THE 100% DIFFERENCE

Healthcare Plan Administration and Fiduciary Responsibility: How Self-Insured Employers Unwittingly Lose Millions in Overpaid Claims Annually

The Buck Stops with Senior Leadership, Not the TPA

Do Not Assume Healthcare Expenses Are Being Paid with 100% Accuracy

Paying Too Much

Senior leaders should know that their companies are funding some level of overpaid medical claims every year.

That's right, every single year. These overpayments can amount to **up to 3 percent or more** of a self-insured employer's annual healthcare spend. In fact, this level of error is uniquely *accepted* in the healthcare industry and often written into agreements with Third-Party Administrators (TPA) via performance guarantees.

In his BenefitsPro article, How to Improve Transparency and Take Control over Health Care Costs, Brian Tolbert, author of "Breaking Through The Status Quo," says that benefits are typically the largest expense item in a company's budget next to payroll.

"Traditionally, managing the benefits budget hasn't been like managing other business expenses, as employers have had little to no transparency into these costs," Tolbert writes. "While most employers would be averse to accepting annual increases of 10 or 15 percent on other business expenses, they have never been able to apply the same level of scrutiny to their health care spend."

Given the nature of the self-insured set-up, TPAs who are processing payments on the employer's behalf have less incentive to confirm the accuracy of payments since they have no dollars at risk. In addition, overpayments benefit the insured or the providers, and therefore it is unlikely the employer would ever be notified of these overpayments. **It becomes vital to implement a robust post-payment review process, also known as an annual healthcare claims audit, in order to recover overpaid dollars, erroneously paid claims or claims not paid according to plan intent.**

Fiduciary Responsibility

ERISA is designed to protect employee benefits plans, including retirement and health plans. Under ERISA laws, the people responsible for running the health plans are bound by fiduciary duties. Failure to fulfill those duties when administering a self-insured healthcare plan can expose leaders of companies to unnecessary legal risk, just like if they were mismanaging a 401K plan.

In his Forbes article, CFOs And HR Execs Facing Millions in Personal Liability Due to Unmanaged Health Benefits Plans, speaker, author and entrepreneur Dave Chase warns that increased scrutiny is coming for health benefits, similar to what is already commonplace for retirement benefits.

"This shouldn't be a surprise in light of the fact that employers commonly spend two and a half times more on health benefits than on retirement benefits," Chase writes. "Employers typically have extremely rigorous oversight of retirement benefits with independent investment committees, regular audits and more. Though the same fiduciary responsibility exists for health benefits, evidence suggests that the vast majority of employers have fallen short."

Employers who self-insure are the fiduciary for their health plans. Therefore, it is imperative that they choose their own audit partner to verify claims payments in order to fulfill their responsibilities to stakeholders. Doing so is likely to yield up to 3 percent of the employer's medical spend in recovered overpayments, which can then be returned to the bottom line and stakeholders. TPA service agreements can impose restrictions such as:

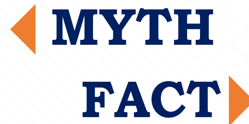
- Allowing only random-sample audits. This approach prevents an experienced audit firm from reviewing *all* the claims data, determining the most probable errors and discovering systemic issues.
- Restricting recoveries to two years (the two-year no-recovery limitation).
- Limiting the number of claims that can be reviewed on-site.
- Preventing employers from hiring an audit firm on a "contingent fee" basis.

Chase interviewed Chris Shoffner, who has been a Chief Risk Officer for health plans and a broker/consultant for 401k plans, and asked him to describe one of the primary risks he observes when stepping in as a fiduciary on behalf of his clients.

"Since there is personal financial liability as a health plan or retirement plan fiduciary, I take it very seriously," Shoffner said. "ERISA covers both and the level of diligence, process and audit that takes place in running a typical 401k is extensive. Typically a health plan has twice as much money running through it and almost none of the same oversight or transparency. I don't see how it's possible to serve as a fiduciary while not having access to claims data, the ability to

hold providers accountable by auditing detailed bills or providing transparency in cost and outcomes to guide participants."

There is a built-in system by your claims payer to catch 100% of payment errors.



Only a handful of randomly selected claims are audited by the TPA on the employer's behalf each year.

