

EMPLOYEE BENEFITS OFFICE

OCTOBER 17, 2000

REPORT NO. 512

**OFFICE OF THE COUNCIL AUDITOR
AUDIT OF THE EMPLOYEE BENEFITS OFFICE
REPORT #512**

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OFFICE OF THE COUNCIL AUDITOR
Suite 200, St. James Building



October 17, 2000

Report No. 512
Executive Summary

Honorable Members of the City Council
City of Jacksonville

INTRODUCTION

Pursuant to Section 5.10 of the Charter of the City of Jacksonville and Chapter 102 of the Jacksonville Municipal Code, we examined the activities of the Employee Benefits Office of the City of Jacksonville and present this report thereon.

The Employee Benefits Office is an activity of the Risk Management Division for the City of Jacksonville. The Office is responsible for the solicitation, evaluation, purchase, communication, orientation, enrollment, premium collection, implementation, monitoring and maintenance of all Employee Benefits programs. Participants in benefits programs include all active employees of the City, the Jacksonville Housing Authority (JHA), the Northeast Florida Regional Planning Council, the First Coast Workforce Development, Inc., and their covered dependents. The programs may also cover City (and some State) retired employees, former elected officials, Consolidated Omnibus Budget Reconciliation Act (COBRA) participants, and associated covered dependents.

The Employee Benefits Office provides and manages the following benefits: group health insurance, group employee and retiree term life insurance, group dental insurance, group vision insurance, group legal activities, the Section 457 deferred compensation plan, State and Federal statutory life benefits, flexible spending accounts, dependent life insurance, hospital income insurance, pre-tax deductions, and Fraternal Order of Police (FOP) heart/hypertension benefits.

STATEMENT OF OBJECTIVES

The objectives of the audit were as follows:

1. To determine if Group Health Insurance participants are eligible recipients and if the premiums being paid to the providers are correct.
2. To determine if Group Life Insurance claims are being properly processed and documented.
3. To determine if Deferred Compensation benefits are being properly processed and documented.
4. To determine if the FOP Heart/Hypertension benefits are being properly processed and documented.

5. To determine if manual payments received by Employee Benefits are being properly processed and documented.
6. To determine the efficiency and effectiveness of the electronic enrollment process for the benefits period beginning January 1, 2000.

STATEMENT OF SCOPE

The audit period of our examination was January 1, 1999 through December 31, 1999.

STATEMENT OF AUDITING STANDARDS

We conducted our audit in accordance with generally accepted government auditing standards issued by the Comptroller General of the United States. Those standards require that we plan and perform the audit to afford a reasonable basis for our judgements and conclusions regarding the organization, program, activity, or function under audit. This audit also included an assessment of applicable management controls and compliance with requirements of laws and regulations when necessary to satisfy audit objectives. We believe that our audit provides a reasonable basis for our conclusions.

AUDIT CONCLUSIONS

1. Based on our testing, the premiums paid to the health insurance providers were materially correct; however, we could not determine if all of the group health insurance participants were eligible recipients because Employee Benefits does not require documentation for all dependents.
2. It appears that life insurance claims are being properly processed, but are not being properly documented for all claims.
3. Deferred Compensation benefits were properly processed and documented.
4. The FOP Heart/Hypertension benefits are being properly processed and documented; however, we did note an internal control weakness in the area as stated later in the report.
5. Manual Payments are not being properly processed and documented.
6. Numerous errors and problems, many of which were beyond the control of Employee Benefits, negatively impacted the efficiency and effectiveness of the electronic enrollment process.

In addition to the above audit conclusions, we noted numerous internal control weaknesses at Employee Benefits which are stated later in the report.

Respectfully submitted,

Robert O. Johnson, CPA
Council Auditor

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Suite 200, St. James Building



October 17, 2000

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City of Jacksonville

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6. To determine the efficiency and effectiveness of the electronic enrollment process for the benefits period beginning January 1, 2000.

STATEMENT OF SCOPE

The audit period of our examination was January 1, 1999 through December 31, 1999.

STATEMENT OF METHODOLOGY

For each audit objective we used a specific method to determine the items we would test for our audit period. All random samples were selected using the Stats computer program. In the testing of group health insurance benefits (audit objective 1) we first selected two random months for testing. We obtained the eligibility lists for these two months and randomly selected page numbers from the lists for testing. We then took a block sample of the third, fourth and fifth persons listed on each page of the eligibility list. In order to test terminations of group health benefits we randomly selected two pay periods from our audit period. For those two pay periods we obtained the list of terminated employees. We then used a random sample obtained from these two pay periods for testing. For the testing of life insurance benefits (audit objective 2), we requested that all of the life insurance providers give us a list of all claims paid during 1999. From these lists, we took a random sample of persons for testing. To test the persons on waivers of premium for life insurance benefits, we determined all of the persons that were stated by Employee Benefits as being covered under the waiver and selected a random sample from these persons. To test deferred compensation benefits (audit objective 3) we randomly selected four pay periods during the audit period for testing. We then pulled the files for these four pay periods and judgmentally selected every third person in the folders for testing, beginning with a random start. To test the FOP heart/hypertension benefits (audit objective 4) we pulled a list of all of the FOP heart/hypertension checks that were written during the audit period from the City's FAMIS accounting system. We then pulled a random sample of checks to test from the total population of checks. To test manual payments received by Employee Benefits (audit objective 5), we first tested the individual persons who make manual payments for benefits. We selected a random sample of persons from the default payroll report for two months (four pay periods). Due to findings in this area, we judgmentally selected more individuals making manual payments for testing from the population of ledger cards. To test manual payments made by the three outside agencies we tested the same months as those randomly selected for individual payments. To determine the effectiveness and efficiency of the electronic enrollment process (audit objective 6), we asked the Employee Benefits Office and the Information Technology Division (ITD) to compile information for us concerning the problems that were encountered with the open enrollment in 2000. We also compared the number of overtime hours from the 2000 electronic enrollment to those associated with the 1999 re-enrollment and the 1995 open enrollment.

STATEMENT OF AUDITING STANDARDS

We conducted our audit in accordance with generally accepted government auditing standards issued by the Comptroller General of the United States. Those standards require that we plan and perform the audit to afford a reasonable basis for our judgments and conclusions regarding the organization, program, activity, or function under audit. This audit also included an assessment of applicable management controls and compliance with requirements of laws and regulations when necessary to satisfy audit objectives. We believe that our audit provides a reasonable basis for our conclusions.

