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State Auditor

A Review of

# Selected Controls at the Employees Retirement System

March 27, 2002

Members of the Legislative Audit Committee:

The controls and processes at the Employees Retirement System (System) reasonably ensure that it will accomplish its mission, which is to provide retirement and health care benefits for state employees (see text box). However, the System needs to address issues related to its administration of the Uniform Group Insurance Program. These issues, which are detailed in the attachment to this letter, include the following:

- The System does not ensure that health benefit claims are eligible before paying them, even though it has the capability to verify claims electronically. As a result, from January to July 2001 the System reimbursed Blue Cross and Blue Shield of Texas \$395,000 for Health Select claims for employees no longer eligible to receive benefits. Even though the payment errors detected were relatively small, the lack of controls creates the potential for much larger errors.
- The System's contract monitoring program is in development. Also, the System did not enforce certain contract provisions that could have allowed it to collect a \$270,000 performance penalty.
- The System has not been funded to maintain the 60-day contingency reserve mandated by the Texas Insurance Code. The System should seek clarification of legislative intent in continuing the statute without appropriating the required reserve.

## Employees Retirement System

The System paid approximately \$1.3 billion for health insurance benefits covering 523,000 employees, retirees, and dependents.

During fiscal year 2001, the System processed \$920 million in retirement annuity payments, withdrawals, and other retirement benefits. The retirement program covers approximately 246,000 active members, inactive members, retirees, and beneficiaries.

There is also a potential retirement plan (Plan) issue for future consideration. State and employee contributions currently do not cover Plan costs. If adverse market conditions or actuarial losses cause the Plan's assets to fall below liabilities, the Legislature would not be able to increase future retirement benefits without also increasing state and/or employee retirement contribution rates.

The System's responses are included in the attachment. The System generally disagrees with the issues discussed in this report. Subsequent discussions with System management and additional information provided for auditor review did not resolve the disagreement. Therefore, auditor follow-up comments are also included.

The System is in the process of implementing other audit suggestions to improve controls over investment and retirement operations.

We would like to thank the System for its cooperation. If you have any questions, please contact Carol Smith, Audit Manager, at (512) 936-9500.

Sincerely,

Lawrence F. Alwin, CPA  
State Auditor

tgc/Attachment

cc: Employees Retirement System  
Chair and Members of the Board  
Ms. Sheila W. Beckett, Executive Director

SAO Report No. 02-032

## The System Should Improve Its Administration of the Uniform Group Insurance Program

The business processes and controls that the Employees Retirement System (System) uses to administer the Uniform Group Insurance Program (see text box) allow it to provide expected health insurance benefits. In fiscal year 2001, the System paid approximately \$1.3 billion in health care costs for 523,000 state and higher education employees, retirees, and dependents. However, the System needs to address the following issues to ensure that it makes best use of the State's resources.

### The Uniform Group Insurance Program

The Uniform Group Insurance Program consists of several health-related insurance plans. Some of the plans are self-insured, which means the State pays all the claims and assumes all financial risks. The remaining plans are fully-insured—the State pays the service provider a monthly premium and the service provider assumes all financial risk.

The System contracts with third-party administrators to process and pay claims for the self-insured plans. The third-party administrators bill the System for reimbursement of claims. The System pays the third-party administrators a monthly fee for providing these services.

Section 1-A:

### The System Reimburses Health Select and Health Select Plus Claims Without Reviewing Them for Eligibility

The System reimburses Blue Cross and Blue Shield of Texas (Blue Cross) for Health Select and Health Select Plus claims without reviewing the claims, even though the System has the capability to verify claims electronically. (Blue Cross is the

third-party administrator for Health Select and Health Select Plus.) In fiscal year 2001, the System reimbursed \$693 million for Health Select claims and \$215 million for Health Select Plus claims. From January through July 2001, the System reimbursed Blue Cross \$395,000 for Health Select claims that were for employees no longer eligible to receive benefits:

- Of that amount \$288,000 was for individuals clearly shown ineligible in the System's enrollment database.
- The remaining \$107,000 was for ineligible employees whose agencies had not reported their terminations to the System. (See Section 1-B for more information on agencies' late processing of employee terminations.)

