Follow-up of
Audit of Self-Insurance Pharmaceutical Claims

March 2016
Original audit report issued August 2014

Karen E. Rushing
Clerk of the Circuit Court and County Comptroller
Office of the Inspector General
Sarasota County, Florida

CONTENTS

Summary and Results	2
Open Conditions and Pending Corrective Action	4
Closed Conditions and Follow-up Results	7
Appendix A Original Audit Report dated August 2014	9

AUDIT SERVICES

David Beirau, CFE, CIGA
Director of Internal Audit and Inspector General

Lead Auditor
Debra Martin, CPA, CFE, CGMA, CIGA
Senior Internal Auditor/Investigator

Please address inquires regarding this report to David Beirau, by e-mail at dbeirau@scgov.net or by telephone at (941) 861-5280. This and other reports prepared by the Office of the Inspector General are available at www.SarasotaClerk.com/Comptroller Services/Internal Audit.

SUMMARY AND RESULTS

Background

The purpose of the August 2014 Audit of Self-Insurance Pharmaceutical Claims was to review internal controls and compliance with applicable laws, regulations, policies and procedures, and contracts. The scope of the audit included pharmaceutical claims submitted for the period of January 1, 2012 through July 31, 2013 (audit period).

The original audit report concluded that Employee Health and Benefits would benefit from:

- Documenting responsibilities, processes and procedures.
- Strengthening the internal monitoring of pharmaceutical claims paid.
- Maintaining support for the administrative fee paid.
- Gaining an understanding of the Prescription Benefit Manager (PBM) Internal Controls.
- Improving verification procedures of dependent eligibility.

Objective

The objective of this follow-up audit was to evaluate the current status of observations reported in the Audit of Self-Insurance Pharmaceutical Claims, dated August 2014, and corrective actions initiated by responsible management. This was achieved through independent, objective analysis to provide reasonable assurance that the previous concerns have been addressed and appropriate corrective measures implemented.

To meet the objective of the follow-up audit, the following procedures were performed:

- Performed inquiries of the Employee Health and Benefits department managers and staff.
- Obtained an understanding of changes made to Employee Health and Benefits procedures related to Pharmaceutical claims since the original audit report date.
- Tested a sample of employees that requested dependents be placed on the County Plan to ensure eligibility was appropriately validated.

Overall Results

Based on the results of our follow-up audit procedures, responsible management has addressed two (2) of the five (5) previous concerns and implemented appropriate corrective action on those conditions identified in the original audit report. Three (3) recommendations from the original report have not been addressed sufficiently.

Condition	Status
A. Lack of Documented Responsibilities, Processes and Procedures	Open/Partially Completed *
B. Strengthen Monitoring of Claims	Open
C. Support for Administrative Fee Amount Not Maintained	Closed
D. Understanding of Prescription Benefit Manager (PBM) Internal Controls	Open/Partially Completed *
E. Audit Report Includes Recommendations to Improve Verification of Dependent Eligibility	Closed

*Conditions A and D remain outstanding as corrective actions were partially completed by Employee Health and Benefits after the original audit. Corrective action is in process on the remaining portions of the management action plan. Condition B remains open as corrective action has not been completed.

Although three (3) *Opportunities for Improvement* remain open or open/partially completed, this concludes the follow-up audit process as it relates to the Audit of Self-Insurance Pharmaceutical Claims.

OPEN CONDITIONS AND PENDING CORRECTIVE ACTION

Three (3) of the five (5) conditions identified in the original report are open/partially complete, with actions on the items currently being addressed by responsible management.

A. Lack of Documented Responsibilities, Processes and Procedures

Written processes and procedures are needed to ensure the County meets its Plan responsibilities.

