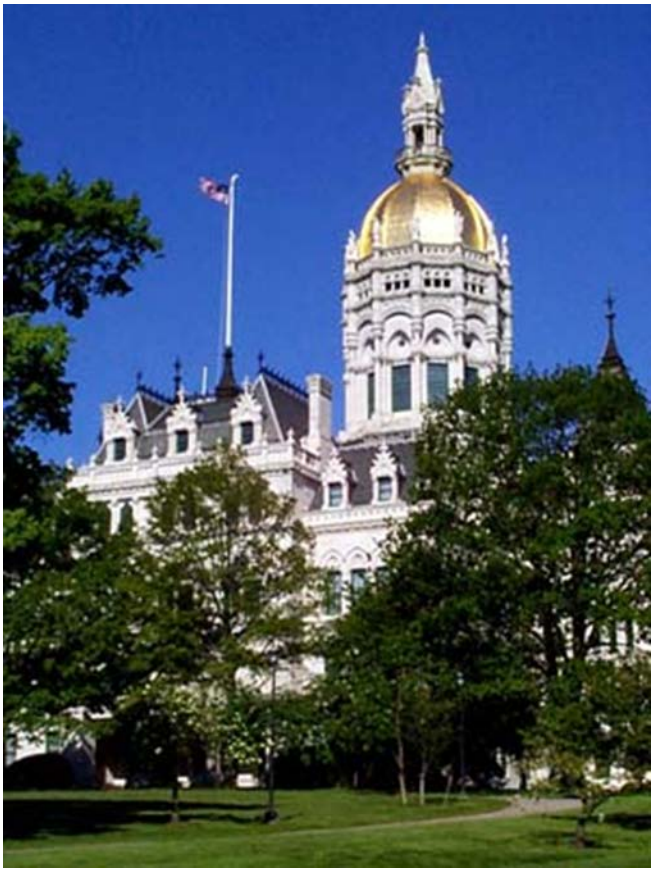
STATE OF CONNECTICUT



AUDITORS' REPORT
DEPARTMENT OF INSURANCE AND
THE OFFICE OF THE HEALTHCARE ADVOCATE
FISCAL YEARS ENDED JUNE 30, 2016 and 2017

AUDITORS OF PUBLIC ACCOUNTS
JOHN C. GERAGOSIAN ❖ ROBERT J. KANE

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May 16, 2019

EXECUTIVE SUMMARY

In accordance with the provisions of Section 2-90 of the Connecticut General Statutes we have audited certain operations of the Department of Insurance and The Office of the Healthcare Advocate. The objectives of this review were to evaluate the department's internal controls, compliance with policies and procedures, as well as certain legal provisions, and management practices and operations for the fiscal years ended June 30, 2016 and 2017.

The key findings are presented below:

Finding 3 Page 10	The Department of Insurance misinterpreted waivers granted by the Office of the State Treasurer which impacted compliance with Section 4-32 of the General Statutes. We also noted revenue coding errors in our test of deposits.
Finding 4 Page 13	The Department of Insurance did not properly document monthly reconciliations between its records and Core-CT and could not readily explain discrepancies noted.
Finding 6 Page 15	The Department of Insurance understated the annual assessment calculations for the audited period due to calculation errors in the Insurance Fund operating budget and fund balance credits.
Finding 7 Page 16	The Department of Insurance, Office of the Healthcare Advocate, and Advisory Committee to the Office of the Healthcare Advocate did not timely file or several required reports or did not file them at all.
Finding 5 Page 9	The Department of Insurance prepared GAAP forms that contained numerous deficiencies, including incorrect dollar amounts, coding errors and were filed late.
Finding 6 Page 8	Our review of expenditures noted several instances in which the Department of Insurance did not complete purchase requisitions. We also noted that the department created purchase orders after the receipt of good or services.
Finding 7 Page 14	The Department of Insurance did not document its annual physical inventory of software items. In addition, our test of software noted discrepancies between purchase order records and the software listing.

STATE OF CONNECTICUT

AUDITORS OF PUBLIC ACCOUNTS

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May 16, 2019

AUDITORS' REPORT
DEPARTMENT OF INSURANCE AND
THE OFFICE OF THE HEALTHCARE ADOVCATE
FOR THE FISCAL YEARS ENDED JUNE 30, 2016 AND 2017

We have audited certain operations of the Department of Insurance and the Office of the Healthcare Advocate in fulfillment 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, 2016 and 2017. The objectives of our audit were to:

1. Evaluate the department's and office's internal controls over significant management and financial functions;

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

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

Our methodology included reviewing written policies and procedures, financial records, minutes of meetings, and other pertinent documents; interviewing various personnel of the department; and testing selected transactions. 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 our audit in accordance with the standards applicable to performance audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States. Those standards require that we plan and perform our 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 such a basis.

The accompanying Résumé of Operations is presented for informational purposes. This information was obtained from the department's management and was not subjected to the procedures applied in our audit of the department. For the areas audited, we identified:

1. Deficiencies in internal controls;

2. Apparent noncompliance with legal provisions; and

3. No need for improvement in management practices and procedures that we deemed to be reportable.

The State Auditors' Findings and Recommendations in the accompanying report presents any findings arising from the audit of the Department of Insurance and the Office of the Healthcare Advocate.

COMMENTS

FOREWORD

The duties, powers and responsibilities of the Department of Insurance (DOI) are set forth primarily by Title 38a of the General Statutes. The responsibilities of DOI include the licensing and oversight of insurance business within the state and the collection of certain taxes and fees arising from such activities. Included within the scope of the term insurance business are the insurance activities related to fraternal benefit societies, certain coverage incident to credit transactions, public adjusters, casualty adjusters, motor vehicle physical damage adjusters, certified insurance consultants, and healthcare centers.

