AUDITORS' REPORT

Office of the State Comptroller – State Employee and Retiree Healthcare and Other Benefits

FISCAL YEARS ENDED JUNE 30, 2020 AND 2021

STATE OF CONNECTICUT
Auditors of Public Accounts

JOHN C. GERAGOSIAN
State Auditor

CRAIG A. MINER
State Auditor

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STATE OF CONNECTICUT

AUDITORS OF PUBLIC ACCOUNTS

JOHN C. GERAGOSIAN

STATE CAPITOL
210 CAPITOL AVENUE
HARTFORD, CONNECTICUT 06106-1559

CRAIG A. MINER

January 8, 2025

INTRODUCTION

We are pleased to submit this audit of the Office of the State Comptroller – State Employee and Retiree Healthcare and Other Benefits for the fiscal years ended June 30, 2020 and 2021 in accordance with the provisions of Section 2-90 of the Connecticut General Statutes. Our audit identified internal control deficiencies; instances of noncompliance with laws, regulations, or policies; and a need for improvement in practices and procedures that warrant management's attention.

The Auditors of Public Accounts wish to express our appreciation for the courtesies and cooperation extended to our representatives by the personnel of the Office of the State Comptroller during the course of our examination.

The Auditors of Public Accounts also would like to acknowledge the auditors who contributed to this report:

Zach Correll
Kristy Sleight
Samantha Smith

Kristy Sleight

Kristy Sleight
Principal Auditor

Approved:

John C. Geragosian
State Auditor

Craig A Miner
State Auditor

STATE AUDITORS' FINDINGS AND RECOMMENDATIONS

Our examination of the records of the Office of the State Comptroller – State Employee and Retiree Healthcare and Other Benefits disclosed the following four recommendations, which were not repeated from the previous audit.

Finding 1

Healthcare Refunds of Overpayments

Background

The Office of the State Comptroller maintains records of payments to medical providers. Changes in processed medical claims are refunded to the state and recorded in the claims detail during reprocessing. The detail shows a reversal of the original claim and a new paid claim which nets out to the credit on the medical claims bimonthly reports.

Criteria

The contract between the Office of the State Comptroller Healthcare Policy and Benefit Services Division and the healthcare contractor requires the contractor to seek refunds of all excess, duplicate, or erroneous payments on claims billed to the Comptroller and return 100% of recovered overpayments to the state. Sound business practices dictate that the Healthcare Policy and Benefit Services Division should verify invoice credit amounts.

Condition

The division did not have a process to reconcile overpayment credits and adjustments to supporting documentation on monthly healthcare contractor invoices. The division was unable to verify the total monthly credits were supported and applied correctly.

Context

In calendar year 2021, contractors refunded $7,803,428 in overpayments and adjustments to the state.

Effect

The failure to verify these credits may result in the state overpaying healthcare contractors.

Cause

The office did not obtain detailed contractor support for the overpayment credits and adjustments. This information was not housed in the office's system which includes thousands of claims each period.

Prior Audit Finding

This finding has not been previously reported.

Recommendation

The Office of the State Comptroller should implement internal controls to ensure it correctly credits all overpayments due to the state.

Agency Response

"The Division has requested the vendor provide detailed backup supporting credits and adjustments applied to invoices. In addition, the Division is seeking an outside audit firm to review, audit and verify all fees and adjustments applied by our medical, pharmacy and dental carriers which will further ensure proper payments moving forward."

Finding 2

Payments to Healthcare Contractors

Background

The Office of the State Comptroller makes bimonthly claims and administration fee payments to its healthcare contractors. The office contracted with four companies for medical, dental, and prescription insurance, and the administration of the health enhancement program.

Each month, the office pays the fully insured premium to the dental provider. As part of the monthly remittance process in Core-CT, the office runs a query to obtain data for the payment.

The prescription insurance provider sends the Office of the State Comptroller two invoices each month. The second payment of each month contains a per employee per month administration fee. Since prescription and medical benefits are packaged together, the prescription insurance provider receives the employee counts from the medical insurance provider.

Criteria

Sound business practices dictate the office should reconcile the amounts healthcare contractors bill the state, including a focus on administrative fees.

Condition

We selected 54 payments to the four health care contractors to review for accuracy. For the prescription insurance provider, five of the selected payments included $1,728,225 in monthly administrative fees. We were unable to verify these five fees due to lack of proper support.

