

Key Points of Report

An Audit Report on Management Controls at the Employees Retirement System of Texas

February 1998

Overall Conclusion

Opportunities exist for the Employees Retirement System of Texas (System) to enhance controls used to monitor customer satisfaction, health maintenance organization (HMO) contract compliance, and compliance with the Texas Employees Uniform Group Insurance Benefits Act. These enhancements could impact accomplishment of the System's mission and future funding and benefit decisions. Overall, however, management controls appear sufficient to provide reasonable assurance that the System will accomplish its mission.

Key Facts and Findings

- The System's four pension plans paid benefits of \$549 million and insurance programs incurred expenses of \$937 million in fiscal year 1997. These programs respectively served approximately 220,000 and 500,000 current and former state employees, beneficiaries, and dependents.
- The System should strengthen and expand processes for monitoring satisfaction of its customers. Accurate identification of customer satisfaction is important to the achievement of the System's mission and may become more significant if projections of insurance funding needs require consideration of benefit changes. Available information, although limited, indicated high levels of satisfaction with retirement processing and relatively few complaints about benefit programs.
- The System's procedures do not ensure that HMOs comply with many contractual provisions. We noted several instances in which the System's contractor oversight procedures did not detect or correct noncompliance.
- The System did not use the method specified in the Group Insurance Benefits Act to compute the minimum required insurance fund reserve. Management indicates that the method used is consistent with the System's insurance reserve computations in prior biennia. However, this computation method resulted in the System requesting from the 75th Legislature approximately \$30 million more in state funds than was necessary to achieve the statutory minimum reserve.
- Better coordination with the Texas Department of Insurance could help the System obtain useful information about insurance complaints, HMOs' financial soundness and regulatory compliance, and insurance programs' actuarial soundness.

Contact:

Carol Smith, CPA, Audit Manager, (512) 479-4700



Office of the State Auditor

Lawrence F. Alwin, CPA

This audit was conducted in accordance with Government Code, Section 321.0133.

Table of Contents

Executive Summary	1
Section 1:	
Procedures Used to Monitor Customer Satisfaction With Benefit Programs Should Be Enhanced	5
Improvements Are Needed in the Processes Used to Receive, Track, and Analyze Complaints	5
The System Should Increase Its Use of Surveys to Monitor Customer Satisfaction	8
Improvements Are Needed in the Process Used to Survey the System's Retirees	10
Improvements Are Needed in the Monitoring of Telephone Call Wait Times and Compliance With System Time Limits	12
Section 2:	
The System Should Improve Controls Over Monitoring HMO Contract Compliance	13
Section 3:	
The System Should Enhance Controls Over Monitoring Compliance With Provisions of the Uniform Group Insurance Act and Determine If the Act's Intent Was Achieved	15
The System Did Not Fully Comply With All of the Provisions of the Act	16
The System Has No Procedures to Demonstrate Whether One of the Stated Purposes of the Act Has Been Achieved	21
Section 4:	
The System Can Enhance Complaint and Compliance Monitoring by Improving Communication and Coordination With the Texas Department of Insurance	22

Table of Contents, concluded

Section 5:	
Controls Related to Automation Could Be Enhanced	28
Processes Related to Communication of Automation Information Should Be Improved	28
Existing Automation Planning and Monitoring Controls Could Be Strengthened	31
Section 6:	
Controls Over Investment Practices Have Improved But Additional Improvements Are Still Possible	33
The System Has Made Significant Progress in Implementing Most Investment Practices Recommendations	33
The System Should Still Seek An Attorney General's Opinion to Clarify Investment Delegation Authority (Prior Recommendation)	38
Appendices	
1 - Objectives, Scope, and Methodology	40
2 - Text of Selected Sections of the Texas Employees Uniform Group Insurance Benefits Act	43

Executive Summary

Opportunities exist for the Employees Retirement System of Texas (System) to enhance control systems used to monitor customer satisfaction, health maintenance organization (HMO) contract compliance, and compliance with the Texas Employees Uniform Group Insurance Benefits Act. These enhancements could impact accomplishment of the System's mission and future funding and benefit decisions. Overall, however, management controls appear sufficient to provide reasonable assurance that the System will accomplish its mission.

Procedures Used to Monitor Customer Satisfaction With Benefit Programs Should Be Enhanced

Formal procedures used to monitor customer satisfaction do not provide sufficient information which management can use to identify program changes necessary to ensure that the System's actions align with its philosophy. The System's philosophy states that "the ERS strives to ensure that every participant in each ERS program will receive quality service and be treated equitably and with respect."

Improvements are needed to both complaint monitoring procedures and customer survey procedures. As a result of identified weaknesses, management may not be obtaining reliable information about complaints received and overall levels of customer satisfaction with all benefit programs. Reliable customer satisfaction information may also be significant if projections of insurance funding needs require consideration of benefit changes.

We did not note significant problems in the System's resolution of complaints. In addition, available information suggested that relatively few complaints are received about benefit programs.

However, the current complaint monitoring procedures include the following weaknesses:

- The System does not log all complaints.
- There is no agency-wide definition of "complaint."
- Procedures for recording complaints are not always documented or consistent.
- Complaint logs omit information that could be used for performance analyses.
- Complaints received are not successfully reconciled to ensure all are accounted for.
- Trend analyses of complaints are not consistently performed.

Furthermore, the System does not survey most of its customers to monitor customer satisfaction. For example, System-conducted surveys are not performed for the health care programs, which serve over 500,000 members and their families.

Although surveys of retirees reported relatively high levels of satisfaction, we noted several opportunities to increase these surveys' effectiveness and efficiency. Weaknesses identified include restricting the surveyed population to recent retirees rather than including a sample of all retirees. Also, survey questions lack adequate detail, and the current performance of monthly surveys appears inefficient.

The System Should Improve Controls Over Monitoring HMO Contract Compliance

The System's procedures do not ensure that HMOs comply with many provisions in the annual Letters of Agreement (Agreement). An Agreement represents the contract between the

Executive Summary

System and an HMO. As a result, the System might not become aware of deteriorating HMO financial conditions, the lack of required HMO financial safeguards, or improper HMO actions taken toward System participants early enough for the System to take appropriate corrective action.

We noted the following instances in which the System's contractor oversight procedures did not detect or correct noncompliance with the Agreements:

- Four HMOs whose financial soundness had been questioned by the Texas Department of Insurance since 1996 did not notify the System of this fact.
- Up-to-date information concerning HMOs' insolvency plans, professional liability coverage, and reinsurance coverage was not consistently on file.
- The System cannot determine whether or not HMOs are complying with the required advance notification for terminations without cause.
- HMOs do not notify the System in advance of System participant grievance hearings or of the outcomes of hearings.

The System Should Enhance Controls Over Monitoring Compliance With Provisions of the Uniform Group Insurance Act and Determine If the Act's Intent Was Achieved

The system should enhance the effectiveness of controls over monitoring compliance with the provisions of the Texas Employees Uniform Group Insurance Benefits Act (Act). We identified a provision of the Act for which the System did not use the required computation method and another provision

with which the System did not comply. Also, the System has no procedures to determine if certain insurance benefits for state employees are at least equal to the benefits provided in private industry, a stated purpose of the Act.

The compliance issues related to the Act's provisions were as follows:

- The System did not compute the statutory minimum group insurance fund balance reserve as of the end of the current biennium in accordance with the Act. The System based the computed minimum reserve balance on estimated total expenses to be paid from the insurance fund rather than on self-insured programs' expenses. As a result, the System requested of the 75th Legislature approximately \$30 million more in state funds than needed to meet the statutory minimum.

The System's insurance actuary recommends that the System maintain a higher reserve balance than the statutory minimum and management indicated that the calculation method was consistent with prior biennial calculations. However, the agency did not present support distinguishing a reason for an increase.

- The System does not obtain reinsurance for all coverages provided by outside carriers and does not approve the reinsurance carrier for coverage that is reinsured, as required by the Act.

Executive Summary

The System Can Enhance Complaint and Compliance Monitoring By Improving Communication and Coordination With the Texas Department of Insurance

The System can improve the effectiveness of some of its monitoring activities by obtaining additional information from the Texas Department of Insurance. This information, some of which is statutorily required to be provided by the Texas Department of Insurance, includes the following:

- Insurance-related complaints
- Instances in which the Texas Department of Insurance has raised questions about the financial condition of HMOs contracting with the System
- Other financial and compliance information maintained by the Texas Department of Insurance about HMOs
- Certification by the Texas Department of Insurance of the actuarial soundness of carrier bids and self-insured benefit programs' proposed contribution rates
- Feedback concerning the System's statutory report to the Texas Department of Insurance containing insurance coverages and benefits

Summary of Management's Responses

Management of the System generally concurs with the findings and recommendations in this report. However, System management disagrees with our findings and recommendations in Section 3-A related to compliance with the requirements of two provisions of the Texas Employees Uniform Group Insurance Benefits Act.

In addition, the Texas Department of Insurance management generally agrees with the findings and recommendations in Section 4, which involves communication and coordination between the two agencies.

Summary of Audit Objectives and Scope

Our audit objectives were to evaluate the management control systems at the Employees Retirement System and to identify strengths and opportunities for improvement.

The scope of this audit included consideration of the System's overall management control systems: control environment and risk assessment, policy management, performance management, information management, and resource management.

This page intentionally left blank.

Procedures Used to Monitor Customer Satisfaction With Benefit Programs Should Be Enhanced

Formal procedures used to monitor customer satisfaction do not provide sufficient information which management can use to identify program changes necessary to ensure that the System's actions align with its philosophy. Accurate identification of the System's customers' level of satisfaction would help the System determine if its benefit programs operate in accordance with its stated philosophy. The System's philosophy, in its 1996 update of the *Agency Strategic Plan*, states that "the ERS strives to ensure that every participant in each ERS program will receive quality service and be treated equitably and with respect." Adequate customer satisfaction information could become even more important if future additional funding needs require a consideration of changes in benefits.

