Internal Audit Report

Cuyahoga County, Ohio
Department of Internal Auditing

Health Care Benefits Program – Phase I
January 1, 2011 – June 30, 2015

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CUYAHOGA COUNTY
DEPARTMENT OF INTERNAL AUDITING

INTERNAL AUDIT REPORT
Cuyahoga County Health Care Benefits Program
Cover Letter

February 5, 2016

To: County Executive, Armond Budish; Interim Human Resource Director Egdilio Morales; County Fiscal Officer; Dennis Kennedy, CPA; and the current management of the Cuyahoga County Benefits Division within the Human Resources Department:

The Department of Internal Auditing (DIA) has conducted an audit over the financial operations and general accounting of the Cuyahoga County Health Care Benefits Program (referred to within this report as the "Program"), for the period of January 1, 2011 through June 30, 2015. The audit objectives were to determine whether controls in place were adequate to safeguard assets from abuse, errors, and loss; revenue transactions and department funds were properly supported, recorded, and deposited in their entirety in a timely manner and in accordance with all governing laws and regulations; and expenditures were properly approved and recorded.

To accomplish our objectives, we focused on the operational controls of the Program, the major revenue and expenditure cycles as well as specific compliance mandates. Interviews with management and staff along with general walk-throughs of each revenue and expenditure cycle were conducted in order to document the controls in place. In addition, substantive testing methods utilized included analytical procedures, tests of detail using sampling methods, as well as confirmation with Program Partners. An extensive review of emails between County employees with responsibilities to the Program and the consultants and vendors of the Program was also performed.

Our audit procedures disclosed internal control weaknesses relating to the Program's revenue and expenditure cycles, asset safeguarding, and recordkeeping. Non-compliance with Ohio Revised Code, filing requirements of the Affordable Care Act, and other County contract provisions were also identified. This report provides the details of our findings.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe the evidence obtained provides a reasonable basis for our findings and conclusions.

The Department of Internal Auditing would like to express our appreciation to the staff of the Benefits Division of Human Resources and interrelated departments that assisted throughout the process for their courtesy and cooperation during this audit. A draft report was provided to the Chief Talent Officer for comment. Where applicable management's responses are included following the related non-compliance citation or internal control recommendation. Additionally, the entire response letter has been included beginning on page A-1.

Respectfully,

Valerie J. Harry, CPA

Valerie J. Harry, CPA
Director of Internal Auditing

Cc: Audit Committee
Cuyahoga County Council
Sharon S. Jordan, Chief of Staff
Robert Triozzi, Law Director

Contents

Glossary

ACA	-	Affordable Care Act
CCBODD	-	Cuyahoga County Board of Developmental Disabilities
CVS	-	Caremark PCS Health. Cuyahoga County's pharmacy provider.
EBI	-	Employee Benefits International, Inc. Cuyahoga County's benefits consultant.
FAMIS	-	Cuyahoga County's accounting information system.
Kaiser	-	Kaiser Permanente. One of Cuyahoga County's medical providers prior to 2015. Plan was not renewed after 12/31/2014.
MHS	-	MetroHealth Services. One of Cuyahoga County's medical providers. This contract is combined with MMO's contract.
MMO	-	Medical Mutual of Ohio. One of Cuyahoga County's medical providers.
ORC	-	Ohio Revised Code. Sections referred to in this report include 9.38, 9.833, and 5705.41
PEPM	-	Per Employee Per Month.
SAP	-	Information system utilized by the Benefits Division to track and store benefits and payroll data.
SOC	-	Service Organization Control
UHC	-	United Healthcare. One of Cuyahoga County's medical providers.
Voya	-	Reliastar Life Insurance dba Voya. Voya provides Stop Loss insurance to County and Regional employees and their eligible dependents. Stop Loss insurance may be necessary to protect the County against large medical and pharmacy claims.
WIQ	-	Wellness IQ is the County's wellness services provider.

Report Details

Purpose

The purpose of this audit was to address concerns surrounding the Health Care Benefits Program (Program) which resulted in a review of the operations and financial condition of the Benefits Division of the Cuyahoga County Department of Human Resources (Benefits). Additionally, the Department of Internal Auditing (DIA) was notified by the County Fiscal Office of budget issues related to the payment of County and Regional medical and pharmacy claims.

DIA evaluated processes for compliance with existing policies, laws, and professional standards. We attempted to identify and address any additional problem areas identified during the audit. The audit included review and evaluation of procedures, practices and controls as deemed necessary.

Audit Objective

Our (DIA) main audit objectives include:

- Determine whether controls are in place, and if controls do exist, determine if they are adequate to effectively and efficiently achieve the County's and the Program's goals.
- Assets are safeguarded from abuse, errors, and loss.
- Revenue transactions are properly supported, recorded and deposited in their entirety in a timely manner and in accordance with all governing laws and regulations.
- Expenditures are properly approved, recorded and in accordance with all governing laws and regulations.
- Assure affected funds maintain the proper fund balances.
- Reporting information is timely accomplished, accurate and in accordance with all governing laws and regulations.

Scope

To accomplish our objectives, focused on the operational controls of the office, the major revenue and expenditure cycles, as well as specific compliance mandates during the period of January 1, 2011 through June 30, 2015. Interviews with management and staff along with general walk-throughs of each revenue and expenditure cycle were conducted in order to document the controls in place and their operation. In addition, substantive testing methods included analytical procedures, test of details using sampling methods, as well as confirmation of transactions and/or assets.

Some findings in this report include results from tests that have not been fully completed. These limitations are noted in the finding where applicable. Additionally, DIA was unable to obtain supporting documentation for some transactions. Any findings related to those transactions will be reported in the Phase II report.

Methodology

In order to accomplish the audit objectives DIA performed the following:

- Conducted interviews with management, staff, and Employee Benefits International.
- Conducted general walk-throughs of Benefits operations.
- Inquired with third party vendors (medical and stop loss providers) and Regional Partners.
- Witnessed and documented procedures and controls in place.
- Observed procedures in place for receipts and expenditures.
- Conducted substantive and control tests on the revenue and expenditure cycles.
- Conducted compliance tests on local, state, and federal regulations.
- Conducted compliance tests on contractual agreements with Regional Partners and providers.
- Reviewed emails between the County's consultants and vendors and the Program employees of the County.

Background

Cuyahoga County provides health care benefits to its employees and their eligible dependents through a self-insured benefit program. The County contracted with Employee Benefits International (EBI) as their professional healthcare consulting and brokerage firm beginning on May 1, 2009 and continuing through the current contract which ends on July 31, 2018. In July of 2009, the Cuyahoga County Land Reutilization Corporation (Land Bank), which is a related organization to Cuyahoga County, began to provide health care benefits to its employees and their dependents through the Cuyahoga County plans. This was the early beginnings of the Regionalization Program. Although no formal approval by resolution of the former County Commissioners or the former and current County Council can be found to expand the program to other political subdivisions, emails show that County officials were approving of the expansion. There is evidence in April of 2010 the incorporator of EBI was promoting expansion of the program to political subdivisions with 10-250 employees within the County's borders. A public statement made by the incorporator of EBI, and quoted from cleveland.com on March 30, 2010, was that "the County's goal is to be cost-neutral." In 2011 the Program expanded to the City of Olmsted Falls and the Village of Walton Hills. It currently has 19 Partners. The table on the next page outlines the current participants, their original effective date, the contract approval date, and the number of covered employees as of June 30, 2015. Please note that Olmsted Township was also a Regional Partner from January 1, 2011 through December 31, 2013.

Regional Partner	Effective Date	Contract Approval Date	Number of Employees	Note
Land Bank	07/01/2009	No Contract Found	28	
Olmsted Falls	01/01/2011	12/02/2010	27	
Walton Hills	01/01/2011	12/02/2010	25	
Mayfield Village	04/01/2012	07/24/2012	62	
Glenwillow	07/01/2012	07/24/2012	9	Under employee limit
Highland Hills	07/01/2012	08/28/2012	23	
North Randall	09/01/2012	10/09/2012	10	
CCBODD	01/01/2013	03/12/2013	821	Over employee limit
Fairview Park	01/01/2014	01/28/2014	97	
University Heights	01/01/2014	02/11/2014	81	
Board of Health	01/01/2014	01/28/2014	113	
Highland Heights	02/01/2014	02/11/2014	65	
Chardon	03/01/2014	10/28/2014	54	Outside of the County
Cleveland Heights	09/01/2014	10/28/2014	414	Over employee limit
South Euclid	01/01/2015	01/27/2015	115	
Regional Income Tax (RITA)	01/01/2015	01/27/2015	165	
SE Emergency Communication	01/01/2015	01/27/2015	18	Outside of the County
Euclid	04/01/2015	05/12/2015	316	Over employee limit
Red Center Logic	05/01/2015	08/25/2015	15	Outside of the County
Total			**2,458**	

Pursuant to the contract the County has with EBI, it is EBI's responsibility to solicit the various providers through a Request for Proposal (RFP) process. The current providers are:

- Medical Mutual Services – MMO and MHS
- UHC
- CVS
- Voya (Stop Loss Coverage)
- Kaiser (Discontinued on 12/31/2014)

The Benefits Division of the Cuyahoga County Department of Human Resources (Benefits) bills the majority of the Regional Partners a monthly premium per employee (PEPM) based upon the selected plan rates recommended by EBI. Two Regional Partners, Cleveland Heights and CCBODD

are billed by EBI, but payments are sent to the County. Plan offerings and rates differ between the County and each Regional Partner in the Program. Benefits receipts these premiums and pays the weekly billed claims to the providers. An administrative fee is included in the EBI stated premium and is charged to the Regional Partner with the intention to recover the County's cost of administering the program in line with the objective of ensuring cost neutrality. All Regional employees and their dependents are maintained in the County's SAP system. Changes to this information are communicated by the Regional Partner to the County so that updates can be made and the providers can be notified of any changes. EBI has a separate contract with each Regional Partner. A monthly per employee fee, typically $8.00 PEPM is paid directly to EBI from the Partner. See the table on **page 16** for more details on this fee.

The County uses four funds and numerous project codes to account for the activity of both the Regional and County Benefit Program. This makes tracking of the activity very difficult to follow. The Department of Internal Auditing is attempting to recreate the activity in the funds by analyzing the revenues coming in and expenditures going out for each individual participant. This should allow a determination to be made as to whether or not the Program requirement to be "Cost-Neutral" to the County is being met as required. Much of the information and analysis to make these determinations was not complete at the date of this report. The Phase II report will provide that additional information.

Professional Healthcare Consultant – Employee Benefits International (EBI)

EBI provides professional healthcare consulting, brokerage and technical services for the County's employee benefit and insurance plan. They are registered with the Secretary of State and the filing shows James Dustin as the Incorporator. There is evidence that EBI's involvement with Cuyahoga County dates back to October, 2008 and they may have had a role prior to that in 2004 when the County converted from a premium based to a self-insured benefit plan. The County also contracts with Wellness IQ which is another company registered with the Secretary of State that lists James Dustin as the Incorporator. Following is the contract information for EBI and Wellness IQ:

	Resolution	Term	Amount	Amount Paid	Bid/No Bid
EBI	2009-0563	5/1/09-4/30/12^	$507,218	$507,037	Bid
EBI	2012-0152	8/1/12-7/31/15	$790,450 **EBI**	$794,516	Bid
			$215,156 **SBE**	$ 51,893	
Wellness IQ	2011-0345	1/1/12-12/31/14	$1,231,000	$1,246,389	Bid (*)
EBI	2015-0094	8/1/15- 7/31/18	$823,375 **EBI** $0 **SBE**		No Bid (**)
Wellness IQ	2014-0156	1/1/15-12/31/17	$1,579,650		No Bid(**)

**There is evidence this contract was bid but Wellness IQ may have played a part in the RFP process.*

*** Ohio Revised Code and County Procurement Policy Section 501.12(B)(2) do not require bidding for consulting contracts.*

^ Term extended through July 31, 2012.

SBE= Small Business Enterprise

Resolution No. R2012-0152, dated August 28, 2012, awarded a three-year contract to EBI. This contract was not to exceed $1,005,606.45 with $790,450 going to EBI and $215,156.45 going to the SBEs. County FAMIS records show the SBEs were only paid $51,893 during the contract period and that EBI was paid $794,516 through June, 2015 which is greater than the $790,450 stated in Exhibit B of the consultant agreement between Cuyahoga County and EBI. The subsequent Resolution (R2015-0094) was a no bid award. During the presentation to Council, the Benefits Representative from the County stated the award on the EBI contract was less than the prior contract when in fact this award was for $823,375 with no SBE requirement. Making the current EBI contract $32,925 more than the prior one. All three EBI contracts contained provisions for payments to be made for "Wellness Consulting." The Wellness IQ contract approved in Resolution No. 2011-0345 was for three years not to exceed $1,231,000. The amount paid on the contract was $1,246,389, $916,224 of which was paid by the County directly to WIQ. The remainder was paid by the medical providers and sent directly to WIQ for the "wellness subsidy." See the comment titled **Provider Wellness Subsidy on page 48** for more details. There is a potential conflict of interest between EBI and Wellness IQ due to the common ownership and possible duplication of services provided in both contracts. Reviewing the time period beginning with January 1, 2012 and ending on August 31, 2015, the County issued checks to both EBI and Wellness IQ. An examination of the County's canceled checks for this time period illustrates the relationship between the two companies.

Checks Written To: *	Endorsed By:	Deposited in Account	Total Amount
EBI	Wellness IQ	EBI	$7,805.50
Wellness IQ	EBI	Wellness IQ	$229,472.51
EBI	EBI	Wellness IQ	$257,593.75
EBI	Wellness IQ	Wellness IQ	$700,927.46

** This table was inserted to show that a relationship exists between EBI and Wellness IQ. See the finding titled **Consulting Fee Payments-EBI and WIQ on page 60** for further testing results on the related invoices.*

As mentioned earlier, the County offers health care benefits to other political subdivisions through the Regionalization Program which is administered by EBI. EBI is in contact with the political subdivisions that are interested in becoming a Regional Partner to the Program. The County has not adopted a policy and procedure manual to guide this activity. There are no guidelines as to recruiting other entities, for determining the financial viability of the potential Partners, or for the setting of premiums. It appears as if these steps have been undertaken by EBI with little oversight by the County's Human Resource Department. DIA was told by one Regional Partner that EBI responded to their RFP request for services but no other information was given that would evidence a plan of future admissions. Additionally, it appears as if EBI is evaluating the potential entrant without concern for their financial condition or their ability to make regular on time premium payments to the County. A cursory review of the financial audits for one of the Regional Partners showed serious Ohio Revised Code budgetary noncompliance, numerous unpaid bills including those due to the Ohio Bureau of Workers Compensation, Ohio Police and Fire Pension Fund, and Ohio Public Employees Retirement System, and an emphasis of matter in the Auditor's opinion regarding the Partner's ability to continue as a going concern.

The audit was publicly released by the Auditor of State's Office on August 16, 2011. The Partner was admitted into the Program on September 1, 2012 with Resolution 2013-0197 approved on October 9, 2012. The subsequent audit released by the Auditor's Office contained the same findings and was released on November 7, 2013. Although most premium payments have been made timely, a payment of $9,083 dated September, 2012 is still due the County.

Rate Setting and Plan Offering are recommended by EBI with little if any input from the County. EBI has offered plan options to its Regional Partners that have not been internally implemented by the County. Quoted rates have been given to the Partners that include options for Employee plus Spouse, and Employee plus Children. DIA discussed the process of rate setting with EBI representatives. EBI's position is that this is proprietary information and therefore could not be shared. DIA attempted to determine what individual dollar amounts of the total premium were attributable to medical, prescription, administrative fee, consultant's fees, reserves, and stop loss coverage. Information that was provided was not sufficient enough to make this determination. We have been told the premium amount included a $15.00 PEPM administration fee due to the County, but in many cases this is below what the contract between the County and the Partner allows. That amount is from 3% to 6% of the fully insured equivalent rate which would be higher than $15.00. See the comment on **page 17, titled County Administrative Fees,** for more details on the loss of revenue to the County. Additionally, the amount the County did collect in Administrative Fees, which is $542,311 through June 30, 2015, is designated by EBI as the Program Reserves. These funds are to be considered as a reduction in the County's cost to run the Program and cannot also be considered as reserves to the Program. The information in the table on the next page is taken from the Net Reserve calculation that EBI has reported as of June 30, 2015. As mentioned earlier EBI considers the County's Administrative Fee to be part of the reserve balances. DIA has adjusted EBI's calculations by removing the $15 ($8 for CCBODD) PEPM Administrative Fee to get to the true reserve balance by Partner.

EBI Net Reserves Less County Administrative Fee at Year End (except 2015 at June 30, 2015)

Partner	2011	2012	2013	2014	2015	Net Reserve
CCBODD	N/A	N/A	$1,687,591	($260,217)	($589,011)	**$838,363**
Chardon	N/A	N/A	N/A	201,320	26,018	**227,338**
Cleveland Heights	N/A	N/A	N/A	(142,866)	(134,650)	**(277,516)**
Euclid*	N/A	N/A	N/A	N/A	533,377	**533,377**
Fairview Park	N/A	N/A	N/A	(123,640)	(27,686)	**(151,326)**
Highland Heights	N/A	N/A	N/A	243,554	(89,425)	**154,129**
South Euclid	N/A	N/A	N/A	N/A	157,292	**157,292**
University Heights	N/A	N/A	N/A	158,383	13,039	**171,422**
Board of Health	N/A	N/A	N/A	(148,218)	(30,986)	**(179,204)**
Land Bank	$14,627	$44,884	139,713	138,036	(24,686)	**312,574**
Mayfield Village	N/A	227,739	38,031	(16,997)	(36,451)	**212,322**
Olmsted Falls	94,774	3,260	10,993	31,003	36,916	**176,946**
Olmsted Township	(145,203)	140,354	(96,916)	(79,650)	N/A	**(181,415)**
Red Center Logic*	N/A	N/A	N/A	N/A	17,128	**17,128**
RITA	N/A	N/A	N/A	N/A	(332,942)	**(332,942)**
SE Communication	N/A	N/A	N/A	N/A	8,593	**8,593**
Glenwillow	N/A	(19,828)	51,845	(241,146)	(3,351)	**(212,480)**
Highland Hills	N/A	45,566	135,709	142,708	11,309	**335,292**
North Randall	N/A	24,854	13,528	4,644	(20,317)	**22,709**
Walton Hills	142,002	100,823	137,287	176,417	83,424	**639,953**
Total	**$106,200**	**$567,652**	**$2,117,781**	**$83,331**	**($402,409)**	**$2,472,555**

* *Surplus shown maybe overstated due to recent entry into the Program.*

The above table shows the plan is being negatively affected by bringing in the new Partners. From 2013 to 2014 there was no rate increase proposed by EBI except for a 1% increase to CCBODD. Using EBI's numbers which have been adjusted for the County's Administrative Fees the 2014 end of year reserves are $2,034,450 less than the year end 2013 reserves. CCBODD is accountable for $1.9 million of the decrease which suggests the rate increase of 1% was not sufficient to handle future claims. Also contributing to the decrease were Mayfield Village ($55,028) and Glenwillow ($292,991) which had no rate increases. Six new Partners were brought in during 2014. It appears as if three of these Partners: Cleveland Heights, Fairview Park, and Board of Health, may have been quoted low premium rates since they were all at negative balances totaling ($414,724) by the end of 2014. None of these three recovered by June 30, 2015 as they all still have negative balances. Of the remaining three Partners brought in during 2014 that have a positive reserve balance at December 31, 2014 (Chardon, Highland Heights, and University Heights) all are experiencing reduced June 30, 2015 balances.

EBI proposed and the County implemented an increase in rates of 1.5% across the board for 2015. In addition, Glenwillow was assessed a 3.5% load factor. At June 30, 2015 the annual reserve balance is $485,740 less than the previous year's annual reserve balance. Five new Partners were brought in during the first six months of 2015. Two of these Partners, Euclid and Red Center Logic have not been in the program long enough to assess their reserves at June 30, 2015 but one Partner, RITA that has been in the Program since January 1, 2015 has a significant negative balance of ($332,942) after 6 months of operation. This fact suggests that rates were set too low for this Partner. Additionally, implementing across the board rate increases is not taking into consideration those Partners that have maintained positive reserve balances like Walton Hills. Walton Hills was given a rate increase of 1.5% although their average premium payments per month were just over $23,000 and their average cost for claims and fees was approximately $8,000 per month. An individual rate analysis may show an increase was not necessary in their situation.

The cumulative deficit for Olmsted Township is another area of concern. The Township was removed from the Program at December 31, 2013. $181,415 of cumulative claims has been paid on behalf of Olmsted Township.

The table on the previous page also shows that either funds on reserve with other Partners or County funds are being used to pay for claims made by those with negative reserve balances. This is indicative of a risk sharing pool where the Partners agree to cover the shortages of others. However, contracts between the County and the Regional Partners do not define the relationship as risk sharing. Without the proper language in the contract the Regional Partner may not be aware of what is actually happening in the pool and the County may be liable for any deficits in funding. See **page 12** for the non-compliance citation titled **ORC 9.833 – Self-Insurance Program** for more information.

EBI contracts separately with each Regional Partner. Their contract calls for a consultant's fee to be paid directly from the Partner to EBI for their services. This rate is typically $8.00 PEPM, but may go as high as $28.00 PEPM, and is separate from the County's administrative fee charged to each Partner. EBI is able to increase their revenue by adding on more Partners to the Program, some of which may be outside of the County's borders, with more employees than their own guidelines have stated, and at lower than market premiums. Please see the finding titled **EBI and WIQ Contracts on page 14** for DIA's estimate of revenue received by EBI from the Partners.

This report has been divided into two sections. The first section beginning on page 12 will report findings related to non-compliance with legal requirements. The second section beginning on page 41 will report on the internal control recommendations to improve operations of the Program.

Non-Compliance Findings

ORC 9.833 – Self–Insurance Program

ORC Section 9.833 provides statutory authority to political subdivisions to engage a variety of methods to secure health care benefits. The County acted in accordance with Section (B)(4) and entered into agreements with other political subdivisions to establish and maintain joint self-insurance health care benefits. Section (C) in ORC 9.833 requires the self-insurance program to follow certain reporting requirements.

In review of the Regional Partner contracts, no language citing ORC section 9.833 or statements indicating the Regional Partner was a part of a self-insurance risk pool was found. DIA has noted the following noncompliance with section (C) requirements:

- (2) - "*Each political subdivision shall reserve funds necessary for an individual or joint self-insurance program in a special fund that may be established for political subdivisions other than an agency or instrumentality pursuant to an ordinance or resolution of the political subdivision and not subject to section 5705.12 of the Revised Code. An agency or instrumentality shall reserve the funds necessary for an individual or joint self-insurance program in a special fund established pursuant to a resolution duly adopted by the agency's or instrumentality's governing board. The political subdivision may allocate the costs of insurance or any self-insurance program, or both, among the funds or accounts established under this division on the basis of relative exposure and loss experience.*"
    - No such reserve fund has been established pursuant to a resolution duly adopted by Council for this Program.
- (8) - "*A political subdivision is not liable under a joint self-insurance program for any amount in excess of amounts payable pursuant to the written agreement for the participation of the political subdivision in the joint self-insurance program. Under a joint self-insurance program agreement, a political subdivision may, to the extent permitted under the written agreement, assume the risks of any other political subdivision. A joint self-insurance program established under this section is deemed a separate legal entity for the public purpose of enabling the members of the joint self-insurance program to obtain insurance or to provide for a formalized, jointly administered self-insurance fund for its members. An entity created pursuant to this section is exempt from all state and local taxes.*"
    - In review of Regional Partner contracts, there is no written agreement that a political subdivision may assume the risks of any other political subdivision nor is there contractual language authorizing the County to request additional funding from a Regional Partner, other than BODD, if a Regional Partners' costs exceed premiums paid. The County may be liable for the Regional Partners' costs if they exceed premiums without having a contractual agreement allowing for the assumption of risk from any other political subdivision.

