Internal Audit Report

Cuyahoga County, Ohio
Department of Internal Auditing

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

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Release Date: 9/29/2017

Audit Report Highlights

Health Care Benefits Program – Phase II — April 2017

Total Potential Recoveries[1] = $2.7 million | **Total Cost Savings[2] = $1.2 million**

Benefits Annual Budget[3] = $104 million | **County Annual Budget[3] =** $1.4 billion

Why DIA Did This Audit

This report provides results and recommendations from the Department of Internal Auditing (DIA) related to financial activity and operational procedures in the County's Benefits Department (Benefits) in Human Resources (HR). This audit had two purposes:

1) A continuation of the Health Care Benefits Program Phase I audit, released September 23, 2016. We performed additional testing on the County's Health Care Program in Phase II and concluded outstanding Phase I audit tests as of the Phase I report date; and

2) Operational concerns noted during the Phase I audit involving the Regional and County Health Care Programs, and the significant potential risks to the County.

What DIA Found

Subsequent to Phase I testing, we continued to perform audit procedures on Benefits for the period January 1, 2014 through June 30, 2015. We extended the audit period if findings were noted in areas of higher risk (e.g. ineligible claims paid, unpaid leave). We found control weaknesses, financial transaction discrepancies, and non-compliance during Phase II of the Benefits audit. The most noteworthy issues identified are listed below.

- Benefits paid over $1.2 million in medical claims for ineligible County and Regional employees and dependents beyond the employees' termination dates from January 1, 2013 through June 30, 2015. As of June 30, 2015, over 1,100 ineligible County and Regional employees and dependents still had access to medical benefits.
- While on unpaid leave (Family and Medical Leave Act, Military Leave, etc.), some employees neglected to pay benefit premiums. 16 County employees failed to pay over $37,000 in premiums while on unpaid leave from January 2013 through June 2015. In addition, these employees erroneously remained active on the County's insurance plans (medical, vision, dental, etc.) while on unpaid leave.
- The bank account associated with the County's Flexible Savings Account (FSA) and Commuter Benefit plans was not monitored or reconciled. Benefits utilized the bank account to deposit and disburse various pre-tax deductions from employees. The deductions related to plans offered as a benefit to employees for medical, dependent care, and commuter parking expenses. We recalculated the bank balance as of August 2016, and noted the balance appeared to be underfunded by over $200,000, according to the plan administrator's recommendation to pre-fund the account for three months of expenses.
- Benefits did not offer Consolidated Omnibus Budget Reconciliation Act (COBRA) benefits to 82 employees and dependents (5% of total employees terminated) between January 2013 and October 2015. COBRA requires the County to notify their plan administrator within 30 days of a qualifying event (e.g. termination). The plan administrator must offer the employee/qualified beneficiary an option to continue benefits through the County within 14 days after receiving notification from the County. The County is at risk of paying significant penalties and fines if employees are not timely notified after a qualifying event.
- We identified discrepancies between County-approved medical rates and rates recorded in SAP, Benefits' database used to record and maintain employee benefits data. In 2015, deductions from 43 employees' paychecks were less than the approved medical rates, totaling $4,583, and deductions from 10 employees' paychecks were more than the approved medical rates, totaling $2,639. Clerical errors occurred from manually entering medial rates in SAP throughout the year.

"What DIA Found" continued on next page.

[1] *Total overpayments identified by DIA the County could potentially recover.*

[2] *The amount the County could save by implementing recommendations. This a result of policy changes that could reduce expenses or increase revenue.*

[3] *Taken from the updated 2017 budget approved by Council on December 28, 2016. The County Annual Budget includes operating appropriations from all County funds.*

Audit Report Highlights

Health Care Benefits Program – Phase II — April 2017

What DIA Found (cont'd)

- We recalculated potential overpayments to the County's life insurance provider ($10,000), former wellness consultant ($66,000), and COBRA provider ($23,000) between 2013 and 2015. All potential overpayments resulted from overstated headcounts on invoices.
- SAP lacked sufficient information technology (IT) application controls. A workflow function in SAP was disabled that would prevent changes in benefits information without supervisor approval. HR and IT Department staff, without oversight, could modify benefits information.
- We found that 779 dependents had "999-99-999" as their Social Security Number (SSN). Benefits used this number as a placeholder, but no follow-up was done to update the SSNs. 579 other SSNs appeared to be invalid based on the Social Security Administration's (SSA) methodology.

What DIA Recommended

We made recommendations to Benefits focused on resolving weaknesses noted above, to help move Benefits toward a more efficient and productive function prior to the implementation of the County's new Enterprise Resource Planning (ERP) system. We communicated these recommendations to Benefits. Based on their responses we believe corrective action has been or will be taken to mitigate the risks identified during the Phase II audit. The audit report includes management responses at the end of each section. We made the following recommendations to improve the operations of the Benefits Department:

- Benefits should consult with the Law Department on recovering the $2.66 million identified in the audit report. Specifically, the Law Department should consider recovering claims paid for ineligible employees and dependents, and overpayments to the County's life insurance, wellness and COBRA providers.
- Benefits began furnishing eligibility files to medical providers on a bi-weekly basis during the audit. We still recommend that Benefits receive and compare the provider eligibility files with employee termination lists to ensure ineligible employees and dependents are not receiving benefits.
- Benefits should closely monitor the FSA and Commuter Benefits bank account to heighten the likelihood that sufficient funds are available to cover claims. Benefits should periodically perform a review on transactions to identify ineligible participants.
- Benefits should review SAP SSNs on a monthly basis and timely update dependent SSNs if using a placeholder of "999-99-9999". More specifically, Benefits personnel should receive notifications from SAP or the new ERP system after a pre-determined amount of time (e.g., monthly) to update placeholder numbers for dependent SSNs.
- Although Benefits should implement IT control recommendations in SAP, the IT control recommendations throughout the audit report should be considered during implementation of the new ERP system. The new ERP system should incorporate the following recommendations related to the findings noted above:
  - Benefits should automate the process to track employees on unpaid leave. The new ERP system should notify Benefits staff when an employee's leave status exceeds the maximum time allowed under County policy and federal laws.
  - Benefits should consider adding an attribute in SAP and the new ERP system to track COBRA eligibility. Employee termination lists and COBRA provider files should be reconciled to ensure timely notification of COBRA benefits.
  - IT controls should be updated to streamline processes and ensure integrity of employee benefits data. Segregation of duties should be incorporated into SAP and the new ERP system (e.g. supervisor approval should occur prior to posting manual medical rate changes to the system).
  - Benefits should explore the option of having SSA's methodology coded into the new ERP for SSNs on new employees and dependents to reduce the risk of ghost employees.

CUYAHOGA COUNTY
DEPARTMENT OF INTERNAL AUDITING

INTERNAL AUDIT REPORT
Cuyahoga County Health Care Benefits Program – Phase II
Cover Letter

April 28, 2017

To: County Executive, Armond Budish; Chief Talent Officer Douglas Dykes; 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 Benefits Division (referred to within this report as "Benefits") in Human Resources (HR), for the period of January 1, 2011 through June 30, 2015. DIA extended the audit period if findings were noted in higher risk areas and to recognize new procedures and processes in Benefits. This audit was a continuation of the Health Care Benefits Program – Phase I audit released on September 23, 2016. The audit objectives were to determine whether controls in place were adequate to safeguard assets from abuse, errors, and loss; revenue transactions and 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.

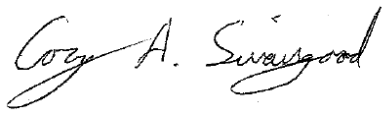
To accomplish our objectives, we focused on the operational controls in Benefits, the major revenue and expenditure cycles as well as specific compliance mandates. Interviews with management and staff along with general walk-throughs of each revenue and expenditure cycle were conducted in order to document the controls in place. In addition, substantive testing methods utilized included analytical procedures, tests of detail using sampling methods, as well as confirmation with providers.

Our audit procedures disclosed internal control weaknesses relating to Benefits' revenue and expenditure cycles, asset safeguarding, and recordkeeping. Non-compliance with Ohio Revised Code, federal regulations, 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 Benefits staff 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. Benefits' processes could substantially improve if recommendations are implemented with the County's new Enterprise Resource Planning (ERP) system. Based on responses received from Benefits, we believe corrective action is being taken to mitigate the risks identified during the Phase II audit. Management responses are included within the audit report.

Respectfully,



Cory A. Swaisgood, CPA
Director of Internal Auditing

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

Contents

Glossary

FSA	-	Flexible Spending Account. The County offers Medical and Dependent Care payment plans.
CCBODD	-	Cuyahoga County Board of Developmental Disabilities
CVS	-	Caremark Health System. Cuyahoga County's pharmacy provider.
EBI	-	Employee Benefits International, Inc. Cuyahoga County's former health care consultant.
FAMIS	-	Cuyahoga County's accounting information system.
MHS	-	MetroHealth System. 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, 149.351, 149.38, and 5705.41
PEPM	-	Per Employee Per Month.
SAP	-	Information system utilized by the Benefits Division to track and store benefits and payroll data.
PPM	-	Human Resources' Non-Bargaining Employee Policy and Procedure Manual.
UHC	-	United Healthcare. One of Cuyahoga County's medical providers.
NWGS	-	Northwest Group Services. County's provider for pre-tax FSA and commuter parking benefits.
WIQ	-	Wellness IQ was the County's former wellness services provider.
Zjournal	-	Report from SAP used to separate the "Flex Employee" deduction in the pay registers. The Zjournal includes medical, dental, vision, FSA, and life insurance contributions.

Report Details

Purpose

The purpose of this audit was to address concerns surrounding the County's Health Care Benefits 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). The Department of Internal Auditing (DIA) was originally notified by the County Fiscal Office of budget issues related to the payment of County and Regional medical and pharmacy claims. The Phase II audit was a continuation of the Phase I audit, released September 23, 2016. The Phase II audit was performed because of operational concerns noted during the Phase I audit involving the Regional and County Programs, and the significant potential risks to the County from ineffective processes. We performed additional testing on the County's Program in Phase II and concluded on tests outstanding as of the Phase I audit report date.

This report provides results and recommendations related to financial activity and operational procedures in Benefits. We focused on providing County management with best practices and sound internal controls to mitigate potential risks related to various functions in Benefits, such as medical claims eligibility, employees on leave time without pay, information technology performance and controls, and compliance with statutory legislation.

Audit Objective

DIA included the main audit objectives below. This report outlines DIA's findings and recommendations in 15 objectives related to the below audit objectives.

- Determine whether controls were in place, and if controls did exist, determine if they were adequate to effectively and efficiently achieve the County's goals.
- Assets were safeguarded from abuse, errors, and loss.
- Revenue transactions were properly supported, recorded and deposited in their entirety in a timely manner and in accordance with all governing laws and regulations.
- Expenditures were properly approved, recorded and in accordance with all governing laws and regulations.
- Health care funds maintained the proper fund balances.
- Reporting information was timely accomplished and accurate.
- Procedures, transactions, and reports were in accordance with all governing laws and regulations.

Scope

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

Methodology

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

- Conducted interviews with management, staff, and consultants.
- 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, benefit providers, and consultants.

Background

Cuyahoga County provides various benefit programs to employees and their eligible dependents. The following programs were administered by Benefits with four staff, two managers, and one director (eight total) as of the audit report date.

- Medical Health Plans
- Dental Plan
- Vision Plans
- Life Insurance Plans
- Flexible Spending Accounts (FSA)
- Pre-Tax Commuter Parking Account
- COBRA (Consolidated Omnibus Budget Reconciliation Act)
- FMLA (Family Medical Leave Act)
- Unpaid Leaves of Absence
- Military Leave
- Wellness Program

Benefits is responsible for assuring medical, dental, and vision plans are accurately and timely entered into the Human Resources software, SAP. Benefits receives plan contribution rates from the County's health care consultant and updates each plan classification in SAP for the subsequent plan year. Employee plan selections are entered into SAP after open enrollment, usually October of every year, or within 30 days of a qualifying event (new hire, birth of child, etc.). The County's medical plans are self-insured, meaning the County pays all claims up to a specific individual stop loss threshold. During the audit, the County offered various medical plans under three providers – MMO, MHS, and UHC. Medical plans include a pharmacy plan with CVS. Benefits pay weekly claims and monthly administration fees to the providers. Benefits is responsible for ensuring all employees are eligible to receive medical service on County plans. See page 7 for results on ineligible subscribers receiving medical benefits.

The dental and vision plans are fully insured, meaning the County is not responsible for paying individual claims and only responsible for making monthly premium payments on eligible County employees. Employees elect life insurance plans, a premium-based plan, during open enrollment or within 30 days of a qualifying event. The County contributes to a portion of employees' life insurance coverage and medical, dental, and vision plans based on non-bargaining or bargaining status.

Benefits updates and monitors employees' FSA plans and commuter parking benefits. These benefits are pre-tax deductions, deposited into a County-owned bank account and withdrawn from a County vendor that administers the programs. Benefits notifies the vendor when employee accounts must be updated. See comments on page 30 for more details on the pre-tax benefits.

Benefits must observe and strictly follow COBRA laws. Benefits notifies the COBRA administrator when qualifying events occur, such as employee terminations, so notification can be timely sent to employees. The County could be subject to fines and penalties if processes do not conform to COBRA regulations. See more details on page 38.

Benefits must also follow local, state, and federal laws on leaves of absence. Benefits must update and track FMLA, personal leave, and military leave to ensure employees remain eligible for County benefits. Benefits must further monitor employees on unpaid leave to determine eligibility of benefits if employees fail to make timely payments. See results on testing for leaves of absence on page 18.

As noted in the Phase I report, Benefits also administers a Health Care Regional Program for political subdivisions. This program was reviewed and tested in detail during the Phase I audit. Some findings and recommendations for tests outstanding as of the Phase I audit were disclosed in this report. See results on page 13 and page 73.

Since the Phase I audit report, Benefits reorganized the department and hired a Director of Benefits. Benefits also replaced their former health care consultant, EBI, with a consultant that implemented changes in Benefits. The new consultant, Oswald Companies, contracted with an independent party to conduct a dependent verification eligibility audit. The dependent audit identified over 550 potential ineligible dependents at the end of 2016. According to the report, unaudited by DIA, over $2.9 million was calculated as future cost avoidance. Benefits also contracted with a new wellness vendor to revamp their wellness program.

This report is divided into 15 sections based on audit objectives. Each section is broken out into findings and recommendations from DIA's audit results. The report discloses non-compliance and internal control findings within the appropriate sections.

Findings and Recommendations

Objective #1 – Medical Eligibility Files were Updated and Monitored to Ensure Claims were Paid on Eligible Subscribers

FINDING **2,167 ineligible employees and dependents were identified and approximately $1.3 million in medical claims was paid on ineligible employees and dependents.**

Health benefits for County and Regional Partner employees should discontinue upon termination or after a qualifying event, like COBRA. The Regional Partner and the County should document procedures to notify Benefits of employee terminations. Benefits should have a process to ensure provider plan records are timely updated.

DIA conducted substantive tests on County and Regional Partner employees that met the criteria of having access to medical benefits after their benefits termination date in SAP. DIA compared benefits termination dates in SAP from January 1, 2010 through June 30, 2015 to medical provider eligibility files and COBRA files. Utilizing IDEA's data analytic software, DIA used medical provider eligibility files to extract employees with plan end dates subsequent to benefits termination dates in SAP. The following table displays our total population for the County and Regional Program:

	Total Population of Employees Terminated (SAP)	Number of Employees with Coverage Beyond Termination Date
County	3,016	927
Regional	311	112
Total	3,327	1,039

The number of County and Regional employees identified for testing (1,039) erroneously had coverage beyond their termination dates, a 31% error rate (36% for Regional and 31% for County employees). The table below shows the number of ineligible employees and dependents with claims paid by the County.

	Ineligible Employees	Ineligible Dependents	Total Ineligible	Ineligible Employees and Dependents the County Paid Claims	Error Rate
County	927	947	1,874	627	33%
Regional	112	174	286	90	31%
	1,039	1,121	2,160	717	33%

Furthermore, DIA calculated the unnecessary costs associated with County and Regional employees that were not timely deactivated from receiving medical benefits after termination. The following table represents the dollar amount of claims paid for the aforementioned employees and dependents by provider.

	CVS	Medical Mutual	Metro Health	United Health Care*	Claims Paid In Excess of Termination Date
County	$200,415	$51,519	$62,567	$886,340	$1,200,841
Regional	$73,267	$8,860	$336	$867	$83,330
				Total	**$1,284,171**

**Claims data was provided by CVS, MMO, and MHS from January 1, 2014 through June 30, 2015. UHC provided DIA with claims data from January 1, 2013 through June 30, 2015.*

DIA could only quantify the number of claims paid for ineligible County and Regional employees and dependents for the dates noted for each provider. The total number of claims paid for the ineligible employees and dependents identified above could be greater.

As of June 30, 2015, 1,150 ineligible County and Regional Partner employees (524) and dependents (626) still had access to medical benefits. The following table shows these results:

Length of Time Since Termination with Active Benefits as of June 30, 2015	County	Regional	Total
< 4 Months	312	52	364
4 to 11 Months	638	72	718
1 to 6 years	61	15	68
Total	1,011	139	1,150

In addition to paying claims for ineligible County and Regional Partner employees and dependents, provider administrative fees were also paid on ineligible employees and dependents. The following table displays the estimated amount of MMO and UHC administrative fees incurred for employees and dependents identified above.

Provider	Provider Administrative Fee Estimate
County	$51,519
Regional	5,786
Grand Total	**$57,305**

Note: DIA was unable to calculate the MHS administrative fee due to limited data related to the Health Reimbursement Account (HRA) that was managed by MHS prior to 2015. The data obtained from MHS on administrative fees has HRA fees included. In addition, CVS did not separately bill and charge administrative fees. These fees were calculated into an employee's claim.

Furthermore, we noted the following instances after review of the confirmations from the Regional Partners. These instances were quantified with the results above if ineligibility was found:

- Benefits termination dates in SAP varied by more than a year for two Regional Partner employees.
- One Regional Partner employee was assigned to the wrong Regional Partner in SAP. This error could lead to billing discrepancies and inaccurate allocation of costs between Regional Partners.

*NOTE: These test results are in addition to the findings on page 8. Employees' **benefits** termination dates from SAP were compared to the providers' eligibility date in that test, and not the **employment** termination date.*

In addition to the tests performed above, DIA completed testing on County employees with access to medical benefits beyond their employment termination dates in SAP. DIA identified exceptions in comparing the medical benefits termination date to the employment termination date in SAP from January 1, 2011 to June 30, 2015. DIA identified 48 employees in SAP with a benefits termination date at least one month after their employment termination date. Results were reviewed for benefits termination dates exceeding one month since employees are eligible for benefits until the last day of the month following the employment termination date. We selected a judgmental sample of 11 individuals with the highest dollar amount of claims spent beyond their employment termination date. The following table displays our results:

Total Sampled out of 48	Number of Employees with Coverage Beyond Termination Date	Claims Paid on Ineligible Employees
11	7	$11,090
Projected Amount to Total Population		$49,113

After receiving supporting documentation, we noted that seven employees had benefits available past their employment termination dates in SAP, for an error rate of 64% (7÷11). DIA projected the error rate to conclude that 31 (64% × 48) of the 48 former employees could potentially have benefits past their employment termination dates. The projected dollar amount of ineligible claims being paid totaled $49,113 ($11,090÷7×31).

The erroneous and untimely benefits termination mainly occurred in non-Executive agencies. Most non-Executive agencies have their own human resource function and employment termination notification was updated through the County's Fiscal Officer. IT runs a batch job to update the employment termination dates in SAP from the Fiscal Office, but termination of benefits does not occur until a Benefits Office Change form (BOC) is received from the non-Executive agencies. There was a risk these forms were not received for months after an employee was terminated resulting in terminated employees having access to medical benefits during this time. There are no detective or preventive controls in SAP to identify these issues and no compensating controls are in place.