The System currently has some procedures to monitor customer satisfaction:

- The System's benefit programs receive, track, analyze, and resolve complaints from participants. We did not note significant problems in the System's resolution of complaints received.
- The System surveys some of its customers.

Available information indicated high levels of satisfaction with retirement processing and relatively few complaints about benefit programs. However, we noted several opportunities for the System to improve its processes for monitoring customer satisfaction. The System's two largest benefit programs, the pension plans and the health care program, respectively serve approximately 220,000 and 500,000 current and former state employees, beneficiaries, and dependents.

Section 1-A:

Improvements Are Needed in the Processes Used to Receive, Track, and Analyze Complaints

The System should improve its processes used to receive, track, and analyze complaints. Procedures used by the various departments lack standardization and consistency. Some departments do not have documented procedures. The Member Benefits Division's current process does not require telephone complaints to be logged. Therefore, the System is not in compliance with Section 815.508 (a) of the Texas Government Code. (This law requires that an information file be maintained about every pension-related complaint received that the System has the authority to resolve.)

While we observed instances in which informal processes resulted in appropriate corrective action to address customer complaints, several conditions suggest that overall complaint processes could be enhanced. The Group Insurance Division worked with an HMO to obtain program changes and better disclosure when many members

complained about drug formulary changes. However, several enhancements would help ensure that the System has a more consistent and structured approach to dealing with complaints.

Improved, standardized complaint management procedures will be particularly important as the System implements an Interactive Voice Response (IVR), or “one-stop shopping,” system for member inquiries. This new system has the potential to improve customer satisfaction with the System’s service delivery by enhancing the accuracy and efficiency of information transfer to or from participants. We noted complaints from both an agency benefits coordinator and a retiree concerning the difficulty in consistently finding an employee to provide accurate information.

- **There is no formal, written, agency-wide definition of “complaint.”** Some divisions or departments appear to use informal definitions. These are not consistent. Without a consistent definition, each department may interpret “complaint” differently. Thus, complaint records may not be consistent, and management may not obtain reliable information concerning customer satisfaction.

Senate Bill 385, 75th Legislature, mandates the following definition of a complaint for HMOs:

“Complaint” means any dissatisfaction expressed by a complainant orally or in writing to the health maintenance organization with any aspect of the health maintenance organization’s operation, including but not limited to dissatisfaction with plan administration; appeal of an adverse determination; the denial, reduction, or termination of a service; the way a service is provided; or disenrollment decisions, expressed by a complainant. A complaint is not a misunderstanding or a problem of misinformation that is resolved promptly by clearing up the misunderstanding or supplying the appropriate information to the satisfaction of the enrollee.

The System could adopt this definition for use by all departments with only minor modifications.

- **Procedures for recording complaints are not always documented, vary across departments, and do not always require all complaints to be logged.** Only two departments had written procedures for both oral and written complaints. The written procedures for either type of complaint were not consistent across departments.
- **Existing complaint logs omit information that could be used for performance analyses.** Complaint reports do not always show the date a complaint was closed. Although various dates are shown, reports do not

automatically compute and display the number of days a complaint was open for aging and performance analysis purposes.

- **Reconciliations are not used effectively to compare complaints received to open and closed complaints.** We did not identify any documented attempts to reconcile total complaints received against those remaining open and those closed. Without adequate reconciliation procedures, management cannot identify errors such as open complaints dropped from the tracking system.

We noted three dental maintenance organization participant complaints that were apparently dropped from reports of open or closed complaints without being detected by routine procedures. A prior internal audit report identified the inability to reconcile different reports, and it appears that this problem has not been corrected.

- **Trend analyses of complaints by type or by vendor are not consistently performed.** Complaint summary reports do not contain documentation that any review was performed to identify possible trends. Without documented trend analysis, management cannot be certain that appropriate corrective action was taken or was contemplated if trends were identified.
- **The reports with the most detail used only four complaint categories.** Additionally, more detailed complaint categories may be needed for more informative, long-term trend analysis. For example, the Texas Department of Insurance reportedly uses about 70 categories for insurance-related complaints.
- **There is no formal process for sharing complaint information between the System and the Texas Department of Insurance.** Both agencies have responsibilities for monitoring and helping resolve insurance-related complaints. (This issue is discussed in Section 4.)

Recommendation:

We recommend that the System take the following actions to improve its processes for handling customer complaints and to comply with statutory requirements for documenting pension-related complaints:

- Adopt a written, agency-wide definition of complaint. Consider using the definition for HMO complaints contained in Senate Bill 385, tailored as necessary to meet the System's specific needs.
- Require all departments that receive or process complaints to adopt written procedures for complaint documentation and processing. These procedures should be consistent across departments to the extent practical, and should cover both oral and written complaints.

- Develop a consistent format for complaint logs and ensure that the logs include all information useful for performance and trend analysis. Such information could include automated calculations of various complaint processing times, aging reports, and detailed codes for type of complaint.
- Perform periodic reconciliations of complaints to ensure that all complaints received have been resolved or continue to be tracked.
- Periodically perform formal trend analyses of complaints to identify problems with vendors or with benefit plan design or administration. The ability to sort complaints by vendor and by type should assist these analyses when numerous complaints are received. The conclusions from such analyses, and any resulting follow-up actions taken, should be clearly documented.
- Consider expanding the number of complaint categories to assist in more precise trend analysis.

Management's Response:

The ERS agrees that an agency-wide definition of complaint may be useful in improving customer service efficiency. Written procedures will be established for adoption which consistently document complaints in all program areas. A complaint tracking system will be established for performance and trend analysis as well as for analyzing complaint categories.

Section 1-B:

The System Should Increase Its Use of Surveys to Monitor Customer Satisfaction

The System does not survey most of its customers. The System only conducts periodic customer satisfaction surveys of recent retirees. However, the health care program is the System's largest program, serving 500,000 active and retired employees and their families. Other System programs include Flexible Benefits (the Cafeteria Plan), two deferred compensation plans, and a death benefit program for survivors of certain law enforcement officers and other employees.

A newly adopted performance measure requires the System to conduct customer satisfaction surveys of a random sample of HealthSelect participants, but the Group Insurance Division is not doing so.

The Division has access to HealthSelect plan survey results from Blue Cross/Blue Shield. However, the System cannot necessarily rely on this information. Blue Cross/Blue Shield, as the administrator of the System's self-insured health care plans, organizes the networks of health care providers and processes claims. Therefore, it has a vested interest in obtaining high levels of customer satisfaction. In addition, the

System has no control over the administrator's survey design, sample selection process, or tabulation of responses.

Additionally, the Group Insurance Division does not survey the participants in any of the 16 HMOs contracted with the System. Although not a required performance measure, such a survey could provide useful information about the levels of customer satisfaction with individual vendors, the System's administration of the program, and the overall level of HMO benefits.

The Division does have access to the HMOs' own surveys of customer satisfaction. (The System's contracts require HMOs to report the results of their own surveys.) Again, the System cannot rely on this information because the HMOs have a vested interest in reporting good results. Other deficiencies that impair the usefulness of this information include a lack of survey standardization and lack of timely information.

The Group Insurance Division does not survey health care providers, either in the self-insured or the HMO plans. We believe that high levels of provider dissatisfaction would be a concern to System management. High provider dissatisfaction may result in higher rates of provider withdrawal from the plan and lower quality of care and can ultimately impact member satisfaction.

Recommendation:

We recommend that the System implement the following to obtain a more complete assessment of customer satisfaction with benefit programs (other than retirement):

- Develop and conduct satisfaction surveys of the System's active members concerning all aspects of the System's benefit programs and service delivery.
- Develop and conduct surveys of participants in all health care programs, including the required survey of HealthSelect plan participants. When the System chooses to instead rely on surveys performed or contracted by the plan administrator or vendors, the System should perform monitoring procedures to ensure that those surveys contain standardized questions and are fairly conducted.
- Consider periodically surveying health care providers concerning their satisfaction with plan design and individual vendors. Specifically targeting providers who have withdrawn from a plan might provide useful information, although such information may not be representative of that plan's total population of providers.

Management's Response:

The ERS agrees. The ERS will analyze the effectiveness of current surveys now in use in order to determine the extent to which additional surveys and related costs can be justified.

Section 1-C:

Improvements Are Needed in the Process Used to Survey the System's Retirees

The Member Benefits Division surveys recent retirees, but the effectiveness and efficiency of the process needs to be improved. A performance measure, added to the System's strategic plan in fiscal year 1996, requires retiree surveys for the Employees Retirement System plan and the Judicial Retirement System Plan I. We identified the following problems with the survey process used by the Member Benefits Division:

- **The process does not provide results that are applicable to all retirees and does not comply with the performance measure's definition.** Large portions of the retiree population are not eligible to be included in the survey. Instead, the System monthly sends surveys only to members who have been retired exactly six months. This methodology excludes all retirees who retired more than six months before the adoption of this survey. Also, problems retirees might encounter later in retirement will never be addressed because no one who has been retired more than six months is ever surveyed.

Additionally, retirements for participants in the Judicial Retirement System Plan I averaged less than two per month in fiscal years 1996 and 1997. The results of monthly surveys of such a small group may not be very meaningful considering that there are over four hundred retirees in this plan.

The performance measure was defined as follows:

The % will be derived from sample populations using modern methodologies for opinion assessment. These methodologies will be developed by ERS during FY 1996 and may include focus groups and a standard, statistically valid survey instrument. This process will result in a refined, precise set of questions indicating the level of retiree satisfaction with respect to member benefit services.

This definition indicates an expectation that the assessment of retiree satisfaction will be based on methodologies sophisticated enough to apply to all retirees.

