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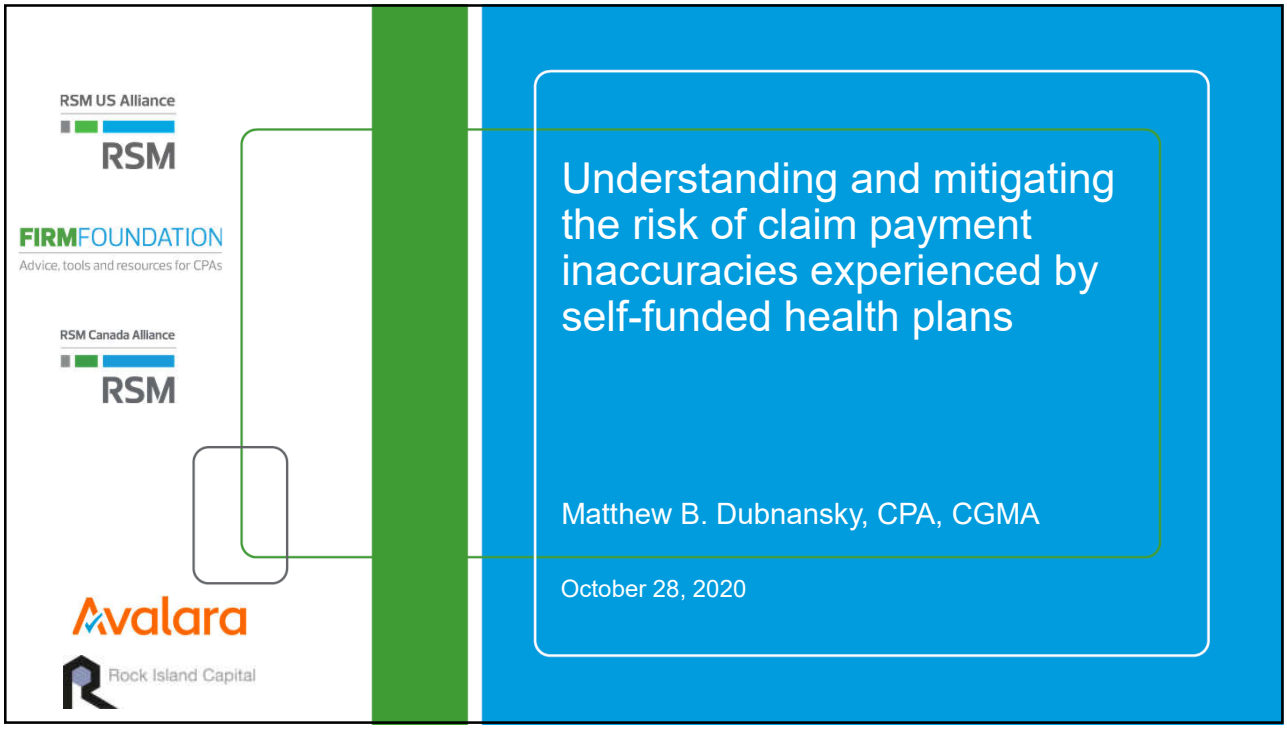
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Advice, tools and resources for CPAs
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Understanding and mitigating the risk of claim payment inaccuracies experienced by self-funded health plans
Matthew B. Dubnansky, CPA, CGMA
October 28, 2020

Speaker

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Matthew Dubnansky performs assurance and risk consulting services for qualified Employee Retirement Income Security Act (ERISA) plans, as well as for their related plan sponsors. He primarily works with complex collectively-bargained union plans, and his clients include some of the firm's largest Fortune 500 companies. In addition to previously serving on the board of directors and the service line leader board for PBMares, he heads up the firm's healthcare assurance and risk consulting practice, TMDG.

