Cherry Bekaert LLP
CPAs & Advisors

Report of Independent Accountant
On Applying Agreed-Upon Procedures

Honorable Members of the District School Board
District School Board of Osceola County, Florida
Kissimmee, Florida

Dear Members:

We have performed the procedures enumerated below, which were agreed to by the District School Board of Osceola County (the "District"), solely to assist you in evaluating the processing of claims by the third party administrator, Johns Eastern (the "Provider") for the year ended June 30, 2016. The District's management is responsible for the District's accounting records. This agreed-upon procedures engagement was conducted in accordance with attestation standards established by the American Institute of Certified Public Accountants. The sufficiency of these procedures is solely the responsibility of those parties specified in the report. Consequently, we make no representation regarding the sufficiency of the procedures described below either for the purpose for which this report has been requested or for any other purpose.

Our procedures and findings are as follows:

1. We inquired of Nick Mullins, TPA Liability Manager, and Greg Burden, Quality Assurance Manager, to identify existing policies and procedures related to the claims processing system that were in place, and Messrs. Mullins and Burden advised us that these policies and procedures were as follows (we did not perform any procedures to verify Messrs. Mullins' and Burden's representations):

   The District is self-insured. The District funds an account maintained in the Provider's name, referencing the District, out of which all payments for the District's general and vehicle liability and workers' compensation claims are made.

   Generally, an authorized District Risk Management employee initiates the claims process for a general or vehicle liability claim or a workers' compensation claim by completing a claim form, which is used by the claims adjuster at the Provider to set up a claim in the claims management system. Once the claim form is completed, it is transmitted to the claims adjuster electronically. The initial entry by the claims adjuster into the claims management system assigns a system-generated event number. One entry field within the claims management system, "District," helps ensure that only the District's claims are entered into the system. The District can also transmit claims to the Provider by phone, fax, or mail and provides appropriate supporting documentation, such as a police report or other proof of loss, to the claims adjuster in order for a claim to be set up. Upon receipt of the needed information, a claim is formally set up, with a claim number assigned to the claim.

   Vehicle accident claims where the automobile is still "drivable" generally require receipt of two or three estimates from repair providers. After verifying the validity of the facts supporting the claims (usually review of the police report or driver exchange of information and some investigatory procedures), the claim will either be denied or approved by the claims adjuster for payment, with the lowest cost repair estimate always being selected. At that point, the claims adjuster will contact the claimant, usually by phone, and propose a settlement. The claimant can then approve or decline the settlement and the payment process can proceed if the proposed settlement is approved. Authorized District personnel have read-only access to the claims management system so they can research the status of a particular claim at any time.

For a first-party only claim, the claims adjuster will set up the claim as a vehicle accident claim in the claims management system and will process the claim with an appropriate $1,000 per claim deductible, which would be paid to the District out of pooled funds. As the claims process proceeds, the claims adjuster enters comments into the notes section of the particular claim to update the status. Generally this would include information on receipt of qualified repair quotes, decisions on whether a claim has been approved for payment or denied, and any status updates. Generally, the Provider does not offer a rental car for claimants but can provide one if requested in some situations. Once final payment has been made, the claim file will be placed on a list to close. The next time the file is reviewed, and a “release from liability” form has been obtained from the claimant, the claim file will be closed.

For vehicle accident claims where the vehicle is no longer “drivable,” an outside appraiser is used to determine the amount to be paid for damages. After reviewing the report provided by the appraiser and cross-checking certain details from the report to other source documents, such as the police report, in the claim file, the Provider will approve and pay claims up to the maximum amount from the appraisal provided by the outside appraiser.

Additional investigation and possibly litigation might be required in situations where the claimant and claimant’s attorney do not accept the outside investigator’s recommended settlement amount. Generally, the claims adjuster will key into the claim file notes and the appraised value amount and then propose a settlement to the claimant. The claims adjuster has been given authority to make judgments on individual claims up to $10,000. For claims in excess of this amount, the Provider's TPA Liability Manager is required to be involved.

