



BENEFIT *Advisor*

In This Issue

In this first issue of the McGrawWentworth Benefit Advisor for 2005, we examine employee benefit plan audits in detail. Audits are important to ensure the accuracy of your administrator's claims payment process as well as the eligibility of the individuals covered by your plan. Audits can deliver significant benefits, especially if your claims payer has not diligently examined claim activity as a part of the payment process.

We welcome your comments and suggestions regarding this issue of our technical bulletin. For more information on this Benefit Advisor, please contact your Account Manager or visit the McGrawWentworth web site at www.mcgrawwentworth.com.

“Auditing Your Plan’s Performance”

While health care costs appear to be rising more slowly in 2005, increases above the rate of inflation still make health plan cost a priority. In the last several years, employers have increased deductibles, copays, and employee contributions in an effort to provide reasonably priced coverage. In many organizations, these types of changes will cause employees serious hardship if they continue.

Employers concerned with cost may want to consider conducting an audit of their plans. Audits can focus on different aspects of plan administration, including:

- **Eligibility:** An eligibility audit involves investigating whether the dependents and employees listed as covered on your plan should be covered.
- **Claims Payments (both system capabilities review and sample of claims paid):** Numerous areas of your health plan's claims base can be reviewed to seek out ineligible charges, improper discounts, and inadvertent provider billing and coding errors.
- **Coordination of Benefits:** Health plans are generally designed to be the secondary payer when another payer is

liable. Plan administrators may not always realize when another payer may be primary.

Self-funded plans benefit the most from plan audits. When it is discovered a claim has been paid in error, the auditing firm or the claims payer generally begins the process of recovering the claim amount. Any claim amounts recovered from a claim paid in error are returned to the employer. Audits can also encourage your claims payer to be more vigilant. Once a third party administrator realizes your plan is committed to regular plan audits, the TPA will be more diligent in investigating and paying claims. The result is that your plan will operate with greater efficiency.

Fully-insured plans can benefit as well. A fully insured plan will reap benefits from an eligibility audit. For every ineligible member discovered during an audit, the plan will pay less in premiums. If your plan is fully insured and experience-rated, a claims audit may improve your historical claims experience; however, potential recovered amounts will more directly benefit the insurance carrier.



This *Advisor* describes various audits. Typically, employers will hire a firm specializing in health plan audits to review their claims. Some audit firms may charge on a “flat fee arrangement” for different aspects of a plan audit; while other firms may charge on a “contingency arrangement”. Under a contingency arrangement, the audit firm will retain a percent of the recoveries as a fee. Typically, contingency fees can range from 25% to 50% of the amount recovered.

Eligibility Audits

Eligibility audits received significant press this year in Southeastern Michigan because of the shocking results of Ford and Daimler Chrysler eligibility audits. Budco conducted dependent eligibility audits for both automakers and found their plans covered about 70,000 ineligible individuals.

Audits review the plan’s eligibility criteria and then look for participants that no longer meet those requirements. Ineligible individuals may be ex-spouses of employees, children who no longer meet the eligibility requirements for the plan, employees’ grandchildren, and so on.

Budco has conducted eligibility audits for many larger organizations.



Professional firms can conduct eligibility audits; however, internal Human Resource staff can conduct them as well. Ideas for conducting your own dependent eligibility audit include:

In some organizations, they have discovered at least 10%-15% of covered dependents are ineligible for the plan. These dollars can add up.

Some companies will benefit more than others from an eligibility audit:

- Traditionally paternal organizations that have historically funded a generous plan requiring little or no employee contribution.
- Organizations that have undergone complex merger and acquisition activity especially when multiple eligibility provisions are retained.
- Organizations with routine high turnover rates where the sheer volume of employee additions and terminations makes administering the plan difficult.
- Organizations with multiple locations and a centralized administration hub where direct access to employees may be limited.

- **Advance communication:** Frequently, an employee does not realize a dependent may no longer be eligible for coverage. A good place to start is to inform your employees that your plan is reviewing plan records to ensure only eligible individuals are covered and provide a list of eligibility requirements. Offer amnesty for past claim payments or premiums paid for employees who notify your plan of any ineligible dependents prior to the audit.
- **Eligibility Questionnaire and Documentation:** To determine whether covered dependents are eligible, send your employees a questionnaire asking the following:
 - **Is your legal spouse covered under the plan?** If the answer is yes, request a marriage certificate or the front page of a tax return to verify spouse status.
 - **Do you cover any dependent children on the plan?** If the answer is yes, request the names and dates of birth for all children. Verify that children beyond the limiting age are full-time students at a university. You may want to request the child’s current semester schedule to verify student status.
 - **Is any dependent child covered under your plan married?** If yes, most likely the child will no longer be eligible for the plan.
 - **Is any dependent covered by the plan your dependent grandchild?** If yes,

NOTABLE THOUGHTS

**REAL GENEROSITY IS DOING SOMETHING NICE FOR
SOMEONE WHO WILL NEVER FIND IT OUT.**

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are you the legal guardian of the child? If the answer is yes, request documents verifying legal guardianship.