The System's contract with Blue Cross specifies that Blue Cross recover payments made for erroneous claims.

Also, the System reimbursed \$132,000 in claims for individuals whose eligibility could not be determined because eligibility dates were missing from its enrollment database. Although some of these claims may have been for eligible employees, Blue Cross should not have paid the claims until eligibility was determined.

Each week, Blue Cross submits a voucher to the System that contains the sum of the claims processed and paid by Blue Cross. At the end of each month, Blue Cross provides the detail for all Health Select medical claims paid during that month. The System does not compare the detailed information to its enrollment database. Such a comparison would identify all claims paid for ineligible employees. The System has not received detailed information for Health Select Plus claims since 1999.

The System contracts annually with an external auditor to review the claims processed for the previous year. The review covers the adequacy of the processing system, including timeliness and accuracy. However, the System should not rely upon the auditor's review as a substitute for its own review of the billing detail. The findings of the external audit are not timely; in some cases more than a year could pass between erroneous processing of a claim and receipt of audit findings. Also, audit findings identify only those errors found in a statistical sample of files.

Recommendations:

The System should:

- Require that Blue Cross provide detailed information about Health Select Plus claims.
- Routinely test Health Select and Health Select Plus claims for eligibility by comparing Blue Cross's billing detail to the System's enrollment database.
- Routinely verify that Blue Cross has recovered payments for ineligible claims (including all past claims) as provided in administrator contracts.

Management's Response:

*ERS disagrees that the HealthSelect and HealthSelect Plus claims are not reviewed. ERS has adequate controls in place to ensure that claims are paid properly. ERS intends to pay only eligible claims. While any payment for ineligible claims is disturbing, the amount of ineligible HealthSelect claims preliminarily identified by the auditors is not material considering that ERS reimbursed BCBSTX \$693 million for HealthSelect claims in Fiscal Year 2001.*

- *BCBSTX contracts require detailed claims information and ERS continues to work with BCBSTX to provide this information.*
- *ERS will investigate the feasibility of electronically checking all HealthSelect billed claims against the ERS eligibility file. Such a test, however, will likely show valid claims as ineligible. For example, claims for eligible services rendered during employment but paid after an employee terminates would appear to be an invalid claim since the employee would not be reflected on the current ERS eligibility file. A test file will be run against the HealthSelect billing file to determine if such an eligibility check is cost effective. ERS expects to pilot this system in April 2002.*
- *ERS does recover payments for ineligible claims through the existing process. ERS provides BCBSTX a weekly file that is used to update its eligibility records. All terminations and additions for the prior week are included on this file. If a claim is processed after an employee terminates but prior to the update, BCBSTX's records will reflect this individual as an eligible member. However, a process is already in place to identify these claims. Each month, BCBSTX produces a report that identifies any such claims paid after the*

*coverage end date. BCBSTX recoups any such claims and credits those funds back to ERS. Under this recoupment process, BCBSTX notifies the provider of the ineligible payment and requests a refund. If the refund is not received within 30 days, a follow-up request for the refund is made to the provider. If payment is not received within 30 days of the second request, the charge is set up for auto-recoupment. The auto-recoupment process provides that any future payment to the provider is reduced by the amount of the overpayment. ERS is reviewing all of the claims identified by the auditors as ineligible to ensure that these claims have been paid properly. Furthermore, an outside audit is conducted annually to ensure that claims are paid accurately and that recoveries are made, if necessary.*

State Auditor's Office Follow-Up Comment:

All evidence provided by the System during our review showed that System management (including the System's actuary) and staff review Health Select and Health Select Plus billing data at the invoice summary level only. Monthly management reports reflect only the total number and the total amount of claims paid. Interviews with management and staff personnel revealed that no one within the System reviews Health Select billing detail data, and the System does not receive Health Select Plus billing detail data (as required in the contract).

We agree that the amount of discovered loss for the period reviewed is relatively small. However, the absence of this procedure creates the potential for substantial loss. Additionally, because the System has not checked past billing detail it cannot know whether it has suffered loss or not.

We discovered ineligible claims by analyzing the data available in the System's files.