FINDING 29 employees had concurrent medical plans during the audit period.

DIA did not analyze MHS due to other HRA eligibility included in the eligibility file. Benefits included CVS plan rates with other medical plans and could not be analyzed in this test.

During benefits open enrollment or within 30 days of a qualifying event (new hire, birth of child, etc.) an employee may elect one single or family medical plan. The County does not offer an option of having more than one medical plan at the same time. Benefits should have preventive controls in place to ensure no concurrent plans exist with County employees.

DIA analyzed UHC and MMO eligibility data from January 1, 2011 through June 30, 2015. We extracted the number of employees having more than one medical plan during the same period (1 for MMO and 1 for UHC) to identify if claims were paid by the County for both providers. The following table displays our results as DIA identified 29 employees with concurrent medical plans with MMO and UHC during the same period:

Description	Number of Instances	Dollar Amount
SAP records did not agree with Provider eligibility files*	29 Employees	N/A
Claims paid to the provider that was not elected by the employee, according to SAP.	11 Employees	$4,755
Duplicate claims paid to the provider that was not elected by the employee, according to SAP.	**4 Employees**	**$132**

**SAP eligibility dates differed from provider eligibility dates. See the following table for an example of one employee that was covered under two plans from January 1, 2015 through April 30, 2015.*

Provider Eligibility File			SAP Eligibility Records		
Plan Start Date	Plan End Date	Provider	Plan Start Date	Plan End Date	Provider
1/1/2012	4/30/2015	UHC	1/1/2012	12/31/2014	UHC
1/1/2015	6/30/2015^	MMO	1/1/2015	6/30/2015^	MMO

^End of audit period

Risk to the County if Findings Not Corrected

Benefits did not have defined policies and procedures to ensure the County's eligibility records are accurate and complete for County and Regional employees and their dependents. Periodic reviews of the County's SAP database, or supervisor approval of employee changes was not evident during the audit. Additionally, there was no process in place to validate provider records were up-to-date.

Failure to have adequate internal controls in place may result in eligibility discrepancies between the County's database, SAP, and the provider's database. More importantly, there is an increased risk of the County paying claims beyond the termination date for County and Regional employees. Without adequate controls in place on concurrent

medical plans the County is also at risk of paying duplicate claims for employees and their dependents.

Recommendations

1.1 DIA recommends Benefits implement the following procedures and controls to mitigate the risk of paying claims on ineligible employees and dependents:

- Upon receiving a signed resignation letter from an employee, HR should complete a checklist for the required documentation. The HR Analyst assigned to the employee should sign the form to confirm receipt of all required documentation and verification of the event. The form should be distributed to each department that is affected by a termination. HR Benefits should receive the form in order to change the employee's benefit status. The form should be signed by Benefits, which verifies the employee's benefit status has been changed. The form should be sent back to the HR Analyst or sent to the next department who should be notified of the change, like HR Payroll. The form should also be copied by Benefits and filed away, preferably to a folder on the County's server dedicated to these types of events.
- IT should develop a report in SAP to identify all County employees with benefit changes within a specified period. This report should be reviewed for accuracy and existence and compared to supporting documentation, like the action forms mentioned above. Benefits should compare all action forms added within the last month to SAP to ensure completeness of SAP data by an employee other than the one that made the original changes. After the review is complete, the employee should sign and submit the review to his or her immediate supervisor for review and approval, which should be evident by initials or signature.
- Monthly, a list of terminated County employees should be compared to provider files to assure ineligible employees and dependents are not actively enrolled in medical benefits.
- The IT Department should export a copy of the County's eligibility files to all providers on a bi-monthly basis. These files should be saved to the secure server by the 1st and 15th of the month.
- Periodically, the County’s eligibility files should be compared to the Provider’s eligibility file to verify all employees, dependents, and plan types are accurate.
- SAP should be programmed to require the entry of a benefits termination date simultaneously to an entry of an employment termination date. Benefits should consider adding this control to the new ERP system.
- The County should modify their benefit change policy to require the submission of BOC forms within a week of an employee being terminated to ensure more timely receipt of authorized benefit changes. DIA recommends that HR should be communicating with County departments on a monthly basis to obtain an accurate list of all terminated employees in each department over the past 30 days.

1.2 IT should create a preventative control in SAP and the new ERP system to prohibit the system from allowing one employee to participate in more than one medical plan.

1.3 Benefits should consult with their legal counsel on recovering the medical claims and administrative fees paid on ineligible employees and dependents identified in this audit from former employees or medical providers, if medical providers are found to be at fault.

Management's Response

Ensuring the accuracy of benefit eligible participants is an important responsibility of our benefit administration staff. We believe it is equally as important to ensure the County's funds are used only on eligible expenses and participants.

Prior to the release of this Audit, after learning about the issue with inaccurate eligibility within our programs, the County embarked on a multi-layered approach to recover erroneous payments and resolve the discrepancies. Over $ I M has been recovered from providers and/or claimants who received benefits erroneously.

The County's SAP system i s currently considered the "system of record" for all eligibility with our participants, former employees and vendors. Unfortunately, the SAP system is antiquated and in desperate need of updating (which is scheduled for 2018).

In the interim, the County's has implemented a stop-gap monthly auditing process designed to compare enrollment activity, terminations, duplicate enrollments, the SAP system or record and carrier records. The medical and prescription program is online and validating payments made on a monthly basis against active coverage status. This process has greatly reduced the number of erroneously covered participants to a negligible amount. Due to the success of this process, this same auditing procedure is currently being implemented across all other benefit items and corresponding benefit payments. We anticipate all benefit items will be within the monthly eligibility audit cycle by January 1, 2018.

Our Benefit Administration team is also working closely with the Information Technology group to further refine and improve the validity of data within the SAP, carrier, employee election and payroll systems. Finally, the Benefit Administration team has reviewed and continues to review and implement process/procedure enhancements to ensure analysts are correctly posting qualified events and terminations.

Auditor's Response

Benefits will notify DIA when funds are recovered going forward. DIA will periodically follow-up with Benefits on recovery efforts.

Objective #2 – County and Regional Program Cash Balances were Accurately Recorded and Sufficient to Cover Program Expenses

FINDING **DIA recalculated the Regional Program's cash balance to be approximately $1.4 million less than the County's financial system at June 30, 2015.**

During our audit, the County could not provide an accurate number on the Regional Program's cash balance. EBI, Benefits, and the Office of Budget & Management calculated different cash balances for the program. DIA performed a reconciliation on the Regional Program's cash balance at June 30, 2015. We obtained detailed documentation on revenue received from regional partners and related costs to the regional program. Costs included regional medical claims, provider administrative fees, and stop loss insurance fees. With this data, DIA attempted to confirm the accuracy of the cash balance in FAMIS for the regional program at June 30, 2015. DIA performed the same procedures to reconcile the County Program's cash balance. Benefits should have a process in place to ensure accuracy of the cash balance in FAMIS, used by management to make decisions and for financial reporting.

During our testing of the Regional and County Health Care Programs, we noted commingling of funds between the Regional and County subfunds in FAMIS. Some Regional expenses, like medical claims and stop loss insurance fees, were paid out of the County Program's subfund. DIA recalculated the cash balance in the Regional Program and found the Regional Programs balance was approximately $3.2 million, over $1.4 million less than the cash balance in FAMIS. The table on the following page shows our results of the reconciliation. DIA was able to obtain data from third parties (i.e. medical providers) for 99% of the data needed. DIA used EBI's numbers for the 1% of data not obtained.

Dates in Program	Entity	Revenue Received	County Admin Fees	Total Medical/Rx Cost	Administrative Cost/Fees	Total Cost	Reserve as of 6/30/15
1/1/13-Present	BODD	$25,401,506	$ (195,856)	$ (22,796,094)	$ (1,351,777)	$ (24,147,872)	$ 1,057,779
1/1/14-Present	BOH	2,088,924	(29,835)	(2,119,603)	$ (118,615)	$ (2,238,217)	$ (179,128)
3/1/14-Present	Chardon	1,129,708	(13,560)	(834,014)	$ (52,336)	$ (886,350)	$ 229,798
9/1/14-Present	Cleveland Hts.	3,874,731	(62,100)	(3,892,857)	$ (217,406)	$ (4,110,263)	$ (297,632)
4/1/15-Present	Euclid	1,244,367	(14,445)	(608,744)	$ (40,721)	$ (649,465)	$ 580,457
1/1/14-Present	Fairview Park	1,699,025	(25,140)	(1,694,262)	$ (97,006)	$ (1,791,268)	$ (117,383)
7/1/12-Present	Glenwillow	381,734	(5,295)	(598,963)	$ (19,621)	$ (618,584)	$ (218,600)
7/1/12-Present	Highland Hills	703,602	(12,450)	(402,626)	$ (41,175)	$ (443,801)	$ 334,034
1/1/14-Present	Highland Hts.	1,039,863	(16,545)	(799,593)	$ (68,809)	$ (868,403)	$ 154,915
7/1/09-Present	Land Bank	902,705	(17,025)	(897,959)	$ (55,284)	$ (953,243)	$ 322,851
4/1/12-Present	Mayfield Village	2,136,709	(33,480)	(2,054,145)	$ (134,643)	$ (2,188,788)	$ 233,227
9/1/12-Present	North Randall	309,095	(4,485)	(283,704)	$ (15,263)	$ (298,967)	$ 14,725
1/1/11-Present	Olmsted Falls	1,010,220	(24,690)	(1,262,053)	$ (91,603)	$ (1,353,656)	$ 280,556
1/1/11-12/31/13	Olmsted Twp	771,889	(22,650)	(1,716,017)	$ (89,041)	$ (1,805,058)	$ 91,388
1/1/15-Present	RITA	854,449	(14,385)	(1,119,489)	$ (53,657)	$ (1,173,146)	$ (333,082)
1/1/15-Present	S.Euclid	874,041	(10,095)	(632,640)	$ (43,594)	$ (676,234)	$ 187,712
1/1/15-Present	SECC	49,539	(900)	(30,885)	$ (2,912)	$ (33,796)	$ 14,842
1/1/14-Present	University Hts.	1,518,296	(21,555)	(1,237,838)	$ (84,108)	$ (1,321,945)	$ 174,795
1/1/11-Present	Walton Hills	739,111	(17,580)	(462,284)	$ (71,665)	$ (533,949)	$ 633,455
5/1/15-Present	Red Center LOGIC	31,067	(450)	(10,447)	$ (843)	$ (11,289)	$ 19,327
	Totals	**$49,830,852**	**$ (542,521)**	**$ (43,454,216)**	**$ (2,650,079)**	**$ (46,104,296)**	**$ 3,184,035**
						FAMIS Balance	***$ 4,666,672***
						Variance	***$ (1,482,637)***

To further analyze DIA's recalculation of the Regional Program cash balance at June 30, 2015, we compared our reconciliation to EBI's experience reports. Experience reports displayed the Regional Program's monthly reserve balance. The reserve balance was 8%, or approximately $248,000 less in EBI's experience reports than DIA's recalculation. We deemed this immaterial due to a timing difference in recognizing claims expense. EBI would recognize the claims expense in their experience reports when the expense was incurred contrary to the County recognizing the expense in FAMIS when paid.

FINDING The County did not accurately present cash balances in the County's full- and self-insurance subfunds in FAMIS. In addition, program revenue did not appear to be sufficient to cover program expense.

Benefits used an Internal Service Fund to account for and report claims and administration of the County's Health Care Program for covered employees and eligible dependents, and the accumulation and allocation of costs associated with health care. Benefits utilized two subfunds within the Internal Service Fund to record and report full- and self-insurance activity for the County's benefits program. Employee (EE) and employer (ER) contributions were recorded as revenue to cover expenses of the Internal Service Fund. Benefits should have procedures in place to ensure all activity is accurately and timely posted to the correct subfund.

During the audit period, subfund activity should have consisted of the following transactions:

Subfund	Revenue	Expenses
Self-Insurance	• Medical and FSA Employee and Employer Contributions • COBRA Receipts • FMLA Receipts • Provider Rebates • Stop Loss Reimbursements • FSA Reimbursements • HRA Reimbursements • Benefits Staff Reimbursements	• Medical Claims • Pharmacy Claims • Provider Admin. Fees • COBRA Admin. Fees • FSA Admin. Fees • Stop Loss Fees • Other Administrative Fees Relating to Self-Insurance Activity • Benefits Staff Salaries • Benefits Admin. Expenses • Healthcare Consultant • Wellness Consultant
Full-Insurance	• Life, Vision, and Dental Employee and Employer Contributions	• AFSCME Care Plan Premiums • Vision Premiums • Dental Premiums • Life Insurance Premiums

The County (Benefits and Fiscal Office) posts all full- and self-insurance EE and ER contributions to the self-insurance subfund in FAMIS after each payroll run. Once a month, Benefits submitted a journal entry to the Fiscal Office to reclassify full-insurance EE and ER contributions from the self-insurance subfund to the full-insurance subfund. The reclassified amount was not calculated from actual payroll withholdings. Instead, a SAP report was printed to recalculate the fully insured contributions. DIA performed a reconciliation between the County's full- and self-insurance subfunds to confirm the cash balances in FAMIS were accurately presented as of June 30, 2015. We obtained supporting documentation (i.e. medical claims data) to recalculate the cash balances. DIA's recalculation of cash balances in comparison to FAMIS cash balances is shown in the below table:

Cash Balances by Subfund from 1/1/2011 through 6/30/2015 for County Benefits Program

	Self-Insurance Subfund	Full-Insurance Subfund	Total Program (Internal Service Fund)
Total Revenue*	$315,988,892	$40,410,677	$356,399,569
Total Cost/Expenses*	(344,020,975)	(25,446,911)	(369,467,886)
Beg. Cash Balances in FAMIS (System) at 1/1/2011	17,359,207	-	17,359,207
Cash Balances at 6/30/2015*	(10,672,876)	14,963,766	4,290,890
Cash Balances in FAMIS at 6/30/2015	1,755,873	2,378,271	4,134,144
Variance (Shortage)	$12,428,749	($12,585,495)	($156,746) (3.8%)

** Recalculated*

DIA noted material differences between the self-insurance subfund and full-insurance subfund due to the recording of various expenses out of the wrong subfund. Benefits posted expenses related to self-insurance activity to the full-insurance subfund, (i.e. healthcare consultant payments and FSA contributions), and vice versa. Full-insurance expenses were recorded in the self-insurance subfund (i.e. life insurance premiums). In total, the County's internal service fund cash balance only varied by 3.8%, which supports the inaccurate allocation of program expenses between the two subfunds. This variance may have resulted from a timing difference in medical claim payments between the invoices used by DIA to recalculate the cash balance and FAMIS postdate. Part of the variance could be due to some regional expenses being paid out of County funds.

Finally, the County's benefits program had a cash balance of approximately $4 million at June 30, 2015. This balance did not appear to be sufficient to cover the County's Benefits program as monthly expenses for the first six months in June 2015 averaged about $7 million (full- and self-insurance plans).

Risk to the County if Findings Not Corrected

Benefits did not have procedures in place to reconcile support to FAMIS for accuracy. This oversight did not result in misrepresentation in the County's Comprehensive Annual Financial Report, but would lead to unreliable information in making management decisions. Benefits is at a higher risk of misreporting full-insurance and self-insurance subfunds to County management and Council.

No internal calculation of the County's or Regional's reserve balance has ever been conducted by Benefits. The County is at greater risk of misreporting County and Regional Health Care Program costs if monthly reconciliations between supporting documentation and FAMIS is not performed.

Recommendations

2.1 DIA recommends that Benefits perform monthly reconciliation procedures between the County and Regional Health Care Programs to heighten the likelihood that Regional expenses are not posted against County program funds. The monthly reconciliation would confirm that all Regional Program expenses are paid out of the correct subfund. This reconciliation should be reviewed and approved by a supervisor.

2.2 Benefits should create a schedule of all transactions that are posted to the County's and Regional's Internal Service Fund from the County's and Regional's Benefits Program. This list should be followed and reviewed to ensure that all transactions are recorded in the correct subfund to increase the likelihood that FAMIS reports will be accurately generated.

2.3 DIA recommends that Benefits staff receive training on the importance of recording program transactions in the correct subfund.

2.4 Contributions (EE and ER) for fully insured plans that are reclassified from the self-insurance subfund should be calculated from actual payroll withholdings instead of SAP reports to improve the accuracy of contributions recorded between subfunds. All contributions (EE and ER) should be automatically posted in FAMIS to the correct subfund during the payroll run. Monthly, Benefits should be reviewing FAMIS to reconcile the contributions posted in the full- and self-insurance subfunds with SAP data. If not feasible with the current systems in place, this process should be implemented in the new ERP system.

Management's Response

The Auditor 's historical review of County and Regional Program Cash Balances during the period leading up to June 30, 20 15 reinforces the findings of Benefit Advisory Team members, Finance, presentations to the Executive leadership group and County Council.

While significant adjustments to both the County's revenue accrual and Regional program rates were required to resolve the underfunded nature of the program, it is important to underscore that the County 's overall budget remained sufficient to cover all liabilities associated with the benefits program.

Staff has been dedicated and assigned to the benefit administration group to ensure consistency and compliance with reporting revenue and expenses in the correct subfunds. This staff will receive continuous training to ensure consistency in process moving forward.

In 20 17, the County is in the first of a three-year reserve redevelopment plan that is designed to rebuild reserves to levels consistent with the State of Ohio Auditor's guidelines.

The County's independent consultants are also reviewing quarterly FAMIS, Internal Service Fund and benefits reporting against their systems for additional validation.

Objective #3 – County Employees with Benefits on Leave without Pay were Accurately Monitored and Payments were Timely made

FINDING **Benefits did not comply with County policies in monitoring employees on leave without pay. Benefits did not collect premiums from employees on leave without pay and paid claims for these employees, totaling over $40,000.**

DIA performed detailed testing on Benefits' process for tracking employees on unpaid leaves of absence (FMLA, extended sick/medical, personal, and military). We extracted all employees on unpaid leaves of absence from SAP in March 2015. Benefits should ensure all employees on unpaid leave are making payments towards their benefits in order to remain eligible. 50 employees were tested to ensure Benefits had adequate controls in place to comply with various sections of the PPM. DIA noted the following findings by each section of the PPM.

Section 8.04 – Amount of Leave

An eligible employee is limited to a total of 12 workweeks of FMLA leave during any forward rolling 12-month period, except in the case of leave to care for a covered service member with a serious injury or illness.

During our testing of the 50 employees on leave in March 2015 one employee was on FMLA for 20 weeks during 2015, eight weeks greater than the PPM allows. Benefits should have changed the employee's type of leave in SAP to extended medical leave instead of FMLA. The employee correctly paid their portion of vision, dental and supplemental life benefits for the first 12 weeks of leave. Benefits did timely shut off the employee's benefits at 12 weeks.

Section 8.07 – Continuation of Benefits

According to the PPM, the County will continue to pay its portion of medical and supplemental benefits (i.e. life insurance, vision, etc.) when an employee is on FMLA leave. Employees on FMLA leave are responsible to pay the employee's contribution of benefits. Employees on paid leave will continue to have their usual payroll deduction for health insurance benefits. Employees on unpaid FMLA leave are billed for their contribution of medical and supplemental benefits.

Although eight employees tested made monthly payments to continue benefits with the County. SAP did not reflect which plans the employees should have been paying.

Four employees on unpaid leave received one of two paychecks in March 2015. The employees went on leave without pay and did not receive a second paycheck during the month and no partial monthly payments were required by the employees to maintain insurances for the month. DIA calculated the total amount of uncollected employee portion of insurance premiums for the four employees to be $81.

