



## ACHIEVING TRANSPARENCY AND CONTROLLING RISK AND COST IN SELF-FUNDED PLANS

THE POWER OF ANALYTICS APPLIED TO THE PROBLEM OF HEALTH  
CARE EXPENSE

A White Paper by VitalSpring Technologies

## INTRODUCTION

In this age of growing oversight and scrutiny, a little-noted fact of the financial world is that Fortune 500 companies pay millions of dollars annually based on nothing more than an electronic request for funds. They pay this money without requesting documentation, with few controls, and with very little understanding of where the money goes. An email scam circulating on the internet? Corrupt executives run amok? No, this is simply business as usual when it comes to paying for health benefits. In an age of scandals and calls for greater controls, health care payments – one of a company's largest expenditures – remain largely unmonitored.

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## THE PROCESS AND THE PROBLEM

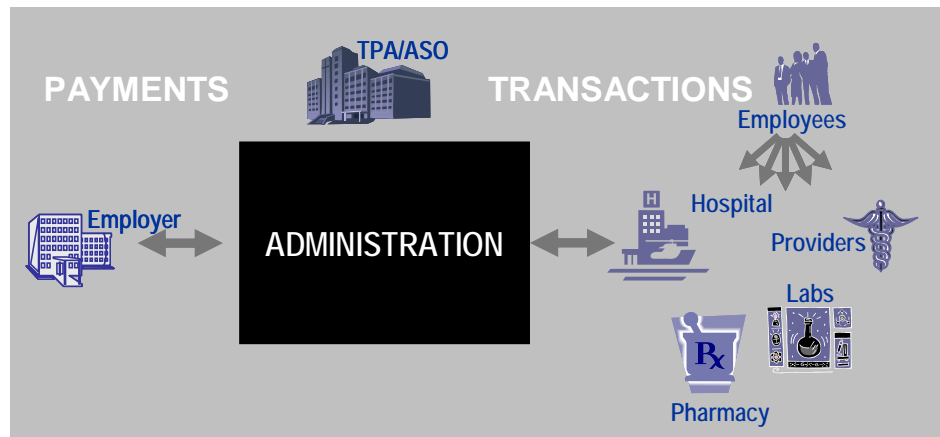
How did we get here? A bit of historical perspective is in order. Self-funded, employer-sponsored health plans gained traction in the mid 1970s with the Employee Retirement Income Security Act (ERISA) of 1974<sup>1</sup>. Employee populations were generally young and healthy. Health care was less expensive. Self-insurance was a less costly alternative that provided significant financial benefits to a corporation. As health care costs and complexity grew, however, managing risk and cost required more sophistication.

By its very nature, the business of providing health care to a large number of employees requires a myriad of transactions, including:

- **Enrollment** of employees in a constantly changing work force. This requires enrolling, maintaining and terminating employees.
- **Tracking benefits** for each individual and family. This includes the initial load and setup of plans, as well as ongoing management.
- **Claims adjudication** and processing in a timely and accurate manner.
- **Tracking payments** in and out of accounts for the purpose of collecting premiums, paying claims, and adjusting payments.

Each of these areas requires significant infrastructure, administration, and oversight which necessitates the use of third party administrators (TPAs). Health care delivery is further complicated by the fact that numerous parties (physicians, hospitals, etc.) are involved. An overwhelming number of transactions occur between these various parties. To adequately oversee this process, one faces the daunting task of tracing each transaction through a maze of systems and processes managed by third party administrators or Administrative Services Only

(ASO) providers. Employers are left with a “black box” where administration occurs. Control is completely outsourced to the TPA or ASO, which gives the employer no meaningful visibility into their own health care expense.



Additional factors complicate the issue of ceding control to a third party without adequate oversight. For example:

- Due to its materiality and the multitude of its transactions, the health benefit account can have a significant impact on a company’s financial reporting. These accounts routinely rate high in misstatement risk assessments performed as part of compliance with the Sarbanes Oxley Act of 2004.
- Cost of care increases year over year make it difficult to judge reasonability of the account balance based on variance analysis. This makes it less likely that variance analysis will disclose problems.
- Health care is susceptible to fraud. As noted by the Federal Bureau of Investigation, health care fraud and abuse accounts for up to 10 percent of all health care cost nationwide<sup>ii</sup>.

Few companies have the internal capacity to achieve the levels of control they otherwise require in the purchasing cycle. Having handed over a complex and multifaceted job to a third party, most companies have no way of monitoring the quality of administrative services provided. In many cases they are even precluded from doing so by limitations set by TPAs and ASOs on claims review and audit.

