Office of Internal Audit

Medicare Split Contract Invoicing Audit

August 18, 2021

Prepared for Audit Committee Meeting of the Department of Employee Trust Funds, 9.16.21;
prepared by Kim Richmond

Reviewed and approved by Yikchau Sze, Director, Office of Internal Audit

Yikchau Sze Electronically Signed 9/1/21

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Executive Summary

We have completed an audit of the Medicare Split Contract invoicing for annuitants managed by the Insurance Unit of Employer Service Section (ESS) within the Division of Retirement Services (DRS) at the Department of Employee Trust Funds (ETF). This audit was completed in accordance with the fiscal year 2020-2021 Biennial Audit Plan to evaluate the design and operating effectiveness of internal controls over the Medicare Split Contract invoicing process for the year 2020.

The State of Wisconsin Public Employer Group Health Insurance Program (GHIP) and the Wisconsin Public Employers Group Health Insurance Program (WPE) are authorized by Wis. Stats. 40.51 and administered by ETF under the authority of the State of Wisconsin Group Insurance Board. The GHIP is available to state and some local employees and retirees. The WPE is available to Wisconsin Retirement System (WRS) employers and governmental employers who are not in the WRS but who meet the definition of employer under Wis. Stats. s. 40.02(28). ETF also administers the Local Annuitant Health Program (LAHP), which was established by 1987 Wisconsin Act 107 to provide group health insurance for local retirees from local employers who do not participate in WPE. All programs offer retirees the opportunity to choose from multiple health plan choices.

Beginning January 1, 2020, Medicare Split Contracts became available to State and Local retirees. A Medicare Split Contract is a contract that provides retirees with the option to divide their family health insurance contract into a Medicare plan and a non-Medicare plan, which provides members with more flexibility, lower premium cost, and a wider selection of health care providers. All health plans that participate in GHIP, WPE, and LAHP have coverage options that are coordinated with Medicare.

Our audit focused on Medicare Split Contracts that were processed by ESS during the period January 1, 2020 to December 31, 2020. There were 1,197 Medicare Split Contracts with health premiums totaling approximately $4.9 million during this period.

We did not identify any billing errors as a result of our audit testing, and we do not have any significant findings to report. However, we believe that the internal controls could be strengthened by the following:

- Performing the audit review process for Contract Adjustment Maintenance System (CAMS) adjustments by the ESS supervisor should take place more consistently throughout the year to reduce the risk of members being incorrectly billed as a result of an incorrect CAMS adjustment being made.
- Adding a step to the audit review process for CAMS that includes verifying that each CAMS adjustment has supporting documentation to ensure that the CAMS adjustment was properly made.

Background

Medicare Split Contracts Enrollment & Available Health Plans

The ESS Insurance Unit staff is responsible for processing health insurance applications for Medicare Split Contracts. A retiree may request to change their health plan to a Medicare Split Contract when a retiree or their dependents gain or lose Medicare enrollment Parts A, B, or both. In order to enroll in a Medicare Split Contract, retirees must submit a *Health Insurance Application/Change form for Retirees and COBRA Continuants* (form ET-2331). The retiree must apply within 30 days of the Medicare event taking place. Health insurance coverage is effective on the date of enrollment or disenrollment in Medicare.

There are special enrollment periods for local retirees enrolling in Medicare Split Contracts under a LAHP. Medicare eligible retirees enrolling in LAHP insurance are eligible for Medicare Split Contracts when the individual terminates from their non-participating local employer or when they become eligible for and enrolled in Medicare Parts A and B. COBRA applicants with Medicare can enroll in a Medicare Split Contract if a life event[1] occurs or during the It's Your Choice (IYC) enrollment period. State retirees may only enroll in a Medicare Split Contract under a High Deductible Health Plan (HDHP) if the retiree has a dependent on a state health insurance contract who is enrolled in Medicare.

Medicare Split Contract applications can be submitted to ETF by fax, mail, or electronically. Applications are required to be signed by the member and must contain all applicable information prior to being processed. Cancellations for split contracts may be submitted using form ET-2331, a handwritten note, *Sick Leave Account Depletion Letter* (ET- 4561) form, or by email.

