OFFICE OF THE NEW YORK STATE COMPTROLLER

DIVISION OF LOCAL GOVERNMENT & SCHOOL ACCOUNTABILITY

Buffalo Sewer Authority

Internal Controls Over Health Insurance

Report of Examination

Period Covered:

July 1, 2005 — April 26, 2007

2007M-140

Thomas P. DiNapoli

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State of New York
Office of the State Comptroller

Division of Local Government
and School Accountability

November 2007

Dear Sewer Authority Officials:

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

Following is a report of our audit of the Buffalo Sewer Authority, entitled Internal Controls Over Health Insurance. This audit was conducted pursuant to the State Comptroller's Authority as set forth in Article X, Section 5 of the State Constitution.

This audit's results and recommendations are resources for authority officials in effectively managing operations and in meeting the expectations of taxpayers. If you have questions about this report, please feel free to contact the local regional office for your county, as listed at the back 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 expenditure for the Buffalo Sewer Authority (Authority). The cost of providing health insurance coverage to Authority employees and retirees has increased 69 percent over five years,[1] costing $3 million during fiscal year 2005-06.

The Authority provides health care coverage to its employees according to the provisions of collective bargaining agreements with the Communications Workers of America, AFL-CIO (CWA) and the Civil Service Employees Association, Inc., Local 1000, AFSCME, AFL-CIO (CSEA). Also, the Authority provides the same health care benefits that it provides to the CSEA employees to its exempt and managerial staff. The Authority offers several choices for health insurance coverage, some of which require contributions from employees or retirees toward the health insurance premiums. The Authority currently funds approximately 98 percent of health insurance premiums, while employees and retirees contribute the remaining 2 percent.

Scope and Objective

We examined health insurance records for the Authority for the period July 1, 2005 to April 26, 2007. The objective of our audit was to evaluate internal controls over the Authority'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 the health insurance bills for current and retired employees?

- Are adequate policies and procedures in place to ensure the timely collection of all insurance premium payments due to the Authority?

- Has the Authority initiated any other practices which have resulted in health insurance cost savings that other authorities and local governments may emulate?

Audit Results

Generally, the Authority has adequate health insurance billing and collection processes in place that are working effectively. However, the Authority lacks written procedures regarding the day-to-day

[1] From the 2000-01 fiscal year to the 2005-06 fiscal year. The Authority's fiscal year is from July 1 to June 30.

administration of health coverage for Authority employees, officials, and retirees. In addition, there are no controls in place to prevent management from allowing certain individuals to receive health insurance benefits that they are not entitled to. In our review of the health insurance records, we identified $134,885 in improper benefits extended to four Board members[2] ($87,000), four retirees[3] ($37,000), and three active employees[4] ($10,885). We also estimate that it could cost the Authority an additional $1.1 million to provide health insurance benefits to the four retirees in the future.

In addition, we found that Authority has not established policies or written procedures to periodically verify the status of retirees receiving health insurance benefits, and it does not have written policies or procedures concerning the collection of health insurance premium contributions from employees and retirees.

We commend the Authority for effectively using a cost-savings mechanism. We found that the Authority reduced its potential health insurance costs by approximately $218,000 for the fiscal year 2005-06 by offering a Payment in Lieu of Health Insurance Program (Program). We estimated that without the Program, the Authority would have paid out an additional $260,000 for health insurance premiums for the year; instead, it paid $39,180 in waiver payments to 30 individuals.

Comments of Authority Officials

The results of our audit and recommendations have been discussed with Authority officials and their comments, which appear in Appendix A, have been considered in preparing this report. Authority officials generally agreed with our recommendations and indicated they planned to initiate corrective action.

[2] During a two-year period, from the 2005-06 fiscal year to the 2006-07 fiscal year

[3] During the 2006-07 fiscal year

[4] During the 2005-06 fiscal year

Introduction

Background

The Buffalo Sewer Authority (Authority) employs approximately 220 employees. The Authority is a public benefit corporation that is authorized to borrow money, issue bonds and provide for their repayment, and fix and collect sewer rates and rentals. It has a Board which comprises five mayoral-appointed members. The Authority's General Manager is appointed by the Board and provides general supervision and direction for the Authority's business affairs. The City Comptroller serves as the Authority's comptroller.

