Office of the Auditor General

Audit of Benefits Processing – Compliance and Program Management

Tabled at Audit Committee
November 26, 2019

Table of Contents

Acknowledgements

The team responsible for this audit, comprised of Suzanne Bertrand and Louise Proulx from the Office of the Auditor General (OAG) and Raymond Chabot Grant Thornton, under the supervision of Ed Miner, Deputy Auditor General and the direction of Ken Hughes, Auditor General, would like to thank those individuals who contributed to this project, and particularly, those who provided insights and comments as part of this audit.

Original signed by:

Auditor General

Executive summary

Purpose

The Audit of Benefits Processing – Compliance and Program Management focused on whether the City's systems, practices and procedures effectively managed benefits processing during 2016, 2017 and 2018. As part of the audit, we examined whether the firms contracted by the City for benefits processing, administration and analysis provided services as specified in their respective contracts, and that only eligible expenses were paid. The audit also focused on whether the City processes were adequate to ensure the privacy and security of employee and dependents health and personal information handled by benefits contractors. The audit was included in the 2018 Audit Plan of the Office of the Auditor General (OAG), approved by City Council in November 2017.

Rationale

Within the City, the responsibilities for the benefits management was shared between Human Resources and Corporate Finance departments. Human Resources was the Plan Sponsor and managed the benefits plans for the City of Ottawa providing benefits to roughly 15,800 employees and retirees, their spouses and dependents. Whereas, the main responsibilities of the Pensions and Benefits Branch of Corporate Finance was to ensure the insurer had accurate information on eligible employees, retirees, their spouses and dependents as well as to remit insurance premiums monthly to the insurer.

The City had contracts with three service providers for both itself and the Amalgamated Transit Union 279 Conventional (ATU)[1] to deliver its benefits program. The core activities performed by each provider included:

- Insurer – reviewed, approved or rejected submitted claims and paid approved claims;

[1] ATU 279 benefits are handled through an Employee Benefit Trust covered by a Trust Indenture agreement. Day-to-day administration has been delegated to the City for payroll deductions and benefits eligibility administration. A Trust Committee comprised of City HR Management and staff and Union representatives are involved in selecting the insurance companies.

- External Benefits Consultant – supported the City's management of benefits with services that included audits of the insurer's claims, reviewing the insurer's claims approval processes, as well as actuarial and communication services; and
- Third-party administrator – provided benefits administration for retirees and dependents; provided ATU recipients with cost of living adjustments benefit payments; calculated and provided ATU with Ontario Health Premium benefit payments; and, calculated and provided LTD recipients with benefit top-up payments.

We did not examine the benefits program of the Ottawa Public Library or the Ottawa Police Service, the procurement processes for the benefits contracts, specific assessment of the ATU Benefit Trust Indenture agreement, or long-term disability benefits. Long-term disability benefits may be addressed in a future audit.

This audit was important because the City pays over $80 million per year for benefits and this cost has increased by 17.9% between 2014 and 2018, while the number of insured employees and retirees has only increased 2.2%. The increase in the cost of benefits per employee was mainly due to the rising cost of health care, particularly the cost of prescription drugs and an increase in the cost of long-term disability claims. Additionally, the City's group benefit program is a self-funded plan in which the City assumes the financial risk for providing these benefits should claims exceed forecasts.

More details about the audit objective, scope, approach, and criteria are provided in our full report.

Findings

The key findings associated with the audit's objectives are as follows:

1. **Professional fees paid to the external benefits consultant during 2017 exceeded the amount in the original contract by 89% ($616,471 paid versus $325,900 contract)**

The City contracts with its external benefits provider for six services (i.e., contract renewal, LTD benefits consulting, financial audits, core benefits consulting, actuarial valuation and communications for the benefits plan). During 2017, fees were paid to the external benefits consultant for activities that were not included in the original contract. While there are emails from City staff approving these additional activities and fees, they were not approved via the City's formal contracting practices and as such did not comply with the Procurement By-law.

The external benefits consultant is paid both by the City and by the insurer. The practice of the insurer paying the external benefits consultant a percentage of claims is not unusual in the industry, however, it reduces the City's control over the amounts paid to the external benefits consultant under the contract and was a contributing factor in the payments exceeding the contract limit.

2. Satisfactory controls to ensure only eligible claims paid

In addition to the insurer's processing controls over the claim submissions, the external benefits consultant conducts compliance reviews. We found that compliance reviews were conducted on drug claims and health claims and no significant discrepancies were identified. Where it was discovered that ineligible expenses had been paid by the insurer, the City recovered these amounts from the insurer.

These findings were consistent with the detailed testing that we performed on drug claims and on claimant eligibility which also found minor exceptions.

3. Lack of monitoring of amounts paid to its insurer for reimbursement of claim paid versus the insurer's fees

The City pays its insurer a retention/administrative fee (i.e., combination of a fixed fee per transaction, percentage of the value of claims paid), and percentage of premiums depending upon the transaction. The City does not monitor how much is paid to the insurer for reimbursement of benefits claims paid versus the insurer's fees.

