Copiague Union Free School District

Internal Audit Report on Medical and Dental Benefits, Retiree Health Insurance and Administrator Fringe Benefits

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R.S. ABRAMS & CO., LLP
Accountants & Consultants for Over 75 years

Robert S. Abrams
(1926–2014)

Marianne E. Van Duyne, CPA
Alexandria M. Battaglia, CPA

Board of Education
Copiague Union Free School District
2650 Great Neck Road
Copiague, NY 11726

We have been engaged by the Board of Education (the "Board") of the Copiague Union Free School District (the "District") to provide internal audit services with respect to the District's internal controls related to medical and dental benefits, retiree health insurance, and administrator fringe benefits for the period July 1, 2019 through February 28, 2020.

The objectives of the engagement were to evaluate and report on the District's internal controls pertaining to medical and dental benefits, retiree health insurance, and administrator fringe benefits, and to test for compliance with laws, regulations, and the District's Board policies and procedures.

In connection with the following procedures, we have provided findings and recommendations for the internal controls related to medical and dental benefits, retiree health insurance, and administrator fringe benefits. Our procedures were as follows:

- Reviewed the District's policies, procedures, and practices with regards to the internal controls related to medical and dental benefits and retiree health insurance;
- Interviewed key District employees involved in the medical and dental benefits and retiree health insurance processes;
- Tested a sample of employees who received health insurance declination payments to determine that proper supporting documentation existed, the payment was properly calculated, and the employee was paid in agreement with stipulations within their respective employment contract;
- Tested a sample of individuals receiving health benefits to determine that proper supporting documentation existed, coverage was in agreement with contract stipulations, and the employees' payroll deductions were properly calculated;
- Tested a sample of retirees receiving Medicare Part B reimbursements to determine that proper supporting documentation existed and the reimbursement amount was accurate;
- Tested a sample of retirees and spouses receiving health insurance coverage to determine that the individual is not deceased and still receiving health benefits paid by the District;
- Tested a sample of retirees to verify the retiree's share of insurance premiums was properly calculated based on the terms of the collective bargaining agreement and the

premiums charged by NYSHIP, the payment received by the District was properly recorded, and the retiree's outstanding balance was properly calculated;

- Tested a sample of individuals receiving dental benefits to determine that proper supporting documentation existed, coverage was in agreement with contract stipulations, and the employees' payroll deductions were properly calculated;

- Tested a sample of Flexible Spending Account deductions to determine that proper supporting documentation existed, the employee's payroll deduction was properly calculated, and that the amounts withheld were properly remitted to the third-party administrator;

- Tested a sample of administrator fringe benefits to determine that they were properly calculated in accordance with the terms of the respective employment contract.

The results of our procedures are presented on the following pages.

Our procedures were not designed to express an opinion on the internal controls related to medical and dental benefits, retiree health insurance, and administrator fringe benefits, and we do not express such an opinion. As you know, because of inherent limitations of any internal control, errors or fraud may occur and not be prevented or detected by internal controls. Also, projections of any evaluation of the accounting system and controls to future periods are subject to the risk that procedures may become inadequate because of changed conditions.

We would like to acknowledge the courtesy and assistance extended to us by personnel of the District. We are available to discuss this report with the Board or others within the District at your convenience.

This report is intended solely for the information and use of the Board, the Audit Committee and the management of the District and is not intended to be and should not be used by anyone other than those specified parties.

Very truly yours,

R.S. Abrams & Co., LLP

R.S. Abrams & Co., LLP
April 21, 2020

MEDICAL BENEFITS AND RETIREE HEALTH INSURANCE OVERVIEW

There are three options that school districts have when providing employees with health care benefits. The first option is to offer a "fully-insured health plan", where the District pays a pre-determined premium to an insurance company for providing health care benefits to the District's employees. With this type of arrangement, the insurance company administers the benefits for the District. In addition, the insurance company takes on full responsibility and assumes all financial risks of providing coverage; the District is only responsible for the premiums. The second option is to create a "self-funded health plan". Under this type of plan, a school district pays for their employees' health care benefits. The third option is for the District to join a health care consortium which is a group of school districts that join together to purchase group health insurance at lower premium rates. Additionally, consortiums have the ability to lower the costs incurred with health claims and they have the ability to spread risk among a large number of policy holders. The consortiums can be a "fully-insured consortium", "self-funded consortium", or "minimum premium consortium".

