



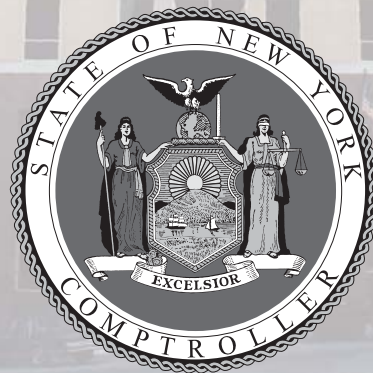
Niagara Falls City School District Internal Controls Over Health Insurance

Report of Examination

Period Covered:

July 1, 2006 — March 4, 2008

2008M-111



Thomas P. DiNapoli

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State of New York Office of the State Comptroller

Division of Local Government and School Accountability

December 2008

Dear School District Officials:

A top priority of the Office of the State Comptroller is to help school district officials manage their districts efficiently and effectively and, by so doing, provide accountability for tax dollars spent to support district operations. The Comptroller oversees the fiscal affairs of districts statewide, as well as districts' compliance with relevant statutes and observance of good business practices. This fiscal oversight is accomplished, in part, through our audits, which identify opportunities for improving district operations and Board of Education governance. Audits also can identify strategies to reduce district costs and to strengthen controls intended to safeguard district assets.

Following is a report of our audit of the Niagara Falls City School District, entitled Internal Controls Over Health Insurance. This audit was conducted pursuant to Article V, Section 1 of the State Constitution, and the State Comptroller's authority as set forth in Article 3 of the General Municipal Law.

This audit's results and recommendations are resources for district officials to use in effectively managing operations and in meeting the expectations of their constituents. If you have questions about this report, please feel free to contact the local regional office for your county, as listed at the end of this report.

Respectfully submitted,

*Office of the State Comptroller
Division of Local Government
and School Accountability*



State of New York Office of the State Comptroller

EXECUTIVE SUMMARY

Health insurance benefits are an integral part of an employee's compensation and represent a significant component of a school district's costs. The increasing cost of providing health insurance coverage to employees and retirees substantially contributes to the financial challenges confronting district officials.

Pursuant to collective bargaining agreements in place, the Niagara Falls City School District (District) provides health insurance related benefits to 1,655 employees and retirees. In addition, the District allows 147 employees and retirees who are not eligible for District benefits, to purchase health coverage through the Consolidated Omnibus Budget Reconciliation Act (COBRA)¹ or as a self-pay individual. The District uses a third-party vendor to administer benefits, establish specific plans, and negotiate premium rates with insurance providers. The District is part of a consortium and offers just one medical provider (BlueCross[®] BlueShield[®] of Western New York).

Scope and Objective

We examined health insurance records for the District for the period of July 1, 2006 to March 4, 2008. The objective of our audit was to evaluate internal controls over the District's health insurance functions to identify cost-saving opportunities. Our audit addressed the following related questions:

- Are adequate processes and controls in place to ensure the accuracy of health insurance bills for current and retired employees?
- Are adequate policies and procedures in place to ensure the timely collection of all insurance premiums due to the District?

Audit Results

We identified a number of process, procedure and control deficiencies with the District's health insurance program. Problems we identified were related to contract language adherence, which allowed inappropriate benefits to be paid; and the lack of monitoring and communicating with the District's third-party employee benefits administrator, which resulted in billing errors and unnecessary payments.

¹ COBRA is a Federal law that provides for health care coverage to employees whose coverage would cease due to termination, layoff, or certain other changes in their employment status. COBRA participants are generally entitled to pay for group coverage up to 18 months. In special circumstances, a participant will be permitted to extend his or her coverage for a maximum of 36 months.

We found instances where enhanced benefits were provided contrary to contract stipulations, or the basis for the benefits could not be adequately determined by review of the contract provisions. These actions will result in unnecessary and inappropriate payments, which we project will total approximately \$2 million for the 2007-08 fiscal year. For example, the District would save over \$1.8 million in the 2007-08 fiscal year if officials follow contract provisions and require all retirees age 65 or older to change from their current plan to a supplemental Medicare plan. We also found 23 retirees that inappropriately received incentive payments totaling \$21,250, five retirees who received health insurance they were not entitled to costing \$44,339 and seven current or former administrators who inappropriately received certain insurance coverage costing the District \$14,440.

We found that the District does not adequately monitor or communicate with its third-party employee benefits administrator (vendor) or ensure that there are proper retiree verification procedures resulting in unnecessary payments totaling approximately \$122,000. For example, we identified 14 retirees or spouses the District continued to insure even though they were deceased, costing the District approximately \$114,000. We also found instances where District records did not match vendor records resulting in billing errors. For example, the District was mistakenly billed \$5,314 for two individuals who were not receiving health coverage.

Comments of District Officials

The results of our audit and recommendations have been discussed with District officials and their comments, which appear in Appendix B, have been considered in preparing this report. District officials generally disagreed with our findings and recommendations. OSC comments to issues raised in the District's response can be found in Appendix C.

Introduction

Background

The Niagara Falls City School District (District) is located in Niagara County, and has 11 schools and a separate administrative building, with approximately 7,500 students. The District employs 1,254 full and part-time employees and is governed by the Board of Education (Board), which comprises nine elected members. The Board is responsible for the general management and control of the District's financial and educational affairs. The Superintendent of Schools (Superintendent) is the chief executive officer of the District and is responsible, along with other administrative staff, for the day-to-day management of the District under the direction of the Board.

The District's 2007-08 adopted budget includes appropriations of \$18.5 million for health insurance, which represent approximately 11 percent of the District's total appropriations. These costs have steadily risen and increased by 10 percent over the prior year.² Starting in 2007, the Governmental Accounting Standards Board (GASB) required local governments and school districts to provide a more complete reporting of "other post employment benefit costs,"³ which includes health insurance, in their financial statements. Local governments and school districts are now required to calculate the estimated costs of post-retirement obligations for current employees and retirees.

The District obtains its current premium quotes based on an experience-rated⁴ scale. There are two separate experience ratings at the District, one for instructional⁵ employees, retirees and administrative staff, and another for Civil Service Employees Association (CSEA) employees⁶ and retirees. Pursuant to collective bargaining agreements, the District provides health insurance related benefits to 1,655 employees and retirees. In addition, the District allows 147 employees and retirees who are not eligible for District

² 2006-07 actual expenditures for health insurance were \$16.7 million.

³ GASB Statement 45

⁴ This experience-rated scale is a rating method that insurance underwriters use to analyze a group's recorded healthcare costs by type and calculate the group's premium partly or completely based on the group's experience.

