Plainview-Old Bethpage Central School District

Review of Benefits

November 2015

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The Board of Education
Plainview-Old Bethpage Central School District
Plainview, New York 11803

Board of Education:

We have been retained to function as the internal auditor for the Plainview Old-Bethpage Central School District (hereinafter, "the District"). Our responsibility is to assess the internal control system in place for the accounting function within the District, and to make recommendations to improve upon certain control weaknesses or deficiencies. In doing so, we hope to provide assurance to the District's Board, management, and residents, that the fiscal operations of the District are being handled appropriately and effectively.

BACKGROUND:

The District offers health insurance coverage only to eligible persons (i.e., current employees, including those on workers' compensation or unpaid leave, terminated employees who have elected COBRA, certain employees on LOA, surviving spouses, vested employees and retirees) from the New York State Health Insurance Program (NYSHIP) also known as The Empire Plan and HIP from Emblem Health (very few employees are enrolled in this insurance plan). Each eligible employee must actively elect the type of coverage desired or specifically waive coverage.

We previously performed a review of this area and issued our report with our recommendation in December 2007. Since then, the District implemented all recommendations noted in the report. Since this area was tested several years ago, the District requested that internal audit reassess the internal controls within the benefits operations. A major portion of our testing focused on the legitimacy and accuracy of health benefits expenditures to ensure that health benefits being provided by the District are in accordance with contracts and policies approved by the Board.

SCOPE:

As part of this testing, we selected a sample of 50 individuals from the New York State Empire Health Insurance detailed invoice as of May 2015, and 4 individuals from HIP May 2015 invoice, and performed procedures to determine if:

- each individual was eligible for benefits;
- the employee contribution rates were accurate according to the bargaining unit contracts;
- coverage was not waived;
- the employee actually elected the type of coverage being provided;
- and the employee submitted the required documentation necessary to receive coverage.

We then selected a sample of the various individuals receiving health insurance benefits to verify that appropriate elections were made to continue coverage, the District was billed the correct rates and amounts for those insured, and the District was collecting the correct payments for such coverage as applicable. This included 30 retired employees, 12 surviving spouses, 8 employees on

Leave of Absence (LOA), 2 vested employees, and 3 former employees receiving benefits under COBRA.

Lastly, we selected 25 employees who declined health benefits and performed testing of employees to ensure that the District's buy-back expenditures were accurate and in accordance with the contracts and policies approved by the Board and to verify there were no instances of double-dipping occurring by which an employee would receive buy-back payments and health coverage for the same time periods.

CONCLUSION:

We noted the controls surrounding benefits within the District are strong, with a few minor issues noted during our testing. We have detailed our findings below:

COMPLIANCE WITH AFFORDABLE CARE ACT (ACA):

In accordance with the regulations stipulated by the ACA, the District has prepared a written procedure documenting the standard measurement period, the administrative period, and the stability period. In addition, the District has provided the Summary of Benefits of Coverage (SBC) and the Notice of Exchange to all new hires as well as to all employees on an annual basis. The District is currently obtaining the data to adhere to the IRS January 31, 2016 filing deadline to report the information required under sections 6055 and 6056 about offers of health coverage and enrollment in health coverage for District employees. As such, it appears the District is ensuring compliance with the ACA. **No exceptions were noted**.

POLICIES and PROCEDURES:

Overall, we believe that the Benefits Senior Account Clerk in the District is very knowledgeable of the guidelines that have been set forth by New York State, and has made tremendous effort to ensure appropriate support documents are obtained and kept in the employee files. When we reviewed the benefits process, we noted that the District has sufficiently separated duties, with other departments working in conjunction with the Benefits Department during this process.

Issue #1: Formal documented procedures have not been prepared. While the Benefits Administrator has prepared notes on many of the processes that are to be performed within the department, formal procedures do not exist. In addition, we noted that the District has not assigned a dedicated back-up to perform the benefits administration should the need arise.

Risk: Loss of continuity of historical knowledge. Increased risk of benefits administered improperly or inefficiently.

Level: Moderate

Recommendation: We commend the Benefits Clerk's efforts to commence documenting the specific procedures to be performed. We recommend that the District create formal procedures which detail specific processes that are to be performed such as enrolling

new employees, ensuring forms are completed and returned, and entering employee's benefits information in WinCap (the financial software application utilized by the District). The creation of formalized procedures will also serve as a guide for a back-up person to perform certain tasks, in the event that the Benefits Clerk should be out of the office. In addition, we recommend that the District assign another person to receive training in benefits and work with the current Benefits Clerk to ensure continuity of operations.

