

HEALTH INSURANCE CLAIMS AUDIT

(CIGNA – THIRD PARTY ADMINISTRATOR)



WEST PALM BEACH

Internal Audit

Audit No. 19-02
June 27, 2019

City of West Palm Beach Internal Auditor's Office

Beverly Mahaso, Chief Internal Auditor, Esq., CIA, CFE
Public Sector Performance Associates, Contract Auditors

INTENTIONALLY LEFT BLANK

Executive Summary

HEALTH INSURANCE CLAIMS AUDIT - AUD19-02

JUNE 27, 2019



OVERVIEW

- The City of West Palm Beach, through the Human Resources Department, offers health insurance to all eligible employees across all departments.
- Since July 1, 2016, the City has used a self-funded insurance plan model, administered on the City's behalf by Cigna.
- The City also utilizes the services of the Gehring Group for the provision of insurance brokerage services. Gehring has advised the City in the development of the City's current self-funded health insurance program.
- In addition, the City provides health care services and prescriptions at no cost to its members through the City-owned Employee and Family Health Center located adjacent to City Hall.

SUMMARY FINDINGS

1. **Verification of Eligibility:** There is a risk that payment of benefits could occur when certain life events that impact eligibility are not reported timely, as the City does not require employees to periodically attest to coverage of dependents, or conduct periodic dependent eligibility audits to ensure compliance with City policy.
2. **Reconciliation of Claims Payments:** Historically, the City has not been able to reconcile requests for payments by Cigna due to a perceived lack of supporting documentation and limited access. However, all information available to support the payment request is available through Cigna's secure portal.
3. **Healthcare Cost Management:** The health care cost data currently available to senior management is not contained in a single report that is readily accessible, which would permit management to more easily make informed decisions regarding the overall cost effectiveness of the self-insured plan.
4. **Contractual Limitations:** The current limitations in the Cigna contract create challenges for an independent review, as well as proper monitoring and administration of claims processed.
5. **Internal Control Review:** Our assessment of best practice controls identified some gaps in the City's current state, including Performance Guarantees, Key Performance Indicators, a review of the healthcare providers Service Organization Control (SOC) Report, and the need for documented policies and procedures for the administration of healthcare benefits.

SUMMARY RECOMMENDATIONS

1. HR should implement periodic dependent verification audits, as well as annual attestations. Further, periodic reconciliations of the City's member eligibility data with Cigna's data should be performed.
2. HR and Finance should review the reports available through Cigna's portal to assist in reconciling the payment requests.
3. The HR Department, with input from the Finance Department, should prepare and submit to senior City management, an annual full-cost report of the health care cost.
4. HR and the Gehring Group should work to enhance the services provided to the City, including identifying contractual provisions for future contracts that would benefit the City.
5. HR should take measures to close the gaps between recommended practices and the current state.

INTENTIONALLY LEFT BLANK



Internal Auditor's Office
P.O. Box 3366
West Palm Beach, Florida 33402
Tel: 561-822-1380
Fax: 561-822-1424

June 27, 2019

Audit Committee
City of West Palm Beach
401 Clematis Street
West Palm Beach, Florida

RE: Health Insurance Claims Audit, AUD19-02

Dear Audit Committee Members:

Attached is the City of West Palm Beach's Internal Auditor's Office report on the Health Insurance Claims audit.

We thank the management and staff of the Human Resources Department for their time, assistance, and cooperation during this audit.

Respectfully Submitted,

/s/ Beverly Mahaso
Chief Internal Auditor

cc: Keith James, Mayor
Jeff Green, City Administrator
Jose-Luis Rodriguez, Chief Human Resources Officer

INTENTIONALLY LEFT BLANK

Contents

BACKGROUND.....	1
STATEMENT OF SCOPE.....	2
STATEMENT OF OBJECTIVES.....	2
STATEMENT OF METHODOLOGY	3
STATEMENT OF AUDITING STANDARDS.....	3
AUDIT CONCLUSIONS AND SUMMARY OF FINDINGS	3
NOTEWORTHY ACCOMPLISHMENTS	3
HR ORGANIZATION CHART	4
OPPORTUNITIES FOR IMPROVEMENT	5
1. VERIFICATION OF ELIGIBILITY.....	5
2. RECONCILIATION OF CLAIMS PAYMENTS.....	7
3. HEALTH CARE COST MANAGEMENT	9
4. CONTRACTUAL LIMITATIONS.....	10
5. INTERNAL CONTROL REVIEW	13
CLAIMS AUDIT TESTING RESULTS	15
EXHIBIT 1 - MEDICAL BENEFITS INTERNAL CONTROLS	18
EXHIBIT 2 – EXAMPLES OF APPLICABLE PERFORMANCE MEASURES	20

Background

The City of West Palm Beach offers health insurance to all eligible employees across all departments. The City subsidizes most of the cost of the health insurance premium, and employees are responsible for paying a portion of the premium, deductibles and co-payments. The City pays almost all of the employee deductible through a health reimbursement account.