4. Some of the Quality Assurance requirements stipulated in the contract with the insurer are not fulfilled

The City's contract with the insurer requires the insurer to have a quality assurance process in place that includes case management audits, claims adjudication audits, system coding audits and call center audits.

The insurer provides an annual report to the City on the timeliness and quality of services provided in accordance with the case management audit requirements. However, the claims adjudication audits and the systems coding audits have been carried out by the City's external benefits consultant and not the insurer. As the City pays its external benefits consultant separately, it is in effect paying for these services twice.

Additionally, we found that the contracted call center audits have not been completed. As a result, the City cannot confirm that employees and retirees receive a consistent level of service when they call the insurer.

5. Service level agreement penalties on performance were not received by the City in a timely fashion

The City's service level agreement (SLA) with its insurer defines service level targets to be provided and agreed-upon penalties if service levels are not achieved. Throughout the year, the insurer measures their performance against these targets and reports on these and any penalties to the City annually - within 90 days of year-end.

In its SLA reports the insurer calculated that penalties of $16,650 for 2016 and $5,300 for 2017 were owed to the City for failing to achieve some of the specified service standards. We found that the City did not receive these penalties in a timely fashion as penalties for 2016 were not applied until October 2018 and 2017 penalties had not been applied at the time of the audit.

6. Measures are in place to protect personal information

To process benefits, the City and its contractors are provided with personal information on City employees, retirees and their dependents. All involved parties are required to protect this personal information.

We found that the City's Technology Solutions Branch has implemented measures that require all outgoing and incoming messages from the domains of the insurer, external benefits provider and third-party administrator be encrypted.

In addition, during the contracting process for the insurer, the City included mandatory requirements related to the protection of personal information, which the insurer, external benefits consultant and third-party administrator satisfied prior to contract award.

As required by its contract with the City, the insurer provided annual reports from third-party firms verifying that its controls were designed and operating effectively for the protection of personal information. No significant weaknesses were identified in the audit reports.

Conclusion

Overall, we found that the City's systems, practices and procedures to manage benefits processing are designed and operating effectively. However, there remain opportunities for improvement, particularly related to the management of contracts in respecting contract amounts and formalizing changes to contractual agreements.

With minor exceptions, City employees, retirees and dependents are only reimbursed for eligible expenses. The City has undertaken various quality assurance activities, which have identified ineligible expenses being paid by the insurer. In these cases, the City has been successful in recovering these amounts from the insurer.

We found that while the City's insurer and external benefits consultant are generally providing services in the manner specified in contracts, including the approval of claims by employees and retirees accurately and in timely fashion, not all reporting requirements are being fulfilled.

Potential savings

While potential savings were not quantified, opportunity to reduce the City's costs were identified through:

- Ensuring that service providers provide all the services specified in their contracts;
- Not paying the external benefits consultant to carry out tasks that are already included in the insurer's contract; and
- Ensuring that penalties are applied in a timely fashion.

Recommendations and responses

Recommendation #1

That the City ensure that the insurer is completing quality assurance activities described in the contract and actively monitor the results of the quality assurance activities.

Management response:

Management agrees with the recommendation and it has been implemented.

Human Resources has developed a Quality Assurance Monitoring Procedure that outlines the detailed steps and responsibilities of Human Resources and the Insurer to ensure that quality assurance and monitoring activities will be completed as described in the contract.

The Insurer will deliver the quality assurance audit reports quarterly to Human Resources, within six weeks of the close of the calendar quarter. Human Resources will then assess the results and bring forward matters for discussion to the next standing business meeting with the Insurer. Actions required based on the assessment will be documented in the business meeting minutes and monitored until completion.

Quality assurance audits for year-to-date 2019 have been received and are on the agenda for the bi-monthly business meeting with the insurer in November 2019.

Recommendation #2

That the City ensure that penalties applied under the service level agreement are enforced at agreed upon rates in a timely fashion.

Management response:

Management agrees with the recommendation and it has been implemented.

Human Resources has developed a Service Level Agreement Penalty Payment Procedure to ensure that the penalties applied under the service level agreement are enforced in a timely fashion.

The Insurer will provide the Annual Service Level Agreement Reports, which include the details of the penalties due and at what rate, to Human Resources and the External Benefits Consultant within 12 weeks of the close of the calendar year. Human Resources will assess the reports and bring forward matters for discussion to the following regular bi-monthly business meeting with the Insurer and the External Benefits Consultant. Actions required based on the reports will be documented in the bi-monthly business meeting minutes, including the specific penalties that the Insurer is to apply. The Insurer will apply the penalties before the end of June of the calendar year.

This process is complete for 2019 and all outstanding penalties have been applied.

Recommendation #3

That the City document and properly approve all changes to the scope of work, deliverables and/or fees in its benefits contracts.

Management response:

Management agrees with the recommendation.

