Antitrust and Health Plans

This Web Site (antitrusthealthplans.com) was created and is maintained by:

Self-Funding Actuarial Services, Inc.
8025 North Point Blvd., Suite 207W
Winston-Salem, NC 27106
Carlton Harker, FSA, MAAA, Principal

Tel (336) 759-2035
Fax (336) 896-0392
harker2@earthlink.net
See www.self-fundhealth.com

Overview

The purpose of this Web Site is to:

- Bring under one cover…
- All relevant aspects of monopoly, trade restraints and unfair acts and deceptive practices…
- Relevant to self-funded health plans…
- For the purpose of maximizing the usefulness of self-funding…
- Thereby preserving employer-financed health care.

A Sub-Site, Statement of Concerns and Purposes, justify the existence of this Web Site.

Presentation

The topic is bifurcated thusly:
Part A – Unfair trade practices without such being antitrust infractions
Part B – Antitrust infractions.

Part A – Unfair Trade Practices

An overview of this subtopic is set forth in Health Plans and Unfair Trade Practices. The two major areas of concern are then discussed in some detail: (a) the Hospital Billing Controversy and whether the present Hospital Billing Practices-Can/Should Survive and (b) Bundled Vendor Services and Possible Unfair Methods of Competition. To establish whether an act or practice is unfair and/or deceptive, a Special Purpose Audit is often required; this differs in many ways from the Standard Health Plan Audit. A menu of a few Suggested Self-Funded Health Plan Changes in response to potential unfair trade

practices are offered. Elaboration, explanation, etc. of various words, terms, concepts, laws, etc. are easily accessible through the user-friendly tools.

Part B – Antitrust Infractions

Antitrust infractions include (a) those activities which tend toward monopolization or restraint of trade and include (b) those unfair acts and/or deceptive practices which have such effect. Such topic is treated thusly:

1. **Applicable to All Industries**
   Statutory Background Etc.

2. **Specific to Health Care**
   McCarran-Ferguson Act

User-Friendly Tools

- Glossary of Topics
- Dictionary of Selected Legal Words/Phrases
- Abbreviations and Acronyms
- Compilation and Brief Description of Relevant Court Cases.

Statement of Concerns and Purpose

Two current activities directly affecting self-funded health care plans deserve our attention:

1. **Hospital Billing Practices**
   For a variety of reasons (most fully understandable), hospitals are currently billing in a manner that is, at best, difficult to comprehend and, at worst, potentially violative of trade practice laws. The focus must be on (a) the oligopolistic nature of the hospital industry and (b) the *blank check* aspects of the present patient-provided consent to treatment statement.

2. **Bundled Vendor Services**
   The primary vendors (administrative, utilization review, network management and stop-loss carrier) while historically independent, are increasingly acting in combination (bundling), which, given the inherent conflicted interest aspects of such combining, create the opportunity for bias in decision-making. Such has the *potential* of being (a) an unfair trade practice or deceptive act or worse yet, (b) an antitrust violation.

Infractions of either the letter or spirit of any law above-cited for the purposes of this Web Site are known to exist anecdotally but the extent of such infractions must necessarily be established by a special-purpose audit. New skills to the audit team (economic, paralegal, actuarial, e.g.) must be considered.

Essential to the logic of this Web Site is that each of the above-cited activities do offer to the *potential* miscreants the opportunity for direct and significant financial gain which is available to such almost *for the asking*. Such financial gain may be used by the vendors or the hospital as (a) stockholder dividends, (b) executive compensation or (c) producer compensation.

The focus of the Web Site is only on the *possibility* of infractions. Any *suspected* infractions must be clearly *demonstrated* to be such. The Web Site is silent on matters of enforcement, or related. The Web Site, however, asserts that even the *possibility* of infractions deserve attention. This logic is based on the fact that a few instances of abuse can quickly multiply into politically-motivated demands for major health plan changes (i.e., a single-payer health system).

Health Plans and Unfair Trade Practices

Overview

I consider certain current industry activities as being potentially damaging to employer-sponsored health care plans in general and to self-funded health plans in particular.

1. The activities are two in number:
    - Chaotic, if not discriminatory, hospital billing methods
    - Bundling of certain vendor services.
2. The potential damages are these:
    - Plan sponsors will use such activities as one more reason to drop their plans.
    - Governments will use such activities as one more reason to intrude; especially of concern is the increasing possibility of a single-payer scheme.

Both of the activities above-cited have the potential of being deemed an unfair trade practice which includes either or both of the following:

- Unfair methods of competition (narrow)
- Unfair acts or deceptive practices (broad).

