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Correspondence Memorandum

Date: June 8, 2016

To: Audit Committee Members

From: Yikchau Sze, Director
Office of Internal Audit

Subject: Full File Compare Audit

This report is for Audit Committee review and discussion. No action is required.

Attached is the Full File Compare (FFC) audit report. The results of this audit have been submitted and discussed with the Office of the Secretary, Department of Employee Trust Funds (ETF).

This audit was conducted in accordance with the biennial Audit Plan for 2015-2017.

The FFC process is a monthly, automated process that compares ETF's health insurance database to health plan databases. Discrepancies are recorded in the FFC Exception Report. ETF and the health plans are contractually responsible for both reconciling discrepancies and updating their databases.

The primary focus of this audit is to evaluate the effectiveness and timeliness of the FFC process and to determine potential financial impacts if the process is not working as designed.

Based on the audit performed, the Office of Internal Audit (OIA) concludes the current FFC process is followed by neither the majority of health plans nor ETF to resolve exceptions generated by the process. More than one-third of exceptions were caused by data that are either not required or cannot be captured by ETF's health insurance system.

The OIA concludes that the major impacts of the process breakdown 1) will affect administrative efforts to reconcile the accumulated exceptions and 2) may cause service delays for health insurance subscribers. The financial impact to the group health insurance program is minimal.

Reviewed and approved by Robert J. Conlin, Secretary

Electronically Signed 6/10/16

Board	Mtg Date	Item #
AUD	6.23.16	3A

To improve the efficiency and effectiveness of the FFC process, we encourage management to review the design of the FFC process to ensure that only pertinent information is compared.

Following the possible redesign of the process, we recommend management implement appropriate oversight and accountability internally and communicate with the health plans for a synchronized approach to resolve FFC exceptions in a timely manner.

This audit was conducted by Jackie Van Marter, Auditor–Advanced, who will be available at the Audit Committee meeting to answer any questions.

Attachment: FFC audit report

Office of Internal Audit

Full File Compare Process

May 31, 2016

Prepared for Audit Committee meeting of the Employee Trust Funds Board, 6.23.2016

Objective:

The audit objectives were to evaluate the effectiveness and timeliness of the Full File Compare (FFC) process and determine potential financial effects if the process is not working as designed.

Scope:

The audit scope focused on the FFC monthly process for calendar year 2015.

Background:

Program: The State of Wisconsin Group Health Insurance Program is an employer-sponsored program offering group health insurance coverage for active and retired employees of both state and local government employers. This program is authorized under Wis. Stat. § 40 and administered by the Department of Employee Trust Funds (ETF), under the direction of the Group Insurance Board. In 2015, ETF conducted business with 18 health insurance plans providing coverage to approximately 252,000 individuals statewide. The total amount of annual health insurance premiums was $1.525 billion (2014).

As program administrator, ETF acts as the intermediary between the employer and the participating health plans, handling member enrollment, generating monthly health insurance invoices to employers and making monthly premium payments to the health plans. Because of ETF's role with direct enrollment, the health insurance database maintained by the Department is the authoritative record.

Business Objective of the FFC process: The business objective is to validate that participating **health plan records** for each group health insurance program subscriber and dependent parallels (mirrors) **ETF's records**. This ensures that the correct premium amounts are paid for the correct coverage level with the correct carrier. In addition, the FFC process ensures subscribers are enrolled correctly in the benefits they elected.

FFC Process: The FFC process is a monthly, automated comparison of ETF's health insurance database to participating health plan databases. Discrepancies are recorded in the FFC Exception Report. Both ETF and the health plans are contractually responsible for reconciling discrepancies and updating their databases.

On a daily basis, information about new and changed health insurance contracts and covered individuals is extracted from ETF's health insurance database and made available to the health plans on ETF's secure file transfer protocol (sFTP) server.

Specifically, ETF generates a daily maintenance compare file for each health plan that had a contract change that day. The information contained in these files includes subscriber name and Social Security number, plan network information, subscriber eligibility and/or benefit information, and product and/or service identification.

These daily updates keep the health plan current with changes of contract information. Without these updates, the changes would be identified as exceptions and become reconciling items.

Health plan access to the sFTP server is verified by user ID and password. The user ID and password were approved by ETF's Employee Services Section (ESS) and set up by the Bureau of Information Technology (BITS).

