STATE OF NEW HAMPSHIRE
DEPARTMENT OF ADMINISTRATIVE SERVICES
EMPLOYEE AND RETIREE HEALTH
BENEFIT PROGRAM

PERFORMANCE AUDIT REPORT
JUNE 2011

To The Fiscal Committee Of The General Court:

We conducted an audit of the Department of Administrative Services' (DAS) oversight of the State Employee and Retiree Health Benefit Program (Program) to address the recommendation made to you by the joint Legislative Performance Audit and Oversight Committee. We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

The purpose of the audit was to determine whether the DAS managed the Program in an efficient, effective, and economical manner. The audit period includes State fiscal years 2009 and 2010.

This report is the result of our evaluation of the Program noted above and is intended solely for the information of the DAS and the Fiscal Committee of the General Court. This restriction is not intended to limit the distribution of this report, which upon acceptance by the Fiscal Committee is a matter of public record.

Office Of Legislative Budget Assistant

June 2011

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ABBREVIATIONS

COBRA	Consolidated Omnibus Reconciliation Act Of 1986
CBA	Collective Bargaining Agreement
CY	Calendar Year
DAS	Department Of Administrative Services
DoP	Division Of Personnel
DVRA	Division Of Vital Records Administration
Fund	Employee And Retiree Benefit Risk Management Fund
G&C	Governor And Council
GHRS	Government Human Resources System
HBAC	Health Benefits Advisory Committee
HIPAA	Health Insurance Portability And Accountability Act Of 1996
HR	Human Resource
LBA	Office Of Legislative Budget Assistant
LPAOC	Legislative Performance Audit And Oversight Committee
NCSL	National Conference Of State Legislatures
NHRS	New Hampshire Retirement System

OPEB	Other Post-Employment Benefits
PHI	Protected Health Information
PPACA	Patient Protection And Affordable Care Act
Program	Employee And Retiree Health Benefit Program
RMU	Risk Management Unit
RSA	Revised Statutes Annotated
SFY	State Fiscal Year
SJD	Supplemental Job Description
SSN	Social Security Number
TPA	Third-Party Administrator
U.S.	United States
USC	United States Code
USDHHS	United States Department Of Health And Human Services

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SUMMARY

Purpose And Scope Of Audit

This audit was performed at the direction of the Fiscal Committee of the General Court consistent with the recommendation of the joint Legislative Performance Audit and Oversight Committee (LPAOC). It was conducted in accordance with generally accepted government auditing standards applicable to performance audits. The purpose was to determine whether the Department of Administrative Services (DAS) managed the Employee and Retiree Health Benefit Program (Program) in an efficient, effective, and economical manner. The audit period is State fiscal years (SFY) 2009 and 2010.

Background

RSA 21-I:26 authorizes health care benefits to New Hampshire State employees, spouses, and their dependent children; and retired State employees and their spouses. In SFY 2004, the State began self-funding its employee and retiree health benefit program established in RSA 21-I:26 through RSA 21-I:36. Self-funding health insurance means an employer assumes the risk for paying all covered claims, instead of the traditional model of purchasing commercial insurance from a private insurer. Within the DAS, the Risk Management Unit (RMU) is primarily responsible for administering the self-funded Program, with some aspects also administered by the Division of Personnel (DoP) and the Division of Plant and Property Management. The State contracts with several vendors to assist with Program administration, including services for third-party administration of claims, member enrollment, and benefit consulting. In SFY 2010, the RMU reported spending $235 million in health care expenses and an additional $10 million in operating expenses. Figure 1 shows all expenses incurred for medical and pharmaceutical costs for employees, spouses, dependents, retirees, and beneficiaries and operating expenses during SFY 2010. Administrative costs, including contracts, salaries and benefits, and consultants, make up the operating expenses portion of the chart.

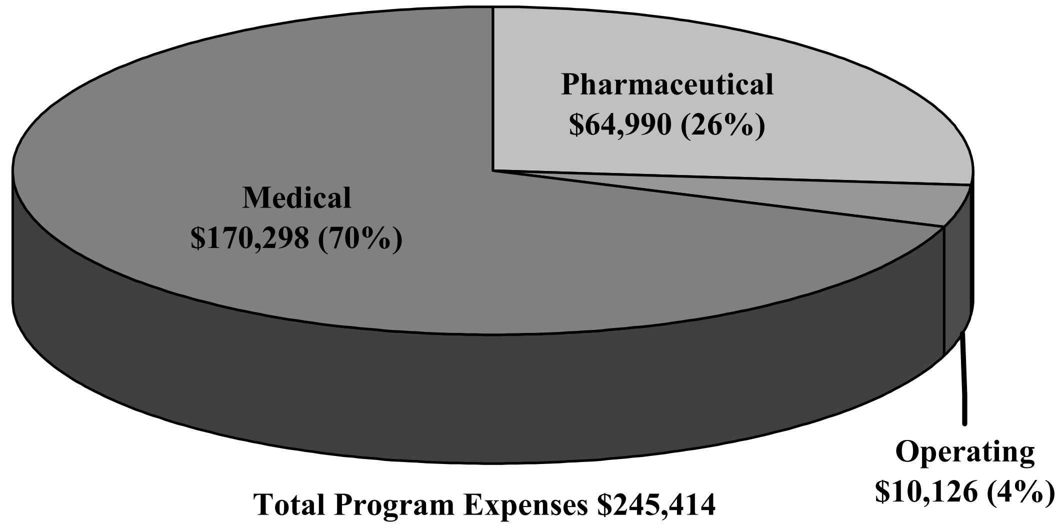
In SFY 2010, nearly 40,000 members were enrolled in the Program in two groups (Figure 2). The active employee group, consisting of employees, spouses, and dependents accounted for approximately 73 percent of all enrollees, while the retiree group, consisting of retirees and their spouses, dependents, and beneficiaries, accounted for approximately 27 percent of all members.

Results In Brief

The RMU's administration of the Program has generally improved since our 2004 financial audit which found insufficient resources were applied to effectively establish and administer the State's self-funded program. During this audit, we found the DAS had increased Program staffing, improved its contracted service procurement practices, and implemented health care cost containment strategies. However, additional improvements need to be made by the DAS to more efficiently, effectively, and economically manage the Program.

Figure 1

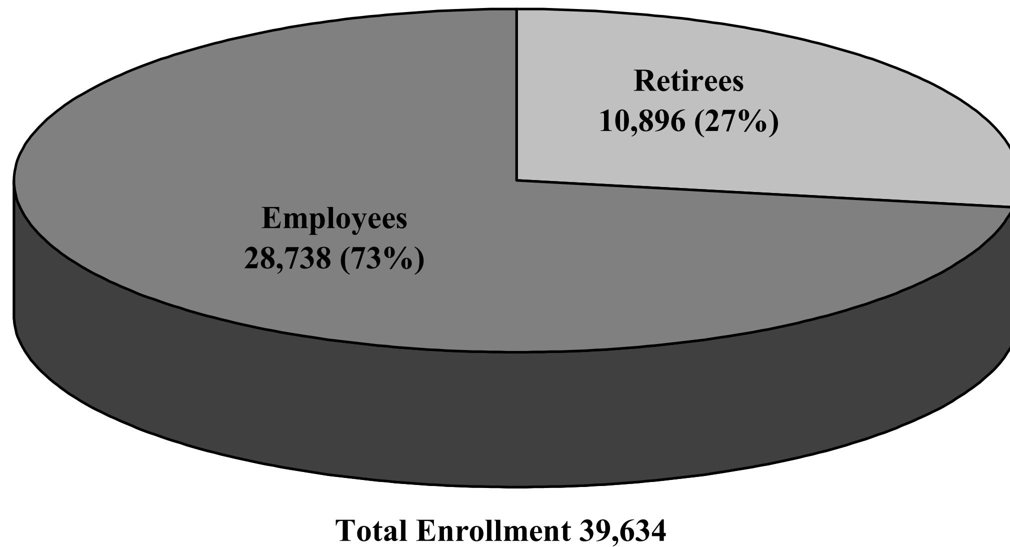
Total Program Expenses, SFY 2010
(In Thousands)



Source: LBA analysis of SFY 2010 State of New Hampshire Comprehensive Annual Financial Report.

Figure 2

Employee And Retiree Enrollment, SFY 2010



Source: LBA analysis of Program annual report for SFY 2010.

Our audit presents ten observations with recommendations to assist the DAS, the RMU, and the Legislature in ensuring the Program is managed efficiently. Three observations may require legislative action. We also present three other issues and concerns, which were not developed into formal observations, we consider noteworthy.

We found the Program would benefit from additional documentation, a greater division of labor, as well as more formalized roles and responsibilities. Six observations address general Program management. We found the Program lacks risk-based policies and procedures for activities and functions. The RMU should improve vendor contract monitoring and the administration of the consulting contract to be more efficient in meeting Program goals.

Eligibility determination and monitoring is a critical part of the Program; four observations address Program eligibility concerns. We found the lack of eligibility controls create significant risk for the Program, especially regarding whether ineligible individuals receive health benefits. The DAS does not conduct eligibility audits. It could, for example, verify eligibility data by matching it with data held by the State's Division of Vital Records Administration or an independent data source. In addition, the DAS should seek to clarify Legislative intent of RSA 21-I:30, allowing a retiree to grant health benefits to a beneficiary following the retiree's death, and whether dependent children should receive health benefits at the retiree's expense. The DAS should promulgate administrative rules for Program eligibility and ensure its active employee and retiree plan benefit booklets and procedures align.

We identified other issues and concerns for the DAS and the Legislature's consideration, such as: future Program costs may trigger an excise tax liability under the "Cadillac" provisions of the federal Patient Protection and Affordable Care Act, the need for improved communications within the DAS, and the need to implement the State's NH First human resource module as a replacement of its current government human resource and payroll system, GHRS.

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RECOMMENDATION SUMMARY

Observation Number	Page	Legislative Action Required?	Recommendation	Agency Response
1	27	No	Establish policies and procedures for activities and functions based on risk. Periodically reassess policies and procedures to ensure they meet Employee and Retiree Health Benefit Program (Program) needs and are being followed by Department of Administrative Services (DAS) personnel.	Concur
2	30	No	Develop policies and procedures addressing requests for exceptions and clarifications to health benefits. Retain all exception requests and their resolutions in a single location accessible to the DAS management.	Concur
3	32	No	Establish policies, procedures, and disclosure forms required by the Privacy and Security Rules of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and issue notice of privacy practices. Determine if HIPAA-related materials are binding on human resource personnel at State agencies or health plan members, and adopt administrative rules as needed. Establish policy prohibiting sending private health information via email and provide HIPAA compliance training to all Program employees and personnel deemed part of the Program.	Concur
4	36	No	Provide appropriate disclosures when requesting Social Security Numbers (SSN). Eliminate unnecessary collection of SSNs and reduce the use of SSNs by exploring alternative identifiers.	Concur

Observation Number	Page	Legislative Action Required?	Recommendation	Agency Response
5	37	No	Reassess staffing resources to more effectively manage Program vendors. Specify roles and responsibilities of personnel interacting with vendors and assign vendors a contact person from the Program. Consider distributing contract management responsibilities among staff to improve control over contracts.	Concur In Part
6	40	No	Ensure the consulting contract is adequately financed to cover needed services, consider including an amount for contingencies, and seek contract amendment approvals from the Governor and Council. Ensure consultant invoices are itemized and services are accurately tracked and paid as specified. Consider centralizing communications between the Risk Management Unit and the benefits consultant as well as implementing performance measures in future consultant contracts.	Concur
7	45	No	Promulgate administrative rules requiring human resources or payroll personnel obtain documentation supporting eligibility as a condition of employment. Require retirees, surviving spouses, and dependents provide eligibility documentation in the event of life changes. Conduct eligibility audits to verify eligibility, explore independent sources to verify eligibility information is correct, and consider re-enrollment requiring appropriate documentation for all current employees.	Concur
8	49	Yes	Request the Legislature consider whether benefits for dependent children should be offered to retirees at their expense. Align benefit booklets for retirees with applicable laws and rules. Promulgate administrative rules establishing Program eligibility criteria for retirees.	Concur In Part

Observation Number	Page	Legislative Action Required?	Recommendation	Agency Response
9	51	Yes	Pursue an agreement with the State's Division of Vital Records Administration (DVRA) to access information to help verify the eligibility of Program participants or seek statutory authority to do so. Reconcile DVRA data with enrollment administrator data to help confirm eligibility for matched records.	DAS: Concur In Part DVRA: Do Not Concur
10	54	Yes	Request the Legislature clarify the intent of RSA 21-I:30 granting a designated beneficiary retiree health benefits. The New Hampshire Retirement System and the Division of Personnel should develop procedures to inform retirees of the beneficiary option from the State after the retiree dies, and ensure the procedures are equitably implemented.	DAS: Concur NHRS: Concur In Part

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OVERVIEW

In July 2010, the Fiscal Committee approved the joint Legislative Performance Audit and Oversight Committee's (LPAOC) recommendation for a performance audit of the efficiency and effectiveness of the Department of Administrative Services' (DAS) management of the State Employee and Retiree Health Benefit Program (Program). The LPAOC approved the audit scope in June 2010.

SCOPE, OBJECTIVES, AND METHODOLOGY

Scope And Objectives

Our audit sought to answer the following question: **Did the DAS manage the State Employee and Retiree Health Benefit Program in an efficient, effective, and economical manner?** To address this question, the audit focused on oversight and eligibility functions performed by the Department's Risk Management Unit (RMU) and the Division of Personnel (DoP) during State fiscal years (SFY) 2009 and 2010. The audit scope did not include the State's dental program overseen by the RMU. Our efforts examined:

- RMU management and oversight generally, including contract procurement and management, organizational structure, staffing, and cost containment; and
- Enrollment practices for members receiving health benefits through the Program.

Methodology

To gain a general understanding of the DAS statutory authority, legal requirements, organizational structure, health plan, and support of the Program, we:

- reviewed relevant federal laws and regulations, State laws, DAS administrative rules, Executive Orders, and collective bargaining agreements;
- reviewed organizational charts, supplemental job descriptions, and prepared a logic model for the Program;
- interviewed RMU and DoP personnel and officials;
- reviewed RMU revenues and expenditures;
- reviewed Program annual reports and DAS reports to the Fiscal Committee; and
- reviewed benefits booklets and summaries.

To assess how the RMU manages the Program and ensures only eligible individuals receive health benefits paid by the Program, we:

- reviewed our prior audit reports and other reviews of the Program;
- evaluated the RMU's work to address our prior observations;
- interviewed RMU, DoP, and other DAS personnel and officials;
- reviewed various materials related to Program contracts;

- evaluated the RMU's compliance with contract procurement procedures;
- interviewed representatives of the Program's vendors;
- reviewed health care consultant invoices and related materials;
- reviewed the online enrollment manual;
- examined the database from the online enrollment vendor;
- attempted to obtain access to certain portions of the State's Vital Records Administration database;
- reviewed a vendor's reports on the Program's internal controls;
- interviewed State Employees' Association of New Hampshire officials;
- interviewed New Hampshire Retirement System (NHRS) officials;
- interviewed human resource administrators from State agencies;
- reviewed documents related to various Program improvement projects; and
- obtained draft Program polices and procedures.

To collect information to compare to the RMU's Program, we:

- reviewed literature on health care costs, other states' employee health plans, privacy requirements, and audits of other states' plans;
- indentified common cost containment practices for employee health plans;
- reviewed contract performance measures used by other states; and
- interviewed officials of certain other states that self-fund employee health benefits to collect information on staffing levels, organization structures, and use of contractors.

BACKGROUND

RSA 21-I:26 authorizes health care benefits to New Hampshire State employees, spouses, and their dependent children; and retired State employees and their spouses. The statute states it is an accepted view among small and large private sector employers and the other five New England states that group health benefits contribute to the well-being and efficiency of employees. Therefore, the policy's purpose is to ensure health benefits offered by the State compare favorably to private sector employers and the other five New England states.

Until 2003, the State provided health coverage to its employees and retirees by purchasing commercial insurance for covered employees, retirees, spouses, and eligible dependents. Starting in SFY 2004, RSA 21-I:30-d mandated the DAS to implement a self-insured health plan. This mandate was repealed effective July 2006; thereby allowing the DAS Commissioner to decide whether the State will self-fund or purchase insurance.

Self-Funding

With traditional insurance, commercial insurers collect premiums in exchange for a promise to pay claims. The premium amount is designed by the insurer to cover all expected claims, set aside funds for future unexpected claims (a reserve), pay for the insurer's administrative overhead, and return a profit. With insurance, the insurance company is assuming the risk it may

have to pay claim amounts that are greater than its premium revenue. The insurance purchaser pays a set amount in premiums and is not liable for claims payments.

When entities choose to forgo purchasing insurance and assume the risk for all covered health claims, the entity is said to be self-funded or self-insured. One benefit of a large population of covered employees is claim cost estimates become more predictable and therefore easier to plan for. Actuaries can predict the number and types of health claims that a given population is expected to generate. In theory, by self-funding, large employers avoid the costs associated with insurance companies accepting risk and generating profits. Self-funded entities create a reserve to pay future claims and maintain adequate funding to pay unexpected claims, and may purchase stop-loss insurance coverage to mitigate the risks of unexpected high-cost claims.

According to the National Conference of State Legislatures, New Hampshire is one of 46 states self-funding at least one of their employee health care plans in 2010. The RMU's health benefits consultant stated the State's large and statistically predictable Program membership made self-funding more beneficial than purchasing private insurance. The RMU compares the cost of fully insuring Program benefits to self-funding when it contracts for third-party administrators.