This lack of control has become more acute over time. Risks have grown as a result of rising health care costs, benefit complexity, demographic changes, chronic disease progression, aging populations, and direct to consumer marketing, just to name a few. With more at stake, companies have come to realize that more needs to be done to enhance control. But without a way to assess all these transactions, what meaningful oversight can be achieved?

## ATTEMPTING TO GAIN CONTROL

There are two fundamental problems companies face in trying to oversee the relationship with their health plan administrator:

- **Control over health care expenses lies with the administrators.** After employee information is provided by the company, administrators fully control the determination of *member eligibility, benefit eligibility and setup*, and the *accuracy of the payment* made to providers. Understandably, companies cannot possibly track and monitor these areas because they lack the information to do so. How then do they ensure that members are eligible, benefits are accurate, and payments are timely and valid?
- **Third party administrators provide little if any backup to support their requests for funding.** It is nearly impossible for companies to reconcile what they pay for the health care of their employees. As such, how do they know their payments are justified?

Employers have recognized the risk that the “black box” of administration poses, and have responded with strategies for managing that risk. However, each of these strategies carry serious limitations.

Risk Strategy	Description	Limitations
Performance Guarantees	<p>Outcome targets for core administrative processes are agreed to, such as enrollment and update timeframes, accuracy of claims payments, customer service resolutions.</p> <p>Some arrangements carry penalties for non-performance.</p>	<ul style="list-style-type: none"> <li>♦ Performance guarantees are almost always measured and reported on by the vendors themselves, who by definition lack independence.</li> <li>♦ Performance levels can be set as low as 95%, allowing significant cushion for poor performance.</li> <li>♦ Penalties are seldom enforced.</li> </ul>
Periodic Claims Audits	<p>Outside auditors review a selection of claims for payment accuracy, processing timeliness, and member eligibility.</p>	<ul style="list-style-type: none"> <li>♦ Claims selected are only a small percentage of overall claims processed.</li> <li>♦ Claims audits are generally performed only every two years.</li> <li>♦ Carriers often limit claims review to only subsets of total claims to extrapolate performance.</li> </ul>

The Internal Audit community recognizes the significant risk posed by health care-related accounts, and has advocated for greater scrutiny and control specifically for self-insured health care costs<sup>iii</sup>. Companies may try to focus on controlling the health care expenditure cycle, but how can they increase their visibility into processes that are fully controlled by TPAs and ASOs?

## ACHIEVING VISIBILITY & TRANSPARENCY

Leading companies see technology solutions as an enabler for necessary control and oversight of their health care account. Trying to do this manually is impossible. By analyzing volumes of health care information, corporations can assess processes and data integrity. To gain control of the health care expense cycle, a company must be able to **see** the entire universe of transactions. Ideally, the solution will achieve the following objectives:

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Objective		Benefit
1	Efficiently acquire transaction level data for analysis and properly map data to key fields	Facilitate analysis of 100% of claims at the individual transaction level
2	Understand the business rules and adjudication process	Design effective, repeatable testing
3	Interpret test results and understand the anomalies	Monitor the administrative activities of the TPA/ASO for each transaction
4	Reconcile financial and statistical information provided	Validate process integrity and identify gaps and process breakdowns
5	Perform key screening of eligibility and claims adjudication for duplicates errors and omissions.	Identify breakdowns in the company's internal HR and financial processes Identify errors made by the TPA/ASO
6	Analyze claims and the integrity of the financial information provided	Reconcile the company's financial records with actual claims data  Ultimately validate that a claim submitted to the company for payment was: <ul style="list-style-type: none"> <li>• for an employee (or dependent) of the company</li> <li>• for an employee actually enrolled in the health plan</li> <li>• to a provider of health care services</li> <li>• for a covered benefit</li> <li>• for a service that was delivered</li> <li>• paid at the correct amount</li> </ul>

The goal is for companies to continuously monitor the validity of 100% of the health care expense and reconcile actual transaction level activity to financial statements. This is essentially only possible with a sophisticated technology solution.

## **CASE STUDIES IN HEALTH BENEFITS FINANCIAL CONTROL**

The following case studies present actual situations where major corporations have applied a technology solution to improve their control over health plan administration.

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### ***Case Study #1: Claims Review & General Ledger***

For a particular company, health care represented roughly 8 percent of over \$3 billion in total annual expenses. Not only was health care one of their highest expenses but also it was estimated to grow 11 percent annually. Breaking down health care benefit expenses was not an easy task since three different vendors administered plans. Checks were cut to each ASO vendor with little or no backup. This made reconciliation of the amounts requested by the vendors to supporting documentation impossible. Matters were further complicated by the fact that each of these vendors individually controlled a significant spend, but all were accounted for in a single general ledger account.