Current Status, Follow-Up Audit dated March 2016: Employee Health and Benefits is in the process of developing and documenting Standard Operating Procedures (SOPs). As of the time of the follow-up audit fieldwork, there are twenty-two (22) SOPs, of which six (6) are adopted and sixteen (16) are in draft form, including SOPs for verifying employee and dependent eligibility and the determination of administrative fees. There are no SOPs in relation to the monitoring of prescription claims or document retention and destruction.

Original Audit Observation, Report dated August 2014: The County contracts with BeneCard to process Plan claims and perform various functions for the Plan. The County's responsibilities include verifying that employees and dependents are eligible to participate in the Plan, calculating and approving the administrative fee paid to the Prescription Benefit Manager (PBM) and monitoring claims administration.

Currently, limited guidance is provided to responsible employees on how to fulfill these duties. The County new hire enrollment documents provide some guidance; however, these documents do not include specifics on the procedures that should be performed. Currently, personnel perform procedures that have been verbally passed down from previous employees.

Original Recommendation, Report dated August 2014: Document responsibilities for monitoring the Plan and the processes and procedures used to ensure that those responsibilities are being met. Written procedures provide a tool for existing and future employees to perform their functions effectively and can be used to communicate responsibilities and expectations to staff. At a minimum, written procedures should address the monitoring of prescription claims, the determination of administrative fees, the processes for verifying employee and dependent eligibility, and document retention and destruction.

Management Action Plan: Staff will complete and implement the sixteen remaining SOP's currently in process by June 1, 2016. It should be noted that many of the processes to be documented in the SOP's have previously been implemented. Finally, the development and adoption of the two additional recommended SOP's will also be implemented by June 1, 2016.

B. Strengthen Monitoring of Claims

Procedures to analyze and monitor pharmaceutical claims do not exist.

Current Status, Follow-Up Audit dated March 2016: Procedures for analyzing and monitoring claims have not been substantially modified since the original audit. The auditor was advised by Employee Health and Benefits management that an external vendor will be procured to perform claim audits in fiscal year 2017.

A report prepared by BeneCard for the County (dated July 29, 2015) was provided to the auditor by Employee Health and Benefits management. The auditor observed that the report included trend reports, review of clinical programs, and case management of high cost claims. Employee Health and Benefits management provided evidence that pharmaceutical claims paid are tracked in total monthly by the County; however, there are no procedures to ensure that individual claims are duplicate or inaccurate.

Original Audit Observation, Report dated August 2014: The County contracts with BeneCard to process pharmaceutical claims. Additionally, the County is responsible for monitoring expenses and services performed by BeneCard. Member inquiries and disputes related to claims are referred to the County for resolution. Currently, there are no procedures for monitoring the eligibility or accuracy of claims or handling claim disputes.

Original Recommendation, Report dated August 2014: The County could benefit from performing additional procedures to analyze and monitor claims each month. Examples of monitoring procedures include searches for duplicate claims, reviewing claims over a high dollar threshold, and instituting routine claims audits.

Management Action Plan: Staff is in the process of procuring a claims audit firm to conduct an audit by the end of fiscal year 2016. Formal audits will be conducted every other year, at minimum, going forward. Because there are thousands of claims processed every month, the only practicable way (beyond the current spot-check process) to find duplicate or inaccurate individual claims is through a formal audit. Staff will also continue to monitor vendor performance guarantees to verify claims processing accuracy.

D. Understanding of Prescription Benefit Manager (PBM) Internal Controls

The Service Organization's Control (SOC) Report for BeneCard PBM is not maintained or reviewed.

Current Status, Follow-Up Audit dated March 2016: The SOC Report in relation to the effectiveness of internal controls designed and implemented by the PBM throughout the period August 1, 2014 to January 31, 2015, was obtained by Employee Health and Benefits and reviewed for any weaknesses identified. There was no documentation supporting that the County evaluated and addressed the suggested "user controls" provided in the report. Additionally, there is no SOP adopted or in draft to provide guidance for these processes.

