Compensation and Benefits Division Audit - #787

Executive Summary

Why CAO Did This Review

Pursuant to Section 5.10 of the Charter of the City of Jacksonville and Chapter 102 of the Municipal Code, we conducted an audit of the Compensation and Benefits Division of the Employee Services Department. This area was chosen for the audit based on the periodic City-wide risk assessment performed by our office.

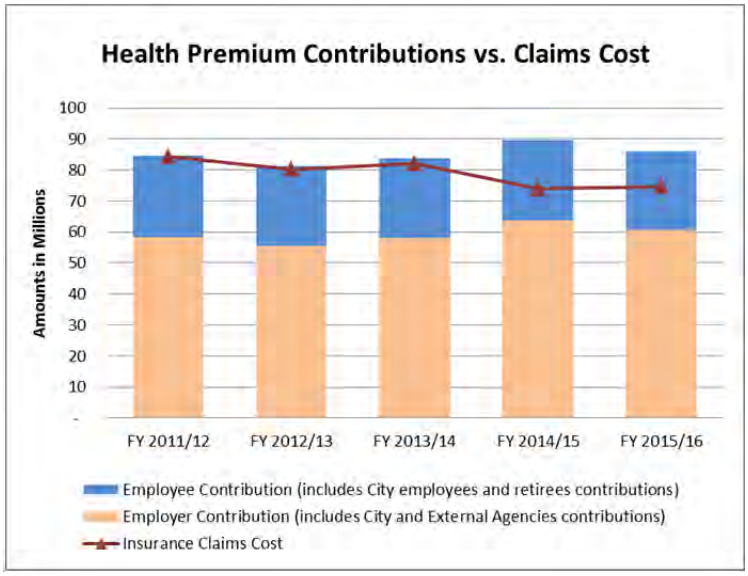
What CAO Recommends

- We recommend the City reevaluate its practice of not offering insurance to some employees who qualify under the Affordable Care Act.
- The Compensation and Benefits Division should create an exception report to flag any retirees that failed to pay premiums so premiums are timely collected and/or benefits are canceled.
- The division should update its process of confirming eligibility of dependents age 26-30 to address timeliness problems. Also, the taxation of the benefits for these dependents needs to be adjusted to comply with the IRS Code.
- The division needs to review and modify the benefits termination process to ensure that employees are only charged for benefits when benefits are active. Also, the process of adjusting premiums should be modified so employer's premiums are corrected simultaneously with employee's premiums.
- The City should consider forcing retirees to switch to Medicare and claims could be audited to decrease the overall costs for the plan.

What CAO Found

Overall, eligible individuals were properly offered insurance and enrolled into the City's health plan in a timely manner, and the health premiums were also properly assessed and collected in a timely manner. However, we found the following issues:

- Some employees are not offered health insurance.
- The City failed to accurately assess premiums for five retired members causing a loss of $66,188.
- The enrollment eligibility and the taxation of benefits for dependents age 26-30 are not properly managed.
- Some terminated employees are charged for one or two pay periods after coverage is already terminated.
- Employer's portion of premiums paid is not adjusted when changes are made to employee's portion.
- Retirees eligible for Medicare are not forced to apply for it making City's insurance secondary.
- Claims processed and paid by the third party administrator are not reviewed for accuracy.



Council Auditor's Office

Compensation and Benefits Division Audit

October 13, 2016

Report #787

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EXECUTIVE SUMMARY

AUDIT REPORT #787

OFFICE OF THE COUNCIL AUDITOR
Suite 200, St. James Building

October 13, 2016 Report #787

Honorable Members of the City Council
City of Jacksonville

INTRODUCTION

Pursuant to Section 5.10 of the Charter of the City of Jacksonville and Chapter 102 of the Municipal Code, we conducted an audit of the Compensation and Benefits Division of the Employee Services Department. This division is responsible for the development, procurement, and administration of the benefit programs for all city employees, retirees, and eligible dependents. These services are also provided to constitutional offices and some outside agencies. The programs that are administered by this division include, but are not limited to, the health, life, dental, and vision insurance plans as well as associated programs (e.g. COBRA, flexible spending accounts, and the employee assistance program). The Division also oversees a 401(a) defined contribution plan and a 457(b) deferred compensation plan. The approved budget for the FY 2016/17 included 8 full-time employees, 3,440 part-time hours and over $94 million in expenditures. The vast majority of the budget is related to the Health Program which is the focus of our audit.

In the past, the City used to be fully-insured which meant the City paid a fixed premium amount per policy while the insurance company assumed the risks associated with the claims. On January 1, 2015, the City became self-insured which means the City assumes the financial risk of providing health care benefits to its employees. Therefore, the City pays for all medical and pharmaceutical claims as they incur instead of paying a fixed premium amount to the insurance company. However, the City does have specific stop loss coverage ($550,000 per claim for calendar year 2016). A third party insurance administrator is used to assist with the administration of the benefits and to process medical claims. The approved budget for the FY 2016/17 included over $81 million for claims and $4.5 million for the third party administrator services.

