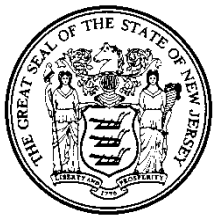

New Jersey State Legislature
Office of Legislative Services
Office of the State Auditor

Department of the Treasury
Division of Pensions and Benefits
Health Benefits Programs - Member Eligibility

July 1, 2015 to July 31, 2016

Stephen M. Eells
State Auditor

New Jersey State Legislature

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The Honorable Stephen M. Sweeney
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Enclosed is our report on the audit of the Department of the Treasury, Division of Pensions and Benefits, Health Benefits Programs – Member Eligibility for the period of July 1, 2015 to July 31, 2016. If you would like a personal briefing, please call me at (609) 847-3470.

Stephen M. Eells
State Auditor
December 20, 2016

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Scope

We have completed an audit of the Department of the Treasury, Division of Pensions and Benefits, Health Benefits Programs - Member Eligibility for the period July 1, 2015 through July 31, 2016. Our audit included financial activities of the Health Benefits Program Fund – Local Education, the Health Benefits Program Fund – Local Government, and the Health Benefits Program Fund – State; each fund includes health benefits and prescription drug benefits. Dental funds were excluded from the audit. Our audit also included an evaluation of the logical access controls over the State Health Information Processing System (SHIPS).

Fiscal year 2015 combined expenditures from the health benefits and prescription drug programs were approximately $6.3 billion representing subscriber and dependent health benefit coverage for 860,000 members, of which 66 percent are active and 34 percent are retired, and prescription coverage for 703,000 members, of which 59 percent are active and 41 percent are retired. The state portion of these expenditures was approximately $3 billion; the balance was expended at the local government and education levels.

We intend to return to the Division of Pensions and Benefits to audit health benefit contract expenditures and the health benefit premium rate renewal process. These areas have been excluded from the scope of this audit.

Objectives

The objective of our audit was to determine whether insured members were eligible for coverage in accordance with the division's policies. An additional objective was to determine the adequacy of logical access controls over the SHIPS.

This audit was conducted pursuant to the State Auditor's responsibilities as set forth in Article VII, Section I, Paragraph 6 of the State Constitution and Title 52 of the New Jersey Statues.

Methodology

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

In preparation for our testing, we studied legislation, the administrative code, circular letters promulgated by the Department of the Treasury, and policies of the division. Provisions that we considered significant were documented and compliance with those requirements was verified by interview, observation, and through our testing of eligibility factors. We also read the budget messages, reviewed financial trends, reviewed audited program financial statements, and interviewed division personnel to obtain an understanding of the programs and the internal controls.

A nonstatistical sampling approach was used. Our samples were designed to provide conclusions about eligibility of insured members and related claims as well as internal controls and logical access controls over the SHIPS. Because of the timing and availability of paid claims data, we used calendar year 2015 completed claims information for testing purposes.

Conclusions

We found that insured members were eligible for coverage. In making this determination, we noted improvements should be made over the termination process and communication between the health benefits operations and financial units. We also noted that access controls over the SHIPS were inadequate with regard to third-party users.

Background

The Division of Pensions and Benefits contracts with private vendors to administer health benefit and prescription drug coverage. The division offers benefits to eligible employees and retirees, and their dependents, participating in the State Health Benefit Program (SHBP) for state and local employers or the School Employee Health Benefit Program (SEHBP) for education employers. Eligibility is determined by the division and is dictated by state law and division policy; eligible individuals are enrolled by the division. The division uses the State Health Information Processing System (SHIPS) to track all enrolled members. The SHIPS interfaces with private vendors and provides pertinent information including names, social security numbers, and dates of enrollment. The private vendors are responsible for paying claims to health care providers and are then reimbursed by the respective health benefit program. To fund the reimbursements to the private vendors, premiums are charged to and paid by the participating employers. In most circumstances employees are also required to contribute a share of the premium charged. In some circumstances the premiums are paid in full by the state or by the insured member.

Ineligible Members

Claims should not be paid for members who are no longer eligible.

