The Benefits Auditor and the Detective

by Howard Gerver

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As health care grows more complex, the ability to discover overpayments has grown equally challenging. Given the high cost of health care and the expected annual trend of approximately 15% for the next several years, stopping profit losses is critical in any organization.

Discovering profit losses (leaks) and recapturing health care overpayments requires training and skills similar to that of Sherlock Holmes. While capturing an elusive criminal is quite different from identifying a group of eligibility "suspects," the stakes are equally high in their respective contexts.

The majority of employers confidently administer 95-98% of their health care budgets. While a 2% leakage rate may seem insignificant, 2% translates into $120 per employee per year waste (based on a $6,000 annual health care spend per employee). An organization with 10,000 employees could have annual profit leaks of $1.2 million or more. For a business operating on a 10% profit margin, $12 million in sales (or budget) would have to be generated to pay for this waste. Professionals do not dispute these profit leaks because of the complex environment in which health care operates. In order to identify, quantify and recapture overpayments, the same skills employed by the great detectives must be employed by benefit auditors.

Sherlock Holmes, the world's greatest detective, was clearly the master of his industry. Beyond Holmes other greats also existed. While these sleuths always solved the crime, they all employed different approaches. Regardless of the approach, they all had common characteristics. Great detectives gather all of the evidence, accurately investigate the information and find the truth. While other people have access to the same information, it is only the great detective who knows precisely what to look for and how to put the disjointed pieces together. This unique ability to solve a mystery applies to the world of auditing health and welfare plans.

A benefits auditor must have unparalleled knowledge of the industry, including expertise in benefits administration, medicine, pharmacy, mental health, dental, legal, technology, auditing, health plan administration and finance, to be able to tease out overpayments. Needless to say, it is rare for one person to possess all of these skills.

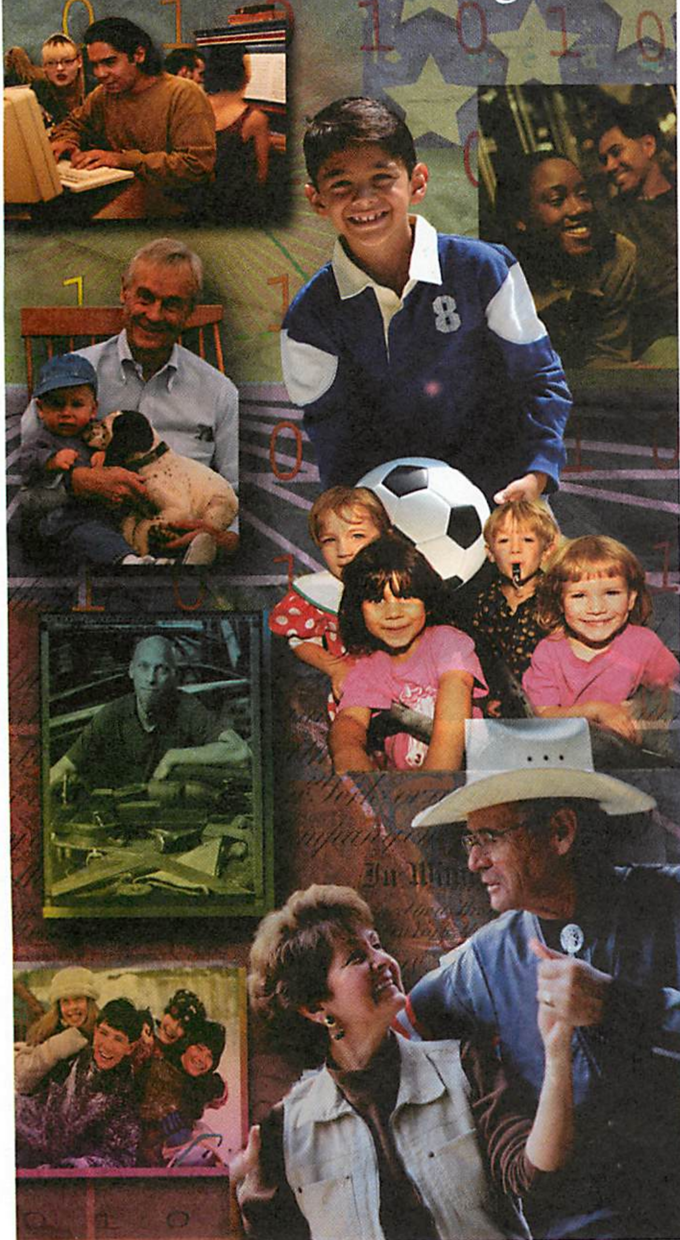
A critical success factor for being an effective benefits auditor is having a fundamental understanding of both the health and welfare and health care industry administration environments. The health and welfare and health care administration environment is comprised of employers (plan sponsors), employees (members), providers (physicians, pharmacies and hospitals) and health plan vendors (insurers, third-party administrators (TPAs) and pharmacy benefit managers (PBMs)). Profit loss due to eligibility is common to all of these entities. The role of benefit administrators, consultants and brokers has been excluded from this article. Behind the scenes, a "black box" facilitates the movement of huge amounts of health care transactions. While the overall process is certainly more effective and efficient than in the past, leakage still exists everywhere. One of the reasons leakage exists is because the member receives the service, but generally does not pay for it (except for the copay or to a lesser extent, the coinsurance). An overview of profit leaks in the administration environment follows.