- (11) - "*A joint self-insurance program shall pay the run-off expenses of a participating political subdivision that terminates its participation in the program if the political subdivision has accumulated funds in the reserves for incurred but not reported claims. The run-off payment, at minimum, shall be limited to an actuarially determined cap or sixty days, whichever is reached first. This provision shall not apply during the term of a specific, separate agreement with a political subdivision to maintain enrollment for a specified period, not to exceed three years.*"
    - According to the Regional Partner contracts, liability for claims and costs after termination of the contract by the County or Regional Partner is the responsibility of the Regional Partner. The Regional Partner contracts do not state the Regional Partners should have enough reserves to cover claims and costs after leaving the program. Olmsted Township withdrew from the program at the end of 2013 with a deficit reserve balance. The township did not have sufficient funds in reserve to pay run-off expenses, which should include County administration fees and provider claims and fees. The run-off claims totaled almost $80,000 from January to December 2014 resulting in a total cumulative deficit balance of approximately $181,000. The County has not recouped this deficit from the Township as of December 2015.

Without the proper controls and agreements in place to assure compliance with ORC 9.833, the County may be liable for costs and claims associated with the Program.

Recommendation

DIA recommends the County comply with ORC 9.833 and perform the following actions:

- A reserve fund should be established and approved by Council for the Program in accordance with ORC 9.833(C)(2). Reserves should be sufficient enough to cover run-out claims and costs of the Program if the Program ended.
- The County should amend Regional Partner contracts to include language from ORC 9.833. Specifically, each contract should state:
    - The Regional Partner is joining a self-insurance risk pool and the Regional Partner may assume the risk of other Partners in the pool with negative reserve balances, if that is the intention of the Program.
- The County's Law Department should be asked to issue an opinion on the collectability of the deficit balance of Olmsted Township.
- Past County practice utilized a Benefits Advisory Board to aid in decision making for the Program. We recommend the County reestablish this Board or consider creating a self-insurance program Regional oversight board established pursuant to the rights and privileges conveyed by the constitution and laws of the State of Ohio as defined by ORC Chapter 167. The oversight board should be formed to carry out a cooperative program for the provisions and administration of health care benefits for member employees and

covered dependents in accordance with the consortium's agreement. Minutes of the board should be kept. The board should include representation of the Regional Partners.

- Although not required by the ORC, we recommend the County consider preparing separate financial statements for the Program which would include all income and costs.

Management's Response

The Auditor's recommendation concerning reserve fund resolution and the appropriateness of reserve levels will be presented moving forward as part of our rating and renewal process.

Like many aspects of the County' s program, the County's new Benefits Advisory Committee and Healthcare Consultant will review the terms and provisions contained in our Regional Partner Participation Agreements to ensure compliance with all Federal and State guidelines along with common best practices.

The County has created a Benefit Advisory Committee which will be staffed with multiple departments including Human Resources, the Executive's Office, the Fiscal Officer, the Law Department and our independent Healthcare Consultants. This Advisory Committee will be tasked with auditing all processes, procedures and guidelines as it relates to overseeing the Regional Plan.

EBI and WIQ Contracts

EBI is responsible for benefits consulting which include the following services: enrollment support, stop loss marketing, review of medical costs, ORC compliance, and creating RFPs for stop loss and medical providers. WIQ is responsible for providing vitality services, a wellness program to County employees. WIQ is owned and operated by the same personnel that operate EBI. The County should have adequate controls in place to assure EBI and WIQ contracts are reviewed and closely monitored. Without these controls, the County is at risk of overpaying the vendors for duplicative services or services not provided.

During our review of the County's contracts with EBI and Wellness IQ, we noted no Request for Proposal (RFP) was issued on the most recent EBI contract renewal awarded for $823,375 for three years. EBI's new contract began August 1, 2015 and was put through the procurement process as an extension to the old contract dated August 1, 2012-July 31, 2015. The contract was presented to the Human Resources, Appointments, and Equity Committee by the former interim HR Director on May 19, 2015. The former interim HR Director explained to Council how EBI's service was nearly sole-source and the new contract amount was less than the prior contract amount. The new contract amount was $32,925 more than the previous contract. Unlike the prior contract, SBE compensation was not included in the total amount to be approved by Council. The WIQ contract was also extended from January 1, 2015 to December 31, 2017 without

being competitively bid. The extension allowed for an additional $1,579,650 to be encumbered for WIQ's services. This was an increase of $348,650 from the prior three-year contract which was $1,231,000. WIQ was paid $1,246,389 on the prior three-year contract as $916,224 was paid from the County and $330,165 was paid directly from the County's medical providers to WIQ with the County's wellness subsidy credit. See the **Provider Wellness Subsidy comment on page 48** for more details. The County also had the option to purchase pedometers from WIQ for resale to County employees at $40 or $45 per pedometer. This cost is in addition to vitality services. The County's records indicate employees were charged $40 per pedometer. No more than $20,000 of the wellness subsidy was payment to WIQ for pedometers in 2012. Benefits was unable to provide the invoice for nearly 500 pedometers. Although WIQ was not overpaid on their contract, HR authorized payments in excess of the award amount by $15,389. The County was not in compliance with ORC Section 5705.41(B) which states the County shall not "Make any expenditure of money unless it has been appropriated."

Although the EBI and WIQ contract were not required to be competitively bid, ORC Section 9.833(C)(3) still requires public disclosure which "at a minimum shall include a statement listing all representations made in connection with any possible savings and losses resulting from the contract and potential liability of any political subdivision or employee. The proposed contract and statement shall be disclosed and presented at a meeting of the political subdivision not less than one week prior to the meeting at which the political subdivision authorizes the contract." This requirement was not met.

In addition, EBI's contract with the County from August 1, 2012 through July 31, 2015 states the billable rate for general consulting fees. EBI provides a detailed invoice of the services provided and hourly rates charged. We tested 15 detailed invoices from January 1, 2014 to June 30, 2015 and compared the hourly rates charged to EBI's contract. We found a billing rate of $80 per hour for administrative support that was not included in the contract. The County was billed a total of $6,960 for the administrative support. Failure to review and approve detailed invoices has resulted in the County paying for services not under contract.

DIA also reviewed contracts between the Regional Partners and the County. The contracts stated the following:

> *It is the County's intention that the operation of the Regionalized Benefits Program be cost neutral to the County. Political Subdivisions that wish to participate will pay the County's healthcare consultant a consulting fee as outlined in the Sub-Agreement. This fee has already been incorporated into the quoted rates; however, the fee will be paid directly to the consultant.*

EBI contracted directly through sub-agreements with the Regional Partners to perform services for a fee PEPM. Although a review of all the sub-agreements has not been completed, a sample of one Partner's quoted contract rate is the same as the amount billed for premiums and not a lesser amount adjusted for that Partner's PEPM paid directly to EBI. Further testing in Phase II may show that some Regional Partners have overpaid. The table on the following page shows

the amount PEPM that EBI receives per Partner (DIA confirmed with all Partners in Program). We have also included the estimated total amount of revenue EBI received from the Regional Partners.

Partner	Paid to EBI PEPM	2011	2012	2013	2014	2015 thru 6/30/15	Total
CCBODD	$5	N/A	N/A	$48,670	$50,125	$24,485	**$123,280**
Chardon	28	N/A	N/A	N/A	16,044	9,268	**25,312**
Cleveland Heights	8	N/A	N/A	N/A	13,248	19,872	**33,120**
Euclid	8	N/A	N/A	N/A	N/A	7,728	**7,728**
Fairview Park	8	N/A	N/A	N/A	8,752	4,656	**13,408**
Highland Heights	8	N/A	N/A	N/A	5,720	3,104	**8,824**
South Euclid	8	N/A	N/A	N/A	N/A	5,384	**5,384**
University Heights	8	N/A	N/A	N/A	7,696	3,800	**11,496**
Board of Health	8	N/A	N/A	N/A	10,552	5,448	**16,000**
Land Bank	8*	$1,500	$2,000	2,104	2,472	1,392	**9,468**
Mayfield Village	8	N/A	3,984	5,496	5,528	3,016	**18,024**
Olmsted Falls	8	3,072	2,912	2,904	2,944	1,264	**13,096**
Olmsted Twp.	8	4,176	3,960	3,392	N/A	N/A	**11,528**
Red Center Logic	8	N/A	N/A	N/A	N/A	240	**240**
RITA	8	N/A	N/A	N/A	N/A	7,672	**7,672**
SE Emergency Communication	8	N/A	N/A	N/A	N/A	480	**480**
Glenwillow	$500 (per quarter)	N/A	1,000	2,000	2,000	1,000	**6,000**
Highland Hills	8	N/A	1,072	2,120	2,304	1,144	**6,640**
North Randall	$500 (per quarter)	N/A	500	2,000	2,000	1,000	**5,500**
Walton Hills	8	2,224	1,936	1,880	2,184	1,200	**9,424**
Total		**$10,972**	**$17,364**	**$70,566**	**$131,569**	**$102,153**	**$332,624**

**Land Bank's fees were $500 per quarter through June 2013 when they were amended to the $8 PEPM.*

EBI's contract with the County includes **Exhibit B-Services to be Performed**; Regionalization is one of the services. Regionalization work includes the "design of the underwriting guidelines and any related meetings with administration. Consulting services include development of the Regionalized stop loss health pool, expansion of underwriting guidelines, due diligence on pharmacy integration and expansion for non-ORC Regionalized development opportunities." Since the Program is designed to be cost neutral to the County, any payments made to EBI for "Regionalization" work should be charged against the County's administrative fee collected from Regional Partners. In review of 15 EBI detailed invoices from January 2014 to June 30, 2015, we noted over $10,000 worth of invoices from EBI were due to services performed for the Program.

The County has spent and is at risk of spending County general fund monies for a Program that should be cost neutral to the County. Further testing on these invoices may be reported on in the Phase II report.

Recommendation

DIA recommends the following:

- Benefits and the Fiscal Office implement procedures to assure vendors are monitored and all detailed invoices are reviewed and approved prior to payment. Any discrepancies or questions on vendors' contracts and invoices should be further investigated prior to payment.
- The WIQ contract should be reviewed and compared to the cost of contracting directly with Vitality for the wellness program.
- The County should assess all costs associated with the Regional Program and allocate allowable costs, like EBI payments, to the Regional Self-Insurance Fund.
- Evaluate the Administrative fee to ensure fees collected by the County are sufficient to pay costs incurred to bring in new Regional Partners and allow the County to remain "cost-neutral."

Management's Response

The County has terminated all agreements with EBI and WellnesslQ. The County has created a process, procedure and corresponding scope of services for the replacement vendors which will require more detailed accountability for services performed on behalf of the County and the Regional Plan.

The County and its new Healthcare Consultant are actively reviewing the accounting and allocation of time, services and payments to EBI and WellnesslQ to ensure that Regional Partners were appropriately charged during their participation in the program. It is also important to note that any expansion (including non-ORC Regionalized development opportunities) is pending further review.

County Administrative Fees

The Program was created in 2010 to provide cost saving benefits to local government entities. The County agreed to enter into a contract with these entities as long as the Program would be cost neutral to the County. According to contracts between the County and Regional Partners, the County may charge an administrative fee to offset their costs of the Program. The contracts state the following:

The county has the sole discretion to set the Administrative Fee, at a minimum of 3% and a maximum of 6% of the fully-insured equivalent rate. The County will provide written notice to political subdivisions of the Administrative Fee and Risk Surcharge, if applicable, at the time of entry into the Benefits Regionalization Program.

According to Benefits staff and the EBI consultant, the County's administrative fee was set at $15.00 PEPM for each Partner other than one Partner that was set at $8.00 PEPM. DIA requested support to prove each Partner was made aware of the County administrative fee and proper approval was granted by the County for the fee. Out of the 20 Regional Partners in the Program, only one Partner was given a written notice of the County administrative fee. DIA was unable to obtain proof of written notice on the 19 Partners charged $15.00 PEPM.

DIA performed additional testing on the 19 contracts since the County administrative fee of $15.00 PEPM was not stated in the contracts, nor was there proof of written notice stating the fee was $15.00. Since the contracts state the County may charge between 3% and 6% of the fully-insured equivalent rate we attempted to recalculate the rates to verify the $15.00 was contractually accurate. In 2015, the lowest rate at 3% of a single plan was $10.04 while the highest rate at 3% of a family plan was $61.75. The lowest rate at 6% of a single plan was $16.90 and the highest rate of a family plan was $123.49. These results prove the $15.00 PEPM was not in compliance with all Regional contracts.

In addition, the County does not separately recognize the administrative fee as revenue to offset the cost of administrating the Program. EBI does not separately account for the administrative fee in their monthly reserve reports, either. The County's and EBI's reserve calculation is inaccurate as the administrative fee is included in the reserve balance to cover claims and fees. The table below shows the amount of revenue the County should have recognized to offset costs based on the $15 administrative fees from the start of the Program. DIA also generated Regional employee plan data from SAP to provide estimates of the minimum (3%) and maximum (6%) amounts the County should have charged according to Regional contracts.

Year	Administrative Fee Collected by County*	Administrative Fee at 3% of Rate**	Administrative Fee at 6% of Rate**
2011	$20,325	$46,865	$93,728
2012	30,975	71,066	142,132
2013	114,733	159,262	240,652
2014	206,149	348,590	616,980
2015 thru 6/30/2015	170,129	312,079	584,983
Total	**$542,311**	**$937,862**	**$1,678,475**

** This was the amount of administrative fees collected by the County, but not separately accounted for as Program revenue to offset Program costs.*

***Recalculated total by DIA based on the fully-insured equivalent rate. DIA was able to approximate the amount of provider plans per employee per month to estimate the administrative rates the County should have charged in accordance with the Regional contracts. Based on a restriction with SAP information, if more than one plan was offered per Partner per provider the more conservative rate was used to recalculate the administrative fee.*

Without recognition of the administrative fee, the County continues to pay for salaries and supplies out of the County's Self-Insurance Fund that should be paid out of the Regionalization Self-Insurance Fund. Furthermore, the County is unable to determine if the Program is cost neutral by not monitoring and separately recording the administrative fee.

Recommendation

DIA recommends the following in regards to monitoring and recording the County administrative fee:

- The administrative fee should be recognized separately as Program revenue in FAMIS.
- All costs associated with the Program should be charged against the Regionalization Self-Insurance Fund. Costs should include supplies, consultant services, and partial salaries of the following County personnel:
    - HR Director and Benefits personnel
    - Fiscal Officer and personnel involved with budgeting and recording Program funds
    - Other personnel involved in the Program.
- The administrative fee charged to the Partners should comply with contractual language:
    - The fee should be set at a rate between 3% and 6% as the current contracts state.
    - Regional Partners should be given written notice on the amount of the fee.
- The rate should be re-assessed on an annual basis to determine if the rate is sufficient to cover costs of the Program. Any rate changes should be documented and approved by the County and Regional Partners, as specified in a recommended County policy.

Management's Response

Based upon the information available at this time, prior to 2016, the County recovered necessary administrative expenses through the premiums charged to Regional Participants as part of the premium. Entering into the current rating period, additional workload required to comply with reporting for ACA coupled with an evaluation of the program, participation agreements and departmental resources required an increase to the administrative expense levied by the County. In addition, due to ACA regulation and reporting requirements, the County identified and separated the contractual surcharge as a separate line item for all participants beginning January 1st.

Prior to the release of this audit, the County began accounting for administrative fees separately in order to better track, monitor and allocate resources to operate the program.

The County remains determined to find opportunity to leverage technology and create efficiency. It is our goal to ensure the program remains cost effective to both the County and our Regional Partners. Through recent enhancements to our service approach and via new support initiatives with our vendor partners, members are beginning to see more meaningful value from this program.

The County's Benefit Advisory Committee will review and complete a transparent review of County expenses prior to rate development in future periods. Components of program expense, including all aspects of rating, administrative charges, risk charges and claim projections will be reviewed.

HRA Utilization and Operating Procedures

The County offers a Health Reimbursement Account (HRA) to County employees with medical insurance. The HRA is funded through participation in Vitality, the County's wellness program, which is administered through WIQ. County employees can earn credits into their HRA to be used for deductibles, copays, and or/coinsurance. The credits can be used through County issued debit cards or through manual reimbursement requests. Employees can obtain Vitality status credits by signing up for Vitality and at a minimum, completing the Vitality Health Review (VHR). Credits can also be earned by completing the Smokers' Affidavit, attending wellness lunch-and-learns, and tracking physical activity. The County should have adequate monitoring procedures over participant eligibility, vendor payments, and program funding to ensure the objectives of the program are met.

The HRA was administered by MHS until the beginning of 2015 when administration of the HRA was taken over by WIQ. According to WIQ, MHS was having issues with the timing of credits to employee accounts. Since WIQ has a direct feed link into Vitality, the former interim HR Director and Benefits agreed to transfer the HRA to WIQ without an approved contract amendment or evidence of the Executive or Council's approval. A review of emails documented a discussion with the former interim HR Director and WIQ regarding their administration of the HRA dating back to August, 2014. WIQ/EBI provided a contract amendment which was never acted upon by the former interim Director.

Utilization

DIA received HRA transaction data from WIQ from January through June 2015 and performed a test to analyze the number of employees utilizing the HRA benefits compared to the number of County employees with medical benefits. The table on the following page highlights utilization of the HRA program by employees for the first six months of 2015:

Month / Year	# of Employees Utilizing HRA* (WIQ File)	SAP Employees with Health Benefits (SAP)	% Employee Utilization
Jan-2015	18	6,039	0.30%
Feb-2015	266	6,056	4.39%
Mar-2015	417	6,078	6.86%
Apr-2015	420	6,082	6.91%
May-2015	409	6,080	6.73%
Jun-2015	377	6,101	6.18%

**Number of employees that used their HRA card during the month.*

The total number of employees that earned, but may not have used HRA funding credits for the first six months of 2015 was 2,606. This number may also include roll over credits from the prior year. The average number of employees with medical benefits in the first six months of 2015 was 6,072 resulting in 43% (2,606/6,072) of eligible employees earning HRA funding credits through Vitality. However, 1,935 of those employees earning credit only received credit for filling out the VHR and/or the Smoker's Affidavit form and did not complete any other milestones in the program. This represents 74% (1,935/2,606) of employees earning credits. Additionally, only 11% (671/6,072) of all eligible employees earned credits from something other than completing the VHR and Smoker's Affidavit. The total number of employees that spent available HRA funds during the first six months of 2015, was 887 which is 34% (887/2,606) of those with funds available. Only 15% (887/6,072) of County employees with medical benefits have utilized the HRA benefit card for this time period.

Low utilization of HRA funds may be due to the lack of information communicated by the County on the program. DIA searched the County's intranet and MyHr web site for more information on the HRA program. A program overview on Vitality was on MyHr, but the HRA program was not described in detail. After inquiring with Benefits, no program information is given to employees on what costs may be considered as qualified expenses.

Eligibility

DIA obtained a file on the HRA transaction detail from WIQ for the first six months of 2015. We performed an eligibility test to assure only County employees with medical benefits have access to the HRA. The HRA benefit should be discontinued when medical benefits eligibility is terminated.

DIA compared the medical eligibility termination date in SAP to the last date that HRA funds were available to spend in order to verify that all terminated employees did not have access to HRA funds. The table on the following page highlights the number of employees, by month that had access to HRA funds after termination:

Fund Availability After Medical Eligibility Terminated			
Month – Year	# of Employees With HRA Access after Termination	Funds Available for Use	Maximum Months Available After Termination
Jan-2015	4	$170	1
Feb-2015	20	$896	4
Mar-2015	32	$1,486	9
Apr-2015	52	$2,663	10
May-2015	62	$4,489	11
Jun-2015	68	$4,789	12

The total employees with HRA access after medical eligibility termination grew from four in January to 68 in June. This is an increase of 1,600% when WIQ initially took over the administration of the program in January 2015 to the last period tested in June 2015. Additionally, employees terminated in 2014 were added to the program and given access to funds in February 2015. This is exemplified by the maximum number of months that funds were available after termination increasing from one in January 2015 to four in February 2015.

DIA also tested for transactions made to increase available funds and for funds that were spent after termination of medical benefits. The table below highlights the number of transactions that were processed with the County issued debit card after an employee's termination date by month.

Transactions Executed After Medical Eligibility Terminated				
Month - Year	# of Instances Where Fund Availability Increased	Total Amount of Increase	# of Instances Where Funds Were Used	Total Dollar Amount of Funds Used
Jan-2015	4	$170	0	$0
Feb-2015	5	235	0	0
Mar-2015	2	105	5	91
Apr-2015	13	766	9	169
May-2015	1	90	11	128
Jun-2015	0	0	3	55
Total	25	$1,366	28	$443

The maximum number of days when account balances increased was 253 days and when funds were used was 262 days after medical eligibility termination.

Administration

DIA was unable to find a documented agreement with WIQ for the administration of the HRA account which began on January 1, 2015. MHS was informed of the change in August of 2014 just after the WIQ contract was extended on July 22, 2014 through December 31, 2017, without HRA administration in the contract. WIQ stated the compensation for their services was informally established at the same rate of MHS's administrative rate ($1.75 PEPM). MHS informed DIA that

as of January 5, 2015, $5,897.20 was still remaining in MHS's bank account for the County's HRA program. The funds were never recovered after the program was transferred to WIQ.

DIA inquired with Benefits about the issuance of HRA wellness cards. There is no formal process to request or issue a wellness card. The card is issued through WIQ when an employee participates in Vitality. Benefits does not have procedures in place to track employees who are issued wellness cards. DIA did confirm that all participants with a wellness card were employees of the County.

WIQ is responsible for monitoring and reconciling the HRA bank account for the County. WIQ is the authorized signatory to the bank account. At the beginning of 2015, the County sent WIQ a $50,000 check to fund the HRA. During the year, WIQ will request additional funds if or when the account balance reduces to $10,000. During review of one funding request in 2015, no support detailing the request was provided. The request listed the bank transactions and bank balance as of certain date, but no detail was provided. Benefits does not receive monthly bank reconciliations from WIQ and relies on WIQ's accuracy to fund the HRA bank account without the County's verification of the balance in the account.

Additionally, the County incurred an overdraft charge of $37.00 for the HRA bank account in June of 2015. A check was cut on May 26, 2015 to fund the account, but the money did not get deposited into the bank account until June 3, 2015. Either a delay in check processing by the County or an untimely deposit by WIQ caused the account to be overdrawn and an overdraft fee to be charged by the bank. Neither the County's Accounts Payable Department nor WIQ were able to provide any support documentation regarding this incident.