AUDIT CONCLUSIONS

1. Based on our testing, the premiums paid to the health insurance providers were materially correct; however, we could not determine if all of the group health insurance participants were eligible recipients because Employee Benefits does not require documentation for all dependents.
2. It appears that life insurance claims are being properly processed, but are not being properly documented for all claims.
3. Deferred Compensation benefits were properly processed and documented.
4. The FOP Heart/Hypertension benefits are being properly processed and documented; however, we did note an internal control weakness in the area as stated later in the report.
5. Manual Payments are not being properly processed and documented.
6. Numerous errors and problems, many of which were beyond the control of Employee Benefits, negatively impacted the efficiency and effectiveness of the electronic enrollment process.

In addition to the above audit conclusions, we noted numerous internal control weaknesses at Employee Benefits which are stated later in the report.

AUDIT OBJECTIVE #1

In order to determine if Group Health participants were eligible recipients and the premiums being paid to providers were correct, we selected a sample of persons from the eligibility list that supports each request for each insurance provider for two randomly selected months. Within our sample we verified that the individuals were eligible to receive the benefit by insuring that the persons worked for or were retired from an eligible employer, were a surviving dependent of an eligible individual or were covered under COBRA. We also verified the reasonableness of dependents covered under the individuals by examining birth dates for reasonableness. We examined last names and for any that were not the same as the participant, we pulled the file to examine documentation of eligibility as a dependent. We also confirmed with insurance representatives that any dependent children over the age of nineteen were eligible

dependents. In addition, we verified that the premium being paid for the individual was the correct amount.

We also tested a sample of terminated employees to verify that the terminated employees were not included in the eligibility list for the premium paid to the provider for that period. In testing terminated employees we examined the termination date per the Employee Status Record (ESR) and compared it to the date when the benefits codes were turned off to determine if the City paid premiums beyond the termination date.

Our audit findings and recommendations for Objective #1 are as follows:

Finding #1

We tested 353 persons from the eligibility lists to determine that the dependents covered under the person had birth dates that were reasonable. We found one exception in which the birth dates of the dependents were not reasonable and there was no documentation (birth certificates or adoption certificates) in the file to explain the unreasonable dates.

Recommendation #1

We recommend that Employee Benefits establish procedures to document dependent eligibility for all dependents. For this particular person, Employee Benefits should obtain additional documentation to determine that the dependents are eligible for coverage.

Auditee's Response to Finding #1

The file addressed indicated that dependents had the same last name as the employee; however, the birth dates were different on separate enrollment documents completed in different years. They were off by days of birth and years of birth on the documents. We find that this occurs many times when the father completes a form for dependent children. In this instance, the father was the divorced parent of children living with their mother. He chose to drop them off the plan because he did not have their birth certificates and did not wish to obtain new ones from the Bureau of Vital Statistics. The children were already covered by the mother's insurance plan. It has not been city policy to require employees who have been on the plans for many years to submit proof of eligibility on a spouse and/or children who have been covered, sometimes for 10 - 20 years. It is impossible to require this during an open enrollment because of the volume of enrollments, unless we detect a problem; however, we will begin requesting the information based on a random sampling of our population, as we discussed in our meeting with the auditors.

Finding #2

We tested 353 persons from the eligibility lists to determine that the dependents had the same last name as the employee, or had documentation in the file verifying that the children were eligible dependents. We found that eight of the 353 (2.3%) persons (a total of eleven dependents) had dependents with different last names, but did not have proper documentation of those dependents in the file.

Recommendation #2

We recommend that Employee Benefits request documentation from those persons to verify their dependents, and in the future request documentation for all dependents.

Auditee's Response to Finding #2

Although we have requested documentation for several years on dependents added to our plans, some have been added without this documentation. Many times, the dependents were added to meet an enrollment deadline (payroll entry) and the employee was to bring in the documentation thereafter. Obviously this did not always happen. We are now holding up all enrollments on any dependents for whom we do not have valid marriage/birth certificate(s) at the initial enrollment meeting. Newborn children are covered automatically for 30 days without payment of premium and although added at birth, we do not collect a premium for them until the end of the 30 days. This is a Florida law.

Finding #3

We tested 33 terminated employees to determine the length of time between the termination date per the ESR and the date that their benefits codes were turned off. We found that 3 of the 33 (9%) had a lag of at least one pay period between termination and turning off their benefits. One of those persons had a lag of 5 months. The total cost to the City for paying unnecessary insurance premiums for these three employees was \$989.12. If we were to project this total cost onto our population, we would have an estimated total annual cost incurred of approximately \$5,934.72.

Recommendation #3

We recommend that the City modify its termination procedures to notify Employee Benefits immediately upon termination of an employee. Employee Benefits should be included in the departments that receive a copy of the ESR to eliminate these lags. In addition, Employee Benefits should adopt a standard procedure dictating how edit reports (reports that show employee's changes in status, including termination) should be used to notify the person responsible for reconciling any differences which may occur.

Auditee's Response to Finding #3

The city payroll clerks are responsible for providing the Employee Benefits office with a copy of the ESR or notice on a form designed by the benefits office when an employee terminates. Not all payroll clerks comply with this request; therefore, the benefits office does not know when an employee terminates from the City. Also, because our payroll system is not a "real time" system, employees' termination dates are removed so the employees' leave time can be paid to him/her, which leads to an "on again" - "off again" termination date in our payroll system. On occasion, the department payroll clerk, City payroll clerk, or a HR clerk will fail to put a termination date in the HR FNINF1 screen. Employee Benefits personnel usually rely on this information to term benefits, but it is not always possible. Sometimes these employees do not show up on an edit report until two to four weeks later. This is beyond the control of the Employee Benefits Office. The new Oracle system should eliminate the above problems by maintaining an electronic ESR online that should be viewed by all payroll/HR/benefits personnel involved.

AUDIT OBJECTIVE #2

In order to determine if Group Life Insurance claims were being properly processed and documented, we selected a sample from the population of life insurance claims paid by insurance providers during the year. We then examined the files for our sample for evidence to support the claims. We verified that the person that received the check was the actual beneficiary by examining a copy of the driver's license in the file or a certified mail receipt with a signature. We also verified that the file contained a copy of the certified death certificate. In addition, we verified that the amount paid to the beneficiary was correct.

We also selected a sample from the persons who are exempt from paying life insurance premiums due to disability. We examined the files from our sample to verify that there was proper physician documentation (at least as recent as January 1, 1997) of disability or proof from the insurance provider of the continued coverage. We also examined the files to verify that the beneficiary card and other information had been verified at some point since January 1, 1997.