The Authority provides health insurance coverage to approximately 375 current employees, officials, retirees, and surviving spouses, which cost the Authority $3 million for the fiscal year July 1, 2005 through June 30, 2006. This is an increase of $1.2 million or 69 percent over five years.[5]

The Authority's obligation to provide health care coverage has been established through collective bargaining agreements between the Authority and the Communications Workers of America, AFL-CIO (CWA) and the Civil Service Employees Association, Inc., Local 1000, AFSCME, AFL-CIO (CSEA). Through a Board resolution,[6] the Authority extended the CSEA contract benefits to the Authority's exempt and managerial staff. The Authority budgets for health insurance costs, including those for retirees, on an annual basis. Starting in 2007, the Governmental Accounting Standards Board (GASB) will require the Authority to provide a more complete reporting of "other post-employment benefit costs" (which includes health insurance) in their financial statements. Because of this GASB requirement, the Authority will be required to calculate the future estimated costs of its post-retirement obligations for its current employees and retirees.

For current and retired employees and officials, the Authority offers a choice of four health insurance plans: Univera, Independent Health, Community Blue,[7] or BlueCross BlueShield®. The Authority currently funds 98 percent of the total health insurance costs, while employees and retirees contribute the remaining 2 percent.

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[5] From the fiscal year July 1, 2000 through June 30, 2001 to the fiscal year July 1, 2005 through June 30, 2006

[6] The Authority extended the terms of the CSEA contract, for the period July 1, 2002 to June 30, 2005, to its exempt and managerial staff. The Authority continues to operate under this Board resolution, which was dated December 10, 2003.

[7] Univera, Independent Health, and Community Blue are health maintenance organization (HMO) plans.

Objective

The objective of our audit was to evaluate internal controls over the Authority'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 the health insurance bills for current and retired employees?
- Are adequate policies and procedures in place to ensure the timely collection of all insurance premium payments due to the Authority?
- Has the Authority initiated any other practices which have resulted in health insurance cost savings that other authorities and local governments may emulate?

Scope and Methodology

We examined health insurance records for the Authority for the period July 1, 2005 to April 26, 2007.

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 B of this report.

Comments of Local Officials and Corrective Action

The results of our audit and recommendations have been discussed with Authority officials and their comments, which appear in Appendix A, have been considered in preparing this report. Authority officials generally agreed with our recommendations and indicated they planned to initiate corrective action.

The Authority has the responsibility to initiate corrective action. Pursuant to Section 35 of the General Municipal Law, the Authority should prepare a plan of action that addresses the recommendations in this report and forward the plan to our Office within 90 days. For guidance in preparing your plan of action, you may refer to applicable sections in the publication issued by the Office of the State Comptroller entitled *Local Government Management Guide*. We encourage the Authority to make this plan available for public review in the Clerk's office.

Inappropriate Benefits

The Authority provides health insurance as an employee benefit. To maintain control over the cost of providing this benefit, and to operate in a fair and equitable manner, it is important that the Authority provide health care coverage only to those individuals who are entitled to the coverage. In addition, individuals who are contractually responsible for paying a portion of their premiums must pay the appropriate amount to the Authority in a timely manner.

In our review of the health insurance records for five Board members, 63 retirees, and seven active employees, we found that the Authority provided enhanced benefits to four Board members, three active employees, and four retirees beyond those provided for by Public Authorities Law or through collective bargaining agreements. We identified $134,885 in improper benefits.

Board Member Health Insurance

Public Authorities Law provides that authority board members are to be compensated at a fixed dollar amount[8] for each full year of service, and be reimbursed for their actual and necessary expenses incurred in the performance of their official duties. The term "compensation" refers to the total consideration paid to an officer or employee for his of her services, including wages and authorized benefits. Therefore, any additional fringe benefits provided to board members are not allowed.

The Authority provides health insurance benefits to four of its five Board members. The cost to the Authority to provide this benefit to its Board members was approximately $87,000 for the two-year period July 1, 2005 through June 30, 2007. However, the Board members' total compensation from the Authority for these two years included $22,000 in salaries and the $87,000 for the health insurance benefits, totaling $109,000. This situation resulted in the Authority paying $87,000 more than it should have in compensation for these Board members.

Authority officials told us that it is a past practice to provide Board members with health insurance coverage. However, we did not identify any provision in the Authority's enabling act, or any other State statute, that would authorize the Authority to do so. Therefore, the Authority may not provide this benefit to its Board members.

[8] Annual compensation is $2,500 for each Board member and $3,500 for the Chairman of the Board.