Section 9.09 – Unpaid Leaves of Absence

The County offers employees three types of unpaid leave: New-Hire Administrative Leave of Absence, Personal Leave of Absence (LOA), and Extended Unpaid Sick/Medical Leave. Depending on the practice of an employee's respective agency, the employee may be required to complete an *Employee Request for Leave Form* to request an unpaid leave of absence. Any leave approved upon a false statement is invalid and any approved leave shall terminate if the reason for granting the leave is no longer applicable. Moreover, employees providing false statements or documentation are subject to discipline, up to and including removal, under Section 13 of the PPM.

With the exception of Extended Unpaid Sick/Medical Leave taken concurrently with FMLA leave, an employee in an unpaid status on the first day of the month will not receive health care coverage and related benefits unless he or she elect to pay the entire expense. The employee may be required to pay up to one-hundred and two percent (102%) of the entire health insurance and related benefits premium cost to retain his or her benefit status. The total amount of time for all leaves under this section shall not exceed six (6) months in any forward rolling twelve (12) month period. Employees are responsible to ensure they have received proper approval when taking unpaid leave.

Personal Leave of Absence

A personal leave of absence involves a temporary separation from active pay status, authorized by the County. Such leave must be for a minimum of 10 working days, but may not exceed a maximum period of six months, with no extension or renewal allowed.

One employee from Juvenile Court was on personal leave for 15 months. Although the County accurately accounted for the employee's benefits during the 15 months, the employee was on personal leave nine months greater than the PPM allowed.

Extended Unpaid Sick/Medical Leave

An employee who is unable to perform any of the essential functions of his or her position due to disabling illness, injury or condition, and the disability continues after the employee has exhausted his or her accumulated sick leave benefits, may be granted a leave of absence without pay for a period of up to six months upon presentation of evidence as to the probable date for return to active work status.

Benefits did not comply with this County policy for 11 employees between September 2014 through August 2015. These employees continued to have medical, prescription drug, dental, vision, and/or life insurance while on unpaid leave without Benefits receiving any payments. The employees were required to pay the employer and employee portion of the insurance cost every month the employees were on leave. The County failed to collect $21,475 from the 11 employees during that time. Ineligible claims were paid for two employees from

January through June 2015 totaling $2,459. DIA only had access to review paid claims per employee from January 2015 through June 2015. The following instances were the biggest offenders:

- One employee from Juvenile Court was on medical leave for 23 months (September 2014 - August 2016) before resigning, 17 months greater than the PPM allows. DIA could not locate evidence to confirm this employee paid to continue medical, vision, prescription drug, and dental coverage for the 23 months on medical leave. SAP reflects the employee continued to have insurance coverage from January 2015 through August 2016 at a projected cost of $11,717 for employee and employer premiums. DIA verified the County did not pay any claims for this employee from period January – June 2015.
- One employee from Health and Human Services (HHS) was on unpaid Medical leave from February 18, 2015 through June 30, 2015, and received disability separation on August 18, 2015. This employee continued to have medical and prescription drug insurance coverage through June 2015. No payments were made by the employee to continue the insurance coverage while on unpaid leave from April 5, 2015 through June 2015 (2 months). During this time, the County paid insurance claims for the employee totaling $783. The projected amount for the employee and employer portion of insurance totals $1,435 for two months.

In addition, DIA noted discrepancies with employee information in SAP when compared to actual payroll information. Employee's information in SAP should properly reflect accurate payroll activity of the employee. Two employees from non-Executive agencies were reflected in SAP as being on medical leave although they were working full-time during a portion of this time. SAP was not timely updated by Benefits.

Section 10.02 – Unpaid Military Leave

Pursuant to the Uniformed Services Employment and Reemployment Rights Act (USERRA), an eligible County employee shall be granted, upon giving notice to his or her Department and Human Resources, a leave of absence to serve in the uniformed service, as defined in 38 U.S.C § 4301-4335 (1994). This leave shall be without pay and shall be considered as a leave of absence from service with reinstatement rights. No single leave of absence or combination of uniformed service leaves of absence may exceed five (5) years or a single, longer period required to complete an initial period of obligated service. Employees on military leave without pay for up to thirty (30) days must be given the option of making direct payments of the employee's share of the health insurance premium. Employees with longer periods of service will be given the option of continuing health care coverage and related benefits for up to twenty-four (24) months. Such continuation shall be at the employee's expense. The employee may be required to pay up to one-hundred and two percent (102%) if the entire health insurance and related benefits premium costs.

One employee in the County Prosecutor's Office was on military leave from November 2012 to the date of this audit report, longer than twenty-four (24) months. The employee had medical, prescription drug, dental and vision insurance during this time. No payments for insurance from the employee on military leave were found. The projected cost of the employee and employer portion of insurance coverage from January 2013 through June 2015 totals $16,372. The County paid no claims for this employee from January – June 2015.

Potential Benefit Losses to the County Summarized from Above Comments:

PPM Section	Description	Projected Unpaid Premiums	Claims Paid by County	Total
8.07	Continuation of Benefits	$81	$0	$81
9.09	Unpaid Leaves of Absence	21,475	2,459	23,934
10.02	Unpaid Military Leave	16,372	0	16,372
	Grand Total	**$37,928**	**$2,459**	**$40,387**

FINDING No review or approval was evident prior to sending invoices to employees on leave without pay. This resulted in discrepancies between SAP and invoice premium amounts.

Benefits prepared invoices for employees on approved leave without pay. Employees were required to pay these invoices to continue receiving medical and supplemental benefits. Benefits completed invoices based on information obtained from SAP to determine the amount of premium owed by the employee on unpaid leave. These invoices were sent to the employees without supervisor approval and a copy was maintained by Benefits. The process was time consuming and performed manually. We also noted supporting documentation (SAP screen shots) were not always maintained with the invoices. DIA noted immaterial calculation errors during our test of invoices from April 2014 through June 2015.

FINDING Benefits records do not accurately reconcile to the County's financial system for life insurance revenue.

Benefits maintained an excel spreadsheet titled "Check Register" (register) of all insurance premium payments received from employees on leave without pay (i.e. FMLA or LOA). The Benefits staff member receiving the payments populated this register prior to depositing checks with the Treasurer's Office. There was no evidence the register was reviewed by Benefits to determine if employees should have been shut-off from receiving benefits. In addition, Benefits did not reconcile this register to ensure the revenue was accurately and timely posted to FAMIS. DIA reconciled this register from January 2014 through June 2015 to FAMIS and noted discrepancies as shown in the following table:

Total Population on Check Register	Clerical Errors on Check Register*	Recorded on Check Register, Not Recorded in FAMIS**	Recorded in FAMIS, Not Recorded on Check Register
89 Transactions ($9,385)	$562	5 payments ($54)	8 payments ($291)

**This amount includes two receipts that were duplicated on the check register and two premium payments that were incorrectly recorded on the check register.*

***These payments were for life insurance premium payments from employees according to the check register. DIA could not verify if the checks were deposited or mishandled.*

- Deposits to the County Treasurer were not made timely, checks were held up to a year before being deposited. See more details on page 76.
- Receipts were not consistently labeled in FAMIS before October 2014. The description in FAMIS was not detailed enough to identify all types of payments. One revenue receipt's (RR) description read "Employee Payments for HRA Coverage" while all the other RR's read "FMLA Payment". Payments totaling $2,426 were labeled in FAMIS as FMLA payments even though they were receipts for other purposes; one receipt for $2,394 was a pharmacy rebate.
- Detailed documentation for two RRs was not maintained by Benefits. When performing this reconciliation, the supporting documentation for the two RRs totaling $2,607 had to be obtained from the Fiscal Office.

FINDING Benefits' reports are not accurately completed and reconciled to the County's financial system.

Monthly, Benefits manually prepared premium reports for each type of insurance (i.e. medical, dental, life insurance, etc.) which listed the amount of premiums payments by employees on LOA, FMLA, and COBRA. Benefits compiled these reports from information received from the County's COBRA administrator and from employees on unpaid leave who self-paid for benefits. The information on these reports was added to another report prepared by another Benefits staff member. This report was known as the "Monthly Benefits Revenue Summary". This summary was a report listing the total dollar amount of EE and ER Contributions and the number of subscribers for each type of insurance for all County employees. The summary grand totals were used to determine the amount of revenue in the full-insurance subfund and self-insurance subfund. Benefits submitted a request to the Fiscal Office to transfer the necessary funds from the self-insurance subfund to the full-insurance subfund.

DIA selected 12 employees on leave during March 2015 who self-paid for insurance benefits based on the aforementioned criteria. Benefits should have separated each payment by insurance type on the premium reports. During this review, we noted discrepancies between 22 payments made by the 12 employees versus the premium reports by insurance type. 8 out of 22 employee payments were not included on the respective premium report by type of insurance. This resulted in $203 that was not reflected on the Monthly Benefits Revenue Summary. Furthermore, this resulted in an

accounting error between the self-insurance subfund and full-insurance subfund. DIA also noted similar errors amounting to $317 in months preceding and following the month of March.

Risk to the County if Findings Not Corrected

Benefits did not adequately monitor employees on paid or unpaid leave. No formal procedure manuals were developed to note the process on how paid and unpaid leave status should be initiated and monitored. This has led to violations of the PPM. Furthermore, Benefits is at a higher risk of paying ineligible employee claims and losing revenue if monitoring controls are not put in place.

Benefits does not have adequate procedures in place to ensure invoices are accurately prepared and paid. By not automating this process and not maintaining documentation on invoices there is a higher risk of billing errors.

By not performing a reconciliation between Benefits' Check Register and receipts posted in FAMIS, errors could continue to go undetected and jeopardize the accuracy of the revenue actually received.

Recommendations

3.1 Benefits should monitor all employees on leave on a monthly basis. A report should be generated from SAP listing all employees on leave, the type of leave, any insurance coverage, and start date of leave. This report should be used to:

- Determine if the employee is still eligible for leave per the PPM.
- Determine if the employee should be self-paying for benefits.
- Compare to a listing of employees who are self-paying for benefits to determine that all employees on approved unpaid leave of absence are self-paying for coverage.
- Amount owed/paid.
- Note date billed.
- Note date paid.
- Note date shutoff if not paid.
- Review the prior month.
- Check support for new people on leave to ensure accurate type of leave.
- This report should be monitored in case changes need to be made to employee status or to determine if benefits should be shut-off or continued.

3.2 SAP should notify Benefits through email or an alert in the system when an employee's leave status should be changed to comply with the PPM's various leave policies. Benefits should review the employee's leave status as of the day of the notification to determine if the employee's benefits should be shut-off or continued.

3.3 The County should consider deducting an additional pay period contribution from the employee's first paycheck upon hire to ensure that monthly benefits are paid if an employee leaves the County during the middle of the month.

3.4 Benefits should automate the invoice process by utilizing SAP to generate invoices with the monthly premiums owed by each employee. If not feasible with the current system, Benefits should consider automating this process with the new ERP.

3.5 Supporting documentation should be obtained on the invoice and receipt process. Support should include a checklist of the process that needs to be followed from the time an invoice is generated until the check is received and deposited. This checklist should contain, at minimum, the following:

- Date invoice generated.
- Dollar amount and insurance plan type on invoice is accurate.
- Date approved by supervisor, if necessary.
- Date invoice sent.
- Date check received.
- Check amount reconciles to invoice.
- Date check was deposited.

3.6 A supervisor should be reviewing and approving invoices prior to mailing them. If resources are not available to review and approve all invoices, Benefits should have a policy in place that, at a minimum, all invoices prepared for the first time on employees changing to unpaid leave status should be reviewed and approved for accuracy. Any changes in premium amounts for that employee going forward should be reviewed and approved by the supervisor.

3.7 Benefits should perform a monthly reconciliation between the Check Register and receipts posted in FAMIS. An additional column should be added to the excel spreadsheet to note when the review was completed and by whom. The register should also be reviewed on a monthly basis to determine if payments were not made for employees on unpaid leave so benefits eligibility can be timely adjusted.

3.8 Benefits should review the monthly process of making adjustments from the self-insurance subfund to the full-insurance subfund and consider allocating monies between funds at the time of receipt. This process should be evaluated with the new ERP if not feasible with the current system.

3.9 Benefits should consult with their legal counsel on recovering the medical claims paid on ineligible employees and insurance premium payments not collected as identified in this audit.

Management's Response

As outlined earlier, the County is currently administering a complex benefits program on behalf of 18,000 members on an antiquated system that is scheduled to be replaced in 2018. The lack of alerts and tracking capabilities from this system are areas we continue to address on a temporary basis.

The Benefit Administration Team is working on implementing safeguards to more accurately track premiums due from employees while on leave. At this time, this remains a manual process.

Prior to the release of the Phase II Audit, the County instructed its independent consultant to issue a Request For Proposal for assistance with the creation of sustainable procedures, support and compliance services for Leave/Absence Compliance and Administrative services. Our goal is to have a system implemented to handle this functionality in 2018. We appreciate the Auditor 's recommendations; however, due to limitations within the SAP system, we are presently evaluating alternative safeguards.

Auditor's Response

Benefits will notify DIA when funds are recovered going forward. DIA will periodically follow-up with Benefits on recovery efforts.

Objective #4 – Effective Information Technology Controls were in SAP to Increase Process Efficiencies in Benefits

FINDING SAP lacked adequate segregation of duties and application controls.

Personnel information regarding benefit plans, contribution amounts, and dependents is maintained within SAP for Regional and County employees. The County's IT Department and an on-site third-party contractor supports the software. SAP is a critical system for business operations in assuring the integrity, privacy, security, and consistency of data for reporting and compliance purposes.

DIA met with Benefits staff and IT personnel to ensure controls and procedures were sufficient in supporting Benefits' processes in SAP. The following was noted during our walk-through with IT and Benefits personnel related to benefits data entry:

Performance

- Instead of electronically importing the cost rules for employee and employer contributions for each provider (i.e. MMO) and classification (i.e. SuperMed 90/10 plan), Benefits personnel manually entered the cost rules into SAP.

- No data dictionary existed on the application of cost rules to employees in the system for employee and employer medical contributions. DIA had to inquire with IT Personnel in order to trace classifications of approved rates from the consultant to employee files in SAP.

Application Controls

- A workflow function is available in the current SAP version utilized by the County. This function would not allow any changes to benefits information until there is supervisor approval. The function was not enabled during the audit. Review or approval for changes made to employee benefits was not documented inside or outside of the system.

General Controls

- Any changes made to employees' withholdings during payroll week were not communicated to the employees. If an error from a prior pay period was identified by Benefits, an adjustment is made during the following pay run. Employees were not notified of these changes.
- Employee and employer medical contributions could be modified on the mainframe (application used to import payroll data from SAP into INFOR). The mainframe did not maintain an audit trail and these changes were not reconciled with benefits records in SAP.
- Only the last adjustments to benefits made on the mainframe were saved and stored in a file for record keeping. DIA observed that two of the files were missing during the audit period.
- Multiple individuals from different departments (IT, HR, and Fiscal) had access to change medical contributions amounts on the mainframe.
- Once the final payroll files were imported into INFOR changes to benefits were called in by an HR employee. There was no documented support, or approvals, required for these changes. Also, DIA was unable to determine if changes were timely updated in SAP. There is no evidence the final payroll register was reconciled to SAP.

Segregation of Duties

- SAP lacks segregation of duties between end user duties, operations, maintenance, database administrator (DBA), and security functions within the system. IT completed the import of batch files, performed mass updates and end user duties of modifying records on an as-needed basis. Multiple employees in IT had DBA and security duties and performed development, operations, and end user functions. There was no formal system of HR authorizing changes to employee benefits by IT personnel.
- IT was able to authorize changes to access and create, modify, or delete records on the mainframe as well as making changes themselves.

- There was an onsite IT consultant specifically for SAP. The consultant could make changes to the development, production, and test environments as well as perform DBA duties. End user duties were performed on an as-needed basis as well.

New methods for operating SAP more efficiently have not been implemented due to the customization of the system for integration with the net payroll system under the old County Auditor's Office (now Fiscal Office) and the anticipation of the new integrated ERP system. The allocation of duties to IT staff were not designed with proper segregation of duties, or adequate compensating controls.

Risk to the County if Findings Not Corrected

Without adequate IT controls in place Benefits is at greater risk of unauthorized access and changes to data stored in SAP. Resources (e.g. staff hours, system support) required to maintain and operate the system will increase unless new procedures are put in place to operate the system more efficiently.

Recommendations

4.1 DIA recommends the following controls be put in place to streamline processes and assure the integrity of Benefits data:

Performance

- Benefits should work with IT to develop an import function for benefit cost rules. Rules should be created for employer and employee health benefit contributions in excel spreadsheet format for the approved consultant rates. The cost rules should be imported into the SAP. A reconciliation should be performed between SAP and the cost rule excel spreadsheet for accuracy.
- A data dictionary should be developed to correlate employees with cost rules based on criteria programmed into SAP. All employee classifications in SAP should be reconciled to the approved rates provided by the consultant as mentioned above.

Application Controls

- The workflow function in SAP should be enabled to ensure secondary review of any and all changes to benefits in SAP. All changes to personnel and benefits information should not be posted (parked) until supervisor approval occurs (post).

General Controls

- Employees should receive a documented notification, in the form of an e-mail or letter, if adjustments are made to their withholdings.
- No adjustments to medical contributions should be made on the mainframe. Access to modifying the file should be turned off and all parties should have read-only access to the mainframe. All changes should be made directly in

SAP to maintain an audit trail and reduce the risk for errors or unauthorized changes.

- A reconciliation should be performed between INFOR and SAP after payroll is run. Any unreconciled difference should be researched and adjustments made accordingly in SAP. Retroactive adjustments should be reflected on the following pay run.

Segregation of Duties

- An organizational chart should be developed for the management and operations of SAP. This organizational chart should show that DBA, security, development, operations, and end users duties are properly segregated between employees and departments. There should be appropriate compensating controls, such as the review of audit logs for all employees with incompatible duties.
- The authority for mainframe access and making changes on the mainframe are incompatible and should be properly segregated within IT and HR if adjustments in the mainframe occur.
- The IT consultant job duties should be limited to aiding in the development, configuration, and training of staff on the system. This should reduce operational overhead and limit the number of individuals who have direct access to confidential employee information.

4.2 The County was in the process of planning and implementing a new ERP system. This system will integrate the Fiscal Office's accounting system with Fiscal Office payroll, HR Payroll and Benefits. Throughout the Benefits audit, control weaknesses found should be implemented with the new ERP system. We recommend Benefits review this audit report and consider implementing applicable recommendations into the new ERP system. Specifically, the following information technology controls should be included:

- Recommendations noted in ***Recommendation 4.1*** should be implemented with the new ERP system. Most importantly, DIA believes a workflow function should be enabled to require supervisor approval for all benefit changes.
- An attribute should be added to track employees on COBRA and when the COBRA Provider was notified of qualifying events per employee. This attribute should also be used in comparing the total headcount on monthly COBRA provider invoices to County records.
- An attribute should be added to track employees with FSA and pre-tax benefits so that number can be compared to headcounts on provider invoices (NWGS during audit).
- An attribute should be added to track employees in the wellness program (Health Reimbursement Account). This file should be used to compare the total headcount to monthly invoices and to compare with the third-party administrator's files (MHS and WIQ during audit).

