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INDEPENDENT STATE AUDITOR'S REPORT ON
CERTAIN ACTIVITIES OF THE
COMMONWEALTH HEALTH INSURANCE
CONNECTOR AUTHORITY
JULY 1, 2009 THROUGH NOVEMBER 30, 2009

**OFFICIAL AUDIT
REPORT
OCTOBER 29, 2010**

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In order to expand access to health care for Massachusetts residents, the legislature enacted Chapter 58 of the Acts of 2006 titled, An Act Providing Access to Affordable, Quality, Accountable Health Care. Section 101 of this Act added Chapter 176Q to the General Laws which established the Commonwealth Health Insurance Connector Authority (HICA) as an independent public entity. Section 12 of Chapter 58 added Chapter 111M to the General Laws which required that individuals maintain health insurance coverage, as well as requiring employers to arrange for the purchase of health insurance for their employees. In response to this requirement, the HICA was designed to assist individuals and small business in acquiring quality, affordable health coverage through either its unsubsidized plan (Commonwealth Choice) or its subsidized plan (Commonwealth Care), established by Chapter 118H. According to the Massachusetts Division of Health Care Finance and Policy's, Health Care in Massachusetts: Key Indicators Report, dated November 2009, since the implementation of health reform over 408,000 additional people have obtained health insurance coverage.

In accordance with Chapter 11, Section 12, of the Massachusetts General Laws, the Office of the State Auditor (OSA) has conducted an audit of the HICA's administration and oversight of the programs it has implemented to provide health insurance plans to eligible individuals and groups for the period July 1, 2009 through November 30, 2009. The scope of our audit did not include a review of other Commonwealth subsidized health insurance programs such as MassHealth and the Health Safety Net and therefore we offer no opinion on the total cost to the Commonwealth of the health insurance mandate. The objectives of our audit were to determine the adequacy of internal controls that ensure compliance with applicable laws, regulations, contracts, and policy regarding: (1) financial operations, including compliance with Medicaid Managed Care Organizations (MMCO) contracts including premium payments, enrollee premium contributions, and approved administration fees; (2) procurement activities, including contracts with MMCO and outside vendors; (3) appeals processing; (4) administration of Stop-Loss Pool; and (5) Internal Control Plan documentation.

Based on our review, we have concluded that, except for the issues reported in the Audit Results section of this report, during the period July 1, 2009 to November 30, 2009, HICA has implemented adequate oversight, policies, procedures and internal controls to effectively fulfill its mission of assisting individuals and businesses in acquiring quality, affordable health insurance coverage in accordance with Chapter 176Q of the state healthcare reforms enacted in 2006.

AUDIT RESULTS**6**

**IMPROVEMENTS NEEDED IN HICA'S OVERSIGHT AND MONITORING OF
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Our audit revealed that the HICA had developed policies, procedures and controls over the procurement process, but in several instances could not provide evidence of the required management approval of the Request for Proposal process or documented approval for sole source procurements. Without monitoring of established internal controls, HICA management has no assurance that the controls are functioning as designed.

INTRODUCTION

Background

In order to expand access to Health Care for Massachusetts residents, the legislature enacted Chapter 58 of the Acts of 2006 (the Act) titled, an Act Providing Access to Affordable, Quality, Accountable Health Care. The Act included sections that amended the Massachusetts General Laws by adding the following chapters:

- Section 12 added Chapter 111M. Section 2 (a) of Chapter 111M states the following:

As of July 1, 2007, the following individuals age 18 and over shall obtain and maintain creditable coverage so long as it is deemed affordable under the schedule set by the board of the connector, established by chapter 176Q: (1) residents of the commonwealth; or (2) individuals who become residents of the commonwealth within 63 days, in the aggregate. Residents who within 63 days have terminated any prior creditable coverage, shall obtain and maintain creditable coverage within 63 days of such termination.

- Section 101 added Chapter 176Q. Section 2 (a) of Chapter 176Q states the following:

There shall be a body politic and corporate and a public instrumentality to be known as the commonwealth health insurance connector authority, which shall be an independent public entity not subject to the supervision and control of any other executive office, department, commission, board, bureau, agency or political subdivision of the commonwealth except as specifically provided in any general or special law. The exercise by the authority of the powers conferred by this chapter shall be considered to be the performance of an essential public function. The purpose of the authority is to implement the commonwealth health insurance connector, the purpose of which is to facilitate the availability, choice and adoption of private health insurance plans to eligible individuals and groups as described in this chapter.