In accordance with Section 36a-285 of the General Statutes, in conjunction with the Department of Banking, DOI is responsible in certain instances for the oversight of mutual savings banks of the state, which engage in the marketing of savings bank life insurance. DOI also has oversight for workers' compensation for mutual associations of employers formed for the purposes of insuring their liabilities to compensate employees for injuries sustained under Sections 31-328 through 31-339, and for policies of insurance issued by either insurers or self-insured, purporting to cover an employer's liabilities for workers' compensation under Sections 31-345 through 31-348a. Katharine L. Wade was appointed commissioner on March 20, 2015 and served in that capacity during the audited period.

The duties, powers and responsibilities of the Office of the Healthcare Advocate (OHA) are set forth primarily by Title 38a, Chapter 706b of the General Statutes and, pursuant to these provisions, the office is placed within the Department of Insurance for administrative purposes

only. OHA assists consumers with healthcare issues through the establishment of outreach programs related to consumer rights and responsibilities as members of managed care plans. OHA is under the direction of a Healthcare Advocate, who is appointed by the Governor with the approval of the General Assembly. Victoria Veltri was appointed Healthcare Advocate in April 2011 and served until June 10, 2016. Ted Doolittle was appointed as Healthcare Advocate on January 20, 2017 and continues to serve in that capacity.

Commission on Health Equity

The duties, powers and responsibilities of the Commission on Health Equity are set forth in Title 38a, Chapter 706b, Section 38a-1051 of the General Statutes and, pursuant to these provisions, are placed within the Office of the Healthcare Advocate for administrative purposes only. The mission of the 32-member commission is to eliminate disparities in health status based on race, ethnicity, and linguistic ability and to improve the quality of health for all state residents. Membership consists of commissioners or their designees and appointed public members. The Commission on Health Equity was eliminated, effective July 1, 2016.

Advisory Committee to the Office of the Healthcare Advocate

Section 38a-1049 of the General Statutes established the Advisory Committee to the Office of the Healthcare Advocate. The advisory committee meets to review and assess OHA performance and conducts an annual evaluation of OHA. We disclose further information relating to the advisory committee within our State Auditors' Findings and Recommendations section of this report.

Significant New Legislation

Public Act 15-5, Section 345, of the June Special Session of the General assembly, effective July 1, 2015, created a new public health fee. The Insurance Commissioner assesses this fee annually against each insurer or health care center providing health insurance that provides coverage of the types specified in subdivisions (1), (2), (4), (11) and (12) of Section 38a-469 of the General Statutes. The public health fee is used to recover the Department of Public Health's appropriation for the needle and syringe exchange program, AIDS services, breast and cervical cancer detection and treatment, x-ray screening and tuberculosis care, and venereal disease control. The Secretary of the Office of Policy and Management, in consultation with the Commissioner of Public Health, must annually determine the amount appropriated for these purposes.

Public Act 16-3, Section 208, of the May Special Session of the General Assembly, effective July 1, 2016, eliminated the Commission on Health Equity.

Public Act 17-2, Section 164, of the June Special Session of the General Assembly, effective January 1, 2018, established the Office of Health Strategy (OHS) within the Department of Public Health. As a result, 5 positions and associated Insurance Fund support of $3,425,149 for the State Innovation Model Initiative will be transferred from the Office of the Healthcare Advocate to the OHS in fiscal year 2018-2019. Additionally, 1 position and associated Insurance Fund support of $262,978 will be transferred from the Department of Insurance to OHS in fiscal year 2019.

RÉSUMÉ OF OPERATIONS

General Fund Receipts

Receipts for the General Fund are summarized below for the fiscal years ended June 30, 2015, 2016, and 2017, respectively.

	Fiscal Year Ended June 30,		
General Fund Receipts by Account	**2015**	**2016**	**2017**
Fees	$5,739,602	$6,844,491	$9,215,975
Licenses	23,758,647	47,363,401	20,282,610
Surplus Line Tax	20,209,047	20,228,825	21,239,943
Fines and Costs	2,001,212	1,274,668	2,299,824
Other Receipts/Refunds	(46,912)	(76,755)	(42,370)
Total Receipts	**$51,661,596**	**$75,634,630**	**$52,995,982**

General Fund receipts consist primarily of fees collected from domestic and foreign insurance companies, and health care centers doing business in the state. The various fees are established by Section 38a-11 of the General Statutes and are collected mainly for licenses, applications, exams, and the filing of annual reports. Additionally, DOI collects surplus line taxes in accordance with Section 38a-743 of the General Statutes that are equal to 4% of the surplus line brokers' gross insurance premiums.

Licenses increased by $23,604,754 for the 2015-2016 fiscal year and then decreased by $27,080,791 for the 2016-2017 fiscal year. Every two years (even fiscal year), the department bills for all appointed insurance agents, resulting in a large revenue fluctuation.

Fees increased by $1,104,889 for the 2015-2016 fiscal year and then increased again by $2,371,484 for the 2016-2017 fiscal year. Revenues received for fees are derived from applications for various licenses issued by the department. The volume is driven by economic conditions and changes in license laws. Public Act 14-64 amended Section 38a-11 of the General Statutes by adding licensure for portable electronics insurance during the 2014-2015 fiscal year, which attributed to the increase in fees in the following fiscal years.

