

# STATE OF CONNECTICUT



*AUDITORS' REPORT  
INSURANCE DEPARTMENT  
AND  
OFFICE OF THE HEALTHCARE ADVOCATE  
FOR THE FISCAL YEARS ENDED JUNE 30, 2008 AND 2009*

**AUDITORS OF PUBLIC ACCOUNTS**  
JOHN C. GERAGOSIAN ❖ ROBERT M. WARD

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May 17, 2011

**AUDITORS' REPORT  
INSURANCE DEPARTMENT  
AND  
OFFICE OF THE HEALTHCARE ADVOCATE  
FOR THE FISCAL YEARS ENDED JUNE 30, 2008 AND 2009**

We have made an examination of the financial records of the Insurance Department and the Office of the Healthcare Advocate for the fiscal years ended June 30, 2008 and 2009. This report on that examination consists of the Comments, Recommendations and Certification that follow.

Financial statement presentation and auditing of the books and accounts of the State are done on a Statewide Single Audit basis to include all State agencies including the Insurance Department and the Office of the Healthcare Advocate. This audit examination has been limited to assessing compliance with certain provisions of financial related laws, regulations, contracts, and evaluating both Agencies' internal control policies and procedures established to ensure such compliance.

**INSURANCE DEPARTMENT  
COMMENTS**

**FOREWORD:**

The duties, powers and responsibilities of the Insurance Department are set forth primarily by Title 38a of the General Statutes. The responsibilities of the Department include the licensing and oversight of insurance business carried on 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, coverage sometimes incident to credit transactions, public adjusters, casualty adjusters, motor vehicle physical damage adjusters, certified insurance consultants and health care centers.

Under Section 36a-285 of the General Statutes, the Department, in certain instances, is also responsible, in conjunction with the Department of Banking, for the oversight of mutual savings banks of the State, which engage in the marketing of savings bank life insurance.

## *Auditors of Public Accounts*

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The Department also has oversight responsibilities for Workers' Compensation under the following sections of the General Statutes:

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.

Sections 31-345 through 31-348a – for policies of insurance issued by either insurers or self-insureds, purporting to cover an employer's liabilities for Workers' Compensation.

Thomas R. Sullivan was appointed Commissioner on April 21, 2007, and continued to serve in that capacity throughout the audited period.

### **Significant New Legislation:**

Public Act 07-178 makes several changes to laws affecting health care centers (i.e. HMO's). It requires an HMO to deposit \$500,000 with the insurance commissioner or designated trustee. The commissioner must use this deposit to provide health care services to the HMO's enrollees if the HMO is placed in receivership and may use them for related administrative costs.

Public Act 07-200 requires pharmacy benefit managers (PBM's) with exceptions, to obtain a certificate of registration from the Insurance Department. It requires PBM's already operating in the State on January 1, 2008 to obtain one by April 1, 2008 to continue operating here. PBMs must apply for registration by giving the department (1) a completed application form that contains information on the people running the PBM (2) a nonrefundable \$50 fee; and (3) evidence of a surety bond that is between \$25,000 and \$1 million.

Public Act 08-178 generally increases the fines the insurance commissioner may assess against insurance companies, related companies, and the people for violating Connecticut's insurance laws, including those related to utilization review for unauthorized insurance, producer and company licensing, unfair and prohibited practices, and fraud. It leaves unchanged most fines enacted since 1996, including those related to privacy, preferred provider networks, and self-insured workers' compensation laws.

**RÉSUMÉ OF OPERATIONS – INSURANCE DEPARTMENT:**

**General Fund Revenues and Receipts:**

General Fund revenues for the past two fiscal years were as follows:

	<u>2007-2008</u>	<u>2008-2009</u>
Taxes	\$ 12,609,660	\$ 11,740,035
Licenses	20,226,278	10,858,030
Fees - Assessments	9,044,950	9,045,000
Fees	2,786,368	3,085,395
Fines and costs	4,217,893	2,076,399
All other receipts	<u>164,436</u>	<u>6,675</u>
<b>Totals</b>	<b><u>\$ 49,049,585</u></b>	<b><u>\$ 36,811,534</u></b>

General Fund revenues for the fiscal year ended June 30, 2007, totaled \$34,058,739, for comparative purposes. Revenue from “Taxes” represent amounts assessed under Section 38a-743 of the General Statutes, known as the “Surplus Line Tax”, and is equal to four percent of the gross premiums on insurance provided by Surplus Line Brokers. Revenues from the Surplus Line Tax declined nearly eleven percent during the audited period from 2006-2007 levels of \$13,202,676, representing a reduction of over \$1.4 million, due to a decrease in the total amount of direct premiums written in the State. Revenues generated from licenses are substantially higher in even fiscal years because both insurance agent and producer licenses are renewed biennially. Revenue from “Fees-Assessments” of \$9,044,950 and \$9,045,000 during the respective audited years represent receipts from each domestic insurer or health care center doing life insurance or health insurance business in the State for the purchase of routine vaccines to immunize children from low-income families, in accordance with Section 19a-7j, subsection (b), of the General Statutes. Such fees are calculated on the basis of life insurance premiums and health insurance premiums and subscriber charges in the same manner as calculations under Section 38a-48 of the General Statutes for assessments, as described below.

**Insurance Fund:**

Section 38a-52a of the General Statutes established the Insurance Fund. This Fund is used to account for the assessments of insurance companies for the recovery of operating expenses of the Insurance Department and the Office of the Healthcare Advocate.

Sections 38a-47 and 38a-48 of the General Statutes provide for the manner in which the assessments are calculated. Section 38a-47 of the General Statutes states in part: “All domestic insurance companies and other domestic entities subject to taxation under Chapter 207 shall, in accordance with Section 38a-48, annually pay to the Insurance Commissioner, for deposit in the Insurance Fund established under Section 38a-52a, an amount equal to the actual expenditures made by the Insurance Department during each fiscal year, and the actual expenditures made by the Office of the Healthcare Advocate, including the cost of fringe benefits for department and office personnel as estimated by the Comptroller, plus the expenditures made on behalf of the department and the

office from the Capital Equipment Purchase Fund pursuant to Section 4a-9 for such year...”