These are just a few of the questions your organization may need to ask to weed out any ineligible dependents. The key is to require documents proving the dependent meets eligibility requirements.

- **Identify former employees:** Dependents are not the only ineligible individuals that a plan may inadvertently cover. Former employees and COBRA continuants should be monitored as well. To verify an employee is still covered, compare employees electing coverage on your plan with your payroll records. Anyone shown on your plan eligibility report should also appear on your payroll. While this task would have been arduous just 10 years ago, you can now obtain eligibility status and payroll reports electronically in Excel spreadsheets from most vendors. You can then match a few data elements to compare files. If an employee shows as covered by your plan and not on payroll, you need to check if he/she is on COBRA.

COBRA continuants are another area of concern. Your plan should monitor the maximum coverage period for these continuants. In addition, several events can terminate COBRA coverage. Survey your COBRA continuants on a regular basis to determine whether they are still eligible under the COBRA rules.

Even the most careful administrator can have plan participants that should no longer be covered. This is often the case because employers must rely so much on their employees to determine whether their dependents continue to be eligible under the plan.

It is a good practice for organizations to require employees to prove that any dependents are eligible when they initially enroll in the plan. However, that proof may not be enough on an ongoing basis. Family status and circumstances change frequently. Regularly scheduled dependent audits will help make sure your plan is covering only eligible dependents. They will also encourage employees to inform you of any changes. When employees know you check and re-check to make sure only eligible dependents are covered under the plan, they will be less likely to enroll or maintain coverage for an ineligible dependent.

Claim Audits

To determine whether your third party administrator (TPA) or health plan carrier is processing claims correctly, choose an audit firm specializing in health plans to conduct an audit. All audit vendors do not use the same process but the overall goals should be the same. A claim audit can focus on several key areas:

- Claim payment process
- Review of a sampling of actual medical or dental claims paid
- Review of pharmacy benefits

- Review of subrogation and coordination of benefits activities

Your organization can structure an audit to cover any of these key areas or even to focus on a specific area of possible overpayment, such as hospital bills that exceed \$10,000.

Claim Process Review

This type of audit is designed to examine your organization's third party administrator's ability to pay claims quickly and accurately. The



process of paying claims has become much more complicated over the last 20 years. The process is now more automated which means, in some circumstances,

claims are processed electronically, without a claim analyst ever reviewing the claim.

To review the claim paying process, your audit firm will need to visit your claim payer's worksite. The audit firm will analyze the electronic system and the process used to log, review, and pay claims. The following are the areas of claim processing and administrative procedures that should be reviewed:

- How does the system flag claims for medical review?
- How are updates made for eligibility changes? In particular, COBRA administration should be reviewed.
- How does the system flag coordination of benefit

opportunities? What is the process for investigating potential coordination opportunities? How often does the vendor update other coverage information for families?

- Is the TPA using the appropriate reasonable and customary schedules for claims paid out of network?
- What is the process for investigating and acquiring possible recoveries for subrogation opportunities?
- What are the timeframes for clean claim turn-around in the vendor's system? What is the process to follow up on necessary information for incomplete claims?
- What measures does the TPA take to identify duplicate claim payments and fraudulent claims?
- How does the TPA verify that subjective treatments are medically necessary for certain conditions, such as back problems or hysterectomies?
- What is the process for identifying the primary payer? Can the vendor take a secondary stance to Medicare when it is permitted? For example, a 66-year-old employee terminates employment. The employee is entitled to elect 18 months of COBRA continuation; however, Medicare can pay primary. What is the process to make sure the



health plan is paying primary only when necessary?

- How does the TPA identify situations where a provider is unbundling services for billing purposes?
- If the plan includes pre-existing condition limitations, how are potential pre-existing conditions claims flagged and investigated?
- What cost management software does the claim payer use and how effective is it?
- Does the vendor look for cost management opportunities, such as buying durable medical equipment if renting does not make sense for a long-term need, or paying claims promptly to qualify for potential discounts?
- How does the claims payer audit hospital bills?
- How does the claims payer coordinate communication internally? This coordination is especially crucial for effective large claim management.
- How does the claim payer take into account PPO discounted fees? If the fees are loaded directly on their system, how often are providers and discount arrangements updated?

A system and process audit can assure an organization that its third party administrator is responsibly investigating and paying claims. An efficient process should maximize opportunities for the plan to save money. This type of audit can also be performed when a company is

considering changing from one TPA to another. The audit will help determine the capabilities of a new administrator.

Analysis of a Sample of Paid Claims

The foundation to effective and efficient claims payment is a system with checks and edits to find opportunities for saving money. While the process can seem effective, it is always good to evaluate how it works in practice. This means auditing a sample of claims paid for accuracy.