- **The survey would be more effective if the questions were expanded to give the System more detailed, precise information.** Only five questions are included in the current survey, and these are relatively general. An expanded set of more detailed questions would enable the System to determine

exactly what problem areas exist and how to eliminate them. Also, questions regarding the length of time since the respondent's last contact and the type of contact (in-person, telephone, or written correspondence) would be useful. This information would help the Member Benefits Division determine if dissatisfaction is based on recent experience (for example, after changes in processes had been made) and at what points in the process the problems are occurring.

The Member Benefits Division compiles and reports the results of only one of the survey questions. This question requests an assessment of "the overall quality of service provided you." While this may satisfy the performance measure, low scores for this question would not provide the Member Benefits Division with a clear indication of what processes or services need correcting. Compiling the responses for all questions on the survey, especially if more detailed questions are added, would provide valuable feedback. Such feedback might help the System improve specific processes or benefit programs. It might also identify a need for more in-depth questions on noted problem areas for future surveys. Trend analysis of survey results could also yield valuable information.

Questions concerning the demographics (for example, the retiree's age and year of retirement) or other characteristics of the respondents could also be effective. This information would permit data to be sorted and analyzed in different ways, possibly revealing a problem related to a specific group of retirees. Examples are the respondent's age or the number of years since retirement (if the six-month sample period is not used). This data could be coded on the survey questionnaire by the Member Benefits Division from its automated records when address labels for the questionnaire are generated.

- **The current process of surveying on a monthly basis appears inefficient.** Currently, two monthly surveys (twenty-four surveys per year) are performed and analyzed by the Member Benefits Division. The System's performance measures require separate results for the two plans.

Monthly surveys probably do not provide better information than annual or semi-annual surveys of the two groups. An annual or semi-annual survey could be used that would provide equally valid results and require fewer System resources.

Recommendation:

We recommend that the System take the following actions to improve its processes for surveying retirees:

- Survey recipients should be selected using statistical sampling methods. All plan participants should be included in the population to be sampled, regardless of membership categories or length of time since retirement.

- Expand the number of questions on the existing survey and refine the questions to provide more specific feedback on which processes are or are not working well. Responses to all survey questions should be tabulated and monitored over time to identify trends. Demographic information about respondents should be captured to assist in data analysis. The System may consider contracting with an outside consultant to obtain assistance in refining the survey and/or tabulating and reporting the results. The Teacher Retirement System recently contracted with The University of Texas at Austin for performance of an extensive customer satisfaction survey of its membership.
- The surveys should be performed less frequently, for example on an annual basis.

Management's Response:

The ERS agrees with the recommendations to improve survey processes for retirees. The ERS is committed to analyzing the effectiveness and limitations of survey processes now in use. In addition, improvement and expansion of these processes will be carefully analyzed and implemented as appropriate and cost justified.

Section 1-D:

Improvements Are Needed in the Monitoring of Telephone Call Wait Times and Compliance With System Time Limits

Improvements are needed in the monitoring of telephone call wait times and compliance with System time limits:

- The Automated Call Distribution report for the Telephone Service Center does not show average wait time per call. Callers to the Telephone Service Center sometimes wait for periods of 15 to 20 minutes. In one week, almost 22 percent of calls received were abandoned (some of these may represent callers who left the queue to access newly established "user mailboxes"). Without accurate statistics on call wait times it is difficult to monitor the effects of any changes the System might make.
- One-third of the twenty-four complaints we examined exceeded the System's five-day time limit for processing acknowledgment letters. Monitoring compliance with time limits can help ensure expected service levels are met.

Recommendation:

We recommend that the System improve monitoring related to customer satisfaction by improving information on telephone call wait times and capturing information on complaints not consistently processed within expected time frames.

Management's Response:

The ERS agrees with the recommendation to reduce telephone call wait time. The ERS has undertaken a complete reorganization of its customer service call centers. In January, 1998, the ERS will establish a centralized customer service call center in the Benefits Communication Division. This new center will provide telephone customer service support for all program divisions. The center will utilize available technology in order to better serve customers and monitor our effectiveness and performance.

Section 2:

The System Should Improve Controls Over Monitoring HMO Contract Compliance

The System's procedures do not ensure that HMOs comply with many provisions in the annual Letters of Agreement (Agreement). An Agreement represents the contract between the System and an HMO. As a result, the System might not become aware of deteriorating HMO financial conditions, the lack of required HMO financial safeguards, or improper HMO actions taken toward System participants early enough for the System to take appropriate corrective action.

We noted the following instances in which the System's contractor oversight procedures did not detect or correct noncompliance with the Agreements:

- **Notification of questioned financial condition** - Four HMOs whose financial soundness had been questioned by the Texas Department of Insurance since 1996 did not notify the System of this fact. The Agreement requires notification. (This issue is discussed in Section 4.)
- **Submission of up-to-date insolvency plans and professional liability and reinsurance coverages** - Up-to-date information concerning HMOs' insolvency plans, professional liability coverage, and reinsurance coverage was not consistently on file. Group Insurance Division personnel do not compare annual application disclosures to file documents to ensure that HMOs have submitted the most current policies. They also do not confirm with the external insurance carriers that the reported coverage is still in effect.

For three of the four HMO files we examined, carrier names and/or coverage limits on the application differed from the carrier names and/or coverage limits on the policies on file. Two of these three files also lacked either an insolvency plan policy or a professional liability coverage policy. A policy on file for one HMO expired in 1994.

- **Notification of physician terminations** - The System does not require physician termination notices to include disclosure of the termination type. Therefore, the System cannot determine if HMOs are complying with the required 45-day advance notification for terminations without cause. The

termination notice provided to us as an example did not appear to provide the required advance notice, but the System had not called this to the HMO's attention.

- **Advance notification of grievance hearings** - Although an Agreement requirement, HMOs do not notify the System in advance of System participant grievance hearings. In addition, HMOs typically do not inform the System of the outcomes of hearings. The HMO we tested did not provide advance notification to the System for any of the five appeal hearings we reviewed. The HMO only notified the System of the outcome in one case in which the complaint was initially forwarded to the HMO by the System. During the annual application process, the HMOs submit a list of prior year grievances but Group Insurance Division personnel do not compare this list to grievances reported by the HMOs during that year.

The System performs an effective procedure to monitor the HMOs by annually requesting detailed information from the Texas Department of Insurance about all HMOs applying to contract with the System for the upcoming plan year. The financial and non-financial information requested from the Texas Department of Insurance appears useful in the System's assessment of various aspects of the HMOs' operations. However, this procedure could be improved to better enable the System to monitor the HMOs with whom the System ultimately contracts. (This issue is discussed in Section 4.)

The System has recently contracted with an outside firm for audits of three HMOs. Each of these audits will have a limited scope. Future audits could be expanded to include verification of some Agreement requirements, thereby enhancing the System's compliance monitoring processes.

Recommendation:

We recommend that the System thoroughly assess the risk related to requirements in the Letter of Agreement and take more active and continual compliance monitoring steps. The following enhancements address the requirements we tested:

- Routinely use information submitted by HMOs in their annual applications to confirm insolvency, professional liability, or reinsurance coverage on file and to check for compliance with grievance notifications.
- Consider directly confirming with the stated insurance carriers the existence of coverages for insolvency, professional liability, and reinsurance.
- Require that the physician termination notice categorize the reasons for termination and ensure that the required 45-day advance notice is provided for terminations without cause.

- The scope of external audits of HMOs could be expanded to include verification of several compliance issues either in place of or in addition to the System's recommended procedures.

Management's Response:

- *The ERS agrees and will examine the feasibility of a letter of agreement with the Texas Department of Insurance (TDI) which would allow for additional information to be provided by the TDI to the ERS on HMO financial and compliance matters.*
- *In their bid proposals and applications, the HMOs will be required to confirm that they are in compliance with all applicable TDI requirements. The ERS will request written confirmation from TDI of the HMOs' compliance during the bidding and application reviews. The ERS will ensure that HMO files are properly maintained.*
- *The ERS is unable to comply with this recommendation. The reasons for termination of a provider's contract are considered confidential and proprietary; however, in accordance with the Patient Protection Act, providers cannot be terminated without due process. The 45-day advance notice is not always enforceable, since HMOs and providers may have 30-day agreements; therefore, ERS will consider eliminating this provision from the agreement.*
- *The ERS agrees. The Group Insurance Division will take into consideration expansion of the scope of the HMO audits.*

Section 3:

The System Should Enhance Controls Over Monitoring Compliance With Provisions of the Uniform Group Insurance Act and Determine If the Act's Intent Was Achieved

The System should enhance the effectiveness of controls over monitoring compliance with the provisions of the Texas Employees Uniform Group Insurance Benefits Act, Revised Civil Statutes Insurance Code, Article 3.50-2 (Act). We identified a provision of the Act for which the System used an incorrect computation method as well as another provision with which the System did not comply. Also, the System has no procedures to demonstrate whether one of the stated purposes of the Act has been achieved.

Management has asserted that some noncompliance may have occurred because provisions of the Act, written in 1976, may no longer be compatible with modern insurance benefit management practices. However, if the System had been performing ongoing monitoring of compliance with the Act, such out-of-date provisions could

have been identified and appropriate changes could have been requested during legislative sessions.

Section 3-A:

The System Did Not Fully Comply With All of the Provisions of the Act

We identified compliance issues related to two of the five specific provisions of the Act we tested. Noncompliance was observed for provisions related to computation of the statutory minimum group insurance fund balance reserve and reinsurance coverages. The result of using an incorrect computation method for the group insurance fund reserve was that the System requested of the 75th Legislature an estimated \$30 million more in state funds than needed to achieve the statutory minimum reserve.

