

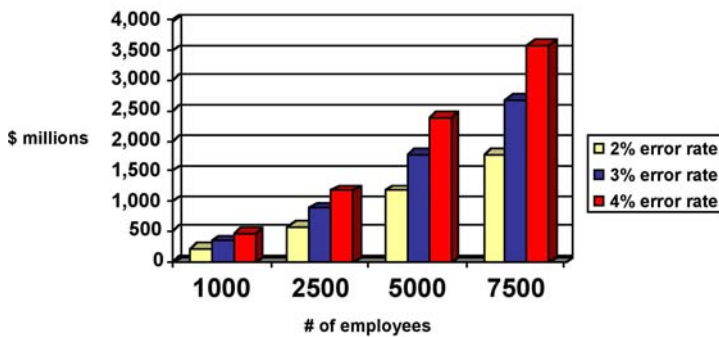
On the Case of Healthcare Cost Management: Eligibility and Claims Auditing

Howard Gerver, CEO, HR Best Practices

ADP invited Howard Gerver of HR Best Practices to discuss an innovative approach to containing healthcare premium costs. We are pleased to bring you Mr. Gerver's paper on claims auditing.

Now that employers, consultants and brokers have exhausted the options of plan design modifications, cost shifting and health plan vendor changes, they are searching for new ways to cost effectively manage the bottom line. Claims eligibility integrity is the new gold standard of healthcare cost management. Quantifying claim payment errors based on eligibility mistakes that occur at the point of care is a financially fertile frontier that can provide a material short-term refund or credit to the plan. Given that eligibility-based claim errors often account for a minimum of 1% to 2% of a healthcare budget, it is becoming easier to get management's attention to fix these historically elusive profit leaks. The math makes this clear: With the annual healthcare costs averaging \$7,000, a 2% premium error rate equals \$140 per employee, which multiplies to a significant figure at any size company.

Recovery Potential



Assumes \$6,000 in claim benefits paid per employee per year over a 2 year period

Discovering claim errors and recapturing healthcare overpayments requires trained skills similar to those of a detective. The process begins with significant research or fact-finding. The review of all the data points leads to identification of a group of suspects, from which the true culprits emerge. As healthcare grows more complex due to the nature of the illnesses, as well as advances in medical and pharmaceutical treatments, the ability to discover overpayments has grown equally challenging.

Gathering the Facts

Professionals do not dispute that claim dollars are leaking because of the complexity of the healthcare environment. The healthcare administration environment comprises employers (plan sponsors), employees and dependents (members), providers (physicians, pharmacies and hospitals) and health plan vendors (insurers, third-party administrators and pharmacy benefit managers). Each of these entities has a clear role in the healthcare process and ownership of specific information. Employers hold census and other indicative data on the employee as well as department, job title and performance information. Providers hold record of diagnosis and treatments. Health plan vendors have record of claims filed and processed.

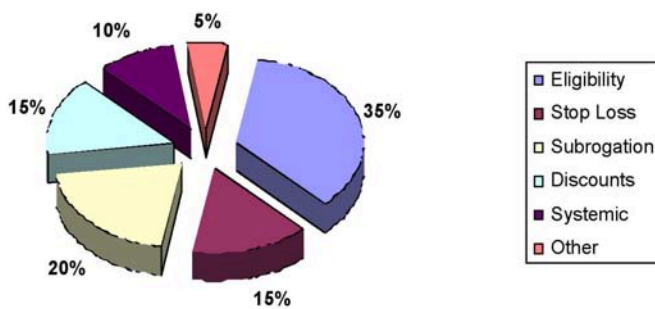
Data management is common to all of these entities. Behind the scenes, within a "black box," huge amounts of information are exchanged between systems as healthcare transactions are completed. While the overall process is certainly more effective and efficient than in the past, the process is ripe for errors at many points. For example, one party may hold crucial information that would impact claim eligibility had it gotten to the claims payor in time. Some information is still gathered and passed manually, and a handful of records may simply be incorrect. Data exchanges among all parties in the process may simply not be established in a way that maximizes timely and accurate claim processing or disease case management.

The Likely Suspects

Let's face it—healthcare benefits are viewed as a great way to attract and retain employees. While hiring and keeping employees supports ongoing business operations, management must take into account that employees have become high-volume healthcare consumers because of the accessibility and availability of products and services. Given the sheer magnitude of eligibility, enrollment and claim transactions, claim leaks exist in many places. A newly discovered leakage area is employees and

dependents. This is happening at a point in time when healthcare utilization is viewed by employees (as consumers) as an entitlement. In addition to employee-based leaks, other leakage areas exist within claim payments because of errors in eligibility, stop loss, subrogation, discounts, systemic and others.

Claims Leakage Areas



Source, HR Best Practices, 2005

Through the experience of performing more than 50 comprehensive audits, we found claims errors that resulted in recouping expenses within five major categories.

1. *Eligibility*: plan sponsors paid claims in error to individuals not intended for plan coverage at the time of care or service.
2. *Stop Loss*: catastrophic claims covered by reinsurance that were not reimbursed at the correct level.
3. *Subrogation*: claims were paid by the primary health carrier that should have been covered by another third party, i.e., another company’s insurance, an automobile policy, or homeowners coverage.
4. *Discounts*: claims were paid at a rate higher than the previously negotiated discount rate.
5. *Systemic*: claims were paid in error based on incorrect system set up, which may have undercharged a co-payment or incorrectly credited a deductible.