For one monthly $7,306,457 dental insurance premium payment, we noted $3,450,000 was not adequately supported. The contractor billed the unsupported portion based on the number of retirees.

Context

The prescription insurance provider's administrative fees amounted to approximately $8,300,000 out of $513,638,201 total prescription insurance payments during the audited period. The office made monthly payments during the audited period to the dental insurance, health enhancement plan and the medical insurance providers totaling $182,257,361, $12,388,567, and $996,657,662, respectively.

We selected for review all 24 payments to the health insurance contractor, and judgmentally selected 30 payments to the remaining three healthcare contractors. Selected payments to the medical insurance, dental insurance, health enhancement plan, and prescription insurance providers totaled $996,657,662, $75,571,980, $5,746,185, and $98,428,436, respectively.

Effect

The state could be overpaying for benefits and services.

Cause

The office did not have procedures to reconcile prescription insurance provider administrative fees and was unable to locate the necessary supporting documentation for dental insurance premium payments.

Prior Audit Finding

This finding has not been previously reported.

Recommendation

The Office of the State Comptroller should perform reconciliations of payments to healthcare contractors to ensure it pays the proper amount for benefits and services.

Agency Response

"Dental premiums are calculated by using the monthly Core-CT remittance process to calculate the monthly premium based on enrollment in Core-CT. In September 2020 Core-CT had recently reconfigured retiree eligibility which impacted the normal remittance process. As a result, the eligibility did not feed correctly into the remit process. The issue was brought to the attention of Core-CT to review and correct. The dental provider was paid an estimated premium payment which was based on the prior month's premium and a correction was sent in October 2020 with the following month's premium payment. An Access database query was created to calculate the correct retiree premium for September 2020 and was sent with back-up in October 2020 to adjust the estimated September payment.

Historically, the office did not reconcile the prescription vendor admin fees. Process and procedures have been updated to correct

this oversight. Office staff will conduct an audit on prior payments. Going forward, an additional step has been added in the vendor payment process to confirm the administrative fees."

Finding 3
Group Life Insurance

Background

The Office of the State Comptroller oversees the state's group life insurance plan. Upon retirement of an insured plan member, the office calculates the member's life insurance coverage amount. Upon death of an insured member, the office notifies the beneficiaries of their group life insurance benefits and requests the information needed to process the life insurance claim. The office then sends the claim documents to a third-party vendor for processing and payment.

Criteria

According to Section 5-257(d) of the General Statutes, the amount of life insurance of an insured retiree is calculated using years of state service as defined in Section 5-196. Section 5-196(24) defines state service as the "occupancy of any office or position or employment in the service of the state, but not of local governmental subdivisions thereof, for which compensation is paid." Actual state service begins on the employment commencement date. Retirees with 25 or more years of state service receive one half of the amount of life insurance for which the employee was insured immediately prior to retirement. Those with less than 25 years of service receive a proportionate amount.

The Group Life Insurance plan booklet dictates that a lump sum or installment life insurance payment will be made to the beneficiary or designated beneficiaries.

Condition

Our review of group life insurance disclosed that the office did not use actual state service to calculate life insurance coverage amounts. OSC instead used credited service which includes personal, medical, or family leave without pay, qualifying military leave without pay, prior eligible military service, prior eligible CT municipal service or prior full-time service to other reciprocal states.

We also reviewed 20 group life insurance claims paid and noted the following:

- In six instances, the combined total paid was $24,378 greater than the benefit amount per the Schedule of Basic Life Insurance.

- In seven instances, the combined total paid was $175,846 less than the benefit amount per the Schedule of Basic Life Insurance.
- In one instance, we could not find member information in Core-CT and were therefore unable to review the selection.
- In nine instances, it took 137 to 869 days from the retiree's death to the life insurance payment to the beneficiary.
- In three instances, we did not find a group life death notification letter to the beneficiary. In addition, the office submitted claims to the vendor 213 to 814 days after the date of death.

Context

On average, 29,574 and 28,782 retirees and 29,802 and 30,449 active employees were enrolled in the state's group life insurance plan during the fiscal years ended June 30, 2020, and 2021, respectively. The office paid 855 and 1,005 death claims, totaling $15,564,446 and $18,093,171, during the fiscal year ended June 30, 2020, and 2021, respectively.