As of January 31, 2016, based on the enrollment data provided by the division and the third party administrator, we determined there were 8,044 policies associated with employees, former employees, and retirees enrolled in the City's group health plan. The following three external agencies and their current and former employees participate in the City's group health plan:

- Jacksonville Housing Authority;
- First Coast Workforce Development Consortium;
- Northeast Florida Regional Council.

Enrollees could choose between the Preferred Provider Organization (PPO), High Deductible Health Maintenance Organization (HD HMO), and the Health Maintenance Organization (HMO). The breakdown of policies is shown in the table below.

	HD HMO	HMO	PPO	TOTAL
City Employee	557	4,973	1,139	6,669
Retiree	29	921	140	1,090
External Agency	13	238	20	271
COBRA		10	4	14
Grand Total	**599**	**6,142**	**1,303**	**8,044**

Enrollees also could cover their spouses and children in the City's group health plan. We determined that there were 14,056 members in the City's group health plan on January 31, 2016. The members could be broken down into the following groups.

	Self	Spouse	Children	TOTAL
City Employee	6,669	1,468	4,068	12,205
Retiree	1,090	248	111	1,449
External Agency	271	40	74	385
COBRA	14	2	1	17
Total	**8,044**	**1,758**	**4,254**	**14,056**

STATEMENT OF OBJECTIVES

The objectives of the audit were as follows:

1. To determine whether eligible individuals were properly offered and enrolled into the City's group health program in a timely manner.
2. To determine whether health premiums were properly assessed and collected in a timely manner.

STATEMENT OF SCOPE AND METHODOLOGY

The scope of the audit was January 1, 2015 through January 31, 2016. We obtained the population of the City's group health plan members as of January 31, 2016 from the City and the third party administrator. We tested that all participants were eligible to receive health insurance benefits through the City by ensuring that they are current City employees, retirees, external agencies employees or eligible dependents of plan members. For all members of the group health plan as of January 31, 2016, we confirmed that correct premium payments and contributions were made. Finally, we also confirmed on a sample basis that changes in premiums caused by various life events (e.g. new hires, terminations, marriage, etc.) were processed accurately and timely.

REPORT FORMAT

Our report is structured to identify Internal Control Weaknesses, Audit Findings, and Opportunities for Improvement as they relate to our audit objectives. Internal control is a process implemented by management to provide reasonable assurance that they achieve their objectives in relation to the effectiveness and efficiency of operations and compliance with applicable laws and regulations. An Internal Control Weakness is therefore defined as either a defect in the design or operation of the internal controls or is an area in which there are currently no internal controls in place to ensure that objectives are met. An Audit Finding is an instance where management has established internal controls and procedures, but responsible parties are not operating in compliance with the established controls and procedures. An Opportunity for Improvement is a suggestion that we believe could enhance operations.

SUGGESTED ADDITIONAL AUDIT WORK

In limiting the scope of this audit, we did not pursue the following areas, and as such they should be considered for future audit work:

- This audit only focused on the health insurance program due to its size relative to the operations of the area. A similar audit could be done for the dental, vision, and life insurance programs.

STATEMENT OF AUDITING STANDARDS

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 that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

AUDITEE RESPONSES

Responses from the auditee have been inserted after the respective finding and recommendation. We received these responses from the Compensation and Benefits Division, via Robert E. Parr, Chief of Compensation and Benefits, and Mary DiPerna, Manager of Personnel Services - Employee Benefits, in a memorandum dated December 1, 2016.

AUDIT CONCLUSIONS

By Objective:

1. Overall, eligible individuals were properly offered and enrolled into the City's group health program in a timely manner; however, we found some issues with the enrollment

documentation of dependents 26 and older as well with some full-time employees not being offered insurance.

2. Overall, the health premiums were properly assessed and collected in a timely manner; however, we did find some issues with assessing premiums for the retired members and with how some benefits are taxed.

OVERALL ISSUES

Overall Internal Control Weakness 1 *Issues with Access Rights to HR Systems*

There are several employees with improper access rights to the systems used to administer benefits. Best business practices suggest that employees should only be granted the access rights needed to perform their job functions. We found employees with excessive access rights in the City's payroll and human resources information system (HRMS) as described below:

1. Out of 24 HRMS users that can perform benefit-related activities such as adding, canceling or changing employees' benefits plans, seven (7) employees are from the Accounting Division even though those activities are outside of their job functions.
2. Out of nine (9) employees from the Compensation and Benefits Division who have access to HRMS, four (4) have super access rights ("US HRMS Manager") and can perform human resources and payroll-related activities such as issue quick pays, process employees' refunds, and add or delete employees from HRMS. Those activities are outside their job functions. These four (4) employees also have "COJ Manager Worklist" and "Manager Self Service" access rights in HRMS which they do not actually use or need.