Two thoughts of interest are these:

- Such activities may violate all manner of statutory law and/or common-law without being ERISA infractions; these infractions involve civil penalties only.
- Such activities may be unfair trade acts and *also* restraint of trade infractions; the latter infractions may involve criminal penalties as well as civil penalties.

It is my view that all of us whose lives are touched in some way by health care plans should respond to these words of warning as follows:

1. See that the potential for any activity being questions is eliminated. To that end:
    - Transparent hospital *sticker prices* should be available, hospital rating should be state-regulated because of the oligopolistic nature of the industry and a new consent to treatment agreement should be adopted as soon as possible.

- Bundling of vendor services should be used cautiously and with an abundance of consumer-alerts because of the pervasive and inherent conflicted interest problems.

2. A new audit, called a *special-purpose* audit should be made available which will ascertain whether or not any plan-related activity is potentially an illegal act (i.e., unfair method of competition or unfair act or deceptive practice).

A commentary follows which focuses briefly on the three major issues:

- Hospital billing Practices
- Vendor Bundling
- Special Purpose Audit.

Hospital Billing Practices

Current Spate of Class Action Lawsuits

Some 50 class action lawsuits have been filed against some 370 hospitals nearly all of which involve tax-exempt hospitals and non-indigent uninsured persons.

1. Surrounding this litigation, we hear much ugly rhetoric (*bloated* hospitals, *fleecing* of the *unwary* patient, e.g.); hospitals appear to be responding rationally and responsibly.
2. The typical complaint alleges (a) unfair trade laws; (b) violations of letter and spirit of the hospital's IRC §501(c)(3) mandates; (c) various federal laws (Federal Emergency Medical Treatment Act, e.g.); and (d) breach of contract, unjust enrichment, civil conspiracy, concealed action, e.g.
3. It has been reported that as a result of these class action suits, the IRS is examining the tax status of some tax-exempt hospitals.
4. Conflicted interest of some hospitals, by using their billing practices as one part of their overall scheme of gaining a financial advantage with the Medicare Outlier formula, is targeted by most of these class action suits.

The economic reality is that hospitals are taking a *major hit* from the growing significance of the uninsured problem; more than or few are facing serious financial challenges at the same time being *pushed to the wall* by Medicare and the networks.

Unfair Trade Practices

By this term, we mean (a) unfair methods of competition and (b) unfair acts and deceptive practices as set forth in Federal Law (15 USC ch.2 §45) and nearly all state laws as well as common law.

The core problem is that the hospitals' billing practices appear to violate unfair trade practices using the following logic:

1. The presence of discriminatory pricing of services is apparent.
2. Any economic or cost justification therefore would be likely not be shown.
3. Therefore, the issue clearly appears to be (a) an unfair trade practice and, in addition, (b) a potential restraint of trade violation.
4. Any review by the FTC or a state office of equivalence might find some compelling reasons to not view such practice casually (conflicted interest, Medicare Outlier, charity patient reimbursement practices, e.g.).

Suggested Solutions

It seems apparent to the writer, that in light of its oligopolistic nature, the hospital industry can do one of two things at once:

1. Embrace rate regulation as a state function.
2. Make several changes to its billing systems; e.g.:
   - Transparent pricing
   - More user-friendly and meaningful consent to treatment statement.

Any idea of a longer-range solution is not rational in that the present billing systems is reported to be near collapse and needing immediate attention.

Vendor Bundling

Overview

When any of the four vendor-provided functions to a self-funded health plan are provided in combination (i.e., bundled) there exists the possibility of unfair competition as contemplated by state or federal laws. Potentially unfair trade practices exist because of the presence of conflicted interest (disclosed or otherwise) with such combinations. Where the four vendors are each freestanding, no conflicted interest is deemed possible.

If a special-purpose audit is made of the activities of the combined vendors, it may well be demonstrated that, as a result of the conflicted interest of the vendors, an unfair trade practice did, in fact occur. If such is shown to be the case, an FTC investigation might be made at the instigation of: (a) interested parties (regulators, e.g.); (b) aggrieved parties (providers, e.g.) (c) any of the four vendors not involved with, but harmed by, such alleged discrimination and (d) plan sponsors. It is important to note that plan beneficiaries are not involved in that the unfair trade practices under discussion do not typically affect plan benefits.

