

STATE OF CONNECTICUT



*AUDITORS' REPORT
DEPARTMENT OF INSURANCE AND
THE OFFICE OF THE HEALTHCARE ADVOCATE
FISCAL YEARS ENDED JUNE 30, 2014 and 2015*

AUDITORS OF PUBLIC ACCOUNTS
JOHN C. GERAGOSIAN

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State Capitol
210 Capitol Avenue
Hartford, Connecticut 06106-1559

JOHN C. GERAGOSIAN

December 8, 2016

AUDITORS' REPORT DEPARTMENT OF INSURANCE AND THE OFFICE OF THE HEALTHCARE ADVOCATE FOR THE FISCAL YEARS ENDED JUNE 30, 2014 AND 2015

We have audited certain operations of the Department of Insurance and the Office of the Healthcare Advocate in fulfillment of our duties under Section 2-90 of the Connecticut General Statutes. The scope of our audit included, but was not necessarily limited to, the fiscal years ended June 30, 2014 and 2015. The objectives of our audit were to:

1. Evaluate the department's and office's internal controls over significant management and financial functions;
2. Evaluate the department's and office's compliance with policies and procedures internal to them or promulgated by other state agencies, as well as certain legal provisions; and
3. Evaluate the economy and efficiency of certain management practices and operations, including certain financial transactions.

Our methodology included reviewing written policies and procedures, financial records, minutes of meetings, and other pertinent documents; interviewing various personnel of the department; and testing selected transactions. We obtained an understanding of internal controls that we deemed significant within the context of the audit objectives and assessed whether such controls have been properly designed and placed in operation. We tested certain of those controls to obtain evidence regarding the effectiveness of their design and operation. We also obtained an understanding of legal provisions that are significant within the context of the audit objectives, and we assessed the risk that illegal acts, including fraud, and violations of contracts, grant agreements, or other legal provisions could occur. Based on that risk assessment, we designed and performed procedures to provide reasonable assurance of detecting instances of noncompliance significant to those provisions.

We conducted our audit in accordance with the standards applicable to performance audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States. Those standards require that we plan and perform our audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides such a basis.

The accompanying *Résumé of Operations* is presented for informational purposes. This information was obtained from the department's management and was not subjected to the procedures applied in our audit of the department. For the areas audited, we identified:

1. Deficiencies in internal controls;
2. Apparent noncompliance with legal provisions; and
3. Need for improvement in management practices and procedures that we deemed to be reportable.

The State Auditors' Findings and Recommendations in the accompanying report presents any findings arising from the audit of the Department of Insurance and the Office of the Healthcare Advocate.

COMMENTS

FOREWORD

The duties, powers and responsibilities of the Department of Insurance (DOI) are set forth primarily by Title 38a of the General Statutes. The responsibilities of DOI include the licensing and oversight of insurance business within the state and the collection of certain taxes and fees arising from such activities. Included within the scope of the term insurance business are the insurance activities related to fraternal benefit societies, certain coverage incident to credit transactions, public adjusters, casualty adjusters, motor vehicle physical damage adjusters, certified insurance consultants, and healthcare centers.

In accordance with Section 36a-285 of the General Statutes, DOI, in conjunction with the Department of Banking, is also responsible in certain instances for the oversight of mutual savings banks of the state, which engage in the marketing of savings bank life insurance. DOI also has oversight responsibilities for workers' compensation under Sections 31-328 through 31-339 for mutual associations of employers formed for the purposes of insuring their liabilities to compensate employees for injuries sustained, and under Sections 31-345 through 31-348a for policies of insurance issued by either insurers or self-insured, purporting to cover an employer's liabilities for workers' compensation. Thomas B. Leonardi was appointed commissioner on February 14, 2011 and served in that capacity until December 12, 2014. Katharine L. Wade was appointed commissioner on March 20, 2015 and continues to serve in that capacity.

The duties, powers and responsibilities of the Office of the Healthcare Advocate (OHA) are set forth primarily by Title 38, Chapter 706b of the General Statutes and, pursuant to these

provisions, the office is placed within DOI for administrative purposes only. OHA acts to assist consumers with healthcare issues through the establishment of outreach programs related to consumer rights and responsibilities as members of managed care plans. OHA is under the direction of a Healthcare Advocate, who is appointed by the Governor with the approval of the General Assembly. Victoria Veltri served as the Healthcare Advocate throughout the audited period.

Commission on Health Equity

The duties, powers and responsibilities of the Commission on Health Equity are set forth in Title 38a, Chapter 706b, Section 38a-1051 of the General Statutes and, pursuant to these provisions, are placed within OHA for administrative purposes only. The mission of the 32-member commission is to eliminate disparities in health status based on race, ethnicity, and linguistic ability and to improve the quality of health for all state residents. Membership consists of commissioners or their designees and appointed public members. Glenn Cassis, executive director for the African American Affairs Commission, served as the commission chairman during the audited period.