For two other provisions, the System could improve communication and coordination with the Texas Department of Insurance to obtain certification of the actuarial soundness of benefit programs and feedback on the System's report of coverages provided and benefits received. (These two issues are discussed in Section 4.) The System complied with required biennial reporting of state contribution levels.

The compliance issues were as follows:

- **The System did not compute the statutory minimum group insurance fund balance reserve as of the end of the current biennium in accordance with the Act.** The Act requires that the projected unrestricted fund balance be at least 10 percent of the benefits estimated to be provided from self-insured programs. However, the System calculated the minimum fund balance as 10 percent of the estimated total expenses to be paid from the fund. Total expenses include premiums paid for insurance coverage, such as HMO plans, which should not have been included in the calculation. The System therefore requested of the 75th Legislature an insurance funding increase approximately \$40 million higher than needed to meet the statutory minimum. Approximately \$30 million of this request was to be funded by the State and the remainder from plan members and investment income.

The insurance actuary recommends maintaining a reserve balance higher than the statutory minimum and the System indicated that the calculation method was consistent with prior biennial calculations. However, presentations to legislative budget writers did not distinguish between the minimum funding increase needed to comply with the Act and the increase needed to maintain a fund balance deemed actuarially sound.

- **The System does not obtain reinsurance for all coverages provided by outside carriers and does not approve the reinsurance carrier for coverage that is reinsured, as required by the Act.** During fiscal year 1997, the System did not require reinsurance of the dental indemnity or term-life coverages. In addition, although the accidental death and dismemberment plan is reinsured and Letters of Agreement require HMOs to obtain reinsurance, the System's governing board has not specifically approved the reinsurers. Management has suggested that these requirements may be out-of-date for the current insurance environment.

Recommendation:

The System should comply with the Texas Employees Uniform Group Insurance Benefits Act. The System should perform a thorough review of the requirements of the Act and their appropriateness to the current insurance environment. If the System identifies requirements that are incompatible with the current environment, no longer provide intended benefits, or are unnecessarily burdensome, the System should propose the necessary changes to the Legislature. If the related requirement remains in the Act, we recommend the following actions:

- **Computation of insurance fund minimum balance** - The System should compute and report the insurance fund's minimum fund balance reserve requirement using only the expected level of self-insured claims. Requests for additional funding from the State based on actuarial considerations should be clearly distinguished from the statutory minimum required.
- **Reinsurance policies** - The System should mandate reinsurance policies for purchased coverages and should approve carriers eligible to provide reinsurance.

Management's Response: [Computation of insurance fund minimum balance]

The ERS disagrees with the State Auditor's interpretation of this provision of the Act. This provision of the statute specifies a minimum fund balance and it enumerates certain contingencies against which the fund is intended to provide protection. The statute does not limit the size of the fund balance through specification of a maximum, does not specify how the ERS should determine the desired level of the fund balance, does not preclude the ERS from considering contingencies other than those listed in establishing such balance, and does not require specific action by the ERS or the Legislature when the fund balance exceeds the required minimum level, however that level may be determined.

The auditor indicates that the Act requires that the projected unrestricted fund balance be at least 10% of the benefits estimated to be provided from "self-insured programs." In fact, the Act does not discuss self-insured programs; instead, it requires maintenance of a minimum unrestricted fund balance of ". . . 10% of the total benefits

expected to be provided directly from the fund . . .” All benefits, insurance and self-insured alike, are paid directly by the fund, either in the form of premiums or benefits.

The UGIP is exposed to significant risk even with fully insured plans (predominantly HMO coverage) due to the biennial budgetary process. ERS is required to project the premiums for such coverage a minimum of six months prior to the beginning of the biennium. At that time there may be preliminary indications as to the premiums for the first year of the biennium, but there are no indications as to what the premiums may be for the second year of the biennium.

There are no sources of funding other than the contributions of the State and the members. Once the State appropriation has been established, the fund is fully at risk for premiums that rise faster or reach higher than expected levels just as it is for unexpected increases in self-funded benefits and expenses. The Act clearly recognizes this risk. Obviously, premiums for fully insured coverages are an important element of “future charges, claims, costs, or expenses of the program.” Accordingly, the contingency reserve must be established in recognition of the amount of such premiums.

The auditor asserts that ERS requested funding in excess of that required to meet the statutory minimum. In fact, the Act provides a directive for funding only in the case in which the unrestricted fund balance is not sufficient to provide the minimum required level of 10% of total benefits. In such case, the ERS is required to include in the contributions the amount necessary to establish such a balance. The Act provides no directive in the case in which the unrestricted fund balance exceeds the minimum. Specifically, it does not require the ERS to set the contributions at a level low enough to reduce the fund balance to some specified level.

In its funding request to the 75th Legislature, ERS requested less than the amount required to cover costs expected to be incurred during the biennium. ERS requested a lesser amount because, in consultation with the Legislature, it was agreed that a portion of the contingency reserve would be used to offset otherwise required funding amounts. Since the Act does not specify conditions under which ERS is required to spend a portion of the contingency reserve, the auditor is incorrect in finding that ERS requested funds in excess of those “needed to comply with the Act.”

ERS plans to work with interim legislative committees to clarify legislative intent of computing minimum level of reserve fund.

State Auditor’s Follow-Up Comment:

We agree with the System’s contention that the Act does not prohibit the fund balance from exceeding the statutory minimum, does not establish a maximum, and does not prevent the System from requesting more than the minimum. At issue, however, is the method to *compute* the minimum projected fund balance allowable.

The sentence quoted in management's response more fully states ". . . 10 percent of the total benefits expected to be provided directly from the fund *as a result of claims incurred during the fiscal year, . . .*" (emphasis added; see Appendix 2 for text of Section 5[g] of the Act and other relevant sections). Our interpretation is based, in part, on the phrase "as a result of claims incurred." Payment of insurance premiums to carriers are not "claims incurred." The word "claims" is related to self-insured programs (see Appendix 2, Section 5[h]). Our interpretation is also based on other language in the Act, which consistently distinguishes between the purchase of insurance and the provision of coverages directly from the insurance fund (see Appendix 2, Sections 5[f], 5[g], 5[h], and 5[j]).

Language mandating the computation of a specific minimum reserve balance in the insurance fund was added to the Act in 1983 by the same legislation (House Bill 1792, 68th Legislature, Regular Session) which initially gave the System permission to self-insure its plans of coverages. Prior to that time, when the System was required to purchase insurance for all coverages, there was no statutory requirement for a reserve. This chronology suggests the need for a reserve balance is limited to self-insurance and is not based on the payment of insurance premiums.

In addition, from a purely economic viewpoint, we believe it makes sense to directly link the size of the required reserve to the amount of risk retained by the System through the use of self-insurance. The System's computation of the minimum would result in the same reserve requirement regardless of whether the System contracted with insurance carriers for all coverages (100 percent risk transfer) or chose to self-insure all coverages (100 percent risk retention).

We concur with the System's plan to obtain legislative input to clarify the intended computation.

Management's Response: [Reinsurance policies]

Article 3.50-2, Section 8 addresses the issue of reinsurance in the UGIP. ERS does not believe that Section 8 has been properly interpreted by the auditor.

In a traditional sense, reinsurance is a term used to describe the insurance which primary insurers secure to protect their solvency against catastrophic losses. ERS believes that Section 8 does not use the term reinsurance to address the issue of solvency for the primary insurer; instead, it addresses the concept of the creation of an insurance pool that would allow more than one insurer to participate in insurance coverages provided to ERS under the UGIP.

ERS' interpretation of Section 8 is supported by the fact that Section 5 of the Act addresses the financial ability of insurers and the actuarial soundness of insurance proposals. Section 5 requires the TDI to determine eligible carriers and certify the actuarial soundness of proposals. Section 5 also specifies that ERS shall select carriers based on, among other criteria, financial ability. Section 5 requires the TDI and ERS, generally, to address the financial ability of primary insurers. It does not

require that specific attention be directed toward reinsurance nor does it require that criteria be established in connection therewith. It is not reasonable to interpret the Act such that (a) ERS and TDI would first qualify carriers and accept proposals based on the conditions established in Section 5 and then, (b) subsequent to awarding a contract, ERS would unilaterally require the contracting carrier to obtain a specified level of reinsurance from reinsurers determined to be eligible to provide such coverage.

The use of reinsurance is a complex internal management decision made by each insurer based on its overall operations, as well as the characteristics of individual risks. It would be impractical and inappropriate to interject ERS into the internal management affairs of each of the carriers with which it does business. Such a requirement would place ERS in a position of second guessing TDI's regulation of insurance carriers. In addition, it would create a level of complexity in the carrier contracting process that would obstruct ERS' ability to exercise its other management duties under the Act.

ERS plans to work with interim legislative committees to clarify legislative intent of reinsurance provision.

State Auditor's Follow-Up Comment:

The System has not provided us with support for their contention that the intent of this provision (see Appendix 2 for text of Section 8 of the Act) was to require anything other than reinsurance "in a traditional sense" as defined in management's response. In addition, we would question the reliance on the Texas Department of Insurance's certification of the actuarial soundness of carrier proposals in lieu of reinsurance for the following reasons:

- The Texas Department of Insurance, in their response to Section 4 (fourth bullet) of this report, indicates that their work is not equivalent to a "full certification of actuarial soundness," but is instead "an actuarial review" of carrier bids. The Texas Department of Insurance indicates that it lacks both adequate information from the System and adequate time as the process is currently functioning to perform a full certification.
- Actuarial soundness may not render the concurrent requirement of reinsurance unreasonable. As noted in management's response, reinsurance protects a carrier's solvency against catastrophic loss. This unpredictable type of loss may not be used in the determination of the actuarial soundness of a carrier's proposal.

We concur with the System's plan to obtain legislative input to clarify the intent of this provision.