Employee Level

Profit leaks exist at the employee level. Health care 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 great health care consumers because of the accessibility and availability of products and services. In all likelihood, leakage exists among employees in the following areas.

Ineligible Employees

In spite of timely and accurate interfaces to health plan vendors, ineligible employees routinely are receiving benefits. One of the biggest challenges facing health plan vendors is their back-office technology environments and their abilities to get eligibility correct. Even though good business processes are in place, they are not always practiced es-



pecially at companies that have large turnover and many employees at multiple locations.

In industries with high turnover operating in decentralized environments, such as retail, employee terminations are not generally communicated to the health plan vendor nor are they entered into the vendor's eligibility system on a timely basis. As a result, ineligible employees do not self-report their enrollment. From an actuarial perspective, an employer can expect to waste $6,000 per year per ineligible employee. Again, for a company operating on a 10% margin, that translates into $60,000 of sales. In the case of retail, 2,400 shirts costing $25 each would have to be sold to pay for this waste.

Ineligible Dependents

Profit leaks due to ineligible dependents remain one of the most elusive areas to control. Neither employers nor health plan vendors make managing dependent eligibility a high priority. In many cases, fraud exists. For example, an employee in a public sector environment tried to enroll 83 dependents during open enrollment. Fortunately, the director of benefits administration caught this in time. A family with 83 dependents and many claims would have a material impact on the employer's experience rating.

Excessive Utilization

There is an adage among cost-containment consultants: "Put a telephone on a desk and it will ring." The parallel here is related to availability and accessibility, which often translates into excess. For example, in a recent analgesic drug analysis, several employees were receiving excessive amounts of Oxycontin and Hydrocodone (opiates that are highly addictive). These drugs are also sold on the black market for up to $100 per pill. A member was identified who received 6,000 80-milligram pills at a cost to the plan sponsor of almost $45,000. In addition to the high cost, the volume of pills that was consumed was highly inconsistent with the manufacturer's labeling. The "street value" of this medication is over $700,000.

In order to stop the profit losses, likely suspects first have to be identified. This can be done by aggregating, reconciling and reviewing eligibility and claims data from disparate sources.

Preventive #1

The most effective way to identify health care "likely suspects" is to create a claims analysis database linked to the eligibility database. 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 vendor's system must be merged. Care must be taken to protect employee confidentiality—This is best accomplished by creating an alias for the employee and his or her dependents. Once this data is merged, benefits and auditing professionals can ask the right questions and get the right answers including:

- Is the member eligible?
- Is the member spending within the summary plan description (SPD) guidelines?
- Is the member "gaming" the system by visiting numerous providers?

- Did the member share his or her card with ineligible dependents?
- Is the member receiving excessive amounts of services or medication?
- Is the member paying the correct contribution?

An analysis recently performed in a health care vendor's system revealed broken copay logic. This error translated into a $300,000 problem. The vendor assumed responsibility for the error and credited the plan sponsor. If identifying and reducing profit leakage is the objective, then the best way to meet this objective is to build an integrated health information system that can be easily queried to identify costly suspects.

Employer Level

Profit leaks exist at the employer level. Benefits administrators are only as good as their technology, processes, people and data. But most employers have limited resources. This resource limitation coupled with the economy and staff reductions, fosters a "less-than-perfect" back office. Time is generally spent "putting out fires." Little time is spent reconciling the past and providing assurance that claims have been accurately paid. Unfortunately, what most executives fail to realize is that the amount they are saving on having leaner operations is actually dwarfed by profit leakage. The following types of leakage exist at the employer level.

