the Department charged the PDA the rates charged for contributions for health benefits of active employees, rather than the COBRA rates (102% of active rates).

Recommendation:

The Department should establish policies and procedures for administering the COBRA continuation of employee health benefits.

- The policies and procedures should definitively establish the plan's COBRA contribution rate.

- The policies and procedures should include methods for administering the provisions for State payment of COBRA contributions pursuant to Chapter 319:7, Laws 2003. Guidelines should be established for:
  1. Determining the initial and continued eligibility of prior employees for State paid COBRA benefits.
  2. Determining which State agencies are billed for providing State paid COBRA benefits.
  3. Controlled billing of COBRA costs to State agencies and other organizations covered by State paid contributions pursuant to Chapter 319:7, Laws 2003.

Auditee Response:

We concur.
The Department does not have formal written policies and procedures specific to COBRA billings and monitoring benefits. Our priority was and continues to place reliance on the COBRA administrator to ensure benefits are being made available to workers. To adequately address COBRA issues, additional staffing needs are necessary. Accordingly, additional positions have been requested in the current budget.

Observation No. 10: Policies And Procedures Should Be Established For The Identification And Reconciliation Of Funds Due Under COBRA

Observation:

The Department, during fiscal year 2004, had not developed comprehensive policies and procedures for the identification and reconciliation of COBRA contributions collected by the administrator on behalf of the Department.

The federal Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1986 gives workers and their families who lose their health benefits under certain circumstances such as voluntary or involuntary job loss, reduction in the hours worked, transition between jobs, death, divorce, and other life events the right to choose to continue group health benefits provided by their group health plan for limited periods of time. COBRA allows that qualified individuals may be required to pay the entire premium for coverage up to 102 percent of the cost to the plan.

For the period of October 2003 through April 2004, the Department did not identify that the administrator of its COBRA policy inappropriately retained $12,600 as an administrative fee for its services. This administrative function was included in the fixed costs of the contract between the parties and should not have been separately charged by the administrator.

The Department's contract with its plan administrator provided for a fixed price contract, including the administration of any COBRA activity under the plan. The Department does not appear to have identified the contractual obligations of its COBRA administrator, as the Department had not implemented appropriate procedures to monitor COBRA activity. The Department was unaware that the administrator was inappropriately retaining an administrative charge from the amounts remitted from prior employees participating in a COBRA continuation of benefits.

The administrative fee of $12,600 inappropriately withheld during the period October 2003 through April 2004, which was brought to the Department's attention in May, was recovered from the administrator in September 2004.

In addition, the Department does not appear to be monitoring its administrator's remitting of COBRA contributions for timeliness. The Department did not question, and apparently did not notice, that it received the December 2003 contributions totaling $49,719 on February 27, 2004, ten days after it received the contributions for January.

Recommendation:

The Department should develop and implement comprehensive policies and procedures for monitoring contract requirements, including COBRA administration, and identifying and reconciling monies it is due. A thorough understanding of each party's responsibilities to the contract is necessary to aid the Department in the identification of what services are to be provided and what the associated costs are to be.

Auditee Response:

We concur in part.
With no increase in staff, the responsibility and duties of the Department have increased enormously with the addition of the state's self-insured plan. To address COBRA and other issues from an administrative, day-to-day task, the Department will require additional staff. Accordingly, the Department has requested three additional positions in the budget process. The Department is firmly committed to develop and address issues of the audit and other, as staffing resources will allow.

We disagree with the conclusion that the Department does not monitor Cobra remittances. For all billed accounts, a separate log of payments is maintained to track remittances and to follow up with entities not paying in a timely manner.

Observation No. 11: Policies And Procedures Should Be Established To Ensure Only Eligible Dependents Of Active Employees Are Provided Plan Coverage

Observation:

The Department has not developed or implemented controls to ensure dependents receiving benefits from the State health and dental plans are eligible for such benefits.

During the period the self-funded plan operated in fiscal year 2004, employees eligible for benefits added information describing their dependents onto their medical and dental coverage via a web based interface (On-Line Benefits Manager). Controls do not appear to be in place to ensure that information entered by the employees accurately described dependent status. For example, the Department does not require evidence of a legal spousal or other dependent relationship to the employee. In addition, during fiscal year 2004, the State and its administrator did not attempt to confirm eligibility status of dependent children. During the fall of fiscal year 2005, the State through its administrator sent a letter to employees with dependent children over

the age of 19 asking for substantiation of full-time student enrollment status to provide for continued dependent eligibility status. Per the Department, the employee was required to respond to the letter by a specific date or the dependent's coverage would be automatically terminated.

Recommendation:

The Department must institute controls to ensure that only eligible employees, retirees, and dependents are provided State-paid health benefits. Controls should be established that provide reasonable assurance that employee, retiree, and dependent eligibility status remains current and accurate. The Department should review and consider whether requiring periodic documented substantiation of legal dependent status should be required from employees.

Auditee Response:

We concur in part.
The eligibility enrollment administrator does verify on an annual basis, dependents who are at least 19 years but less than 25 years of age enrolled in school as a full time student. Additionally, the Department has requested that the eligibility administrator develop reporting systems to make available detailed enrollment information available to agency human resources offices. These reports would include information on dependents that have been added or deleted by employees. This would in turn allow agency human resources offices to use this data for the purpose of obtaining necessary documentation (such as birth certificates, divorce decrees, etc) for their records. The Department recognizes the importance of strengthening controls to ensure that only eligible employees, retirees and dependents are provided State-paid benefits and will continue to monitor the progress by the on-line benefits administrator in developing necessary reporting mechanisms.

Observation No. 12: Controls Must Be Established To Ensure The Retiree Eligibility Data Remains Current And Accurate

Observation:

During fiscal year 2004, the Department relied upon the New Hampshire Retirement System (System) to provide accurate health benefits eligibility data for State retirees. The Department had no established process for ascertaining the accuracy of the data originally provided by the System at the inception of the plan or the regular changes to the data that occurred as retirees and dependents were added to or removed from plan coverage during the year.

