

Medicare Supplement Insurance Fund

**For the Year Ended
June 30, 2002**

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**STATE OF TENNESSEE
COMPTROLLER OF THE TREASURY**

State Capitol
Nashville, Tennessee 37243-0260
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John G. Morgan
Comptroller

March 11, 2003

The Honorable Phil Bredesen, Governor
and

Members of the General Assembly
State Capitol
Nashville, Tennessee 37243

and

The Honorable Dave Goetz, Chairman
State Insurance Committee
State Capitol
Nashville, Tennessee 37243

Ladies and Gentlemen:

Transmitted herewith is the financial and compliance audit of the Medicare Supplement Insurance Fund for the year ended June 30, 2002. You will note from the independent auditor's report that an unqualified opinion was given on the fairness of the presentation of the financial statements.

Consideration of internal control over financial reporting and tests of compliance disclosed certain deficiencies, which are detailed in the Results of the Audit section of this report. The Department of Finance and Administration's management has responded to the audit findings; the responses are included following each finding. The Division of State Audit will follow up the audit to examine the application of the procedures instituted because of the audit findings.

Sincerely,

John G. Morgan
Comptroller of the Treasury

JGM/mb
02/075

State of Tennessee

Audit Highlights

Comptroller of the Treasury

Division of State Audit

Financial and Compliance Audit
Medicare Supplement Insurance Fund
For the Year Ended June 30, 2002

AUDIT OBJECTIVES

The objectives of the audit were to consider the fund's internal control over financial reporting; to determine compliance with certain provisions of laws, regulations, and contracts; to determine the fairness of the presentation of the financial statements; and to recommend appropriate actions to correct any deficiencies.

INTERNAL CONTROL FINDINGS

The Tennessee Insurance System (TIS) Is Not Functioning Efficiently and Effectively*

TIS has not been designed, implemented, and maintained in a manner which allows it to function efficiently and effectively. As a result, changes are being made directly to the TIS database through a software program, necessitating manual reconciliations and adjustments.

The Division of Insurance Administration (DIA) Does Not Monitor the Claims Processed by BlueCross BlueShield (BCBS) on Behalf of the State

DIA has not been monitoring claims processing by BCBS to ensure that only allowable claims are processed.

* This finding is repeated from the prior audit.

OPINION ON THE FINANCIAL STATEMENTS

The opinion on the financial statements is unqualified.

Audit Report
Medicare Supplement Insurance Fund
For the Year Ended June 30, 2002

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Medicare Supplement Insurance Fund For the Year Ended June 30, 2002

INTRODUCTION

POST-AUDIT AUTHORITY

This is a report on the financial and compliance audit of the Medicare Supplement Insurance Fund. The audit was conducted pursuant to Section 4-3-304, *Tennessee Code Annotated*, which authorizes the Department of Audit to “perform currently a post-audit of all accounts and other financial records of the state government, and of any department, institution, office, or agency thereof in accordance with generally accepted auditing standards and in accordance with such procedures as may be established by the comptroller.”

Section 8-4-109, *Tennessee Code Annotated*, authorizes the Comptroller of the Treasury to audit any books and records of any governmental entity that handles public funds when the Comptroller considers an audit to be necessary or appropriate.

BACKGROUND

The State Insurance Committee was created by an act of the General Assembly, codified as Title 8, Chapter 27, Section 301, *Tennessee Code Annotated*. The purpose of the committee is to provide insurance benefits and services to qualified retired state employees, higher education employees, teachers, and certain local government retirees. A separate fund was established in January 2001 to account for revenues received and claims paid on behalf of retirees who are eligible for Medicare coverage and elect coverage under the Medicare Supplement Insurance Plan.

ORGANIZATION

The State Insurance Committee, in cooperation with the Local Education and Local Government Insurance Committees, oversees the administration of the Medicare Supplement Insurance Fund. The State Insurance Committee is composed of the Commissioner of Finance and Administration, the Comptroller of the Treasury, the State Treasurer, the Commissioner of Commerce and Insurance, the Commissioner of the Department of Personnel, a representative of the Tennessee State Employees Association, two elected representatives of state employees, and an elected representative of higher education.

The Department of Finance and Administration’s Division of Insurance Administration and the Treasury Department’s Tennessee Consolidated Retirement System (TCRS) coordinate in

the administration of the Medicare Supplement Insurance Plans. TCRS is responsible for the day-to-day operations including customer service to retirees, enrollment, and collection of premiums through TCRS. The Division of Insurance Administration is responsible for the processing of all payments, refunds, and cash receipts of the Medicare Supplement Insurance Fund.

