

STATE OF NEVADA

Audit Report

Public Employees' Benefits Program

2012



Legislative Auditor
Carson City, Nevada

Audit Highlights



Highlights of Legislative Auditor report on the Public Employees' Benefits Program issued on December 13, 2012. Report # LA12-23.

Background

The Public Employees' Benefits Program (PEBP) was established in 1999 to manage the state's group health insurance program for its employees and retirees. The program provides health, dental, vision, and life insurance to state and local government employees, retirees, and their covered dependents. A nine-member Board appointed by the Governor oversees PEBP's operations. The Board appoints an Executive Officer to direct the day-to-day operations.

Purpose of Audit

The purpose of this audit was to determine whether: (1) PEBP can provide additional information on the costs of healthcare procedures to assist participants with healthcare decisions, (2) PEBP has adequate controls over contract management, (3) information technology controls are sufficient to protect the confidentiality, integrity, and availability of participant information, and (4) accounting policies and procedures are complete and up-to-date. Our audit focused on healthcare cost information available to participants and included a review of PPO claims paid from July 1, 2011, through April 30, 2012. The audit also focused on contract management practices in place from July 1, 2010, through July 1, 2012. Finally, we reviewed information security controls and accounting policies and procedures in place during fiscal year 2012.

Audit Recommendations

This audit report contains three recommendations to provide participants with additional cost information when making healthcare decisions. In addition, five recommendations were made to improve contract management, and five recommendations to strengthen information security controls. Finally, one recommendation was made to update accounting policies and procedures.

The Public Employees' Benefits Program accepted the 14 recommendations.

Recommendation Status

PEBP's 60-day plan for corrective action is due on March 13, 2013. In addition, the six-month report on the status of audit recommendations is due on September 13, 2013.

Public Employees' Benefits Program

Summary

Beginning in fiscal year 2012, PEBP changed its health plan to a consumer driven high deductible health plan. Because of the high deductible amounts, participants have an incentive to become informed consumers when making healthcare decisions. In addition, a wide range in costs exists for some medical services; therefore, participants could save themselves and the Plan money by comparing prices among providers when feasible. Although PEBP has provided some information on costs, additional tools are needed to help participants fully assess the cost and quality trade-offs of healthcare decisions. Finally, Explanation of Benefits statements should include clear descriptions of services provided and medical procedure codes. This would help participants verify that billings are correct.

PEBP can take steps to strengthen contract oversight. We found contracts did not always include required performance standards. In addition, certain vendors should report performance information more timely, and other vendors' required evaluations were not done. We also found weaknesses in some contract provisions and information reported to PEBP was not always reliable. Finally, contracting policies and procedures were out-of-date and need revision.

PEBP's information technology controls can be strengthened. Sensitive data including credit card numbers and other information could be better protected. In addition, background investigations were not conducted on staff with access to confidential information.

Key Findings

A wide range in costs can occur for the same healthcare procedures in Nevada. Costs can vary widely because providers charge different amounts and negotiate varying discounts with insurance providers. When planning nonemergency procedures participants should consider comparison-shopping. Comparing prices among providers could save the participant and the Plan money. (page 6)

PEBP is taking steps to provide participants with additional information to assist with comparing healthcare costs. These include providing participants with access to several on-line tools that provide information on healthcare and prescription drug costs. In addition, PEBP is working with its third party administrator (TPA) to provide participants with additional cost information for certain medical services. Although PEBP is taking steps to provide participants with additional tools to price healthcare and pharmacy costs, more work needs to be done. PEBP should periodically inform participants of the wide range in healthcare costs, tools available, and the best methods to compare prices. (page 8)

Participants do not receive adequate information to verify that billings are correct. Explanation of Benefits (EOB) statements, provided to participants after a claim is processed, do not always provide clear descriptions of services billed or medical billing codes. As a result, there is an increased risk that participants and the Plan could overpay for healthcare services. (page 9)

PEBP can strengthen its monitoring of vendor performance. We found 7 of 13 contracts did not include required performance standards. In addition, when standards were included in contracts, performance results were not always reported to PEBP. Finally, evaluations or audits of vendors were not always done as required by contract. (page 13)

Several weaknesses were found in PEBP's contract with the wellness vendor. First, the contract did not include deadlines to ensure performance results were provided timely. Second, program implementation dates were not included in the contract. Third, the contract did not specify how results should be presented to ensure consistent reporting. (page 16)

PEBP has good information technology controls over participant information. However, access to sensitive data including credit card numbers and other information could be further restricted. Five PEBP staff had access to credit card information whose job duties did not require access. In addition, PEBP and vendor staff can view sensitive participant information even though access is not needed to perform their job duties. (page 21)

Prior to 2012, PEBP did not conduct background investigations on staff with access to confidential information. During our audit, PEBP began conducting *Civil Name Check* background investigations on new hires; however, current practice does not follow state requirements to conduct fingerprint based investigations on new employees. Granting employees access to sensitive data without appropriate background investigations increases the risk that individuals could gain access to sensitive information and use it inappropriately. (page 23)

PEBP did not have up-to-date accounting policies and procedures. Policies and procedures have not been updated in more than 7 years despite changes to the Program's accounting function. For example, procedures refer to the prior Enrollment and Eligibility System that was replaced in 2007. (page 25)

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This report contains the findings, conclusions, and recommendations from our completed audit of the Public Employees' Benefits Program. This audit was conducted pursuant to the ongoing program of the Legislative Auditor as authorized by the Legislative Commission. The purpose of legislative audits is to improve state government by providing the Legislature, state officials, and Nevada citizens with independent and reliable information about the operations of state agencies, programs, activities, and functions.

This report includes 14 recommendations to improve the quality of information provided to participants when making healthcare decisions, contract management, information security controls, and accounting policies and procedures. We are available to discuss these recommendations or any other items in the report with any legislative committees, individual legislators, or other state officials.

Respectfully submitted,

Paul V. Townsend, CPA
Legislative Auditor

November 29, 2012
Carson City, Nevada

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Introduction

Background

The Public Employees' Benefits Program (PEBP) was established in 1999 to manage the state's group health insurance program for its employees and retirees. Its mission is "recognizing the fiduciary responsibility of the Board, promote wellness, transparency, ease of use, communications and integration of PEBP programs centered around the people we serve." PEBP provides health, dental, vision, and life insurance to state and local government employees, retirees, and their covered dependents.