The monthly FFC process involves each health plan extracting 100% of its active membership database, converting it to a secure file format and placing the file on the sFTP server. When the FFC files are transmitted to the sFTP server, an ETF automated batch process authenticates, translates, formats and validates the data to ensure it is compliant with the Health Insurance Portability and Accountability Act (HIPAA).

Note: HIPAA compliance is not within the scope of this audit.

After files are authenticated, the FFC process is executed by BITS. This process compares all data captured in ETF's health insurance database to the data in the health plans' FFC files. Discrepancies between ETF's records and that of the health plans are generated automatically and captured in the FFC Exception report. This exception report is placed on ETF's sFTP server for the health plans to retrieve. It is the health plans' responsibility to conduct the initial research into the causes of these discrepancies.

Upon completion of its review, the health plan sends ESS the complete file for evaluation and to make updates to its health insurance database, based on the responses received from ESS. ESS may need to update ETF's health insurance database if the corrections suggested by the health plans are proved to be correct.

The FCC roles and responsibilities chart is included in the appendix for reference.

<u>Organizational Change:</u>
The FFC function was the responsibility of the Insurance Administration Bureau (IAB) within the Division of Insurance Services (DIS) until January 1, 2015, when an organizational restructuring was initiated by the Secretary's Office. This restructuring consolidated IAB into ESS, an operations unit within the Division of Retirement

Services. This change was initiated to better align business operations and improve management oversight.

Conclusion:

The current FFC process is not diligently followed by either the health plans or ETF to resolve exceptions generated by the process. More than one-third of exceptions were caused by data that is either not required or cannot be captured by the current health insurance system of ETF (which is called MEBS, short for myETF Benefit Systems). To improve the efficiency and effectiveness of the FFC process, we encourage management to review the design of the FFC process to ensure that only pertinent information is compared.

Based on the testing results, OIA concludes that the major impacts of the process breakdown 1) will affect administrative efforts to reconcile the accumulated exceptions, and 2) may cause service delays for health insurance subscribers. The financial impact to the group health insurance program is minimal.

Findings, Recommendations and Management Responses:

1. **Exceptions generated by the FFC process were not resolved in a timely manner.**

   In 2015, Security Health Plan was the only health plan that submitted a FFC **exception reconciliation report** each month. Of the 12 reports submitted, ESS reviewed 2. Of the 206 exception reports generated by the FFC process in 2015, health plans reconciled 28 (14%) and ESS evaluated five (18% of the 28).
   The audit revealed that the reconciliation of exception reports had been declining for a number of years, which could be attributed to the following factors:

   - Lack of management oversight: Prior to the reorganization consolidating the employer services functions into ESS, the responsibility for the FFC function resided primarily with one individual whose work was rarely reviewed by the supervisor.
   - Turnover and lack of knowledge transfer: Turnover at both the supervisor level and staff level, coupled with limited procedures and business knowledge documentation, has made transition of the FCC responsibility to new staff assigned to the role difficult.
   - Repeated exceptions generated by the process, despite the reconciliation efforts (for details, see Finding No. 2)

- File naming convention was not observed by health plans. Some health plans failed to follow established file naming conventions. As a result, some reconciliation files returned by health plans were not recognized and retrieved timely by the ESS staff, while others remained on the sFTP server.

  Recommendations:
  - Improve management oversight by establishing accountability and monitoring results
  - Create detailed procedures and a work manual to alleviate the impact of staff turnover
  - Define and standardize communication protocols with health plans

  Management Responses:
  The Division of Retirement Services management agrees with the recommendation. DRS will:
  - Obtain Full File Compare contacts for each health plan from ETF's Office of Strategic Health Policy.
  - Provide training for the health plan contacts regarding the contractual requirement that each plan shall submit files to ETF and make corrections when necessary.
    - The training will include instructions on how to securely submit files to ETF and what data to include in the file.
  - Make the training material, instructions and procedures available to the health plan contacts.
  - Create a standard monthly email reminder for each health plan contact.
  - Develop a staggered schedule for when health plans should submit their data, which should help spread out the work more evenly for ETF.