Advisory Committee to the Office of the Healthcare Advocate

Section 38a-1049 of the General Statutes established the Advisory Committee to the Office of the Healthcare Advocate. The advisory committee meets to review and assess OHA's performance and conducts an annual evaluation of OHA. The committee completed its annual evaluations during the fiscal years ended June 30, 2014 and 2015.

Significant New Legislation

Public Act 14-217, Section 66, effective, July 1, 2014, required DOI to deposit the health and welfare fee in the Insurance Fund instead of the General Fund. By law, the insurance commissioner assesses this fee annually against each domestic insurer and health management organization conducting health insurance business in Connecticut, third-party administrators (TPA) providing administrative services for self-insured health benefit plans, and domestic insurers exempt from TPA licensure who administer self-insured health benefits. The health and welfare fee is used to pay for the purchase, storage, and distribution of vaccines under the Department of Public Health's Connecticut Vaccine Program, as well as for other vaccine, biologic, and antibiotic purchases and distribution. The secretary of the Office of Policy and Management, in consultation with the Department of Public Health, must annually determine the amount appropriated for these purposes.

RÉSUMÉ OF OPERATIONS

General Fund Receipts

Receipts for the General Fund are summarized below for the fiscal years ended June 30, 2013, 2014, and 2015, respectively.

	<u>Fiscal Year Ended June 30,</u>		
General Fund Receipts by Account	<u>2013</u>	<u>2014</u>	<u>2015</u>
Fees	\$22,693,619	\$34,989,598	\$5,739,602
Licenses	21,731,721	48,980,699	23,758,647
Surplus Line Tax	18,422,013	18,916,608	20,209,047
Fines and Costs	4,330,447	2,555,055	2,001,212
Other Receipts/Refunds	(34,743)	(21,032)	(46,912)
Total Receipts	<u>\$67,143,057</u>	<u>\$105,420,928</u>	<u>\$51,661,596</u>

General Fund receipts consist primarily of fees collected from domestic and foreign insurance companies and health care centers doing business in the state. The various fees are established by Section 38a-11 of the General Statutes and are collected mainly for licenses, applications, exams, and the filing of annual reports. Additionally, surplus line taxes are collected in accordance with Section 38a-743 of the General Statutes and are equal to four percent of the gross premiums on insurance provided by surplus line brokers.

Pursuant to Section 19a-7f of the General Statutes, the department collects an assessment from domestic insurers, health care centers, licensed third-party administrators, and exempt domestic insurers for the vaccine assessment, which funds a variety of services provided by the Department of Public Health. Fees increased by \$12,295,979 for the 2013-2014 fiscal year due to a change in the appropriation for services invoiced under the assessment and the late collection of fees for prior fiscal years. New licenses for approved companies and increases in other state fees also contributed to the increase. Effective July 1, 2014, the vaccine assessment was transferred from the General Fund to the Insurance Fund, which resulted in decreased revenue for the 2014-2015 fiscal year.

Licenses increased by \$27,248,978 for the 2013-2014 fiscal year and then decreased by \$25,222,052 for the 2014-2015 fiscal year. Every two years, in the even fiscal year, the department bills for all appointed insurance agents, resulting in a large revenue fluctuation.

Insurance Fund

The Insurance Fund was established by Section 38a-52a of the General Statutes and is used to account for the recovery of operating expenses of DOI from insurance companies. Sections 38a-47 and 38a-48 of the General Statutes provide for the manner in which the assessments are calculated. Generally, domestic insurance companies and other domestic entities subject to taxation under Chapter 207 are assessed on an annual basis using certain estimated expenses of DOI and shared expenses of the Department of Social Services and the Office of Policy and Management. Included within the assessment calculation is an adjustment for actual expenditures

in the previous fiscal year. Receipts for the Insurance Fund are summarized below for the fiscal years ended June 30, 2013, 2014, and 2015, respectively.

Insurance Fund Receipts by Account	<u>Fiscal Year Ended June 30,</u>		
	<u>2013</u>	<u>2014</u>	<u>2015</u>
Expenses Recovered from Insurance Cos.	\$25,461,204	\$31,424,060	\$29,789,751
Investment Interest	18,040	16,686	21,823
Insurance Licenses	-	800	8,140
Fees	18,690	(542,045)	31,481,519
Other Refunds	(414,771)	(102,231)	(3,925)
Refunds	50,522	213,874	29,863
Total Receipts	<u>\$25,133,685</u>	<u>\$31,011,144</u>	<u>\$61,327,171</u>

Fees increased by \$32,023,563 during the 2014-2015 fiscal year due to the transfer of the vaccine assessment from the General Fund to the Insurance Fund. The Expenses Recovered from Insurance Companies category reflects the annual assessment receipts pursuant to Section 38a-47 of the General Statutes.

Expenditures for the Insurance Fund are summarized below for the fiscal years ended June 30, 2013, 2014, and 2015, respectively.