Manual Payments

Bank statements were obtained from WIQ for January, 2015 through June, 2015 for the HRA bank account, which is in both WIQ and Cuyahoga County's name. The bank statement contained transactions that were transferred from the HRA bank account to another account controlled by WIQ. The other bank account was used to issue manual payments to employees for HRA reimbursement requests. WIQ was asked why these transfers were made instead of issuing the checks directly from the HRA bank account. WIQ stated that issuing the checks out of the WIQ/Cuyahoga County account would have cost more to issue since it did not have check writing privileges. The total amount of the nine transfers was $4,075. A sample of the five largest transfers, which equated to 45 total claims, totaling $3,600 (88%) was tested. Each manual payment should include a County HRA Reimbursement Form and an Explanation of Benefits Form or other documents that show the date, patient name, medical purpose, and amount of payment made. The following are the results of our testing:

- Five claims totaling $315 were paid when no documentation was provided to substantiate the claim. Five additional claims totaling $187 were paid lacking some combination of the date, patient name, medical purpose, or amount.
- Nineteen claims totaling $1,191.29 did not include the required HRA Reimbursement Form.

- The individual HRA accounts were not reduced by the amount of the manual payments allowing 25 tested accounts to be overdrawn by $1,611.75. These individuals are overdrawn on their accounts due to subsequent use of their benefit cards.

Monthly Billing of Administrative Fees

In review of HRA data received from WIQ from January through June 2015, DIA recalculated the amount of fees that should have been charged for the administration of the HRA at $1.75 PEPM. We summarized the amount of employees that were qualified for benefits by month end and multiplied the total by $1.75. The table below shows the variance between the amount the County paid WIQ and the amount DIA determined should have been paid to WIQ.

HRA Administrative Fees Recalculation				
Month - Year	Monthly Fee Recalculated	Amount Invoiced and Paid to WIQ or EBI **	Variance Over/(Under) Billing	Variance Over/(Under) Billing %
Jan-2015	$2,597	$1,400	$(1,197)	(46%)
Feb-2015	3,612	2,651	(961)	(27%)
Mar-2015	3,847	5,717	1,870	49%
Apr-2015	4,062	11,625*	7,563	186%
May-2015	4,337	5,983	1,646	38%
Jun-2015	4,442	6,269	1,827	41%
Total	$22,897	$33,645	$10,748	47%

** WIQ billed the County twice this month for two different amounts and invoice numbers. The County paid both of these invoices in the amounts of $5,717 and $5,908. Both invoices from WIQ were obtained and both were for April 2015 administrative fees.*

*** WIQ manages the HRA account for the County, but some payments were made to EBI. See the finding titled* ***Consulting Fee Payments – EBI and WIQ on page 60****.*

WIQ stated that DIA did not include 2,123 employees in the above analysis from the 2014 HRA plan year. DIA compared these employees to the original files and found 1,135 duplicate employees. Any reimbursements in 2015 for the 2014 HRA program were issued by MHS. Additionally, a WIQ brochure for the 2015 HRA program stated that all carryover balances from 2014 will be loaded onto the 2015 wellness cards. WIQ should not have billed for employees other than the ones that had balances loaded onto their cards in 2015. DIA was originally provided with that data from WIQ. Therefore, the above table is complete and the County was overbilled in the first six months of 2015.

In addition, DIA noted a one-time "Implementation Fee" paid to WIQ in the amount of $5,000 in January 2015. DIA could not obtain a formal contract or written approval by the Board of Control or Council to allow for this fee to be paid.

Policies and procedures have not been developed to provide proper oversight of the HRA and WIQ to ensure that program objectives have been met. The absence of a formal agreement

between the County and WIQ may have resulted in unauthorized administrative rate increases and other unauthorized payments made to WIQ. Furthermore, if controls are not implemented over this process the County could continue to overpay WIQ for the administration of the HRA account. Without adequate controls in place the risk that ineligible employees could receive HRA benefits and the risk of program funds being misappropriated greatly increases.

Recommendation

DIA recommends the following be implemented for the HRA program:

Utilization

- Review the Vitality HRA program to determine if the costs outweigh the benefits provided to employees and the County.
- HRA program details and benefits should be communicated to all employees of the County. Specifically, eligible employees should receive information on how to utilize the wellness card. This information should contain details on tracking the employees' balance, what are qualifying expenses, and how to earn credits.

Eligibility

- Develop a separate attribute in SAP to track who is enrolled in Vitality in addition to their medical plan. This file should be sent to WIQ every month to ensure that employees are removed from the HRA benefit after termination.
- Monthly, the County should request a file of active participants from WIQ and reconcile the listing to the County's records.
- Compare a listing of terminated employees by month to the file provided by WIQ to verify that all terminated employees have been removed, unless COBRA benefits are elected for the HRA program.
- The contract with the HRA account administrator should stipulate liability for any HRA usage that occurs after medical eligibility termination if timely termination notification is provided by the County.

Administration

- A formal agreement with WIQ to administer the HRA account should be created. This agreement should include the monthly administrative fee, contract terms, and WIQ's responsibilities in monitoring the program.
- An HRA plan document should be developed outlining the funding source of each individual account, the qualified claims which can be reimbursed, how to request reimbursement, what is to happen to the account at year end, and the time frame that funds are available after termination.
- Benefits should pursue the remaining balance from MHS of $5,897.20

- Develop clear policies and procedures addressing the issuance of wellness cards.
- HRA program details and benefits should be communicated to all employees of the County. Specifically, eligible employees should receive information on how to utilize the wellness card. This information should contain details on tracking the employee's balance, qualified expenses, earning credits, and reimbursements.
- Detailed information on transactions and the bank balance should be provided to the County when additional funding is requested.
- Benefits or the Fiscal Office should request a monthly bank reconciliation from WIQ. This bank reconciliation should be reviewed for reasonableness prior to payment of any funding requests.

Manual Payments

- A checklist that outlines the requirement for each manually paid claim should be created. This checklist should be completed before each payment is made assuring all proper documentation is obtained prior to issuing the check.
- The County should attempt to recover the HRA funds from the employees whose account balances were overdrawn.

Monthly Billing of Administrative Fees

- The Fiscal Office or Benefits staff assigned to processing payments of the monthly HRA administrative fee should complete a monthly trend analysis. The trend analysis should compare the monthly head count to ensure reasonableness of the amounts being billed. In addition, the amount paid by month should be tracked to ensure that duplicate monthly payments are not made to the vendor. This monthly trend analysis should be reconciled with amounts already recorded as paid in FAMIS.
- The County should verify and determine whether they should pursue a refund from WIQ of $10,748 for overpayment of HRA administrative fees. The $10,748 includes the overpayment for two invoices in April. All HRA Administrative Fee invoices paid after June of 2015 should be reviewed for overpayments, as well. Additionally, the County should research the $5,000 one-time "Implementation Fee" payment and consider Board of Control approval for the payment since there is not contractual agreement.
- The Law Department should consider recovery of all funds paid to WIQ for HRA administration since there is no contract authority to make these payments.

Management's Response

The County believes the overall health and wellness of our workforce is an important part of not only controlling healthcare expense but improving the lives of our employees. We are currently working on new strategic objectives and opportunities to make our commitment

to overall employee engagement more widely adopted and meaningful.

The County acknowledges that administrative procedures and accountability relative to the Health Reimbursement Account by WellnesslQ were not consistent with best practices necessary to operate accurately. The agreement with WellnesslQ has been terminated, Mutual Health Services has resumed operations of the Health Reimbursement Account on a temporary basis and a new Request for Proposal (RFP) has been issued for a replacement wellness plan vendor.

As part of the RFP recently issued, appropriate accounting, eligibility and process will be contractually outlined to ensure compliance with the appropriate safeguards.

Provider Expenditures Contract Encumbrances

ORC Section 5705.41(B) states the County shall not "Make any expenditure of money unless it has been appropriated." Furthermore, Cuyahoga County Code Section 501.04 states that County Council approval is required for "All contracts, purchases, sales, grants provided by the county, or loans provided by the county resulting in the County's expenditure of more than $500,000." Having sufficient controls in place to manage these requirements is critical to financial accountability and reporting.

DIA performed a test on provider contracts from 2012 through 2014. We attempted to compare provider contract encumbrances approved by Council with FAMIS data as well as actual expenditures. We noted noncompliance with the ORC and County Code Sections as well as insufficient funds in the Agency Fund from where providers are paid. After the Office of Procurement and Diversity (OPD) receives required approval (Council, Law Department, Fiscal Officer, Executive) to certify a contract encumbrance, the request is sent to the Fiscal Office for posting in FAMIS. As explained more in the **Advances to Agency Fund finding on page 56**, advances are made from the County and Regional Self-Insurance Funds to an Agency Fund in order for wire payments to be made to providers. These advances initiate a reduction of the encumbrance in FAMIS, but encumbrances are not reduced by the actual amount paid to providers. The check amount requested from the Treasurer's Office by Benefits is a random whole amount that does not agree to provider invoices. The payment is an advance from the County or Regionalization Self-Insurance Fund to the Agency Fund for wire payments made to medical providers. The check amount, which is the amount transferred to the Agency Fund, is the amount that reduces the provider encumbrance in FAMIS. Having a complicated process of accounting for encumbrances and advances has resulted in financial reporting issues, accountability issues and, noncompliance with ORC 5705.41(B) on provider contracts.

The table on the next page provides a comparison on actual payments made to providers and encumbrance reductions in FAMIS for contracts beginning 1/1/2012 and ending 12/31/2014. In two of the four contracts, expenditures exceeded Council approved amounts.

Provider	Contract Amount	Amount Encumbrance Reduced in FAMIS*	O/S Encumbrance in FAMIS at End of Contract	Actual Paid to Provider	Contract Amount Less Actual Paid(Over)/Under Spent
UHC	$94,194,221	$64,606,236	$29,587,985	$64,084,588	$30,109,633
CVS	36,570,329	37,028,942	(458,613)	39,097,100	(2,526,771)
MMO	92,093,992	117,892,016	(25,798,024)	118,554,659	(26,460,667)
Kaiser	20,885,340	13,552,399	7,332,941	13,266,230	7,619,110

** The contract encumbrance is reduced by the amount advanced to the Agency Fund, not the amount paid to the provider. NOTE: MHS is included in MMO contract.*

In the MMO contract, an encumbrance for $24 million was certified in FAMIS for Regionalization claims and fees, but the MMO contract was not amended to address the additional encumbrance needed for MMO claims. This results in noncompliance with ORC 5705.41(B) and with County Code Section 501.04. We further investigated how the MMO Regional encumbrance was certified in FAMIS without Council's approval. We received support from OPD that HR requested the additional $24 million and OPD approved it without reviewing the contract. The Fiscal Office posted the additional certification also without reviewing the contract. The other $2.4 million on MMO's contract and the $2.5 million on CVS's contract were overspent due to lack of oversight by HR, OBM, and the Fiscal Office. Once the encumbrance was posted in FAMIS by the Fiscal Office, payments were made against it.

In addition to the way encumbrances are recognized in FAMIS, a project code for each provider contract is setup in FAMIS to account for funds transferred to the Agency Fund. The Fiscal Office can monitor and account for each advance and wire payment by provider contract. DIA attempted to track advances and wire payments through FAMIS to assure the advance amounts were sufficient to cover wire payments. In addition, we reviewed balances at the end of each provider contract to assure any outstanding cash balances were transferred back to the County or Regional Self-Insurance Fund. See the table on this page and the following page for results.

2009 Contracts (1/1/2009 – 12/31/2011)

Provider	Advances into Agency Fund	Wire Payments to Provider	Close Out Transfer to County Self-Insurance Fund	Balance as of 10/31/2015
UHC	$85,628,448	$(84,700,960)	$(919,239)	$8,249^
CVS	35,738,300	(35,517,365)	(220,935)	-
MMO	59,663,364	(56,710,950)	(2,952,414)	-
MHS	13,627,440	(9,251,147)	(4,376,293)	-
Kaiser	32,592,647	(32,592,647)	-	-
Totals	**$227,250,199**	**$(218,773,069)**	**$(8,468,881)**	**$8,249**

^Cash still in Agency Fund that should be transferred to County or Regional Self-Insurance Fund.

For 2009 contracts, there was sufficient cash in the Agency Fund to cover provider claims and fees. All the provider codes had positive cash balances at the end of 2012. Each project code, other than UHC's project code, was closed and remaining cash balances were transferred to the County's Self-Insurance Fund. However, the close out entries to transfer cash back to the County's Self-Insurance Fund was not completed until August 2014, 32 months after the contract end date. As of October 31, 2015 UHC's project code remains open with a positive cash balance of $8,249.

2012 Contracts (1/1/2012 – 12/31/2014)

Provider	Advances into Agency Fund	Wire Payments to Provider	Close Out Transfer to County Self-Insurance Fund	Balance as of 10/31/2015
UHC	$64,606,110	$(64,084,588)	$ 0	$521,522^
CVS	37,272,555	(39,097,100)	0	(1,824,545)*
MMO	67,954,594	(69,589,099)	0	(1,634,505)*
MHS	48,566,317	(48,965,560)	0	(399,243)*
Kaiser	13,552,399	(13,266,230)	0	286,169^
Totals	**$231,951,975**	**$(235,002,577)**	$0	**$(3,050,602)**

** Other Agency Fund sources were used to pay provider invoices.*

^ Cash still in Agency Fund that should be transferred to County or Regional Self-Insurance Fund.

For 2012 contracts, there was not sufficient cash in the Agency Fund to cover provider claims and fees. Specifically, the CVS, MMO, and MHS project codes had negative cash balances while the Kaiser and UHC project codes had positive cash balances. The positive cash balances were never transferred back into the County or Regional Self-Insurance Fund. Cash from sources other than the Self-Insurance Funds was used to pay provider invoices since overall cash had a negative balance of $3,050,602. No cash has been transferred from the Self-Insurance Funds to reimburse the Agency Fund.

2015 Contracts (1/1/2015 – 12/31/2017)

Provider	Advances into Agency Fund	Wire Payments to Provider**	Close Out Transfer to County Self-Insurance Fund	Balance as of 10/31/2015
UHC	$19,000,000	$(18,725,051)	$ 0	$274,949
CVS	16,457,346	(14,091,100)	0	2,366,246
MMO	24,280,000	(23,601,949)	0	678,051
MMO - Regional	10,200,000	(10,647,422)	0	(447,422)*
MHS	19,873,036	(20,058,540)	0	(185,504)*
Totals	**$89,810,382**	**$(87,124,062)**	$ 0	**$2,686,320**

** Other Agency Fund sources are being used to pay provider invoices.*

*** As of October 31, 2015.*

For 2015 contracts, UHC, CVS, and MMO project codes appear to have sufficient funds advanced into the Agency Fund to cover provider claims and fees, however, MMO-Regional and MHS project codes at October 31, 2015 are at a deficit, meaning cash is being used from other sources to cover provider invoices.

Various provider contracts from 1/1/2009 to 10/31/2015 had negative cash balances in the Agency Fund. The negative cash balances prove provider invoices were paid from other Agency Fund sources besides the County or Regional Self-Insurance Fund.

Recommendation

The process of issuing checks to the Treasurer's Office to advance funds to the Agency Fund should be discontinued. This should decrease the risk of expenditures exceeding appropriations as actual payments to providers will decrease encumbrances. Discontinuing these checks will eliminate the risk of advancing amounts different than the invoice.

In addition, the Fiscal Office should request all supporting documentation when an encumbrance is recognized in FAMIS. Specifically, Council's approved resolution should be obtained by the Fiscal Office to assure the correct amount is encumbered under the right contract number. OPD and the Fiscal Office should not allow encumbrances to be certified if not properly approved by the appropriate board.

Finally, the use of project codes should be simultaneously discontinued along with advances to the Agency Fund. All remaining benefit related cash balances in the Agency Fund should be transferred into the County or Regional Self-Insurance Fund to close out any open project codes. Project codes with negative balances should be closed out by transferring funds from the County and/or Regional Self-Insurance Fund to reimburse the Agency Fund. In total, the Agency Fund should be reimbursed for the net amount of $356,033 from the County and/or Regional Self-Insurance Fund as of October 31, 2015.

Management's Response

The County acknowledges the Auditor's recommendation that all appropriations for medical and pharmacy claims and fees be approved before the plan year begins and will take it under advisement.

The County does want to acknowledge the complexity and potential uncertainty around operating a self-insured plan for nearly 8,000 employees. Due to changing healthcare trends, new technologies, pharmaceutical inflation, enrollment fluctuations and the somewhat unpredictable nature of catastrophic claims –the County's ability to perfectly coordinate appropriations to expenditures cannot be exact.

The County is evaluating different methods to enhance the accuracy of our appropriations approach for 2017. Due to the timing of the appropriations process requiring resolutions in advance of open-enrollment – there is a high likelihood of population shifts within each of the various plans offered to our participants. Moving forward, the County may propose an overall global appropriation for all healthcare plan expenses along with an updated itemization of plan components following the completion of open-enrollment.

Auditor's Response

The DIA fully understands the budgetary process and does not expect original appropriations to "perfectly coordinate" with expenditures. DIA does expect that all amendments to appropriations will be approved by Council, that appropriations will be reduced by the correct amounts, and that claims are paid with funds from the proper Self-Insurance funds.

2015 Provider Appropriations

The County negotiated new contracts for all medical providers at the end of 2014 for the 2015 through 2017 plan years. The contracts for MMO (including MHS), UHC, and CVS were approved on December 9, 2014. Based upon the recommendation of EBI, the County entered into a new contract with their stop loss provider (Voya) for the 2015 plan year. The following tables display the contract details:

Provider	MMO - C	MHS - C	MMO- R		UHC - C	UHC - R
Contract #	CE1400325-01	CE1400325-02	CE1400325-03		CE1400326-01	CE1400326-02
Contract Period	1/1/15-12/31/17		1/1/15-12/31/17		1/1/15-12/31/17	1/1/15-12/31/17
Contract Amount	$116,156,022		$25,480,000		$68,308,890	$2,800,000
Resolution - Date	R2014-0259 - 12/9/14		R2015-0095 - 5/26/15		R2014-0260 - 12/9/14	R2015-0248 - 12/8/15

Provider	CVS - C	CVS - R		Voya - C & R
Contract #	CE1400324-01	CE1400324-02		CE1500030-01
Contract Period	1/1/15-12/31/17	1/1/15-12/31/17		1/1/15-12/31/15
Contract Amount	$40,189,733	$2,800,000		$2,485,909
Resolution Date	R2014-0258 - 12/9/14	R2015-0247 - 12/8/15		R2015-0031 - 2/24/15
Amendments	$9,000,000			$450,000
Resolution Date	R2015-0163- 8/25/2015			R2015-0265 - 12/8/15

After review of the above contracts, DIA noted the dates at which some encumbrances were approved. The Regional portion of MMO's encumbrance was not approved until May 26, 2015. The Regional portions of UHC's and CVS's encumbrances were not approved until December 8, 2015. This resulted in Regional claims and fees being paid out of the County's Self-Insurance Fund until the Regional encumbrances were approved. In addition, the Voya contract for 2015 was not approved by the County until February 24, 2015, resulting in late stop loss payments for January and February of 2015. The County could be at risk of not having stop loss insurance if this type of contract is not in place prior to January 1 of each year. The contract was also amended for additional appropriations in December 2015 due to new Regional Partners being added at the beginning of 2015. The County did not timely request additional appropriations for the 2015 Voya contract when new Regional employees were added to the Program.

The Voya contract is renewed annually by the County. The County has tasked EBI with the RFP process for acquiring the stop loss provider. Sealed bids are sent to the County and turned over to EBI for evaluation. EBI then submits a recommendation to the County on which stop loss provider to contract with. There is no evidence that EBI provided the County with the necessary backup or official documentation submitted as part of this RFP. Voya has been the provider for 2014, 2015, and has been recommended by EBI to be the provider in 2016. EBI stated the County is part of EBI's risk pool and receives a discount from Voya. This relationship between EBI and Voya should be reviewed by the Law Department or the Inspector General for a potential conflict of interest. In addition, EBI's annual review of the stop loss arrangement should have been negotiated within the scope of their standard consulting agreement and not at an additional fee. EBI's annual review of the stop loss RFP resulted in an additional cost and time to the County.

In addition to the review of each contract as a whole, DIA selected appropriations that were certified for the 2015 plan year for each contract. When a multi-year contract is entered into, the Office of Procurement and Diversity (OPD) creates a contract cover with the amounts certified by year. We reviewed the timeliness and accuracy of the 2015 appropriations certified for each provider. The following table displays our results.

Appropriations Certified for 2015

Provider	MMO - C	MHS - C	MMO - R		UHC - C	UHC - R
Appropriations	$16,080,000	$21,500,000	$25,480,000		$22,100,000	$2,800,000
Adjustments	12,892,784	$6,860,655	($4,945,648)		0	0
Total Appropriations	$28,972,784	$28,360,655	$20,534,352		$22,100,000	$2,800,000

Provider	CVS - C	CVS - R		Voya - C & R
Appropriations	$13,002,599	$2,800,000		$2,485,909
Adjustments	9,000,000	0		450,000
Total Appropriations	$22,002,599	$2,800,000		$2,935,909

C – County
R - Regionalization

MMO and CVS appropriations were increased in 2015 from the total contract encumbrance approved by Council. These were not increases to the contract as encumbrances for subsequent years were reduced to increase appropriations in 2015. The $9 million appropriation increase for the County's CVS claims was approved by the County on August, 22, 2015. Eight months after the original appropriation was approved. This increase of 69% from the original appropriations for 2015 was due to an unexpected increase of pharmacy claims according to EBI and the former interim HR Director. This explanation has not been confirmed by DIA. However, Regional and County CVS claims paid by the County in 2014 were $15.7 million. Prior to the County increasing 2015 appropriations for the CVS contract in August, 2015, the County's actual expenditures were $8.4 million in CVS claims for County and Regional employees through June 30, 2015. The annual total of CVS claims paid in 2015 was $17.4 million. DIA also noted Regional claims were being paid out of the County's portion of the CVS contract during this time.

The 2015 MMO and MHS certified appropriations were increased by $14.8 million in December of 2015 due to December 2014 payments being made against 2015 appropriations. The Fiscal Office requested this increase to accurately account for payments in the correct accounting period. The $14.8 million was split between Regional and County contracts. The variance between the $14.8 million appropriation increase and the total adjustments for MMO was due to an expense adjustment made from the County Self-Insurance Fund to the Regional Self-Insurance Fund. This expense adjustment correctly adjusted the appropriations and expenditures in each fund; however, the detailed support maintained did not provide justification on the amount used for the adjustment. Without proper controls in place over current year contract appropriations and expense adjustments, the County is at risk of spending more than approved appropriations.

Recommendation

We recommend Benefits and the Fiscal Office develop the following formal procedures concerning appropriations with medical providers:

- Appropriations for medical and pharmacy claims and fees for Regional and County employees should be approved before the plan year begins.
- The process of annually contracting with a stop loss provider should be reviewed. The County should consider contracting with a stop loss provider on a multi-year contract with price renewals each year.
- If the County relies on outside consultants, like EBI, to procure provider contracts, the County should require all supporting documentation from their consultants prior to accepting their recommendation.

Management's Response

See management's response in "Providers Expenditures Exceeding Contract Encumbrances" issue on page 30. Along with the following comment:

The Auditor also introduces concerns over how stop-loss has historically been purchased. The County is now with a different stop loss provider as of January 1, 2016. As a result of a review of market alternatives, the County was able to secure more competitive pricing and operational terms directly with Medical Mutual of Ohio.