Original Audit Observation, Report dated August 2014: BeneCard is the PBM contracted by the County to process prescription Plan claims and perform various functions for the Plan. BeneCard' s internal controls are evaluated periodically by an independent CPA firm that issues a SOC report that describes and reviews internal controls related to the PBM's prescription claims processing functions, including any internal control weaknesses identified. The SOC report also includes a description of internal controls that are recommended for user entities like the County.

The County does not obtain or review the PBM's SOC report to, 1) identify any PBM internal control weaknesses that could impact the administration of the County's pharmaceutical plans, or 2) evaluate whether or not the County has addressed the recommended controls for "user" entities that are included in the report. The audit found that the most recent SOC report covering the period from June 1, 2012 through November 30, 2012 included a clean opinion on the design and operating effectiveness of the PBM's internal controls. The report also includes suggested "user controls" and notes that the PBM's internal controls are designed with the assumption that internal controls are implemented at the user entities. While the SOC report is extensive, the County would benefit from an in depth review of it in its entirety. Page 20 of the report lists various complimentary controls. See Appendix A.

Original Recommendation, Report dated August 2014: Obtain and review the PBM's SOC Report which describes and evaluates internal controls related to the PBM's claims processing functions. Identify and address internal control weaknesses at the PBM that could impact the administration of the County's Plan. The report also includes suggested "user controls" for the County's evaluation.

When SOC reports are not issued annually, the County should request a "bridge letter" from the PBM. A "bridge letter" will notify the County of any significant changes that have been made to the reported internal controls of the PBM and can provide assurance for periods in which SOC reports are not issued.

Management Action Plan: Staff is in the process of developing an SOP to document the SOC Report review process. It is the intent of staff to mirror the applicable "user controls" in the development of Employee Health& Benefits controls, which will be identified in the SOP. This SOP will be implemented by June 1, 2016.

CLOSED CONDITIONS AND FOLLOW-UP RESULTS

C. <u>Support for Administrative Fee Amount Not Maintained</u>

Monthly lists of participating prescription members are not created or maintained.

Current Status, Follow-Up Audit dated March 2016: The County maintains two files related to the monthly administrative fee paid to BeneCard. One file is the invoice, which includes the total number of employees enrolled in the Plan, and the second file includes the names of all employees enrolled as of the first of the month. The total number of employees is compare on the two files prior to submitting the invoice for payment of the administrative fee.

The auditor observed that for the months of September, October, and November 2015, the total number of employees shown on the invoice agreed with the total number of employees listed on the detail report.

Original Audit Observation, Report dated August 2014: The County calculates the monthly administrative fee paid to BeneCard. The fee is calculated based on the number of members enrolled in the Plan on the first of each month multiplied by a per member rate. The County's Employee Benefits Enrollment System tracks the number of members enrolled in the Plan. The system has been programmed to automatically generate a report on the first of each month of the total number of members participating in the Plan. However, a detailed list of these participating members is not generated. Once time has passed, the system is not able to generate an accurate list of members from a past point in time. This means that a post-audit of the accuracy of the number of members enrolled and used to calculate the administrative fee cannot later be performed.

Original Recommendations, Report dated August 2014: Instead of solely auto-generating the total number of members participating in the Plan generate the full listing of Plan participants each month. Maintain this listing to support administrative fee calculations and payments.

E. Audit Report Includes Recommendations to Improve Verification of Dependent Eligibility

Lack of process to verify all enrolled dependents are eligible to participate in the Plan.

Current Status, Follow-Up Audit dated March 2016: Procedures were developed and implemented after the original audit to include validation of dependent's eligibility to be placed on the County Plan. The procedures include requiring that the employee provide appropriate documentation in support of dependent eligibility and monitoring of child dependents that are close to reaching the normal maximum age of eligibility. Employee Health and Benefits is in the process of documenting the responsibilities, processes, and procedures (see Condition A.).