BlueCross BlueShield of Tennessee has been contracted for the administrative services, coordination with Medicare intermediaries, and payment of claims for the Medicare Supplement plans.

An organization chart of the fund's administration is on the following page.

AUDIT SCOPE

The audit was limited to the period July 1, 2001, through June 30, 2002, and was conducted in accordance with auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States. Financial statements are presented for the year ended June 30, 2002. The Medicare Supplement Insurance Fund forms an integral part of state government and as such has been included as an enterprise fund in the *Tennessee Comprehensive Annual Financial Report*.

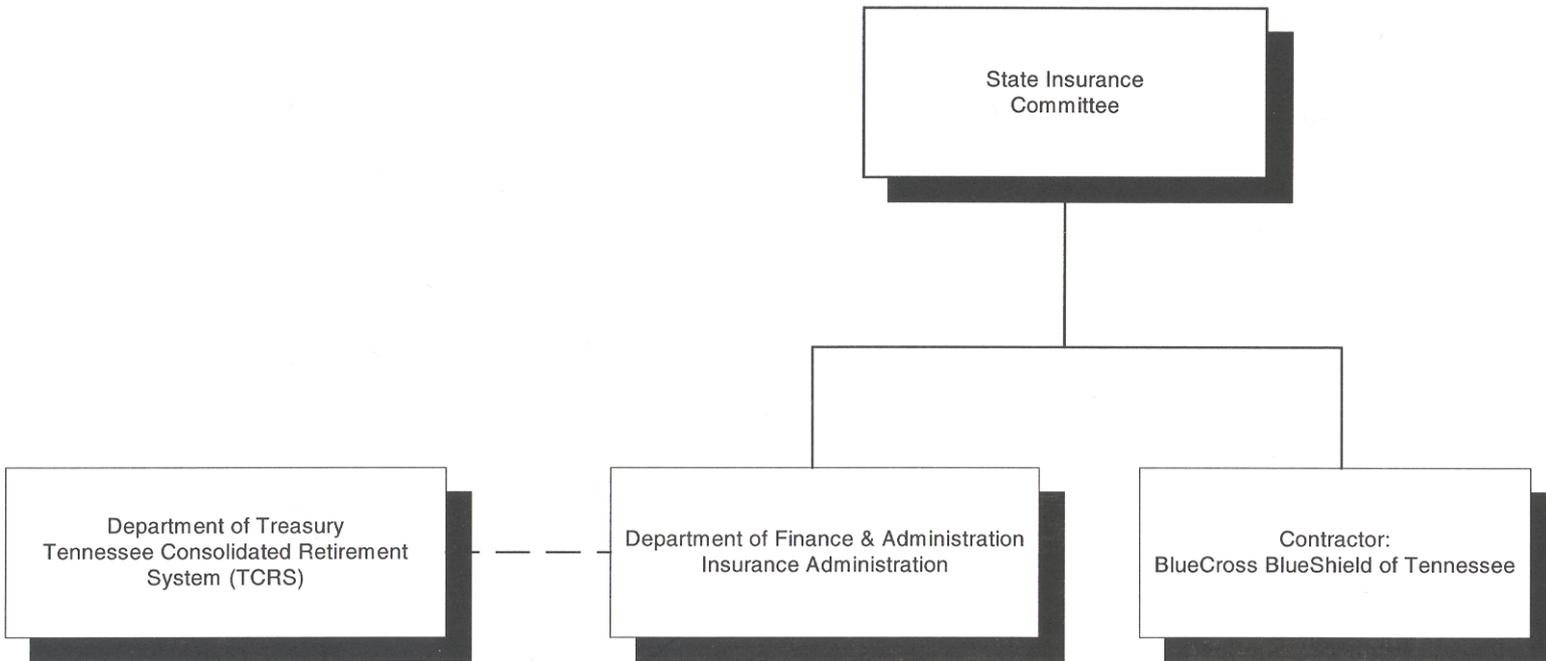
The audit covered fund 59 of the State of Tennessee Accounting and Reporting System (allotment code 317.86).