At the time of the transition to the State-funded plan, it was recognized that many of the approximately 7,500 State retirees did not have Internet access and requiring their enrollment for health benefits coverage through the contracted on-line benefits enrollment system would be problematic. As a result, the System became responsible for entering retiree health benefit enrollment information and changes in enrollment information, including adding and deleting dependents, into the administrator's database.

As of September 20, 2004, the Department had not performed a reconciliation between the System's and the administrator's enrollment data to ensure that the administrator's eligibility

file, which is used to establish eligibility for payment for all plan benefits, accurately reflects the System's data. The Department reports it cannot easily compare the enrollment data available from the System to the plan administrator's data for plan participants, as the data files are incompatible. System data files include the retiree's social security number as the identifier for both the retiree and spouse and any eligible dependents. The administrator's data file uses a unique number, not social security number, as an identifier for each covered plan member. The Department stated that, if it were possible, it would be a very difficult and time-consuming reconciliation to perform.

The Department has not undertaken any efforts to ensure the eligibility data provided by the System is accurate and remains current. In addition to establishing authority for the administrator to pay health benefits claims, retiree eligibility data is also used as a basis to charge self-funded State agencies the retiree health benefits plan contribution costs.

Recommendation:

The Department must establish controls to ensure that retiree eligibility data remains current and accurate.

The Department must work with the System and the Department's on-line benefits enrollment agent and its administrator to establish more efficient retiree data update and accuracy controls, including periodic data testing and reconciliation.

Once established, controls must be monitored to ensure they are operating as planned, remain relevant, and problems identified by the controls are resolved in a timely manner as intended by management.

Auditee Response:

We concur.
We currently have on-going discussions with the NH Retirement System (NHRS) to both obtain an understanding and consensus as to the best approach to ensure that retiree eligibility data is accurate. It is our belief that a coordination of effort between our Department, NHRS, and our eligibility provider will provide these desired results.

Observation No. 13: Policies And Procedures Should Be Established To Ensure Only Eligible Dependents Of Retirees Are Provided Plan Coverage

Observation:

The Department does not have policies and procedures to ensure that dependents of retired State workers provided coverage by the plan through retiree deductions are eligible for coverage according to the plan's summary plan description.

State retirees are given an option to pay a monthly fee to continue medical coverage for eligible dependents who were covered by the State's active employee health plan, but would otherwise loose coverage upon the employee's retirement. If the retiree chooses this option, funds are

withheld from the retiree's monthly annuity check for the cost of the additional coverage. While the retiree electing this additional coverage completes an *Enrollment Form* and signs an *Annuity Deduction Authorization Form*, no documentation is required to establish the dependent's eligibility for the coverage. Due to the nature of a self-funded plan, the actual cost of coverage provided to each individual could be greater than the contributions collected on behalf of those individuals. As a result, allowing an ineligible individual to participate in the plan could have a negative effect on the plan if the individual's use of medical services is not covered by the contributions.

The New Hampshire Retirement System (System), which oversees the health benefits eligibility issues for retirees, stated that under the prior, fully-insured plan, it was the responsibility of the carrier to ensure that dependents participating in the State health plan were eligible. When the State changed from a fully insured to a self-funded health plan, the responsibility for ensuring dependent eligibility was not addressed.

Recommendation:

The Department should work with the System and the plan administrator to establish policies and procedures for ensuring only eligible individuals are covered by the plan. These policies and procedures should include periodic confirmation of eligibility status to ensure that changes to the status of covered individual are made timely.

Auditee Response:

We concur.
We currently have on-going discussions with the NH Retirement System (NHRS) to both obtain an understanding and consensus as to the best approach to ensure that retiree eligibility data is accurate. It is our belief that a coordination of effort between our Department, NHRS, and our eligibility provider will provide these desired results.

Observation No. 14: Policies And Procedures Should Be Established To Ensure Retiree Health Benefits Contributions Are Funded Appropriately

Observation:

The Department does not have policies and procedures to ensure that other State departments and organizations responsible for contributions towards the cost of retiree health benefits are paying the appropriate amounts.

RSA 21-I:30 provides for the State to offer medical plan benefits to its retired employees meeting criteria outlined in statute. RSAs 100-A:52 through 100-A:55, provide for the New Hampshire Retirement System (System) to pay a portion of the health benefits provided to retired State employees, spouses, and certain certifiably dependent children from a separate System medical account known as a 401(h) subtrust with the remainder paid by the State's General and other Funds. The legislature has historically appropriated the State's share of funding for retiree health benefits in the System's budget with the exception of self-sustaining agencies, where retiree health benefits are budgeted in the individual agencies' appropriations.

Currently the System is responsible for monthly calculating the amount of retiree health contributions to be paid by the 401(h) subtrust, self-sustaining agencies, the State, and retirees. The System processes a cash receipt document and deposits monies into the Employee Benefit Fund for the 401(h) contribution as well as deductions from retirees' pensions. The System also prepares monthly invoices for the self-sustaining agencies. The Department's Division of Accounting Services receives a copy of the cash receipt, the monthly invoices, and a spreadsheet listing all the individual retirees showing gross premiums, retiree deductions, medical subsidy (i.e., 401(h) contributions), and net State cost. The Department processes an intergovernmental payment voucher to charge the State's General Fund appropriations and the self-sustaining agency accounts for their share of the retiree health contributions for the month.

During our review of the June 2004 monthly billing and supporting documentation we noted the following:

- The actual premium paid for 24 of the approximate 7,900 individuals listed on the Retiree Premium Spreadsheet differed from the gross premium due. The differences ranged from a shortage of $25 to an overage of $723. There was no indication that the reasons for the differences were investigated or resolved.
- Two individuals that were coded on the Retiree Premium Spreadsheet as retirees of the Banking Department, a self-funded agency, were not included on the invoice to the Banking Department and the contributions for these retirees totaling $659 were paid by the General Fund. There was no indication that the reasons for this difference in information was investigated or resolved.
- The total amount due to be deposited into the Employee Benefit Fund for June 2004 representing 401(h) subsidy payments and retiree deductions was $1,018,318. The actual cash receipt totaled $1,016,267. The difference, $2,051, reportedly represents credits processed by the System for amounts previously paid in error (i.e., retiree was deceased and the System did not become aware of this until two months subsequent the death.) The credits are netted against amounts due prior to payment of the subsidy's contribution. The Department did not appear to be aware that the credits were netted against the current month's payment. Also, as a general rule, the Department does not refund overpayment by the self-sustaining agencies and the General Fund related to these credits and other adjustments from the Employee Benefit Fund.

