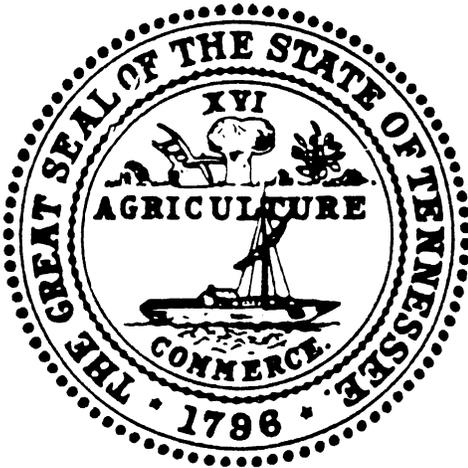


AUDIT REPORT

Medicare Supplement Insurance Fund

For the Year Ended
June 30, 2005



STATE OF TENNESSEE
COMPTROLLER OF THE TREASURY

Department of Audit
Division of State Audit



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**STATE OF TENNESSEE
COMPTROLLER OF THE TREASURY**

State Capitol
Nashville, Tennessee 37243-0260
(615) 741-2501

John G. Morgan
Comptroller

May 4, 2006

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, 2005. 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 resulted in no audit findings.

Sincerely,

John G. Morgan
Comptroller of the Treasury

JGM/cj
05/100

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, 2005

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.

AUDIT FINDINGS

The audit report contains no findings.

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, 2005

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Medicare Supplement Insurance Fund For the Year Ended June 30, 2005

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*. In addition to the committee’s responsibilities related to current state employees, the committee’s purpose is also 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 Fund.

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 the 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 Fund. 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 Insurance Fund.

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

AUDIT SCOPE

The audit was limited to the period July 1, 2004, through June 30, 2005, 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, 2005, and for comparative purposes, the year ended June 30, 2004. 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*.

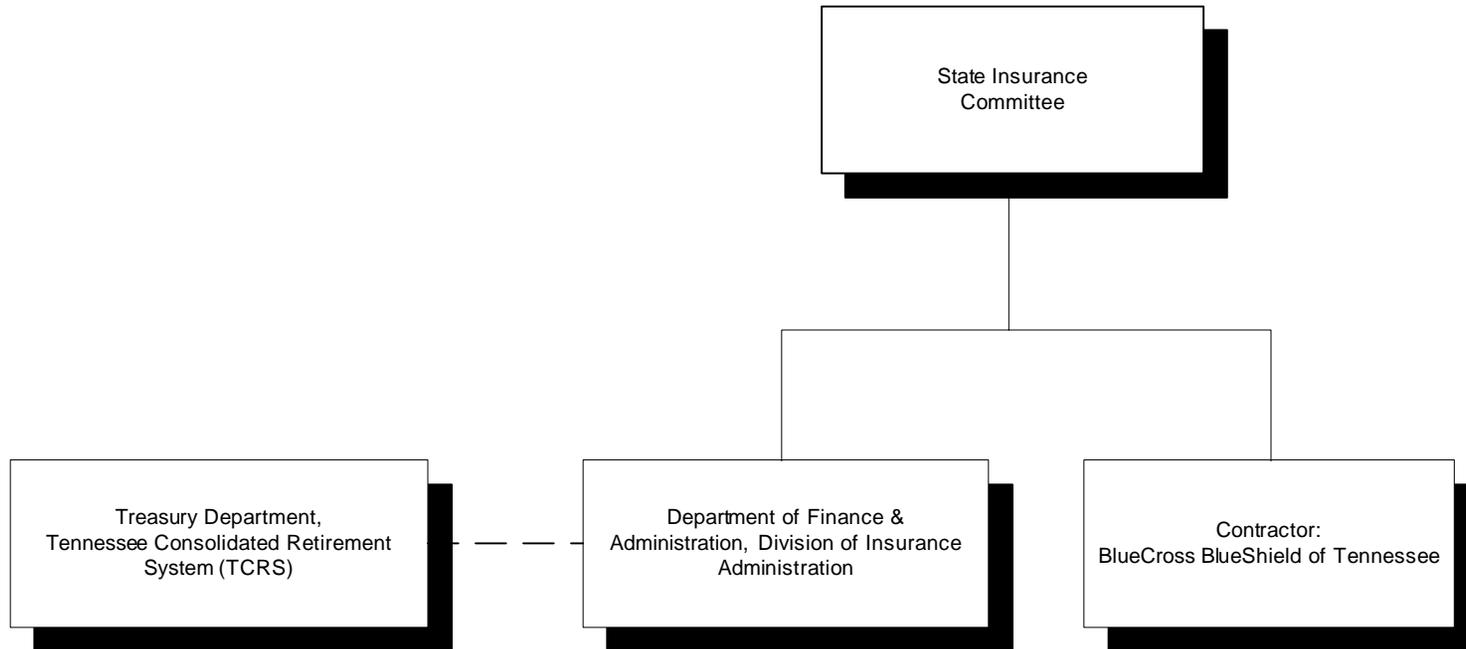
The audit covered fund 59 of the State of Tennessee Accounting and Reporting System (allotment code 317.86).