We initially judgmentally selected one retiree file for review of state service time. We then selected 20 death claims, ten judgmentally selected from each fiscal year.

Effect

The office did not comply with the requirements of Section 5-257(d) of the General Statutes. Beneficiaries may not be receiving the proper amount of life insurance benefits.

Cause

The office could not explain why it uses credited service instead of actual state service to calculate life insurance coverage.

Prior Audit Finding

This finding has not been previously reported.

Recommendation

The Office of the State Comptroller should improve its internal controls to ensure it correctly calculates life insurance coverage amounts in accordance with Section 5-257(d) of the General Statutes. The office should correct errors resulting from the miscalculation of plan member life insurance coverage.

Agency Response

"General Statute § 5-257(d) notes that state service utilized for the calculation of retiree group life benefit is defined in section 5-196. Section 5-196(24) defines "State Service" as "occupancy of any office or position or employment in the service of the state, but not of local governmental subdivisions thereof, for which compensation is paid." This definition aligns with the Total Service value noted on an employee's Application for Retirement Benefits. Total Service is utilized for the purpose of group life retirement benefit calculation. Actual State Service is a term that has been more recently defined and utilized for retiree health purposes only. Division Memorandum

2013-06 defines Actual State Service as "service during which an employee is eligible for state-paid health benefits and is participating in a State of Connecticut retirement plan. Actual State Service includes purchased military service (but no other purchased service time). The amount of Actual State Service required may vary based on the type of retirement, date of hire, age, employment status, or other factors outlined below." This definition does not comport with the definition noted in CGS §5-196(24). Calculations for group life retiree benefit are appropriately calculated.

The exception instances noted have been reviewed, and a document and back up files including and explaining the details for each paid benefit. Based upon the additional review performed by unit staff the Division, with has determined that all fully reviewed claims have been processed and paid appropriately, 3 claims reviews remain outstanding awaiting final copy of the check from vendor, but other backup information is consistent with accurate payment."

Auditors' Concluding Comments

The office's online Retirement Counseling Workshop enables employees to obtain a general explanation of retirement issues. In this workshop summary, the Group Life Insurance section states, "If you have 25 years or more actual state service" and "If you have less than 25 years actual state service" to describe the calculation of a retiree's policy coverage. If the office disagrees with the use of actual state service, it should seek a legislative change.

Finding 4

Retiree Health Contribution Refunds

Background

The Office of the State Comptroller processes refunds of member healthcare contributions to the state retiree health fund that meet certain eligibility criteria. The office also processes refunds of erroneously deducted healthcare contributions.

Criteria

An essential part of the administration of the retiree healthcare benefits program is refunding contributions to employees who leave state service before they are eligible for retiree healthcare. Sound business practice dictates that an agency must substantiate all payments to avoid incurring unnecessary expenses.

Condition

In our review of fifteen retiree health contribution refunds, totaling $425,639, we noted that the office did not maintain evidence of its review for four refunds, totaling $143,825.

Context

The Office of the State Comptroller issued 1,939 contribution refunds totaling $9,643,476 during the audited period. We selected fifteen refunds for testing. They included the five largest refunds, the five largest refunds in excess of calculated contributions, and five judgmentally selected refunds.

Effect

Failure to verify the accuracy of refunds increases the risk of improper payments. Employees could be receiving excessive refunds.

Cause

It appears the agency did not have adequate controls to ensure that it completed and properly documented its verification of healthcare contribution refunds.

Prior Audit Finding

This finding has not been previously reported.

Recommendation

The Office of the State Comptroller should establish internal controls to ensure that it properly reviews and supports contribution refunds prior to processing.

Agency Response

"The division has updated its policies and procedures related to refunds to ensure that proper documentation is kept, and all payments are verified – copy of updated policies and procedures provided."

STATUS OF PRIOR AUDIT RECOMMENDATIONS

Our prior audit report on the Office of the State Comptroller – State Employee and Retiree Healthcare and Other Benefits contained no recommendations.

OBJECTIVES, SCOPE, AND METHODOLOGY

We have audited certain operations of the Office of the State Comptroller – State Employee and Retiree Health Care and Other Benefits, in fulfilment of our duties under Section 2-90 of the Connecticut General Statutes. The scope of our audit included, but was not necessarily limited to, the fiscal years ended June 30, 2020 and 2021. The objectives of our audit were to evaluate the:

1. Office's internal controls over significant management and financial functions;

2. Office's compliance with policies and procedures internal to the office or promulgated by other state agencies, as well as certain legal provisions; and

3. Effectiveness, economy, and efficiency of certain management practices and operations, including certain financial transactions.

