

**Group Health Fund Audit
February 2011**

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Group Health Fund Audit



Office of the City Auditor

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Report #09-11

February 11, 2011

Executive Summary

*Claims data is reasonably
accurate and reliable*

*Management should
increase oversight over
healthcare revenue and
expenditures*

Opportunities for Improvement

- ***Reconcile enrollment data, COBRA payments and FSA balances***
- ***Conduct dependent eligibility audit***
- ***Prepare annual Group Health Fund budget***

As part of the Fiscal Year 2009 Annual Audit Plan, the City Auditor's Office conducted an audit of the City's Group Health Fund. The audit was conducted in accordance with generally accepted government auditing standards, except for peer review. 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. The objectives of the audit were to determine whether:

- claims data received from United Healthcare (UHC) is reliable and reasonably accurate to make benefit plan decisions;
- Workforce Services exercises the appropriate amount of control over health claims administrative expenditures;
- Workforce Services has identified adequate performance measures and standards to evaluate the long-term impact of plan design changes and the wellness program;
- the City is accurately accounting for revenue received from Consolidated Omnibus Budget Reconciliation Act (COBRA) participants and is verifying the accuracy of COBRA subsidies received under the American Reinvestment and Recovery Act (ARRA);
- Workforce Services has established appropriate controls over the flexible spending arrangement (FSA) program; and,
- the City has developed an appropriate strategy for addressing the outstanding Other Post Employment Benefit (OPEB) liability.

Generally, payments to health vendors for managed care and administrative expenses were accurate, supported by appropriate documentation and made in accordance with written agreements. However, the City Auditor's Office noted some immaterial exceptions due to the lack of detailed reconciliation of enrollment data. In addition, reconciliation of COBRA payments and FSA balances was not performed. Lack of reconciliation can lead to undetected errors or irregularities and inaccurate account balances.

The City has begun efforts to ensure that dependents enrolled in the City's health plans are eligible for participation. The City is now requiring employees to provide social security numbers for dependents and requires documented proof of qualifying life events in order for employees to add dependents during mid-year. However, the City has not performed a comprehensive dependent eligibility audit. Such an audit may result in cost savings as it may reveal dependents that were erroneously or fraudulently enrolled in the City's health plans.

The City has established controls that complement controls in place at the third party administrator (TPA), but has not demonstrated that periodic risk assessments are conducted to determine when changes to controls are necessary.

The City Auditor's Office noted that a budget is not prepared for the Group Health Fund. Due to the significance of the fund and the expectation of rising healthcare costs, the City Auditor's Office recommends that a budget be prepared for the Group Health Fund. A published budget for the fund will increase transparency and accountability, in addition to documenting reasonable expectations related to premium increases, claims expenses and administrative expenses.

The findings and recommendations are discussed in the Detailed Audit Findings section of this report.

Audit Scope and Methodology

The audit was conducted in accordance with generally accepted government auditing standards, except for peer review. The following methodology was used in completing the audit.

- Interviewed various Workforce Services and Financial and Management Resources personnel.
- Reviewed the Statement on Auditing Standards (SAS) No. 70 (Reports on the Processing of Transactions by Service Organizations) report on controls relating to the claim administration process of UHC. A SAS 70 report is an auditor-to-auditor communication that allows user auditors to gain an understanding of the internal controls in operation at the service organization.
- Identified and tested key internal controls over retiree health premium payments, payments to UHC and other vendors delivering health services, enrollment changes, COBRA payments and the FSA program.
- Reviewed claims data and reports from the UHC employer services website.
- Reviewed claims and administration expenditures recorded in the Lawson financial system.
- Identified and reviewed self-funded employer best practices related to claims administration.

The review covered fiscal years 2009 and 2010. The City Auditor's Office limited the review to documentation produced and retained by the City and to claims information on the UHC employer services website. While the claims information available on the UHC website was sufficient to support City claims payments and verify the reliability of participant data, it was not always sufficient to perform specific detailed analysis. For example, the available claims data was not detailed enough to determine if significant variations in cost and/or service levels exist between treatments or facilities.

The City Auditor's Office also did not have access to detailed FSA account claims data. Therefore, the City Auditor's Office was unable to verify that amounts held in escrow for employee's tax saver accounts agreed to statements provided by UHC.

This review also did not specifically include any analysis of the Patient Protection and Affordable Care Act (PPACA) or the Health Care and Education Reconciliation Act of 2010. The acts intend to put in place comprehensive health insurance reforms that will hold insurance companies more accountable, lower health care costs, guarantee more health care choices, and enhance the quality of health care for all Americans. The acts were enacted in March 2010, after the planning stages of this audit. The City Auditor's Office will include additional steps in its follow-up audit to ensure that the City is prepared to comply with the relevant provisions of these acts.

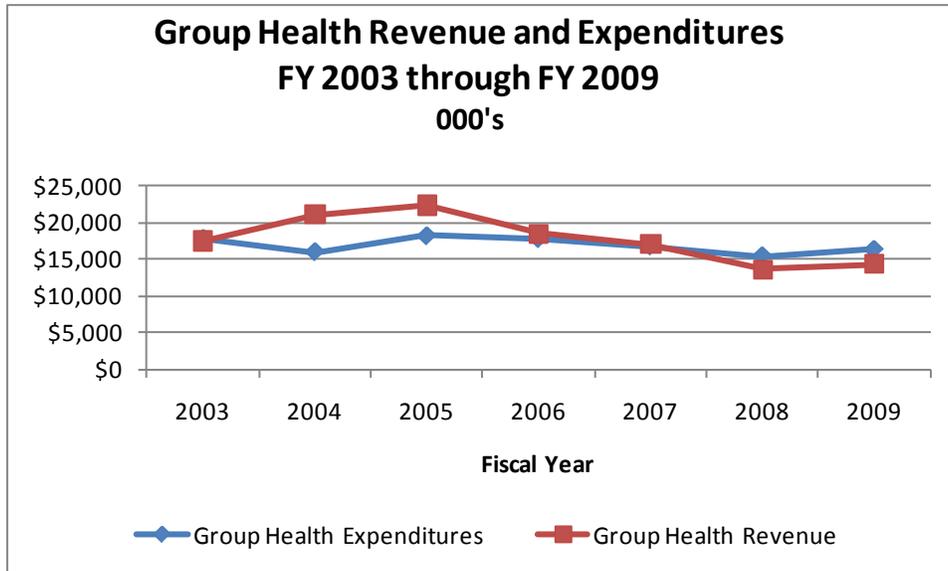
Background

The City of Arlington's health benefit plans became self-funded on January 1, 2003. The City has contracted with a TPA to perform claims processing and other plan administration activities for its self-funded health benefit plans. No risk is assumed by the TPA (currently UHC) for the actual cost of claims, so the contract is related only to processing claims transactions and other plan administration processes such as customer service, care coordination, technical reporting, etc.