The System's statement that "claims for eligible services rendered during employment but paid after termination would appear to be an invalid claim . . ." is incorrect. We considered a claim as invalid only when the service date was after the termination date. The System can program the electronic eligibility check to select the appropriate date fields.

The monthly recoupment report the System references is a component of the same monthly billing detail cited above. The System relies on Blue Cross to tell it what is in the report. The System did not know (until the State Auditor's review) the contents of the billing report. The System does not have a procedure to compare recoupments against this high-risk (erroneously paid) group of ineligible claims to determine whether they are recovered or not. In preparing this response we determined that of the \$68,045 in ineligible claims paid in January 2001, only \$963 was recovered during the subsequent six months.

Section 1-B:

### **The System Relies on Agencies to Report Employee Terminations, Which Increases the Potential for Payment of Ineligible Claims**

An independent audit of Health Select claims processing in 1998 found one former employee who used his or her Blue Cross benefits card to incur more than \$100,000 in claims before the former employee's agency reported the termination to the System. Although the System was reimbursed in this particular case, it has not reduced the potential for fraud or error caused by agencies' untimely processing of changes in employee status. From January through July 2001, Blue Cross paid claims totaling \$107,000 for 302 members who were terminated but not yet reported to the System. (See Section 1-A for information on other ineligible claims paid during the same period.)

Agencies and institutions of higher education calculate the amount they pay for health insurance contributions based on their own data. The System calculates the amount agencies and institutions owe based on data in its enrollment database. The two amounts can differ because of terminations and other changes the agencies have not reported to the System. When differences occur, the System generates a "Statement of Account" for each agency to use to reconcile the differences and make the necessary enrollment adjustments. The System does not verify agency reconciliations or adjustments. The System's records as of January 2002 showed that state agencies (not institutions of higher education) could not reconcile a difference of \$1,369,190 between the System's contribution calculations and actual payroll deductions for active employees in fiscal year 2001.

The System has the capability to verify employees' insurance eligibility without relying on agency personnel. The System requires all agencies' payroll systems (not including higher education institutions) to electronically report state and employee contributions for retirement and health benefits. The report details contributions by agency, fund, and social security number. The System uses this report to post contributions to individual retirement accounts, but it does not use the report for insurance account reconciliation.

#### Recommendations:

The System should:

- Reconcile insurance enrollments and contributions at the System level, rather than the agency level, and provide confirmation to the agencies. This could be accomplished by matching the social security numbers in the agencies' payroll system reports to the System's enrollment database.
- As identified in Section 1-A, verify that Blue Cross recovers claims for ineligible employees when they are discovered.

Management's Response:

ERS disagrees that an enrollment/contributions match will provide reconciliation due to the following:

- Contribution information is not received from higher education institutions (about 26% of our customers);
- Employees on leave are not reported as terminated from payroll; and
- Lag times between payroll and enrollment information will cause the data to never completely match.

ERS will consider the feasibility, fiscal impact and statutory authority for assuming reconciliation responsibilities for agencies and institutions. This in-house reconciliation program would replace current tools, such as the Daily Report of Changes, the Monthly 100% Enrollment Snapshot, and the USPS Comparison Report.

See response to I-A.

State Auditor's Office Follow-Up Comment:

The System's current procedures, which rely on agencies for reconciliation, do not preclude the potential for fraudulent or erroneous payments, as were detected. The use of electronic data currently available to the System (which covers the majority of the System's customers) would detect terminations at the time an employee's state-paid-insurance payroll deductions cease.

We agree the System would need an in-house reconciliation program to implement our recommendation. The current tools the System refers to in its response are tools used by agencies for reconciliation. The tools are not effective if agencies and institutions do not use them. The same technology (databases) used to create the tools for the agencies could be used in a centralized in-house system.

Section I-C:

**The System Has Not Finalized Its Program for Contract Monitoring**

The formal written program for monitoring the System's health insurance contractors is in development. In fiscal year 2001, the System paid approximately \$1.3 billion to these contractors in premiums, claims, and fees. Contract monitoring helps ensure that contractors consistently provide quality services and comply with contract provisions. A written monitoring program will better enable the System to enforce contract provisions. Examples of provisions that were not enforced are:

- In fiscal year 1999 the System did not attempt to collect a penalty of more than \$270,000 when Blue Cross did not achieve the 99 percent processing accuracy rate for Health Select claims as specified in its contract.