OBJECTIVES OF THE AUDIT

The objectives of the audit were

1. to consider the fund's internal control over financial reporting to determine auditing procedures for the purpose of expressing an opinion on the financial statements;
2. to determine compliance with certain provisions of laws, regulations, and contracts;
3. to determine the fairness of the presentation of the financial statements; and
4. to recommend appropriate actions to correct any deficiencies.

**Medicare Supplement Insurance Fund
Administration
Organization Chart**



PRIOR AUDIT FINDINGS

Section 8-4-109, *Tennessee Code Annotated*, requires that each state department, agency, or institution report to the Comptroller of the Treasury the action taken to implement the recommendations in the prior audit report. A follow-up of all prior audit findings was conducted as part of the current audit.

RESOLVED AUDIT FINDING

The current audit disclosed that the Medicare Supplement Insurance Fund has corrected the previous audit finding concerning Application Development Facility changes that were not always properly supported or made correctly.

REPEATED AUDIT FINDING

The prior audit report also contained a finding concerning the Tennessee Insurance System not functioning efficiently and effectively. This finding has not been resolved and is repeated in this report.

RESULTS OF THE AUDIT

AUDIT CONCLUSIONS

Internal Control

As part of the audit of the Medicare Supplement Insurance Fund's financial statements for the year ended June 30, 2002, we considered internal control over financial reporting to determine auditing procedures for the purpose of expressing an opinion on the financial statements, as required by auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States. Reportable conditions, along with recommendations and management's responses, are detailed in the findings and recommendations. Consideration of internal control over financial reporting disclosed no material weaknesses.

Compliance

The results of our audit tests disclosed no instances of noncompliance that are required to be reported under *Government Auditing Standards*.

Fairness of Financial Statement Presentation

The Division of State Audit has rendered an unqualified opinion on the Medicare Supplement Insurance Fund's financial statements.



**STATE OF TENNESSEE
COMPTROLLER OF THE TREASURY
DEPARTMENT OF AUDIT
DIVISION OF STATE AUDIT**

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**Report on Compliance and on Internal Control
Over Financial Reporting Based on an Audit of
Financial Statements Performed in Accordance With
*Government Auditing Standards***

January 17, 2003

The Honorable John G. Morgan
Comptroller of the Treasury
State Capitol
Nashville, Tennessee 37243

Dear Mr. Morgan:

We have audited the financial statements of the Medicare Supplement Insurance Fund, as of and for the year ended June 30, 2002, and have issued our report thereon dated January 17, 2003. As discussed in Note 1 to the financial statements, the Medicare Supplement Insurance Fund implemented Governmental Accounting Standards Board Statement No. 34, *Basic Financial Statements—and Management's Discussion and Analysis—for State and Local Governments*. We conducted our audit in accordance with auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States.

Compliance

As part of obtaining reasonable assurance about whether the Medicare Supplement Insurance Fund's financial statements are free of material misstatement, we performed tests of the fund's compliance with certain provisions of laws, regulations, and contracts, noncompliance with which could have a direct and material effect on the determination of financial statement amounts. However, providing an opinion on compliance with those provisions was not an objective of our audit, and accordingly, we do not express such an opinion. The results of our tests disclosed no instances of noncompliance that are required to be reported under *Government Auditing Standards*.

The Honorable John G. Morgan
January 17, 2003
Page Two

Internal Control Over Financial Reporting

In planning and performing our audit, we considered the Medicare Supplement Insurance Fund's internal control over financial reporting in order to determine our auditing procedures for the purpose of expressing our opinion on the financial statements and not to provide assurance on the internal control over financial reporting. However, we noted certain matters involving the internal control over financial reporting and its operation that we consider to be reportable conditions. Reportable conditions involve matters coming to our attention relating to significant deficiencies in the design or operation of the internal control over financial reporting that, in our judgment, could adversely affect the Medicare Supplement Insurance Fund's ability to record, process, summarize, and report financial data consistent with management's assertions in the financial statements.

The following reportable conditions were noted:

- The Tennessee Insurance System is not functioning efficiently and effectively
- The Division of Insurance Administration does not monitor the claims processed by BlueCross BlueShield on behalf of the state

These conditions are described in the Findings and Recommendations section of this report.

A material weakness is a condition in which the design or operation of one or more of the internal control components does not reduce to a relatively low level the risk that misstatements in amounts that would be material in relation to the financial statements being audited may occur and not be detected within a timely period by employees in the normal course of performing their assigned functions. Our consideration of the internal control over financial reporting would not necessarily disclose all matters in the internal control that might be reportable conditions and, accordingly, would not necessarily disclose all reportable conditions that are also considered to be material weaknesses. However, we believe none of the reportable conditions described above is a material weakness.