Since July 1, 2016, the City has used a self-funded insurance plan model which is administered on behalf of the City by Cigna Health and Life Insurance Company (Cigna) through an Administrative Services Only Agreement (ASO). Prior to July 1, 2016, the City provided health benefits for almost ten years through a fully insured model that was also administered by Cigna.

The City also utilizes the services of the Gehring Group for the provision of insurance brokerage services. Gehring has advised the City in the development of the City's current self-insured health insurance contract with Cigna as well as any proposed Cigna rate and benefit changes.

Both the City and Cigna provide numerous health programs and services to members. These include, but are not limited to, a 24-hour health information hotline, telehealth, case management, employee assistance, well visits, wellness programs and incentives, and biometric and health assessment testing.

The City also provides health care services to its members at no cost through the City owned Employee and Family Health Center (EHC) located adjacent to City hall. The EHC is operated for the City by the Treasure Coast Medical Association (TCMA). Members can also use TCMA affiliated centers in Jensen Beach and Okeechobee, Florida, also at no cost. The Gehring Group reported that during calendar year 2018 there were 8,692 office visits to the health center.

Role of the City's Benefits Division

The Benefits Division within the Human Resources (HR) Department manages the City's medical benefits function. A Benefits Officer oversees the Division and is responsible for administering the health care program and ensuring that covered employees, spouses, and dependents, are eligible to participate in the Plan. Any new, terminated employee, or change in qualifying event is reported to Cigna on a weekly basis. The Benefits Officer is assisted by a Benefits Analyst and a part-time Human Resources Technician. In addition, the Benefits Officer is assisted by a full-time, on-site Cigna employee and a full-time, on-site Gehring Group employee to assist in various aspects of the medical benefits program.

Cigna's ASO Responsibilities

Under the ASO agreement, Cigna is responsible for claims administration including contracting with providers, receiving benefit claims, processing claims in accordance with

the ASO provisions, tracking deductibles, coinsurance amounts, and reimbursing covered participants, as applicable. Cigna is also responsible for paying service providers based on service contracts with its pool of providers.

Cigna's internal controls are evaluated and reported on annually by an independent consultant and documented in a Service Organization Control (SOC) report, the purpose of which is to describe and evaluate internal controls and internal control weaknesses related to Cigna's claims processing functions. The SOC report also includes recommended controls for user entities like the City.

The City agreed to a three-year contract with an option for two one-year renewals with Cigna in 2016. The City utilized one of the renewals early in 2019. The City's health insurance Plan Year (PY) runs from July to June of each year.

Statement of Scope

The scope of the audit was from July 1, 2017 to September 30, 2018 (audit period). The City's contract with Cigna limits the number of claims that can be audited to 225 claims. For sampling purposes, Cigna provided a data file of all the medical claims received and processed during the audit period. The data represented approximately \$55.4 million of charges submitted to Cigna by the health services providers, and approximately \$12.9 million of charges paid to those providers after contracted provider discounts were applied.

City's Health Insurance Program Costs

The following costs are based on data prepared by the Gehring Group for the City. For the audit scope period, the approximate cost of health care including pharmacy was about \$23 million which includes administrative fees paid to Cigna of approximately \$843,000 and the stop loss premium of approximately \$1.8 million. Further, there were about 1,550 enrollees for a combined total of about 3,000 people, which includes dependents. These costs do not include vision, dental, or the health center.

Statement of Objectives

The objectives of this audit were to:

- a. Assess the adequacy of the procedures within the Human Resources Department for establishing employee health care benefits, including eligibility determinations.
- b. Determine if claims are being paid accurately and in accordance with the contract.
- c. Evaluate the interaction between the City and the third-party administrator.
- d. Determine if the City is realizing savings from being self-insured for health benefits.

Statement of Methodology

The methodology used to meet the audit objectives included the following:

- Interviews and inquiries of key City employees as well as personnel from the third-party administrator Cigna, and the Gehring Group.
- Review of insurance plan documents, service agreements, benefit and eligibility information, and third-party administrators' activity reports.
- On-site claims review at Cigna's operations center and use of data analytics to achieve claims testing objectives. Refer to the Claims Audit Testing Section for results.

Statement of Auditing Standards

We conducted this 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.