Program Overview

RSA 21-I:30 establishes the State's responsibility for providing medical coverage to current and retired State employees, stating "[t]he state shall pay a premium for each state employee… including spouse and minor, fully dependent children, if any, and each retired employee…and his or her spouse…toward group hospitalization, hospital medical care, surgical care and other medical benefits plan or a self-funded alternative…."

The DAS Commissioner is ultimately responsible for the Program.[1] Since 2003, the Program has been operated largely by the RMU within the DAS, although the DoP and the Division of Plant and Property Management also play roles in managing aspects of the Program, as shown in the organization chart in Figure 3. The RMU (formerly the Bureau of Risk Management) was established by RSA 21-I:7-c and is responsible for:

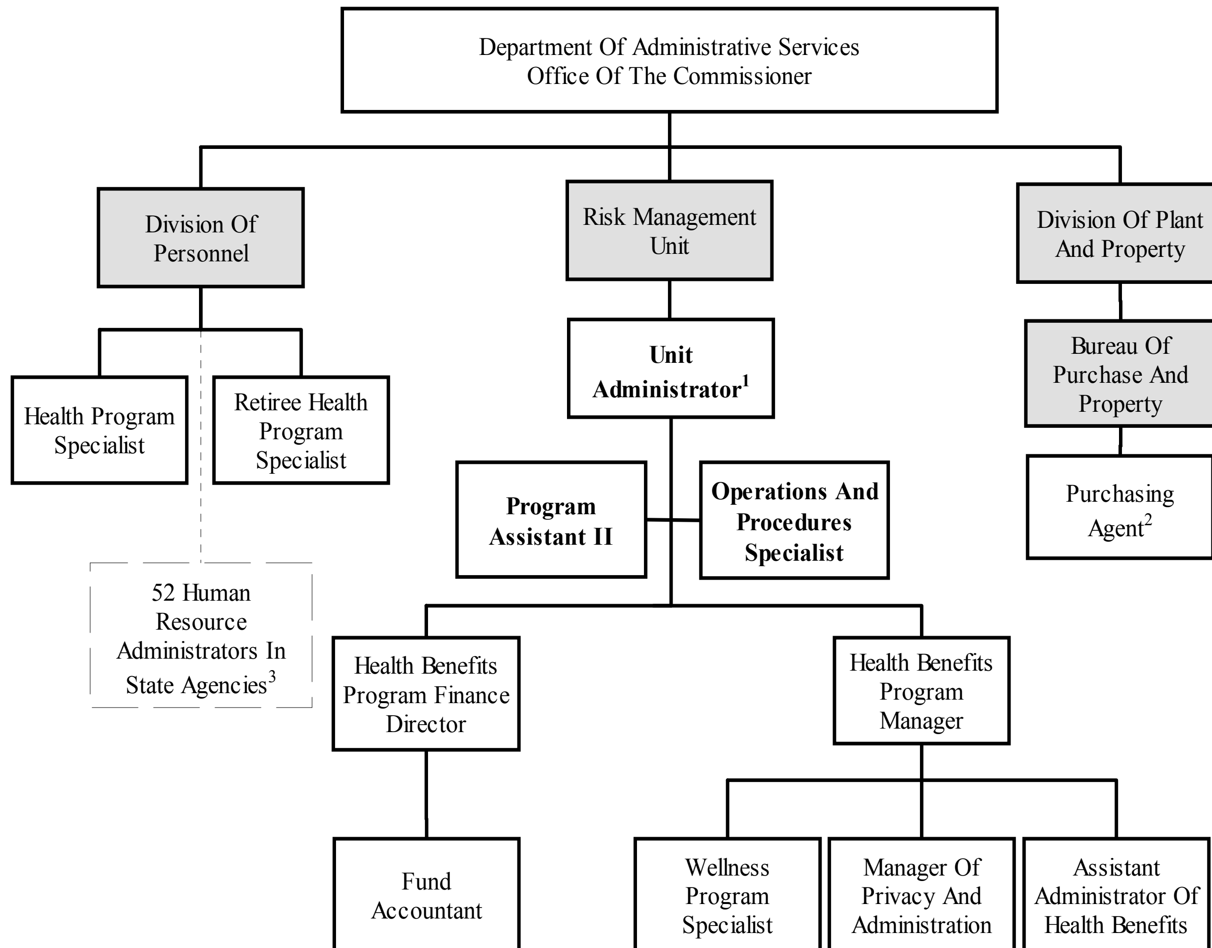
- identifying loss exposure for State-owned property,
- developing and operating risk reduction programs,
- identifying cost-effective means of protecting against various types of losses that may be incurred by the State,
- preparing bid specifications for commercial insurance purchases, and
- purchasing liability insurance for State-owned vehicles.

The statute does not specifically provide the RMU with responsibility for administering the Program.

[1] Although not named in statute, "Self-Funded Employee and Retiree Health Benefit Program" is the name given the program by the DAS.

Figure 3

Employee And Retiree Health Benefit Program Organization Chart, As Of May 2011



Notes: [1] Personnel in bolded positions divide their time between the Program and other risk management functions of the RMU, such as property and casualty insurance or workers' compensation for State employees. The Figure does not include three positions within the RMU working exclusively on other risk management programs.
[2] Purchasing Agent divides time between Program procurements and other Division of Plant and Property Management procurements.
[3] Human resource administrator positions located in other State agencies with some Program responsibilities but not under direct DAS control.

Source: LBA analysis of New Hampshire statutes and DAS organization charts.

The RMU performs day-to-day oversight of the Program and operates within the Commissioner's Office separately from other DAS divisions. There are six full-time employees in the RMU working exclusively on health benefits, in addition to three personnel who share

other risk management responsibilities of the RMU. A purchasing agent in the Division of Plant and Property Management is responsible for procuring health-related vendor contracts for the RMU. The DoP has two program specialists serving as liaisons between the Program and its enrollees. There are 52 human resource (HR) administrators in State agencies who have limited Program responsibilities.

Eligibility For State Employees And Retirees

RSA 21-I:32 allows all full-time State employees and retired State employees to voluntarily participate in the State's health benefit program. RSA 21-I:30 further defines which employees and their family members are covered, should an eligible employee choose to receive health benefits:

- full-time State employees, their spouses, and minor fully dependent children;
- permanent temporary and permanent seasonal employees as defined in RSA 98-A:3, their spouses, and minor fully dependent children; and
- retired State employees and their spouses or beneficiaries.

Eligibility for retiree health benefits is determined when a State employee files for retirement with the NHRS. Eligibility requirements for retiree health benefits are stated in RSA 21-I:30, I; coverage is provided to "each retired employee…and his or her spouse, or retired employee's beneficiary, only if an option was taken at the time of retirement and the employee is not now living…." Generally, a retiree cannot receive health benefits without also receiving a State pension. Normally, in order to be considered retired, one must receive a pension from the State. Employees who cash out their investments at retirement (and take no pension) are not considered retired for health benefit eligibility purposes. RSA 21-I:30, I limits retirees' health benefits to "funds appropriated at each legislative session." For each employee retired under NHRS rules, NHRS pays a medical subsidy to the State to help offset the costs of retirees' health benefits.

If a State employee becomes retirement-eligible due to ordinary (non-job related) or to accidental (job-related) disability retirement, medical coverage is provided under the Program with the NHRS pension, regardless of age. In cases of post-retirement death of the retired employee, the State provides State-paid medical coverage to the surviving spouse or beneficiary when the retiree passes.

The Program provides health coverage for retirees under age 65. If a retiree chooses to participate in the State's plan, the retiree pays $65 monthly for the health coverage. If the retiree has a spouse enrolled in the State's program, the spouse also pays $65 monthly. Upon turning 65, a retiree becomes Medicare-eligible. Medicare is a health benefit provided by the U.S. Department of Health And Human Services (USDHHS) to persons aged 65 or older, persons under 65 with certain disabilities, and persons of any age with end-stage renal disease. Retirees apply for Medicare when they turn 65; their State-provided health benefit plan converts to a plan supplementing Medicare, which becomes the primary payer of health benefits. Retirees must enroll in Medicare Parts A (hospital) and B (physician and other medical services) in order to keep coverage under the State's supplemental policy. State-provided health benefits for Medicare-eligible retirees include comprehensive prescription drug coverage, so they do not

need to enroll in Medicare Part D prescription drug coverage. Medicare-eligible retirees only pay the USDHHS monthly cost for coverage under Medicare; currently, the State provides the supplemental coverage and prescription coverage, which is partially subsidized by the federal government, at no cost to the enrollee. Medicare eligibility also results in a reduced medical subsidy paid by the NHRS and a reduced pension amount. Table 1 summarizes persons eligible for State health benefits under the Program.

Table 1

Persons Eligible For State Health Benefits

Active State Employees	Retired State Employees
Full-Time, Permanent Temporary, Permanent Seasonal, And Certain Other State-Related Entities	Eligible For Retirement Per NHRS And Receiving A NHRS Pension
Spouse	Spouse
Dependent Children	Dependent Children
Disabled Children	Disabled Children[2]
Children Up To Age 26[1]	Student Children
Ordinary (Non-Job-Related) Disability	Ordinary (Non-Job-Related) Disability
Accidental (Job-Related) Disability	Accidental (Job-Related) Disability
Death: Spouse And Minor Children Or Beneficiary	Death: Spouse Or Beneficiary

[1] Children of active employees are covered up to age 26 so long as no other health benefits are available to said individual.

[2] Retiree disabled children are covered by the Program as long as they were not previously removed from the Program and have a medical disability form on file with the medical third-party administrator (TPA).

Source: LBA interpretation of statutes, administrative rules, benefit booklets, and DAS practice.

RSA 100-A:54, I specifies the State's intent to continue funding a subsidy for medical benefits under RSA 100-A:52 to the extent of adequate funding in a special account established by RSA 100-A:16, II (h) and specific eligibility limitations identified in RSA 100-A:55. Notwithstanding the State's specified intention identified above, RSA 100-A:54, II states the Legislature may cease providing medical subsidy benefits "for any reason, at any time" including medical benefits for Group I State employee, teacher, and political subdivision employee members, as well as Group II employee members.

Enrollment

Table 2 shows enrollment by employee group. Total enrollees for both SFYs 2010 and 2009 are approximately 40,000 employees, retirees, spouses, dependents and beneficiaries. Active employees and their spouses and dependents account for approximately 73 percent of all

enrollees, while retirees, their spouses, dependents, and beneficiaries account for approximately 27 percent.

Table 2

Health Plan Enrollees By Employee And Retiree Group
As Of June 30, 2010 And June 30, 2009

Group		Number of Enrollees			
		SFY 2010	Percent of Total	SFY 2009	Percent of Total
Active Employees	Employees	11,701	29.5	11,968	29.9
	Spouses/Dependents	17,037	43.0	17,469	43.6
	Total Active Group	28,738	72.5	29,437	73.5
Retirees	Retirees	9,844	24.8	9,505	23.7
	Spouses/Dependents/ Beneficiaries	1,052	2.7	1,112	2.8
	Total Retiree Group	10,896	27.5	10,617	26.5
	Total Enrollees	**39,634**	**100.0**	**40,054**	**100.0**

Source: LBA analysis of Program annual reports for SFYs 2010 and 2009.

Federal Statutes Affecting Administration Of The Program

In addition to State statutes, the DAS must adhere to a variety of federal laws governing health plans. Federal laws with some applicability to the Program during the audit period included:

- **Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA):** The COBRA requires group plan providers to offer continued coverage, on a temporary basis, to individuals and their dependents who would otherwise lose this coverage due to certain events. Such events include termination for reasons other than gross misconduct, the death of a covered employee, or reductions in hours worked by a covered employee. An employer may require individuals receiving continued coverage to pay the full cost of coverage, plus a two percent administrative fee. COBRA participants in the Program pay 102 percent of the "premium" amount.
- **Genetic Information Nondiscrimination Act**: Enacted in 2008, it prohibits insurers and employers from discriminating on the basis of genetic information.
- **Health Insurance Portability and Accountability Act of 1996 (HIPAA)**: The HIPAA established nondiscrimination requirements intended to prevent insurers and group health plans from discriminating against participants based on health status. Additionally, the HIPAA required the USDHHS to issue rules regarding the privacy of individually identifiable health information. The resulting rules apply to "health plans, health care providers, health care clearinghouses" and other entities transmitting health care data in electronic form. The rules identify permissible disclosures of personally identifiable

information and prohibit disclosures which do not fall within these permissible categories.

- **Mental Health Parity Act:** Enacted in 1996, it does not require employers to provide mental health coverage but mandates plans offering such benefits not impose lower lifetime or annual limits on mental health benefits than they do on medical and surgical benefits.

The federal Patient Protection and Affordable Care Act (PPACA), signed into law on March 23, 2010, was intended to ensure universal availability of quality health insurance.[2] Although the impact of the PPACA on individual and employer-provided health plans is far from settled, the USDHHS, the U.S. Department of the Treasury, and the U.S. Department of Labor have offered guidance to plan administrators in the form of interim final regulations.

In 2010, the PPACA began to impose a variety of restrictions upon group health plans. Since self-funded health plans are considered a type of "group health plan" under the PPACA, references to "group health plan" in the Act apply to the Program. The PPACA further distinguishes between grandfathered and non-grandfathered plans. According to the RMU, the plans administered by the Program are grandfathered.

Grandfathered plans are those which were in effect at the time of the PPACA's passage on March 23, 2010 and which have not changed substantially in terms of either (a) the benefits offered to members or (b) the cost-sharing requirements imposed upon members. Grandfathered plans are exempt from several requirements imposed upon new plans, and so, retaining grandfathered status is likely desirable from an employer's standpoint.

Effective in SFY 2011, the PPACA imposes the following restrictions on grandfathered, self-funded plans:

- prohibition on lifetime benefits limits,
- restriction on annual benefits limits,
- restriction on rescissions (denial of coverage for reasons unrelated to medical necessity),
- extension of dependent coverage to age 26, regardless of the dependent's marital status or whether they are a full-time student,[3]
- requirement that plans offer a uniform explanation of plan benefits, and
- requirement that plans report medical loss ratios and provision of rebates.

[2] Some portions of the PPACA were amended as a result of the Health Care and Education Reconciliation Act of 2010, passed via the reconciliation process and signed into law on March 30, 2010. In this document, "PPACA" refers to the PPACA as amended.

[3] For non-grandfathered plans, the PPACA requires plans to cover dependents up to age 26 *regardless of the dependent's ability to obtain coverage elsewhere*. Because the State's plan is likely grandfathered, it does not provide coverage for adult dependent children (if they have access to such coverage) until 2014. The RMU estimates this provision will cost $2.6 million annually to implement, and accordingly, has opted to delay implementation until 2014. Until that time, the RMU will continue to deny coverage to adult dependent children, who have access to health coverage through other means.

The Program could lose grandfathered status if the State alters health benefits or cost-sharing requirements by more than a certain amount. The precise changes which would cause a plan to lose grandfathered status have been described in detail in regulations promulgated by the USDHHS. Were the Program to lose grandfathered status, it would be subject to additional requirements, including:

- coverage for preventive services with no cost-sharing, and
- internal and external appeals processes.

Logic Model

Measuring the performance of a government program is difficult because many factors contribute to outcomes. Determining the absolute extent to which a government entity contributes to a particular outcome is not usually possible. Instead, the aim of performance measurement is to acquire insight and provide evidence the program or activity actually has an impact. A key tool for determining attribution is a logic model, which illustrates intended relationships.

Figure 4 focuses on four RMU responsibilities for administering State employee and retiree health benefits. This logic model is an aid to understand the management of these functions; it is not intended to describe all activities carried out by the DAS or the RMU.

Logic models are flow charts depicting programs in a way that facilitates developing relevant measures by portraying intended causal relationships between activities, outputs, and outcomes. Individual program activities, outputs, and outcomes are arranged in rows. Relationships between the various activities, outputs, and outcomes are arranged vertically on the page according to the sequential flow of program logic. The arrows linking the program elements signify the intended flow of the program.

Significant Achievements

Performance auditing by its nature is a critical process, designed to identify weaknesses in past and existing practices and procedures. Noteworthy management achievements related to the scope of the audit are included here to provide appropriate balance to the report. Significant achievements are considered practices, programs, or procedures that evidence indicates are performing above and beyond normal expectations.