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

There were no findings in the prior audit report.

OBSERVATIONS AND COMMENTS

MANAGEMENT'S RESPONSIBILITY FOR RISK ASSESSMENT

Auditors and management are required to assess the risk of fraud in the operations of the entity. The risk assessment is based on a critical review of operations considering what frauds could be perpetrated in the absence of adequate controls. The auditors' risk assessment is limited to the period during which the audit is conducted and is limited to the transactions that the auditors are able to test during that period. The risk assessment by management is the primary method by which the entity is protected from fraud, waste, and abuse. Since new programs may be established at any time by management or older programs may be discontinued, that assessment is ongoing as part of the daily operations of the entity.

Risks of fraud, waste, and abuse are mitigated by effective internal controls. It is management's responsibility to design, implement, and monitor effective controls in the entity. Although internal and external auditors may include testing of controls as part of their audit procedures, these procedures are not a substitute for the ongoing monitoring required of management. After all, the auditor testing is limited and is usually targeted to test the effectiveness of particular controls. Even if controls appear to be operating effectively during the time of the auditor testing, they may be rendered ineffective the next day by management override or by other circumventions that, if left up to the auditor to detect, will not be noted until the next audit engagement and then only if the auditor tests the same transactions and controls. Furthermore, since staff may be seeking to avoid auditor criticisms, they may comply with the controls during the period that the auditors are on site and revert to ignoring or disregarding the control after the auditors have left the field.

The risk assessments and the actions of management in designing, implementing, and monitoring the controls should be adequately documented to provide an audit trail both for auditors and for management, in the event that there is a change in management or staff, and to maintain a record of areas that are particularly problematic. The assessment and the controls should be reviewed and approved by the head of the entity.

FRAUD CONSIDERATIONS

Statement on Auditing Standards No. 99, *Consideration of Fraud in a Financial Statement Audit*, promulgated by the American Institute of Certified Public Accountants requires auditors to specifically assess the risk of material misstatement of an audited entity's financial statements due to fraud. The standard also restates the obvious premise that management, not the auditors, is primarily responsible for preventing and detecting fraud in its own entity. Management's responsibility is fulfilled in part when it takes appropriate steps to assess the risk of fraud within the entity and to implement adequate internal controls to address the results of those risk assessments.

During our audit, we discussed these responsibilities with management and how management might approach meeting them. We also increased the breadth and depth of our inquiries of management and others in the entity as we deemed appropriate. We obtained formal assurances from top management that management had reviewed the entity's policies and procedures to ensure that they are properly designed to prevent and detect fraud and that management had made changes to the policies and procedures where appropriate. Top management further assured us that all staff had been advised to promptly alert management of all allegations of fraud, suspected fraud, or detected fraud and to be totally candid in all communications with the auditors. All levels of management assured us there were no known instances or allegations of fraud that were not disclosed to us.