Audit Conclusions and Summary of Findings

Overall, the City would benefit from strengthening the internal management and monitoring activities over the self-funded health benefits program. Specifically:

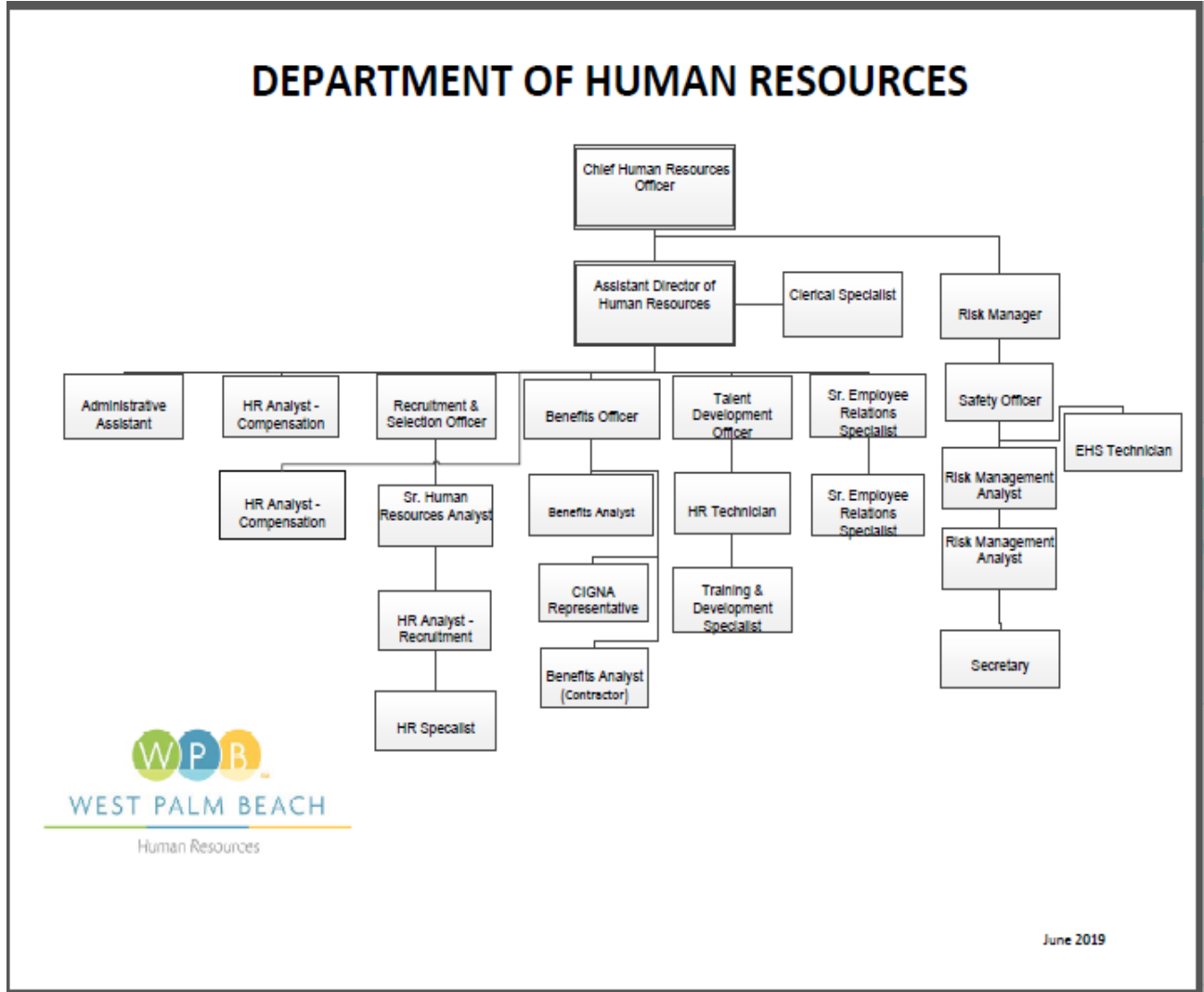
- A single comprehensive report of all health care costs would assist in financial and strategic planning;
- Periodically verifying member eligibility would be helpful to ensure that only eligible members are on the health care plan;
- Reconciliations are needed for claims paid on behalf of the City to the amount requested by Cigna; and
- Contractual limitations may create challenges for independent reviews and monitoring of the third-party administrators.

Noteworthy Accomplishments

We acknowledge the Human Resources Department Benefits Division's efforts to administer the health benefits program. In July 2018, the Benefits Division team achieved cost savings by raising the stop loss insurance limit from \$200,000 per incident to \$225,000 per incident, using data analyses. This action reduced the stop loss premium payment by 1.2% from the previous plan year which was set to increase. Further, the Benefits Division was able to negotiate for the purchase of a new Ultrasound machine

which is now available at the Employee and Family Health Center.

HR Organization Chart



Opportunities for Improvement

1. Verification of Eligibility

Condition

Although the City has some controls in place to ensure that benefits are paid only for eligible members, there is a risk that payment of benefits in error could occur when certain life events that impact eligibility are not reported timely.

