



For Self-funded Health Plans The Best Defense is a Good Offense

Si Nahra, President
June 2007

Introduction

Persons familiar with how health claims are paid know it is as much art as science. Claims must be paid quickly (within a week or two of receipt). This means payers (**all** payers from the biggest to the smallest, TPAs, insurers, HMOs and “Blues” plans) must rely on the facts they have at hand when they pay a claim for an employer, other group health plan, or individual.

Most payers pay claims with a high degree of accuracy. However, accurate claim payment using the information at hand has two consequences that cost both self-funded and underwritten plans a lot of money.

1. **Providers “stack the facts” in their favor.** Providers hire staff and consultants to maximize claim payment revenue. Payers’ use pre-payment screens in response. But, in this cat-and-mouse game, providers definitely have the upper hand.
2. **Facts about people change all the time.** Payers must rely on others (employers, brokers, enrollees and individuals) to keep facts current. It is not uncommon to find the facts as reported to payers at the time of claim payment to be incomplete, out-of-date or simply wrong.

The financial impact from these issues can be substantial. For underwritten groups, these “losses” contribute to double-digit premium rate increases. However, self-funded plans bear the direct financial burden. For every one-thousand employees, a self-funded group health plan stands to lose hundreds of thousands of dollars. The growing trend towards “auto-adjudication” (I.e., automated claim payment) only worsens matters for self-funded plans.

Most self-funded plans are unaware of these realities or assume their Third-Party Administrator (TPA) is handling it. What most don’t realize is that the TPA has done all it can do; all it’s been paid to do; and has done it well. The self-funded plan must decide what else to do. Doing nothing means the self-funded plan accepts these losses. Doing something entails knowing more about the problem and what needs to be done.

Boiled down to basics, the best defense is a good offense. To reduce or eliminate these losses, you must attack them. “What You are Attacking” and “How to Attack” are reviewed next.

What You are Attacking

Providers “stack the facts” a number of ways. Here are the more common ones.

- **Credit Balances:** Health care is the only service industry where a double payment is not reconciled and returned. Providers carry double payments (claims paid twice or payments from two different sources for the same care) on their books as “credit balances”. If a self-funded plan asks for a refund, they will be re-paid. If no one asks, the “credit balances” are kept by the provider.
- **Fee Manipulation:** Providers, intentionally and inadvertently, submit PPO bills in a manner that eludes re-pricing discounts. Or, providers incrementally raise fees for the same service each month by an amount small enough to elude detection but large enough to appreciably inflate fees over a contract year.
- **Coding Manipulation:** Sometimes referred to as unbundling or upcoding, a common definition is any billing practice that does not conform to the federal Correct Coding Guidelines mandated by Medicare and Medicaid and endorsed by the American Medical Association as well as others.
- **Contract Manipulation:** Providers with exceptions or “side-bars” in their payer contract can influence contract terms by what they report and how they report it. Self-policing is often relied upon but does not work.

Examples of factual gaps that effect payment include:

- **Termination Gap:** The communication of a termination event is a multi-step, multi-party process made vastly more complex by COBRA coverage continuation requirements. Any delay or miscommunication in this process (not to mention conscious manipulation of COBRA election options by former enrollees) can result in services being paid for ineligible persons.
- **Dependent Gap:** Maintenance of dependent data requires timely, accurate and complete reporting from individuals and its proper processing by multiple staffs for employers, plans and payers. Any missing link results in payments for ineligible persons. Divorces and loss of student status are often miss-reported, reported late, or not reported at all.
- **COB (coordination-of-benefits) Gap:** Other (generally spousal) coverage information is in constant need of update. Employment changes; benefit changes by another employer; payer ownership changes; and changes in coverage verification requirements are just some of the events that intervene to cause another liable party to go undetected.
- **Medicare Gap:** For self-funded plans with retirees, this area dwarfs all others. Even plans without retirees are impacted. Medicare aggressively looks for cases where it can have employers pay (MSP, VDSA, DEFRA are some of the initiatives with this as a purpose). However, Medicare does not ever check for cases where it should have paid first but didn't. These cases occur across all areas of Medicare entitlement and can be both complicated and very costly.

How to Attack

Self-funded plans can take steps to counteract these issues. It starts with a simple commitment to pursue post-payment reviews. These reviews are referred to variously as audits, recovery projects, data mining, management reviews and other terms. Whatever term you choose, all efforts start with a plan of attack. Think of the plan as having four steps: Commit, Commence, Collect, and Control.

- **Commit:** To make your commitment real, someone needs to be in charge. This can be HR staff, risk management, internal audit or others designated by the self-funded plan fiduciaries. This person then needs to assemble their technical support team from internal and external resources.
- **Commence:** Everything starts with getting control of your data (claims, enrollment and related administrative files). Your TPA will have the bulk of this data and should be engaged early. This initial contact can be revealing. A cooperative TPA can be a valuable partner. Simply letting the TPA know you are willing and able to perform post-payment reviews can have an important “sentinel” effect on future claim payments. With data in hand, initial analyses can profile the status quo to show areas for priority attention and set benchmarks for monitoring progress. There are dozens of ways “provider stacking” and “factual flaws” can cost a self-funded plan. If they cannot all be addressed at once, prioritize your efforts. This will both maximize the value of post-payment reviews and put in you a position to exert management control over time.
- **Collect:** Successful post-payment reviews entail two types of collection. Collection of current and correct facts (that can affect 25% or more of covered persons). Collection of money due the self-funded plan (that can yield savings of \$5-\$15 per employee per month). These collection efforts are intertwined. Each can employ a variety of techniques. Whatever the specifics of your collection efforts may be, they are integral to successful post-payment reviews.
- **Control:** To obtain the full value from post-payment reviews, they must be maintained. Think of it as a Continuous Quality Improvement (CQI) effort for self-funded health plan costs. With sustained commitment, post-payment reviews produce a substantial return-on-investment both financially and from a management perspective.

Unlike current claim payment processes, post-payment reviews have time to do the identification and investigation inherent in this process. Instead of a mere week or two, post-payment reviews can take the time needed (a month or two is not unusual) to get the facts right and be sure that the self-funded plan has only paid for claims that are a true plan liability.

Passive acceptance of health care costs is an expensive option. To remain competitive, health care costs must be addressed and managed. As is so often the case, the best defense is a good offense. Post-payment reviews (that start after the TPA/payer is done) are central to that management strategy. When done correctly and on a sustained basis, post-payment reviews become the offense you need to defend against and control health care costs.