AUDIT COMMITTEE

As a result of the fraud-related business failures of companies such as Enron and WorldCom in recent years, Congress and the accounting profession have taken aggressive measures to try to detect and prevent future failures related to fraud. These measures have included the signing of the *Sarbanes-Oxley Act of 2002* by the President of the United States and the issuance of Statement on Auditing Standards No. 99 by the American Institute of Certified Public Accountants. This new fraud auditing standard has not only changed the way auditors perform audits but has also provided guidance to management and boards of directors on creating antifraud programs and controls. This guidance has included the need for an independent audit committee.

In the previous audit report, we recommended that the insurance committee establish an audit committee. As of the end of our audit, the audit committee options were still in the discussion phase. In recognition of the benefits of audit committees for government, the Tennessee General Assembly has enacted legislation known as the "State of Tennessee Audit Committee Act of 2005." This legislation requires the creation of audit committees for those entities that have governing boards, councils, commissions, or equivalent bodies that can hire and terminate employees and/or are responsible for the preparation of financial statements. Applicable entities are required to develop an audit committee charter and appoint the audit committee in accordance with the legislation. The specific activities of any audit committee will depend on, among other things, the mission, nature, structure, and size of each agency. In

establishing the audit committee and creating its charter, each board should examine its agency's particular circumstances. Anti-fraud literature notes that there are two categories of fraud: fraudulent financial reporting and misappropriation of assets. The audit committee should consider the risks of fraud in its fund in general as well as the history of its particular fund with regard to prior audit findings, previously disclosed weaknesses in internal control, and compliance issues. The audit committee should consider both the risk of fraudulent financial reporting and the risk of fraud due to misappropriation or abuse of fund assets. Also, the insurance committee and the audit committee should keep in mind that entities receiving public funding should have a lower threshold of materiality than private sector entities with regard to fraud risks.

Boards should exercise professional judgment in establishing the duties, responsibilities, and authority of their audit committee. The factors noted below are not intended to be an exhaustive listing of those matters to be considered. The committee should not limit its scope to reacting to a preconceived set of issues and actions but rather should be proactive in its oversight of the fund as it concentrates on the internal control and audit-related activities of the entity. In fact, this individualized approach is one of the main benefits derived from an audit committee.

At a minimum, audit committees should:

1. Develop a written charter that addresses the audit committee's purpose and mission, which should be, at a minimum, to assist the insurance committee in its oversight of the fund.
2. Formally reiterate, on a regular basis, to the insurance committee, agency management, and staff their responsibilities for preventing, detecting, and reporting fraud, waste, and abuse.
3. Serve as a facilitator of any audits or investigations related to the fund, including advising auditors and investigators of any information they may receive or otherwise note regarding risks of fraud or weaknesses in the fund's internal controls; reviewing with the auditors any findings or other matters noted by the auditors during audit engagements; working with the fund management and staff to ensure implementation of audit recommendations; and assisting in the resolution of any problems the auditors may have with cooperation from fund management or staff.
4. Develop a formal process for assessing the risk of fraud for the fund, including documentation of the results of the assessments and assuring that internal controls are in place to adequately mitigate those risks.
5. Develop and communicate to staff for the fund their responsibilities to report allegations of fraud, waste, or abuse to the committee and the Comptroller of the Treasury's office as well as a process for immediately reporting such information.
6. Immediately inform the Comptroller's office when fraud is detected.
7. Develop and communicate to the insurance committee, fund management, and staff a written code of conduct reminding those individuals of the public nature of the fund and the need for all to maintain the highest level of integrity with regard to the

financial operations and any related financial reporting responsibilities of the fund; to avoid preparing or issuing fraudulent or misleading financial reports or other information; to protect fund assets from fraud, waste, and abuse; to comply with all relevant laws, rules, policies, and procedures; and to avoid engaging in activities which would otherwise bring dishonor to the fund.

