Chapter 3

The Board of Trustees Needs to Attend to Pressing Issues

This chapter presents the findings and recommendations of our review of selected operations of the Hawaii Public Employees Health Fund (health fund). We examined the health fund's use of reserves and the practice of porting funds to the union health benefit plans. We also reviewed the health fund's efforts to replace its computer system, the status of establishing a long-term care benefits plan, and customer service.

Summary of Findings

1. The Board of Trustees has not ensured that the Hawaii Public Employees Health Fund's reserves have been properly managed. Erratic premium rates indicate ineffective rate stabilization efforts. In addition, excess reserves have not been returned to employees.

2. The board has not ensured that premiums are being paid to purchase health benefits from union plans. The State's interest is significant as millions are ported to union health plans. However, the board has never audited the union benefit plans' use of the ported funds.

3. The board has taken far too long to replace the health fund's inadequate computer system. Numerous systemic problems have been known for years. The health fund's new computer system may not be compatible with other public employee computer systems. Work has begun even though complete funding for the computer system is not secured.

4. The board has yet to implement a long-term care plan. The health fund has had the statutory requirement to establish a plan since 1989. Delays in establishing the plan persist.

5. The health fund's customer service could be improved. Our survey of enrollees identified areas of concern regarding retirees. Respondents also reported problems with their insurance carriers.

The Board Has Not Ensured That the Health Fund's Reserves Have Been Properly Managed

The Board of Trustees has the fiduciary responsibility over the Hawaii Public Employees Health Fund. Several trustees indicated that the board controls health care costs through the use of rate stabilization funds and also by negotiating the best plan with the carriers. Over the past ten years, the health fund has set aside significant moneys to stabilize insurance premium rates. However, the health fund's medical indemnity insurance plan premium rates have fluctuated erratically, indicating ineffective rate stabilization efforts. In addition, excess reserves have not been returned to employees as required by law.

Erratic premium rates indicate ineffective stabilization efforts

Setting aside funds or *reserves* for stabilizing insurance premium rates is a common practice in the health insurance industry. Based on a plan's claims experience and other factors such as inflation, a rate stabilization amount is set aside to keep premium rates within a certain range, for instance plus or minus 10 percent of the previous year's annual costs.

Our recent financial audit of the health fund (Report No. 99-18) found that the health fund has no definition of reserves. In addition, our actuarial consultant found that the health fund's medical plan premium rates have been relatively volatile, ranging from minus 19 percent to plus 42 percent over the past ten years as shown in Exhibit 2.15, Exhibit 2.16, and Exhibit 2.17. Although substantial claims surpluses have accumulated in the past, they have not been used to moderate rate changes. Given such large fluctuations, the board should review and improve its rate stabilization strategy.

Excess reserves have not been returned to employees

Our financial audit also found that the board has not returned the excess contributions to employees and retirees. Several laws (Act 183, SLH 1995, Act 269, SLH 1996, and Act 276, SLH 1997) have been passed to return the employers' share of the excess contributions. However, the board has had difficulty determining how the employees' share of the reserves should be returned. One trustee observed that the health fund does not have a mechanism to return the reserves to employees. The board has a bill in the 1999 legislative session seeking to return the excess reserves to employee beneficiaries. This topic is discussed in more detail in our financial audit of the health fund, Report No. 99-18.

The Board Has Not Ensured That Premiums Are Being Paid to Purchase Health Benefits From Union Plans

The Board of Trustees has not ensured that premiums ported to the union plans are being used to purchase health benefits. The State's interest here is significant, as more employees have been enrolling in the union plans and the amount of premiums paid (ported) to union plans has grown to many millions. The board has never audited whether the union plans are using the ported funds to purchase health benefits