We also noted other matters involving the internal control over financial reporting, which we have reported to the fund's management in a separate letter.

This report is intended solely for the information and use of the General Assembly of the State of Tennessee and management and is not intended to be and should not be used by anyone other than these specified parties. However, this report is a matter of public record.

Sincerely,



Arthur A. Hayes, Jr., CPA,
Director

AAH/mb

FINDINGS AND RECOMMENDATIONS

1. The Tennessee Insurance System is not functioning efficiently and effectively

Finding

As noted in the previous audit, the Tennessee Insurance System (TIS) has not been designed, implemented, and maintained in a manner which allows it to function efficiently and effectively. As a result, changes are being made directly to the TIS database through the Application Development Facility (ADF) software program, necessitating manual reconciliations and adjustments. Management responded to the prior audit finding by stating that the TIS upgrade project began in March 2000, accounting transactions had been brought up to date, and accounting positions had been added to the Division of Insurance accounting section. Also, management stated that in addition to the TIS upgrade project, the division had implemented the TIS automated reconciliation project. Our review indicated that most accounting transactions were up to date, positions were added, and the TIS upgrade project is in progress. We also found that the automated reconciliation process is functioning and items that still require manual reconciliation are being handled appropriately. However, the automated reconciliation process does not eliminate the need for additional manual reconciliation, and the upgrade project and Master Transaction Study are not complete. The TIS Upgrade Project is to be completed in June 2005. The TIS Master Transaction Study scheduled to begin after July 1, 2003, has been modified and is now a TIS Master Transaction Task that is to be rolled into the TIS Upgrade Project and will be initiated within the TIS Upgrade Project at no predetermined time. Therefore, ADF is still used, and differences between TIS and the State of Tennessee Accounting and Reporting System (STARS) still occur that result in manual processing.

The division is still using ADF to manually adjust participants' accounts directly in the TIS database rather than through transactions. The system's security must be overridden in order for an ADF change to be made. The division sends a request for the ADF change to the department's Information Systems Management (ISM) group, which in turn submits a request to the Office for Information Resources (OIR). OIR assigns one of its employees to make the ADF changes on the TIS database. As noted in the prior audit, overriding system security to make manual adjustments is a significant deficiency in the design and operation of the system.

The Division of Insurance Administration continues to use ADF as a "quick fix" to correct participant balances or errors attributable to unresolved system problems. Although division staff maintain paper documentation of the ADF changes, the system has no history or record of the changes because division staff simply overwrite previous information in the database. If the system had been designed and was functioning properly, use of ADF would not be necessary. As previously noted, making changes directly to a database instead of correcting errors through properly authorized and documented transactions circumvents system controls.

In addition, when the TIS database is corrected using ADF, the State of Tennessee Accounting and Reporting System (STARS) is not updated concurrently. As a result, the two

systems do not agree. We noted that differences between the daily net change in the TIS database and the cumulative accounting transactions passed from TIS to STARS daily during the year ended June 30, 2002, ranged from (\$10,000) to \$9,507.93. Differences in the daily net change must be researched and adjusted as necessary. However, if the system had been designed and was functioning properly, there would not be a need for these additional manual procedures.

Recommendation

To ensure that all TIS system problems are corrected as soon as possible, the Director of Insurance Administration should complete the TIS upgrade project that began in March 2000 and is scheduled to be completed by June 2005. As the system problems are corrected, the use of ADF changes should be minimized and, if possible, eventually eliminated. As problems arise in the future, causes of the problems should be quickly identified, and TIS should be corrected quickly through program changes or other appropriate means.

Management's Comment

We concur. As stated previously, the issue of reconciliation between TIS and STARS has been the topic of considerable effort on the part of the Division. The Division has implemented a number of changes that focus on this issue. Two years ago, accounting transactions were brought up to date, and the backlog of accounting transactions was eliminated. Positions were added to the accounting section to assist in this task. The TIS Automated Reconciliation Project has been completed. All of these improvements have positively addressed the TIS to STARS balancing problem.

Insurance Administration, Information Systems Management and the Office of Information Resources are also engaged in a multiple year effort to upgrade the Tennessee Insurance System (TIS). TIS is the basic business tool that provides the eligibility, enrollment, and premium collection activities to support the state sponsored plans. TIS began operation in the summer of 1991.