The Biggest Error is Ignoring What is Left Behind

Errors costing an employer up to 3 percent of its annual healthcare spend may not look like an unreasonable amount at first glance. However, when we consider that benefits are typically the largest expense item in a company's budget next to payroll, the magnitude of the error rate becomes clearer.

For example, if a large self-insured employer covers 50,000 lives (employees and dependents) averaging $10,000 per year in claims, the medical spend is $500 million. **An error rate of 1 to 3 percent means that the company may have paid out $5 to $15 million in unnecessary claims.** The effect is multiplied if considering errors that are embedded in the system and have gone unnoticed and uncorrected for several years. Money that could have been returned to stakeholders is instead being misspent, and the CFO and HR executives are ultimately responsible.

The good news is that *it is possible to identify and recoup these erroneous expenses*. In fact, it is a reasonable and necessary expectation to comprehensively audit this significant expense to potentially return up to 3 percent (or more) to a company's stakeholders and extend the viability and sustainability of its healthcare plan offerings to its employees.

Why Not Audit EVERY Claim to Return Every Possible Dollar to Your Plan?

Some companies choose not to audit or are unaware that they should be auditing their healthcare claims, assuming that their broker and TPA are taking care of these issues for them. However, we know from experience that is not always the case. People make mistakes, but the self-insured employer has the ultimate responsibility for ensuring the plan is administered properly.

Some companies choose a "check the box" style of audit to fulfill their minimum responsibility. However, they could be missing out on hundreds of thousands of dollars in recovered overpayments, which would have been discoverable with a comprehensive audit. Many are unaware that audits typically pay for themselves through monies recovered.

As healthcare claims experts, we often hear of other reasons companies choose not to conduct a comprehensive audit:

- My TPA performs audits. (Not always and certainly not in a comprehensive manner. They may look at a few high dollar claims.)
- My TPA already utilizes external audit resources. (Hiring your own auditing firm ensures they are working for you, not the TPA.)
- Auditing is the TPA or broker's job, not mine. (The self-insured employer holds the ultimate fiduciary responsibility for the healthcare plan.)
- My broker knows everything they should be doing with respect to monitoring our plan. (Not necessarily. The industry standard on auditing has changed over the years, and there can be a wide knowledge gap on this issue.)

Tolbert says that auditing is one of the three main ways to reduce the claims spend and "think like a CFO" when it comes to benefits.

"Industry groups estimate 80 percent of medical bills contain errors, and employees are often over-billed," Tolbert writes. "Insurers don't always have an incentive to audit these bills and drive claims down, so this presents a big opportunity to reduce cost pressure in the benefits plan. Part of the administrative costs in a self-insured plan can include auditing services to ensure bills are accurate."

The 100% Difference: Comprehensive vs. Random Audits

Employers can prevent repetitive errors hidden within the payment system and recover significantly more in overpayments than random sampling allows.

It is likely that only randomly selected claims are audited by the TPA on the employer's behalf each year and that **HR leaders may have signed a contract that actually prohibits the company from reviewing all claims to in order to recoup thousands, even millions of dollars annually.** In addition, some TPA agreements include a two-year no-recovery clause, which means that if the errors and overpayments are not discovered and collected within two years of the claim, the self-insured employer loses that money forever. It is important to know your audit rights, and Healthcare Horizons offers agreement reviews to ensure that their clients fully understand their TPA agreements.

An annual, comprehensive audit will ensure that the employer identifies the most errors and recoups the most overpaid claims. What is the difference between a random and comprehensive audit? It's the 100% Difference that Healthcare Horizons offers.

The typical (and sometimes contractually required) methodology for healthcare claims auditing features auditors randomly selecting 200 to 300 claims out of millions of transactions. They

examine those claims for errors based on predetermined criteria and extrapolate the results across the entire population of claims to determine an error rate that is statistically valid. This approach may be considered standard practice by your TPA when handling so many claims, but it is an ineffective approach.

Does a random sample audit take your financial best interests into account? Some things to consider:

- If the auditor encounters an error on a selected sample claim, it is virtually impossible to determine if the error is isolated or systemic in nature.
- It is highly likely that significant one-off errors exist outside of the random sample selection.
- It is often difficult to convince payers to issue settlements based on the results of a random-sample audit.