Insurance Fund Expenditures by Account	<u>Fiscal Year Ended June 30,</u>		
	<u>2013</u>	<u>2014</u>	<u>2015</u>
Personal Services & Employee Benefits	\$21,495,345	\$23,357,718	\$24,377,154
Premises and Property Expenses	1,365,799	1,388,444	1,355,357
Purchased & Contracted Services	468,638	265,291	524,324
Information Technology	109,700	53,437	157,156
Purchased Commodities	101,063	113,365	86,256
Capital Outlays – Equipment	130,087	85,592	49,653
Other Expenditures	554,736	804,123	462,032
Total Expenditures	<u>\$24,225,368</u>	<u>\$26,067,970</u>	<u>\$27,011,932</u>

Total expenditures increased by \$1,842,602 and \$943,962 for the 2013-2014 and 2014-2015 fiscal years. The increases were mainly due to an increase in personal services and changes in the fringe benefit contributions to the State Employees' Retirement System as established by the State Comptroller. Purchased and Contracted Services decreased by \$203,347 for the 2013-2014 fiscal year and then increased by \$259,032 for the 2014-2015 fiscal year. The fluctuations were due to an agreement the department has with the University of Connecticut for consulting services for the Connecticut Regulatory Information System (CRIS). The application is used by the licensing, fraud, consumer affairs/market conduct, and financial regulation divisions and contains licensing records for over 200,000 licensees. The system tracks complaints and fraud investigations conducted by the department and tracks licensed and registered insurance companies within the state as well as bail bonds.

Other expenditures fluctuated during the 2013-2014 and 2014-2015 fiscal years due to indirect overhead. The State Comptroller bills self-funded agencies for work performed by

central agencies, including the Department of Administrative Services (DAS), Department of Public Works (DPW), Office of the Attorney General (OAG), and the Bureau of Enterprise Systems and Technology (BEST).

The available cash balance in the Insurance Fund was \$8,962,848 and \$5,579,887 as of June 30, 2014 and 2015, respectively.

OHA is a separately budgeted agency that is under DOI for administrative purposes only. The Insurance Fund is charged for the expenditures of OHA, which were \$2,598,423 and \$5,024,971 for the 2013-2014 and 2014-2015 fiscal years, respectively. These expenditures were mainly attributed to payroll and an increase in management consulting fees to administer the federal State Innovation Model (SIM) Test Grant from the Center for Medicare & Medicaid Innovation (CMMI). Due to staffing changes, federal funds were not drawn down timely and expenditures were instead charged to the Insurance Fund. The agency has since assigned oversight of grant funds to prevent this issue going forward.

Special Revenue Fund – Federal and Other Restricted Account

Federal and Other Restricted Account receipts for DOI totaled \$538,550 and \$437,750 for the 2013-2014 and 2014-2015 fiscal years, respectively. Receipts consisted of license fees from insurance companies and are dedicated to the regulation of utilization reviews, which is the use of a set of formal techniques designed to monitor or evaluate the medical necessity of health care services. The increase in the 2013-2014 fiscal year was due to receipts for the Insurance Department Education Account, which utilizes fees imposed on insurance companies to protect consumers through educational programs.

Expenditures from this fund totaled \$653,155 and \$472,471 for the fiscal years ended June 30, 2014 and 2015, respectively. The majority of expenditures were for auditing services to conduct the surety bail bond agent examinations and advertising and marketing for outreach campaigns.

Federal and Other Restricted Account receipts for OHA totaled \$1,409,281 and \$0 for the fiscal years ended June 30, 2014 and 2015, respectively. In 2014, the state was awarded a four-year \$45 million SIM grant. The purpose of the grant was to “test state-led, multi-payer health care payment and service delivery models that will improve health system performance, increase quality of care, and decrease costs for Medicare, Medicaid and Children’s Health Insurance Program (CHIP) beneficiaries and for all residents.” The large decrease in receipts for the 2014-2015 fiscal year was due to the office not drawing down grant funds as previously noted.

Federal and Other Restricted Accounts expenditures totaled \$3,215,459 and \$1,205,832 for the fiscal years ended June 30, 2014 and 2015, respectively. The majority of expenditures were for consulting services and grant transfers to other state agencies.

Special Revenue Fund - Brokered Transactions Guaranty Fund

The Brokered Transactions Guaranty Fund operates under Sections 38a-880 through 38a-889 of the General Statutes. This fund was established to compensate state residents aggrieved by

various actions of insurance agents or brokers, including embezzlement and fraud. Newly-licensed insurance agents and brokers are required to pay a \$10 fee to the fund. Section 38a-882 of the General Statutes requires that the fund balance be maintained in the amount of \$500,000 and receipts in excess of that amount are to be deposited to the General Fund. There have been no disbursements from this fund for at least 17 years; the fund balance has been maintained in the amount of \$500,000. During the 2013-2014 and 2014-2015 fiscal years, receipts totaling \$130,190 and \$204,092, respectively, were deposited into the General Fund.

Trust Deposits and Escrow Accounts Held by the State Treasurer

Under various statutory provisions, certain insurance companies are required to deposit securities with the State Treasurer for the benefit of their policyholders. The par value of these deposits totaled \$352,901,500 as of June 30, 2015. These amounts include (1) retaliatory deposits made under the provisions of Section 38a-83 of the General Statutes, which require companies domiciled in states that require deposits of Connecticut companies, to make equivalent deposits in Connecticut, (2) deposits made under Section 38a-371 of the General Statutes for companies desiring to be self-insured for their automobile coverage, and (3) other deposits required by the commissioner and determined to be necessary for the protection of Connecticut policyholders.