Our audit findings, and recommendations for Objective #2 are as follows:

Finding #4

We tested twenty-nine of the files of life insurance benefits claims paid to determine if Employee Benefits was following its policy for disbursing checks to beneficiaries. The policy is to mail checks to beneficiaries using certified mail or require the beneficiary to pick up the check in person and provide a photo i.d. This policy was not followed in seven of the twenty-nine (24%) files reviewed.

Specifically, we found the following:

- For one claim there were three beneficiaries and one of the beneficiaries was allowed to pick up all three of the checks.
- For one claim the son of the beneficiary picked up the check. A copy of his ID (the son) and the beneficiary's ID were in the file, although the picture on the beneficiary's ID was not clear.
- For one claim the file did not contain a copy of the beneficiary's driver's license or a certified mail receipt signed by the beneficiary.
- For one claim, three beneficiaries signed consent forms allowing a non-beneficiary person to pick up the checks for all three persons.
- For two claims there was nothing in the files regarding any claim paid. There was no death certificate or beneficiary information. Employee Benefits states that these persons dealt directly with the insurance providers to receive their money.
- For one claim, the beneficiary card had not been updated since 1983 and subsequently the beneficiary was deceased. The policy was divided equally among the children.

Recommendation #4

The process of paying life insurance claims should be restructured so that beneficiaries contact the insurance company directly and obtain the check without going through Employee Benefits. This would eliminate some of the liability and responsibility on the part of the City. Employee Benefits should maintain updated insurance information on

every employee and updated beneficiary information so that if the beneficiary did not know whom to contact they could call Employee Benefits to determine this. In addition, Employee Benefits should request a list once a year from each provider to determine who obtained life insurance claims and place a copy of the list in the person's file.

Auditee's Response to Finding #4

We had a change in personnel in that area last year before the Open Enrollment and the employee assigned to life insurance was in the process of verifying and updating all beneficiaries when the audit began. The files will be updated on a continual basis. Since January 1, 2000 (before your audit began) we have had a new life insurance provider, Prudential. They are paying the claims directly to the beneficiaries and copying the City when the claims are paid. The City will continue to file the claims with the insurance provider and will not relinquish control of that. We will receive an experience report from them to show claims paid. We need this to determine appropriate premium changes and verify all claims are paid or actively on waiver of premium.

Finding #5

We tested twenty-nine of the files for recipients of life insurance benefits claims paid to determine that a copy of the death certificate was in the file. We found that three of the twenty-nine (10%) files tested did not contain a copy of the death certificate.

Recommendation #5

With the implementation of recommendation #4, Employee Benefits should get a letter each year from the insurance providers for claims that were paid during the year and place a copy in the person's file. This would eliminate the need for a copy of the death certificate.

Auditee's Response to Finding #5

See response to Finding #4.

Finding #6

We tested twenty-nine of the files for the recipients of life insurance benefits claims paid to determine that the amount paid to the beneficiary was correct. We found that for two of the twenty-nine (7%) recipients there was not sufficient information in the file to verify that the amount of the claim paid was correct.

Recommendation #6

With the implementation of recommendation #4, Employee Benefits should get a letter each year from the insurance providers for claims that were paid during the year and place a copy in the person's file. This would be verification that the amount of the claim paid was correct.

Auditee's Response to Finding #6

See response to Finding #4.

Finding #7

We tested forty-one of the persons who are exempt from paying life insurance premiums due to disability waivers to determine if documentation of the disability had been updated as of January 1, 1997. We found that four of the forty-one (10%) did not contain proper physician documentation of the disability in the file.

Recommendation #7

We recommend that Employee Benefits adhere to its procedure of updating the file documentation on an annual basis.

Auditee's Response to Finding #7

After the initial claim is filed for Waiver of Premium, physician's information is not submitted to the benefits office. The insurance provider deals directly with the disabled employee and not through benefits. We follow up on each participant with Waiver of Premium directly with the provider to insure that benefits are still intact on an annual basis.

Finding #8

We tested forty-one of the persons who are exempt from paying life insurance premiums due to disability to determine if the beneficiary cards had been updated as of January 1, 1997. We found that twenty-six of the forty-one files (63%) did not contain updated beneficiary cards. Four of the forty-one (10%) person's cases had been closed and eleven of the forty-one (27%) were in compliance with the procedure.

Recommendation #8

We recommend that Employee Benefits adhere to its procedure of updating the file documentation on an annual basis.

Auditee's Response to Finding #8

Waiver of Premiums participants, especially the ones from earlier years, deal primarily with the insurance companies and have sent beneficiary changes to them. We will be following more closely (see response to finding #7 above) and update the beneficiaries on an annual basis.

AUDIT OBJECTIVE # 3

To determine if Deferred Compensation benefits were being properly processed and documented, we first selected a sample of participants who completed deferred compensation change forms (used to start deferred compensation, make increases, make decreases, stop deferred compensation or change providers). From our sample we verified that the amount deferred for each participant was correct as of the effective date of the change. We also verified that the amount deferred for each participant was going to the correct provider. In addition, we verified that at year-end the amount paid in by each participant did not exceed the maximum amount allowed by the IRS and if it had, we verified that the excess was refunded to the individual.

We did not have any findings for this audit objective.

AUDIT OBJECTIVE #4

To determine that the Fraternal Order of Police (FOP) Heart/Hypertension benefits were being properly processed and documented, we selected a sample from the population of checks disbursed during the audit period by examining the FAMIS accounting system for all checks written. From our sample, we verified that the person receiving the benefit was eligible for the benefit. We also recalculated reimbursements for mathematical accuracy and examined the endorsements on the cancelled checks.

We did not have any findings for this audit objective; however, we noted an internal control weakness that is discussed later in the report.

AUDIT OBJECTIVE #5

To determine that the manual payments received by Employee Benefits were properly processed and documented, we first selected a sample of persons from the default payroll reports for two months and verified that they had a ledger card that indicated that a payment had been made. If there was no ledger card for the person, we verified that the benefits for the person were terminated or that they went into default mode for no longer than six months. (A person may go on a leave of absence and still be covered by the default level of coverage without making any payments for a period of six months.) For those in the sample who had ledger cards, we verified that the payment on the ledger card was also recorded on a spreadsheet (D-Base or Excel) maintained by Employee Benefits and included in the Tax Collector deposit. Next we agreed the spreadsheet deposit information to the Payroll Updates Report (1256 Report), which shows the amounts posted into the computer for the recording of manual payments. We also performed these steps on six additional manual payments, which we selected judgmentally to supplement our initial sample.