Planning, analysis, and general design phases of the TIS Upgrade Project were complete in March 2002. Detailed design and programming will be completed in stages rather than in its entirety. The components specifically related to the balancing of TIS and STARS are scheduled early in the overall work program. In its totality, the project should be completed by the middle of 2005. The TIS upgrade project is intended to enhance the capabilities of the present system, provide some flexibility in reconfiguring specific TIS components and activities, and improve maintainability. Every effort is being made to correct as many problems as possible in the current version of TIS while designing the upgraded TIS so that current use of ADF will be minimized. The TIS Master Transaction Study has been combined with the TIS Upgrade Project.

In summary, the Division of Insurance Administration, while only one of the organizational units responsible for the upgrade project, is committed to correcting the

deficiencies in the Tennessee Insurance System; to the judicious use of ADF changes; and to resolving the issue of TIS to STARS balancing.

2. **The Division of Insurance Administration does not monitor the claims processed by BlueCross BlueShield on behalf of the state**

Finding

The Division of Insurance Administration does not monitor claims processing by BlueCross BlueShield of Tennessee (BCBS). The Medicare Supplement Insurance Fund plans are entirely self-insured, which means that the state is responsible for 100% of the payments to health care providers. BCBS does not participate in the cost of services and therefore does not have a monetary incentive to ensure that the claims are valid and reasonable. BCBS is paid an administrative fee, based on the total number of members, to process the claims. As the claims are processed, BCBS writes checks from the state account to pay the claim. BCBS then sends the last page of the check register, which shows the total amount paid, as support for the payments.

The Division of Insurance Administration does not monitor the claims processing by BCBS to ensure that only allowable claims are being processed and that claims are being processed correctly. Without this control, BCBS has the ability to pay unallowable claims with state funds. This could result in increased claim payments for the state and unnecessary insurance premium increases.

Recommendation

The Director of Insurance Administration should implement a monitoring process that enables the Division of Insurance Administration to closely monitor claims processing by BCBS to ensure that claims being paid are in fact allowable and that they have been processed correctly.

Management's Comment

We concur. In the past, the Division of State Audit has, at the request of the Division of Insurance Administration, conducted claims audits of the payment of claims by BlueCross BlueShield of Tennessee. The purpose of these audits was to determine whether claims were paid in accordance with plan benefits and the contract between BlueCross BlueShield of Tennessee and the State. The Division agrees that the process of auditing claims for all self-insured plans needs to be re-instituted. The Division therefore intends to request the Division of State Audit to continue to assist the Division by periodically auditing claims payments for all the self-insured plans. If the Division of State Audit is unavailable, the Division will secure these services through a contract for these services.



**STATE OF TENNESSEE
COMPTROLLER OF THE TREASURY
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DIVISION OF STATE AUDIT**

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Independent Auditor's Report

January 17, 2003

The Honorable John G. Morgan
Comptroller of the Treasury
State Capitol
Nashville, Tennessee 37243

Dear Mr. Morgan:

We have audited the accompanying statement of net assets of the Medicare Supplement Insurance Fund, an enterprise fund of the State of Tennessee, as of June 30, 2002, and the related statements of revenues, expenses, and changes in fund net assets and cash flows for the year then ended. These financial statements are the responsibility of the fund's management. Our responsibility is to express an opinion on these financial statements, based on our audit.

We conducted our audit in accordance with auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audit provides a reasonable basis for our opinion.

As discussed in Note 1, the financial statements present only the Medicare Supplement Insurance Fund, an enterprise fund, and do not purport to, and do not, present fairly the financial position of the State of Tennessee, as of June 30, 2002, and the changes in its financial position for the year then ended in conformity with accounting principles generally accepted in the United States of America.

The Honorable John G. Morgan
January 17, 2003
Page Two

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of the Medicare Supplement Insurance Fund of the State of Tennessee, as of June 30, 2002, and the changes in its financial position and cash flows for the year then ended in conformity with accounting principles generally accepted in the United States of America.

As discussed in Note 1 to the financial statements, the Medicare Supplement Insurance Fund implemented Governmental Accounting Standards Board Statement No. 34, *Basic Financial Statements—and Management’s Discussion and Analysis—for State and Local Governments*.