Section 3-B:

The System Has No Procedures to Demonstrate Whether One of the Stated Purposes of the Act Has Been Achieved

The System does not collect evidence to compare state-provided life, accident, and health benefit coverages to those provided in private industry. The Act's stated purposes include the expectation that such state-provided benefit coverages be "at least equal to those commonly provided in private industry." As trustee of the insurance benefits programs and administrator of the Act, the System is the logical entity to perform the comparison necessary to determine if this expectation is being achieved.

The System might need some legislative input to determine the criteria for such comparative studies. The Act does not make clear what criteria should be used in making the comparison. For example, a comparison of the average per-employee contributions by employers could not conclude on the equality of specific benefits provided. Likewise, a comparison of the level of benefits provided might also need to consider employee contribution requirements to determine if the State's benefit coverages compared favorably to the private sector's coverages.

Such a comparison was performed in 1986, when the System's group insurance actuary performed a study of the health benefits offered under the Blue Cross/Blue Shield indemnity plan. That study, which is now out-of-date, concluded that the Blue Cross/Blue Shield benefits were comparable to those of private and public industry. It is unclear whether the study also examined life, accident, and HMO health benefits, which would be necessary to determine if the Act's purpose had been achieved.

Recommendation:

The System should begin periodically performing comparative studies to determine whether the State's life, accident, and health benefit coverages compare favorably with those provided by private industry. The System may want to first discuss with legislators the criteria to be used in making that determination. The results of such studies should be made available to the Legislature. If a comparison determines that the State's benefit coverages are less than those of private industry, the System should consider making recommendations on how to enhance the State's coverages.

Management's Response:

Although the ERS agrees that there is no formal procedure to compare coverages, the ERS relies on the expertise of an independent actuarial consulting firm that has many clients in both the public and private sectors. Also, surveys and data collected from membership organizations and national consulting firms are reviewed. It is ERS' position that, overall, UGIP benefits compare quite favorably with the private sector.

However, ERS will review this statutory requirement with the Legislature to determine their intent.

The System Can Enhance Complaint and Compliance Monitoring by Improving Communication and Coordination With the Texas Department of Insurance

The System can improve the effectiveness of some of its monitoring activities by obtaining additional information from the Texas Department of Insurance. Better communication and coordination with the Texas Department of Insurance could help the System obtain useful information about members' insurance complaints, HMOs' financial soundness and regulatory compliance, and insurance programs' actuarial soundness and general reviews. Some of this information is required by the Uniform Group Insurance Benefits Act, which also provides that the Texas Department of Insurance will "cooperate fully" with the System "in carrying out the purposes of the Act."

- **Complaint Information** - Insurance complaints received by one agency are not necessarily communicated to the other. Both agencies have responsibilities for monitoring and helping to resolve complaint information. Sharing this information would help the System obtain a better picture of contractor performance. (This issue is also discussed in Section 1-A.)
- **Information about the Financial Condition of HMOs** - The System does not periodically ask if the Texas Department of Insurance has requested management conferences with HMOs. The Texas Department of Insurance requests these management conferences when concerns exist about an HMO's financial soundness. The System could better ensure HMO contract compliance by obtaining this information from the Texas Department of Insurance. (This issue is also discussed in Section 2.)
- **Exchange of Other Information to Monitor HMOs Applying for System Contracts** - The System could expand and request periodic updates to its annual inquiry to the Texas Department of Insurance to help monitor HMO compliance. The System currently does not request information from the Texas Department of Insurance about the adequacy of HMO reserves. Also, the System does not inquire about the results of the Texas Department of Insurance's on-site audits of HMOs. These audits include evaluations of HMO adherence to statutory grievance processes. We obtained the results of one such audit that identified substantial noncompliance in this area. Quarterly updates of this information from the Texas Department of Insurance would enhance the System's ability to monitor its HMOs.

In addition, the response from the Texas Department of Insurance to the System's inquiry about prospective HMOs omitted answers to a key question. This question inquired about HMOs that might have difficulty providing services. The System did not attempt to follow up on this omitted information. By obtaining the requested response from the Texas Department of Insurance,

the System might be in a better position to closely monitor problem HMOs. (This issue is also discussed in Section 2.)

- **Certification of the Actuarial Soundness of Benefit Programs** - The System did not explicitly request that the Texas Department of Insurance certify the actuarial soundness of carrier bids or self-insured benefit programs. The Act requires that the Texas Department of Insurance “evaluate the bidding contracts and certify their actuarial soundness” to the System for benefit programs insured by outside carriers. The Act also requires that the Texas Department of Insurance certify the actuarial soundness of the rates, or recommend modifications to the programs, for coverages to be provided directly from the insurance fund (that is, self-insured). The System sent the Department of Insurance information about insurance carrier offers it had accepted and approved contribution rates for self-insured benefits.

The System’s actuary is closely involved in contract negotiations and rate-setting. This involvement reduces the risk related to the Texas Department of Insurance not providing the required actuarial certifications. Nevertheless, the Texas Department of Insurance’s review would provide an additional, independent check on the financial soundness of the System’s insurance benefit programs. (This issue is also discussed in Section 3-A.)

- **Feedback on Report of Coverages Provided to, and Benefits Received by, Members** - The System provided the written report to the Texas Department of Insurance as required by the Act but did not explicitly request, and did not receive, feedback from the Texas Department of Insurance. The Act requires the Texas Department of Insurance “to review such report and advise the trustee [the System] in regard to the features of the coverages provided for employees . . .” (This issue is also discussed in Section 3-A.)

Recommendation: (Complaint Information)

The System should coordinate with the Texas Department of Insurance to develop procedures for the timely sharing of insurance-related complaints from System customers.

Employee Retirement System Management’s Response:

The ERS agrees that improvement may be possible in exchanging information on complaints. Currently, TDI forwards all UGIP participant complaints to the ERS. The ERS will explore ways to improve complaint resolution with the TDI.

Texas Department of Insurance Management's Response:

TDI concurs with this recommendation. It is TDI's policy to refer all complaints identifiable as involving ERS coverage to ERS. Some complaints refer only to the carrier or HMO with no indication that the coverage is provided through ERS. Those complaints identified as related to ERS coverage which are received by TDI's consumer protection division have been referred within 48 hours of receipt to ERS. Complaints against HMOs, which are received by TDI's HMO Unit, have not been as consistently forwarded to ERS upon receipt during the past year but are now, effective January 12, 1998. TDI agrees that the two agencies should develop additional procedures for timely sharing of insurance related complaints from system customers. On several occasions, TDI management has offered to establish regular meetings between the agencies' personnel. Such meetings could be useful to share complaint information, assist in resolution of complaints and identify trends which may require regulatory action or be factored into contracting decisions by ERS.

The Commissioner has directed agency staff to notify him promptly of concerns or potential problems that may arise in the future. The Commissioner will then work with the Executive Director of ERS to ensure that effective communication and coordination continues.

Recommendation: (Information about the Financial Condition of HMOs)

The System should expand the annual HMO information request to TDI to add questions concerning: disclosure of any "Management Conferences" TDI requested of HMOs; sufficiency of reserves; and results of recent TDI compliance audits.

Employees Retirement System Management's Response:

The ERS agrees and is interested in improving cooperative efforts of the two agencies to obtain up-to-date information. The ERS will request this additional information from TDI.

Texas Department of Insurance Management's Response:

TDI shares the auditor's objective of providing ERS with comprehensive financial information. To the extent permitted by law, TDI will provide any additional information that will assist ERS in securing coverage through well managed, financially sound carriers and HMOs.

The "management conferences" referred to in the auditors findings are conducted as part of the financial examination process and are confidential proceedings under Article 1.15. Because TDI may request a conference for many reasons, the simple occurrence of a conference is not a reliable indicator of financial problems and knowledge of such conferences would not be particularly helpful to ERS in identifying

companies with solvency or compliance issues. In the response to FINDING 3, TDI staff suggests what we believe to be a more effective way of providing ERS with useful information about companies.

The Commissioner has directed agency staff to notify him promptly of concerns or potential problems that may arise in the future. The Commissioner will then work with the Executive Director of ERS to ensure that effective communication and coordination continues.

Recommendation: (Exchange of Other Information to Monitor HMOs Applying for System Contracts)

The System should negotiate with the Texas Department of Insurance to accept similar information requests periodically throughout the plan year, for example quarterly, to obtain up-to-date information on HMOs' financial or compliance problems observed since the System's last inquiry. In addition, the System should follow up with the Texas Department of Insurance concerning any requested information that was not provided in the Texas Department of Insurance response to ensure that the omitted response was not due to an oversight.

Employee Retirement System Management's Response:

The ERS agrees. However, TDI does have certain statutory restrictions on releasing certain information.

Texas Department of Insurance Management's Response:

TDI will provide current information on contracting carriers.

TDI maintains significant financial information on licensed health insurers and HMOs, much of which is public record. In addition to the specific financial information which ERS requests, TDI staff have offered to provide all public information to ERS and to assist ERS staff in reviewing relevant information. ERS has recently attended the public portion of meetings of the HMO Solvency Surveillance Committee, established under Art. 20A.36 to assist the Commissioner to detect and prevent HMO insolvencies. TDI staff believe that the public information maintained by TDI and discussed in the public portion of the Solvency Surveillance Committee meetings is adequate for ERS or any employer to determine if a company is financially sound and otherwise qualified to contract to provide health coverage. The "audit reports" referred to by the Auditor are examination reports which are confidential under Art. 1.15. In addition, Art. 21.28 §3A addresses the confidentiality of information pertaining to the supervision or conservation status of financially troubled companies. Neither statute recognizes an exception which would apply to ERS as a customer. TDI will share any information which it is permitted by law to share and

will provide technical assistance in interpreting the information. The decision whether to contract with a particular company belongs to ERS.