Management's Response: The District will begin creating a formal procedures manual documenting our regular benefits administration procedures and routines. The District agrees that cross-training is an important strategy in maintaining continuity and improving accuracy. Business office administration will assign other personnel to be trained in the Benefits Clerk's duties.

ACTIVE EMPLOYEES:

Invoice Charges and Employee Payments: Using the May 2015 invoices, we judgmentally selected a sample of 50 individuals who elected health coverage through Empire, and 4 individuals who elected health coverage through HIP. We then traced each selection to the Payroll Deduction Register Report in WinCap for the month of May 2015, to verify that the person was a current paid employee, and if not, verified whether he or she was otherwise eligible for benefits through COBRA or as an employee on unpaid leave or worker's compensation. We verified that the District was billed the correct rate for the enrollee selected. We also verified that the employee did not elect to waive coverage. In addition, we examined the election forms to verify the employee elected the coverage he or she was actually receiving. Lastly, we verified the amounts the employees were contributing toward their health insurance coverage (as reflected in the most recent payroll register) were accurate based on the employee contribution rates stated in the appropriate bargaining unit contract.

At the start of the calendar year, the rates for the health insurance premium generally increase. As such, the Benefits Clerk calculates the new benefits deduction amount, and the Assistant Business Associate reviews the calculations. Once approved, the deduction amounts are given to payroll and the Payroll Clerk inputs the changes in the payroll system in WinCap. Once all the changes are entered, the Payroll Clerk prints out a report of the revised health deduction amounts and the Benefits Clerk reviews the report and reconciles that the new deduction amounts are correct. Any discrepancies would be communicated to payroll to make the necessary corrections. From our review of the employees receiving health benefits, we confirmed that employees are contributing the correct benefits deductions and that the District is billed correctly. **No exceptions were noted**.

Proof of Eligibility: The District currently requires employees to submit proof of eligibility when requesting family coverage. Coverage election forms are completed by employees, with social security numbers listed for all dependents. It had been past practice that when a new hire elected family coverage in the District, there was no requirement for the employee to provide documentation to support the eligibility of the names listed as dependents.

Issue #2: Documents to support family coverage were lacking. Our sample of the 54 individuals tested included 27 employees who received family coverage. We noted that the majority of these 27 employees' files, many of which were hired before the current Benefits Clerk was with the District, did not have supporting documents (marriage license, birth certificate) verifying existence of dependents. The current Benefits Clerk has advised us that she has been recently requiring proof for any life event change, and copies of marriage and birth certificates have been filed in the employee's benefits folder. In addition, we noted that NYSHIP performed their own eligibility audit in 2009, and was responsible for notifying all District employees to submit proof of family status in order to continue receiving family coverage. Those employees who did not comply or did not have proper documentation to substantiate family coverage were automatically switched to single coverage.

Risk: The District may be paying for insurance an employee is not entitled to.

Level: Low

Recommendation: We are aware that the Benefits Clerk has been requiring proof of family coverage eligibility and has been working to ensure employee files have all the proper documents. We applaud this effort and recommend that the District continue ensuring all proper documentation is in the employee's files.

***Management's Response*:** The Benefits Clerk will continue to acquire the proper dependent documentation.

RETIREE TESTING:

The District provides health benefits to employees eligible for retirement, and the amount that the retiree contributes towards coverage is dependent on the employee's bargaining unit. We judgmentally selected from the health insurance census a sample of 30 retired employees to verify the District was providing the coverage elected, and the correct amounts for such coverage were being paid. As part of our testing, we verified that:

- the amount the District was contributing toward health insurance was accurate per the bargaining unit contract;
- the amount the retiree is required to pay the District was correct and remitted on a timely basis;
- the employee completed the appropriate number of required years of service to be entitled to receive retiree benefits; and
- the election forms (e.g., individual or family coverage) agree with the coverage type the retiree is receiving.

Employees who are eligible to retire contribute a percentage of the cost of their health benefits as outlined in their respective bargaining unit contracts. We noted the majority of the retirees have elected to have their contribution deducted directly from their pension. The remaining retirees are invoiced by the school directly, and are required to remit payment on a monthly basis. The District

is currently responsible to pay the remaining percentage. We verified that the District is properly tracking amounts owed by the retirees, and they are properly posting the payments.