Human Resources worked with Supply to identify opportunities to strengthen practices for the documentation and approval of changes to the scope of work, deliverables

and/or fee in its benefits contracts. Supply Services made a series of recommendations to Human Resources in October of 2018, which have been adopted. Supply Services will be updating the City's procedure on contract changes in Q4 2019 after which, Human Resources will review and update the processes as required based on the requirements of the revised procedure. This work will be completed by Q1 2020.

Recommendation #4

That the City only pay its external benefits consultant directly and stop indirect payments from the insurer to the external benefits consultant.

Management response:

Management agrees with the recommendation.

Human Resources is developing new payment protocols and an account structure that will enable the City to pay the External Benefits Consultant directly from a City account.

These payment protocols and an account structure will be implemented by Q1 2020.

Recommendation #5

That the City analyze the costs and benefits of implementing a process to verify the accuracy of spousal and dependent information provided by City employees.

Management response:

Management agrees with the recommendation.

The Finance Services Department will analyze the costs and benefits of implementing a process to verify the accuracy of spousal and dependent information provided by City employees. The review is scheduled to be completed by Q2 2020.

Recommendation #6

That the City complete Management Action and Response Plans for recommendations included in reviews performed by the external benefits consultant.

Management response:

Management agrees with the recommendation and it has been implemented.

Human Resources has completed Management Action and Response Plans for all recommendations included in reviews performed to date by the External Benefits Consultant.

Human Resources, the Insurer and the External Benefits Consultant review the Action and Response Plan at the regular bi-monthly business meetings as required to resolve all items. Resolutions are captured in the bi-monthly business meeting minutes.

This process was instituted in Q2 2019 and will be followed for future recommendations resulting from reviews performed by the External Benefits Consultant.

Detailed audit report

Introduction

The Audit of Benefits Processing – Compliance and Program Management was included in the 2018 Audit Plan of the Office of the Auditor General (OAG), approved by City Council in November 2017.

Background and context

Human Resources Services (HR) manages the benefit plans for the City of Ottawa providing benefits to approximately 15,800 employees and retirees, as well as their spouses and dependents. This includes managing contracts between the City and its insurer and communicating benefits information to employees.

Actual expenditures for 2018 were approximately $86.2 million for employees and retirees of the City. This expenditure reflects the City's expense ($80.8 million) as well as employee and retiree contributions. The City is self-insured for mandatory health, dental and long-term disability benefits. It contracts an insurer to review, approve and pay claims. The insurer is paid a retention/administrative fee, which is a combination of a fixed fee per transaction, percentage of the value of claims paid, and percentage of premiums depending upon the transaction. The City's insurer currently provides this service for all mandatory benefits except for basic Accidental Death and Dismemberment (AD&D).

The City issued a Request for Proposal (RFP) in 2015 for an insurer and in 2016, the City entered into an agreement with its current insurer for a five-year term with the option of extending the agreement for two additional five-year terms.

The City has established Service Level Agreements with its insurer for both itself and the Amalgamated Transit Union 279 Conventional (ATU)[2] that define service level standards and penalties for not meeting them.

[2] ATU 279 benefits are handled through an Employee Benefit Trust covered by a Trust Indenture agreement. Day-to-day administration delegated to City for payroll deductions and benefits eligibility administration. Trust Committee comprised of City HR Management and staff and Union representatives involved in selecting Insurance companies.

The City is required to leave a minimum amount on deposit with its insurer for meeting claims.

During the period between 2014 and 2018, the cost of benefits has increased from $73 million to $86.2 million (17.9%) while the number of insured employees and retirees increased from 15,544 to 15,884 (2.2%). The increase in the cost of benefits per employee was mainly due to the rising cost of health care, particularly the cost of prescription drugs and an increase in the cost of long-term disability claims.

Table 1: 2018 benefits expenditures (before amounts paid from surplus)

Benefit	**2018 actual expenditures (in millions)**
Health (including drugs)	$39.4
LTD (Long Term Disability)	$25.0
Dental	$14.8
Life	$6.4
AD&D	$0.4
Semi-private hospital	$0.2
Total	**$86.2**

Within Health benefits, drugs were the most significant expenditures ($19.9 million in 2017). Claims for drugs are reviewed and approved by a third party working on behalf of the insurer.

Other areas of significant expenditures within the Health benefits category included vision care ($2.6 million), and paramedical services ($5.3 million). Paramedical services include massage therapy, physiotherapy and psychologist treatment and have combined maximums per person per calendar year.

In addition to its agreement with its insurer, the City also has an agreement with an external benefits consultant. The consulting firm supports the City's management of benefits with services that include audits of the insurer's claims, reviewing the insurer's claims approval processes, as well as actuarial and communication services.

As of July 1, 2018, the City's HR Services managed 13 benefits plans, covering 71 divisions[3]. Active employees account for 25 divisions while 46 divisions are for retirees.