If ERS desires, however, TDI could assist ERS in making this decision by defining objective criteria for the bid specifications designed to determine financial strength. (For example, to be eligible to bid, an insurer must be at least "B" rated by AM Best and have a net worth of at least \$50 million, etc.) Only entities that meet the criteria would be eligible to bid on an ERS contract. Such assistance would require TDI to be consulted much earlier in the selection process than it currently is.

The Commissioner has directed agency staff to notify him promptly of concerns or potential problems that may arise in the future. The Commissioner will then work with the Executive Director of ERS to ensure that effective communication and coordination continues.

Recommendation: (Certification of the Actuarial Soundness of Benefit Programs)

The System should clearly request that the Texas Department of Insurance certify the actuarial soundness of all carrier bids and of self-insured programs' contribution rates. It may also be necessary to coordinate with the Texas Department of Insurance concerning the timing of the information submitted by the System and the Texas Department of Insurance's subsequent performance of the certifications.

Employee Retirement System Management's Response:

The ERS agrees. However, the current requirement presents logistical problems for both ERS and TDI. ERS plans to work with interim legislative committees to remove this requirement.

Texas Department of Insurance Management's Response:

If ERS does request a full certification of actuarial soundness, it will be necessary for TDI to become involved in the process much earlier than our receipt of ERS' formal request.

The Auditor notes that ERS does not explicitly request that TDI certify the actuarial soundness of the carrier bids. The statute requires such a process; ERS does request that TDI perform an actuarial review of the bids received and TDI does so. As a practical matter, a full certification of "actuarial soundness" would require a determination of whether the rates proposed by the carrier are sufficient to cover the benefits and other expenses. TDI actuaries do not ordinarily perform this kind of analysis for health benefit plans. In reviewing the ERS bids, TDI actuaries rely to a large extent on the work of the ERS actuary, which has appeared to be competent and reasonable. A more thorough review would require more information than has been provided by ERS in the past and more time than the 15 days from the date received

currently allowed in Article 3.50-2. TDI actuaries would need to review at least all of the information provided to the ERS actuary including prior system experience and benefits to be provided and the actuarial analysis, assumptions, and data used by the bidder to derive its rates. In addition, the TDI actuary would need to consult with the ERS actuary. Because the statute allows only 15 days for TDI's review, this agency does not believe that the statute contemplates a full actuarial certification by TDI in addition to the actuarial work performed by ERS.

The above discussion [concerning full certification of "actuarial soundness"] would also apply to the self-insured benefit programs as the statute allows only 15 days for TDI's review of the actuarial soundness of proposed contribution rates.

The Commissioner has directed agency staff to notify him promptly of concerns or potential problems that may arise in the future. The Commissioner will then work with the Executive Director of ERS to ensure that effective communication and coordination continues.

Recommendation: (Feedback on Report of Coverages Provided to, and Benefits Received by, Members)

The System should request that the Texas Department of Insurance provide, in a form and timeframe acceptable to both agencies, the required feedback to the System's report on coverages and benefits. The request could be included in the transmittal letter accompanying the report.

Employee Retirement System Management's Response:

The ERS agrees and will include in its transmittal letter, accompanying the annual report, a request for TDI's feedback on the coverages and benefits.

Texas Department of Insurance Management's Response:

ERS has provided the annual report as required by Art. 3.50-2 §7 but did not request a response, nor does a response seem useful since the report merely reflects what has already happened. TDI agrees with the Auditor's findings that TDI provide coverage recommendations and believes it would best serve state employees and fulfill the intent of the legislature to have an opportunity, as set forth in Art. 3.50-2§5, to offer feedback on the trustee's proposed coverage decisions and make recommendations before the trustee puts the coverages out for bid. TDI's input could assist ERS both in determining what kinds of coverages should be sought and how to secure financially sound bidders. TDI will make every effort to "cooperate fully with the trustee in carrying out the purposes of the Act", believes that it has consistently done so and welcomes any Auditors' recommendation to make TDI's cooperation more effective.

The Commissioner has directed agency staff to notify him promptly of concerns or potential problems that may arise in the future. The Commissioner will then work with the Executive Director of ERS to ensure that effective communication and coordination continues.

Section 5:

Controls Related to Automation Could Be Enhanced

The System has controls in place addressing the design and implementation of major automated systems. This includes adequately planning for potential programming problems that could occur with the advent of the date January 1, 2000 (Year 2000). However, additional control procedures could help ensure effectiveness and efficiency. Committees established to address automation strategies and project implementation have not been designed to ensure sufficient communication of information needed by internal departments dependent on automation. In addition, the System does not perform a documented needs analysis process prior to hardware and software purchases, and the Information Systems Division does not monitor total costs for development of major automated systems.

Communication problems have contributed to dissatisfaction among the System's departments involved in major automated system changes. Also, current procedures do not ensure that the System has the information needed to make the best automation acquisition decisions and assess how cost-effectively it implements major automation projects.

The System relies heavily on automation in its administration of a variety of benefit programs, each with complex rules, covering a substantial number of state employees and their dependents. Since 1990, the System has been implementing a massive project to redesign its automated systems for these benefit programs in order to administer the benefits more effectively and efficiently. Strong management controls over automated systems help the System achieve the desired outcome from these efforts.

Section 5-A:

Processes Related to Communication of Automation Information Should Be Improved

A lack of effective communication channels throughout the System concerning automation issues has increased the frustration level within the benefit program areas which depend extensively on automation. Staff members within each benefit program, or automation "user" area, have voiced frustration to us concerning the lack of current and relevant information. Although many staff members report that some improvement has occurred in the past year, communication processes could be further improved in the following areas:

- Members of the Executive Management Team develop and prioritize automation strategies for the System. This team is composed of the highest levels of management and Information Systems Division representatives. However, such committee members will typically lack a detailed knowledge of all user-area activities. As a result, the committee may not adequately assess the impact on user areas of proposed automation changes.

As decisions are made, committee participants are responsible for communicating the information to their respective user areas. However, user-area staff members have indicated to us that they frequently have not received sufficiently detailed information.

- Automation project steering committees do not include representatives from each user area that may be affected by the automation changes. The only project steering committee we identified did not meet consistently and consisted of high-level, non-technical staff representing only a few benefit program areas.

The System eventually formed more technical “module-level” committees for individual portions of the larger project. Staff members working on other modules of the project were not always kept informed of progress made by the module-level committees and therefore were often unaware of issues affecting their module(s).

For example, a new automated software module scheduled for full implementation in a few days, was apparently delayed for more than a year, at least in part to resolve any potential impact on another affected area. The potentially affected user area was able to stop implementation only because its staff members inadvertently learned of the plan. Although weekly meetings concerning this plan had been occurring at the deputy director level, the plan was not communicated to other user areas because it was believed that other user areas were to be unaffected.

- Although the System adequately allocates its current automation resources to accomplish System-wide priorities, the user areas are not always promptly informed of changes to these priorities and of the accompanying changes in programmer assignments. Personnel from several different user areas reported instances of not knowing that a programmer was no longer assigned to their area until requesting assistance or program changes.

A change in priorities for programmers often results in requests not being ready when promised. The lack of timely communication may mean user personnel are unable to meet deadlines.

Recommendation:

Although precise reasons for automation user frustration are difficult to pinpoint, we believe the System could improve both the structure and consistency of its processes to communicate important automation information.

- We recommend that the System expand the staffing of the Executive Management Team to include participants from the benefit program areas who possess more detailed knowledge of those program areas. These additional participants could then help ensure that the effects of automation decisions on user areas are fully identified and effectively communicated.
- We recommend that the System formalize overall project steering committees. These committees should include technical personnel from all benefit program areas who may be affected by the project. The committee participants could then ensure that decisions impacting their program areas are communicated in a timely manner.
- We recommend that the Information Systems Division become more customer service oriented and strive to maintain better communication with automation users. While we realize Information Services Division staff members are extremely busy with current projects and meeting deadlines, they should make a more concerted effort to inform user areas of changes in status, assignments, and priorities in a timely fashion.

Management's Response:

General Comments Regarding Section 5:

Communications and Customer Service - ERS agrees that communication can be improved. During the time of this review, the ERS was in the process of implementing a large number of critical projects, including those resulting from legislation, which could have adversely impacted communication.

Processes Related to Communication of Automation Information Should be Improved (Section 5-A):

- *ERS agrees. ERS will ensure that appropriate staff are participating. The current approach, and one that has been used over the past several projects, not only includes the Executive Management Team, made up of the Deputy Directors as well as the Executive Director and Deputy Executive Director, but also the directors and representatives from the divisions that will be directly impacted by the decisions. The determination of project or issue importance is decided within the context of overall agency priorities, and will be communicated in a timely manner.*

- *ERS agrees. Each component of the PeopleSoft implementation is planned to use project management committees.*
- *ERS agrees. ERS is committed to enhanced customer service and better communications. Information Systems meets with each user division on a regular basis. The coordination and communication of issues related to a specific project or specific problems are discussed and addressed during these meetings. The divisions that are in the midst of a high impact time critical project or problems are met with more frequently. The attendees are generally the IS manager in charge of the project with the support staff and the user division functional/technical liaison with user area staff directly affected by the current issues or the overall project. The ERS plans increased involvement in coordination and planning by the Executive Management Team, the involved user divisions, and IS. This effort is expected to have a positive impact on the projects.*

Section 5-B:

Existing Automation Planning and Monitoring Controls Could Be Strengthened

Despite some delays encountered in implementing individual modules of the Integrated Employee Benefits System (IEBS) software, the System has been generally effective in implementing new computer programs. In 1990, the System began contracting for outside services to help it integrate the computer programs used by the various benefit program areas. The System has successfully used a system design methodology to develop this project. However, several weaknesses in automation planning and monitoring activities were noted, including the following:

- A documented needs analysis is not always performed prior to the procurement of computer hardware and software. A needs analysis should include:
 - A formal request from users who desire the hardware/software
 - An analysis of all automated information requirements
 - A thorough review of the present system to evaluate existing capabilities and deficiencies and determine if a change is really necessary
 - An identification of the new system's impact on other automated systems
 - A review of alternative courses of action
 - An identification of all costs and benefits of a change
 - A justification for the selected alternative

Instead of a formal needs analysis, the Information Services Division typically discusses requests for hardware and software with the requesting user departments and makes a final decision. Approved requests are included in the Information Services Division's annual operating budget.