While the total contributions for the month reviewed appears to be materially supported by the documentation provided by the System, the minor differences noted indicate the source of funding used to pay for the contributions may be incorrect in some instances.

Department personnel reported they were aware of problems with the monthly Retiree Premium Spreadsheet received from the System and had approached the System about obtaining improved information. Reportedly, the System responded that the spreadsheet is a legacy from an old program and the System does not have the ability to adjust the data presented. Additionally, the System reports that their new pension data system will not provide the Department the detail that the Retiree Premium Spreadsheet currently provides, which may make the Department's review of contributions for retiree health benefits more problematic.

Recommendation:

The Department and System should implement policies and procedures to ensure that contributions towards retiree health benefits are being funded appropriately. The Department should require the System to continue to maintain and provide data related to which agencies State employees retire from to ensure that readily accessible information is available to support the System's and Department's billings for retiree health benefits contributions.

The Department should review the monthly data, invoices, and other information supporting the System's contributions towards retiree health benefits. Such information should also be shared with the State agencies to ensure that they also review the data for accuracy.

Auditee Response:

We concur.
The Department does not have formal written policies and procedures to ensure retiree health benefits are funded appropriately through billings to state agencies. Due to limited staffing and the short time period given to transition to a self-insured plan, we have placed a high priority on ensuring retirees are receiving benefits.

We also placed extra reliance on the information provided to us by the NHRS, although we concur a more thorough review is needed. During the budget process, additional staff was requested.

As additional staffing resources come available, the Department and the NHRS will work together to ensure more accurate information is provided and in turn is used to bill agencies their share of the retirees' health costs.

Observation No. 15: Policies And Procedures Should Be Established To Ensure Financial Records Reflect Account Activity

Observation:

The Department initially did not record an account receivable for the Department of Safety's June 2004 contributions toward employee health benefits even though the Department recognized that the amounts would not be paid until the subsequent fiscal year.

The Department deferred the collection of the Department of Safety's June contribution toward employee health benefits due to the Department of Safety not having sufficient appropriations. Emails between the departments indicated that there was agreement that additional appropriations could not be obtained prior to the close of the fiscal year. Even though the Department deferred the collection of this revenue, it did not accrue an accounts receivable from the Department of Safety for the June amount owed but unpaid. The effect of this omission was to understate fiscal year 2004 revenue to the Employee Benefit Fund by $257,000 and understate the Department of Safety's employee benefit expenses by an equal amount in the initial closing of the State's accounts. These accounts were subsequently adjusted in the financial statements through an audit adjustment.

Similarly, the Department did not record accounts receivable for contributions owed by five special participant groups including the Pease Development Authority, Business Finance Authority, participating Legislators, COBRA participants (terminated employees selecting extension of coverage), and Department of Employment Security retirees, who received health benefits coverage for the month of June 2004, but had not made payment to the Department for this coverage until July 2004. Reportedly, the Department was aware that it should have recorded $161,000 of accounts receivable in the Employee Benefit Fund from these organizations at June 30, 2004; however, the entry was overlooked or otherwise not made in the initial closing of the State's accounts. These accounts were subsequently adjusted in the financial statements through an audit adjustment.

Recommendation:

The Department should have policies and procedures to ensure that the State's accounting records represent the underlying financial activity of the State. Accruals and other adjustments to the accounts should be prepared concurrently with the recognition of the underlying events to minimize the risk that they may be subsequently overlooked.

Auditee Response:

We concur.
This was the first year the State was required to prepare financial statements related to the self-insured health program. No additional staffing resources were provided to aid in this new responsibility. During FY04, over $100 million in collections and payments were made from this new self-insured fund. During the audit 2 adjustments (totaling approximately $418,000) were brought to our attention and were corrected prior to the issuance of the financial statements. While the errors were less than 1% of the revenue collected, we recognize the need and importance for a more thorough review process. As additional staffing resources are made available, we will work on developing better procedures to ensure the accuracy of the financial activity of this program.

Observation No. 16: Implementation Reports On State Employee Self-Funded Health Plan Should Be Submitted In A Timely Manner

Observation:

Implementation reports of the self-funded health plan have not been submitted to the Fiscal Committee on the schedule provided for in law.

Chapter 319:32 of the Laws of 2003 directs the Commissioner of the Department of Administrative Services to report to the Fiscal Committee of the General Court every 60 days regarding the implementation of the employee self-funded health plan.

The State's self-funded employee health benefits plan went into effect October 1, 2003. The Department submitted required reports on its implementation of the plan in January, June, and September 2004 and April 2005.

The Department indicated that it recognizes it has not been in compliance with the reporting requirement.

Recommendation:

The Department should submit required reports on the implementation of the State's self-funded health benefits plan every 60 days as required by Chapter 319:32 of the Laws of 2003.

If the Department determines that the reporting requirement is not responsive to the needs of the Department, it should request the Legislature to revise or remove the reporting requirement.

Auditee Response:

We concur.
For management purposes, we update and review the financial schedules monthly and will make every effort to report to Fiscal Committee as provided by Chapter 319:32, L'03. The Department will propose legislation to change the reporting requirement from 60 days to quarterly.

Observation No. 17: Policies And Procedures Should Be Established To Effectively Monitor And Administer Ancillary Health Benefits

Observation:

The Department does not have policies and procedures in place to effectively monitor and administer ancillary health benefits provided by the State's health benefits program.