Bodily injury claims are usually initiated by the District via notice of complaint by an attorney for the claimant. The attorney files a complaint and the District advises the provider that a claim should be set up in the claims management system. The claims adjuster or their outside investigator will investigate the details of any potential bodily injury situations so they can handle them appropriately. They will research any claims history on claimants to analyze the reasonableness of claims. They often do a scene investigation and interviews of investigating police officers and any witnesses that might have been present. The payment of claims is generally based on a settlement agreement or a court order. The bodily injury portion of vehicle accident claims often take longer to settle than the property damage portion of these claims. In situations where a bodily injury situation exists, the claims adjuster will set up an estimated liability reserve in the claims management system, with a separate estimate for the property damage portion of the claim and a separate estimate for the bodily injury portion. Generally in Florida, individuals are required to carry personal injury protection ("PIP") coverage. PIP coverage covers 80% of the liability on the first $10,000 of a bodily injury claim. The District would prospectively be liable on the other 20% of the first $10,000 and the entire claim amount in excess of the $10,000 base amount. Ordinarily, the treatment process is essentially complete, where maximum medical improvement is achieved, at the point of filing of the bodily injury claim. For claims incurred prior to 10/01/2011, there is a statutory limit on such claims filed in state court of $100,000 per claimant and $200,000 total per claim. Claims incurred after 10/01/2011 are limited to $200,000 per claimant and $300,000 total per claim. There is no such limit for claims filed in Federal court. Files are closed upon final payment and receipt of a signed “release of liability” form by the claimant.

With regard to general liability type claims, the Provider handles claims related to errors and omissions, general liability, property damage, and crime/employee dishonesty. For errors and omissions claims, the District generally initiates the claims process, filing liability forms and forwarding applicable documentation to the claims adjuster, who sets up the claims in the claims management system. Claimants often have to obtain a "Right to Sue" letter from the Equal Employment Opportunity Commission. Upon notification of a potential errors and omissions claim, the Provider forwards the case to its representative law firm, which then proceeds to litigate or settle cases depending on the

circumstances. They generally pay only the legal bills on claims until the cases are settled or litigated to their successful conclusion. Upon a notice of final judgment or a settlement agreement, the claim is submitted for payment. Files are closed upon final payment and receipt of a signed "release of liability" form from the claimant.

For general liability type claims, the District generally initiates the claims process by completing a claim form and electronically transmitting it to the claims adjuster. This is usually followed by receipt of all supporting documents required to set up a claim. At this point, an event number and a claim number are assigned to each claim in the claims management system by the claims adjuster. With regard to personal injury-related claims included within the general liability category, the claims adjuster or an outside investigator will perform appropriate site investigation, interviews of injured and offending parties, and other applicable investigatory procedures. Certain claims, such as hurricane claims, are immediately referred through the TPA Liability Manager to an outside appraiser who assesses the property damage and resolves issues with the claims. The claims adjuster can set up a liability reserve in the claims management system based on the preliminary judgment of the adjuster, which can be modified based on changes in status of the claim. A report of open claims is made available to the District, which can be reviewed at any time by authorized District personnel.

Payments of vehicle or general liability type claims are initiated by the claims adjuster, who will enter check payment information into the claims management system. The claims adjuster is not allowed to edit the payee name on checks. Claims that require a payee name change must be processed by the home office. Changes are made in accordance with settlement payment request forms, prepared by the claims adjuster. Before printing of checks occurs, a pre-check register is reviewed by the home office, which verifies accuracy of information and verifies that claims are being paid from the proper bank account. The home office prints all checks approved for payment and sends them to the TPA Liability Manager, who is authorized to sign checks on the bank account. The TPA Liability manager verifies the payees and amounts on the checks before signing them. Copies of the checks and remittance advices are retained for the claims files and originals are mailed out.