- The new system should have controls in place to ensure invalid SSNs are not entered into the system. Benefits should research the SSAs methodology and include this methodology in the new ERP system. If placeholder SSNs must be used for dependents, Benefits should have a control in the system to notify Benefits staff if the placeholder has been in the system for longer than 2 months.
- The new ERP system should be implemented with a control that does not allow employees to have concurrent medical plans.
- Reports and self-prepared invoices (i.e. life insurance premiums) on SAP data that were not generated from SAP should be generated directly from the new ERP system.
- Benefit termination dates should be simultaneously required when termination dates are entered for employees in the new ERP system.
- Benefits should consider using payroll registers when determining the dollar amounts for adjusting funds from the self-insurance subfund to the full-insurance subfund. Payroll registers should also be used when depositing pre-tax FSA funds into the appropriate bank account. With the new ERP system, the “Flex Employee” deduction should be separated in the payroll registers, and on employee paystubs, to identify the total dollar amount per benefit plan.
- Benefits should receive system notifications for employees on extended leave (FMLA, military, etc.) when employees exhaust all their leave and when employees exceed the amount of time allowed on leave. These controls should be setup in the new ERP system based on the PPM and federal regulations.
- Benefits should also include an attribute in the new ERP system for employees on leave without pay. Monthly, all employees on leave without pay should be compared to employee self-pays for benefits. If no payment is received, the employee should be deactivated from benefits.
- Invoices for employees on leave without pay should be automatically generated from the new ERP system.
- Supporting documentation for benefit changes should be scanned and maintained in the new ERP so documentation can be reviewed and approved by a supervisor.

Management's Response

Prior to the release of Phase II of this Audit, the Benefits Administration team began a series of meetings with the Information Technology department to develop ways to improve the accuracy, efficiency and integrity controls of the SAP structure. The OBA, security, development, and end users' duties have been realigned between employees and departments, and restrictions to changes have been put in place to ensure no changes can be made in SAP unless proper approvals have bene granted. Human Resources has been given the overall authority and approvals for changes to benefits setup in SAP.

The County is presently moving ahead with implementation of a new ERP to replace the SAP structure. With limited resources and competing priorities, the team has decided to focus on resolving issues in the current platform and building the architecture of the new system slated for 2018 implementation.

In the interim, the Benefit Administration team, Information Technology department and our independent consultants are working together to audit short term process and inputs while working toward accommodation of the Auditor's recommendations within the new ERP.

Objective #5 – Benefits Effectively Monitored the County's Pre-tax "Cafeteria Plans" and Conformed with Federal Regulations.

FINDING Benefits did not adequately monitor the County's pre-tax FSA and commuter parking benefits bank account.

Section 125 of the Internal Revenue Code (IRC) allows employers to offer "cafeteria plans" to employees. A cafeteria plan is a separate written plan maintained by an employer to provide employees an opportunity to receive certain benefits on a pre-tax basis. Qualified benefits offered by the County include Dependent Care (DCPA) and Medical (MPA) Payment Accounts, which are Flexible Savings Accounts (FSA). FSAs are savings accounts set up by an employer for an employee with specific tax advantages. The accounts allow employees to contribute a portion of their regular earnings to pay for qualified medical and dependent care expenses. In addition, the County offers employees another pre-tax benefit in accordance with IRC Section 132 for commuter parking.

FSA and commuter parking plans are funded through pre-tax employee deductions. The Internal Revenue Service (IRS) limits the amount of annual deductions. The 2016 limits are listed on the following page.

- FSA MPA = $2,550 for the year
- FSA DCPA = $5,000 for the year
- Commuter Parking = $255 per month

Employees can elect the deduction amount during open enrollment or after a qualifying event (i.e. child's birth, marriage, etc.) for each FSA plan. Employees may be reimbursed up to the total annual election for the MPA anytime during the plan year even if contributions have not totaled the annual election amount. DIA noted County employees could only elect up to $2,080 for the MPA account. This amount was noted in the 2011 contract with NWGS and has not been updated to reflect current IRS legislation of a $2,550 limit on annual elections. Since employees could receive reimbursement up to the total elected amount at any time, the County has not increased the limit as of the date of this report. If the limit is increased, the County increases the risk of paying more in claims than what was contributed by an employee that separated from the County during the year.

Employees could be reimbursed for the DCPA during the plan year up to the total amount contributed by the employee at the date of request. Commuter parking deductions could be elected and canceled through HR Payroll at any time during the year. Commuter parking reimbursements could only be submitted up to the total contribution amount to date, not total annual election amount.

During the audit, we noted deductions were deposited into a County-owned bank account (NWGS account) every month by Benefits for FSA deductions and by Fiscal Payroll for commuter parking deductions. Benefits ran a report from SAP with all FSA deductions for the prior month to calculate the deposit amount. Fiscal Payroll determined the commuter parking deposit amount by reviewing the total deductions from the payroll register of the prior month.

NWGS contracted with the County to administer the FSA plans. Although administration of the commuter parking plan was not included in the NWGS contract the County still utilized NWGS to administer the commuter parking plan as well (See more details on page 60). NWGS received manual employee reimbursement claims for FSA and commuter parking plans from employees. The company issued a check to employees providing that a receipt and invoice was included noting allowable services incurred. Twice a month, Benefits issued a wire to NWGS after Benefits received a list of employees with manual reimbursements. Debit card transactions, used for the MPA plan only, are withdrawn from the NWGS account by NWGS on a daily basis after an email with the amount of debit card transactions from the prior day was sent to Benefits and the Treasurer's Office. NWGS monitored debit card transactions and declined participants if debit cards were used for unallowable expenses.

DIA selected the most recent plan year during our fieldwork (2016) and tested deposits, disbursements, and bank reconciliations to ensure adequate monitoring

controls were in place on the NWGS account. DIA noted the following control weaknesses and financial discrepancies.

Deposits

While testing deposits, DIA noted variances between the bank deposits and amount deducted from employee paychecks. The report generated from SAP (Zjournal) did not accurately calculate the total amount of FSA deductions that were actually deducted from employees' paychecks. DIA ran the Zjournal from SAP which is the most accurate report to the pay registers detailing FSA deductions. The following table shows our results when comparing bank deposits to the Zjournal from January through August 2016.

2016	FSA Deposits per Bank Stmt.	FSA Deductions per SAP Zjournal	Variance from Bank Activity (Deposits over Zjournal)
January	$198,815	$216,861	($18,046)
February	110,236	117,052	(6,816)
March	118,176	116,435	1,741
April	226,949	114,970	111,979
May	115,543	115,892	(349)
June	114,118	116,561	(2,443)
July	-	118,451	(118,451)
August	170,948	178,092	(7,144)
Totals	**$1,054,785**	**$1,094,314**	**($39,529)**
Large variance occurred in April and July 2016 due to timing of deposit.			

Bank Withdrawals

DIA inquired with Benefits on how support for manual reimbursements and debit card transactions are reviewed and reconciled to the bank. The support received twice a month on manual reimbursements was only used by Benefits to calculate the amount of the wire transfer. Benefits did not perform formal reviews on detailed transactions and employees to ensure transactions do not appear unusual and employees were active employees at the County. Benefits could not confirm if reimbursements were made to eligible employees since supporting documentation was not reviewed in detail. Wire transfers averaged approximately $45,000 a month in 2016.

In addition, Benefits did not receive supporting documentation on daily withdrawals by NWGS for debit card purchases. Benefits and the Treasurer's Office received daily emails from NWGS with the amount of debit card purchases from the prior day, and NWGS withdraw the funds from the NWGS account. Withdrawals averaged about $2,602 a business day in August 2016.

DIA noted that debit cards were only offered to employees with MPA plans. Per inquiry with NWGS, the County may offer debit cards for the DCPA and commuter parking

plans, as well. The County could reduce the cost and resources of issuing wires twice a month and could negotiate a lower administrative contract rate with NWGS since the process of issuing reimbursement checks to participants should decrease. However, DIA understands there are risks associated with issuing more debit cards as employees are capable of using debit cards for unallowable transactions in advance of submitting support.

In addition, DIA noted refunds from participants were paid directly to the Benefits Department. Refunds occurred due to unallowable expenses or inaccurate reimbursement amounts. Benefits received the refunds and deposited them into the County's main bank account resulting in the refunds being posted to the self-insurance subfund. Refunds were not deposited into the NWGS account where the funds originated.

Bank Reconciliation

Benefits did not perform monthly bank reconciliations on the NWGS account. No reconciliation was performed to ensure thee accuracy of all withdrawals and deposits from the NWGS account. Furthermore, Benefits should perform reconciliations to heighten the likelihood the bank balance was sufficient to cover FSA and commuter parking reimbursements.

DIA performed procedures on the NWGS account to determine if the bank balance was sufficient to cover FSA and commuter parking reimbursements. NWGS advises all clients to have three months of pre-funded coverage in the bank account since total MPA elections may be reimbursed at any time during the plan year regardless of the amount contributed to date. DCPA and commuter parking plans can only be reimbursed up to the total contributions. DIA recalculated the bank balance for August 31, 2016 in the table below.

Recalculation of Bank Balance with 3 Months pre-Funded Coverage					
2016 FSA Elections	2015 FSA Carryover	2016 Parking Contributions Projection For 2016	Total Amount Available for Reimbursement for Plan Year 2016	Approximation of Funds Needed Per Month	Pre-Funded Coverage for 3 Months
$1,528,858	$119,429	$152,757	$1,801,044	$150,087	$450,261

The bank balance at August 31, 2016 should be approximately $450,261, but the actual bank balance was $202,122. DIA recalculated the bank balance to be underfunded by $248,139. Part of the reason stems from the deposit variance noted on page 32 over the life of the program. Benefits has utilized the SAP Zjournal on funding the NWGS account for over eight years.

DIA performed additional procedures to determine the maximum balance Benefits could have in the NWGS bank account at August 31, 2016. This calculation was based

on IRS regulations that require the County to reimburse employees up to the elected amount for the MPA plan regardless if employees contributed enough funds. The following table shows the maximum cash balance that could be available in the event all employees request reimbursement of their 2016 MPA elections, 2015 MPA carryover, and 2016 DCPA and commuter parking contributions as of August 31, 2016.

2016 MPA Elections	2015 MPA Carryover	2016 DCPA & Parking Contributions as of August 2016	Funds Disbursed as of August 2016	Total Amount Available for Reimbursement as of August 2016
$1,243,832	$119,429	$298,408	$(1,128,212)	$533,457

The cash balance in the NWGS bank account at August 31, 2016 was $202,122. This does not mean the bank account is underfunded by over $330,335, but shows a perspective on the potential liability to the County if this account is not monitored on a monthly basis. Benefits did not receive monthly bank statements and was unaware of the bank balance and the cash balance that should be available for FSA and commuter parking reimbursements.

FINDING Benefits does not have a process to track forfeited FSA funds nor a policy to use the forfeited funds in accordance with federal regulations.

According to IRS regulations, contributions from the FSA and commuter parking plans can be forfeited if not used or reimbursed by a certain date. Forfeited funds in the County's NWGS bank account have accumulated since inception of the FSA and commuter parking plans. Benefits should have adequate monitoring controls on forfeited funds within the FSA and commuter parking plans.

DIA reviewed each plan offered by the County (DCPA, MPA, and commuter parking) for compliance with IRS regulations and to ensure monitoring controls were in place on forfeited funds. The following are results noted per plan.

FSA MPA

According to IRS Notice 2013-71, effective January 1, 2014, an employer may allow employees to carryover up to $500 to the immediately following plan year. For this purpose, the amount remaining unused after medical expenses have been reimbursed at the end of the plan's run-out period for the plan year may be carried over into the following plan year. The carryover of up to $500 does not count against or otherwise affect the election limits applicable to each plan year.

Effective for plan year 2014, the County amended their Section 125 cafeteria plan with NWGS to comply with IRS Notice 2013-71 and offer employees the $500 carryover of unused MPA contributions while removing the grace period option. Any balances from the plan year over $500 is forfeited to the County after the run-out period. The

County's run-out period ends March 31st following the plan year. Participants have the period from January 1 to March 31 to file claim reimbursements from the prior plan year.

Monthly, NWGS provides Benefits with a detailed report by participant enrolled in each type of FSA. This report includes termination dates, annual election, contributions, disbursements, forfeiture balance, and available balance. Benefits does not have procedures or policies in place to track or monitor employee balances. Specifically, Benefits has not implemented a policy on forfeited balances, which would include balances over $500 after the run-out period and balances after employee termination.

Under IRS regulations (Treasury Regulation 1.125-5(o)), the County may use MPA forfeitures in the following way:

1) Retain by the employer maintaining the FSA.
2) If not retained by the employer, may be used only in one or more of the following ways:
   (a) To reduce required salary reduction amounts for the immediately following plan year, on a reasonable and uniform basis. However, in no case may the experience forfeitures be allocated among employees based (directly or indirectly) on their individual claims experience.
   (b) Returned to the employees on a reasonable and uniform basis.
   (c) To defray expenses to administer the FSA.

FSA DCPA

DCPA plans do not allow participants to carryover unused funds into the following plan year. All contributions must be reimbursed for qualified expenses incurred during the plan year. IRS does allow participants to submit reimbursements up to March 31 following the plan year for expenses incurred during the plan year. All contributions not reimbursed for plan year expenses are forfeited to the County after March 31 following the plan year. The County may use forfeited funds in accordance with Treasurer Regulation 1.125-5(o) as noted in the FSA MPA section above.

The monthly report provided by NWGS as noted in the FSA MPA section above includes DCPA participant data as well. Benefits does not have procedures or policies in place to track or monitor employee balances. Specifically, Benefits did not implement a policy on forfeited balances, which would include balances from DCPA plans after March 31 and balances after employee termination.

Commuter Parking

Participants contributing to the County's commuter parking plan may be reimbursed for all commuter parking expenses incurred during the participant's employment time. As long as the employee is an active employee any unused contributions may carry over from year to year. The IRS does allow the County to retain commuter parking plan funds after a certain period beyond an employee's termination. However, the County has never retained any funds from the program and does not have a policy

in place on how and when commuter parking plan balances should be forfeited to the County (i.e. 90 days after termination).

Monthly, NWGS provides the County with a report on participant account balances. This report includes contributions, claims paid, and account balances. However, termination dates are not noted on the report.

Risk to the County if Findings Not Corrected

Benefits is at a higher risk of insufficient funds in the NWGS account if the bank deposit is not regularly monitored and does not accurately reflect the FSA deductions from the pay registers.

Benefits is at a higher risk of transactions occurring from ineligible participants in addition to unallowable purchases if Benefits does not maintain support and review daily withdrawals out of the NWGS account.

In addition, without a policy in place or procedures to track forfeited funds the County could be losing necessary revenue to defray administrative expenses on the FSA program.

Recommendations

5.1 DIA recommends Benefits implement procedures on Deposits in the NWGS account. Specifically, the following should be implemented:

- The SAP Zjournal should be used when determining how much should be deposited in the NWGS bank account every month since INFOR does not separate FSA contributions. The SAP Zjournal is the most reliable source on the contributions deducted from employee paychecks. DIA ultimately recommends that FSA contributions be split out into MPA and DCPA on the County's pay registers each pay period. Deposits into the NWGS account should be calculated from the total amount deducted from the pay registers. This should be incorporated into the new ERP as the current system is incapable of splitting out the FSA plans.
- Periodically, Benefits should spot check employee deductions from the Zjournal to ensure deductions agree to employee elections.
- The County should review and consider allowing employees to elect up to the IRS annual limit for the MPA plan ($2,550 in 2016).

5.2 Bank Withdrawals from the NWGS accounts should be monitored and reviewed for accuracy. Specifically,

- Benefits should review the details of supporting documentation received from NWGS on employee reimbursements prior to making a wire transfer. Support should be reviewed for unusual or extraordinary transactions and for ineligible participants. This review can be a spot check of a sample of employees.

- Benefits should obtain and maintain support from NWGS for daily withdrawals from MPA debit card transactions. Monthly, the support should be reviewed for unusual or extraordinary transactions and for ineligible participants. This review can be a spot check of a sample of employees.
- Benefits should consider the feasibility of offering debit cards to participants for all plans administered by NWGS. Benefits should ensure benefits outweigh the risks on issuing debit cards for the DCPA and commuter parking plans. If determined so, participants should have the option of using a debit card for DCPA and commuter parking transactions. The debit card could reduce the cost and resources of issuing wires twice a month and may result in a lower contract rate with NWGS since the process of issuing reimbursement checks to participants should decrease.
- All refunds from employees should be deposited into the NWGS account where the funds originated.

5.3 Benefits should perform monthly bank reconciliations. Specifically,

- The NWGS bank account should be monitored and reconciled monthly. A reconciliation should be performed at the end of each month to confirm cash is sufficient to cover FSA and commuter parking reimbursements. NWGS recommends the bank balance should contain three months of pre-funded coverage. According to DIA's calculation, the bank balance at August 31, 2016 should be approximately $450,261.
- During the monthly bank reconciliation, Benefits should ensure all transactions are supported with transaction details from NWGS (disbursements) and FAMIS (revenue).
- A supervisor in Benefits should review monthly bank reconciliations. Review should be documented on the reconciliation with signature or initials of the supervisor.

5.4 DIA recommends Benefits develop policies and procedures on monitoring and distributing forfeited funds. Specifically, the following procedures should be implemented for the FSA MPA and DCPA plans:

- Every April, Benefits should calculate the amount of contributions remaining from the prior plan year in excess of $500 per participant from the MPA plan and the amount of contributions remaining from the prior plan year from the DCPA plan. The total amount should be forfeited to the County and be used in accordance with Treasury Regulation 1.125-5(o).
- Benefits should implement a policy that any unused contributions remaining after a period (i.e. 90 days) following termination will be forfeited to the County and used in accordance with Treasury Regulation 1.125-5(o).
- The monthly NWGS report with participant data should be reviewed for employee balances that have been dormant for a period of time, and determine if their balance should be forfeited.

5.5 The following policies and procedures should be developed on forfeitures of commuter parking plan funds:

- After Reimbursement claims should be submitted for eligible expenses incurred during employment for up to a period after any employee has been terminated (i.e. 90 days.)
- Unused contributions not requested for reimbursement within the run-out period, designated by the County, should be forfeited.
- NWGS should include termination dates on their monthly reports. Benefits should review this report for dormant balances, and determine if their balance should be forfeited.

Management's Response

Pre-tax Cafeteria benefits, or Flexible Spending Accounts, provide County employees with access to a meaningful way to pay for predictable expenses on a pre-tax basis.

The County agrees with the Auditor 's findings regarding ban k reconciliation, examination of any opportunity to reduce administrative expense (i.e., bank wires) and offering participants the most efficient means to submit claims (via debit card or mobile app).

Prior to the release of Phase II of this audit, our independent consultants have been instructed to issue a Request For Proposal for the administration, compliance and ongoing management of our Cafeteria Plan. As part of the vendor evaluation process, we will consider the Auditor's recommendations as an important part of prospective vendor review. We will be updating various provisions of the plan including forfeiture rules, rollover provisions and annual maximums in conjunction with our January 1, 2018 renewal.

Objective #6 – Employees were Timely Notified of COBRA Eligibility Benefits in Accordance with the Federal Act

FINDING 5% of employees terminated from 2013 to 2015 were not notified of COBRA benefits.

COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985) requires, in part, employers to notify their plan provider within 30 days of qualifying events. Qualifying events for employees and dependents include:

- Voluntary or involuntary termination of employment for reasons other than gross misconduct.
- Reduction in the number of hours of employment.
- Loss of dependent child status under the plan rules.

- Covered employee becoming entitled to Medicare.
- Divorce or legal separation of the covered employee.
- Death of the covered employee.

After notification is sent by the employer, the plan administrator has 14 days to provide employees and dependents a notice to elect COBRA benefits to continue using their previous employer's health benefits. Ceridian was the County's COBRA provider during the audit period.

DIA received COBRA data from Ceridian for County employees between January 1, 2013 and October 1, 2015. We attempted to compare the entire population of employees terminated from SAP to COBRA records to identify any employees or dependents not offered COBRA benefits. The number of employees and dependents that were eligible to be offered COBRA benefits during this time frame was 1,757. The following instances were noted:

- 82 employees and dependents, or 5%, were never offered COBRA benefits.
- An additional 49, or 3%, of social security numbers from the County's SAP database did not agree to Ceridian's database.