Contributions collected on behalf of employees through payroll deduction, and retirees through direct payments, are deposited into the Group Health Fund along with contributions made by the City. These funds are used to pay for actual medical and pharmacy claims and UHC's charges for administrative services. As part of the administrative services agreement, UHC serves as the City's claims fiduciary. In other words, UHC makes decisions on behalf of the City regarding payment of claims, processes those claims, hears any appeals, and makes payment decisions based on the benefit plan design approved by the City of Arlington. The TPA is also responsible for establishing and maintaining a network of providers who have entered into or are governed by contractual arrangements under which they agree to provide health care services to City participants and accept negotiated fees for those services.

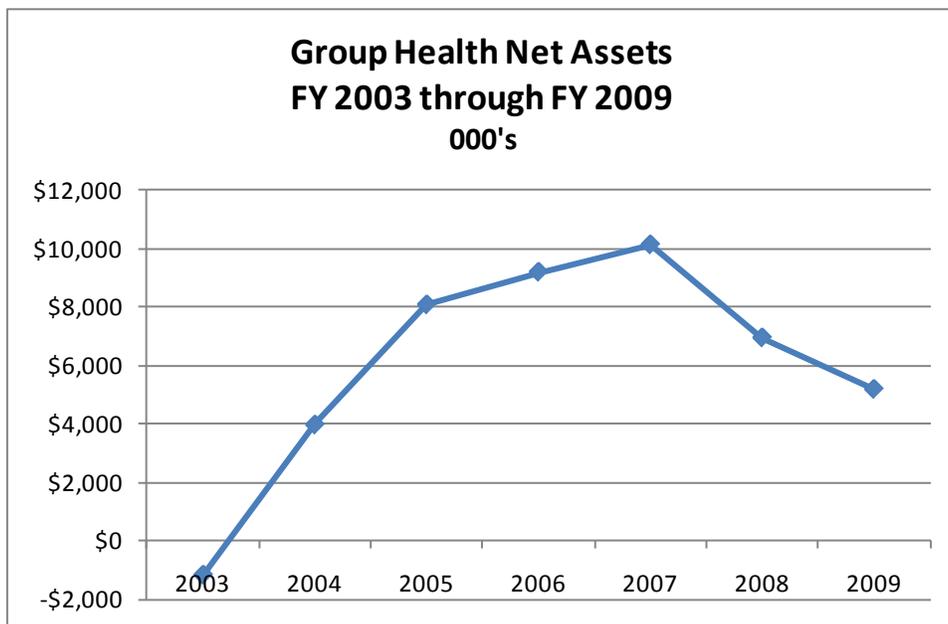
In addition to the self-funded medical plans, the City also purchases managed care services (dental, vision, and various medical plans for retirees over 65) on behalf of employees and retirees. For these plans, the City is not at risk for claims expenditures that exceed premiums. The City contributes a portion of the cost of the medical plans for retirees based on the date of the employee's retirement and the number of years of service.

The following chart summarizes total Group Health Fund revenue and expenses for fiscal years 2003 through 2009. The totals exclude contributions and expenditures associated with retirees in order to comply with accounting standards. Those standards require that the cost of post employment health benefits be disclosed in the financial statements in the period services are received.



Source: City's CAFR

As shown in the chart above, revenue exceeded claims expenditures in fiscal years 2004 and 2005. As a result, the Group Health Fund built up a reserve that reached \$10 million in FY 2007. However, due to increasing claim costs and transfers of “excess” reserves to the General Fund, the reported net assets for the Group Health Fund decreased to approximately \$5.2 million by FY 2009 as shown in the following graph.



Source: City's CAFR

Based on an estimate of FY 2010 claims expenditures prepared by the City Auditor’s Office, it appeared likely that the remaining reserves would be depleted by the end of FY 2010. However, City management transferred \$2.4 million from the General Fund to the Group Health Fund in July 2010. This amount should be sufficient to ensure that the reserves are not completely

depleted. The Workforce Services Department has proposed premium increases and benefit plan changes for calendar year 2011 to help offset expected medical claims increases.

Sources of Funds

During FY 2009, total contributions to the Group Health Fund exceeded \$16.8 million. Employees and retirees contributed 100% of the cost of managed care dental and vision insurance - the City is not at risk for claims exceeding the premium amounts. For medical and pharmacy coverage, the City contributed over 80% of calculated premiums for employees and over 65% of the calculated required premiums for retirees, as shown in the table below.

Group Health Fund Contributions FY 2009							
	EMPLOYEES			RETIREES			City Total
	Employees	City	Total	Retirees	City	Total	
Medical and Pharmacy	2,490,550	10,289,188	12,779,738	1,090,484	2,038,449	3,128,933	15,908,671
Vision	206,812	-	206,812	38,282	-	38,282	245,094
Dental	565,047	-	565,047	114,436	-	114,436	679,483
Total	3,262,409	10,289,188	13,551,597	1,243,202	2,038,449	3,281,651	16,833,248
Medical Share	19.49%	80.51%		34.85%	65.15%		

Source: Lawson Financial System

Total contributions exceed the amounts reported in the City's Comprehensive Annual Financial Report (CAFR) due to reporting requirements related to accounting for post employment benefits. In addition to the vision and dental insurance, the City also purchases some managed care medical and pharmacy products for retirees over the age of 65. As a result, approximately \$14.9 million of the medical and pharmacy premiums were associated with self-funded medical coverage. The City would also be responsible for any claims and administrative costs that exceeded that amount.