The auditor randomly selected a sample of twenty (20) individuals from populations provided by Employee Health and Benefits that included new hires during fiscal years 2015 and 2016 (through November 2015) as well as employees who made changes to dependents covered by the County Plan, either during the audit period or during open enrollment. Results of the testing performed concluded that the procedures related to verification of the eligibility of dependents on the County Plan are functioning as intended.

Original Audit Observation, Report dated August 2014: While the verification that participating dependents were eligible for Plan benefits was specifically excluded from the scope of this audit, an audit dated February 2014 of dependent eligibility was issued by HMS Employer Solutions, Inc. That audit indicated that a number of dependents in the Plan did not sufficiently support their eligibility to participate in the Plan. Discussions with County personnel indicated that the County does not routinely maintain documentation supporting dependent eligibility verifications.

If ineligible dependents have participated in the Plan, the County may have incurred costs for ineligible benefits. This could have had an impact on plan premiums, and also affected the amounts paid as administrative fees to the pharmaceutical Plan PBM, which are calculated based on the number of Plan participants.

Original Recommendation, Report dated August 2014: Establish clear processes to verify that all newly enrolled dependents are eligible to participate in the Plan. In addition, develop procedures for the routine verification of participating dependents as dependent eligibility can change.

APPENDIX A

Following is the original *Audit of Self-Insurance Pharmaceutical Claims* dated August 2014.

KAREN E. RUSHING

Clerk of the Circuit Court and County Comptroller

Audit of Self-Insurance Pharmaceutical Claims

Audit Services

Karen E. Rushing
Clerk of the Circuit Court and County Comptroller

Jeanette L. Phillips, CPA, CGFO, CIG
Director of Internal Audit and Office of the Inspector General

Audit Team
David Beirau, CFE, CIGA
Senior Internal Auditor/Investigator

Kerkering, Barberio & Co.
Certified Public Accountants
Patricia J. Entsminger, CPA, CFE, CIA
Mandi Someson, CPA, CFE, CIA
Lindsey Breaux

August 2014

TABLE OF CONTENTS	***Page***

Summary and Results 3

Opportunities for Improvement and Management Response 6

Appendix A 12

Summary and Results

The Clerk of the Circuit Court and County Comptroller's *Internal Audit Department and Office of the Inspector General* has completed an audit of the County's self-insurance pharmaceutical claims. The audit was planned and conducted in accordance with Generally Accepted Government Auditing Standards. 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 the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives. The purpose of the audit was to review internal controls and compliance with applicable laws, regulations, policies and procedures, and contracts. The scope of this audit included pharmaceutical claims submitted for the period of January 1, 2012 through July 31, 2013 (audit period).

Background

The Employee Health & Benefits department, within Human Resources, is responsible for overseeing administration of the self-funded employee health benefit plans of Sarasota County, including determining employee and dependent eligibility to participate in the plans and administrative fees paid to third parties who provide services to the plans. Employees are eligible for Plan coverage, including pharmaceutical benefits, on the 31st calendar day of employment. Enrollment in a plan may be elected by employees within the first thirty (30) days of employment through the County's self-enrollment system. The system also allows employees to enroll dependents in the plans.

The County entered into Contract number 2011-138 commencing on January 1, 2011 with BeneCard PBF (BeneCard) to administer Prescription Benefit Manager (PBM) services on the prescription portion of the County's self-funded employee health benefits plan (Plan). The Contract has an initial term of three (3) years, and the County has the option to extend the agreement for two (2) additional one (1) year periods under the original terms and conditions with written agreement between both parties. The agreement was extended through December 31, 2014.

The County is responsible for monitoring administration of the Plan; funding pharmaceutical benefits and administrative costs of the Plan; and ensuring that employees, their spouses, and dependents covered under the Plan are eligible to participate in the Plan. The County provides BeneCard with participant eligibility updates, including new hires, terminations, and qualified benefit changes. As of July 2013, there were 6,895 members participating in the Plan, including dependents.