Under the "self-funded health plan", school districts engage a third-party administrator to process employee health claims, as well as to negotiate rates with health care providers. Additionally, the third-party administrator must estimate the amount of funding that is required to cover health care claims. Many school districts choose to purchase a "stop-loss" policy from a third-party insurance company, which is designed to protect the District from catastrophic health care costs, usually over a predefined threshold.

The District should maintain a proper system of controls to ensure that health care payments are accurate and properly supported, and that the District provides health insurance coverage only to employees and retirees as required by collective bargaining agreements or individual employment contracts. Additionally, the system of controls in place should also ensure that payments and documentation agree with various laws and regulations and stipulations outlined in the District's collective bargaining units' contracts.

The District has established a health insurance plan with *The New York State Health Insurance Program* ("NYSHIP"), the "Plan". All employees, excluding substitute teachers, who work more than twenty hours per week are eligible to enroll in the Plan. The Plan offers both individual and family coverage for employees and retirees. The Plan has four main parts:

- Hospital Program
- Medical/Surgical Program
- Mental Health & Substance Abuse Program
- Prescription Drug Program

COBRA

The Consolidated Omnibus Budget Reconciliation Act (Public Law 99-272, Title XXII), also known as COBRA, requires that most employers sponsoring group health plans offer employees and their families the opportunity for a temporary extension of health and dental insurance at group rates in certain instances where coverage would otherwise end. The administering of COBRA is an employer responsibility and employers must not offer more than the minimum coverage mandated by COBRA law.

COBRA beneficiaries generally are eligible for group coverage during a maximum of 18 months for qualifying events including employment termination or reduction of hours of work. COBRA beneficiaries who become disabled within the first 60 days of COBRA continuation coverage may be eligible for a maximum of 29 months of coverage. An employee's spouse or dependent child is eligible for group coverage during a maximum of 36 months for qualifying events including employee enrollment in Medicare, divorce, legal separation, death of employee, or loss of dependent-child status. If a qualified beneficiary waives COBRA coverage during the election period, he or she may revoke the waiver of coverage before the end of the election period, which is 60 days from the receipt of notification to elect for COBRA benefits or the date health coverage ended, whichever is later.

There are three exceptions to the maximum adherence that are permitted:

1) COBRA allows employers to deny coverage when an individual is terminated for "gross misconduct", however, the participating agency may allow COBRA in cases because the individual is entitled to similar coverage under New York State Continuation of Coverage law, even if the participating agency denies COBRA.

2) COBRA allows a participating agency to deny COBRA coverage to individuals who acquire other coverage after electing COBRA. Due to the difficulty of determining whether the other coverage is equivalent to the NYSHIP coverage lost, the participating agency (school district) may continue COBRA when an individual acquires coverage other than Medicare after COBRA election. When an individual becomes entitled to Medicare benefits under COBRA election, COBRA must be cancelled.

3) COBRA must be offered to legally separated spouses who have been removed from NYSHIP coverage prior to a divorce since such coverage would still be available under the New York State Continuation Coverage Law.

   A qualifying event must occur before COBRA coverage can be provided such as:

   - The death of a covered employee.
   - The termination (other than by reason of the employee's gross misconduct), or reduction of hours.
   - Divorce or legal separation of the covered employee.

- The covered employee enrolls in Medicare.
- A dependent child ceases to be an eligible dependent.

Employees who have been excessed (involuntary laid off) or "dismissed" are entitled to COBRA, but terminations by reason of such employee's "gross misconduct" are not eligible for COBRA payments.

RETIREE ELIGIBILITY

Retirement eligibility rules to continue on the District's health insurance plan vary by bargaining unit. Each retiree is required to contribute a percentage of health insurance premiums. The percentage is determined by the applicable collective bargaining agreement or individual employment contract, and may vary based upon hire date.