Issue #3: Increased risk of errors in retiree payment calculation. Retirees are given the choice to have their Medicare Part B reimbursement deducted from the insurance premium amount owed to the District. While we did not note any exceptions in our testing of payments received by retirees as well as payments made by the District, we noted that the District deducts the Medicare Part B reimbursement amount from the health insurance premium owed. As such, it was more difficult to verify that proper payments were being remitted to the District.

Risk: There is an increased risk that the amount owed to the District could be miscalculated, making it more difficult to determine the cause for any discrepancies in the amounts owed.

Priority: Moderate

Recommendation: We recommend that the District separate the transactions for requiring payments from retirees and reimbursing employees for Medicare Part B.

Management's Response: Beginning January 1, 2016, the District will require separate transactions for Medicare Part B reimbursement. Retirees will pay the District the full amount of the premium owed. The District will reimburse eligible retirees by issuing a check.

The District is informed by NYSHIP on a monthly basis of any retiree who is becoming eligible to receive Medicare coverage. The Benefits Clerk notifies the retiree of the upcoming eligibility, and requests that they attest that they would not be receiving Medicare Part B reimbursement from another source. The letters need to be signed, notarized, and returned to the District on an annual basis. Medicare reimbursements are disbursed twice during the year. If the retiree is receiving family coverage, the District is responsible for reimbursing the Medicare portion for the retiree as well as his or her spouse.

Issue #4: Missing Medicare attestation. We verified that the District received signed attestations from those retirees who were Medicare eligible. We noted that one attestation for the Medicare Part B reimbursement could not be located; however the retiree was reimbursed. Further review of the files indicated that this appears to be an isolated incident.

Risk: The District may be reimbursing a retiree unnecessarily.

Priority: Low

Recommendation: To ensure that the District is properly reimbursing retirees for Medicare, we recommend that reimbursements only be made when the District has received a signed attestation.

Management's Response: District management has reinforced the importance of acquiring proper and current documentation to support Medicare part B reimbursement.

COBRA TESTING:

The District had three individuals who were listed as receiving COBRA benefits on the May 2015 health insurance invoice. When an individual is terminated, the Benefits Clerk sends a letter to the employee stating that he or she can opt for COBRA, and lists the amount of the premium on the letter. We noted that she maintains a spreadsheet of all payments, and confirms that the payments are received by reviewing the cash receipts journal in WinCap. If payments are not received, the Benefits Clerk will follow up with the individual, and if no response is received within two months, the individual will be removed from the insurance.

Issue #5: Payment calculation for COBRA individual on Medicare is understated. We noted that one former employee, who was eligible for Medicare, was charged incorrectly for the COBRA payment. The District deducted the Medicare Part B reimbursement from the total premium the individual owes for health insurance. In addition, the District calculated the 2% administrative fee based on the net amount, rather than the total health insurance premium, resulting in a slightly lower amount charged. The annual underpayment totaled $25.28.

Risk: The District may be overpaying for health insurance benefits.

Level: Moderate

Recommendation: We recommend that the District separate the transactions for requiring payments from retirees and reimbursing employees for Medicare Part B. In addition, the District should calculate the 2% administrative fee on the total premium amount.

Management's Response: The District acknowledges this inconsistency. The District will document its procedure to reflect that the 2% administration fee must be based on the total health insurance premium.

SURVIVING SPOUSE AND VESTED EMPLOYEE TESTING:

When an employee of the District passes away, the District provides their surviving spouse with health insurance for the three subsequent months following the death. At the end of the three months, the spouse has the option of continuing to receive Empire Insurance through the District. All spouses that elect to continue coverage through the District must make monthly payments for the cost of the benefits provided to them. We reviewed the health insurance census and selected 12 of the 38 employees receiving benefits as a surviving spouse to verify the District was providing the proper coverage, and the correct amounts were being paid for the elected coverage. Our testing included verifying:

- the surviving spouse receiving coverage was placed in the correct category,

- the individual provided proof of the deceased employee; and
- the surviving spouse is making payments for the correct amount to continue their coverage.

Issue #6: Increased risk of errors in surviving spouse payment calculation. While we did not note any exceptions in our testing of payments received by surviving spouses as well as payments made by the District, we noted that the District deducts the Medicare Part B reimbursement amount from the health insurance premium owed. As such, it is more difficult to verify that proper payments were being remitted to the District.

Risk: There is an increased risk that the amount owed to the District could be miscalculated, making it more difficult to determine the cause for any discrepancies in the amounts owed.

Priority: Moderate

Recommendation: We recommend that the District separate the transactions for requiring payments from retirees and reimbursing employees for Medicare Part B.