The State's interest is significant as millions are ported to union health plans

The State's interest is increasingly significant as the premiums paid have grown with more and more public employees enrolling in the union plans. In FY1993-94, 5,640 active employees, about 8 percent of all active employees under the health fund, were enrolled in union medical plans. By FY1996-97, this number had grown to 25,403, or about 53 percent of active employees. From FY1993-94 to FY1996-97, premiums paid by the employers for health benefit plans of the Hawaii Government Employees Association (HGEA) increased nearly 216 percent, from $9,815,046 to $31,001,911. For the same time period, premiums paid by the employers for the health benefit plans of the Hawaii State Teachers Association (HSTA) increased 381 percent, from $3,767,097 to $18,119,524. Employers' premiums paid for the plans of the United Public Workers (UPW) increased over 620 percent, from $1,458,931 in FY1993-94 to $10,516,871 in FY1996-97. Yet, in spite of the significant increases in premiums ported to union health plans, the current board has not requested the unions to provide information on their health benefit plans' operations until this study.

The board has never audited funds ported to union plans

The board has never audited the union health benefit plans. Consequently, the board falls short of fulfilling its fiduciary responsibility to carry out the purposes of the health fund. Section 87-21, HRS, gives the board the power to administer and carry out the purposes of the fund. The fund's administrative rules require the union plans to maintain records for the board's review.

State law identifies the nature of contributions toward purchasing union health benefits. Under Chapter 87, HRS, the board transfers or ports the employer's monthly contribution to the appropriate union plan. By statute, the amount ported is determined by collective bargaining agreements or the actual monthly cost of the coverage, whichever is less. However, without auditing the union health benefit plans, the board has no way of verifying the actual monthly cost of the coverage. Beyond the unions' assertion, the board has no assurance that the ported funds are used for purchasing health benefits for union plan enrollees. At least one union that was about to receive a premium refund from a health insurance

carrier has contacted the health fund inquiring about the disposition of the refund. None of the union plans has ever returned any difference between what it cost to provide coverage and what was ported to them.

The health fund's administrative rules, Title 6, Chapters 34.9(3), 35.5(3), and 36.7(3), require the union plans to state that they will comply with the board's requirements to maintain reasonable accounting records and furnish such records and reports as may be requested by the board, administrator, or state comptroller. In addition, the union plans agree to permit representatives of the board or state comptroller to audit and examine their records and accept adjustments for errors or other reasons that may be required under Chapter 87, HRS, or the administrative rules.

We asked the Board of Trustees to request on our behalf from the three largest public employee unions—HGEA, HSTA, and UPW—actuarial and other information regarding their health plans that was important for our study. However, to date, those unions have not provided any information on their plans, raising additional questions about the system of porting funds to union plans.

Lack of monitoring traced to a 1979 attorney general opinion

The lack of monitoring the union plans is traced to a 20-year-old opinion of the state attorney general. In 1979, the Board of Trustees requested an attorney general opinion on its responsibilities and liabilities for the union health benefit plans. Specifically, the board asked whether it is obligated to require employee organization plans to submit an accounting or annual report on health fund contributions paid to them on behalf of employees. The then attorney general stated that porting funds to the union plans discharges the health fund from being accountable for those funds and the board is not obligated to require the submission of accounting or annual reports on contributions paid on behalf of employees. Once the payment is made, the employee organization (union) becomes trustee of the funds received and must apply them for the purpose designated. In addition, some trustees also indicated that the health fund may be liable for the union plans if the board monitors the plans.

In FY1978-79, the health fund ported approximately $186,000 in employer contributions to union health benefit plans. In FY1996-97, the health fund ported $63,571,634 to the union plans, almost 342 times the money ported in FY1978-79.

We believe that the board should fulfill its fiduciary responsibilities by ensuring that the union plans are using the ported funds to provide health benefits, and are in compliance with the statutory requirements set forth in Section 87-22.3(2), HRS. The amount of the funds ported to the union

plans is significant. We also believe that the board should reexamine the scope and applicability of the 1979 attorney general opinion.

The Board Has Taken Far Too Long to Replace the Health Fund's Inadequate Computer System

The Board of Trustees has taken far too long to replace the health fund's inadequate computer system. Numerous systemic problems have been known for years and few dispute the health fund's need for a new computer system.