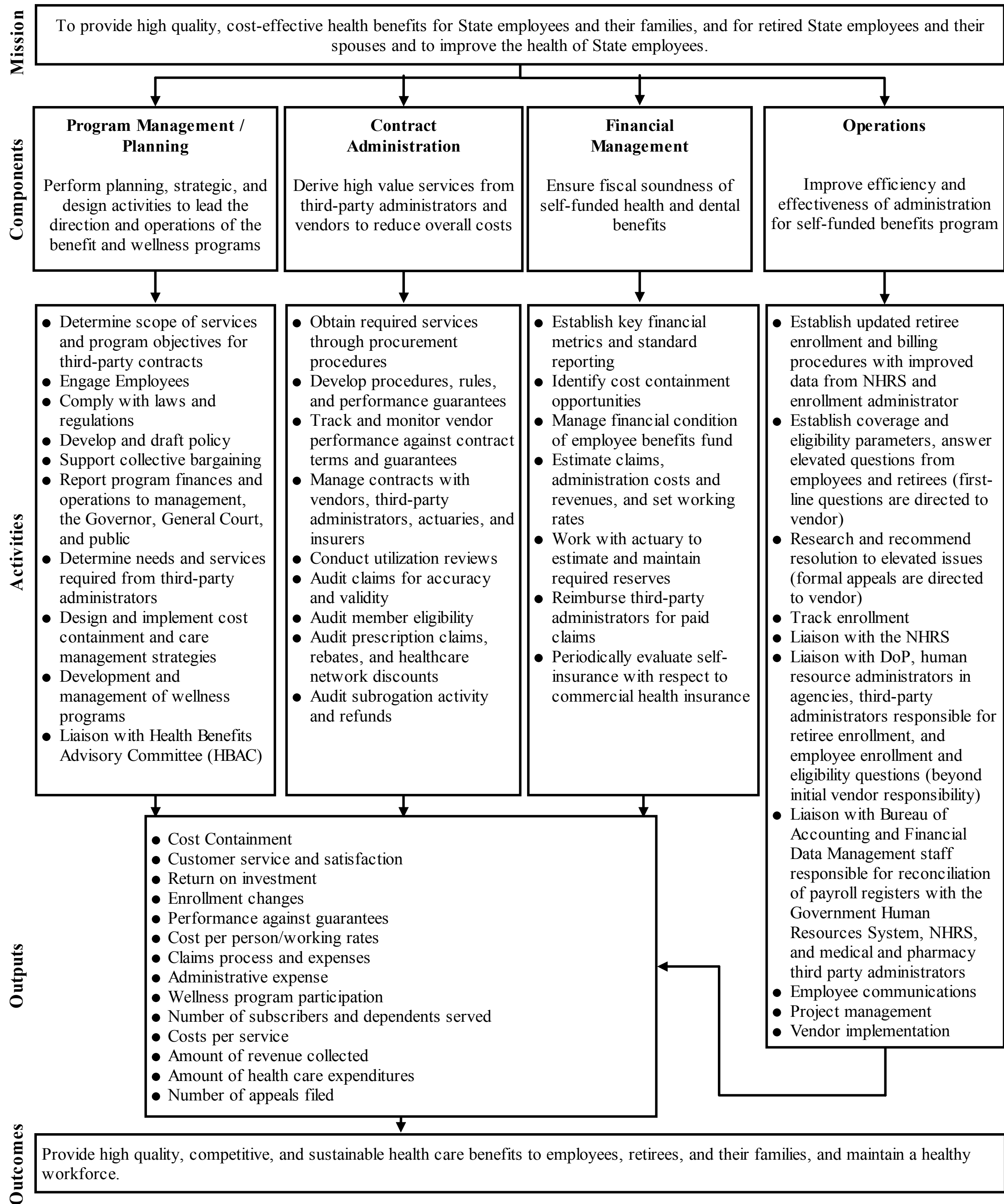
Employee Wellness Program

Employee wellness is a long-term strategy to reduce health care costs by promoting healthy lifestyles and behaviors. Wellness programs typically seek to reduce behaviors leading to increased health care costs such as tobacco, alcohol, and other substance abuse, as well as poor diet and lack of exercise. It is estimated individual behaviors are responsible for at least 50 percent of health care costs, excluding costs related to lost productivity, poor performance, and on-the-job accidents. Research supports the view that wellness programs can be effective in controlling costs. RMU staff project the wellness program could reduce long-term medical

expenditures by one percent, a substantial figure given the State's current yearly expenditures for health care.

Figure 4

Employee And Retiree Health Benefit Program Logic Model



Source: RMU and LBA analyses of Program statutes and annual reports.

In 2006, the Governor signed Executive Order 2006-07, directing each State agency to appoint a wellness coordinator to support agency wellness efforts in coordination with the Health Benefits Advisory Committee. The RMU hired a full-time Wellness Coordinator in May 2010, which best practice indicates is ideal to create a cohesive wellness team. The RMU's Wellness Coordinator meets with other agency coordinators once every three months to discuss the State's wellness agenda for the next three-month period. The State's third-party administrator contracted through the RMU also provides wellness services, including web-based health coaching and health promotion training at State agencies.

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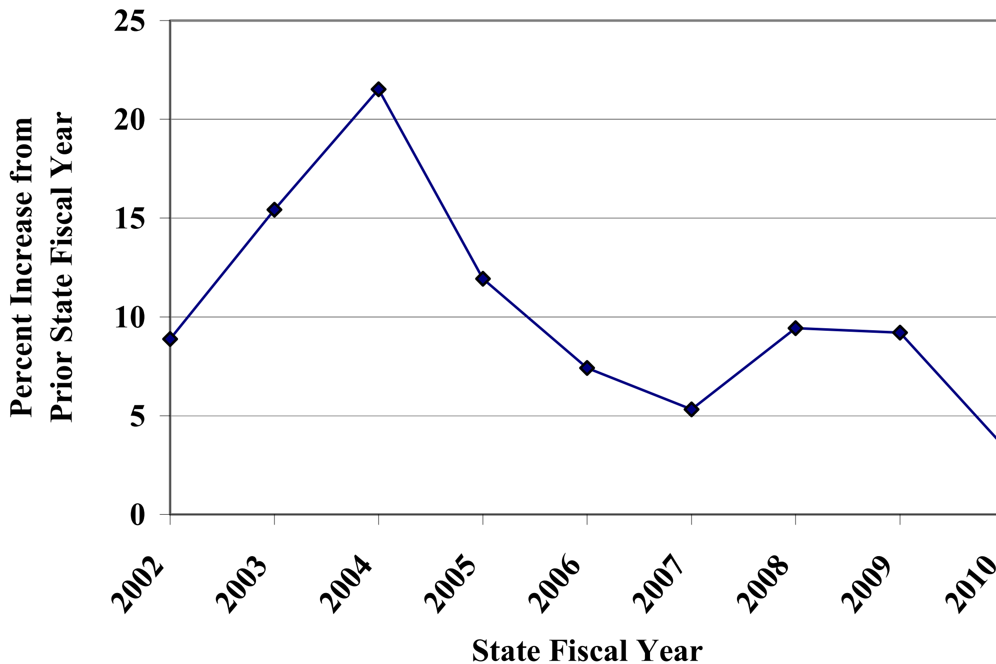
HEALTH CARE COSTS

The Risk Management Unit (RMU) reports the shift to self-funding in October 2003 has resulted in substantial cost savings to the State. The Employee And Retiree Health Benefit Program's (Program) aggregate annual cost increases have decreased substantially over time, from a high of nearly 25 percent in State fiscal year (SFY) 2000 to a low of 3.4 percent in SFY 2010. Although Program costs have increased each year, the *rate of increase* has declined significantly, which the RMU contends has resulted in substantial cost savings. Analyzing the Program expenses confirms this decline in the Program's annual cost growth, which is displayed in Figure 5. However, our analysis of national and regional trends in health care costs indicate the Program's rate of cost growth has followed the same general trend as overall health care inflation, reaching a peak in the early 2000s and gradually leveling off in recent years. Although some portion of the decline in yearly cost increases may be attributable to the RMU's management of the Program, it is difficult to disentangle the effects of Program management from the effects of decreasing medical cost inflation.

Figure 5

Percentage Growth In State Health Care Costs, SFY 2002 To 2010



Note: Excludes dental costs.
Source: LBA analysis of Program documents.

Although the annual rate of increase has decreased over time, health care costs for New Hampshire State employees and retirees continue to be more expensive than for public sector

employees elsewhere in the country and for private sector employees in New Hampshire. In 2009, a family working rate or "premium" for New Hampshire State employees was $20,885; according to the National Conference of State Legislatures (NCSL), the average family premium among state governments nationwide was $12,907, while the average premium for New Hampshire private sector employees was $13,883, according to a Medical Expenditures Panel Survey commissioned by the U.S. Department of Health and Human Services (USDHHS). These higher costs can be attributed to a variety of factors, which are largely outside of the RMU's control. These factors include the high cost of health care in New England compared to other regions and the Program's benefit structure, which utilizes relatively little cost-sharing between the State and its employees. These factors are briefly examined in the following sections.

Health Care Costs In The Northeast Are Higher Than Average

Health care in the Northeast is generally more expensive than health care in other areas of the country. According to a 2010 Kaiser Foundation survey of employers, average family premiums in the Northeast were 9.3 percent higher than family premiums in the other three regions, costing an average of $14,815 per year, compared to an average of $13,558 in the other regions. Individual coverage was 10.5 percent more expensive in the Northeast than in the other three regions, with premiums averaging $5,484 per year, compared to $4,962 in the other three regions. The survey also found health care costs for public sector employees were more expensive than health care costs for employees in other sectors. According to the survey, average yearly family premiums for state and local government employees were $14,684 nationwide in 2010, compared to $13,616 for all other sectors, a difference of 7.8 percent. Although the survey did not determine health care costs for each sector in each region of the country, it is reasonable to conclude costs for public sector employees in the Northeast would be among the highest groups in the country. The reasons for the high cost of care in the Northeast are varied and include such structural factors as the strong influence of hospitals, which reportedly exercise considerable power when negotiating rates with insurance companies. These factors, however, are beyond the RMU's control and are unlikely to be affected by the RMU's management of the Program.

Plan Design

As with the high cost of regional care, plan design issues are largely outside of the RMU's control, as the State's health plan is negotiated during the collective bargaining process, and plan specifications are set out in the resulting Collective Bargaining Agreement (CBA). As the entity responsible for overseeing most aspects of the Program, the RMU is charged with adhering to the health benefit provisions of the CBA.

Five stakeholders and four Department of Administrative Services (DAS) employees we talked to reported the State's health plan is "generous" in the sense it contains relatively little cost sharing in the form of co-pays, deductibles, or co-insurance. This view was supported by a 2009 survey of state health benefits conducted by the NCSL, which revealed in 2009 state employees paid, on average, 1.7 percent of the costs of the premium for family coverage, compared with an average of 18.8 percent paid by employees in the other 46 states responding to the survey. Individual coverage did not show as large a discrepancy, with New Hampshire State employees

paying 5.3 percent of the total cost of individual premiums, compared to an average of 9.0 percent in the other 46 states responding to the survey. Although the State employee share of costs has likely increased since that time as a result of the biweekly employee contribution increasing from $25 to $30, a review of cost-sharing in states similar to New Hampshire suggests the State employees' share of health costs is still relatively low. Academic research on health care costs suggests low cost-sharing may encourage high utilization, as plan members may utilize services without regard to their actual cost.

Controlling Costs

According to an April 2009 *Government Finance Review* article entitled "Health-Care Cost Containment Strategies," there are three primary areas in which employers can make changes in their efforts to control health care costs. Employers can 1) change the health benefits plan offered to employees, 2) change how the plan is administered and funded, and 3) reduce the demand for services. According to the article, a commonly used cost containment method is transferring some percentage of plan costs to employees who use the services, which reduces direct costs to the employer and may reduce employees' demand for services. Table 3 presents recommended strategies to control costs we identified in this article and others, along with an indication of whether the RMU has put them into practice.

Program Revenues And Expenditures

RSA 21-I:30-e establishes the Employee and Retiree Benefit Risk Management Fund (Fund) to account for all funds received from any source, for active State employee and retiree health benefits and all expenses, including administrative costs related to providing these health benefits. The Fund is an internal service fund administered by the DAS. The Fund is non-lapsing and continually appropriated and cannot be used for any other purpose. Interest income generated on the funds is credited to the Fund by the State Treasurer at the end of each fiscal year.

RSA 21-I:30-c establishes a reserve fund to protect the State from unexpected and self-insured losses and related expenses incurred while using a self-funded alternative to providing medical and surgical benefits. According to RSA 21-I:30-b, the State must keep a minimum balance in the account at least equal to five percent of estimated annual claims and administrative costs of the plan along with an amount determined by an actuary "necessary to fund the unpaid portion of ultimate expected losses, including incurred but not reported claims, and related expenses incurred in the provision of benefits for eligible participants…." The amount determined necessary may be reduced to the extent the State purchases excess or stop-loss insurance as recommended by an actuary.

Revenues to the Fund include: contributions from State agencies for active employees and retirees, retired judges, and constitutional officers as well as certain State-related entities such as the Pease Development Authority and the State Employees' Association of New Hampshire, one of the labor unions representing classified employees; contributions from active full-time State employees and retirees, legislators, and other eligible part-time State employees; contributions from former employees eligible to participate under the Consolidated Omnibus Budget

Reconciliation Act of 1986 (COBRA); and other miscellaneous revenues such as prescription drug rebates, federal subsidies, subrogation (recoveries from third-parties), and assessments imposed on vendors resulting from contractual performance guarantees.

Table 3

Health Care Cost Containment Strategies

	Used By The RMU
Conduct Eligibility Audits	No
Ensure Payments Made In Accordance With Plan	Yes
Ensure Coordination Of Benefits	Yes
Request Price Quotes Every Few Years	Yes
Combine Purchasing Power Of Several Employers	Yes[1]
Incentivize Use Of Generic Drugs	Yes
Incentivize Use Of The Mail Order Drug Option	Yes
Incentivize Providers For High-Quality Medical Outcomes	Yes[1]
Indentify High-Use Health Plan Components That Could Be Trimmed	Yes
Case Management Of Long-Term Or High-Cost Illnesses	Yes
Separate Active And Retiree Populations In Plan Design	Yes
Increase Employee Co-Payments And Premiums	Yes[2]
Periodically Analyze The Costs Of Self-Funding Or Purchasing Insurance	Yes
Directly Allocate Benefit Costs To All Departments	Yes
Educate Employees On Healthy Living	Yes
Conduct Utilization Management	Yes

Note: [1] Strategy used by RMU vendor.
[2] Not under the direct control of the RMU.
Source: LBA review of best practice literature, RMU documents, and interviews with RMU personnel.

Fund expenses include payments for medical, surgical, pharmaceutical, and hospital costs for covered participants, including eligible spouses, dependents, and beneficiaries. All administrative costs are also paid out of the Fund, including salaries and benefits costs of employees affiliated with the health benefit program, consultant and actuarial costs, contracted vendors, and ancillary benefits such as health club reimbursements and health-related education classes. The program contracts for most services including an enrollment administrator, which provides employees with an Internet-based application to self-register for health benefits and make necessary changes, as well as third-party administrators (TPA) to receive and process

medical, dental, and pharmacy claims. The Fund reimburses the TPAs after the TPAs pay the claims directly to the service providers.

Program costs for active employees are budgeted in class 060 benefit accounts for each agency, along with the State's share of payroll taxes, pension contributions, and dental benefit costs. When developing the State's budget, the RMU must estimate future health care expenditures and calculate plan rates to be used by agencies for budgeting purposes. The Program's health care consultant makes these budget estimates and recently started using a different methodology to provide a more predictive estimate. Every year the consultant calculates calendar year "working rates" used by agencies to make their transfers to the Program. The working rates may be different from the budgeted rates which were set months earlier.

By entering into new contracts, cost assumptions used to generate budgeted and working rates can change. In addition, claims experience may not be as planned. As a result, the actual claims experience may create a surplus or deficit for the Program. One reason for the required reserves is to protect the State from unexpected increases in health care expenditures.

When the RMU determines the Program is generating a surplus (above the required reserve amount), a "rate holiday" is used. During the rate holiday, the DAS does not bill agencies for employees' health benefits for a certain amount of time (i.e., rate holiday), thereby allowing the Program's surplus to be spent down. According to an RMU official, during the audit period the DAS undertook two rate holidays totaling $20.6 million in agency savings.

Table 4 shows the revenues, expenditures, and changes in fund balance accounts for health benefits only for the Employee and Retiree Benefit Risk Management Fund for SFYs 2010 and 2009. The health benefits portion of the Fund (excluding dental) experienced an operating surplus of $7.6 million in SFY 2010 and a $13.1 million deficit in SYF 2009.

Table 4 also shows program expenditures for both SFYs 2010 and 2009 were comprised primarily of health benefits, which were nearly 96 percent of total expenditures in each of those fiscal years. Enrollment and administrative costs accounted for 4.1 percent and 4.2 percent of total expenditures in SFYs 2010 and 2009, respectively. Medical payments to providers were 72.0 percent and 71.5 percent of health care expenditures in SFYs 2010 and 2009, respectively, while pharmaceuticals were approximately 28 percent of health care expenditures in each fiscal year.

At the group level, active employees accounted for a majority of costs associated with medical payments to providers, accounting for approximately 78.5 percent of total health care expenses in each year. In contrast, the retiree group accounted for approximately 45 percent of total pharmaceutical expenditures in each year.

Table 4

Revenues, Expenditures, And Changes In Fund Balance Accounts
For State Fiscal Years Ending June 30, 2010 And June 30, 2009 (In Thousands)

	SFY 2010			SFY 2009		
	Active	Retirees	Total	Active	Retirees	Total
Operating Revenues						
State Contributions:						
Active Employees	$ 163,060	$ -	$ 163,060	$ 156,642	$ -	$ 156,642
Retired Employees	-	52,823	52,823		51,487	51,487
Non-State Contributions:			-			-
Active Employees	8,986	-	8,986	-	-	-
Other Employers	1,253	-	1,253	1,118	-	1,118
COBRA Participants	822	-	822	491	-	491
Legislators/Former Legislators	694	161	855	622	144	766
Retirement Subsidies & Deductions	-	18,704	18,704	-	15,023	15,023
Recoveries & Investment Income	3,421	3,046	6,467	3,401	2,544	5,945
Total Operating Revenues	178,236	74,734	252,970	162,274	69,198	231,472
Operating Expenses						
Health Care Expenses:						
Medical Payments	132,760	36,649	169,409	129,320	38,163	167,483
Pharmaceuticals	35,515	29,475	64,990	34,065	31,851	65,916
Ancillary Benefits (Exercise Program)	889	-	889	841	-	841
Total Health Care Expenses	169,164	66,124	235,288	164,226	70,014	234,240
Administrative Expenses	5,562	4,170	9,732	6,083	3,955	10,038
Enrollment	221	173	394	187	144	331
Total Operating Expenses	174,947	70,467	245,414	170,496	74,113	244,609
Change in Net Assets	3,289	4,267	7,556	(8,222)	(4,915)	(13,137)
Net Assets - July 1	6,724	4,807	11,531	14,946	9,722	24,668
Net Assets - June 30	$ 10,013	$ 9,074	$ 19,087	$ 6,724	$ 4,807	$ 11,531

Note: Excludes dental benefit revenue and expenditure accounts which totaled approximately $12 million each, in each fiscal year, and net assets of approximately $1 million at the end of each year.