Under the City's plan, members are required to report life events, such as state residency status or student status changes of children ages 26 to 30, a divorce, or the end of a domestic partner relationship. The employee must log into BenTek within 30 days of the qualifying event to make the appropriate changes to the employee's coverage. Beyond 30 days, the employee may be responsible, both legally and financially, for any claim and/or expense incurred as a result of an employee or dependent who continues to be enrolled, but no longer meets eligibility requirements. To be eligible for benefits, dependent children between ages 26 and 30 must meet specific criteria, such as being a Florida resident or a full-time or part-time student. If the dependent moves from Florida and is not a part-time or full-time student, the City would continue to pay benefits unless the parent reports the change. If divorce occurs or domestic partnerships end, there is a risk that the City may continue to pay benefits for a former spouse or partner who is no longer eligible.

Although periodic comparisons are done between the Payroll and the Health Benefits database, the City does not require employees to periodically attest to coverage of dependents, but relies on the annual open enrollment process. In addition, the City does not conduct periodic dependent eligibility audits to ensure that employees are complying with City policy on dependents.

Criteria

Management is responsible for designing and implementing appropriate controls for the entity's operations. This would include taking steps to ensure that only eligible employees and dependents are receiving health insurance benefits. The importance of proactive measures such as attestation statements and periodic eligibility audits are a best practice among both private and public sector employers as a means to ensure that only eligible member claims are being paid, thereby containing health insurance costs. Further, eligibility audits help to manage both regulatory compliance risks and ensure fair treatment for all employees.

Cause

Documentation for new employees and/or their spouses and dependents are required at the time of initial enrollment, or when requesting status changes. Periodic audits are not conducted to ensure that dependent members continue to be eligible. In 2018, HR began a process to verify dependent eligibility by requesting that employees attest that dependent(s) eligibility remained the same, and that certain listed dependents continued to be eligible for the benefits they were receiving. Three of the main areas under review were: 1. employees who may not have reported a divorce from their spouse after their

initial enrollment, 2. an unreported end to a domestic partnership and 3. any dependent children between the ages of 26 and 30 who no longer met the criteria to be covered under the City's health plan. An attestation form was sent out but not all employees responded, though this is an area where it would be prudent to follow up.

Effect

There is a risk that the City could be paying benefits for ineligible dependents which could increase its health care costs.

Recommendation 1

- a. HR should implement periodic dependent verification audits to identify any dependents no longer eligible for benefits due to status or relationship changes. Attestations should be required annually, with an appropriate response from HR if an employee fails to respond. Further, the attestation process should be automated.

- b. For further improvement, HR should consider periodic reconciliations of the City's member eligibility data with the member eligibility data maintained by Cigna. To accomplish this, HR could request a semi-annual member eligibility report from Cigna, and obtain from BenTek, a current master list of new hires, terminations, status changes, as well as the dates these changes occurred. The reconciliation of the two reports would help ensure that the City, through Cigna, is only paying benefits for eligible members.

Management Response 1

HR agrees with the recommendation and will work with the BenTek solutions provider to assess if an electronic attestation form can be incorporated into the BenTek system so that an eligibility attestation form can be completed annually by all employees.

The enrollment data will also be reconciled no less than annually, as part of the open enrollment process to ensure only eligible members are receiving health benefits under the City's plan.

Target Implementation Date: July 1, 2020

2. Reconciliation of Claims Payments

Condition

In the City's self-insured model, Cigna pays out claims on behalf of the City. Once the claims have been paid, Cigna requests lump sum payments from the City ranging anywhere from \$100,000 to over \$800,000 for claims paid on a weekly basis. However, historically the City has not been able to reconcile the requests for payments due to a perceived lack of supporting documentation.

The current process is that the City receives an email with a request to reimburse Cigna for claims paid and a wire transfer is sent for the amount requested. No corresponding claims information, such as a claim number and amount, to support the request for payment is provided. In our interviews of employees, we were advised that they made requests to obtain the supporting documentation and none was provided. However, the documentation needed to reconcile the payment request is available in Cigna's portal which is accessible only to necessary personnel and requires log-in credentials due to the protected information stored therein. We reviewed the report available and found that it had sufficient information to support the payment request, but it also contained protected information, which is likely why the information is only available through Cigna's portal. At one point, a Finance employee and an HR employee had access to the portal, though there is no evidence to support that the employees retrieved the supporting documentation or used the report to reconcile the payment requests. That access has been assigned to one relatively new HR employee who has access to the portal, however, this employee is not tasked with, nor responsible for payment reconciliations.

Criteria

Management is responsible for ensuring that the City obtains relevant, accurate, and timely financial data and operational reports in order to effectively monitor programs. In developing information requirements, management should work with subject matter experts to ensure that information needs are clearly communicated to and understood by third party vendors.

Cause

The condition stated can be attributed to a breakdown in communication between multiple departments, a third party contractor, and employee turnover.