BeneCard is responsible for prescription claims administration including processing claims in accordance with Plan and Contract provisions, providing mail order pharmacy services, and paying pharmacies and reimbursing covered participants, as applicable. In addition, they provide other services such as rebate negotiations with drug manufacturers, development of pharmacy networks, and formulary management.

Prescription claims processed for the period under audit, January 1, 2012 through July 31, 2013, totaled $10,448,480 and consisted of 186,504 claims. Of that amount, claims totaling

$10,237,966 qualified for payment either by the Plan or through patient co-payments or co-insurance.

The County's Internal Service Fund (Fund) accounts for health and dental plan benefits. Fund revenues are derived from health insurance premiums paid by the County and employees, retirees and Consolidated Omnibus Budget Reconciliation Act (COBRA) participants. Fund expenses include healthcare costs (medical, prescription, and dental), short-term disability claims, and administrative costs, including BeneCard's administrative fees. BeneCard receives administrative fees as compensation for PBM services. Administrative fees for the prescription services are calculated based on a fixed "per member per month" (PMPM) rate, multiplied by the number of enrolled members in the prescription plan on the first day of each month. The administrative fee per enrolled member was $1.50 per month for 2012 and 2013. Total fees paid to BeneCard for administering prescription benefit services for the nineteen (19) month audit period was $217,573.

Objectives, Scope and Methodology

The objectives of this audit were to determine if internal controls related to pharmaceutical claims processing and payment are operating effectively and in compliance with applicable laws, rules, regulations, policies and procedures, and contracts. More specifically, the audits objectives were to:

- Determine whether the County's prescription claims and administrative fees are processed and paid in compliance with the Plan provisions and applicable agreements.

  Medical claims, which were processed by a different third party administrator (TPA), were audited and reported in a separate report.

- Obtain reasonable assurance that there are controls in place to ensure that only eligible employees received benefits under the Plan.

  Employee dependents may be eligible to participate in the Plan and receive benefits; however, a separate audit of dependent eligibility was being conducted by an outside party at the time of this audit. In order to avoid duplicating audit efforts, this audit specifically excluded verification of dependent eligibility.

To meet the objectives of the audit, the procedures performed included, but were not limited to, the following:

- Performed inquiries of County and Prescription Benefit Manager (PBM) personnel.

- Reviewed Plan documents, PBM service agreements, enrollment information provided to employees, and information on the County's intranet site related to Plan eligibility and prescription benefits.

- Obtained and reviewed the PBM's Service Organization's Control (SOC) Report, issued by an independent CPA firm, describing and evaluating the PBM's internal controls related to PBM services and claims processing.

- Examined a sample of 205 pharmaceutical claims totaling $7,221 to determine if claims were processed in accordance with Plan and PBM contract provisions, including the timely processing and payment of claims and the proper application of co-payments. The sample size was determined based on audit sampling guidance provided by the American Institute of Certified Public Accountants (AICPA). The sample was randomly selected using sampling software and was designed to reach a confidence level of 90% with a 10% margin of error.

- Recalculated amounts paid for the 205 pharmaceutical claims using the following sources:

    - Plan documents;
    - Plan Formularies maintained by the PBM, which list all prescriptions drugs eligible for coverage under the Plan and the respective co-payment amounts;
    - Contracts between the PBM and the pharmacies which include the formulas used to determine claim amounts;
    - Standard Average Wholesale Price (AWP) rates provided by the PBM;

- Compared pharmaceutical claim amounts paid for the sample tested to prescription costs listed on the website *goodrx.com* to assist in determining if the amounts paid by the Plan were reasonable. The website reports the amounts that non-insured consumers can expect to pay for FDA approved drugs at each pharmacy nationwide.

- Compared the sample of pharmaceutical claims tested to other claims paid by the Plan with the same fill date to detect possible duplicate payments.

- For the sample of pharmaceutical claims tested, verified that employees were eligible to participate in the Plan. There were 100 employee claimants verified as a result.