Risk to the County if Findings Not Corrected

The findings noted above are significant internal control deficiencies that expose the County to the following potential penalties and fines according to COBRA, which is administered by the Department of Health and Human Services for government entities:

- Under United States Code Section 4980B - "Failure to satisfy continuation coverage requirements of group health plans" the County is subject to an excise tax of up to $100 per day per violation for each qualifying beneficiary during the noncompliance period. (Minimum fee for noncompliance finding from the Internal Revenue Service (IRS) is $2,500 up to a maximum of $500,000.). The IRS requires employers, The County, to self-report all instances of non-compliance with provisions of COBRA or face additional penalties.
- Liability for payment of health care claims and fines for eligible beneficiary not offered COBRA.
- Civil lawsuits.
- Attorneys' fees and interest.

Recommendations

6.1 DIA recommends the following control procedures be implemented to ensure compliance with COBRA when notifying Ceridian:

- Every month, a report from SAP should be generated listing all employees with COBRA qualifying events in the prior month. Benefits should submit this report to the COBRA provider to ensure the County is in compliance with COBRA on notifying

the administrator of qualifying events. All employees and eligible dependents should be included in this report.

- SAP should be modified to add an attribute for COBRA eligibility. A time stamped field should be added to indicate the County notified the COBRA administrator and if COBRA was elected.
- Periodically, Benefits should be reviewing the COBRA provider's database to ensure all terminated employees were sent to the provider and employees and dependents were notified of COBRA benefits. During this review, Benefits should ensure the COBRA provider's database is complete and all individuals on the list are qualified County employees or dependents. This comparison should also verify the accuracy of social security numbers. Upon completion of the review, it should be submitted to a supervisor for verification and approval.

6.2 The County should immediately complete the following procedures:

- All employees not notified of COBRA benefits should be notified immediately as penalties are subject to an excise tax per day per violation. The notification letters should be issued retroactively.
- The County is required to self-report non-compliance with provisions of COBRA to the IRS on Form 8928 - "Return of Certain Excise Taxes Under Chapter 43 of the Internal Revenue Code".
- Research should be conducted by the County to verify if there are any self-reporting requirements for COBRA violations with the Department of Health and Human Services. DIA could not find any.
- Due to multiple instances of non-compliance with COBRA the County should do a comprehensive review of all COBRA requirements not included in this report and verify compliance with the Act.

Management's Response

Access to continuous coverage through COBRA is an important element of our benefit offering. The County does regret that due to system issues, qualified beneficiaries were not notified of their COBRA rights on a timely basis.

The County discovered this error in late 2015 and immediately issued the appropriate notice and opportunity for individuals to secure coverage continuation. The County also voluntarily filed an 8928 notice with the Federal Government identifying the error and resolution.

Moving forward, our multi-layered auditing process will help the County ensure that in the event of a process failure from an outside technology system, such as in this case, we will identify and resolve the error in a more expedited manner.

Objective #7 – Employee and Employer Life Insurance Premiums were Accurately Deducted and Paid to the Life Insurance Provider

FINDING **County did not accurately contribute or deduct over $21,000 on 15 employees sampled in 2015 for life insurance premiums.**

The County had three life insurance categories offering a combination of Accidental Death & Dismemberment (ADD), Dependent-Life, and Basic Life coverage through Guardian Life Insurance during the audit period. DIA attempted to perform a reconciliation between the SAP Premium Life Insurance Report from January 1, 2015 and the SAP Benefits Journal (Zjournal) for January 2015 to ensure that all employee and employer life insurance premiums were accurate and complete in the County's HR management system and the County's payroll system.

SAP Premium Life Insurance Report – Report on elections made for each employee receiving life insurance benefits and the amount the County paid the provider for the employee and employer portion of the premium.

SAP Benefits Journal ZJournal (ZJournal) – Report on the amount deducted from employees' paychecks and the employer's portion of benefits. DIA compared employee deductions from the Zjournal to the pay registers and did not note any discrepancies.

DIA selected a sample of employees that appeared to have a variance between the SAP Premium Life Insurance Report and the ZJournal – meaning employee deductions may have differed from elected coverage. 1,707 employees appeared to have variances. DIA selected 15 employees to perform detailed testing. We also selected 12 employees with a category other than full-time (i.e. part-time) since only full-time employees are eligible for life insurance benefits. Results from this test included issues found with other benefits deductions (medical, dental, etc.) since DIA reviewed the total deduction amount. DIA provided a summary of findings in the table below on page 42.

Full – Time Employees Test – 15 sampled

- DIA noted the County was contributing more to supplemental life insurance for six employees than allowed through payroll deductions. The County should have only paid $.03 for $6,000 minimum life insurance coverage per eligible employee. The total projected amount the County over contributed was $9,982 for six employees out of our sample of 15 in 2015.
- Certain employees were credited an allowance ($35 or $23 per pay) towards their cost of benefits. The allowance was credited to the total cost of the employee's withholding for benefits. The County credited two employees for the allowance and added the amount to the employer's portion of the cost of benefits. Therefore, double counting the allowance. The total additional amount the County paid was $2,511 for the two employees in 2015.

- Both the County and employees pay contributions toward dental coverage. For one employee, the County was also including the employee premium in the employer contribution amount towards dental coverage. The total projected additional amount the County paid was $183 for 2015.
- One employee of the 15-tested had no withholdings for benefits from the second paycheck in January. The County attempted to correct this on the third check in January. The County paid four times their share of benefits instead of two. In addition, the County did not withhold any amount from the employee but instead should have withheld two times the employee-withholding amount. The additional projected amount the County paid was $622 and the amount not collected from the employee was $364 for 2015.
- One employee of the 15-tested had the incorrect rate for supplemental life insurance withheld from their pay. The projected underpayment from the employee for 2015 premiums was $795.

Other than Full - Time Employees

Per 11.01 PPM – Part-time employees hired on or after January 1, 2008 are not eligible for County provided benefits. Part-time employees receiving County benefits prior to January 1, 2008 will continue to remain eligible to receive benefits. DIA tested 12 employees classified other than full-time (i.e., part-time, terminated, temporary) on the SAP Premium Life Insurance Report which indicates the employees received life insurance benefits. This review was to ensure employees were accurately labeled in SAP and employee deductions for life insurance agree to the life insurance benefit elected. The results of this testing are below:

- 11 employees labeled other than full-time in the Benefits SAP Zjournal were actually full-time employees. One employee was part-time and hired before the date above.
- One employee had no employee or employer withholdings for all eligible benefits (life insurance, dental, medical, etc.) for the first four pays of 2015. The error amount for the first four pay periods was $83 for the employee and $2,456 for the employer. No corrections were made throughout the year.
- One employee had incorrect employee and employer withholdings for the first seven pays of 2015 for all eligible benefits. The error amount for the first seven pay periods was $171 for the employee and $4,188 for the employer. No corrections were made throughout the year.

Instances with monetary effect to the County noted above were summarized in the table below. These errors had a negative effect on the County's Internal Service Fund.

	Employee (Loss of Revenue)	Employer (Not Contributed)	Total (Loss of Revenue)
Total Dollar Amount of Discrepancies Found	($1,413)	($19,942)	($21,355)

FINDING **Benefits overpaid the life insurance provider, Guardian Life, by approximately $10,000 in 2015 due to reporting errors in SAP.**

Benefits self-prepared life insurance premium invoices by inputting the headcount, coverage amount in dollars, and rate for each $1,000 of coverage by category into an excel spreadsheet. This information was obtained by running reports in SAP that summarized the headcount by line of coverage. Once Benefits entered the totals into the excel spreadsheet the amount of the premium due was calculated for payment. There should be controls in place over the process of generating the invoice to ensure all employees with life insurance coverage are accurately included in each plan type.

DIA selected the invoice for the month of January 2015 to reconcile the headcounts, dollar amount of life insurance coverage, and total employee and employer contributions to SAP. The supporting documentation did not give a detailed breakout of the employees in each coverage area. A report in SAP did not exist that displays detailed information for the entire month, however there was a County customized premium report in SAP that could generate the data for one day within the period. This report was used to complete DIA's testing of life insurance premium payments.

DIA noted an unreconciled variance of over $800 between the invoice and SAP premium report when DIA attempted to reconcile the amount of employee contributions for ADD. When DIA performed the dollar amount of life insurance coverage reconciliation between SAP and the invoice the cause of the variance was identified. The ADD coverage is broken out on the invoice by AFSCME and non-AFSCME employees. AFSCME employees are required to contribute 100% of their premiums for each line of coverage. AFSCME employee dollar amount life insurance coverage for ADD was over reported on the invoice by $82,856,000 which caused a premium overpayment of over $800 for January 2015. The SAP premium report used to populate the invoice was double counting AFSCME supplemental life insurance coverage in two different categories on the invoice, ADD and supplemental life.

DIA noted the same issue existed in life insurance invoices through April 2015. We projected the results for the remainder of 2015. The following table shows the results of the review.

Period	AFSCME ADD $ Coverage Per Invoice	AFSCME ADD $ Coverage Recalculated	AFSCME AD&D Variance (Invoice - Recalculated)	Overpayment*
Jan - Apr 15 Act.	$359,876,000	$26,850,000	$333,026,000	$3,330
May - Dec 15 Projected**	719,752,000	53,700,000	666,052,000	6,661
Total Overpayment (Act. + Proj.)	$1,079,628,000	$80,550,000	$999,078,000	$9,991

**Overpayment calculated by multiplying ADD monthly rate of $.01 per $1,000 of coverage by the AFSCME ADD Variance column.*

*** Projected amounts calculated by dividing the life insurance coverage amounts from January through April 2015 by four and multiplying the results by the remaining eight months.*

FINDING Imputed life insurance income was incorrectly calculated on employee W-2s in 2015.

Internal Revenue Code (IRC) section 79, administered by the Internal Revenue Service (IRS), requires imputed life insurance income to be reported on employee W-2s when an employer provides any amount of group term life insurance, directly or indirectly, and employee coverage is in excess of $50,000. A group term life insurance policy is considered to be paid directly if the employer pays any of the cost and indirectly carried if employee life insurance premium rates are subsidized for employees. When employees elect coverage in excess of $50,000 they are subject to imputed life insurance coverage due to the County contributing to employee life insurance coverage on a pre-tax basis under Section 125 of IRS's cafeteria plan.

Monthly imputed life insurance income is calculated using the following equation:
Monthly IRS rate based on employee's age at December 31 x [(insurance coverage amount - $50,000)/1,000)]

IT coded this calculation into SAP and automatically calculated each pay period. DIA recalculated imputed life insurance income for all employees with coverage for 2015 based on the 2015 IRS rate schedule. Recalculated amounts were traced to payroll records to ensure accuracy and completeness.

DIA noted 536 of the 5,764 employees, or 9%, that had life insurance coverage for the entire year did not have the correct amount of imputed life insurance income reported on their W-2s. DIA only reported on discrepancies in excess of $12 to provide for rounding errors. The total amount of underreported life insurance imputed income was $30,798, while $9,267 was over reported on employee W-2s.

$4,308 of the over reported life insurance imputed income pertained to misreported domestic partner imputed income. This imputed income only qualifies to employees electing medical plans with domestic partners as dependents. Since the IRS does not recognize domestic partners as dependents under 26 U.S. Code Section 152, the County must include any benefit provided to a domestic partner as taxable income to the employee. The domestic partner imputed income should have been calculated differently based on IRS rate schedules for non-tax dependents and reported on employee W-2s in box 14 (other item) instead of box 12C (cost of group term life insurance).

DIA inquired with Benefits but could not identify the cause of all variances, however other variances were caused by the method of calculating imputed life insurance income for employees moving into a new age bracket throughout the year. The IRS

requires imputed life insurance income to be calculated based on the age the employee attained at the end of the year for the entire year, not pro-rated as it is currently calculated and applied at the County.

Additionally, seven employees had duplicate lines of coverage for term life insurance, when they only qualified for one. It appeared the employees were covered under non-bargaining life insurance and AFSCME life insurance for the same coverage. Benefits did not provide a reason for the multiple lines of coverage.

FINDING Benefits did not approve life insurance claims and SAP was not accurately updated to record the status of terminated employees as "deceased".

The County is responsible for completing the initial documents when beneficiaries reach out to the County to receive life insurance claims. Once the County confirms the beneficiary is eligible to receive the life insurance claim, all documentation is sent to Guardian for processing and payment. The County does not handle physical checks for life insurance claims

DIA obtained a list of life insurance claims for all County employees from January 1, 2010 through July 12, 2016 from Guardian. All claims processed during 2014 and 2015 were tested for accuracy. DIA was able to extract all employees from SAP that were coded as deceased during the same period. The two reports were compared for errors or irregularities. The following was noted:

- SAP disclosed 16 employees that were deceased during 2014 and 2015. All life insurance claims for the 16 employees were properly handled by the County (14 received life insurance claims through Guardian, one was handled through the AFSCME Care Plan, and one did not receive a claim since life insurance premiums were not paid while the employee was on medical leave). However, SAP failed to record four employees in SAP as "deceased" that received claims during 2014 and 2015. Upon further examination in SAP the four employees were coded as "resigned" rather than "deceased". DIA confirmed the four employees were deceased through support maintained by Benefits and online obituaries, but SAP was not accurately updated.
- During review of supporting documentation maintained by Benefits for life insurance claims, we noted no supervisor approval is required before submitting the support to Guardian for claim processing.

Risk to the County if Findings Not Corrected

The County is at a continued risk of overpaying life insurance premium to Guardian and losing contribution revenue if preventative monitoring controls are not put in place. Not detecting differences between the SAP Benefits Zjournal and the SAP Premium Life Insurance Report has caused inaccurate life insurance payments for employees' insurance coverages and a loss of revenue to the County. This could ultimately lead to

the underfunding of the self-insurance subfund for life insurance premium commitments.

Benefits or Fiscal has never attempted to recalculate imputed life insurance to ensure employees tax liability is accurate. These instances of noncompliance have led to the filing of inaccurate employee W-2s. Additionally, the IRS can levy up to $260 for each incorrect W-2, up to a maximum of $3,193,000 per year.

The County is at risk of tracking and reporting terminated employees incorrectly if controls are not established or adequate training is not given to ensure employees status is accurately entered in SAP. The County is also at a greater risk of filing false or inaccurate claims without a secondary level of review prior to submitting life insurance claims.

Recommendations

7.1 DIA recommends benefits periodically review the SAP Benefits Zjournal and investigate any employer life insurance contribution greater than $.03 per employee per paycheck and any employer dependent life insurance contribution greater than $.16 per employee per paycheck. A spot check of a small sample of employees should be performed periodically throughout the year to verify employees' insurance coverages are accurate as well as the payroll deduction.

7.2 An annual reconciliation between the SAP Premium Life Insurance Report and Zjournal should be performed to ensure all deductions reconcile to the elected life insurance coverages. This reconciliation should be incorporated into the new ERP.

7.3 DIA recommends the following preventative and corrective controls to address the findings on generating invoice data from SAP for life insurance premium payments:

- A new invoice report should be generated in SAP to replace the excel document currently in use. This report would summarize the total headcount by plan type, amount of life insurance coverage, rate, and employee and employer contributions. This will help reduce data entry errors, increase consistency, and make the process more efficient. Staff members will spend time analyzing the data instead of running multiple reports and entering the information into a separate software package.
- The life insurance premium report should be modified to run for an entire month rather than one day. This detail can then be compared with the new invoice report for the headcount, dollar amount of life insurance coverage, and overall premium amounts for accuracy and completeness.
- The headcount, dollar amount of life insurance coverage, and overall premium amounts should be compared month over month and year over year for reasonableness. This will ensure the system is operating as intended.
- Benefits should consult with the Law Department and consider recovering the overpayment to Guardian and verify the projected overpayment from May through

December 2015. If so, $9,991 should be considered for recovery from Guardian. In addition, Benefits should review prior year invoices and 2016 invoices for potential overpayments due to misreporting of AFSCME ADD premiums. Any overpayments identified from the review should be considered for recovery.

7.4 DIA recommends the following preventative, detective, and corrective controls to address the findings and ensure compliance with IRC 79 in future periods:

- Review W-2s to determine if amended tax returns are necessary for the employees with misreported imputed life insurance income.
- Correct the calculation of imputed life insurance income in SAP for 2017, and going forward, so the calculation is based on the age the employee attained at the end of the year, instead of prorated throughout the year.
- Break out domestic partner imputed life insurance income to ensure it is not reported erroneously with life insurance imputed income.
- Review prior years' information to see if the same issue occurred, and follow the same corrective steps above if issues identified.
- An application control should be implemented in SAP that will not allow an employee to have more than one term life insurance policy in the system.
- On a periodic basis, such as quarterly, review the life insurance premium schedules for employees with more than one line of coverage and correct any errors.
- Annually, a random sample of employees should be selected to recalculate their imputed life insurance income and compare to their pay checks. This audit will assure the rates were accurately calculated in SAP.

7.5 DIA recommends that all life insurance claim forms be reviewed and approved by a supervisor in Benefits before submission to Guardian for processing. The supervisor should verify that all support is maintained and the employee is properly reflected in SAP as "deceased". If a discrepancy is noted in SAP Benefits should notify an HR Analyst to correct the record. Furthermore, Benefits should ensure HR Analysts receive the necessary training and state the importance on recording the correct status of an employee in SAP.

Management's Response

County-paid life insurance and employee optional life insurance are important aspects of our benefits program. We know employees' families rely on these benefits in the unfortunate event that a family member is deceased. We believe it is paramount to underscore that no employees or dependents were denied access to qualified life insurance benefits through the County's program.

With the significant system limitations that exist in our current ERP and current staffing levels in the benefits administration team, several the Auditor's recommendations are impossible to

address however we are confident the new ERP platform will streamline work and will accommodate a more robust set of rules and processes in the future. This will help to ensure the consistency and accuracy of billing, eligibility and premium remittance.

As mentioned earlier, the County is actively working on building the infrastructure behind our new ERP slated to be live in 2018. This new platform will contain a more rigid structure to ensure the consistency and accuracy of billing, eligibility and premium remittance. While many of the Auditor's recommendations are impossible to address within our existing ERP, we are confident the new platform will be able to accommodate a more robust set of rules and process.

In the interim, the County's Benefit Administration team, IT staff and our independent consultants have integrated a variety of data sources that will be auto-audited through a technology solution moving forward. This auditing process will allow the County to operate in a more compliant manner in the short term. For those items that cannot be audited we have begun the process of developing a project plan to map out what needs fixed, how we will get there, who will be involved and a related timeline.

Auditor's Response

Benefits will notify DIA when funds are recovered going forward. DIA will periodically follow-up with Benefits on recovery efforts.

Objective #8 – Social Security Numbers in SAP agreed to Provider Eligibility Files and were Consistent with the Social Security Administration Methodology on Assigning Numbers.

FINDING Over 1,300 County and Regional employees' and dependents' SSNs in SAP did not follow the SSA's methodology on assigning SSNs

Accurate and complete employee and dependent social security numbers (SSN) are crucial to operations in Benefits. Employees are required to submit a SSN for themselves and their dependent(s), if family plans are selected, to HR after selecting a medical plan. A SSN should be a unique identifier of personal identity issued by the Social Security Administration (SSA). Benefits should ensure SSNs are accurately and timely recorded in SAP and provider eligibility files.

The SSA has disclosed their methodology for issuing SSNs by area (state, zip code, and address). DIA performed a test on County and Regional employee and dependent SSNs in SAP with medical benefits. The table on the following page identifies the types of

tests performed and the instances noted when comparing SAP SSNs to the SSA's methodology on assigning SSNs.

County and Regional employees and dependents in SAP with medical benefits from January 1, 2010 through June 30, 2015	
Total Population	28,641
Total tested with potential issues	2,014, or 7%

After reviewing the 2,014 SSNs with potential issues, DIA identified 1,358 SSNs that appeared to be invalid SSNs according to SSA's methodology on assigning SSNs.