The City also has a separate contract with a firm (referred to as the third-party administrator) for four specific benefits related services. The responsibilities of the third-party administrator are:

- Retiree Benefits: Providing benefit administration to City retirees and their dependents. Note that claim processing and payment for retirees and their dependents is done by the City's insurer.
- ATU Cost of Living Adjustment (COLA): Providing ATU recipients with COLA benefit payments.
- ATU Ontario Health Premium (OHP) for Retirees and their dependents: Calculating and providing ATU recipients with OHP benefit payments.
- Self-Insured LTD Statutory Deductions: Calculating and providing LTD recipients with benefit top-up payments.

As part of these services, the third-party administrator is also responsible for communication to members and for financial reporting.

As part of their duties, the City's insurer, external benefits consultant and third-party administrator have access to and retain significant personal information of City employees, retirees and their dependents.

Audit objectives

The overall objective of this audit was to assess whether the City's systems, practices and procedures effectively manage benefits processing. This overall objective was comprised of the following three objectives:

[3] A division is a group of individuals with the same benefit entitlement.

Audit objective #1

The City ensures that contractors engaged for benefits processing, administration and analysis are providing services in the manner specified in the respective contracts.

Audit objective #2

Only eligible expenses are being paid.

Audit objective #3

City processes are adequate to ensure the privacy and security of employee and dependent health and personal information handled by benefits contractors.

Scope

The scope of the audit was Benefits Processing – Compliance and Program Management for 2016, 2017 and 2018 and was undertaken from April 2018 to December 2018.

The scope included:

- Benefits processing for the City; and
- Benefits processing for the ATU Benefit Trust: the portion for the day-to-day administration delegated to the City for payroll deductions and claims administration.

This audit excluded the following:

- Benefits for the Ottawa Public Library and the Ottawa Police Service and their employees, retirees and dependents;
- The procurement processes for the benefits contracts;
- Specific assessment of the ATU Benefit Trust Indenture agreement; and
- LTD benefits which may be addressed in a separate audit[4].

[4] The processes and controls related to LTD benefits are significantly different than those for other benefits.

Audit approach and methodology

The audit was designed and conducted in accordance with the requirements of the City's Audit Standards to ensure that sufficient and appropriate audit procedures were conducted, and evidence gathered to provide reasonable assurance of the accuracy of audit findings and conclusions, as they existed at the time of the audit.

To assess whether the City's systems, practices and procedures effectively manage benefits processing, activities performed included:

- Interviews with City staff members as well as staff at the City's insurer, external benefits consultant and third-party administrator;
- Analytical procedures to confirm the eligibility of insured individuals;
- Testing of select drug benefits paid;
- Review of contracts between the City, the insurer, the external benefits consultant and the third-party service provider;
- Review of documentation to assess whether the insurer, external benefits consultant and third-party administrator are fulfilling contractual requirements; and
- Review and testing of processes to protect the personal information of City employees, retirees and their spouses and dependents.

Audit observations and recommendations

This section provides details on the key observations resulting from the audit. Where applicable, recommendations are also provided.

Audit objective #1: Contract management

For the delivery of its benefits program, the City has entered into contracts with three service providers. The core activities performed by the contractors include:

- The insurer: Reviewing, approving or rejecting submitted claims and paying approved claims;
- The external benefits consultant: Plan management, financial audit, contract renewal, actuarial and communication services; and
- The third-party administrator: Administrating benefits for retirees, retiree's spouses and dependents.

Contract management: Insurer

The City selected its insurer through an RFP process, entering into a contract with its current provider for services beginning in 2016. The insurer is responsible for reviewing, adjudicating and processing claims submitted by City employees[5]. The insurer is paid a retention/administrative fee, which is a combination of a fixed fee per transaction, percentage of the value of claims paid, and percentage of premiums depending upon the transaction. Including reimbursement for claims paid by the insurer and professional fees, the City paid its insurer $76.3 million in 2017 and $86.2 million in 2018[6].The City does not calculate the breakdown of amounts paid to its insurer for reimbursement of claims paid versus the insurer's fees.

1. Quality assurance

In addition to core tasks of reviewing, adjudicating and processing claims, the contract with the insurer includes a requirement for a quality assurance process to be implemented. Per the contract, this quality assurance process must include each of the following:

- Claims adjudication audits to determine both the financial and non-financial accuracy of claims paid under all the benefit programs.
- System coding audits to ensure that the coding aligns with the policy/contract terms.
- Case management audits to review the timeliness and quality of services provided to employees and to the City's Disability Management Consultant. Although LTD was out of scope for the audit, we did verify that the insurer was providing the full scope of quality assurance deliverables including case management audits.
- Call center audits to evaluate the accuracy, completeness, quality and effectiveness of call center employees in handling questions from employees and/or from the plan administrators.

We found that the insurer was providing only one of these four required components. The insurer provided annual reports to the City that included information on the timeliness and quality of services provided in accordance with the requirement for case management audits. However, two of four required components of the insurer's quality

[5] The accuracy and timeliness with which the insurer reviews, adjudicates and processes claims is addressed below (see audit objective #2).