Eligibility. Eligibility remains hidden among most employers. Savvy business professionals know it exists, but do not have the tools or resources to harness it. Leakage rates ranging from 2-5% often exist and rates as high as 12% have been found. Reasons why this exists vary; some examples follow.

- *Untimely Data.* Many employers operate in a decentralized environment where "the field" is responsible for communicating terminations to the benefits department. Since many field staff are hourly workers, pay is not at risk because positive hours are not transmitted. However, time delays have a material impact on benefits. During this lag, expensive claims can be incurred. In one example, a $55,000 claim was paid out erroneously. Error rates can reach millions of dollars in a large organization.
- *Process Inefficiency.* Benefits administrators operate under the misperception that the health plan vendors have correctly updated their enrollment systems. Many health plan vendors have significant problems managing eligibility data. Benefits administrators must continuously manage vendor data to ensure leakage is minimized.
- *Vendor Inefficiencies.* Perhaps the greatest source of leakage is vendor driven. It is common for vendor enrollment systems not to be in synchronization with vendor claim systems. While this appears to be a "vendor problem," it is the employer that is paying for these costly vendor inefficiencies and the employer needs a method to check the timelag of the vendor.

Fee Overpayments. Administrative-services-only (ASO) fees are a function of enrollment. If enrollment data are inaccurate, then ASO fees will also be inaccurate. Left undetected, ASO fees can be as high as $360 annually. A 2% leakage rate in an employer with 10,000 employees translates into $72,000. That's almost $0.75 million in sales or revenue loss. For insured plans, incorrect eligibility leads to increased experience ratings and premium payments.

Accounting Codes. Plan members are generally grouped into plans that have corresponding accounting codes (business unit, department). Given the high cost of health care, a single claim can have a material impact on earnings. An employer recently performed a chargeback analysis and identified a claim of $475,000 that was charged to the wrong business unit. Not only did this impact the profit-and-loss statement, but the respective business unit managers received incorrect bonuses.

Ineligible Dependents. Many employers do not maintain dependent information in their HR systems because they do not perceive dependents as high medical risks. However, this data void can have a material financial impact. For example, an employer in an insured plan recently had a $600,000 baby claim. This claim resulted in an increase of $120,000 to their budget. The claim is under dispute because the plan sponsor is challenging the eligibility of this particular claim.

Preventive #2

Eligibility and claims data must be converted into actionable information. The claims analysis database will be able to answer the following critical questions:

- Is this member eligible?
- Is this member's claim eligible?
- Is this member getting coverage under multiple plans?
- Was the claim charged to the correct business unit or accounting code?
- Are life events getting communicated on a timely basis?
- How much are we spending on health care erroneously?

The answers to these questions will enable the benefits department to determine if process improvement opportunities exist or if policy changes are required.

Provider Level

Profit leaks exist at the provider level. Duplicate billing, overpayments, excessive utilization and discount accuracy are common problems with providers.

Duplicate Billing. In spite of significant investments in payment systems and end-user training, invoices are often paid twice. An employer recently had a situation where a member was paid based upon a precertification for dental work.

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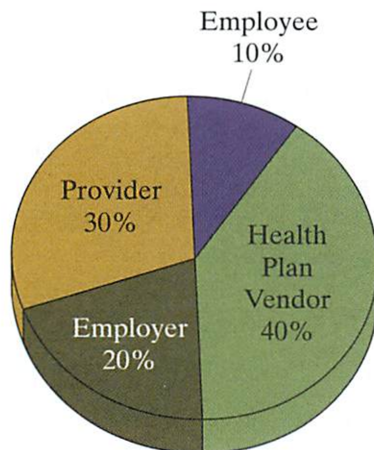
Figure 1

Root Cause Allocations



Source: ©HR Best Practices.

When the work was completed, the dentist was paid as well for the same amount. Some providers such as hospitals have high turnover and inefficient billing systems. As a result, if an accounting clerk leaves the hospital in the midst of an overpayment collection, then there is an excellent chance that the credit will not be fully recovered. Vendors do not deny the existence of duplicate payments and overpayments.