Years-of-Service Requirement

As defined in the collective bargaining agreements since 1998,[9] the Authority has had a minimum years-of-service requirement for retirees to be eligible for health insurance benefits. The CWA contracts covering the periods July 1, 1998 to June 30, 2002 and July 1, 2002 to June 30, 2007, and the CSEA contract covering July 1, 1998 to June 30, 2002, each required 10 years of continuous service with the Authority to be eligible for retiree health benefits. The subsequent CSEA contract, which was effective July 1, 2002 to June 30, 2006, required five years of continuous service for such benefits.

We reviewed the eligibility of 63 retirees receiving health insurance benefits from the Authority during the 2005-06 fiscal year, comparing the contract requirements to the actual years-of-service for all Authority retirees who are subject to those requirements, and found that four individuals were not eligible to receive these benefits from the Authority.

Position	Union	Requirement	Start Date	Retirement Date	Actual Years of Service
Millwright	CWA	10 years	11/5/1990	9/3/1998	7 years
Executive Secretary	CSEA	10 years	4/5/1993	12/30/2000	7 years
Operator	CWA	10 years	5/22/1995	1/20/2001	5 years
Special Assistant	Exempt[a]	5 years	3/19/2001	4/4/2004	3 years

[a] According to a Board resolution dated 12/10/2003, the Authority extended the terms of the CSEA contract covering the period 7/1/2002 to 6/30/2005 to its exempt and managerial staff.

We estimate that the current annual cost to the Authority to provide coverage to these four individuals is approximately $37,000. The Authority has already paid the health insurance premiums for these individuals for varying amounts of time, ranging from three to almost nine years. Using life expectancy tables published by the New York State Department of Health and projected health insurance cost increases from the U.S. Department of Health and Human Services, we estimate that it could cost the Authority an additional $1.1 million to provide health insurance benefits to these individuals in the future.

No Contributions

The Authority pays for the entire premium costs for active employees who were hired before July 1, 2003 (CSEA employees) or June 1, 2006 (CWA employees) if they select Univera, Independent Health, or Community Blue as their health insurance provider. Employees

[9] The CWA contract covering July 1, 1993 to June 30, 1998 refers to the retiree health insurance benefits contained in the CSEA contract. However, the CSEA contract for the period July 1, 1993 to June 30, 1995 does not include any information on retiree health insurance benefits, and Authority officials did not provide us with the subsequent CSEA contract.

who choose BlueCross BlueShield as their health insurance provider must pay a portion of the health insurance premiums.[10]

We identified and reviewed the seven active employees receiving health insurance benefits from the Authority during the period July 1, 2005 to June 30, 2006 who were contractually required to contribute toward their health insurance premiums. Four of them are exempt employees operating under the terms of the CSEA contract and three are CWA employees. We found that the exempt employees contributed the appropriate amounts toward their health insurance premiums during 2005-06 through payroll deduction. However, we found that the three CWA employees were not making the required contributions toward their health insurance premiums.

The three individuals each chose BlueCross BlueShield, a plan for which they are contractually required to contribute toward the premium. In accordance with the terms of their contract, the required contributions from these three employees totaled $10,885 for fiscal year 2005-06. Authority officials told us that these individuals were "grandfathered in" and deemed exempt from premium contributions due to extreme medical conditions, and that this was part of the union agreement. However, we found that neither of the Authority's collective bargaining agreements provided for such exemptions, nor did previous contracts that we reviewed.

Although the personnel files for these individuals referred to a "Memorandum of Agreed Changes" that would allow employees to petition the Authority for "continued coverage" in the case of an extreme medical condition, Authority officials could not provide us with a copy of the referenced "Memorandum of Agreed Changes." In addition, the Memorandum was not included in the body of, or as an amendment to, the collective bargaining agreement. Authority officials also did not provide us with any supporting documentation that the Board authorized or directed that unique health insurance provisions be extended to certain individuals.

Recommendations

1. The Board should develop adequate monitoring procedures to identify whether Authority management has provided benefits beyond those required by the Public Authorities Law and employee agreements. Also, the Board should ensure that Authority officials implement these procedures.

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[10] The collective bargaining agreements with the two unions include specific hiring dates that govern whether employees must provide contributions toward their health insurance premiums. Required contribution amounts also are included in the agreements. CSEA employees may choose the BlueCross BlueShield Indemnity plan, and CWA employees may choose the Blue Cross Traditional plan.

2. Authority officials should ensure that only individuals who are eligible to receive health insurance benefits are receiving these benefits.

Health Insurance Billing and Premium Collection

An adequate system of internal controls over health insurance ensures that health insurance is provided only to those individuals for whom the benefit is authorized, and that premium payments from employees, retirees, and COBRA participants are regularly examined for accuracy and timeliness. Additionally, it is important for Authority officials to maintain proper segregation of duties, as explained by clearly written job descriptions, to ensure that no single individual controls all phases of a transaction. The Board is responsible for establishing and maintaining a system of internal control and executing direct oversight of the management of the Authority. The Board depends on the General Manager to effectively manage the Authority's daily operations.