- Section 45 added Chapter 118H. Section 2 of Chapter 118H states the following:

For the purpose of reducing uninsurance in the commonwealth, there shall be a commonwealth care health insurance program within the commonwealth health insurance connector, established by chapter 176Q. The program shall be administered by the board of the connector, in consultation with the office of Medicaid and the health safety net office. The program shall provide subsidies to assist eligible individuals in purchasing health insurance, provided that subsidies shall only be paid on behalf of an eligible individual who is enrolled in a health plan that has been procured by the commonwealth health insurance connector under said chapter 176Q, and shall be made under a sliding-scale premium contribution payment schedule for enrollees, as determined by the board of the connector. Eligibility for premium assistance payments under this section shall be determined in coordination with and using the procedures of the office of Medicaid. After consultation with the director of the office of Medicaid, representatives of any carrier eligible to receive premium subsidy payments under this chapter, representatives of hospitals that serve a high number of uninsured individuals, and representatives of low-income health care advocacy organizations, the board shall develop a plan for outreach and education that is designed to reach low-income uninsured residents and maximize their enrollment in the program.

The Commonwealth Health Insurance Connector Authority (HICA) has promulgated regulations (956 CMR) to implement its responsibilities under the Act.

A Board of Directors governs the HICA. By law, the Board consists of 10 members: the Secretary for Administration and Finance, ex officio, who serves as Chairperson; the Director of Medicaid, ex officio; the Commissioner of Insurance, ex officio; the Executive Director of the Group Insurance Commission; three members appointed by the Governor, one of whom shall be a member in good standing of the American Academy of Actuaries, one of whom shall be a health economist, and one of whom shall represent the interests of small businesses; and three members appointed by the Attorney General, one of whom shall be an employee health benefits plan specialist, one of whom shall be a representative of a health consumer organization, and one of whom shall be a representative of organized labor.

The HICA has established two health insurance programs to meet this responsibility. Both programs comply with insurance coverage requirements established in Chapter 111 of the General Laws (Individual Health Coverage Mandate).

Commonwealth Care

This program provides state subsidies to assist eligible individuals in purchasing health insurance. MassHealth, a department within the Executive Office of Health and Human Services (EOHHS), determines eligibility for Commonwealth Care applicants consistent with the HICA's regulations regarding eligibility, which include:

- Must be a Massachusetts resident for previous six months.
- Must be U.S. citizen, qualified alien, or alien with special status.
- Must not be eligible for any MassHealth program.
- Must be 19 or older.
- Must not have access to Employer Sponsored Insurance (ESI) for which the employer covers 20% of the annual premium cost for a family insurance plan or at least 33% for an individual insurance plan.
- Must not have accepted a financial incentive from his/her employer to decline ESI.
- Must not have income that exceeds 300% of Federal Poverty Level (FPL).

- Must not be eligible for TriCare (federal health insurance program for active military members), Massachusetts Fisherman's Partnership (state health insurance program for low-income fisherman), Qualifying Student Health Insurance Programs (for college students in Massachusetts), or the Massachusetts Division of Unemployment Assistance's Medical Security Program (subsidized health insurance for people collecting unemployment benefits).

The HICA has contracted with five Medicaid Managed Care Organizations (MMCO) to provide enrolled individuals with managed care services. As of November 2009 the five MMCOs and the number of enrolled individuals were:

<u>MMCO</u>	<u>Enrollment</u>
Boston Medical Center	59,828
CeltiCare Health Plan	22,936
Fallon Community Health Plan	9,037
Neighborhood Health Plan	31,889
Network Health Plan	<u>47,254</u>
Total	<u>170,944</u>

Individuals earning more than 150% of the FPL are required to contribute to the cost of the health insurance premiums, with the amount of the contribution increasing as the level of income increases. The HICA has executed a contract with an outside vendor, Perot Systems, to provide customer service and administration of premium billing and collection activities. The HICA administers a stop-loss pool on behalf of the MMCOs whereby each MMCO pays 1.25% of the monthly premium payment into the pool. If the costs for a specific enrollee exceeds the maximum threshold of \$150,000, the stop-loss pool will reimburse the MMCO for 75% of the excess costs of medical services.