Along with the usual medical, surgical, and pharmaceutical benefits provided to covered employees and retirees, the State also provides additional health related benefits under a program administered by the Department's contracted health benefits administrator for active employees selecting the Health Maintenance Organization (HMO) plan option. This ancillary program includes up to $450 per year in reimbursement of health club fees, when employees meet a certain level of exercise activities, and reimbursement up to $200 per year for employee purchases of approved exercise equipment. The Department has allowed the contracted administrator to become completely responsible for establishing and communicating plan requirements to plan members and for ensuring these ancillary benefits are provided in a controlled manner. Examples of problems that have developed with this program include the following.

- We reviewed documentation accumulated during the Department's internal auditor review of health club membership reimbursement payments and noted 11 reimbursement payments were made to one person on the same day. Total dollar amount of the reimbursements was $544 and, because the amount appeared problematic as it exceeded the expected $450 limit, we requested the Department obtain documentation from the administrator supporting the reimbursements. Documentation provided included a cover letter from the employee asking for reimbursement; log files printed from the health club showing member activity; and

receipts from the health club showing dollar amount paid. A review of the documents indicated the following issues.

1. Per conversation with the Department's internal auditor, the employee had elected COBRA post employment continuation of benefits effective May 2004. When we asked whether the plan provided for COBRA coverage of health club membership, the Department indicated it did not and notified the administrator to discontinue coverage for COBRA participants.

   Generally, COBRA qualified beneficiaries must be offered coverage identical to that available to similarly situated beneficiaries who are not receiving COBRA coverage under the plan (generally, the same coverage that the qualified beneficiary had immediately before qualifying for continuation coverage). It is not clear that COBRA allows for the Department's contention that under the Collective Bargaining Agreement (CBA), the administrator's website, and plan documentation, health club membership reimbursement is only provided to active employees in the HMO plan.

2. The participant did not submit required workout logs to document workout activities for fiscal year 2004. Instead, health club log files were submitted. Per review of the log files, the member met the eight workout per month requirement for two of the nine months during this period. Regardless, the administrator made reimbursement payments for all nine months.

   Errors in calculating the rate as well as errors in paying for months when the participation criteria were not met, as noted above, appear to have resulted in an overpayment totaling less than $480 for this individual.

- Information on ancillary benefit payments was reviewed to gain an understanding of how the payments were processed. A certain record included in information provided by the administrator appeared unusual and indicative of a potential benefit fraud involving an employee's submission of questionable documentation supporting health club reimbursement payments.

  Documentation provided by the administrator showed an employee submitted reimbursement requests for the period November 2003 through May 2004. Documentation supporting those requests included workout logs and payment receipts as required by the program. The circumstances that appear unusual and indicative of potential fraud include:

  1. The employee's mother, an employee of the health club during a portion of the period in question, signed all payment receipts issued by the club supporting the employee's request for plan reimbursement.
  2. All workout logs contained the initials of the employee's mother, to evidence the employee completed a required workout.
  3. Nine workout log entries and two payment receipts signed by the mother were for periods subsequent to the mother's termination of employment with the health club.

4. Certain receipt documents submitted to support reimbursements for club membership payments were sequentially numbered, even though they were dated as though they were paid months apart.

This situation was brought to the Department's attention for further consideration and action.

- The health education component of the ancillary benefits is not specifically provided for by the CBA or the summary plan description. According to the Department, the benefit is provided based on a continuation of past practice. The plan reimburses active covered employees up to $150 per calendar year for health education courses.

Recommendation:

The Department should establish policies and procedures to improve the controls over the ancillary benefits provided under the State's health benefits plan. The Department must understand the provisions of its plan and the controls that will be in place to ensure that the plan is administered as intended by the State. The Department cannot rely upon its contracted administrator to operate the plan in a controlled manner without monitoring those controls for effectiveness.

Auditee Response:

We Concur.
The Bureau of Risk Management does not have formal policies and procedures to monitor controls over the ancillary benefits administered by the contracted administrator. However, the Bureau reviews on a monthly basis, detailed reimbursement reports provided by the contractor and approves all payments by the State.

Additionally, the Department's internal auditor performed a review of the wellness program administered by the contractor and noted weaknesses in internal controls including some that led to overpayments and provided several suggestions to the contractor for strengthening internal controls in the administration of the program. As a result of this review the contractor has taken steps to address areas of concerns addressed in the internal audit review.

The Department has also addressed the potential fraud incident cited by the LBA with the contractor and determined that although the member improperly submitted reimbursement requests, the member did meet the reimbursement requirements for payments received from the contract administrator. The Department recognizes the importance of strengthening controls over the administration of the wellness program and will continue to monitor the progress made by the contractor in following through with the changes recommended by the Department. The Department will detail ancillary benefits in the anticipated and revised summary plan documents effective with the new contract on July 1, 2005.

Observation No. 18: Only Statutorily Authorized Groups Should Participate In The Health Benefits Plan

Observation:

Over nine months into its operation of the State's self-funded health benefits plan, the Department had not developed policies and procedures to identify eligible groups of participants. In addition, the Department was inconsistent in its handling of non-statutorily authorized participants initially allowed in the plan and did not include coverage for the University System of New Hampshire (USNH) or request timely exception from the requirement in statute for USNH coverage.

RSA 21-I:30 outlines the State's responsibility for providing health benefits for certain groups of active and retired employees. The State pays toward group hospitalization, medical care, etc., for each State employee and permanent temporary or permanent seasonal employee as defined in RSA 98-A:3 including spouse, minors, and fully dependent children, if any. Also each retired State employee, as defined in the statute, and spouse or beneficiary, if an option was taken upon retirement, is provided coverage. In addition to employees covered by RSA 21-I:30, over the course of years, other categories of employees have been granted eligibility for participation in the State health benefits plan through various chapter laws and statutes.

The Department did not attempt to formally identify groups eligible to participate in the State's health benefits plan until May 21, 2004, when it issued a listing of eligible groups in response to an auditor's request.