Contingent Premium

In the Cuyahoga County Board of Developmental Disabilities' (CCBODD) Program contract with the County, it states,

> *Upon execution of this Agreement, CCBODD agrees to pay to the County funds in the amount of $1,750,000 to be held by the County in its hospitalization self-insurance fund to be used for the purpose of payment of Contingent Premiums and Run-out claims under Sections 4.1 and 4.3 (of the contract). Within 150 days of the end of each calendar year, the Reserve Fund amount will be evaluated to determine if it is adequate.*

Section 4.1 of the contract states,

> *In the event that health care costs attributable to CCBODD and its employees exceed the actual premiums paid by CCBODD and its employees, CCBODD will pay a Contingent Premium. The Contingent Premium arrangement will be settled within one hundred fifty (150) days following each year-end of the contract period December 31.*
>
> - *If the incurred claims for the Contract Period are less than 90% of the group's paid premium (minus retention), a refund will be made to the CCBODD for the difference only to the level of the 90% of incurred claims.*
> - *If the incurred claims for the Contract Period are in excess of 110% of the group's paid premium (minus retention) the CCBODD will be liable for the difference only to the level of the 110% of Incurred claims.*

DIA inquired with Benefits and reviewed the County's financial system (FAMIS) to assure the $1.75 million was deposited with the County and calculations were annually done to determine if claims incurred exceeded premiums paid by 110% or were less than 90%. We did not see any

support or verify any transactions in FAMIS to prove the contractual agreement between CCBODD and the County was followed.

Failure to comply with the contractual language could terminate the contract by either party. Also, the Program's reserve balance could be at risk of paying excessive claims for CCBODD employees if the contract is not followed.

Recommendation

At the end of 2015, CCBODD and the County were negotiating a new and similar contract. Benefits and the Fiscal Office should assure the $1.75 million is timely deposited with the County and tracked separately from the Regional's reserve balance. At the beginning of every year, the County and CCBODD should communicate and agree on the amount of incurred claims, the amount of retention, and premiums paid. The $1.75 million should be used to pay incurred claims in excess of premiums paid by 110% or the County should refund or adjust future billings of CCBODD if incurred claims are less than premiums paid by 90%.

Management's Response

The County and Cuyahoga County Board of Developmental Disabilities (CCBODD) have resolved the initial reserve funding discrepancy and the County and CCBODD have modified the agreement effective January 1, 2016 to allow the CCBODD to participate in the County's Plan on a full cost pass through basis. Final reconciliation of prior years' liabilities and settlement should be completed within the very near future.

Auditor's Response

As of June 30, 2016 CCBODD has not deposited the contingent premium with the County nor has the reconciliation been provided to the DIA to resolve this funding discrepancy for a different amount.

ACA Transitional Reinsurance Fees

The Affordable Care Act (ACA) was created in 2010 with major provisions beginning in 2014 that affected the County. Section 1341 of the ACA established a transitional reinsurance program to stabilize premiums in the individual market. The transitional reinsurance program will collect contributions from contributing entities for 2014, 2015, and 2016 benefit years. Each year, entities are required to file a submission form no later than the 16th day of November. The fee associated with the transitional reinsurance program is a rate set by ACA. The rate is multiplied by the entities' number of enrolled benefit members for the year. The number of enrolled

members is based on a calculation allowable by ACA. The entities can either make a single payment by January 15th or two payments with the first on January 15th and the second on November 15th.

In 2014, the County received an email from EBI on how to submit and pay their reinsurance fee. Two different calculations were provided to the County in determining the average amount of enrolled members in 2014 and EBI recommended the County pay the lowest amount. In 2014, the submission date was extended to December 5, 2014. The County submitted their form in compliance with ACA requirements on December 2, 2014 and selected to make two payments totaling $838,396. The County failed to make the first payment of $698,663 that was due on January 15, 2015. On November 13, 2015, the second payment along with the first payment was wired to the Internal Revenue Service (IRS) totaling $838,396. The total payment was posted to the County's Self-Insurance Fund. The Regional portion of the payment was not allocated to the Regional Self-Insurance Fund.

Without proper monitoring controls in place, the County is at a higher risk of noncompliance with federal regulations. The ACA could enforce steep penalties against the County for nonpayment.

Recommendation

Benefits and the Fiscal Office should assure all federal fees are paid by the due date to avoid penalties. A Fiscal Office employee responsible for overseeing Benefits transactions should review FAMIS to assure the payment was made and posted to the correct fund. If the payment was not posted, the employee should inquire about the payment with the Controller and Treasurer. Additionally, the ACA payment should be allocated between the Regional and County Self-Insurance Funds.

Management's Response

The County acknowledges the oversight of ACA Transitional Reinsurance Fee payment due to changes in staffing and has setup appropriate redundancies to ensure the proper monitoring controls are in place moving forward.

Invoicing Regional Partners

Benefits is responsible for generating Regional employee information from SAP and remitting invoices to most Regional Partners (two Partners are billed by EBI) at the beginning of each month for enrolled employee premiums. Regional Partner contracts with the County state the Partner is required to "pay all fees on an as-billed basis, subject to adjustments and reconciliation by the County on the subsequent month's invoice."

During a review of invoices sent to Regional Partners from November 2012 through June 2015, DIA noted multiple instances where payments were not made as-billed. Specifically, there were 91 instances out of 395 bills (23%) generated during this period in which the Regional Partner did not pay the billed rate. The billed amount for this time period was $38,946,136 and the amount received was $38,907,759. Regional Partners pay the County based on their internal records when the bill is received. This equated to a lesser amount being paid than billed of $38,377. According to the contract, any discrepancies should be adjusted in the subsequent month's invoice and not be adjusted by the Partner.

In violation of record retention policies, Benefits was unable to provide detailed support for Regional receipts prior to November 2012. In addition, there were two payments made by two Regional Partners in May and June of 2015 for a total of $426,158 in which no copy of the invoice was maintained by Benefits. DIA was unable to assure the amount billed agreed to the amount paid. The County is at a greater risk of lost program revenue if the amount billed is not received.

DIA also reviewed plan rates in the Regional contracts to assure the approved rates agreed to the billed rates. We reviewed all January bills from 2011 to 2015 since rate changes occurred mostly during this month. There were three bills out of 40 tested in which the billed rates did not agree to the approved rates. DIA reviewed subsequent month's invoices and did not identify any retroactive corrections or adjustments. Benefits does not compare premium rates on monthly bills sent to Regional Partners to current rates provided by EBI. The following table will provide more details and the amount of over or under billing for each Partner and plan type:

Partner	Invoice Period	Plan Type	Contract Rate	Billed Rate	Contract vs. Billed Rate	Employees Enrolled	Total Over/(Under) Billed
Board of Health	January 2014	MHS Select-Single	$437	$454	$17	6	$102
Board of Health	January 2014	MHS Select - Family	$1,201	$1,363	$162	7	$1,134
Fairview Park	January 2014	HSA -Single	$344	$159	($185)	2	($370)
Fairview Park	January 2014	HSA -Family	$1,033	$477	($556)	1	($556)
CCBODD	Jan–Jun 2015	MMO - O/A Dep.	$311	$214	($97)	8	($776)
CCBODD	Mar–Dec 2014	MMO - O/A Dep.	$294	$210	($84)	26	($2,184)

In addition, DIA noted the following control issues while reviewing invoices sent to Regional Partners:

- Two Partners appear to send multiple checks for their monthly invoice. No justification was given by Benefits.

- One Partner's invoice had social security numbers listed for all their employees. The invoice was prepared by EBI.
- Invoices sent to Regional Partners on a monthly basis are not reviewed by an immediate supervisor. Two Partners' invoices are completed and sent by EBI; however, no sign of County approval is noted before the invoices are sent.

Failure to have procedures and controls in place increases the risk of personal information being accessed by unauthorized users. Also, the County may not receive all program revenue in accordance with contractual amounts.

Recommendation

DIA recommends Benefits review past invoices to Regional Partners to assure the amount billed was received or find justification on the differences between billed amounts and received amounts (and contract amounts) identified in the finding. We also recommend the following be implemented to address the control weakness:

- Monthly invoices sent to Regional Partners should be reviewed and approved by an immediate supervisor. Any invoices prepared by EBI should be reviewed and approved by the County before sending to the Partner. During this review, premium rates should be compared to contracted/approved amounts. Approval can be shown by an e-mail, initials on the document, or electronic signature on the document.
- All social security numbers should be redacted or excluded from the invoices.
- Benefits should communicate with the Regional Partners and reinforce the contractual language that they are to pay as-billed. If adjustments are necessary, they will be made on the subsequent month's invoice.
- Benefits should reduce the amount of checks handled by requesting the Regional Partners send one check for monthly payments unless a reason is formally documented.

Management's Response

In partnership with our vendors, healthcare consultant, the Fiscal Officer and our Regional Partners, the County will be evaluating a more efficient and accurate method of plan administration and premium collection. The County's objective remains to provide our Partners with accurate information and make the administration of the program as seamless as possible.

The County will also develop a process which requires regular monitoring and auditing of invoices to payments received by both internal and external partners.

Deposit of Public Monies

ORC Section 9.38 states, in part:

> *A person who is a public official other than a state officer, employee, or agent shall deposit all public moneys received by that person with the treasurer of the public office or properly designated depository on the business day next following the day of receipt, if the total amount of such moneys received exceeds one thousand dollars. If the total amount of the public moneys so received does not exceed one thousand dollars, the person shall deposit the moneys on the business day next following the day of receipt, unless the public office of which that person is a public official adopts a policy permitting a different time period, not to exceed three business days next following the day of receipt, for making such deposits, and the person is able to safeguard the moneys until such time as the moneys are deposited."*

During the audit period, Benefits held Regional and stop loss reimbursement checks for multiple days and months before filling out a revenue receipt and depositing the money with the Treasurer's Office. Failure to deposit public money in a timely manner increases the County's exposure to theft, or potential loss of money and untimely deposits. DIA was unable to determine how many checks were not deposited in accordance with the ORC since the date checks were received was unknown. Based on inquiries with the Benefits Department and check dates on Regional and stop loss reimbursement checks, DIA was able to determine checks were not being deposited in accordance with ORC Section 9.38 by comparing check dates to FAMIS posting dates. DIA provided the average dollar amount of revenue receipts deposited during the audit period (1/1/11-6/30/15) in the table below.

Type	# of Revenue Receipts	Average # of Checks on Revenue Receipt	Average Amount on Revenue Receipt
Regional Payments	89	6	$562,459
Stop Loss Reimbursements	41	7	$183,200

The check dates on stop loss reimbursements compared to the FAMIS posting dates appeared to have resulted in noncompliance with ORC Section 9.38. The following instances were noted in our test of stop loss reimbursements:

- Revenue Receipt #RR1112941 for $256,086.30 was posted in FAMIS on 11/28/2011. Checks from the stop loss provider were dated as far back as 4/11/2011.
- Revenue Receipt #RR1311391 for $842,003.55 was posted in FAMIS on 10/22/2013. Checks from the stop loss provider were dated as far back as 12/5/2012.
- Revenue Receipt #RR1311460 for $176,182.14 was posted in FAMIS on 10/24/2013. Checks from the stop loss provider were dated as far back as 3/12/2013.

- Revenue Receipt #RR1402061 for $157,286.79 was posted in FAMIS on 3/6/2014. Checks from the stop loss provider were dated as far back as 11/15/2013.

Additionally, checks deposited from the Regional Partners did not appear to be in compliance with ORC Section 9.38. The following are instances noted during testing of revenue receipts:

- One Regional check deposited in November 2012 for $16,778.16 was issued by the Regional Partner on 7/11/2012.
- Two Regional checks deposited in December 2012 totaling $21,880.65 were issued by the Regional Partner in July 2012.
- One Regional check deposited in November 2014 for $9,731.40 was issued by the Regional Partner on 8/27/2014.

After discussing the above issues with Benefits, they were unaware of the ORC requirement to deposit checks within 24 hours of receipt. Checks were held in an employee's drawer and not deposited with the Treasurer's Office until more checks were received.

Recommendation

Benefits should either deposit monies collected with the Treasurer's Office on the next business day following the day of receipt or adopt a policy permitting a different time line for deposits under the guidelines established and permitted by ORC Section 9.38. The policy must include procedures to safeguard the monies until the time of deposit. Furthermore, we recommend a log be kept listing all checks received from all sources and the date they were received. This log should be reviewed by the supervisor to assure compliance with this Revised Code section.

Management's Response

The County has a process to ensure all payments are posted to the correct system and deposited on a timely basis in compliance with ORC Section 9.38. Appropriate procedures have been reviewed to ensure ongoing compliance with these processes.

Internal Control Findings

New Entrant and Renewal Procedures

The operations of the Program should have robust controls in place over the underwriting and renewal procedures due to the amount of risk and the diversity of the parties involved. This includes proper and timely authorizations from the County and ensuring that all parties involved are aware of the risks and responsibilities of the Program. Per the Political Subdivision Participation Agreement that each Partner in the Program has, EBI and the County are responsible for initial underwriting, renewal development, group installation, reporting, and providing an online enrollment tool. EBI provided DIA with their policies and procedures relating to these responsibilities. Control testing was performed based upon this document. A sample of 40 items pertaining to underwriting new entrants and renewals were requested from EBI on July 31, 2015. An incomplete response was received on August 17th. A follow up request was sent on September 30th and final response was received on October 27th. After all responses were reviewed nine out of the 40 items requested, or 22%, were not responsive to our request.

The following highlights issues throughout this test from the County's Benefits personnel and EBI's responses. The highlights have been broken down by topic:

Underwriting

- No formal report or proof of outside actuarial review pertaining to the weights on premium calculations was furnished by EBI.
- No documentation was obtained from EBI specifying why rates did or did not include the risk factor premium.

Eligibility

- There was no documentation available to show employees and dependents for a Partner were verified for eligibility prior to enrollment in the Program.

Insurance Administration

- A list of a Partner's employees and dependents was not sent to the stop loss carrier for enrollment until more than six months after the employees and dependents were enrolled in medical benefits. In support obtained by DIA, this task was performed by EBI.
- No written proof could be provided with the County Executive's, or his designee's, approval on a Partner's annual premium rate change from 2014 to 2015 during a non-renewal year.
- The County has relied heavily on EBI for administration of the Program without verifying their procedures. The procedures on approving Partner rates and fees were frequently, but not always done through email. In our review of Regional contracts and annual rate determination by EBI, we were initially unable to verify if the County Executive reviewed and approved rates before being offered to the Regional Partners. Requests for

documentation for rate and fee approvals were not provided by the County or EBI. A subsequent review of email files showed the following:

Rate Recommendation and Approval for New Entrants

Regional Partner	Effective Date	Rates Recommended to County from EBI Y/N	Approving Authority	Date Approved	Recommended Rates Agree to Contract
Land Bank	07/01/2009	N			
Olmsted Falls	01/01/2011	N			
Walton Hills	01/01/2011	N			
Mayfield Village	04/01/2012	N1	HR Deputy Director	01/31/2012	N/A
Glenwillow	07/01/2012	N			
Highland Hills	07/01/2012	Y	HR Deputy Director	06/08/2012	Y
North Randall	09/01/2012	N			
CCBODD	01/01/2013	N			
Fairview Park	01/01/2014	N1	HR Deputy Director	10/02/2013	N/A
University Heights	01/01/2014	Y	Chief of Staff	12/10/2013	Y1
Board of Health	01/01/2014	Y	HR Deputy Director	06/22/2013	Y1
Highland Heights	02/01/2014	Y	Executive	12/05/2013	Y
Chardon	03/01/2014	Y	HR Director	02/10/2014	Y
Cleveland Heights	09/01/2014	Y	HR Deputy Director	08/01/2014	N2
South Euclid	01/01/2015	Y	HR Deputy Director	11/05/2014	Y
RITA	01/01/2015	N			
SECC	01/01/2015	Y	HR Deputy Director	12/09/2014	Y
Euclid	04/01/2015	Y	No Written Approval		N3
Red Center Logic	05/01/2015	N1	No Written Approval		N/A
Olmsted Twp.	01/01/2011	N			

N1 – A recommendation email was sent to the County from EBI, but no rates were included in the recommendation.

N2 - Recommended rates from EBI were 6% lower than contracted rates for the MMO plans. The recommended Rx rate was 6% higher than the contract rate.

N3 - Recommended rates from EBI were 10% lower than contracted rates.
Y1 – EBI did not originally recommend the MetroHealth Select plan but the plan was included in the executed contract.
N/A – Since no rates were recommended to the County, DIA was unable to compare recommended rates to contract rates.

Recommendation and Approval on Annual Rates

Year	Date Recommended by EBI	Increase Recommended	Date Approved by County	Actual Increase
2012	10/18/2011	5.0%	No Written Approval	5.0%
2013	09/27/2012	6.0%	No Written Approval	6.0%
2014	09/23/2013	0.0%	No Written Approval	0.0%
2015	09/05/2014	1.5%	No Written Approval	1.5%

These issues could lead to Regional Partners entering into the program without proper review and approval by the County Executive or his designee. Additionally, employees and dependents not eligible for coverage could be insured by the County. All of these potential outcomes are significant considering that most risk resides solely with the County in the contractual relationships with the Regional Partners.

Recommendation

DIA recommends EBI maintain adequate support in accordance with their own policies and procedures manual for underwriting, authorizing, and processing Regional Partners for the Program. The County should assure all documentation is maintained by EBI on the County's behalf or retain all Regional Partners' documentation in the County's files. Specifically, the following should be addressed:

Underwriting

- A formal report by an outside actuary should be maintained to provide proof that weights for premiums by type of coverage offered to Regional Partners is reasonable.
- The risk factor rate applied to a Partners' premium should be documented, whether or not the risk premium was added. At the completion of underwriting, a breakdown in the rate structure by element (i.e. medical, Rx, stop loss, etc.) should be provided to the County. An employee with knowledge of the risk rating structure should review and approve the rate structure in writing, or by e-mail, prior to presenting the information to the Executive and Council for approval.

Eligibility

- Regional employees enrolled need to be verified for the following:
    - The employee meets the full-time eligibility requirements by having a representative of the Regional Partner certify all enrollees are full-time prior to enrollment.
    - A representative from the Regional Partner must certify none of the enrollees are retirees prior to enrollment.
    - An audit of a sample of the Regional Partner's employee eligibility must be conducted, at least annually, to verify continuing eligibility. If exceptions are found the entire population must be subjected to an audit.
- Regional dependents enrolled need to be verified for the following:
    - All identifying information such as the date of birth, relationship to employee, and social security number must be obtained for every dependent prior to enrollment.
    - Prior to enrollment there should be supporting documentation for each dependent including, if applicable, copies of birth certificates, social security cards, marriage certificates, etc.
    - An audit of a sample of the Regional Partner dependent's eligibility must be conducted, at least annually, to verify continuing eligibility. If exceptions are found the entire population of dependents must be subjected to an audit.

Insurance Administration

- A listing of employees and their dependents should be sent to the stop loss carrier within one month after enrollment in the program.
- All changes in rates on an annual basis must be approved by the County Executive, or designee, in writing prior to changing rates.

Management's Response

The County is developing a detailed, transparent and accountable process for managing both the County Plan and Regional Healthcare Plan moving forward.

The Benefit Advisory Committee will review the performance of the new Healthcare Consultant to ensure the appropriate controls are established. This group will also remain engaged to ensure the County's management and oversight remains appropriate. Plan management functions will be reviewed regularly and as appropriate.

Net Reserve Comparison by Regional Partner

The County relies on EBI to calculate the reserve balances for each Regional Partner and for the Program as a whole. The Program's reserve balances should accurately reflect the Program's financial condition. The County administrative fee charged to each Partner should be separately

accounted for from the reserve balance. As stated in each Regional contract, except CCBODD, the administrative fee should be set between 3% and 6% of the fully-insured equivalent rate ($8 PEPM for CCBODD).

Monthly, EBI's experience reports for the Program are sent to the County. The experience reports show reserve balances by Partner and for the Program as a whole. The following table consists of reserve balances by Partner from EBI's experience reports from the beginning of the program January 1, 2011 to June 30, 2015.

Net Reserves as Reported by EBI						
Partner	**2011**	**2012**	**2013**	**2014**	**2015***	**Net Reserve**
CCBODD	N/A	N/A	$1,764,839	($180,833)	($549,787)	**$1,034,219**
Chardon	N/A	N/A	N/A	209,915	30,983	**240,898**
Cleveland Heights	N/A	N/A	N/A	(118,026)	(97,390)	**(215,416)**
Euclid	N/A	N/A	N/A	N/A	547,822	**547,822**
Fairview Park	N/A	N/A	N/A	(107,230)	(18,956)	**(126,186)**
Highland Heights	N/A	N/A	N/A	254,279	(83,605)	**170,674**
Euclid	N/A	N/A	N/A	N/A	167,387	**167,387**
University Heights	N/A	N/A	N/A	172,813	20,164	**192,977**
Board of Health	N/A	N/A	N/A	(128,673)	(20,696)	**(149,369)**
Land Bank	$17,222	$48,274	143,748	142,311	(22,166)	**329,389**
Mayfield Village	N/A	235,164	48,336	(6,632)	(31,066)	**245,802**
Olmsted Falls	100,534	8,720	16,438	36,658	39,286	**201,636**
Olmsted Township	(137,313)	148,139	(89,941)	(79,650)	0	**(158,765)**
Red Center Logic	N/A	N/A	N/A	N/A	17,578	**17,578**
RITA	N/A	N/A	N/A	N/A	(318,557)	**(318,557)**
SE Emergency Communication	N/A	N/A	N/A	N/A	9,493	**9,493**
Glenwillow	N/A	(19,033)	53,600	(239,271)	(2,481)	**(207,185)**
Highland Hills	N/A	47,576	139,684	147,028	13,454	**347,742**
North Randall	N/A	25,334	14,998	6,279	(19,417)	**27,194**
Walton Hills	146,082	104,453	140,812	180,512	85,674	**657,533**
Total	**$126,525**	**$598,627**	**$2,232,514**	**$289,480**	**($232,280)**	**$3,014,866**
County Admin. Fee	**$(20,325)**	**$(30,975)**	**$(114,733)**	**$(206,149)**	**$(170,129)**	**$(542,311)**
Total Less Fee	**$106,200**	**$567,652**	**$2,117,781**	**$83,331**	**$(402,409)**	**$2,472,555**

**Reserves are reflected from January 1 to December 31 of each year, except 2015 which is as of June 30th. The "Net Reserve" column is a calculation of the Regional Partner's total reserve at June 30, 2015.*

In review of the six new entrants in 2014 we noted three (Cleveland Heights, Fairview Park, and Board of Health) had a deficit balance at the end of 2014. It should be noted that they remain in a deficit condition at June 30, 2015. A possible explanation for these year-end deficits is that premium rates were set too low for these entities. DIA was not provided with EBI's rate setting documentation to prove or disprove this possibility. Of the remaining three partners (Chardon, Highland Heights, and University Heights) with positive balances at December 31, 2014, Chardon and University Heights, have a positive balance at June 30, 2015 but both are showing a downward trend and Highland Heights is at a deficit. EBI provided a document that was purportedly used to determine the premium rates for RITA, who became a Partner effective January 1, 2015. The medical and Rx claims provided were for the time period beginning January 2013 and ending April 2014. EBI's policy requires two years of claims experience for Partners over 100 employees. Contrary to their policy, EBI only used 12 months of history (May 2013 – April 2014) to determine their monthly premium payment. DIA did not verify the claims payments on the EBI provided document. However, a comparison of eight months of claims data estimated the current average monthly claims to be approximately $70,000 higher than an eight-month average of the claims history data used to set the rate.