Retirees can elect upon retirement whether to pay the retiree share of the premiums through a pension deduction, or to remit payment directly to the District. For retirees who elect a pension deduction, the District is billed only the District's share of the premium by the Plan. For retirees who elect to remit payment directly to the District, the District is billed the full premium by the Plan. The benefits administrator is responsible for calculating the retiree share of monthly premiums, which varies by bargaining unit and retirement date. The calculation is reviewed and approved by the Assistant Business Administrator and the Assistant Superintendent for Finance and Operations. The benefits administrator sends an annual notice to each retiree with the updated monthly premiums for the year. Retirees are responsible for remitting payment on a monthly basis, although some elect to pay several months in advance. The benefits administrator tracks the payments received, and is responsible for contacting retirees regarding any past due balances.

An enrolled employee who terminates employment before retirement age is eligible to continue coverage under NYSHIP. In order to be eligible to continue coverage as a vestee the employee must meet the employer's minimum service requirements and be at least 55 years of age. To retain eligibility for coverage as a retiree, a vestee must continue coverage under NYSHIP as an enrollee or a dependent of an enrollee with no lapse in coverage. A vestee whose coverage lapses is not permitted to reinstate coverage, either during vested status or after retirement.

MEDICARE

Medicare is a federal health insurance program for people age 65 or older. Medicare has two parts, Part A and Part B. Individuals are automatically enrolled in Part A at age 65. Medicare Part A helps pay for in-patient hospital care, in-patient care in a skilled nursing facility, home health care, and hospice care. Individuals may enroll in Part B upon turning age 65. Medicare Part B helps pay for necessary medical doctors' services, outpatient hospital services, home health services and a number of other medical services and supplies that are not covered by the hospital insurance part of Medicare (Medicare Part A). NYSHIP requires retirees, vestees, dependent survivors, and Preferred List enrollees to be enrolled in Medicare Parts A and B when

first eligible for Medicare coverage. Additionally, dependents must enroll in Medicare Parts A and B when they are first eligible for primary Medicare coverage.
NYSHIP provides secondary coverage for Medicare eligible enrollees and dependents, whether or not that individual has enrolled in Medicare. It is very important that each individual (enrollee and dependent) who becomes eligible for Medicare primary coverage to enroll in both Medicare Parts A and B. If an individual fails to enroll in Medicare Parts A and B, their health benefits will be drastically reduced.

MEDICARE PART B REIMBURSEMENTS

When NYSHIP benefits are secondary to Medicare (whether or not the individual is enrolled in Medicare), Section 167-A of the New York State Civil Service Law requires each school district to reimburse Medicare eligible enrollees and dependents in an amount equal to the current Medicare Part B premium charge, including any income related monthly adjustment amount (IRMAA).

The reimbursement is required for all individuals covered under NYSHIP who are eligible for Medicare that is primary to NYSHIP, including Dependent Survivors, with the following exceptions:

1) The individual or dependent who is eligible for Medicare coverage is receiving Medicare reimbursement from another source.

2) A retiree who returns to employment in a benefits eligible position from the same agency from which they retired is no longer eligible for Medicare reimbursement regardless of whether they continue their coverage as a retiree or active employee. NYSHIP is primary to Medicare while they are in a benefits eligible position.

3) An active employee or dependent of an active employee who enrolls in Medicare for secondary benefits.

4) An active employee or dependent of an active employee who elects Medicare as primary coverage. In this case, the individual's enrollment in NYSHIP must be terminated and the provisions of Section 167-A of the Civil Service Law would not be applicable.

The Medicare Part B reimbursement must be effective as of the date the employee or dependent first becomes eligible for primary Medicare coverage. Some acceptable reimbursement methods include issuing checks at periodic intervals or the required premium contribution may be reduced by the amount of the reimbursement. Monthly premium amounts are established by the Social Security Administration and NYSHIP and the District must reimburse the monthly premium regardless of whether the individual has accepted the Medicare Part B.

DEPENDENTS

Spouses

An employee's spouse, including a legally separated spouse, is eligible for health insurance coverage. However, if an employee is divorced or the marriage has been annulled, the former spouse will no longer be eligible for health insurance, which will end on the effective date the marriage ends. A spouse may be able to continue coverage under the New York State Continuation of Coverage Law (COBRA). Additionally, parties to a same-sex marriage under the jurisdiction where a same-sex marriage is permitted, including New York State, are eligible for spousal benefits for health insurance.