We also tested manual payments made to Employee Benefits by outside agencies. We used the two months selected above and obtained the 1411 reports for those periods for the Jacksonville Housing Authority (JHA), Northeast Florida Regional Planning Council (NEFRPC) and First Coast Workforce Development (FCWD). The 1411 Reports show the amounts per the City records that should be paid to the City by the agencies. We agreed the 1411 Reports to the eligibility reports that were submitted by the agencies and recalculated any reconciliations between the two. We then agreed the reconciled amount to the amount of the check submitted by the agency and to a Tax Collector cash receipt (CR).

Our findings and recommendations for Audit Objective #5 are as follows:

Finding #9

We tested thirty-three persons from the default report to verify that either a payment was received or their benefits were terminated, or that the person went into default mode for a period no longer than six months. We found exceptions for six of the thirty-three (18%) persons tested. The total cost of overpayment by the City to the insurance providers associated with these exceptions was \$6,247.32. If we projected this cost onto our total

population we would have an estimated total annual cost incurred of approximately \$37,483.92. Specifically, we found the following exceptions:

- One person had an end date per the payroll system of 9/19/98 but received default coverage until 2/19/99. Total cost of overpayment: \$817.88.
- One person had default coverage from 12/31/96 to 3/19/99. Total cost of overpayment: \$2,959.08.
- One person had default coverage from 2/19/99 to 3/17/00. Total cost of overpayment: \$1,036.62.
- One person had an end date per the payroll system of 4/9/99 but continued to receive default coverage until 6/11/99. Total cost of overpayment: \$596.54.
- One person had an end date per the payroll system of 6/1/99 but received default coverage until 10/15/99. Total cost of overpayment: \$837.20.
- One person was allowed to pay a large amount in arrears. He paid for benefits for 2/19/99 through 7/23/99 on 9/30/99. This person terminated on 7/26/99 and in order to keep his benefits under COBRA, he had to pay for all of the back payments that he had not paid during his leave of absence.

Recommendation #9

Employee Benefits should exercise more care when reviewing the default payroll reports for persons who are receiving benefits without deductions being made from their payroll or pension checks. All City departments should be required to notify Employee Benefits immediately when employees take or return from a leave of absence. See Improvement Opportunity later in report for related recommendation.

Auditee's Response to Finding #9

See response to Finding #3. In addition to a cleaner termination date, Oracle will place anyone who does not receive a paycheck into arrears if no termination date is present. A letter for the amount of arrears will automatically be generated and mailed to the Employee for payment. If payment is not made timely, benefits will be turned off.

Finding #10

We examined records for fourteen persons making manual payments to determine if the payments received were recorded in the check receipts log, recorded on the Excel spreadsheet, included in the Tax Collector deposit and agreed to the Payroll Updates Report (1256). Although all payments were deposited with the tax collector, we could not find one of the payments (7%) in the check receipts log and we could not find two of the payments (14%) on the 1256 Report.

Recommendation #10

We recommend that Employee Benefits enter all checks into the check receipts log, the Excel spreadsheet, and the Employee Benefits system (to update the participant's account) daily, and deposit all checks with the Tax Collector daily. Employee Benefits should then put together a voucher package consisting of the check receipts log, the 1256 report, the Tax Collector cash receipt and a copy of the checks. The total of these should all equal, thus providing a control that all amounts were entered correctly. If the totals are

not equal, Employee Benefits should perform a reconciliation to explain why they are not equal.

Auditee's Response to Finding #10

We are reviewing our process on this to insure deposits are made timely and follow the recommendation.

Finding #11

We tested the three outside agencies' manual payments to verify that their premium payments based on their eligibility report agreed to the premium payment due according to the City's 1411 report or that a reconciliation had been performed that explained the difference. We found that the reports did not agree in nine of twelve (75%) instances and although the differences may have been due to normal adjusting items, formal reconciliations had not been prepared to explain the differences. In addition, Employee Benefits could not locate one of the 1411 reports.

Recommendation #11

We recommend that a formal reconciliation spreadsheet be prepared for each month that reconciles the amount per the 1411 report to the eligibility list received from the agency. The amount of the check should agree to the reconciled amount and a copy of the 1411 report, the eligibility list, the reconciliation between the two, a copy of the check and the Tax Collector's cash receipt all be maintained together as supporting documentation.

Auditee's Response to Finding #11

A formal reconciliation spreadsheet is now being prepared each month and all records have been reconciled. Since Oracle will provide the City with electronic interfaces from the outside agencies, reporting discrepancies will be much easier to identify and correct.

Finding #12

We tested three agencies making manual payments for two months (four pay periods) to determine if the reconciled amount agreed to the amount of the check submitted to Employee Benefits by the agency. Since we could not reconcile nine of the twelve (75%) payments made, we could also not agree the reconciled amount to the amount of the check for those nine.

Recommendation #12

As stated above in recommendation #11, we recommend that a formal reconciliation spreadsheet be prepared for each month that reconciles the amount per the 1411 report (or import report) to the eligibility list received from the agency. The amount of the check should agree to the reconciled amount and a copy of the 1411 report, the eligibility list, the reconciliation between the two, a copy of the check and the Tax Collector's cash receipt all be maintained together as supporting documentation.

Auditee's Response to Recommendation #12

See response to Finding #11.

Finding #13

During our testing of manual payments, we found that Employee Benefits did not collect a \$10,962.26 check from one of the outside agencies until four months after the benefits had been provided. On 6/18/99 Employee Benefits received a check in the amount of \$11,048.26 from the agency. Per Employee Benefits, they returned the check because it was \$86.00 over. The agency never received the check and issued a stop payment order on 9/28/99. Employee Benefits received a replacement check for the agency on 10/1/99, but it was also for \$11,048.26, so Employee Benefits returned it. Employee Benefits finally received a check in the correct amount on 10/22/99. Employee Benefits cannot explain how the initial check was lost or why it took four months to obtain a replacement check.

Recommendation #13

We recommend that if this occurs again, Employee Benefits should deposit the check and credit the agency with the overage, or require that the agency provide a new check promptly.

Auditee's Response to Finding #13

I totally agree with the auditors' comments on this finding and assure you it will not happen again. We will deposit large checks from outside agencies and work out the problems immediately with them. The employee who did this is no longer employed with the City.