Additionally, we found one (1) former Compensation and Benefits Division employee who had access to the third party plan administrator's information system had left the division two years prior to our testing. Finally, we also found four (4) out of 18 users with inappropriate access to the Compensation and Benefits Division's electronic shared files: three (3) of them worked for other departments and one (1) of them was no longer employed by the division.

Recommendation to Overall Internal Control Weakness 1

We recommend that the Compensation and Benefits Division along with the Information Technologies Division periodically review the access rights in HRMS and any other information system used by the division to ensure that employees are only granted the access rights they need to perform their job functions.

Auditee Response to Overall Internal Control Weakness 1

Agree ☒ Disagree ☐ Partially Agree ☐

We agree that the Compensation and Benefits Division along with the Information Technologies Division review the access rights in HRMS and other systems used by the division. Based upon

the audit results, we have taken immediate action and access is aligned with specific job functions.

Access for the seven (7) employees in the Accounting Division has been removed. We are also revising our system functionality that creates access levels be modified depending on job responsibilities.

An annual review of access rights will be scheduled with ITD beginning in 2017.

AUDIT OBJECTIVE #1

To determine whether eligible individuals were properly offered and enrolled into the City's group health program in a timely manner.

Finding 1 – 1 *Health Insurance Not Offered to Some Employees*

Under the Affordable Care Act, the City is required to offer insurance to employees who work at least 30 hours per week. In general, the City does not offer health insurance to temporary full-time employees or part-time employees. This is consistent with the fact that it is in the Municipal Code that temporary full-time employees will not work longer than six months and the Employee Services Department sent out a written directive in 2013 that states that the temporary full-time employees should not be employed longer than 120 days. Furthermore, part-time employees are not to work more than 25 hours per week pursuant to the Municipal Code. The Employee Services Department uses special reports to monitor employees who are not classified as full-time employees and to determine how many hours per week they work on average. If an employee's hours are over the threshold, the employee's department is notified about the issue, so the employee's department could take necessary action to ensure compliance.

We reviewed the report for April 2016 and discovered that 217 part-time and full-time temporary employees were flagged as working on average over 30 hours per week. Of those, 213 were Jacksonville Sheriff's Office (JSO) employees. In the same report from November 2015, those figures were 207 and 195, respectively. We later reviewed communication records between JSO and Employee Services from which we concluded that this issue was brought up to JSO's attention in 2014, but no action was taken to change the practice of not offering insurance to these employees.

By not offering health insurance to some of the JSO employees, the City could be subject to penalties under Section 4980H of the Internal Revenue Code if employees who were not offered insurance did in fact receive an exchange subsidy. That penalty would be on a person by person basis; however, the City could become a subject to much larger penalties under the same section of the Internal Revenue Code if it fails to offer health insurance to at least 95% of its full-time employees. At the current point this is not an issue, but if the practice is not kept in check that status could change.

Recommendation to Finding 1 – 1

The City needs to re-evaluate this practice and determine what is the most prudent and cost effective practice. Any analysis should be formalized for historical purposes and re-evaluated on an ongoing basis.

Auditee Response to Finding 1 – 1

Agree ☒ Disagree ☐ Partially Agree ☐

The Compensation and Benefits Division worked with the previous Director of Employee Services to make JSO aware of the potential issues arising out of their decision to not offer coverage to these employees. We agree that this a potential risk to the City and should be re-evaluated.

Finding 1 – 2 *Eligibility Issues with Dependents Age 26-30*

Section 627.6562 of the Florida Statutes provides an option to insure a child at least until the end of the calendar year in which the child reaches the age of 30 if certain conditions are met. We found various issues with the process of verifying eligibility of dependents age 26-30. Employees are required to provide a signed eligibility form annually. In this form they attest that their dependents age 26-30 are still eligible to continue receiving health benefits. Current practice is that a report is periodically run to identify such dependents based on their birthday date. Next, the Compensation and Benefits Division sends out a letter that informs the employee that a signed eligibility form must be returned within 10 days. If the signed form is not returned within 45 days, coverage for the dependent is removed. When these forms are not processed in a timely manner, it is possible that ineligible dependents remain enrolled in the City's group health plan which could have a negative impact on the City and other participants.