  The Full File Compare process was moved to DRS in 2015. It was previously in ETF's Division of Insurance Services. The individuals who previously worked on the FFC are no longer with ETF. Since the previous employees did not develop procedures for the Full File Compare process, there has been a significant loss of institutional knowledge and a learning curve for the new contractors and limited-term employees (LTEs) who have been assigned this task by DRS management. DRS management intends to attempt to implement the recommendations in the audit with the LTEs who have been hired for this task. DRS management will monitor the progress to determine how many employees and what skills are needed to effectively carry out this task and develop documentation. Based on our review, DRS management will submit a request to the Secretary's Office for more permanent positions to oversee this process if appropriate, depending on our findings. The supervisors in the unit currently

responsible for the FFC project believe that two to three full-time, dedicated positions are needed to fully perform this responsibility and achieve the long-term goal of completing a monthly Full File Compare process on each health plan. That number is consistent with the past position requests submitted by the Division of Insurance Services.

Regardless of the position type and number, DRS management feels this process needs continuity to carry out the audit recommendations and the objective of the FCC. Not developing a structured process with documentation and not addressing bad data will cause more work in the future for employees who have been and will continue to be busy implementing the Wisconsin Department of Administration's State Transforming Agency Resources (STAR) project and the Department's Benefit Administration System (BAS) for years to come.

While DRS management agrees with the recommendations to improve the process for the exception report, it is important to note the implementation of changes to the FFC exception report is behind these other competing business priorities: 1) day-to-day operations/services for members and employers, 2) the design and implementation of the BAS, and 3) interfaces with the STAR project. Unlike the FFC exception report, these other priorities have significant and immediate financial implications on ETF. DRS management anticipates a large amount of DRS resources will be devoted to the reconciliation of state employee data from STAR that has been or will be submitted through the health insurance interface between STAR, ETF's current health insurance IT system and health plans. It is important to have the STAR health insurance data reconciled with the health plan data before the 2017 health insurance open enrollment period, which begins in mid-October 2016. These other critical business priorities may cause a need to extend the completion date.

Responsible staff: Jaymee Meier, Director Employer & Contact Services Bureau

Completion date: January 1, 2017

2. **More than one-third of exceptions generated by the FFC process were caused by data that either is not required or cannot be captured by the MEBS. These types of exceptions have no effect on premium payment and customer service.**

The SSN of a dependent is not required at enrollment. If this information is captured by either the health plan or ETF, or both have an SSN but they are not identical, a mismatch will be generated. Additionally, MEBS does not have the capacity for

suffixes and middle names/initials. This was the main factor for “Last Name Mismatch” for both subscriber and dependent. ETF and the health plans have worked to respond to these types of exceptions. However, in many cases, the effort became a repeated exercise with no real impact.

Recommendations: We recommend management evaluate the data being compared by the FFC to align the reconciliation effort with the business objective of the process. We also suggest a comprehensive review of the data being captured by MEBS, so that only accurate and relevant data will be migrated to the new BAS.

Management Responses:
DRS management agrees with this recommendation. Multiple units and initiatives at ETF touch on demographic and enrollment/termination data. As resources permit, DRS management intends to work with other units to 1) better define what data and fields health plans should include in the file, and 2) prioritize the data elements. Thirty-one fields are programmed into ETF’s current IT system, which is scheduled to be decommissioned soon after the deployment of Rollout 2 of the BAS (scheduled for January 1, 2018). The current fields will serve as a starting point for those discussions about priorities, etc. Once the various ETF units are able to prioritize data and determine the necessary data elements, we will communicate with health plans and create and/or adjust procedures accordingly. However, DRS management does not support coding changes to ETF’s current health insurance IT system because of its short shelf-life and the system’s fragility.

Responsible staff: Matt Stohr, DRS Administrator

Completion Date: November 1, 2016 (preferably before the training in finding No. 1)

3. Delayed resolution resulted in significant duplication of work for both Health Plan and ETF.

Exceptions generated by the FFC process remain on the exception report until health plans and ETF reach agreement on the resolutions and the health insurance database is updated. Any reconciliation efforts put forth by one party without responses from the other will not eliminate exceptions. As indicated in Table 6 on page 17, 87% of the 5,383 total exceptions of Security Health Plan were duplicates. This means, 87% of the effort put into resolving these exceptions by Security resulted in zero progress.

Recommendation: We recommend management communicate and coordinate with the health plans for a synchronized and prioritized approach to eliminate the accumulative effect of delayed exception resolution.