- The System's contract with health maintenance organizations (HMOs) contains extensive technical requirements for the HMOs' Web sites. A review of five of the eight HMO Web sites found they did not contain all of the components specified in the contracts. In fact, one of the five Web sites reviewed was not functional. Six HMO Web sites gave incomplete (misleading) pricing information about the prescription mail order program, which is intended to provide a 33 percent cost reduction for subscribing members.

Also, the System's contract with its actuarial consultant is an hourly fee-for-service type contract. The contract does not identify all deliverables with specificity or what performance standards the contractor must meet. Furthermore, the System has renewed its contract with its actuarial consultant without re-bid since 1988.

Recommendations:

The System should:

- Finalize and implement a written contract monitoring program. The program should include a risk assessment process to select contractors for review, have standardized criteria to evaluate contractor performance, and follow up on monitoring results to ensure corrective actions have been taken.
- Identify all current contracts that contain provisions for penalties and verify that those provisions are applied or that they are formally waived.
- Ensure that all contracts specify the deliverables to be provided and the required performance standards. Ensure that all contracts are regularly re-bid.

Management's Response:

- *ERS disagrees that a program for contract monitoring is not in place. Although no written plan was in place at the time of the auditors' initial visit, a written plan has been formalized and ERS has always had controls in place to ensure that vendors perform in accordance with contract provisions. These controls include monitoring by ERS and its actuary, annual audits of the health plan contractors by an outside auditor, annual site visits by ERS staff to all contractors, daily interaction with contractors, ongoing review of an internal complaint monitoring system, meetings with the Texas Department of Insurance (TDI), and weekly, monthly or quarterly status meetings with each contractor. A draft of the formal monitoring plan was provided to the auditors, which has since been implemented.*
- *ERS will ensure that if applicable contractual damage provisions are waived or otherwise not collected, appropriate documentation surrounding these circumstances will be provided.*
- *ERS does ensure that contracts specify in appropriate detail the services to be provided, and adequately protect ERS in the event the contractor does not properly perform its obligations. Each contract is reviewed to determine if it*

*should be renewed, amended or terminated in accordance with what is in the best interest of ERS and the UGIP.*

State Auditor's Office Follow-Up Comment:

As noted in this report, the formalized written monitoring plan was in development (draft stage) during the period of our review. The implementation of the written plan should help prevent a reoccurrence of the issues cited in the report.

The System's internal audit division issued the following observations in its Report to Management, Review of Contract Monitoring, dated October 26, 2001:

Written procedures have not been developed for the contract monitoring function. Written procedures can assist staff in performing duties as management intended them to be performed. Written procedures can also improve consistency, provide employee evaluation criteria, and assist with continuity when staff turnover occurs.

As noted in this report, the System's contract with its actuary firm has not been competitively bid in 13 years and does not specify deliverables or performance standards. Contracts may be subject to abuse when they do not include limits on dollars or hours. Limits on dollars and/or hours would help ensure that decisions to expend state resources are made wisely.

Section 1-D:

**The System Does Not Adequately Measure Customer Satisfaction**

The System does not conduct its own customer satisfaction survey of the members and dependents enrolled in its health plans. The System has not implemented recommendations from previous audits regarding this issue.

The System uses the results of a survey that Blue Cross conducts to report "The Percent of Health Select Participants Satisfied with Network Services" as an outcome measure in the Automated Budget Evaluation System of Texas (ABEST). Blue Cross contracts with a marketing firm to conduct the survey. The System does not monitor, control, or independently verify the design or content of the survey, the sample selected, or the tabulation of results. It does not verify the quality of the contracted firm. Blue Cross developed the survey for its own uses and has a vested interest in reporting good results. The System does not have access to all the data from the survey. Consequently, it is questionable whether the System should rely on survey results without adequate monitoring of the survey process.