The division paid claims for some members after they were deemed ineligible for the program. We matched the State Health Information Processing System (SHIPS) calendar year 2015 enrollment records to calendar year 2015 claims and found 4,879 members who did not appear to be enrolled. We also found 3,939 members who had claims with a date of service subsequent to their termination date. We selected random and judgmental samples of both populations to validate the members' eligibility at the time the services were provided. The results of our tests are displayed below.

	Test of Claims for Members Not Enrolled			
	Questionable Eligibility			Amount of
	# of Members	# Tested	# Deemed Ineligible	Questioned Claims
Health	2,765	120	7	$ 80,354
Prescription	2,114	63	24	$ 339,571
Total	4,879	183	31	$ 419,925

Test of Claims After Termination Date			
Questionable Eligibility			Amount of
# of Members	# Tested	# Deemed Ineligible	Questioned Claims
1,948	120	73	$ 141,702
1,991	80	73	$ 307,110
3,939	200	146	$ 448,813

The majority of members tested, who appeared as not enrolled, were actually eligible; errors in their social security numbers caused them to appear ineligible. All of the questioned claims for those not enrolled were for members who were previously enrolled but where coverage had terminated as early as 2010.

An additional test of all members whose coverage terminated in November or December of 2014 identified an additional 80 ineligible members with $58,000 in 2015 claims.

Retroactive terminations caused most of the ineligible claims paid for terminated members. The division does not consistently verify the existence of claims prior to retroactively terminating a member and does not have a policy for the treatment of claims paid before coverage was rescinded.

Our test of claims after termination disclosed 77 percent of members with questioned claims were terminated retroactively and 67 percent of the questioned claims occurred during the period of time between the effective termination date and the date termination was entered in the SHIPS.

Prior to releasing payment, the private vendors are required to verify, via the interface with the SHIPS, that a member is covered on the date medical service was provided. In some circumstances, the division must terminate enrollment retroactively making it appear to the vendor that the member was still eligible at the time services were provided and that payment was made. Retroactive terminations occur when there is a delay in the communication of enrollment changes between the member and the division or when a member who is required to pay the full premium for their benefits is delinquent more than 45 days.

The Federal Consolidated Budget Reconciliation Act (COBRA) requires employers sponsoring group health plans to offer temporary extension of benefits under certain circumstances such as termination of employment. Under Chapter 375 of New Jersey Public Law 2005 (Chapter 375) certain over-age dependents may be eligible for coverage until age 31. The division complies with both laws and requires full payment of premiums from the member.

We judgmentally selected a sample of 50 COBRA and Chapter 375 members whose coverage began and was retroactively terminated to the same date in 2015. Our test results disclosed 27 members whose coverage was terminated retroactively due to nonpayment. On average, it took the division over 100 days from the effective termination date to the date it was entered in the SHIPS. Detailed claims information is available from the vendors upon request, but is not utilized by the division. Since the division does not consistently verify if claims were paid, any premiums due from these members were written-off and any medical attention received by the terminated member was free to the member.

Recommendation

The division should ensure claims are not paid for ineligible members. The division should also verify whether or not claims were paid prior to retroactive termination and develop a consistent policy to recover claims or premiums. The policy should include a requirement to refer outstanding receivable balances to the Department of the Treasury, Division of Revenue and Enterprise Services for collection.

State Health Information Processing System – SHIPS

Access to the SHIPS should be limited to users who require access and edits to the system should be reviewed on a routine basis.

The health benefits operations unit has granted high-level edit access to the State Health Information Processing System (SHIPS) to remote users employed by the private vendors. Edit access allows a user to make changes to, or add subscriber and dependent information. The level of access provided dictates what changes or additions a user can make. It is reasonable for the division to grant inquiry access to certain users including employees of the private vendors; however, edit access should be strictly limited.

There were approximately 1,600 SHIPS users at the time of our review. We identified 542 active users employed by two of the private vendors. We judgmentally sampled the access level of 312 of those users and found that 170 have the ability to add new subscribers to the SHIPS. We also found six have the ability to change social security numbers and the employer associated with the subscriber, and four users can add new dependents. This type of access exposes the division to the risk that ineligible members may be added fraudulently.

The SHIPS mainframe does not log the types of edits noted, therefore we could not test activity to identify vendor users who may have fraudulently produced changes to the SHIPS's insured members. The operations unit prints a SHIPS daily activity report subsequent to a day's activity and the report is distributed to the user who made the changes to review the activity for accuracy, providing no independent review of changes made.