The health fund's computer system has been revised over the years to accommodate new data requirements and plan modifications. In December 1997, the health fund installed a local area network to share files and print records in anticipation of the new Health Fund Information Management System (HFIMS). But the health fund's existing computer system is still slow and the functional needs of the health fund are no longer being met.

The health fund is making progress toward installing a new computer system. However, some are concerned that it may not be compatible with other public employee related computer systems. Furthermore, the unanticipated added expense of the contract for the new HFIMS system has led the health fund and its contractor to begin work on Phase II and verbally agree that the health fund will seek funding for Phase III during the 1999 legislative session and 2000 session if needed.

Numerous systemic problems have been known for years

The health fund's existing computer system was developed in 1975. In 1993, the Department of Budget and Finance retained the Segal Company to prepare an in-depth study of the health fund's operations. Segal found that the health fund's computer application programs lacked many features that are standard in most health benefit programs. Segal recommended a complete replacement of the fund's computer system.

Information integrity has been lacking

In 1997, Watson Wyatt Worldwide's (Watson) Conceptual Design Study for the Health Fund Information Management System, which had been commissioned by the board, listed a number of problem areas. For example, there was no easy way for an employee to update personal changes, such as marriage, divorce, or birth information. The system did not provide a confirmation notice when an employee entered a plan, or changed coverage level. The 20-year-old computer system limited payroll entries to $999.99. This caused an incorrect amount to be passed through the health fund system if an employee's deductions were doubled up or adjustments exceeded $999.99. Another problem was that the health fund could handle only one enrollment application, update, or any other transaction which affected the premium per employee each month.

Watson also noted that there was no standard procedure to correct invalid data. Data was not validated before processing. The actual data editing occurred when it was processed through the system. Even then, the editing was incomplete and many data errors occurred. For example, the system did not identify duplicate spouse enrollment until after the transaction was posted. Because errors were identified at the end of the process, rather than at the beginning, many processing delays resulted in an attempt to determine the correct information that should be processed.

Service center concept was proposed

The Watson study provided the system requirements and design alternatives for a new computer system for the health fund. Watson recommended a service center concept where all employee, employer, union plan, and insurance carrier inquiries are handled at a central location. This approach was intended to completely redesign the health fund's current processes. The health fund would use an interactive voice response system backed up by on-line service representatives and off-line referral specialists to answer employee questions, process employee transactions, and respond to union plan and insurance carrier needs. While Internet access would not be added at this time, the recommended system was intended to reduce paperwork, automate access to information, and provide improved customer service.

Also recommended was improved access to better management information not readily available from the health fund's obsolete computer system. For example, the health fund would be able to access information on transactions and enrollment patterns; track the number and content of inquiries from employees and other users; identify situations that are generating the most problems; and track costs and customer satisfaction.

The design and implementation consultant has begun working even though complete funding is not secured

The Hunter Group was selected by the board to develop and implement the health fund's new computer system, working from Watson's recommendations with the health fund's input. The Hunter Group is a custom vendor which builds computer applications depending on the client's needs. The new system will use *PeopleSoft* software. The Watson study noted that this software's specialty is benefits administration and appears to satisfy almost all of the needs for a human resource information system.

Hunter Group staff began working at the health fund in February 1999. As of March 1999, the consultant is in the design phase working toward creating the customized prototype for the new computer system. However, work has begun even though complete funding for both the design phase and the implementation phase has not been secured.

The Hunter Group's proposed price for both phases exceeded earlier project estimates. The unanticipated added expense of the consultant's

proposal exceeded the $3.6 million trust fund appropriation authorized by the Legislature in FY1998-99. The board chair noted that the board frequently implements contracts before they are executed because it takes a long time to get the attorney general's approval. To move the project ahead, the health fund and its contractor verbally agreed to begin work under a contract covering the design phase before securing the funding for the entire project and executing a contract for the implementation phase. In the 1999 legislative session, the health fund is seeking an additional $2.5 million trust fund appropriation to cover the remaining cost of the project agreed to by the board and the Hunter Group.