For example, the System recently decided to use a vendor's software for several functions, including the final module of the IEBS project. Only two

potential vendors' software packages had been reviewed, and one of those packages was not evaluated for some of the uses now contemplated for the new package. Instead of relying on a formal, documented needs analysis, the various user areas were asked to determine if the proposed software could meet their needs. As a result, the System risks the possibility that the selected software may not address all required needs, may not address those needs as well as other software, or may not be the most cost effective package available.

- Information Services Division management has not maintained detailed total costs, which it roughly estimated at \$30 million through September 1997, for each phase of the IEBS project. Although the System does maintain costs for contracted services, costs for internal programming and training have not been maintained.

Recommendation:

To further strengthen controls over planning and monitoring automation activities, we recommend the following actions:

- The System should perform and document a formal needs analysis prior to the selection and procurement of major hardware and software systems. This analysis should include a detailed assessment of the current equipment or computer programs, the identification of need, the identification of available alternatives and their costs, and justification for the final decision.
- The Information Services Division should track and report all costs for major systems development. This would enable the System to monitor whether or not projects accomplish their primary objectives within a reasonable cost.

Management's Response:

Due to the lengthy timeframes and large sums of money required to implement custom-developed mainframe computer systems, the ERS has chosen to purchase uniform client-server based application software. The object-oriented and table-driven nature of these products will greatly reduce the time and cost of computing at the ERS, improve customer service, and enable the ERS to respond more readily to change. The ERS will endeavor to critically analyze older business processes and workflow for modern relevance and reengineer operations as appropriate. An Executive Management Team will oversee all aspects of the project and heavy user division involvement will occur. Modern software packages provide powerful tools to enable users to define their own processing rules, edits, screens, reports and workflow. The ERS will also continue to participate in statewide efforts to utilize common technology for common functions, such as accounting, payroll, human resources and benefit processing. It is the intent of the ERS to reengineer business, not software. It is also our intent to leverage both trust fund and taxpayer dollars to integrate statewide systems on common technology platforms.

- *ERS agrees that a documented needs analysis should be performed where appropriate. The referenced example of not relying on a formal needs analysis for selection and purchase of a specific software package was a unique situation. The overall requirement stemmed from the final phase of a current project and the addressing of Year 2000 compliance issues. The selection of this software package was based on the direction and support of the statewide projects including Uniform Statewide Payroll System (USPS) and Uniform Statewide Accounting System/Integrated Statewide Administrative System (USAS/ISAS). The Comptroller of Public Accounts was involved with several large agencies in the bid, evaluation and awarding process in support of this, a similar statewide endeavor. The ERS accepted the decision of this committee and executed the agreement in support of the Comptroller's contract, knowing that the products are extremely flexible.*
- *ERS agrees. IS does track personnel and contractor costs associated with major systems development; however, the process needs to become more formalized. The effect of the staff allocation, whether development, support, or maintenance is used in the determination of strategies associated with the budget process for the following budget cycle. The project team for the next group of large software projects has been directed to systematically track all project costs.*

Section 6:

Controls Over Investment Practices Have Improved But Additional Improvements Are Still Possible

Section 6-A:

The System Has Made Significant Progress in Implementing Most Investment Practices Recommendations

The System has made significant progress in implementing recommendations from our 1996 report, *A Review of Controls Over Investment Practices at Six Major State Investing Entities* (SAO Report No. 97-014, November 1996). Most recommendations have been implemented, partially implemented, or implementation is currently in progress. We also identified differences between our status assessments and those reported by the System's Internal Audit Department in an August 1997 report to the Audit Committee. The status of recommendations from the System's section of our prior report on investment controls is presented in Table 1 on the next page.

Table 1

Implementation Status of Prior Recommendations (ERS Section of Report) <i>Review of Controls Over Investment Practices at Six Major State Investing Entities</i> SAO Report No. 97-014, November 1996		
Summary of Findings and Recommendations	Summary of Management's Actions	Auditor's Assessed Status ¹
Section 1-A: Investment Compliance Monitoring Reports		
<ul style="list-style-type: none"> Ensure that investment policy compliance monitoring is performed in a timely manner. 	<ul style="list-style-type: none"> Some reports were timely, but a report due June 30, 1997, was not completed as of mid-September 1997. 	NI
<ul style="list-style-type: none"> Obtain or develop compliance monitoring software. 	<ul style="list-style-type: none"> Software was obtained, but problems existed in implementation. 	IP
<ul style="list-style-type: none"> Ensure that omitted information on automated reports is manually recorded. 	<ul style="list-style-type: none"> A report for the quarter ended February 28, 1997, had one automated item omitted that was not manually recorded. 	NI
Section 1-B: Securities Lending		
<ul style="list-style-type: none"> Modify contract to prohibit loans to affiliates and restrict loans of mortgage-backed "pass-throughs" and "CMOs." 	<ul style="list-style-type: none"> The contract was modified as recommended; loans of CMOs were not restricted. 	PI
<ul style="list-style-type: none"> Report to the governing board program performance measures in addition to income and include trend information. 	<ul style="list-style-type: none"> The expanded report is to include prior year estimated and actual income; other relevant performance measures were not developed. 	PI
¹ Definitions of "Auditor's Assessed Status" abbreviations are as follows: I - Implemented NI - Not Implemented IP - In Process PI - Partially Implemented DNA - Did Not Agree		

Table 1 (concluded)

Implementation Status of Prior Recommendations (ERS Section of Report) <i>Review of Controls Over Investment Practices at Six Major State Investing Entities</i> SAO Report No. 97-014, November 1996		
Summary of Findings and Recommendations	Summary of Management's Actions	Auditor's Assessed Status ¹
Section 2: Board Oversight of Investment-Related Activities		
<ul style="list-style-type: none"> Commit to periodic (at least annual) reviews of investment policies. Enhance investment training of governing board members by evaluating needs and identifying and making available additional training. Attempt to coordinate investment training programs with those of other large investing entities. Improve the presentation of brokerage commission reports. 	<ul style="list-style-type: none"> The investment policy was changed to require annual reviews; the first full review is scheduled. Governing board members were surveyed to identify needs; members were notified of external training opportunities; several members have already attended. The Executive Director has had discussions with the Teacher Retirement System about possible coordination. Reports now show basis points and cents per share. 	<p>I</p> <p>I</p> <p>IP</p> <p>I</p>
Section 3: Procedures to Ensure Independence		
<ul style="list-style-type: none"> Board and Investment Advisory Committee members should receive and agree to Standards of Professional Conduct established by the Association for Investment Management and Research. Board members should file financial disclosure statements for review by System personnel. Investment staff members should obtain pre-approval for personal trades in securities also owned by the System. 	<ul style="list-style-type: none"> Standards have been distributed and affirmations have been received. The System did not agree to implement this recommendation; the governing board is not involved in day-to-day investment activities. The pre-approval process has been implemented, although formal written procedures and forms are not yet developed. 	<p>I</p> <p>DNA - (comment not repeated)</p> <p>I - (subject to documenting procedures)</p>
Section 4: Investment Employee Performance Evaluation Process		
<ul style="list-style-type: none"> Evaluation criteria should, where practical, include quantitative assessments of investment skills and achievement of specific goals. 	<ul style="list-style-type: none"> Awaiting approval of new evaluation form, which allows customization; no quantitative evaluation measures are yet developed. 	<p>NI - (by itself, new form will not result in implementation)</p>
¹ Definitions of "Auditor's Assessed Status" abbreviations are as follows: I - Implemented NI - Not Implemented IP - In Process PI - Partially Implemented DNA - Did Not Agree		

An August 1997 System internal audit status report to the governing board indicated several recommendations as implemented that are noted above as partially implemented, in process, or not implemented. The inconsistency of status evaluation generally involved investment compliance monitoring and securities lending activities, and was due primarily to the following:

- The System's internal audit follow-up procedures were limited to inquiries of other System personnel. Internal audit procedures did not include obtaining independent evidence to verify the representations of those personnel. Performance of such additional procedures may have allowed us to place reliance on the Internal Audit Division's work and avoid duplication of effort.
- Investment Division management might not have agreed with all parts of each recommendation but did not express that disagreement in the written responses to our prior report. This might also account for management's consideration that a recommendation was implemented while we judged it only partially implemented.

Recommendation:

- In general, we recommend that the System continue its progress on those recommendations not yet fully implemented. The governing board should be made aware of those portions of the recommendations the System chooses not to implement.
- In addition, we recommend that the Internal Audit Division enhance its procedures to follow up on prior State Auditor's Office audit recommendations. Follow-up procedures should extend beyond inquiries of System personnel and should include collection of audit evidence, such as observation of physical documents.

Management's Response:

- Section 1-A: Investment Compliance Monitoring Reports

Timeliness of Compliance Reports: The timeliness of the June 30, 1997 compliance report was impacted by the large number of division vacancies which was complicated by the transition of three portfolios at that time. In order to compensate for this, responsibilities were prioritized. Compliance is an important issue which is continuously monitored; however, the reports themselves were given a low priority. They are an after-the-fact recounting of what has been a non-issue, i.e. the reports have never shown the agency to be significantly out of compliance. Compliance reports normally are due thirty days after the end of the quarter and all reports, with the exception of the June 30th report, have been prepared on time.