Management Responses: See management responses to finding No. 2

4. Access to the secured sFTP server was not monitored.

OIA requested and received from BITS an access activity log for all active sFTP server accounts for 2015. This log revealed nine current ETF staff accounts have not been used since 2011(five accounts), 2013 (three accounts), and 2014 (one account).

Recommendation: Given the Personal Identifiable Information is contained in this server we recommend BITS include monitoring ETF account access activity for this system and disable inactive accounts.

Management Responses:
The BITS agrees with the audit finding for additional monitoring of ETF accounts on the sFTP server. This will be implemented with our next monthly review.

Responsible staff: Mark Robinson, BITS Deputy Director

Completion Date: August 1, 2016

Audit Methodology and Testing

The following provides detailed information about the audit procedures and testing results.

OIA conducted this audit by:

- examining FFC process guides provided by BITS;
- conducting discussions with responsible management and staff;
- performing process walkthroughs;
- inspecting key information, such as sFTP server access logs and FFC files uploading and retrieving records; and
- tracing specific records to supporting documents and performing analytical analysis to identify patterns and anomalies.

Testing health plans' compliance to the contractual agreement of submitting FFC file monthly to the ETF sFTP server

To verify contract compliance, OIA reviewed ETF's sFTP server logs for the 18 health plans submitting FFC files for the calendar year 2015. As displayed by Table 1 below, health plans were compliant to the contract. The 10 files rejected by ETF were due to file formatting issues. OIA reviewed the email exchanges between BITS staff and the health plan IT staff and determined that genuine effort had been made and the formatting issues were resolved in a later month.

Table 1 - FFC Monthly Data Transmission Table

Health Plan	Jan	Feb	March	April	May	June	July	August	Sept	Oct	Nov	Dec
WPS & Arise	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES
Anthem	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES
Dean	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	NO
Humana	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	NO
GHC EC	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES
GHC SC	YES	YES	YES	YES	YES	YES	NO	NO	YES	YES	YES	YES
GLHP	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES
Unity	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES
Health Traditions	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES
MAHP	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES
MercyCare	YES	YES	NO	NO	NO	NO	NO	YES	YES	YES	YES	YES
Network	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES
Security	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES
Physician Plus	NO	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES
Health Partners	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES
WEA Trust	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES
UHC	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES

*Health plans WPS and Arise submit combined full file to ETF.

Testing of Health Plans and ETF's compliance to the contractual agreement of monthly FFC exception resolution

To test contract compliance, OIA reviewed work performed on each FFC Exception report available either on the sFTP server or on the ESS file server. The results were compiled and displayed in Table 2 below.

Table 2 - FFC Exception Reports Reconciliation Activities for the Year of 2015

Health Plans	Reconciliation Report Submitted by HP	Retrieved by ESS	Evaluated by ESS
Gunderson	2	1	1
Security	12	4	2
WEA Trust	6	2	1
Unity	6	3	1
Anthem	2	-	-
Total Actual	28	10	5
Total Annual for 2015	206	206	28
Actual to Annual Total	**14%**	**5%**	**18%**

As a result of the monthly-automated FFC process, 216 total FFC exception reports should have been generated. By taking out the 10 failed transmissions discussed in Table 1, the 2015 annual total reports were 206. Of all the health plans, only Security reconciled its exception report every month. However, of the 12 FFC reconciliations submitted by Security, ESS only reviewed 2.

Given that limited follow-up had been performed in 2015 to resolve exceptions by the majority of health plans and ESS, OIA expanded the review period to examine the extent of the delayed action. As indicated in Table 3, this lack of resolution to FFC has occurred for many years.