- The first three numbers in the SSN for a County employee and a Regional employee may have never been issued. The employees' SSNs begin with "821" and "999", respectively.
- Four Regional employees, 342 Regional and County dependents (346 total) had SSNs with group numbers that were never issued with the area number as identified by SSA prior to 2011.[1]
- The first three numbers in the SSN for 784 Regional and County dependents may have never been issued. The dependents SSNs begin with "904", "921", "922", "944", "984", and "999". 779 of the 784 dependents had SSNs as "999-99-9999".
- 226 County and Regional dependents had SSNs that appeared to be invalid due to area numbers being issued after 2011.[2]

Other issues noted during this test included:

- A County or Regional dependent had the same SSN as another dependent in six different instances.
- 19 County or Regional dependents appeared to be covered on multiple medical plans for more than one County or Regional employee during the same period. These instances are not in compliance with the PPM, section 11.01, which states, "No dependent can be covered by more than one County sponsored benefit plan."
- Clerical errors appeared to occur for two County employees. Both employees had two different SSNs that varied by one number.
- One Regional employee appeared too young to be an employee with a birth date of March 6, 2015.

[1] *Prior to 2011, the first three digits of the SSN denote the area (or State) where the application for an original SSN was filed. Within each area, the middle two digits, or group number, range from 01 to 99 but are not assigned in consecutive order. Group numbers issued first consist of the odd numbers from 01 through 09 and then even numbers from 10 through 98, within each area number allocated to a State. After all numbers in group 98 of a particular area have been issued, the even groups 02 through 08 are used, followed by odd groups 11 through 99. SSA maintains a list of the highest group numbers issued as of a specified date. DIA utilized this information to support our results.*

[2] *In June 2011, SSA developed a new method, "randomization", when issuing SSNs. More area numbers became available beyond "586". The area numbers identified in this comment were not issued prior to 2011.*

Benefits used "999-99-9999" as a placeholder in SAP until the actual SSN was provided for a newborn dependent. DIA noted SSNs were updated and corrected in some cases, but not all were changed to a valid SSN as 779 dependents still had the SSN at the time of the audit.

The above results were research by DIA in SAP and the payroll records to determine if ghost employees existed. DIA did not find any instances of ghost employees when comparing to W-2s, but more detailed testing could be performed on these results and will be considered by DIA in future audit plans. The list was given to Benefits so further review could be done with supporting documents.

FINDING 116 medical subscriber SSNs in provider eligibility files could not be located in the County's HR system, SAP.

The County should have adequate internal controls established to verify that only eligible employees and their qualified dependents are enrolled in the County's health insurance coverage. Section 11.01 of the County's PPM dictates that only employees and qualified dependents can have benefits through the County.

DIA compared County and Regional subscriber SSNs between medical provider eligibility files and SAP eligibility files to confirm all subscribers eligible for benefits were County or Regional employees. The provider files had 8,614 unique social security numbers of which 116 could not be located in SAP for the period January 1, 2012 through June 30, 2015. DIA tested 87 of the 116 subscriber numbers with claims paid on their behalf as these were deemed higher risk. The following table is a breakdown by category, and County or Regional subscribers, of the issues found.

Head count by Reason for Exception

Reason for Exception	County Subscribers	Regional Subscribers	Grand Total
No Record of Employee in SAP, *	5	11	16
No Health Benefits in SAP **	21	2	23
Benefits Terminated Prior to 2010	5	-	5
Benefits Eligibility Backdated in SAP	1	-	1
Differing SSN Between Provider and SAP	11	31	42
Grand Total, * **	43	44	87

** HR Benefits only researched the County subscribers and suggested that it was due to former employee dependents having COBRA after their termination. No support was provided to substantiate these responses.*

*** 16 County dependents were not associated with a subscriber in SAP. Four County Employees had benefits at some point in SAP audit logs, but not shown in SAP personnel records meaning the file was deleted. No support provided for the modifications to one former employee benefits in SAP.*

**** Seven ineligible County subscribers and one regional subscriber had benefits as of June 30, 2015. Benefits only verified the former County employees still had coverage and discontinued their benefits with the providers. No response received on the Regional employee.*

The following table is a summarization of the associated claims for the period under audit, except for UHC which only provided claims detail from January 1, 2013 through June 30, 2015. Results shown below are in addition to other findings in this report on claims being paid for ineligible medical subscribers.

Summarization of Claims Paid by Reason for Exception			
Reason for Exception	**County Subscribers**	**Regional Subscribers**	**Grand Total**
No Record of Employee in SAP	$21,449	$48,361	$69,810
No Health Benefits in SAP	56,888	38,401	95,289
Benefits Terminated Prior to 2010	3,470	-	3,470
Benefits Eligibility Backdated in SAP	190	-	190
Differing SSN Between Provider and SAP	31,434	25,150	56,584
Grand Total	**$113,431**	**$111,912**	**$225,343**

Risk to the County if Findings Not Corrected

By not having the correct SSNs for each employee or dependent there is an increased risk of having a fictitious employee or dependent on a County medical plan.

HR Benefits does not have any procedures to test provider eligibility to ensure that only eligible employees, and their qualified dependents, have insurance coverage. This lack in oversight of provider eligibility increases the risk of health insurance fraud and increases the risk of unnecessary claim payments.

Recommendations

8.1 DIA recommends Benefits periodically review dependent and employee SSNs in SAP to ensure accuracy and completeness with provider files and the SSA. Any anomalies identified by DIA should be researched and corrected, if necessary. Annually, Benefits should request a list of SSNs in SAP for County and Regional employees and their dependents. This list should be reviewed for any anomalies. SSNs that appear to be invalid (less than 9 digits or area number never issued) should be investigated further. This file should be reviewed for SSN duplicates and concurrent plans for dependents. DIA recommends exploring the option of having SSA's methodology coded into the new ERP for SSNs on new employees and dependents to reduce the risk of ghost employees being entered into the system. Any invalid SSNs entered should notify a HR supervisor to investigate the incident.

8.2 Benefits should also review SAP SSNs on a monthly basis to ensure dependent SSNs are timely updated if a placeholder of "999-99-9999" is used. Benefits personnel should receive notifications from SAP after a pre-determined amount of time (e.g., monthly) if dependent SSNs have not been changed from the placeholder number.

8.3 Benefits should develop and document a process in ensuring ineligible subscribers are not receiving benefits under County or Regional plans. See recommendations on page 11 for more details.

Management's Response

In Fall 2016, the County began a comprehensive eligibility audit and review process. Member identification information was collected from all plan participants and updated in the various systems the County employs to manage the benefit program.

A process has been established and in formation will be audited by the Benefits Administration team monthly to ensure that member identification information remains accurate in County systems. The monthly audit will be completed at the end of each month and will allow us to look at things such as duplicate social security numbers (SSN), temporary SSN's and any other anomalies. In addition, it will be the County's goal to complete a comprehensive eligibility audit every three to five years moving forward.

The process for tracking temporary SSN's, (e.g. 999-99-9999) has now been documented and a related procedure has been put in place which will be monitored in the monthly audit moving forward. The temporary SSN is entered for the birth of a child who has yet to be issued a SSN by the government. Upon enrollment in benefits for the new child, the employee is notified that they have sixty days to update HR with the assigned SSN or the dependent will be dropped from coverage barring extenuating circumstances if there is a delay.

Auditor's Response

Benefits will notify DIA when funds are recovered going forward. DIA will periodically follow-up with Benefits on recovery efforts.

Objective #9 – Benefit Rates were Formally Approved by Appropriate County Management and Accurately Recorded in SAP. Changes in Benefits Status was Done in Accordance with the PPM.

FINDING No sign of formal approval was evident on benefit rates for the 2016 plan year.

The County's previous healthcare consultant, EBI, annually proposed rates to the County on benefits offered to employees. These proposed rates were broken down by employee and employer contributions on a monthly basis. Maintaining an optimal balance between the employee and employer contributions represents a material

financial and personnel risk to the County as it impacts the County's budget and employee paychecks. There should be a formal approval process involving upper management that documents the overall rates and the breakdown between employee and employer contributions.

DIA made inquiries of Benefits personnel about the process for approving the employee and employer medical contributions in 2015 for the 2016 plan year. Benefits could provide a spreadsheet of the rates that were input into SAP. Benefits could not provide support on approval of the rates in effect for the 2016 plan year. Benefits stated the former Interim HR Director, who managed the process of implementing the rates for 2016, would have obtained verbal approval for the rates from the County Executive's Office.

FINDING DIA noted discrepancies between medical rates selected and actual payroll deductions for 53 employees in 2015.

DIA performed a reconciliation of the premium rates by plan to the SAP Zjournal for 2015 to ensure that all medical contributions from employees and the County were accurately deducted in accordance to the rates set by the County. Benefits should have procedures in place to ensure rates are accurately entered into SAP and deducted from employees' paychecks.

DIA obtained the medical premium rates for 2015 and only tested employees with 27 pay periods in 2015, due to the complexity and time of recalculating the annual premium for employees with less than 27 periods.

We sampled 4,801 out of 6,231 employees with medical benefits in 2015, or 77% of the total population. Out of 4,801 employees tested in 2015 with medical benefits, we noted variances in 53 employee deductions netting to $1,929 in shortages. In addition, ER contributions for 4,736 employees with medical benefits in 2015 were not deducted netting $79,728 in shortages. The following table shows our results:

Contributions	Number of Employees out of Sample with EE Discrepancy	EE Dollar Amount (Not Deducted)	Number of Employees out of Sample with ER Discrepancy	ER Dollar Amount (Not Deducted)
Too Little was Deducted	43*	($4,568)	4,721	($81,863)
Too Much was Deducted	10	2,639	15	2,135
Total	53	($1,929)	4,736	($79,728)

** For example, 24 employees from various agencies throughout the County failed to contribute over $118 per employee for 2015 to the County's MMO health plan.*

The findings above appear to result from clerical errors when Benefits enter premium rates into SAP for a specific plan and, in some cases, for a specific employee. Since 1,430 employees were not tested, DIA projected the error rate for 2015 according to the findings above to be approximately $106,081[3] in the amount not deducted from employee paychecks for medical contributions in 2015, employee and employer contributions.

We noted employees were unable to identify any errors in their deductions due to system constraints with the Fiscal payroll system. All employee contributions for medical, dental, vision, life insurance, and flexible savings accounts were included in summary on the employees' pay stubs. The Fiscal payroll system lacks an important detective control that could be discovered by the employees if employee deductions are separated on their paystubs.

FINDING Benefits did not maintain appropriate supporting documentation in accordance with the PPM for 40 out of 50 employees with medical plan changes.

Benefits is responsible for receiving and updating changes in employee benefits status. Having controls in place to ensure employees and their dependents are authorized to receive County benefits is critical to Benefits' operations. Section 5.03 of the PPM states that an employee is required to complete an eligibility verification form within three days of being hired. This form requires the new employee to submit verification support like their social security card, driver's license, and/or birth certification. Furthermore, Section 11.01 of the PPM states, "New employees have thirty (30) days from their hire date to make their benefit elections and to submit documentation regarding dependents." The following documentation is required to be submitted for dependents:

- Marriage License (Spouse)
- Social Security Card (Spouse and Dependent)
- Birth Certificate (Spouse and Dependent)
- Legal Guardianship Documents (Dependent)

DIA conducted controls and compliance testing on 40 employees added to County medical plans during the period of July 1, 2014 through June 30, 2015. The following issues were noted:

- Benefits lacked documentation to support 35 (88%) employees added to the County's medical plans. That documentation includes a combination of documents as required by section 5.03 of the PPM.
- Benefits did not maintain sufficient documentation in accordance with Section 11.01 for three of 10 (30%) employees adding a spouse. In two instances, no

[3] *(81,657 ÷ 4801 x 6237 total employees with medical benefits in 2015)*

documentation was maintained. In one instance, the spouses W-2 was submitted as support to Benefits.

- Benefits did not maintain sufficient documentation in accordance with Section 11.01 for one of 17 (6%) employees adding children. Support maintained was a divorce decree to provide health care to the children.
- After employees and their dependents were verified and entered into SAP, no review or approval was evident by an immediate supervisor to confirm supporting documentation was obtained in accordance with the PPM in all 40 (100%) employees tested.

In addition, DIA also tested a sample of 10 employees that had a change of benefits status during the period of July 1, 2014 through June 30, 2015 to confirm that changes were made for a qualifying event. According to the PPM, Section 11.04, examples of benefits status changes include:

- Marriage.
- Divorce, legal separation, or annulment.
- Birth, adoption, placement for adoption, or legal guardianship.
- Change of status in child custody.
- Death of dependent.
- A child who is no longer a legal dependent or a dependent reaching age twenty-three (23).
- Loss of alternate coverage.
- Certain reductions/increases in work hours and or work status (i.e., from part-time to full-time).

DIA noted that proper documentation was not maintained for adding a dependent for 1 (10%) employee. A change of benefits form or birth certificate was not maintained by Benefits for adding a dependent.

Benefits did not require approval for adding new employees and dependents to medical plans. Contrary to their PPM, Benefits did allow exceptions to their policy for allowable documentation on adding dependents.

In addition to the 50 employees tested above, we noted two employees that switched to a MHS plan from the UHC or MMO plan during 2014 absent a qualifying event. DIA was unable to obtain documentation to authorize these changes. Benefits stated that there was an informal undocumented appeals process, which allowed them to make these changes throughout the plan year. The PPM does not specify allowable events for an appeal, approving authority, or documentation necessary for the plan change.

Risk to the County if Findings Not Corrected

There is no formal approval process to authorize the rates and the breakdown between employee and employer contributions. Without proper oversight, there is an increased risk that unauthorized medical rates are input into SAP.

By not having controls in place to review and approve adding new employees and dependents to medical plans there is a higher risk of missing documentation or the addition of fictitious dependents to County medical plans. Furthermore, Benefits is at risk of accepting dependents without proper documentation absent a formal policy on acceptable documentation.

The lack of a clearly defined appeals process could lead to unauthorized medical plan changes. Furthermore, employer medical benefit contributions could be affected without proper fiscal considerations.

Recommendations

9.1 In Phase I of the benefits audit, "ORC 9.833 - Self-Insurance Program" finding, DIA recommended the County re-establish the Benefits Advisory Board to provide monitoring and oversight over the administration of benefits at the County. This Board should review and approve all benefits rates for the County, including the breakdown between employee and employer contributions, on an annual basis.

9.2 The process of entering approved rates should be automated so that rates can be imported into SAP rather than manually entering them under each plan. The risk of clerical errors is reduced and Benefits staff can utilize their time on other pressing matters. After the approved premium rates are imported into SAP, Benefits should spot check the import, confirm rates were accurately recorded and comply with the approved premium rates per plan.

9.3 The Fiscal Office should separate each plan deduction on employee pay stubs so employees can review and detect any discrepancies in their deductions, and timely notify Benefits.

9.4 DIA recommends the following on adding dependents or changes in benefit status:

- Benefits should comply with the PPM and maintain copies of employee and dependent documentation to support all participants in the County's medical plans.
- HR should update or formalize their policy on acceptable documentation for adding dependents if tax documents or court orders are acceptable (i.e., divorce decrees, spouse's W-2).
- After changes to an employee's medical plan occurs, a supervisor should review that all required documentation is received and maintained by Benefits. Approval by the supervisor should also be evident with a signature or initials. Benefits should consider performing the supervisor review electronically with the new ERP system. The new ERP system should also incorporate a workflow function in the system to prohibit benefit status changes from posting to the system until an immediate supervisor electronically approves the change.

9.5 The PPM should be amended to clearly define changes in medical plans throughout the year. Specifically, the PPM should identify allowable events for an appeal, the approving authority, and documentation necessary. In addition, the medical plan field should be locked within SAP to prohibit changes throughout the plan year unless proper authorization and supporting documentation is obtained. A change in medical plans should not be allowable unless approved by a supervisor. This could be implemented with the new ERP if the current system is incapable of the change.

Management's Response

Ensuring the accuracy of rate development, organizational charges and employee contributions is a critical element of managing the County's complex benefits program.

As outlined in Phase I of the Auditor's findings, the County has created a collaborative Benefit Advisory Team which consists of members from the benefit administration group, finance, legal and the Executive's office. One of this group's responsibilities includes a review of plan performance and rating. County rates for 2017, which were developed during 2016, were reviewed by this group and have been presented to County Council. This review and approval process will continue for future plan years.

The Auditor' s recommendations for entering rates and separation of employee contributions are being addressed as the County creates processes and procedures with the new ERP solution as the current SAP structure is unable to accommodate these items. As these new processes and procedures are created, the benefit administration team is also working to ensure consistent execution of the PPM.

Objective #10 – Payments on Contacts were made in Accordance with the Contractual Agreements and Encumbered in Conformity with the ORC

FINDING DIA identified potential overpayments for three contracts totaling $90,237 from 2012 to 2015.

Benefits agreed to contract with various benefits providers. During the audit, we identified potential overpayments to three vendors 1) WIQ – Wellness plan provider, 2) Ceridian – COBRA provider, and 3) NWGS – FSA and commuter parking benefit administrator. The findings are noted on the following pages.

WIQ

Benefits entered a contract with WIQ to administer the Vitality Wellness Program for employees from January 1, 2012 through December 31, 2014. In December 2014, the contract was extended from January 1, 2015 through December 31, 2017. The contract specified that WIQ would bill the County at a specified rate PEPM for each employee enrolled in medical benefits (MMO, UHC, MHS). The rates were set as follows:

Year	Rate
2012	$5.00 PEPM
2013	$5.50 PEPM
2014	$6.00 PEPM
2015	$6.00 PEPM

DIA recalculated the Vitality fees paid to WIQ from January 1, 2012 through November 30, 2015. We used monthly reports generated by Benefits, and sent to EBI (common ownership as WIQ), that show a headcount of employees with medical benefits by provider. Benefits was not able to locate all of these reports. A headcount of employees with medical benefits was obtained by directly accessing SAP when the report was not available. These headcounts were used to recalculate the number of employees enrolled in medical benefits for comparison to WIQ's monthly invoices. The following table highlights the total headcount by year based on the County's records compared to WIQ's invoices.

Description	2012 *	2013	2014	2015 **
Recalculated Participants* **	71,007	70,266	71,406	66,330
Participants Billed by WIQ	74,224	74,580	74,699	67,928
Variance Over / (Under)	3,217	4,314	3,293	1,598
Variance Over / (Under) %	4.5%	6.1%	4.6%	2.4%

** No invoices were obtained from WIQ for the first four months in 2012. DIA used the number of participants billed by WIQ from the May 2012 invoice which should not materially differ.*

*** Recalculation does not include December 2015 employees, as the fees associated with the headcount were not been paid as of April 2017.*

**** Summarization of the number of employees enrolled in a medical plan per month by year.*

In addition, DIA reviewed monthly experience reports from EBI for 2013, 2014, and through June 2015 as a comparison to the above-recalculated headcount. Headcounts on the monthly experience reports were derived from County eligibility files provided to EBI. DIA did not obtain the experience reports for 2012 or July through November of 2015. Based upon the records obtained DIA concluded that our headcount recalculations in 2013, 2014, and through June 2015 were not materially different from EBI's experience reports. EBI's experience reports were 1,145 employees (average of

38 a month) more than DIA's recalculation for the 30 months. EBI's experience report headcounts were, however, materially different from WIQ's invoices. On average per month, WIQ's invoices listed 266 more participants than EBI's experience reports. WIQ billed the County for 7,990 more participants than the number of employees enrolled in medical benefits when comparing to EBI's experience reports (30 months).

Finally, DIA recalculated the total fees that should have been paid to WIQ compared to the actual amount of payments. WIQ also received "Wellness Subsidies" directly from MMO and UHC. The subsidies were included in the County's contract with the providers as an incentive to establish a wellness program. The providers reimbursed the County up to a certain dollar amount each year for wellness expenses. The County elected to have some of the reimbursements sent directly to WIQ. Subsequent invoices from WIQ for vitality services were credited for the wellness subsidy. The County used a portion of the 2009 through 2011 subsidy to pay WIQ for pedometers in 2012. As stated in WIQ's contract, pedometers could be purchased by the County at an additional fee. The wellness subsidy payments and pedometers payable were included in the total payments made to WIQ in the following table.

