SYOSSET CENTRAL SCHOOL DISTRICT

Internal Audit Report on
Medical and Dental Benefits
and Retiree Health Insurance

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We have been engaged by the Board of Education (the "Board") of the Syosset Central School District (the "District") to provide internal audit services with respect to the District's internal controls related to medical and dental benefits and retiree health insurance for the period July 1, 2018 through June 30, 2019.

The objectives of the engagement were to evaluate and report on the District's internal controls pertaining to medical and dental benefits and retiree health insurance 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 benefits and retiree health insurance. 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 declined health benefits to determine that proper supporting documentation existed, the buyout 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 calculated properly;
- 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 individuals receiving dental benefits to determine that proper supporting documentation existed, coverage was in agreement with contract stipulations, and the employees' payroll deductions were calculated properly;

- Tested a sample of payments remitted to the District's dental plan administrator to determine payments were accurately recorded and documentation existed to substantiate the amount remitted; and

- 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.

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 and retiree health insurance, 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

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. The District's obligation to provide health insurance coverage to employees and retirees has been established and determined through collective bargaining agreements. 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 two health insurance plans with *The New York State Health Insurance Program* ("NYSHIP"). All employees working half-time or more are eligible to enroll in the Plans. Each Plan offers both individual and family coverage for employees and retirees. The Plans have 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, and may vary based upon hire date.

Each month the District is billed the full premium for each retiree enrolled in the Plans. Most retirees are billed directly through a pension deduction. For retirees billed by the District, the benefits administrator is responsible for sending invoices to retirees for premium contributions, and for monitoring any past due invoices. Retirees remit payment to the District, and the personnel clerk records the cash receipt in the accounting information system.

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 must 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 or EEHP 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 PLAN SELF AUDITS

The District conducts an annual self-audit of the District's Empire and HIP health insurance plans. The self-audit is conducted by the benefits administrator who prints a list of all employees receiving a health insurance deduction from the accounting information system, and verifies the employees' hire date and position. The benefits administrator then verifies the employees' coverage type per the detailed monthly health insurance invoice and recalculates the per period deduction based on the appropriate collective bargaining agreement. The benefits administrator reconciles the health insurance buy back list to the employee list and the detailed health insurance invoice to verify that all eligible employees are receiving either health care coverage or the health insurance buyout applicable per the collective bargaining agreement. The benefits administrator also verifies that no employees are receiving both health care coverage and a health insurance buyout.

Upon completion of the self-audit, the benefits administrator will discuss any variances that have been identified with the payroll supervisor. Any deductions withheld in excess of the appropriate amount will be refunded to the employee. Employees whose withholdings were insufficient will be contacted to review repayment procedures. The benefits administrator will also contact the District's representative for each health insurance plan, typically via email, to notify the health care plan of any employees who are not receiving appropriate coverage.

DENTAL INSURANCE

The District has established a self-insured dental insurance plan for active employees administered by Ameritas. All employees working a half-time or more are eligible to enroll in the plan. Employees that are benefits eligible at the time of retirement are eligible to continue coverage under the District's dental plan until they reach the age of 65 at which point, they are eligible to continue coverage under the District's dental plan administered by Fitzharris & Company. Active District employees and retirees contribute towards their monthly premium as outlined in their respective collective bargaining agreement. For active District employees, the employee's contribution is withheld as a payroll deduction. Retirees remit premium contributions directly to the insurance company.

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 and retiree health insurance outlined above.

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 and retiree health insurance. 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 and retiree health insurance.

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

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Health Declinations

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

- A completed, declination of health insurance form exists.
- The employee is not receiving health care coverage through a District sponsored health plan.
- The buy-out option is 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 two out of twenty-five individuals selected for testing did not have documentation on file to support dependent coverage and one out of twenty-five individuals selected for testing did not have a completed enrollment form on file. These individuals enrolled in the District's health insurance plan before the current benefits administrator was in place.

Recommendation: We recommend the District maintain enrollment forms for all employees as well as supporting documentation for all dependents on file.

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Medicare Part B Reimbursements

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

- 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 June of 2019.

Finding: We noted one out of ten retirees selected for testing received a Medicare reimbursement for an amount in excess of the basic and income-related monthly adjustment amount (IRMAA) total on their Social Security 1099 form. The District could not provide support to justify the amount reimbursed.

Recommendation: We recommend the District reimburse retirees for Medicare in accordance with Civil Service Law Section 167-A which requires reimbursement for the basic premium amounts and IRMAA. Subsequent to our audit procedures, we noted the District has initiated the process to attempt to recoup the necessary funds and has completed a detailed review of all Social Security 1099 forms.

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Retirees

Procedure Performed: We selected a sample of five retired employees and spouses receiving health insurance coverage to verify the following:

- The retiree or spouse is not deceased and still receiving health benefits.

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

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Dental Insurance Coverage

Procedure Performed: We selected a sample of forty individuals (20 employees, 20 dependents) receiving dental 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.
- The amount deducted per payroll journal agrees with employment contract.

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

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Cash Disbursements

Procedure Performed: We selected a sample of five payments remitted to the District's dental plan administrator for dental insurance during the 2019 calendar year to verify the following:

- Supporting documentation exists to substantiate the amount remitted.
- The amount remitted agrees to the disbursement reported on the District's bank statement.

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 ten 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.
- The employee's payroll deduction is properly calculated.
- The District's contribution to the third-party administrator indicates the correct contribution amount for the employee selected.

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

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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.