We believe that verbal agreements to continue work place the State in a position of being potentially liable for the cost of the next phase (implementation) if the health fund cannot get approval for full funding. Our financial audit of the health fund, Report No. 99-18, identified other contract management concerns. The health fund should ensure that work on the implementation phase does not happen prior to a properly executed contract.

Compatibility with other public employee computer systems is unresolved

The health fund's existing computer system is not linked to other public employee related systems, such as personnel, payroll, and the Employees' Retirement System. There has been much discussion about designing the new computer system to be compatible and integrated, but no trustee or state personnel are sure that integration will be successfully implemented. Many trustees expressed concern that the health fund's new computer system may not integrate with other public employee computer systems. Even the administrator is not sure how well the health fund's computer system will interface with the Department of Human Resource Development's new computer system, which is using an earlier version of *PeopleSoft* than the health fund plans to use. Although that department's new computer system is expected to be running by 2000, the health fund administrator reports that there have been no discussions on linkage with the health fund's system.

The Board Has Yet to Implement a Long-Term Care Plan

The board has yet to implement a long-term care benefit plan for the Hawaii Public Employees Health Fund. Act 334, SLH 1989 required the health fund to establish a long-term care benefit plan for the health fund's beneficiaries. In 1991, the health fund's consultant, William M. Mercer, Inc., issued its report on the benefit design, pricing, administration, and communication strategies to establish a long-term care benefit plan. However, in the eight years since the Mercer study, the board has been unable to obtain approval to adopt such a plan or to follow up on the study. Our financial audit Report No. 99-18 discusses these issues in detail.

The board has attempted to obtain funding to establish the long-term care plan. However, the health fund's budget requests to implement a long-term care plan for fiscal biennium (FB) periods FB1991-93, FB 1993-95, and FB1995-97 were not funded. At one point, it was thought that the Executive Office on Aging's statewide long-term care initiative, the Hawaii Family Hope Project, would eliminate the need for the health fund to establish a long-term care plan for public employees. However, Hawaii Family Hope failed because the plan was to be funded through a new tax on all taxpayers.

Delays in establishing a long-term care plan persist

Delays in establishing the health fund's long-term care plan persist. In the 1999 legislative session, the health fund is seeking $103,000 to hire a consultant to review the 1991 Mercer reports and to develop a request for proposal for the long-term care benefit plan. The health fund is seeking an additional $3,000 for training and communication related to establishing the plan. We believe that the Board of Trustees should proceed to implement the law that calls for a long-term care plan for state and county employees, retirees, and beneficiaries.

Customer Service Could Be Improved

The health fund currently provides a basic level of assistance to participants. According to the administrator, the health fund is not structured to be a high-powered customer service organization. Neither the board nor the administrator has surveyed those it represents. We randomly sampled public employees and retirees about their health benefits, customer service, experiences with insurance carriers, and suggestions for improvement. Our survey of enrollees identified areas of satisfaction and concern. We found that satisfaction is generally lower among retirees. The health fund also needs to improve its communication with public employers and their staff to ensure that health benefit enrollments are handled efficiently and effectively.

Importance of communication

Benefit plans must be frequently restudied to determine whether a group benefit plan is continuing to meet its desired purpose and the needs of the workforce. It should clarify what the benefits mean and explain why changes are made. Effective communication can minimize dissatisfaction that arises from misunderstandings about the benefit program and can encourage prudent use of benefits.

The health fund's primary communication with employees and retirees each year is through its benefit plan booklets delivered prior to the open enrollment period. For the first year of the two-year benefit period, a booklet presents information on each of the health fund's plans offered,

and instructions for enrolling in those plans. In the following year, since the benefits do not change, the health fund prepares an abbreviated benefit newsletter for active employees and retirees.