Insurance Fund

The Insurance Fund, established by Section 38a-52a of the General Statutes, is used to account for the recovery of DOI operating expenses from insurance companies. Sections 38a-47 and 38a-48 of the General Statutes provide for the manner in which DOI calculates the assessments. Generally, domestic insurance companies and other domestic entities subject to taxation under Chapter 207 are assessed on an annual basis using certain estimated expenses of DOI and shared expenses of the Department of Social Services and the Office of Policy and Management. Included within the assessment calculation is an adjustment for actual expenditures in the previous fiscal year. Receipts for the Insurance Fund are summarized below for the fiscal years ended June 30, 2015, 2016 and 2017 respectively.

	Fiscal Year Ended June 30,		
Insurance Fund Receipts by Account	**2015**	**2016**	**2017**
Expenses Recovered from Insurance Cos.	$29,789,751	$41,242,443	$30,306,091
Investment Interest	21,823	178,824	665,354
Insurance Licenses	8,140	-	-
Fees	31,481,519	41,498,438	42,885,065
Other Refunds	(3,925)	(4,300)	(1,068,086)
Refunds	29,863	14,584	125,472
Total Receipts	**$61,327,171**	**$82,929,989**	**$72,913,896**

Fees increased by $10,016,919 during the 2015-2016 fiscal year due to revenues received for the new public health fee assessment. Public Act 15-5 (June Special Session) Section 345 implemented the public health fee to recover the Department of Public Health (DPH) appropriation for programs and services provided under Section 19a-7p of the General Statues.

The Expenses Recovered from Insurance Companies category reflects the annual assessments collected pursuant to Section 38a-47 and 38a-48 of the General Statutes. Revenues increased by $11,452,692 during the 2015-2016 fiscal year, and then decreased by $10,936,352 during the 2016-2017 fiscal year. Annual receipts vary depending on the calculated assessment, which is based upon various appropriations funded for the year, netted against the Insurance Fund's remaining balance.

Expenditures for the Insurance Fund are summarized below for the fiscal years ended June 30, 2015, 2016 and 2017, respectively.

	Fiscal Year Ended June 30,		
Insurance Fund Expenditures by Account	**2015**	**2016**	**2017**
Personal Services & Employee Benefits	$24,377,154	$25,380,665	$24,782,216
Premises and Property Expenses	1,355,357	1,367,447	1,354,021
Purchased & Contracted Services	524,324	489,039	439,705
Information Technology	157,156	38,545	68,098
Purchased Commodities	86,256	96,838	79,946
Capital Outlays – Equipment	49,653	34,034	21,565
Other Expenditures	462,032	335,093	617,218
Total Expenditures	**$27,011,932**	**$27,741,661**	**$27,362,769**

Total expenditures increased by $729,729 during the 2015-2016 fiscal year, and then decreased by $378,892 during the 2016-2017 fiscal year. The fluctuations were mainly due to changes in personal services and fringe benefit contributions to the State Employees' Retirement System as established by the State Comptroller.

The fluctuations in the Other Expenditures category during the 2015-2016 and 2016-2017 fiscal years were a result of indirect overhead expenses. The State Comptroller bills self-funded agencies for work performed by central agencies, including the Department of Administrative Services, Department of Public Works, Office of the Attorney General, and the Bureau of Enterprise Systems and Technology.

The available cash balance in the Insurance Fund was $13,416,597 and $10,346,652 as of June 30, 2016 and 2017, respectively.

The Office of the Healthcare Advocate is a separately budgeted agency that is under the Department of Insurance for administrative purposes only. The Insurance Fund is charged for the expenditures of OHA, which were $4,922,993 and $5,035,411 for the 2015-2016 and 2016-2017 fiscal years, respectively. These expenditures were mainly attributed to personal services, employee benefits, and management consulting fees to administer the federal State Innovation Model Initiative (SIM) test grant from the Center for Medicare & Medicaid Innovation (CMMI).

Special Revenue Fund – Federal and Other Restricted Account

Federal and Other Restricted Account receipts for DOI totaled $442,450 and $445,450 for the 2015-2016 and 2016-2017 fiscal years, respectively. Receipts consisted mainly of utilization review licensing fees and fees collected from the licensing of bail bond agents. The slight increase in the 2016-2017 fiscal year was due to a non-federal grant receipt in the Insurance Department Education Account, which utilizes fees imposed on insurance companies to protect consumers through educational programs.

Expenditures from this fund totaled $395,383 and $204,616 for the fiscal years ended June 30, 2016 and 2017, respectively. The majority of the expenditures were for auditing services to conduct examinations of surety bail bondsmen and marketing for outreach campaigns. The decrease in the 2016-2017 fiscal year was mainly due to the transfer of salaries for several employees involved in regulating the utilization review activities to the Insurance Fund.

Federal and Other Restricted Account receipts for OHA totaled $270,202 and $3,972,469 for the fiscal years ended June 30, 2016 and 2017, respectively. In 2014, the state was awarded a 4-year $45 million federal State Innovation Model Initiative grant. The purpose of the grant was to "test state-led, multi-payer health care payment and service delivery models that will improve health system performance, increase quality of care, and decrease costs for Medicare, Medicaid and Children's Health Insurance Program (CHIP) beneficiaries and for all residents." The large increase in receipts for the 2016-2017 fiscal year was due to the office drawing down grant funds that were available, but not drawn down in fiscal years 2015 or 2016.

Federal and Other Restricted Accounts expenditures totaled $3,973,639 and $4,380,510 for the fiscal years ended June 30, 2016 and 2017, respectively. The majority of expenditures were for consulting services and grant transfers to other state agencies. The increase in the 2016-2017 fiscal year was due to the increase in SIM grant expenditures, resulting in greater reliance on federal funding for consultant expenses.