Uses of Funds

In preparing the FY 2009 CAFR, Financial and Management Resources staff used information provided by outside consultants to record the outstanding liability for incurred but not reported (IBNR) claims. The consultants estimated that total FY 2009 self-funded claims expenditures would be approximately \$15.28 million, which was slightly higher than the self-funded premium revenue. In addition, the City incurred administrative, wellness and managed medical care costs that brought total medical expenditures to \$17.8 million, resulting in a reported loss of \$1.75 million, after considering interest earnings.

Through July 2010, the UHC employer eServices website included reports indicating that total FY 2009 self-funded claims equaled \$15.17 million, summarized in the following chart.

City of Arlington Healthcare Medical Costs FY 2009		
<u>Healthcare Category</u>	<u>Total Paid</u>	<u>Pct.</u>
Facility Inpatient	\$ 4,006,728	26.4%
Facility Outpatient	3,411,610	22.5%
Primary Care	905,464	6.0%
OB/GYN	371,362	2.4%
Speciality	3,089,329	20.4%
Allied Health	218,473	1.4%
Managed Pharmacy	3,168,531	20.9%
Total	\$ 15,171,497	100.0%

Source: UHC eServices Report

Excluding pharmacy costs, the expenditures by diagnosis chapter is presented in the following table.

City of Arlington Healthcare Medical Costs FY 2009		
<u>Diagnosis Chapter</u>	<u>Total Paid</u>	<u>Pct.</u>
Neoplasms	\$ 1,486,705	12.4%
Respiratory System	1,254,174	10.4%
Musculoskeletal	1,172,769	9.8%
Circulatory System	1,110,069	9.2%
Digestive System	927,841	7.7%
Injury and Poisoning	882,313	7.4%
Genitourinary System	810,021	6.7%
Nervous System	709,545	5.9%
Pregnancy/Childbirth	624,447	5.2%
Mental Disorders	192,966	1.6%
All Other Diagnosis Chapters	2,832,116	23.7%
Total	\$ 12,002,966	100.0%

Source: UHC eServices Report

Cost Driving Factor – Large Loss Claims

Extraordinary claims represent a large percentage of total claim costs. As shown in the following chart, seven percent of claimants were responsible for over 62% of total expenditures in FY 2009. Due to the uncertainty surrounding large-loss claims, effective January 2011, the City is planning to purchase stop-loss coverage to limit its exposure to catastrophic claims.

CITY OF ARLINGTON CLAIMS EXPENSES BY SIZE OF CLAIM FY 2009						
	Number of Claimants	Pct. Of Claimants	Cumulative Pct. Of Claimants	Payments	Pct. Of Payments	Cumulative Pct. Of Payments
<\$.01	6	0.1%	0.1%	\$ -	0.0%	0.0%
\$.01-\$49	277	6.4%	6.5%	6,321	0.0%	0.0%
\$50-\$99	205	4.7%	11.2%	15,465	0.1%	0.1%
\$100-\$249	732	16.8%	28.0%	124,990	0.8%	1.0%
\$250-\$499	696	16.0%	44.0%	250,759	1.7%	2.6%
\$500-\$999	627	14.4%	58.4%	447,709	3.0%	5.6%
\$1,000-\$2,499	755	17.4%	75.8%	1,208,432	7.9%	13.5%
\$2,500-\$4,999	450	10.3%	86.1%	1,589,014	10.4%	24.0%
\$5,000-\$9,999	302	6.9%	93.0%	2,127,645	14.0%	38.0%
\$10,000-\$14,999	120	2.8%	95.8%	1,441,731	9.5%	47.5%
\$15,000-\$19,999	60	1.4%	97.2%	1,023,214	6.7%	54.3%
\$20,000-\$24,999	30	0.7%	97.9%	676,415	4.5%	58.7%
\$25,000-\$29,999	17	0.4%	98.3%	473,563	3.1%	61.8%
\$30,000-\$39,999	23	0.5%	98.8%	803,582	5.3%	67.1%
\$40,000-\$49,999	18	0.4%	99.2%	800,170	5.3%	72.4%
\$50,000-\$74,999	10	0.2%	99.4%	645,047	4.3%	76.7%
\$75,000-\$99,999	14	0.3%	99.7%	1,196,848	7.9%	84.5%
\$100,000-\$124,999	3	0.1%	99.8%	333,903	2.2%	86.7%
\$125,000-\$149,999	3	0.1%	99.9%	403,438	2.7%	89.4%
\$150,000-\$174,999	1	0.0%	99.9%	173,950	1.1%	90.6%
\$175,000-\$199,999	1	0.0%	99.9%	176,038	1.2%	91.7%
\$200,000-\$249,999	1	0.1%	100.0%	240,219	1.6%	93.3%
\$350,000-\$399,999	1	0.0%	100.0%	374,887	2.5%	95.8%
\$500,000+	1	0.0%	100.0%	642,821	4.2%	100.0%
	4,353	100.0%		\$ 15,176,161	100.0%	
> \$9,999	303	7.0%		\$ 9,405,826	62.1%	

Source: UHC eServices website

Cost Driving Factor – Retiree Claims

Of the approximate \$15.2 million in FY 2009 claims expenditures, \$3.05 million was associated with retirees and their dependents. Expenditures on a per member, per month (PMPM) basis were much larger for retirees than active employees, as shown in the following table.

City of Arlington Healthcare Medical Costs - PMPM FY 2009			
	Employees	Retirees	Total
Total Medical Costs	\$ 12,126,194	\$ 3,049,948	\$ 15,176,142
Average Monthly Members	4,629	569	5,198
Per Member, Per Month	\$ 218.30	\$ 446.68	\$ 243.30

Source: UHC eServices website

There is a possibility that the City will receive a subsidy for retiree healthcare from the Federal government in the future. As part of the Affordable Care Act, the Department of Health and Human Services has made available \$5 billion in financial assistance to employers to help them maintain coverage for early retirees not yet eligible for Medicare. The City has applied and was granted access to the Early Retiree Reinsurance Program. The program will provide subsidies based on 80% of claim expenditures for retirees that exceed \$15,000 per year, up to a ceiling of \$90,000. UHC has projected potential reimbursements to the City under the program of over \$600,000 for plan year 2011. Any future actual subsidy amount will be limited based on available funds and final requirements issued by the federal government.

