

benefits

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Although insurance carriers and third-party administrators generally administer self-funded plans efficiently and effectively, plan sponsors have a duty to make sure. Administrative claims audits take a retrospective look at claims that have already been paid.

Driven primarily by opportunities to lower costs and for greater flexibility of plan design, organizations over the past few years have steadily moved from fully insured to self-funded, administrative-services-only (ASO) health plans.

In a self-funded arrangement, the plan sponsor assumes the liability and risk associated with uncertain health care costs in exchange for potentially significant financial benefits. Self-funding can give organizations better cash flow, tax benefits and reduced administration costs.

Most insurance carriers and third-party administrators (TPAs) do a good job of administering self-funded plans, but maintaining regular oversight of health care expenses is always prudent and is, in fact, a plan sponsor's fiduciary responsibility. The Employee Retirement Income Security Act (ERISA) says it is the duty of plan trustees and other fiduciaries to act in the best interests of plan participants, including reducing claims expenses and ensuring the quality of administrative processes. It's a wise policy to trust carriers and TPAs—but verify their work.

A close-up photograph of a person's face, partially obscured by a large magnifying glass. The magnifying glass is held by a hand, and its lens is focused on the text below. The background is a blurred portrait of a person with dark hair, wearing a dark suit jacket and a white shirt. The text is centered within the white circular area of the magnifying glass.

Trust But Verify— Claims Audits

by | **Steve J. Noury**

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John C. Garner, CEBS, editor. International Foundation. 2015.

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In the case of fully insured plans, most insurance carriers will offer only a limited number of “standard” plan designs. But with a self-funded plan, the sponsor has greater flexibility in design and administration. Because the number of plan designs for a self-funded ASO client is potentially unlimited, complexity increases for the carrier or TPA and creates the potential for more administrative mistakes.

Administrative claims audits retrospectively look at claims the carrier or TPA has paid in order to identify possible processing errors, overpayments and underpayments. Such audits are conducted by accountants, independent health care cost-containment firms and employee benefits consultants. Some large plans may have their own internal auditing departments. (*Medical bill audits*, not discussed in this article, typically examine large-dollar bills from the clinical rather than administrative side to determine if the provider properly billed the claim to the administrator.)

Errors and incorrect payments can result from:

- Improperly coordinating payment with other responsible parties
- Paying the same claim multiple times
- Paying the provider more than the contracted rate
- Paying for benefits for someone who no longer is eligible for coverage
- Using obsolete and invalid codes for procedures and diagnoses
- Duplicating payments among workers’ compensation and Medicare claims
- Improperly applying a member’s copayments, deductibles, coinsurance and out-of-pocket maximums
- Failing to file a required treatment plan or provide required authorization

- Making payment for noncovered services.

These are only a handful of more than 100 common processing errors that administrative claims audits can identify.

Most audits find that 1-3% of the total amount spent on claims annually is potentially overpaid or incorrectly paid and possibly recoverable. Once overpayments are identified, the best practice is to involve both the plan sponsor and the carrier to pursue recoveries and make sure future payments are accurate.

The ASO agreement between the plan sponsor and the administrator will dictate much about how the audit can be conducted, usually outlined in the audit rights section of the agreement. Items addressed in this section typically include:

- **The audit time frame.** Most agreements will allow for only a 12- to 24-month look-back from the date the audit begins. And, while the ASO agreement might allow for up to 24 months, the provider network contracts in place usually will allow for only 12 months when it comes to recovering claims that were identified as overpaid. A clear understanding of this difference in time frames will help set the right expectations about how much money can actually be recovered.
- **Sample claim size.** Almost no carrier or TPA will allow a full audit of 100% of the claims that were adjudicated during the allowed 12- to 24-month time frame. The auditors usually can review 100% of the claims but then must whittle them down to within the sample claim size—usually ranging from 200 to 400 total claims. Most auditors will apply a filtering process to the entire data file in order to flag claims that show signs of having been paid incorrectly and/or over- or underpaid. From the filtered subset, the claims can then be chosen for the sample that would be a representative cross section of the entire claim file. (If certain kinds of errors are found, this might indicate a “systemic” error, and the carrier/administrator would be instructed in the audit report to correct the problem going forward so that future claims are paid correctly.)
- **Random sample vs. handpicked.** The method by which the sample is chosen is very important, although some ASO agreements require that the sample be chosen via a statistically valid random sample. A quality sample that is representative of the entire claim file can be generated only from a statistically valid random

sample. Otherwise, the quality and accuracy of the audit could be compromised. Audits conducted under the random sample method rarely present any opportunity for recoveries and are performed mainly for administrative compliance purposes—i.e., to ensure that the carrier/TPA is administering the plan according to the plan document. The likelihood of the random sample including large-dollar claims with opportunities for recovery is slim, although not impossible. On the other hand, if the ASO agreement allows for it, the auditor can handpick the sample. This method allows for more of a focus on the large-dollar claims that may have been overpaid and where there is potential for a recovery from the provider.

A popular variation of these two methods is to split the sample: Handpick the large-dollar claims (with recovery potential) using a portion of the sample and randomly select the other portion in order to check for administrative compliance with the plan document.