Source: LBA analysis of SFY 2010 and SFY 2009 State of New Hampshire Comprehensive Annual Financial Reports.

PROGRAM MANAGEMENT

Management is responsible for ensuring program goals are achieved. A key factor in achieving desired goals and minimizing operational problems is to design and implement appropriate management controls. Management controls, sometimes called internal controls, include the plans, policies, procedures, and methods management uses to meet its mission, goals, and objectives. Properly designed and implemented management controls include the processes for planning, organizing, directing, and controlling program operations. Appropriate controls are integral in providing reasonable assurance programs operate efficiently and effectively, financial reporting is reliable, and laws and regulations are followed.

The Department of Administrative Services (DAS), through its Risk Management Unit (RMU), Division of Personnel (DoP), and Division of Property and Plant Management is responsible for developing and implementing appropriate management controls to efficiently and effectively operate the Employee and Retiree Health Benefit Program (Program). The following observations identify management control weaknesses related to the Program. We found the Program lacks complete policies and procedures, an issue identified in our 2004 financial audit and 2006 performance audit of insurance procurement practices, and yet still largely unresolved. Our findings indicate the Program has not taken adequate steps to ensure compliance with privacy and security requirements of federal laws such as the Health Insurance Portability and Accountability Act of 1996 (HIPAA). We also found improving vendor management practices, such as assigning a single RMU staff member to manage each major contract, improving management of a consulting contract, and improving communications between vendors and the RMU, would improve Program efficiency and effectiveness.

Observation No. 1

Implement Policies And Procedures For Long-Standing Weaknesses

The DAS has not established written policies and procedures governing the Program. Policies and procedures are an integral part of a well-structured management control environment and can assist the organization in operating in accordance with its mission, applicable laws, and regulations. Inadequate management controls, such as not having written policies or procedures, increases the risks of inefficient program operations and reduces the likelihood organizational goals are achieved.

Our 2004 Employee Benefit Fund Financial and Compliance Audit Report and 2006 Insurance Procurement Practices Performance Audit Report recommended the DAS develop and implement policies and procedures for many of the Program's functions. Table 5 contains a list of 14 observations from these audits specifically identifying management control weaknesses related to the current audit. RMU personnel provided draft written policies and procedures addressing five of the 14 issue areas; however, none of these policies or procedures were officially implemented (i.e., finalized, reviewed, and approved for use) during State fiscal years 2009 and 2010. We did not assess the adequacy of the draft policies and procedures; instead, we

accepted them as evidence the RMU had started to address known weaknesses in its control environment.

Table 5

Prior LBA Observations Recommending Policies And Procedures Be Established

Observation Issue Areas	Observation Report Dates	Policies Drafted
Timely Review Of Summary Plan Descriptions	2004 2006	No
Conduct Formal Risk Assessment	2004	No
Ensure Compliance To The HIPAA	2004	Yes
Billing For Health Benefits Extended By The Consolidated Omnibus Budget Reconciliation Act Of 1986 (COBRA)	2004	Yes
Ensure Only Eligible Dependents Of Active Employees Are Provided Coverage	2004	Yes
Ensure Only Eligible Dependents Of Retirees Are Provided Coverage	2004	Yes
Ensure State Agencies Are Billed Appropriately For Retiree Health Benefits	2004	No
Monitor And Administer Ancillary Health Benefits	2004	No
Ensure Only Authorized Groups Receive Coverage	2004	No
Handling Of Pharmacy Benefit Claim Disputes	2006	No
Conduct Reviews Of The State's Third-Party Administrator	2006	Yes
Control DAS Relationships With Insurance Producers	2006	No
Improve Employee Benefit Procurement Oversight And Compliance With Procurement Requirements	2006	No
Ensure Business Is Only Conducted With Licensed Consultants When Required By Law	2006	No

Source: LBA analysis of prior LBA audit reports and RMU documentation.

Nine of the 14 observations (64 percent) in Table 5 were made in 2004 and subsequently the RMU dedicated a position to developing polices, procedures, and administrative rules. The RMU established an Operations and Procedures Specialist position in 2005. According to the supplemental job description:

> [t]his position is responsible for the development and on-going evaluation of administrative rules and policies and procedures that relate to the workflow and

> statutory functions and responsibilities of the Unit of Risk Management….This work also involves continual assessment and updating of rules, policies and procedures, and all associated, appropriate communications.

RMU personnel provided us with approximately 100 pages of draft policies and procedures. Half of the drafts related to implementing privacy and security requirements mandated by the HIPAA.

Policies and procedures provide a foundation for managing the Program efficiently and effectively. For example, in the event of staff turnover, written policies and procedures provide valuable guidance for new employees to correctly and consistently carry out program functions and activities. DAS responses that concur or concur in part to prior audit recommendations and the RMU's work on drafting policies and procedures demonstrate the DAS understands the importance of having written policies and procedures; however, progress to actually implement policies or procedures since 2004 is lacking.

Recommendations:

We recommend the DAS prioritize establishing policies and procedures for its activities and functions based on risk. Once implemented, DAS management should periodically reassess the policies and procedures to ensure they continue to meet Program needs and are being followed by DAS personnel.

Auditee Response:

We concur.

The Department acknowledges the importance of establishing written policies and procedures for the activities and functions of the employee and retiree health benefit program. In the future, the health benefit program will strengthen the priority of drafting and adopting written policies and procedures. In addition, the program will reassess existing policies and procedures as necessary.

Despite hiring for a newly-created position to write policies and procedures half way thru FY 2009, the Program and the Department faced many competing demands on this new resource. While some progress was made, as noted in the Observation, we are not satisfied with our level of documentation of the numerous processes, which comprise benefit program operations. We will endeavor to dedicate the necessary resources to document key program activities in the upcoming fiscal year.

During FY2009 and FY2010 the Department was required to elevate certain projects over documentation progress, due to unexpected implementation deadlines, and other time-sensitive requirements. For example, the federal Patient Protection and Affordable Care Act of 2010 (PPACA) was enacted during FY2010 and presented numerous immediate (and unforeseeable) compliance and implementation requirements. The passage of this vast piece of legislation required the Department to allocate resources within the health benefit program to implement the many required changes and exploit its program opportunities (i.e., the Early Retiree

Reinsurance Program). Beyond the PPACA, other federal enactments, such as the American Recovery and Reinvestment Act of 2009 and Mental Health Parity and Addiction Equity Act of 2008 impacted the health benefit program during the biennium, necessitating the diversion of the policy and procedure resource.

Second, the Department has seen a striking increase in "Right to Know" requests pursuant to RSA 91-A in recent years. Several of these requests were related to the health benefit program and required a significant time commitment. RSA 91-A mandates the Department respond to Right to Know requests within particular timeframes.

Finally, the volume of LBA fiscal note worksheet requests has increased along with the amount of legislation affecting health and dental coverage in the State. Because much of this legislation may have a direct or potential impact on the health benefit program (or some other fiscal impact to the State), the program has been challenged to provide timely and accurate worksheets in response to these increased requests. In addition, the Department must monitor even those bills that do not generate a fiscal note request because of the many indirect relationships to the program.

All of these many compliance, legal and documentation-related demands have competed for the time and resources of the position created to draft policies and procedures. Each has had a direct impact on the ability of the health benefit program to produce timely the full range of policies and procedures and reassess existing policies and procedures. Nevertheless, we are re-committed to this important activity.

Observation No. 2

Establish Policies And Procedures For Granting Exceptions And Clarifications To Health Benefits

Program management has not established policies and procedures for handling requests for exceptions and clarifications to State-provided health benefits. A Program manager reported the DAS has granted occasional deviations from the benefits package to current and retired employees and their dependents. Four examples involved pharmacy benefits.[4] DAS staff were unable to locate documentation for a fifth exception, involving retiree medical coverage. A DAS staff member stated there may have been other requests in addition to the five, but finding them would be difficult because the DAS does not file exceptions in a single location.

[4] The four documented exceptions and clarifications we reviewed involved relatively minor, technical changes to the State's health benefits package. For example, prior to the federal Food and Drug Administration's approving Botox for migraine treatment, Botox injections were not covered by the State because they were deemed cosmetic treatments. Upon a plan member's request, and determination other health plans covered Botox as non-cosmetic treatment, the DAS covered the member's Botox migraine treatments. In another instance, the DAS covered a certain over-the-counter medication a plan member required in large doses.

The Program's benefit booklets detail what the State will cover. However, these documents do not address all coverage issues that may arise. RSA 21-I:27 assigns the DAS Commissioner responsibility for administering the Program. Therefore, the DAS is responsible for coverage decisions in unanticipated situations. However, the DAS has no formal process for addressing requests for exceptions or clarifications and has not designated personnel responsible for determining the outcome of these requests. Due to the lack of policies and procedures, and the lack of a single repository for decisions, some possible scenarios may arise preventing the DAS from making consistent and informed decisions in response to exception requests. For example, Program personnel may be unable to compare one request with prior ones, making it difficult to resolve similar cases in a consistent manner. DAS employee turnover could also prevent consistent decision-making, as new employees may be unable to locate past decisions.

Recommendation:

We recommend the DAS develop policies and procedures for addressing requests for exceptions and clarifications to health benefits, and retain all requests and their resolutions in a single location accessible to DAS decision makers.

Auditee Response:

We concur.

The Program endeavors to be responsive to its enrollees while at the same time ensuring accountability on the part of its benefit administrators to provide comprehensive, quality customer service. Thus, covered members are instructed in various Program communications (i.e., Benefits Booklets, periodic notices and memoranda from the Division of Personnel, language in Explanation of Benefits accompanying adverse determinations and the like) to contact the appropriate administrators whenever they encounter difficulties accessing coverage for a particular service, treatment or drug. The general instruction to enrollees is that they should follow available administrative procedures offered by Program vendors. If they continue to have difficulties, they are invited to contact the Department. For example, in the current medical Benefits Booklet for Active Employees, the Appeals Procedure section provides:

> *Because the State of New Hampshire benefit program is self-funded, the New Hampshire Insurance Department does not regulate Anthem in its administration of this coverage. If you are not satisfied with the outcome of your internal appeal or independent External Review, or if you believe at any time that Anthem is not following the appeal process as described in this Section or in your communications with Anthem, you should contact the State of New Hampshire Division of Personnel for assistance.*

In the course of managing these kinds of contacts, the Division of Personnel has occasionally received requests for coverage exceptions. These constitute requests for coverage beyond the express terms of the benefit plan. While the State does not routinely grant such requests, very occasionally it is presented with a unique set of circumstances warranting specialized treatment. These are very rare events in which the application of plan provisions in a particular situation results in an extremely unreasonable denial of coverage. In addition, there have been a very

limited number of circumstances in which enrollees were promised an on-going exception prior to the initiation of the Program.

In those rare instances in which the DOP believes there may be merit in a request for exception, it will consult with the RMU in evaluating the request. And, in the few instances in which exceptions have been granted, the communication with the vendor or enrollee has generally been authored by RMU.

While the Department agrees that process for decision-making regarding coverage exceptions should be memorialized in a written procedure, we want to stress the rarity of these determinations. The Department and Program staff firmly believe it is inappropriate to grant exceptions to the express, written provisions of plan coverage except in the most extraordinary and patently justifiable cases. Such cases are rare indeed.

The Department will adopt a policy and procedure for coverage exceptions by December 31, 2011.

Observation No. 3

Comply With Federal Privacy Requirements

The DAS has not taken significant action to bring the Program into compliance with privacy and security requirements mandated by the federal HIPAA.

The HIPAA was enacted in part to protect the privacy of medical and other health-related information. The Act directed the U.S. Department of Health and Human Services (USDHHS) to establish a set of uniform rules identifying permissible disclosures of protected health information (PHI). The resulting *Standards for Privacy of Individually Identifiable Health Information*, more commonly known as the Privacy Rule, require covered entities, including group health plans such as the Program, to adhere to multiple requirements addressing the use and disclosure of PHI. Among other things, the Privacy Rule requires entities to:

- develop written policies and procedures for implementing HIPAA requirements,
- provide training on HIPAA requirements to all employees directly accountable to the covered entity,
- obtain individuals' written consent prior to disclosures of PHI for reasons other than payment or health care operations, and
- provide plan members with a *Notice of Privacy Practices* informing them of how the entity will use and disclose PHI.

Noncompliant Since State Began Self-Funding

The Privacy Rule imposed a compliance deadline of April 14, 2003. At that time, the State was providing health coverage by purchasing commercial insurance and reportedly relied on the insurance provider to ensure HIPAA compliance. In October 2003, the State became self-funded, and HIPAA compliance became the State's responsibility. As of March 2011, the DAS has made

minimal progress towards satisfying HIPAA requirements. A 2008 review conducted by the Program's contracted consultant identified 17 areas where the DAS's compliance with the Privacy Rule required improvement, including all four of the areas identified above.

Since the 2008 HIPAA review, the DAS has provided HIPAA compliance training for two Program employees, but training has not been made available to all DAS employees associated with the Program. The DAS has also prepared a HIPAA Privacy and Security Resource Guide, but this guide remains in draft form and has not been disseminated to all DAS employees accountable to the Program. According to two Program managers, widespread training has not occurred because the DAS has not formally adopted HIPAA-related policies and procedures. As a result, there are no materials for training employees.

The DAS has drafted policies and procedures for most Privacy Rule requirements, but none have been formally adopted or put in practice.[5] These documents contain several draft disclosure forms the Program plans to issue to members requesting access to or restrictions on the use of their PHI, which is a central component of the Privacy Rule. According to two Program managers, because these forms are draft documents, they are not currently in use. We also note disclosure forms or other HIPAA-related policies may be considered binding on health plan members, in which case the DAS would need to promulgate administrative rules.

Privacy Notice

In addition to written disclosure requirements, the Privacy Rule mandates covered entities to furnish a written *Notice of Privacy Practices* to health plan members. The Notice is required to include information such as the ways the covered entity will use and disclose PHI, as well as the member's individual rights, including the right to file a formal complaint if the member believes his or her privacy rights have been violated. Under the Privacy Rule, covered entities were required to provide the Notice to members by April 14, 2003 or, in the case of members enrolling after that date, upon enrollment. Covered entities must also send a reminder at least once every three years informing members the Notice is available upon request. As of March 2011, the DAS had not provided members with a *Notice of Privacy Practices*. Two Program managers stated the Notice has not been provided because it would need to reference policies and procedures, which have not been formally adopted.

Electronic Data Security Rule

In 2005, the USDHHS issued *Security Standards for the Protection of Electronic Protected Health Information*, more commonly known as the "Security Rule." While the Privacy Rule specifies who within a covered entity is allowed access to PHI and what they may permissibly do with it, the Security Rule focuses specifically on electronic PHI, and establishes standards for ensuring electronic PHI is accessible only to authorized users. The Security Rule imposed a

[5]The DAS has adopted a Department-wide policy on protection of confidential information, which peripherally addresses HIPAA privacy concerns. However, the policy mentions the HIPAA only briefly and does not reference any of the HIPAA-specific requirements found in the Privacy Rule.

compliance deadline of April 20, 2005. In 2008, the Program's contracted consultant conducted a security review, distinct from the privacy review mentioned previously, and identified several areas needing greater compliance with the Security Rule. Most of these areas involved policies and procedures regarding use and storage of electronic PHI. As of March 2011, the DAS had not issued formal policies and procedures addressing these issues. The review also identified poor physical security and unencrypted email between State personnel and the Program's contracted vendors as potential weaknesses. The DAS has not addressed the physical security issues identified by the consultant's review. However, according to two Program managers, the DAS has established email encryption between State email accounts and the Program's vendors. Reportedly, security challenges remain regarding emails between the DAS and some State agencies using their own email servers. Two Program managers reported these challenges need to be addressed with help from the Department of Information Technology.

HIPAA Requirements May Extend To Agency HR Personnel

Several components of the Privacy and Security Rules may apply to State personnel not directly accountable to the Program. Human resource (HR) personnel within State agencies may encounter PHI if agency employees bring billing or other issues to their attention. Since they are not employed by the DAS and are not accountable to the Program, it is unclear whether agency HR personnel are subject to the Rules. Two Program managers suggested agency HR personnel should adhere to the same privacy and security standards as DAS employees working directly for the Program and stated HIPAA-related policies and procedures, when formally adopted, should apply to agency HR employees. If the DAS chooses to issue requirements for personnel in other agencies, it must promulgate administrative rules as specified in RSA 541-A.

The USDHHS Office for Civil Rights is responsible for investigating alleged violations of the Privacy and Security Rules and is authorized by the HIPAA and other statutes to levy fines against noncompliant entities. Although the DAS has made some progress in the form of draft policies and procedures, it still has much to do to ensure the Program is fully compliant with the Privacy and Security Rules. Much of this work depends on formally adopting policies, procedures, and, if necessary, administrative rules. Without this foundation, the State does not comply with multiple other requirements, such as widespread training efforts and disseminating a Notice of Privacy Practices to health plan members.