Healthcare Horizons' comprehensive audits review every healthcare claim, rather than a random selection. Our approach, called the 100% Difference, yields much better results because we identify both isolated and systemic errors and assign actual dollar impact to those errors, making a stronger case to the payer. As a result, employers can recover significantly more in overpayments than random sampling allows. Additionally, our clients can correct systemic issues, preventing future claims paid in error, saving their companies thousands -- or millions -- of dollars over time. This fulfills the senior leaders' fiduciary responsibility in administering the plan and ensures that money once lost to overpayments and errors is returned to company stakeholders.

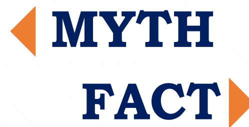
For a quick visual demonstration of how the 100% Difference works, visit the Tips and Tools section of our website.

How Does an Audit Affect TPA Relationships?

Some employers have partnered with a TPA for several years and believe that asking for an audit could damage the relationship. On the contrary, all national TPAs expect audits as part of an employer's fiduciary responsibility. A successful and experienced auditor will not damage the relationship between an employer and its TPA. **In fact, the goal of the audit is to improve the service that a TPA delivers to the mutual employer client.**

Healthcare Horizons auditors have years of experience handling healthcare claims audits, and we monitor the reconciliation and recovery process. In addition, the employer is always in charge of the audit process. Employers decide what overpayments to recover after taking into account any adverse impact recovery may have on their employees.

Your TPA will tell you if there is a systemic error in your plan costing you thousands or millions annually.



There is no way to know without a comprehensive audit.

The Difference is in Knowing

Employers will sometimes say they are unaware of any significant problems or complaints with the health plan. In our experience, overpaid claims do not cause disruption or complaints because they are not generally reported to the TPA.

As an example, Healthcare Horizons recently identified an issue in which the administrator was incorrectly paying all out-of-network claims at full billed charges versus the maximum limitation outlined in the plan design. As all parties received benefits in excess of the plan design, no complaints were generated. Once the issue was identified through a comprehensive audit, the TPA directly credited the employer $500,000 and initiated root-cause correction to prevent ongoing overpayments. Do the math and imagine the savings that were secured for the employer going forward.

Executives should expect Human Resources leaders to routinely display efforts to monitor and reduce healthcare expenditures by reviewing the organization's service agreement with the TPA and ensuring that annual comprehensive audits are not only allowed, but mandated. Finally, management should report on comprehensive audit results and real findings versus random-sample or "check-the-box" audits.

Contact Us

Contact Healthcare Horizons to discuss how we can help C-Suite executives ensure that an effective program is in place to manage healthcare expenses. Connect with us socially to learn more about how we help our clients return money to their bottom line and ensure future savings.

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About Healthcare Horizons

Healthcare Horizons Consulting Group, Inc. is one of the most trusted and people-centered expert healthcare claims auditing firms in the nation, focused exclusively on self-insured employers. The company is a leading expert in providing healthcare claims audit services, identifying overpaid or erroneous claims through its 100% Difference model, and recovering millions of dollars for clients' bottom lines with uncompromising ethics and accuracy. Healthcare Horizons is committed to putting people and relationships first, offering a streamlined process with high-yield return on investment, making the clients' financial interest its number one priority. Since 1999, the Knoxville, Tennessee-based company has provided superior healthcare claims audits for some of the world's largest self-insured employers, involving all national and most regional payers.

When 'close enough' isn't, the 100% Difference approach yields more comprehensive results, leading to long-term future savings for our clients.

Our unique approach to healthcare claims auditing yields more comprehensive results than a standard random sample audit offered by most healthcare audit firms. Our audits result in the highest possible savings for our clients. We have successfully identified and facilitated the recovery of millions of dollars of overpaid claims for employers across the country.

Since 1999, Healthcare Horizons has been focused exclusively on providing accurate and reliable audits for self-insured employers, working with our clients and with their third-party administrators (TPAs) to make sure claims are paid accurately. Using a process that was designed by our company founder, we use database tools coupled with a team of experienced auditors to identify and verify claims errors against an entire claims population – not just a sample. This process was perfected over many years and hundreds of client experiences, and we continue to innovate each day to be able to offer the most thorough, accurate and efficient healthcare claims audits possible.