Effect

Insufficient reconciliation controls and procedures create risks that the City may inaccurately pay claims. Further, insufficient documentation to support claims may limit the City's ability to properly manage health care programs or simply raise questions about potential errors. These concerns are increased because the City does not have performance guarantees in its contract that may provide some assurances.

Recommendation 2

- a. HR and Finance should review the reports available through Cigna's portal to assist in reconciling the payment requests, as well as the City's general ledger to the banking records.

- b. HR and Finance should identify the information needed on a regular basis and if the necessary reports are not already available in the portal, then they should consider requesting customized reports from Cigna that could help the City manage its claims.
- c. HR should include performance guarantees in future contracts with its third party administrator as fully discussed in finding 4.

Management Response 2

HR and Finance agree with this recommendation. Steps have already been taken to begin identifying the reports in the portal and information needed by both departments. Reconciliations will begin immediately while the departments review and assess the other reports in the portal. Cigna has agreed to include performance guarantees beginning on July 1, 2019, and we will consider including performance guarantees in future contracts.

Target Implementation Date: September 30, 2019

3. Health Care Cost Management

Condition

The health care cost data currently available to senior management is not contained within a single report that is readily accessible. Comprehensive information is required so that management is able to make informed decisions regarding the overall cost effectiveness of the self-insured plan, identify areas of variations from anticipated costs, and potential areas for cost savings.

The Gehring Group provides a monthly “Self-Insured Medical Claims Experience report”, based on information provided by Cigna. This report provides much of the medical, HRA, and pharmacy cost information, but does not include information related to a full cost calculation of the program such as the EHC.

Criteria

Management should have access to relevant and reliable data that is compiled into quality information to assist the City in achieving its objectives regarding employee health care. Management should be working with all third party-providers to provide data in a manner that will enable senior City managers to fully execute the management and cost-containment/savings potential of a self-insured health care model.

Cause

Management relies on the information provided by Cigna, Gehring Group, and TCMA for monitoring health care costs, in addition to reports available through Oracle. Internal cost monitoring procedures provide fragmented reports that do not provide one comprehensive report on all cost components of the program.

Effect

Senior City management is relying on their third-party vendors for a significant amount of information regarding the costs of the health care program. Without a unified report of all the program cost elements, the information available is of limited use for financial and strategic planning.

Recommendation 3

The Human Resources Department, with input from the Finance Department, should prepare and submit to senior City management an annual full-cost report of the health care cost. The report should be presented electronically in an easy-to-read format and include claims, administrative fees (including stop loss premiums, capitation costs), costs incurred through the Employee Health Center budget, cost for the opt-out program and the HRA incentive.

Management Response 3

HR agrees with the recommendation and will work with the Finance Department to prepare a full cost report on the 2018-2019 plan year by December 2019.

Target Implementation Date: December 2019

4. Contractual Limitations

Condition

Contractually, the City is permitted to conduct an audit of claims processed by Cigna. However, certain conditions in the contract or matters of practice, created challenges in reviewing claims as follows:

1. Auditors must be approved by Cigna prior to beginning a claims review audit.
2. Cigna requires an onsite claims review which is limited to 5 days at 1 of 3 locations in the United States - none of which are in Florida.
3. The sample selection size is contractually limited to 225 claims, of which the contract prohibits extrapolating results to the entire population, whether or not the sample size is statistically valid.
4. Cigna utilizes an audit client manager to act as a facilitator during the onsite claims review though this person has no knowledge of the City's contract with Cigna. We acknowledge that they were instrumental in scheduling the onsite claims review, escalating questions, and assisting as much as possible.
5. Once onsite, Cigna provides a technical adviser to assist auditors in learning how to navigate their system which is a much older DOS system. This technical adviser also does not have knowledge of the City's Contract with Cigna. Considering that Cigna only allows 5 days onsite, much of that time can be spent simply learning how to navigate the system, let alone clearing exceptions. Again, we acknowledge that the technical adviser was very helpful and ultimately assumed the role of navigating the system. This assistance was critical to completing the onsite claims review.
6. We requested certain claims processing results from Cigna. However, Cigna advised that the City's current contract does not have ongoing performance guarantees in place, thus the reports were not available for us. We requested samples of performance guarantees that Cigna could provide had they been negotiated in the contract. Cigna provided the following sample of performance guarantee metrics that the City could work to implement in future contracts:
 - a. Financial Accuracy – 99% of total audited claim dollars are correctly paid (evaluates overpayments & underpayments). Note: Quality is based on a quarterly post payment stratified audit program.
 - b. Payment Accuracy – 97% of total audited claims correctly paid (evaluates claim payment accuracy) Note: Quality is based on the quarterly post payment stratified audit program.
 - c. Processing Accuracy – 95% of total audited claims correctly processed (evaluates payment & non-payment errors) Note: Quality is based on the quarterly post payment stratified audit program.
 - d. Procedural (coding) Accuracy – 97% of total audited claims correctly processed without a non-payment/coding error. Note: Quality is based on the quarterly post payment stratified audit program.