Under the prior insured employee health benefits system, there was no ramification to the State if additional groups were allowed coverage as long as the premiums were paid in full and apparently the State has allowed certain groups of individuals to purchase medical and dental coverage as a convenience even though there may not have been explicit authority to do so. With the State's self-funded plan, the State is operating a cost-sharing plan where each contributor to the plan is sharing the cost experience of all members in the plan. For example, if the employees of one group have a particularly costly period, all contributors will be impacted by increased future contribution rates. While it may be appropriate to cost share among State agencies and other authorized participant groups, it may not be appropriate to cost share with entities that are not explicitly authorized to be covered by the plan.

Examples of groups that were allowed participation during fiscal year 2004 for whom authority for participation in the plan could not be provided by the Department include:

- Two employees of Blind Services, a non-profit entity operating within the State. According to email documents and conversations with Department employees, the State decided to terminate the coverage of this group effective July 1, 2004.
- Former employees of the State Employees Association, either terminated or retired, who have been allowed to retain participation in the health benefits plan. Per email documents, it appears this group has been allowed to retain coverage to improve the State's bargaining position in the current State employee contract negotiations.

- Retired judges. Management was not able to provide any statutory authority to allow retired judges to participate in the health benefits plan. The authority cited was RSA 100-C:3, which requires all full-time judges to participate in the judicial retirement system. Per review of the retired judges billing, it appears the State is also paying the cost of coverage for one retired judge's dependent children even though this coverage is not available to retired State employees.

Recommendation:

The Department should establish policies and procedures for determining the eligibility criteria for participation in the State's health benefits plan. These policies and procedures should identify all groups with statutory authority to participate. Groups identified without statutory authority should be excluded from coverage in a consistent manner according to the policies and procedures developed. If it is determined that groups without the statutory authority to participate should retain their eligible status, the Department should seek appropriate legislative changes.

Auditee Response:

We concur in part.
With the change to a self-insured plan, we reviewed payments to the plan from all sources. This review identified a limited number of members carried forward from the previous plan and now participating in the current without apparent authority. The Department with the exception of judges, has not added new retirees to the current health plan without explicit written authority. Because the legislature continues to budget and fund retiree health care for retired judges by specific appropriation as approved and passed into law under the budget act, we have not denied them this benefit.

As we entered this activity, it became clear that the Department did not have the capacity to administer the University program and requested exemption from the legislative fiscal committee in a timely manner.

Auditor's Report On Management Issues

To The Fiscal Committee Of The General Court:

We have audited the accompanying financial statements of the Employee Benefit Fund of the State of New Hampshire as of and for the fiscal year ended June 30, 2004, as listed in the table of contents, and have issued our report thereon dated December 23, 2004.

We conducted our audit in accordance with auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement.

In planning and performing our audit of the financial statements of the Employee Benefit Fund as of and for the fiscal year ended June 30, 2004, we noted one issue related to the operation of the Employee Benefit Fund that merits management consideration but does not meet the definition of a reportable condition as defined by the American Institute of Certified Public Accountants, and was not an issue of noncompliance with laws, rules, regulations, contracts, grant agreement, or other matters.

The issue that we believe is worthy of management consideration but does not meet the criteria of reportable condition, noncompliance, or other matter is included in Observation No. 19 of this report.

This auditor's report on management issues is intended solely for the information of the management of the Employee Benefit Fund and the Fiscal Committee of the General Court and is not intended to be and should not be used by anyone other than these specified parties.

Office Of Legislative Budget Assistant
Office Of Legislative Budget Assistant

December 23, 2004

Management Issues Comment

Observation No. 19: Issues Raised During Contracted Claims Audit And Operational Review Should Be Resolved

Observation:

A report issued by a firm hired by the Department to perform a claims audit and operational review of the medical and drug claims paid by the plan during fiscal year 2004 contains a number of issues that need to be pursued and resolved with the administrator and highlight the need for greater Department involvement in the review of the operation of the plan.

During the planning stages of the audit in the spring of 2004, we discussed with the Department the need to have audit coverage over the administrator's payments of medical claims on behalf of the Department. During fiscal year 2004, the Department had not developed any ability to review or audit the plan's payment of medical and other claims. The Department was completely reliant upon the administrator for the proper adjudication and payment of submitted claims. In order for an audit of the plan's financial statements to occur, the payments made by the plan had to be subject to sufficient audit work to allow for a conclusion as to whether the payments were materially correct in terms of amount, period of reporting, and account distribution. At the time, we discussed with the Department the options available to have this work performed, which included our performing the work or the Department hiring a firm to perform a claims audit. If a contracted claims auditor was used, we would test the work performed by the contractor to determine its sufficiency for our financial audit of the plan.

In September of 2004 the Department contracted with a firm to provide actuarial, rate consulting, claims auditing, and other services related to the Department's operation of the plan. Claims audit work was performed at the administrator's sites in Minnesota and New Jersey. Legislative Budget Assistant auditors accompanied the contractor's auditors in New Jersey and tested by reperformance a sample of the contractor's claims audit test work. The contractor's claims audit formed the basis for a report dated January 24, 2005 containing sections summarizing detailed work on the plan's medical, behavioral health, and prescription drug claim payments and the plan's enrollment vendor. Included in the report are a number of issues and recommendations related to the plan's payment of claims during the period October 1, 2003 through June 30, 2004. The issues raised in the claims audit report are included by reference and have not been restated in this report. As part of its claims audit, the firm has initiated a follow-up process for the issues and recommendation contained in the report.

Recommendation:

The Department must establish regular processes for gaining assurance that payments made on its behalf by the administrator are accurate and based upon the plan's summary plan descriptions (SPDs). In addition to regular claims audit work performed on its behalf, the Department should require regular reporting by the administrator on the results of the administrator's internal audit efforts covering the plan's payments. The Department should involve its internal auditor in the review of these reports and service audit reports covering the plan's operation as well as in the

periodic review of plan payments to gain additional comfort that the plan is operating as intended.

The Department should continue monitoring the follow up of the issues contained in the recent claims audit and operational review. The Department should ensure that all corrective actions recommended by the contractor are considered for implementation and that the administrator continues to cooperate in the audit resolution process.