In planning and conducting our audit, we focused on areas of operations based on assessments of risk and significance. We considered the significant internal controls, compliance requirements, or management practices that in our professional judgment would be important to report users. The areas addressed by the audit included healthcare contributions and refunds, healthcare and dental dependent eligibility, group life insurance, and healthcare vendor payments for active and retired state employees. We also determined the status of the findings and recommendations in our prior audit report.

Our methodology included reviewing written policies and procedures, financial records, minutes of meetings, and other pertinent documents; interviewing various personnel of the office; and testing selected transactions. Our testing was not designed to project to a population unless specifically stated. We obtained an understanding of internal controls that we deemed significant within the context of the audit objectives and assessed whether such controls have been properly designed and placed in operation. We tested certain of those controls to obtain evidence regarding the effectiveness of their design and operation. We also obtained an understanding of legal provisions that are significant within the context of the audit objectives, and we assessed the risk that illegal acts, including fraud, and violations of contracts, grant agreements, or other legal provisions could occur. Based on that risk assessment, we designed and performed procedures to provide reasonable assurance of detecting instances of noncompliance significant to those provisions.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

The accompanying financial information is presented for informational purposes. This information was obtained from various available sources including, but not limited to, the office's management and the state's information systems, and was not subjected to the procedures applied in our audit of the office. For the areas audited, we identified:

1. Deficiencies in internal controls;

2. Apparent noncompliance with laws, regulations, contracts and grant agreements, policies, or procedures; and

3. A need for improvement in management practices and procedures that we deemed to be reportable.

The State Auditors' Findings and Recommendations section of this report presents findings arising from our audit of the Office of the State Comptroller – State Employee and Retiree Benefits.

ABOUT THE AGENCY

Overview

The Office of the State Comptroller operates primarily under the provisions of Article Fourth, Section 24, of the State Constitution, and Title 3, Chapter 34 of the General Statutes. The Office of the State Comptroller's Healthcare Policy and Benefit Services Division administers benefits programs for all state employees, retirees and their families including medical, pharmacy, and dental benefits. The division is also responsible for the contract procurement, administration, and evaluation of these programs. In addition, the division administers the state employees defined contribution plans and coordinates group life insurance, unemployment insurance, and supplemental benefits.

Kevin Lembo was elected State Comptroller in November 2010 and served throughout the audited period. He served until his resignation on December 31, 2021. Governor Lamont appointed Natalie Braswell to succeed Comptroller Lembo for the remainder of his term. Sean Scanlon was elected State Comptroller in November of 2022 and was sworn in on January 4, 2023. Dr. Thomas Woodruff served as director of the Healthcare Policy and Benefit Services Division during the audited period. He served in this capacity until February 14, 2022, when he was succeeded by Joshua Wojcik.

Significant Legislation

Public Act 19-117 (Section 378) amended Section 3-123sss of the General Statutes, adjusting the Partnership Plan premium calculation for employers enrolled in coverage on and after July 1, 2019. This change was phased in during a two-year period beginning July 1, 2020 to adjust each participating non-state public and nonprofit employers premium payments to reflect the healthcare costs of the county of the majority of their partnership plan employees.

Financial Information

State Employees' Health Service

Under the provisions of Section 5-259 of the General Statutes, Connecticut is obligated to pay 100% of the portion of the hospital and medical insurance premium charged for individual coverage and 70% of the portion charged for each state employee's spouse or family coverage and members of the General Assembly. As with all statutory provisions concerning employee benefits, approved collective bargaining contract language may supersede the provisions of Section 5-259. The state negotiates the hospital and medical insurance plans offered through the collective bargaining process. The State Employees Bargaining Agent Coalition (SEBAC) agreement requires the state to provide Point of Service, Point of Enrollment, Point of Enrollment-Gatekeeper, and out-of-area plans, that include prescription drug coverage. Based on SEBAC requirements, the Office of the State Comptroller goes out to bid for the agreement's state plans through a request for proposal (RFP) process. Insurance carriers respond to the RFP with proposed costs. The State Comptroller then chooses the carriers, and their plans. Effective October 1, 2020, Anthem Blue Cross and Blue Shield became the sole medical insurance carrier for active employees. Prior to October 1, 2020, employees could choose between Anthem and United Healthcare/Oxford medical plans.