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TMDG Healthcare Assurance & Risk Consulting

TMDG, a Division of PBMares, LLP

Professional Associations

- American Institute of Certified Public Accountants
- Maryland Association of Certified Public Accountants
- International Foundation of Employee Benefits Plans

Education

- Bachelor of Arts from Loyola University Maryland in Baltimore, Maryland

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Agenda

Topic	Minutes
Self-funded health plan basics and the plan sponsor's management and oversight responsibilities	15
Self-funded health plan exposure	15
Payment integrity process – healthcare payer	15
Payment integrity process – plan sponsor	15

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Objectives

By the end of this course, you will be able to:

- Understand self-funded health plan basics
- Understand the responsibilities of a plan sponsor to monitor and oversee the administration of the plan
- Identify key risk factors that drive plan administration exposure
- Understand how healthcare payers mitigate these risks
- Understand the plan sponsor's role in mitigating these risks

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SELF-FUNDED HEALTH PLAN

Basics

- Employer assumes the financial risk for providing healthcare benefits to its employees and may mitigate this risk by purchasing stop loss insurance
- Employer retains a third-party payer or an insurance company to administer the benefits, pay claims and perform certain limited fiduciary functions
- Plan is subject to ERISA
- Claims may be paid from the general assets of the employer or from a trust

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SELF-FUNDED HEALTH PLAN

Advantages and Disadvantages

- Advantages of a Self-Funded Health Plan
  - More flexibility and customization of plan benefit design
  - Recognize increased cost savings from positive claims experience
  - More control over selecting, monitoring and coordinating plan vendors
  - Not subject to state insurance laws and mandates
  - Greater access to healthcare data to identify trends and opportunities for cost savings
- Disadvantages of a Self-Funded Health Plan
  - Recognize increased financial loss due to poor claims experience
  - Exposed to financial loss due to operational inefficiencies
  - More oversight and monitoring responsibility of plan vendors
  - Increased fiduciary responsibility

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PLAN SPONSOR'S MANAGEMENT & OVERSIGHT OF SELF-FUNDED HEALTH PLAN

Best Practice - Integrated Risk Management Approach

- Overall plan management level, inclusive of all plans
- Involves collaboration of plan sponsor and key stakeholders
- Considers internal and external environments, systems, circumstances, and key stakeholders
- Continuous process (improvement, diligent management practices, and ongoing monitoring)

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SELF-FUNDED HEALTH PLAN EXPOSURE

Claim Payment Inaccuracies

- Industry standard error rates for national healthcare payers range from 3% to 5%
- Risk factors
  - Decentralized control environment
  - Complex benefit design
  - Carve out benefits
  - Complex provider network and reimbursement strategy
  - Regulatory environment

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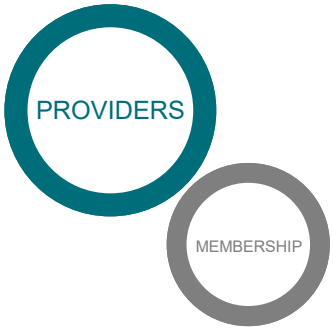
PAYMENT INTEGRITY

Healthcare Payer Process

- Administrative process of ensuring health claims are paid correctly –
  - To the responsible party
  - For an eligible member
  - According to contractual terms
  - Not in error or duplicate
  - Free of wasteful, abusive or fraudulent practices
- Comprised of comprehensive prospective and retrospective activities that are deployed by the payer throughout the life cycle of a claim
- Key elements – prevention, detection, identification and education



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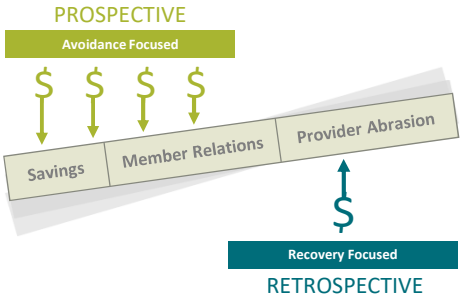
PAYMENT INTEGRITY STRATEGY

End-to-End Solution

- Prospective – cost avoidance process
  - Submission reviews
  - Pre-adjudication and mid-adjudication reviews
  - Pre-payment evaluations & negotiations
- Retrospective – post-payment process
  - Data mining

Factors that Drive the Process

- Organization goals and objectives
- Regulatory mandates
- Available resources and technology
- Operational workflows



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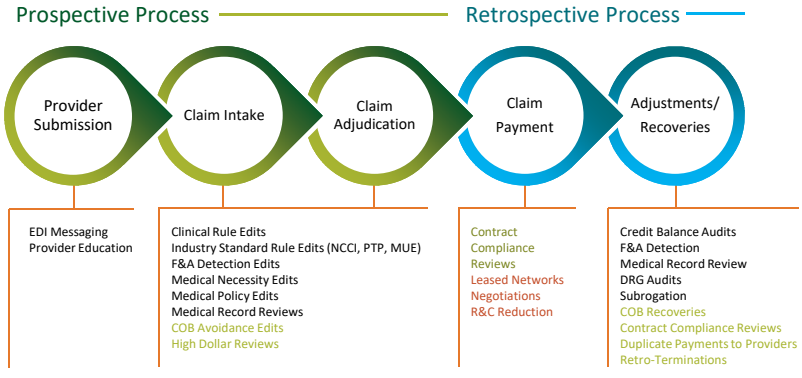
PAYMENT INTEGRITY DESIGN