While it would not be practical for the System to survey each of its approximately 523,000 members and dependents (membership as of fiscal year 2001), surveying a statistical sample would provide useful information. Measurement of customer satisfaction is essential in determining if the System is accomplishing its goal, which is "to provide employees, retirees, and dependents with a comprehensive, quality health program." Customer satisfaction survey results can be used as a leading



indicator of employee insurance issues, and can help management develop strategies to better align plan objectives with customer needs.

Recommendations:

The System should:

- Consider developing its own customer satisfaction surveys. Sampling procedures should target all members of the health insurance programs. Survey results should be analyzed to identify plan shortcomings and potential improvements.
- Evaluate System use of the Blue Cross survey. If the System chooses to rely on Blue Cross data, it should monitor the survey procedures and require submission of all survey data for independent analysis.
- Disclose that customer satisfaction levels reported in ABEST are the results of sample surveys conducted by Blue Cross.

Management's Response:

- *ERS disagrees. ERS believes that the well-designed and distributed Survey of Organizational Excellence provides adequate benefit-related data from state employees. Satisfaction with HMOs is garnered from results of the comprehensive survey conducted by the TDI. Survey experts advise against doing single purpose surveys, particularly if there is no ability to improve in areas where survey results are low. Cost estimates for a survey of this type run about \$40,000, a cost that is hard to justify in the current economic climate.*
- *ERS conducts a number of satisfaction surveys targeted to specific customers and will continue to expand on these.*
- *ERS agrees. The survey conducted by Blue Cross Blue Shield is the best indicator for "Percent of Health Select Participants Satisfied with Network Services" required by ABEST. ERS will continue to monitor survey procedures and review the data from the complete survey.*
- *ERS agrees and will include a note in ABEST that the data is obtained from BCBSTX sample surveys.*

State Auditor's Office Follow-Up Comment:

The Survey of Organizational Excellence provides good information about the overall level of employee satisfaction with the benefits provided by the State of Texas. However, the survey lacks the specificity needed to identify issues in sufficient detail to make informed plan design changes.

Without the benchmark provided by customer surveys the System cannot assess the impact of management decisions or the migration of customer attitudes.

Section 1-E:

### **The Balance in the Contingency Reserve Fund for Self-Funded Insurance Plans Is Not in Compliance With the Texas Insurance Code**

Current law requires the System to place an amount estimated to cover 60 days' worth of expenditures for the self-funded insurance plans (Health Select and Health Select Plus) into a contingency reserve fund (see text box). As of August 31, 2001, the contingency reserve fund balance was \$18 million, which is approximately five days' worth of expenditures. The purpose of the contingency reserve fund is to provide for adverse fluctuations in claims and administrative expenses.

#### **Texas Employees Uniform Group Insurance Benefits Act**

Before the first day of each state fiscal biennium, the trustee shall estimate for an average 60-day period during the biennium the expenditures from the fund anticipated for self-funded plans, considering claims and administrative expenses for those plans that are projected to be incurred. The trustee shall place the estimated amount in a contingency reserve fund to provide for adverse fluctuations in claims or administrative expenses. The trustee shall include in each request for legislative appropriations to the program the amount the trustee determines to be necessary to maintain the contingency reserve fund at the level required by this subsection . . . .

Source: Texas Insurance Code, Article 3.50-2, Section 5(e)

The System's actuarial consultant estimates that 60 days' worth of expenditures is \$230 million. The actuary projects that the amount will increase to \$287 million by the end of fiscal year 2003 because more and more members will be moving from HMOs to self-funded plans.

As required by the law, the System's legislative appropriations request included \$194 million to fund the State's portion of the reserve for the 2002-2003 biennium. The money was not appropriated to the System.

#### Recommendation:

The System should seek clarification of legislative intent in continuing the statute without appropriating the required reserve.

#### Management's Response:

*ERS disagrees. The Statement of Legislative Intent, as reflected in the House Journal on May 25, 1999 and the Senate Journal on May 29, 1999, states that the current law does not compel the Legislature to make appropriations for this purpose. ERS is instructed to request appropriations to maintain the contingency reserve fund at the defined level. The statute does not bind any future legislatures to fund it. ERS is in compliance with the current law in that the System requested the funds for the contingency reserve from the Legislature. Although not currently funded, ERS believes that a contingency reserve fund is necessary for optimal long-term financial soundness.*

State Auditor's Office Follow-Up Comment:

The System's comments are not responsive. Our recommendation is simply that the System *seek clarification* of the inconsistency created by its unfunded legislative mandate ("The trustee *shall . . .*").