A nine-member Board oversees PEBP's operations. Eight Board members are appointed by the Governor, and the ninth member is the Director of the Department of Administration or his designee. The Board appoints an Executive Officer to direct the day-to-day operations. In fiscal year 2012, PEBP had 32 authorized positions with one office located in Carson City. The agency includes the following sections:

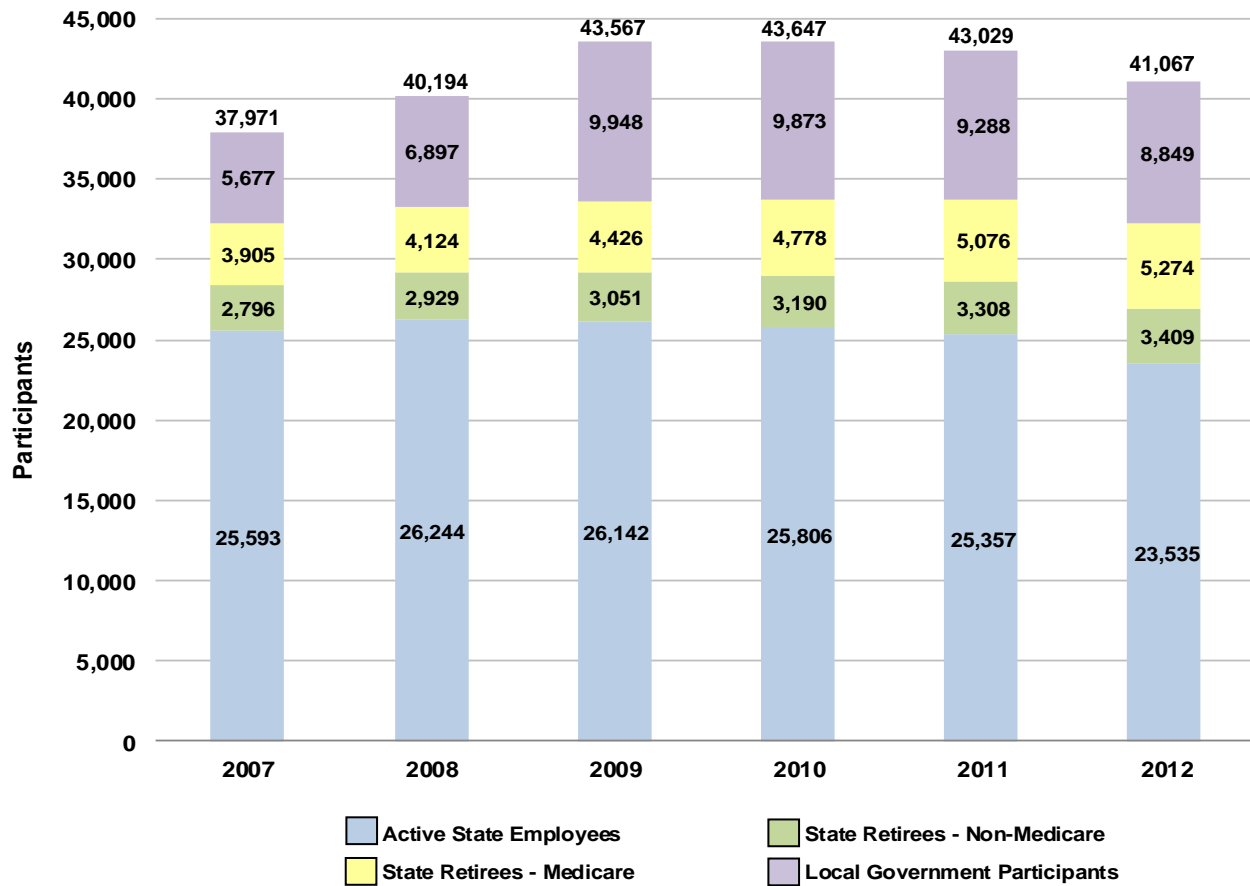
- **Operations** – includes document production, customer service, enrollment and eligibility management and personnel.
- **Accounting** – includes accounting, finance, and payroll.
- **Quality Control** – includes contract management, appeals, complaints, and research.
- **Information Technology** – is responsible for general information systems management.
- **Public Information** – is responsible for PEBP communications with participants and special interest groups including: benefits orientation, open enrollment communications, the agency newsletter, and press releases.

In fiscal year 2012, the number of participants totaled more than 41,000. Exhibit 1 shows PEBP's participant counts for fiscal years

2007 to 2012 including state employees, state non-Medicare and Medicare retirees, and local government participants.

PEBP Participant Counts Fiscal Years 2007 – 2012

Exhibit 1



Source: PEBP records.

PEBP's main funding sources include state and local government contributions and participant premiums. Funding is used primarily for medical, dental, and prescription drug expenses. Exhibit 2 shows PEBP's revenues, expenses, and reserves for fiscal years 2008 to 2012.

**PEBP Revenues, Expenses, and Reserves
Fiscal Years 2008 to 2012**

Exhibit 2

	2008	2009	2010	2011	2012
Total Revenues	\$276,324,409	\$323,195,112	\$353,046,011	\$381,506,755	\$317,671,286
Expenses					
Operating	5,043,547	4,956,094	5,215,065	5,201,560	4,797,923
Fully Insured Program Costs ⁽¹⁾	68,263,630	82,457,043	87,907,848	98,410,150	105,832,932
Self Insured Administrative Costs ⁽²⁾	10,763,182	11,119,858	10,969,972	10,169,337	8,035,508
Self Insured Claims Costs ⁽²⁾	200,557,720	237,086,632	245,557,268	247,261,008	148,198,631
HSA/HRA Contributions ⁽³⁾	--	--	--	--	26,818,856
Total Expenses	\$284,628,079	\$335,619,627	\$349,650,153	\$361,042,055	\$293,683,850
Income or (Loss)	(8,303,670)	(12,424,515)	3,395,858	20,464,700	23,987,436
Reserve Balance	\$ 93,428,094	\$ 81,003,579	\$ 84,399,437	\$104,864,137	\$128,851,573

Source: State accounting system.

⁽¹⁾ Includes payments to health maintenance organizations (HMO) and the life insurance vendor.

⁽²⁾ Costs for the self-funded health plan managed by PEBP.

⁽³⁾ HSA and HRA accounts were introduced in fiscal year 2012.

Exhibit 2 shows revenues and expenses declined in fiscal year 2012 compared to previous years. These changes resulted from a reduction in employee numbers, changes in the health plan, and moving Medicare retirees into a Medicare Exchange.¹ Exhibit 2 also shows increasing reserves over the past several years. Fiscal year 2012 reserves of nearly \$129 million include about \$77 million in planned reserves to cover claims and unforeseen expenses. The remaining \$52 million are unallocated or excess reserves. In March 2012, the PEBP Board made several program changes to spend \$29 million in excess reserves. The remaining \$23 million will be included in PEBP's budget request for fiscal years 2014 and 2015.²

PEBP contracts for a variety of services including actuarial, preferred provider networks (PPO), health maintenance organizations (HMO), management of large claims cases and utilization review, and audit services. In addition, PEBP contracts with a third party administrator (TPA) to pay medical and dental claims, and a pharmacy benefits manager to access drug

¹ The Medicare Exchange offers Medicare supplemental and Advantage Plans.

² For more information on reserves see Appendix A.

discounts, rebates, and to pay claims. Annual payments to these vendors exceeds \$100 million.³

Recent Program Changes

When preparing its budget request for fiscal years 2012 and 2013, PEBP was instructed by the Governor to keep its state subsidy levels flat or at the same level as fiscal year 2011. PEBP estimated to maintain the same benefits as fiscal year 2011, and factoring in medical inflation, plan utilization, and costs associated with federal healthcare reform, would require an additional \$85 million in state funding. To address the shortfall, the PEBP Board approved a series of plan changes including:

- Replacing the Self-funded PPO Plan with a consumer driven High Deductible Health Plan (HDHP).
- Annual deductibles were increased from \$800 to \$1,900 for an individual and from \$1,600 to \$3,800 for a family.
- Co-pays for office visits were eliminated. Participants pay the entire cost for office visits and other services, excluding wellness visits, until deductibles are met.
- Coinsurance or the amount the Plan pays after deductibles are met was reduced from 80% to 75%.
- A Health Savings Account (HSA) or Health Reimbursement Arrangement (HRA) were provided for all HDHP participations. To establish the account, the Plan contributed \$700 for each participant and \$200 for each dependent up to a maximum of three dependents or \$600.
- The rate structure methodology was changed to a more traditional model. Previously, rates were determined based on costs incurred by each tier. The new methodology identifies costs by two groups, adults and children. The change in rate methodology resulted in lower monthly premiums for the individual and individual plus spouse tiers, and higher monthly premiums for the tiers with children.
- Medicare retirees with Medicare Part A coverage were moved to a Medicare Exchange for health insurance. An HRA was established for Medicare retirees with a state

³ For more information on contracted services and payments see Appendix B.

contribution of \$10 per month per year of service up to 20 years or \$200 monthly.