Section 38a-48 (b) of the General Statutes states in part: “On or before July thirty-first, annually, the Insurance Commissioner and the Office of the Healthcare Advocate shall render to each domestic insurance company or other domestic entity liable for payment under Section 38a-47, (1) a statement which includes the amount appropriated to the Insurance Department and the Office of the Healthcare Advocate for the fiscal year beginning July first of the same year, the cost of fringe benefits for department and office personnel for such year, as estimated by the Comptroller, and the estimated expenditures on behalf of the department and the office from the Capital Equipment Purchase Fund pursuant to Section 4a-9 for such year, (2) a statement of the total taxes imposed on all domestic insurance companies and domestic insurance entities under Chapter 207 on business done in this state during the preceding calendar year, and (3) the proposed assessment against that company or entity, calculated in accordance with the provisions of subsection (c) of this Section..”

Insurance Fund receipts for the fiscal years ended June 30, 2008 and 2009, were as follows:

	<u>2007-2008</u>	<u>2008-2009</u>
Expenses Recovered from Insurance Companies	\$23,188,024	\$23,526,225
Interest Income Credited	256,673	95,347
Other Receipts/Revenue	<u>263,173</u>	<u>129,466</u>
<b>Total Insurance Fund Receipts</b>	<b><u>\$23,707,870</u></b>	<b><u>\$23,751,038</u></b>

For comparison purposes, total Insurance Fund receipts totaled \$21,235,101 for the fiscal year ended June 30, 2007.

A summary of Insurance Department expenditures from the Insurance Fund for the two audited fiscal years, were as follows:

	<u>2007-2008</u>	<u>2008-2009</u>
Personal Services	\$ 12,271,411	\$12,669,478
Other Expenses	2,525,930	2,521,750
Equipment	287,299	56,646
Fringe Benefits	6,624,301	6,928,727
Indirect Overhead	<u>291,159</u>	<u>524,348</u>
<b>Total Expenditures</b>	<b><u>\$22,000,100</u></b>	<b><u>\$22,700,949</u></b>

For comparative purposes, Insurance Fund expenditures for fiscal year 2006-2007 totaled \$20,943,896. Total expenditures increased 8.6 percent during the audited fiscal years, primarily due to increases in personal services and related fringe benefits.

As of June 30, 2009, the available cash balance in the Insurance Fund was \$5,780,692. For comparison purposes, the available cash balance in the Insurance Fund, as of June 30, 2007, was \$7,160,121. In accordance with Public Act 09-2, “An Act Concerning Deficit Mitigation Measures for the Fiscal Year Ending June 30, 2009”, the amount of \$1,000,000 was transferred from the Insurance Fund to the General Fund during fiscal year 2008-2009.

As of June 30, 2009, the Insurance Department numbered about 152 employees.

**Special Revenue Fund – Federal and Other Restricted Accounts:**

Federal and Other Restricted Accounts receipts totaled \$337,400 and \$410,600 for the fiscal years ended June 30, 2008 and 2009, respectively. Most of these receipts consisted of Utilization Review Fees resulting from the collection of license and external appeal fees from insurance companies involved with health care utilization reviews in accordance with Section 38a-226a of the General Statutes. Each utilization review company conducting utilization reviews must be licensed by the Commissioner and pay an annual license fee of \$2,500, which is dedicated to the regulation of utilization review.

Utilization review account expenditures totaled \$385,983 and \$368,887 for the fiscal years ended June 30, 2008 and 2009, respectively. The majority of expenditures were for personal services and outside professional services for arbitration and mediation services.

As of June 30, 2008, the cash balance in the Utilization Review account totaled \$2,061,324. As of June 30, 2009, the balance was \$1,047,297. In accordance with Section 48 of Public Act 09-111, the amount of \$956,641 was transferred from the Utilization Review account to the General Fund for deficit mitigation.

**Brokered Transactions Guaranty Fund:**

The Brokered Transactions Guaranty Fund operates under Sections 38a-880 through 38a-889 of the General Statutes. This Fund compensates 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. Pursuant to Section 38a-882 of the General Statutes, the Fund is to be maintained at a level not to exceed \$500,000. Receipts are credited to the Fund as long as the Fund balance is below \$500,000. Any amounts in excess of this level are deposited to the General Fund. There have been no cash receipts or disbursements in this Fund for the last several fiscal years, including the fiscal years audited. During fiscal years 2007-2008, and 2008-2009, receipts of \$193,560, and \$171,676, respectively, were deposited in the General Fund representing fees received in excess of the maximum \$500,000 fund balance as of June 30, 2009.

**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. These deposits include:

1. Retaliatory deposits made under the provisions of Section 38a-83 of the General Statutes, which require companies, that are 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.

3. Other deposits required by the Commissioner determined to be necessary for the protection of Connecticut policyholders.

The par value of these deposits amounted to \$333,106,000 and \$326,153,000, as of June 30, 2008, and June 30, 2009, respectively.

## CONDITION OF RECORDS

Our review of the Insurance Department's records revealed the following areas that require improvement.

### **Purchase Orders Not Prepared Prior to Receipt:**

*Criteria:* Section 4-98, subsection (a), of the General Statutes states that no budgeted agency may incur any obligation except by the issuance of a purchase order transmitted to the State Comptroller to commit the agency's appropriations to ensure that funds are available for the payment of such obligations.

The State Accounting Manual requires that, "... commitments be submitted *at least five working days prior* to the submission of invoices to ensure commitments are posted to the system prior to payment. Payments will not be processed when a commitment is required but has not been submitted."

*Condition:* Out of 20 vouchers tested, four vouchers, totaling \$8,043, were not supported by a valid commitment document (purchase order) prior to the receipts of the goods or services.