Finding #14

We found that one person received what should have been a one-time reimbursement for nine pay periods, and it was not noticed by Employee Benefits until the person reported the error. This person received an additional \$254.74 per pay period in his check for nine consecutive pay periods due to a code remaining turned on for a reimbursement. Codes in the Employee Benefits computer program must be turned on and off manually.

Recommendation #14

We recommend that Employee Benefits' computer program be modified to allow Employee Benefits to enter a stop-date for a benefit when a deduction or reimbursement code is turned on.

Auditee's Response to Finding #14

The new Oracle system has the capabilities to control this finding.

Finding #15

We found that there are no written agreements between the City and the outside agencies (Northeast Florida Regional Planning Council-NEFRPC, Jacksonville Housing Authority- JHA, and First Coast Workforce Development-FCWD) who purchase their benefits through the City, other than the Ordinances (for NEFRPC and FCWD) approved by Council that authorize the provision of these benefits. These agencies pay Employee Benefits an administrative fee each year, and paid an additional fee for the Request for Proposal (RFP) process for the benefit period, which started on January 1, 2000.

Recommendation #15

We recommend that there be a written contract annually between the City and these agencies, which lists the duties of each party, including the format of all information to be provided by the agencies, as well as the amount or method of calculation for all fees.

Auditee's Response to Finding #15

We agree with the recommendation, but you must understand that these deals were set up without the inclusion of the employee benefits office. We were informed after the decision was made on a much higher level that we would include those agencies in the city's group program. It took years to get Northeast Florida Regional Planning Council to go to the city council and have an Ordinance passed. It was easier to do it for the First Coast Workforce Development group. We still do not have an Ordinance for the Jacksonville Housing Authority. We were just told to cover them. As you know, dealing with them is very labor-intensive because everything is manually done. In the future, they will submit their information electronically or on a disk. We are building them into our Oracle system. We will work toward resolution of this through the General Counsel's office. The Ordinances for all groups need more clarification and will be changed with the cooperation of the administration and city council.

AUDIT OBJECTIVE #6

To evaluate the electronic enrollment process and problems that occurred for the benefits period beginning January 1, 2000, we questioned the employees of Employee Benefits and the Information Technology Division (ITD) to determine all of the problems that occurred during the open enrollment. We also obtained the number and cost of overtime hours worked for the open enrollment for 2000, the open enrollment for 1995 and the re-enrollment for 1999. We compared these to determine if there was a significant amount of overtime incurred by switching to the electronic enrollment system. Our comparison of the number of overtime hours worked by Employee Benefits during the three enrollment periods indicates that the differences in the number of overtime hours worked (and the cost associated with those differences) are not significant enough to influence our evaluation of the 2000 electronic enrollment.

Finding #16

Based on discussions with and information from Employee Benefits and ITD, we compiled the following list of errors and problems that negatively affected the efficiency and effectiveness of the 2000 open enrollment:

- 16 a** Employee Benefits did not have a computer set up when employees arrived at the initial enrollment session at the St. James Building, so those employees were unable to enroll at that time.

Auditee's Response to Finding #16 a

We had arranged to use the computer in the Renaissance Room, however, when we tried to use it, it crashed. We were told by other employees who came to the session that their computers were crashing in their individual offices that same day. ITD problem ?

- 16 b** Per Employee Benefits, the computers sat idle much of the time because people did not take advantage of the enrollment sessions.

Auditee's Response to Finding #16 b

This is a problem we continually experience with employees. It is very difficult to get them to respond to benefits, enrollments, or issues.

- 16 c** When enrollment began, it was discovered that connections and hardware were not available/set up at many departmental enrollment locations.

Auditee's Response to Finding #16 c

It never occurred to us that this would be a problem because the ITD was responsible for the program development along with us. I believe this should have been their responsibility.

- 16 d** ITD developed the on-line enrollment system to operate on the standard City computer platform. However, many of the City's computers had not been upgraded to this standard, and as a result, employees had trouble logging onto the system.

Auditee's Response to Finding #16 d

Same as above.

- 16 e** Initially, the enrollment program allowed 15 minutes per screen, after which it "timed out", forcing the enrollee to start over. Many employees timed out when they took too much time to decide what insurance they wanted to select, or while they looked for a piece of information such as a dependent's social security number. In response, ITD increased the time limit to 20 minutes per screen.

Auditee's Response to Finding #16 e

Agree.

- 16 f** The enrollment program did not allow an enrollee to save partially completed enrollment forms. As a result, if an enrollee needed to look up some piece of requested information and hoped to enter it the next day, he was forced to start from the beginning.

Auditee's Response to Finding # 16 f

The software program does not permit this. The employee should have all information when he/she begins enrollment. We informed employees about what was needed before they ever started the electronic enrollment.

- 16 g** The fire academy was designated for the Public Safety on-site enrollment, but its radio modems were too slow and caused people to time out when enrolling electronically.

Auditee's Response to Finding #16 g

Agree; however, we were told before we went out there that everything was ready for us. We did not know they were linked through the radio modems.

- 16 h** Because of problems enrolling electronically, inexperience with computers or not having access to computers, many refused to enroll electronically and instead filled out paper enrollment forms at the Benefits Office, which Benefits personnel had to manually input into the system.

Auditee's Response to Finding #16 h

Agree.

- 16 i** Personal identification numbers (pin #s) were computer-generated for all employees eligible for benefits and printed on individual form letters. These letters were hand-delivered to each employee by their payroll clerk. Employees were supposed to fill out and sign an attached card and return it to the employee benefits office. Some employees did not read the letters or threw them away because they did not want to enroll on-line. Because of this, many PIN cards were not returned to the benefits office. As a result, employees who later wanted to enroll on-line could not do so, because their pin #s had not been activated. They were then required to go to the benefits office, have benefits personnel look up their pin #, and sign a card or have another one sent to them for completion.

Auditee's Response to Finding #16 i

Agree. Many employees merely threw the envelope away because they thought it was junk mail.

- 16 j** Many city employees have been in the habit of keeping the same coverage from year to year and did not pay attention or understand that this year they had to enroll in new plans, as happens every five years when the City has to go out for bid on benefits. As a result, many employees and retirees ignored everything sent to them about the enrollment because they thought they could just keep what they had the year before.

Auditee's Response to Finding #16 j

Agree. We always experience this problem when we send information to our employees. They either do not read their mail, throw it away, or don't think the information applies to them.

- 16 k** Employee Benefits had difficulty contacting some retirees when they did not respond to the written material because the retirees had changed phone numbers or addresses without notifying Employee Benefits.