Auditee Response:

We concur.
The Department currently and continues to follow up with the plan's administrator and consultant as a result of the recent audit. To address these and other issues from an administrative and day-to-day task, the Department will require additional staff.

Accordingly, the Department has requested three additional positions in the budget process and is firmly committed to develop and address issues of the audit and other, as staffing resources will allow.

Independent Auditor's Report

To The Fiscal Committee Of The General Court:

We have audited the accompanying financial statements of the Employee Benefit Fund of the State of New Hampshire as of and for the fiscal year ended June 30, 2004, as listed in the table of contents. These financial statements are the responsibility of the Employee Benefit Fund's management. Our responsibility is to express an opinion on these financial statements based on our audit.

We conducted our audit in accordance with auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States of America. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audit provides a reasonable basis for our opinion.

As discussed in Note 1, the financial statements are intended to present the financial position, the changes in financial position, and cash flows of only the Employee Benefit Fund and do not purport to, and do not, present fairly the financial position of the State of New Hampshire as of June 30, 2004 and the changes in its financial position for the fiscal year then ended in conformity with accounting principles generally accepted in the United States of America.

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of the Employee Benefit Fund as of June 30, 2004, and the changes in financial position, and cash flows thereof for the fiscal year then ended in conformity with accounting principles generally accepted in the United States of America.

The management of the Employee Benefit Fund has not presented the management discussion and analysis that the Governmental Accounting Standards Board has deemed necessary to supplement, although not required to be a part of, the basic financial statements.

Our audit was conducted for the purpose of forming an opinion on the financial statements referred to in the first paragraph. The Schedule of Net Assets - By Activity - GAAP Basis and Schedule of Revenues, Expenses, and Changes in Net Assets - By Activity - GAAP Basis on pages 53 and 54, respectively, are presented for the purpose of additional analysis and are not a required part of the financial statements of the Employee Benefit Fund. Such information has been subjected to the auditing procedures applied in our audit of the financial statements referred to in the first paragraph and, in our opinion, is fairly presented in all material respects in relation to the financial statements taken as a whole.

In accordance with *Government Auditing Standards,* we have also issued a report dated December 23, 2004 on our consideration of the Employee Benefit Fund's internal control over financial reporting and on our tests of its compliance with certain provisions of laws, rules, contracts, grant agreements, and other matters. The purpose of that report is to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing and not to provide an opinion on the internal control over financial reporting or on compliance. That report is an integral part of an audit performed in accordance with *Government Auditing Standards* and should be read in conjunction with this report in considering the results of our audit.

Office Of Legislative Budget Assistant
Office Of Legislative Budget Assistant

December 23, 2004

STATE OF NEW HAMPSHIRE
EMPLOYEE BENEFIT FUND

STATEMENT OF NET ASSETS
JUNE 30, 2004
(Expressed In Thousands)

Assets	
Cash And Cash Equivalents	$ 3,244
Total Assets	3,244
Liabilities	
Accounts Payable	1,338
Incurred But Not Reported (IBNR)	14,037
Total Liabilities	15,375
Net Assets	
Unrestricted Net Assets (Deficit)	(12,131)
Total Net Assets (Deficit)	$ (12,131)

The accompanying notes are an integral part of this financial statement.

STATE OF NEW HAMPSHIRE
EMPLOYEE BENEFIT FUND

STATEMENT OF REVENUES, EXPENSES, AND CHANGES IN NET ASSETS
FOR THE FISCAL YEAR ENDED JUNE 30, 2004
(Expressed In Thousands)

Operating Revenues		
Charges For Sales And Services		
Contributions For Health Benefits		
State Contributions		
Active Employees	$	79,255
Retired Judges And Constitutional Officers		308
Retired Employees		22,531
Total State Contributions For Health		102,094
Non-State Contributions		
Retirement Subsidy And Deductions		9,003
Other Employers		518
COBRA Participants		449
Legislator Participants		324
Total Contributions For Health Benefits		112,388
State Contributions For Dental Benefits		6,371
Total Operating Revenues		118,759
Operating Expenses		
Health Care Expenses		
Health Care Claims		
Medical Payments		84,629
Pharmaceuticals		33,554
Dental Insurance Premiums		6,364
Administration		5,681
Enrollment		365
Anciliary Benefits		297
Total Operating Expenses		130,890
Operating Income (Loss)		(12,131)
Change In Net Assets		(12,131)
Net Assets - July 1, 2003		-0-
Net Assets (Deficit) - June 30, 2004	$	(12,131)

The accompanying notes are an integral part of this financial statement.

STATE OF NEW HAMPSHIRE
EMPLOYEE BENEFIT FUND

STATEMENT OF CASH FLOWS
FOR THE FISCAL YEAR ENDED JUNE 30, 2004
(Expressed In Thousands)

Cash Flows From Operating Activities	
Receipts From Contributions	$ 10,294
Receipts From Interfund Charges	108,465
Payments To Vendors	(6,343)
Payments For Medical Claims	(102,808)
Payments For Dental Insurance	(6,364)
Net Cash Provided (Used) By Operating Activities	3,244
Net Increase (Decrease) In Cash And Cash Equivalents	3,244
Cash And Cash Equivalents July 1	-0-
Cash And Cash Equivalents June 30	$ 3,244
Reconciliation Of Operating Income (Loss) To Net Cash Provided (Used) By Operating Activities:	
Operating Income (Loss)	$ (12,131)
Change In Operating Assets And Liabilities:	
Increase (Decrease) In Claims Payable	15,375
Net Cash Provided (Used) By Operating Activities	$ 3,244

The accompanying notes are an integral part of this financial statement.

STATE OF NEW HAMPSHIRE
EMPLOYEE BENEFIT FUND

NOTES TO THE FINANCIAL STATEMENTS
FOR THE FISCAL YEAR ENDED JUNE 30, 2004

NOTE 1 - SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

The accompanying financial statements of the Employee Benefit Fund have been prepared in accordance with accounting principles generally accepted in the United States of America (GAAP) and as prescribed by the Governmental Accounting Standards Board (GASB), which is the primary standard-setting body for establishing governmental accounting and financial reporting principles.