Scope and Objectives

This audit is part of the ongoing program of the Legislative Auditor as authorized by the Legislative Commission, and was made pursuant to the provisions of NRS 218G.010 to 218G.350. The Legislative Auditor conducts audits as part of the Legislature's oversight responsibility for public programs. The purpose of legislative audits is to improve state government by providing the Legislature, state officials, and Nevada citizens with independent and reliable information about the operations of state agencies, programs, activities, and functions.

Our audit of the Public Employees' Benefits Program focused on healthcare cost information available to participants and included a review of PPO claims paid from July 1, 2011, through April 30, 2012. In addition, we reviewed contract management practices in place from July 1, 2010, through July 1, 2012. Finally, we reviewed information technology controls and accounting policies and procedures in place during fiscal year 2012. Our audit objectives were to determine whether:

- PEBP can provide additional information on the costs of healthcare procedures to assist participants with healthcare decisions.
- PEBP has adequate controls over contract management.
- Information technology controls are sufficient to protect the confidentiality, integrity, and availability of participant information.
- Accounting policies and procedures are complete and up-to-date.

Information on Costs Could Assist Participants With Healthcare Decisions

Beginning in fiscal year 2012, PEBP changed its health plan to a consumer driven high deductible health plan. Because of the high deductible amounts, participants have an incentive to become informed consumers when making healthcare decisions. In addition, a wide range in costs exists for some medical services; therefore, participants could save themselves and the Plan money by comparing prices among providers when feasible. Although PEBP has provided some information on costs, additional tools are needed to help participants fully assess the cost and quality trade-offs of healthcare decisions. Finally, Explanation of Benefits statements should include clear descriptions of services provided and medical procedure codes. This would help participants verify that billings are correct.

Wide Range in Costs for Some Healthcare Procedures

A wide range in costs can occur for the same healthcare procedures in Nevada. Costs can vary widely because providers charge different amounts and negotiate varying discounts with insurance providers. When planning nonemergency procedures participants should consider comparison-shopping. Comparing prices among providers could save the participant and the Plan money.

We compared costs for procedures in Nevada by reviewing claims processed by the Plan from July 1, 2011, through April 30, 2012. Exhibit 3 shows the range in cost for six procedures performed in Elko, Carson City, Reno, and Las Vegas.

Range in Costs for Selected Healthcare Procedures by Location**Exhibit 3**

Procedure	Elko	Carson City	Reno	Las Vegas
Chest X-ray – two views	\$11 to \$162	\$15 to \$54	\$11 to \$57	\$12 to \$65
Colonoscopy	\$775 to \$1,620	\$546	\$278 to \$807	\$248 to \$532
Dental Exam	\$40 to \$88	\$40 to \$89	\$40 to \$89	\$39 to \$84
Sinus Endoscopy	\$230 to \$461	\$178	\$90 to \$254	\$94 to \$197
Treadmill Electrocardiogram	\$367	\$95 to \$313	\$131 to \$186	\$95 to \$173
Ultrasound – fetal	\$157	\$70 to \$225	\$50 to \$236	\$42 to \$243

Source: PEPB claims processed from July 1, 2011 to April 30, 2012.

Note: 95% of costs fell within stated range for the locations shown.

Exhibit 3 shows a wide range in costs for specific procedures within a location and between locations. For example, a colonoscopy can range from \$278 to \$807 in Reno. In addition, a colonoscopy can cost as little as \$248 in Las Vegas and as high as \$1,620 in Elko. As a result, the amount PEBP and participants pay for the same procedure can vary significantly.

A wide range in cost for medical procedures also exists in other states. The July 2012 Consumer Reports magazine reported a wide range in prices for certain procedures nationwide. For example, Consumer Reports found the cost for a colonoscopy ranged from \$800 to \$3,160. The cost for a fetal ultrasound ranged from \$120 to \$480. Consumer Reports recommended comparing prices as one method for participants to save money.

With the change to the high deductible health plan (HDHP), participants have a financial incentive to compare prices when planning surgeries and other procedures. Comparison-shopping could save the participant and the Plan money. Because the HDHP is a self-funded plan, insurance premiums must cover costs. As a result, significant increases in costs would most likely result in future increases in premiums and possible reductions in benefits. Therefore, participants have an additional incentive to compare prices.

PEBP Is Taking Steps to Provide Participants With Information

PEBP is taking steps to provide participants with additional information to assist with comparing healthcare costs. These include providing participants with access to several on-line tools that provide information on healthcare and prescription drug costs. In addition, PEBP is working with the third party administrator (TPA) to provide participants with additional cost information for certain medical services.

Although PEBP is taking steps to provide participants with additional tools to price healthcare and pharmacy costs, more work needs to be done. PEBP should periodically inform participants of the wide range in healthcare costs, tools available, and the best methods to compare prices.

Resources Available to Participants on PEBP's Website

Through its website, PEBP has made several pricing tools available to assist participants with pricing prescription drugs and healthcare costs. These include:

- Rx Drug Pricing Tool – provides prices at retail pharmacies based on the drug, quantity, and location. PEBP's pharmacy benefits vendor manages this pricing tool. It is available to participants through the pharmacy vendor's secured website.
- Healthcare Blue Book – provides medical and dental prices based on the procedure and zip code. The Blue Book prices are based on the typical fee providers in a geographic area accept as payment from insurance companies.
- Fair Health Consumer Price Look-up – provides medical and dental prices based on the procedure, zip code, and insured or not insured. Prices listed include a 30% provider discount.

Both the Healthcare Blue Book and Fair Health Consumer Price Look-up provide general estimates of prices by procedure and location. However, we found a wide range in prices among these pricing tools. For example, the price for a colonoscopy in Carson City ranged from about \$500 to \$800. Our review of PEBP claims found the plan cost for a colonoscopy in Carson City was \$546,

shown in Exhibit 3. Therefore, these pricing tools provide participants with a starting point when comparing prices.

Plans to Make Cost Information Available for Some Procedures Based on PEBP Claims

PEBP is working with its TPA to provide participants with an additional pricing tool for medical procedures. This tool should enable participants to access information on the TPA's secured website and search for prices based on the procedure and zip code. Cost estimates will be based on PEBP claims data similar to the information used in our review shown in Exhibit 3.

Therefore, the TPA's pricing tool should provide more accurate estimates than found in the Healthcare Blue Book or the Fair Health Consumer Price Look-up websites.

The TPA plans to implement the pricing tool in two phases. The first phase should be completed by the end of 2012 and will include average costs for office visits and other physician services such as x-rays, electrocardiograms, and various laboratory tests. The second phase will include costs for surgeries and other procedures. Once established, PEBP should periodically inform participants of this tool and how to make price comparisons.