Table 3 - Exception Report Reconciliation Timeliness History

	Most Current File		Lapsed Time as of Dec. 2015	
Health Plans	HP Submitted (month & year)	ESS Evaluated (month & year)	Health Plan (in months)	ESS (in months)
UHC	Dec-08	Dec-08	84	84
Physician Plus	Jan-09	Jan-09	83	83
Health Traditions	Feb-09	Feb-09	82	82
MAHP	Mar-10	No activities in the history available (2007)	69	96
Humana	Jan-12	Jan-12	48	48
WPS	Jul-12	Jul-12	42	42
Network	Mar-14	Mar-14	21	21
GLHP	Sep-15	Sep-15	3	3
WEA Trust	Oct-15	May-15	2	7
Anthem	Oct-15	Sep-12	2	39
Dean	Jul-14	Jul-14	17	17
GHC EC	Aug-14	Aug-14	16	16
GHC SC	Oct-14	Oct-14	14	14
Mercy Care	Oct-14	Oct-14	14	14
Health Partners	Oct-14	Oct-14	14	14
Unity	Nov-15	Jul-15	1	5
Security	Nov-15	Jul-15	1	5

Upon review of these results, it became apparent to the OIA that a combination of several factors caused the process breakdown at ETF:

- Lack of management oversight: Prior to the reorganization consolidating the employer services functions into ESS, the responsibility for the FFC function resided primarily with one individual whose work was rarely reviewed by the supervisor.
- Turnover and lack of knowledge transfer: Turnover at both the supervisor level and staff level, coupled with limited procedures and business knowledge documentation, has made transition of the FCC responsibility to new staff assigned to the role more difficult.
- File naming convention was not observed by health plans: Some health plans failed to follow established file naming conventions and, as a result, some

returned reconciliation files were not recognized and retrieved timely by the ESS staff, while others remained on the sFTP server.

Testing accuracy of FFC resolutions completed in 2015

OIA examined the five exception reports completed by ESS and by the health plans. The responses from ESS were mostly accurate. One notable exception was that both health plans and ESS provided resolutions that were unrelated to the causes of the exceptions. For example, when a health plan entered subscriber's correct SSN in the comment field for the solution of "Subscriber Member ID Mismatch", ESS then accepted health plan's solution, instead of providing a correct member ID to cure the exception.

In addition, when employers are contacted for verification of information by ESS, there was no evidence, either in records management (imaging) or any follow-up comments on the reconciliation report, that the requested information was received. For example, OIA cannot verify that inquiries made by ESS to the employers concerning subscriber or dependent's SSN was ever received.

Understanding the FFC exceptions and the effects of delayed resolution

OIA reviewed monthly Enrollment Exceptions Summary Reports by health plans for 2015. These are system-generated reports, separating exceptions into categories identified by the FFC process.

Three health plans (UHC, GHC SC and Unity), accounted for 60% of the total exceptions (See table 4 for the complete distribution).Three types of exceptions accounted for 70% of the total exceptions: Dependent SSN Mismatch, Dependent Not on Health Plan and Subscriber Not Found on Health Plan (See table 5 for the complete distribution). Note that the number of exceptions does not correlate to the number of healthcare contracts, since one contract can generate multiple exceptions. The Exceptions Summary Report retains only exception counts. The exception details generated during the monthly FFC process at the contract level are retained only until the next monthly FFC process is run. The prior month's data is overwritten and replaced by the data of the current month.

Table 4 - Distribution of Exceptions by Health Plans

Health Plan	Exception Counts	Percentage to Total
UHC	13,682	30%
GHC SC	8,227	18%
Unity	5,207	12%
Humana	3,976	9%
Dean	3,114	7%
Gunderson	1,916	4%
Physician Plus	1,888	4%
WEA Trust	1,420	3%
Health Traditions	1,328	3%
WPS	1,213	3%
Health Parters	902	2%
Network	696	2%
Anthem	498	1%
Security	427	1%
Arise	146	0%
GHC EC	114	0%
Mercy Care	82	0%
MAHP	46	0%
	44,882	100%

Table 5 - Distribution of Exceptions by Type

Category	Exception	Total	Percentage to Total
Dependent Field Mismatches	Dep Birth Date Mismatch	205	0%
	Dep Gender Mismatch	75	0%
	Dep Handicap Mismatch	96	0%
	Dep Last Name Mismatch	523	1%
	Dep Med Plan Mismatch	1,782	4%
	Dep Member ID Mismatch	643	1%
	Dep SSN Mismatch	12,813	29%
Dependent Not Found	Dep Contract Not Found	87	0%
	Dep Not on Health Plan	10,827	24%
	Dep Not Found	12	0%
Subscriber Field Mismatches	Birth Date Mismatch	39	0%
	Gender Mismatch	13	0%
	Last Name Mismatch	818	2%
	Med Plan Mismatch	1,471	3%
	Sub Member ID Mismatch	461	1%
Subscriber Not Found	Carrier Code Mismatch	1,478	3%
	Contract Terminated	976	2%
	Coverage Type Mismatch	1,293	3%
	Employee Type Mismatch	24	0%
	Empr Grp Number Mismatch	1,010	2%
	Not Found at Health Plan	7,559	17%
	Program Option Mismatch	1,793	4%
	Surcharge Code Mismatch	467	1%
	Surcharge Code Not Found	4	0%
	SSN Mismatch	413	1%
		44,882	100%