Overpayments. While providers frequently complain about getting shorted by the insurance companies, some providers know how to "game the system." Some pharmacies will routinely claim a drug is not in stock and will ask the physician to substitute a more costly or profitable drug. This may be particularly relevant in the PBM world where armies of pharmacists are on the phone all day with doctors to obtain therapeutic substitution approvals. In some cases, rebates from pharmaceutical manufacturers are sent to the PBM. It is extremely difficult to follow the payment trail back to the employer to ensure the plan sponsor is getting charged accurately.

Excessive Utilization. Providers include physicians, hospitals, dentists and pharmacists. In a recent hospital bed analysis, the admission rate was significantly higher among hospitals with higher vacancy rates than those with lower vacancy rates. Managed care has significantly changed the economics of health care. Provider bills must be continuously reviewed (by provider and by CPT code) in order to prevent a likely problem from growing into a bigger problem.

A recent claims audit identified numerous high-cost claims. In one example, a member was treated by an out-of-network hospital. The bill for three days was approximately $100,000: $5,000 for room, board and tests and $95,000 for ancillary charges. Upon further review the ancillary charges were identified as pharmacy charges. The analysis determined that the hospital overcharged the plan sponsor by $85,000. The health plan vendor did not catch the mistake because the analysis was neither reviewed nor audited. The auditing policy for this particular health plan vendor is to only audit 2-3% of out-of-network claims above $10,000.

Discount Accuracy. Health plan vendors routinely go to market with network discount messages. In many cases, the discount rates that are communicated to plan sponsors during the vendor negotiation process are inconsistent with actual charges incurred throughout the plan year. For example, a plan sponsor recently reviewed its prescription drug charges and found that the actual rates were more than those promised. This translated into a five-digit number of missed savings. In another example, a recently completed audit revealed that a discount was not taken for multiple surgeries in the same area of the anatomy during an operation—This was a $360 error on a $1,100 procedure.

Duplicate billing, overpayments, excessive utilization and discount accuracy all significantly contribute to profit losses in the provider community.

Preventive #3

The claims data warehouse is particularly effective in identifying duplicate payments, overpayments, excessive utilization cases and discount accuracy. Without an automated tool to identify these exceptions, this type of financial leakage would remain undetected. Duplicate billing is easier to catch than overpayments. In order to catch overpayments, provider billing needs to be reconciled to reasonable and customary (R&C) costs at the transaction level. Identifying excessive utilization at the member level requires a different approach. Claims need to be aggregated for a period of time both within a particular plan and across multiple plans.

In order to detect medical treatment utilization exceptions, an on-site review of the claims must be performed. While this is easy to say, it is less than easy to implement. Most large employers have hundreds of thousands of claims. The technology has to be first used to identify the claims to be reviewed. Then, the health plan vendor needs to be notified of the claims audit. It is only during the on-site claims audit where the hospitalization detail can be reviewed to identify and confirm likely suspects, such as excessive ancillary charges. Also, surgical and medical claims can be checked with diagnosis and utilization of all services to determine leakage.

The bottom line is that providers are routinely billing employers that, in all likelihood, are paying for these losses.

Vendor Level

Financial leakage exists at the health plan vendor level. Health plan vendors process millions of transactions. The law of large numbers indicates that these problems exist, regardless of controls, auditors' opinions (Enron) and quality control procedures. Health plan vendors often serve as TPAs. In this capacity, they make payments as authorization requests are received from providers. Given the high volume of transactions, only a small percentage of transactions actually get au-