Auditee's Response to Finding #16 k

Agree. We spent days trying to locate retirees who had not responded because if they fall out of the insurance program, they cannot come back into it. We were

concerned that they did not receive or understand the information we sent to them. Some mail was returned because they had moved and left no forwarding addresses. We found that some retired people had moved in with family members or to nursing homes. We felt we had a moral responsibility to search them out.

- 16 l** The formula to compute the cost per pay period for supplemental life insurance was not programmed into the electronic enrollment program. As a result, many enrollees thought that supplemental life insurance was free. Compounding this problem, the enrollment confirmation letters sent to all enrollees did not show a deduction amount for the supplemental life code. Some employees did not question deductions until well into January and February. Then they demanded refunds for benefits they had enrolled for but did not want, e.g., the supplemental life coverage.

Auditee's Response to Finding # 16 l

This formula has always been a problem. It was compounded with enrollment because the Open Enrollment period fell at the same time as annual raises were being given. With Oracle, it will no longer be a problem because the formula will be built in to the program. The electronic enrollment file has been modified to improve the enrollment, especially separating the basic life screen from the supplementary life. There should be no confusion with this during the coming enrollment period.

- 16 m** In prior open enrollments, the City required all providers to adopt its eligibility tape file structure. When the contracts were negotiated for the current contract period, Employee Benefits agreed to adopt the file structures of the providers. Because each provider has its own file structure, ITD had to write six different COBOL programs, one for each new health insurance provider as well as the dental, life, and vision insurance providers. This was a significant amount of additional work during a busy time of year compounded by the Y2K workload.

Auditee's Response to Finding #16 m

The insurance market has changed significantly since we went out to bid five years ago. This year we received only four responses to the RFP for health insurance. We can no longer dictate our requirements. The market is not there for us. We have an overburdened system and each year we have to make changes to it. With the Oracle system, we should be able to have more compatibility with outside vendors' programs.

- 16 n** Employee Benefits' telephone lines are inadequate to handle the volume of calls. Employee Benefits estimates that it receives between 100 and 200 phone calls per day throughout the year, but up to 1,000 calls per day during enrollment.

Auditee's Response to Finding #16 n

We will have a better phone system this year with voice attendant that includes 70 lines.

- 16 o** Aetna treated Employee Benefits' second test tape as the initial enrollment eligibility list and loaded it into their eligibility system without sufficient testing of the file structures. Differences in the file structures caused dependents to drop out of the Aetna system. As a result, enrollment cards were not issued for dependents. When Employee Benefits learned of this by employees calling the Benefits office, it was immediately reported to Aetna. To fix the problem, ITD had to make programming changes to the eligibility list file structure and submit the revised eligibility list to Aetna. The lack of enrollment cards caused much inconvenience for dependents that needed to see a physician or obtain a prescription and resulted in many additional phone calls and additional work for the Benefits office to take care of individuals experiencing these problems.

Auditee's Response to Finding #16 o
Agree. We did not anticipate this problem.

- 16 p** Aetna, being new to the Jacksonville area, had to assimilate their existing network into the PruCare network of physicians, hospitals, and other providers to accommodate the large number of subscribers who selected their plans. It was difficult for Aetna to keep provider directories and websites updated because they were contracting with the providers simultaneously with the enrollment period. This was aggravating to enrollees because many of them followed their doctors into whichever plan they were available. After enrolling in a plan, a large number of employees changed their enrollment because they found out that their doctors were available within another plan.

Auditee's Response to Finding #16 p
Same as above.

- 16 q** There was confusion regarding network provider physicians who stated that they were not accepting new patients. For example, some people enrolled with an insurance plan that offered their existing physician, under the impression that they were not a new patient. After enrolling, they discovered that they were considered new because they were with a new insurance plan and the network provider would not accept them as a patient.

Auditee's Response to Finding #16 q
Same as above.

Recommendation #16

Employee Benefits should develop an action plan for future enrollments and re-enrollments that will significantly reduce, if not prevent, problems from occurring. This action plan should address ways to prevent all conceivable errors or problems; even those caused by other parties.

Auditee's Response to Finding #16

Open Enrollment has been critiqued to the point that there is not much left to address that has not been discussed before. The "End of Enrollment" message has been changed so employees will know when the process ends. More computers will be set up at the JSO and Fire department with the correct software and a citywide testing will occur before we begin the enrollment for the month of October. We have requested that the city make a 2-hour class mandatory for all employees who are eligible for benefits which will instruct each individual on what benefits are available, how to access them, and how to review the electronic web site, make changes, and enroll. The response has been positive, but it is very difficult to get employees to the classes. Employee Benefits personnel is calling and sending flyers out to all payroll/personnel clerks and individuals in an attempt to reach every employee. We have experienced problems with supervisors denying employees access to the training.

INTERNAL CONTROLS

During our preliminary survey and during the testing of our audit objectives of Employee Benefits, we noted internal control strengths and weaknesses that we would also like to report on and make recommendations for improvements regarding any weaknesses.

INTERNAL CONTROL STRENGTHS

General Processes

Strength #1

Employee Benefits computer screens have limited access and passwords to prevent unauthorized changes from occurring.

Strength #2

The City pays insurance providers in arrears, which allows for any adjustments to be made before the check is sent to the provider.

Group Health Insurance

Strength #3

The Mandated Benefits Specialist who is in charge of COBRA benefits verifies with the Employee Benefits Assistant in charge of individual manual payments that a payment has been received prior to processing COBRA applications.

Group Life Insurance

Strength #4

The details of the life insurance policy are only discussed with the beneficiary.

State and Federal Statutory Life Benefits

Strength #5

To collect any of these life benefits, the beneficiary must submit a certified copy of the death certificate, a police report, and an autopsy report.

FOP Heart/Hypertension Special Benefit

Strength #6

The employee responsible for this area looks up prescriptions in a Physicians Drug Reference book to verify their use as a heart/hypertension drug before approving their reimbursement. In addition, diagnoses for claims submitted are required and are looked up in an ICD-9-C code book established by the medical profession.

Manual Payments

Strength #7

Files are maintained by the Employee Benefits Assistant responsible for individual manual payments that contain a copy of the deposit slip, a copy of the D-Base or Excel spreadsheet, a calculator tape, a copy of all of the checks, and a copy of the cash receipt received from the Tax Collector.

Strength #8

Files are maintained by Employee Benefits Temporary position in charge of manual payments by outside agencies which contain a copy of each check, the envelope the check came in, a copy of the deposit slip and the receipt from the Tax Collector.