Recommendations:

We recommend the DAS:

- **Establish HIPAA-related policies, procedures, and disclosure forms as required by the Privacy and Security Rules, ensuring all weaknesses identified by the contracted consultant's 2008 reviews are adequately addressed.**
- **Determine whether HIPAA-related policies, procedures, and disclosure forms are binding on HR personnel at State agencies or health plan members, and adopt administrative rules as needed.**
- **Issue a Notice of Privacy Practices to all Program members.**
- **Establish a policy to prohibit using email for transmitting PHI to address security**

concerns identified by the consultant's 2008 review.

- **Provide HIPAA compliance training to all Program employees, as well as any non-DAS State personnel deemed part of the Program.**

Auditee Response:

We concur.

The Department acknowledges the employee and retiree health benefit program has not made satisfactory progress in finalizing and implementing HIPAA Privacy-related polices, procedures, forms and requisite administrative rules. HIPAA compliance is a complex topic and there are various impediments to achieving significant progress, including staff workload. Currently, there is one employee with documented responsibility for ensuring the Program is in compliance with Privacy rules. That individual is also responsible for managing seven vendor contracts, is a key contributor on all health care reform related projects, and is also tasked with project management assignments related to wellness, procurement and data analysis.

The Department has previously determined the promulgation of administrative rules is required in order for HIPAA-related policies, procedures and forms to be enforceable to non-DAS HR personnel. That determination is based on advice from the Attorney General's Office as well as Program consultants. Administrative rules are needed because HIPAA regulations require the Program to have the ability to sanction employees that violate HIPAA policies and procedures. The Department anticipates the implementation of an updated human resource system and the centralization of some human resource services will reduce the State's risk related to non-DAS HR personnel's exposure to PHI.

The Department recognizes HIPAA requires issuance of a Notice of Privacy Practices to Program members. Prior to issuing a Privacy Notice, the Program must complete and implement enforceable privacy policies and procedures as well as train Program staff. A Privacy Notice refers to and establishes individual privacy rights that require a Program infrastructure that does not currently exist. For example, a Privacy Notice can afford plan participants the ability to authorize a personal representative to provide and obtain PHI. Implementation of that right would require adoption of forms, polices and procedures to ensure representatives are recognized by all Program employees, non-DAS personnel and vendor staff. In addition, the form itself could specify a medical condition, thereby itself becoming PHI and further complicating the storage, transmission, and utilization of the form.

The health benefit program plans to conduct training on HIPAA policy and procedures before the end of FY 2012. Training will be conducted as part of the implementation process following completion of policies and procedures. A Privacy Notice will be issued after all training is complete.

The Department worked with Financial Data Management and the Department of Information Technology (DoIT) to implement email encryption where possible, namely between the "granite domain" and Program vendors. Best practice is for plan participants to address claims or billing issues directly with Program vendors. Encouraging HR personnel to limit email

transmissions of PHI will decrease the risk of a breach due to email address errors or reply/forward mistakes. In addition, this would reduce the existence of PHI on the State's network, servers, and backup tapes.

The Department believes our vendors are best equipped to handle any issues involving PHI and the administrative fees paid to Program vendors already include these services. Our intent is to develop policies and procedures that direct such customer service issues to Program vendors for handling. Failing that, we would require all HR personnel to communicate with Program vendors via secure email web portals, many of which are already in place. This issue was contemplated during the security assessment and the report details what would be required of the State if it were to continue the policy of allowing unsecured PHI on State networks.

Observation No. 4

Follow Federal Laws For Social Security Number Use

Certain documents used by State agencies for State health benefits administration require a Social Security Number (SSN) but do not contain federally required privacy disclosures. Federal law (5 USC 552a, note) requires any government agency requesting an individual disclose his or her SSN to inform the individual the authority for the organization to collect the information, whether the information is mandatory or voluntary, and the routine uses of the information.

Best practice suggests agencies eliminate the unnecessary collection and reduce the use of SSNs by exploring alternative identifiers. In 2007, the U.S. Office of Management and Budget released Memorandum 07-06, *Safeguarding Against and Responding to the Breach of Personally Identifiable Information*, requiring all federal agencies to develop a plan within 120 days to eliminate unnecessary collection of SSNs within 18 months.

Beginning in August 2009, the DAS began identifying dependents enrolled in the Program with missing or invalid SSNs to comply with the federal Mandatory Insurer Reporting Law (42 USC 1395y (b)(7) and (8)). Although the letter to employees appears to satisfy the federal law, the State asks employees and retirees for their SSNs on other documents without the required disclosures. For example, the Division of Personnel (DoP) asks for a SSN on its "Retirement Medical Coverage Pre-Application" form and the medical third-party administrator's (TPA) "Member Enrollment/Change" form used by the DoP to collect retiree information for entry into the enrollment administrator's system.

Requiring SSNs without the proper protection is against federal law and may expose State employees, retirees, and their dependents to an increased risk of identity theft.

Recommendations:

We recommend:

- **State agencies provide appropriate disclosures when requesting SSNs from employees, retirees, and dependents.**

- **State agencies reduce the use of SSNs by exploring alternative identifiers and eliminating unnecessary collection.**

Auditee Response:

We concur.

The Department acknowledges the applicability of The Federal Privacy Act of 1974 (5 USC § 522a, note), to the employee and retiree health benefit program. In future health benefit program correspondence, the Department will more uniformly provide appropriate disclosures when requesting necessary social security numbers (SSN) from employees and/or retirees.

The Department is actively pursuing the implementation of an alternative identifier and the elimination of the unnecessary collection of SSNs. The structure of the State's current Governmental Human Resource System (GHRS) is based on the SSN as the key to employee records. It would be both impractical and overly burdensome to alter GHRS to accommodate an alternate employee identifier in lieu of using an SSN. The use of an alternate employee identifier is absolute in the plan to implement an updated human resource system (Lawson HR/Payroll) as part of NH FIRST. The implementation of an updated human resource system is subject to an appropriation from the NH State Legislature in the current capital budget. Post-implementation, employee SSNs will continue to be required for tax reporting purposes. The Department will also continue to be required to obtain SSNs in compliance with Medicare Secondary Payer Mandatory Reporting laws (42 USC § 1395y(b)(7)&(b)(8)).

Observation No. 5

Improve Vendor Contract Monitoring And Communications

The current vendor management structure both within the RMU and between the RMU and the DoP needs improvement. The RMU has assigned responsibility for monitoring vendor performance to a single employee, which may be insufficient to adequately monitor each vendor's performance. Also, at times, communication from different program personnel to vendors has been confusing.

Vendor Contract Monitoring

After a health benefits vendor is procured and a contract is negotiated and approved by the Governor and Council (G&C), the RMU Manager of Privacy and Administration (Manager) has primary responsibility for monitoring vendor performance against the contract. During the audit period, the Manager monitored five ongoing contracts

- medical benefits TPA,
- pharmacy benefits manager,
- dental benefits TPA,
- enrollment administrator, and
- administrator of flexible spending and health reimbursement accounts.

In SFY 2011, the Manager began monitoring two additional contracts: the life insurance administrator and administrator of the Early Retiree Reinsurance Program of the Patient Protection and Affordable Care Act (2010). In addition, the Manager oversees a cooperative project agreement with the University of New Hampshire commonly known as the New Hampshire Purchasers Group on Health Facilitation. In State fiscal year 2009, the Manager also oversaw a contract assessing the State's privacy and security compliance with the HIPAA.

While other RMU personnel are assigned supportive tasks related to contracts, the Manager of Privacy and Administration monitors the performance guarantees, reporting requirements, financial guarantees, weekly and quarterly vendor meetings, systemic issues regarding enrollment, and the benefits consultant's audits of vendor health claims. According to the supplemental job description, the Manager's primary responsibility "is to ensure that the administrative vendors of the [Program] perform according to service and financial levels that have been contracted or otherwise agreed." However, the Manager reported other ad-hoc issues periodically emerge and require a substantial portion of his attention. This has created difficulty monitoring vendors and responding to other ongoing responsibilities, such as privacy and security compliance with the HIPAA. Additionally, the Manager reported not being equally knowledgeable about all the contracted services.

Assigning one staff member monitoring responsibilities for seven complex contracts, involving over $9.6 million for services in State fiscal year 2010, may not be an adequate management control. The RMU Director reported responsibility for these contracts could be better distributed.

Communication Between The DAS And Vendors

Our 2006 performance audit of the State's insurance procurement practices recommended developing a formal plan to administer employee benefits. In its December 2010 updated response to this observation, the DAS stated one of the strategic goals to improve administration was implementing a communications strategy to routinely and proactively inform decision-makers. The update also referred to the *FY 2008 Annual Report of the Self-Funded Employee and Retiree Health Benefit Program*, showing an extensive appendix detailing DAS business operations related to the Program's administration. The appendix lists the RMU as responsible for interfacing with vendors.

However, in our interviews, communication between the vendors and the State was cited as fractured, confusing, and duplicative. Three members of the RMU indicated the reporting structure is unclear between the vendors and either the RMU or the DoP. Two vendors stated when working on various issues, there are multiple State contact people, and communication is not well coordinated. Vendors reported there are unclear lines of authority within the RMU and between the RMU and the DoP. One vendor reported not knowing who among the multiple State contacts is the decision-maker, which creates confusion and prolongs problems. Another vendor reported the RMU and the DoP were separately making alterations to a health plan program change. Although many aspects of program management require input from both the RMU and the DoP, inconsistent communication and an unclear chain of command between the State and vendors risks inconsistencies in administering health benefits.

Recommendations:

We recommend the DAS reassess staffing resources needed to more effectively monitor vendor performance and specify the roles and responsibilities of personnel interacting with vendors. Given the number of contracts, the complexity of the services, and the costs of health services provided, the DAS should consider distributing its contract monitoring responsibilities among its staff in order to improve control over its contracts. In addition, the DAS should assign each vendor a specific contact person from the Program.

Auditee Response:

We concur in part.

Pursuant to its responsibility to manage the contracts for, and vendors of, the administration of the health benefit program, the Risk Management Unit assigned general, day-to-day management responsibility to two individuals. One individual has been responsible for all implementation-related projects and issues, as they pertain to new vendors and benefits. The other was responsible for on-going, post-implementation performance. Prior to the creation of the health program manager position in 2010, this assignment was appropriate. That is, there were only two positions qualified to perform the range of functions comprising vendor and contract management. Further, the distinct technical skills and the volume of activities associated with the two areas justified an assignment along those lines. For instance, the contract manager instituted a consolidated spreadsheet for tracking issues and performance guarantee satisfaction. Now that Risk Management has another health benefits subject matter expert, it is appropriate that the original assignment be revisited. Over the past several months, as the new position has been incorporated into the functioning of the Unit, we have begun to consider that arrangement and expect to make changes in the near term. As part of that process, we may ultimately assign particular vendors to individuals, and we will make any appropriate revisions to the supplemental job descriptions (SJD).

The Department's regular programmatic interactions with vendors are divided between day-to-day operations and issue resolution. The former are handled directly by numerous individuals throughout the Department. Despite the formal assignment of contract management to one individual, the scope of that assignment does not entail handling every interaction with vendors. Various employees in the Department routinely interact with vendors regarding day-to-day issues such as, coverage questions, data requests, communications development as well as invoice and enrollment processing. While we appreciate vendors would find it more convenient to have a single point of contact, the volume and diversity of daily interactions make that impractical and inefficient. At times it is also necessary to elevate issues to the level of an administrator, director or commissioner. On occasion multiple individuals may have been mistakenly assigned to a particular project but that is not a common, or standard, practice. Overall, we do not agree communications within RMU have affected the efficient and effective management of the Program. We recognize the management structure between RMU and DOP can lead to some inefficiency. However, we believe necessary improvements will result from updated SJDs and formal documentation of Program procedures.

Observation No. 6

Improve Administration Of The Health Benefits Consulting Contract

The RMU's management of the health benefits consulting contract needs improvement to ensure needed services are provided as planned to the greatest extent possible. The RMU has a $1.3-million contract with a health benefits consultant, effective November 2008 through December 2011. Contractor services include actuarial analysis; auditing health benefits claims; and consulting for vendor procurement, collective bargaining, and general issues. According to the contract language, services are paid for on either a flat retainer fee or an hourly basis. Hourly fees for services have not-to-exceed limitations, with a schedule of hourly rates based on positions within the consultant's firm. Hourly rates range from $190 to $395.

Table 6

List Of Consulting Services By Payment Method

Retainer-Based Services	Hourly-Based Services
Medicare Part D attestation	Procurement consulting
Monthly actuarial analysis	Organizational analysis of the RMU
Claims audits of health vendors	General health benefits consulting
Other post-employment benefits (OPEB) actuarial valuation	Consulting related to collective bargaining and the Health Benefits Advisory Committee (HBAC)

Source: LBA Analysis of consulting contract.

Hourly-Based Service Use Exceeded Plan

The RMU exceeded the allocation for hourly-based services in the current contract. As of January 2011, remaining contract funds for claims audits and all hourly services amounted to approximately $300,000. The RMU estimated needing approximately $90,000 of the amount remaining to initiate three procurements: an enrollment and eligibility administrator, an administrator of the flexible spending and health reimbursement accounts, and a medical TPA. The RMU was concerned there would be little remaining for a claims audit of the dental TPA and consulting related to collective bargaining, health reform, the HBAC, and the HIPAA.

Within the $1.3-million aggregate contract limit, the contract had limitations for certain services. These limitations were exceeded for general health benefits and procurement consulting. General health benefits consulting is a catchall for issues requiring external analysis or an expert's perspective. The RMU spent more than originally intended, partly to respond to issues which arose after the contract began. Unanticipated events included the Patient Protection and Affordable Care Act (2010), analyses of voluntary employee beneficiary associations during a collective bargaining session, and impacts of the Health Information Technology for Economic and Clinical Health Act (2009) on HIPAA compliance. General health benefits consulting has a

limitation of $201,000 over the life of the contract, and RMU data indicate this amount was nearly depleted by December 2010. Also, the RMU greatly underestimated the funds it would need for procurement consulting. The contract maximum for this service is $240,000, and by January 2011 approximately $15,000 remained available for that purpose.

The RMU took actions which reduced contract funds available for other purposes as follows:

- The RMU paid the consultant approximately $100,000 for services provided during the prior consulting contract term. As the consulting contract neared its end, effective August 31, 2008, the G&C authorized a two-month extension to maintain regular consulting services while the DAS completed procurement on a successor contract effective November 1, 2008. The RMU's letter to the G&C indicated funds were still available from the prior contract, but during the extension period, the RMU found prior contract funds were fully expended. After determining the incumbent consultant was the apparent bid-winner for the successor contract, the RMU instructed the consultant to delay sending invoices until the successor contract took effect. The RMU then used funds from the successor contract to pay the $100,000 in consulting services performed during the extension period. While the General Provisions Agreement of the contract (form P-37) allowed paying for services predating the effective date, it effectively reduced the funds available for services planned under the successor contract.

- The RMU incurred approximately $18,500 in consulting services for implementing HIPAA privacy and security compliance and related training. These services were originally requested as an optional part of a separate contract, but the RMU did not ask the G&C for additional contract funds for them. Instead, the RMU has partially paid for these services with funds from the consulting contract. Although these services were technically related to general health benefits consulting, they came at the opportunity cost of other services planned for under the consulting contract.

The RMU's oversight and use of the consultant is not well controlled. Reportedly, there is no single contact person at the RMU responsible for managing communications with the consultant, and any staff member of the RMU can contact the consultant for advice. The consultant can (but we found no evidence they did) bill for each of these communications, and this lack of control risks potentially costly contacts with the consultant.

Reduced Vendor Oversight

Due to the available dollars remaining in the consultant contract, the RMU strategically reduced or eliminated certain consulting services. Six benefits claims audits originally included in the contract will not be initiated. The RMU originally contracted for nine audits, aggregately examining three years of claims each for medical, behavioral health, pharmaceutical, and dental benefits. The consultant only reviewed one year of medical and behavioral health claims and 2.5 years of prescription claims in fulfillment of the current contract. (The RMU is not conducting a claims audit of the dental TPA in the current contract period, and the RMU concedes such an audit has not been conducted since dental benefits became self-funded in 2007.)

Claims auditing is an important component of maintaining appropriate oversight over health-related vendor contracts. In State fiscal year 2010, the RMU paid $173 million in medical claims, $65 million in prescription claims, and $11 million in dental claims. Our review of cost containment measures found auditing vendor health claims cited as a best practice to ensure TPAs pay benefits according to plan rules. Additionally, claims audits review vendors' operational procedures, coordination of benefits, fraud controls, and provider discounts. The most recent prescription claims audit found the State was underpaid approximately $14,400 in drug rebates, a potential error in dispensing fees collected for specialty prescriptions filled at retail, and deductibles and maximum out-of-pocket expenses may have been exceeded for some retirees. The most recent medical and behavioral health claims audits uncovered only three overpayments of approximately $2,500 total and one very minor underpayment.

To save money, the RMU and the consultant changed certain payment terms of the consulting contract. In December 2010, OPEB actuarial valuations and a claims audit of the pharmacy benefits manager were switched to hourly-based services. In January through March 2011, monthly actuarial consulting services were billed at the calendar year (CY) 2010 rate, which is $250 less per month than the CY 2011 rate. Although unforeseen situations and changing circumstances may necessitate negotiating different terms of payment, the RMU did not seek an amendment from the G&C, and the consulting contract does not list any process for amending payment terms without G&C approval.