STATE AUDITORS' FINDINGS AND RECOMMENDATIONS

Our review of the records of the Department of Insurance and the Office of the Healthcare Advocate disclosed areas of concern, which are discussed below.

Medical Leave

- Criteria:* The statewide Family and Medical Leave Policy sets forth procedures for requesting a leave of absence under the Family and Medical Leave Act (FMLA). The policy outlines the required forms and submission deadlines.
- According to Section F of the department's employee handbook, if an employee will be absent for five or more days, the employee must obtain a medical certificate form.
- Condition:* Our review of ten medical leaves of absence revealed the following conditions:
1. Required FMLA documentation was not on file for three of the seven employees absent on FMLA leave.
 2. A medical certificate was not on file for one employee using sick leave for five or more consecutive working days.
- Effect:* Medical leave was not processed in accordance with department policies or FMLA requirements.
- Cause:* The noncompliance and unsupported absences appear to be the result of management oversight.
- Recommendation:* The Department of Insurance should strengthen internal controls to ensure medical leave is taken in accordance with department policies and state and federal FMLA requirements. (See Recommendation 1.)
- Agency Response:* "The Department of Insurance agrees and has now taken steps to strengthen its internal controls with respect to medical leave, including the development and implementation of an FMLA checklist to ensure that all required documentation is received and on file."

Travel Expenditures

- Criteria:* Section 5-141c-3 of the Department of Administrative Services Travel Regulations, states that all travel shall be approved by the agency head and shall be in accordance with the criteria set forth in sections 5-141c-2 to 5-141c-11, inclusive, of the Regulations of Connecticut State Agencies, policies issued by the Commissioner of Administrative Services or the commissioner's designee and the Office of the State Comptroller or the applicable statute or collective bargaining agreement.
- The State Comptroller's Travel Policies require that a travel authorization form (Form CO-112) be completed and approved by the necessary parties four weeks prior to travel. The approved form is then provided to the travel coordinator for assignment of a travel authorization number.
- Condition:* We noted that 11 out of 35 travel authorization forms selected for review were not completed and approved prior to the department securing travel arrangements. We also found that one travel authorization form could not be located.
- Effect:* Employee travel was not approved on the required form prior to securing travel arrangements, which may lead to unauthorized expenditures and loss of state funds.
- Cause:* It appears as though internal travel procedures do not require the completion of the travel authorization form and assignment of a travel authorization number until arrangements have been made.
- Recommendation:* The Department of Insurance should strengthen internal controls to ensure travel authorization forms are complete and approved prior to securing travel arrangements in accordance with state travel regulations and policies. (See Recommendation 2.)
- Agency Response:* "While the Department does not believe that its prior travel authorization practices have created a substantial likelihood of unauthorized expenditure or loss of state funds, it does acknowledge that there have been departures from the Comptroller's Travel Policies. In many cases, the department employees' travel is reimbursed either by the National Association of Insurance Commissioners or by a company under examination, and such departures have been intended to minimize costs to such third-parties by earlier booking, subject always to cancellation in the event of later disapproval. The department will revise its travel practices to assure authorization execution and number assignment

prior to finalizing arrangements, in accordance with the Comptroller's Policies.”

Deposit Documentation

- Criteria:* Sound internal controls dictate that documentation should be maintained to support deposits, including copies of checks, deposit slips, and bank transaction receipts.
- Condition:* We tested 20 deposits totaling \$2,639,984 and noted that documentation supporting two deposits totaling \$2,142,330 could not be located by the department.
- Effect:* Without supporting documentation, we could not verify that the deposits were complete, accurately accounted for, and deposited in a timely manner.
- Cause:* The deposit documentation may have been misplaced or misfiled.
- Recommendation:* The Department of Insurance should strengthen internal controls to ensure that documentation is on file to support deposits. (See Recommendation 3.)
- Agency Response:* “Misfiled and lost paperwork appears to be the result of human error and therefore cannot be entirely eliminated. Nevertheless, the documentation of monetary deposits is an important control item and the department management will stress to affected employees the importance of care in dealing with deposits documentation and the proper labeling of file containers. In this regard, it should be noted that the department now utilizes electronic depositing of items with daily records of scanned items (front and back) maintained digitally.”

Receipt Tracking Process

- Criteria:* In accordance with Chapter 2 of the Receipts section of the State Accounting Manual, internal control over cash receipts shall be established by each agency to minimize the risk of loss.
- The employee opening the mail should record the date of receipt, name of remitter, amount of receipt, type of receipt, and purpose of the remittance on a form, in duplicate, or in a journal. When receipts are delivered, the person authorized to receive them should verify the amounts entered on the forms or in the journal and acknowledge delivery of the receipts.

A receipts journal should be maintained by all agencies receiving money. The journal should include the date of receipt, name of payer, revenue classification, total receipts, amount deposited, deposit slip number, and date of deposit.