[6] Of which $80.8 million was the City's portion and $5.4 million was from employees and retirees.

assurance program, claims adjudication audits and systems coding audits, have been completed by the City's external benefits consultant and not the insurer. As the City pays its external benefits consultant separately, it is in effect double paying for the service.

We also found that one required component was not being fulfilled by the insurer or the external benefits consultant as no call center audits have been completed.

Recommendation #1

That the City ensure that the insurer is completing quality assurance activities described in the contract and actively monitor the results of the quality assurance activities.

Management response:

Management agrees with the recommendation and it has been implemented.

Human Resources has developed a Quality Assurance Monitoring Procedure that outlines the detailed steps and responsibilities of Human Resources and the Insurer to ensure that quality assurance and monitoring activities will be completed as described in the contract.

The Insurer will deliver the quality assurance audit reports quarterly to Human Resources, within six weeks of the close of the calendar quarter. Human Resources will then assess the results and bring forward matters for discussion to the next standing business meeting with the Insurer. Actions required based on the assessment will be documented in the business meeting minutes and monitored until completion.

Quality assurance audits for year-to-date 2019 have been received and are on the agenda for the bi-monthly business meeting with the insurer in November 2019.

2. Service Level Agreement

The City has established a Service Level Agreement (SLA) with its insurer. Under the SLA, the insurer agrees to provide specified services to the City within defined service levels, including accuracy of claims processing. Performance against these targets is measured by the insurer and reported annually to the City. Additional assurance related to the accuracy of performance related to claims processing is provided to the City by the external benefits consultant.

The SLA includes penalties for service levels not met by the insurer. Penalties are assessed annually based on performance throughout the year. The annual report is to be provided to the City within 90 days of year end. We found that the insurer did provide

the City with reports for both 2016 and 2017. Based on these reports, penalties of $16,650 (2016) and $5,300 (2017) were due to the City from the insurer for failing to achieve some of the specified service standards.

We found that the service standards and penalties reported upon for the ATU agreement did not align with the standards included in the SLA. Had the correct service standards been used, we calculated that penalties for the insurer would have been roughly $10,000 higher.

We were informed that the City had agreed with the insurer to lower both the service standards and the penalties for the OC Transpo Employment Benefit Trust. This was because the ATU plan has far less members than the City's plans, so both the insurer and the City agreed that the penalties should also be less. However, the City and the insurer did not formalize these changes and the SLA was not amended.

In addition, we found that the penalties were not applied by the City in a timely fashion. Penalties for 2016 were not applied until October 2018 and 2017 penalties had not been applied at the time of the audit.

Recommendation #2

That the City ensure that penalties applied under the service level agreement are enforced at agreed upon rates in a timely fashion.

Management response:

Management agrees with the recommendation and it has been implemented.

Human Resources has developed a Service Level Agreement Penalty Payment Procedure to ensure that the penalties applied under the service level agreement are enforced in a timely fashion.

The Insurer will provide the Annual Service Level Agreement Reports, which include the details of the penalties due and at what rate, to Human Resources and the External Benefits Consultant within 12 weeks of the close of the calendar year. Human Resources will assess the reports and bring forward matters for discussion to the following regular bi-monthly business meeting with the Insurer and the External Benefits Consultant. Actions required based on the reports will be documented in the bi-monthly business meeting minutes, including the specific penalties that the Insurer is to apply. The Insurer will apply the penalties before the end of June of the calendar year.

This process is complete for 2019 and all outstanding penalties have been applied.

3. Fee payment

The City's Payroll, Pensions and Benefits (Payroll), remits insurance premiums to the insurer each month based on staffing actions and benefit rate tables provided by the insurer and included in the City's financial and human resources system.

For each line of the benefits rate tables, the total premium is calculated by multiplying the prescribed rates by the number of claimants. We examined one of the insurer's invoices. We found that 4 out of 36 lines (11%) contained inaccurate rates. However, the total dollar impact resulting from these errors was insignificant.

Contract management: External benefits consultant

The City entered into a contract with its external benefits provider for six services as detailed in the table below.

Table 2: Services provided by external benefits provider

Service	Description
Contract renewals	Annual budgets for the upcoming year are negotiated with the insurer for all plans. These budgets determine the per employee rates to be paid based on several factors including past claims experience. The External Benefits Consultant conducts the negotiations with the insurer on the City's behalf.
LTD benefits consulting	Preparing annual report on LTD benefits and proposing rates for the upcoming year.
Financial audits	Producing verified financial reports for all benefits plans. This includes reconciling of premiums, claims, fund balances etc. with the insurer.
Core benefits consulting	Providing plan management advice and consulting services throughout the year.
Actuarial valuation	Valuing *Non-Pension Post Retirement and Post-Employment Benefits* for the City's financial statements. These actuarial services are managed by the City's Corporate Finance group. We

Service	Description
	did not examine the provision of these services, as they were not directly related to the City's management of claims.
Communications for the benefits plan	Managing and maintaining the City's existing benefit plan communication materials.