⁵ Includes the following employee unions: Niagara Falls Teachers (NFT), Administrative and Supervisory Council (ASC), Niagara Falls Classified Administrators and Supervisors (NIAS), and Niagara Falls Substitute Teachers United (NYSTU).

⁶ Also includes Civil Service Employees Association Teacher Associates (TAUL)

benefits, to purchase health coverage through the COBRA program⁷ or as self-pay individuals.

The District uses a third-party vendor (vendor) to administer benefits, formalize specific plans, and negotiate premium rates with insurance providers. The District is part of a consortium⁸ and offers just one medical provider (BlueCross BlueShield of Western New York). Prescription drugs are self-funded through the vendor. In addition, several dental and vision providers are offered as part of the District's benefits package. District employees and retirees are provided with an annually adjusted flexible benefit package. Each year, employees and some retirees, receive a predetermined amount of benefit dollars that they use to select the level and type of coverage desired. The amount of benefit dollars allotted is determined by several factors, including the applicable collective bargaining agreement and eligible dependents.

In addition, employees can choose to opt-out of District medical coverage as long as they can provide sufficient proof that they have coverage from another source. Employees can allocate all of their benefit dollars into three available flexible spending accounts⁹ or they can receive 50 percent of any remaining benefit dollars in the form of a cash opt-out payment. Employees who do select a medical coverage plan have these options as well, providing that the plans they choose leave them with excess benefit dollars. Retirees have similar options that vary depending upon the collective bargaining agreement in place at the time of their retirement. The majority of retirees and employees receive health insurance coverage paid in full by the District.

Objective

The objective of our audit was to evaluate internal controls over the District's health insurance functions to identify cost savings opportunities. Our audit addressed the following related questions:

- Are adequate processes and controls in place to ensure the accuracy of health insurance bills for current and retired employees?

⁷ COBRA (Consolidated Omnibus Budget Reconciliation Act) is a Federal law that provides for health care coverage to employees or former employees whose coverage would cease due to termination, layoff, or certain other changes in their employment status. COBRA participants are generally entitled to pay for group coverage up to 18 months. In special circumstances, a participant will be permitted to extend his or her coverage for a maximum of 36 months.

⁸ We did not examine this arrangement as it was outside the scope of our audit.

⁹ There are three flexible spending accounts available; health care expense, dependent care expense and employer-sponsored medical premium.

- Are adequate policies and procedures in place to ensure the timely collection of all insurance premiums due to the District?

Scope and Methodology

We examined health insurance records for the District for the period July 1, 2006 to March 4, 2008. We conducted our audit in accordance with generally accepted government auditing standards (GAGAS). More information on such standards and the methodology used in performing this audit are included in Appendix D of this report.

Comments of District Officials and Corrective Action

The results of our audit and recommendations have been discussed with District officials and their comments, which appear in Appendix B, have been considered in preparing this report. District officials generally disagreed with our findings and recommendations. OSC comments to issues raised in the District's response can be found in Appendix C.

The Board has the responsibility to initiate corrective action. Pursuant to Section 35 of the General Municipal Law, Section 2116-a (3)(c) of the Education Law and Section 170.12 of the Regulations of the Commissioner of Education, a written corrective action plan (CAP) that addresses the findings and recommendations in this report must be prepared and forwarded to our office within 90 days. To the extent practicable, implementation of the CAP must begin by the end of the next fiscal year. For more information on preparing and filing your CAP, please refer to our brochure, *Responding to an OSC Audit Report*, which you received with the draft audit report. The Board should make the CAP available for public review in the District Clerk's office.

Inappropriate Benefits

The District provides health insurance as a benefit to both employees and retirees. To maintain control over the cost of providing this benefit, it is important that the District provide health care coverage only to those individuals who are entitled to the coverage. Contract provisions should be followed to ensure that employees and retirees are receiving only those benefits to which they are entitled and taxpayer monies are being expended only for properly authorized benefits.

We found instances where enhanced benefits were provided contrary to contract stipulations, or the basis for the benefits could not be adequately determined by review of the contract provisions. These actions will result in unnecessary and inappropriate payments, which we project will total approximately \$2 million for the 2007-08 fiscal year.

We selected 72 employees, 186 retirees and COBRA/self-pay participants for audit testing. When we found widespread discrepancies, we expanded our testing to attempt to identify all members affected. The District would have saved over \$1.8 million in the 2007-08 fiscal year alone, if officials complied with contract provisions and required all retirees of age 65 or older to change from their current plan to a supplemental Medicare plan. The remaining unnecessary and inappropriate payments are discussed in the respective sections of the report. An itemization of these payments is included in Appendix A.

Medicare Eligible Retirees

Four collective bargaining agreements¹⁰ provide District paid health insurance benefits upon retirement. All four contracts state that a change in coverage will occur when the retiree becomes eligible for Medicare. To illustrate, the CSEA contract states “When the retiree reaches his/her sixty-fifth (65th) birthday and qualifies for Medicare under the Social Security Program, the type of BlueCross BlueShield and Major Medical coverage shall be changed to cover his/her new circumstances.” The NFT contract also includes a similar provision “Upon exhaustion of this coverage,¹¹ the teacher shall be granted fully paid BlueCross BlueShield supplemental health coverage (including prescription co-pay) for his/her lifetime at no cost to the teacher.” It is apparent that the term “supplemental” refers to coverage plans that are a supplement or enhancement to Medicare. We found the same language in previous contracts dating back to

¹⁰ CSEA, NFT, ASC, and NIAS

¹¹ This reference appears to relate to a previous passage (section 45.1) that states insurance will be provided until the retiree is eligible for Medicare.

the late 1970s and early 1980s. All the versions of contracts we reviewed had this same provision for retirees who become eligible for Medicare.

The Medicare program was established to provide affordable health coverage to seniors, age 65 and older, and to certain individuals with disabilities. Medicare Part A provides inpatient hospital coverage and Part B covers doctor visits, outpatient services, diagnostic tests, and some medical equipment. Medicare Part A generally carries no additional cost; however, Part B requires a monthly contribution that currently starts at \$96.40 per month. The rate increases based on income levels and marital status. Medicare coverage is somewhat limited and carries deductibles and co-payments. To fill in these coverage gaps, individuals or employers can purchase supplemental coverage from private insurance companies. The cost of supplemental coverage is usually much less expensive than coverage that does not use the Medicare program. BlueCross BlueShield offers supplemental Medicare programs that are available to District employees and retirees, 65 and older, who have both Medicare Parts A and B. For example, CSEA retirees currently receive a BlueCross BlueShield PPO¹² plan that costs the District \$19,192 per year for a family plan. Comparable, and in some cases, better coverage, is available for this same CSEA retiree through a Medicare PPO plan for \$6,332 per year, when the individual is covered by Medicare Part B. For perspective, this represents a savings to the District of \$12,860 for each such CSEA retiree.