Condition: The department's receipt tracking process is inadequate. The person opening the mail distributes receipts to the billing divisions without first logging them on a form or in a journal. Additionally, a consolidated receipts journal is not maintained to document all receipts received by the various divisions of the department.

Effect: The inadequate receipt tracking process increases the risk that cash receipts will go missing or not be deposited in a timely manner.

Cause: The inadequate receipt tracking process appears to be the result of a lack of management oversight over the administrative functions of the department.

Recommendation: The Department of Insurance should review its internal controls over receipts to ensure compliance with the State Accounting Manual. (See Recommendation 4.)

Agency Response: "The department agrees that its current receipt tracking process is not in compliance with the State Accounting Manual and acknowledges the need to upgrade internal controls over cash receipts. In this regard, the department's management is formulating procedures for, and will shortly be instituting, a check and money order journaling procedure. This electronic journal will be maintained within the Business Office, and all cash items will be logged in when received and prior to distribution to the applicable division. The journal will also serve as a way to assure that deposits are made in a timely manner."

Software Inventory

Criteria: In accordance with Chapter 7 of the State Property Control Manual, a software inventory must be established to track and control all software media and license agreements; a software inventory report must be produced on an annual basis; and an annual physical inventory of the software library should be conducted.

Condition: Our review of the department's software inventory and ten software items revealed the following conditions:

1. The annual physical inventory of the software library was not documented.
2. The department's software inventory report appeared incomplete, with many software items missing software costs, acquisition detail, or the number of licenses available and in use.
3. Two software items did not have license agreements on file.

Effect: Software records are not properly maintained, increasing the risk that software purchases are not properly accounted for and reported.

Cause: The directives set forth in the State Property Control Manual for software were not followed.

Recommendation: The Department of Insurance should strengthen internal controls to ensure that its software inventory records are maintained and reported in accordance with the State Property Control Manual. (See Recommendation 5.)

Agency Response: "The department agrees that software inventory practices should be improved in order to be in accordance with the audit report recommendation. Specifically, the department agrees to make changes in our procedures to ensure future compliance with the State Property Control Manual, including: (A) perform a fiscal year-end annual physical inventory, under direction of Computer Services Support (CSS) Division head; (B) require that the Business Office forward all purchasing information for software items to the Computer Support Services division for inclusion in the CSS software database; and (C) upgrade the CSS Division software data base to enhance compliance with the Property Control Manual."

General Assessment Calculations

Background: The Insurance Fund supports the operation of the Department of Insurance and the Office of the Healthcare Advocate. The department assesses domestic insurance companies and entities to cover the cost of these agencies. The assessment is built around the total amount of premium taxes paid to the Department of Revenue Services by domestic insurance companies and entities for the preceding year.

- Criteria:* Sections 38a-47 and 38a-48 of the General Statutes outline the annual assessment process. In accordance with Section 38a-48 subsection (c), the proposed assessments for each domestic insurance company or entity shall be calculated by allocating the amount to be paid under Section 38a-47 among the domestic insurance companies and entities in proportion to their respective shares of the total taxes and charges imposed under Chapter 207 on such entities on business done in the state during the preceding calendar year. Section 38a-48 subsection (g) requires that at the end of the year, the department recalculate the assessment amount for domestic insurance companies and entities using actual expenditures and show the difference between the recalculated amount and the amount previously paid.
- Condition:* For the fiscal year ended June 30, 2014, the department assessed insurance companies and entities \$21,355,536; the assessment was understated by \$2,597,619. For the fiscal year ended June 30, 2015, the department assessed insurance companies and entities \$27,701,292; the assessment was understated by \$415,852. The understatements were due to calculation errors in the Insurance Fund operating budget and year-end adjustments for amounts previously paid. Additionally, for the fiscal year ended June 30, 2014, the department included a \$200,000 contingency that does not appear to be permitted by Sections 38a-47 or 38a-48 of the General Statutes.
- Effect:* The underassessment of insurance companies and entities increases the risk that sufficient funding will not be available to cover the operating costs of the Department of Insurance and the Office of the Healthcare Advocate.
- Cause:* Management’s calculation was not technically accurate, did not include the appropriate adjustment period for expenditures, and accounted for potential shortfalls with a contingency fee.
- Recommendation:* The Department of Insurance should strengthen controls to ensure assessments are calculated in accordance with Sections 38a-47 and 38a-48 of the General Statutes. (See Recommendation 6.)
- Agency Response:* “The audit findings note that there were Insurance Fund assessment understatements for both fiscal years. Upon investigation, it appears that the misstatement for the fiscal year ended 2014 resulted from a human error, being a failure to account for a \$2.8 million year-end 998 adjustment. For that fiscal year there was in addition a legal error, being the inclusion of a \$200,000 “contingency” line. Neither error was found to be

repeated for the fiscal year ended 2015. During that latter period, however, the audit findings note a \$416,000 understatement, apparently resulting from human error in selecting the department's operating expense figure from the wrong column. The Department agrees with the findings and has taken steps to strengthen controls over those that had been in effect during fiscal years 2014 and 2015. Specifically, the department is committed to a more formal and detailed set of written procedures detailing the steps to create the annual Insurance Fund assessments and institution of a checks and balances control, whereby at least two Business Office employees are involved in that process and charged with checking each other's work."