After excluding actuarial valuation services, of the remaining five requirements, we found that the external benefits consultant had provided four of the required services. Specifically, the external benefits consultant did not provide a LTD benefits consulting services report. We were advised that City management decided that a LTD benefit consulting report would be required every third year, rather than annually as is set out in the contract and that this work would be completed during 2018. However, the City did not formally change the requirement for LTD Benefit Consulting in the contract with a contract amendment. Note that the external benefits consultant's fees are determined based on services provided so the City did not pay for LTD Benefit Consulting services that it did not receive.

Professional fees paid to the external benefits consultant during 2017 were analyzed and we found that fees exceeded the amount in the original contract by 89%[7].

Table 3: 2017 external benefits consultant professional fees

Professional fees	Contract	Actual fees	Variance
Total fees	$360,200	$671,046	$310,846
Less: Actuarial valuation fees	$34,300	$54,575	$20,275
Total	$325,900	$616,471	$290,571

We noted that during that period, fees were paid to the external benefits consultant for activities that were not included in the original contract. While there are emails from City staff approving these additional activities and fees, they were not approved via the

[7] Fees for Actuarial Valuation services were excluded because they are managed separately.

City's formal contracting practices and as such did not comply with the Procurement By-law.

The external benefits consultant is paid both by the City and by the insurer. We were informed that the practice of the insurer paying the external benefits consultant a percentage of claims is not unusual in the industry. However, this practice reduces the City's control over the amounts paid to the external benefits consultant under the contract and was a contributing factor in the payments exceeding the contract limit.

Recommendation #3

That the City document and properly approve all changes to the scope of work, deliverables and/or fees in its benefits contracts.

Management response:

Management agrees with the recommendation.

Human Resources worked with Supply to identify opportunities to strengthen practices for the documentation and approval of changes to the scope of work, deliverables and/or fee in its benefits contracts. Supply Services made a series of recommendations to Human Resources in October of 2018, which have been adopted. Supply Services will be updating the City's procedure on contract changes in Q4 2019 after which, Human Resources will review and update the processes as required based on the requirements of the revised procedure. This work will be completed by Q1 2020.

Recommendation #4

That the City only pay its external benefits consultant directly and stop indirect payments from the insurer to the external benefits consultant.

Management response:

Management agrees with the recommendation.

Human Resources is developing new payment protocols and an account structure that will enable the City to pay the External Benefits Consultant directly from a City account.

These payment protocols and an account structure will be implemented by Q1 2020.

Third-party administrator contract management

The City contracts with a third-party administrator to provide administration services for retirees and other specified benefits related services. We found that City staff met with

the third-party administrator on an annual basis to review that it was providing the contracted scope of work and deliverables. These services for City retirees include:

- Administration of Health, Dental, and Life Insurance Benefits;
- Communication to Members; and
- Financial Reporting.

We also found that Service Standards have also been established for the performance of key deliverables and that the third-party administrator was fulfilling its obligations within established service standards.

Audit objective #2: Eligibility

We assessed the extent to which the City only paid for eligible benefit expenses. To do so, we obtained transaction details for claims paid by the insurer on the City's behalf. We then tested the eligibility of the individuals making claims and that the claims were eligible for reimbursement under the applicable benefit plan. We focused our testing on specific types of claims given the risks and the testing that was done by the external benefits consultant. We also reviewed the timeliness of claims processing, comparing it to agreed service standards.

Overall, we found that the system of controls in place to ensure only eligible claims paid was functioning well.

Eligibility of employees, retirees and dependents

To be eligible for benefits, a claimant must be City employee, spouse or dependent of a City employee, a City retiree, spouse or dependent of a City retiree. New City employees who are eligible for benefits are responsible for entering information on their spouse and/or dependents in a City system at the start of their employment. For subsequent changes, employees complete and sign a "Group Benefits Change Form" and submit it to the Payroll, Pensions and Benefits Branch. As is general practice in the benefits field, the City does not verify spousal and dependent information provided by employees. This increases the risk of inaccurate and/or fraudulent spousal or dependent information being entered into the system and ineligible claims being paid for these individuals. The costs and benefits of implementing reviews of spousal and dependent information has not been analyzed by the City.

The Payroll, Pensions and Benefits Branch provides the insurer with a file from the City's SAP system with all these changes every two weeks. The insurer uses this

information to update its systems to assess the eligibility of individuals submitting claims.

We conducted automated tests to assess whether the information on City employees and their dependents was aligned between City and insurer records. Of the thousands of records compared, four discrepancies were identified that increased the risk of ineligible claims being processed.[8] Specifically, one individual had been enrolled by the insurer in error and three records where the employee's dependents were incorrectly set-up as eligible in the insurer's system. While these errors could have resulted in the insurer incorrectly reimbursing an ineligible claim, City staff confirmed that the insurer corrected each of the errors and no claims were paid to the ineligible dependents. Of these four, one error was identified by the insurer and one was identified by the City. It is unclear who identified the remaining two errors.