Section 2 – POTENTIAL ISSUE FOR FUTURE CONSIDERATION:

## **Future Increases to Retirement Benefits May Require Increased Contributions From Employees and/or the State**

It is possible that the Legislature may not be able to increase future retirement benefits without also increasing state and/or employee retirement contribution rates. State statute prevents any changes (such as increased benefits) that would extend the Plan's amortization period to 31 years or longer. The amortization period is the length of time it would take excess retirement contributions to eliminate, or pay off, any unfunded actuarial accrued liability (where the actuarial value of Plan assets is less than Plan liabilities). The following conditions combine to create the risk that the Plan—at some point in the future—may have an infinite amortization period, which would prevent any increases to retirement benefits:

- The Plan currently does not have excess contributions; it has a contribution shortfall. The current year's cost of benefits, or the "normal cost," exceeds the contribution rate by 0.67 percent (the normal cost is 12.67 percent of pay; the State and members each contribute 6 percent of pay). According to the System's actuary, as of August 31, 2001, the actuarial value of the Plan's assets exceeded its actuarial liabilities; however, this surplus is almost entirely offset by the present value of the contribution shortfall assuming the shortfall continues indefinitely.
- If the Plan's investments do not meet their five-year average return target of 8 percent or if other actuarial losses occur, the Plan's liabilities might exceed its assets, or the surplus might no longer be sufficient to offset the contribution shortfall. (We cannot predict whether the Plan will meet or exceed its investment return target or whether other actuarial losses will occur.)

If the Plan's actuarial liabilities exceed its actuarial assets and there is a contribution shortfall, the amortization period would be infinite. (Without excess contributions, there is no projected surplus revenue that could be actuarially allocated to paying off the unfunded liabilities.) Consequently, the Legislature would not be able to increase future benefits until (1) it also increased the contribution rate and/or (2) the Plan's assets grew enough to exceed liabilities and again cover the contribution shortfall indefinitely.

Management's Response:

*ERS disagrees. ERS believes that current levels of funding are adequate to pay all benefits promised to active employees as well as to provide future increases to retirees. The assumptions used to determine the actuarial soundness of the ERS retirement fund take into account the fact that current normal costs exceed current contribution rates. In addition, the ERS actuary uses a rolling 5-year smoothing method of valuing investment returns. Such a method evens out the market's inherent fluctuations providing a more conservative actuarial analysis. This further means that any individual year's results have a less material impact maintaining the long-term view necessary for the sound management of a retirement plan. Legislative action would be required before ERS could provide a benefit increase so large that it could not be funded without an increase in contribution rates.*

State Auditor's Office Follow-Up Comment:

Contributions do not cover normal Plan costs. If the Plan's five-year averaged rate of return falls below 8 percent then the Plan's actuarial asset value may fall below actuarial liabilities, which by statute would preclude a benefit increase. The actuarial available asset balance at the end of fiscal year 2001 was \$8.3 million. When the fiscal year 2002 rate of return is added to the five-year smoothing average it will replace fiscal year 1997 in the formula. The fiscal year 1997 rate of return was 21.44 percent. While we cannot predict the fiscal year 2002 rate, it will need to be sufficiently high to offset the loss of the fiscal year 1997 rate in the five-year average. The fiscal year 2001 rate of return was negative 6.91 percent.

## Summary of Objectives, Scope, and Methodology

The objectives of this review were to gain an understanding of the key system controls used at the Employees Retirement System and assess the effectiveness of those controls not covered by the System's external financial opinion audit.

The scope included review of selected controls for completeness, accuracy, timeliness, and statutory compliance. Certain controls over areas of identified high risk were tested for accuracy.

The review methodology consisted of gaining an understanding of each control system. This was accomplished through interviews with System management and staff and through reviews of various System documents. The review methodology included process mapping of the System's business processes and corresponding automated systems. The review was conducted in accordance with generally accepted government auditing standards.