As stated earlier, EBI does not separate the County administrative fee from the reserve balances. The fee is included as part of the reserve balances per Partner. Even with the fee included, which is revenue to the County, the program appears to be running at a deficit of $232,280 for the period of January 1, 2015 to June 30, 2015.

The $15.00 PEPM was verbally agreed upon between the County and Regional Partners according to Benefits and EBI, except for CCBODD which agreed to $8.00 PEPM. This fee was not consistent with the contracts between the Partners and the County. The contracts state an administrative fee between 3% and 6% of the fully-insured equivalent rate would be charged to the Regional Partners. The $15.00 fee was less than 2% of the average fully-insured equivalent rate. The following tables show the Program's estimated reserve balances for each Partner had the County collected the contractual amount of Administrative fees at both the 3% and 6% rate.

EBI Net Reserves Less County Administrative Fee at 3% ($8 for CCBODD)

Partner	2011	2012	2013	2014	2015*	Net Reserve
CCBODD	N/A	N/A	$1,686,967	($261,033)	($588,963)	**$836,971**
Chardon	N/A	N/A	N/A	189,706	19,244	**208,950**
Cleveland Hts.	N/A	N/A	N/A	(169,808)	(175,063)	**(344,871)**
Euclid	N/A	N/A	N/A	N/A	513,734	**513,734**
Fairview Park	N/A	N/A	N/A	(145,414)	(39,473)	**(184,887)**
Highland Hts.	N/A	N/A	N/A	234,519	(94,598)	**139,921**
South Euclid	N/A	N/A	N/A	N/A	147,730	**147,730**
University Hts.	N/A	N/A	N/A	142,581	5,497	**148,078**

Board of Health	N/A	N/A	N/A	(169,892)	(41,814)	**(211,706)**
Land Bank	$10,705	$40,428	134,568	132,651	(27,739)	**290,613**
Mayfield	N/A	218,911	26,313	(28,377)	(43,290)	**173,557**
Olmsted Falls	89,823	(1,862)	5,678	25,159	34,200	**152,998**
Olmsted Twp.	(159,203)	125,689	(107,427)	(79,650)	0	**(220,591)**
Red Center Logic	N/A	N/A	N/A	N/A	16,704	**16,704**
RITA	N/A	N/A	N/A	N/A	(343,108)	**(343,108)**
SECC	N/A	N/A	N/A	N/A	7,876	**7,876**
Glenwillow	N/A	(20,842)	49,649	(243,459)	(4,530)	**(219,182)**
Highland Hills	N/A	43,750	132,197	138,821	9,404	**324,172**
North Randall	N/A	24,258	11,733	2,805	(21,286)	**17,510**
Walton Hills	138,335	97,228	133,574	172,281	81,114	**622,532**
Total	**$79,660**	**$527,560**	**$2,073,252**	**($59,110)**	**($544,361)**	**$2,077,001**

**Reserves are reflected from January 1 to December 31 of each year, except 2015 which is as of June 30th. The "Net Reserve" column is a calculation of the Regional Partner's total reserve at June 30, 2015.*

EBI Net Reserves Less County Administrative Fee at 6% ($8 for CCBODD)						
Partner	**2011**	**2012**	**2013**	**2014**	**2015***	**Net Reserve**
CCBODD	N/A	N/A	$1,686,967	($261,033)	($588,963)	**$836,971**
Chardon	N/A	N/A	N/A	169,497	7,506	**177,003**
Cleveland Hts.	N/A	N/A	N/A	(221,590)	(252,735)	**(474,325)**
Euclid	N/A	N/A	N/A	N/A	479,647	**479,647**
Fairview Park	N/A	N/A	N/A	(183,597)	(59,991)	**(243,588)**
Highland Hts.	N/A	N/A	N/A	214,759	(105,592)	**109,167**
South Euclid	N/A	N/A	N/A	N/A	128,074	**128,074**
University Hts.	N/A	N/A	N/A	112,348	(9,170)	**103,178**
Board of Health	N/A	N/A	N/A	(211,112)	(62,931)	**(274,043)**
Land Bank	$4,188	$32,582	125,388	122,991	(33,311)	**251,838**
Mayfield	N/A	202,657	4,290	(50,122)	(55,515)	**101,310**
Olmsted Falls	79,111	(12,444)	(5,083)	13,660	29,114	**104,358**
Olmsted Twp.	(181,092)	103,240	(124,913)	(79,650)	0	**(282,415)**
Red Center Logic	N/A	N/A	N/A	N/A	15,830	**15,830**
RITA	N/A	N/A	N/A	N/A	(367,658)	**(367,658)**
SECC	N/A	N/A	N/A	N/A	6,258	**6,258**
Glenwillow	N/A	(22,651)	45,698	(247,647)	(6,578)	**(231,178)**
Highland Hills	N/A	39,925	124,710	130,614	5,355	**300,604**
North Randall	N/A	23,183	8,469	(668)	(23,156)	**7,828**
Walton Hills	130,589	90,003	126,336	164,051	76,554	**587,533**
Total	**$32,796**	**$456,495**	**$1,991,862**	**($327,499)**	**($817,262)**	**$1,336,392**

**Reserves are reflected from January 1 to December 31 of each year, except 2015 which is as of June 30th. The "Net Reserve" column is a calculation of the Regional Partner's total reserve at June 30, 2015.*

The County does not have procedures in place to assure EBI is following their policy requirements for reviewing the claims history of each Partner during the initial underwriting process and when rate increases are determined. Without monitoring controls in place the County may be liable for short- or long-term costs of a program that should be cost neutral to the County. Furthermore, failure to separately recognize the administrative fee as program revenue and offsetting County costs results in the overstatement of expenditures from the County's funds.

Recommendation

DIA recommends the County review EBI reports and recalculate Program reserve balances by Partner to assure the Program is financially stable. The County Administrative fee should be separately accounted for as program revenue and the County's Program costs should be charged to this revenue.

Management's Response

The County acknowledges the importance of creating a fiscally sound yet efficient rating methodology. The County's Benefit Advisory Committee and new Healthcare Consultant will be thoroughly reviewing the rating of participants in the Regional Healthcare Plan to ensure its long term viability.

The County is conducting a thorough review of rates that will take into account relevant methodologies, updated data and projected future liabilities and necessary reserve levels.

The County has reaffirmed our commitment to maintain the current rates/benefit options to our Regional Partners through the balance of 2016. Regional Partners have been advised of the County's timing and strategic plan development along with our intent to provide an overview of the long term strategy, rates and plan design in or around September, 2016. The County remains committed to continuing, improving and expanding the Regional Plan in the future.

Provider Wellness Subsidy

UHC and MMO offer a wellness credit to the County. The County may be reimbursed up to a certain dollar amount each year for expenses related to wellness. The County utilizes WIQ for wellness services and submits invoices to UHC and MMO to receive reimbursement for WIQ invoices. The County should have adequate controls in place to assure the annual wellness credit with MMO and UHC is reimbursed to the County for payments made to WIQ. Failure to monitor and request reimbursements from medical providers results in a loss of funds for the County.

DIA reviewed the contracts between the County and the medical providers. MMO's contracts from 2009 through 2015 noted the County may receive a wellness credit up to $75,000 a year. UHC's contract did not mention a wellness credit or amount the County may receive. DIA inquired with UHC and received confirmation the County was eligible to receive up to $56,000 a year from 2012 to 2014. UHC and MMO provided a confirmation to support the amount of wellness credit disbursed by the medical providers from 2012 to 2014. In addition, MMO provided a confirmation on the wellness credit for 2009 through 2011. We attempted to trace the medical providers' support to FAMIS and WIQ invoices. The tables below display our results.

UHC Wellness Subsidy

Year	Reimbursement According to Confirmation	Reimbursement Received According to FAMIS	Difference
2012	$31,000	$0	($31,000)
2013	56,000	0	(56,000)
2014	56,000*	0	(56,000)
Total	**$143,000**	**$0**	**($143,000)**

** Received by WIQ in 2015 and credited to the 1/1/2015-12/31/2017 contract.*

Benefits sent WIQ invoices to UHC in 2012, 2013, and 2014. Support sent to UHC from the County stated the reimbursements should be sent directly to WIQ. WIQ stated that payments are sent directly to WIQ based on the County's choice to use the wellness credit toward vitality services. Vitality services were credited on subsequent WIQ invoices to offset the wellness credits paid to WIQ.

MMO Wellness Subsidy

Year	Reimbursement According to Confirmation	Reimbursement Received According to FAMIS	Difference
2009-2011	$224,958	$5,331	($219,627)
2012	75,000	0	(75,000)
2013	75,000	68,838	(6,162)
2014	75,000	75,000	0
Total	**$449,958**	**$149,169**	**($300,789)**

MMO's support on the 2009 through 2011 wellness credits indicated $22,488 was sent directly to MHS for wellness fair screenings and flu shots and $197,139 was sent directly to WIQ for vitality services and pedometers. DIA was not able to obtain invoices to support these payments. According to MMO's support on the 2012 wellness credit, $28,974 was sent directly to MHS for wellness fair screenings and flu shots and $46,026 was sent directly to WIQ for vitality services. The County did not pay MHS for the two invoices totaling $28,974 since MMO sent payment directly to MHS. Vitality services were credited on subsequent WIQ invoices to offset the wellness credit paid to WIQ.

In 2013, only a portion of the wellness credit was received by the County. MMO's confirmation for 2013 and 2014 stated the County was reimbursed $75,000 each year. DIA was only able to verify the 2014 wellness credit was reimbursed to the County for $75,000. No explanation could be given by Benefits for the discrepancies noted in 2013.

In addition, the County did not record the wellness credits paid directly to WIQ and MHS as an expenditure and reduce the vendors' contract encumbrances by the amounts paid. Therefore, WIQ's expenditures from 2012 through 2015 were understated by $386,165. Furthermore, this resulted in an overpayment of WIQ's 2012 through 2014 award amount of $15,389.

Recommendation

Unless the WIQ or MHS contract states the wellness credit must be sent to the vendors, Benefits or the Fiscal Office should assure all wellness funds from the medical providers are sent directly to the County. The medical providers' wellness credit is strictly to reimburse the County for wellness expenses. No funds should be sent directly to WIQ or MHS. The County should research these discrepancies and determine whether or not these funds should be recovered.

Management's Response

The County and our new Healthcare Consultant have reviewed the WellnesslQ invoices and carrier subsidies to ensure accurate accounting of all wellness related activities.

The County has already implemented safeguards to separate direct payment of subsidies to third-party vendors. The County and their Healthcare Consultant will manage the tracking of future subsidy sponsorships and amounts received separate and outside of third party service firms.

Stop Loss Transactions

Each year, Cuyahoga County contracts with a stop loss provider to mitigate the risk of paying a large amount of medical and pharmaceutical claims on behalf of an individual subscriber or his/her dependent. The insurance was purchased through Sun Life Financial from 2012 through 2013 and Voya from 2014 through 2015. The County pays a fee PEPM per plan type for County and Regional employees. The stop loss provider reimburses the County after an employee or dependent exceeds an established threshold of medical and prescription drug expenses for the policy year. The threshold for 2012 and 2013 was $225,000 and $275,000 respectively. The threshold for 2014 and 2015 was $300,000. DIA inquired with Benefits staff and performed control and substantive tests on monthly fee payments to and reimbursements from the stop loss providers for County and Regional employees.

Expenditures (Premiums Paid)

DIA attempted to test 39 payments, totaling over $6.6 million, for stop loss coverage from July 2012 to June 2015. Support for 11 payments, totaling $2,576,958, was not provided to DIA. The support for the remaining 28 payments was provided. We tested for controls in place, accuracy of support maintained, and completeness of FAMIS. The following was noted:

- No indication of supervisor review or approval for the stop loss payment was evident on any of the 28 payments tested. The only signatures noted were Benefits staff and staff from the Office of Budget & Management.
- Payments were not accurately recorded in the County and Regional Self-Insurance Fund. Five of 28 payments tested were recorded in the Regional Self-Insurance Fund although a portion of each payment pertained to County employees. The amount of payments related to County employees equated to $817,971. Of the remaining 23 tested payments, 16 were recorded in the County Self-Insurance fund although a portion of the payments should have been allocated to the Regional Self-Insurance fund. The Regional portion of these payments equated to $325,088.
- Records were not retained as required by the County's record retention policies as support for 11 payments was not located and two of the 28 payments located lacked invoices.

Reimbursements

DIA tested 100% of the stop loss reimbursements received for Regional and County employees from January 1, 2011 to June 30, 2015 which included 41 revenue receipts totaling over $7.5 million in reimbursement checks. DIA reviewed controls in place, verified the accuracy of support maintained, and tested the completeness of FAMIS. The following was noted:

- Four stop loss reimbursement checks on three different revenue receipts were for Regional employees that were incorrectly recorded in the County Self-Insurance Fund instead of the Regional Self-Insurance Fund. The four checks totaled $582,756.
- Two stop loss reimbursement checks on one revenue receipt were for County employees that were inaccurately recorded in the Regional Self-Insurance Fund instead of the County Self-Insurance Fund. The two checks totaled $709.
- Supporting documentation was not maintained for eight revenue receipts that totaled $1,051,245. Sufficient documentation consists of detailed information from the stop loss provider with the claimant's name and amount of the check. DIA was able to confirm all eight revenue receipts through confirmations received from Sun Life Financial and Voya for reimbursements in 2013 through 2015.
- No signature by a supervisor was noted on 37 revenue receipts indicating approval or review.

There are also issues in the accounting of stop loss reimbursements. The reimbursement is posted in a revenue sub-object code as revenue instead of being recognized as an expenditure

reduction. When the claim is originally paid, the accounting records show a payment made which increases expenditures and reduces the corresponding encumbrance. Recording the reimbursement as revenue overstates the revenue and does not allow for a reduction in the expenditures resulting in an overstatement in expenditures as well. Failure to reinstate the encumbrance understates the amount still available to be spent.

Benefits does not have adequate controls in place to review and verify stop loss payments and reimbursements. Without these controls, the risk of posting payments and reimbursements to the wrong fund is increased. Furthermore, inaccurate information on reserve balances could be given to management if payments and reimbursements are misstated. Benefits is also at risk of overstating revenue and expenditures and understating encumbrances if stop loss reimbursements are not appropriately entered into FAMIS.

Reimbursements on EBI Report vs. Received by County

While comparing County and Regional employee stop loss reimbursements received by the County to EBI reports, we noted discrepancies. According to EBI, the County may have been eligible for more stop loss reimbursements than actually received. The following table displays our results for the Regional Partners only.

	2011	2012	2013	2014	2015	2011 - 2015
County Received	$ 0	$ 0	$455,384	$366,451	$20,008	$841,843
EBI Reports	0	417,257	406,776	$ 0	97,588	921,621
Variance	**$ 0**	**$(417,257)**	**$48,608**	**$366,451**	**$(77,580)**	**$(79,778)**

DIA was unable to trace a total of $79,778 of stop loss reimbursements claimed to be owed to the County according to EBI reports. EBI's stop loss reimbursement amounts could not be traced to Voya's or Sun Life's confirmations.

Recalculation of Stop Loss Reimbursements per Provider Claims Data

DIA recalculated claims data from the providers by member (employee or dependent) for the 2014 policy year. The 2014 policy year covered all claims having a date of service from July 1, 2013 through December 31, 2014 with a pay date in calendar year 2014. DIA was not able to obtain all claims data for CVS with a date of service from July 1, 2013 through December 31, 2013, but we were able to obtain all claims paid in 2014. The claims data was summarized by individual for the relevant periods of the 2014 policy year and compared to Voya's confirmation. Our results follow:

- The amount recalculated that should have been reimbursed for the 2014 policy year was $2,209,670. According to Voya's confirmation and FAMIS, the County was only reimbursed $2,040,765 through December 2015, resulting in an underpayment by Voya of $168,905. $144,830 of the variance was denied claims from Voya as a result of the County paying claims for ineligible employees.

There are no controls in place to recalculate the amounts the County should be reimbursed under the stop loss policy for the plan year. This has led to underpayment of stop loss reimbursements for the 2014 policy year and could lead to the same issue in the 2015 policy year.

Denial of Stop Loss Reimbursements from Voya

While reviewing Voya's confirmation for County and Regional employee stop loss reimbursements, we noted over $286,000 in potential stop loss reimbursements to the County were denied in 2015. Out of 18 total claims, 11 were denied due to ineligibility. The claimants were not eligible for benefits during the time of the claims or the claimants purchased an ineligible prescription drug. The total amount denied for ineligibility was $248,618. DIA was unable to find contractual language that Voya could deny claims due to ineligibility. If the County determines claims to be eligible and pays the claims, even though the employee was not eligible, the stop loss carrier may still reimburse the County if total claims paid exceed the contractual threshold. The other seven claims were denied due to claims being paid outside the plan year or reconciling differences between the provider and Voya.

Recommendation

DIA recommends the following in regards to stop loss transactions:

Expenditures (Premiums Paid)

- Before stop loss premium payments are made by Benefits, an immediate supervisor of the preparer should review and sign the voucher and invoice.
- The County's portion of stop loss payments should be recorded in the proper fund (County Self-Insurance Fund) and the Regional's portion should be recorded in the Regional Self-Insurance Fund. Benefits or the Fiscal Office should review payments in FAMIS to assure the proper fund is charged. One of the departments should review past payments and consider making adjustments to correct any mis-postings.
- All supporting documentation should be maintained by Benefits for stop loss premium payments in accordance with Benefits' Record Retention Schedule.
- The County should make the adjustments to the County and Regional Self Insurance Funds and correct the fund balances for the known errors. A search for the support for the remaining 11 payments should be conducted and any additional errors should be properly adjusted as well.

Reimbursements

- All stop loss reimbursements should be separated by Regional and County employees and be accurately recorded between the County and Regional Self-Insurance Funds. In addition, the Partner name should be posted in FAMIS to support reserve balance calculations.

- An immediate supervisor of the preparer should review and sign all receipt documents prior to depositing with the Treasurer's Office and posting in FAMIS.
- All supporting documentation should be maintained by Benefits for stop loss reimbursements in accordance with Benefits' Record Retention Schedule.
- Reimbursements should be recorded as a reduction of expenditure and the encumbrance should be reinstated to properly reflect the substance of the transaction.

Recalculation of Stop Loss Reimbursements per Provider Claims Data/Reimbursement on EBI Report vs. Received by County

- Annually, Benefits or the Fiscal Office should recalculate the amount that should be received for that policy year. This would include aggregating claims detail from all of the medical providers by employee and dependent based on the terms of the stop loss policy. Once aggregated, the totals can be compared to actual reimbursements. Any variances should be further investigated.
- The County should communicate with Voya and attempt to further research and collect reimbursements not paid to the County for the 2014 plan year.
- The County should compare stop loss reimbursements received to EBI's reports to assure the County received all reimbursements the County is entitled to receive. Any discrepancies should be investigated and communicated to the stop loss provider.

Denial of Stop Loss Reimbursements from Voya

- All denied claims by the stop loss provider should be documented and if they are rightfully denied the HR Director or his designee should approve the denial.
- The County should review the contract with Voya to assure stop loss claims for ineligibility can be denied. If the contract does not specify that claims for ineligible employees are not reimbursable, the County should consult with their Law Department about requesting payment of denied claims for ineligibility.

Management's Response

Through our selection of Medical Mutual of Ohio for stop-loss, the County has initiated a process which will ensure greater integration of claim data and potential reimbursements. The County's Fiscal Officer and new Healthcare Consultant are actively reviewing historical claim data, refunds received and contract provisions to ensure the County's reimbursements are accurate and complete.

New Program Participants

Regional Partners entering the Program should be approved by the County Executive, or his designee and County Council prior to participating in the program.

DIA inspected the documents associated with the most recent entrant to the Program, Red Center Logic. Employees from the Partner were listed as eligible in provider files on May 1, 2015, which was prior to County Council approval. The entry entered into NOVUS was not ready for Council's agenda until July 13, 2015 and did not appear for first reading until August 11, 2015. County Council retroactively approved the contract on August 25, 2015. The final approval, authorized with Resolution R2015-0160, was not approved until 116 days after the Partner's enrollment date into the Program. From May through August of 2015, the County paid $28,891 in claims and stop loss and provider administrative fees for Red Center Logic employees. The County started billing Red Center Logic in May of 2015. Red Center Logic is not the only anomaly. Of the 19 current Partners, 16 were approved after the effective date. The average time from effective date to Council approval is 51 days with a low of 10 and a high of 240 days. Contract approval for the Land Bank has never been found. The table included on **page 6** further illustrates the delays in the contract approval process.

There is a risk the County could pay claims for participants denied access to the Program by County Council at a later date.

Recommendation

DIA recommends Benefits create policies and procedures for the process of adding new Partners to the Program. These policies should include a statement that no prospective Regional Partner employees can be entered into the provider eligibility database until approval is received first by the Executive, or his designee, and then by County Council to enter the Program. Policies should also include a checklist prepared by EBI assessing the potential claims and financial risk to the County's Program.

Management's Response

As stated earlier, expansion of the Regional Healthcare Plan is temporarily suspended. Further expansion of the Plan along with establishment of new underwriting, evaluation, rating and approval process will be evaluated by the County's Benefits Advisory Committee.

Allocating County and Regional Expenditures

Regional claims and fees for CVS and UHC were not being allocated to the Regional Self-Insurance Fund. The total amount from provider invoices, which included County and Regional claims and

fees, were being paid out of the County's Self-Insurance Fund. DIA only noted one expense adjustment for $8,284,992, made on June 19, 2015, from the Regional Self-Insurance Fund to the County Self-Insurance Fund to reimburse claims paid; however, this adjustment was to cover only MMO claims.

Even though Council approved an amount for Regional expenses on the 2012 UHC contract, no advances were made from the Regional Self-Insurance Fund to the Agency Fund for UHC claims and fees. The CVS contract amount approved by Council did not allocate an encumbrance for Regional claims and fees.

Other fees not allocated between County and Regional funds included provider administration fees, ACA fees, stop loss fees, and shared services fees.

The County is at a higher risk of making inaccurate financial decisions since there is no oversight or accuracy in allocating expenditures between the County and Regional Self-Insurance Funds. Furthermore, the County is unable to calculate an accurate reserve balance for County and Regionalization Programs due to the current allocation of expenditures.

Recommendation

The County should revise current procedures on accounting for provider payments. CVS and UHC Regional claims and fees as well as ACA, stop loss, and shared services fees should be accurately allocated between the County and Regional Self-Insurance Funds.

Management's Response

The County's human resources, technology and fiscal departments have been working to recode eligibility tracked by the County and our vendors to ensure claim payments are attributed to the correct population moving forward. The fiscal department continues to review historical allocation of expenses since inception of the Regional Plan to ensure accounting for all expenses has been adjusted.