Dependents

As required by the Patient Protection and Affordable Care Act (PPACA), the eligibility rules for covering dependent children under NYSHIP are as follows:

1) Children under 26 years of age.

2) Disabled dependent children age 26 or over who are incapable of self-sustaining employment because of mental illness, development disability, mental retardation as defined in the Mental Hygiene Law or physical handicap who became incapacitated before the age at which dependent coverage would otherwise be terminated in accordance with the eligibility rules in effect at the time the disability commenced is eligible.

The term "children" includes natural children, stepchildren, children of domestic partners and legally adopted children, including children in a waiting period prior to finalization of adoption. Other children who are chiefly dependent on the employee and for whom the employee have assumed legal responsibility in place of the parent are also eligible. In such cases, eligibility and documentation must be verified upon enrollment and every two years thereafter.

Young Adult Option

The Young Adult Option allows a young adult child of an individual enrolled in NYSHIP to purchase individual health insurance coverage through NYSHIP when the young adult does not otherwise qualify as a dependent as specified above. The young adult or his/her parent must pay a separate premium for the Young Adult Option. The District does not contribute towards the cost of the Young Adult Option. The young adult or his/her parent is required to pay the full cost of the premium for individual coverage for the NYSHIP option selected for coverage.

In order for a young adult to be eligible to enroll in NYSHIP under the Young Adult Option, the following requirements must be met:

- Be a child, adopted child, or step-child of a NYSHIP enrollee (including those enrolled under COBRA);
- Be age 29 or younger;

- Be unmarried;
- Not be insured by or eligible for coverage through the young adult's own employer-sponsored health plan, whether insured or self-funded, provided that the health plan includes both hospital and medical benefits;
- Live, work or reside in New York State or the insurer's service area; and
- Not be covered under Medicare.

Eligibility for NYSHIP enrollment under the Young Adult Option ends when one of the following occurs:

- The young adult voluntarily terminates coverage;
- The young adult's parent is no longer enrolled in NYSHIP;
- The young adult no longer meets the eligibility requirements for the Young Adult Option; or
- The NYSHIP premium for the young adult is not paid in full within the 30-day grace period.

HEALTH INSURANCE DECLINATION PAYMENTS

The District offers employees in certain bargaining units who are eligible to participate in the Plan the option to decline coverage in exchange for a health insurance declination payment. In order to be eligible for the declination payment, the employee must obtain health insurance from another source. For certain bargaining units, the District requires that the employee be enrolled in the Plan for two years prior to becoming eligible for the declination payment. Health insurance declination payments provide a cost savings to the District, as the amount of the payment, which varies by bargaining unit, is less than the cost of providing coverage. To be eligible for the payment, the employee must complete a health insurance declination form indicating they have declined coverage through the Plan, and provide proof of health insurance coverage from another source. Health insurance declination payments are prepared by the benefits administrator, and are reviewed and approved by the Assistant Business Administrator. The payments are issued in July, following the fiscal year in which coverage was declined.

DENTAL INSURANCE

The District has established a self-insured dental insurance plan for active employees in certain bargaining units administered by *Delta Dental.* The majority of full-time District employees, excluding clerical staff, custodians and substitute teachers are eligible to enroll in the dental insurance plan. Active District employees contribute towards their monthly premium as outlined in their respective collective bargaining agreement. The employee's contribution, which is required only for nurses, is withheld as a payroll deduction. Employees that are benefits eligible at the time of retirement are eligible to continue coverage under the District's dental plan for a maximum of eighteen months. The District does not contribute toward the premiums for retirees. Retirees are invoiced by, and remit payment directly to, the third-party administrator. On a

monthly basis, the third-party administrator issues a check to the District for the premiums which have been collected.

The District offers dental insurance benefits to clerical and custodial employees through fully insured dental plans from *Solstice Dental* and *Dutchess Dental* which are administered by the Civil Service Employees' Association, and *Healthplex* which is administered by the United Public Service Employees' Union. The employee's contribution is withheld as a payroll deduction. These carriers offer coverage options for retirees. Any retiree who elects to continue coverage in retirement can contract directly with the carrier.