A. Financial Reporting Entity

The Employee Benefit Fund, established by RSAs 21-I:30 through 30-d, is an internal service fund of the State which accounts for State employee and retiree health benefit costs. Effective October 2003, the fund was established to account for the State's self-funding of employee and retiree health benefits and employee dental insurance. During this nine month period, State government organizations and limited others contributed to the fund based upon rates intended to cover the cost of benefits provided and also to fund a ninety-day reserve. The accompanying financial statements report the financial activity of the Employee Benefit Fund which reported nine months of operation during fiscal year 2004.

B. Fund Financial Statements

The Statement of Net Assets and the Statement of Revenues, Expenses, and Changes in Fund Net Assets, and the Statement of Cash Flows report information on the activities of the Employee Benefit Fund. These activities are normally supported through contributions from State departments and agencies, limited other employers, a subsidy from the New Hampshire Retirement System for retirees, covered employees, retirees, and recent employees.

The Statement of Net Assets presents the reporting entity's current assets and liabilities, with the difference reported as net assets or deficit. Net assets are reserved when constraints placed on it are either externally imposed or are imposed by constitutional provisions or enabling legislation. Internally imposed designations of resources are not presented as reserved net assets.

The Statement of Revenues, Expenses, and Changes in Fund Net Assets demonstrates the degree to which expenses are offset by revenues. Revenues are classified by major revenue source and expenses are classified by function.

The Statement of Cash Flows provides relevant information about the cash effects (i.e. receipts and payments) of the Employee Benefit Fund's operations during the fiscal year ended June 30, 2004. Operating income is reconciled to net cash flows from operating activities.

C. Measurement Focus and Basis of Accounting

The financial statements of the Employee Benefit Fund, an internal service fund, are reported using the economic resources measurement focus and the accrual basis of accounting. Revenues are recorded as earned and expenses are recorded when a liability is incurred, regardless of the timing of the related cash flows.

In reporting proprietary activities, including its internal service fund, the State only applies applicable GASB pronouncements as well as the following pronouncements issued on or before November 30, 1989, for its business-type activities and enterprise funds, unless these pronouncements conflict with or contradict GASB pronouncements: Financial Accounting Standards Board Statements and Interpretations, Accounting Principles Board Opinions, and Accounting Research Bulletins of the Committee on Accounting Procedure.

D. Financial Statement Presentation

The financial activity of the Employee Benefit Fund is accounted for and reported in the State's Proprietary-Enterprise Funds in the State of New Hampshire's Comprehensive Annual Financial Report (CAFR). Assets, liabilities, and net assets are reported by fund for the State as a whole in the CAFR.

The activities of the Employee Benefit Fund are recorded in an internal service fund, which is a separate accounting entity with a set of self-balancing accounts. Fund accounting is designed to report financial position and the results of operations, to demonstrate legal compliance, and to aid financial management by segregating transactions related to certain government functions or activities. The internal service fund provides services primarily to other agencies or funds of the State, rather than to the general public. These services include health related fringe benefits. In the State's government-wide financial statements, the internal service fund is included with governmental activities.

E. Cash and Cash Equivalents

Cash includes currency on hand as well as demand deposits with banks or other financial institutions. For the purposes of the Statement of Cash Flows, cash equivalents represent short-term investments with original maturities less than three months from the date acquired by the State.

F. Revenues And Expenses

In the Employee Benefit Fund financial statements, revenues and expenses are classified as operating or non-operating and are subclassified by object. Operating revenues and expenses generally result from providing services in connection with the Fund's ongoing operations. The principal operating revenues are employer contributions. Principal operating expenses include the cost of medical and pharmaceutical services received by covered individuals, dental insurance, and administrative costs.

G. Budget Control And Reporting

General Budget Policies

The statutes of the State of New Hampshire require the Governor to submit a biennial budget to the Legislature for adoption. This budget, which includes a separate budget for each year of the biennium, consists of three parts: Part I is the Governor's program for meeting all expenditure needs and estimating revenues. There is no constitutional or statutory requirement that the Governor propose or that the Legislature adopt a budget that does not resort to borrowing. Part II is a detailed breakdown of the budget at the department level for appropriations to meet the expenditure needs of the government. Part III consists of draft appropriation bills for the appropriations made in the proposed budget.

The operating budget is prepared principally on a modified cash basis and adopted for the governmental and proprietary fund types with the exception of the capital projects fund. The capital projects fund budget represents individual projects that extend over several fiscal years. Fiduciary funds are not budgeted.

In addition to the enacted biennial operating budget, the Governor may submit to the Legislature supplemental budget requests necessary to meet expenditures during the current biennium. Appropriation transfers can be made within a department without the approval of the Legislature; therefore, the legal level of budgetary control is at the department level.

Both the Executive and Legislative Branches of government maintain additional fiscal control procedures. The Executive Branch, represented by the Commissioner of the Department of Administrative Services, is directed to continually monitor the State’s financial operations, needs, and resources, and to maintain an integrated financial accounting system. The Legislative Branch, represented by the Joint Legislative Fiscal Committee, the Joint Legislative Capital Budget Overview Committee, and the Office of Legislative Budget Assistant, monitors compliance with the budget and the effectiveness of budgeted programs.

Unexpended balances of appropriations at year end will lapse to undesignated fund balance and be available for future appropriations unless they have been encumbered or legally defined as non-lapsing, which means the balances are reported as reservation of fund balance. The balances of unexpended encumbrances are brought forward into the next fiscal year. Capital Projects Fund unencumbered appropriations lapse in two years unless extended or designated as non-lapsing by law.

NOTE 2 - CASH, CASH EQUIVALENTS AND INVESTMENTS

Deposits

The following statutory requirements and New Hampshire Treasury Department policies have been adopted to minimize risk associated with deposits.