Additional Information Would Help Participants Verify That Billing Statements Are Correct

Participants do not receive adequate information to verify that billings are correct. Explanation of Benefits (EOB) statements, provided to participants after a claim is processed, do not always provide clear descriptions of services billed or medical billing codes. As a result, there is an increased risk that participants and the Plan could overpay for healthcare services.

Medical Procedure Descriptions Not Clear

Descriptions of medical procedures found on EOB statements do not always clearly describe what services were billed. As a result, it is difficult for participants to verify that services billed were provided or billed correctly.

After processing a claim, the TPA sends participants an EOB statement through the mail. The EOB identifies the patient, healthcare provider, services billed, and date of service. It also identifies financial information including the amount billed, provider discount, deductibles, amount paid by the Plan, and patient

liability. One purpose of EOB statements is to provide controls to help detect erroneous billings.

The EOBs currently include broad descriptions such as professional services, radiology, or laboratory to describe billed services. For example, an ultrasound of the veins in the arm or leg was identified on the EOB as "laboratory." In another example, an ultrasound of the arteries in the arm or leg was identified as "radiology." These general descriptions of "laboratory" and "radiology" do not provide enough information for participants to verify services were billed correctly.

Verifying billing accuracy is even more difficult when several procedures were performed. Exhibit 4 shows a comparison of procedures billed by the provider with information provided to the participant on the EOB.

**Comparison of Information Billed by Provider
With Information Provided to Participant on EOB**

Exhibit 4

Procedures Billed by Provider		Information Provided to Participant on EOB	
Procedure	Amount Billed	Procedure	Amount Billed
1 Anesthesia	\$ 782.00	1 Professional Service	\$ 782.00
2 Recovery Room	1,532.00		
3 Facility Drug Charge	5.50		
4 Facility Drug Charge	5.00		
5 Operating Room	975.00	8 Hospital Ancillary	3,015.00
6 Sterile Medical/Surgical Supplies	145.00		
7 Sterile Medical/ Surgical Supplies	66.25		
8 Non-sterile Medical/Surgical Supplies	179.50		
9 Pharmacy	106.75		
10 Facility Drug Charge	40.00	1 Professional Service	40.00
Total	\$3,837.00	Total	\$3,837.00

Sources: PEBP paid claims data and participant EOB.

Exhibit 4 shows the provider billed for 10 separate services. However, these 10 services were grouped into three items on the EOB sent to the participant. The three items listed on the EOB

have vague descriptions. For example, both anesthesia and a facility drug charge were listed on the EOB as a “professional service.” In addition, eight services including operating and recovery room services, supplies, and drug charges were combined on the EOB as “hospital ancillary.” As a result, from the information provided on the EOB, it is difficult for the participant to verify that billings are correct. We found similar vague descriptions on other EOBs.

CPT Codes Not Provided to Participants

Current Procedural Terminology (CPT) codes are not provided on EOBs. CPT codes are developed and maintained by the American Medical Association, and define medical, surgical, and diagnostic services. All healthcare procedures and services have a corresponding CPT code. Providers include codes on bills submitted to the TPA.

PEBP’s TPA and other health insurers have typically included CPT codes on information provided to participants. These codes were included on EOBs until July 2011. Other healthcare insurers including PEBP’s northern Nevada HMO and Medicare provide CPT codes on information provided to participants. For example, Medicare provides participants with CPT codes and clear descriptions of services billed on periodic statements of services provided.

Along with clear descriptions, participants need CPT codes to compare prices when planning nonemergency procedures and to help verify that billings are correct. Clear descriptions and CPT codes on EOBs would also provide another way to prevent and detect medical billing fraud. Currently, providers could bill for services not provided and the participant would not be able to detect the inflated charges.

PEBP Has Concerns With Healthcare Information Sent Through the Mail

PEBP has concerns with including CPT codes and specific descriptions of services on EOBs sent through the mail. PEBP is concerned that disclosing these codes and providing clear descriptions on EOBs could result in improper disclosure of

medical information and a violation of the Health Insurance Portability and Accountability Act's (HIPAA) privacy requirements. For example, if an EOB was inadvertently placed in the wrong envelop or sent to the wrong address, specific healthcare information could be improperly disclosed. PEBP could be fined for improper disclosure.

Clear Descriptions and CPT Codes Could Be Provided Through the TPA's Website

PEBP's TPA could provide participants with clear descriptions of healthcare services billed and CPT codes through its secure website. Currently, participants can view their claims on the TPA's website through a user name and password. However, claims information currently available on the website includes the same information sent to participants by mail, and does not include CPT codes or clear descriptions of services provided.

CPT codes and related billing information is retained in the TPA's database and could be made available to participants. Providers include CPT codes with billing information because the TPA needs these codes to properly process claims. PEBP should work with the TPA to make CPT codes and clear descriptions of services provided available to participants through the TPA's website. Providing these codes and clear descriptions will give participants additional information to verify that services billed were correct.

Recommendations

1. Periodically inform participants of the wide range in costs for some healthcare procedures and the possibility of significant savings by comparing prices among providers.
2. Provide additional resources to participants to facilitate comparing prices among providers.
3. Through the third party administrator's website, provide participants with access to Explanation of Benefits statements that include clear descriptions of medical procedures provided and CPT codes.

Contract Management Can Be Improved

PEBP can take steps to improve contract oversight. We found contracts did not always include required performance standards. In addition, certain vendors should report performance information more timely, and other vendors' required evaluations were not done. We also found weaknesses in some contract provisions and information reported to PEBP was not always reliable. Finally, contracting policies and procedures were out-of-date and need revision.

Monitoring of Vendor Performance Can Be Strengthened

PEBP can strengthen its monitoring of vendor performance. We found 7 of 13 contracts did not include required performance standards. In addition, when standards were included in contracts, performance results were not always reported to PEBP. Finally, evaluations or audits of vendors were not always done as required by contract.

Contracts Without Performance Standards

PEBP has not ensured that all contracts include performance standards as required by policy. About half of PEBP's contracts did not have performance standards. Performance standards are important to periodically evaluate vendor performance and to detect potential problems. The seven contracts without standards are shown in Exhibit 5.

Contracts Without Required Performance Standards

Exhibit 5

	Contracted Service	Contract Effective Date
1	National PPO Network	July 1, 2012
2	Southern Nevada HMO	July 1, 2012
3	Health Plan Audits	October 11, 2011
4	Northern Nevada HMO	July 1, 2011
5	Medicare Exchange	December 14, 2010
6	Financial Statement Audit	January 1, 2010
7	Dental PPO Network	July 1, 2009

Source: PEBP contracts.

Note: See Appendix B for a listing of PEBP's contracts reviewed.

In June 2009, the Board changed PEBP's Duties, Policies, and Procedures to require performance standards in all services contracts. At that time, staff indicated that specific performance standards would be customized for each contract. Previously, performance standards for claims processing had been a requirement in the third party administrator contract.

Staff indicated that performance standards have not been included in all contracts for several reasons:

- Standards have not been required of HMOs because they handle their own claims and customer service.
- Vendors such as the dental PPO have small dollar, simple, and straightforward claims with few problems.
- Staff were unsure what standards to use for some vendors.

PEBP should be able to include performance standards in all contracts. For example:

- Standards were included in the prior contract with the southern Nevada HMO. These standards were offered by the HMO and addressed claims processing and customer service. Performance standards were left out of the current contract; however, PEBP staff indicated the HMO is agreeable to amending standards into the contract.
- The current in-state PPO network contract includes performance standards addressing pricing claims and

providing information timely and accurately. Similar standards could be developed for the national and dental PPO network vendors.