- Identified opportunities for improvement.

Overall Results

For the sample of pharmaceutical claims tested, it appears the Prescription Benefit Manager (PBM) has internal controls to ensure that it correctly calculates and pays prescription claims for the self-insured Plans.

The County would benefit from increased monitoring over prescription claims processing and participant eligibility along with defined and documented policies and procedures. The *Opportunities for Improvement* section of this report discusses these results and recommendations in detail. The following summarizes the result of the audit:

- *Lack of Documented Responsibilities, Processes and Procedures* – The County currently has no written procedures for monitoring prescription claims, the secondary

County review of claims processed, determining administrative fees, or verifying employee or dependent eligibility.

- *Strengthen Monitoring of Claims* – The County could benefit from performing additional procedures to analyze and monitor claims. Examples of monitoring procedures include searches for duplicate claims, reviewing claims over a high dollar threshold, and instituting routine claims audits.

- *Support for Administrative Fee Amount Not Maintained* – Details of those members who were "eligible members" used to calculate administrative fees paid to BeneCard were not maintained during the audit period. Therefore, there is not a reliable way to verify that the number of participating members used to calculate the administrative fee was accurate.

- *Understanding of Prescription Benefit Manager (PBM) Internal Controls* – The internal controls of the prescription benefit manager are evaluated and reported on by an independent CPA firm. This Service Organization's Control (SOC) Report can provide the County with assurance regarding the internal controls of BeneCard or insight into any control weaknesses. The report also includes recommended controls for "user" entities like the County that utilize BeneCard's services. The County does not obtain or review the PBM's SOC report to, 1) identify any PBM internal control weaknesses that could impact the administration of the County's pharmaceutical plans, or 2) evaluate whether or not the County has addressed the recommended controls for "user" entities.

- *Audit Report Includes Recommendations to Improve Verification of Dependent Eligibility* – While verifying that participating dependents were eligible for plan benefits was specifically excluded from the scope of this audit, an audit dated February 2014 of dependent eligibility was issued by HMS Employer Solutions, Inc. That audit indicated that a number of dependents in the Plan did not sufficiently support their eligibility to participate in the Plan.

Opportunities for Improvement

The audit disclosed that procedures and practices could be improved. The audit was neither designed nor intended to be a detailed study of every relevant system, procedure, or transaction. Accordingly, the ***Opportunities for Improvement*** presented in this report may not be all-inclusive of areas where improvement may be needed. Observations and recommendations were made in the following areas:

A. Lack of Documented Responsibilities, Processes and Procedures
B. Strengthen Monitoring of Claims
C. Support for Administrative Fee Amount Not Maintained
D. Understanding of Prescription Benefit Manager (PBM) Internal Controls
E. Audit Report Includes Recommendations to Improve Verification of Dependent Eligibility

A. Lack of Documented Responsibilities, Processes and Procedures

Written processes and procedures are needed to ensure the County meets its Plan responsibilities.

Observation

The County contracts with BeneCard to process Plan claims and perform various functions for the Plan. The County's responsibilities include verifying that employees and dependents are eligible to participate in the Plan, calculating and approving the administrative fee paid to the Prescription Benefit Manager (PBM) and monitoring claims administration.

Currently, limited guidance is provided to responsible employees on how to fulfill these duties. The County new hire enrollment documents provide some guidance; however, these documents do not include specifics on the procedures that should be performed. Currently, personnel perform procedures that have been verbally passed down from previous employees.

Recommendation

Document responsibilities for monitoring the Plan and the processes and procedures used to ensure that those responsibilities are being met. Written procedures provide a tool for existing and future employees to perform their functions effectively and can be used to communicate responsibilities and expectations to staff. At a minimum, written procedures should address the monitoring of prescription claims, the determination of administrative fees, the processes for verifying employee and dependent eligibility, and document retention and destruction.