Advances to the Agency Fund

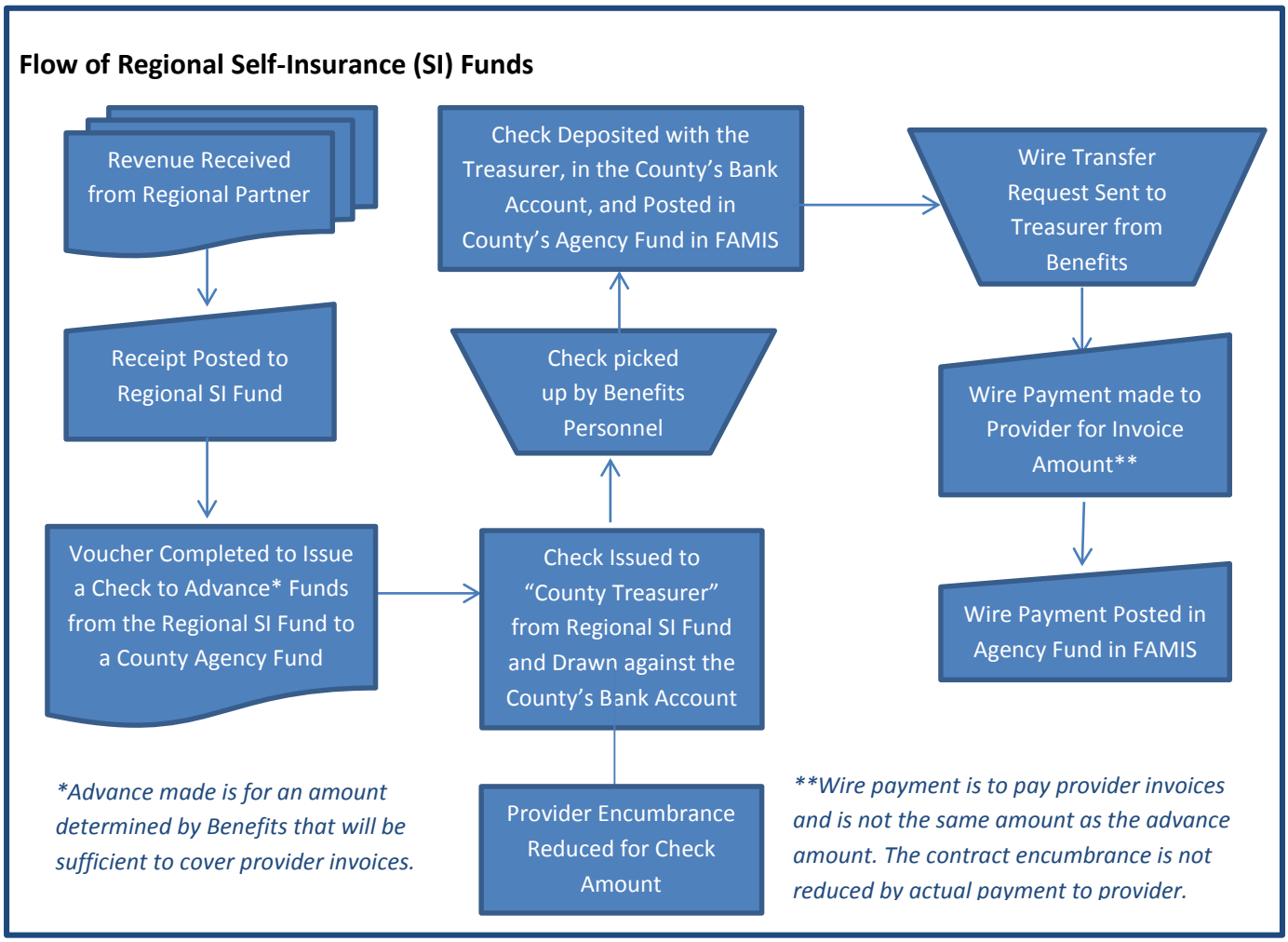
An encumbrance is a promise to pay a particular amount of money in the future in exchange for a good or service that a vendor or contractor will provide. Government organizations, like the County, use encumbrances to appropriate funds for specific obligations. An encumbrance allows the organization to record the anticipation of a future transaction.

DIA performed a walkthrough on how Benefits initiates payment to medical providers and how encumbrances are recognized and reduced in the County's Financial System (FAMIS). Without

the proper controls and oversight in place, the County is at risk of disbursing more than the amount encumbered or approved by Council.

Encumbrances are recognized in FAMIS by the Fiscal Office on an annual basis or when proper Council approval is obtained. After Council approval, OPD will approve the encumbrance and send proper support to the Fiscal Office. For multi-year contracts, like MMO and CVS, the encumbrance is allocated equally over the number of contract years and appropriated at the beginning of each year. The encumbrance is reduced in FAMIS whenever a payment is made. If a payment is attempted on an encumbrance that has been reduced to zero, the Fiscal Office will reject the request.

Multiple control weaknesses were identified after reviewing the procedures in place for payments to medical providers. When a payment is made on an encumbrance, Benefits completes an encumbrance voucher and sends the voucher to the Office of Budget & Management (OBM). An OBM analyst reviews the voucher and signs it to indicate funds are available. The voucher is sent to Accounts Payable for a check to be issued from the County or Regionalization Self-Insurance Fund. As the check is issued, the encumbrance for the vendor is automatically reduced in FAMIS. The checks are held for pick-up and issued with the Treasurer's Office as the payee. After Benefits picks up the check, a revenue receipt is completed and taken to the Treasurer's Office to deposit the check into the same bank account from which it was issued. The revenue receipt is sent from the Treasurer's Office to the Fiscal Office to be posted in an Agency Fund. The Agency fund is utilized to wire payments for both County and Regional claims, to the medical providers. Authorization to make the wire payment is sent to the Treasurer's Office from Benefits along with the provider invoices. Once approval is received from the Fiscal Office that funds are available to pay the invoices, the Treasurer's Office sends the wire payment. All support is sent from the Treasurer's Office to the Fiscal Office to be posted as a wire payment from the Agency Fund in FAMIS. The flowchart on the following page was constructed to show the flow of Program funds:



During the review of this process, DIA noted the following internal control weaknesses:

- The current process is cumbersome and inefficient. Checks are issued from the Self-Insurance funds and deposited into the Agency Fund so encumbrances can be reduced in FAMIS. In order to reduce an encumbrance automatically a check must be issued or an ACH must occur. An encumbrance cannot be automatically reduced for wire payments unless an extra step is taken to manually reduce the encumbrance by completing a decertification form. Issuing checks to be picked up and deposited back into the same bank account in order to accommodate FAMIS's transaction coding should not be accepted by the Fiscal Office. The amount of additional steps and documents costs the County more than manually inputting an encumbrance reduction.
- The only signatures noted on encumbrance vouchers are from OBM employees which signify appropriations are available in the Self-Insurance Fund for the request. Support attached to the voucher is HR generated and signed by a Benefits employee who completes the vouchers and handles checks. No director approval is noted on the encumbrance voucher or support.

- Revenue receipts and checks sent to the Treasurer's Office to be deposited are completed and signed by a Benefits staff member. No supervisor review or approval is noted.
- There was no wire payment approval by an immediate supervisor prior to December 31, 2014. As of January, 1, 2015, invoices and wire requests are being signed off by the HR Director. The Treasurer and Fiscal Officer made supervisor approval a requirement beginning September 1, 2015.
- Encumbrances are either over or understated when the amount advanced for payment is not the amount of the invoice and subsequent wire payment.

Coding wire payments to automatically reduce encumbrances was not completed when FAMIS was designed. The current process increases the risk of asset misappropriation. Furthermore, the potential for financial misstatement exists due to the complicated process currently in place.

Recommendation

DIA recommends the following to improve efficiencies and internal controls:

- Approval by an immediate supervisor should be noted by signature on the encumbrance voucher and support should be maintained with the voucher. The supervisor should sign-off on an encumbrance decertification form, as well.
- Approval by an immediate supervisor should be noted by signature on all revenue receipts when depositing checks.
- The process of issuing checks from the Self-Insurance funds to the Agency Fund to pay all vendors, especially medical providers, should be discontinued. All wire payments should be recognized in the necessary fund (i.e. Regionalization or County Self-Insurance Fund) and the entry to reduce the encumbrance should be manually entered if FAMIS cannot adapt to the change. The process of paying all vendors via wire payment should be changed to the following procedures:
    1. An encumbrance decertification form should be completed and sent to OBM. The decertification amount should agree to the invoice amount that will be wired to the provider. All supporting documentation should be attached to the decertification form including the provider invoice. This form should be approved and signed-off by an immediate supervisor of the requestor. OBM shall approve the decertification and send it to General Accounting for posting in FAMIS.
    2. Once the decertification occurs, all supporting documentation should be provided to the Treasurer's Office to request the wire payment. This step should not change from the current process, other than charging the payment to the necessary Self-Insurance Funds instead of the Agency Fund. The request for a wire payment should be signed-off by an immediate supervisor of the requestor. General Accounting should continue to approve the wire transfer after verifying sufficient funds are in the Self-Insurance Funds and the encumbrance decertification has

been completed. No wire payments should be made until the encumbrance has been decertified to reflect the wire payment.

3. On a monthly basis, Benefits or the Fiscal Office should review FAMIS and assure invoice amounts agree to the wire payments as well as the encumbrance decertification amounts.

This process may add another step to record the encumbrance, but efficiencies and cost savings will be evident as the process of issuing and depositing County checks will be eliminated. By discontinuing the issuance of checks, there will be a reduced risk of noncompliance with ORC 5705.41(B) as encumbrances will be reduced by actual payments to providers. In addition, accuracy in financial reporting will be improved as the Self-Insurance Funds will reflect actual expenditures and outstanding encumbrances.

Management's Response

The Fiscal Department has made corrections with internal accounting, advancements and necessary redundancies to ensure compliance with ORC 5705.41(B) on a go forward basis.

Consulting Fee Payments – EBI and WIQ

The County has established various classifications to account for funds segregated for specific purposes with laws and regulations or special restrictions and limitations. DIA reviewed EBI's and WIQ's 2012 contract covers to assure funds were disbursed from the approved fund. See the following issues:

- According to EBI's contract cover approved by the Fiscal Officer and Law Director for the time period August 1, 2012 through July 31, 2015, payments to EBI were to be made from the Regular Insurance Fund – Index Code CC499012. DIA noted payments made to EBI prior to April 1, 2015 were correctly paid out of the Regular Insurance Fund. However, payments made to EBI for April, May, and June 2015's consulting fees were incorrectly paid out of the County's Self-Insurance Fund – Index Code CC499004. These payments totaled $58,662.50.

- According to WIQ's contract cover approved by the Fiscal Officer and Law Director for the time period January 1, 2012 through December 31, 2014, payments to WIQ were to be made from the County's Self-Insurance Fund – Index Code CC499004. DIA noted all payments to WIQ, approximately $1.12 million, during the contract period were incorrectly paid out of the Regular Insurance Funds – Index Code CC499012. The WIQ contract was extended through December 31, 2017 with payments to be made out of the County's Self-Insurance Fund, as well. Payments made on January, 2015 through June, 2015 invoices, totaling $248,311, were still paid incorrectly out of the Regular

Insurance Fund. Beginning with the July 2015 invoice from WIQ, payments were made out of the correct fund – County Self Insurance Fund.

In addition, we reviewed EBI and WIQ payments to assure the accuracy and completeness of checks issued to the vendors. We noted checks were issued by the County to EBI for WIQ invoices during the audit period from January 1, 2014 to June 30, 2015. DIA tested 41 checks issued to EBI. 21 of the 41 checks, totaling $544,868, were incorrectly issued to EBI for WIQ invoices.

Finally, DIA requested detailed invoices for payments made to WIQ for vitality services since the number of employees (approximately 6,100 a month) appeared to be higher than expected. WIQ bills the County on a PEPM basis. Benefits was unable to provide DIA with detailed invoices for the transactions tested in 2014 through the end of the audit period June 30, 2015. However, DIA did obtain two detailed invoices in September and October of 2015. We noted WIQ was permitted by contract to bill the County for all employees who had medical benefits even if employees were not enrolled in Vitality. DIA was unable to obtain a list of all employees who utilize Vitality, but estimated about 2,600 employees did based on the amount WIQ billed the County for the HRA program. The WIQ contract does state the PEPM fee is calculated based on monthly eligibility files and the estimates in the contract are based on total employees enrolled in medical benefits not just those enrolled in the vitality program. Therefore, the County is paying a PEPM fee between $5.00 and $6.00 depending upon the contract year, to WIQ for employees with health benefit coverage but that are choosing to not use the vitality services.

The County does not have controls in place to assure payments are accurately disbursed from the correct fund. The County is at risk of expending more than appropriated if funds are not disbursed according to the contract cover. Also, failure to issue checks to the proper vendor results in inaccurate reporting and does not reflect accurate payments made to or balances remaining on contractual commitments.

Recommendation

DIA recommends Benefits and the Fiscal Office put policies and procedures in place to assure all payments made to vendors are accurately made out of the fund approved by Council, Fiscal Officer, and Law Director. We also recommend that all checks issued to vendors should accurately correspond to the vendor's name on the invoice. DIA recommends the County review the WIQ contract on vitality services and consider contracting with a vendor that will invoice the County for employees only electing to use the wellness services.

Management's Response

The County is evaluating our internal accounting and review processes to accurately assign all expenses and is evaluating wellness vendor partners along with potential fee alternatives.

The County is in the process of verifying the Auditor's findings related to the total amount of the overcharge (if any) from WellnessIQ and the basis for recovery (if appropriate and proper).

Program Reserve Calculation

The County is responsible for collection of revenue and disbursement of claims and fees associated with the Program. Having adequate controls and procedures in place to monitor revenues and expenditures is critical to the Program. Furthermore, the County should be aware of Program reserves per Partner to track Partner performance.

The County has experienced budget and cash flow problems within the Regional and County Self-Insurance, Agency and Regular Insurance funds and has never performed their own reserve calculation on the Program. Instead, the County has relied on EBI to calculate and track reserve balances for each Partner and the Program as a whole. EBI's reserve balances are based on expenditures incurred and revenue earned since EBI does not have access to the County's cash transactions. Consequently, no reserve calculation is done on a cash basis.

The County will continue to experience problems within these funds until they begin monitoring their own reserve balances based on cash transactions. Without monthly reserve calculations County Council, County Administration and the Program's management has received inaccurate information on the Program's performance.

Recommendation

DIA recommends Benefits perform their own reserve calculation of the Program on a monthly basis. The calculation should be compared to EBI's reserve calculation as well as fund balances in FAMIS. DIA is currently recalculating the reserve balances per Partner and for the Program as a whole. Results of this calculation will be reported in Phase II of the Health Care Benefits Program Audit. At a minimum, the following information should be included in the reserve calculations for each Partner and the program as a whole:

- Month
- Number of Employees
- Number of Dependents
- Number of Members (Employees and Dependents)
- **Income (Checks received from Regional Partners)**
- **County Administrative Fees**
- **Provider Administrative Fees**
- **Stop Loss Fees**
- **ACA Fees (PCORI and Reinsurance)**
- **Shared Services Fees**

- **Claims Paid**
- **Adjustments to Claims**
- **Stop Loss Reimbursements**
- **Reserve Balance**

Bolded Black = Positive Amount
Bolded Red = Negative Amount
Bolded Blue = Positive or Negative Amount

Management's Response

The County agrees that an independent review of rates and reserve requirements is paramount to ensure the financial viability of the Plan. As part of the new Healthcare Consultant Agreement - the County will engage an independent Actuary to perform a third-party audit of the Consultant's recommendations.

The County recognizes the need to establish an appropriate reserve fund. With the corrective restatement of cash reserves between the Regional and County Plans and increasing claim liabilities, the County is reviewing the Independent Actuarial Reserve recommendation to increase our cash reserve. The Fiscal Office is also reviewing a recommendation to adopt a more conservative reserve recommendation to set aside additional monies to offset unanticipated increases in the frequency and level of catastrophic activity.

SOC Reporting

The American Institute of Certified Public Accountants (AICPA) has mandatory and optional reporting for service organizations. These are referred to as Service Organization Control (SOC) reports and are completed by the service organization's auditor. The SOC 1 report is required if external auditors need to rely on the service organization's internal controls for financial reporting and their ability to achieve related control objectives. The optional SOC 2 report is for controls at service organizations relevant to security, availability, processing, integrity, and confidentiality. The SOC 2 report is intended for management's use. The SOC 1 and SOC 2 have two types. Type 2 reports are more comprehensive than Type 1 reports, and include an opinion on the operating effectiveness as well as a detailed description of the service auditor's test of controls.

The County utilizes EBI and WIQ for consulting and administrative services related to health benefits offered to County and Regional employees and their dependents. EBI and WIQ are commonly owned companies that collect, disseminate, and store personal medical information for employees and their dependents. In 2015 WIQ took over the administration of the County's Health Reimbursement Account (HRA) program. With the HRA account, WIQ is responsible for

processing and recording financial transactions, requesting funding from the County, and making payments to the credit card company.

EBI does not have either SOC audit. EBI stated there is no requirement for them to complete SOC reporting since they do not handle financial transactions. Since WIQ is responsible for HRA transactions beginning in 2015, the company will likely be responsible for completing a SOC 1 report in 2016.

The County does not contractually require EBI or WIQ to complete SOC reports. Without independently verifying if EBI or WIQ have adequate controls for financial reporting, security, availability and privacy the County cannot assure their financial data is accurate or that their confidential information is secure.

Recommendation

DIA recommends the County contractually require EBI and WIQ to complete SOC reports based on services provided. The SOC 2 report should be required from EBI if the determination is made that EBI does not process financial transactions and the County does not rely on EBI for financial reporting. In 2016, WIQ should be required to complete the SOC 1 report as the company is responsible for handling HRA financial transactions. We recommend EBI and WIQ complete type 2 reports for the SOC reports due to their comprehensiveness and added detail. DIA did receive notification from WIQ that a SOC 1 report is anticipated for 2015 and will be completed during the 2nd quarter of 2016.

Management's Response

DIA asserts that the County cannot assure the confidentiality of information managed by EBI or WellnesslQ due solely on their lack of SOC1 and SOC2 status. Upon initial review of potential vendors, the County's selection of EBI and WellnesslQ considered the importance of protecting the confidentiality of our members' personal health information. Furthermore, the County, EBI and WellnesslQ maintain the appropriate Business Associate agreements to ensure the protection of confidential Protected Health Information (PHI) on behalf of our participants.

It is important to note that completion of the SOC1 and/or SOC2 do not in and of themselves ensure the vendor's ability to guarantee security. Consideration of appropriate safeguards and certifications remains a key component of our vendor evaluation process.

The County believes our new and future partners will maintain controls in excess of the necessary standards for financial reporting, security, availability and privacy.

Auditor's Response

Management's response only addresses confidentiality of data. SOC1 and SOC2 reports are also necessary to provide assurance that controls over the processing of accounting data are in existence and operating at EBI and WIQ.

HRA Financial Accounting and Reporting

Generally Accepted Accounting Principles (GAAP) and the Governmental Accounting Standards Board (GASB) require the reporting of contingent liabilities and prepaid assets in the government-wide financial statements. Contingent liabilities are potential obligations that may be incurred depending on the outcome of a future event. They are recorded if the outcome is probable and the amount can be estimated. Prepaid assets are expenses that have been paid in advance for services not yet rendered.

The County's health reimbursement account (HRA) has attributes that meet both of these financial reporting requirements. If a qualified employee meets certain milestones of the wellness program the employee can accrue credits to be used towards medical expenses on a debit card. Once a certain level of credits is accumulated the employee will be assigned a status in the wellness program. Employees who reach the "Platinum" and "Gold" status can rollover a percentage of the accrued health benefits from one benefit year to another, otherwise the benefits expire in the year incurred. The liability incurred from the rollover benefits represents a contingent liability to the County. DIA inspected the 2014 Comprehensive Annual Financial Report (CAFR) and was unable to identify a contingent liability in the report that could relate to the HRA program. The estimated value of the contingent liability at December 31, 2014 was immaterial to the financial statements at approximately $89,245.

Beginning in January 2015, the HRA bank account is maintained and monitored by WIQ. Payments made to WIQ for the HRA bank account are recorded as expenditures in the County's accounting system (FAMIS). However, the balance unspent at year-end should be reflected in the CAFR as a prepaid asset. DIA inspected the 2014 CAFR and could not identify a prepaid expense asset line item. DIA confirmed with the previous administrator (MHS) the ending balance of the HRA bank account at December 31, 2014 was $5,897.20. We averaged the first six months' ending balance of the HRA bank account in 2015 to determine the approximate dollar amount that should have been recognized in the CAFR as a prepaid expense but determined the estimated amount was immaterial to the 2014 financial statements.

Benefits and the Fiscal Office do not have any procedures in place to ascertain the outstanding liability pertaining to the HRA program, or any ongoing monitoring of the HRA bank account balance. Therefore, the County is unaware of the outstanding liability created by the program or the prepaid asset as reflected by the HRA bank balance at any point in time. Without controls in place, noncompliance with GAAP and GASB requirements will continue into future reporting periods.

Recommendation

DIA does not recommend a prior period adjustment for 2014 as the amounts are immaterial to the 2014 financial statements as a whole. The Fiscal Office should request detailed information for the HRA rollover credit from WIQ to recognize a contingent liability at 2015 year-end. Additionally, the Fiscal Office should request a year-end reconciled bank balance for the HRA bank account. The balance should be recognized as a prepaid asset in the Statement of Net Position as required by GAAP and GASB.

Management's Response

The HRA program administered by WellnesslQ has been terminated and our temporary replacement vendor, Mutual Health Services is appropriately equipped in assisting the County with the management of this Plan.

DIA's assertion on the lack of process or procedure in place to ascertain the outstanding liability of the HRA is erroneous. The Fiscal Officer and Human Resources Department were monitoring the outstanding liability of this program during WellnesslQ's administration of the Plan.

Auditor's Response

As of June 30, 2016, Benefits has not provided the liability or pre-paid asset amounts to the Fiscal Office for inclusion in the County's CAFR.

COBRA Administration-Regional Partners

COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985) administration is an important process for the County and Regional Partners. COBRA is a supplemental insurance policy providing temporary health insurance to eligible workers and their dependents after a qualifying event occurs. Qualifying events include: voluntary or involuntary termination, reduction in hours, divorce, or loss of dependent status. COBRA administration consists of notifying employees and their dependents that they are eligible for COBRA benefits upon a qualifying event. All Partners and the County should communicate and agree upon the way COBRA benefits are handled.

DIA conducted substantive tests on employees identified as potentially having medical plan coverage beyond their termination date. As of the date of this audit report, these employees are being reviewed by Benefits to verify our results and also determine claims paid on those employees. These results will be reported in Phase II of the Healthcare Benefits Program Audit.

DIA conducted tests on 14 Regional Partners to determine how each Partner administers COBRA. Only 14 Regional Partners were chosen since these Regional Partners had employees that appeared to have medical plan coverage beyond their termination date. In that request, we asked for information on how they administer COBRA benefits.

DIA received responses from all 14 Partners, but one Partner was not with the program as of June 30, 2015 and did not respond with their COBRA administration process. We noted COBRA administration was not consistent among the 13 Partners for premium receipts and claim payments. One of the 13 Partners retains the premiums and is responsible for paying claims associated with the medical plans. The other Partners remit the premiums to the County and the liability for the claims resides with the County.