Reporting Requirements

Criteria: The Department of Insurance, Office of the Healthcare Advocate, advisory committee to the Office of the Healthcare Advocate, and Commission on Health Equity are required to comply with numerous reporting requirements set forth by the General Statutes and by the Office of the State Comptroller.

Condition: Our review of the reports required to be filed during the fiscal years ended June 30, 2014 and 2015 by the Department of Insurance, Office of the Healthcare Advocate, advisory committee to the Office of the Healthcare Advocate, and Commission on Health Equity revealed the following conditions:

Department of Insurance:

1. The Annual Report of Budgeted Agencies required by Section 4-60 of the General Statutes was submitted 39 days late for the fiscal year ended June 30, 2015.
2. The Annual Report of the Insurance Commissioner required by Section 38a-12 of the General Statutes was submitted 84 and 77 days late, for the fiscal years ended June 30, 2014 and 2015, respectively.
3. The timeliness could not be verified for the Medical Malpractice Annual Report required by Section 38a-395 subsection (d) of the General Statutes for the fiscal years ended June 30, 2014 and 2015.

4. The annual report on the Regulation of Managed Care required by Section 38a-478a of the General Statutes was submitted 43 days late for the fiscal year ended June 30, 2015.
5. The Annual Internal Control Questionnaire required by the Office of the State Comptroller was not completed for the fiscal year ended June 30, 2015.

Office of the Healthcare Advocate:

6. The annual report of the Healthcare Advocate required by Section 38a-1041 subsection (e) of the General Statutes was submitted 58 and 67 days late for the fiscal years ended June 30, 2014 and 2015, respectively.

Advisory Committee to the Office of the Healthcare Advocate:

7. The annual evaluation of the advisory committee to the Office of the Healthcare Advocate required by Section 38a-1049 subsection (b) of the General Statutes was submitted 124 days late for the fiscal year ended June 30, 2015.

Commission on Health Equity:

8. The annual report of the Commission on Health Equity required by Section 38a-1051 subsection (e) of the General Statutes was submitted 136 and 94 days late for the fiscal years ended June 30, 2014 and 2015, respectively.

Effect:

The Department of Insurance, Office of the Healthcare Advocate, advisory committee to the Office of the Healthcare Advocate, and Commission on Health Equity were not in compliance with the reporting requirements established by the General Statutes and the Office of the State Comptroller. Additionally, due to a lack of documentation, we were unable to determine whether one report was submitted in a timely manner.

Cause:

The lack of reporting compliance by the Department of Insurance appears to be the result of managerial oversight.

The annual report of the Healthcare Advocate due on January 1st in accordance with Section 38a-1041 subsection (e) of the General Statutes was submitted late because OHA combines the report with the Office of the Healthcare Advocate's administrative report to the Governor due annually on March 1st in accordance with Section 38a-1050 of the General Statutes. OHA combines the two

reports due to staffing constraints and because the January 1st deadline does not allow the agency to capture complete annual data.

The untimely reporting of the annual evaluation of the advisory committee to the Office of the Healthcare Advocate and the annual report of the Commission on Health Equity appear to be the result of administrative oversight within the advisory committee and the commission.

Recommendation: The Department of Insurance should submit all reports required by the General Statutes and Office of the State Comptroller in a timely manner and strengthen internal controls to ensure evidence is maintained to support timely submittal. The Office of the Healthcare Advocate should submit all reports required by the General Statutes in a timely manner or seek legislation to clarify the reporting requirements established by Sections 38a-1041 subsection (e) and 38a-1050 of the General Statutes. The advisory committee to the Office of the Healthcare Advocate and the Commission on Health Equity should strengthen controls to ensure compliance with reporting timeframes as prescribed by the General Statutes. (See Recommendation 7.)

Agency Response: “Five department reports are referenced in the audit report. In general, compliance responsibility for reporting obligations has been dispersed among affected divisions. It is now appropriate that the department centralize oversight of its reporting obligations under a single person, who is responsible for monitoring reporting obligations and logging reports as filed.

Regarding the specific findings in the Audit Report:

- With respect to the Annual Report of Budgeted Agencies under CGS Sec. 4-60, the Department is taking steps so that for 2016 and going forward the Section 4-60 report to the Governor will be timely filed by September 1st.
- With respect to the reports required under Section 38a-12 and 38a-395(d), the department acknowledges the lateness. For the latter, the March 15 filing date imposed by statute is infeasible because the department relies on data provided by insurers, many of which do not report their closed claims data in time to permit the timely preparation of the annual report. The department may decide to seek legislative relief from this filing deadline during the 2017 session.