Since the enactment of the pension and benefits agreement, the State of Connecticut and SEBAC negotiations resulted in one arbitration award and separate SEBAC agreements, which changed the terms of the initial agreement. The SEBAC I, II, III, IV and V agreements were enacted and effective prior

to the 1997-1998 fiscal year. The SEBAC V pension agreement provided that the State Employees Retirement System would not be changed through June 30, 2017, unless mutually agreed to by all parties.

The SEBAC 2009 agreement modified sections of SEBAC V and required that all employees hired on or after July 1, 2009, and existing employees with less than five years of service as of July 1, 2010, contribute 3% of their salary for ten years, to be deposited into a newly established retiree healthcare trust fund. A 2011revision of the SEBAC pension agreement extended the requirement of the trust contributions to all other state employees to be phased in beginning July 1, 2013 as follows: 0.5% of salary for the fiscal year ended June 30, 2013; 2% of salary for the fiscal year ending June 30, 2014; and 3% of salary for the fiscal year ending June 30, 2015 and thereafter, with a period of required contributions of ten years or to the beginning of retirement, whichever occurs first.

Revisions in the SEBAC agreement in 2009 and 2011 also changed benefits as cost control measures, including the creation or modification to emergency room and prescription drug copayments, the use of mail-order prescriptions, and the implementation of a voluntary health enhancement plan. The Health Enhancement Program is available to all state employees and retirees (including all enrolled dependents) and requires enrolled individuals to adhere to a schedule of health assessments and screenings. There are no additional costs to employees choosing the program, but there are increased premium shares and a deductible for those who decline to enroll in or fail to comply with the program's requirements.

The SEBAC 2017 agreement encompassed changes to employee healthcare including 1% increases to premiums for active employees on July 1, 2019, 2020 and 2021, provided these increases did not push the employee's premium share above 15%. The agreement also split the generic drug copay into two tiers (Preferred Generic and Non-Preferred Generic) and increased emergency room copays to $250 for non-emergencies.

Each fiscal year, the state's share of employee health services is initially met from authorized General and Special Transportation Fund appropriations. Based on the payroll transactions submitted by state agencies, the Office of the State Comptroller charges the General and Special Transportation Fund appropriations for the state's portion of the premiums due to the private insurance carriers and makes payroll deductions for the balance of premiums for employees with additional coverage. Reimbursements to the General Fund are received from certain federal and state funds or restricted accounts charged with salaries of employees covered under the state's health insurance program.

Effective July 1, 2010, the State of Connecticut self-insured for medical and prescription claims rather than paying premiums. The base rates for all benefit plans are determined by an actuarial consultant. The derived rates are used to establish state employee payroll deductions and adequate appropriations for the state share of health claims based on historical trends in claims data. Dental insurance is paid by premium.

An analysis of the total payment of the state's share of such costs for the audited period compared to the preceding fiscal year follows:

	Fiscal Year Ended June 30,		
	2019	2020	2021
Expenditures- General Fund:			
Employer's Share- State Employees	$ 634,210,107	$ 681,984,939	$ 674,876,441
Expenditures- Transportation Fund:			
Employer's Share- State Employees	47,495,758	51,690,136	52,545,101
Grand Total- Employer's Share- State Employees	$ 681,705,865	$ 733,675,075	$ 727,421,542

Retired State Employees' Health Service

For retirements before July 1, 1997, the state paid 100% of the health insurance premiums for each retiree receiving benefits from a state-sponsored retirement system, except those under the Municipal Employees Retirement System and the Teachers' Retirement System. This coverage includes the payment of 100% of health coverage provided through the State Comptroller or in conjunction with federal medical benefits provided under the Medicare Part B Program. Members retiring on or after July 1, 1997, may be required to assume a share of the premium cost, depending on their selected plan. Pursuant to the SEBAC 2017 agreement, current Medicare retirees were covered through a Medicare Advantage vehicle, effective July 1, 2018. Premium shares increased by 1.5% for future non-Medicare covered non-hazardous duty retirees with less than 25 years of service, who retire after October 2, 2017, but before July 1, 2022. For hazardous duty and non-hazardous duty employees retiring on or after July 1, 2022, premium shares increased to 3% and 5%, respectively. Effective July 1, 2022, the state began reimbursing the full standard Medicare Part B premium for all applicable retirees. The state also reduced its reimbursement to high earners to half of the additional Medicare charges beyond the standard premium.