In addition to City employees, retirees and their dependents are eligible for benefits. We found sixteen records with discrepancies that increase the risk of payments to ineligible claimants. Specifically, nine records were missing the dependent's date of birth or there were discrepancies in dates of birth, which could result in payments to dependents over the age of 25, the cut-off age for dependent eligibility. Further, during testing we identified seven dependent records for members identified only having single coverage within the City's system. However, we found that no payments had been issued on behalf of these dependents.

Recommendation #5

That the City analyze the costs and benefits of implementing a process to verify the accuracy of spousal and dependent information provided by City employees.

Management response:

Management agrees with the recommendation.

The Finance Services Department will analyze the costs and benefits of implementing a process to verify the accuracy of spousal and dependent information provided by City employees. The review is scheduled to be completed by Q2 2020.

[8] There were 93 records with other minor discrepancies such as inconsistently spelled names or missing birthdates; however, these discrepancies did not increase the risk of ineligible claims being processed.

Eligible expenses

To assess the risk that eligible individuals may submit and be reimbursed for an ineligible claim, we reviewed the many categories of benefits provided, the verification work done by the benefits consultant as well as audits completed in other municipalities. We concluded that the highest risk claim related to four categories of drugs.

Based on the City's collective agreements, certain drug categories have eligibility restrictions. These include, but are not limited to, smoking cessation drugs, fertility drugs, oral erectile dysfunction (OED) drugs and fentanyl. We tested claims made in these four drug categories[9] to assess whether the insurer was properly applying eligibility criteria.

Table 4: Drug categories tested by OAG

Drug category	Eligibility restrictions	Findings
Smoking cessation drugs	Lifetime maximum of $400 per claimant.	No cases of the insurer paying ineligible expenses and/or exceeding applicable limits for smoking cessation drugs.
Fertility drugs	Lifetime maximum of $15,000 per claimant.	No cases of the insurer paying ineligible expenses and/or exceeding applicable limits for fertility drugs
Oral erectile dysfunction drugs	Ineligible for reimbursement.	A total of 80 out of 259 claims for oral erectile dysfunction drugs totaling $8,557 were paid by the insurer to 31 claimants. The insurer stated that the payments were due to a coding error, which it claimed to have resolved. [10] The insurer reimbursed the City for the amounts paid for OED Drugs.

[9] The City's external benefits consultant conducted a drug claim eligibility review for two large union groups, which found only limited problems. Therefore, we tested drug claims made by members of the next largest union.

[10] While the insurer stated that the coding error was resolved, 12 of the claims for OED drugs that we found were approved after the insurer stated the coding error was resolved. The City and the insurer

Drug category	Eligibility restrictions	Findings
Fentanyl	No restrictions.[11]	No unusual claim patterns were identified (e.g. for claimants reviewed, claims for fentanyl were not frequent or for high dollar amounts).

In addition to the testing we performed, the City's external benefits consultant identified that 718 claims for OED drugs totalling $59.6K were paid by the insurer. The insurer conducted further investigation and in total, reimbursed the City $134.6K for ineligible payments of OED drugs paid under three union agreements.

Accuracy of claims adjudication and processing

It is the responsibility of the insurer to ensure that claims are reviewed and adjudicated accurately. As part of enabling, the insurer to adjudicate claims accurately, the Payroll, Pensions and Benefits Branch of the City has to keep employee information up to date so that the insurer knows who is eligible, which division rules and collective agreements limits apply.

To provide the City with assurance the insurer is adjudicating claims accurately, the external benefits consultant reviews the insurer's performance. This has included a drugs review and a health review. The objectives and conclusions of these reviews are summarized in the table below.

continue to investigate the cause of the error; and found that in all the 12 cases the drug was indicated for another condition.

[11] Fentanyl was included in the scope of the audit because of a high risk of fraud resulting from its resale value on the streets.

Table 5: Objectives and conclusions of external benefits consultant's reviews

1. Drug review	
Review objective:	Review the electronic pay direct drug claims data and paper drug claims adjudicated on the insurer claims system to ensure that coverage provisions are coded accurately to reflect provisions in the City's contracts and to identify any discrepancies.
Review conclusion:	The review confirmed that for the majority of key adjudication areas tested, the insurer is reimbursing claims in line with the City's plan provisions and industry standards.
2. Health review	
Review objective:	The review was undertaken to Provide a third-party review of the accuracy of the insurer's claim payment performance; Assess whether claims eligibility and reimbursement is in accordance with the terms of detailed in the former insurer's policies; Identify payment errors; Identify problem areas and provide recommendations to proactively address these issues; and Provide a basis for evaluation of future performance.
Review conclusion:	The review found that for the most part, the insurer's claims system accurately reflects the City/Benefit Trust's general contract provisions.