- With respect to the findings regarding the Commissioner's report under Sec. 38a-478a, the Department acknowledges that such statute does require the submission of the report "on March first annually". We note that the 2015 report was dated March 2, 2016, and we commit that future years' reports will be prepared for submission as close as possible to the statutory date.
- With respect to the OHA annual reporting under Sec. 38a-1041(e) and Sec. 38a-1049(b): In fiscal years ending June 30, 2014 and 2015, the agency's annual reports have been submitted after the statutory deadline of January 1st. As the report necessarily includes a summary of agency activities and data up to and including December 31st of each year, it is impossible to generate an all-inclusive and accurate report for the prior calendar year by the January 1st deadline. Given the additionally required administrative report due to the Governor on March 1 of each year, OHA has combined these two reports to maximize efficiency and ensure that the reporting would be comprehensive and representative of the agency's operations.

Further, given the impracticability of compliance with the January 1st submission deadline for the annual agency report, and in the interests of maintaining the ability to produce a consistently detailed and representative report of the agency's actions, OHA will seek legislation to adjust the required filing date for this report to align with the required administrative report to the Governor due on March 1st of each year.

- Additionally, with respect to the Advisory Committee to the Office of Healthcare Advocate under 38a-1049(b): The lateness of the annual report due from the Advisory Committee (no later than April 1st each year) stems primarily from a lack of clear administrative control within the Committee. OHA will seek to mitigate this issue by recommending a revision to the Committee by-laws to include the appointment of one Committee member to serve as Chairperson. This Chairperson would be responsible for adhering to Committee requirements, including monitoring committee member attendance at quarterly meetings, and the coordination and assignment of members to draft the annual report. This enhanced model should mitigate the lack of internal oversight that's resulted in late reporting in prior years.
- With respect to the annual report of the Commission on Health Equity (CHE)(38a-1051)(e), the Department and OHA

acknowledge that reporting has been untimely, as noted in finding 8 (page 14). In light of the termination of CHE during the 2016 Session, the issue as to what corrective action should be taken has become moot.”

Commission Information

Background: The Commission on Health Equity (CHE) was established by Section 38a-1051 of the General Statutes to eliminate disparities in health status based on race, ethnicity, gender, and linguistic ability, thereby improving the quality of health for all state residents. The commission is within the Office of the Healthcare Advocate for administrative purposes only.

Criteria: The commission is comprised of 32 members as outlined by Section 38a-1051 subsection (a) of the General Statutes. Of the 32 members, 14 are appointed by House and Senate leaders from both parties. A sound internal control would be to maintain all appointment letters to document compliance with the General Statutes.

Section 38a-1051 subsection (d) of the General Statutes requires the commission to meet at least once per calendar quarter. Section 1-225 subsection (b) requires meeting schedules to be made available to the public and posted on the commission’s website at the start of the calendar year.

Section 1-225 subsection (c) of the General Statutes requires meeting agendas to be made available to the public and posted to the commission’s website.

Section 1-225 subsection (a) of the General Statutes requires meeting minutes to be made available to the public and posted on the commission’s website.

Section 38a-1051 subsection (b) of the General Statutes states that any member absent for either three consecutive meetings or for 50 percent of such meetings during any calendar year shall be deemed to have resigned from the commission. A sound internal control would be to maintain consistent and complete accurate attendance records in order to document compliance with this requirement.

Condition: Our review of the Commission on Health Equity for the fiscal years ended June 30, 2014 and 2015 revealed the following conditions:

1. The commission did not consist of the statutorily required number of members during the audited period; of the 32 statutory positions, there were nine and 11 vacancies as of June 30, 2014 and 2015, respectively.
2. Of the 14 appointed positions, there were no appointment letters on file to support the seven and nine appointed positions filled as of June 30, 2014 and 2015, respectively.
3. We could not verify that the commission met at least once for the quarter ended December 31, 2013 due to a lack of meeting minutes.
4. There is no evidence that the commission posted its meeting schedules to its website at the start of the calendar year to support the meetings held during the audited period.
5. Of the 17 meetings held during the audited period, there was no agenda on file for seven meetings. Additionally, of the ten agendas on file, nine were not posted to the commission's website.
6. Of the 17 meetings held during the audited period, there were no meeting minutes on file for nine meetings. Additionally, of the eight meeting minutes on file, six were not posted to the commission's website.
7. Due to incomplete and inconsistent recordkeeping, we could not determine meeting attendance for the 17 meetings held during the audited period; therefore, we could not verify compliance with the attendance requirements established by Section 38a-1051 subsection (b) of the General Statutes.

Effect: The Commission on Health Equity is not in compliance with the General Statutes.

Cause: There appears to be a lack of administrative oversight within the Commission on Health Equity.

Conclusion: Public Act 16-3, Section 208, effective July 1, 2016, repealed Section 38a-1051 of the General Statutes which established the Commission on Health Equity. Therefore, no recommendation is warranted.

Agency Response: "With respect to the Commission on Health Equity (CHE), it operated under the auspices of the Office of Health Advocate prior

to dissolution of the CHE on July 1, 2016. The Office has been apprised of the findings in the audit report.”

RECOMMENDATIONS

Our prior report on the Department of Insurance and the Office of the Healthcare Advocate contained seven recommendations, five of which will be modified and repeated and two of which were resolved.