The inconsistencies noted above were due to a lack of defined COBRA administration responsibilities between the County and Regional Partners. DIA inspected all 14 contracts and noted 13 did not contain a provision addressing COBRA administration responsibilities.

If noncompliant with COBRA requirements, the County and/or Regional Partners could face the following significant penalties:

- Excise tax of up to $100 per day per violation for each qualifying beneficiary during the noncompliance period. (Minimum fee for noncompliance finding from IRS is $2,500 up to a maximum of $500,000).
- Liability for payment of health care claims and fines for eligible beneficiary not offered COBRA.
- Civil lawsuits.
- Attorneys' fees and interest.

Recommendation

The administration of COBRA should be clearly defined between the County and Regional Partners involved in the Program. COBRA notification to eligible employees as well as premium and claims payments for Regional employees, or their dependents, should be clearly defined and agreed upon in Regional contracts with the County. This should be consistently applied for all Regional Partners. DIA recommends Regional Partners have the responsibility of administering COBRA and billing and receiving COBRA payments. The County should be notified of COBRA status so SAP can be updated. The County should continue to bill the Partner and pay claims until COBRA benefits expire.

Management's Response

The County believes that administration and compliance with COBRA guidelines on behalf of Regional Partners remains an employer responsibility and therefore the role of the Regional

Partner. We do not believe the County was at risk or suffered any disadvantage from allowing the Regional Partners to manage COBRA through their preferred solution.

The County does recognize a need to assist our Regional Partners with a more standardized process of administering their benefit programs and we are working on solutions which leverage technology to integrate administration, billing and employer responsibilities like COBRA as part of the program's evolution in the future.

Revenue Cycle (including premium billing)

The County is responsible for billing and collecting premiums from Regional Partners enrolled in the Program. Key controls should be in place to reduce risks in the revenue cycle. Physical safeguards should be implemented on checks received. An essential aspect of internal controls over the revenue cycle is proper segregation of duties.

DIA identified the following procedures lacking sufficient internal controls in the revenue cycle of the Program:

- One employee is assigned the duty of invoicing the Regional Partners, collecting their checks, completing revenue receipts, depositing checks with the Treasurer's Office, and reconciling amounts billed to the amount collected. This represents a complete lack of segregation of duties in the revenue cycle.
- No reconciliation is done to compare the internal database (SAP) records for Regional employee eligibility to that of the providers' eligibility records.
- No reconciliation is done to compare the amounts recorded in FAMIS to the amounts received by the Benefits department.
- Amounts received from the Regional Partners are not posted in FAMIS by Partner. One amount is included on the revenue receipt for multiple Partners' checks.
- Revenue receipts are not signed by a supervisor prior to the checks being sent to the Treasurer's Office for deposit.

DIA conducted additional substantive tests on 110 Regional employees that were identified as potential employees with medical plan coverage beyond their termination date. As of the date of this audit report, these employees are being reviewed by Benefits to verify our results and also to determine claims paid on those employees. These results will be reported in Phase II of the Healthcare Benefits Regionalization Program Audit.

For this report, the 110 Regional employees were selected to verify proper cut-off in premium billing. Specifically, we attempted to 1) confirm terminated Regional employees were not billed in subsequent months after termination and 2) confirm Regional employees were included on the invoice in the month they were terminated and the month prior to termination. The table on the following page shows the number of employees that were included on invoices in subsequent

months after their termination date and the number of employees not on the invoice for the month they were terminated from January 1, 2011 through June 30, 2015. DIA was unable to find proof that adjustments for the discrepancies were made on invoices in subsequent months.

Year	Number of Terminated Employees the County Billed Partner for	Average Number of Months Regional Partner was Billed for Terminated Employee	Total Amount of Over Billings	Number of Employees County Failed to Bill Partner in Month Employee was Terminated	Total Amount of Under Billings
2011	2	2	$2,105	1	($872)
2012	3	2	7,217	0	0
2013	2	1	3,146	0	0
2014	10	4	26,937	9	(11,234)
2015	6	1	9,077	0	0
Total	23		$48,482	10	($12,106)

During 2014 one employee was included on a bill for 13 months after termination, resulting in $5,928 in overbillings during the 13 months.

Testing shows the County has experienced a billing error rate of 30% (33 errors on terminated employees compared to 110 sampled) over the past five years. DIA was not able to determine which party was at fault for the billing errors identified above. We noted the Regional contracts do not specify which Partner, County or Regional, is responsible for claims paid after an employee has been terminated due to the Regional Partner's failure to notify the County of an employee's termination.

Lack of training and competency in the revenue cycle has resulted in poor controls and billing errors. The revenue cycle processes were not designed with best practices, such as proper segregation of duties, in mind. Lack of effective internal controls over the receipt and billing cycles has led to incorrect billing and increases the risk of unauthorized transactions, misappropriation of cash, and unreconciled differences in financial records.

Recommendation

DIA recommends the following changes to improve the internal controls over the revenue cycle of the Program:

- The process of billing and receiving payments should be segregated. One employee should complete the billing process, which includes updating the spreadsheet on billed amounts. A second employee should receive the checks and reconcile the received amounts to the billed amounts. Any discrepancies should be further investigated and documented. The second employee should complete the revenue receipt to be deposited with the Treasurer's Office. An immediate supervisor should sign off on the revenue receipt prior to depositing. A third employee or the immediate supervisor should

reconcile the received amount recorded in FAMIS. Any amounts billed, but not received, should be reviewed and the Regional Partner contacted, if necessary. Any amounts not collected should be approved by the supervisor with a reason noted.

- Unless the County creates a revenue receipt with multiple lines to post revenue in FAMIS by Partner, a revenue receipt should be completed for each Partner when a check is received. This will also help to perform monthly reconciliations on reserve balances for each Partner.
- Revenue receipts should be reviewed and signed by an immediate supervisor prior to depositing with the Treasurer's Office.
- Prior to preparing monthly bills, the County should request a current eligibility list from each Regional Partner. This eligibility list should be accompanied by a "change in benefits form" for new hires, terminations, or eligible life events in the past month. Any changes should be accurately updated in SAP. After changes are made in SAP, eligibility lists from the Regional Partners should be compared to invoices generated from SAP. In addition, eligibility files from the providers should be compared to Regional members billed and Regional members in SAP. Any discrepancies between these final reviews should be investigated.
- Contracts between the County and Regional Partner should state which party is responsible for claims paid after an employee has been terminated. If the Partner does not timely notify the County of the termination, the County should seek reimbursement for the claims paid from the Partner to reimburse the Regionalization Self-Insurance Fund. If the employee was included on the invoice, the County should seek reimbursement from the Partner less the premium paid for the employee.

Management's Response

As acknowledged earlier, the County continues to evaluate all aspects of the Regional Healthcare Plan, including appropriate processes and policies around billing and revenue collection. To ensure we improve the Regional Partner experience and establish greater accuracy moving forward, the County is establishing redundant processes with "backup staff" and cross trained departmental personnel.

Invoice and Encumbrance Supervisor Approval

All disbursements of Cuyahoga County funds should be approved for payment by an authorized approver. Approval of expenditures ensures that all monies being disbursed are for a proper public purpose, relate to the department and purpose which is being charged, that required supporting documentation has been obtained, and items and/or services have been received. Authorizing disbursements is considered to be a critical preventive control in the disbursement process. Furthermore, it is imperative to develop a system of controls where

disbursements being charged to a certain contract are being reviewed on a timely basis by obtaining and reviewing the detailed expenditure ledgers. Reviewing expenditures posted to the accounting system ensures the payments are posted in the correct amount, are posted to the proper account, and provide a means to determine whether duplicate payments were made for the same invoice. Reviewing disbursements is also considered to be a critical detection control in the disbursement process.

All encumbrance vouchers and invoices during the audit period lacked evidence of approval from a Benefits supervisor or the HR Director. These encumbrance vouchers consisted of payments to EBI, WIQ, MMO, UHC, and CVS.

Failure to have a process in place to ensure that all contract disbursements are authorized and reviewed by appropriate individuals has resulted in payments being made to the wrong vendor, duplicate payments, or payments being made outside of management's expectations.

Recommendation

All disbursements must be authorized and reviewed by appropriate individuals. Implemented control procedures which show that a level of authorization and review has been performed should be evidenced by initials, dates, check marks, etc. prior to payment on invoices and vouchers. Approval of the voucher should be from someone other than the employee that initiated the payment.

Management's Response

The County's Fiscal Office has the appropriate policies and procedures in place. This department is auditing the approval sequence to ensure compliance with the appropriate policies and procedures moving forward.

Vendor Checks Held for Pick-Up

The Accounts Payable function in the Fiscal Office of Cuyahoga County serves as the center for processing, paying, and mailing disbursements for all County related expenditures. This structure of government is set up in order to eliminate any fraud risk factors in the process of handling monies.

During our expenditure test on payments to Benefits' vendors we noted that "PLEASE HOLD CHECK FOR PICKUP" was stamped in red ink on encumbrance vouchers. 45 out of 46 encumbrance vouchers for payment to EBI and WIQ were stamped to be held for pick-up.

The practice of not allowing the Fiscal Office to mail checks directly is considered a fraud risk factor. Furthermore, the risk of checks being mishandled by unauthorized personnel and the potential for fraud increases when checks are not mailed immediately after issuance.

Recommendation

DIA recommends that all checks be mailed directly by Accounts Payable. Accounts Payable should be responsible for sending any remittances or support that must be accompanied with the check.

Management's Response

The County recognizes the high number of payments identified on a "pickup" basis on behalf of EBI and WellnesslQ which is not unlawful. Regardless of the method of payment, the County will continue to ensure that payments to all vendors are appropriate.

Auditor's Response

The Auditor recognizes the process of holding checks for pickup is not "unlawful" and may be necessary under certain circumstances. However, making "Hold for Pickup" the normal process as evidenced by our testing is a fraud risk factor.

Accounting for Wire Payments

Posting receipts and expenditures in FAMIS should be completed in a timely manner along with adequate detail to accurately reflect the current financial position of the organization. Failure to timely post transactions to FAMIS may result in financial reporting issues in recording transactions in the correct period.

DIA selected 27 wire transfers to medical providers from January 1, 2011 to June 30, 2015 and calculated the amount of days between the wire transfer date and FAMIS posting date. The average number of days between the wire transfer date and the FAMIS posting date was over 12 days ranging from zero to 69 days.

Recommendation

Wire payments to medical providers should be posted in FAMIS in a timely manner, within 3 business days of the wire transfer. Benefits or the Fiscal Office should review FAMIS to assure wire payments are accurately posted in a timely manner.

Management's Response

The County's Fiscal Office has the appropriate policies and procedures in place. This department is auditing the approval sequence to ensure compliance with the appropriate policies and procedures moving forward.

CVS Group Identifiers

The establishment and maintenance of provider group identifiers should ensure the integrity and consistency of data the County receives from CVS and medical providers. The group identifiers allow internal staff to allocate the costs of medical benefits between the County and Regional Partners. Additionally, the identifiers allow for the comparison of costs by Partner and the identification of claims' trends.

Group identifiers for CVS and medical providers are created and stored in SAP. Monthly, the SAP file is transmitted to the providers with updated participant eligibility. The providers update their systems with the County's information. CVS Regional group identifiers for the period of January 1, 2014 through July 24, 2015 were found to be inconsistent and overly complex. DIA was not provided with CVS data prior to January 1, 2014. The following issues were noted:

- The total number of group numbers used for Regional Partners was 25, but there have only been 20 Partners to ever enroll in the program. Of the 25 group identifiers only 15 conform to a text length of 12. The remainder range in length from nine to 14 characters. The first digits in the group identifiers begin with "RG" or "CYHGA". 22 out of 25 group identifiers for Regional Partners begin with "CYHGA". Confusion between Cuyahoga County and Regional Partner employees could occur when allocating costs between the two programs.
- There are two group identifiers that represent the same Regional Partner without any differing factor, such as bargaining versus non-bargaining employees.
- 68 group identifiers were noted for the County. Of the 68 identifiers, 65 conform to a text length of 12. The remainder range in length from 10 to 11 characters.
- County identifiers could not be matched to a particular group (union) or department.
- The first digits in the County's identifiers begin with "CBRAS" or "CYHGA." There is no specific reason for the usage of "CBRAS" as an identifier.
- There are 23 group identifiers that contain "BOCC", which refers to the Board of County Commissioners. The County is no longer under this form of government.
- No data dictionary is maintained by the County that matches each group identifier to a specific Partner, or County group.

Benefits and the Information Technology Department are aware of the complicated system and stated changes will be made in 2017. No explanations were given on the above mentioned issues.

Difficulties in allocating Regional and County claims in the financial records have occurred with the current group identifiers. This leads to inaccurate County financial reports between the County and Regional Self-Insurance Funds. Furthermore, the County's current way of tracking group identifiers has resulted in rate and plan errors going undetected.

Recommendation

DIA recommends that Benefits, in conjunction with IT, address the CVS group identifier issues by developing internal controls and processes that encompass the following:

- The number of group identifiers for Regional Partners should be reduced to the minimum amount required to properly track the associated costs and plans. As of October 2015, the number of Regional Partners in the program was 19.
- The number of group identifiers for the County should be reduced to the minimum amount required to properly track all the associated costs and plans. This minimum number may be one.
- The text length should be consistent and a parameter should be established in the SAP database to track information within the County to ensure data uniformity.
- The naming convention for Regional Partners should all begin with "RG" to clearly identify Regional employees and "CYHGA" for the County group. The acronyms used to identify the Regional Partners should clearly identify which Partner they pertain to. All data identifiers that contain "BOCC" should be changed since this form of government no longer exists.
- A data dictionary addressing all group identifiers for CVS and medical providers should be developed.

Changes to group identifiers should begin as soon as possible so the County can increase the accuracy of reports, simplify analysis of data, and be prepared to smoothly transition to the new Enterprise Resource Planning system.

Management's Response

The County acknowledges DIA's findings and human resources had already initiated a process to adjust CVS group identifiers to create a more aligned structure to ensure data, payments and information is tracked on the easiest and most accurate basis.

Vendor Information in FAMIS

Vendor names and contract numbers should be correctly recorded in FAMIS. The County should have adequate procedures in place to assure FAMIS information agrees to contract information approved by Council or the Board of Control. Failure to record contract information accurately could result in expenditure misstatement and payments being made to wrong vendors.

Information from the WIQ contract with Benefits was inaccurately recorded in FAMIS when Benefits first contracted with WIQ in 2012. The contract (CE-1200077) was from January 1, 2012 to December 31, 2014. The correct encumbrance of the contract was entered into FAMIS; however, the contract name was entered as "Employee Benefits International" and not “Wellness IQ”. This error resulted in checks being issued to EBI instead of WIQ from January 1, 2012 to March 5, 2015 when the current Fiscal Officer noted the issue. Even though checks are currently being issued to the correct payee, the contract name in FAMIS is still recorded as EBI.

Recommendation

DIA recommends Benefits and the Fiscal Office review and correct contract information in FAMIS. “Wellness IQ” should replace “Employee Benefits International” as the contract name in contract number CE1200077.

Management's Response

Due to confusion regarding vendor and Employer Identification Information, the County's FAMIS reporting system incorrectly identified EBI as the name on CE1200077.

The County's Fiscal Office has the appropriate policies and procedures in place. This department is auditing the approval sequence to ensure compliance with the appropriate policies and procedures moving forward.

Benefit Change Request from Regional Partners

Benefits is responsible for updating regional employees’ eligibility with the providers. All benefit changes are communicated from the Regional Partners to Benefits by email or phone throughout the year. The online enrollment tool provided by the County is only utilized during open enrollment. Having adequate and consistent procedures in place to assure timely and accurate benefit changes is crucial to the Program's operations.

All Regional Partners communicated benefit changes via phone or email. No consistency in the way benefit changes are communicated to Benefits was noted. If a benefits change is made by email, a benefits change form is completed by the Regional Partner and sent to Benefits. This form is completed and signed by the regional employee. No signature or initials are noted on the form by Benefits to confirm the change is made in SAP.

Benefits does not have formal procedures to apply consistently across the Program on benefit changes. Failure to implement consistent procedures could result in untimely or incorrect changes to employee benefits which could lead to claims and fees being paid for ineligible employees or the rejection of claims for eligible employees or their dependents.

Recommendation

DIA recommends Benefits implement and enforce written formal procedures on benefit change requests from Regional Partners. The procedures should require consistency across the Program in how benefit changes are communicated. We recommend benefit changes be communicated to Benefits through email or other electronic methods, which may be the online tool provided by the County. Monthly, the Benefits Manager should review all change requests to assure the changes were accurately and timely updated in SAP. If a benefits change form is utilized, Benefits should sign-off on the form when the change is made in SAP.

Management Response

Human Resources and the County's new Healthcare Consultant are currently evaluating this procedure and working to establish a more efficient and accurate process moving forward.

Staffing Level

The County should have sufficient staffing to ensure proper administration and oversight over the Program. Staffing levels should assure proper segregation of duties exist over the receipt and disbursement cycle of the Program. The internal work handled for the Program is not complex, but there are many transactions and processes required to run the program effectively.

As of the date of this report, the Program has one part-time employee in Benefits and a full-time employee in the Fiscal Office. These staff members are responsible for the following procedures:

- Monthly invoices prepared and sent to 17 of the 19 Partners enrolled in the Program as of October 2015. EBI provides services to send the remaining two Partners' invoices due

to previous errors by the County which may have been due to a lack of resources on the County's side.

- Collection of checks from Regional Partners. The amount of funds receipted in 2014 was over $18 million and the amount expected to be received in 2015 is over $20 million. The staff members also collect stop loss reimbursements for the Program.
- Preparation and approval of documentation to record revenue in FAMIS and deposit with the Treasurer's Office.
- Reconciliation of amounts billed compared to amounts received.
- Review and authorization of any adjustments to Regional account balances.
- Addition, deletion, or modification of Program members in SAP.
- Preparation and approval of documentation to pay medical providers, stop loss carrier, and ACA fees.
- Allocate premiums and stop loss reimbursements between County and Regional Self-Insurance Funds.
- Review and reconciliation of support to revenue and expenditure postings in FAMIS.

The current staffing levels lack segregation of duties over the custody, recordkeeping, and approval of transactions for the receipt and disbursement functions of the Program.

There is no evidence to show the County has reviewed the current staffing level in the Program. Segregation of duties cannot be maintained with the current staffing levels and work assignments. This increases the risk for material misstatements, inability to plan or project net reserve balances for Partners, potential for errors over administration of the Program, and potential for fraudulent reporting or theft.

Recommendation

DIA recommends Benefits perform an analysis on current staffing levels while considering the necessary functions of administering the Program. The County should consider increasing staffing levels on administrating the Program to two full-time staff members. Furthermore, the County should assure the appropriate administration rate is charged to each Partner to cover salaries, benefits, and supplies of personnel working on the Program. This will allow the Program to function properly while minimizing the potential for any errors or fraud. See the finding titled **County Administrative Fees on page 17** for additional information.

Management's Response

Human Resources and the County's new Healthcare Consultant are currently evaluating overall operational efficiency and working to establish a more efficient and accurate orientation moving forward.

Policy and Procedure Manual

Written policies and procedures ensure consistency in the operations of a department. Existence of codes of practice and other regulations or guidance regarding acceptable practices, conflicts of interest, or expected standards of ethical and moral behavior, and their communication throughout the organization is an essential part of a policy and procedure manual. Furthermore, a policy and procedure manual assures consistency in day-to-day operations. Formalized procedures reinforce management's expectations for the department.

Benefits does not have formal written policies and procedures for the management and operation of the County and Regional Benefit Program. Failure to have some form of internal guidance may result in undefined procedures that can lead to inconsistency in the operations of the Department as well as actions and discipline that are inconsistent with the intentions of management.

Recommendation

DIA recommends Benefits develop formal written policies and procedures that include, at a minimum, the following items:

- Documentary flowcharts or narratives of significant operational cycles describing significant steps and procedures for each cycle as well as methods of accounting for each type of transaction (e.g. steps for billing, handling checks, receipting revenue, monitoring members and rates).
- Documentation of all accounting procedures performed, including reconciliations and review procedures (e.g. who is responsible for reconciling revenue to support and accounting system, how to handle variances between checks received and invoices billed, approval and review of revenue and expenditures).
- Monthly billing, receipt, and disbursement processes.
- Record retention.
- Safeguard procedures (including cash, computer, and physical controls as well as securing personal information).
- A list of standardized forms utilized including a description of their purpose.

Management's Response

None received.

Subsequent Event

On January 6, 2016, the County sent Wellness IQ and EBI a termination notice regarding any and all contracts the County had with Wellness IQ and/or EBI. Pursuant to the termination provisions in the respective contracts, the Wellness IQ contract terminated within 30 days of that termination notice and the EBI contract terminates within 90 days of the termination notice. Replacement of these services is currently being evaluated based upon responses given to an RFP issued on January 14, 2016 that closed on February 8, 2016.

Phase II Reporting

The following bullet points will be addressed and reported on during the Phase II portion of this audit:

- Recalculation of the Program's reserve balance by Partner and as a Program.
- Recalculation of the amounts that should have been posted in the Agency, Regional Self-Insurance County, Self-Insurance, and the County Regular Insurance Funds
- Results of provider claims, administrative fees, and stop loss fees paid for ineligible Regional employees and dependents.
- Recalculation of County employee and employer contributions for medical, eye, and dental insurance. Assure proper accounting for contributions and contributions were sufficient to cover County claims and fees.
- Results of COBRA compliance testing.
- Results of FMLA controls and substantive testing.
- Evaluation of payments to all contractors.
- Follow-up on support not obtained as identified in this report.
- Updates to any comments issued in the Phase I report.

June 9, 2016

Valerie J. Harry, CPA
Director of Internal Auditing
Cuyahoga County
2079 East 9th Street, #7-200
Cleveland, Ohio 44115

RE: Internal Audit Report Health Care Benefits Program Phase I

Dear Mrs. Harry:

On behalf of the Department of Human Resources at Cuyahoga County I would like to thank you for the opportunity to respond to the findings from the above audit. The County strives to provide employees and dependents of the County and our regional partners with access to high quality, affordable healthcare coverage. The County's staff takes great care to administer this complex program with an understanding of Federal and State guidelines along with administrative best practices.

The purpose of our response is to acknowledge, clarify and identify corrective actions in relation to the findings of your independent audit presented for our final review on June 6, 2016.

Items Related to Professional Healthcare Consultant

As noted in your findings, on January 6, 2016, the County sent EBI and Wellness IQ a notice terminating any and all contracts that the County had with EBI and Wellness IQ. Although professional services contracts are not required to be competitively bid and the County laws allow the County to take advantage of exemptions to the competitive bidding process, the County went through a competitive process to obtain a new Healthcare Consultant and is going through a competitive process to obtain a wellness provider.

Noted Concern - overall payments to EBI:
To ensure the County's contractual provisions and pricing were indeed honored, the County and our new Healthcare Consultant will be working to ascertain and audit all payments related to EBI, EBI's SBE partner, and WellnessIQ for the period of May 1, 2009 forward.

Noted Concern – WellnessIQ potential conflict of interest due to EBI ownership:
While the County is aware of some potential overlap in ownership/common ownership with WellnessIQ and EBI, (i.e., one or more people may be partial owners of both EBI and Wellness IQ), the County selected WellnessIQ as our service partner beginning approximately January 1,

2012 through a competitive process. Wellness IQ was selected due to their overall combination of value, price and scope. The County maintains a number of vendor contracts where multiple services are provided and we do not believe some overlap in ownership poses a conflict of interest. In addition, Wellness IQ and EBI performed different services for the County.