The charter of the audit committee should include, at a minimum, the following provisions:

1. The audit committee should be a standing committee of the insurance committee.
2. The audit committee should be composed of at least three members. The chair of the audit committee should preferably have some accounting or financial management background. Each member of the audit committee should have an adequate background and education to allow a reasonable understanding of the information presented in the financial reports of the fund and the comments of auditors with regard to internal control and compliance findings and other issues.
3. The members of the audit committee must be independent from any appearances of other interests that are in conflict with their duties as members of the audit committee.
4. An express recognition that the insurance committee, the audit committee, and the management and staff for the fund are responsible for taking all reasonable steps to prevent, detect, and report fraud, waste, and abuse.
5. The audit committee should meet regularly throughout the year. The audit committee can meet by telephone, if that is permissible for other committees. However, the audit committee is strongly urged to meet at least once a year in person. Members of the audit committee may be members of other standing committees of the insurance committee, but the audit committee meetings should be separate from the meetings of other committees of the insurance committee.
6. The audit committee should record minutes of its meetings.

The Division of State Audit will be available to discuss with the insurance committee any questions it might have about the creation of its particular audit committee. There are also other audit committees which have already been established at other state agencies that the insurance committee may wish to contact for advice and further information.

COMPLIANCE AUDIT PERFORMED

The Medicaid/TennCare Section of the Division of State Audit has performed a compliance audit of the State Insurance Plans for the period January 1, 2003, through December 31, 2003. The results of that audit have been issued in a separate 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, 2005, 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. Consideration of internal control over financial reporting disclosed no material weaknesses.

Compliance and Other Matters

The results of our audit tests disclosed no instances of noncompliance or other matters 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 Internal Control Over Financial Reporting and on
Compliance and Other Matters Based on an Audit of
Financial Statements Performed in Accordance With
*Government Auditing Standards***

December 20, 2005

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, 2005, and have issued our report thereon dated December 20, 2005. 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.

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 an opinion on the internal control over financial reporting. 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 fund's ability to record, process, summarize, and report financial data consistent with the assertions of management in the financial statements. We noted no matters involving the internal control over financial reporting and its operation that we consider to be material weaknesses.

The Honorable John G. Morgan
December 20, 2005
Page Two

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

Compliance and Other Matters

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 or other matters that are required to be reported under *Government Auditing Standards*.

This report is intended solely for the information and use of the General Assembly of the State of Tennessee, the State Insurance Committee, 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,

A handwritten signature in black ink that reads "Arthur A. Hayes, Jr." in a cursive style.

Arthur A. Hayes, Jr., CPA
Director

AAH/cj



STATE OF TENNESSEE
COMPTROLLER OF THE TREASURY
DEPARTMENT OF AUDIT
DIVISION OF STATE AUDIT
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Independent Auditor's Report

December 20, 2005

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

Dear Mr. Morgan:

We have audited the accompanying statements of net assets of the Medicare Supplement Insurance Fund, an enterprise fund of the State of Tennessee, as of June 30, 2005, and June 30, 2004, and the related statements of revenues, expenses, and changes in fund net assets and cash flows for the years 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 audits.

We conducted our audits 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 audits provide a reasonable basis for our opinion. Tennessee statutes, in addition to audit responsibilities, entrust certain other responsibilities to the Comptroller of the Treasury. Those responsibilities include approving accounting policies of the state as prepared by the state's Department of Finance and Administration, approving certain state contracts, and participating in the negotiation and procurement of services for the state. The Comptroller of the Treasury also serves as a member of the State Insurance Committee per state statute.

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, 2005, and June 30, 2004, and the changes in its financial position and cash flows for the years then ended in conformity with accounting principles generally accepted in the United States of America.