Dependent Social Security Number (SSN) Mismatch (29%):

At present, Dependent SSN is not a required field in MEBS, but the system accepts the number when it is supplied. If a dependent SSN is missing in either ETF's system or the health plan's system, or the numbers do not agree, an exception is generated.

A possible solution is to exclude this SSN exception by modifying the FFC program code to eliminate the exception category from the reconciliation. The BITS staff responsible for monitoring the FFC process advised that the modification could be achieved by "comment out" the code that creates those exceptions, which would

facilitate the ability to add those exceptions back in the future if dependent SSN's become relevant. It was estimated by the aforementioned staff that the code change would take less than twenty working hours to achieve.

Dependent Not on Health Plan (24%):
Dependents were in ETF's health plan database, but not in the health plans' database. OIA did sample testing of these dependent exceptions, comparing them to later months, and the same exceptions were not present. The result of this testing indicates that the cause of these exceptions was chiefly due to timing.

Subscriber Not Found at Health Plan (17%):
Timing was the main driver for this exception. At times it took months for the health plan to set up the subscriber in its system. This could be an indication that health plans may not retrieve the daily compare files from ETF's sFTP server timely to update their records, as required by the contract.

Impact of Delayed Resolutions
The majority of the exceptions in table 5, including the top three exceptions, do not have a financial effect on the group health insurance program. However, subscribers may experience delayed services and ETF may experience increased workloads in assisting members to resolve healthcare records issues.

The exception type of "Subscriber Contract Terminated" was the result of terminations of employment, death of annuitants, and COBRA terminations that were recorded in MEBS, but not in the health plans' records. By reviewing the two resolved Security FFC reconciliation reports and comparing the detailed exception records to later months, OIA concluded that the cause of this exception is timing. It is possible for subscribers with terminated contracts to continue to receive healthcare services. However, because ETF had stopped premium payments for the terminated contracts, and the number of exceptions in this category was limited, the potential costs to the program were minimal.

The exception type of "Coverage Type Mismatch" was primarily due to the changes of coverage status, such as single or family coverage changes. Since the change of coverage was reflected timely in ETF's system, the financial effect on the program was minimal.

In reviewing the exception follow-up performed by Security -- the only health plan that has submitted monthly FFC exception reconciliation report to ESS for resolutions -- OIA noticed that, due to the delayed responses from ESS, Security's reconciliation effort was significantly increased. OIA uploaded the twelve exception reports from Security to the Audit Command Language software to identify identical transactions carried forward

from January to December 2015. As indicated in Table 6, for 2015 only 13% of the exceptions were unique.

Table 6 – Security Health Plan Duplicated Reconciliation Effort

Month	Record Count	Duplicate Records	New Records
January	488	240	248
February	499	449	50
March	460	429	31
April	446	428	18
May	435	427	8
June	467	419	48
July	446	411	35
August	450	402	48
September	457	408	49
October	438	392	46
November	370	350	20
December	427	355	72
	5,383	4,710	673
		87%	13%

Review Access to sFTP Server

OIA reviewed the access permission of the sFTP server and identified that four terminated individuals still had access rights to the server. OIA confirmed with BITS that their access to the Active Directory was timely removed upon their departure. Additionally, upon notification by the OIA, BITS deleted their access to the sFTP server.