As noted previously, Public Act 17-2 of the June Special Session of the General Assembly, effective January 1, 2018, created the Office of Health Strategy (OHS). Pursuant to this legislation, federal funds for the SIM grant will be transferred to OHS during the 2018-2019 fiscal year.

Special Revenue Fund - Brokered Transactions Guaranty Fund

The Brokered Transactions Guaranty Fund operates under Sections 38a-880 through 38a-889 of the General Statutes. This fund was established to compensate state residents aggrieved by actions of insurance agents or brokers, including embezzlement and fraud. Newly licensed insurance agents and brokers are required to pay a $10 fee to the fund. Section 38a-882 of the General Statutes requires that the fund maintain a $500,000 balance. Any receipts in excess of that amount are deposited to the General Fund. There have been no disbursements from this fund for at least 19 years and a $500,000 fund balance has been maintained. During the 2015-2016 and 2016-2017 fiscal years, receipts totaling $152,276 and $333,915 were deposited into the General Fund, respectively.

Public Act 18-137, effective July 1, 2018, reduced the amount to be maintained in this fund from $500,000 to $100,000.

Trust Deposits and Escrow Accounts Held by the State Treasurer

Under various statutory provisions, certain insurance companies are required to deposit securities with the State Treasurer for the benefit of their policyholders. The par value of these deposits totaled $315,606,000 as of June 30, 2017. These amounts include (1) retaliatory deposits made under the provisions of Section 38a-83 of the General Statutes, which require companies domiciled in states that require deposits of Connecticut companies, to make equivalent deposits in Connecticut, (2) deposits made under Section 38a-371 of the General Statutes for companies desiring to be self-insured for their automobile coverage, and (3) other deposits required by the commissioner and determined to be necessary for the protection of Connecticut policyholders.

STATE AUDITORS' FINDINGS AND RECOMMENDATIONS

Our review of the records of the Department of Insurance and the Office of the Healthcare Advocate disclosed areas of concern, which are discussed below.

Procurement

Criteria: Section 4-98 (a) of the General Statutes states that no budgeted agency may incur any obligation except by the issuance of a purchase order transmitted to the State Comptroller to commit the agency's appropriations to ensure that funds are available for the payment of such obligations.

The department's internal policy requires that a properly approved purchase requisition must be in place prior to the purchase of goods and services.

Condition: Our review of 20 expenditure transactions processed during the audit period identified 5 instances in which the purchase order was issued after the receipt of goods and services. In addition, we noted that 6 transactions did not have a purchase requisition on file.

In a separate review of 40 purchasing card (P-Card) transactions, our audit found 5 instances in which a purchase requisition was not on file.

Effect: Incurring an obligation without a valid commitment circumvents budgetary controls and increases the risk that funding will not be available at the time of payment.

Cause: The Office of the Healthcare Advocate (OHA) administered the majority of the expenditure transactions noted as exceptions. During the audit period, there was a lack of OHA fiscal staff in place, which contributed to these issues.

Recommendation: The Department of Insurance and the Office of the Healthcare Advocate should strengthen their internal controls to ensure that funds are committed prior to purchasing good and services. (See Recommendation 1.)

Agency Response: Department of Insurance: "Connecticut Insurance Department (CID) management believes that the efforts of its business office to instruct agency staff about the need for a completed purchase order that precedes any purchase commitment have mitigated this issue within CID over the past year. Those efforts need to continue with

a goal of 100% compliance going forward. In addition, CID has taken steps, such as assuming responsibility for the OHA P-Card, which have effectively tightened controls over expense incurrence at OHA."

Office of Healthcare Advocate: "OHA agrees with the auditors' findings, and is committed to continuing to work with the administrative staff at the Department of Insurance to insure that all of OHA's procurements meet state requirements. We do note that some of these affected transactions were executed by the State Innovation Model (SIM) and/or Health Information Technology Office (HITO); and both offices as of February 2018 have been transferred to the new Office of Health Strategy (OHS) within the Department of Public Health."

GAAP Reporting

Criteria: The Office of the State Comptroller requires that each state agency submit an annual GAAP Closing Package, enabling the State Comptroller to prepare accurate financial reports in accordance with generally accepted accounting principles (GAAP). The procedures and requirements are outlined in the State Comptroller's GAAP reporting instructions for state agencies.

The State Accounting Manual includes a comprehensive chart of accounts for coding revenue transactions. Proper coding of revenues on the GAAP forms is essential in providing accurate financial information to the State Comptroller.

Condition: Our review of the department's GAAP reporting package for the fiscal years ending June 30, 2016 and 2017 disclosed the following conditions:

1. DOI submitted its GAAP reporting packages 50 and 49 days late for the fiscal years ended June 30, 2016 and 2017, respectively.
2. DOI reported receivables of $172,289 for the fiscal year ended June 30, 2016. It should have reported $34,952, which resulted in an overstatement of $137,337.
3. DOI reported receivables of $54,048,911 for the fiscal year ended June 30, 2017. The entire amount reported was incorrect because the department reported actual amounts collected during the fiscal year instead of amounts owed as of June 30, 2017.

4. DOI reported deferred revenue of $9,540,960 for the fiscal year ended June 30, 2016. It should have reported $7,717,960, which resulted in an overstatement of $1,823,000.
5. We noted revenue account coding errors for the fiscal years ended June 30, 2016 and 2017.

Effect: The state's GAAP basis financial statements may contain misstatements.

Cause: The majority of the conditions noted appear to be the result of a lack of management oversight.