Management's Response: Beginning January 1, 2016, the District will require separate transactions for Medicare Part B reimbursement. Retirees will pay the District the full amount of the premium owed. The District will reimburse eligible retirees by issuing a check.

Employees who work in the District for 5 years or more are eligible for benefits when they retire. If any employee leaves the District before retirement age of 55, the employee may continue to pay for their health insurance benefits in full and then pay the retiree rate upon reaching 55 years of age. Per the May 2015 invoice, there were two individuals listed as vested. We confirmed that the individual was receiving the correct coverage as per the supporting documentation in their file, and that the individual was remitting the correct payment to the District. **No exceptions were noted**.

LEAVE OF ABSENCE (LOA) TESTING:

The District allows employees to take a leave of absence for a number of reasons, including maternity leave and health issues. We obtained a list of employees who requested Leave of Absence from 2014-2015. We then compared the list to the May 2015 health insurance invoice to determine if the employee was listed as receiving health benefits. For those eight employees that were listed as LOA and receiving health benefits in May 2015, we confirmed that the employee was either on paid leave (using vacation or other accrued time earned) or paying the district the correct amount for the health insurance coverage. To verify the validity and accuracy of the benefit payments made by these three employees, our testing included:

- examining personnel files to ensure that they contained appropriate forms and approval for the time off requested by the employee,
- verifying that the dates of the employee's leave of absence are tracked by personnel,
- verifying that payments to continue benefits are received by the District and are recorded in the cash receipts journal in WinCap or deducted from payroll; and

- confirming that payments made by the employee are for the correct amount during their leave of absence.

Employees that are currently employed by the District and choose to take a leave of absence without pay are responsible for remitting the full cost of the insurance payment to receive health insurance benefits. **No exceptions were noted**.

DECLINATION AND BUY-BACK TESTING:

It is current District policy to offer an employee 50% of the cost of insurance to the District to employees who elect to decline health insurance coverage. To receive the buy-back, the employee completes a "Declination of Health Benefits" form. Buy-backs are paid semi-annually for all employees and can be pro-rated by month to the point when the employee discontinues coverage.

As part of our testing, we judgmentally selected 25 employees from the 75 receiving the buy-back on June 2015 based on the database maintained by the benefits coordinator. For each employee, we examined the health insurance census to ensure that the individual was not on the census list. For each employee on the waive list, we then verified that the employee was receiving the correct buyback for declining the insurance as per the employee's contract. We also verified that all supporting documentation existed to substantiate that the employee was entitled to receive family coverage. Lastly, we noted that all employees completed and signed the necessary form to waive health benefits coverage. **No exceptions were noted.**

WORKERS' COMPENSATION:

All employees in the District are entitled to workers compensation days (the total number of days depends on their contract with the District). When an employee is injured while working at the District, the employee completes an accident report at the building level and the completed report is forwarded to the Business Office for the necessary processing. The Benefits Clerk completes the C2 form and sends to the insurance company for processing. Payroll is notified of the injured employee's status, and the payroll clerk will track the number of days the injured employee is out of work. A file is maintained in an Excel spreadsheet which lists the date and time of the occurrence, the name of the employee, the employee's hire date, the number of days the employee is out, and the contract unit the employee is part of. Should an employee qualify to receive worker's compensation, the employee would be required to submit a doctor's note. The District keeps track of repeat offenders, but if their medical report confirms the injury, then the District's workers compensation carrier (Wright Risk) will determine if additional follow up is needed. An employee who is out on workers compensation would need a doctor's note to return to work in the District. Workers compensation days are used first, then sick time as needed. The employee is reimbursed for some of their sick time when the District gets reimbursed from Wright Risk. Based on our discussions with the District, the internal controls surrounding worker's compensation appear to be adequate.

> **Auditor's Comment: To further strengthen the internal controls over monitoring workers' compensation, the District should ensure that District management is formally informed when an employee is injured. By notifying management, the District has an opportunity to discuss the incident with the employee, inquire about**

the prospective date the employee will return to work, and ensure there is appropriate work coverage in place.

We would like to thank the staff at the District for its cooperation and professionalism during our testing.

We understand the fiduciary duty of the Board of Education, as well as the role of the internal auditor in ensuring that the proper control systems are in place and functioning consistently with the Board's policies and procedures.

Should you have any questions regarding anything included in our report, please do not hesitate to contact us at (631) 582-1600.

Sincerely,

Cerini & Associates LLP

Cerini & Associates, LLP
Internal Auditors