Invoice Management

During the audit period, approximately 15 percent of the consultant's invoices did not itemize by service type. Each service in the contract has a dollar limit, which the RMU was not able to accurately track because of the invoice format. During the audit period, each page of a typical invoice from the consultant stated a narrative of one or more hourly services being billed, the employee positions at the consultant's firm attributed to the work, a list of hours worked per position, each position's hourly rate, the total amount billed by each position, and the page subtotal. However, many invoices mixed different hourly service types, inhibiting the RMU's ability to reconstruct the total spent per service. The RMU and the consultant have improved the tracking of services on 2011 invoices, but because prior invoices were not itemized by type of service, the RMU's ability to manage the current contract limitations is hampered.

We found some of the consultant's invoices contained mathematical errors, which appear to be clerical mistakes. Eight of 65 (12 percent) hourly-based invoices either did not correctly total the amount billed by each position or the subtotal. The errors favored both the consultant and the State, and the net total of the eight errors is only $95 in favor of the consultant. However, individual errors ranged as high as $1,121, and in all cases, the RMU paid the amount as it appeared on the invoice. RMU personnel reported no review process in place before payment.

Consultant Contract Lacks Performance Measures

The benefits consultant contract lacks performance measures, unlike contracts for medical third-party administration, pharmacy benefits management, or enrollment administration. Such measures either quantify or rate a specific vendor output against a pre-determined standard of

quality. If the vendor fails to meet the standard, a financial penalty is usually imposed. Performance measures can provide an incentive for vendors to monitor their own quality and can be useful in areas where a vendor's performance warrants improvement. The RMU has applied performance measures to other vendors to address prior problems and improve standards of quality over time. Although performance measures might be more substantial for vendors which generally conduct less qualitative or ad-hoc tasks, some of the consultant's tasks, such as invoice submission and certain actuarial services, are repetitive enough to merit consideration.

Recommendations:

We recommend the RMU improve its administration of the benefits consulting contract by:

- **Ensuring the consulting contract is adequately financed to cover all necessary services. The RMU should consider including an amount for contingencies and seek contract amendment approvals from the G&C as needed.**
- **Ensuring services are accurately tracked and paid as specified by the contract terms.**
- **Ensuring the consultant's invoices itemize by service type and are accurate.**
- **Considering centralization of communications between the RMU and the benefits consultant.**
- **Considering implementation of performance measures in future consultant contracts.**

Auditee Response:

We concur.

The Department agrees the consulting services provided in late summer 2008 should not have been paid for with funds authorized under a successor contract. RMU staff did not realize the use of such funds was inappropriate. Approval of the two-month, no-cost extension of the Segal contract was requested of Governor and Council at a time when RMU believed adequate funding remained under the in-force agreement. By the time staff realized funding was exhausted, not only the extension, but the successor contract, had been approved by Governor and Council. Since 2009, the Unit has had a tracking mechanism in place to be aware of contract funding levels so as to avoid a recurrence of any over-expenditure.

The Department and the Unit agree that invoicing errors are to be avoided. Over the course of the years audited, the LBA discovered a number of mathematical errors, which in the aggregate favored Segal by $95.00. The current invoice review process involves one financial review and one management review, within the RMU. Thereafter, the Department reviews all invoices.

The procurement of administrative services is a core and critical function of the Program, the effective performance of which delivers significant cost savings to the State. The State benefits from the Program's strategic use of consultants in procurement because it is the State's chief opportunity to obtain favorable prices for health care services and to guarantee the realization of expected financial terms in the self-funded setting.

The Department agrees that all vendor contracts, including the health benefits consultant contract, must be administered pursuant to terms of the contract approved by Governor and Council. Furthermore, deviations from the contract terms must be properly approved through the Governor and Council process. In the future, RMU will seek adequate funding for consultants, ensure flexibility in utilizing those funds and seek an allowance for Program "contingencies".

Starting in 2009, invoices were itemized by service type and billed separately throughout the month. Since that time RMU has been tracking invoices by service type. The change to invoicing that occurred in 2011 was to aggregate billing for all services so that the Department was only billed monthly. That monthly bill also itemizes billing by service type.

Communications between the RMU and the benefits consultant are now adequately centralized. The RMU administrator acts as gatekeeper of access to consultants and delegates authority to contact consultants on a per topic basis. For example, an employee working on a particular procurement would have limited authority to contact benefits consultants directly to discuss the project. Conversely, access to benefits consultants for ad-hoc questions would generally not occur without the knowledge and/or approval of the RMU administrator. It would be both inefficient and impractical for the administrator to handle all communications with benefits consultants directly.

The Department incorporates performance guarantees in contracts if feasible and/or appropriate. The Department has negotiated specific performance guarantees in its medical, dental and pharmaceutical contracts that relate to both reporting and performance. Those performance guarantees incent vendors to provide timely reports and meet certain cost savings goals by imposing a monetary penalty for failing to meet a particular metric. The Department is considering whether it is appropriate to incorporate performance guarantees into our consulting contracts. The nature of these consulting contracts makes this difficult because services are less dependent on readily measurable customer service metrics, such as call response time, accuracy of claims payments or timeliness. Finally, LBA auditors have suggested invoice submissions are an area to consider a performance guarantee. The Department believes it could address that issue by negotiating detailed invoicing requirements in the consultant contract and only paying invoices that are submitted appropriately.

PROGRAM ELIGIBILITY

By statute, the State is responsible for providing health care benefits to State employees, as well as their spouses and dependent children and to retirees, spouses, or beneficiaries. RSA 21-I:30, I states,

> The state shall pay a premium for each state employee and permanent temporary or permanent seasonal employee as defined in RSA 98-A:3 including spouse and minor, fully dependent children, if any, and each retired employee, as defined in paragraph II of this section, and his or her spouse, or retired employee's beneficiary, only if an option was taken at the time of retirement and the employee is not now living, toward group hospitalization, hospital medical care, surgical care and other medical benefits plan or a self-funded alternative within the limits of the funds appropriated at each legislative session and providing any change in plan or vendor is approved by the fiscal committee of the general court prior to its adoption.

Given the substantial cost of providing health care to employees, retirees, and their spouses, dependents, or beneficiaries – claims were nearly $240 million in State fiscal year (SFY) 2010 – the cost of ineligible individuals receiving health benefits represents a significant monetary risk to the State. As the entity charged with overseeing the Employee and Retiree Health Benefit Program's (Program) cost control functions, the Department of Administrative Services (DAS), through its Risk Management Unit (RMU) and Division of Personnel (DoP), is responsible for ensuring the Program has controls in place to prevent ineligible individuals from enrolling in the Program and to detect ineligible individuals once they become ineligible for coverage. However, we found significant weaknesses in the Program's eligibility controls. The following observations indicate a lack of formal controls preventing new employees or retirees from enrolling individuals ineligible for health benefits or detecting when a dependent or spouse becomes ineligible for benefits. We also found eligibility practices that appear to lack legislative authority and another practice where it appears retirees are inconsistently informed of a certain optional benefit.

Observation No. 7

Establish Controls To Ensure Only Eligible Spouses And Dependents Are Enrolled

The DAS has no formal controls to ensure spouses and dependents claimed by employees are eligible for Program coverage. Six of ten DAS employees knowledgeable of the Program identified eligibility as a risk. Agency human resource (HR) personnel also identified eligibility as a problem area. However, neither the DoP nor the RMU have administrative rules or any other formal directive requiring HR or payroll personnel in State agencies to verify eligibility by documenting the employee's claimed relationship with a spouse or dependents. This issue was also identified as a weakness in our 2004 financial and compliance audit.

New Employees

When new employees are hired, there is no requirement for agencies to obtain proof of a relationship between the employee and claimed spouse or dependent(s), such as marriage or birth certificates. Employees enroll themselves, spouse, and dependents in the enrollment administrator's system to obtain health benefits. The enrollment administrator's system automatically accepts transactions without intervention from HR or payroll personnel. Allowing new employees to self-enroll for health benefits, without requiring verification of an eligible relationship, risks ineligible individuals receiving the Program's health benefits at the State's expense.

There are no readily available definitions of "spouse" and "dependent children" for employees to use when enrolling in benefits, meaning employees must substitute their own judgments of who fits those definitions. The terms "spouse" and "dependent children" used in RSA 21-I:30, I are not defined in statute. Although the medical third-party administrator's (TPA) 103-page benefit booklets define "spouse" as the individual lawfully married to the subscriber (employee) or the individual with whom the subscriber has entered into a lawful civil union, the document is not readily available to employees, as it can only be found through a hyperlink on the DAS' Division of Personnel web page.

Without defining "spouse" and "dependent children," and making these definitions readily available to employees while self-enrolling in the Program, employees may incorrectly assume some family members are eligible for the Program. For example, employees may enroll an individual they consider their spouse because they have cohabitated for a long period of time, considering this individual as their common-law "spouse." However, New Hampshire does not recognize common-law marriages, except for probate purposes. Therefore, an employee may consider a common-law spouse as eligible for health benefits and erroneously enroll them, but under the medical TPA's definition, the individual should be denied coverage. Likewise, the medical TPA defines eligible children as natural children, legally adopted children, children for whom the subscriber is a legal guardian, and children placed in the custody of the subscriber while awaiting final adoption. Foster children and grandchildren are expressly ineligible for coverage (unless legally adopted or a legal guardianship exists).

Enrolled Employees

For enrolled employees, the primary risk to the Program occurs when an employee's spouse or dependent becomes ineligible for health benefits. If an employee is legally separated or divorced, the employee's spouse is ineligible for continued coverage. However, HR or payroll personnel do not always know when an employee is legally separated or divorced. Agency HR and DAS personnel reported they rely on personal knowledge or self-reporting by the employee to become aware of eligibility events. Neither the RMU nor the DoP take any other steps to proactively identify spouses of continuing employees losing eligibility due to legal separation or divorce.

In effect, removal from continued enrollment following legal separation or divorce depends on the honesty of the employee and the employee's knowledge of eligibility rules. Agency HR personnel reported they request birth and marriage certificates once they learn of a life event but

are less comfortable requesting divorce or separation documentation. Although the enrollment administrator's user manuals and other related documents mention collecting appropriate documentation, there is no formal policy or administrative rule requiring HR or payroll personnel to collect evidence of life events.

Retirees

Neither the RMU nor the DoP requires documentation proving Program eligibility for retiree spouses, dependents, or beneficiaries.

For continuing retirees, the Program primarily relies on the retiree or spouse to inform the DoP of life events, such as death or divorce, although at times the New Hampshire Retirement System (NHRS) informs the DoP. When informed of life events, DoP personnel ask the retiree to complete the medical TPA's "Member Enrollment/Change" form, and enter the information in the enrollment administrator's system on the retiree's behalf. Similar to active employees, the RMU and the DoP require no documentation supporting the change and take no other steps to proactively identify retirees and spouses losing eligibility due to death, divorce, legal separation, or remarriage.

Unless HR or payroll personnel are required to obtain evidence supporting eligibility, the State may incur unnecessary health expenses if ineligible family members remain enrolled in the Program.

Moreover, without administrative rules requiring employees to provide documentation of eligibility changes, agency HR and payroll personnel may not have authority to require employees provide sufficient documentation proving eligibility or take remedial action against employees withholding documentation.

Recommendations:

We recommend the RMU, through the DAS Commissioner, promulgate administrative rules to require:

- **agency HR administrators or payroll personnel to obtain appropriate documentation supporting dependent eligibility at time of hire and document proof of qualifying events thereafter;**
- **new employees, and continuing employees with life event changes, to provide hiring agencies appropriate documentation supporting dependent eligibility as a condition of employment; and**
- **retirees and surviving spouses and dependents to provide eligibility documentation in the event of life changes.**

We also recommend the RMU:

- **seek a change to the enrollment process to ensure self-reported life-event transactions by employees are effective only if approved by agency human resource**

administrators or payroll personnel, after obtaining appropriate documentation establishing eligibility;

- **conduct regular, periodic eligibility audits at the agency level to verify spouse and dependent eligibility is documented;**
- **explore whether independent sources exist to verify employee, retiree, spouse and dependent eligibility information is correct and up to date; and**
- **consider requiring all current employees to re-enroll in the Program, providing appropriate documentation establishing eligibility for spouses and dependents.**

Auditee Response:

We concur.

The Department recognizes the importance of and remains committed to improving controls to ensure the eligibility of dependents enrolled in the health plan by State employees and retirees. Currently, there are certain, limited controls in place. A major factor to those limitations is our reliance on a third-party enrollment administration system not fully integrated with State human resources and retirement systems. These controls require strengthening.

As of this response, the Department is in the process of procuring enhanced Enrollment and Eligibility Management Services to include improvements to controls. The next contract for services in this area will include greater automation to support eligibility verification. For example, enhanced benefit enrollment administration services will enable enrollment events to be "pended" while documentation is provided to HR personnel. These enhanced services will also improve the Program's ability to conduct periodic eligibility audits. These enhancements will improve controls and enable the Department to determine more precisely what, if any, new administrative rules are needed to require non-DAS agency-based HR personnel to collect and maintain supporting documents for each enrolled employee and each enrolled dependent.

Furthermore, the Department is pursuing the implementation of a human resources and payroll system as part of the State's NH FIRST Lawson ERP system. Full implementation is dependent on funding in FY 2012 and is planned to complete in January 2013. The NH FIRST HR/Payroll implementation will include full functionality for enrollment and ongoing HR health benefits administration for employees and retirees. This will enable the State to eliminate the dependency on a third-party enrollment administrator. This also represents a fully integrated database to support employee and retiree inputs, automated edits, controls, and process-flow to HR administrators, as well as the ability for State health benefits administrators and Division of Personnel administrators to access more information more readily, audit information, and apply controls to the enrollment and eligibility process for employees and retirees.

Since the initiation of the current health benefits program, the Department has provided and continues to provide information and tools to agency-based HR personnel throughout State government that includes direction, guidance and procedures designed to ensure that only eligible dependents are enrolled in the health plans. The State's enrollment and eligibility administrator provides management reports to agency management and HR personnel. These reports identify when employees enroll new dependents and can be used by HR personnel to

pursue documentation substantiating eligibility. The Department provides training and written instructions, and materials are posted on the State's intranet (Sunspot), to enable HR administrators to obtain reports, verify transactions and collect necessary documentation.

In addition, the Department intends to conduct an "active" open enrollment for CY 2012, at which time all current enrollees will be asked to provide appropriate documentation. Further, the Department recognizes the utility of periodically auditing spouse and dependent eligibility. In the future, we will explore available options and consider the feasibility of utilizing independent resources.

Finally, the State's third-party administrator for medical benefits manages issues related to the continuing eligibility of retirees' dependents. The LBA addresses retiree dependent issues in Observation No. 9 and Observation No. 2. The Department will consider whether it must resolve the issues identified in those observations prior to adopting final eligibility procedures for retirees.

Observation No. 8

Clarify Eligibility Guidelines For Retirees

Some Program eligibility practices for retirees appear to lack legislative authority. Although RSA 21-I:30, I provides authority for paid health benefits for the retiree and spouse, the DAS allows retirees to purchase health coverage for dependent children as well, without apparent statutory authority. DoP employees reported retirees can purchase coverage for their dependents, including full-time students between ages 19 and 25, if: (1) the retiree pays $640 per month (regardless of the number of dependents) in addition to the $130 normally paid for retiree and spouse coverage, and (2) the retiree's pension is sufficient to cover the cost. Disabled adult children remain eligible so long as an incapacitated child form (*Certification for a Mentally or Physically Disabled Dependent Child Over Maximum Age*) is on file. The $640 cost is the difference between the 2011 retiree-under-65-plus-one monthly rate ($1,824) and the retiree-under-65-family monthly rate ($2,464). DAS personnel were unable to provide administrative rules or a policy supporting the practice.

The DoP also interprets the statute to permit continued health benefit coverage for widowed spouses of retirees after the retiree's death. However, the medical TPA's benefit booklets for retirees contradict this practice and deny continued coverage to widowed spouses after 36 months following the retiree's death. It states:

> Your coverage will terminate on the date of your death. If coverage ends because of your death, your covered dependents may continue group coverage for as long as 36 months. Your covered spouse may continue group coverage for as long as 36 months if coverage would otherwise terminate by divorce or legal separation or because you become entitled to Medicare Benefits. Your dependent children may continue group coverage for as long as 36 months if coverage would otherwise cease because they fail to meet the [medical TPA's] definition of dependent child.

The medical TPA's retiree benefit booklets advise retirees to contact the DoP for questions about dependent eligibility. However, there is no official retiree eligibility guidance provided by either DoP or RMU administrative rules or other documents. It is also unclear under what circumstances widowed spouses may remain eligible for health coverage. We found no eligibility rules regarding whether widowed spouses retain coverage if they remarry, whether their new spouses are eligible for coverage, or whether children born to or adopted by a widowed spouse after the retiree's death could be added to the plan.

Contradictions between statutes, benefit booklets, and practices, and the lack of formal retiree eligibility guidance or administrative rules from the DoP or RMU, could lead to confusion and possible misinterpretation of eligibility for the State's health benefits program, potentially incurring higher Program costs.