The overstatement of $54,048,911, reported as a receivable for the fiscal year ended June 30, 2017, was the result of the department's misunderstanding of the State Comptroller's reporting instructions.

Recommendation: The Department of Insurance should strengthen its internal controls to ensure that GAAP reporting packages are prepared timely, accurately and in accordance with the State Comptroller's instructions. (See Recommendation 2.)

Agency Response: "As necessitated by recent budgetary constraints, CID now maintains a staffing level in its business office lower than during prior audit periods. Concurrently, demands on the business office have increased materially due to (a) changes responsive to prior audit recommendations (e.g. consolidation of P-Card processing and travel responsibilities in this unit), as well as (b) additional legislative mandates relating to assessments on the insurance industry.

Management understands the importance of GAAP reporting and will strive to mitigate the issues noted above. A significant factor in this regard is that, until recently, OSC memos concerning GAAP reporting packages were not reaching the appropriate CID staff member, a condition which has now been remedied and which should result in enhanced compliance."

Deposits

Criteria: Section 4-32 of the General Statutes requires that any state agency receiving any money or revenue for the state amounting to more than $500 shall deposit such receipts in depositories designated by the Treasurer within 24 hours of receipt. Total daily receipts of less than $500 may be held until the total receipts to date amount to $500, but not for a period of more than 7 calendar days. The Treasurer is authorized to make exceptions to the limitations herein prescribed

upon written application from the head of any state department stating that compliance would be impracticable and giving the reasons therefore. The Treasurer has granted the department a 1 business-day extension waiver for checks totaling $500 or more. As a result, the department has 48 hours to deposit these checks into a state account.

The State Accounting Manual defines "Funds Awaiting Distribution" as any money received by state agencies that has to be held in suspense until final disposition is determined. It further states that any receipt of money that cannot be posted to the correct funding source must be deposited to the Funding Awaiting Distribution fund. This fund was established to enable agencies to comply with statutory deposit requirements.

Revenue coding should enhance the accountability for receipts and provide for the compilation of the total receipts collected by category.

Condition: The Department of Insurance and Office of the Healthcare Advocate collected revenue totaling $160,275,061 and $130,327,797 during the fiscal years ended June 30, 2016 and 2017, respectively. Our review of 20 receipts, totaling $2,347,914, disclosed the following conditions:

1. DOI did not deposit a receipt, totaling $750, within the time limit required by the waiver obtained from the Treasurer. Further investigation revealed that the department's procedures for collecting certain receipts prevents it from depositing checks in a timely manner. Specifically, the business office logs received checks and then distributes those checks to various DOI divisions. The divisions perform investigations and determine the validity of the receipt. Upon completion of their reviews, the checks are returned to the business office for deposit. This process may result in checks being deposited significantly later than the 48-hour extension.

2. DOI incorrectly coded 3 deposits. One deposit, totaling $136,612, represented a federal funds receipt; however, it was coded to a non-federal revenue account. DOI coded the other 2 deposits, totaling $203,570, to the incorrect license classification.

Effect: The lack of prompt deposits increases the opportunity for loss and misappropriation of state funds. There is also an increased risk that checks are not properly safeguarded.

Inaccurate account coding errors could potentially impact the state's annual financial reports

Cause: The late deposit condition appears to be caused by the DOI misinterpretation of the Office of the State Treasurer's deposit waiver. The department presumed that receipts could be withheld from deposit until a final disposition was known, which could be several months in certain rare instances. Conversely, the Treasurer's waiver was only for an extension of 1 business-day, allowing the department 48 hours to make deposits.

The coding errors appear to be caused by a lack of management oversight.

Recommendation: The Department of Insurance should strengthen internal controls to ensure that receipts are coded correctly and deposited in accordance with Section 4-32 of the General Statutes. The department should utilize the Funds Awaiting Distribution Fund for any monies received for which the disposition cannot be readily determined. (See Recommendation 3.)

Agency Response: "Noncompliance with respect to Section 4-32 of the General Statutes one-day deposit requirement resulted directly from CID's good faith reading of the waiver letter it received from the Treasurer's office. In the context of its being a response to CID's written waiver request, the Office of the Treasurer's (OTT) letter was read as permitting CID to hold certain checks un-deposited until such time as agency personnel could verify that the payment was to be accepted. During the conduct of the audit, management was advised that the OTT had intended to add only one additional day to the holding period.

In recent years, CID has implemented improvements which have the effect of dramatically reducing the payments it receives by check. Such transition to credit card payments is continuing and management expects that the volume of physical items the agency handles should diminish further over the coming year. With respect to checks CID does continue to receive, the process going forward will be to utilize the Funds Awaiting Distribution Fund, as described. Management does wish to note that all physical payments received by CID have been carefully tracked, and there were no lost items or misappropriated funds discovered during the audit. Revising the check processing protocol will increase the time demands on agency personnel who handle checks, and questions

remain as to the costs and benefits in this area given the relatively low dollar amounts of the items involved."

Receipt Reconciliations

Criteria: The State Accounting Manual states that the Comptroller's records are the official accounting records of the State of Connecticut. Core-CT is the official book of record for the state. The manual further states that it is the responsibility of each agency's management to reconcile its records with the Comptroller's records.

Condition: Our review identified weaknesses in the DOI monthly receipt reconciliation process. The department did not document reconciliations between its receipt records and Core-CT. As a result, it could not readily explain the following variances noted below:

- For the month ending June 30, 2016, we identified a discrepancy of $4,099,027 between the DOI receipt records and the amounts recorded in Core-CT.
- For the month ending June 30, 2017, we identified a discrepancy of $1,565,480 between the DOI receipt records and amounts recorded in Core-CT.