In general, we found that the Authority has adequate health insurance billing and collection processes in place, and these processes are operating effectively. There is an adequate segregation of duties between the collection and recordkeeping functions, and employee and retiree premium contributions were generally made in accordance with their respective collective bargaining agreements. However, we found that Authority has not established policies or written procedures to periodically verify the status of retirees receiving health insurance benefits, and it does not have written policies or procedures concerning the collection of health insurance premium contributions from employees and retirees.

Retiree Verification

Good internal controls for verifying the accuracy of health insurance bills involves monitoring the eligibility status of retirees. The Authority has not established policies or written procedures to periodically verify the status of retirees receiving health insurance benefits. For retirees who choose the Authority's base insurance plan through Independent Health, there is no premium contribution requirement and, therefore, no real incentive for them (or their spouse) to notify the Authority of a change in status.

Currently, the Authority provides health insurance coverage to 149 retirees,[11] their surviving spouses and in some cases, their eligible dependents. The Authority's Senior Administrative Assistant, who administers health insurance benefits, told us that she periodically reviews the obituary listings in the local newspapers to identify covered individuals who may have died. In addition, the Authority receives a letter from the New York State Employee's Retirement

[11] There are 163 retirees; 14 waive insurance coverage from the Authority.

System when a former employee receiving a State pension has died. Authority officials are often notified of the death of a retiree or their spouse through word-of-mouth among current employees. While the Authority is able to obtain certain information using these methods, these methods alone are not sufficient to identify the current status of enrolled retirees.

Due to the lack of written policies and procedures, and the number of retirees that the Authority provides coverage for, we performed tests to determine if covered retirees and their spouses were still alive. We compared a list of all retirees and their spouses, totaling 232 individuals, against the Social Security Administration's Master Death Index and found no exceptions. However, we were unable to use this method for 15 retirees' spouses because their social security numbers were not available. Consequently, there is a possibility that the Authority could be paying for health insurance premiums for individuals who are deceased.

Employee Premium Contributions

A good system of internal controls over health insurance benefits includes the development and implementation of written policies and procedures for the collection of health insurance premium contributions from employees and retirees. It is important for these policies to include explanations of procedures for staff to follow to ensure that premium payments are accurate and collected in a timely manner. The Authority does not have written policies or procedures for the collection of health insurance premium contributions.

Employee and retiree contributions are established by the terms of their respective collective bargaining agreements and the rates set by the health insurance providers. An Authority official told us that she calculates contribution amounts based on updated rates from the HMOs, which are effective July 1. However, the rates for BlueCross BlueShield are subject to change every six months, in January and July each year. Therefore, contribution amounts for BlueCross BlueShield coverage need to be revised whenever rates are changed by the providers.

Premium contributions for current employees are processed through payroll deduction. During 2005-06, there were seven active employees who were required, by the terms of their union contracts, to contribute toward their health insurance premiums. We tested the accuracy of the amounts being withheld and found that four individuals had the correct amounts withheld and three did not contribute any amount toward their premiums (refer to the Inappropriate Benefits section for further information).

Retirees' contributions are deducted from their monthly pension payments by the New York State Employee Retirement System, as agreed to by the retiree, and forwarded to the Authority. We compared actual reductions from retirees' pension payments, according to monthly retirement reports, to required contribution amounts that were calculated in accordance with their respective bargaining agreements. We found that the amounts were generally correct with the exception of some minor inconsistencies resulting from mid-year rate changes. These errors were identified and corrected by the Authority's health insurance administrator.

Recommendations

3. Authority officials should document all procedures for health insurance payment processing including retiree verification and employee premium contributions.

4. Authority officials should consider sending out periodic data requests to all employees and retirees. Such data requests should be used as a means of updating the Authority's records and capturing various changes in household status.

Cost Savings Practices

Health insurance is a significant cost for local governments. The Office of the State Comptroller recognizes the increasing burden these costs have on municipal budgets and has published a brochure entitled "Containing Employee Health Insurance Costs." This brochure contains useful information on such topics as Payments in Lieu of Health Insurance. Municipal officials are encouraged to read this booklet to identify additional means to reduce these costs. Any successful efforts by a municipality to reduce health insurance costs should be explored and emulated by other local governments.