The current limitations in the City's contract with Cigna, create challenges for independent reviews as well as proper monitoring and administration of claims processed. We also acknowledge that Cigna is a large company likely dealing with many audits on a continuous basis and that there is a need to manage all the audits that their clients may request efficiently. However, considering that the City paid Cigna about \$843,000 during the audit period to manage the City's claims, it would be beneficial for the City to negotiate better terms.

Criteria

The City is responsible for administration and management of the Health Insurance Program including ensuring that claims are paid timely to the appropriate plan members. Further, the City's contract with the Gehring Group (insurance broker) states in relevant part that their services shall include but are not limited to:

- Assist the City on a regular basis and in a timely manner to provide information, analysis, and guidance on any and all aspects of City benefit program policy and administration.
- Assist with the development of contracts with vendors.
- Advise and assist the City in negotiating renewal rates and plan provisions.
- Conduct any required negotiations of benefits, plan design, premium rates, and performance guarantees.

Cause

As a major insurance provider, Cigna has a much stronger bargaining position when entering into contractual agreements. Therefore, the City may have challenges when negotiating for better terms with Cigna.

Gehring Group's contractual relationship with the City is that of an insurance broker that researches health care options and assists the City in negotiating terms on behalf of the City. Thus, there may be opportunities for the Gehring Group to assist the City. However, it should be noted that contractually the Gehring Group is paid on a commission basis from vendors (in this case Cigna) selected by the City to provide insurance services. This appears to be a common practice in the industry.

Effect

Certain information necessary for full monitoring of services rendered and claims processed may not be provided such that City management may not have all relevant information to assist them in making decisions about the health care program and its third party administration. Without complete claims processing information and metrics, the City may not have all relevant information to assess the results of the health care program.

Recommendation 4

HR should work with the Gehring group to enhance the services provided particularly as related to advising and assisting the City in negotiating provisions within Health care contracts. The Gehring group should, in conjunction with HR and other stakeholders, identify contractual provisions to incorporate in future contracts that would benefit the City

and provide assurances that quality services are provided particularly from third party administrators. This should include performance guarantees as Cigna may be open to track and monitor its performance and provide those results to the City.

Management Response 4

HR agrees with the recommendation and will work with the Gehring Group and Cigna during the next contract extension or RFP period on negotiating performance guarantees into a new contract. Currently, Cigna has agreed to include performance guarantees beginning on July 1, 2019, which is the start of the next plan year that the City has already contracted with Cigna.

Target Implementation Date: July 1, 2020

5. Internal Control Review

Condition

Although the City's insurance benefits eligibility and claims administration processes include some internal controls necessary for the achievement of operational objectives, our assessment of best practice controls resulted in a number of observations and recommendations designed to further strengthen the system of controls.

We performed inquiries to identify and verify the design and implementation of key controls for benefits eligibility and claims administration. We then compared the internal control activities performed by the City to 12 commonly used internal controls, and noted any existing gaps between the best practice controls and the City's current state as follows (Exhibit 1 - Medical Benefits Controls Matrix details this information):

- Seven controls (1, 5, 6, 8, 9, 11, and 12) did not have any gaps.
- Two controls had gaps, but have already been addressed through other report findings (see controls 2 and 10).
- Three controls had gaps that have not been addressed in other report findings (see controls 3, 4, and 7). These gaps include:
 - Performance guarantees: The City's current service agreement with Cigna does not include a clause for performance guarantees. Cigna offers performance guarantees as an added service, and Cigna only issues performance information if performance guarantees are included in the service agreement. See Exhibit 1, best practice control #3. Without performance results, management is unable to assess Cigna's performance on a continuous basis.
 - Service Organization Control (SOC) report: Although the City's Benefits Officer requested and obtained Cigna's SOC Report for the period ended September 30, 2018, management has not reviewed the report widely to determine whether the City's Complimentary User Entity Control Considerations (CUEC), as disclosed in the report, are adequate. See Exhibit 1, best practice control #4. Without a thorough review of the City's (user entity) CUEC controls as itemized by Cigna, the City is not aware of all the controls that the City should implement so that Cigna is able to achieve its control objectives as a service organization provider to the City.
 - Policies and Procedures: The City has not developed documented policies and procedures for activities such as enrollment for medical benefits, changing employee benefit status, and terminating employees from the medical plan. See Exhibit 1, best practice control #7.

Criteria

Management is responsible for the establishment of performance measures and indicators so that analyses of relationships can be made and appropriate actions taken. Best practices in the management of self-insured programs require the application of cost containment measures to maximize savings. Analysis and greater utilization of program data can help reduce costs, increase employee health outcomes, and prompt changes to the City's and Cigna's health related programs and services.