Effect: Failure to perform proper reconciliations between department records and Core-CT increases the risk that errors will go undetected and prevents identified errors from being corrected in a timely manner.

Cause: The lack of monthly receipt reconciliations appears to be the result of management oversight.

Recommendation: The Department of Insurance should strengthen internal controls to ensure that it performs and documents monthly reconciliations of receipts to Core-CT in accordance with the State Accounting Manual. (See Recommendation 4.)

Agency Response: "Management does not agree that CID failed to perform monthly reconciliations. The business office staff conducts regular monthly conferences for the specific purpose of performing such reconciliations. Management acknowledges that CID's records of its monthly reconciliations to Core-CT were not documented on the designated form; that control weakness will be remedied going forward. Finally, management believes that all of the apparent discrepancies were able to be explained, although some

explanations were delayed due to the pressure of other work near the end of the fiscal year."

Auditor's Concluding Comment: The State Accounting Manual states that the Comptroller's records are the official accounting records of the State of Connecticut and that Core-CT is the official book of record. We acknowledge that DOI staff perform monthly reconciliations of receipts collected with their internal records. However, DOI did not perform those reconciliations to the Core-CT general ledger. Furthermore, the department should have documented and explained those discrepancies between department records and Core-CT during the monthly reconciliation process, rather than at the auditor's request.

Software Inventory

Criteria: In accordance with Chapter 7 of the State Property Control Manual, each state agency must establish a software inventory to track and control all software media and license agreements. The agency must produce an annual software inventory report. In addition, the agency must conduct an annual physical inventory of the software library.

Condition: Our review of the DOI software inventory, including a test of 10 software items, revealed the following conditions:

1. DOI did not document an annual physical inventory of its entire software library for the fiscal years ended June 30, 2016 and 2017.

2. For 3 of the 10 software items tested, we noted discrepancies between purchase order records and the software inventory listing. Specifically, DOI incorrectly recorded software costs and the number of licenses associated.

Effect: DOI has not properly maintained software inventory records, increasing the risk that it is not properly accounting for and reporting software purchases.

Cause: It appears that the person responsible for software inventory was not completely aware of the specific directives outlined in the State Property Control Manual.

Recommendation: The Department of Insurance should strengthen internal controls to ensure that it maintains and reports its software inventory records in

accordance with the State Property Control Manual. (See Recommendation 5.)

Agency Response: "Although CID has been performing an annual physical inventory of our software library, the results of the inventory were not being clearly documented by fiscal year. This oversight has been corrected. Additionally, in the past, some purchase information may not have been available when an inventory record was created. In some cases, the incomplete record was not updated later, when the information did become available. This deficiency has been corrected. Management believes that such enhancements should ensure that software is inventoried and documented in accordance with the State Property Control Manual."

General Assessment Calculations

Background: The Insurance Fund supports the operation of the Department of Insurance and the Office of the Healthcare Advocate. DOI assesses domestic insurance companies and entities to cover the cost of these agencies. The assessment is built around the total amount of premium taxes paid to the Department of Revenue Services by domestic insurance companies and entities for the preceding year.

Criteria: Sections 38a-47 and 38a-48 of the General Statutes outline the annual assessment process. In accordance with Section 38a-48 (c), DOI should calculate the proposed assessments for each domestic insurance company or entity by allocating the amount to be paid under Section 38a-47 among the domestic insurance companies and entities in proportion to their respective shares of the total taxes and charges imposed under Chapter 207 during the preceding calendar year. Section 38a-48 (g) requires that at the end of the year, the department recalculate the assessment amount for domestic insurance companies and entities using actual expenditures, and show the difference between the recalculated amount and the amount previously paid.

Condition: For the fiscal year ended June 30, 2016, DOI assessed insurance companies and entities $24,975,457, which it understated by $441,591. For the fiscal year ended June 30, 2017, the department assessed insurance companies and entities $22,376,860, which it understated by $171,346. The understatements were due to calculation errors in the Insurance Fund operating budget and the fund balance credits.

Effect: The underassessment of insurance companies and entities increases the risk that sufficient funding will not be available to cover the operating costs of the Department of Insurance and the Office of the Healthcare Advocate.

Cause: Management's calculation was incorrect because it did not account for the appropriation of a nonfunctional budgetary item and did not include the health benefit mandate assessment credits.

Recommendation: The Department of Insurance should strengthen controls to ensure assessments are calculated in accordance with Sections 38a-47 and 38a-48 of the General Statutes. (See Recommendation 6.)

Agency Response: "Management agrees fully that its assessment calculations should be as accurate as practically possible. It notes several mitigating points in relation to this point, however:

(A) Both understatements appear to have resulted from CID's use of fiscal year-end Insurance Fund balances, as reflected at a point in mid-July while such balances remained subject to small post-closing adjustments. In light of the Sec. 38a-48 requirement that bills be rendered to domestic companies by July 31st, CID is forced to use mid-July balances, even if that entails a possibility of "missing" a subsequent retroactive reduction in the Fund balance;

(B) To the extent that one year's Insurance Fund assessment is understated, the mechanics of the assessment calculation correct for that understatement in the subsequent year; and

(C) The risk of underfunding CID operations is minimal. A substantial balance is carried within the Insurance Fund on a year-to-year basis, and underassessments on the order of 1.7 percent and 0.8 percent do not pose a material risk of insufficient funding under current conditions."

Reporting Requirements

Criteria: The Department of Insurance, Office of the Healthcare Advocate, and the advisory committee to the Office of the Healthcare Advocate are required to comply with numerous reporting requirements set forth by the General Statutes and by the Office of the State Comptroller.