Management Response

Management concurs that responsibilities, processes and procedures related to the ongoing administration of the program are needed to ensure smooth transitions when there is staff turnover. Employee Health & Benefits (EH&B) staff will document current practices and create a process/procedure manual that identifies responsibilities/functions of specific staff positions related to the administration/operations of the prescription program within the health plans by July 31, 2015.

B. Strengthen Monitoring of Claims

Procedures to analyze and monitor pharmaceutical claims do not exist.

Observation

The County contracts with BeneCard to process pharmaceutical claims. Additionally, the County is responsible for monitoring expenses and services performed by BeneCard. Member inquiries and disputes related to claims are referred to the County for resolution. Currently, there are no procedures for monitoring the eligibility or accuracy of claims or handling claim disputes.

Recommendation

The County could benefit from performing additional procedures to analyze and monitor claims each month. Examples of monitoring procedures include searches for duplicate claims, reviewing claims over a high dollar threshold, and instituting routine claims audits.

Management Response

Management concurs that additional periodic, routine scrutiny of claim payments is desirable and recommends the following actions:

1) Perform periodic, routine Rx claim audits through a qualified, external vendor every third year (the next one would occur in 2017).
2) Confer with current contracted benefits consultant on guidelines for performing additional internal staff claim or "spot" audits and/or working with consultant partners to analyze claim samples, i.e., numbers of claims, application of co-pays, etc. Based on consultant recommendations, EH&B staff will:
    a. Include the analysis parameters and process in the documented staff Responsibilities, Processes and Procedures as previously identified in Management Response A, and
    b. Provide a written summary of the internal review findings annually.
3) Management will closely monitor the amount of time required to perform the additional functions above to determine if additional resources are needed to fulfill these requirements.

C. Support for Administrative Fee Amount Not Maintained

Monthly lists of participating prescription members are not created or maintained.

Observation

The County calculates the monthly administrative fee paid to BeneCard. The fee is calculated based on the number of members enrolled in the Plan on the first of each month multiplied by a per member rate. The County's Employee Benefits Enrollment System tracks the number of members enrolled in the Plan. The system has been programmed to automatically generate a report on the first of each month of the total number of members participating in the Plan.

However, a detailed list of these participating members is not generated. Once time has passed, the system is not able to generate an accurate list of members from a past point in time. This means that a post-audit of the accuracy of the number of members enrolled and used to calculate the administrative fee cannot later be performed.

Recommendation

Instead of solely auto-generating the total number of members participating in the Plan, generate the full listing of Plan participants each month. Maintain this listing to support administrative fee calculations and payments.

Management Response

Management concurs that the reported eligibility should be verifiable with links to employee and dependent names. Back-up reports will be developed and securely retained for each administrative fee request for the purpose of future audits by March 31, 2015.

D. Understanding of Prescription Benefit Manager (PBM) Internal Controls

The Service Organization's Control (SOC) Report for Benecard PBM is not maintained or reviewed.

Observation

BeneCard is the PBM contracted by the County to process prescription Plan claims and perform various functions for the Plan. BeneCard's internal controls are evaluated periodically by an independent CPA firm that issues a SOC report that describes and reviews internal controls related to the PBM's prescription claims processing functions, including any internal control weaknesses identified. The SOC report also includes a description of internal controls that are recommended for user entities like the County.

The County does not obtain or review the PBM's SOC report to, 1) identify any PBM internal control weaknesses that could impact the administration of the County's pharmaceutical plans, or 2) evaluate whether or not the County has addressed the recommended controls for "user" entities that are included in the report. The audit found that the most recent SOC report covering the period from June 1, 2012 through November 30, 2012 included a clean opinion on the design and operating effectiveness of the PBM's internal controls. The report also includes suggested "user controls" and notes that the PBM's internal controls are designed with the assumption that internal controls are implemented at the user entities. While the SOC report is extensive, the County would benefit from an in depth review of it in its entirety. Page 20 of the report lists various complimentary controls. See Appendix A.