OPEB

The City administers a single-employer defined benefit health care plan. The plan provides post retirement health care benefits to eligible retirees and their spouses.

Eligible employees can continue their health care coverage in retirement if their age plus years of service is at least 70, with a minimum age requirement of 50 years and a minimum of ten years of service with the City. Employees hired after December 31, 2005 are not eligible for post retirement health care benefits. As of July 2010, 401 active employees are eligible for post retirement health benefits. Another 316 employees will become eligible over the next five years and another 330 in ten years.

The retirement committee of the City has the authority to establish and amend contribution requirements of the plan. Currently, the plan is funded on a pay-as-you-go basis. Details of the annual OPEB cost, net OPEB obligation and funded status and funding progress are included in the City's CAFR. As of January 1, 2009, the unfunded actuarial accrued liability for post employment health care benefits was \$104.5 million.

COBRA ARRA Assistance

As part of ARRA, the cost of health insurance for eligible employees was subsidized for individuals that experienced an involuntary termination of employment during the period beginning September 1, 2008 and ending December 31, 2009 (subsequently extended to May 31, 2010). Eligible employees are allowed to pay only 35% of their required COBRA premium for up to 15 months. The City receives the remaining premium amount directly from the federal government. Through June, 2010, the City had received \$23,944 in ARRA COBRA subsidy payments for individuals covered through the first quarter of 2010.

Staffing

Employees in the Workforce Services (WFS) and Financial and Management Resources (FMR) Departments perform various duties related to the administration of the Group Health Fund. In addition, two United Healthcare employees are assigned to the City on a full-time basis to oversee the health and wellness programs and to provide employees assistance with claims, pharmacy and FSA issues.

In Workforce Services, the following positions support the Group Health Fund.

- Employee Services Manager - Oversees benefits design, claims administration

- Benefits Specialist – Provides technical assistance to WFS consultants and management in benefits design and administration
- Service Assistant – Assists retirees and employees with benefit questions
- Analyst – Provides employee and retiree benefit information on an as needed basis

In FMR, the following positions support the Group Health Fund

- Payroll Assistant – Responsible for reconciling and preparing premium and administrative service fee payments based on participant data; recording COBRA receipts
- Lead Data Entry Operator – Responsible for recording retiree premium payments in an Excel spreadsheet
- Treasury Analyst – Responsible for receiving retiree payments and preparing the daily bank deposit

Dependent Eligibility

In the past, the City did not verify dependent eligibility for newly hired employees or for existing employees adding dependents during the open enrollment period. During FY 2009, the City started to increase its efforts to verify dependent eligibility for employees that experienced mid-year qualifying life events such as marriage, divorce, birth of a child or loss of spousal health insurance. Such employees are now required to submit proof (birth certificates, social security numbers, statements regarding loss of insurance, etc.) before enrollment changes are authorized. However, there are still dependents that enrolled in the City's various health plans prior to FY 2009 which have not been subjected to verification.

Accomplishments

The City of Arlington is among seven U.S. companies honored this year for innovative solutions in employee healthcare management, according to Hub Magazine which recently presented its 2010 Apex Awards. The award recognizes initiatives that improve the healthcare experience for consumers.

Each year, Hub Magazine's Apex Awards program honors the innovation and leadership showcased by employers that are improving the health care experience for all consumers. According to the magazine, the bar is raised further each year as pioneering solutions bring the future of health care to the here and now.

The City's "Wellness Works for 'ME' Incentive Program" was first launched in January 2008 to all full-time employees enabling them to earn points based on healthful activities. Financial incentives, or rewards, are provided to participants based on the number of points earned. While national medical expenses per employee increased 13 percent from 2007 to 2009, City of Arlington employees who participated in the workplace Wellness Program saw their medical expenses decrease by as much as 32.7 percent, according to Workforce Services management.

The City has previously been recognized by UHC for its wellness program, receiving the Golden Apple award in 2009. The City has also recently received the “Champions in Health” award for its commitment to wellness.

Detailed Audit Findings

1. The City does not reconcile all enrollment information when making monthly premium and administration payments.

The UHC SAS 70 report includes the following control as one of those that should be in operation at user organizations to complement the key controls at UHC.

“The user reconciles monthly invoices using the number of enrollees and rates specified in the Administrative Services Agreement (ASA), and notifies the Claim Administrator of any discrepancies.”

In addition to payments to UHC for medical claims, administrative and dental managed care costs, the City also processes monthly invoices for vision insurance, pharmacy coverage, and various medical plans for individuals over the age of 65. Some of these plans require that the retiree enroll in the plan by contacting the appropriate vendor.

The City Auditor’s Office reviewed a sample of monthly invoices and found only immaterial exceptions. However, the City Auditor’s Office did not see evidence that the City had performed a detailed reconciliation of enrollees and communicated any discrepancies to UHC or the other health services vendors. Supporting documentation for monthly invoices paid did not include demonstration of any comparison of enrollment data to the related invoice. The following immaterial errors were noted.

- An invoice paid to UHC did not include payment for one former employee on a dental plan.
- Payment for the UHC pharmacy plan included payment for a retiree who was recorded as cancelled by the City for not making the required premium payments to the City.
- Payment to AARP included the City contribution for a retiree that had not contributed the required premium to the City.
- Payment to AARP did not include the City contribution for a retiree that had been making the required payment for AARP Plan J to the City, but had apparently not enrolled in the plan through AARP. Although this retiree contributed his premium payments to the City, the retiree was not included on the monthly invoices from AARP.

Lawson Financial System reports are available to assist staff with reconciling monthly invoices. During this audit, the City Auditor’s Office met with representatives of WFS and FMR to discuss the changes necessary to various reports to simplify the reconciliation process. For example, some vendors provided invoices that separately listed spouses but Lawson reports may have only listed the employee. If monthly invoices are not reconciled, errors may go undetected and could result in the City paying for unnecessary coverage.

Recommendation:

The Deputy City Manager over Workforce Services should ensure that staff automates and simplifies the reconciliation of monthly premium and administration payments, including the communication and resolution of discrepancies with the appropriate vendors.

