Trends

CHECKS AND BALANCES

Claims audits can strengthen plan governance and uncover cost savings

BY MICHELE BOSSI

It’s no secret that health and dental benefits represent a substantial cost for organizations. Yet most employers pay for these costs with little more than blind faith, because the types of internal controls and audits used to verify other company expenses just won’t work for benefits costs.

First, benefit payments depend on the adjudication protocols of third-party providers. Second, the payments are difficult to verify since the beneficiaries are not just employees but any number of pharmacies, healthcare providers and dentists. Finally, adjudicators are prohibited by law from providing the confidential supporting documentation—such as detailed monthly payment invoices—that employers would require to verify that the benefit payments are truly representative of the promise made to employees. All of this has created a need for independent claims audits.

In the U.S., the Sarbanes-Oxley Act has sparked a growing demand for health claims audits since the act was introduced in 2002. That trend is now spreading to Canada—partly because of an increased focus on governance, but also because U.S. companies are now requiring that these audits be conducted on their foreign benefits plans.

Understanding the Process

A claims audit reviews the adjudication protocols of an employer’s benefits provider to ensure that claims are being processed correctly. The audit examines the adjudication system for payment accuracy, ensures contractual compliance between source documents (collective agreements, employee booklets and contracts/policies) and the claims system, and inspects a sample of actual claims to ensure that they’ve been processed in accordance with the source documents.

For an audit to be successful, the auditor and benefits provider must work together co-operatively and respectfully throughout the process. Prior to releasing the final audit report, the auditor often gives a draft to the provider so that the provider can look into any concerns raised, respond to those concerns and provide informed commentary during the ensuing discussion. The benefits provider, auditor and employer will then determine the appropriate course of action to remedy any issues and implement recommendations.

Since errors resulting in underpayments tend to be reported by employees and fixed immediately, most errors uncovered during an audit tend to be overpayments. Depending on the circumstances, these can often be recovered from the provider. More importantly, correcting the errors results in cost savings on a go-forward basis.

Choosing an Auditor

Increased demand for audits has created a need for specialists in this area. When selecting an auditor, employers should ask the following questions:

• How many audits has the auditor conducted?
• Has the auditor worked for organizations of similar size and with comparable coverage and plan complexity?
• Does the auditor have specialized staff to deal with different claim types and compliance requirements (e.g., lawyers, pharmacists, medical personnel and dentists)?
• What is the auditor’s reputation within the benefits and/or consulting industry?

Since the goal of the audit is to give the employer confidence in the provider’s adjudication systems, the audit should be viewed as a constructive exercise rather than an opportunity to lay blame on the provider. Similarly, the results should be considered in the proper perspective. An in-depth review of any complex process is likely to uncover errors, oversights or opportunities for improvement. Experienced auditors understand this and can assess whether or not the results are within an acceptable range.

Generally, it is a good governance practice to conduct a claims audit every two to three years. The savings achieved will often more than pay for the audit itself—and the peace of mind that it brings can be invaluable.