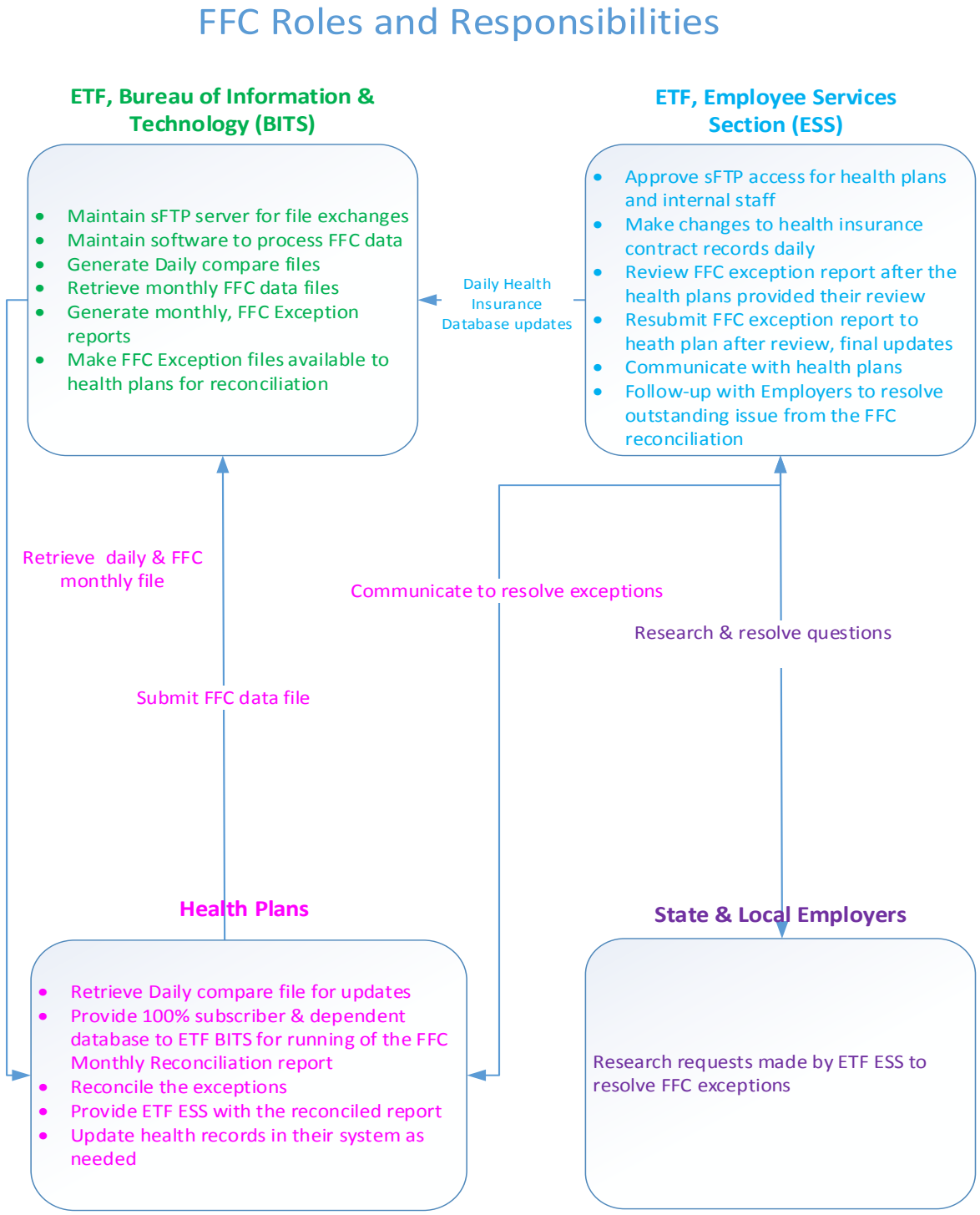
In addition to access permission, OIA reviewed access activities and identified the following: five staff last accessed the server in 2011, three in 2013, and one in 2014. Given the personally identifiable information contained in this sFTP server, OIA recommended that access to the server should be part of the regular review of account access conducted by the BITS.

Testing accuracy of premium invoices

ETF generates employer's premium invoices from ETF's health insurance database. Updates to the healthcare contracts in the database are communicated daily to health plans through the daily compare process. These daily updates are also used to

generate updates for invoices for state and participating local employers. OIA conducted testing to verify whether premium invoices generated from MEBS accurately reflect healthcare contracts. Based on the agreement of invoice summary reports to the detailed MEBS records for October, November and December 2015, OIA concluded that the invoice process is working as designed.