The required supplementary information on page 21 is not a required part of the basic financial statements but is supplementary information required by the Governmental Accounting Standards Board. We have applied certain limited procedures, which consisted principally of inquiries of management regarding the methods of measurements and presentation of the required supplementary information. However, we did not audit the information and do not express an opinion on it.

In accordance with *Government Auditing Standards*, we have also issued our report dated January 17, 2003, on our consideration of the fund’s internal control over financial reporting and our tests of its compliance with certain provisions of laws, regulations, and contracts. That report is an integral part of an audit performed in accordance with *Government Auditing Standards* and should be read in conjunction with this report in considering the results of our audit.

Sincerely,

A handwritten signature in black ink that reads "Arthur A. Hayes, Jr." The signature is written in a cursive style with a large initial "A" and a distinct "H".

Arthur A. Hayes, Jr., CPA,
Director

AAH/mb

Medicare Supplement Insurance Fund
Statement of Net Assets
June 30, 2002

(Expressed in Thousands)

Assets:

Current assets:

| | |
|---------------|------------------|
| Cash (Note 2) | \$ <u>25,943</u> |
|---------------|------------------|

| | |
|--------------|---------------|
| Total assets | <u>25,943</u> |
|--------------|---------------|

Liabilities:

Current liabilities:

| | |
|-------------------------------|-------|
| Accounts payable and accruals | 4,867 |
|-------------------------------|-------|

| | |
|------------------|------------|
| Deferred revenue | <u>417</u> |
|------------------|------------|

| | |
|-------------------|--------------|
| Total liabilities | <u>5,284</u> |
|-------------------|--------------|

Net Assets:

| | |
|--------------|---------------|
| Unrestricted | <u>20,659</u> |
|--------------|---------------|

| | |
|------------------|-------------------------|
| Total net assets | \$ <u><u>20,659</u></u> |
|------------------|-------------------------|

The notes to the financial statements are an integral part of this statement.

Medicare Supplement Insurance Fund
Statement of Revenues, Expenses, and Changes in Fund Net Assets
For the Year Ended June 30, 2002

(Expressed in Thousands)

Operating revenues:

| | |
|--------------------------|------------------|
| Premiums | \$ <u>43,619</u> |
| Total operating revenues | <u>43,619</u> |

Operating expenses:

| | |
|--------------------------|---------------|
| Contractual services | 4,882 |
| Benefits | 30,771 |
| Other | <u>5</u> |
| Total operating expenses | <u>35,658</u> |
| Operating income | <u>7,961</u> |

Nonoperating revenues:

| | |
|--|-------------------------|
| Interest income | <u>396</u> |
| Total nonoperating revenues | <u>396</u> |
| Income before transfers | 8,357 |
| Transfers from state general fund (Note 3) | <u>5,263</u> |
| Increase in net assets | 13,620 |
| Net Assets, July 1 | <u>7,039</u> |
| Net Assets, June 30 | \$ <u><u>20,659</u></u> |

The notes to the financial statements are an integral part of this statement.

Medicare Supplement Insurance Fund
Statement of Cash Flows
For the Year Ended June 30, 2002

(Expressed in Thousands)

Cash flows from operating activities:

| | |
|---|-----------|
| Receipts from fund members | \$ 43,800 |
| Payments to insurance companies and health care providers | (34,863) |
| Payments for state services | (6) |
| | (6) |

| | |
|------------------------------------|-------|
| Net cash from operating activities | 8,931 |
|------------------------------------|-------|

Cash flows from noncapital financing activities:

| | |
|--------------|-------|
| Transfers in | 5,263 |
|--------------|-------|

| | |
|---|-------|
| Net cash from noncapital financing activities | 5,263 |
|---|-------|

Cash flows from investing activities:

| | |
|-------------------|-----|
| Interest received | 396 |
|-------------------|-----|

| | |
|------------------------------------|-----|
| Net cash from investing activities | 396 |
|------------------------------------|-----|

| | |
|----------------------|--------|
| Net increase in cash | 14,590 |
| Cash, July 1 | 11,353 |

| | |
|---------------|-----------|
| Cash, June 30 | \$ 25,943 |
|---------------|-----------|

Reconciliation of operating income to net cash provided by operating activities:

| | |
|---|----------|
| Operating income | \$ 7,961 |
| Adjustments to reconcile operating income to net cash provided by operating activities: | |
| Increase in accounts payable | 790 |
| Increase in deferred revenue | 180 |
| Total adjustments | 970 |
| Net cash from operating activities: | \$ 8,931 |

The notes to the financial statements are an integral part of this statement.