Strength #9

Each pay period, the employee responsible for individual manual payments verifies that those persons who were supposed to drop off of the default report because they are not eligible to receive benefits through manual payments have actually dropped off.

INTERNAL CONTROL WEAKNESSES

Group Life

Weakness #1

There is a lack of segregation of duties in the processing of life insurance claims. The same person is responsible for processing claims, receiving checks, notifying the beneficiary, dispersing checks, and maintaining the files.

Recommendation #1

The same person may process the claims and maintain the files. However, as recommended previously, the responsibility for handling life insurance claims should rest with the life insurance company.

Auditee's Response to Weakness #1

Since January 1, 2000 all payments from the new provider have been sent directly to the beneficiaries, however, with the waiver of premium life payments, the checks do come to our office for disbursement. They are first sent to the accounting area to be logged in, then given to the life insurance representative to contact the beneficiary for delivery. We will continue doing this because we want to monitor those employees on waiver to ensure that they continue to receive coverage from the companies responsible. We feel it is more efficient for the same person to handle the life insurance from the beginning until resolution of the claim. We have been able to force previous life insurance companies who have merged several times, to honor claims for those on waiver of premium. This would never be addressed if we left it up to the insurance providers, and former employees would lose the benefits to which they are entitled.

Weakness #2

Life insurance checks are not logged in by anyone.

Recommendation #2

Life insurance checks should be logged in when received by someone other than the person processing the claims. However, as stated in recommendation #1, the responsibility for handling life insurance claims should rest with the life insurance company.

Auditee's Response to Weakness #2

See #1 above. Life insurance checks are being logged in the accounting area.

FOP Heart/Hypertension Special Benefit

Weakness #3

There is not a proper segregation of duties for this activity because the same employee handles all steps (authorization, accounting and custody) associated with the FOP benefit process. The Management Improvement Officer authorizes expenses, calculates the amount of the benefit, prepares the check request, receives the checks from City General Accounting, and distributes the checks.

Recommendation #3

Someone other than the person approving the reimbursements should prepare the reimbursements. We also recommend that Employee Benefits pursue having the checks for this benefit mailed out directly to the person from the Treasury Department for the City of Jacksonville.

Auditee's Response to Weakness #3

A Benefits Assistant will be adjudicating the claim payments after re-enrollment. Check requests are keyed into the FAMIS system by the accountant; the AMIO approves them on-line; and, the checks are currently being mailed out by Treasury. The FAMIS system is checked to determine when checks are issued to the recipients. The individual files are noted.

General Processes

Weakness #4

The processes for FOP Heart/Hypertension reimbursements and the payment of life insurance claims are each completely performed by one person from start to finish with no review. The manual payments process is performed by one person when one of the accounting personnel is out on leave.

Recommendation #4

Process duties should be allocated so that the same person is not performing the authorization, accounting, and custody functions for a given process. In addition, there should be more supervisory review of all of the processes that involve the flow of money through the office.

Auditee's Response to Weakness #4

For life insurance and the FOP Heart/Hypertension claims see #3 above. Life insurance processes are reviewed by the Mandated Benefits Specialist and by the AMIO. The Internal Audit Specialist and the Accountant supervise the manual payment process. Payments are logged in on an Excel spreadsheet and endorsed by the accountant and processed and deposited by the employee benefits assistant. During the absence of personnel, the same person will no longer handle a complete process.

Weakness #5

The Employee Benefits' computer program does not automatically halt deductions for benefits for a City employee on the termination date entered into the computer (FNINF1 screen-screen containing ESR information) by the City Human Resources Department. The lag between when an employee is terminated and when Employee Benefits is notified typically is from two weeks to a month, although we noted one lag of five months during our testing. Similarly, the program does not allow Employee Benefits to set start and stop dates for deductions and refunds. Starting and stopping deductions and refunds must be done manually.

Recommendation #5

The Employee Benefits' computer program should be programmed to automatically stop benefits deductions on an employee's termination date and allow Employee Benefits to enter start and stop dates for deductions and refunds.

Auditee's Response to Weakness #5

This is a program problem. Our current system has been overloaded and some functions were not built in it because it was not possible. With the Oracle system, this problem will be resolved because it is being built into the program. When a termination date is placed into the Oracle system, all deductions will cease. Start and Stop dates will also be available in Oracle.

Weakness #6

Dependents with the same last name and within a reasonable age group are not verified when enrolling in benefits.

Recommendation #6

Original verification should be performed of all dependents and maintained in the file while the dependent remains under coverage.

Auditee's Response to Weakness #6

We are currently requiring all new enrollees to furnish copies of marriage certificates and birth certificates. This has been our practice for a long time; however, we have not gone back for those employees who have been covered for years. We will begin doing random audits on those employees.

Weakness #7

Employee Benefits does not have written policy and procedures manuals. These are especially needed in the manual payments and accounting areas of the organization.

Recommendation #7

Employee Benefits needs to write policies and procedures for all areas and require that employees follow those policies and procedures.

Auditee's Response to Weakness #7

Employee Benefits has developed basic policies and procedures as part of a citywide requirement by the administration. It is very difficult to establish set rules because of the industry that we deal with and the insurance policies set the rules on most of what we do.

Weakness #8

We noted numerous items that were processed differently from the procedures explained to us, but the reasons were rarely documented in the applicable file.

Recommendation #8

Any instance where an exception to the general rule or practice is made should be documented in writing in the appropriate file(s). The written explanation should be signed and dated by the supervisor (Assistant Management Improvement Officer).

Auditee's Response to Weakness #8

We waive the 90-day waiting period for some employees. Directors, Division Chiefs, Council members, and other key employees have it waived as a condition of employment. We also waive it for part time employees who become full time. We give them credit for time served as part timers. This may not be specifically documented in the individual files. For years we have had a form to be used to document files. It should be done and although this practice was supposed to be followed, it was not done in some instances.

457 Deferred Compensation

Weakness #9

The current payroll system does not automatically prevent deductions from exceeding the IRS maximum for a calendar year. Because the amount of deductions must be monitored manually, excess deductions do occur and must be returned to the employee. When this occurs, the service providers return the excess funds to Employee Benefits so that the funds can be returned to the employee/owner. In some cases, the City has not identified the employee/owner of the excess deductions. The City is currently holding \$12,799.54 of deferred comp monies for which it has not identified the owners.