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, 2005, and June 30, 2004, and the changes in its financial position and cash flows for the years then ended in conformity with accounting principles generally accepted in the United States of America.

The Medicare Supplement Insurance Fund has not presented the management's discussion and analysis section that accounting principals generally accepted in the United States of America have determined are necessary to supplement, although not required to be a part of, the basic financial statements. The required supplementary information on page 19 is not a required part of the basic financial statements, but is supplementary information required by accounting principles generally accepted in the United States of America. We have applied certain limited procedures, which consisted principally of inquiries of management regarding the methods of measurement 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 December 20, 2005, on our consideration of the fund's internal control over financial reporting and on our tests of its compliance with certain provisions of laws, regulations, and contracts and other matters. The purpose of that report is to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing, and not to provide an opinion on the internal control over financial reporting or on compliance. 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, appearing to read "Arthur A. Hayes, Jr.", written in a cursive style.

Arthur A. Hayes, Jr., CPA
Director

AAH/cj

Medicare Supplement Insurance Fund
Statements of Net Assets
June 30, 2005, and June 30, 2004

(Expressed in Thousands)

	<u>June 30, 2005</u>	<u>June 30, 2004</u>
Assets:		
Current assets:		
Cash (Note 2)	\$ 27,645	\$ 28,251
Accounts receivable	<u>247</u>	<u>464</u>
Total assets	<u>27,892</u>	<u>28,715</u>
Liabilities:		
Current liabilities:		
Accounts payable and accruals	5,772	5,348
Unearned revenue	<u>888</u>	<u>783</u>
Total liabilities	<u>6,660</u>	<u>6,131</u>
Net Assets:		
Unrestricted	<u>21,232</u>	<u>22,584</u>
Total net assets	<u>\$ 21,232</u>	<u>\$ 22,584</u>

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

Medicare Supplement Insurance Fund
Statements of Revenues, Expenses, and Changes in Fund Net Assets
For the Years Ended June 30, 2005, and June 30, 2004

(Expressed in Thousands)	Year Ended June 30, 2005	Year Ended June 30, 2004
Operating revenues:		
Premiums	\$ 37,388	\$ 36,805
Total operating revenues	<u>37,388</u>	<u>36,805</u>
Operating expenses:		
Contractual services	5,606	5,438
Benefits	38,897	35,875
Other	632	299
Total operating expenses	<u>45,135</u>	<u>41,612</u>
Operating loss	<u>(7,747)</u>	<u>(4,807)</u>
Nonoperating revenues:		
Interest income	592	290
Total nonoperating revenues	<u>592</u>	<u>290</u>
Loss before transfers	(7,155)	(4,517)
Transfers from state general fund (Note 3)	5,803	5,653
Increase (decrease) in net assets	(1,352)	1,136
Net Assets, July 1	<u>22,584</u>	<u>21,448</u>
Net Assets, June 30	<u>\$ 21,232</u>	<u>\$ 22,584</u>

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

Medicare Supplement Insurance Fund
Statements of Cash Flows
For the Years Ended June 30, 2005, and June 30, 2004

(Expressed in Thousands)

	Year Ended June 30, 2005	Year Ended June 30, 2004
Cash flows from operating activities:		
Receipts from fund members	\$ 37,710	\$ 36,717
Payments to insurance companies and health care providers	(44,079)	(41,498)
Payments for state services	(632)	(299)
Net cash used for operating activities	<u>(7,001)</u>	<u>(5,080)</u>
Cash flows from noncapital financing activities:		
Transfers in from state general fund	<u>5,803</u>	<u>5,653</u>
Net cash from noncapital financing activities	<u>5,803</u>	<u>5,653</u>
Cash flows from investing activities:		
Interest received	<u>592</u>	<u>290</u>
Net cash from investing activities	<u>592</u>	<u>290</u>
Net increase (decrease) in cash	(606)	863
Cash, July 1	<u>28,251</u>	<u>27,388</u>
Cash, June 30	<u>\$ 27,645</u>	<u>\$ 28,251</u>
Reconciliation of operating loss to net cash used for operating activities:		
Operating loss	\$ <u>(7,747)</u>	\$ <u>(4,807)</u>
Adjustments to reconcile operating loss to net cash used for operating activities:		
(Increase) decrease in accounts receivable	217	(228)
Increase(decrease) in accounts payable	424	(185)
Increase in unearned revenue	<u>105</u>	<u>140</u>
Total adjustments	<u>746</u>	<u>(273)</u>
Net cash used for operating activities	<u>\$ (7,001)</u>	<u>\$ (5,080)</u>