Condition: Our review of the reports required to be filed during the fiscal years ended June 30, 2016 and 2017 by the Department of Insurance, Office of the Healthcare Advocate, and the Advisory Committee to

the Office of the Healthcare Advocate revealed the following conditions:

Department of Insurance:

1. DOI did not complete the annual report to the joint standing committee of the General Assembly having cognizance of matter related to insurance, required by Section 38a-12 (b) of the General Statutes, for the fiscal years ended June 30, 2016 and 2017.

2. DOI submitted the Medical Malpractice Annual Report, required by Section 38a-395 (d) of the General Statutes, 107 and 69 days late for the fiscal years ended June 30, 2016 and 2017, respectively.

3. DOI submitted the Annual Internal Control Questionnaire, required by the Office of the State Comptroller, 73 days late for the fiscal years ended June 30, 2017.

Office of the Healthcare Advocate:

4. OHA submitted the annual report of the Healthcare Advocate, required by Section 38a-1041 (e) of the General Statutes, 77 and 60 days late for the fiscal years ended June 30, 2016 and 2017, respectively.

5. We were unable to determine whether OHA timely submitted the Annual Report of Budgeted Agencies, required by Section 4-60 of the General Statutes, for the fiscal years ended June 30, 2016 and 2017.

Advisory Committee to the Office of the Healthcare Advocate:

6. The advisory committee submitted the annual evaluation of the advisory committee to the Office of the Healthcare Advocate, required by Section 38a-1049 (b) of the General Statutes, 158 days late for the fiscal year ended June 30, 2016. The advisory committee did not complete the report for the fiscal year ended June 30, 2017.

Effect: The Department of Insurance, Office of the Healthcare Advocate, and Advisory Committee to the Office of the Healthcare Advocate did not comply with the reporting requirements established by the General Statutes and the Office of the State Comptroller.

Cause: The lack of reporting compliance by the Department of Insurance appears to be the result of managerial oversight.

The Office of the Healthcare Advocate submitted annual report of the Healthcare Advocate due on January 1st was late because OHA combines this annual report with 3 other annual reports required by Section 38a-1041 (g) and Section 38a-1050 of the General Statutes. OHA combines these reports due to staffing constraints and because the January 1st deadline does not allow the agency to capture complete annual data.

The untimely and lack of reporting of the annual evaluation of the Advisory Committee to the Office of the Healthcare Advocate appears to be the result of the advisory committee's administrative oversight.

Recommendation: The Department of Insurance should submit all reports required by the General Statutes and Office of the State Comptroller in a timely manner.

The Office of the Healthcare Advocate should submit all reports required by the General Statutes in a timely manner and strengthen internal controls to ensure that it documents those submissions. OHA should also consider seeking legislation to clarify the reporting requirements established by Sections 38a-1041 (e) and (g) and Section 38a-1050 of the General Statutes.

The Advisory Committee to the Office of the Healthcare Advocate should strengthen controls to ensure compliance with statutory reporting timeframes. (See Recommendation 7.)

Agency Response: Department of Insurance: "CGS 38a-12(b): This statute provides for CID to report to the Insurance and Real Estate Committee "the information the commissioner received during the past year pursuant to sections 29-311, 31-290d, 38a-356 and 53-445." The referenced sections relate generally to informational reports on transgressions such as arson, workers comp fraud, etc. To the best knowledge of the CID staff, none of the informational reports listed under 38a-12(b) has been received by the department. It is arguable, therefore, that no 38a-12(b) reporting obligation arose in the absence of reportable information. In fact, until the conduct of this audit, it appears to have been generally believed that Sec. 38a-12(b) related only to the Annual Report requirement of 38a-12(a), and not its own separate reporting statute.

To the best knowledge and belief of CID management, the 38a-12(b) report has not been requested or filed in many years, due in part to the erroneous belief that subpar. 12(b) was merely a continuation of subpar. 12(a). It therefore appears that CID should seek guidance as to whether the General Assembly desires to maintain the 12(b) requirement in place or to repeal it. If kept in place, CID will take steps to ensure future compliance.

CGS 38a-395: Timely reporting under this section has been raised in a past audit. And, as noted in response to that prior audit, the statutory filing deadline for the Medical Malpractice Claims Report (as in effect during fiscal years 2016 and 2017) made compliance infeasible, due to the unavailability of information from the carriers so early in the calendar year. That situation has now been remedied by enactment of Sec. 9 of P.A. 17-198, which re-set the annual filing deadline to June 30th. Timely filing should not be an issue going forward.

Annual Internal Control Questionnaire: Management will make the timely completion of this document a priority.

The Insurance Department has taken additional measures to ensure compliance with required reports through the creation of a "report repository." The repository contains a listing of required reports; their statuary reference, due date, whom they are to be submitted to, date submitted, and division(s) responsible for drafting. There is a corresponding file that contains an electronic record of each report's submission." Office of the Healthcare Advocate: "OHA agrees with the Auditors' findings, including the desirability of clarifying legislation to synchronize reports that are better done simultaneously. We have legislative language prepared that will correct the statutory conflicts, and are working with the Advisory Committee to promote more proactive attention to this required report in the future, including offering significant procedural assistance. The documentation and tracking processes for OHA's and the Advisory Committee's findings were affected by transition issues stemming from the fact that the Healthcare Advocate resigned in 2015 to take another position, and the new Healthcare Advocate was not appointed and confirmed until February 2017. Such transition periods will continue to pose a challenge for a small independent agency with limited administrative resources such as OHA. However, in order to reduce the risks of similar situations, OHA will instruct all senior OHA managers and supervisors about the importance of continuing to track and document these important filing requirements during any similar future leadership transitions."