Recommendation #9

The City should make sure that the new Oracle payroll system is programmed to deduct no more than the annual maximum allowed by the IRS. The payroll system should allow Employee Benefits to override this maximum to permit employees to exercise the “catch-up” option in their final three years before retirement. Employee Benefits should also work to identify the owners of the excess deductions.

Auditee’s Response to Weakness #9

Rate elements within Oracle will be set for maximum amounts for the deferred compensation program. This will eliminate this weakness. In the meantime, this issue will be researched and resolved.

Manual Payments

Weakness #10

The Employee Benefits temporary position maintains the check receipts log, has the access to record individual manual payments and records the outside agencies manual payments, makes deposits and performs reconciliations for the outside agencies making manual payments. This is not a proper segregation of duties. In addition, when the temporary position is absent, the Employee Benefits Assistant records cash receipts in the cash receipts journal, which is not compatible with her normal functions of preparing and making deposits of cash receipts.

Recommendation #10

The duties of keeping the check receipts log, recording manual payments and performing reconciliations and making deposits should be performed by separate personnel or verified and approved by a higher authority. The ability to change any records should be restricted to the person performing that function.

Auditee’s Response to Weakness #10

See comments to #3 & #4. This was changed during the audit and the Accountant is maintaining the check log.

Weakness #11

Deposits of manual payments are not being made in a timely manner. They are being held and deposited every week to a week and a half.

Recommendation #11

Deposits should be made daily.

Auditee's Response to Weakness #11

The checks are now being deposited daily.

Weakness #12

The previous Employee Benefits Assistant allowed persons making manual payments to carry a negative balance. A negative balance may occur when processing manual payments if an individual makes a payment for less than the amount that is required for benefits. The Employee Benefits Assistant was taking the balance due, subtracting the payment made from it, and carrying forward any unpaid negative balance.

Recommendation #12

Persons should not be allowed to carry a negative balance when making manual payments. If a payment is short, Employee Benefits should contact the person and request payment of the shortage amount.

Auditee's Response to Weakness #12

This does not happen anymore. The employee mentioned no longer works for the City. This is audited by the Internal Audit Specialist and reviewed by the Accountant to ensure that all monies are received on time and posted appropriately.

Weakness #13

The records dealing with manual payments are unorganized and not properly maintained for both the payments received from outside agencies and from individuals. Reconciliations for outside agencies' benefits payments were not properly documented. We also noted that on the ledger cards used to record individuals' manual payments, items are being changed with the use of "Wite-out."

Recommendation #13

Records and reports should be maintained in an organized manner. Written reconciliations should be performed between the 1411 report and the outside agencies' eligibility reports each pay period. Wite-out should not be used in accounting records. Instead, the item should be struck through and initialed so that the change can be seen.

Auditee's Response to Weakness #13

We agree with the findings and the accounting area is being restructured. Wite-out is not being used on any accounting records now.

Weakness #14

For manual payments received from other agencies, the agencies continue to use their own deduct codes on their eligibility reports. When Employee Benefits receives the

eligibility report from the agency, they must manually reconcile the agency's codes to Employee Benefit's codes.

Recommendation #14

Outside agencies that obtain benefits through the City should be required to submit their eligibility reports in a format dictated by Employee Benefits.

Auditee's Response to Weakness #14

This will change with the Oracle program and we will require all outside agencies to deliver the information in a compatible format.

Computer Security

Weakness #15

Terminated employees are left with access to some of the screens within the Employee Benefits System.

Recommendation #15

Passwords should be changed and logons removed no later than an employee's termination date.

Auditee's Response to Weakness #15

Computer passwords remaining in the system has been a citywide problem and has been addressed through ITD with the new division chief. We currently remove terminated employees off all the systems of which we have control. For those current employees, passwords are changed every 90 days.

EFFICIENCY WEAKNESS

During our preliminary survey and testing of audit objectives we found one efficiency weakness.

Weakness #1

Currently, the process for recording manual payments duplicates some steps by requiring payments to be recorded both on manual ledgers and in the computer.

Recommendation #1

Through the use of spreadsheets that are already being utilized, the ledger cards, which are also being used to record payments, can be eliminated.

Auditee's Response to Weakness #1

We realize that we are maintaining two sets of records; however, with our antiquated system we have felt that it was necessary. If we had not maintained paper copies of data, we would have lost our data with the Y2K. We lost DOS and Cobraeas® on January 1. We are building this into Oracle and will not keep paper records after it is implemented.

OPPORTUNITY FOR IMPROVEMENT

During our preliminary survey and testing of audit objectives we found two opportunities for improvement.

Opportunity #1

Currently, the City uses checks to transfer money to the deferred compensation service providers and group health benefits providers, instead of using wire transfers. Wire transfers are instantaneous, while preparing a check, receiving approval and cashing it takes several days at best. To fulfill its fiduciary responsibility, the City should wire transfer this money to the service providers to expedite its investment benefit for the employees.

Auditee's Response to Opportunity #1

We requested permission to electronically transmit funds for all deferred compensation participants; however, the prior Treasurer did not want us to do it. The city is now reviewing this decision and I believe we will see more electronic transfers in the near future.

Opportunity #2

There is currently no requirement that the Employee Status Record (ESR) go through the Employee Benefits office when changes are made for an employee. It is essential that Employee Benefits be notified immediately of changes in status such as an increase in pay, a change in department or job function, a leave of absence, a suspension, a termination or a retirement so that the office can make the appropriate changes in the person's benefits. Becoming one of the departments that is required to sign-off on the ESR would ensure that changes were made to the employee's benefits in a timely manner.

Auditee's Response to Opportunity #2

This will change with Oracle. We should receive "real time" information and it will be entered into our system.

NOTEWORTHY ACCOMPLISHMENTS

During our preliminary survey and our testing of audit objectives we found some noteworthy accomplishments of Employee Benefits that we would like to report.

Accomplishment #1

Representatives from some of the health insurance companies work in Employee Benefits' office to assist with problems that Employee Benefits' assistants or employees of the City may have.

Accomplishment #2

The employees of the Employee Benefits office are cross-trained in areas so that they may help each other during busy periods.

Accomplishment #3

Employee Benefits saves money on certified mail for COBRA processes by having the mailroom attendant sign that the forms have been mailed rather than paying for certified mail.

Auditee Comment

Please include in your audit that you came into our office in January, immediately following the worst Open Enrollment Period in history. We were still resolving enrollment issues when you arrived. Thank you for your patience.

We would like to thank Employee Benefits for their assistance and cooperation throughout our audit.

Respectfully Submitted,

Robert O. Johnson, CPA
Council Auditor

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