*Effect:* Expenditures were incurred for goods and services prior to funds being committed in violation of Section 4-98 of the General Statutes.

*Cause:* It appears that inadequate communications between the business office and other agency staff for the purchasing of goods and services was the cause of this condition. The business office was not informed of the purchases of goods received or services rendered until after the vendor invoice was received from agency staff.

*Recommendation:* The Insurance Department should improve purchasing procedures to ensure compliance with Section 4-98 of the General Statutes. (See Recommendation 1.)

*Agency Response:* "The CT Insurance Department will continue to prepare purchase orders in a manner that satisfies the requirements of Section 4-98 of the Connecticut General Statutes. The Business Office has communicated to the applicable departments the necessity of notifying the Business Office prior to incurring any obligation."

**Lack of an Employees' Personnel Manual:**

<i>Criteria:</i>	Good business practices require that an employer produce and maintain an employees' Personnel Manual.
<i>Condition:</i>	The Insurance Department has not developed an employees' Personnel Manual.
<i>Effect:</i>	A Personnel Manual provides critical policy and procedural guidance relative to the employer-employee relationship and strengthens internal control over personnel.
<i>Cause:</i>	The cause was not determined.
<i>Recommendation:</i>	The Insurance Department should develop an employees' Personnel Manual. (See Recommendation 2.)
<i>Agency Response:</i>	"DOI will develop a Personnel Manual. DOI does have critical policies and procedures in place, and DOI employees are regularly updated when changes occur."

**I-9 Forms Not on File or Incomplete:**

<i>Criteria:</i>	The "Immigration Reform and Control Act of 1986" requires employers to complete the U.S. Department of Justice INS Form I-9. The form is now known as the U.S. Department of Homeland Security CIS Form I-9, and is required for any employee hired after November 6, 1986.
<i>Condition:</i>	<p>Our test of twenty employees found numerous instances of missing I-9's or the I-9's that had not been filled out properly. Based on that test, we expanded our review to include all current employees of the Department, which found additional instances of missing, incomplete, or incorrectly filled-out I-9's.</p> <p>We provided this expanded list to the Department. During our audit fieldwork, the Department undertook a project to obtain an I-9 from each current employee required to have one on file, and to correct those I-9's which were found to be incomplete, or incorrectly filled out.</p>
<i>Effect:</i>	The Department of Homeland Security may impose penalties if an investigation reveals that an employer has knowingly hired or knowingly continued to employ an unauthorized alien, or has failed to comply with the employment eligibility verification requirements, with respect to employees hired after November 6, 1986.

Employers who fail to properly complete, retain, and/or make available for inspection Form I-9 as required by law may face civil money penalties in an amount of not less than \$110 and not more than \$1,100 for each individual with respect to whom such violation occurred.

*Cause:* The cause was not determined.

*Conclusion:* During our audit fieldwork, the Department undertook a project to obtain an I-9 from each current employee required to have one on file, and to correct those I-9's which were found to be incomplete, or incorrectly filled out. Accordingly, we are not issuing a recommendation at this time.

**Incorrect Use of Administrative Leave with Pay:**

*Criteria:* Section 5-240-5a (f) of the State Personnel Regulations state that “an appointing authority may place an employee on leave of absence with pay for up to fifteen (15) days to permit investigation of alleged serious misconduct which could constitute cause for dismissal under C.G.S. Section 5-240-1a (c).”

*Condition:* The Insurance Department placed an employee on administrative leave with pay on November 7, 2007, until December 14, 2007, a period of 26 days, 11 days more than allowed by State Personnel Regulation.

*Effect:* The State Personnel Regulation limiting paid administrative leave with pay to 15 days was not complied with.

*Cause:* The cause was not determined.

*Recommendation:* The Insurance Department should limit the use of administrative leave with pay to no more than 15 days, as required by the State Personnel Regulations. (See Recommendation 3.)

*Agency Response:* “DOI will comply with this recommendation. Should a DOI employee go out on Administrative Leave with Pay, the code would be changed after the fifteenth day.”

**Use of the Leave in Lieu of Accrual Time Reporting Code:**

*Criteria:* The Leave in Lieu of Accrual (LILA) time reporting code (TRC) was established in Core-CT to allow employees to charge time (i.e., personal, vacation and sick leave) in advance of accrual of that time. The LILA

TRC should be used for the period between the 1<sup>st</sup> of a month and when the month's accrual is posted to the leave balance. LILA can also be used when an employee earns and uses compensatory or holiday time in the same pay period. The code is meant to be temporary and should be changed once the accrual/comp time has been posted and is available to use.

*Condition:* We found procedural errors in the way the Core-CT LILA TRC job aid has been applied. For example, negative LILA hours were posted to employees' attendance records, however the LILA code should always be a positive number. As a result, subsequent changes to reflect actual leave time used had to be doubled in order to compensate for the initial negative posting, causing employee's attendance cards to suggest that more hours were worked than was actually the case. If Core-CT job aid procedures are properly applied, the LILA TRC should be eliminated and not appear on the employees' attendance card, however, this was not the case with respect to the employees' attendance cards we reviewed.

*Effect:* We could not determine any effects other than a misapplication of the Core-CT job aid procedures. It is possible that some employees' LILA postings were not correctly changed to accrued time, but upon further review it appears that no net errors resulted actually from the misapplication of the procedures during the period that was reviewed.

*Cause:* The cause appears to be a misunderstanding of the LILA TRC job aid procedures.

*Recommendation:* The Insurance Department should correctly apply the Leave in Lieu of Accrual job aid procedures when the LILA time reporting code is posted to employees' timesheets. (See Recommendation 4.)

*Agency Response:* "DOI agrees with this finding. DOI will comply with the Leave in Lieu of Accrual (LILA) Core-CT time reporting code procedure."