RECOMMENDATIONS

Our prior report on the Department of Insurance and the Office of the Healthcare Advocate contained 7 recommendations, 3 of which will be modified and repeated and 4 of which were resolved. As a result of the current examination, we have identified 4 new recommendations.

Status of Prior Audit Recommendations:

- **The Department of Insurance should strengthen internal controls to ensure medical leave is taken in accordance with department policies and state and federal FMLA requirements.** Corrective action was taken; therefore, this recommendation will not be repeated.

- **The Department of Insurance should strengthen internal controls to ensure travel authorization forms are complete and approved prior to securing travel arrangements in accordance with state travel regulations and policies.** Corrective action was taken; therefore, this recommendation will not be repeated.

- **The Department of Insurance should strengthen internal controls to ensure that documentation is on file to support deposits.** Corrective action was taken; therefore, this recommendation will not be repeated.

- **The Department of Insurance should review its internal controls over receipts to ensure compliance with the State Accounting Manual.** Our current audit noted improvements involving the department's receipt tracking process; therefore, this recommendation will not be repeated.

- **The Department of Insurance should strengthen internal controls to ensure that its software inventory records are maintained and reported in accordance with the State Property Control Manual.** We noted similar issues during our current review; therefore, the recommendation will be repeated. (See Recommendation 5.)

- **The Department of Insurance should strengthen internal controls to ensure assessments are calculated in accordance with Sections 38a-47 and 38a-48 of the General Statutes.** We noted similar issues with the assessment calculations during the current review; therefore, the recommendation will be repeated. (See Recommendation 6.)

- **The Department of Insurance should submit all reports required by the General Statutes and Office of the State Comptroller in a timely manner and strengthen internal controls to ensure evidence is maintained to support timely submittal.**

  The Office of the Healthcare Advocate should submit all reports required by the General Statutes in a timely manner or seek legislation to clarify the reporting requirements established by Sections 38a-1041 subsection (e) and 38a-1050 of the General Statutes.

The advisory committee to the Office of the Healthcare Advocate and the Commission on Health Equity should strengthen controls to ensure compliance with reporting timeframes as prescribed by the General Statutes. We noted similar issues relating to reporting requirements; therefore, the recommendation will be modified to reflect current conditions. (See Recommendation 7.)

Current Audit Recommendations:

1. **The Department of Insurance and the Office of the Healthcare Advocate should strengthen their internal controls to ensure that funds are committed prior to purchasing good and services.**

   Comment:

   Our current review of expenditures noted several instances in which purchase requisitions were not completed. We also found that purchase orders were created after the receipt of goods or services.

2. **The Department of Insurance should strengthen its internal controls to ensure that GAAP reporting packages are prepared timely, accurately and in accordance with the State Comptroller's instructions.**

   Comment:

   We noted numerous deficiencies on GAAP forms prepared during the audit period, including incorrect dollar amounts, coding errors, and late filings.

3. **The Department of Insurance should strengthen internal controls to ensure that receipts are coded correctly and deposited in accordance with Section 4-32 of the General Statutes. The department should utilize the Funds Awaiting Distribution Fund for any monies received for which the disposition cannot be readily determined.**

   Comment:

   DOI misinterpreted waivers granted by the Office of the Treasurer impacting compliance with Section 4-32 of the General Statutes. We also noted revenue coding errors were also noted during our test of deposits.

4. **The Department of Insurance should strengthen internal controls to ensure that it documents and performs monthly reconciliations of receipts to Core-CT in accordance with the State Accounting Manual.**

   Comment:

DOI did not properly document monthly reconciliations between the department's internal records and Core-CT and could not readily explain noted discrepancies.

5. **The Department of Insurance should strengthen internal controls to ensure that it maintains and reports its software inventory records in accordance with the State Property Control Manual.**

   Comment:

   Our review of the department's software inventory listing and test of 10 items revealed that DOI did not document its annual physical inventory and we noted discrepancies between purchase order records and the software listing.

6. **The Department of Insurance should strengthen controls to ensure assessments are calculated in accordance with Sections 38a-47 and 38a-48 of the General Statutes.**

   Comment:

   DOI understated the annual assessment calculations for the audited period due to calculation errors in the Insurance Fund operating budget and fund balance credits.

7. **The Department of Insurance should submit all reports required by the General Statutes and Office of the State Comptroller in a timely manner.**

   The Office of the Healthcare Advocate should submit all reports required by the General Statutes in a timely manner and strengthen internal controls to ensure that it documents those submissions. OHA should also consider seeking legislation to clarify the reporting requirements established by Sections 38a-1041 (e) and (g) and Section 38a-1050 of the General Statutes.

   The Advisory Committee to the Office of the Healthcare Advocate should strengthen controls to ensure compliance with statutory reporting timeframes.

   Comment:

   Our review of the reports required to be filed during the fiscal years ended June 30, 2016 and 2017 by the Department of Insurance, Office of the Healthcare Advocate, and Advisory Committee to the Office of the Healthcare Advocate disclosed several deficiencies, including reports that were not filed or filed late.

ACKNOWLEDGEMENT

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

Xiaofeng Chen
Stefania Novello
Jaimie Przygocki

CONCLUSION

We wish to express our appreciation for the courtesies and cooperation extended to our representatives by the personnel of the Department of Insurance and the Office of the Healthcare Advocate during the course of our examination.

Stefania Novello
Principal Auditor

Approved:

John C. Geragosian
State Auditor

Robert J. Kane
State Auditor