Cause

The City has not undertaken a best practice controls analyses in the past to evaluate internal controls associated with benefits management.

Effect

The City may miss opportunities to reduce health care costs and improve health outcomes of its members.

Recommendation 5

HR Management should take measures to close the gaps between recommended practices and the current state (see Exhibit 1) as follows:

- a. Performance guarantees: Ensure that future service contract renewals include access to performance guarantee data. Management should use this data to guarantee the full and complete performance under the contract. Once this process is established, management should document the ownership of each of the performance guarantees and investigate variances when they occur.
- b. Service Organization Control: Establish a committee of HR, IT and Finance representatives to evaluate Cigna's Service Organization Control (SOC) report. Specifically, determine whether there are any Complimentary User Entity Controls (CUECs) that need to be implemented by the City. The review of the Cigna SOC report should be documented and a crosswalk of the CUEC's to the City's internal controls should be developed.
- c. Policies and Procedures: Develop policies and procedures such as those related to enrollment, changing benefits, and terminating employees.
- d. Key Performance Indicators: Work with the Gehring Group to develop key performance indicators that are deemed essential for the City's ability to plan and manage healthcare costs. Exhibit 2 provides examples of applicable metrics.

Management Response 5

HR agrees with this recommendation. Our goal is to work with Cigna and provide annual SOC reports to City management. This coincides with the time when it is also provided to the outside auditor. As mentioned in different findings, Cigna has agreed to include performance guarantees beginning on July 1, 2019. We will continue to work on performance guarantees for future contracts as well as developing policies and procedures as described in the recommendation.

Target Implementation Date: January 31, 2020

Claims Audit Testing Results

Overall Results

Based on the claims testing results and the review of Cigna’s most recent SOC report, we noted that Cigna has internal controls in place to ensure that it adequately pays medical claims for the City. We encountered one scope limitation in that one of the provider contracts requested for one of the tests, was not made available by Cigna.

Detailed Results

During the audit period there were over 112,000 claims processed. Contractually, we were limited to a sample size of 225 claims which we randomly selected from a data file provided by Cigna. Our review of the selected claims included testing of 9 attributes in 3 areas as described below.

1. Testing of certain attributes for all claims within the 225 randomly selected claims. The attributes tested and their results included:

Attribute Tested	Work Performed	Results
Attribute 1: Participant Eligibility at the Time Service was Provided	Verified that all the employees (participants) within the sampled claims were covered during the scope period.	No exceptions were identified.
Attribute 3: Duplicate Claims	Identified identical matches of participant, procedure code, and charged amount for every participant and for the same service date and provider identification. Every potential duplicate claim was researched with Cigna.	No exceptions were identified.
Attribute 5: Timelines in Claims Processing	Calculated the number of working days between the date the claim was received and the date the claim was paid for the sample of 225 claims and for the entire population.	Eighty-seven (87%) of the sampled claims were processed within 20 working days after the claim was received ¹ . Eighty-six percent (86%) of all the claims in the population were processed within 20 working days after the claim was received. Per Florida Statutes a health maintenance organization shall, within 20 days of receipt of the claim, pay the claim or notify a provider or designee if a claim is denied or contested.
Attribute 6: Coordination of	Verified that benefits were coordinated in those claims that presented another	No exceptions were identified.

¹ Of the remainder 13% of the sampled claims, 3% were processed between 21 to 35 days, 7% between 36 to 90 days, 2% between 91 and 120 days, and 1% in over 121 days.

Benefits with Secondary Insurer	primary or secondary insurance carrier (other than Cigna). Only one percent of the claim records had coordinated benefits both in the sample and in the population.	
Attribute 9: Allowability of Services	Selected 11 of 44 procedure code categories that are not allowed for payment under normal circumstances, and searched the entire sample to determine if the procedure codes were present.	Two (2) of the procedure codes not allowed in normal circumstances were found in the sample. Per Cigna, those codes were allowed for payment because they were considered medically necessary.

2. Targeted testing of claims within the 225 claims selected as a valid means for obtaining results in certain control areas. The attributes tested and their results included:

Attribute Tested	Work Performed	Results
Attribute 2: Accuracy of Payments by Cigna to Providers	Judgmentally selected 25 different medical service providers (16 facilities providers and 9 physicians) and confirmed the amount Cigna paid to the providers per contract stipulations after all adjustments were applied. (Cigna limits the provider review to 25.)	No provider overpayment or underpayment occurred; provider payments were accurate. We encountered one scope limitation in that one of the provider contracts requested for one of the tests, was not made available by Cigna.
Attribute 4: Accuracy of Deductibles and Co-Insurance Amounts	Judgmentally selected 33 (15%) of the sampled claims encompassing all plan types within the sample, verified that deductibles and co-payments were properly applied.	One exception was identified, but it was cleared because the member changed their plan which changed their deductible and coinsurance amounts.
Attribute 8: Denied Payments	Identified claim line items within the sample that were denied for payment in part or in full, and documented the reason for the denial.	All the denials identified were reasonable. The claim history showed that upon further research by Cigna, several of the claims that were denied at first, were subsequently paid.