We tested eligibility of 48 dependents that were age from 26-30 years old. We found the following issues with 36 (or 75%) of the dependents tested:

1. In 2 cases (or 4%), there was neither a copy of the sent form nor a copy of the signed form on file. For these two cases, the benefits were canceled only as a result of the parent's employment terminating 57 and 109 days after the most recent birthdays.
2. In 7 cases (or 15%), there was not a sent form on file, but the signed returned form was on file. Although there was a signed form on file, there was still a breakdown in the process since the time lapse from the birthday compared to the date the form was received was anywhere between 28 and 226 days. Due to the fact there was not a copy of the form sent out we are unable to determine the cause of the delay.
3. In 7 cases (or 15%), a form was not sent out timely by the division, no form was returned, but benefits were canceled in a timely manner after the forms were sent out. The gap between the birthday and the date form was sent out was anywhere between 22 and 103 days.
4. In 8 cases (or 17%), a form was not sent out timely and benefits were not canceled timely due to no reply. In these instances it took anywhere from 34 to 123 days to send the form

out and the benefits were not canceled for another 49 to 61 days after the forms were sent out.

5. In 12 cases (or 25%), a form was not sent out timely by the division. It took anywhere from 15 to 276 days to send the form out. With these 12, there was no issue with the process after the form was sent out.

Recommendation to Finding 1 – 2

The Compensation and Benefits Division should modify the report used to identify birthday dates for dependents age 26-30 so they are flagged ahead of time to give enough time for the staff to process and send out letters to employees before dependent's birthday. Alternatively, as discussed in the Recommendation to the Opportunity for Improvement 1 – 1 below, the division should consider obtaining these forms annually on a set date instead (e.g. January 1) to make the process of obtaining such forms more manageable and efficient.

Finally, the Compensation and Benefits Division should implement review procedures to ensure that eligibility letters are sent out in a timely manner and ineligible dependents are timely removed from the City's group health plan.

Auditee Response to Finding 1 – 2

Agree ☐ Disagree ☐ Partially Agree ☒

Moving this to an annual process, per the recommendation, causes concerns that failure to evaluate these situations could allow someone to remain covered for many months when they no longer qualify under Section 627.6562. We will continue to monitor these situations on a monthly basis, however, we will work with ITD to modify the report to identify birthday dates for dependents age 26-30 so they are flagged ahead of time.

The Compensation and Benefits Division is reviewing and implementing the appropriate procedures to ensure eligibility letters are sent in a timely manner and ineligible dependents are removed timely from the City's group health plan.

Finding 1 – 3 *Issues with Processing Termination of Benefits*

There was not a coding sheet prepared for terminated employees whose name started with the letters L-Z. A benefits representative was not aware of the changes in the procedures that required a coding sheet to be filled out and signed by a preparer and a reviewer when cancelling benefits of a terminated employee. Due to the fact there was not a coding sheet created there was not a review of the termination of benefits for these employees. Not maintaining and not reviewing proper supporting documentation could lead to benefits being erroneously cancelled or cancelled on the wrong effective date.

Recommendation to Finding 1 – 3

We recommend that benefit representatives periodically familiarize themselves with the standard operating procedures set by the Compensation and Benefits Division.

Auditee Response to Finding 1 – 3

Agree ☒ Disagree ☐ Partially Agree ☐

Although the identified coding sheet was not completed correctly, the termination was processed appropriately. Management has counseled with the employee as to the proper procedure to follow.

Opportunity for Improvement 1 – 1 *Dependent Eligibility Form for 26-30 Year Olds*

Based on what we found during testing and by obtaining copies of similar forms for other local governments, the form that is used to verify a dependent age 26 to 30 years old is eligible to be covered could be significantly improved. Here are a few examples of opportunities:

1) Instead of requiring such form to be submitted annually on a dependent's birthday, this form could be obtained for all eligible employees on the same date.
2) Language on requiring employees to notify the City about changes in a dependent's status within 30 days could be added to the form.
3) A statement could be added reminding employees of the requirement for children who were not previously covered under the plan to have had continuous coverage through another provider without a gap in coverage of more than 63 days.
4) Language on tax consequences should be added to the form to remind employees that contributions must be post-tax and there is to be an imputed tax on the portion of the employer's subsidy attributable to the dependent's coverage.
5) Language reminding that a person filing an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree could be added.
6) Statement could be included that any claim costs could be recovered from an employee if a post audit shows that eligibility requirements were not met.
7) Language requiring the employee submits a copy of a dependent's Florida Driver License showing a valid Florida address or school schedule for students who are not residents of Florida could be added.

It is a good business practice to design forms that disclose all relevant and important information and statements. It helps to ensure that forms are filled out accurately and that applicants could be held accountable if information provided is incorrect. Requesting this form annually on the same date for all dependents would make the process of obtaining such forms more manageable and will decrease the likelihood of forms being missed. Improvements in this form would increase the likelihood that information provided is accurate and only eligible dependents age 26-30 are enrolled. Also, it should improve City's ability to recover funds if information provided was incorrect.