### **Development of an Agency Business Continuity Plan:**

*Criteria:* Good business practices require organizations to develop plans to provide for resumption of operations following a catastrophic event that disrupts normal operations. The objective of a plan, known as a "disaster recovery", or a "business continuity" plan, is to enable an organization to resume operations as quickly as possible following such an event. To assist agencies in the development of a plan, the Department of Information Technology has provided agencies with a "Business Continuity Plan" template.

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<i>Condition:</i>	The Insurance Department does not currently have a comprehensive Business Continuity Plan.
<i>Effect:</i>	In the event of a business interruption, the lack of a comprehensive plan diminishes the ability of the Department to resume key critical operations in a timely fashion.
<i>Cause:</i>	The cause was not determined.
<i>Recommendation:</i>	The Insurance Department should develop a comprehensive business continuity plan using the template provided by the Department of Information Technology. (See Recommendation 5.)
<i>Agency Response:</i>	“The Department currently has a Business Continuity Plan in place. This plan was developed several years ago in coordination with the Department of Administrative Services. The Department recognizes, however, that its current Business Continuity Plan is deficient in some respects. To address these deficiencies, the Department is in the process of enhancing its Business Continuity Plan by including responses to natural disasters and other types of emergencies. In addition, we are in the process of implementing new procedures to communicate with staff during emergencies and have taken a more active role with the state-wide Emergency Operations Center.”

**Internal Control over Cash Receipts:**

*Criteria:* The State Accounting Manual (SAM) requires agencies to establish internal control procedures over cash receipts. The procedures will vary from one agency to another depending on factors unique to that agency, but certain factors are common to all agencies. According to SAM: “Mail received by an agency may contain cash, money orders and checks. Receipts of such moneys can be safeguarded by procedures which include controls of incoming mail and bank deposits. When feasible, each of the following duties should be assigned to a different employee: opening incoming mail, recording receipts in a receipts journal, depositing receipts, and issuing licenses, permits, etc. to the remitter.”

“If duties are separated as above, the employee opening the mail should record the following information either on forms, in duplicate, to be devised by the agency, or in a bound journal: date of receipt, name of remitter, or the person for whom the remittance was sent, amount of receipt, type of receipt: cash, money order, check, and purpose of the remittance. When the receipts are delivered the person authorized to receive them should verify the amounts entered on the forms or in the journal. If in agreement, he should acknowledge delivery of the receipts to him either by signing both copies of the forms, returning the original to

the person making the delivery, or by signing the journal or issuing a receipt to cover the amounts entered in the journal.”

The Office of the State Treasurer has a lock-box agreement with banks for agencies to use if the volume of checks received justifies such an arrangement.

*Condition:* We found that no original listing is made of checks received a “bound journal” as required by the SAM upon receipt in the Department’s mail room, but instead, checks are sorted and delivered to the appropriate unit for processing, then subsequently delivered to the Business Office (note that some receipts, such as assessments on insurance companies, go directly from the mail room to the Business Office). The checks from the various units are sent to the Business Office for recording in the cash receipts journal and for deposit in the bank.

*Effect:* Internal Control over cash receipts is potentially lessened.

*Cause:* There are multiple causes to this Condition. First of all, it should be noted that the Department receives tens of millions of dollars of receipt each fiscal year from various sources: licenses, fees, taxes, etc. In addition, the volume of checks received each fiscal year is very high. It would appear that sufficient resources are not available at the point of original receipt (the mail room) that would permit the Department to log each individual check at this point, and still be able to deposit these checks within the statutorily mandated timeframes required by Section 4-32 of the General Statutes.

*Recommendation:* The Insurance Department should revise its cash receipts procedures to conform to the requirements of the State Comptroller’s State Accounting Manual. In lieu of logging each receipt in the mailroom, the Department should consider implementing a bank lock-box system for its receipts. (See Recommendation 6.)

*Agency Response:* “The CT Insurance Department acknowledges that it generates tens of millions dollars annually in licensing, tax collections and other fees for the General Fund with minimum Business Office staff. The Department has implemented numerous electronic fund transfers with the National Insurance Producer Registry (NIPR), System for Rate and Form filings (SERFF) and the use of On Line Credit Card Payments for Insurance Agent License applications and renewals. As a result, the actual volume of paper checks on a daily basis has been decreasing. It is our belief that the cash receipts function within the business office is operating efficiently and deposits are made within statutorily mandated time periods. The business office has made inquiries with the Office of the Treasurer regarding the feasibility of implementing a lock-box system”

**GAAP Reporting of Receivables:**

*Background:* In October 2008, the Insurance Department filed a complaint against Golf Marketing Worldwide, LLC, et al, for violation of multiple sections of the General Statutes, and for failing to apply for or to receive an insurance license from the Commissioner. Included in the complaint were several counts of alleged failure by the Golf Marketing Worldwide, LLC to pay on contracts that provided for cash prizes in the event that contestants made a “hole-in -one”, or similar, shot at various golf tournaments, and other events.

*Criteria:* The Insurance Commissioner is charged with the administration and enforcement of the insurance laws and regulations pertaining to insurance and makes certain that the provision of Title 38a of the general statutes are faithfully executed. Pursuant to Section 38a-8 of the General Statutes the Commissioner is vested with all the powers that are reasonable and necessary to enable the Commissioner to protect the public interest, in accordance with the provisions of the insurance laws of the State of Connecticut.

According to the State Accounting Manual (SAM), agencies should report on GAAP Form 2, “...claims owed by private individuals and organizations on or prior to June 30”. In addition, according to SAM, agencies also enter the amount of the receivable that is estimated to be “uncollectible”.

*Condition:* In January 2009, the Commissioner of Insurance imposed a fine of \$5.9 million against Golf Marketing Worldwide, LLC, et al, for various violations of General Statutes. However, the amount of the fine, along with an amount estimated to be uncollectible, was not reported on GAAP Form 2 as of June 30, 2009. It should be noted that the fine has not been paid as of the date of our fieldwork, August 2010, and it appears collection, either in whole or in part, is highly unlikely.