Status of Prior Audit Recommendations:

- *The Department of Insurance should improve the monitoring of employee sick time usage and scheduled hours and take appropriate action when necessary.* The prior issues related to sick leave and employee schedules were resolved. However, we did note issues with medical leave, which will be included in the current audit recommendations. (See Recommendation 1.)
- *The Department of Insurance should establish a network connection and move its server to its offsite location to fully implement its disaster recovery plan.* Corrective action was taken; therefore this recommendation will not be repeated.
- *The Department of Insurance should have procedures in place to ensure that software is maintained in accordance with the State Property Control Manual.* We noted similar issues during our current review; therefore, the recommendation will be modified and repeated. (See Recommendation 5.)
- *The Department of Insurance should establish internal controls that are designed and followed to ensure that receipts, revenues, and write-offs are documented and accounted for properly.* The prior recommendation related to written procedures for the write off of accounts receivables valued at less than \$1,000 was resolved. However, we continued to note similar issues regarding internal controls over revenue and receipts; therefore, this recommendation will be modified and repeated. (See Recommendation 3.)
- *The Department of Insurance should calculate the assessments in accordance with Section 38a-48 of the General Statutes.* We noted similar issues with the assessment calculation during the current review; therefore the recommendation will be repeated. (See Recommendation 6.)
- *The Department of Insurance should improve its internal controls by segregating the duties of preparing and approving the Generally Accepted Accounting Principles Closing Package to ensure accurate reporting to the Office of the State Comptroller.* Corrective action was taken; therefore, this recommendation will not be repeated.
- *The Commission on Health Equity should comply with Section 38a-1051 of the General Statutes and work with the Office of the Healthcare Advocate to consider seeking a legislative change to clarify the assignment provision under subsection (h).* This recommendation will be repeated due to similar issues noted during the current audit. (See Recommendation 7.)

Current Audit Recommendations:

1. **The Department of Insurance should strengthen internal controls to ensure medical leave is taken in accordance with department policies and state and federal FMLA requirements.**

Comment:

During our review of ten medical leaves of absence, we noted required FMLA documentation was not on file for three out of seven employees absent on FMLA, and a medical certificate was not on file for one employee using more than five days of consecutive sick leave.

2. **The Department of Insurance should strengthen internal controls to ensure travel authorization forms are complete and approved prior to securing travel arrangements in accordance with state travel regulations and policies.**

Comment:

During our expenditure testing, we noted that travel authorization forms were not completed and approved prior to the department securing travel arrangements. We also found that one travel authorization form could not be located.

3. **The Department of Insurance should strengthen internal controls to ensure that documentation is on file to support deposits.**

Comment:

From our test of 20 deposits, we noted a lack of documentation for two; therefore, we could not verify that the deposits were complete, accurately accounted for, and deposited in a timely manner.

4. **The Department of Insurance should review its internal controls over receipts to ensure compliance with the State Accounting Manual.**

Comment:

We noted inadequacies in the department's receipt tracking process. Receipts are not logged when the mail is opened and a receipts journal is not maintained to document all receipts from the various divisions of the department.

- 5. The Department of Insurance should strengthen internal controls to ensure that its software inventory records are maintained and reported in accordance with the State Property Control Manual.**

Comment:

During our review of the department's inventory and ten software items, we noted that documentation to support the annual inventory process was not maintained and the records were missing information required by the State Property Control Manual.

- 6. The Department of Insurance should strengthen controls to ensure assessments are calculated in accordance with Sections 38a-47 and 38a-48 of the General Statutes.**

Comment:

The annual assessment calculations for the audited period were understated due to calculation errors in the Insurance Fund operating budget and year-end adjustments for amounts previously paid. Additionally, for the fiscal year ended June 30, 2014, the department included a \$200,000 contingency that does not appear to be permitted by Sections 38a-47 or 38a-48 of the General Statutes.

- 7. The Department of Insurance should submit all reports required by the General Statutes and Office of the State Comptroller in a timely manner and strengthen internal controls to ensure evidence is maintained to support timely submittal.**

The Office of the Healthcare Advocate should submit all reports required by the General Statutes in a timely manner or seek legislation to clarify the reporting requirements established by Sections 38a-1041 subsection (e) and 38a-1050 of the General Statutes.

The advisory committee to the Office of the Healthcare Advocate and the Commission on Health Equity should strengthen controls to ensure compliance with reporting timeframes as prescribed by the General Statutes.

Comment:

Our review of the reports required to be filed during the fiscal years ended June 30, 2014 and 2015 by the Department of Insurance, Office of the Healthcare Advocate, advisory committee to the Office of the Healthcare Advocate, and Commission on Health Equity noted numerous deficiencies, including late filings and missing reports.

CONCLUSION

We wish to express our appreciation for the courtesies and cooperation extended to our representatives by the personnel of the Department of Insurance and the Office of the Healthcare Advocate during the course of our examination.



Rebecca M. Balkun
Principal Auditor

Approved:



John C. Geragosian
Auditor of Public Accounts