Recommendation to Opportunity for Improvement 1 – 1

The Compensation and Benefits Division should review the best practices and modify its eligibility form for dependents age 26-30 to ensure that it includes all of the important and necessary information and statements. Finally, the division should consider obtaining these forms annually on a set date for all dependents turning 26-30 years old in the next twelve months. It would make the process of obtaining such forms more manageable and efficient.

Auditee Response to Opportunity for Improvement 1 – 1

Agree ☒ Disagree ☐ Partially Agree ☐

We are in agreement with the Auditor's recommendations in this area. The form is being revised and used in conjunction with the new annual reporting methodology. We will adopt as mentioned in Finding 1-2.

Opportunity for Improvement 1 – 2 *Improving Life Events and Weekly Hours Reports*

The Compensation and Benefits Division could improve design of some of its reports. The Life Events report is used on a regular basis to track new hires, terminations, and other events so that adjustments can be made accordingly. The report on weekly hours worked is used to monitor hours worked per employee per week, and the data is used to ensure that health insurance is offered to all eligible employees as required by the Affordable Care Act.

A large portion of the Life Events report is comprised of new hires which do not require any action from the staff unless new hires have reached their respective benefits eligibility date (first of the month after 55 days of employment) and failed to enroll. We observed reports that were a few pages long and only some items required an action. Moreover, for the new hires, the staff can only identify those items that require action by reviewing the hire date for each new hire and comparing it to the date when benefits should start. If this report is customized so it only lists data that requires action, it would reduce the amount of time staff has to spend reviewing this report. Also, the likelihood of missing the issue on the report and not addressing it in a timely manner would be decreased. Finally, it also would be easier for the supervisor to review and manage this process.

Another opportunity is created by the fact that the report on weekly hours worked is designed to add all types of the hours per employee per week as recorded in the systems. However, it appears that due to the system's design sometimes those hours are double counted. For example, holiday overtime hours are already included in regular hours (so they should not be added up, but instead should be ignored). The City should strive to improve the accuracy of its reports. In this particular case, the accuracy of the report on weekly hours worked is pivotal in achieving compliance with the Affordable Care Act.

Recommendation to Opportunity for Improvement 1 – 2

We recommend the Compensation and Benefits Division create another version of the Life Events report so that it only includes items that require an action from the staff. Also, the division should periodically review the list of the type of hours used in the systems and adjust design of the report on weekly hours worked to improve its accuracy and value.

Auditee Response to Opportunity for Improvement 1 – 2

Agree ☐ Disagree ☐ Partially Agree ☒

Changing the Life Events Report is a concern, as it is our only source of all life events. Although it does contain certain information that does not trigger an action at that time, we review all of the events to make sure nothing is missed.

With regards to the Hours Report, we are working with ITD to review the report to determine what hours are being double counted so the revised report will be more accurate.

AUDIT OBJECTIVE #2

To determine whether health premiums were properly assessed and collected in a timely manner.

Finding 2 – 1 *Issues with Collecting Premiums for Retired Employees*

We found 5 out of 1,090 health insurance policies associated with retirees were not being paid by the retiree for an extended period of time. Also, during the testing of 131 changes in health premiums throughout the audit scope, we also identified a similar issue for one (1) retiree. We concluded that some of these problems started as far back as 2012. In total, we estimate that the City lost a total of $66,188 in health insurance premiums/costs. There also appears to be losses related to dental, health, and life insurances contribution amounts which were excluded from the $66,188 amount. The issues were as follows:

1. For one (1) retiree, the Compensation and Benefits Division failed to deduct from the retiree's pension check a total of $2,074 in health insurance premium from August 1, 2015 through November 15, 2015.
2. Three (3) retirees were receiving health insurance through the City without paying the corresponding insurance premiums for approximately a year causing a total loss of $32,818.
3. Two (2) retirees that passed away in March 2012 and January 2013 respectively were still listed as receiving health insurance through the City as of May 31, 2016. Therefore, the City erroneously paid a total of $31,296 in health insurance premiums (up until January 1, 2015) and administrative fees (starting January 1, 2015) to the group health administrator on behalf of these two deceased retirees.

Recommendation to Finding 2 – 1

We recommend that the Compensation and Benefits Division create an exception report that would flag those retired participants that did not make their required insurance premium contributions on their retirees' paychecks similar to the one done for active employees. Also, since retirees have an option of paying by a check, the division should consider performing a periodic reconciliation for retired members to ensure that premiums are accurately collected via a pension check deduction or by check.

Auditee Response to Finding 2 – 1

Agree ☒ Disagree ☐ Partially Agree ☐

This problem had been previously identified by the Benefits staff earlier this year and a corrective ticket filed with ITD. Since being discovered during the audit, the IT Department has been working with Benefits staff to design and test a new report that will be generated daily. A new policy will be created and implemented by January 1, 2017.