With the largest number of erroneous payments being attributable to eligibility-based errors, we will explore this area in greater detail.

Eligibility Errors

Ineligible Employees – Despite timely and accurate interfaces to health plan vendors, ineligible employees routinely receive benefits. One of the biggest challenges facing health plan vendors is their back-office technology environment and their inability to get eligibility correct at the point-of-care. Even though good business processes are in place, they are not always followed—especially at companies with large turnover or multiple locations.

Companies with high turnover operating in decentralized environments (such as retail or food services) are particularly vulnerable to eligibility problems. Generally employee terminations are not communicated to the health plan vendor nor entered into the vendor’s eligibility system on a timely basis. Employee eligibility is also impacted by reductions in work hours—an employee may still work for the same company, but not in a benefits eligible capacity. In other cases, an employee has resumed working for another company that also offers the same coverage as the previous employer, and claim payments are charged against the wrong company’s experience.

Ineligible dependents – Claim leakage due to ineligible dependents remains one of the most elusive areas to control. Neither employers nor health plan vendors make managing dependent eligibility a high priority. It is widely accepted that at any given point in time, as much as 10% of enrolled spouses and dependent children are ineligible for their coverage. In a population with 5,000 employees and 11,500 total members, a dependent eligibility audit should identify up to 650 ineligible spouses and/or dependent children. Identification of records with multiple spouses, dependents over the limiting age and ineligible dependents are typical audit results.

Examples of Real Culprits

Dependent Eligibility Audits – A Case Study

In an attempt to control healthcare costs, one company recently completed a dependent eligibility audit. The initiative was conducted in two phases. Phase One consisted of a letter of notice campaign and an amnesty program where employees could correct their eligible dependent record without question. Phase Two consisted of a minimally invasive, more intelligent, technology-based audit.

A critical process driver in the audit was the access to census, medical claims and prescription drug claims data. In essence, the data was used to identify members with demographic anomalies or members that were actively consuming healthcare dollars. Examples of demographic anomalies include, but are not limited to: spouses aged 20 plus years apart, children with overlapping birthdays, dependents living in different places, families with more than seven children, and over-age dependents (who were not disabled according to the clinical information on their medical claims).

Data from medical claims and prescription drug claims were also used to identify members who were actively using the plan. The management team felt this was important, since the overall goal was to save money (i.e., terminating inactive members would not save the plan any money, since their respective contributions do not vary based on the number of dependents, nor is the ASO fee driven by the number of dependents).

Upon completion of the dependent audit, hundreds of dependents were removed from the company's eligibility rosters. Management computed its return on investment for the project to be nearly 700%. Needless to say, the dependent eligibility audit exceeded management's expectations.

Prescription Eligibility Audits – A Case Study

The management team of a domestic manufacturer could not understand the significant increase in prescription drug costs. While management did not have any proof that ineligible claimants were receiving benefits, they sensed this was the problem. Because of this, 100% of the drug claims were audited for eligibility.

In order to meet the business objectives, the audit team integrated 100% of the census, enrollment, COBRA and drug claim data. The eligibility business rules were then applied to the data. This comparison showed nearly 4% of the claims were paid erroneously due to ineligibility. While ten different eligibility tests were executed, most of the errors were made on behalf of "members" that were not included on the employer's HR system. Not only did the plan get a refund, but the employer and the pharmacy benefits manager (PBM) fixed the respective process to ensure eligibility-based audits occurred in the future.

Preventing the Crime in the First Place—How to Control Leakage

The most effective way to identify, quantify and monetize healthcare eligibility suspects is to first create an integrated census, enrollment, COBRA and claims data warehouse. To accomplish this, 100% of the census data in the employer's HR system and 100% of the enrollment and claims data in the health plan vendors' system(s) must be merged. Care must and can be taken to protect employee confidentiality. Once this data is merged, benefits and auditing professionals can ask the right questions and get the right answers, including:

- Is the member eligible?
- Did the member meet the eligibility waiting period requirements?
- Did the member share his/her card with ineligible dependents?

- Did the member receive services beyond his/her termination date?
- Did the member receive services beyond his/her COBRA paid thru date?
- Did the carrier pay benefits for a spouse or dependent child who was not covered?
- Is the member paying the correct contribution of premium?
- Did the member pay the appropriate cost share for the claim?

In addition to recapturing overpayments, eligibility-based auditing can identify “root cause” issues, such as sub-optimal carrier data integration between their eligibility and claim systems, or processes that lead to delayed termination notifications.

Summary – Be Proactive, Take Action

Eligibility leakage is the problem; eligibility auditing through advanced data mining methods is the solution. Plan sponsors, consultants and brokers have the opportunity to remedy the situation and foster an environment of data and financial integrity. HR and Finance can continue to demonstrate value-add to the C-suite and to shareholders by auditing claims-based eligibility and bolstering the bottom line.

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For more information about how ADP Benefit Administration Services can help your company control healthcare cost leaks, call 800.548.6547 x2884.