Experts in employee benefits management suggest that effective communication about health benefits is more than just distributing a summary plan description. The basic purpose of benefits communication is to help achieve the goals of the benefit program and increase employee awareness, understanding, and appreciation of the benefits provided. Person-to-person contact is important to keep tabs on what employees, managers, and supervisors are thinking and to clear up any misunderstandings that may arise.

Customer service in other states

We contacted a number of states about their public employee health benefit programs. We found that many states have detailed health benefit information ranging from newsletters, brochures, publishing employee survey results, and establishing Internet web sites.

A number of states, including California, Connecticut, Georgia, Maine, Michigan, and Pennsylvania have Internet web sites. Maine and New Hampshire provide ombudsman assistance for enrollees if there are problems with their insurance carriers. Colorado surveys its membership on a regular basis. Oregon and Pennsylvania have conducted membership surveys about customer service. Oregon recently published its survey results in a booklet for its membership.

Pennsylvania has customer service representatives and an interactive voice response system. Pennsylvania's benefit plan representative noted that the interactive system did not result in a big reduction of calls to customer service representatives because most people want to talk to a real person, not a computer.

Arizona and Pennsylvania prepare newsletters for enrollees. Maine requires its insurance vendor to provide a quarterly newsletter for its membership.

There are many ways in which the Hawaii Public Employees Health Fund can improve customer service to enrollees. Improving customer service and communication with enrollees is an important tool to help people understand and appreciate health benefits and use those benefits in a cost effective manner.

Our survey of enrollees identifies areas of satisfaction and concern

The health fund is established to provide health, life, and long-term care benefits for public employees, retirees, and their beneficiaries. However, to date, neither the Board of Trustees nor the health fund has surveyed enrollees about customer service, benefits, or concerns about their insurance carriers. Also troubling is that the health fund does not track inquiries or complaints from participants.

We randomly sampled public employees and retirees using the health fund's master list. Our survey found that overall, respondents are satisfied with their health benefits. However, retirees are less satisfied than active employees. Some enrollees would like the health fund to provide clearer and more information. Respondents also want the health fund to ask for their suggestions.

Our random sample included participants in the health fund and union plans. Nearly 75 percent of health fund medical plan participants reported that they are not likely to transfer to a union medical plan. Similarly, 78 percent of the union plan participants are not likely to transfer to a health fund plan. For health fund participants, the leading reasons for choosing the health fund plans were cost, better coverage, and wanting to stay with the same health plan. Union plan participants reported that cost and better coverage were the reasons for choosing the union plan.

Differences indicate that retirees need more attention

We found that retirees are less satisfied than active employees with the length of time spent waiting for assistance, courtesy, quality of response to request for information, quality of response to a complaint, and speed in making a change or correction. For instance, when contacting the health fund for information, 93 percent of active employees were satisfied compared to 64 percent for retirees.

We also asked participants to rate their satisfaction regarding how long they waited for assistance. Over 83 percent of our respondents were satisfied with how long they waited for assistance. While the majority of active employees, 90 percent, were satisfied with their wait, fewer retirees, 67 percent, were satisfied.

The majority of respondents, about 87 percent, understand the information in the open enrollment benefit plan booklets. However, slightly fewer retirees, 85 percent, report that they understand the benefit booklets compared to 88 percent for active employees.

Evaluations of respondents' satisfaction with the courtesy of health fund staff showed a similar spread between retirees and active employees. Over 87 percent of respondents are satisfied with the courtesy of the

health fund's staff. However, 73 percent of the retirees reported satisfaction with staff courtesy compared to over 93 percent of active employees.

We asked respondents to rate the quality of the response by the health fund to their complaint. Seventy-three percent of respondents were satisfied with the quality of the health fund's response. Slightly over three-quarters, 77 percent, of active employees indicated that they were satisfied with the health fund's response to complaints, compared to about two-thirds, 67 percent, of retirees.