3. Assessment of Administrative Services Fees

Attribute Tested	Work Performed	Results
Attribute 7: Accuracy of Administrative Fees Paid to Cigna	For two judgmentally selected months within the audit period, we calculated the administrative fee paid to Cigna in accordance with the contract and verified that the underlying data was accurate. We confirmed the number of participating employees used to calculate the administrative fee.	The calculation of the monthly administrative fee paid to Cigna was accurate for the two months tested.

Exhibit 1 - Medical Benefits Internal Controls

Best Practice Control	Current State	Gap Noted (Yes/No)	
Area: Eligibility			
1	Eligibility is tracked for employees to include an effective and termination date for eligibility, where applicable, on at least a monthly basis.	New or changes to benefit information flows from Oracle to BenTek to Cigna via interface. The interface to Cigna yields a report with discrepancies that are discussed and resolved. Audit and cross-checks between the Human Resources and the Benefits teams ensure that benefit changes are complete and accurate.	No.
2	Periodic reviews are performed to verify eligibility of employees, spouses, dependents.	There is no periodic tracking of dependents to determine whether eligibility has changed as a result of an unreported life change event.	Yes. See Finding 1.
Area: Vendor Selection and Monitoring Processes			
3	Monthly reviews are conducted to ensure performance guarantees within Cigna's contract are met.	The City's current service agreement with Cigna does not include a clause for performance guarantees. Cigna offers performance guarantees as an added service, and Cigna only issues performance information if performance guarantees are included in the service agreement.	Yes. See Finding 5.
4	Service Organization Control (SOC) reports are obtained and reviewed annually for the following: -Complimentary User Entity Control Considerations (CUEC) -Vulnerabilities within internal controls of the service organization and -Carve-out's for sub-service providers.	Although the City's Benefits Officer requested and obtained Cigna's SOC Report for the period ended September 30, 2018, there is not a concerted effort by City management to comprehensively determine, at minimum, whether the City's CUEC are complete and adequate.	Yes. See Finding 5.
5	Medical plans are periodically re-bid to ensure competitive pricing and maximization of services provided.	The City re-bids its medical plans every five years.	No.
6	A risk assessment is performed at least annually for the overall health status of the organization.	There is a formal process to periodically assess the overall health status that shows trends, and helps identify areas of higher risk where the focus of wellness and other programs and services should be placed.	No.

Best Practice Control		Current State	Gap Noted (Yes/No)
Area: Medical Benefits Plan Administration			
7	Formal documented policies and procedures have been developed for review and monitoring of medical plans.	The City has not developed formal documented policies and procedures for review and monitoring of medical plans, for activities such as enrollment for medical benefits, changing employee benefit status, and terminating employees from the medical plan.	Yes. See Finding 5.
8	The organization provides case management for high dollar claims to control health care costs and provide benefit management services to employees.	Cigna provides cost management services for high dollar claims.	No.
9	Educate employees in understanding the value of health-care benefits provided by existing plans such as; network provider discounts and prescription drug savings.	The City communicates changes to plans during open enrollment. Changes related to specific plans are communicated either via e-mail or informational session to affected plan holders. The City communicates information on wellness programs and discounts on prescriptions throughout the year. The City recently began communicating the value of the benefits received.	No.
10	Claims and activity are communicated to those responsible for governance periodically.	The health care cost data currently available to senior management is not contained within a single report that is readily accessible. Comprehensive information is required so that management is able to make informed decisions regarding the overall cost effectiveness of the self-insured plan, identify areas of variations from anticipated costs, and potential areas for cost savings of the self-insured health care model.	Yes. See Finding 3.
11	As changes occur within existing plans they are communicated to employees in a timely manner.	Plan changes are communicated through open enrollment annually. Informational sessions are also used to communicate changes and explain impacted benefits to employees.	No.
Area: Performance Metrics			
12	A process is in place to periodically gather and internally report performance metrics for the health claims administration function.	The City does obtain periodic performance metrics reports for health claims administration.	No.

Exhibit 2 – Examples of Applicable Performance Measures

- Average monthly cost of medical claims
- Average cost of claims per employee per month
- Average monthly cost of claims per member per month
- Total health care costs per year (with and without pharmaceutical)
- Average medical spend per employee per year
- Average medical spend per member per year
- Average out-of-pocket per member per year
- Total City contribution
- Total employee contribution
- Total medical spend per year
- Medical cost trend per year
- Catastrophic trend increase or decrease