The Authority currently offers a Payment in Lieu of Health Insurance Program (Program), the terms of which are defined in the collective bargaining agreements. If an employee or retiree can demonstrate that they have alternate insurance coverage, they are eligible for waiver payments from the Authority. During fiscal year 2005-06, waiver payments for CSEA employees varied depending on the level of health insurance coverage they were entitled to (i.e., single, double, or family coverage). CWA employees receive the same waiver amount whether they were entitled to single, double or family coverage.

We found that the Authority reduced its potential health insurance costs by approximately $218,000[12] for the fiscal year 2005-06 by offering this program. We based our calculations on average premium costs for each coverage level and the type of coverage each waiver recipient was entitled to. We estimated that without the Program, the Authority would have paid out an additional $260,000 for health insurance premiums for the year; instead, it paid $39,180 in waiver payments to 30 individuals.

Recommendation

5. Authority officials should periodically assess the effectiveness of the health insurance waiver program to ensure that they are optimizing their savings.

[12] We calculated these savings by subtracting waiver payment amounts, and FICA expenses on those amounts, from the estimated additional health insurance costs that the Authority would have paid for these individuals ($260,000 - $39,180 - $2,997= $217,823).

APPENDIX A

RESPONSE FROM AUTHORITY OFFICIALS

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

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November 14, 2007

[redacted] Local Government and
School of Accountability
State of New York
Office of the State Comptroller
110 State Street
Albany, New York

Health Insurance

This administration had only been here six months when the State audit started. We were still learning about many of the problems and/or differences in philosophy from the previous administration and instituting new policies.

During the audit process, I wanted to know immediately of any deficiencies; so, I had ongoing discussions with your assigned auditors. We changed those policies we could immediately upon notice of deficiencies.

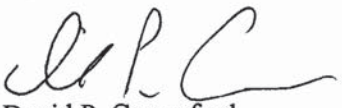
The following areas were identified in the Health Insurance area:

- Board Member Health Insurance - I have spoken to our attorney and he will give an opinion. Upon receipt, I will provide this opinion to you and our actions to address it.
- Years-of-Service Requirement - The prior administration allowed four individuals to retire and collect full medical benefits without working the appropriate number of years with the Authority. Because they retired with the General Manager and Board approval and probably wouldn't have done so otherwise, I don't think there is anything we can do about it. However, I have submitted this for a legal opinion, as well. The practice will not continue.

- No Contributions - There were three individuals who continue to receive traditional Blue Cross/Blue Shield even though they do not pay into it. This accommodation was made for them in the prior administration as a quid pro quo for the entire union accepting the new HMO's. These three individuals had extreme medical conditions that wouldn't be covered under the new HMO plans. Taken individually, it seems that the Authority favored three individuals. Taken in the context of contract negotiations and the amount of money saved by switching all employees from Traditional to HMO's, this was a wise business decision.
- Retiree Verification – During the course of the audit, this was identified to us and we have developed a policy whereby each active or retired employee must complete an enrollment application each year verifying coverage information.
- Cost Saving Practices – We looked into this and feel we are paying a competitive in lieu of payment that encourages waivers, yet saves the Authority money.

Very truly yours,

BUFFALO SEWER AUTHORITY



David P. Comerford
General Manager

APPENDIX B

AUDIT METHODOLOGY AND STANDARDS

We conducted an audit of the Authority's health insurance program to determine if adequate controls are in place and to identify cost-savings opportunities that the Authority may be using to offset rising health insurance costs. To accomplish this we interviewed Authority officials, reviewed current contracts, and examined insurance billing records, personnel files, minutes of the proceedings of the Board, and other relevant documents maintained by the Authority. The following are specific techniques we used:

- For current employees, we examined current contracts and for retirees we obtained the contracts in place at the time of the individual's retirement. We then compared these individuals' benefits and premium costs with the applicable contract to determine compliance. If exceptions were noted, we used current insurance rates and estimates to quantify the impact on the Authority.

- We also conducted a test to determine if all retirees and spouses are currently living. We acquired social security numbers through insurance billing records and employee personnel records for retirees, retirees' spouses, and surviving spouses, and compared 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 that the Death Master File is accurate.

- For all employees and retirees required to contribute toward their premiums during fiscal year 2005-06, we verified the accuracy of premium payments per contract stipulations by examining recent payroll records, health insurance billing records, retirement reports, and Authority spreadsheets. We also assessed the effectiveness of the Payment in Lieu of Health Insurance Program by analyzing payments made, reviewing applicable contract provisions, and interviewing applicable Authority officials.

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 C

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