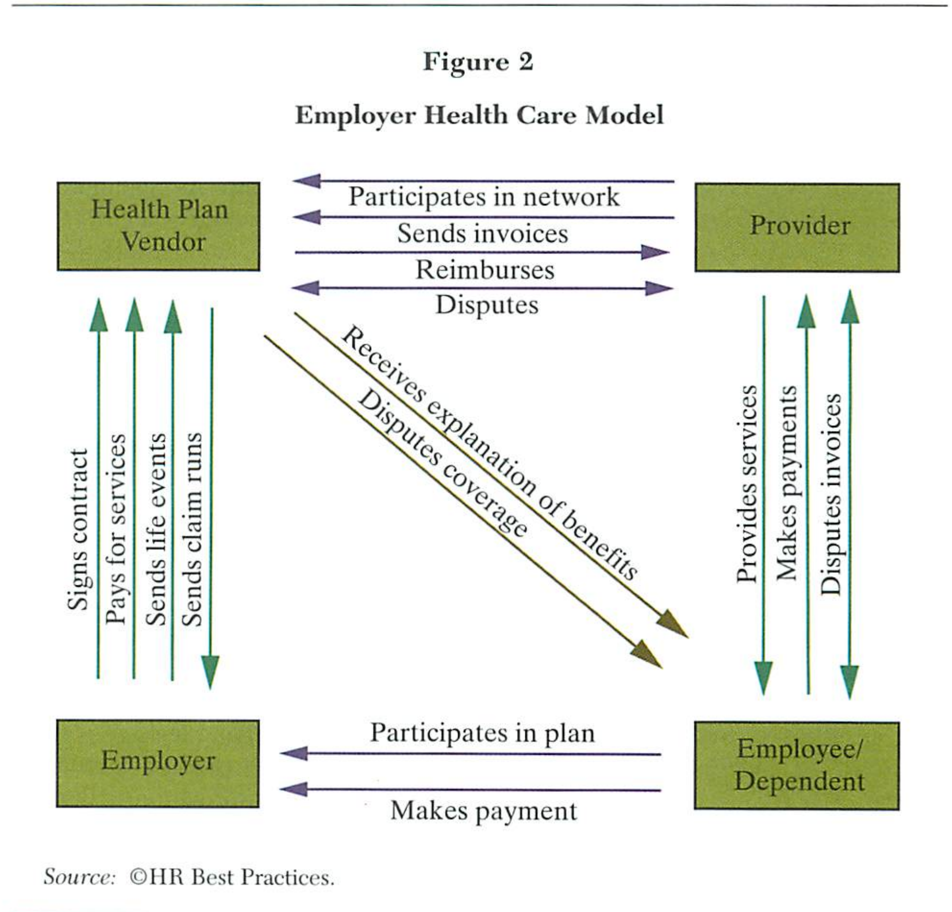
dited. As a result, profit leaks often go undetected and continue to exist here as well.

Employers are increasingly turning to their employees and are asking them to review their explanation of benefits (EOBs) to ensure that services billed are for services rendered. Again, a critical concept that distinguishes health care transactions from other consumer-driven transactions is that the health plan vendor invoices the organization, not the member. Therefore, the health care operating model assumes a high degree of trust.

As with most arrangements regarding claims payment vendors, duplicate payments routinely plague the industry. Payment accuracy is also a common problem. The total amount due based upon plan design and the total paid amount must agree. In the case of disparities, underpayments to providers operate in a self-policing environment, but overpayments do not. Unless overpayments are caught by auditors, overpayments can remain unnoticed and can contribute significantly to financial leakage. Unfortunately, given the fairly low financial amount of each individual transaction and the lack of resources and tools, most overpayments are not pursued.

Figure 2

Employer Health Care Model



Source: ©HR Best Practices.

Additional financial leakage exists at the health plan vendor, including claims that could be better financially controlled by case management and copayment accuracy.

Case Management. Many people believe that it is only those things that get managed that ultimately get improved. The same theory applies to case management. Two examples illustrate this. First, a member was taking a very expensive biotech drug at a cost of $235,000 annually. According to the drug manufacturer, the financial upper limit for a patient is $200,000 (i.e., there were opportunities to reduce this spending by at least $35,000 annually for this particular patient). The client manager at the health plan vendor never apprised this client of this claim. The cost of the drug was only discovered during a claim audit. While the plan sponsor was surprised, it was even more surprised to learn that this claim would not count toward the patient's $1 million lifetime health care maximum because of the incompatibility of the health plan vendor's technology platforms that would allow prescription drug costs to be integrated with other health claims costs.

Upon review of a $350,000 hospitalization claim, it was determined that concurrent case management was not performed even though the patient was hospitalized for 2½ months. Again, this claim was first brought to the plan sponsor's attention during a claim audit even though the health plan vendor had the patient's insurance information. Unfortunately, this claim was reviewed one year after the patient was dismissed. In all likelihood, if the claim was reviewed from the point of hospitalization, the costs would have been less.

Copayment Accuracy. Many people assume that all health plan vendors, particularly the marketplace leaders, have excellent technology and procedures supporting their clients. Unfortunately, these systems are flawed. As a result, financial leakage exists and it is incumbent upon the plan sponsor to discover the leakage to protect their bottom line. Referring back to the copayment example, an employer recently obtained a substantial refund from one of its health plan vendors. The message is loud and clear: Employers should not assume perfection on the part of the health plan vendor. Health plan vendors often make these mistakes.