Finding 2 – 2 *Inaccurate Taxation of Benefits Associated with Dependents Aged 26-30*

Per the Affordable Care Act, the value of any employer-provided health coverage for an employee's child is excluded from the employee's income through the end of the taxable year in which the child turns 26. Also, premium deductions paid by employee could be pre-tax up until that same time. Florida Statutes allow for children up to age of 30 to be covered through their parents' insurance plan under certain conditions. However, after the calendar year in which dependent turns 26, the federal tax benefits described above are no longer applicable.

The value of the health coverage provided by the City for dependents after the calendar year in which they turn 26 was not included in the taxable income for the employees, and employee contributions related to the coverage of these dependents were made on a pre-tax basis.

Recommendation to Finding 2 – 2

The Compensation and Benefits Division along with the Payroll Office within the Accounting Division should modify its processes to ensure that the value of the health coverage provided by the City for dependents after the calendar year in which the dependent turns 26 is treated as taxable and that employee contributions related to such coverage be made on a post-tax basis.

Auditee Response to Finding 2 – 2

Agree ☒ Disagree ☐ Partially Agree ☐

We are collaborating with Accounting and ITD to implement this recommendation in Oracle. We are mindful that employees may have several children of varying ages insured. At the present time, there is only one premium category for child or children coverage. This means that the

premium will be the same for 1 child or several. An administrative decision will be determined as to how the taxation issue will be resolved.

Finding 2 – 3 *Overcharging Terminated Employees on Last Paychecks*

While testing the population of 8,044 policies as of January 31, 2016, we found ten (10) employees that terminated employment in December 2015 or early January 2016 who still had the employee's portion of the premium for the health insurance for the second part of January 2016 deducted even though their health insurance benefits were already cancelled. A total of $716 in health insurance premiums was erroneously deducted and never refunded to these terminated employees.

We also tested 27 terminations throughout the audit scope period and found that in 9 out of 27 (or 33%) terminations tested employees were incorrectly charged for health insurance during the separation process:

1. Eight (8) employees were overcharged a total of $588 because they were charged for one or two pay periods for health insurance after health benefit was already terminated.
2. One (1) employee was undercharged $14.82 because the health deduction was erroneously not included in his last paycheck.

Finally, while testing 131 changes in health premiums (new hires, terminations, changes in coverage, etc.), we also found that $14.82 was deducted on the last paycheck of one (1) terminated employee for a period in which the employee was no longer covered.

Recommendation to Finding 2 – 3

We recommend that the Compensation and Benefits Division thoroughly review the last paychecks issued to terminated employees to ensure that all benefits deductions are accurate. This process should take place approximately a month after termination when all necessary payments are already processed. Finally, the Payroll Office in the Accounting Division should ensure that benefits deductions are removed from the paychecks as needed when a payment for the terminal leave is made.

Auditee Response to Finding 2 – 3

Agree ☒ Disagree ☐ Partially Agree ☐

We will conduct a periodic review and will work towards implementing beginning in 2017.

Finding 2 – 4 *Issues with the External Agencies that Use City's Health Insurance*

The City provides group health insurance to three external agencies: Jacksonville Housing Authority (JHA), Northeast Florida Regional Council (NFRC), and First Coast Workforce Development Consortium (FCWDC). We reviewed some of the invoices issued to these agencies and their respective benefits agreements, and we noticed the following issues:

1. The Compensation and Benefits Division is double-charging an administrative fee of $45.75 per employee per month to FCWDC and to NFRC. This additional charge in their invoices is intended to cover the third party health plan administrator fee, the stop-loss insurance premium, the employee assistance program fee, and fees related to the Affordable Care Act; however, these fees are already included in the total premium. For instance, no City employee or retiree or JHA employee pays those fees on the top of their regular health premiums.
2. We reviewed the corresponding agreements between the City and these external agencies regarding employee benefits and noticed that these agreements were signed 15 to 23 years ago which appears to be unreasonable. Since the City became self-insured on January 1, 2015, these agreements might not reflect the current business environment as well as the new administrative costs incurred by the City to manage the group health program. Additionally, we noticed that the agreements do not clearly state whether or not the retirees from these outside agencies should receive health benefits through the City.

Recommendation to Finding 2 – 4

We recommend the Compensation and Benefits Division review the fees charged to each outside agency. We also recommend that the benefits agreements between the City and these outside agencies be reviewed and revised. Finally, the updated agreements should also clearly state whether retirees from these outside agencies are eligible to receive benefits through the City.