- Standards in other contracts could address categories such as timeliness and accuracy.

PEBP Should Require Performance Results in Quarterly Reports

Three of the six vendors with contracts that include performance standards provide PEBP with quarterly reports on activities; however, reports do not include performance results. More timely reporting of vendor performance would improve monitoring and could identify potential problems. The three vendors that could provide quarterly performance information include the in-state PPO network, utilization review, and pharmacy.

- The in-state PPO network has requirements to help ensure that healthcare claims are processed appropriately. Specifically, the PPO is required to electronically price 95% of claims timely and 97% accurately. Additionally, the PPO is required to furnish the TPA with changes in provider information within 2 weeks of the effective date of the change.
- The utilization review vendor pre-approves hospitalization and some outpatient surgeries, oversees large dollar cases to contain costs, and assist participants. Performance standards require specific times to notify the TPA of certifications and periodic case reviews, and notify PEBP staff of large dollar cases.
- The pharmacy vendor manages PEBP's pharmacy program including paying claims. Performance standards require the vendor to process claims without errors, ship prescriptions within specified timeframes, and answer phones and resolve customer problems within certain times.

All three vendors provide PEBP with quarterly reports on activities. For example, the pharmacy vendor's quarterly reports provide information on drug utilization, costs, and new generic drugs. Although the information provided is useful, quarterly reports could be improved by including performance results.

Some Vendors Performance Not Assessed When Required

Two of four vendors did not receive an annual evaluation or audit as required in their contract. The two vendors without a required assessment were the consultant/actuary and the utilization review vendor. Annual evaluations or audits provide PEBP with another tool to monitor and assess vendor performance.

The consultant/actuary contract, effective July 1, 2008, requires PEBP staff to evaluate the vendor's performance annually. The contract includes performance standards in the following service categories: timeliness of work, quality of work, accuracy of work, setting goals and program objectives, and accessibility and responsiveness of staff. Each service category should be evaluated on a scale of 1 to 5, and the consultant/actuary is subject to financial penalties if the overall score is below 3.

The contract with the utilization review vendor requires annual audits by PEBP's health plan auditor.⁴ The purpose is to verify compliance with performance standards. However, audits have not been done. In addition, PEBP has not budgeted for annual audits. PEBP's contract with the health plan auditor budgeted for two audits over a 6-year period. Staff indicated the utilization review vendor is audited when problems are identified.

Contract Weaknesses Make It Difficult to Assess the Wellness Vendor's Performance

Several weaknesses were found in PEBP's contract with the wellness vendor. First, the contract did not include deadlines to ensure performance results were provided timely. Second, program implementation dates were not included in the contract. Third, the contract did not specify how results should be presented to ensure consistent reporting.

In April 2010, PEBP entered into a 4-year contract with a vendor to administer a Wellness Program for participants beginning July 1, 2010. The contract includes several performance standards including implementation success, participant satisfaction, participation, and reduction in health risk factors. The vendor agreed to financial penalties if certain standards were not met.

⁴ PEBP contracts with a vendor to perform quarterly audits of the TPA, annual audits of the pharmacy and Medicare Exchange vendors, and audits of several other vendors on an as needed basis.

Contract Did Not Include Deadlines to Report Performance Results

PEBP's contract with its wellness vendor did not include deadlines identifying when performance results should be reported. Although Year 1 for the Wellness Program ended June 30, 2011, performance results were not reported until March 2012. Therefore, results were not available timely for PEBP to monitor performance and consider program changes.

PEBP staff indicated late reporting of performance information resulted from several misunderstandings with the vendor. In January 2012, staff recognized performance results for fiscal year 2011 had not been provided. Staff contacted the vendor and after several drafts of the report were reviewed, a final report was completed in March 2012. This issue could be avoided by establishing reporting deadlines in the contract.

Annual Implementation Dates Not Included in Contract

Dates for implementing the Wellness Program each year were not included in the contract for the first 3 years. The contract included the following milestones to implement the program each year:

- Marketing campaign launched.
- On-line system live and registration period completed.
- On-site blood test period completed.
- First incentive received by participants.
- Care management program outreach begins.
- Claims data loaded.

However, for the first 3 years of the 4-year contract the beginning and ending dates for these milestones were listed as TBD (to be determined). Staff explained preparing the contract took longer than expected. In addition, staff indicated they did not have enough time to establish start and end dates for each milestone with the vendor before the contract was due to the Board of Examiners for approval. After the contract was approved, implementation dates should have been included through a contract amendment. PEBP staff indicated this was an oversight.

Implementation dates will help establish clear expectations for the vendor and PEBP. Additionally, the vendor has placed a portion of their administrative fees at risk if implementation dates are not met. Without specific dates in the contract it is difficult to enforce this provision.

Information Reported Was Not Consistent

Program information provided by the wellness vendor was not consistent for two reasons. First, participant information was not consistently reported from one year to the next. Second, different start and end dates were reported for program implementation. As a result, PEBP does not have reasonable assurance that vendor information is reliable.

The wellness vendor did not consistently report the number of participants completing the health risk assessment and biometric screenings. The vendor reported the number of non-Medicare retirees participating in Year 1, but did not identify retirees in Year 2. Information reported by the vendor is shown in Exhibits 6 and 7.

**Participants Completing Health Risk Assessment and Biometric Screenings
Year 1 – Fiscal Year 2011** **Exhibit 6**

Population	Eligible	Participants	Participation Rate
Active Employees	16,507	7,643	46.30%
Non-Medicare Retirees	5,843	3,165	54.17%
Total	22,350	10,808	48.36%

Source: Wellness vendor's March 2012 report.

**Participants Completing Health Risk Assessment and Biometric Screenings
Year 2 – Fiscal Year 2012** **Exhibit 7**

Population	Eligible	Participants	Participation Rate
Active Employees	21,520	7,386	34.32%
Spouses	4,860	1,009	20.76%
Total	26,380	8,395	31.82%

Source: Wellness vendor's March 2012 report.

Note: Spouses were allowed in the Wellness Program beginning in Year 2 (July 1, 2011).

Exhibit 6 shows non-Medicare retirees participated in the Wellness Program in Year 1 (July 1, 2010 to June 30, 2011). However, non-Medicare retirees are not listed in Exhibit 7, Year 2 information. PEBP staff were unsure if the non-Medicare retirees were included in the active employee numbers or excluded entirely from Year 2 numbers.

Accurately reporting participation numbers is important for three reasons. First, non-Medicare retirees are typically in the over 50 age group, which on average has higher claims expense. Therefore, it is important for PEBP to have information on the number of retirees that receive periodic screenings for early detection of potential health problems. Second, PEBP staff and the Board need accurate information to effectively evaluate the Wellness Program. Third, the wellness vendor is subject to financial penalties if less than 60% of eligible participants enroll in the program in Year 1 and 65% in Year 2.

The wellness vendor also reported different dates for Year 1 program implementation. The vendor provided two reports on program implementation; the first in November 2010, and the second in March 2012. Exhibit 8 shows information provided to PEBP from these two reports.