A Medicare Split contract consists of two sides: a Medicare side and a Non-Medicare side. For the Medicare side of the split contract, there are two health plans available to members. Members may enroll in Medicare Plus through health plan WEA Trust or Medicare Advantage through United Healthcare. For the Non-Medicare side of the contract members choose from the IYC health plans. Various funding sources may be made available to State and Local Annuitants to pay health insurance premiums. The sequence for funding sources used to pay health insurance premiums is directed by State Statutes.

Systems Used in Process

ESS uses myETF Benefit System (MEBS), the Benefit Payment System (BPS), the Accumulated Sick Leave System (AcSL), and the Contract Adjustment Maintenance System (CAMS) for invoicing health insurance premiums for Medicare split contracts.

[1] A life event is considered to be a change in marital status, the addition of new dependent, death of a spouse, Medicare coverage changes (this list is not all inclusive)

MEBS contains health insurance applications, coverage changes, and terminations of health insurance. Health Insurance coverage demographics, and information for member's dependents is also stored in MEBS. Health insurance invoices are calculated and generated in MEBS. MEBS has the ability to automatically refund or retroactively change up to six months of premiums when there is a change to a health insurance contract.

BPS maintains deductions, net pay, and tax information for annuitant payments and processes an annuitant's retirement, disability, and death benefits. BPS is used to process health insurance deductions for split contracts when an annuitant is using an annuity deduct funding source (premium deducted from annuity payment) to pay health insurance premiums.

AcSL keeps track of an annuitant's sick leave balances and determines if an annuitant using a sick leave funding source has an adequate amount of sick leave to pay each month's health insurance premium. Accumulated sick leave credits are available to State of Wisconsin employees. These credits are converted to a dollar value upon retirement and can be used to pay health care premiums.

CAMS allows ESS to track retroactive premium charges and refunds and update changes to premiums as needed. This system was created to process adjustments to health insurance billings that cannot be performed in MEBS. Invoicing issues occur when the MEBS invoicing system does not correctly adjust premiums when a change is made to a health insurance contract. Invoicing issues can occur for the following reasons:

- Deleting a previously terminated contract.
- Adding a termination date to a previously terminated contract.
- Changing the health plan and switching the contract from single to family or family to single on the same day.
- Adjustments that are automatically made by MEBS are inaccurate.

Invoicing Process

Upon receiving a member's health insurance application for enrollment in Medicare Split Contract, ESS reviews the application to ensure that the application is not missing information. The member's Medicare eligibility is then verified by ESS. Information from the application is entered into MEBS and BPS, which includes the health plans selected by the member for the Medicare and Non-Medicare sides of the contract. The monthly premium amount is based upon each of the health plans selected and is automatically generated from the Health Insurance Premium Rate Table.

A Health Insurance Premium Rate Table, a table consisting of health care premiums for each health plan, is loaded into MEBS by ESS annually for each enrollment period. The health premiums from the rate tables are pulled into BPS from MEBS automatically. There is a periodic review of individuals who are authorized to access premium rate tables. Data from an annuitant's application is entered into MEBS and BPS manually. For split contracts, there are two separate health insurance deductions that are set-up in both MEBS and BPS. There is a health insurance deduction for the Non-Medicare side of the contract and a health insurance deduction for the Medicare side of the contract. MEBS and BPS calculate an annuitant's monthly health insurance contract amount based on their coverage level and health plan choice. There is a two-month time lag between the time an annuity deduct contract is entered into MEBS and the time the contract is processed in BPS due to the difference in the billing cycles of these two systems.

During the open enrollment period, there is a weekly batch run that updates the existing health insurance deduction in BPS for contract changes that become effective on January 1 of the following year. Deductions for new contracts and contract terminations are entered manually into MEBS and BPS during the open enrollment.

Each month, ESS generates the Exception Report to identify discrepancies between the MEBS and BPS deductions. After the Exception Report has been reviewed and errors have been identified, the report is then provided to a different staff member to make the necessary corrections.