The Claim Lifecycle



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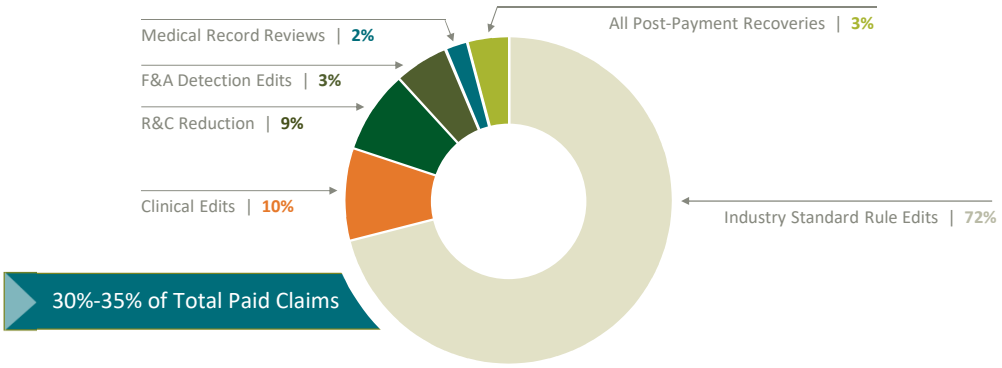
PAYMENT INTEGRITY RESULTS [Excludes Provider Submissions]

Healthcare Payer Evaluation



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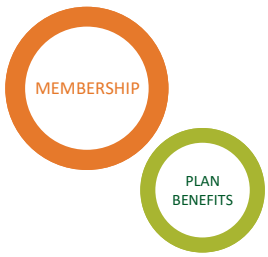
PAYMENT INTEGRITY PROCESS

Plan Sponsor Process

- Monitoring and oversight process to ensure health claims are paid correctly –
  - To the responsible party
  - For an eligible member
  - According to contractual terms
  - Not in error or duplicate
  - Free of wasteful, abusive, or fraudulent practices
- Comprised of comprehensive prospective and retrospective activities that are deployed by the plan sponsor throughout the eligibility and claim lifecycle based on annual risk assessment



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SELF-FUNDED HEALTH PLAN EXPOSURE

Ineligible Members

- Industry standard error rates for dependents range from 3% to 6%
- Risk factors
  - Decentralized control environment
  - Complex eligibility design
  - Complex of inadequate dependent validation process
  - Regulatory environment

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PAYMENT INTEGRITY STRATEGY

Annual Risk Assessment

- Comprehensive evaluation of the plan risk universe inclusive of –
  - The eligibility life cycle
  - The claim life cycle
- Risk identification and ranking process designed to focus plan resources on monitoring and oversight activities
  - Process reviews and evaluations
    - Plan sponsor
    - Healthcare payer
  - Data mining
- Key elements – prevention, detection, identification and mitigation

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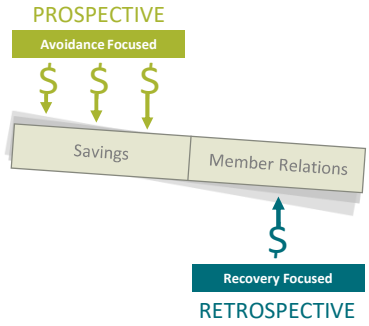
PAYMENT INTEGRITY STRATEGY

Plan Sponsor Solution

- Prospective – Cost Avoidance
  - Eligibility process reviews
  - Pre-implementation reviews
- Retrospective – Post-Payment Process
  - Data mining
  - Monitoring of healthcare payer

Factors that Drive the Process

- Organization goals and objectives
- Regulatory mandates
- Available resources and technology
- Healthcare payer restrictions and limitations