Auditee Response to Finding 2 – 4

Agree ☒ Disagree ☐ Partially Agree ☐

We agree that new agreements should be executed between the City and participating agencies and administrative fees should be standardized. We are discussing with the administration how this will be structured and will work with OGC to develop the agreements.

Finding 2 – 5 *Issues with Employer Portion of the Health Insurance Premium*

We found various issues with the employer's portion of the health premium when we tested premiums collected. We specifically tested contributions for every member of the group health plan as of January 31, 2016.

First, we found that there was a "skip rule" in HRMS, the City's payroll and human resources information system. Under this rule, the employer contribution for the health insurance is automatically not charged when the employee's portion of the premium is not paid. We found seven (7) instances where employer's health premium contributions totaling $2,418 were not made because an employee had insufficient earnings to pay employee's portion of the premium even though the employee did go on to make the contribution and/or was retroactively switched to a high deductible plan which did not require a contribution from the employee. It appears that the division was not aware of this rule, so even if the employee subsequently paid the owed premium by a check, the employer contribution was not retroactively made as well.

Also, during the same testing noted above, we found 53 instances where the division did not make the appropriate adjustments to reflect retroactive changes in benefits or to subsequently refund excessive employer contributions on final checks. There were two types of issues:

1. 30 of the 53 instances were due to excessive premiums paid by the employer on the final paychecks where premiums were paid by employees and employer after benefits were already terminated. It should be noted that employees may or may not have been refunded later. This issue was also covered in Finding 2 – 2. This resulted in the employer over contributing $9,676.
2. 23 of the 53 instances were due to the division not charging or refunding the employer's portion of the health premiums when retroactive changes in employees' coverage were made. This resulted in the employer under contributing $2,625.

The net result of the issues noted above was that the employer over contributed $4,633.

Recommendation to Finding 2 – 5

The Compensation and Benefits Division should change its procedures to ensure that when corrections are made to employee's contributions, the employer's contributions are adjusted as well.

Auditee Response to Finding 2 – 5

Agree ☒ Disagree ☐ Partially Agree ☐

We agree that the "skip rule" in Oracle should be removed if possible. We will consult with ITD to see if this system modification is possible.

We also agree that with a retroactive change; the affected department should be credited or charged as appropriate. We do agree that these adjustments should be made and will work towards implementing this process in 2017. With a finding of $4,633, we will try and accommodate.

Opportunity for Improvement 2 – 1 *Forcing Retirees to Apply for Medicare Part B*

The Compensation and Benefits Division currently does not require retirees to apply for Medicare Part B at the eligible age so that Medicare can be used as the primary insurance. It appears that it is a common practice for employers to force or at least encourage retirees to opt for Medicare Part B. Per the consulting firm used by the City to manage health benefits, nearly all private employers this large that the consulting firm deals with have implemented some form of Medicare opt out. In the public sector, approximately half of the consultant's clients force retirees to switch to Medicare. Of even more significance, the State of Florida requires its group health plan retired participants to apply for Medicare so the State's group health plan becomes the secondary insurance. Given the City is now self-insured, there is a great incentive for the City to force or encourage retirees to apply for Medicare and offer City's insurance as secondary insurance. It would likely decrease City's claims costs since the population of group health plan

members would likely become younger and healthier. Also, there may be more cost effective options the City could make available for retirees if the City's insurance were secondary.

Recommendation to Opportunity for Improvement 2 – 1

The Compensation and Benefits Division should consider forcing retirees to apply for Medicare and offer City's insurance to retirees only as secondary insurance if they qualify for Medicare Part B.

Auditee Response to Opportunity for Improvement 2 – 1

Agree ☒ Disagree ☐ Partially Agree ☐

The City consistently considers the options. There are many important aspects to this decision that the Administraion is carefully examining. Among these are collective bargaining agreements, employee/retiree morale and the financial impact this may have on City retirees.

Opportunity for Improvement 2 – 2 *No Costs Allocation Review per Member Group Type*

The Compensation and Benefits Division is not periodically performing a cost recovery analysis across the groups within its group health plan to make sure that the City charges enough in premiums to each group to cover each group's respective medical and administrative expenses. Currently, the City offers four health insurance coverage options: employee only, employee & spouse, employee & children, and employee & family. Also, there are three types of coverage: high deductible HMO, HMO and PPO. The premium rates are different for each of those types.

In 2015 and 2016 (when the City was self-insured), the premium rates were the same as the premium rates that were determined by the insurance provider and used by the City for 2014 (when the City was fully-insured). Therefore, since no periodic review is taking place, one group of employees might start "subsidizing" another group now or in the near future if no review is performed. It is a good business practice to fairly allocate the costs based with the usage of the resources and to periodically review the cost drivers. Also, there is a direct financial impact on the City and employees if costs are incorrectly allocated. For example, the City could be underpaying (if the employee only group is "subsidized") or overpaying (if the employee only group is "subsidizing" other groups) its employer's portion of the health premiums since employer contributions are greater for the employee only group. The same issue applies to HMO versus PPO policies. It is likely that costs incurred under different options are changing at different speed, so after some time one group of members would end up "subsidizing" another if premium levels remain the same.