Their solution was implemented in three phases:

1. Financial leadership segmented expenses by type and established more workable and smaller sub-accounts. With the expenses segmented, finance could now reconcile accounts by vendor and service type.
2. Financial leaders leveraged technology to reconcile dollars spent with actual transaction level data. As data from the vendors arrived and reconciliation began, the company identified some significant gaps in the area of ineligible claims. This was enabled by large scale data processing to match financial records to claims data and verify that the amounts requested were for eligible employees and reconciled to actual services provided.
3. Finance reconciled the vendor's activity to its own financial records.

This effort identified that out of \$400 million spent over two years, \$20 million, could not be tied to claims data. This called into question the reliability of information being reported by the vendor that also served as the basis for disbursements to the vendor and for financial reporting. Clearly there was an error, but how serious was it? To what extent did this challenge the accuracy of

payments over the prior two years?

This error was undetected in core administrative processes for so long that it fundamentally called into question the company's control over their health care expenditure process. This also raised legitimate concerns around the accuracy and completeness of the information and reporting being produced by the vendor.

Having achieved transparency and visibility, the corporation took control of their relationship with the vendor. Rather than simply receiving information and responding with payment, the company now dictates how information flows and requires full support for all transactions.

### ***Case Study #2: Focused Auditing***

For one corporation medical benefits for retirees over the age of 65 were capped at \$100,000. While the company had communicated this to the ASO vendor, they had no way of verifying that the cap was being adhered to or monitored. Vendor reports provided showed very little in the way of denials based on retirees having reached their lifetime limit. This did not fit with what the company knew about the growth of its own retiree population.

The company installed a software platform designed to analyze large volumes of transactions. With this platform the company checked total payments by retiree for claims from the entire enrolled population. This audit uncovered many retirees with healthcare expenses greater than \$100,000. The company alerted its vendor to these cases and demanded an enhancement to monitoring retiree spend. The company's internal audit also initiated a process of continuously monitoring the vendor's adherence to caps, and to send alert as individual retirees approached their limit.

### ***Case Study #3: Reserve Requirements***

Companies who self-insure are required to reserve against claims which have been incurred but not yet reported (IBNR). This amount can be material. Accurate calculation of IBNR reserves requires proper diligence.

While IBNR calculations are complex, they follow standard industry guidelines and can be programmed into analytical software. In the case of one company using outside consultants to estimate reserves, the general practice of most self-insured plans, grew costly over time. In addition, using the outside vendor produced a reserve based on industry norms and expected completion rates. By utilizing analytics on all claims over a two and a half year period, the company was able to utilize its own experience with completion rates, adjustments, and other risk considerations to accurately estimate IBNR expense.

### ***Case Study #4: Business Unit Cost Reporting***

As a significant expense, health care costs are often budgeted equally to each business unit throughout the company. In actuality, health care costs vary greatly by business unit. For example, the number of dependent lives, which drives expense, generally varies from unit to unit. Utilization of services and even health risk can also affect costs. Given information provided by a typical TPA/ASO vendor, it is difficult or impossible to identify these factors across all business units and to accurately allocate costs.

One corporation faced this dilemma and found itself unable to distribute costs fairly across business units in any meaningful way. With sophisticated technology, the company associated members and their dependents to specific business units. Matching these individuals to claims allowed them to determine accurate business unit level expenditures. The company improved its budgeting and financial reporting as a result.

### **RISK MITIGATION AS AN IMPERATIVE**

Both regulators and investors are demanding more accountability. They are far less forgiving of companies that allow monies to be misdirected or that carelessly monitor spending. Proper governance demands that companies diligently monitor their spending and seek opportunities to eliminate waste. Without automation to facilitate visibility and transparency, this becomes an impossible task. Only with a comprehensive, industry specific solution can companies even attempt to analyze their health care expense cycle. In an age of technology, they can offer investors no less.

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**VitalSpring Integrity** is an award winning hosted software that delivers financial performance information, metrics and scorecards that illustrate opportunities to improve financial performance for claims administration, funding, and accounting.

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<sup>i</sup> Donald W. Moran, "Whence and Whither Health Insurance? A Revisionist History," *Health Affairs* 24, no. 6 (2005): 1415-1425. <http://content.healthaffairs.org/cgi/content/full/24/6/1415>

<sup>ii</sup> Federal Bureau of Investigation, "Financial Crimes Report to the Public, Fiscal Year 2007." [http://www.fbi.gov/publications/financial/fcs\\_report2007/financial\\_crime\\_2007.htm#health](http://www.fbi.gov/publications/financial/fcs_report2007/financial_crime_2007.htm#health)

<sup>iii</sup> Dennis Applegate, "An Overlooked Risk: Audits of Self-Funded Health-Care Plans Can Apprise Management Not Only of Potential Fraud, but Also of Compliance Issues Requiring Remediation," *Internal Auditor* (February 2007): PAGES

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