These two reviews included recommendations for the insurer as well as three recommendations for the City. While City staff created a tracking document that identified City actions related to one out of three recommendations, overall the City's implementation of the recommendations was either incomplete and/or not documented.

Recommendation #6

That the City complete Management Action and Response Plans for recommendations included in reviews performed by the external benefits consultant.

Management response:

Management agrees with the recommendation and it has been implemented.

Human Resources has completed Management Action and Response Plans for all recommendations included in reviews performed to date by the External Benefits Consultant.

Human Resources, the Insurer and the External Benefits Consultant review the Action and Response Plan at the regular bi-monthly business meetings as required to resolve all items. Resolutions are captured in the bi-monthly business meeting minutes.

This process was instituted in Q2 2019 and will be followed for future recommendations resulting from reviews performed by the External Benefits Consultant.

In addition to reviews completed by the external benefits consultant, the City has an SLA with its insurer that includes service standards related to the health and dental claims that it audits. The service standards in the SLA require the insurer to achieve 98% financial accuracy and 96% non-financial accuracy on audited claims.

The insurer provides the City with an annual report that evaluates their performance against the agreed service standards. For the 2016, the insurer reported Health and Dental claims had 99.4% financial accuracy and 99.6% non-financial accuracy. For 2017, the insurer reported 99.9% financial accuracy and 99.5% non-financial accuracy. As such, the insurer has satisfied SLA requirements for financial and non-financial accuracy for Health and Dental claims, providing additional assurance that claims are being adjudicated accurately.

Timeliness of claims adjudication and processing

It is important to the City and its employees that claims be adjudicated and processed in a timely manner. The SLA with the insurer sets out the City's expectations related to timeliness. The table below provided the service standard and the insurer's self-reported 2017 performance:

Table 6: Insurer's 2017 service performance

Service	Service standard	2017 performance
Health and dental claims	90% within 7 calendar days 99% within 14 calendar days	94.7% within 7 calendar days 99% within 14 calendar days
Life claims	90% within 5 business days	100% within 5 business days
Critical illness claims	90% within 10 business days	100% within 10 business days

Based on these reports, we found that the insurer is adjudicating and processing claims in a timely manner.

Audit objective #3: Protection of personal information

To process benefits, the City and its contractors are provided with personal information on City employees, retirees and their dependents. All involved parties are required to protect this personal information.

We found that the City sends personal information to its insurer, external benefits consultant and third-party administrator via email encrypted using Transport Layer Security (TLS) Protocol. The City's Technology Solutions Branch has implemented measures that require all outgoing and incoming messages from the domains of the insurer, external benefits provider and third-party administrator be encrypted using TLS protocol.

In addition to controls established by the City, during the contracting process for the insurer, the City included mandatory requirements related to the protection of personal information, which the insurer, external benefits consultant and third-party administrator satisfied. The insurer is required to provide the City with annual reports from third-party firms verifying that its controls are designed and operating effectively for the protection of personal information. These reports are the Statement on Standards for Attestation 16 Systems and Organization Controls 2 Audit Report[12] and the Canadian Standard on Assurance Engagements 3416 Audit Report[13].

The insurer provided the City with these audit reports performed by independent auditors for years 2015-16 and 2016-17. The third-party auditors examined the insurer's management, monitoring and organization controls, system controls, including security of systems and data, systems development and maintenance, and computer operations and scheduling. The third-party auditors also examined the insurer's transaction processing controls and the insurer's management and control of third-party service providers. No significant weaknesses were identified in the audit reports.

The City also requires the external benefits consultant to have a privacy policy as well as comprehensive process and procedures to deal with and address potential privacy breaches. The external benefits consultant provided the City with a copy of its Personal Information policy. This policy states that personal information is protected using technical, physical and organizational measures designed to prevent unauthorized

[12] Focuses on a business's non-financial reporting controls as they relate to security, availability, processing integrity, confidentiality and privacy of a system.

[13] Report on controls at service organizations.

access, unlawful processing and unauthorized or accidental loss, destruction or damage to the personal information.

The external benefits consultant‘s policy also requires its employees to immediately report all incidents involving the suspected or actual loss, theft, unauthorized disclosure or inappropriate use of personal information. An incident response team that includes representatives from the relevant functions and businesses then investigates the implications and significance of incidents and determines any obligations under the applicable technical, security, regulatory and/or legal frameworks. The City has not received any such reports from the external benefits consultant.

Lastly, the City required its third-party administrator to implement a privacy policy and comprehensive processes and procedures to deal with and address potential privacy breaches.

We found that the third-party administrator has implemented a privacy policy that identifies that they are accountable for all personal information in their possession, custody or control, including any personal information that has been collected about clients and their employees, members and past members. It also states that personal information will be safeguarded from loss or theft, and from unauthorized access, disclosure, duplication, use or modification.

However, the City has not verified [14] that the third-party administrator has established procedures to address potential privacy breaches.

[14] Subsequent to our fieldwork, management indicated that it verified that a procedure does exist.