Description	2012	2013	2014	2015*
Recalculated Vitality Fees**	$355,035	$386,463	$428,436	$397,980
Estimated Pedometer Fees ***	19,160	-	-	-
Total Fees Payable	**374,195**	**386,463**	**428,436**	**397,980**
County Paid to WIQ	211,600	312,253	392,372	351,569
Wellness Subsidy Paid to WIQ	197,139	77,026	56,000	56,000
Total Amount Paid to WIQ	**408,739**	**389,279**	**448,372**	**407,569**
Over /(Under) Payment Per Year	**34,544**	**2,816**	**19,936**	**9,589**
Total Over / (Under) Payment				**$66,885**

** Recalculation does not include December 2015 fees, as the invoice was not paid at of the time of this audit report.*

*** PEPM rate x recalculated participants noted in the tables on page 58.*

**** DIA was unable to obtain an invoice for pedometers charged to the County by WIQ, therefore an estimate had to be used. DIA reviewed FAMIS and revenue receipts for revenue the County collected from employees for pedometers to estimate the pedometer cost. The fee to purchase the pedometer by employees was $40, which is comparable to the pedometer fee options available from WIQ's contract. DIA added the $19,160 above to give WIQ credit for the pedometer fees that we could confirm were received by the County.*

Benefits did not reconcile the medical employee eligibility headcount from SAP to invoices received from WIQ. This resulted in the County overpaying WIQ by $66,886 from 2012 through 2015.

Ceridian

The County contracts with Ceridian COBRA administrative services. Monthly Ceridian invoices included the number of County employees, description of service, and price of service per contract. Invoices included a fixed covered employee charge at $0.30 per employee for 8,000 employees. The County was also charged per employee for

additional services such as eligibility reporting to carriers. Having adequate controls in place to ensure proper payment of Ceridian invoices is critical to Benefits' operations.

DIA tested three invoices (December 2014, January 2015, and June 2015) to ensure accuracy of the invoices to County records and to Ceridian's contract. The following issues were noted:

- The County is charged $4 per paper invoice received from Ceridian every month instead of opting to receive invoices electronically.
- According to the Ceridian contract from 2013 through 2015, the County was required to pay an administrative fee of $0.29 PEPM. DIA noted the County was charged $0.29 in 2013, $0.30 in 2014, and $0.31 in 2015 PEPM for 8,000 employees. In addition, the PEPM of 8,000 appeared to be overstated when comparing employee headcount to provider eligibility reports. The contract did not specify how the number of employees charged per month was determined. The following table calculates the amount of overpayment identified.

	2013	2014	2015
Rate Charged PEPM	$0.29	$0.30	$0.31
Number of Employees on Invoice	8,000	8,000	8,000
Total Actual Amount Paid per Month	**$2,320**	**$2,400**	**$2,480**
Rate According to Contract PEPM	$0.29	$0.29	$0.29
Number of Employees with Health Benefits (SAP)	6,000	6,100	6,100
Total Estimated Amount per Month	**$1,740**	**$1,769**	**$1,769**
Estimated Overpayment per month	**$580**	**$631**	**$711**
Annualized	**$6,960**	**$7,572**	**$8,532**
2013 - 2015 Total Estimated Overpayment	**$23,064**		

NWGS

The County paid Northwest Group Services (NWGS) monthly administrative fees for maintaining and administrating employee FSA and commuter parking plans. Invoices from NWGS were received and paid by Benefits at the contracted rate per the number of employees utilizing NWGS services. Having review and monitoring controls in place was critical in ensuring timely and accurate payments of invoices.

DIA reviewed the June 2015 invoice and noticed a $24 wire fee was included on the invoice. When Benefits submitted the voucher for payment, an additional $24 for the wire transfer was added to the total invoice amount. The preparer of the voucher in Benefits was instructed to add an additional $24 to the invoice amount when the employee assumed duties of paying NWGS in October 2014, which resulted in a duplicate payment. The annual projected cost to the County for the duplicate payment was $288. Benefits corrected this issue during the audit.

NWGS sent a detailed list of employees with FSA and commuter parking plans with monthly invoices. However, there was no evidence the number of employees on the invoices were verified to SAP numbers by Benefits. DIA pulled the number of

employees with FSA and commuter parking deductions from SAP to compare to the June 2015 invoice. The number of employees charged by NWGS was comparable to SAP with a variance less than .5%.

In addition, the County was charged on monthly invoices for the following fees:

- $3.50 per participant for employees *with* FSA debit cards.
- $3.00 per participant for employees *without* FSA debit cards.
- $3.00 per participant for employees with pre-tax commuter parking and accounts.

The NWGS contract only states a charge of "$3.50 per employee served per month" will be assessed to the County. Furthermore, DIA was unable to verify the fee charged for pre-tax commuter parking accounts nor could a contract for this service be located. Ultimately, Benefits exceeded the contract encumbrance for the NWGS contract during the audit period. See the following finding for more details.

FINDING Noncompliance with ORC Section 5705 was identified as expenditures exceeded contract encumbrances for two contracts. Three additional contracts did not comply with the contract cover.

ORC Section 5705.41(D)(1) states, "Except as otherwise provided in division (D)(2) of this section and section 5705.44 of the Revised Code, make any contract or give any order involving the expenditure of money unless there is attached thereto a certificate of the fiscal officer of the subdivision that the amount required to meet the obligation or, in the case of a continuing contract to be performed in whole or in part in an ensuing fiscal year, the amount required to meet the obligation in the fiscal year in which the contract is made, has been lawfully appropriated for such purpose and is in the treasury or in process of collection to the credit of an appropriate fund free from any previous encumbrances." Furthermore, Cuyahoga County Code Section 501.04(B) states that County Board of Control 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 but not 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 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 in 3 out of the 12 contracts tested related to encumbering funds for specific contracts.

Ceridian

Benefits entered into a contract with Ceridian for COBRA administrative services for the period January 1, 2013 through December 31, 2015. The Contracts and Purchasing Board (CPB) approved the contract on December 27, 2012 for $51,000 ($17,000 a year). DIA compared actual payments to the approved contract encumbrance for the three years. The below table summarizes payments made on the contract:

Year	Encumbered	Total Payments to Ceridian	Variance-Over/(Under) Encumbrance	Journal Entries to Increase Encumbrance
2013	$17,000	$16,285	($715)	$0
2014	17,000	45,814	28,814	49,665
2015	17,000	44,825	27,825	19,808
Total	$51,000	$106,924	$55,924	$69,473

Ceridian was responsible for receiving COBRA checks from eligible individuals and disbursing the funds to the County. We noted the checks were received by the County and accurately recorded as revenue in FAMIS, however, a journal entry was erroneously recorded in eight separate instances, totaling $69,473, to increase Ceridian's contract encumbrance in 2014 and 2015. This allowed Benefits to continue paying Ceridian even though total payments exceeded the contract encumbrance approved by the CPB. DIA did not identify any amendments to the original contract encumbrance.

NWGS

Benefits entered into two contracts with NWGS from January 1, 2011 through December 31, 2016 for FSA and commuter parking account administration. The County Commissioners and Board of Control approved the contracts on October 26, 2010 and October 21, 2013, respectively. DIA compared actual payments to the contract encumbrances. The table below summarizes our results:

Year	Encumbered Amount (plus any approved amendments)	Total Payments to NWGS	Variance-Over/(Under) Amount Encumbered	Journal Entries to Increase Encumbrance
2013	$30,810	$31,231	$421	$0
2014	42,630	49,973	7,343	10,382
2015	$53,280	$56,039	2,759	0
Total			$10,523	$10,382

One check received from Ceridian, totaling $10,382, was erroneously recorded to increase the contract encumbrance in 2014. This check was payment for COBRA benefits from eligible individuals as noted in the "Ceridian" section above. This allowed Benefits to continue paying NWGS even though total payments exceeded the contract encumbrance approved by the Board of Control. DIA did not identify any amendments to the original contract encumbrance.

Ohio AFSCME Care Plan

The County had agreements with The American Federation of State, County and Municipal Employees (AFSCME) Ohio Council 8, Local 1746, Local 2927, and Local 27. Articles of these agreements specify the County to contribute to Ohio AFSCME Care Plan for covered employees. The collective bargaining agreements (CBA) state the following:

- Local 1746, Article 73 - "The County shall contribute to the AFSCME Care Plan seventy dollar and seventy-five cents ($70.75) per month for each employee in the bargaining unit. The benefits which will be provided are: Vision I, Life I, Hearing and Dental Level III."
- Local 2927, Article 22 - "The Employer shall contribute the sum of seventy dollar and seventy-five cents ($70.75) per month to the AFSCME Ohio Health and Welfare Fund for each employee in the bargaining unit. The benefits which will be provided are: Vision I, Life I, and Hearing and Dental Level III."
- Local 27, Article 63 - "The County shall contribute to the AFSCME Care Plan $56.00 per month for each employee in the bargaining unit for the provision of dental benefits."

Even though the CBAs were properly approved by the County and appropriated in the County's Internal Service Fund (Self-Insurance Subfund), the dollars to meet the contractual obligations were not encumbered during 2015. The following table shows the amount of expenditures from the County's Internal Service Fund in 2015 for the AFSCME Care Plan.

Year	Encumbered Amount	Total Payments to AFSCME Care Plan	Variance-Over/(Under) Amount Appropriated
2015	$0	$1,297,850	$1,297,850

If not properly encumbered, there is an increased risk of budget not being available to spend on the AFSCME Care Plan for the year. In all three contracts, County Council and the Board of Control were unaware of encumbrances needed to satisfy the contracts. In addition, the payments were made from the County's Self-Insurance Subfund even though the AFSCME Care Plan is a premium-based insurance and should have been expended from the County's Full-Insurance Subfund.

Contract Cover Compliance

Every approved contract is accompanied with a contract cover that clearly identifies the following items:

- Contractor
- Contract number
- Requisition number
- Time Period
- Contract Amount
- Fiscal Officer's Certification of Funds
- Law Director's Approval of Legal Form and Correctiveness
- Index Code to Record Payments

Upon the contract expiration date, any outstanding encumbrance is decertified and available for appropriation for other means. DIA noted the following regarding contracts managed by Benefits:

- Expenditures for three contracts were not posted to the correct index code as indicated by the contract cover. The table below gives further information on contracts tested during the audit period:

Contract	Provider	Actual Contract Expenditures	Index Code on Contract Cover	Actual Index code Used
CE1300097	Guardian Life Insurance	$9,095,432	CC499004	CC499012
CE1300033	Guardian Life Insurance	$63,505	CC499004	CC499012
CE1100145	NWGS	$102,421	CC499004	CC499012

- Two contracts were not decertified in FAMIS for more than a year from the end of the contract term. The following table gives further information.

Contract	Contract End Date	Amount Unspent	Decertification Amount	Decertification Date
CE1100145	12/31/13	$880	$880	4/18/16
CE1400060	12/31/14	$336,837	$336,837	4/18/16

Risk to the County if Findings Not Corrected

Benefits does not have adequate monitoring controls in place to ensure invoices are accurately billed to the County. By not verifying invoice details, like the number of participants and fee amounts, the County is at a higher risk to overpay invoices.

Furthermore, the County is at a higher risk of paying for services not under contract if formal procedures and adequate monitoring controls are not in place.

Without adequate monitoring controls in place to heighten the likelihood that total payments do not exceed the total contract amount, the County is at risk of paying vendors more than the legislatively approved amount. In addition, County decision makers may not be aware of actual expenditures on the Ohio AFSCME Care Plan without encumbrances.

Finally, the County does not have formal procedures to timely decertify outstanding encumbrances. The County may not be aware of additional funds if outstanding encumbrances are not timely decertified. Furthermore, Benefits failed to comply with the certification authorized by the Fiscal Officer, which increases the risk of expending funds from index codes without sufficient budget.

Recommendations

10.1 DIA recommends the following preventative and corrective controls to address the findings on overpaying vendors:

- If the County establishes a contract with any provider that invoices based on the number of employees enrolled in medical benefits a Benefits employee should, at least annually, reconcile the total eligible employees listed on the invoice to the County's files. Monthly invoices not reconciled to the County's medical eligibility files should be reviewed for consistency to ensure the total headcount on each invoice does not significantly vary between months. Any discrepancies should be investigated and communicated to the vendor.
- Prior to payment, invoices should contain evidence of supervisory review and approval before submitting for payment. The review should ensure the number of employees and rates charged on the invoice are accurate and conform to contractual language.
- Benefits should inquire with Ceridian on the variance between the number of employees billed (8,000) and the number of employees in SAP.
- Benefits should discontinue receiving monthly paper invoices from Ceridian and elect to receive invoices electronically.
- All rates charged to the County on monthly invoices should be agreed to the appropriate contract
- The $24 wire transfer fee that was paid in duplicate should be researched. Benefits should consider requesting a credit from NWGS for the months in which the duplicate fee was paid.
- The $3.00 fee charged to the County by NWGS should be researched to ensure the fee was legally charged according to a contractual agreement between the County and NWGS. If a contractual agreement does not exist, one should be written and approved by the appropriate legislative body.
- Benefits should research and obtain a contract for the pre-tax commuter parking account service charged to the County by NWGS. If a contractual agreement does not exist, one should be written and approved by the appropriate legislative body.
- The County should consult with the Law Department to determine whether the overpayments to WIQ, Ceridian, and NWGS in the amount of $90,237 should be recovered.

10.2 DIA recommends Benefits personnel develop formal procedures on monitoring contracts. The following, at a minimum, should be included:

- Assure total expenditures do not exceed the contract encumbrance. Payments received should not be used to increase a contract encumbrance unless a refund is issued from the vendor. Any adjustments to encumbrances should be reviewed and approved by the Fiscal Office before adjustments are posted. The Fiscal Office should maintain all documentation (i.e. legislative approval, refund support) to support the adjustment.
- All payments made from Benefits' funds should be properly appropriated and/or encumbered by the necessary board. An encumbrance should be created for the AFSCME Care Plan payments. In addition, the AFSCME Care Plan should be appropriated and paid from the full-insurance subfund since the plan is a premium-based insurance plan.

- The approved contracts and CBAs should contain a contract cover indicating the index code and object code for payments to be made.

10.3 DIA recommends that Benefits comply with the contract cover and only make payments to contracts from certified index codes. Any deviations from the contract cover should be communicated to the Fiscal Office/OPD and changes should be made to the contract cover. In addition, any outstanding encumbrances upon contract expiration should be decertified within FAMIS in a timely manner, i.e. 6 months after the end of the contract period.

Management's Response

Prior to the release of the audit findings, the County's current benefit administration team has mad e great progress at implementing the appropriate procedures to address these items - as evidenced even within the Auditor 's findings.

The County has initiated recovery efforts for those items which were overpaid. In addition, the benefit administration group and independent consultants are reviewing all contracts to ensure compliance with terms and adherence to pre-negotiated terms.

Through training of the staff and better use of technologies available through our current contracts, we have been able to create a process to monitor program expense and reconciliation errors.

Auditor's Response

Benefits will notify DIA when funds are recovered going forward. DIA will periodically follow-up with Benefits on recovery efforts.

Objective #11 – The Wellness Program was Effectively Monitored and HRA Claims were Accurately Paid

FINDING Issues with negative account balances, eligibility, and stipend payments were found in the 2014 HRA program

The County offered a Health Reimbursement Account (HRA) to County employees with medical insurance during the audit period. County employees could earn credits into their HRA for deductibles, copays, and or/coinsurance. In 2014 the credits were used through County issued debit cards, manual reimbursement requests, or payroll stipends for employees enrolled in the MHS medical plan. The County should have adequate monitoring procedures over account balances, participant eligibility, and payment methods under the HRA.

The HRA was administered by Mutual Health Services (MH) for all of 2014 and in 2015 for the 2014 run-out period. DIA obtained all 2014 HRA transactions from MH. Stipends issued in 2014 for employees on the MHS medical plan were obtained. These stipends were included in employee paychecks during the final pay of 2014. The following issues were identified during detailed testing of these transactions and stipends.

Negative Balances

After summarizing all transactions (credits and debits) per employee, DIA identified negative account balances in 200 of the 3,899 (5%) HRA accounts, allowing employees to spend more funds than credited. The total negative balances, incurred through manual entries made to account balances or card transactions, was $17,163. There were no provisions in the HRA benefit documentation that allowed employees to incur negative balances.

MH did not have programmed controls built into their system to prohibit negative account balances. This allowed negative account balances from manual entries, or a worst-case scenario of employees utilizing benefits that were not earned.

Eligibility

DIA compared the file from MH to SAP. We noted any instances where transactions were executed after employees' benefit eligibility date in SAP. The table on the following page are results where the account balance available to spend was increased, or where money was spent beyond the employee's eligibility date in SAP:

Transactions Executed After Medical Eligibility Terminated				
Month and Year	Count of Instances Where Fund Availability Increased*	Amount of Increase	Count of Instances Where Funds Were Used**	Amount of Usage
Dec-13	-	$ -	1	($8)
Jan-14	3	442	-	-
Feb-14	-	-	1	(10)
Mar-14	7	335	-	-
Apr-14	6	300	3	(115)
May-14	30	1,955	1	(5)
Jun-14	1	50	3	(125)
Jul-14	1	35	2	(42)
Aug-14	1	50	-	-
Sep-14	1	50	-	-
Oct-14	-	-	6	(148)
Nov-14	-	-	4	(85)
Dec-14	1	225	6	(138)
Jan-15	180	11,636	5	(90)
Totals	**231**	**$15,078**	**32**	**($766)**

** There was one instance where funds were increased over 2 years after the employee's benefits were terminated.*

*** The maximum months that funds were used after an employee's benefits were terminated was 7 months.*

Benefits either did not timely notify the third-party provider of benefit termination, or MH failed to shut off benefits in a reasonable amount of time. This led to employees having access to more funds than they were entitled to and HRA funds being used after benefits were terminated.

Stipend Payments

DIA extracted data from the file obtained from MH to identify MHS plan participants that also used funds through the HRA. MHS plan participants should not have access to spend funds from the HRA since these participants only received stipends at the end of the 2014. 13 employees of 1,309 (1%) with the MHS plan utilized HRA funds, totaling $1,391.

DIA also identified 4 employees out of 2,586 (2%) that were not enrolled in the MHS plan in 2014, but did receive a stipend. The total amount of stipends paid in error was $140 ($35 a person).

FINDING Revenue for the wellness program could not be determined within medical rates set by the County. Support on pedometers received for the wellness program was not maintained.

Benefits contracted with WIQ to provide vitality services, a wellness program for employees, in 2015. The contract also allowed the County to purchase pedometers from WIQ for employees. The County's self-insurance subfund, an Internal Service Fund, was the source of funding for the WIQ contract. Internal Service Funds are used to account for the financing of goods or services provided by one department to other departments on a cost-reimbursement basis. All expenditures and revenue associated with the contract should be recorded in the funding source for the contract. Additionally, the source of revenue in the County's self-insurance subfund should be clearly associated with the costs incurred within the fund.

Vitality Services Revenue

DIA made inquiries of Benefits and Fiscal Office personnel in order to gain an understanding of the methodology of recognizing revenue in the County's self-insurance subfund to cover WIQ's contract expenditures. No source of funding could be clearly identified or verified other than wellness subsidy payments from MMO and UHC from 2013 through 2015. The wellness subsidy and employee/employer contributions appeared to be the sources of funding. DIA then inspected rate schedules and other documents provided to the County by EBI to see if there was a reference to the source of revenue for vitality services.