*Effect:* By not including the receivable on GAAP form, the Comprehensive Annual Financial Report’s Statement of Net Assets is understated by the “net realizable value” of the receivable, which is equal to the gross amount of the fine less any amount determined by the Department to be uncollectible. As noted in the “Condition”, the uncollectible portion of this receivable is likely to be close to 100 percent.

*Cause:* The cause was not determined.

*Recommendation:* The Insurance Department should report a \$5.9 million receivable resulting from the fine of Golf Marketing Worldwide, LLC, et al, and any other receivables, resulting from fines, which are outstanding as of June 30, on GAAP Form 2, along with an amount of the receivables estimated to be uncollectible. (See Recommendation 7.)

*Agency Response:* “The Business Office is responsible for the preparation of the annual GAAP report. They are usually notified of fines and penalties by the appropriate department when the stipulation order is presented with the accompanying payment. The business office was not notified of the \$5.9 million fine that was levied against Golf Marketing Worldwide, LLC, as it represents a unique occurrence. Consequently, it was never included in the GAAP report. As a result, the Business Office has notified the appropriate departments about the need to communicate this type of unique situation to the Business Office, should it ever occur again.”

**A SAS 70 Report Should be Obtained:**

*Background:* The National Insurance Producer Registry (NIPR), a non-profit affiliate of the National Association of Insurance Commissioners (NAIC), developed and implemented a producer (insurance agent) database, which links participating State regulatory licensing systems into one common repository. The Connecticut Department of Insurance is a participant in this database. Producers are able to make payment for their insurance licenses through this database, with the license fees collected then remitted to the respective States, including the State of Connecticut, by electronic funds transfer. The NAIC also provides an electronic rate and form filing service called “SERFF”, of which the Department of Insurance also is a participant. In fiscal year 2009-2010, over \$7 million was remitted to the Department through NIPR.

*Criteria:* Statement on Auditing Standards (SAS) No. 70 requires that when an outside organization provides processing, executing and recording of transaction services, an audit report should be obtained on the internal controls over the processing of those transactions.

*Condition:* The Insurance Department has not obtained a SAS 70 report from the service provider.

*Effect:* Without the SAS 70 report, the Insurance Department cannot fully monitor and assess the internal controls over the service organization’s processing of the Department’s license and filing fee collections.

*Cause:* The cause was not determined.

*Conclusion:*

During our audit field work, we were informed that the NIPR has engaged a firm to conduct a SAS 70 audit, which is scheduled to be completed during calendar year 2011. As a result, we are not issuing a recommendation at this time.

**OFFICE OF THE HEALTHCARE ADVOCATE  
COMMENTS**

**FOREWORD:**

The duties, powers and responsibilities of the Office of the Healthcare Advocate are set forth primarily by Title 38a, Chapter 706b of the General Statutes and, pursuant to these provisions, is placed within the Insurance Department for administrative purposes only. The Office acts as an advocate to assist consumers with health care issues through the establishment of effective outreach programs and the development of communications related to consumer rights and responsibilities as members of managed care plans. An agency assigned to a department for “administrative purposes only” exercises its statutory authority independent of such department and without approval or control of the department as set forth under Section 4-38f of the General Statutes.

The Office is under the direction of a Healthcare Advocate, who is appointed by the Governor with the approval of the General Assembly. Kevin P. Lembo served as the Healthcare Advocate during the audited period.

**Advisory Committee to the Office of Healthcare Advocate:**

Section 38a-1049 of the General Statutes established the Advisory Committee to the Office of the Healthcare Advocate (the Advisory Committee). The Advisory Committee meets four times a year to review and assess the performance of the Office of Healthcare Advocate, and also makes an annual evaluation of the Office of Healthcare Advocate. As of June 30, 2009, the following were members of the Advisory Committee:

Ellen Andrews  
Mark Dewaele  
Steve Karp  
Keith Stover  
Gary Collins  
William Sweeney, Esq.

**Significant New Legislation:**

Public Act 08-171 established the 32-member Commission on Health Equity within the Office of the Health Care Advocate for administrative purposes only. The Commission must work to (1) eliminate disparities in health status based on race, ethnicity, and linguistic ability and (2) improve the quality of health for all State residents. The Commission may (1) employ necessary staff within available appropriations and in compliance with State Personnel Act; (2) use any funds available from Federal, State or other sources; and (3) enter contracts to carry out its duties.

**Commission on Health Equity:**

As noted above, Public Act 08-171 established the Commission on Health Equity. The Commission consists of the following commissioners, or their designees, and public members: The Commissioners of Public Health, Mental Health and Addiction Services, Developmental Services, Social Services, Correction, Children and Families, and Education; the dean of The University of Connecticut Health Center, or his designee; the director of The University of Connecticut Health Center and Center for Public Health and Health Policy, or their designees; the dean of the Yale University Medical School, or his designee; the dean of Public Health and the School of Epidemiology at Yale University, or his designee; one member appointed by the president pro tempore of the Senate, who shall be a member of an affiliate of the National Urban League; one member appointed by the speaker of the House of Representatives, who shall be a member of the National Association for the Advancement of Colored People; one member appointed by the majority leader of the House of Representatives, who shall be a member of the Black and Puerto Rican Caucus of the General Assembly; one member appointed by the majority leader of the Senate with the advice of the Native American Heritage Advisory Council or the chairperson of the Indian Affairs Council, who shall be a representative of the Native American community; one member appointed by the minority leader of the Senate, who shall be a representative of an advocacy group for Hispanics; one member appointed by the minority leader of the House of Representatives, who shall be a representative of the state-wide Multicultural Health Network; the chairperson of the African-American Affairs Commission, or his or her designee; the chairperson of the Latino and Puerto Rican Affairs Commission, or his or her designee; the chairperson of the Permanent Commission on the Status of Women, or his or her designee; the chairperson of the Asian Pacific American Affairs Commission, or his or her designee; the director of the Hispanic Health Council, or his or her designee; the chairperson of the Office of the Health Care Advocate, or his or her designee; and eight members of the public, representing communities facing disparities in health status based on race, ethnicity and linguistic ability, who shall be appointed as follows: Two by the president pro tempore of the Senate, two by the speaker of the House of Representatives, two by the minority leader of the Senate, and two by the minority leader of the House of Representatives.