Recommendations:

We recommend the RMU, through the DAS Commissioner:

- **request the Legislature to consider whether health care benefits for dependent children should be offered to retirees at the retiree's expense. If so, the DAS should seek authority under RSA 21-I:30, I to allow retirees to purchase health coverage under the Program, if paid for by the retiree;**
- **align benefit booklets for retirees with applicable laws and rules; and**
- **promulgate administrative rules establishing Program eligibility criteria for retirees; including continued eligibility of widowed spouses, dependents, including eligibility for a new spouse when a surviving spouse of a retiree remarries; and premium payment terms.**

Auditee Response:

We concur in part.

The Department will investigate if the Legislature has interest in legislation that would eliminate the ability of State retirees to purchase dependent coverage. Prior to 2006, the New Hampshire Retirement System (NHRS) administered retiree health benefits. It was the longstanding practice of NHRS to allow retirees to add dependents based on the criteria described by the LBA above. When the Department took over administration of retiree health benefits, we continued that practice. If the Legislature were interested in eliminating the option, we would recommend applying the law to retirees prospectively, thereby allowing retirees who have already elected to add dependents to continue do so.

The Department acknowledges the approximately 100 page benefit booklets applicable to State retirees contain some inaccurate references. The State's retiree plans include the following:

- *Preferred Blue for Retirees Under Age 65*
- *BlueChoice New England for Retirees Under Age 65*

- *Medicomp Three for over 65 Retirees or Retirees on Medicare Parts A&B Due to Disability*

Vendor and benefits changes require frequent revisions to the State's benefit booklets managed by the Program. Limited resources have impacted the Program's ability to revise all benefit booklets without delay. The Program will prioritize updating benefit booklets to align them with applicable laws and eligibility rules.

The Department does not agree administrative rules are necessary to establish eligibility criteria for retirees. Per RSA 21-I:30, I, the State shall pay a premium for each "retired employee and his or her spouse, or retired employees beneficiary" towards retiree health benefits. RSA 21-I:30, II thru IV establish the definition of a retired employee for the purpose of retiree health benefits eligibility. A straightforward reading of RSA 21-I:30 dictates a retiree's spouse is eligible for coverage until death unless he or she ceases to be a spouse (e.g. through a divorce from the retiree). It is not necessary to promulgate administrative rules to establish eligibility criteria for spouses of retired employees because the statute is unambiguous. If necessary, clarifications to eligibility requirements can be accomplished through revisions to the benefit booklets.

Observation No. 9

Access Available State Data To Help Verify Eligibility Information

As we recommend in Observation No. 7, neither the RMU nor the DoP use independent means to verify the birth, death, or marital status of Program members, other than relying on assertions and, in some instances, documentation provided by the employee or retiree. However, the DAS could periodically verify Program eligibility using electronic vital records data from the Department of State, Division of Vital Records Administration (DVRA). A vital record is defined by RSA 5-C:1, XXXVII as a "certificate or report of a vital event," meaning a birth, adoption, death, marriage, divorce, legal separation, or civil annulment (RSA 5-C:1, XXXVI). RSA 5-C:12 states, "Certified copies, certificates of partial facts, verifications, or search of the records may be made for any federal, state, or local government agency by special arrangement without regard to the provisions of RSA 5-C:10."

DVRA records provide a unique and independent data source not reliant on self-reported information. We requested access to vital records data for the purpose of testing Program eligibility. The DVRA denied our request citing RSA 5-C:9, III which states, "Commercial firms or agencies requesting a listing of names and addresses shall not be considered to have a direct and tangible interest." We requested the DVRA reconsider its position, as the LBA is not a commercial entity, we are authorized to receive confidential information under RSA 14:31 IV, and RSA 5-C:12 authorizes the DVRA to furnish vital record information to State agencies under special arrangement. The DVRA did not respond to our reconsideration request.

We intended to use electronic DVRA records to identify potentially ineligible enrollees by matching DVRA records to the enrollment administrator's system. Using data analysis software to match electronic records in a similar manner was successful in an audit we reviewed of

another state's health benefits program. Without access to the DVRA data, we were unable to attempt to identify, in an efficient manner, if ineligible enrollees received State-paid health benefits.

Identifying and removing ineligible enrollees from the Program could reduce claims costs for the State. Likewise, removing deceased members from the enrollment system could potentially lower costs to the employee's agency. Agencies contribute the premium-equivalent cost (i.e., the working rate) into the Employee and Retiree Health Benefit Fund for each of their employee members. Self-funded agencies also contribute the premium-equivalent cost for their retiree members.

Recommendations:

We recommend the DAS periodically review the accuracy of its employee, retiree, and other beneficiary records by comparing that data to independent sources. The most efficient and cost effective source of relevant data would be the State's DVRA.

We recommend the DAS pursue an interagency agreement with the DVRA or seek statutory authority, if necessary, to access vital records information held by the DVRA for the purpose of verifying eligibility for employees and retirees, their spouses and beneficiaries, and dependents.

We also recommend the DAS consider using readily available data analysis software to match DVRA data with the enrollment administrator's data and follow up on any inconsistent records to determine whether the data inconsistency indicates incorrect eligibility determinations in the DAS data.

Auditee Response:

We concur in part.

The Department does not agree it would be appropriate to implement a blanket data match process with the Department of State, Division of Vital Records Administration (DVRA) for the purpose of verifying eligibility for employees and retirees, their beneficiaries, and dependents. We recognize the potential value of periodically reviewing eligibility records with an independent data source. However, utilization of vital records services is not customary among benefits administrators and the Department is hesitant to be an innovator in this sensitive area. The program has embarked on a plan to improve its dependent eligibility verification process, and the results of this effort should allow the program to obtain requisite documentation. We believe we can achieve the goal of improving the dependent eligibility verification process without pursuing an interagency agreement with the DVRA or statutory authority to establish a data match process.

As part of the plan to improve its dependent eligibility verification process, the Department intends to implement an affirmative requirement on employees to periodically certify marital status. We recognize that access to vital records pertaining to marital status would provide the

Department with an additional tool to verify the continuing eligibility of spouses. The Department is willing to approach the Secretary of State to discuss the possibility of an arrangement allowing us to utilize marital status records held by DVRA. If the Secretary of State is agreeable, we believe it would also be necessary for the Department to obtain clear statutory authority prior to implementing such an arrangement.

Division Of Vital Records Administration Response:

We do not concur.

This observation states that the DAS and RMU should be granted full access to the division's vital records database citing RSA 14:31, IV, and RSA 5-C:12. The DVRA does not agree with this interpretation and maintains that neither the DAS nor the RMU were included or identified in RSA 5-C:12.

This position is supported by RSA 5-C:4 II; "[i]n collecting information prime consideration shall be given to the protection of the privacy of the individuals about whom information is given. In accordance with the provisions of this chapter, the Secretary of State shall ensure that, when information is collected, the minimum of data shall be collected to accomplish a specific purpose, that no information shall be available to unauthorized personnel, that only the minimum be made available to authorized personnel, and that no information that could possibly adversely affect an identified individual be made public…".

Additionally, RSA 5-C:9, III as cited in the observation states "Commercial firms or agencies requesting a listing of names and addresses shall not be considered to have a direct and tangible interest". RSA 5-C:9, VI does identify the Department of Health & Human Services (DHHS) as having tangible interest in public health data for the specific reasons identified in RSA 126:24-d. As a result, it is our belief that RSA 14:31 does not apply to vital records.

Furthermore, the thought that any of this data possibly being used to support any findings or observations of the LBA, as outlined in RSA 14:31 is chilling. It is difficult to see how any findings regarding ineligibility for benefits made using a resident's private records could be supported without documentation being released either through Right to Know (91-A) requests or litigation. There may not be a clear understanding on the part of the LBA of the scope of data that is collected in vital records.

Very personal medical information is collected on birth and death records and its release to DAS and the RMU could be considered a violation of HIPAA laws. We believe that opening vital records for this type of investigation is a willful violation of the public trust, bad public policy and sets a very dangerous precedent.

LBA Rejoinder To The DVRA Response:

We agree with the DVRA for the need to restrict protected health information contained in the DVRA database. However, the subset of information in the DVRA vital records database requested for audit use, and proposed for use by the RMU, did not require the

DVRA to provide protected medical information or other confidential information. Though not requested in this instance, it is our contention the LBA is entitled to confidential information, including protected health information, under RSA 14:31 and HIPAA regulations, for audit purposes.

Our request for access to data held by the DVRA was limited primarily to matters of public record such as marital separations and divorces, and names of deceased individuals and dates of death. Despite our telephone conversations and written communications regarding the purpose and scope of our data request, as well as our statutory authority to obtain such information, the DVRA failed to provide the information requested.

We disagree with the DVRA's interpretation of the coverage of RSA 5-C:12. That statute provides, "[c]ertified copies, certificates of partial facts, verifications, or search of the records may be made for any federal, state, or local government agency…." The statute clearly does not include or exclude any named State agency.

We also disagree with the DVRA's description of our request as "a willful violation of the public trust, bad public policy and sets a very dangerous precedent." Accordingly, we stand by our recommendation for the DAS to seek an interagency agreement with the DVRA as provided in RSA 5-C:12, or statutory authority to access data held by the DVRA for the purpose of verifying eligibility for State employees and retirees, their spouses, beneficiaries, and dependents.

Observation No. 10

Clarify Beneficiary Eligibility For Retiree Health Benefits

RSA 21-I:30, I extends the possibility of lifetime State-paid health benefit premiums to individuals who are not the spouse of a retired employee, but a beneficiary, after the employee's death. According to statute, the State shall pay a premium for the retired employee and "his or her spouse, or retired employee's beneficiary, only if an option was taken at the time of retirement and the employee is not now living, toward group…" health benefits.

We found no definition of "beneficiary" in RSA 21-I, nor any requirement the beneficiary be related to the retiree. Because "beneficiary" is undefined, it appears any individual, including a child or someone unrelated to the retiree, can receive the Program's health benefits for the remainder of the beneficiary's life as a result of this provision. Retiree health benefits can go to either the retiree's spouse or the named beneficiary, but not both. Health beneficiaries become eligible for benefits only after the retiree dies, whereas the retiree's spouse becomes eligible for health benefits upon the employee's retirement. DoP and RMU officials did not know the origin of this provision, but a NHRS official surmised its purpose was to provide health benefits to a retiree's disabled child after the retiree's death.

DoP and NHRS personnel report the number of non-spouse beneficiaries receiving a deceased retiree's health benefits is not tracked; however, personnel from both agencies speculate there have probably been no more than 25. The DoP employee responsible for enrolling retirees in the

State's health plan reported remembering only two instances in the six years preceding 2011 where a retiree selected a non-related beneficiary. However, we found retiring employees are not normally provided the opportunity to select a beneficiary to receive their health benefits when a spouse is not selected. Neither the NHRS nor the DoP informs retiring employees State law allows naming any person to receive their health benefits when they die if the retiring employees do not enroll their spouse. According to an NHRS official, NHRS staff do not discuss non-spouse beneficiary's eligibility for State health insurance benefits with retiring employees.[6] In addition, DoP personnel do not inform retirees about the option to leave their health benefits to someone when they die. None of the DoP material given to retiring employees informs them of this option or gives them the opportunity to name a beneficiary other than a spouse.

Because the number of non-spouse beneficiaries is not easily identifiable, the number and health care claims costs of these beneficiaries are unknown. We also do not know how many retirees may have elected to have a non-spouse receive their health benefits had they been given the option.

Recommendations:

We recommend the RMU request the Legislature clarify the intent of the language contained in RSA 21-I:30 granting a designated beneficiary retiree health benefits.

We also recommend the NHRS and the DoP develop procedures regarding when to inform retirees of the option to select a beneficiary to receive health benefits from the State after the retiree dies and ensure the procedures are equitably implemented.

Auditee Response:

We concur.

The Department will approach the Legislature to introduce legislation that would clarify the intent of the statutory language allowing retirees to designate a beneficiary for health benefits. The language in RSA 21-I:30, I granting this right has been in place for many years.

Program staff in DOP and RMU are committed to coordinating with NHRS to develop procedures and/or update forms to inform retirees of the option to select a beneficiary to receive health benefits from the State after the retiree dies, and ensure the procedures are equitably applied.

[6] However, the *NHRS Retirement Medical Coverage Pre-application For Deceased State Employees* form asks for "Spouse/Beneficiary Information" and specifically references RSA 21-I:30. This form has been used by the NHRS to name a non-relative beneficiary and was accepted by the DoP for identifying a non-spouse beneficiary. According to a NHRS official, this form is not given to retirees "under normal retirement situations."

New Hampshire Retirement System Response:

We concur in part with this audit observation.

We concur with the recommendation that RMU request the Legislature clarify the intent of the language contained in RSA 21-I:30 granting a designated beneficiary retiree health benefits.

We concur in part with the second part of the observation recommending NHRS and the DoP develop procedures regarding when to inform retirees of the option to select a beneficiary to receive health benefits from the State after the retiree dies, and ensure the procedures are equitably implemented. We believe that DoP should take the lead on this notification with assistance from the agency that the employee retires from. NHRS will provide whatever assistance we can, however, since retirees are not required to have counseling sessions pre- or post- retirement, notification of beneficiary health benefit selection would be more appropriate during an agency exit interview when the employee retires from an agency. NHRS further suggests that DoP update its FAQ handout supplied to NHRS to include information regarding this benefit for inclusion in NHRS retirement packets for those retiring State employees that do reach out to NHRS for information.

OTHER ISSUES AND CONCERNS

In this section, we present issues we consider noteworthy but not developed into formal observations. The Department of Administrative Services (DAS) and the Legislature may wish to consider whether these issues and concerns deserve further study or action.

Program Costs May Trigger Excise Tax Liability

The Patient Protection and Affordable Care Act (PPACA), federal legislation designed to ensure universal availability of quality health insurance, was signed into law on March 23, 2010. Although the impact of the PPACA on individual and employer-provided health plans is far from settled, the federal Departments of Health and Human Services, Treasury, and Labor have offered guidance to plan administrators in the form of interim final regulations. Beginning in 2018, the PPACA will levy a 40 percent excise tax on employer-provided "Cadillac" plans, plans costing more than $10,200 for individual coverage and $27,500 for family coverage. The tax will only apply to the portion of the costs exceeding the thresholds. Although these thresholds far exceed the national average, the family threshold in particular is not far above current premiums (i.e. working rates) for coverage offered through the New Hampshire Employee and Retiree Health Benefit Program (Program). Yearly premium-equivalent rates (including both the employer and employee share of costs) for an individual plan offered by the New Hampshire Program in State fiscal year 2011 were $7,449 and for a family plan were $23,371. By 2018, the Risk Management Unit (RMU) projects premiums for individual plans will cost $14,516 and premiums for family plans could cost $46,245, far exceeding the current threshold for imposition of the excise tax.[7]

We suggest the RMU continue to monitor the cost of premium-equivalent rates and keep the Legislature informed of the potential tax implications.

<u>Auditee Response:</u>

The Department agrees this is a critical issue and also highlighted it in our FY 2010 Self-Funded Employee and Retiree Health Program Annual Report. The annual report focuses on the importance of managing program costs and recognizes that the rate of current increase in medical costs is not sustainable. To reduce the potential future tax liability, the Program must find ways to lower its overall costs, but within the constraints of the PPACA. This may require changing plan design by separating premium contributions by employee, spouse and children, or increasing co-pays or deductibles. The following illustration depicts the Program's current premium and the fiscal year when the excise tax threshold will be met.

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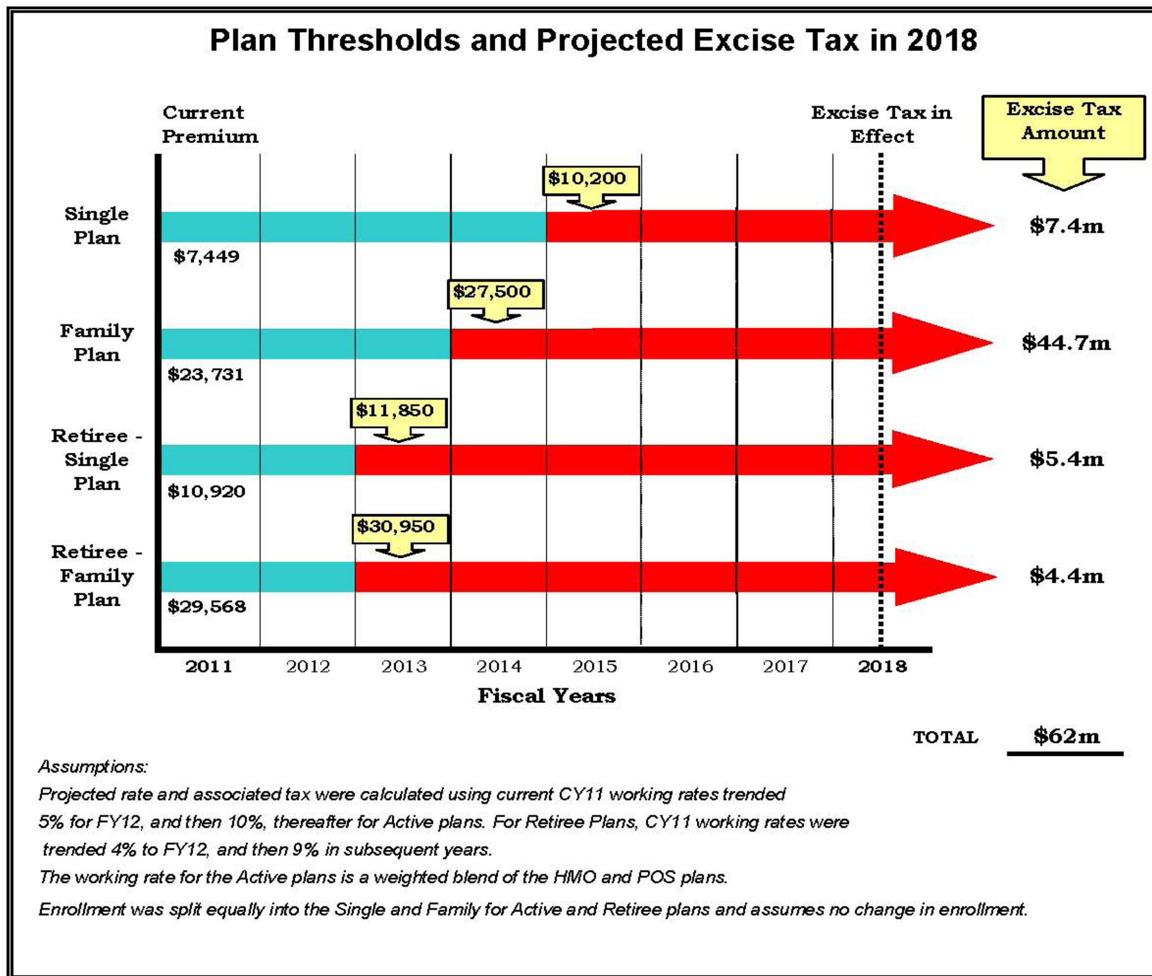
[7] The PPACA ties the threshold to the cost of the Employee Health Benefits Plan available to federal employees. If the per-employee cost of the federal plan increases by more than 55 percent between 2010 and 2018, threshold for imposition of the excise tax will increase by the total rate of increase in the federal plan above 55 percent. In effect, this means the State's potential tax liability will be lower the more dramatically premiums for the federal plan rise.