EBI's monthly experience report noted vitality services as an expense when calculating the County's medical/Rx reserve balance. The report did not provide how much revenue was to be generated for vitality services. The experience report indicated vitality services had been considered in the formulation of the County's rate schedules; however, there was no breakdown in the rates available to identify the total amount of revenue that should have been generated to cover vitality services. Without a breakdown in the premium the determination of whether funding is sufficient to cover expenditures could not be calculated.

In addition, the wellness subsidy received from MMO in 2014 for $75,000 was improperly recorded in the County's full-insurance subfund. The revenue should have been recorded in the County's self-insurance subfund since the subsidy was used to pay WIQ for vitality services. These are subfunds of the County's health insurance Internal Service Fund, so this misclassification does not affect the County's financial statements. Benefits did not ensure the revenue was accurately recorded to reimburse the County's self-insurance subfund for payments to WIQ, which led to the misclassification of the revenue.

Pedometer Revenue

In 2012, the County purchased pedometers from WIQ under Exhibit B of the 2012 contract. A portion of the wellness subsidy from MMO was sent directly to WIQ to pay for the pedometers. Any employee of the County with medical benefits could purchase a pedometer from the County for $40 according to Benefits personnel. Cash or checks were received for the pedometers by Benefits personnel. A revenue receipt was completed in Benefits noting all pedometer numbers sold and the total dollar amount collected.

DIA recalculated the number of pedometers sold based on the recorded revenue in FAMIS divided by the pedometer price of $40. The total recalculated number of pedometers sold was compared with the number of pedometers available for sale per revenue receipt support obtained from Benefits. DIA was unable to obtain an invoice from the County or WIQ that showed how many pedometers the County purchased. DIA had to rely on revenue receipts to determine the number of pedometers bought by Benefits. The following is the result of that analysis:

Pedometer Revenue Recorded	**$19,160**
Pedometer Sales Price to Employees	$40
Recalculated Pedometers Sold	479
Pedometers Available for Sale*	499
Pedometers Unaccounted For	**20**
Revenue Unaccounted For ($40 Price/Pedometer x 20 Pedometers Unaccounted for)	**$800**

** 499 was the highest numbered pedometer recorded on the revenue receipts.*

DIA could not ascertain the cause of the pedometer revenue that is unaccounted for due to a lack of supporting documentation. Current Benefits personnel was unable to identify the cause.

Risk to the County if Findings Not Corrected

Benefits did not have adequate controls in place to ensure stipend payments were, or were not, paid to the appropriate employees. Benefits is at a higher risk of paying stipends not in accordance with expectations set by management without these controls in place.

Without proper review on coding revenue in the correct funds, the risk of misappropriation of assets and misclassification of revenue is greatly increased.

Recommendations

11.1 DIA recommends Benefits implements the following corrective actions and internal controls for the HRA program by area noted below.

Negative Balances

- Benefits should ensure the third-party administrator should have programmed controls built into their application that do not allow for the payment of expenditures, or manual adjustments that reduce the account balance, in excess of the benefits earned per the County's HRA program.
- Benefits should periodically review the transaction detail to verify that no employees have negative account balances. Negative account balances should be researched and corrective action taken to recover overpayments or reverse erroneous entries.
- Benefits should consult with the Law Department and consider recovering the $17,163 of excess HRA funds erroneously credited to employees.

Eligibility

- Develop a separate attribute in SAP to track the number of employees enrolled in the HRA program in addition to their medical plan. This file should be sent to the third-party administrator every month to ensure that employees are removed from the HRA after termination.
- Monthly, the County should request a file of active participants from the third-party administrator and reconcile the listing to the County's records.
- The contract with the third-party administrator should stipulate liability for any HRA usage that occurs after medical eligibility termination if the County provides timely termination notification to the third-party administrator.
- Benefits should consult with the Law Department and consider recovering the $766 of HRA funds used by terminated employees.

Stipend Payments

- The County should have preventive controls in place to ensure stipend payments are not made to employees with access to HRA funds. A comparison should be made between HRA eligibility files and employees receiving a stipend if the HRA benefit is tracked in SAP, or the new ERP system.
- The County should consult with the Law Department to determine if the $1,391 spent through the HRA in addition to the MHS stipend should be recovered.
- The County should consult with the Law Department to determine if the $140 in MHS stipends paid to employees with medical insurance from UHC and MMO should be recovered.

11.2 DIA recommends the following preventative, detective, and corrective controls for the wellness program to address the findings.

Vitality Services Revenue

- The monthly medical rate set by the County should clearly identify the amount of revenue that pertains to various expenditures. These rates should be entered into SAP by cost component so revenue can be properly matched to the associated expenditures within the County's Internal Service Fund. Specifically, the monthly rate should be sufficient to cover the following expenditures:
  - Claims
  - Stop loss fees.
  - Affordable Care Act fees
  - COBRA administrative fees
  - Provider administrative fees
  - Wellness program
  - Healthcare consultant fees
  - Shared services fees
  - Any other healthcare related expenditure paid from the Internal Service Fund.
- Benefits should review and reconcile all revenue posted to the County's full and self-insurance subfunds to supporting documentation. Furthermore, the review should ensure the revenue is posted to the correct fund and subfund. Additionally, the Fiscal Office should review and question the coding of revenue receipts prior to posting in FAMIS and confirm consistency in revenue postings.

Pedometer Revenue

- Benefits should have controls in place for all receipts collected and posted in FAMIS. Benefits should determine if the $800 of unaccounted pedometer revenue should be investigated further. Specifically, Benefits should confirm if the pedometers are actually in storage since DIA could not confirm if the 20 pedometers were sold. If further investigation shows the funds were misappropriated, Benefits should take corrective action to recover the funds.
- The $19,160 of pedometer receipts incorrectly posted to the County Wellness Program Special Revenue Fund should be reclassified as a prior period adjustment to the County's Self-Insurance Fund, unless deemed immaterial.
- Benefits should maintain a list of all revenue that could be posted to each Internal Service and Special Revenue subfunds. That list should be distributed to General Accounting in the Fiscal Office and annually updated.

Management's Response

The Wellness Program and HRA incentive Plan was terminated in 2016 and any systemic recommendations from the Auditor regarding the administration or funding of this or a similar plan will be considered as the County looks at future options.

Auditor's Response

Benefits will notify DIA when funds are recovered going forward. DIA will periodically follow-up with Benefits on recovery efforts.

Objective #12 – Regional Partner Contracts were Followed and Strictly Enforced by the County

FINDING Benefits did not enforce contract compliance with one Regional Partner from 2013 to 2015

CCBODD entered into a contract with the County to participate in the Benefits Regionalization Program. The County's agreement with the CCBODD states; "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% incurred claims. If incurred claims for the contract period are in excess of 110% of the group's paid premium the BODD will be liable for the difference only to the level of 110% of incurred claims." The contract also states the calculation should be performed by the County's consultant and the arrangement is to be settled within 150 days of each year-end.

DIA recalculated the incurred claims in comparison to paid premiums for the 2013 and 2014 plan years. In 2014, incurred claims were 97% of premiums paid resulting in no payments from the County or CCBODD. In 2013, BODD's incurred claims were less than 90% of paid premiums. The County should have been responsible for issuing a refund to BODD. See table below for 2013 calculations:

CCBODD Paid Premiums	90% of Paid Premiums	Incurred Amount per MMO Claims Summary	90% of Paid Premiums Less Incurred Claims (Refund to CCBODD)
$10,105,598	$9,095,038	$8,111,571	**$983,467**

DIA did not obtain any evidence of the consultant or the County performing the above reconciliation for 2013 or 2014. Oswald Companies stated they performed this reconciliation when hired as the new consultant in 2016 and determined no refund was necessary due to the results of the 2015 reconciliation. CCBODD was liable for the difference in 2015 according to Oswald Companies.

Risk to the County if Findings Not Corrected

The County will continue to be out of compliance with CCBODD's contract if this reconciliation is not performed within 150 days of year-end. Furthermore, the County could be liable for claims in excess of 110% of premiums paid.

Recommendations

12.1 The County should have controls in place to ensure an annual reconciliation is performed on BODD's premiums paid compared to incurred claims. The calculation should be reviewed and approved by Benefits prior to notifying CCBODD.

Management's Response

The County's enforcement of contracts with the Regional Partner has been reviewed thoroughly by the benefit administration team and law department.

A thorough review of the Board of Developmental Disabilities Agreement, which considered the 2013, 2014 and 2015 contract periods, was completed in partnership with the Board. Oswald Companies found that no refund was necessary when considering the three-year period in totality. The Board and County agreed to reconcile the arrangement "all at once" as soon as it was discovered that previous years were not reconciled by the former consultant.

Note: The Board of Developmental Disabilities and County maintain a different agreement for the 2016 and 2017 periods to account for this reconciliation process.

Objective #13 – Ensure all Supporting Documentation is Maintained in Accordance with ORC Section 149 and the County's Record Retention Schedule

FINDING Benefits did not maintain supporting documentation on expenditures, revenue, and personnel records in accordance with the ORC and the County's record retention schedule.

Ohio Revised Code Section 149.351(A) states, in part, that all records are the property of the public office concerned and shall not be removed, destroyed, mutilated, transferred, or otherwise damaged or disposed of, in whole or in part.

HR's record retention and disposition schedule approved June 2, 2010, Schedule Number 2010-71 – Vouchers, states the retention period is three years until destroyed. The schedule does not include the retention of receipts.

DIA requested multiple documents and support from Benefits during the audit. The items requested pertained to transactions from January 1, 2014 through June 30, 2015. During the audit, the following records were requested from Accounts Payable or Benefits but never received:

Expenditures

- Documentation or invoices to support payments were not provided for one payment to the MetroHealth System for Healthspot Services in April 2014 totaling $700.

- Documentation to support payments was not provided for five payments to KeyBank (County's NWGS bank account) for flexible spending accounts (FSA) in 2014 and 2015 totaling $484,308. DIA recalculated FSA deductions from SAP for pay periods 1 through 3 in 2015 and noted small variances between the amounts paid to KeyBank.
- No detail was maintained to support the number of participants for which the County was billed on COBRA invoices from Ceridian. Benefits was capable of viewing invoice details online, but was unable to provide these details during the audit. DIA sampled three payments to Ceridian in 2015 totaling $11,550.
- 25, or 100%, of WIQ invoices for wellness services did not have a detailed listing of County employees to justify the number of participants on the invoices. Invoices paid during this time totaled $726,808. In addition, three encumbrance vouchers, totaling $92,400, were not provided for payments to WIQ.
- Detailed invoices from EBI were not provided for three of 18 payments, totaling over $49,000. The detailed invoices provided services rendered and listed the number of hours spent on each service.
- Three out of three expenditures from the County Wellness Fund for flu vaccinations and health screenings were not provided, totaling $48,454.

Revenue

- Four out of 30 Revenue Receipts and supporting documentation totaling $453,085 was not maintained by Benefits or the Fiscal Office. These receipts were claims and wellness reimbursements from medical providers and County employees. DIA was able to view images of checks for three of the Revenue Receipts totaling $384,247 and noted no anomalies.
- Ceridian remits a check to the County after individuals pay Ceridian for COBRA benefits. Detailed information (COBRA participants, amount paid per participant) is available for the Benefits to view online. Benefits did not maintain the detailed information for eight out of eight checks received from Ceridian. Benefits attempted to retrieve the information online during the audit, but was unsuccessful due to a change with Ceridian.
- Two of nine revenue receipts for the sale of pedometers to employees, totaling $5,320, were not maintained.
- 11 of 11 Revenue Receipts tested from the County Wellness Fund did not have supporting documentation to show the number of employees or spouses administered flu shots to reconcile the accuracy of the cash collected.

Personnel Records

- Five of seven, 71%, Benefits Office Change (BOC) forms requested for employees identified as having medical benefits eligibility past their employment termination dates could not be located by Benefits. See results of employees paid beyond their termination dates on page 7.

Risk to the County if Findings Not Corrected

Failure to keep copies of records and dispose of them properly compromises the audit trail and limits transparency within the agency. Without supporting documentation, the ability to reconcile to County systems is also limited. All of these factors contribute to the possibility of misappropriated funds. The unauthorized destruction of records could potentially subject the County to civil lawsuits allowable under ORC sections 149.351(B)(1) & (2).

Recommendations

13.1 Benefits should review their records retention schedule to ensure compliance with the ORC. The schedule should be updated and approved by the appropriate agencies according to ORC Section 149.351(A). The schedule should be updated to include all relevant records, specifically receipts. Absent a record retention policy, these records should be maintained indefinitely. All files destroyed within Benefits should be on an approved RC-3 for proper destruction.

13.2 A policies and procedures manual should be developed to ensure compliance with the approved records retention schedule. Benefits should also conduct a training session on the records retention schedule to ensure all personnel are familiar with the schedule and its contents. The schedule and required forms should be placed on the shared network for Department-wide access.

Management's Response

We agree with the Auditor's findings related to this issue and have either addressed or are in the process of evaluating processes and procedures necessary to comply with ORC 149 and the County Record Retention Schedule.

Objective #14 – Benefits Timely Deposited Revenue Received in Accordance with ORC Section 9.38

FINDING Benefits did not deposit six, or 20%, out of 30 revenue receipts tested in a timely manner to comply with ORC Section 9.38.

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 various 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 the checks were received was unknown. Based on check dates, 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.

The check dates compared to the FAMIS posting dates resulted in noncompliance with ORC Section 9.38. DIA tested 30 revenue receipts recorded in the County's health care Internal Service Fund out of a total population of 224 from January 1, 2014 through June 30, 2015. The following table highlights instances noted in our test of revenue transactions.

Revenue Receipt #	Revenue Receipt Amount	FAMIS Post Date	Earliest Check Date*	Description
RR1402062	$100,077.30	3/6/2014	2/8/2013	COBRA Coverage
RR1410450	$10,381.55	10/17/2014	6/10/2014	COBRA Coverage
RR1405357	$2,136.99	5/30/2014	12/26/2013	Employee HRA Reimbursement
RR1410611	$469.86	10/21/2014.	4/4/2014	Employee HRA Reimbursement
RR1410610	$27,487.51	10/21/2014	2/28/2014	Reimbursement from Healthcare Providers
RR1506249	$373.14	6/5/2014	4/3/2014	FMLA Payment

**Multiple checks were deposited with each revenue receipt. DIA noted the earliest check date for each revenue receipt.*

In addition, DIA tested 100% of receipts posted during our audit period in the County Wellness Fund managed by Benefits. The County Wellness Fund was utilized to record receipts and pay vendors for flu shot clinics offered to County employees and their spouses. Individuals receiving flu shots were required to pay $9 to the County at the time of the flu shot. An employee of Benefits returned to the office with the cash after each clinic. The cash was stored in a safe until a deposit was made with the Treasurer's

Office. We noted the following instances when testing 11 revenue receipts from the flu shot clinics:

- 10 revenue receipts, totaling $5,023, were dated between 22 and 42 days after the date of the flu shot clinic. Revenue receipt dates indicated when the flu shot clinic approximately occurred.
- Benefits did not maintain a log of when the money was received.
- Benefits did not obtain a list of names receiving the flu shots to reconcile the accuracy of cash collected.
- Benefits did not have a policy on depositing cash in their own safe prior to depositing with the Treasurer's Office.

Risk to the County if Findings Not Corrected

Failure to deposit public money in a timely manner increases the County's exposure to theft, loss, or potential loss of investment money. Furthermore, holding on to monies for a long period of time results in untimely posting to the County's accounting system, which in turn creates incomplete accounting reports relied upon by upper management.

Recommendations

14.1 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 and cash received from all sources and the date they were received. This log should be reviewed by the supervisor to ensure compliance with this Revised Code section.

14.2 Benefits should request and maintain a list of names for the number of flu shots administered by the provider after each flu shot clinic. This list should be reconciled to the amount of cash received. At the clinic, Benefits should consider keeping a log of all individuals receiving flu shots. The log should document the individuals' names, signature, employee number, date of shot, and amount paid. This log should be maintained with the revenue receipt as support of the cash collected for the flu shots.

Management's Response

As addressed in our Phase I 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.

Objective #15 – Benefits Had Procedures in Place to Ensure Deposits and Payments were Authorized

FINDING 100% of revenue receipts and office vouchers tested did not have supervisor approval.

Staff members from Benefits prepared revenue receipts (RR) and office vouchers (OV) for submission to the Treasurer's Office for deposit and Accounts Payable for payment, respectively. RRs and OVs should be accompanied with supporting documentation and supervisor approval should be evident prior to submission. Supporting documentation should consist of all information received from the payer or payee and/or the invoice.

DIA sampled 37 RRs and 33 OVs from various Benefits funds for the period January 1, 2014 through June 30, 2015. The following instances were noted:

- All 37 RRs tested, or 100%, lacked evidence of review/approval from an immediate supervisor of the employee completing the revenue receipt prior to deposit with the Treasurer's Office. RRs consisted of payments for COBRA, medical provider reimbursements, wellness reimbursements, flu shot clinics, and FMLA payments.
- Signatures showing supervisor review was not evident on all 33 OVs tested, or 100%. The 33 OVs consisted of payments to AFSCME Care Plan, Center for Families & Children, Ceridian, Guardian Life, Moore Counseling, MetroHealth, KeyBank for Flexible Spending Account, Northwest Group Services, and U.S. Treasury for Affordable Care Act fees.
- Issued checks were held for pick-up for all 33 OVs.

Risk to the County if Findings Not Corrected

Benefits does not have formal procedures with adequate monitoring controls in place. Lack of supervisory approval could lead to costly errors and/or omissions going undetected. In addition, checks held for pick-up signifies a greater fraud risk that lacks proper segregation of duties.

Recommendations

15.1 We recommend Benefits implement mitigating monitoring controls and proper segregation of duties by obtaining supervisory review and approval by an employee other than the preparer of a RR or OV prior to submitting for receipt or payment, respectively. The authorization should confirm all supporting documentation is sufficient and maintained. 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 deposit with the County Treasurer. This control could be incorporated into the new ERP system to ensure approval is obtained prior to payment.

15.2 All checks should be sent from Accounts Payable directly to the vendor. The Fiscal Office updated their procedures so checks cannot be held for pick-up unless requested by the department.

Management's Response

As addressed in our Phase I response, the County has implemented additional safeguards and staff training/development designed to ensure adequate monitoring controls are in place to ensure the accuracy and minimize the fraud risk of deposits and payments.

Follow-up Response from the Chief Talent Officer on Four Areas of Focus

Prior to release of the report, the Chief Talent Officer wanted to ensure complete resolution for changes they have made, and future changes they will make. There are four additional areas of focus for which they want to capture in their responses, and they include:

- ***Aligning organizational structure with current and future needs.***
    - *We have introduced a change in job duties and responsibilities, with an emphasis on strategy and shifting priorities.*
        - *A Sr. Benefits Manager job has been developed and filled with an experienced professional. This job focuses on aligning healthcare and employee benefits with organizational strategic priorities, premium delivery of customer service and the assurance that HR complies with all policies, practices and applicable laws.*
        - *A Benefits Analyst job has been developed and filled. This job focuses on analytics, application of problem solving and ongoing process improvements.*
        - *We have reduced the number of Benefits Coordinator jobs and once the current Benefits Manager retires (anticipated date March 2018), we will not refill that position.*
- ***Designing and implementing employee and functional area development plans to enhance specific and overall knowledge.***
    - *Skill and competency development plans have been initiated for our benefits team.*
        - *We have worked with our healthcare consultant to provide training to our benefits team.*
        - *We are regularly engaging our benefits team and providing them with opportunities for professional growth and networking.*
- ***Identifying and focusing on performance goals and metrics to drive results.***
    - *Each employee on our benefits team has annual performance goals and must deliver and drive identified metrics in their section.*
- ***Ensuring accountability is clearly articulated, aligned and followed.***
    - *We have realigned all benefits supporting staff to report to the recently hired Sr. Benefits Manager, and changed the focus of the current benefits manager to a project based roll.*