As of April 12, 2010, the following were members (designees) of the Commission on Health Equity:

Kenneth R. Alleyne  
Glenn A. Cassis  
Jeannette B. DeJesus  
Lorraine Carrano  
Paul D. Cleary  
Kelson J. Ettienne-Modeste  
Ann M. Ferris, designee of the Commissioner of Social Services  
Sylvia Gafford-Alexander  
James. H. Gatling  
Paul F. Flinter  
Colleen Gallagher, designee of the Commissioner of Corrections  
Cathy R. Graves

Meg Hooper, designee of the Commissioner of Public Health  
Marie Lopez Kirkley-Bey  
Werner Oyanadel  
Marja M. Hurley  
Jose Ortiz, designee of the Commissioner of Mental Health and Addiction Services  
Stephanie Paulmeno  
Natasha M. Pierre  
Marie M. Spivey  
Tory Z. Westbrook  
Janet Williams, designee of the Commissioner of Children and Families  
James E. Rawlings  
Gregory L Stanton  
Michael C. Willams  
Seven vacancies

**RÉSUMÉ OF OPERATIONS – OFFICE OF THE HEALTHCARE ADVOCATE:**

A summary of Agency expenditures from the Insurance Fund for the audited period were as follows:

	<u><b>2007-2008</b></u>	<u><b>2008-2009</b></u>
Personal Services	\$ 437,489	\$ 524,351
Other Expenses	144,779	134,632
Equipment	8,533	1,159
Fringe Benefits	233,465	305,009
Indirect Overhead	<u>14,878</u>	<u>16,426</u>
<b>Total Expenditures</b>	<u><b>\$ 839,144</b></u>	<u><b>\$ 981,577</b></u>

For comparative purposes, expenditures during the 2006-2007 fiscal year totaled \$650,289. Total expenditures increased \$188,855 and \$142,433 during the 2007-2008 and 2008-2009 fiscal years, respectively, primarily due to increased expenditures in personal services and related fringe benefits.

As of June 30, 2009, the OHA numbered seven employees.

## CONDITION OF RECORDS

Our review of the Office of the Healthcare Advocate's records revealed the following areas that require improvement:

### **Administrative Digest Reports Should be Submitted:**

- Criteria:* Section 4-60 of the General Statutes states "the executive head of each budgeted agency shall, on or before September first, annually, deliver to the Governor a report of the activities of such agency during the fiscal year ended the preceding June thirtieth." The agency reports are published in the "Administrative Digest" report published by the Department of Administrative Services.
- Condition:* The Office of Healthcare Advocate did not file a report in accordance with Section 4-60 of the General Statutes for the fiscal years ended June 30, 2008, and 2009.
- Effect:* The required report was not published in the Administrative Digest report produced by the Department of Administrative Services.
- Cause:* The cause was not determined.
- Recommendation:* The Office of Healthcare Advocate should prepare and submit an administrative report to the Governor in accordance with Section 4-60 of the General Statutes. (See Recommendation 1.)
- Agency Response:* "The Office of the Healthcare Advocate, pursuant to Section 38a-1050 of the General Statutes reports to the Governor and the General Assembly "not later than March first of each year" regarding the activity of the office. It is our belief that the newer, specific requirements of 38a-1050, supersede the general reporting requirements of 4-60. We, therefore, disagree with the finding and recommendation. However, in an effort to ensure that the Administrative Digest is complete, the Office of the Healthcare Advocate will forward a copy of the March first annual report to the Department of Administrative Services for inclusion in the Digest beginning in 2011."

### **Advisory Committee Meetings Should Be "Noticed" with the Secretary of State:**

- Criteria:* Section 1-225, subsection (b), of the General Statutes states: "Each such public agency of the State shall file not later than January thirty-first in the Office of the Secretary of State the schedule of the regular meeting of such public agency for the ensuing year and shall post such schedule on such public agency's Internet web site."

Section 1-225 of the General Statutes also provides for agenda of the regular meetings of the public agency to be made available to the public and filed not less than twenty-four hours before the meeting to which they refer, and other related requirements.

*Condition:* During the fiscal years ended June 30, 2008, and 2009, the dates of the four meetings each year of the Advisory Committee, as required by Section 38a-1049 of the General Statutes, have not been filed with the Secretary of State or posted on the Internet website of the Office of Healthcare Advocate. The agendas of the meetings have not been made available to the public or filed not less than twenty-four hours before the meetings.

*Effect:* Section 1-225, subsection (b), of the General Statutes is not being complied with.

*Cause:* The cause was not determined.

*Recommendation:* The Office of Healthcare Advocate and the Advisory Committee to the Healthcare Advocate should take steps to ensure that all provisions of Section 1-225 of the General Statutes are being complied with, with respect to proper noticing of the meetings of the Office of Healthcare Advocate Advisory Committee. (See Recommendation 2.)

*Agency Response:* “This is the first time in a decade of audits, that this issue has been raised. OHA understands the requirements of Section 1-225 (b) of the General Statutes and will take steps to ensure compliance. We will file our Advisory Committee meeting dates with the Secretary of State before January 31, 2011 for the 2011 calendar year, and will publish on our website the agenda for each meeting not less than 24 hours before each meeting.”

### **Vacancies on the Commission on Health Equity:**

*Criteria:* Public Act 08-171 established the 32-member Commission on Health Equity within the Office of the Health Care Advocate, for administrative purposes only. The mission of the Commission is to eliminate disparities in health status based on race, ethnicity and linguistic ability, and improve the quality of health for all of the State's residents.