Noted Concern – Consultant's over-extension of authority in managing regional plan:
The County's Regional Healthcare Plan is one of many ways we are working to assist our partners in the region to secure alternatives to traditional purchasing processes. Through our collective buying power, regional partners are able to secure quality coverage through a more affordable means. While it remains the County's objective to provide this access on a basis which is cost neutral to the County, we are currently evaluating the process, efficiency, value, long term goals and orientation of this program.

Noted Concern – Evaluation of financial viability and collection procedures:
The County has not experienced any inability to pay or delay in payment while operating this program.

The evaluation of financial viability, establishment of payment guidelines and adherence to policies which ensure redundant collection procedures are three of many operational items contained in our ongoing evaluation of the regional plan. In partnership with the County's new Healthcare Consultants, law department and fiscal officer, the County is analyzing the comprehensive set of processes, guidelines and audit procedures in place. The County is also verifying the appropriate and redundant adherence to these guidelines.

Noted Concern – Rate setting and plan offering:
The County respectfully disagrees with the auditor's findings concerning deficits and subsidization.

The County and the Regional Healthcare Plan are able to meet all financial obligations for payment of claims, expenses and reserves. The County is actively analyzing the rate methodology and underlying financial mechanics of both programs. The County's objective remains to leverage our collective buying power to provide employees and dependents of the County and our Regional Partners with access to high quality, affordable coverage. While we believe there are areas where we can continue to improve our value, efficiency, internal process and procedures, the program remains financially viable and able to meet all payment obligations.

Non-Compliance Findings

Noted Concern – No language citing ORC section 9.833 or statements the Regional Partner was a part of a self-insurance risk pool was found:

The contracts and program is in compliance with O.R.C. 9.833. The County's intent, and understanding from all Regional Partners is that coverage is provided through a self-insurance risk pool as further described below.

Noted Concern – No reserve fund has been established pursuant to a resolution duly adopted by Council for this Program:
Pursuant to the requirements of ORC 9.833, the County's Fiscal Officer and new Healthcare Consultant have secured guidance from an independent Certified Actuary to review potential reserve requirements and ensure their appropriateness moving forward.

Noted Concern – There is no agreement that a political subdivision may assume the risks of another political subdivision and the County may be liable for the Regional Partners' costs if they exceed premiums without having a contractual agreement:
Regional Partners participate in a collective joint self-insured pool on a guaranteed cost basis. Participant Agreements outline the provisions of Regional Partners who are contributing fully funded premium equivalents toward the Regional Healthcare Pool. These agreements specify that Partners are not able to share in proceeds, nor will they be liable for deficits. The goal of the Regional Healthcare Pool fully funded premium equivalents is for the pool to operate on a cost neutral basis to the County. The mechanics of this program are consistent with the provisions of ORC 9.833(C)(8).

Noted Concern – According to the Regional Partner contracts, liability for claims and costs after termination of the contract by the County or Regional Partner, is the responsibility of the Regional Partner:
Regional Partners are only required to pay their own liabilities in the event that they default on their Participation Agreement prematurely. The program, and many like it in Ohio setup under ORC 9.833, require that Participants contribute to the program for multiple years to be fully "funded". Participants who terminate the program prematurely are not fully funded and therefore remain responsible for their own incurred but not paid liabilities.

Response to Auditor Recommendations

The Auditor's recommendation concerning reserve fund resolution and the appropriateness of reserve levels will be presented moving forward as part of our rating and renewal process.

Like many aspects of the County's program, the County's new Benefits Advisory Committee and Healthcare Consultant will review the terms and provisions contained in our Regional Partner Participation Agreements to ensure compliance with all Federal and State guidelines along with common best practices.

The County has created a Benefit Advisory Committee which will be staffed with multiple departments including Human Resources, the Executive's Office, the Fiscal Officer, the Law Department and our independent Healthcare Consultants. This Advisory Committee will be

tasked with auditing all processes, procedures and guidelines as it relates to overseeing the Regional Plan.

EBI and WellnessIQ Contracts

As stated earlier, the County has terminated all agreements with EBI and WellnessIQ. The County has created a process, procedure and corresponding scope of services for the replacement vendors which will require more detailed accountability for services performed on behalf of the County and the Regional Plan.

The County and its new Healthcare Consultant are actively reviewing the accounting and allocation of time, services and payments to EBI and WellnessIQ to ensure that Regional Partners were appropriately charged during their participation in the program. It is also important to note that any expansion (including non-ORC Regionalized development opportunities) is pending further review.

County Administrative Fees

Based upon the information available at this time, prior to 2016, the County recovered necessary administrative expenses through the premiums charged to Regional Participants as part of the premium. Entering into the current rating period, additional workload required to comply with reporting for ACA coupled with an evaluation of the program, participation agreements and departmental resources required an increase to the administrative expense levied by the County. In addition, due to ACA regulation and reporting requirements, the County identified and separated the contractual surcharge as a separate line item for all participants beginning January 1st.

Prior to the release of this audit, the County began accounting for administrative fees separately in order to better track, monitor and allocate resources to operate the program.

The County remains determined to find opportunity to leverage technology and create efficiency. It is our goal to ensure the program remains cost effective to both the County and our Regional Partners. Through recent enhancements to our service approach and via new support initiatives with our vendor partners, members are beginning to see more meaningful value from this program.

The County's Benefit Advisory Committee will review a complete and transparent review of County expenses prior to rate development in future periods. Components of program expense, including all aspects of rating, administrative charges, risk charges and claim projections will be reviewed.

HRA Utilization/Operations

The County believes the overall health and wellness of our workforce is an important part of not only controlling healthcare expense but improving the lives of our employees. We are currently working on new strategic objectives and opportunities to make our commitment to overall employee engagement more widely adopted and meaningful.

The County acknowledges that administrative procedures and accountability relative to the Health Reimbursement Account by WellnessIQ were not consistent with best practices necessary to operate accurately. The agreement with WellnessIQ has been terminated, Mutual Health Services has resumed operations of the Health Reimbursement Account on a temporary basis and a new Request for Proposal (RFP) has been issued for a replacement wellness plan vendor.

As part of the RFP recently issued, appropriate accounting, eligibility and process will be contractually outlined to ensure compliance with the appropriate safeguards.

Provider Expenditures Exceeding Appropriations

The County acknowledges the Auditor's recommendation that all appropriations for medical and pharmacy claims and fees be approved before the plan year begins and will take it under advisement.

The County does want to acknowledge the complexity and potential uncertainty around operating a self-insured plan for nearly 8,000 employees. Due to changing healthcare trends, new technologies, pharmaceutical inflation, enrollment fluctuations and the somewhat unpredictable nature of catastrophic claims – the County's ability to perfectly coordinate appropriations to expenditures cannot be exact.

The County is evaluating different methods to enhance the accuracy of our appropriations approach for 2017. Due to the timing of the appropriations process requiring resolutions in advance of open-enrollment – there is a high likelihood of population shifts within each of the various plans offered to our participants. Moving forward, the County may propose an overall global appropriation for all healthcare plan expenses along with an updated itemization of plan components following the completion of open-enrollment.

The Auditor also introduces concerns over how stop-loss has historically been purchased. The County is now with a different stop loss provider as of January 1, 2016. As a result of a review of market alternatives, the County was able to secure more competitive pricing and operational terms directly with Medical Mutual of Ohio.

Contingent Premium

The County and Cuyahoga County Board of Developmental Disabilities (CCBODD) have resolved the initial reserve funding discrepancy and the County and CCBODD have modified the agreement effective January 1, 2016 to allow the CCBODD to participate in the County's Plan on

a full cost pass through basis. Final reconciliation of prior years' liabilities and settlement should be completed within the very near future.

ACA Transitional Reinsurance Fees

The County acknowledges the oversight of ACA Transitional Reinsurance Fee payment due to changes in staffing and has setup appropriate redundancies to ensure the proper monitoring controls are in place moving forward.

Invoicing Regional Partners

In partnership with our vendors, healthcare consultant, the Fiscal Officer and our Regional Partners, the County will be evaluating a more efficient and accurate method of plan administration and premium collection. The County's objective remains to provide our Partners with accurate information and make the administration of the program as seamless as possible.

The County will also develop a process which requires regular monitoring and auditing of invoices to payments received by both internal and external partners.

Deposit of Public Monies

The County has a process to ensure all payments are posted to the correct system and deposited on a timely basis in compliance with ORC Section 9.38. Appropriate procedures have been reviewed to ensure ongoing compliance with these processes.

Internal Control Findings

New Entrant and Renewal Procedures

The County is developing a detailed, transparent and accountable process for managing both the County Plan and Regional Healthcare Plan moving forward.

The Benefit Advisory Committee will review the performance of the new Healthcare Consultant to ensure the appropriate controls are established. This group will also remain engaged to ensure the County's management and oversight remains appropriate. Plan management functions will be reviewed regularly and as appropriate.

Net Reserve Comparison by Regional Partner

The County acknowledges the importance of creating a fiscally sound yet efficient rating methodology. The County's Benefit Advisory Committee and new Healthcare Consultant will be thoroughly reviewing the rating of participants in the Regional Healthcare Plan to ensure its long term viability.

The County is conducting a thorough review of rates that will take into account relevant methodologies, updated data and projected future liabilities and necessary reserve levels.

The County has reaffirmed our commitment to maintain the current rates/benefit options to our Regional Partners through the balance of 2016. Regional Partners have been advised of the County's timing and strategic plan development along with our intent to provide an overview of the long term strategy, rates and plan design in or around September, 2016. The County remains committed to continuing, improving and expanding the Regional Plan in the future.

Provider Wellness Subsidy

The County and our new Healthcare Consultant have reviewed the WellnessIQ invoices and carrier subsidies to ensure accurate accounting of all wellness related activities.

The County has already implemented safeguards to separate direct payment of subsidies to third-party vendors. The County and their Healthcare Consultant will manage the tracking of future subsidy sponsorships and amounts received separate and outside of third party service firms.

Stop Loss Transactions

Through our selection of Medical Mutual of Ohio for stop-loss, the County has initiated a process which will ensure greater integration of claim data and potential reimbursements. The County's Fiscal Officer and new Healthcare Consultant are actively reviewing historical claim data, refunds received and contract provisions to ensure the County's reimbursements are accurate and complete.

New Program Participants

As stated earlier, expansion of the Regional Healthcare Plan is temporarily suspended. Further expansion of the Plan along with establishment of new underwriting, evaluation, rating and approval process will be evaluated by the County's Benefits Advisory Committee.

Allocating County and Regional Expenditures

The County's human resources, technology and fiscal departments have been working to recode eligibility tracked by the County and our vendors to ensure claim payments are attributed to the correct population moving forward. The fiscal department continues to review historical allocation of expenses since inception of the Regional Plan to ensure accounting for all expenses has been adjusted.

Advances to the Agency Fund

The Fiscal Department has made corrections with internal accounting, advancements and necessary redundancies to ensure compliance with ORC 5705.41(B) on a go forward basis.

Consulting Fee Payments – EBI and WIQ

The County is evaluating our internal accounting and review processes to accurately assign all expenses and is evaluating wellness vendor partners along with potential fee alternatives.

The County is in the process of verifying the Auditor's findings related to the total amount of the overcharge (if any) from WellnessIQ and the basis for recovery (if appropriate and proper).

Program Reserve Calculation

The County agrees that an independent review of rates and reserve requirements is paramount to ensure the financial viability of the Plan. As part of the new Healthcare Consultant Agreement – the County will engage an independent Actuary to perform third-party audit of the Consultant's recommendations.

The County recognizes the need to establish an appropriate reserve fund. With the corrective restatement of cash reserves between the Regional and County Plans and increasing claim liabilities, the County is reviewing the Independent Actuarial Reserve recommendation to increase our cash reserve. The Fiscal Office is also reviewing a recommendation to adopt a more conservative reserve recommendation to set aside additional monies to offset unanticipated increases in the frequency and level of catastrophic activity.

SOC Reporting

DIA asserts that the County cannot assure the confidentiality of information managed by EBI or WellnessIQ due solely on their lack of SOC1 and SOC2 status. Upon initial review of potential vendors, the County's selection of EBI and WellnessIQ considered the importance of protecting the confidentiality of our members' personal health information. Furthermore, the County, EBI and WellnessIQ maintain the appropriate Business Associate agreements to ensure the protection of confidential Protected Health Information (PHI) on behalf of our participants.

It is important to note that completion of the SOC1 and/or SOC2 do not in and of themselves ensure the vendor's ability to guarantee security. Consideration of appropriate safeguards and certifications remains a key component of our vendor evaluation process.

The County believes our new and future partners will maintain controls in excess of the necessary standards for financial reporting, security, availability and privacy.

HRA Financial Accounting and Reporting

The HRA program administered by WellnessIQ has been terminated and our temporary replacement vendor, Mutual Health Services is appropriately equipped in assisting the County with the management of this Plan.

DIA's assertion on the lack of process or procedure in place to ascertain the outstanding liability of the HRA is erroneous. The Fiscal Officer and Human Resources Department were monitoring the outstanding liability of this program during WellnessIQ's administration of the Plan.

COBRA Administration-Regional Partners

The County believes that administration and compliance with COBRA guidelines on behalf of Regional Partners remains an employer responsibility and therefore the role of the Regional Partner. We do not believe the County was at risk or suffered any disadvantage from allowing the Regional Partners to manage COBRA through their preferred solution.

The County does recognize a need to assist our Regional Partners with a more standardized process of administering their benefit programs and we are working on solutions which leverage technology to integrate administration, billing and employer responsibilities like COBRA as part of the program's evolution in the future.

Revenue Cycle (including premium billing)

As acknowledged earlier, the County continues to evaluate all aspects of the Regional Healthcare Plan, including appropriate processes and policies around billing and revenue collection. To ensure we improve the Regional Partner experience and establish greater accuracy moving forward, the County is establishing redundant processes with "backup staff" and cross trained departmental personnel.

Invoice and Encumbrance Supervisor Approval

The County's Fiscal Office has the appropriate policies and procedures in place. This department is auditing the approval sequence to ensure compliance with the appropriate policies and procedures moving forward.

Vendor Checks Held for Pick-Up

The County recognizes the high number of payments identified on a "pickup" basis on behalf of EBI and WellnessIQ which is not unlawful. Regardless of the method of payment, the County will continue to ensure that payments to all vendors are appropriate.

Accounting for Wire Payments

The County's Fiscal Office has the appropriate policies and procedures in place. This department is auditing the approval sequence to ensure compliance with the appropriate policies and procedures moving forward.

CVS Group Identifiers

The County acknowledges DIA's findings and human resources had already initiated a process to adjust CVS group identifiers to create a more aligned structure to ensure data, payments and information is tracked on the easiest and most accurate basis.

Vendor Information in FAMIS

Due to confusion regarding vendor and Employer Identification Information, the County's FAMIS reporting system incorrectly identified EBI as the name on CE1200077.

The County's Fiscal Office has the appropriate policies and procedures in place. This department is auditing the approval sequence to ensure compliance with the appropriate policies and procedures moving forward.

Benefit Change Request from Regional Partners

Human Resources and the County's new Healthcare Consultant are currently evaluating this procedure and working to establish a more efficient and accurate process moving forward.

Staffing Level

Human Resources and the County's new Healthcare Consultant are currently evaluating overall operational efficiency and working to establish a more efficient and accurate orientation moving forward.

Phase II Reporting & Summary

The County would like to acknowledge the effort behind DIA's review of the operations and orientation of the County and Regional Partners Healthcare Plan.

The County recognizes the importance of managing external consultants with appropriate oversight, transparency and responsible accountability. Prior to the release of this report, beginning in October 2015, the County Law Department implemented a process in partnership with external auditors and industry experts to assist in the review of a variety of concerns discovered by our law, human resources and fiscal departments. As a result of these engagements, many issues contained herein have already been addressed and corrected, in advance of the release of this report.

The County remains committed to ensuring we are effectively managing the resources of our constituents. We remain deeply committed to ensuring the appropriate policies, procedures and redundancies are in place to ensure accountable management of taxpayer resources.

We continue to believe there is great potential to deliver meaningful value through a collaborative purchasing program designed to improve the health and productivity of families of our employees and our partners throughout the region.

Most importantly, the County's Benefit Advisory Committee pledges to provide transparent oversight regarding our accountability and operations of the program going forward.

I thank you for the opportunity to provide our interim updates and feedback concerning your findings.

Sincerely,

Douglas Dykes
Chief Talent Officer
Cuyahoga County

RESPONSE TO HUMAN RESOURCES LETTER DATED JUNE 9, 2016

The Department of Internal Auditing (DIA) received a response letter from the Department of Human Resources, Chief Talent Officer on June 9, 2016 regarding the Health Care Benefits Program – Phase I audit report. Many of those responses were incorporated within the body of DIA's report following the related non-compliance citation or internal control recommendation. This communication will address some of the comments made in Human Resources' response letter that did not directly pertain to a specific comment. The comment from Human Resources will appear first with a follow-up comment from DIA as necessary.

Noted Concern – overall payments to EBI:
To ensure the County's contractual provisions and pricing were indeed honored, the County and our new Healthcare Consultant will be working to ascertain and audit all payments related to EBI, EBI's SBE partner, and WellnessIQ for the period of May 1, 2009 forward.

DIA response
We have worked with the County's new Healthcare Consultant by providing them with any documents we have related to their work.

Noted Concern – WellnessIQ potential conflict of interest due to EBI ownership:
While the County is aware of some potential overlap in ownership/common ownership with WellnessIQ and EBI, (i.e., one or more people may be partial owners of both EBI and WellnessIQ), the County selected WellnessIQ as our service partner beginning approximately January 1, 2012 through a competitive process. WellnessIQ was selected due to their overall combination of value, price, and scope. The County maintains a number of vendor contracts where multiple services are provided and we do not believe some overlap in ownership poses a conflict of interest. In addition, WellnessIQ and EBI performed different services for the County.

DIA response
Exhibit A of the Professional Healthcare Consultant Agreement between Cuyahoga County and EBI identifies the services to be performed by EBI. One of these services is Wellness Consulting and states "EBI will provide assistance and facilitation of the Wellness objectives set forth by the healthcare committee. This will include: Facilitation of the Wellness fair, Meeting with the committee, Liaising with the County Wellness coordinator, and Research and analysis of carriers to utilize." Absent detailed invoices the determination could not be made as to whether or not WIQ and EBI performed different services for the County.

Noted Concern –Consultant's over-extension of authority in managing regional plan:
The County's Regional Healthcare Plan is one of many ways we are working to assist our partners in the region to secure alternatives to traditional purchasing processes. Through our collective buying power, regional partners are able to secure quality coverage through a more affordable means. While it remains the County's objective to provide this access on a basis which is cost neutral to the County, we are currently evaluating the process, efficiency, value, long term goals and orientation of this program.

DIA Response
DIA has no response to this comment.

Noted Concern – Evaluation of financial viability and collection procedures:
The County has not experienced any inability to pay or delay in payment while operating this program.

The evaluation of financial viability, establishment of payment guidelines and adherence to policies which ensure redundant collection procedures are three of many operational items contained in our ongoing evaluation of the regional plan. In partnership with the County's new Healthcare Consultants, law department and fiscal officer, the County is analyzing the comprehensive set of processes, guidelines and audit procedures in place. The County is also verifying the appropriate and redundant adherence to these guidelines.

DIA Response
Although immaterial in significance to the Program, a payment of $9,083 was not made by one of the Partners to the County. Of greater significance is that there was not a control system or process in place to detect this missed payment.

Noted Concern – Rate Setting and Plan Offering:
The County respectfully disagrees with the auditor's findings concerning deficits and subsidization.

The County and the Regional Healthcare Plan are able to meet all financial obligations for payment of claims, expenses and reserves. The County is actively analyzing the rate methodology and underlying financial mechanics of both programs. The County's objective remains to leverage our collective buying power to provide employees and dependents of the County and our Regional Partners with access to high quality, affordable coverage. While we believe there are areas where we can continue to improve our value, efficiency, internal process and procedures, the program remains financially viable and able to meet all payment obligations.

DIA Response
Prior to 2016, it was common practice for Benefits to hold claims payments, especially near year end, due to a deficit in appropriations which would not allow the payments to be made. Additionally, payments were not always made from the proper funds for the same reason. The UHC and CVS claims were never properly paid out of the Regionalization Funds and were only paid out of the County's funds although portions of the claims were for the Regional Partners.

Noted Concern – No language citing ORC section 9.833 or statements the Regional Partner was part of a self-insurance risk pool was found:
The contracts and program is in compliance with ORC 9.833. The County's intent, and understanding from all Regional Partners is that coverage is provided through a self-insurance risk pool as further described below.

DIA Response
Neither the Political Subdivision Participation Agreement between the County and the Political Subdivision, or the Employee Benefits International Regional Partner Agreement between the Political Subdivision and EBI, identifies the Program as a self-insurance risk pool. DIA is not questioning whether the Program is permitted by ORC 9.833, we are stating that proper notification of the type of coverage (i.e. self-insured risk pool) is not made clear in the language of the contract(s). Conversations that DIA had with a few of the Fiscal Officers from the Political Subdivisions, revealed that some were not aware they were part of a risk pool.

Noted Concern – No reserve fund has been established pursuant to a resolution duly adopted by Council for this Program:
Pursuant to the requirements of ORC 9.833, the County's Fiscal Officer and new Healthcare Consultant have secured guidance from an independent Certified Actuary to review potential reserve requirements and ensure their appropriateness moving forward.

DIA Response
The response received to this comment does not address the issue that DIA was making. The issue is that ORC 9.833 requires Council's approval to set up a reserve fund.

Noted Concern – There is no agreement that a political subdivision may assume the risks of another political subdivision and the County may be liable for the Regional Partners' costs if they exceed premiums without having a contractual agreement:
Regional Partners participate in a collective joint self-insured pool on a guaranteed cost basis. Participant Agreements outline the provisions of Regional Partners who are contributing fully funded premium equivalents toward the Regional Healthcare Pool. These agreements specify that Partners are not able to share in proceeds, nor will they be liable for deficits. The goal of the Regional Healthcare Pool fully funded premium equivalents is for the pool to operate on a cost neutral basis to the County. The mechanics of this program are consistent with the provisions of ORC 9.833(C)(8).

DIA Response
DIA respectfully disagrees with this response. DIA has reviewed all Regional Partners' contracts and these agreements do not specify participation in a collective joint self-insured pool on a guaranteed cost basis, nor do they specify that Partners are not able to share in proceeds or be liable for deficits.

Noted Concern – According to the Regional Partner contracts, liability for claims and costs after termination of the contract by the County or Regional Partner, is the responsibility of the Regional Partner:
Regional Partners are only required to pay their own liabilities in the event that they default on their Participation Agreement prematurely. The program, and many like it in Ohio setup under ORC 9.833, require that Participants contribute to the program for multiple years to be fully "funded." Participants who terminate the program prematurely, are not fully funded and therefore remain responsible for their own incurred but not paid liabilities.

DIA Response
The DIA is not aware of an Ohio Revised Code requirement that requires Participants to contribute to the Program for multiple years to be fully funded, nor is this specified in the Political Subdivision Participation Agreement.