Deductible Accuracy. Deductible amounts vary among plans. These amounts are generally different for in-network and out-of-network scenarios. Out-of-pocket maximums are also in place. A plan sponsor recently learned that an employee (in this case, the employee was the treasurer) was using an out-of-network provider. He was erroneously billed over $10,000. The deductible was $500 and the out-of-pocket maximum was $1,200. The treasurer paid the bill and then informed HR about the error. Needless to say, the problem was straightened out and the treasurer was reimbursed for the error.

Preventive #4

Financial leakage can be stopped at the health plan vendor level. Again, the answers to many questions exist in the claims database. The best method to validate discounts is to compare submitted claims amounts to the net paid claims

amounts. Also, specific claims must be compared to reasonable and customary prices. In order to confirm other types of discounts have been realized, an on-site claims audit must be performed at the health plan vendor claims office. In order to ensure financial leakage is minimized through case management and copayment accuracy, a claims database must be established. Analyses can be performed against the claims database searching for "likely suspects."

Saving the Day: The Holistic Health Care Information Environment

Holistic health care information management remains elusive for most organizations. Not only is there an absence of profit leakage analysis tools, but also a scarcity of health care analytic engines. The "holy grail" of health care information optimization includes an environment with the abilities to perform the following:

- "Period" comparative reporting
- Vendor analysis
- Limit testing
- Exception reporting
- R&C comparisons
- Discount analysis
- Business unit analysis
- Member analysis
- Diagnostic class utilization and spending
- Therapeutic class utilization and spending
- Cross-plan analysis
- High spenders
- Frequent utilization
- GL account code analysis
- Trend monitoring
- "What-if" modeling.

Analytics enable health care benefit managers and the business communities to be more strategic and provide value-added services rather than focusing on no-value or low-value-added transaction administration. This strategic role will enable employers with the information and the tools to control health care costs, redesign health care plans and gain assurance regarding their health care spending.

Bottom Line

The health care industry is here to stay. Health care spending continues to grow due to increased utilization and more expensive innovations. As spending increases, financial leakage will grow at the same, if not higher, rate because there is even more to manage with even fewer resources. Numerous critical success factors are essential for operating a best practice health care environment, including:

- Being proactive. Do not sit back and wait for the errors to surface on their own. Investigate the data; ask questions. Do not wait for your vendors to find the problems. If you do not have the staff to check the data and make recommendations, then hire an independent company that will be looking out for your interests.
- Implementing process improvements. Identifying leakage is not a one-time process; it is a continuous journey. As information is derived and potential respective benefits are determined, they should be applied systemically.
- Making data available. Given the high volume of transactions, significant amounts of raw data exist. Raw data is meaningless until it is converted into actionable information.
- Reviewing transactions daily. Financial leakage does not discriminate, and leakage is created throughout the year. Even when suspicious transactions are batched and set aside, they pile up over time. Timing is of the essence.
- Knowing what questions to ask. Every employer is unique and has different needs. Queries specific to each organization need to be developed. Moreover, employees and providers are dynamic—They change routinely as do their behaviors. Data should be continuously analyzed to spot new patterns and trends.
- When the next contracts are negotiated with your providers, you should build into the contract the schedule of how and when the information should be passed to the company that will be monitoring your health expenditures.

Financial leakage can be controlled with a four-step process.

1. First, build a health care information data warehouse complete with member demographic, claim and payment information.
2. Second, query the data for suspicious activity (and validate these suspicions).
3. Third, perform an on-site review of claims identified in the database.
4. Fourth, implement the improvements throughout the health care process.

Allowing financial leakage to remain unchecked will only exacerbate the issue over time and will cause employers to erroneously pay out hundreds of thousands of dollars to millions of dollars annually. When selecting a benefits auditor, try to ascertain if the auditor thinks like Sherlock Holmes.

- Will the benefits auditor start the project with an objective viewpoint?
- Does the benefits auditor have the resources available to pay attention to the smallest detail?
- Does the benefits auditor have the tools to link disparate facts into a cohesive story?
- Will the benefits auditor keep an open mind to all new, and at times, conflicting information?

As Sherlock Holmes once stated, "They say genius is an infinite capacity for taking pains. It's a very bad definition, but it does apply to detective work." In the field of benefits auditing, only someone who will take great pains to look at all the information will uncover the critical facts. ◆

MORE INFO

For more information on this topic:

- *Health Care Purchasing: A Value-Based Model*, by Laird L. Miller and Joanne E. Miller. To order, call (888) 334-3327, option 4, or visit www.ifebp.org/bookstore.