The collective bargaining agreements state that once retirees become eligible for Medicare (generally, age 65) they will be converted to a plan that is supplemental to Medicare. The District is not adhering to this stipulation. Currently the District provides health benefits for 340 retirees of age 65 and older. However, only 57 (17 percent) subscribe to the Medicare PPO plan, which means the vast majority, 283 (83 percent), do not. Representatives from the third-party vendor (vendor) indicated that the Medicare PPO plan offers comparable coverage and in several areas, better coverage than what the current BlueCross BlueShield PPO plan provides. Any differences in prescription co-pay amounts¹³ would be addressed by providing reimbursements to retirees.

The District would have saved over \$1.8 million in the 2007-08 fiscal year if it complied with contract provisions and required all Medicare-eligible retirees, to change from their current plan to a supplemental Medicare plan. This represents a reduction of almost 10 percent of the District's current health insurance budget.¹⁴

¹² Preferred Provider Organization

¹³ Many District retirees are entitled to \$1 or \$3 prescription drug cards

¹⁴ 2007-08 appropriations are \$18.5 million

Furthermore, the District provides a cash incentive of up to \$1,500 per year to CSEA retirees who voluntarily subscribe to the Medicare PPO. In the 2007-08 school year, these payments to 23 retirees totaled \$21,250. Since contract provisions require the transition to a Medicare plan, these payments are unnecessary and should be discontinued.

Retired Employees

Currently, when District employees retire from active employment, health insurance benefits are based upon the collective bargaining agreement in place at the time of their retirement. Depending upon the contract, a defined minimum number of years of service to the District is required in order to be eligible for these benefits.¹⁵ For individuals who belong to the Niagara Falls Teachers (NFT) union, there is no minimum number of years of service required to be eligible for District paid health coverage at retirement.

The CSEA contract requires that employees must be age 55 or over with at least 20 years of service to the District in order to receive fully paid District health insurance¹⁶ at retirement. We found five individuals, who are receiving District paid coverage, that do not meet this requirement. Two of the individuals did not have the required years of service with the District, only 10 and 14 years each. The remaining three were classified as self-pay for whom the District neglected to bill. One of these three individuals left District employment in 1976 after working for only two years. For the 2007-08 fiscal year these five individuals will inappropriately receive health benefits costing the District \$44,339. It is unclear how long the District has been improperly paying for health coverage for these five individuals. However, it has continued over a number of years and in some cases, 10 years or more.

Another District practice is to provide a Memorandum of Agreement (MOA) for certain individuals who do not otherwise meet contract stipulations, in order to provide them with lifetime health insurance benefits upon retirement. These MOAs were written expressly for these individuals and provided them with benefits that were not extended to other members of their union.¹⁷ We identified five such retirees for which MOAs overrode the retirees' applicable collective bargaining agreement and granted them full retirement benefits. All five individuals had insufficient years of service and would not have

¹⁵ CSEA contract requires 20 years service; NIAS and ASC contracts require 20 years service to the District or at least 10 years service as a District administrator. Two District contracts (CSEA and NIAS) also allow full retirement benefits for those individuals who retire with an approved disability and have at least five years of service to the District.

¹⁶ Does not include dental and vision coverage

¹⁷ CSEA and NIAS unions

been eligible for lifetime health insurance without the MOA. For the 2007-08 fiscal year, the District will spend over \$79,900 for these five individuals' health benefits. District officials did not present rationale as to why these additional benefits were provided or documentation for how the District benefited. Absent such information, we have no way to verify that these MOAs were in the best interest of the District and taxpayers.

Current Employees

Active employees receive flexible benefit dollars based upon two factors, their collective bargaining agreement and whether they qualify for single or family coverage. Family benefit dollars are generally more than twice the amount of single benefit dollars. For example, currently CSEA employees receive benefit dollars of \$5,583 if they are single and \$15,423 if they qualify for family benefits. In the case of instructional employees (teachers and administrators), there are three levels of benefit dollars: single, married and family. When an instructional employee is married to another instructional employee, one receives married benefit dollars and the other receives family benefit dollars.¹⁸ Currently, instructional employees receive \$6,137 for married dollars and \$14,169 for family dollars.

Typically, one member of the couple uses his or her benefit dollars for medical coverage and the other takes cash in the form of an opt-out payment and/or for use in one of three flexible spending accounts. In most cases, this results in additional compensation for married couples who are both employed by the District. We found that not all instructional married couples were provided the lower married benefit dollars. We identified four instances where both members of the couple were receiving the larger family dollar amount. The additional cost to the District for these errors is difficult to measure as it depends upon the combination of benefits the employee chooses. However, we conservatively estimate that the District overcompensated these four employees by a total of \$16,000.¹⁹ District officials informed us that they would correct these errors.

We also found that 32 employees are receiving family benefit dollars but only subscribing to single health coverage. As previously mentioned, family benefit dollars provide significantly more spending options than single benefit dollars. Informal procedures dictate that employees must have eligible dependents in order

¹⁸ Both the NFT and ASC contracts reference an enrollment guide developed by the third-party vendor that states "If a certificated employee is married to another certificated employee, one employee receives 100 percent of benefit dollars and the spouse receives benefit dollars equal to the cost of a single core medical plan"

¹⁹ The District provided over \$32,000 in benefit dollars. For the sake of estimating the cost to the District, we conservatively halved this amount, which would represent an opt-out payment.

to receive family benefit dollars. District officials and vendor representatives indicated that they do not require employees to provide this proof. The only requirement is that they subscribe to family coverage for either dental or vision plans. Nevertheless, we found eight employees who do not follow this requirement. These eight individuals either get single dental and vision or do not subscribe to dental or vision at all. The advantage for these employees is that they have considerably more benefit dollars remaining that they can deposit in flexible spending accounts or take as an opt-out payment. On average, these 32 employees each received an additional \$4,700 in payments²⁰ as well as fully paid health coverage. Such situations should prompt District officials to question whether these individuals' marital or dependent status may have changed. As such, District officials should confirm their status and ensure that the appropriate benefit dollar limit is used. Such procedures would help ensure that the District treats all employees in an equitable and consistent manner and only provides the level of compensation and/or benefits it is obligated to.