Comparison of Various Start and End Dates for Wellness Implementation Success Milestones in Year 1

Exhibit 8

Implementation Milestone	Initial Report to PEBP November 8, 2010 (As of September 30, 2010)		Final Report to PEBP March 12, 2012	
	Start	End	Start	End
1 Marketing Campaign Launched	06/01/10	10/31/10	05/01/10	06/20/10
2 Online System Live and Registration Period Completed	07/01/10	10/31/10	07/01/10	10/31/10
3 On-site Blood Test Period Completed	08/01/10	10/31/10	07/20/10	10/28/10
4 First Incentive Received by Participants	08/15/10	08/15/10	08/01/10	11/01/10
5 Care Management Program Outreach Begins	07/01/10	Ongoing	05/01/10	09/30/10
6 Claims Data Loaded	07/10/10	07/31/10	04/01/10	06/15/10

Source: Wellness vendor reports provided to PEBP.

Contracting Policies and Procedures Are Out-of-Date

Exhibit 8 shows the wellness vendor inconsistently reported the start and end dates for the implementation milestones. The two reports show different start dates for five of six milestones in Year 1. Exhibit 8 also shows different end dates for several milestones. For example, the end date for milestone 4, addressing the first incentive received by participants, is different by more than 2 months. These inconsistencies make it more difficult to monitor vendor performance.

Contracting policies and procedures are out-of-date and need revision. Policies and procedures were last updated in January 2009 and do not reflect current practice. For example, the state's Contract Entry and Tracking System (CETS) has replaced several procedures addressing contract maintenance. However, CETS is not referenced in policies and procedures. Additionally, policies and procedures do not adequately address contract responsibilities such as developing standards and monitoring vendor performance.

The State Administrative Manual, section 2418, requires agencies to review procedures annually, compare them with actual practices, and make changes as needed. During our audit, staff acknowledged that policies and procedures were out-of-date and plan to revise them.

Recommendations

4. Implement Board policy requiring contracts to include performance standards.
5. Require certain vendors to report performance results with quarterly reports.
6. Comply with contract provisions by conducting annual evaluations and audits when required.
7. Develop controls to ensure contracts address reporting deadlines and information provided by vendors is consistently reported.
8. Update contracting policies and procedures.

Information Technology Controls Need Strengthening

Sensitive Data Needs Better Protection

PEBP's information technology controls can be strengthened. Sensitive data including credit card numbers and other information could be better protected. In addition, background investigations were not conducted on staff with access to confidential information.

PEBP has good information technology controls over participant information. However, access to sensitive data including credit card numbers and other information could be further restricted. Five PEBP staff had access to credit card information whose job duties did not require access. In addition, PEBP and vendor staff can view sensitive participant information even though access is not needed to perform their job duties.

Restrict Access to Credit Card Number Files

PEBP stores credit card numbers on its computer network to pay for some participant's health insurance premiums. Access to the computer files containing credit card numbers should be restricted to those employees who process credit card payments and their supervisors. However, we identified five additional staff who had access to credit card numbers even though their job functions did not require access. When access is not adequately restricted, there is increased risk credit card numbers could be accessed and misused.

In addition, we found several files containing expired credit card numbers dating back to 2008 on PEBP's local file server. We observed one file contained more than 300 credit card numbers. These files were no longer needed and should have been deleted.

According to management, PEBP took action to limit access to staff involved in processing the credit card transactions when we brought this issue to their attention. In addition, management

indicated staff removed the old credit card number files and indicated they would periodically monitor and remove such files in the future.

Limit Access to Other Sensitive Information

PEBP should take additional steps to limit access to sensitive participant and dependent information. We identified that eight vendors and PEBP staff could view sensitive information even though this information is not needed to perform their jobs. As a result, participants are at greater risk their confidential information could be misused.

PEBP collects certain information on participants and dependents as part of the enrollment process. PEBP and its vendors need this information to link database records and connect participants to dependents. In addition, information is needed to provide state pay centers with premium deduction information and to report Health Savings Account information to the IRS. However, PEBP has not required vendors to adequately restrict access to sensitive information stored in their computer systems.

State law and security standards require PEBP to protect confidential information from unauthorized access. NRS 603A.210(1) requires organizations collecting personal information to maintain reasonable security measures to protect records from unauthorized access, use, or disclosure. State Security Standard 4.60 requires state agencies to protect confidential information through various methods such as encryption.

PEBP can take steps to better protect sensitive information. Specifically, PEBP should develop plans to:

- Encrypt sensitive information stored in the Enrollment and Eligibility System and transferred between vendors' computer systems.
- Mask sensitive information in all Graphical User Interfaces (computer screens) to prevent PEBP and vendor staff from viewing this information when access is not needed to perform their job functions.

Background Investigations Were Not Conducted on Staff

Prior to 2012, PEBP did not conduct background investigations on staff with access to confidential information. During our audit, PEBP began conducting *Civil Name Check* background investigations on new hires; however, current practice does not follow state requirements to conduct fingerprint based investigations on new employees. Granting employees access to sensitive data without appropriate background investigations increases the risk that individuals could gain access to sensitive information and use it inappropriately. Management should follow state requirements and PEBP policy to ensure appropriate background checks are conducted on all employees.

State Security Standard 4.04 requires agencies to conduct fingerprint based background investigations on all newly hired staff with access to sensitive systems or confidential information. Fingerprint background checks must consist of a State and F.B.I. (nationwide) fingerprint based check.

PEBP developed a policy effective January 1, 2012, to conduct Nevada Department of Public Safety *Civil Name Check* background investigations on all new employees, and on existing employees at least every 3 years. The *Civil Name Check* searches only Nevada criminal history and is designed for employment screening purposes. It is based upon an inquiry made by name, SSN, or birthdate rather than fingerprints. Management represented that *Civil Name Checks* have been performed on all new hires during 2012.

To comply with state requirements, PEBP should implement State Security Standards requiring fingerprint background checks on new employees. In addition, PEBP should ensure that Nevada Department of Public Safety *Civil Name Checks* are conducted on existing employees at least every 3 years.

Recommendations

9. Develop controls to restrict access to files containing participant credit card numbers to PEBP staff who require access as part of their job functions and to remove old files containing participant credit card numbers that are no longer necessary from the computer network.

10. Develop a plan for encrypting sensitive participant information in the Enrollment and Eligibility System and for other vendors who are provided this information.
11. Develop a plan for masking sensitive participant information in all user Graphical User Interfaces for the Enrollment and Eligibility System and for other vendors who are provided this information.
12. Conduct fingerprint based background investigations on all newly hired employees with access to sensitive information or systems as required by the State Security Standard 4.04.
13. Conduct *Civil Name Check* background investigations on all existing employees in accordance with PEBP's background investigation policy.

Accounting Policies and Procedures Need Updating

PEBP did not have up-to-date accounting policies and procedures. Policies and procedures have not been updated in more than 7 years despite changes to the Program's accounting function. For example, the policy and procedures addressing employee timekeeping had not been updated to reflect conversion to the state's NEATS timekeeping system which had been implemented at PEBP in 2004. Procedures also refer to the prior Enrollment and Eligibility System that was replaced in 2007. In addition, procedures referred to employees by name who were no longer employed by PEBP.

The State Administrative Manual, section 2418, requires agencies to review policies and procedures annually and update them as needed. Up-to-date policies and procedures are important to ensure duties and functions are carried out properly. The absence of accurate policies and procedures increases the risk the procedures will not be performed correctly. In addition, policies and procedures provide a resource for current employees and a training tool for new employees. During our audit, PEBP staff acknowledged that policies and procedures were out-of-date and had begun taking steps to revise them.