Medicare Supplement Insurance Fund
Notes to the Financial Statements
June 30, 2002

NOTE 1. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

A. Reporting Entity

The Medicare Supplement Insurance Fund is used to account for revenues received and claims paid on behalf of qualified retired state employees, higher education employees, teachers, and certain local government retirees. Instituted in January 1989, the coverage was offered on a fully insured basis through December 2000. On January 1, 2001, the financial arrangement was converted to self-insured and a third plan option offered to participants. The fund has been included as an enterprise fund in the *Tennessee Comprehensive Annual Financial Report*.

B. Basis of Presentation

The accompanying financial statements have been prepared in conformity with accounting principles generally accepted in the United States of America as prescribed by the Governmental Accounting Standards Board (GASB). The Medicare Supplement Insurance Fund follows all applicable GASB pronouncements as well as applicable private-sector pronouncements issued on or before November 30, 1989.

C. Measurement Focus and Basis of Accounting

The accompanying financial statements have been prepared using the accrual basis of accounting and the flow of economic resources measurement focus. Under this basis, revenues are recorded when earned, and expenses are recorded at the time liabilities are incurred.

Operating revenues and expenses are distinguished from nonoperating items in the Medicare Supplement Insurance Fund. Operating revenues and expenses generally result from providing services in connection with the fund's principal ongoing insurance operations. Operating expenses include the cost of those services and administrative expenses. All revenues and expenses not meeting this definition are reported as nonoperating revenues and expenses.

D. Cash

Cash is defined as cash on hand and demand deposits, such as the pooled investment fund.

Medicare Supplement Insurance Fund
Notes to the Financial Statements (Cont.)
June 30, 2002

E. New Accounting Pronouncement

Effective July 1, 2001, the fund adopted GASB Statement No. 34, *Basic Financial Statements—and Management’s Discussion and Analysis—for State and Local Governments*. To conform to the requirements of GASB 34, the statement of financial position is now presented in a statement of net assets format rather than a balance sheet format, and retained earnings have been reclassified as unrestricted net assets.

NOTE 2. DEPOSITS

The Medicare Supplement Insurance Fund had \$25,942,972 in the State Treasurer’s pooled investment fund at June 30, 2002. The pooled investment fund is authorized by statute to invest funds in accordance with policy guidelines approved by the State Funding Board. The current resolution of that board gives the Treasurer approval to invest in collateralized certificates of deposit in authorized state depositories, prime commercial paper and prime bankers’ acceptances, bonds, notes, and bills of the United States Treasury or other obligations guaranteed as to principal and interest by the United States or any of its agencies and in repurchase agreements for obligations of the United States or its agencies which are fully guaranteed as to principal and interest by the United States; and in certain obligations of the state. The pooled investment fund’s custodial credit risk is presented in the *Tennessee Comprehensive Annual Financial Report*. That report may be obtained by writing to the Department of Finance and Administration, Division of Accounts, 14th Floor William R. Snodgrass Tennessee Tower, 312 Eighth Avenue North, Nashville, Tennessee 37243-0298.

NOTE 3. TRANSFERS FROM STATE GENERAL FUND

During the year ended June 30, 2002, the Medicare Supplement Insurance Fund received transfers of \$5,262,600 from the State of Tennessee’s general fund to support the operations of the fund.

NOTE 4. RISK MANAGEMENT

In 1988, the State of Tennessee adopted legislation authorizing the provision of Medicare Supplement coverage for qualified retired state employees and teachers.

Medicare Supplement Insurance Fund
Notes to the Financial Statements (Cont.)
June 30, 2002

Instituted in January 1989, the coverage was offered on a fully insured basis through December 2000. On January 1, 2001, the financial arrangement was converted to self-insured, and a third plan option was offered to participants.

In accordance with Section 8-27-701, et seq., *Tennessee Code Annotated*, the State Insurance Committee established a Medicare Supplement Insurance Fund, a public entity risk pool, on January 1, 2001. Fund members at June 30, 2002, included 20,869 retirees and dependents who selected one of three Medicare Supplement Insurance plan offerings.