Management's Response:

Concur. The Workforce Services staff will automate and simplify the reconciliation of the benefit enrollment with monthly premium and administration payments, including the communication and resolution of discrepancies with the appropriate vendors. However, WFS staff will need the assistance of IT and FMR staffs to insure proper tools are available to perform this function and that all pertinent information is available to WFS staff to complete the task. The WFS HRIS Specialist will need to work with IT to develop standard reports that reflect accurate enrollment information for both active and retired employees that can be used to compare with the billings from the various vendors on a monthly basis. Once those reports are developed and available, FMR staff will need to advise their contacts to send the billing information to WFS for processing. Once the invoices have been validated, WFS staff will then send the invoices to FMR for entry into the Catalyst system. Meetings have been scheduled with IT staff to develop the standard reports that will be needed to achieve this recommendation.

Target Date: October 1, 2011

Responsibility: Leeann Shackelford, WFS Manager – Employee Services

2. The City does not verify that COBRA payments received from UHC are complete and accurate.

In order to ensure that amounts received as revenue are accurate and complete, sound business practices dictate that personnel responsible for receiving the revenue should have some knowledge of the expected revenue. The City of Arlington has contracted with UHC to administer COBRA continuation coverage. COBRA participants send premium payments to UHC for both self-insured and managed care plans. UHC then forwards the premiums for the self-insured plans to the City, after subtracting its monthly administrative fee. Under the ARRA of 2009, some individuals are only responsible for 35% of the COBRA premium otherwise due to the plan.

The City Auditor's Office tested a sample of UHC submittals and noted minor exceptions related to the calculation of premium amounts for retirees that qualified for COBRA subsidies under the ARRA. The following provides an illustration of one of the immaterial errors noted by the City Auditor's Office.

Retiree Premium Cost	
Premium	\$ 241.90
ARRA Subsidy Amount	<u>(157.23)</u>
Retiree Contribution (35%)	\$ 84.67
UHC Administrative Fee	<u>(33.51)</u>
Amount Due the City From UHC	\$ 51.16
Amount Actually Submitted to City by UHC	<u>73.45</u>
Variance	\$ (22.29)

Although the actual COBRA premium amount (\$73.45) submitted to the City by UHC exceeds the amount due the City (\$51.16), the City Auditor's Office found no indication that the City attempted to resolve or understand the reason for the discrepancy. Neither FMR nor WFS employees could explain the reason for the identified immaterial exceptions.

Historically, WFS staff has had access to COBRA participation but has not reconciled UHC submittals received in FMR to actual COBRA participation. This could lead to the City not receiving COBRA premiums as expected. FMR has not had access to UHC reports of COBRA participants and has not been required to reconcile UHC submittals to actual COBRA participation.

Recommendation:

The Deputy City Manager over Workforce Services should ensure that staff reconciles UHC submittals for COBRA coverage to actual COBRA participation. Workforce Services staff should identify, disclose and resolve any discrepancies between actual COBRA participation and amounts submitted by UHC.

Management's Response:

Concur. WFS staff currently sends the first COBRA notice to employees who are terminating employment or taking an unpaid leave of absence. These notices are triggered by payroll actions within Lawson or direct notification from other staff. To be able to identify, disclose and resolve any discrepancies between actual COBRA participation and amounts submitted by UHC to the City, WFS will work with IT and FMR staffs to insure proper tools are available to perform the function.

Target Date: October 1, 2011

Responsibility: Leeann Shackelford, WFS Manager – Employee Services

3. City staff does not reconcile UHC reports of employee FSA balances to Lawson financial records.

In order to ensure that amounts held in escrow for employee FSA accounts are recorded accurately, the escrow account should be periodically reconciled to supporting documentation.

The City provides employees with health and dependent care flexible spending arrangements, funded through voluntary employee salary deductions. The City's plan allows employees to set aside up to \$5,000 per year for eligible dependent care expenses and up to \$5,000 per year for qualified medical expenses. The City's current healthcare TPA also provides administration of the FSA. Employee payroll deductions are held in an escrow fund until requested by the City's healthcare administrator to pay for FSA reimbursements provided to employees.

FSA's are "use-it-or-lose-it" plans. This means that amounts in the account at the end of the plan year cannot be carried over to the next year. However, the City's plan provides for a grace period of 2½ months after the end of the plan year. Any qualified medical expenses incurred in that period can be paid from any amounts left in the account at the end of the previous year. By federal law, the City is not permitted to refund any part of an employee's balance.

UHC provides periodic reports detailing employee FSA balances by calendar (plan) year. Therefore, for a portion of each calendar year, UHC prepares reports summarizing employee FSA balances for two different calendar years. Once the prior calendar year is considered "closed" and no further transactions are expected to be applied to any outstanding balances, FMR prepares a transfer from the escrow account to the Group Health Fund based on the remaining FSA balances. By law, these amounts are considered "forfeited" by the employee.

As of July 31, 2010, FMR had not yet transferred the outstanding calendar year 2009 balances. Reports received from UHC indicated the following calendar year escrow balances.

Calendar Year FSA Balances			
As of July 31, 2010			
	2009	2010	Total
FSA Dependent Care	\$ 45,699	\$ 37,961	\$ 83,660
FSA Healthcare	<u>57,584</u>	<u>(103,074)</u>	<u>(45,490)</u>
Total	\$ 103,283	\$ (65,113)	\$ 38,170
Less: Lawson Balance, July 31, 2010			<u>101</u>
Difference			\$ 38,069

Source: UHC Member Detail Reports

The 2010 FSA Healthcare balance is negative because employees are allowed to be reimbursed as medical expenditures are incurred even if those expenditures exceed their YTD contributions. Employees are only reimbursed for dependent care expenses to the extent of their YTD contributions. Reimbursements should never exceed the employees' elected amounts.

As of July 31, 2010, the Lawson financial system indicated that the employee FSA escrow account had a balance of \$101, a difference of \$38,069 from the UHC reports. The City Auditor's Office did not have access to sufficient records to identify why the escrow account balance did not match reports from UHC, but did note that the UHC reports indicated a slightly higher amount for employee contributions in CY 2009 (\$857,681 compared to \$855,890) than the amount recorded in Lawson. The City Auditor's Office was not able to verify reimbursements to employees by plan year because the City does not segregate the payments to UHC by plan year in the accounting system.