FINDINGS AND RECOMMENDATIONS

Based on our interviews, observations and detailed testing, we provide our findings and recommendations below to further strengthen the District's internal controls as they pertain to the medical and dental benefits, retiree health insurance, and administrator fringe benefits outlined above. The District's response to our findings and recommendations is included below.

It should be noted that these recommendations are provided to assist management in improving the accounting and internal controls and procedures as they relate to the District's medical benefits, retiree health insurance, and administrator fringe benefits. It is important to note that our findings and recommendations are directed toward improvement of the system of internal controls and should not be considered a criticism of, or reflection on, any employee of the District.

Based on our interviews, observations, and detailed testing, our findings and recommendations are as follows:

Policies and Procedures

Procedure Performed: We reviewed the District's policies, procedures, and practices with regards to the internal controls related to medical benefits, dental benefits, retiree health insurance, and administrator fringe benefits.

Finding: The District's collective bargaining agreement with the United Public Service Employees Union on behalf of the District's maintenance workers, groundskeepers, and custodial workers, does not indicate whether these employees will be eligible for health benefits in retirement, or specify the terms. The District defaults to terms of coverage for retirees per NYSHIP's *General Information Book* for these employees.

Recommendation: We recommend the District state explicitly in all collective bargaining agreements which employees will be eligible for health benefits in retirement, and that the collective bargaining agreements either state the retiree's share of the premiums in retirement, or state that the retiree's share of the premiums in retirement will be based on NYSHIP's *General Information Book.*

District Response: The District has notified its legal counsel and negotiating team of the need to explicitly state in all collective bargaining agreements which employees will be eligible for health benefits in retirement as well as the retiree's share of the premiums. The language will be amended as the contracts come up for renewal.

Finding: We noted a lack of segregation of duties between invoicing retirees for health insurance premiums, opening the mail that contains cash receipts for health insurance premiums, and tracking outstanding balances.

Recommendation: We recommend an individual who is independent of the retiree health insurance billing process open the mail containing cash receipts, and record those receipts in a cash receipt log. The benefits administrator should be provided with a copy of the payment to update outstanding balances.

District Response: The District has instituted new procedures in the business office whereby an individual independent of the retiree health insurance billing process opens the mail, logs the cash receipt and forwards a copy of the payment to the health benefits administrator.

Finding: The health insurance declination forms utilized by the District are required to be completed only once, when health insurance is initially declined. The form specifies an effective date range of one year, however a new form is not required after the date range on the form has elapsed. In addition, employees are not required to provide proof of alternate health insurance on an annual basis.

Recommendation: We recommend that effective dates listed on health insurance declination forms correspond to the timeframe during which the employee actually receives health insurance declination payments, and that proof of alternate insurance be required on an annual basis.

District Response: The District is changing its procedure to require an annual health declination form to be accompanied by proof of other insurance. Employees will be notified of this new procedure by October 31, 2020 and will be in effect for the 2021/22 school year.

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Health Declinations

Procedures Performed: We selected a sample of twenty employees that received health insurance declination payments to verify the following:

- A completed, declination of health insurance form exists.
- The employee was not receiving health care coverage through a District sponsored health plan.
- The payment was properly calculated and approved.
- The employee's payroll check history indicates proper amounts were paid.

Finding: No exceptions were noted as a result of applying these procedures.

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Health Insurance Coverage

Procedures Performed: We selected a sample of twenty five individuals receiving health benefits to verify the following:

- Eligibility criteria were met based on employment contracts and plan guidelines.
- A completed enrollment form is on file and contains appropriate signatures and type of coverage.
- Applicable supporting documentation is on file for coverage selected.
- Deducted amount per payroll journal agrees with employment contract.

Findings: We noted six out of twenty five individuals selected for testing did not have documentation on file to support dependent coverage. The District obtained supporting documentation for five of those individuals subsequent to our testing procedures. We also noted one out of twenty five individuals selected for testing was charged the incorrect amount for health insurance premiums due to a clerical error in prorating the premiums. This appears to be an isolated error. It was not a material amount of money.