Compliance Software: ERS has purchased compliance software from PORTIA. We have had difficulty implementing the software due to the length of time it takes to run the program. This is due to the types of restrictions for which we need to monitor. Our restrictions are holdings-based so the program must constantly search across all the Fund's holdings for violations. We are continuing to work with PORTIA to get the software's deficiencies corrected.

Manual Addition of Omissions: Investments has two staff members who manually check for omissions. The omission noted in the Draft Report was the result of human error. Unfortunately, a manual system is prone to human error. However, it has recently come to our attention that PORTIA has a module which can require all mandatory fields to be populated for input to be accepted. This module should be activated by the end of January and should further reduce the number of omissions that need to be manually checked. Additionally, we have implemented a sign-off procedure indicating who has performed the manual review.

Section 1-B: Securities Lending

Strengthen Securities Lending Contract: ERS agrees and has requested that our contract with Chase be modified to reflect a prohibition on loans of CMO's in addition to the restriction on loans of mortgage-backed pass throughs.

Securities Lending Reporting to Board: The original November 1996 management audit report recommended that "Board oversight of the program should be strengthened by requiring that management submit periodic reports of relevant securities lending results, including comparison to prior periods." To meet this recommendation, page 3 of the Fiscal Year 1997 Investment Summary shows Securities Lending Income for the current and prior fiscal years. We agree that other performance measures could be helpful in evaluating the Securities Lending Program and will be included in the next Investment Summary.

Section 4: Investment Employee Performance Evaluation

ERS agrees that employee evaluations can be improved and that in certain instances evaluation can be quantitatively measured. In particular, we believe that divisional and professional goals should be set at the beginning of each employee's performance period. Thus, employee performance at the end of the period can be judged more objectively. The new CIO should make this a top human resource priority and should begin setting employee goals as each staff member comes up for their next annual performance review.

Internal Audit Procedures

ERS' Internal Auditor agrees. The Internal Auditor will ensure that follow-up procedures will include collection of audit evidence, such as observation of physical documents.

Section 6-B:

The System Should Still Seek an Attorney General's Opinion to Clarify Investment Delegation Authority

(Prior Recommendation)

The System should request an Attorney General's Opinion to clarify the limits on delegating System investment authority to external investment managers. The System apparently sees no need for the recommended Attorney General's Opinion based on current operations. However, clarifying constitutional limits on delegation could be useful information. It would enable the System to quickly respond to its changing investment management needs and opportunities. For example, the System could make a more timely decision if the current level of post-transaction review and the approval of external managers' transactions were deemed inefficient uses of System resources.

Table 2 summarizes the status of this recommendation from our prior report on investment controls:

Table 2

Implementation Status of Recommendations (Crosscutting Section of Report) <i>Review of Controls Over Investment Practices at Six Major State Investing Entities</i> SAO Report No. 97-014, November 1996		
Summary of Findings and Recommendations	Summary of Management's Actions	Auditor's Assessed Status ¹
Section 4: Crosscutting - Attorney General's Opinion to Clarify Employees Retirement System and Teacher Retirement System Investment Delegation Authority		
Both agencies should request an Attorney General's Opinion to determine if they may delegate investment authority, if discretionary investment authority may be delegated to external managers, and if securities lending represents an unconstitutional delegation.	An Attorney General's Opinion was not requested; the System has begun to permit external fixed income managers to initiate and execute trades within predefined parameters (subject to subsequent approval by the System or reversal).	NI - (Repeat recommendation)
¹ Definition of "Auditor's Assessed Status" abbreviation: NI - Not Implemented		

Recommendation:

We again recommend that the System request an Attorney General's Opinion clarifying allowable constitutional limits on delegation of investment functions to external investment managers.

Management's Response:

ERS has not requested an Attorney General's opinion to clarify delegation of investment authority. ERS does not believe that current investment policies or procedures constitute a delegation of investment authority.

Objectives, Scope, and Methodology

Objectives

Our audit objectives were to evaluate the management control systems at the Employees Retirement System (System) and to identify strengths and opportunities for improvement. We evaluated whether the control systems provide reasonable assurance that the System's goals and objectives will be accomplished. The audit evaluated control systems in place during the second half of fiscal year 1997.

Management controls are policies, procedures, and processes used to carry out an organization's objectives. They should provide reasonable assurance that:

- Goals are met.
- Assets are safeguarded and efficiently used.
- Reliable data is reported.
- Laws and regulations are complied with.

Management controls, no matter how well designed and implemented, can only provide reasonable assurance that objectives will be achieved. Breakdowns can occur because of human failure, circumvention of control by collusion, and the ability of management to override control systems.

Scope

The scope of this audit included consideration of the System's overall management control systems: control environment and risk assessment, policy management, performance management, information management, and resource management.

Consideration of the System's control environment and risk assessment systems included a review of:

- Processes used to ensure management's integrity and ethical values
- Processes used to perform internal and external risk assessment
- Management's philosophy and operating style
- Processes used to manage change
- Processes used to ensure compliance with laws and regulations

Consideration of the System's policy management systems included a review of:

- Processes used to create, monitor, and evaluate the System's strategic plan
- Processes used to create, monitor, and revise System budgets
- Processes used to create and communicate System policies and procedures
- Processes used to classify, develop, and evaluate System employees

Consideration of the System's performance management systems included a review of:

- Processes used to monitor customer satisfaction, including processes used to identify, track, and resolve customer complaints and processes used to develop and conduct customer satisfaction surveys
- Processes used develop and track other System performance measures

Consideration of the System's information management systems included a review of:

- Processes used to select, collect, and report information
- Processes used to develop, maintain, and protect computer systems

Consideration of the System's resource management systems included a review of:

- Processes used to monitor HMO vendors' performance
- Actions by management to implement prior State Auditor's Office recommendations for improving controls over investment practices

A review of each of the control areas revealed some specific issues that were examined further.

Methodology

The audit methodology consisted of gaining an understanding of each control system. In select areas, for which specific risk or other issues were identified, tests were then performed to determine if the control systems were operating as described. Finally, the results were evaluated against established criteria to determine the adequacy of the system and to identify opportunities for improvement.

An understanding of the control systems was gained through interviews with System management and staff and through reviews of various System documents. Control systems were tested by comparing the described and actual processes primarily through interviews, observation, and review of System and third-party documents.

The following criteria were used to evaluate the control systems:

- Statutory requirements
- System policies and procedures
- General and specific criteria developed by the State Auditor's Office Inventory of Accountability Systems project
- Other standards and criteria developed through secondary research sources, both prior to and during fieldwork

Fieldwork was conducted from April 1997 through October 1997. The audit was conducted in accordance with applicable professional standards, including:

- Generally Accepted Government Auditing Standards
- Generally Accepted Auditing Standards

The following members of the State Auditor's staff performed the audit work:

- Roger Ferris, CPA (Project Manager)
- Thomas Cone
- Rena Dietrich
- Patricia Perry-Williams, CISA
- Worth S. Ferguson, CPA (Quality Control Reviewer)
- Carol Smith, CPA (Audit Manager)
- Craig Kinton, CPA (Audit Director)

Text of Selected Sections of the Texas Employees Uniform Group Insurance Benefits Act

This appendix contains text of selected sections of the Texas Employees Uniform Group Insurance Benefits Act (Insurance Code, Art. 3.50-2) in effect during fiscal year 1997. Emphasis has been added using italics to highlight some of the specific issues discussed in Section 3-A of this report.

§5. Authority to Establish Group Coverages

Section 5(f): The trustee, in its sole discretion and in accordance with the requirements of this section, shall determine those *plans of coverages for which the trustee does not intend to purchase insurance and which it intends to provide directly from the Employees Life, Accident, and Health Insurance and Benefits Fund*. Any plan of coverages for which the trustee does not purchase insurance but provides under this Act on a self-funded basis is exempt from any other insurance law unless the law expressly applies to this plan or this Act. The trustee shall make an estimate of the unrestricted balance of the fund. Unless such estimated unrestricted balance is equal to at least 10 percent of the *total benefits expected to be provided directly from the fund as a result of claims incurred* during the fiscal year, the trustee shall include in the contributions required the amount necessary to establish an unrestricted balance in the fund of not less than 10 percent. The unrestricted balance shall be placed in a contingency reserve fund to provide for adverse fluctuations in future charges, claims, costs, or expenses of the program.

Section 5(g): The trustee shall determine the *contributions required to provide coverages directly from the fund* and shall submit this information together with supporting documentation to the State Board of Insurance for examination and evaluation. Within 15 days of the receipt of such information, the State Board of Insurance shall certify the actuarial soundness of the proposed level of contributions or shall advise the trustees of any modifications prerequisite to provision of such certification.

Section 5(h): *In the event the trustee determines that benefits shall be provided from the Employees Life, Accident, and Health Insurance and Benefits Fund*, the trustee may contract with a qualified and experienced administering firm on a competitive bid basis to administer the *claims arising from the coverages* provided in Section 5 of the Act.

Section 5(j): The trustee may not *contract for a plan of group coverage or with a health maintenance organization or provide coverage directly from the fund* that:

- (1) excludes or limits coverage or services for . . . ; or
- (2) provides coverage for serious mental illness that is less extensive than . . .

§8. Reinsurance

Section 8(a): The trustee shall arrange with any carrier or carriers issuing any policy or policies under this Act for the reinsurance, under conditions approved by the trustee, of portions of the total amount of insurance under such policy or policies, with other qualified carriers which elect to participate in the reinsurance.

Section 8(b): The trustee shall determine for and in advance of a policy year which qualified carriers are eligible to participate as reinsurers and the amount of insurance under a policy or policies which is to be allocated to the issuing company and reinsurers. The trustee shall make this determination when a participating company withdraws.