COBRA/Self-Pay Participants

The District currently has 147 individuals classified as self-pay (132) or COBRA (15). The self-pay individuals are employees not eligible for District benefit dollars or former employees that did not meet contract requirements for District paid health coverage upon retirement. The only situation that would allow a non-employee to receive coverage through a District plan would be through COBRA. Non-employee COBRA participants are generally one of the following: certain terminated employees and their dependents, dependents who can no longer be covered under their parents' plan, or the spouse of a deceased retiree. Generally, the maximum time an individual can qualify for health insurance under COBRA is 36 months. A vendor representative indicated that BlueCross BlueShield handles all tracking of COBRA participants. The vendor submits the initial start date for COBRA coverage to BlueCross BlueShield who notifies the individual when the time limit has expired and then removes the individual from coverage.

We found two situations where individuals who were not employees of the District were allowed to purchase health coverage beyond COBRA requirements. These individuals, classified as self-pay, had apparently never worked for the District. One individual was married to a former employee and District officials could not confirm whether the other individual was ever an employee or what his relationship is/was to the District. Neither the collective bargaining agreements (CBAs), COBRA or the General Municipal Law, which authorizes local governments to establish health insurance plans by governing

²⁰ Between flexible spending accounts and opt-out payments

board resolution, authorize coverage for this/these individuals.²¹ Therefore, it is unclear why the District is providing them access to its healthcare plan.

Long-term Care Insurance

Long-term care insurance is purchased in order to pay for services beyond what typical health care plans or Medicare will cover. Long-term care helps meet medical or personal needs for individuals who require continuous care, such as those with a disability or the elderly. This type of insurance policy can be expensive, depending upon the age of the individual when coverage is first purchased. In the 2007-08 fiscal year the District made premium payments of \$14,440 for long-term care insurance for two current and five former administrators. We found no express provisions in any of these administrators' contracts²² for the District to obtain or pay for long-term care insurance for any current or retired employee.

Enrollment Guide

The NFT and ASC contracts contain a reference to an enrollment guide, developed by the vendor. We found no evidence that District officials were involved in developing this guide or had approved its content. This guide provides information regarding insurance benefits available to employees and retirees, such as describing benefit dollars, the three flexible spending accounts and identifying eligible reimbursable expenses. This booklet does not always accurately correspond with contract stipulations and therefore may create confusion regarding allowable benefits. For example, both the NFT and ASC contracts state that retirees are only eligible for Traditional - Option A, medical coverage upon retirement. However, the enrollment guide indicates that retirees may also select an HMO plan and use any remaining benefit dollars for flexible spending or opt-out payments. This language contradicts the contracts and results in retirees receiving benefits not clearly established through the collective bargaining process.

Recommendations

1. District officials should comply with contract provisions and convert retirees from their current health insurance coverage to Medicare supplemental coverage. Further, the Board should discontinue the practice of providing cash incentives for such conversion.
2. District officials should discontinue providing District paid health benefits to retirees who do not have the required years of service.

²¹ General Municipal Law § 92-a authorizes coverage for “officers, employees and retired officers and employees of public corporations and their families.”

²² Most of these individuals were working for the District without a collective bargaining agreement or individual contract which would outline the benefits they were entitled to.

3. District officials should investigate recovering improper benefits provided to District employees and retirees.
4. District officials should discontinue allowing unqualified individuals to purchase health insurance through the District. Individuals who qualify for COBRA benefits should be classified correctly and coverage should be terminated upon reaching the maximum time allotment for COBRA benefits.
5. District officials should ensure the practice of providing Memorandums of Agreement (MOA) to provide additional benefits for certain individuals is limited and in situations where it is appropriate, District officials should maintain appropriate documentation that the agreement was in the best interest of the District.
6. District officials should require all employees that request family benefit dollars, but only subscribe to single medical coverage, to provide proof of eligibility.
7. The Board should discontinue paying for long-term care insurance for former employees of the District.
8. The Board should evaluate all collective bargaining agreements in place concerning health insurance coverage to ensure that the appropriate level of coverage is provided at the lowest cost to the District.
9. District officials should periodically review and approve the content of the vendor Enrollment Guide to ensure that it aligns with the intent of the Board and pertinent provisions in the collective bargaining agreements.

Health Insurance Billing

An effective system of internal controls ensures that health insurance premiums are paid for only those individuals appropriately receiving coverage; and that reimbursements from employees, retirees and COBRA participants are regularly examined for accuracy and timeliness. Additionally, good internal controls provide for proper segregation of duties so that no single individual controls key phases of a transaction or process.

Monitoring and Communication Issues

The District does not adequately monitor or communicate with its third-party employee benefits administrator. Since the third-party vendor (vendor) controls almost every phase of the insurance benefits process, it is imperative that the District have proper controls in place. District staff rely on the vendor to notify them of changes in employee/retiree billing status and of premium rates. District staff will not change District records unless directed to by the vendor, other than notifying the vendor when an individual should be canceled for non-payment. Changes in premium rates are communicated by fax or telephone.

In accordance with collective bargaining agreements, the vendor provides a number of plans and options to District employees and retirees. Each of these options has its own rate. Maintaining accurately documented premium rates is essential to ensure that the District is billed correctly and that the District, in turn, bills individuals appropriately. The District does not require regularly updated premium rate sheets from the vendor that would better guarantee these rates are correct. In addition, the District does not perform any periodic auditing or comparisons between District records and vendor records to ensure the accuracy of billing information. However, since the commencement of this audit, the District now requires the vendor to send an electronic version of their insurance data for analysis against District records. This analysis includes social security number and employee verification tests.

Retiree Verification

Good internal controls over health insurance should include monitoring the status of retirees through routine communication, either by personal contact or by correspondence that would determine their continued eligibility.

The District has no established policies or written procedures to verify the status of its retirees that receive District paid health care coverage. A vendor representative indicated that they had sent confirmation letters to CSEA employees, but this was last done

several years ago. District and vendor employees indicated that they periodically review obituaries in the local newspapers. In addition, the vendor sends out an annual benefits enrollment form to all employees and retirees. This form shows the amount of benefit dollars provided and the plan options from which they can choose. However, the employees and retirees are not required to return this form in order to receive coverage for the upcoming year. If the form is not returned, the individual will simply continue to receive the same insurance coverage they did in the prior year. When retirees are not required to contribute towards their coverage, there is little incentive to inform the District of any changes that may affect their coverage. The enrollment form could be used to confirm information and enable the vendor to update its records and make any changes to coverage. Questions could be added to the form that would allow the District to determine changes in address and marital status and to identify adult children and any deceased individuals who should be removed from coverage.