Recommendation

14. Update accounting policies and procedures to reflect current operations.

Appendix A

PEBP Reserves and Plan Adjustments Fiscal Year 2012

Reserve Categories	Subtotals	Totals
Incurred But Not Reported (IBNR) Claims Reserve⁽¹⁾		\$ 33,272,000
Catastrophic Reserve⁽¹⁾		35,015,000
HRA Reserve		8,500,000
Plan Year 2013 Adjustments⁽²⁾		
Reduction in 2013 base rates	6,900,000	
One-time \$400 contribution to HSA/HRA Accounts for employees and retirees	7,900,000	
One-time \$200 Contribution to HSA/HRA Accounts for Employees age 45 and older and Retirees with more than 20 years of service	2,500,000	
One-time additional \$100 contribution to HSA/HRA accounts for each dependent	1,400,000	
Provide same subsidy for domestic partners as is provided for spouses.	500,000	\$19,200,000
Plan Year 2014 Medicare Adjustments⁽²⁾		
One-time additional \$2 per month for each year of service to HRA for Medicare retirees	3,900,000	
Ease rate increases for plan year 2014	6,300,000	10,200,000
Subtotal		\$106,187,000
Unallocated Reserves		22,665,000
Total Reserves		\$128,852,000

Source: State accounting system and PEBP records.

⁽¹⁾ Legislative Approved Budget 2011 – 2013.

⁽²⁾ Board adjustments on March 29, 2012, totaling \$29,400,000.

Appendix B

Contract Payments Fiscal Years 2011 and 2012

Contracted Service	Vendor	Fiscal Year 2011 Payment Totals	Fiscal Year 2012 Payment Totals
National PPO Network	Beech Street	\$ 290,474	\$ 245,181
Pharmacy	Catalyst Rx	831,146	757,865
Dental PPO Network	Diversified Dental Services	345,942	289,440
Health Plan Audits	Health Claim Auditors	165,266	120,797
In-State PPO Network	Hometown Health/Sierra Healthcare	978,563	719,618
Utilization Review	APS Healthcare	933,059	633,991
Third Party Administrator	UMR & HealthSCOPE Benefits	5,505,417	4,500,024
Wellness Program	U.S. Preventative Medicine	913,406	589,316
Southern Nevada HMO ⁽¹⁾	Health Plan of Nevada	42,102,675	36,266,990
Northern Nevada HMO ⁽¹⁾	Hometown Health	48,886,797	64,113,572
Life Insurance ⁽¹⁾	Standard Insurance	7,431,637	5,452,371
Enrollment and Eligibility System	Morneau Shepell	1,213,936	1,172,916
Consulting/Actuarial	Aon Consulting	517,741	339,289
Financial Statement Audit	Casey, Neilon and Associates	44,861	36,791
Medicare Exchange ⁽²⁾	Extend Health	--	179,277
Totals		\$110,160,920	\$115,417,438

Source: State accounting system.

⁽¹⁾ Includes claims costs.

⁽²⁾ Contract began July 1, 2011.

Appendix C

Audit Methodology

To gain an understanding of the Public Employees' Benefits Program (PEBP), we interviewed staff, reviewed statutes, and policies and procedures significant to the Program's operations. We reviewed financial information, budgets, legislative committee and PEBP Board minutes, reports and statistical information, and other information describing Program activities. We also reviewed various reports and other information on the Program's finances, healthcare utilization, and costs prepared by PEBP vendors. In addition, we assessed controls related to participant information, contracts, and information security and their susceptibility to risk.

To determine if there was a wide range in costs for some healthcare procedures, we obtained a download of all PEBP claims processed from July 1, 2011 through April 30, 2012. We sorted claims by Current Procedural Terminology (CPT) codes to identify the healthcare procedures billed. We then identified the range in costs for these procedures within a specific location, and between Elko, Carson City, Reno, and Las Vegas. Our range in costs represents 95% of claims within a specific procedure and location. We removed outliers, those claims in the top and bottom 2.5%, so the range would be more representative of the cost frequency paid. In addition, we compared information received through the download of claims with Explanation of Benefits statements and state financial records to verify data reliability.

To identify the steps PEBP is taking to provide participants with additional information on healthcare costs, we reviewed various pricing tools with links on PEBP's website. We navigated through these tools, reviewed and compared prices for specific procedures between the tools to determine the ease of use and potential benefit to participants. We also reviewed plans for the TPA to provide participants with access to costs based on Plan claims.

To identify additional information to help participants compare pricing and verify the accuracy of billings we compared Explanation of Benefits (EOB) statements with information that providers supplied to the TPA. We also compared current EOBs with information on claims provided by the northern Nevada HMO, Medicare, and PEBP's prior TPA. We then examined the information provided on current EOBs to determine if it was sufficient to enable participants to verify if billings were accurate.

To determine if PEBP adequately monitors contracts we reviewed all 15 service contracts, excluding contracts for voluntary products such as auto and homeowners insurance. We reviewed each contract for compliance with state and agency contracting requirements. We also verified whether each contract included performance standards and timeframes for reporting performance results. We then discussed each contract and PEBP's contracting practices with staff.

To evaluate the contract with the wellness vendor we reviewed contract provisions including performance requirements. We then reviewed various reports on performance prepared by the vendor and compared them with contract requirements. We also discussed contract provisions and the contract preparation process with agency staff.

To determine if PEBP adequately protects participant information we reviewed computer controls that limit access to credit cards and social security numbers. We then reviewed computer files where credit card numbers are maintained to verify controls were in place. We also discussed with agency staff current practices for maintaining social security numbers and compared them with state requirements. In addition, we discussed with staff PEBP's process for conducting background investigations, and compared these practices with state requirements.

To evaluate policies and procedures we reviewed and identified agency functions without complete policies and procedures. We reviewed policies and procedures to ensure they were up-to-date, included effective dates, and were approved by management. We

also discussed policies and procedures, planned changes, and weaknesses with agency staff.

Our audit work was conducted from October 2011 to September 2012. 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.

In accordance with NRS 218G.230, we furnished a copy of our preliminary report to the Executive Officer of the Public Employees' Benefits Program. On November 13, 2012, we met with agency officials to discuss the results of the audit and requested a written response to the preliminary report. That response is contained in Appendix D which begins on page 31.

Contributors to this report included:

Lee Pierson
Deputy Legislative Auditor

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Deputy Legislative Auditor

Rocky Cooper, CPA
Audit Supervisor

Appendix D

Response From the Public Employees' Benefits Program



BRIAN SANDOVAL
Governor

JAMES R. WELLS, CPA
Executive Officer

STATE OF NEVADA
PUBLIC EMPLOYEES' BENEFITS PROGRAM

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LEO M. DROZDOFF, P.E.
Board Chairman

DATE: November 29, 2012

TO: Paul V. Townsend, CPA, Legislative Auditor

FROM: James R Wells, CPA, Executive Officer *JRWells*

SUBJECT: Legislative Audit of the Public Employees' Benefits Program

Please find below the Public Employees' Benefits Program (PEBP) responses to recommendations contained in the recent audit conducted by your office. PEBP's response to recommendations one and two, pertaining to provider pricing, have been consolidated into a single comment. Further, the responses to recommendations four and five, regarding contract performance standards; eight and fourteen, regarding policies and procedures; ten and eleven, regarding encryption of data; and twelve and thirteen, regarding background investigations, have been consolidated.