The state appropriated and transferred $692,189,000, $757,791,000, and $847,309,000 to cover its share of health insurance costs for eligible retirees during the 2019, 2020, and 2021 fiscal years, respectively. The state spent $682,032,180, $743,115,927, and $749,541,898 during those fiscal years, respectively.

In the past, the state funded the health insurance benefits for retired employees as costs were incurred. Unlike retirement benefits, the state did not establish a reserve to provide support for future years. During the fiscal year ended June 30, 2008, the Governmental Accounting Standards Board (GASB) implemented Statement No. 45 (GASB 45), which was later replaced by GASB Statement No. 75 (GASB 75) effective for fiscal years beginning after June 15, 2017. GASB 45 required the state to calculate and record the actuarial accrued liability for future health care benefits of retired employees. As a result, in May 2008, the state created the State Employees Other Post-Employment Benefits Plan (SEOPEBP). SEOPEBP is administered by the State Comptroller as a single-employer defined benefit other post-employment benefit (OPEB) plan covering retired state employees receiving benefits from any state-sponsored retirement system, except the Teachers' Retirement System and the Municipal Employees Retirement System. SEOPEBP provides healthcare and life insurance benefits to eligible retirees and their spouses. The cost of post-retirement health care benefits is funded through the transfer of General Fund appropriations to the OPEB – State Employees trust fund. The fair market value of the net assets within the fund was as follows:

	Fiscal Year Ended June 30,		
	2019	2020	2021
Net Assets	$849,889,000	$1,196,007,548	$1,537,193,620

As noted above, the state must provide an actuarial valuation of the OPEB liability. Actuarial valuations of the system were prepared as of June 30, 2019, 2020 and 2021. As a result of these valuations, the net OPEB liability for the audited period and the preceding fiscal year was as follows:

	Fiscal Year Ended June 30,		
	2019	2020	2021
Net OPEB Liability	$17,264,398,000	$20,682,391,738	$23,540,906,412

The following table shows the number of enrolled OPEB members for the audited period and the preceding fiscal year as follows:

Enrolled OPEB Members:	Fiscal Year Ended June 30, 2019	2020	2021
Active Members	48,015	48,015	49,927
Retired members or beneficiaries currently receiving benefits	77,141	77,141	79,870

Partnership Plan

Section 3-123bbb of the General Statutes authorizes the Office of the State Comptroller to offer non-state public and nonprofit employers the option to obtain healthcare, dental, and prescription coverage under a partnership plan. The Partnership Plan is a point-of-service health plan, and shares benefits, administration, and programs with the state health plan.

The Office of the State Comptroller contracts with an independent actuarial firm through a competitive bidding process. The plan is funded by actuarially determined premiums paid by enrolled employers. All premiums are administered by the Office of the State Comptroller for the payments of claims and administrative fees.

An analysis of premiums and claims for the audited period as compared to the preceding fiscal year follows:

	Fiscal Year Ended June 30, 2019	2020	2021
Partnership Plan Premiums:	$358,398,814	$512,762,495	$557,177,149
Partnership Plan Claims:	$380,547,450	$484,097,446	$508,175,960

Deferred Compensation

Section 5-264a of the General Statutes authorizes the Office of the State Comptroller to offer State of Connecticut employees a deferred compensation plan created in accordance with Section 457 of the Internal Revenue Code. The Office of the State Comptroller contracts with an administrator selected through a competitive process. This plan permits all permanent employees, including elected and appointed officials, to defer a portion of their salary until future years. This deferred compensation is not available to employees until retirement, termination of employment, disability, unforeseeable emergency, or death.

Group Life Insurance

Section 5-257 of the General Statutes authorizes the Office of the State Comptroller to procure group life insurance for State of Connecticut employees from an authorized life insurance company. The plan offers basic and supplemental life insurance as optional benefits available to eligible employees. The benefits of basic life insurance are based on an employee's yearly gross compensation as set forth in the Schedule of Basic Life Insurance in Section 5-257(b) of the General Statutes and is reduced at retirement in accordance with Section 5-257(d).