Because of the lack of written procedures, the length of time from the last confirmation letter, and the large number of older retirees, we tested whether District retirees were currently living. We examined Social Security Administration (SSA) records for 963 District retirees and their spouses and determined that 14 individuals currently insured by the District were actually deceased. In several cases, these individuals had been deceased almost four years and the District continued to pay for insurance coverage. We informed the vendor who subsequently performed their own inquiries and confirmed our results. The vendor contacted BlueCross BlueShield to make the appropriate adjustments.

BlueCross BlueShield agreed to refund the administrative fees for these individuals, back to the date of death. However, the administrative fee is only a small portion of the total premium cost. In addition, one individual was properly removed from BlueCross BlueShield coverage at the date of her death (January 2004); however, the vendor erroneously continued to bill the District for her insurance. Representatives from the vendor stated that they would reimburse the District for the overcharge in premium payments. After administrative fees are subtracted, we estimate the unnecessary cost to the District will be approximately \$114,000.

In addition, because the vendor's records did not include social security numbers for all the retirees' spouses, we could not verify whether 84 spouses of retirees were still alive. Consequently, there is still a risk that the District may be paying health insurance premiums for individuals who are no longer alive.

Other Premium Errors

It is important to review health insurance bills to ensure that all social security numbers of covered individuals from the District's records match those on bills from the insurance provider. BlueCross BlueShield sends a monthly administrative bill to the vendor, who subsequently sends its own bill of premium charges to the District. Because there is this intermediate step between BlueCross BlueShield and the District, it is imperative that all the billing data agree. The vendor indicated that they periodically compare the BlueCross BlueShield bill against their records. However, they have not done this recently.

In two instances, the vendor billed the District in error for individuals listed as COBRA in its records. One of the individuals was not receiving coverage from BlueCross BlueShield. The other individual was listed as subscribing to a single medical plan and was included as a dependent on her mother's District-provided policy. From July 2007 to February 2008, the vendor inappropriately billed the District \$5,314 for these two individuals.

Billing and Collection

Generally, we found that the District has an adequately designed health insurance billing and collection process. Employees in the Tax Office are responsible for certain health insurance billing and collection processes. Duties in the Tax Office are sufficiently segregated and all payments collected were up to date. The clerk in charge of health insurance collection maintained well-documented records and bank deposits were performed on a daily basis. However, we found certain deficiencies during our testing, mainly attributed to the insufficient revision and distribution of information between the vendor and the District.

We examined 161 self-pay and COBRA individuals to ensure that the District accurately billed and received timely payments. Of these 161 individuals, 59 made their payments to the District Tax Office, 101 instructional retirees made their payments directly to the NFT union and one was incorrectly classified as COBRA. The NFT union sends the District a monthly payment along with a report showing individual payments made by the retirees. We found that all payments made to the NFT union correctly corresponded with the coverage to which each individual subscribed. Of the 59 individuals making payments directly to the District, 21 (36 percent) were inaccurate. For the one-month period reviewed, 'net' discrepancies between vendor and District records resulted in under-billing totaling approximately \$2,400. In 14 instances, billing by the District did not match coverage plans subscribed to according to the vendor's records. For example, four individuals billed by the District were not listed in vendor records as receiving any insurance at all. A representative from the vendor indicated that this was an error and their records would be

amended. Examples of other inaccuracies include the District billing individuals for single coverage (dental and vision) when vendor records show the individual subscribed to family coverage, and billing at different plan rates than vendor records indicate.

Recommendations

10. District officials should establish written procedures that will provide for periodic evaluation and comparison between District and vendor records. The District should also evaluate what measures should be taken to improve the communication flow between the vendor and the District.
11. District officials should work with the vendor to revise the annual enrollment form to collect additional status and coverage information from employees and retirees. Furthermore, procedures should be developed to ensure that the forms are returned by a predefined date or coverage will be terminated.
12. District officials should contact the vendor and BlueCross BlueShield and take the appropriate action to recover unnecessary payments made for deceased individuals.
13. District officials should request a credit from the vendor for the inaccurate billing for two individuals.
14. District officials should ensure that the vendor routinely provides the District with premium rate sheets and a listing of coverage plans selected by self-pay and COBRA subscribers.

APPENDIX A

UNNECESSARY, INAPPROPRIATE AND INACCURATE PAYMENTS

Report Page Reference	Description	Inappropriate Benefits	Health Insurance Billing	Totals
9	Savings from Retirees age 65 and over changing to a Medicare PPO plan	\$1,829,638		
10	Inappropriate incentive payment to 23 CSEA retirees	\$21,250		
10	Retirees who do not qualify for insurance or were never billed by District	\$44,339		
11	Retirees who were given a special MOA	\$79,936		
11	Employees who received Family benefit dollars rather than Married benefit dollars	\$16,000		
13	Long-term Care Insurance	\$14,440		
Subtotal				\$2,005,603
16	14 Deceased Retirees		\$114,244	
17	Health Insurance Premium billing errors		\$5,314	
17	One month billing discrepancies		\$2,435	
Subtotal				\$121,993
Total Payments				\$2,127,596

APPENDIX B

RESPONSE FROM DISTRICT OFFICIALS

The District officials' response to this audit can be found on the following pages.



School District of the City of Niagara Falls, New York

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November 21, 2008

New York State
Office of State Comptroller
Buffalo Regional Office
295 Main Street Room 1032
Buffalo, NY 14203

Attention: Robert E. Meller
Re: Niagara Falls City School District

Dear Sir:

The Board of Education of the Niagara Falls City School District acknowledges receipt of the Office of State Comptroller (OSC) Report of Examination of Internal Controls over Health Insurance for Niagara Falls City School District. The District is appreciative of the review made by the OSC and of the explanation by OSC representatives of the matters reviewed. The Report will assist District officials in managing the District more efficiently and effectively. The review and explanation by OSC representatives will assist the District in responding to the items reviewed by this letter, and formulate an appropriate Corrective Action Plan.

The District will respond to the matters reviewed in the Report under Medical Eligible Retirees, Incentive Payment to CSEA Retirees, Retirees Who Do Not Qualify For Insurance, Retirees Given Special MOA, Employees Who Received Family Benefit Dollars, Long-term Care Insurance, Deceased Retirees Health Insurance Premium Billing Errors and One Month Billing Discrepancies.