Unfair trade practices include (a) unfair methods of competition and (b) unfair acts or deceptive practices as contemplated by either federal or state law. It is important to note that an infraction may be either a single act or a practice. Also, such infraction may be both (a) an unfair trade infraction and also (b) a antitrust (restraint of trade) infraction. Infraction (a) is civil only; infraction (b) may be both civil and criminal.

The four vendors are the third party administrator (TPA), Utilization Review Firm/ (UR), stop-loss carrier and the Managed Care organization (MCO).

Examples of Unfair Trade Practices

Three instances of acts which would likely be deemed unfair trade practices characterized by both bundling and conflicted interest are these:

Instance Number One
The TPA is combined with an MCO which also provides its own UR services. A covered person with a serous health problem, capped by an outlier provision, presents a serious financial problem to the network hospital. The solution is to get the person's consent and by ambulance ship such patient to a non-network hospital. The stop-loss carrier will doubtless be apoplectic but it will necessarily have to pay the higher charges unless it takes action in the courts.

Instance Number Two
The TPA and the stop-loss carrier are combined and stop-loss benefits are easily manipulated by simple claims gaming. The employer likely is not aware of such activity.

Instance Number Three
The MCO, TPA, and stop-loss carrier are combined and aggressively slash the hospitals submitted charges. The hospital must acquiesce but recovers much of the cost direct by means of the Medicare Outlier and charity recovery relief.

In none of these examples would ERISA ever be a factor.

Discussion

Additional topic-related comments are as following:

1. *Producers*, while significant to the care and upkeep of the plans, do not have sufficient impact on the unfair competition aspects thereof to be a factor and therefore do not enter the critique. That is, Spitzer-type offences are not discussed in this critique.
2. Central to the writer's thesis is the following assertion:
   - With an *oligopolistic* economic environment such as hospital services...
   - Any significant unfair competition infraction...
   - That does not have an economic justification...
   - Might be deemed a violation of certain federal or state laws...
   - Unless otherwise shown to be pro-competitive by applying the rule of reason test.
3. Miscreant practices are primarily unfair methods of competition or unfair acts or deceptive practices in nature; they are secondarily (if at all) monopolistic or trade-restraining in nature.

4. *MGUs* do not gain a place in the critique because they are an extension (or alter ego) of the stop-loss carrier.

Solution

The vendors, who are bundled or in combination for plan services, have a choice between the following two options as regards the acquisition of a special-purpose audit:

- Do not acquire such audit but rather rely on their actions being immune from any challenge.
- Acquire such audit, correct/amend any instances of unfair methods of competition to the extent possible, and enjoy the comfort of a likely legal safe harbor.

Facts and circumstances will dictate the more prudent course of action in each instance.

It is the assertion of the writer that, while there are instances where conflicted interests might lead to indefensible unfair methods of competition and/or unfair or deceptive practices which would probably fail the rule of reason test, the majority of such vendor combinations are likely above reproach as respects such activities.

Special Purpose Audit

Overview

This Audit has the single purpose of determining whether any acts of any health plan vendors or providers might be deemed unfair methods of competition or unfair acts or deceptive practices as contemplated by relevant state or federal laws. While the health care plan is the enterprise engaging the parties to the audit, the focus of the Audit is on vendor or provider activity which is only tangential to the subject health plan. That is, ERISA infractions are not the target of the Audit.

Purpose

The purpose of the Audit is to assert, positively or negatively, as follows:

- Because of potential conflicted interests…
- Certain named parties, individually or in concert…
- Did commit certain acts or follow certain practices…
- Which might possibly violate the statutory or common-law meaning of "unfair methods of competition and/or unfair or deceptive acts or practices"…
- Where such alleged infractions are set forth and discussed in the Audit Report…
- Following the Instructions, Appendices and Agreements attached hereto.

Scope

The Scope of the Audit is to provide detailed responses to the following questions:

Hospital Billing
Did any hospital provider have a billing practice whereby its variations from a chargemaster are not economically justifiable? Explain.

Bundled Services
Are any of the four major vendors (UR, TPA, Stop-loss carrier, MCO) tied together (by ownership, contract or otherwise) in a combination of either two, three or four in a manner whereby potential conflicted interest exists? If such response is yes, are any of the potential acts deemed to be unfair methods of competition or unfair or deceptive acts or practices? Explain.

Other Issues
To what extent, if any, might an act, identified as a potential unfair method of competition or unfair or deceptive act or practice, also be an incipient act of restraining trade or creating a monopoly? Explain.

Auditor

Because of the nature of the audit, professional skills not normally part of the audit team are candidates for being contributing members thereof; e.g., economists, actuaries, attorneys.