*Condition:* As of April 12, 2010, the following positions on the Commission on Health Equity have never been filled since its establishment:

- a member who is the representative of an advocacy group for Hispanics appointed by the Minority Leader of the Senate,

- a member of the public appointed by the Minority Leader of the Senate,
- a member who is the representative of the Native American Community appointed by the Majority Leader of the Senate,
- a member who is the representative of the State-Wide Multicultural Health Network appointed by the Minority Leader of the House of Representatives
- the Chairperson of the Asian Pacific American Commission, or designee.

In addition to the above, as of April 12, 2010, vacancies existed in the designees for the Commissioner of Developmental Services and the Dean of the Yale Medical School.

It must be noted that the Office of Healthcare Advocate reports having previously notified the appropriate appointing authorities of the above vacancies.

*Effect:* The Commission on Health Equity is not currently operating with the full membership as mandated by Public Act 08-171. Certain constituency groups are not being represented as required by the Public Act.

*Cause:* The cause was not determined.

*Recommendation:* The Office of Healthcare Advocate should continue to periodically notify the appointing authorities of the existing vacancies on the Commission on Health Equity. (See Recommendation 3.)

*Agency Response:* “Pursuant to Section 38a-1051 of the General Statutes, the Commission on Health Equity is within the Office of the Healthcare Advocate for administrative purposes only. The OHA has no control over the lawful activity of the Commission or the appointing authorities as detailed in 38a-1051 (a). Despite repeated attempts on the part of OHA and the Commission, some legislative leaders and Commissioners (detailed above) failed to make their appointments to the Commission on Health Equity. The Commission will employ an Executive Director in the coming weeks. OHA will encourage the new Executive Director and the leadership of the Commission to periodically notify the appointing authorities of the existing vacancies on the Commission on Health Equity.

Note: since the circulation of the draft report by the Auditors of Public Accounts, the following appointments were made, and members seated, on the Commission:

## *Auditors of Public Accounts*

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- a member who is a representative of an advocacy group for Hispanics appointed by the Minority Leader of the Senate;
- a member of the public appointed by the Minority Leader of the Senate;
- a member who is representative of the State-Wide Multicultural Health Network appointed by the Minority Leader of the House of Representatives; and,
- the Chairperson of the Asian-Pacific American Commission, or designee.”

## RECOMMENDATIONS

### *Status of Prior Audit Recommendations:*

*The Insurance Department should comply with Section 4-33a of the General Statutes which requires prompt notification to the Auditors of Public Accounts and the State Comptroller when there is a breakdown in the safekeeping of State resources. This issue has been resolved. Accordingly, we are not repeating the recommendation.*

*The Insurance Department should improve purchasing procedures to ensure compliance with Section 4-98 of the General Statutes. This recommendation is being repeated as Recommendation 1.*

No recommendations were made for the Office of the Healthcare Advocate.

### *Current Audit Recommendations:*

#### **Insurance Department:**

- 1. The Insurance Department should improve purchasing procedures to ensure compliance with Section 4-98 of the General Statutes.**

Comment:

Out of 20 vouchers tested, four vouchers, totaling \$8,043, were not supported by a valid commitment document (purchase order) prior to the receipts of the goods or services.

- 2. The Insurance Department should develop an employees' Personnel Manual.**

Comment:

The Department of Insurance has not developed an employees' Personnel Manual.

- 3. The Insurance Department should limit the use of administrative leave with pay to no more than 15 days, as required by the State Personnel Regulations.**

Comment:

The Department of Insurance placed an employee on administrative leave with pay on November 7, 2007, until December 14, 2007, a period of 26 days, 11 days more than allowed by State Personnel Regulation.

- 4. The Insurance Department should properly apply the Leave in Lieu of Accrual job aid procedures when the LILA time reporting code is posted to employees' timesheets.**

Comment:

We found procedural errors in the way the Core-CT LILA TRC job aid has been applied.

- 5. The Insurance Department should develop a comprehensive business continuity plan using the template provided by the Department of Information Technology.**

Comment:

The Department of Insurance does not currently have a comprehensive business continuity plan.

- 6. The Insurance Department should revise its cash receipts procedures to conform to the requirements of the State Comptroller's State Accounting Manual. In lieu of logging each receipt in the mailroom, the Department should consider implementing a bank lock-box system for its receipts.**

Comment:

We found that no original listing is made of checks received a "bound journal" as required by the SAM upon receipt in the Department's mail room, but instead, checks are sorted and delivered to the appropriate unit for processing, then subsequently delivered to the Business Office (note that some receipts, such as assessments on insurance companies, go directly from the mail room to the Business Office). The checks from the various units are sent to the Business Office for recording in the cash receipts journal and for deposit in the bank.

- 7. The Insurance Department should report a \$5.9 million receivable resulting from the fine of Golf Marketing Worldwide, LLC, et al, and any other receivables, resulting from fines, which are outstanding as of June 30, on GAAP Form 2, along with an amount of the receivables estimated to be uncollectible.**

Comment:

In January 2009, the Commissioner of Insurance imposed a fine of \$5.9 million against Golf Marketing Worldwide, LLC, et al, for various violations of General Statutes. However, the amount of the fine, along with an amount estimated to be uncollectible, was not reported on GAAP Form 2 as of June 30, 2009.

**Office of the Healthcare Advocate:**

- 1. The Office of Healthcare Advocate should prepare and submit an administrative report to the Governor in accordance with Section 4-60 of the General Statutes.**

Comment:

The Office of Healthcare Advocate did not file a report in accordance with Section 4-60 of the General Statutes for the fiscal years ended June 30, 2008, and 2009.

- 2. The Office of Healthcare Advocate and the Advisory Committee to the Healthcare Advocate should take steps to ensure that all provisions of Section 1-225 of the General Statutes are being complied with, with respect to proper noticing of the meetings of the Office of Healthcare Advocate Advisory Committee.**

Comment:

During the fiscal years ended June 30, 2008, and 2009, the dates of the four meetings each year of the Advisory Committee, as required by Section 38a-1049 of the General Statutes, have not been filed with the Secretary of State or posted on the Internet website of the Office of Healthcare Advocate. The agendas of the meetings have not been made available to the public or filed not less than twenty-four hours before the meetings.