- #1 Periodically inform participants of the wide range in costs for some healthcare procedures and the possibility of significant savings by comparing prices among providers.**
- #2 Provide additional resources to participants to facilitate comparing prices among providers.**

PEBP Response:

Agree. The PEBP summer 2012 newsletter was dedicated to informing participants about the Consumer Driven Health Plan, including tools available to assist participants in becoming better healthcare consumers.

PEBP acknowledges the lack of transparency in healthcare provider pricing and agrees it is important for participants to recognize the significant variability in cost among different providers for the same service without a noticeable difference in quality. While PEBP cannot solve every provider pricing issue, it has taken steps to provide participants with nationally recognized pricing tools on its website and continues to work with its vendors to create pricing tools based on PEBP's specific provider contracts. These new tools should be available in calendar year 2013.

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PEBP will continue to provide periodic reminders about those pricing tools and their enhancements in various communications such as newsletters and open enrollment materials.

- #3 Through the third party administrator's website provide participants with access to Explanation of Benefits statements that include clear descriptions of medical procedures provided and CPT codes.**

PEBP Response:

Agree. PEBP's third party administrator, HealthSCOPE Benefits, is working on enhancements to their on-line explanation of benefits which will provide additional details including Current Procedural Terminology (CPT) codes and descriptions. In order to ensure the privacy of sensitive medical data, to view this information, participants will be required to log into the HealthSCOPE website with their user name and password.

- #4 Implement Board Policy requiring contracts to include performance standards.**

- #5 Require certain vendors to report performance results with quarterly reports.**

PEBP Response:

Agree. PEBP is in the process of amending contracts without specific performance standards to incorporate relevant measures. Performance standards will be included in future vendor contracts at the time of implementation.

PEBP is also in the process of revising vendor reporting requirements to include providing actual results against contractual performance standards. Those reports will be monitored for accuracy when PEBP, or its health plan auditor, reviews the vendor's operations.

- #6 Comply with contract provisions by conducting annual evaluations and audits when required.**

PEPB Response:

Agree. PEBP will amend contacts to ensure timely and appropriate vendor audits are conducted and will create a schedule to comply with annual vendor assessments where required by contract.

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#7 Develop controls to ensure contracts address reporting deadlines and information provided by vendors is consistently reported.

PEBP Response:

Agree. PEBP agrees it is important that information provided by vendors be timely and accurate. PEBP will review all vendor contracts to ensure any reporting deadlines are identified and that vendors comply with those deadlines. PEBP will also review all contract deliverables and reports to make sure the information provided is timely, accurate and consistent.

#8 Update contracting policies and procedures.

#14 Update accounting policies and procedures to reflect current operations.

PEBP Response:

Agree. PEBP is in the process of reviewing and updating its contracting and accounting policies and procedures to reflect current operations. An annual review will be conducted per the State Administrative Manual, section 2418, to ensure they remain accurate and current.

#9 Develop controls to restrict access to files containing participant credit card numbers to PEBP staff who require access as part of their job functions and to remove old files containing participant credit card numbers that are no longer necessary from the computer network.

PEBP Response:

Agree. PEBP agrees it is important to protect sensitive data and allow access only to employees who need it to perform their job functions. Access to this information has been restricted to Accounting Staff and related supervisors, including the Financial Analyst, the Chief Financial Officer and the Executive Officer. All credit card numbers pre-dating January 1, 2012 were permanently deleted from the computer network on or about April 2, 2012 and, going forward, non-recurring credit card numbers older than 90 days will be deleted on a monthly basis.

#10 Develop a plan for encrypting sensitive participant information in the Enrollment and Eligibility System and for other vendors who are provided this information.

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#11 Develop a plan for masking sensitive participant information, in all users Graphical User interfaces for the Enrollment and Eligibility System and for other vendors who are provided this information.

PEBP Response:

Agree. PEBP agrees it is important to protect sensitive participant information. PEBP Vendors already have restrictions on data access and are required to encrypt data any time it is transferred between computer systems. However, those restrictions may be further enhanced. PEBP will pursue additional controls, depending on individual vendor system capabilities, to increase stored data encryption levels in all systems containing sensitive information. As existing systems are upgraded and new contracts are entered into, additional safeguards will be required within the limits of the vendors' functionality and system capability.

PEBP will also require future vendor system upgrades and/or implementations to include the masking of certain sensitive information at the graphical interface level. Such masking will be subject to the functional and technical limitations of those systems that still allows for necessary processing. In addition user level access will be further restricted where possible.

#12 Conduct fingerprint based background investigations on all newly hired employees with access to sensitive information or systems as required by the State Security Standard 4.04.

#13 Conduct Civil Name Check background investigations on all existing employees in accordance with PEBP background investigation policy.

PEBP Response:

Agree. PEBP agrees it is important to have adequate background checks for personnel with access to sensitive participant data in order to minimize the risk of that data being compromised. PEBP will work with the Division of Human Resource Management (DHRM), who is taking over our personnel and hiring functions, to create a policy and process for conducting fingerprint based background checks for newly hired employees.

PEBP will also work with DHRM on a policy and process, including revising the warrant and release form, to conduct Civil Name Check background investigations for all current employees on a periodic basis.

Public Employees' Benefits Program Response to Audit Recommendations

<u>Recommendations</u>	<u>Accepted</u>	<u>Rejected</u>
1. Periodically inform participants of the wide range in costs for some healthcare procedures and the possibility of significant savings by comparing prices among providers.	<u>X</u>	<u> </u>
2. Provide additional resources to participants to facilitate comparing prices among providers.....	<u>X</u>	<u> </u>
3. Through the third party administrator's website, provide participants with access to Explanation of Benefits statements that include clear descriptions of medical procedures provided and CPT codes	<u>X</u>	<u> </u>
4. Implement Board policy requiring contracts to include performance standards.....	<u>X</u>	<u> </u>
5. Require certain vendors to report performance results with quarterly reports.	<u>X</u>	<u> </u>
6. Comply with contract provisions by conducting annual evaluations and audits when required	<u>X</u>	<u> </u>
7. Develop controls to ensure contracts address reporting deadlines and information provided by vendors is consistently reported	<u>X</u>	<u> </u>
8. Update contracting policies and procedures	<u>X</u>	<u> </u>
9. Develop controls to restrict access to files containing participant credit card numbers to PEBP staff who require access as part of their job functions and to remove old files containing participant credit card numbers that are no longer necessary from the computer network.....	<u>X</u>	<u> </u>
10. Develop a plan for encrypting sensitive participant information in the Enrollment and Eligibility System and for other vendors who are provided this information.....	<u>X</u>	<u> </u>
11. Develop a plan for masking sensitive participant information in all user Graphical User Interfaces for the Enrollment and Eligibility System and for other vendors who are provided this information.....	<u>X</u>	<u> </u>
12. Conduct fingerprint based background investigations on all newly hired employees with access to sensitive information or systems as required by the State Security Standard 4.04	<u>X</u>	<u> </u>

Public Employees' Benefits Program
Response to Audit Recommendations (continued)

<u>Recommendations</u>	<u>Accepted</u>	<u>Rejected</u>
13. Conduct <i>Civil Name Check</i> background investigations on all existing employees in accordance with PEBP's background investigation policy.....	<u>X</u>	<u> </u>
14. Update accounting policies and procedures to reflect current operations.	<u>X</u>	<u> </u>
TOTALS	<u>14</u>	<u>0</u>