Recommendation: We recommend the District maintain supporting documentation for all dependents on file. We also recommend that prorations of health insurance premiums continue to be reviewed by an individual who did not prepare the calculation prior to recording the deduction in the accounting information system.

District Response: The District concurs, supporting documentation for all dependents should be maintained on file. The health insurance administrator is in the process of reviewing all files to ensure the proper documentation is included in the file. Prorations of health insurance premiums will continue to be reviewed by an individual who did not prepare the calculations.

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Medicare Part B Reimbursements

Procedure Performed: We selected a sample of fifteen retirees receiving Medicare Part B reimbursements to verify the following:

- A *Medicare Part B Reimbursement Form* signed by both the retiree, and spouse if applicable, was maintained on file.
- The amount reimbursed per the Medicare check warrant issued in January 2020 was properly calculated based on the number of claimants, and the number of months being reimbursed.
- Amounts per the Social Security Administration letter or Social Security 1099 for both the retiree and spouse, where applicable, agreed to the amount reimbursed per the Medicare check warrant issued in March 2019.

Finding: We noted no exceptions as a result of applying these procedures.

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Retirees

Procedure Performed: We selected a sample of ten retired employees and spouses receiving health insurance coverage to verify the retiree or spouse is not deceased and still receiving health benefits.

Finding: No exceptions were noted as a result of applying these procedures.

Procedure Performed: We selected a sample of five retirees to verify the following:

- The retiree's share of insurance premiums is properly calculated based on the terms of the collective bargaining agreement and the premiums charged by NYSHIP.
- The payment received by the District was properly recorded, and the retiree's outstanding balance was properly calculated.

Finding: We noted no exceptions as a result of applying these procedures.

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Dental Claims Testing

Procedure Performed: We selected a sample of twenty dental claims paid by the District's third-party administrator to verify the following:

- The covered member was eligible for dental insurance coverage based on employment contracts and plan guidelines; and
- A completed enrollment form was on file, contained appropriate signatures, and if the claim was paid on behalf of a dependent, family or employee and spouse coverage was elected.

Finding: No exceptions were noted as a result of applying these procedures.

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Flexible Spending Accounts

Procedure Performed: We selected a sample of twenty employees making contributions to a District sponsored Flexible Spending Account to verify the following:

- The employee completed an enrollment form (new enrollees only) or appears on the enrollment file provided by the flex plan administrator; and
- The employee's payroll deduction is properly calculated.

Findings: No exceptions were noted as a result of applying these procedures.

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Administrator Fringe Benefits

Procedures Performed: We reviewed employment contracts and payroll transaction reports for all cabinet members to verify the following:

- Tax-sheltered annuity payments were properly calculated, and processed in accordance with employment contracts; and
- Mileage allowances were properly calculated and processed in accordance with employment contracts.

Findings: We noted that while non-elective tax-sheltered annuity payment amounts were properly calculated, they were reported as taxable wages on the administrator's IRS W-2 form, as opposed to being paid and reported as an employer provided non-elective tax deferred annuity.

Recommendation: We recommend an employee of the District be responsible for reviewing all fringe benefits provided in employment contracts to ensure that fringe benefits are processed properly and in accordance with the terms of the employees' respective employment contracts. Regarding non-elective tax-sheltered annuity payments, we recommend the District update the payroll pay type settings in the accounting information system to ensure that the payments are properly reported on the administrator's IRS W-2 form in box 14 and not in box 1 as taxable wages. In addition, we recommend these payments be deposited into an employer provided tax deferred annuity on the administrator's behalf.

District Response: The administrator tax-shelter annuity payments are now being paid as non-elective tax deferred employer contributions. Employment agreements will be updated by the District counsel to reflect the proper treatment.

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CORRECTIVE ACTION PLAN

The District is required to prepare a corrective action plan in response to any findings contained in the internal audit reports. As per Commissioner's Regulations §170.12, a corrective action plan, which has been approved by the Board, should be submitted to the State Education Department within 90 days of the receipt of a final internal audit report.

The approved corrective action plan and a copy of the respective internal audit report should be submitted using the NYSED Business Portal.