Medicare Eligible Retirees

The Office of State Controller (OSC) erred in maintaining the District is not adhering to the stipulation in its Contracts requiring converting employee health coverage to a plan that is supplemental to Medicare when reaching sixty-five (65) years of age and that such failure resulted in approximately \$1.8 million dollars lost savings to the District in year 2007-2008 fiscal year.

See
Note 1
Page 28

To accomplish what the OSC suggests would require the District to default on its obligations to retirees, breach its Contracts, and violate the law. Although, the OSC recognized that there is language in the CSEA Contract requiring that "...when the retiree reaches his/her sixty-fifth (65) birthday and qualifies for Medicare under the Social Security program the type of Blue Cross \ Blue Shield and major medical

coverage shall be changed to cover his/her new circumstances...” and in the NFT Contract that “...upon exhaustion of this coverage (referring to insurance provided until the retiree is eligible for Medicare), the teacher shall be granted fully paid Blue Cross \ Blue Shield supplemental health coverage (including prescription co-pay) for his/her lifetime at no cost to the teacher,” it failed to recognize that such language requires: (1) that when employees convert to Medicare he/she must receive health benefits equal to the benefits received prior to retirement; (2) that any unilateral change in benefits by the District would result in a violation of its Contracts and (3) a unilateral change would violate the law enacted to protect retirees since it would diminish retirees’ benefits without diminishing benefits of active employees.

The language contained in the Contracts and cited by OSC obligates the District to provide retirees, upon reaching the age of sixty-five (65), health benefits equal to the health benefits they received prior to retirement. Since Medicare A and B standing alone do not afford retirees benefits equal to the benefits they were receiving prior to retirement, the District must provide retirees a supplemental plan to Medicare benefits for it to comply with its contractual obligations to the retirees and for most of its employees, represented by the CSEA and NFT unions, it must be a Blue Cross\Blue Shield type supplemental plan.

A plan supplemental to Medicare is, according to the Contracts, one that when combined with Medicare provides the retiree with the benefits he/she had prior to retirement. This was established by the Board more than twenty (20) years ago when, in approving a Contract containing language similar to the language cited by the OSC, it indicated that “by supplemental is meant supplementary to Medicare coverage, such that the health insurance provided by the Board combined with Medicare coverage shall together constitute the equivalent of the health insurance the retirees received as an employee of the Board.... “

See
Note 2
Page 28

As of March 4, 2008, the date of the Audit Report, there were no Blue Cross\Blue Shield supplemental plans working in conjunction with Medicare that would have given benefits equal to the benefits retirees had prior to retirement as they were entitled to by Contract. The plans available, though supplemental to Medicare, would have diminished the retirees’ benefits and as such, if implemented, would have resulted in a violation of the retirees’ contractual rights. Attached is a schedule of Blue Cross \ Blue Shield supplemental plans to Medicare which were available at the time of the audit. Of all the plans, only one, the Traditional Blue Cross \ Blue Shield plan, when combined with Medicare, provided retirees the benefits they were entitled to by Contract. That was the plan the District provided its retirees.

The implementation of any of the other plans would have also been a violation of the law. School districts are specifically prohibited by law from diminishing the health insurance benefits provided retirees and their dependents or from diminishing the

contribution such Board or District makes for such health insurance benefits unless a like diminution is effected from the benefits of the corresponding group of active employees for such retirees.

Therefore, since none of the plans at the time of the audit, other than the Traditional Blue Cross\ Blue Shield plan, when combined with Medicare, would have resulted in retirees receiving benefits equal to what they were receiving prior to retirement, a unilateral implementation of such plans, as suggested by the OSC, would have been a violation of the law as well as a violation of the retirees' rights and the Contracts.

Only as recent as July 1, 2008, some four (4) months after the date of the audit, has there been a supplemental plan, other than the Traditional Blue Cross \ Blue Shield plan, capable of being customized so as to afford the retirees the benefits they are entitled to when combined with Medicare. The plan will be fully effective on January 1, 2009. However, after substantial effort in customizing the plan to protect the rights of the retiree, and avoid violation of Contracts and violation of the law, the District will implement the plan on December 1, 2008 at a projected yearly savings of approximately \$1.2 million.

Since the District could not implement what the OSC suggested, that is a unilateral conversion of health benefits to Medicare, without defaulting on its obligations to its retirees, and without violating its Contracts and the law, the District requests that no reference of this item be contained in the Audit Report. Retaining the item in the Audit Report will result in undue and unfair criticism of the District for it fulfilling its obligations to retirees, honoring its Contracts and complying with the law.

Medicare Eligible Retirees Incentive

The OSC extends its erroneous reasoning on the conversion of retiree benefits to Medicare coverage to the incentives the District gave to CSEA retirees. OSC indicates payments made to the CSEA retirees who voluntarily subscribed to a Medicare PPO, amounting to \$21,250.00, were unnecessary and should be discontinued.

See
Note 3
Page 28

OSC again misinterpreted the provisions of the District's Contracts. As seen in the District's response to the OSC's Medicare position, the District cannot unilaterally change the health care benefits of its retirees without defaulting on its obligations to retirees and without violating its Contracts and the law.

Because of the high usage of prescription drugs by CSEA retirees, the Health Care Administrator suggested and recommended that the CSEA retirees be put in a GAP program through Medicare. The new program, if implemented, changed the prescription co-pay for retirees requiring, a higher co-pay than was available at the time

of retirement. The retirees agreed to increase their co-pay benefit from \$1.00 or \$3.00 to a three (3) tiered program of \$0, \$15.00, \$35.00 and were afforded an incentive to encourage their voluntary participation in the program.

The benefit to the District in securing the voluntary participation of CSEA retirees in the Medicare program was far greater than the incentive paid to the retirees. It also avoided a breach of contract and a violation of the law by the District in implementing the higher co-pay benefit.

Retirees Who Do Not Qualify For Insurance

OSC indicated five (5) retired employees were receiving District paid health coverage who did not meet the contractual eligibility for such coverage, and claim that the individuals received \$44,339.00 in benefits for 2007-2008 fiscal year.

A further review by the OSC of the employment records of the individuals noted would have revealed the following:

One (1) individual was under Social Security Disability. The District continued to pay health insurance benefits notwithstanding she needed both New York State Pension Disability and Social Security Disability pursuant to the terms of the contract.

See
Note 4
Page 28

The individual has applied for New York State Pension Disability and it is believed it will be automatically granted since she has Social Security Disability. The District will continue payment of her insurance until a determination on her New York State Disability application is made by the pension system.