According to HICA's 2009 Independent Auditor's Report, the total state subsidy was \$799,708,595, which consisted of the following:

- \$767,324,828 for premium payments to MMCOs. (NOTE: enrolled individuals contributed \$41,404,805, resulting in total premium payments to MMCOs of \$808,729,633).
- \$32,383,767 in administration fees (4% of premium payments) to pay for HICA administrative and operational costs.

Commonwealth Choice

This program develops and offers commercial health insurance products to individuals and small groups that are not eligible for subsidized health insurance. HICA has contracted with an outside vendor, Small Business Service Bureau Inc. (SBSB) to perform administrative duties. The duties include operating a central call and support center, enrollment processing, and administration of premium billing and collection activities. The HICA has contracted with six insurers to provide enrolled individuals with commercial health insurance. As of November 2009 the six insurers and the number of enrolled individuals (including dependents) were:

<u>Insurer</u>	<u>Enrollment</u>
Blue Cross Blue Shield	5,933
Fallon Community Health Plan	4,185
Harvard Pilgrim Health Care	6,073
Health New England	734
Neighborhood Health Plan	4,518
Tufts Health Plan	<u>1,248</u>
Total	<u>22,691</u>

According to the Independent Auditor's Report, in fiscal year 2009, the HICA received \$3,063,765 in administration fees from the insurers for HICA's administrative and operational costs.

Since the HICA's establishment in 2006, it has served as an intermediary to the residents of Massachusetts for health insurance coverage, rate comparisons, plan details, and other advice on satisfying the recent individual coverage mandate. The HICA, since its inception, has been governed by a Board of Directors and operated by an Executive Director with a staff knowledgeable in both the public and private sector aspects of health care and health care reform in Massachusetts. This staff has worked with the state, as well as with several Medical Managed Care Organizations (MMCO's) and Health Management Organizations (HMO's) to negotiate not only the rates at which health care will be provided to the residents of Massachusetts through these private institutions, but also to establish and secure quality standards for that health care (known as Minimum Creditable Coverage) to meet the individual mandate. Another integral role of the HICA's staff is to secure both state funding and federal reimbursement (50%) for the Authority's subsidized program through the Executive Office for Administration and Finance. To streamline operations, the HICA was mandated to utilize the eligibility determination systems of MassHealth to direct eligible individuals

in need of financial assistance to its subsidized option, Commonwealth Care. In addition, the HICA has sought to enroll other individuals and small groups who are not eligible for financial assistance into its non-subsidized option, Commonwealth Choice. As of November 2009, the combined total of enrollees in both programs had reached over 193,500.

Audit Scope, Objectives, and Methodology

In accordance with Chapter 11, Section 12, of the Massachusetts General Laws, the Office of the State Auditor (OSA) conducted an audit of the HICA's administration and oversight of the health insurance programs established by HICA to facilitate the availability, choice and adoption of private health insurance plans to eligible individuals and groups, in compliance with its enabling legislation. The scope of our audit did not include a review of other Commonwealth subsidized health insurance programs such as MassHealth and the Health Safety Net and therefore we offer no opinion on the total cost to the Commonwealth of the health insurance mandate. Our audit period was July 1, 2009 through November 30, 2009. The objectives of our audit were to determine the adequacy of HICA's internal controls that ensure compliance with applicable laws, regulations, contracts, and policies regarding:

1. Financial operations, including compliance with MMCO contracts regarding premium payments, compliance with regulations regarding enrollee premium contributions, and compliance with approved administration fees.
2. Procurement activities, including MMCO contracting and outside vendors.
3. Applicant health insurance eligibility and tax penalty appeal processing.
4. Administration of the Stop-Loss Pool.
5. Internal Control Plan documentation.

Based on our review, we have concluded that, except for the issues reported in the Audit Results section of this report, during the period July 1, 2009 to November 30, 2009, HICA has implemented adequate oversight, policies, procedures and internal controls to effectively fulfill its mission of assisting individuals and businesses in acquiring quality, affordable health insurance coverage in accordance with Chapter 176Q of the state healthcare reforms enacted in 2006.

AUDIT RESULTS

IMPROVEMENTS NEEDED IN HICA'S OVERSIGHT AND MONITORING OF INTERNAL CONTROL OVER THE PROCUREMENT OF GOODS AND SERVICES

Our audit revealed that the Health Insurance Connector Authority (HICA) had developed policies, procedures and controls over the procurement process, but in several instances could not provide evidence of the required management approval of the Request for Proposal (RFP) process or documented approval for sole source procurements. Without monitoring of established internal controls, HICA management has no assurance that the controls are functioning as designed.