FMR historically has not had access to detail UHC FSA data and must rely on reports provided to the City to make appropriate journal entries. Such access may be required in order to periodically reconcile the FSA escrow balance. To ensure the confidentiality of claims data, it may be necessary that Workforce Services personnel take a more active role in verifying and reconciling FSA reports and data. Periodic reconciliation is needed to identify potential reporting errors. For example, the City Auditor's Office noted the following while reviewing the UHC FSA reports.

- For nine employees, the UHC reports indicated that reimbursements in CY 2009 exceeded the employee elections by a total of \$4,650. Controls should be in place to ensure that reimbursements do not exceed the elected amount.
- Employees do not contribute to their FSA account while on leave of absence without pay – resulting in reimbursements that exceed contributions made for the year.

- Over 23% (13 of 56) of employees enrolled in the dependent care FSA program had CY 2009 balances exceeding \$1,000 for a total of \$35,623.

Upon further research, the City may be able to resolve the reporting issues with UHC. However, reconciliation of the escrow account would help staff identify, research and resolve these types of potential problems.

Subsequent to the initial drafting of this report, UHC provided the City Auditor's Office with revised FSA reports for calendar year 2009, summarized in the following table. Due to the inability to access detailed data, the City Auditor's Office was not able to verify the accuracy of the FSA reports. The production of multiple reports covering the same time period with different reported balances suggests that the City needs to increase oversight of this area.

Calendar Year FSA Balances As of July 31, 2010 Revised for New FSA Schedule			
	2009	2010	Total
FSA Dependent Care	\$ -	\$ 37,961	\$ 37,961
FSA Healthcare	<u>(23,538)</u>	<u>(103,074)</u>	<u>(126,612)</u>
Total	\$ (23,538)	\$ (65,113)	\$ (88,651)
Less: Lawson Balance, July 31, 2010			<u>101</u>
Difference			\$ (88,752)

Source: UHC FSA Reports and Lawson Financial System

Recommendation:

The Deputy City Manager over Workforce Services should ensure that staff coordinates with UHC to ensure that FSA reports are accurate and reconciles UHC reports of FSA balances to amounts recorded in the Lawson financial system on an annual basis.

Management's Response:

Do Not Concur. Currently City staff in Finance does attempt to reconcile the employee FSA balances with UHC to the Lawson Financial records containing the escrow account. However, due to the very nature of the Flexible Spending Account, it is very difficult to reconcile the escrow account, Lawson records, and employee UHC balances particularly on a fiscal year basis vs. a calendar year basis. The FSA is based on a calendar year basis and the City also provides employees with an additional 2 ½ months in the next calendar year to utilize their previous annual pledge.

FSA funds are held in an escrow account once they are deducted from the employee's paycheck until the escrow account is drafted by UHC for payment of claims. Given the nature of FSA accounts and the fact that claims may exceed deductions, particularly at the beginning of the year, accounting is difficult at best. By law, employees are allowed to utilize their entire FSA pledge at any time during the year to pay for medical, dental or vision claims. It is the employee's responsibility to track his or her deductions and claims and monitor their FSA balance on www.mhc.com. A flexible spending account is similar to a personal banking account and is used for the payment of medical related claims and subject to the rules of the IRS. Thus, it is the responsibility of the employee to make sure that his/her account is correct and accurately reflected.

The FSA year cannot be closed for several months after the year closes due to timing issues and the additional 2 ½ month roll-over that the City provides its employees.

WFS staff will continue to work with UHC, FMR and IT personnel to insure that UHC records are accurate and properly reflect the appropriate timeframe and that 2009 and 2010 funds are balanced and properly accounted for by 9/30/2011.

Target Date: July 1, 2011

Responsibility: Leeann Shackelford, WFS Manager – Employee Services

4. The City records claim expenditures without verifying the amount booked to UHC claims reports.

To ensure accurate financial reporting, amounts recorded as claims expenditures on the City's financial system should be reconciled to detail claims data available from UHC. This will help ensure that claims data used for plan analysis is complete and reliable.

Daily, FMR authorizes a wire transfer to "sweep" necessary funds from the City's concentration bank account to a UHC bank account for paid claims. At the end of the month, FMR staff processes a journal entry to record the monthly total of the daily transfers as claims expenditures in the City's financial system. Detail claims expenditure reports are not available to support the daily sweeps. However, monthly reports are available that can be reconciled to the amount booked in the financial system. Any discrepancies noted can then be resolved.

The City Auditor's Office reviewed FY 2010 claims expenditure entries recorded on the City's general ledger through May 2010 and noted that UHC monthly claims reports equaled (with timing adjustments) the total of daily sweep entries. However, the City Auditor's Office noted that monthly claim totals per UHC reports were not compared to the monthly general ledger entries.

FMR does not reconcile the monthly claims report to recorded expenditures because they have not had access to the UHC employer services reporting website. However, Workforce Services personnel do have access to the reports as needed. If claims expenditures are not reconciled, the City will not have sufficient assurance that discrepancies will be identified and resolved.

Recommendation:

The Deputy City Manager over Workforce Services should ensure that staff provides FMR with monthly claims reports to support journal entries of claims expenditures.

Management's Response:

Concur. WFS staff will ensure that FMR staff has access to UHC's E Services and has access to all accounting and banking information to support journal entries of claims expenditures.

WFS staff will review the data on the UHC site and identify those detail claims reports that will substantiate the daily "sweep" that transfers funds from the City's concentration bank account to a UHC bank account for paid claims.

Target Date: July 1, 2011
Responsibility: Leeann Shackelford, WFS Manager – Employee Services
FMR designated personnel

5. The City has not conducted a comprehensive audit of dependent eligibility.

A dependent eligibility audit is a process by which an employer, or a third-party vendor, reviews each dependent enrolled on its medical and dental plans and verifies their eligibility for coverage. According to industry literature, performing this kind of audit is becoming a necessity for all employers, especially those with low turnover, since employees' family situations change over time and the paperwork is not always updated.

There are several business and ethical reasons why an employer should conduct a dependent eligibility audit. Cost-savings is the most compelling. If there are people either erroneously or fraudulently on an insurance plan, it can cost an employer thousands of unnecessary dollars in both claims and administrative expense. Verifying each dependent's eligibility is a way to contain insurance costs without asking employees to pay more to support the plan. Additional reasons include the following.