In auditing a claim sampling, the audit firm will select a subset of claims the plan pays. The firm will review claims in a number of areas including:

- Coordination of benefit opportunities
- Subrogation possibilities
- Workers' compensation claim duplication
- Accuracy of CPT-4 and ICD-9 codes
- Application of benefit plan provisions such as deductibles, copayments, benefit maximums and other plan requirements
- Review of claim location and regional appropriateness of payment to provider
- Review for medical necessity, if applicable
- Determination of plan participant's eligibility
- Review of amount paid in relation to invoiced amount
- Determination of turnaround time for claim

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If the auditing firm reviews a significant sample of claims, it should be able to inform your organization whether payments were justified and what claim errors were identified so that your organization is comfortable with your claims payer's performance.

Prescription Drug Claim Review

A claims payer administers prescription drug benefits differently from other medical claims. In fact, many TPAs contract with a separate Pharmacy Benefit Manager or PBM to manage the pharmacy benefits.

In some respects paying prescription drug claims has become more complicated than paying traditional medical claims. Plan participants expect to pay only the applicable copay when they present their prescription at a pharmacy, and they expect the prescription to be filled immediately. These expectations can lead to claims paid in error. In addition, the contract arrangements with PBMs are complicated. PBMs may offer one set of contract terms to an employer and a better, more aggressive set of contract terms to the pharmacy. Often, an organization may not completely and thoroughly understand what exactly the contract provisions mean.

A PBM audit is usually performed on a randomly selected claim sample. The claims can be examined in a number of key areas:

- Are the claims paid according to the agreed upon discount arrangements? Are the discount arrangements competitive? Is there a difference between the amount charged to the plan and the amount paid to the pharmacy?

NOTABLE THOUGHTS

NO EXPERIMENT IS EVER A COMPLETE FAILURE. IT CAN ALWAYS BE USED AS A BAD EXAMPLE.

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- Are the claims paid for eligible plan participants only? How is eligibility communicated to the PBM and what is the frequency of that communication?
- Are there opportunities for fraudulent or drug abuse claim situations?
- How does the PBM identify and avoid paying for duplicate prescriptions?
- Has a prescription been covered for an off-label use the plan does not cover?
- Has the plan design been properly applied to the prescription claim?
- If step therapy or prior authorization measures are a part of the arrangement, are those programs being properly administered?
- Is the PBM actively pursuing therapeutic equivalent opportunities when they exist?
- If the plan receives all or part of manufacturers' rebates, does the rebate calculation match the provisions of the contract?



Pharmacy benefit payment is complicated; there are many areas ripe for abuse and errors. An audit of

this area will give you a good idea of how effectively your Pharmacy Benefit Manager is administering your plan. The audit will also assist you in determining the competitiveness of the terms of your pharmacy benefit manager contract.

Subrogation and Coordination of Benefits Review

You can examine subrogation and coordination of benefit issues when you review your claim sample or you can do it independently. A plan may choose not to conduct a full claim base audit but may be concerned about whether it is considered the primary or the secondary payer for certain claims. Subrogation and coordination of benefit reviews can focus on a subset of claims

under the plan:

- **Emergency room treatment claims:** Often injured employees will seek emergency care. However, the diagnostic and procedure codes may not fully explain how and where the injury occurred. This information determines which payer is responsible for the medical bills. For example, if an individual slips on a wet floor in a restaurant and sustains a back injury, the

liability carrier for the restaurant should pay the medical bills associated with that injury.

- **Auto accident claims:** Many self-funded plans take a secondary payment stance to auto carriers for medical treatment required as a result of an auto accident. Again, the coding for treatment received as a result of an auto accident will not necessarily specify the treatment was received as a result of injuries sustained in accident.
- **Family medical claims:** In many families, both parents work outside the home. Make sure your vendor knows about any other group health coverage that the participant may have.



In addition, the process for determining payment order for children that are dual covered is important. The industry standard is that the parent with the first birthday in the year will cover the

children under his or her plan on a primary basis.

This carefully focused claim review may produce positive results because these types of claims have a higher probability that another party may be responsible. A plan can see results when other primary parties are identified and the claims are submitted to the proper parties for payment.

Conclusion

No third party administrator will pay claims correctly 100% of the time. In fact, a few third party administrators are able to pay claims correctly even 95% of the time. The process is complicated and there are many areas where claim payment abuses can occur. Some TPAs have built their systems and processes to help en-

sure claims payments are correct and accurate, other TPAs are less sophisticated.

As fiduciary for a group health plan, your organization should be com-

fortable and confident the plan is operating efficiently. Since the TPA handles most of your plan's transactions, your organization's confidence in your TPA is paramount. An audit is an opportunity to verify independently that your plan is being administered properly. It is also an opportunity to generate savings. If claims have been paid incorrectly, the TPA should help you recover those funds.

If you are interested in conducting an audit for your health plan, please contact your McGraw Wentworth Account Director. [MW](#)

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