We obtained a listing of 31 active professional service contracts and selected six of these in order to determine if the procurement process was in compliance with sound business practice and with HICA policies and procedures. Four of the contracts selected were competitively bid and two were sole-source procurements. Our sample included the following:

Procurement Method	Service	Amount
Competitive Bid	Advertising	\$1,500,000
Competitive Bid	Billing/Customer Service	\$172,000
Competitive Bid	Web Development	\$1,524,760
Competitive Bid	Advertising	\$245,000
Sole Source	IT Consulting	Hourly Rate
Sole Source	Legal	Hourly Rate

We found that the four competitively bid procurements tested lacked evidence of approval by the Executive Director or the Chief Operating Officer, the Chief Financial Officer or the General Counsel for the release of a RFP, as required by HICA policy which states, in part:

The RFP, or mini-solicitation may not be posted or released until the Executive Director, or Chief Operating Officer, as well as the Chief Financial Officer and General Counsel have approved the posting or release of the procurement request.

In addition, there was no evidence of an approved RFP budget as required by policy which states, in part:

The requisition must also establish a budget subject to the approval of the Chief Financial Officer.

We also found that for one of the two sole source procurements tested, there was no documentation of approval by the Executive Director, contrary to the HICA policy which states, in part:

a sole source vendor may be selected when, after reasonable, documented research, the Connector determines that because of unique requirements of the supplies or services sought, only one practicable source exists. In such a case, the employment of a sole source selection requires the prior approval of the Executive Director or his designee.

The Office of the State Comptroller's (OSC) Internal Control Guide emphasizes the importance of management in any comprehensive internal control plan (ICP), stating that "management's attitude, actions, and values set the tone of an organization, influencing the control consciousness of its people." In the OSC's Enterprise Risk Management (ERM) framework, there is much emphasis put on the monitoring of controls, and on continuous supervision. The ERM defines continuous supervision as "the ongoing oversight, management and guidance of an activity by designated employees to help ensure that the results of the activity achieve the established objectives."

The Committee of Sponsoring Organizations (COSO) of the Treadway Commission also issued a report titled Internal Controls – Integrated Framework which states that to foster an effective internal control environment, management must establish "a tone at the top" that emphasizes ethical standards. This serves to reinforce the HICA's organizational structure while demonstrating to employees the importance of compliance with internal control requirements.

In addition to the OSC's guidelines and the guidance provided by COSO, Chapter 30B of the General Laws, the Uniform Procurement Act, outlines certain criteria for the solicitation, selection, and monitoring of contracts. The Uniform Procurement Act requires that the entire process, from the initial release of the RFP to the final recommendation and selection of a vendor, be thoroughly documented. Although the HICA is an independent authority and is not mandated by the legislature to abide by the provisions of Chapter 30B, it is funded by a State appropriation. As such, the HICA should incorporate the criteria within the Uniform Procurement Act into its policies and procedures over procurement, which states in part "A procurement officer who awards a contract in the amount of five thousand dollars or more shall maintain a file on each such contract and shall include in such file a copy of all written

documents.” Any upper management approvals required to be obtained over the course of the procurement process should be considered among those documents to be retained.

Recommendation

We recommend that HICA, in order to clarify its policies and procedures over the procurement process, and recognizing that it receives funding from the Commonwealth, incorporate the criteria contained within Chapter 30B, the Uniform Procurement Act, as well as the criteria set forth in 801 CMR 21.00 in its procurement policies.

Auditee’s Response

Our procurements have been run appropriately, objectively, and with the goal of obtaining the best value for the Commonwealth. Where we have engaged in sole source contracts, we have done so properly, under unique circumstances, and, with an eye towards obtaining the best value. Senior management has, in all instances, been aware of the various procurements and has approved the outcomes of the procurement processes. We have always sought to obtain the most appropriate goods and services for HICA at the best price, and there is no suggestion in the OSA audit that any particular procurements posed any problems.

Nonetheless, Connector management recognizes that we have not always fully documented our procurement processes in the manner called for by our own procurement policy. We will review the procurement standards set out in the OSA audit. We will then take steps to ensure that our procurement policy is fully and regularly implemented whenever we engage in procurements or sole source contracts.