For annuitants using a sick leave funding source, health premiums are deducted from their sick leave account during a monthly MEBS batch run. A Sick Leave Depletion Report is ran from the AcSL system and reviewed monthly by ESS to identify members with expiring sick leave account balances. Annuitants are notified that their sick leave account will be expiring approximately four months prior to the account actually being depleted. ESS follows-up on depleted accounts by reviewing the annuitant's MEBS account for changes and cancellations. Upon depletion of an annuitant's sick leave, another funding source must be used to pay for health insurance premiums. Each day ESS runs the Sick Leave Assurance Report from AcSL to identify members with discrepancies in their account.

The Insurance Inquiry Report is run from MEBS on a weekly basis by ESS. This report is used to determine if a CAMS adjustment is warranted for changes made to health contracts and automatic refunds issued by MEBS. CAMS adjustments are manually entered into MEBS and BPS. ESS has one staff member dedicated to making CAMS adjustments[2], and authorized users of the CAMS system are reviewed periodically by the ESS supervisors. An audit of the CAMS adjustments is conducted periodically to ensure that the CAMS adjustments are properly made.

[2] ~300 CAMS adjustments made in the year 2020 with nine for split contracts.

Division of Trust Finance (DTF) is responsible for processing monthly health premium invoicing to employers and health premium payments to health providers. ETF is considered an annuitant's employer for purposes of health insurance. As part of the month-end process, DTF conducts a reconciliation of the MEBS and BPS billings to ensure that there are no discrepancies between the billings.

Audit Objective and Scope

Our audit was conducted in conformance with the International Standards for the Professional Practice of Internal Auditing issued by the International Internal Audit Standards Board.

The audit objective was to evaluate the design and operating effectiveness of internal controls over the Medicare Split Contract invoicing process to ensure that members and health plans are timely and properly billed. The audit scope focused on Medicare Split Contracts that were processed and billed during the period January 1, 2020 through December 31, 2020.

Results and Recommendations

Positive Results

We did not find any exceptions as a result of our testing. As previously noted, we did not have any significant findings to report. However, we did identify areas within the process where internal controls can be strengthened.

Findings, Recommendations and Management Responses:

Finding	**Risk/Effect**
CAMS Audit Review Process In the 2019 Health Insurance Billing audit OIA recommended implementing a secondary review of the CAMS adjustments. This recommendation has been implemented, however; the process did not take place consistently throughout the year. We also found that there was no supporting documentation for one of the CAMS adjustments we sample tested, and the reason for making the adjustment could not be determined.	If CAMS adjustments are not audited consistently throughout the year and do not consists of supporting documentation, inaccurate adjustments could be processed resulting in members being incorrectly billed.

Recommendation

To ensure that CAMS adjustments are processed accurately OIA recommends that the audit of the CAMS adjustments is conducted consistently throughout the year. We also recommend adding a step to the audit process that includes verifying that there is supporting documentation for the CAMS adjustment.

Significance: Low

Management Response

We agree with OIA's recommendation of consistently auditing and documenting CAMS audit results on a regular basis. We will audit results on a quarterly basis as this is a more efficient use of our time compared to a monthly review but would still address the concerns raised in the audit.

Responsible Staff:

Elizabeth Bush and Alene Kleczek

Completion Dates:
July 2021

Process Improvement Observations

Minor process improvement observations were communicated to Management for consideration.

Audit Methodology

The OIA conducted this audit by:

- Obtaining an understanding of the procedures used in the Medicare split contract billing process;
  - Reviewing procedural documentation,
  - Conducting interviews with responsible staff,
  - Performing process walkthroughs,
- assessing processing risk to determine the design of internal controls,
- performing sample testing to determine the operating effectiveness of controls[3] and
- using ACL Analytic software to
  - create MEBS and BPS Reports in order to prepare a reconciliation of the health insurance billings.
  - Test the CAMS Adjustment Report and the Sick Leave Assurance Report for completeness.

[3] Testing related to the Exception Report was conducted as part of the 2020 Health Insurance Deduction Audit. We did not perform testing for the Exception Report as part of this audit.