- The employer has a responsibility under the Employee Retirement Income Security Act (ERISA) to ensure that plan dollars are used for the sole benefit of employees and their eligible dependents.
- The likelihood of this type of fraud is more prevalent now. Financial strain on many families and a high rate of unemployment may prompt individuals to knowingly cover ineligible dependents out of necessity and desperation.
- The employer bears a fiscal responsibility to the plan and the plan participants. If there are excess claim dollars under these plans that are being unjustly paid out, it is unfair not only to the employer but to all of the employees who support the plan financially.

A dependent eligibility audit can be performed in several different ways. It can be done in-house or it can be outsourced to a third party vendor who specializes in audits of this nature.

Typically, ineligible dependents are found in one of the following categories:

- Ex-spouses with court-ordered health coverage
- Common law spouses
- Step children, foster children, married children, grandchildren
- Students not enrolled in an accredited institution
- Students who exceed the maximum age
- Friends, roommates, other relatives
- Domestic partners (when an employer has not chosen to cover them)

According to Workforce Services management, the City has considered conducting a dependent eligibility audit. During this audit, the City Auditor's Office noted that Workforce Services requires supporting documentation for mid-year changes and from newly hired employees. The City does not require supporting documentation for changes made during the annual open enrollment period. In addition, the City has not required long-term employees to provide documentation related to their dependents. The City Auditor's Office found no exceptions during testing of supporting documentation for employees with mid-year qualifying life events.

Supporting dependent documentation is retained in employee benefit files (hard copies) stored in Workforce Services. The receipt, acknowledgement or validation of dependent documentation is not recorded in the City's Lawson Human Resources system. As a result, review of an employee's benefit file is necessary to determine whether benefit eligibility has previously been reviewed. Prior to conducting a dependent eligibility audit, it may be useful to determine how to capture and record the review and validation of dependent eligibility in the human resource system.

Recommendation:

The Deputy City Manager over Workforce Services should coordinate with the Information Technology Department to determine how to incorporate indication of dependent eligibility validation into the Lawson system.

Management's Response:

Concur. The WFS HRIS Specialist will work with IT to identify an appropriate field within Lawson to incorporate indication the dependent eligibility has been validated.

Target Date: July 2011

Responsibility: Leeann Shackelford, WFS Manager – Employee Services

Recommendation:

The Deputy City Manager over Workforce Services should ensure that a dependent eligibility audit is conducted.

Management's Response:

Concur. WFS will conduct a dependent eligibility audit of all employees who have dependents covered under the group health plan after tax returns are filed for 2010. WFS staff requests assistance from the Internal Audit Department to design the audit to seek the information in the most effective manner. After this audit, the same information will be requested from new employees as they enroll in benefits when employed by the City.

Target Date: July 2011

Responsibility: Leeann Shackelford, WFS Manager – Employee Services

6. The City has established adequate complementary controls over claims expenditures to those established by UHC. However, the City has not periodically performed a formal risk assessment of claim expenditures to identify potential control revisions.

In November 2009, UHC received a SAS 70 report from their independent auditors covering controls related to the claim administration process in place between January 1, 2009 and October 31, 2009. The report includes descriptions of controls in place at UHC that provide reasonable assurance that specific identified control objectives could be achieved. The report states that “the relative effectiveness and significance of specific controls at the Claim Administrator and their effect on assessments of control risk at user organizations are dependent on their interaction with internal control, and other factors present at individual user organizations”.

Section II-8 of the SAS 70 report describes controls that should in operation at user organizations to complement the key controls at UHC. The report states that the Claim Administrator has assumed the existence of these user controls in developing the controls described in the SAS 70 report. The key complementary controls identified include the following.

- The user's customer benefit plan is complete, authorized and furnished to UHC timely
- Enrollment files submitted to UHC are complete, accurate and timely
- Only authorized employees have access to the Employer eServices internet portal
- Claim payment charges are authorized
- Claim charges are funded completely and timely
- User reconciles monthly invoices using the number of enrollees and rates specified in the Administrative Services Agreement
- Relevant financial reports are obtained and if used in the preparation of financial statements, such use is complete, accurate and timely
- The user completes any needed actuarial analysis of paid claims data for its internal or external use

The City Auditor's Office identified, reviewed and tested the above controls at the City of Arlington. The City Auditor's Office noted that adequate controls were in place to provide reasonable assurance that the control objectives for each of the above were achieved. Immaterial

exceptions were noted regarding the reconciliation of enrollees and the reconciliation of relevant financial reports. These exceptions are discussed in findings 1 and 4 of this report.

The SAS 70 report includes a statement that projection of the conclusions in the report to future periods is subject to the risk that (1) changes made to the system or controls, (2) changes in processing requirements and (3) changes required because of the passage of time may alter the validity of such conclusions. Due to this risk, the City should periodically evaluate changes in controls and processing requirements at the service organization to identify any needed changes to controls in place at the City.

According to Workforce Services management, the City has not performed a formal risk assessment of claims expenditures. According to the Committee of Sponsoring Organizations of the Treadway Commission (COSO), risk assessment is the identification and analysis of relevant risks to achievement of objectives, forming a basis for determining how the risks should be managed. Because economic, industry, regulatory and operating conditions will continue to change, mechanisms are needed to identify and deal with the special risks associated with those changes.

As an example, the current economic climate and increasing medical claims costs could indicate to the City that additional controls are needed over claims expenditures. Review of the claim administrator's SAS 70 report could lead City management to a decision to establish the following additional monitoring controls.

- Requesting periodic reports of UHC claims adjudication efforts (review of high dollar claims, review of potential duplicate claims, etc.) to verify that such efforts meet the expectations of the City
- Requesting periodic reports of UHC quality management efforts (re-performance of the claims adjudication process for a sample of claims, identification of errors and continuous improvement activities, etc.) to verify that such efforts meet the expectations of the City

If periodic risk assessment is not performed, then there is an increased risk that an organization's objectives (in this case, minimized claim expenditures) may not be achieved.