The health fund acknowledges that its computer system hinders speedy error correction. Accordingly, far fewer respondents, nearly 59 percent, reported that they are satisfied with the speed with which the health fund makes changes or corrections. Still, somewhat more active employees, over 61 percent compared to 50 percent of retirees, reported that they were satisfied with the speed in making changes or corrections.

The differences indicate areas in which the health fund can better serve employees' and retirees' needs. While active employees can contact their designated personnel officer at their work site about their health benefits, the health fund is the primary source of information for retirees when they have questions about their health benefits. These survey responses point to the need for the health fund to examine ways it can improve its communication and services for retirees.

Problems with insurance carriers

We asked participants about their experiences with their insurance carrier. The majority of respondents did not report any problems with their insurance carrier. However, about 13 percent of respondents did report problems. HMSA received 78 percent of the complaints from respondents. Kaiser, Kapi'olani HealthHawaii, and Hawaii Dental Service (HDS) received fewer complaints. Reported difficulties with carriers included long delays in claims reimbursement and poor billing services. Out-of-state beneficiaries also reported problems with insurance carriers. These problems provide an opportunity for the health fund to step in and assist enrollees. Other state health plans perform an ombudsman role to ensure prompt and appropriate action from insurance carriers, to identify and track performance, trends, and also to ensure that enrollees' health benefit needs are met.

One respondent reported a potentially serious problem. A mail-order prescription drug company twice sent medication mixed in with another prescription medicine. Neither HMSA nor the mail-order prescription company reportedly resolved this problem satisfactorily. We did not independently verify this reported problem.

The health fund plans to include performance standards in its HMSA contract. These measures include timely responses to inquiries and prompt problem resolution. The health fund should inform enrollees that all carriers' service to its membership is important. This feedback can be used to improve carriers' performance.

Better communication with employers is needed

We found that the health fund needs to improve its communication with county employers. The health fund relies upon the assistance of state and county staff during the open enrollment period. Much of the person-to-person benefit information and enrollment is handled by approximately 500 designated personnel officers at all levels of state and county government. According to the administrator, the health fund trains these staff once a year prior to the open enrollment period.

County representatives indicated that they would like to have more communication with the health fund to provide feedback on training, benefits, or insurance plans. Three counties identified specific problems needing attention. For example, one county noted the once a year training for open enrollment is intense and provides an overwhelming amount of information. They would like on-going training and more contact with the health fund to provide feedback. Other problems cited by the counties included late notification of shortages in an employee's contributions leading to cancellation notices, problems with insurance carriers, and administrative problems.

Issues for Further Study

The Hawaii State Ethics Commission issued an opinion about a potential conflict of interest. In addition, it noted other issues in the course of its investigation. The commission expressed concern about the board's minutes and the trustees' understanding of the criteria for selecting an insurance carrier. The commission acknowledged that while its other observations about the board were outside its jurisdiction, it nevertheless believed that it has an obligation to bring additional matters to the board's attention. We did not explore these issues in our study, but we believe they may warrant further study.

Potential conflict of interest with union life insurance plans

There were recent concerns about a potential conflict of interest and favoritism regarding health fund trustees who represent unions voting in December 1998 for a life insurance plan offered by an insurance company which handles health benefits for those unions. By statute, three of the nine trustee positions are designated for public employee union representatives. The HGEA and the UPW already offered health benefit plans through Royal State Insurance. Some felt that HGEA's and UPW's

representatives on the board should have recused themselves from voting on the life insurance carrier since the executive directors of their unions serve on the board of Royal State Insurance.

However, those trustees did vote and Royal State was awarded the health fund's life insurance 1999-2000 contract. In FY1996-97 the health fund paid nearly $3.2 million for life insurance benefits. The board's secretary-treasurer protested that Royal State's life insurance plan was more expensive and had less attractive benefits than another insurance carrier's plan. The controversy also led the governor to express his concerns about the matter to the board.[1]

The Hawaii State Ethics Commission examined whether there was a conflict of interest or favoritism. It found insufficient evidence to establish any violation of the State Ethics Code's conflicts of interest law or favoritism law. However, the commission went on to state that it believes that having state officials or board members taking official action directly affecting companies run by boards on which their "bosses" sit raises a matter of concern. As a result, the commission has decided to study whether Section 84-14(a), HRS, Conflicts of Interest, should be amended.