Note that for some groups, depending on their size, the sample size allowed in the ASO agreement may not be large enough to be “statistically valid.” If this is the case, it helps to have an auditor who is adept at negotiating with the carrier/TPA for a larger sample.

An audit typically will begin with a kickoff meeting or call where an overview of the process will be presented to ensure that the plan sponsor’s objectives are fully understood and defined. Most of the plan sponsor’s involve-

ment will be during this planning and data-gathering phase. The auditor will request key documentation, and audit contracts will need to be signed (one with the plan sponsor and one with the carrier/TPA).

A critical component at the beginning of the audit will be to work with the carrier/TPA to negotiate how the audit will be executed. An experienced auditor will work closely with the plan sponsor to help negotiate with the administrator over terms that allow the plan sponsor’s audit objectives to be achieved. The auditor’s previous experience with the particular carrier or TPA will be a plus during these negotiations.

The auditor will collect information from both the plan sponsor and its administrator. From the administrator, that will consist of data files including medical claims and historical enrollment. The administrator may also be asked to complete an audit questionnaire that includes general claims-processing information and guidelines from the administrator as well as details on how it processes the plan sponsor’s claims.

From the plan sponsor, the auditor will request plan design documentation, historical enrollment data, historical long-term disability data, historical Consolidated Omnibus Budget Reconciliation Act (COBRA) data, historical workers’ compensation data and the completion of a brief audit questionnaire. The auditor needs this information to be able to determine whether the administrator is following guidelines both parties previously agreed on.

After receiving the data and information from both the plan sponsor and administrator, most auditors will complete a comprehensive data analysis and scrubbing process. During the initial phase of the project, the auditor typically will need to verify key plan information or enrollment data to ensure an accurate audit.

In the second level of review, the auditor determines whether suspect claims were processed correctly. Once the first- and second-level reviews are completed, all suspect claims may then be verified by a quality analyst, enabling another level of review that allows the analyst to

takeaways

- Audits can reduce claims expense and help ensure quality administrative processes, requirements of ERISA.
- Audits often find 1-3% of the total amount spent on claims annually is potentially overpaid or incorrectly paid and possibly recoverable.
- The ASO agreement between a plan sponsor and an administrator will spell out the audit time frame, the sample claim size and whether samples are to be random or handpicked. Handpicked samples can focus more on large-dollar claims.
- After an audit is conducted, an initial draft report will be provided and outstanding discrepancies addressed before a final audit report is issued.
- Audits should be conducted at least every three to four years and when there is a new carrier/TPA or a significant plan design change or the plan sponsor has administrative concerns.

bio



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choose the claim sample. This sample will be created based on the client's specific objectives.

The next step would normally be the on-site portion of the audit, which will be conducted at the carrier/TPA's claims office. The auditors will have direct access to the administrator's system in order to validate potential overpayments and underpayments and possible systemic errors/issues. Throughout the on-site portion, the auditor usually will present potential errors to the carrier/TPA for review, and the carrier/TPA will provide feedback on the findings.

Once the on-site portion of the audit is complete, along with input from the carrier/TPA, a draft audit report typically will be issued. It should include a report of statistics on the various overpayment/underpayment types along with recommendations for improvement. Typically, this report will also include followup activities as well as a detailed listing of any overpayments that should be placed into the carrier's recovery process.

After the carrier provides feedback to the initial draft audit report, any outstanding discrepancies will be addressed and a final audit report issued. When the final audit report has been reviewed, common practice is to schedule a conference call with all parties to discuss the audit process, results, outstanding issues, recommendations for improvements and the recovery process.

The carrier or TPA usually recovers incorrect payments from providers using future billing offsets or by directly billing providers. Most auditors should track and report the recoveries for the client for a stipulated period of time following the close of the audit.

Other types of audits may be performed in conjunction with a primary claims audit to give the plan sponsor a clearer picture of the status of its plan and contractual relationships with the administrator/TPA. Those include:

- **Operational audits**, which look at procedures associated with enrollment including identification card processing, customer service standards, etc.
- **Reinsurance audits** to discover charges that should have been submitted to a reinsurer for reimbursement but were not
- **Transitional audits** to ensure a plan has set up appropriately in an administrator's systems when a plan is moving to a new carrier, from fully insured to self-insured, or to significantly different benefit designs.

Plan sponsors have a fiduciary obligation to ensure compliance and proper administration of their health plan as outlined in the ASO agreement with their carrier/TPA. Improper administration can lead to higher plan costs. A comprehensive claims audit can keep those costs in line. How often should an audit be conducted? Every three to four years for most plan sponsors if they keep the same carrier/administrator, although some prefer to do it more often. Items that should trigger an audit are:

- A new carrier/administrator
- A significant plan design change
- Administrative concerns by the plan sponsor.

The cost of an audit is typically less than 1% of total annual claim spending and generally is worth the investment. Most of the time, recoveries will more than cover the cost, although that is not guaranteed. Depending on the size of the group and the audit approach, total costs will normally range from \$25,000 to \$50,000 but could be higher for very large groups. The fees are usually fixed but can also be paid on a contingency basis tied to recoveries, although some ASO agreements do not allow for this type of fee arrangement. ❶