Recommendation:

The Deputy City Manager over Workforce Services should ensure that periodic risk assessment activities are performed to identify and analyze relevant risks. At a minimum, the Deputy City Manager over Workforce Services should ensure that staff reviews the claim administrator's future reports on the operating effectiveness of controls and verifies that any identified user complementary controls have been established.

Management's Response:

Concur. See answer below.

Target Date: January 1, 2012
Responsibility: Leeann Shackelford, WFS Manager – Employee Services

Recommendation:

The Deputy City Manager over Workforce Services should ensure that appropriate controls are established as necessary to mitigate the risks noted through its periodic risk assessment activities.

Management's Response:

Concur. WFS staff will be conducting an RFP process this spring for group health administration. WFS staff will work with Legal and Internal Audit to make sure the appropriate questions are asked and answered during the RFP process to achieve a formal risk assessment and verify that proper controls are established to mitigate risk.

Target Date: January 1, 2012

Responsibility: Leeann Shackelford, WFS Manager – Employee Services

7. The City does not adequately segregate revenue and expenditures in the Group Health Fund and does not prepare and publicize an annual operating budget for the fund.

Financial reporting should communicate adequate information to user groups to enable them to assess performance. Accounting standards generally require that financial resource inflows be presented and identified by source and type and financial resource outflows be classified by function and purpose. Currently, the City does not segregate revenue and expenditures by source and purpose in the Group Health Fund within the Lawson financial accounting system. For example, retiree, employee and City contributions are recorded in the same revenue account. In addition, administrative, self-funded medical and managed care costs are combined and shown as health costs in the Lawson financial system.

Total health expenditures for fiscal year 2011 are expected to exceed \$20 million. Workforce Services works with an outside consultant each fiscal year to review health plan rates and benefits. For fiscal year 2011, the consultant communicated an expectation that medical and pharmacy claims expenditures would be 24% higher (\$3,567,000) than the premium revenue collected in fiscal year 2010. Recommended increases to contribution rates and plan design changes are expected to reduce the shortfall to \$1.3 million, as outlined in the following table.

Projected 2011 Shortfall Preliminary Estimates	
Expected Increase in Claims for 2011	\$ 3,567,000
Budgeted Increase to City	490,114
Budgeted Increase to Employees	649,925
Budgeted Increase to Retirees	127,238
Plan Design Changes (Deductibles and Co-Pays)	239,000
Rx Design Changes (Increase Coinsurance Tiers)	350,000
Retiree Reinsurance Program	393,000
Total Changes	<u>\$ 2,249,277</u>
Remaining Balance Needed	\$ 1,317,723

Source: Workforce Services

For FY 2011, it appears that even if the recommended premium increases and plan changes were implemented, the City should expect that expenditures would exceed revenue by more than \$1.3 million. Because the Group Health Fund can have a significant impact on the operating funds of the City, disclosure of the projected financial health of the fund through the budget process would allow formal communication of the funding sources for the expected shortfall and would provide the Mayor and Council information regarding projected reserve balances.

Because a budget for the Group Health Fund is not legally required, City management has chosen not to prepare and include a budget for the fund in the City's annual budget presentation. Management feels that inclusion of health insurance expenditures in the budgets of the various other City funds adequately discloses the City-wide cost of health insurance. Also, because the City is self-insured, payments would have to be made for claim expenditures, even if expenditures exceed budget appropriations. In addition, the City would not require that City Council approve individual health claim expenditures that exceed \$50,000, as done for expenditures from other funds. Preparing a budget for the Group Health Fund would allow the City Council and citizens of Arlington to compare budget versus actual from year to year and gauge reserves versus net profit or loss.

Without a published Group Health Fund budget, it is difficult to determine management's expectations regarding the fund's planned revenues, expenditures and ending reserve balance. This could result in the use of reserves without prior approval of the Mayor and City Council. As an example, the City Auditor's Office noted that a \$2.4 million unbudgeted operating transfer was made in July 2010 from the General Fund to the Group Health Fund to help offset an anticipated FY 2010 deficit. The source of the funds was from fiscal year 2009 designated fund balance for the General Fund. The designation was made after the preparation of the fiscal year 2010 budget but was disclosed in the FY 2009 CAFR. The operating transfer is expected to be disclosed in the fourth quarter FY 2010 Budget Analysis Report.

The cities of Austin, Dallas, Fort Worth, Greenville, Houston, Irving, San Antonio and Waco prepare and present budgets for their self-funded health plans. Generally, the budgets include breakdowns of employee, retiree and employer contributions; interest and other revenue; self-funded claims expenditures; managed claims expenditures; wellness expenditures; transfers out and administrative expenditures.

Recommendation:

The Deputy City Manager over Workforce Services should coordinate with the Financial and Management Resources Department to ensure that a sufficient number of accounts are utilized to segregate revenues and expenditures by source, type, function and purpose.

Management's Response:

Concur. WFS staff will coordinate with FMR staff to ensure that a sufficient number of accounts are used in the Group Health Fund to segregate revenues and expenditures by source, type, function and purpose in the Lawson Financial System. Additional accounts would make accounting reconciliation a little easier.

Target Date: October 1, 2011
Responsibility: Leeann Shackelford, WFS Manager – Employee Services
Appropriate FMR Accounting Staff

Recommendation:

The Deputy City Manager over Workforce Services should consider preparing and publicizing an operating budget for the Group Health Fund.

Management's Response:

Do Not Concur. The Group Health Fund, like the Workers Compensation Fund, is established to account for funds utilized for payment of the health benefit program for City employees and retirees. The fund consists of revenues from the City based on the budgeted subsidy and the employee/retiree premiums and expenditures for employee and retiree medical claims and dental and vision premiums. These amounts are determined annually based on our employee/retiree claims experience and recommendations from the City's benefit consultant and City staff. These premium rates are disclosed to City Council during the budget process each year.

Beginning in 2009, the fund is reviewed on an annual basis by our benefits actuary and the appropriate fund balance is established. Any funds over and above the amount needed to pay group health claims could be used in emergency situations given the balance recommended by the actuary is maintained. It is the goal of WFS to ensure appropriate funds are available for payment of group health claims at all times.

It is the opinion of staff that current processes are sufficient accounting for the City's Group Health Fund.