Appendix


FFC Roles and Responsibilities
ETF, Bureau of Information & Technology (BITS)
Maintain sFTP server for file exchanges
Maintain software to process FFC data
Generate Daily compare files
Retrieve monthly FFC data files
Generate monthly, FFC Exception reports
Make FFC Exception files available to health plans for reconciliation
ETF, Employee Services Section (ESS)
Approve sFTP access for health plans and internal staff
Make changes to health insurance contract records daily
Review FFC exception report after the health plans provided their review
Resubmit FFC exception report to heath plan after review, final updates
Communicate with health plans
Follow-up with Employers to resolve outstanding issue from the FFC reconciliation
Daily Health Insurance Database updates
Retrieve daily & FFC monthly file
Communicate to resolve exceptions
Research & resolve questions
Submit FFC data file
Health Plans
Retrieve Daily compare file for updates
Provide 100% subscriber & dependent database to ETF BITS for running of the FFC Monthly Reconciliation report
Reconcile the exceptions
Provide ETF ESS with the reconciled report
Update health records in their system as needed
State & Local Employers
Research requests made by ETF ESS to resolve FFC exceptions

Relevant State and Local Insurance Contract Wording

2.4 REPORTING

(1) EMPLOYEES, ANNUITANTS and CONTINUANTS shall become or be SUBSCRIBERS if they have filed with the EMPLOYER or DEPARTMENT, if applicable, an application in the form prescribed by the DEPARTMENT, and are eligible in accordance with this CONTRACT, the law, the administrative rules, and regulations of the DEPARTMENT.

(2) On or before the effective date of this CONTRACT, the DEPARTMENT shall furnish electronic eligibility files to the HEALTH PLAN showing the INDIVIDUAL SUBSCRIBERS and FAMILY SUBSCRIBERS entitled to BENEFITS under the CONTRACT during the first month that it is in effect, and such other reasonable data as may be necessary for HEALTH PLAN administration. The DEPARTMENT shall furnish electronic eligibility files while the CONTRACT is in effect.

(3) Monthly or upon request by the DEPARTMENT, the HEALTH PLAN shall submit a data file (or audit listing, if requested by the DEPARTMENT) to establish or update the DEPARTMENT'S membership files in a file format as identified by the DEPARTMENT after seeking input from the HEALTH PLANS. The HEALTH PLAN shall submit these files using the SUBSCRIBER identifiers (currently Social Security Number and unique DEPARTMENT identifier) determined by the DEPARTMENT. The HEALTH PLAN shall create separate files for SUBSCRIBERS and DEPENDENTS, in a format and timeframe specified by the DEPARTMENT, and submit them to the DEPARTMENT or its designated database administrator. When the DEPARTMENT sends HEALTH PLAN error reports showing SUBSCRIBER and DEPENDENT records failing one or more edits, the HEALTH PLAN shall correct and resubmit the failed records with its next update. The HEALTH PLAN shall at least annually collect from SUBSCRIBERS coordination of benefits information necessary to coordinate BENEFITS under the Wisconsin Administrative Code and report this information to the DEPARTMENT at least annually. HEALTH PLANS must follow the DEPARTMENT’S file transfer protocols (FTP), such as using the DEPARTMENT’S secured FTP site to submit and retrieve files.

(4) Unless individually waived by the BOARD, each HEALTH PLAN will submit the current applicable version of the Healthcare Effectiveness Data and Information Set (HEDIS) for its commercial membership by a date specified by the DEPARTMENT for the previous calendar year. The data set will be for both the entire HEALTH PLAN membership and the state group membership where applicable. The HEALTH PLAN will include the state group membership prescription drug data from the pharmacy

benefit manager in their reported prescription drug measures consistent with NCQA requirements. The data will be supplied in a format specified by the DEPARTMENT.

(5) HEALTH PLANS shall submit all reports and comply with all material requirements set forth in the GUIDELINES or the BOARD may terminate the CONTRACT between the HEALTH PLAN and the BOARD at the end of the calendar year, restrict new enrollment into the HEALTH PLAN, or the DEPARTMENT may impose other sanctions as deemed appropriate. These sanctions may include, but are not limited to, financial penalties of no more than $100 per day per occurrence, to begin on the 2nd day following the date notice of non-compliance is delivered to the HEALTH PLAN. Such financial penalty will not exceed $5,000 per occurrence. The penalty may be waived if timely submission is prevented for due cause, as determined by the DEPARTMENT.