Two (2) individuals worked from 1959-1979. Both were eligible for life benefits under CSEA contract, however, by error, both were listed as a self-paid individual at no harm to the District.

The District changed the status of both individuals from self-paid to full benefits based on their eligibility. The District will not collect the amount paid for their insurance since they would have been entitled to the benefit, although albeit erroneously listed as self pay.

One (1) individual applied for Disability Retirement, which was disapproved. However, the District cannot find any documentation from the Retirement System as to the disapproval of her application. Her coverage was terminated in September 2008.

One (1) individual was self-pay. The last payment received from him was for March 2005. The individual passed away in April 2005. Payment of benefits continued.

The individual was removed from rolls in September 2008. Reimbursement will be requested from the Health Care Administrator.

Retirees Given Special Memorandum of Agreement

The OSC questioned the District's Memoranda Of Agreement providing lifetime health care benefits to certain individuals who did not meet contractual stipulations as to age and service for such benefits.

The OSC identified five (5) individuals who were given such benefits and claimed the District failed to present reasons as to why the MOA(s) were in its best interest.

See
Note 5
Page 29

There was a substantial savings to the District in permitting the individuals, all of whom were older employees with long years of faithful service, to retire earlier than normal. Those individuals were at a high rate of pay and were either not replaced or were replaced by employees at a lower rate. The decision to allow them to retire was a sound business decision by the District and the benefits derived outweighed the amount claimed to have been spent by the District.

See
Note 6
Page 29

The OSC did not accept this business decision explanation given by the District.

Employees Receiving Family Benefit dollars

The OSC states it found instances where both members of a couple employed by the District were receiving larger family opt out flex dollar benefits and indicated that such was contrary to the contracts. As justification for its position, the OSC cited an enrollment guide which was referred to in the Niagara Falls Teacher's (NFT) and the Administrative and Supervisory Council (ASC) Contracts.

The OSC misread the provisions in District Contracts and incorrectly stated the District overpaid four (4) married couples a total of \$16,000.00.

The NFT and the ASC Contracts list two (2) levels of benefit dollars; "family" and "single." The only mention of a third level of benefits is found in the Health Care Administrator's Enrollment Guide entitled "Niagara Falls Board of Education Certificated Flexible Benefits Plan Enrollment Guide," which is referenced in only two (2) Contracts. The Health Care Administrator created this guide as a procedural handbook. The language and the procedures therein were neither created with Board of Education personnel nor were they negotiated with the NFT or the ASC. The handbook was last revised in 2003, is not current, and contains information that is no longer applicable. This Enrollment Guide although referenced in the Contracts, was not and has not been distributed to employees since 2003.

See
Note 7
Page 29

The Enrollment Guide, though referenced in the Contracts, did not establish a “married” level of benefits. Such could have been established only in negotiations with the appropriate unions. In addition, the Health Care Administrator’s annual enrollment form did not reference or indicate the third level of “married” benefits. As such, there is no basis in Contract substantiating the OSC’s assertion of overpayment.

The District’s Health Insurance Committee comprised of Central Administration, union presidents and the Health Care Administrator representatives is in the process of updating and correcting the information in the enrollment guide. References to this enrollment guide in both the NFT and ASC Contracts are under review and removal of these references from the Contracts by way of a Memorandum Of Understanding is under consideration. When the revision of the enrollment guide is complete, it will be distributed to all employees and also be placed on the District’s web site. The NFT enrollment form has been modified to include a “married” benefits selection so that the appropriate level of benefits is indicated at the point of enrollment.

Long Term Care Insurance

OSC states that the District made payments to two current and five former administrators for Long-term Care insurance for which it found no express provisions in any of the administrators’ contracts for the District to obtain and pay Long-term Care insurance.

The OSC statement is incorrect as to all but one of the administrators in that the District is contractually obligated to secure and to pay for the Long-term Care insurance of the administrators, although it may not be delineated in any agreement. In August of 1990, some 18 years prior to the date of the Audit, the Board of Education approved and adopted a salary and benefits package for the Superintendent’s Administrative Staff (SAS) Group which included “disability income protection for retired adults” (now referred to as Long-term Care). The original approval of the benefit by the Board was for SAS member positions and not for the individual then in the position. As such, those in the SAS position then and all those who followed in SAS positions, were and are entitled to the approved benefit until otherwise negotiated and determined by the Board.

See
Note 8
Page 29

As to the one administrator, the District is reviewing its files to determine his eligibility.

This item should be excluded from the Audit Report. Although, the OSC’s position that they could find “...no express provision in the administrators’ contracts...” is correct, it fails to recognize the District’s obligation to the administrators to obtain and pay for Long-term Care insurance as agreed to by the Board’s approval of the benefit for SAS members in 1990. Allowing the item to remain in the Report would raise an

improper and unjust inference that the District paid for a benefit it was not obligated to pay.

Deceased Retirees

The District's Health Care Administrator acknowledges that there were payments made for deceased retirees and has fully reimbursed the District the estimated cost amount stated in the report for such payments.

Retirees Health Insurance Premium Billing Errors One Month Billing Discrepancies

The District's Health Care Administrator acknowledges, premium billing errors of \$5,314, and one month billing discrepancies of \$2,435, and has agreed to fully reimburse the District for such errors.

CONCLUSION

The District will address the items reviewed in the Report, and within the constraints of its Contractual obligations and the law, correct any deficiencies that may exist. An appropriate Corrective Action Plan will be prepared and filed in a timely manner with the OSC.

Respectfully submitted,



Robert Kazeangin
President
Niagara Falls Board of Education

APPENDIX C

OSC COMMENTS ON THE DISTRICT'S RESPONSE

The District's response letter refers to an attachment that supports the response letter. Because the District's response letter provides sufficient detail of its actions, we did not include the attachment in Appendix B.

Note 1

Implementing the recommendations in this report would not require the District to default on its obligations to retirees, to breach its contracts or to violate the law. We maintain that the District should have complied with the provisions of the respective collective bargaining agreements prior to 2009. The District's position for disagreeing with our report is based almost entirely on the premise that equivalent coverage was not available until 2008. The extensive discussion of various legal issues is largely irrelevant since the District states that beginning in 2009 it will be complying with the provisions in the contracts. The basis for the District's argument is flawed because there is evidence that appropriate coverage was available. We contacted a representative from BlueCross BlueShield who indicated that customizable group supplemental Medicare coverage was available by mid 2007. Furthermore, the District's third-party administrator, whom the District relies upon for its expertise, also indicated that comparable coverage was available in 2007. The District has a responsibility to actively pursue appropriate Medicare supplemental plans for its retirees. The contract stipulation requiring the coverage change has been included in District contracts for at least 24 years. If District officials were unable to or did not intend to enforce this contract stipulation, then the language should have been revised or eliminated during the collective bargaining process. Furthermore, we are skeptical that the coverage the District will be using to comply with the contract provisions only became available after we had completed our audit.