The Department will continue its commitment to effectively and proactively manage Program costs including, but not limited to, seeking to avoid the excise tax liability created by PPACA.

Improve Communication Within The DAS

Communication between the RMU and the Division of Personnel (DoP) needs improvement. The RMU is responsible for administering most aspects of the Program, such as vendor management and developing policies and procedures, while the DoP determines member eligibility, addresses complaints and enrollment issues, and communicates directly with human resource (HR) personnel in State agencies. As such, both entities must remain properly informed of all pertinent issues regarding the Program. The DoP must be informed of Program updates, and the RMU must be kept aware of any systemic problems regarding enrollment or other issues as they arise. However, the DAS lacks formal policies to mitigate communication problems between the two entities, which could preempt misunderstandings.

The RMU and the DoP relationship is reportedly frictional at times, prone to miscommunication, and cooperation periodically breaks down. Comments from four DAS officials suggest divergent

goals between the RMU and the DoP is part of the problem. The RMU administers the Program while maximizing equitable and cost-effective coverage. The DoP provides customer service to State employees and factual communications to HR personnel. The RMU reported being unable to communicate program changes to State employees via agency HR personnel, without review and approval by the DoP. The DoP reported an instance when it was not updated about a Program change.

We suggest the DAS develop a formal process to ensure entities handling different Program functions are kept apprised of changes and involved with decisions affecting their operations.

Auditee Response:

The State of New Hampshire does not have a long history of centralized health benefits administration. Prior to 2004, the Manager of Employee Relations was the sole, State-wide benefits position in the Department of Administrative Services. Most benefits-related activities were carried out in the agencies in a highly disparate, uncoordinated manner. Seven years into centralized benefits administration, the State Program continues to develop and evolve. One of the challenges in that evolution is the structure of the Program within the Department organization. While the initiation of self-funding warranted housing the Program in RMU, the historical "home" of benefits had been DoP. On the one hand, the RMU staff possesses expertise in health care finance and health benefits administration. On the other hand, the DoP staff possesses established relationships with the 52 human resources administrators throughout State government who have historically assisted employees with benefits enrollment and any necessary support. The two offices work closely together as joint administrators of the large and complex Program. While greater coordination is always possible and further formalization of roles and processes is desirable, all Program staff work hard to communicate effectively so as to achieve the Program's key missions of quality coverage and cost management. The Commissioner continues to evaluate and consider improvements in structural design to improve functionality. Centralization of Human Resource functions will aid in this process.

Implement NH First's Personnel Module To Manage Health Benefits Enrollment

The State's contract with the enrollment administrator expires June 30, 2011. The RMU plans to bring the enrollment and eligibility function in-house, but implementation is moving slowly. The State's enterprise resource planning system, NH First, currently handles the State's finances and will eventually handle the State's human resources and payroll. The State reportedly has already purchased the HR software module which is capable of managing health benefit enrollment.

Management from the DoP and the RMU confirm they are awaiting implementation. Moreover, the RMU does not have all of the tools required to run the health benefit module and plans to use its health benefits consultant to assist with issuing a request for proposal for the benefit enrollment and eligibility service.

If the human resources module were implemented, the State could save on the enrollment administrator's fees and maintenance costs for its current human resource and payroll system. According to the DoP Director, the savings could be approximately $1 million per year.

We suggest the DAS consider implementing the enrollment services module to be more efficient and realize projected savings for the State.

Auditee Response:

We agree. As stated in the Department's response to Observation No. 7, the Department is pursuing the implementation of a human resources and payroll system as part of the State's NH FIRST Lawson ERP system. Full implementation is dependent on funding in FY 2012 and is planned to complete in January 2013. The NH FIRST HR/Payroll implementation will include full functionality for enrollment and ongoing HR health benefits administration for employees and retirees. This will enable the State to eliminate the dependency on a third-party enrollment administrator. This also represents a fully integrated database to support employee and retiree inputs, automated edits, controls, and process-flow to HR administrators, as well as the ability for State health benefits administrators and Division of Personnel administrators to access more information more readily, audit information, and apply controls to the enrollment and eligibility process for employees and retirees.

CONCLUSION

The Risk Management Unit's (RMU) administration of the Employee and Retiree Health Benefit Program (Program) has generally improved since our 2004 financial audit which found insufficient resources were applied to effectively establish and administer the State's self-funded program. During this audit, we found the Department of Administrative Services (DAS) increased Program staffing, improved its contracted service procurement practices, and implemented health care cost containment strategies. However, additional improvement needs to be made by the DAS to more efficiently, effectively, and economically manage the Program.

The DAS did not implement written policies and procedures recommended in 14 observations from our 2004 financial audit and 2006 Insurance Procurement Practices performance audit. The RMU drafted policies for five of these observations, but none were implemented. The DAS needs improved privacy and security controls for handling personal medical and health information and use of Social Security Numbers, as required by federal laws. In 2008, the RMU contracted for two reviews of its handling of protected health information, but their recommendations have not been fully implemented. Additionally, our current audit found the DAS does not have a policy addressing requests for exceptions and clarifications to the State's health plans.

The RMU contracts with a number of specialized vendors for a variety of functions, including third-party administration, online enrollment administration, and health benefits consulting. We found the RMU needs to improve its vendor contract monitoring by reassigning Program staff to improve communication with vendors, ensure contract requirements are met, monitor work completed, and ensure expenses do not exceed contracted limits.

We found significant weaknesses in eligibility determination and monitoring for Program benefits. We also found vague statutory language, and the lack of administrative rules, policies, and procedures increase the risk of the RMU paying health claims for ineligible people. The DAS needs to: 1) clarify eligibility criteria; 2) establish management controls to ensure only eligible dependents, spouses, and beneficiaries are provided health benefits; and 3) conduct eligibility audits. Additionally, the RMU needs to seek clarification on who, besides a spouse, a retiring employee can designate to receive health benefits after death and ensure employees are provided the opportunity to select such a beneficiary.

The RMU's ability to control high employee health care costs is limited. Program officials, contractors, and stakeholders said the State has 1) a relatively expensive health care market compared to other states, and 2) a "generous" benefits plan with low employee contributions, low co-pays, and low deductibles. However, the plans are primarily determined in the collective bargaining process the State undertakes with its employee unions and therefore the RMU has relatively little ability to significantly reduce health care costs. We found the RMU has undertaken nearly all recommended strategies to contain health care costs noted in Table 3 on page 24.

Conclusion

By addressing weaknesses identified in this and previous audit reports, the DAS could improve its management of the Program and assist in controlling costs.

APPENDIX A
DEPARTMENT RESPONSE TO AUDIT

State of New Hampshire
DEPARTMENT OF ADMINISTRATIVE SERVICES
OFFICE OF THE COMMISSIONER
25 Capitol Street – Room 120
Concord, New Hampshire 03301

LINDA M. HODGDON
Commissioner
(603) 271-3201

JOSEPH B. BOUCHARD
Assistant Commissioner
(603) 271-3204

June 9, 2011

Richard J. Mahoney, CPA
Director of Audits
Legislative Budget Assistant
107 North Main Street
State House, Room 102
Concord, NH 03301

Dear Mr. Mahoney:

We thank you for the opportunity to comment on the LBA Performance Audit of the State of New Hampshire Department of Administrative Services Employee and Retiree Health Benefit Program (the "Program"). I would like to express my appreciation to LBA management and audit staff for their effort in performance of the audit and the drafting of the resulting final report. While we have some differences of opinion regarding some conclusions reached during the audit, we were given the opportunity to discuss those differences in a professional manner.

In 2004, the legislature directed the Department to change the historical manner in which the State paid for its health benefits. The directive to self-fund the Employee and Retiree Health Benefit Program was unaccompanied by any plan or meaningful staffing. Prior to 2004, the State was not managing its health benefits expenditures. My Department has successfully transitioned the State's Program and has realized significant savings through the effective management of the vast range of new activities attendant to self-funding. In fact, since FY2006, the Program has kept annual cost increases under 10% every year, and has experienced a health care trend that is more than 2% below the aggregate New Hampshire business of its current third party administrator. These significant savings were achieved because the Program has focused on cost savings initiatives and prioritized the implementation of numerous measures to contain costs.

In this and prior audits of the Program, the LBA has indentified weaknesses that to a great extent focus on the lack of the formal documentation of existing practices. Many of the observations are substantially resolved and will be complete after formal policies and procedures are established and implemented, to reflect those changes. Since the transition of health benefits to self-funding in 2004, the Program has continued to evolve and take on increasing responsibilities. The Department has reassigned three internal positions to the Program in recognition of its important

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TDD Access: Relay NH 1-800-735-2964

function. I remain committed to effectively balancing the need to establish and maintain formal policies and procedures while successfully managing the demands on the Program.

DAS looks forward to working with the Legislature to further enhance the efficient, effective and economic management of the Employee and Retiree Health Benefit Program. If you have any questions regarding our response to the audit report, please contact me at 271-3201.

Sincerely,

Linda M. Hodgdon
Commissioner

APPENDIX B
CURRENT STATUS OF PRIOR AUDIT FINDINGS

The following is a summary of the status of 23 observations related to the Employee and Retiree Health Benefit Program (Program) contained in prior audit reports. Related observations are contained in our:

- Employee Benefit Fund Financial And Compliance Audit Report For The Fiscal Year Ended June 30, 2004; and
- 2006 Insurance Procurement Practices Performance Audit.

Copies of audits issued prior to 1999 may be obtained from the Office of Legislative Budget Assistant Audit Division, 107 North Main Street, State House, Room 102, Concord NH 03301-4906. Audit reports issued after 1999 may be obtained online at our website http://www.gencourt.nh.us/lba/idex.html.

Status Key			
Fully Resolved	●	●	●
Substantially Resolved	●	●	○
Partially Resolved	●	○	○
Unresolved	○	○	○

Our Employee Benefit Fund Financial And Compliance Audit Report For The Fiscal Year Ended June 30, 2004 contained 11 observations on the Program related to our current audit.

No.	Title	Status
1.	The State's Self-Funded Employee Health Benefits Program Was Not Effectively Administered During Fiscal Year 2004	● ● ○
2.	Greater Understanding Of Contracted Operations Is Needed	● ● ○
7.	Formal Risk Assessment Policies And Procedures Should Be Established For The Operation Of The Health Benefits Plan	● ○ ○
8.	HIPAA Compliance Policies And Procedures Must Be Established	● ○ ○
9.	Policies And Procedures Should Be Established For COBRA Billings	● ● ●
11.	Policies And Procedures Should Be Established To Ensure Only Eligible Dependents Of Active Employees Are Provided Plan Coverage	● ○ ○
12.	Controls Must Be Established To Ensure The Retiree Eligibility Data Remains Current And Accurate	● ● ○

No.	Title	Status		
13.	Policies And Procedures Should Be Established To Ensure Only Eligible Dependents Of Retirees Are Provided Plan Coverage	○	○	○
14.	Policies And Procedures Should Be Established To Ensure Retiree Health Benefits Contributions Are Funded Appropriately	●	●	○
17.	Policies And Procedures Should Be Established To Effectively Monitor And Administer Ancillary Health Benefits	○	○	○
18.	Only Statutorily Authorized Groups Should Participate In The Health Benefits Plan	●	●	○

Our 2006 Insurance Procurement Practices Performance Audit contained 12 observations on the Program related to our current audit.

No.	Title	Status		
3.	Return Employee Health Benefits Management To The Division Of Personnel	●	●	●
4.	Develop A Formal Plan To Administer Employee Benefits	●	○	○
12.	Promulgate Administrative Rules For Managing The State Employee Health Benefits Program	○	○	○
14.	Develop And Implement Operating Policies And Procedures To Finalize Health Benefit Summary Plan Documents	●	○	○
15.	Develop and Implement Policies And Procedures For Resolving Pharmacy Benefit Claims Disputes	○	○	○
16.	Realign Claims Appeal Process	○	○	○
19.	Submit Self-Insured Health Plan Implementation Reports Timely	●	●	○
21.	Develop Policies And Procedures Ensuring Semiannual Review Of The State's Third-Party Administrator	●	●	○
32.	Procure Health Insurance Broker Services According To State Policy And Best Practice	●	●	●
35.	Improve Employee Benefit Procurement Oversight And Compliance With Procurement Requirements	●	●	○
36.	Conduct Business With Licensed Consultants	●	●	○
38.	Improve Third-Party Administrator Contract Monitoring Through Performance Guarantees	●	●	●

PERFORMANCE AUDITS
ISSUED BY THE
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TITLE OF REPORT	DATE
Division of State Police Field Operations Bureau	October 2010
Community Mental Health System	July 2010
State Board for the Licensing and Regulation of Plumbers	December 2009
Fuel Oil Discharge Cleanup Fund	December 2009
Bureau of Elderly and Adult Services Medicaid Long-Term Care Program	July 2009
Liquor Commission	April 2009
State of New Hampshire Service Contracting	March 2009
Department of Resources and Economic Development Division of Parks and Recreation Revenues of the State Park Fund	September 2008
Fleet Management	September 2008
Office of Information Technology	July 2008
State of New Hampshire Succession Planning	July 2008
Board of Medicine	April 2008
Department of Fish and Game	January 2008
Department of Environmental Services Alteration of Terrain and Wetlands Permitting	August 2007
Insurance Department Consumer Protection Functions	August 2007
Department of Education No Child Left Behind Fund Distribution	February 2007
Insurance Procurement Practices	September 2006

PERFORMANCE AUDITS
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TITLE OF REPORT	DATE
Enhanced 911 System	January 2006
Department of Education Adequate Education Grant Data	December 2004
Board of Mental Health Practice	November 2004
Home Care for Children with Severe Disabilities	April 2004
Department of Corrections Division of Field Services	December 2003
Judicial Branch Administration	November 2003
Department of Health and Human Services Division of Elderly and Adult Services Home- and Community-Based Care	April 2003
Department of Corrections – Inmate Health Care	January 2003
Department of Corrections – Sexual Harassment and Misconduct	October 2002
Department of Environmental Services Performance-Based Budgeting	March 2002
Department of Safety – Division of Fire Safety	November 2001
Department of Education – Construction and Renovation Programs	September 2001
Department of Health and Human Services Division for Children, Youth and Families Foster Family Care	September 2001
Department of Education – Bureau of Vocational Rehabilitation and Service Delivery	August 2001
Department of Transportation – Bureau of Turnpikes Performance-Based Budgeting	April 2001
Judicial Branch – Family Division Pilot Program	January 2000
Year 2000 Computing Crisis – Special Report – Update	July 1999

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TITLE OF REPORT	DATE
Special Education – Catastrophic Aid Program	July 1999
Year 2000 Computing Crisis – Special Report	March 1999
Juvenile Justice Organization	November 1998
Marine Patrol Bureau Staffing	March 1998
Health Services Planning and Review Board	January 1998
Economic Development Programs	October 1997
Job Opportunities and Basic Skills Training Program	May 1997
Child Support Services	December 1995
Multiple DWI Offender Program	December 1995
Managed Care Programs for Workers' Compensation	November 1995
State Liquor Commission	July 1994
Property and Casualty Loss Control Program	November 1993
Child Settlement Program	March 1993
Workers' Compensation Program for State Employees	January 1993
Prison Expansion	April 1992
Developmental Services System	April 1991
Department of Administrative Services Division of Plant and Property Management State Procurement and Property Management Services	June 1990
Mental Health Services System	January 1990
Hazardous Waste Management Program	June 1989
Review of the Indigent Defense Program	January 1989

PERFORMANCE AUDITS
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TITLE OF REPORT	DATE
Review of the Allocation of Highway Fund Resources to Support Agencies and Programs	March 1988
Review of the Public Employees' Deferred Compensation Plan	December 1987
Review of the Management and Use of State-Owned Passenger Vehicles and Privately Owned Vehicles Used at State Expense	August 1984
Management Review of the Policies and Procedures of the Division of Plant and Property Management	June 1984

Copies of previously issued reports may be received by request from:

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