RSA 6:7 establishes the policy the State Treasurer must adhere to when depositing public monies. The statute restricts deposits to national banks, trust companies, and savings banks within the United States that have a branch in the State of New Hampshire. In addition, all

depositories used by the State must be approved at least annually by the Governor and Executive Council.

RSA 6:11 establishes depositing procedures and procedures for making payments to State Treasury accounts. All accounts opened by departments require the State Treasurer's concurrence.

RSA 6-B:2 requires the State Treasurer to submit quarterly financial reports to the Governor and Executive Council, the Commissioner of Administrative Services, and the Legislative Fiscal Committee.

The Treasury Department examines the financial condition of its depositories quarterly. The State Treasurer is not required to collateralize bank deposits.

The Employee Benefit Fund's cash and cash equivalents as reported on the Statement of Net Assets as of June 30, 2004 consisted of cash on deposit with the State Treasurer. Cash held by the State Treasury for use by the Employee Benefit Fund is commingled with all other State cash. Accordingly, bank balances and risk categories specific to the Employee Benefit Fund cannot be determined.

NOTE 3 - NET ASSETS (DEFICIT)

At June 30, 2004 the Employee Benefit Fund had an unrestricted net asset deficit of $12.1 million. The Employee Benefit Fund accounts for health related fringe benefits for State employees and retirees. The deficit is largely attributable to contributions not being sufficient to pay for medical services provided to covered participants. The deficit will be funded through an actuarially determined increase in future contribution rates intended to eliminate the deficit and build a statutorily required ninety-day reserve.

NOTE 4 - RISK MANAGEMENT AND INSURANCE

Effective October 2003, the State established the Employee Benefit Fund, an internal service fund, to account for its uninsured risks of loss related to employee and retiree health benefits. Under this program, the Fund provides coverage for up to a maximum of $500,000 for each covered participant per year. The State has purchased commercial insurance for claims in excess of this coverage as well as aggregate stop-loss liability coverage set at 125% of the State's expected claims.

Claim liabilities are recorded when it is probable that a claim has occurred and the amount of the claim can be reasonably estimated. Liabilities include an amount for claims that have been incurred but not reported (IBNR) representing medical services provided to covered participants prior to the fiscal year end which have not been submitted for payment to the administrator prior to June 30. The IBNR amount is actuarially determined by an analysis of past, current, and future estimated claim experience.

The following table presents the changes in claim liabilities during the fiscal year ended June 30, 2004. Amounts are shown in thousands.

Governmental Activities	Beginning Balance	Increases	Decreases	Ending Balance	Current	Long-Term
Health Claims Payable	$ -0-	$ 124,547	$ 109,172	$ 15,375	$ 15,375	$ -0-
Total	$ -0-	$ 124,547	$ 109,172	$ 15,375	$ 15,375	$ -0-

STATE OF NEW HAMPSHIRE
EMPLOYEE BENEFIT FUND

SCHEDULE OF NET ASSETS - BY ACTIVITY - GAAP BASIS
JUNE 30, 2004
(Expressed In Thousands)

	Health			Dental	Total
	Active	Retirees	Total		
Assets					
Cash And Cash Equivalents	$ 373	$ 2,864	$ 3,237	$ 7	$ 3,244
Total Assets	373	2,864	3,237	7	3,244
Liabilities					
Accounts Payable	1,167	171	1,338	-0-	1,338
Incurred But Not Reported (IBNR)	9,778	4,259	14,037	-0-	14,037
Total Liabilities	10,945	4,430	15,375	-0-	15,375
Net Assets					
Unrestricted Net Assets (Deficit)	(10,572)	(1,566)	(12,138)	7	(12,131)
Total Net Assets (Deficit)	$ (10,572)	$ (1,566)	$ (12,138)	$ 7	$ (12,131)

STATE OF NEW HAMPSHIRE
EMPLOYEE BENEFIT FUND

SCHEDULE OF REVENUES, EXPENSES, AND CHANGES IN NET ASSETS
BY ACTIVITY - GAAP BASIS
FOR THE FISCAL YEAR ENDED JUNE 30, 2004
(Expressed In Thousands)

	Health			Dental	Total
Operating Revenues	**Active**	**Retirees**	**Total**		
Charges For Sales And Services					
Contributions For Health Benefits					
State Contributions					
Active Employees	$ 79,255	$ -0-	$ 79,255	$ -0-	$ 79,255
Retired Judges And Constitutional Officers	-0-	308	308	-0-	308
Retired Employees	-0-	22,531	22,531	-0-	22,531
Total State Contributions For Health	79,255	22,839	102,094	-0-	102,094
Non-State Contributions					
Retirement Subsidy And Deductions	-0-	9,003	9,003	-0-	9,003
Other Employers	502	16	518	-0-	518
Legislator Participants	449	-0-	449	-0-	449
COBRA Participants	263	61	324	-0-	324
Total Contributions For Health Benefits	80,469	31,919	112,388	-0-	112,388
State Contributions For Dental	-0-	-0-	-0-	6,371	6,371
Total Operating Revenues	80,469	31,919	112,388	6,371	118,759
Operating Expenses					
Health Care Expenses					
Health Care Claims					
Medical Payments	67,637	16,992	84,629	-0-	84,629
Pharmaceuticals	19,297	14,257	33,554	-0-	33,554
Dental Insurance Premiums	-0-	-0-	-0-	6,364	6,364
Administration	3,445	2,236	5,681	-0-	5,681
Enrollment	365	-0-	365	-0-	365
Anciliary Benefits	297	-0-	297	-0-	297
Total Operating Expenses	91,041	33,485	124,526	6,364	130,890
Operating Income (Loss)	(10,572)	(1,566)	(12,138)	7	(12,131)
Change In Net Assets	(10,572)	(1,566)	(12,138)	7	(12,131)
Net Assets - July 1, 2003	-0-	-0-	-0-	-0-	-0-
Net Assets (Deficit) - June 30, 2004	$ (10,572)	$ (1,566)	$ (12,138)	$ 7	$ (12,131)