Conclusion

I wish to alert the reader to the following:

- The present hospital billing activities which I believe require immediate changes in some ways
- Vendor bundling activities which I believe require great caution because of the presence of conflicted interest.

These activities have the *potential* of being:

- An unfair trade practice (i.e. an unfair method of competition or an unfair act or deceptive practice), at the least
- Additively, an illegal restraint of trade.

A special-purpose audit is needed to determine any potential infractions:

- For internal or friendly purposes
- For external or other purposes.

Hospital Billing Controversy

In General

It has been reported that as many as 48 class action suits have been filed against some 370 hospitals charging billing abuses involving non-indigent uninsured patients.

Most are in state courts; they all target nonprofit hospitals. Some stress breach of contract; some stress unfair or deceptive trade practices; some stress violations of the hospital's IRC §501 (c) (3) tax-exemption status. The American Hospital Association is sometimes named as a co-defendant.

The emotional issues are generally stressed. The *suffering* non-indigent uninsured is *fleeced* by the *bloated-rich* hospitals using *trickery* by their *overpaid* hospital officers all contrary to the letter and spirit of the hospital's tax-exempt mandates.

It has been reported that the IRS is, or soon might be, conducting an investigation into the alleged tax-status of some of these nonprofit hospitals.

The consensus among hospital administrators is that the hospital billing system is *sick.* They would obviously prefer having it fixed institutionally rather than by litigation. What may be happening is a flood of litigation which will be similar to the tobacco litigations.

The core issue is that the inherent discrepancy between four hospital sticker prices:

1. Government-paid
2. Employer-paid
3. Self-paid (uninsured)
4. Charity-paid.

The billing problems being confronted by the non-indigent uninsured hospital patient is huge. The problem will grow larger since the number of non-indigent uninsured will grow larger.

One of the dark secrets which must be faced and to date has been ignored is this: Medicare and Medicaid are to a great extent at fault. This is because, in being such huge buyers, these systems pay a sticker price less than cost. It is for this reason that many people opine that the health care reimbursement system is broken and must be fixed.

Analysis of Litigation

Typical Class Action Suit

The typical class action suit complains that uninsured patients at a nonprofit hospital were victims of a scheme by which they were billed much higher charges than either government-paid or employer-paid patients. Being non-indigent, such patients failed to qualify as charity patients. As a result, such patients were presented with bills far in excess of what would be deemed fair or reasonable.

In support of its requested relief, the complaint would typically cite several infractions of law:

1. Violations were made of the state's Unfair and Deceptive Trade Practices Act naming the token plaintiff and all those similarly situated as the victims. Issues of *quality* or *quantity* of hospital services are not involved.
2. The nonprofit status of the hospital is challenged emphasizing these facts:
    - Only a minuscule portion of the hospital's expenditures were for charity
    - The hospital was very *profitable* with huge benefits going to its officers.
    - Of the four types of hospital patients (government-paid, employer-paid, charity and uninsured) only the uninsured is subject to hospital victimization in that the sticker prices for their care are not subject to either publication or negotiation.
    - Evidence exists that such uninsured sticker prices are not set in any way other than to self-serve the hospital when it files for Medicare-reimbursement under the so-called outlier program. The complicated Medicare reimbursement formulas permit the hospital to inflate its losses from uninsured patients thereby inflating what it is able to recover from the Medicare program under the outlier formulas. That is, the purposeful and unjusted overcharging of the uninsured patient is converted into an economic positive for the hospital.
    - The hospital further exacerbated its bad faith by overaggressive patient bill collection tactics which involved, but were not limited to, placing liens on patient's homes, destroying credit ratings, etc.
    - The hospital was in violation of its federal tax-shelter being a IRC §501 (c) (3) hospital.

3. The nonprofit hospital violated the federal Emergency Medical Treatment and Active Labor Acts by failing to provide emergency medical care without regard to the ability of individuals to pay for such care. The defendant hospital violated this federal law by requiring all uninsured patients, including Plaintiffs of the Class, to sign a written agreement agreeing to pay all medical charges not covered by insurance before it will provide them any emergency medical care. The defendant hospital benefits from this violation not only by obtaining an agreement from the uninsured to pay for emergency medical care that they may not be required to pay for, but also by intimidating others from even pursuing emergency

medical care at the defendant hospital that they are entitled to receive under such act. Plaintiffs and the class are alleged to have suffered personal harm as a result of these violations by the defendant hospital. The lawsuit alleges that the defendant hospital has amassed hundreds of millions of dollars in cash and marketable securities that should be available, but is has not provided, to ensure affordable or charitable care of the uninsured whose care was contemplated by the provision of the charitable, non-profit tax exemption that the defendant hospital enjoys.