- 3. The Office of Healthcare Advocate should continue to periodically notify the appointing authorities of the existing vacancies on the Commission on Health Equity.**

Comment:

As of April 12, 2010, several positions on the Commission on Health Equity have never been filled since its establishment.

## INDEPENDENT AUDITORS' CERTIFICATION

As required by Section 2-90 of the General Statutes we have audited the books and accounts of the Insurance Department and the Office of the Healthcare Advocate for the fiscal years ended June 30, 2008 and 2009. This audit was primarily limited to performing tests of the Agency's compliance with certain provisions of laws, regulations and contracts, and to understanding and evaluating the effectiveness of the Agency's internal control policies and procedures for ensuring that (1) the provisions of certain laws, regulations and contracts applicable to each Agency are complied with, (2) the financial transactions of each Agency are properly initiated, authorized, recorded, processed, and reported on consistent with management's direction, and (3) the assets of each Agency are safeguarded against loss or unauthorized use. The financial statement audits of the Insurance Department and the Office of the Healthcare Advocate for the fiscal years ended June 30, 2008 and 2009, are included as part of our Statewide Single Audits of the State of Connecticut for those fiscal years.

We conducted our audit in accordance with auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the Insurance Department and the Office of the Healthcare Advocate complied in all material or significant respects with the provisions of certain laws, regulations and contracts and to obtain a sufficient understanding of the internal controls to plan the audit and determine the nature, timing and extent of tests to be performed during the conduct of the audit.

### **Internal Control over Financial Operations, Safeguarding of Assets and Compliance:**

In planning and performing our audit, we considered the Insurance Department and the Office of the Healthcare Advocate's internal control over its financial operations, safeguarding of assets, and compliance with requirements as a basis for designing our auditing procedures for the purpose of evaluating each Agency's financial operations, safeguarding of assets, and compliance with certain provisions of laws, regulations, and contracts, but not for the purpose of providing assurance on the effectiveness of each Agency's internal control over those control objectives.

Our consideration of internal control over financial operations, safeguarding of assets, and compliance requirements was for the limited purpose described in the preceding paragraph and would not necessarily identify all deficiencies in internal control over financial operations, safeguarding of assets and compliance with requirements that might be significant deficiencies or material weaknesses. However as discussed below, we identified certain deficiencies in internal control over financial operations, safeguarding of assets, and compliance with requirements that we consider to be a significant deficiency.

A *control deficiency* exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent or detect on a timely basis unauthorized, illegal, or irregular transactions or the breakdown in the safekeeping of any asset or resource. A *significant deficiency* is a control deficiency, or combination of control

deficiencies, that adversely affects each Agency's ability to properly initiate, authorize, record, process, or report financial data reliably, consistent with management's direction, safeguard assets, and/or comply with certain provisions of laws, regulations and contracts such that there is more than a remote likelihood that a financial misstatement, unsafe treatment of assets, or noncompliance with laws, regulations and contracts that is more than inconsequential will not be prevented or detected by the each Agency's internal control. We consider the following deficiency, described in detail in the accompanying "Condition of Records" and "Recommendations" sections of this report for the Insurance Department, to be a significant deficiency in internal control over financial operations, safeguarding of assets and compliance with requirements: Recommendation 1 – Purchase orders not prepared prior to receipt, and Recommendation 6-internal controls over cash receipts.

*A material weakness* is a significant deficiency, or combination of significant deficiencies, that results in more than a remote likelihood that noncompliance with certain provisions of laws, regulations, and contracts or the requirements to safeguard assets that would be material in relation to each Agency's financial operations, noncompliance which could result in significant unauthorized, illegal, irregular or unsafe transactions, and/or material financial misstatements by each Agency being audited will not be prevented or detected by each Agency's internal control.

Our consideration of the internal control over each Agency's financial operations, safeguarding of assets, and compliance with requirements, was for the limited purpose described in the first paragraph of this section and would not necessarily disclose all deficiencies in the internal control that might be significant deficiencies and, accordingly, would not necessarily disclose all significant deficiencies that are also considered to be material weaknesses. However, we believe that the significant deficiency described above is not a material weakness.

### **Compliance and Other Matters:**

As part of obtaining reasonable assurance about whether the Insurance Department and the Office of the Healthcare Advocate complied with laws, regulations, and contracts, noncompliance with which could result in significant unauthorized, illegal, irregular or unsafe transactions or could have a direct and material effect on the results of each Agency's financial operations, we performed tests of its compliance with certain provisions of laws, regulations, contracts and grant agreements. However, providing an opinion on compliance with those provisions was not an objective of our audit, and accordingly, we do not express such an opinion.

However, we noted certain matters which we reported to the Insurance Department's and Office of Healthcare Advocate's Management in the accompanying "Condition of Records" and "Recommendations" sections of this report.

The Insurance Department's and Office of Healthcare Advocate's responses to the findings identified in our audit are described in the accompanying "Condition of Records" section of this report. We did not audit the Insurance Department's and Office of Healthcare's responses and, accordingly, we express no opinion on it.

## *Auditors of Public Accounts*

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This report is intended for the information and use of each Agency's management, the Governor, the State Comptroller, the Appropriations Committee of the General Assembly, and the Legislative Committee on Program Review and Investigations. However, this report is a matter of public record and its distribution is not limited.

**CONCLUSION**

In conclusion, we wish to express our appreciation for the courtesies and cooperation shown to our representatives by the personnel of the Insurance Department and the Office of the Healthcare Advocate during the course of our examination.

Gary P. Kriscenski  
Principal Auditor

Approved:

John C. Geragosian  
Auditor of Public Accounts

Robert M. Ward  
Auditor of Public Accounts