Recommendation to Opportunity for Improvement 2 – 2

We recommend the Compensation and Benefits Division periodically reviews the overall costs of providing insurance for different groups to ensure that costs are allocated accurately between the groups based on the actual usage.

Auditee Response to Opportunity for Improvement 2 – 2

Agree ☒ Disagree ☐ Partially Agree ☐

Our Consulting Actuary actually will review this annually going forward.

Opportunity for Improvement 2 – 3 *No Costs & Benefits Analysis for External Agencies*

Three external agencies use the City's group health plan: Jacksonville Housing Authority, First Coast Workforce Development Consortium, and Northeast Florida Regional Council. They are charged the same premiums as any other City's group health plan members. When the City was fully-insured, the risk of covering medical claims was assumed by the insurance provider. Now, when the City is self-insured and bears this risk, a careful and periodic examination of the costs and benefits of allowing external agencies to use the City's group health plan is necessary. Such examination is not being done currently. In other words, the Compensation and Benefits Division is not monitoring whether premiums collected from the external agencies are high enough to cover their respective medical claim costs. However, based on an analysis that we performed, it appears that the City collected enough in premiums from these external agencies to cover their medical claim costs during our audit scope period. It should be noted that we simply looked at the paid claims and premiums collected and did not consider the risk that City is assuming by allowing these external agencies to participate in the City's group health plan. The risk factor should be considered in the proper costs and benefits examination. Also it is important for such analysis to be performed periodically since things could change significantly from year to year.

Recommendation to Opportunity for Improvement 2 – 3

We recommend the Compensation and Benefits Division periodically monitor the claims costs versus premiums collected from the external agencies. The risk factor should also be included in the analysis of costs. If the costs become disproportionately greater than the premiums collected from the agencies, the Compensation and Benefits Division should consider adjusting the external agencies' premiums.

Auditee Response to Opportunity for Improvement 2 – 3

Agree ☐ Disagree ☐ Partially Agree ☒

Because outside agencies participating are small groups, many are often unable to support even a single large claim with premium offsets. We believe it may be more appropriate to re-consider allowing outside agencies to participate in the City plan. We suggest this be considered as part of Finding 2-4.

SUPPLEMENTAL ISSUES

Supplemental Internal Control Weakness 1 *No Audit or Detailed Review of Claims*

The Compensation and Benefits Division does not perform any kind of detailed review or audit to verify that the third party health plan administrator accurately and appropriately pays for claims submitted by health care providers. Because the City became self-insured, it is now bears the financial burden for all claims and has an interest and a fiduciary responsibility to make sure that the third party health plan administrator is appropriately reviewing and approving all claims in accordance with the terms of the plan. Currently, the third party health plan administrator reviews claims and determines if they are valid and allowable. Then the administrator pays for the claims and sends a report with all claims paid during the month to the City. This report contains very limited information such as claim number, date of service, payment date, amount paid, and amount billed. It appears the staff only performs a cursory review of this report. Therefore, the current practice could lead to significant financial losses for the City.

Recommendation to Supplemental Internal Control Weakness 1

We recommend that the Compensation and Benefits Division (or maybe more appropriately an experienced and qualified third party) periodically perform an audit or a detailed review of medical claims processed by the health plan administrator.

Auditee Response to Supplemental Internal Control Weakness 1

Agree ☒ Disagree ☐ Partially Agree ☐

Current budget restraints do not support this finding; however, we will include this in the 2017-2018 budget.

Supplemental Finding 1 *Overpaying Administrative Fees*

We reviewed the invoice for the third party plan administrator for January 2016 and found that the Compensation and Benefits Division overpaid for administrative fees. Those fees are paid per member each month. The total overpayment amounted to $1,711. These overpayments appear to be associated with 45 group health plan members whose insurance was canceled mostly during the first half of January 2016. The agreement between the City and the third party plan administrator is that if health benefits for a member are canceled between the 1st and 15th day of the month, the City does not have to pay the administrative fee for that particular individual during that month.

Recommendation to Supplemental Finding 1

We recommend that the Compensation and Benefits Division review and improve the current process used to calculate and process the administrative fee payments.

Auditee Response to Supplemental Finding 1

Agree ☒ Disagree ☐ Partially Agree ☐

We are working with ITD to make sure that Oracle terminated reports currently being provided accurately reflect all employee charges.

We greatly appreciate the prompt and thorough assistance and cooperation we received from the Compensation and Benefits Division through the course of this audit.

Respectfully submitted,

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