The Medicare Supplement Insurance Fund assumes responsibility for determining plan benefits and eligibility, establishing premiums sufficient to fund plan obligations, recording and reporting financial transactions accurately, reporting enrollment to vendors, processing claims submitted for services provided to plan participants, communicating with plan participants, and complying with appropriate state and federal laws and regulations. Plan participants are required to pay premiums on time, provide for the filing of claims for services received, and report changes in eligibility of themselves or their dependents.

The Medicare Supplement Insurance Fund establishes claims liabilities for the self-insured coverage based on estimates of the ultimate cost of claims that have been reported but not settled, and of claims that have been incurred but not reported. Retirees and providers have 13 months to file medical claims. The process used to compute claims liabilities does not necessarily result in an exact amount. Claims liabilities are recomputed periodically using actuarial and statistical techniques to produce current estimates. At June 30, 2002, reserve requirements were established of 16%, based on claim payments for the prior 12 months. Adjustments to claims liabilities are charged or credited to expense in the period in which they are made. The Medicare Supplement Insurance Fund considers investment income in determining if a premium deficiency exists.

As discussed above, the Medicare Supplement Insurance Fund establishes a liability for both reported and unreported insured events, which includes estimates of both future payments of losses and related claim adjustment expenses. The following represents changes in those aggregate liabilities during the past 18 months (expressed in thousands):

Medicare Supplement Insurance Fund
Notes to the Financial Statements (Cont.)
June 30, 2002

| | <u>7/1/01-6/30/02</u> | <u>1/1/01-6/30/01</u> |
|---|-----------------------|-----------------------|
| Unpaid claims at beginning of period | \$ 4,077 | \$ 0 |
| Incurred claims: | | |
| Provision for insured events of the current year | 30,417 | 13,342 |
| Increase in provision for insured events of prior years | <u>53</u> | <u>0</u> |
| Total incurred claims expenses | 34,547 | 13,342 |
| Payments: | | |
| Claims attributable to insured events of the current year | 25,550 | 9,265 |
| Claims attributable to insured events of prior years | <u>4,130</u> | <u>0</u> |
| Total payments | <u>29,680</u> | <u>9,265</u> |
| Total unpaid claims at end of year | <u>\$ 4,867</u> | <u>\$ 4,077</u> |

Medicare Supplement Insurance Fund Required Supplementary Information Claims Development Information

The table below will illustrate how the Medicare Supplement Insurance Fund's earned revenues and investment income compare to related costs of loss and other expenses assumed by the fund for the last ten years as previous years' information becomes available. As of June 30, 2002, only 18 months of data are available. The rows of the table are defined as follows: (1) This line shows the total of each fiscal year's or period's earned contribution revenues and investment revenues. (2) This line shows each fiscal year's or period's other operating costs of the fund including overhead and claims expense not allocable to individual claims. (3) This line shows the fund's incurred claims and allocated claim adjustment expenses (both paid and accrued) as originally reported at the end of the first year in which the event that triggered coverage under the contract occurred (called policy year); some of these amounts are unavailable. (4) This section shows the cumulative amounts paid as of the end of successive years for each policy year; some of these amounts are unavailable. (5) This section shows how each policy year's incurred claims increased or decreased as of the end of successive years; some of these amounts are unavailable. This annual reestimation results from new information received on known claims, reevaluation of existing information on known claims, as well as emergence of new claims not previously known. (6) This line compares the latest reestimated incurred claims amount to the amount originally established (line 3) and shows whether this latest estimate of claims cost is greater or less than originally thought. As data for individual policy years mature, the correlation between original estimates and reestimated amounts is commonly used to evaluate the accuracy of incurred claims currently recognized in less mature fiscal years. The columns of the table show data for successive fiscal years or periods and policy years.

| | Fiscal and Policy Year Ended (Expressed in thousands of dollars) | |
|--|---|-------------|
| | <u>2001</u> | <u>2002</u> |
| (1) Required contribution and investment revenue earned (fiscal year) | 20,145* | 44,015 |
| (2) Unallocated expenses (fiscal year) | 2,375* | 4,887 |
| (3) Estimated incurred claims and expenses, end of policy year | 28,163 | ** |
| (4) Paid (cumulative) as of: End of policy year | 23,657 | ** |
| (5) Reestimated incurred claims and expenses: End of policy year | 28,163 | ** |
| (6) Increase (decrease) in estimated incurred claims and expenses from end of policy year | 0 | ** |

* Amounts only represent a 6-month fiscal period

** Data not available