Adequacy of board minutes

The ethics commission reported that the Board of Trustees' meeting minutes did not indicate what companies were under consideration by the board, or the views expressed by board members when considering the award of the contract. The lack of minutes providing a description of the board's deliberation in awarding the contract resulted in no record for the commission's review in determining whether or not there was any violation of Section 84-13, HRS, Fair Treatment.

The commission explained that Chapter 92, HRS, Public Agency Meetings and Records, sets forth how minutes for both public and executive portions of board meetings must be prepared and maintained. Section 92-9, HRS, Minutes, states that neither a full transcript nor a recording of the meeting is required, but the written minutes shall give a true reflection of the matters discussed at the meeting and the views of the participants. The commission believed that the issue of whether or not the minutes are in compliance with Section 92-9, HRS, should be brought to the attention of the board's counsel. The board indicated that it intends to include more detail in its meeting minutes.

Concerns about procurement criteria

The commission also noted that there may have been confusion about what aspects of various proposals were significant or not. It observed that Section 87-24, HRS, Selection of a Carrier...for a Health Benefits, Group Life Insurance, or Long-Term Care Benefits Plan, appears to exclude the health fund's board from the State's procurement law. This

allows the board flexibility in determining the specifications for awarding contracts. The commission observed that the board's flexibility and discretion may have created confusion for board members as to what aspects of the life insurance proposals were significant or not. The commission stated that it was difficult to evaluate the allegations of possible wrongdoing because of the flexible process for awarding contracts. It suggested that the board consider taking steps to ensure that trustees clearly understand the weight accorded to various elements of different insurance proposals.

Conclusion

The Board of Trustees of the Hawaii Public Employees Health Fund must address several pressing issues. The board has not effectively handled its reserves to stabilize premium rates and has not returned excess reserves to employees. Another deficiency is the board's insufficient oversight of and pursuit of information about the union health benefit plans and their impact on the health fund.

The health fund's new computer system was long delayed, but now holds the promise of better management information, and streamlined, more efficient operations. The board should ensure that work on the implementation phase does not occur prior to a properly executed contract. Finally, the board needs to improve the health fund's customer service for its employee and retiree beneficiaries.

Recommendations

1. The Board of Trustees of the Hawaii Public Employees Health Fund should fulfill its fiduciary responsibilities by reviewing and improving its rate stabilization efforts.

2. The board should work closely with the Legislature, the Department of Budget and Finance, and the Department of the Attorney General to resolve the disposition of excess reserves created by employee contributions.

3. The board should immediately begin to audit the union health benefit plans on a periodic basis to ensure that premiums are being paid to purchase health benefits.

4. The board should exercise its fiduciary responsibility by analyzing the impact of the union plans on the health fund. It should reexamine the validity and applicability of the attorney general's July 1979 opinion concerning the board's responsibilities and liabilities for the union health benefit plans.

5. The board should continue with its plans to design and implement a new Health Fund Information Management System.

6. The board should ensure that work on the implementation phase of the health fund's new computer system does not begin prior to a properly executed contract.

7. The board should review and improve its contract management practices to protect the interests of the State, the health fund, and the consultant.

8. The board should continue its efforts to establish a long-term care plan for the Hawaii Public Employees Health Fund.

9. The board should improve customer service for retiree and employee beneficiaries by:

    a. requiring the administrator to establish a formalized feedback system with employees, retirees, and beneficiaries, and also with the state and county employers;

    b. examining ways of improving customer service for retirees;

    c. monitoring the carriers' customer service; and

    d. considering the creation of an ombudsman role for the health fund to trouble-shoot problems on behalf of its beneficiaries.