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

Medicare Supplement Insurance Fund
Notes to the Financial Statements
June 30, 2005, and June 30, 2004

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. The fund has elected not to follow subsequent private-sector guidance.

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, 2005, and June 30, 2004

NOTE 2. DEPOSITS

The Medicare Supplement Insurance Fund had \$27,645,116 and \$28,251,002 in the State Treasurer's pooled investment fund at June 30, 2005, and June 30, 2004, respectively. The pooled investment fund, administered by the State Treasurer, 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, and in certain obligations of the state. The pooled investment fund's required risks disclosures are 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 years ending June 30, 2005, and June 30, 2004, the Medicare Supplement Insurance Fund received transfers of \$5,802,560 and \$5,652,540, respectively, 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. 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, *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, 2005, included 23,111 retirees and dependents who selected one of three Medicare Supplement Insurance plan offerings. Fund members at June 30, 2004, included 22,497 retirees and dependents.

The Medicare Supplement Insurance Fund assumes responsibility for determining plan benefits and eligibility, establishing premiums sufficient to fund plan obligations,

Medicare Supplement Insurance Fund
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June 30, 2005, and June 30, 2004

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 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, 2005, and June 30, 2004, reserve requirements were established of 14%, based on claims 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 two years (expressed in thousands):

	<u>2005</u>	<u>2004</u>
Unpaid claims at the beginning of the year	\$ 5,342	\$ 5,533
Incurred claims:		
Provision for insured events of the current year	41,232	38,155
Decrease in provision for insured events of prior years	<u>(419)</u>	<u>(794)</u>
Total incurred claims expenses	<u>40,813</u>	<u>37,361</u>
Payments:		
Claims attributable to insured events of the current year	35,459	32,813
Claims attributable to insured events of prior years	<u>4,923</u>	<u>4,739</u>
Total payments	<u>40,382</u>	<u>37,552</u>
Total unpaid claims at the end of the year	<u>\$ 5,773</u>	<u>\$ 5,342</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, 2005, only 54 months of data were 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 and policy years.

	Fiscal and Policy Year Ended (Expressed in thousands of dollars)				
	<u>2001</u>	<u>2002</u>	<u>2003</u>	<u>2004</u>	<u>2005</u>
(1) Required contribution and investment revenue earned (fiscal year)	20,145*	44,015	34,762	37,095	37,980
(2) Unallocated expenses (fiscal year)	2,375*	4,887	5,433	5,737	6,238
(3) Estimated incurred claims and expenses, end of policy year	28,163	32,387	36,105	39,074	**
(4) Paid (cumulative) as of:					
End of policy year	23,657	27,205	31,050	33,604	**
One year later	28,536	31,875	35,543	**	
Two years later	28,662	31,888	**		
Three years later	28,658	**			
Four years later	**				
(5) Reestimated incurred claims and expenses:					
End of policy year	28,163	32,387	36,105	39,074	**
One year later	28,623	31,890	35,984	**	
Two years later	28,659	31,879	**		
Three years later	28,658	**			
Four years later	**				
(6) Increase (decrease) in estimated incurred claims and expenses from end of policy year	495	(508)	(121)	0	**

* Amounts only represent a 6-month fiscal period

** Data not available