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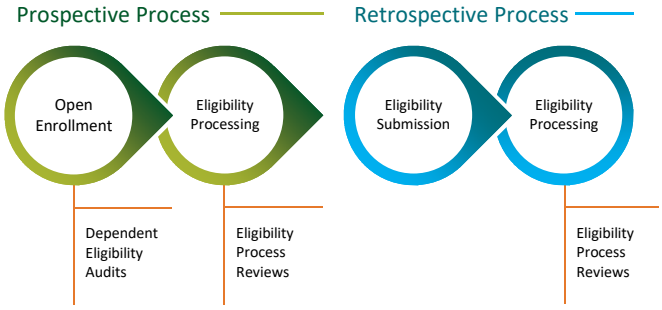
PAYMENT INTEGRITY DESIGN

The Eligibility Lifecycle



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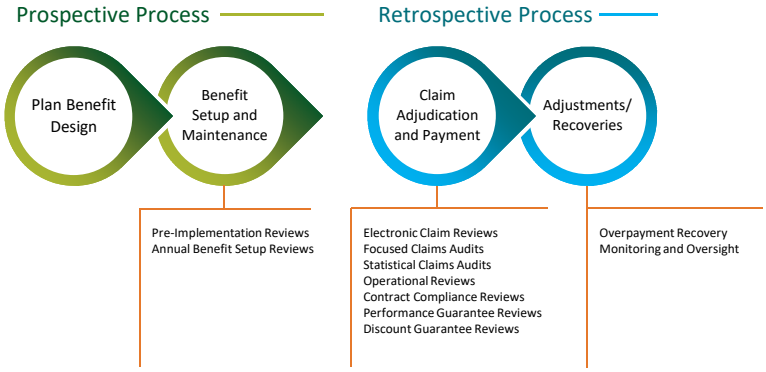
PAYMENT INTEGRITY DESIGN

The Claim Lifecycle



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PAYMENT INTEGRITY BENEFITS

Plan Sponsor

- Closes gaps in healthcare payer payment integrity process
- Results in enhanced claim payment accuracy and operational efficiency
- Maximizes overpayment and recovery opportunities
- Protects plan assets

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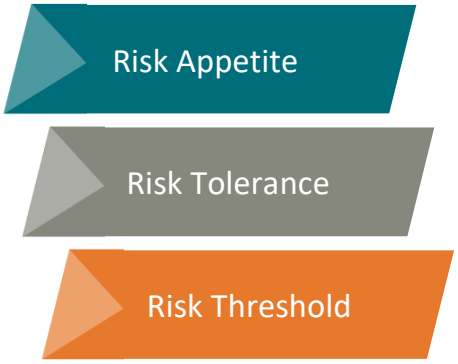
PAYMENT INTEGRITY PROCESS

Plan Sponsor Best Practice

- Designed to reduce risks to acceptable level
- Aligned to risk management plan
- Types and frequency of management and oversight activities generally differ depending on the size of the employer
  - Tier 1 – Jumbo employer – Greater than 20,000 EEs
  - Tier 2 – Large employer – 2,500 - 20,000 EEs
  - Tier 3 – Mid-size employer – 500 - 2,500 EEs
  - Tier 4 – Small employer – Less Than 500 EEs



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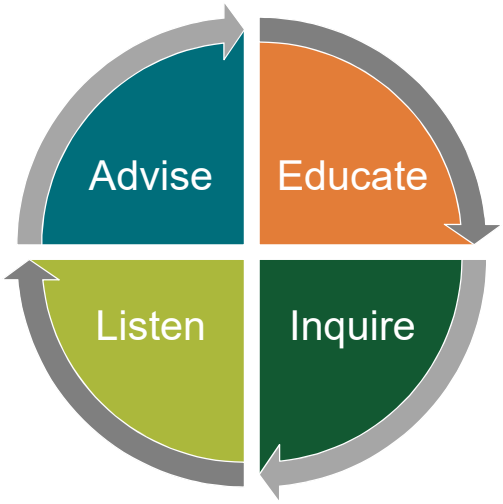
SELF-FUNDED HEALTH PLAN

Becoming the Trusted Advisor



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LIMITED CONFERENCE OFFERING

Client Relationship Partner Consultation

- Individual consultation with client relationship partner to assist your client* better understand and manage the risk of claim payment inaccuracies in their health plan
  - High level review of plan risk factors
  - Evaluation and gap analysis of plan sponsor payment integrity program based on best practices
  - Client relationship partner talking points and client next steps
- For more information come visit us at the pbmares, llp virtual booth in the member showcase

* To qualify, the self-funded health plan of the client must meet the definition of Tier I or II.

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