Note 2

This contract language was not found in any of the contracts reviewed. We found no provision that specified that health insurance supplemental to Medicare must be equivalent to the coverage received as an employee. Furthermore, the District did not indicate which specific contract, from more than 20 years ago, established this practice for all employees.

Note 3

The District should not provide an incentive payment for something that is required by contract.

Note 4

The audit team reviewed all the records that were made available to us for these five individuals and further requested that District officials provide us with any documentation that would substantiate why these individuals were receiving District paid health coverage. District officials were unable to produce any of the requested records by the completion of audit fieldwork. Therefore, we

cannot confirm any of the assertions made by the District in this response letter, concerning these individuals.

Note 5

During fieldwork, the District did not provide any documentation to support this assertion.

Note 6

The average age for the individuals at the time they retired from the District was 65 (ages 58, 64, 65, 67 and 71). Therefore, these individuals were within normal retirement age. Furthermore, four of the five individuals had job titles that are not typically indicative of higher salaries, which would generate the significant savings the District suggests. The average health insurance plan costs the District approximately \$16,000 per year. This represents a significant potential future obligation to the District that will likely exceed the savings the District alludes to. Furthermore, providing such incentives or benefits unique to one individual in a collective bargaining unit exposes the District to subsequent challenges of favoritism. This is especially true when objective criteria are not applied uniformly to all members of an employment class or there isn't other documented rationale.

Note 7

The District appears to be in agreement with the report finding entitled "Enrollment Guide" found on page 13 of this report. However, in practice, the District required all NFT employees who were married to another NFT employee, to receive the reduced "married" benefit dollars rather than larger "family" benefit dollars.

Note 8

A 1990 resolution identified this benefit as "disability income protection for retired adults" rather than the "long term care insurance" that is currently provided. The resolution stated that this benefit would be provided for only three specific job titles and for only three specific fiscal years (1989-90, 1990-91, and 1991-92). If the District chose to extend these benefits beyond those periods or to other individuals, or, as the District contends, the benefit terminology changed, then the Board should have passed a subsequent resolution indicating the changes.

APPENDIX D

AUDIT METHODOLOGY AND STANDARDS

We conducted an audit of the District's health insurance program to determine if adequate controls are in place and to identify cost savings opportunities that the District may consider to offset rising health insurance costs. To accomplish this we interviewed District officials and representatives from the third-party vendor (vendor), reviewed current and previous collective bargaining agreements, and examined insurance billing records, personnel files, and any other relevant documents maintained by the District and the vendor.

To accomplish the objective of this audit, we performed the following audit procedures:

- We examined current and prior collective bargaining agreements, vendor-board census spreadsheets, payroll records, and insurance billings for a sample of current employees.
- We integrated vendor data with District employment data to gather relevant information for District retirees. We determined age, hire date, retirement date, length of service, and age at retirement. We used this information to identify trends and risks, as well as to select a sample of retirees to test.
- We tested a sample of retirees against existing District records. We examined personnel files, insurance billings and spreadsheets. We requested selected memorandums of agreement and, obtained collective bargaining agreements dating back to the late '70s and early '80s. We compared these individuals' benefits and premium costs with applicable contracts to determine compliance. For any exceptions, we used current insurance rates to determine the cost to the District.
- In our review of the COBRA program, we identified 161 individuals currently designated as self-pay or COBRA participants and reviewed their eligibility.
- To estimate the savings from requiring all retirees age 65 or over to subscribe to a health insurance plan that is supplemental to Medicare we did the following:
 - o We identified all retirees age 65 or over by examining District electronic employee data.
 - o From vendor records, we identified the current insurance plans these retirees subscribe to and any flexible spending dollars or opt-out payments they will receive.
 - o We inquired and confirmed with the vendor the current rates for a Medicare PPO plan for both instructional and CSEA retirees.
 - o We made adjustments to plan rates to account for those retirees whose spouse was younger than age 65.

- o We took the difference between their current medical premium rates and the Medicare PPO premium rates to estimate the initial savings.
 - o From current address information, we identified all retirees who are not living in the coverage area and excluded them from our analysis. At this time, the Medicare PPO plan is not “portable” and is only available to individuals residing in the Western New York coverage area.
 - o For those retirees who receive opt-out payments and flexible spending amounts, we estimated the savings by reducing the dollars available based on the Medicare PPO plan premium rate. We then took the difference between the current opt-out payments and flexible spending dollars and this Medicare PPO rate.
 - o We requested that the vendor provide us with prescription reimbursement data for those retirees who currently subscribe to a Medicare PPO plan and receive prescription reimbursements for any differences in their prescription co-pays.
 - o From this prescription reimbursement data, we calculated the average dollar amount of prescription reimbursements provided per individual over the course of one year.
 - o We identified all retirees who may be eligible for a prescription reimbursement and multiplied the calculated yearly reimbursement amount by this number. This amount was subtracted from the total estimated savings amount.
- We performed tests to determine if all retirees and spouses are currently living by acquiring social security numbers for 963 retirees and their spouses and comparing the data with the Social Security Administration’s (SSA) “Death Master File” records. While these records are an effective tool to assist in verifying the accuracy of health insurance bills, they should not be relied on as proof that the individual is deceased. The SSA strongly recommends that users independently verify the accuracy of the Death Master File. To further verify the results, we requested the vendor to contact the individual’s next of kin to confirm the findings.
 - We selected a sample of employees, retirees, COBRA and self-pay participants who contribute an amount toward health insurance. We verified the accuracy of premium co-payments by examining recent payroll records, health insurance billing records, Tax Office records, NFT payment records, and vendor records. We compared this information with the January 2008 payroll checks on the District’s Computerized Information Management System, to verify the accuracy of the deductions. We examined health insurance contributions for all self-pay and COBRA participants made to the District and the NFT for the January through March 2008 billing cycle.
 - We interviewed District staff and vendor representatives to evaluate the current procedures used to process the monthly insurance billings and to make changes to health insurance coverage levels.

- We reviewed collective bargaining agreements to determine if opt-out payments corresponded with contract provisions.

We conducted this performance audit in accordance with generally accepted government auditing standards (GAGAS). 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.

APPENDIX E

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APPENDIX F
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