For workers' compensation claims, the District generally initiates the claims process after receiving a notice of injury from the injured employee's supervisor by completing a claim form and electronically transmitting it to the claims adjuster. At this point, an event number and a claim number are assigned to each claim in the claims management system by the claims adjuster. After a claim has been set up, the adjuster will complete a three point contact to substantiate the information provided is accurate. The claims adjuster can set up a liability reserve in the claims management system based on the preliminary judgment of the adjuster, which can be modified based on changes in status of the claim. District approval is required for reserves in excess of $25,000. A report of open claims is made available to the District, which can be reviewed at any time by authorized District personnel.

Medical bills for workers' compensation claims are submitted directly to the Provider from the provider(s) of medical treatment. Payments are then initiated by the claims adjuster, who will enter check payment information into the claims management system. The claims adjuster is not allowed to edit the payee name on checks. Claims that require a payee name change must be processed by the home office. Copies of the checks and remittance advices are retained for the claims files and originals are mailed out.

Indemnity settlements for lost wages for workers' compensation claims are negotiated with the claimant or the claimant's attorney with District approval and then submitted to a judge of compensation claims for approval. Indemnity payments are then initiated by the claims adjuster, who will enter check payment information into the claims management system. The claims adjuster is not allowed to edit the payee name on checks. Claims that require a payee name change must be processed by the home office. Changes are made in accordance with settlement payment request forms, prepared by the

claims adjuster. Copies of the checks and remittance advices are retained for the claims files and originals are mailed out.

Claimants for claims that are denied by the Provider for lack of fault or not enough support to be paid are sent a letter from the claims adjuster informing them of denial of their claim and documenting the reason for denial. A copy of this documentation is retained in the claim files and notation is made in the electronic claim file notes. A copy of the denial letter is forwarded to the Director of Risk and Benefits Management at the District for his review. There is no formal appeals process in place. Claimants will often file claims with their personal automobile insurance and the outside insurance provider will negotiate a settlement with the Provider. As a matter of practice, for claims that have been set up where there is a long period of inactivity, the claims adjuster has authority to close the file. Loss run reports are made available to the District so they can be made aware of all claims that have been closed, either due to payment, inactivity, or denial of claim. If a claimant attorney is involved, they often leave claims open until the statute of limitation (four years for liability claims and two years for worker's compensation claims) runs out before closing the claim.

2. We selected a sample of 90 claims (45 general and vehicle liability claims and 45 workers' compensation claims) processed and closed between July 1, 2015 and June 30, 2016. The following is a summary of the procedures performed and the findings noted:

   A. We compared the claim number, claimant name, event date, and department specified on the Provider's report of claims processed to related information referenced in the corresponding remittance statements kept in claims files maintained by the Provider.

      No exceptions were noted.

   B. We inspected the claim files for identification as to whether each claim was accepted or denied.

      No exceptions were noted.

   C. For accepted claims, we performed the following procedures:

      1) We inspected documentation in claim files maintained by the Provider to verify that information provided by the District was included to support eligibility of selected claims.

         No exceptions were noted.

      2) We inspected the documentation supporting each claim to ensure it adequately supported payments made on the selected claim.

         No exceptions were noted.

      3) We inspected claims documentation to determine if coordination of benefits was appropriate and any secondary payer claims were handled properly.

         No exceptions were noted.

   D. For denied claims, we inspected documentation to determine it was appropriate to support such denial as well as to determine that a denial letter was sent.

      No exceptions were noted.

We were not engaged to, and did not, conduct an audit, the objective of which would be the expression of an opinion on the claims processed by the Provider for the District. Accordingly, we do not express such an opinion. Had we performed additional procedures, other matters might have come to our attention that would have been reported to you.

This report is intended solely for the information and use of District management and is not intended to be and should not be used by anyone other than this specified party.

Cherry Bekaert LLP

Orlando, Florida
October 14, 2016