Recommendation

Obtain and review the PBM's SOC Report which describes and evaluates internal controls related to the PBM's claims processing functions. Identify and address internal control

weaknesses at the PBM that could impact the administration of the County's Plan. The report also includes suggested "user controls" for the County's evaluation.

When SOC reports are not issued annually, the County should request a "bridge letter" from the PBM. A "bridge letter" will notify the County of any significant changes that have been made to the reported internal controls of the PBM and can provide assurance for periods in which SOC reports are not issued.

Management Response

Management concurs that the SOC reports should be reviewed annually. EH&B staff will obtain the annual or latest SOC report. The EH&B manager will review and address any identified weaknesses as they may apply to the vendor's operations for the County by July 31, 2015. Vendor recommendations regarding complimentary controls will also be reviewed and, if appropriate, be added to the documented staff Responsibilities, Processes and Procedures as previously identified in Management Response A.

E. Audit Report Includes Recommendations to Improve Verification of Dependent Eligibility

Lack of process to verify all enrolled dependents are eligible to participate in the Plan.

Observation

While the verification that participating dependents were eligible for Plan benefits was specifically excluded from the scope of this audit, an audit dated February 2014 of dependent eligibility was issued by HMS Employer Solutions, Inc. That audit indicated that a number of dependents in the Plan did not sufficiently support their eligibility to participate in the Plan. Discussions with County personnel indicated that the County does not routinely maintain documentation supporting dependent eligibility verifications.

If ineligible dependents have participated in the Plan, the County may have incurred costs for ineligible benefits. This could have had an impact on plan premiums, and also affected the amounts paid as administrative fees to the pharmaceutical Plan PBM, which are calculated based on the number of Plan participants.

Recommendation

Establish clear processes to verify that all newly enrolled dependents are eligible to participate in the Plan. In addition, develop procedures to routinely verify dependent eligibility, as a dependent's eligibility status can change.

Management Response

A) Prior to this audit and subsequent to the HMS Employer Solutions audit, internal processes and tracking requirements were modified to preserve the integrity of the

eligibility database. As of March 2014 EH&B staff has been collecting the same documentation as was required by HMS (i.e., marriage certificates, birth certificates, etc.) from newly hired employees, employees making changes during open enrollment and/or following a change in status.

B) Management concurs that external audits of all participants' dependents should continue to be performed every 3 years (standard industry practice) and procedures will be established as previously identified in Management Response A. The next one will be scheduled in 2017.

Appendix A:

Excerpt from BeneCard Prescription Benefit Facilitator Report on Management's Description of the Prescription Benefit System and on the Suitability of the Design and Operating Effectiveness of Controls for the period from June 1, 2012 through November 2012 Service Organization Control Report 1:

- User organizations are responsible for understanding and complying with their contractual obligations to BeneCard;
- User organizations are responsible for notifying BeneCard, in a timely manner, when changes are made to technical, billing or administrative contact information;
- User organizations are responsible for ensuring that user accounts and passwords are assigned only to authorized individuals;
- User organizations are responsible for ensuring the confidentiality of any user accounts and passwords assigned to them for use with BeneCard 's systems;
- User organizations are responsible for requesting the revocation of user accounts and passwords assigned for their employees' use;
- User organizations are responsible for immediately notifying BeneCard of any actual or suspected information security breaches, including compromised user accounts;
- User organizations are responsible for determining whether BeneCard 's security infrastructure is appropriate for its needs and for notifying the service organization of any requested modifications;
- User organizations are responsible for developing their own disaster recovery and business continuity plans that address their inability to access or utilize BeneCard 's services;
- User organizations are responsible for funding escrow accounts at required levels to ensure timely payment of claims;
- User organizations are responsible for funding cash calls in a timely manner to ensure the timely payment of claims; and
- User organizations are responsible for monitoring their escrow account statements and reconciliations and notifying BeneCard of any potential irregularities.