We found that most often an email is accepted from the vendor requesting that the operations unit grant access to a vendor employee. We also found that most often the access granted is copied from an existing user and may include high-level edit access. An authorized individual in the operations unit should complete the New Jersey Office of Information Technology's User Access Request form to initiate access for new users. The level of access provided should directly relate to the user's job requirements. The same form should be used to remove user access. The operations unit produced only one User Access Request form related to the vendor users reviewed.

The operations unit was not aware of the number of users that had been granted access to their system and management was unaware that edit access had been provided at all or to the extent that we found. They were also unaware that users were able to access the SHIPS remotely. The operations unit began corrective action during our field work.

Recommendation

We recommend the operations unit review the access of all SHIPS users and remove users whose access is unwarranted, create an inventory of active users, and adhere to existing policy by utilizing the request form to add and remove users. SHIPS users should be reviewed routinely to determine if continued access is warranted. Daily activity reports should be distributed to someone other than the user to review the activity for propriety. If the operations unit determines that vendor employees with edit access is warranted, their daily activity should be reviewed by a supervisor or higher authority within the division.

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December 19, 2016

John J. Termyna
Office of Legislative Services
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RE: Health Benefit Audit

Dear Mr. Termyna:

Please accept this correspondence as the Division of Pensions and Benefits' response to the audit report of the Department of the Treasury, Division of Pensions and Benefits, Health Benefits Programs-Member Eligibility.

Recommendation #1: Claims should not be paid for members who are not eligible and a consistent policy for recovering claims or premiums should be developed.

The Division of Pensions and Benefits agrees with the above recommendations. The Division is working to better adhere to the procedures in place to prevent the payment of claims for members who are not eligible for State administered health benefits. It also has procedures to ensure that those eligible for coverage have their charges paid. As part of the audit, enrollment records were matched with claims to test whether members' were eligible at the time services were provided. As noted in the findings, retroactive terminations were the principle reason for claims being paid after a termination date. It is the Medical carriers' responsibility to recapture inappropriate payments. The Prescription carrier does not recapture claims paid in error so the Division is taking action to address this problem. The Division is in the process of changing the paid-thru date procedure with the Prescription carrier to prevent claims from being paid before a premium is received for the coverage.

Another reason for members not appearing eligible for benefits, as noted in the findings, was social security numbers. Not all dependents of subscribers have social security numbers at the time services are provided. This is especially true of newborns and foreign national spouses. In order for claims to be paid, the Division assigns "dummy" social security numbers. Once social security numbers are obtained by the dependent, the social security number is changed to the valid number. The Division has revised our biannual letter requesting Social Security Number verification to include a timeframe for member response and actions taken for nonresponse.

The Division will also review the feasibility of referring outstanding receivables to the Division of Revenue and Enterprise Services for those moneys not recaptured.

Recommendation #2: Access to SHIPS should be limited to users who require access and edits to the system should be reviewed on a routine basis.

The Division of Pensions and Benefits agrees with the above recommendations. Based on the feedback, the Division is improving SHIPS security procedures. SHIPS access has already been removed from some state agencies that have access to EPIC for health benefits information. Dormant user accounts have had their SHIPS access revoked; these accounts included both internal state agencies and users from private vendors.

A system malfunction was identified during the audit process. Users who were not found on the Security report were found on a separate audit. Manual intervention was required to correct this issue and action is being taken to prevent this issue from occurring in the future.

In addition, the security report will be reviewed on a monthly basis by the Health Benefits Audit Section supervisor to monitor user access. The Division will also review the feasibility of various options for the evaluation of daily user activities in SHIPS.

Finally, the Division of Pensions and Benefits would like to thank the OLS audit team for their courtesy, feedback, and suggestions while conducting this audit.

Sincerely,

Florence J. Sheppard
Acting Director

c: Ford M. Scudder, Treasurer
John D. Megariotis, Deputy Director, Division of Pensions and Benefits
David J. Pointer, Deputy Director, Division of Pensions and Benefits
Lynn Jahn, Chief of Internal Audit, Department of Treasury
David Kaschak, Assistant State Auditor, Office of Legislative Services