Central to the complaint would be these issues:

- The hospitals' *sticker prices* were non-disclosed; i.e.; a cloak of alleged secrecy existed.
- The hospital practiced bad faith when the patient admission agreement, with undisclosed fees became, in effect, a blank check signed in advance by the patient. The bad faith actually occurred when the hospital did, in fact, overcharge the patient.

The court typically must grapple with these issues:

1. Were the hospital charges in violation of the admission contract?
2. Were the hospital charges unreasonable and unconsciousable?
3. Was the hospital unjustly enriched by its actions?
4. Did the hospital act unfairly and/or deceptively?
5. Are patients eligible for restitution?
6. Is an injunction ruling in order?
7. Is a class action justified?
8. What legal theories might apply?
   - Breach of contact
   - Unjust enrichment
   - Violation of IRC §501 (c) (3)
   - Unfair and deceptive trade practices.

The complaint would typically seek relief from the court in these ways:

1. Certification of class action
2. Compensable and treble damages of at least $10,000
3. Restitution to patients
4. Injunction for the hospital to cease and desist
5. Reimbursement of legal fees.

Relevant Rhetoric is Ugly

Charges being leveled against the hospitals, outside of the court room, are becoming rather ugly. Some samples:

1. "Billing abuses and wrongdoings are widespread throughout the nonprofit hospital industry."
2. "We are becoming painfully aware that many nonprofit hospitals, benefiting from the cross-pollination of information from the AHA, are not meeting the needs of the communities they serve but rather are catering to the special interest groups."
3. "To cover up their actions, such hospitals often engage in manipulative accounting, less than full disclosure and public misinformation campaigns."
4. "Such hospitals are reaping hundreds of millions of dollars in tax benefits but not living up to their end of the obligation in return for these tax benefits; i.e., charitable health care to the uninsured. In effect, the wrongdoers are having the taxpayers underwrite their actions."
5. The adjective *nonprofit* is *counterfeit*; such hospitals while garnishing the wages of its uninsured patients, compensates and/or contributes excess of *six-figure* incomes to many of its executives."

Response from the Defendant Hospital

As the target of the class actions, such defendants do have a rational defense and may properly claim much virtue. Their views are of great importance.

The hospitals couch the issues as follows:

- Hospitals vary their sticker prices and are therefore discriminatory but do so with economic justification.
- Many uninsured patients can well afford to pay and are definitely not indigent.
- Litigation is costly and detracts from the hospital being able to provide the requisite care to its patients.
- Ethos of hospitals being expected to provide free care will only destroy the present health care financing framework.

The hospital-related economics must be reviewed:

- The fundamental and necessary principle in healthcare economics is the concept of cost-shifting to the private sector to compensate for government under-funding of Medicare, Medicaid and the uninsured.
- In general, hospitals across the country have one set of charges for all patients.
- Furthermore, hospitals generally lose money on every single Medicaid or Medicare patient (although this varies from hospital to hospital).
- Therefore, to remain financially viable, hospital must collect a greater percentage of their charges from payors, such as managed care companies, to *make up* the difference for government payors that do not cost of providing care and for those who pay nothing at all.
- Experts argue that hospitals set charges above the cost of providing care, but that most patients don't pay these prices because insurance companies negotiate discounts and government payers set lower reimbursements.
- Additionally, non-profit hospitals historically lose more or break even on some services to carry out their mission, so they must make money on others to remain stable.
- Charity care represents patients who are not able to pay. In most healthcare organizations, the vast majority of the debt expenses also represents charity care for patients that fail to apply for charity or do not cooperate with staff.
- The problem at hand is not a hospital billing problem but rather a larger societal problem.

Restraint of Trade Issue

None of the class action litigations cite on their litany of complaints a restraint of trade infraction. This omission may not be correct.

1. 15 USC ch 1 § 13 forbids discrimination in prices or services which tend to lessen competition unless such discrimination is economically justified.
2. When John, a non-indigent uninsured patient of Dr. Jones, is admitted to Hospital A with no effective choice in the matter by John, Dr. Jones or Hospital A is there a tying agreement? When John is surprised by a bill much larger than comparable bills with insured patients and has no choice in the matter and as a consequence must face bankruptcy, might this be deemed an assault on competition?

The writer has the right to ask the questions but does not offer any answers.

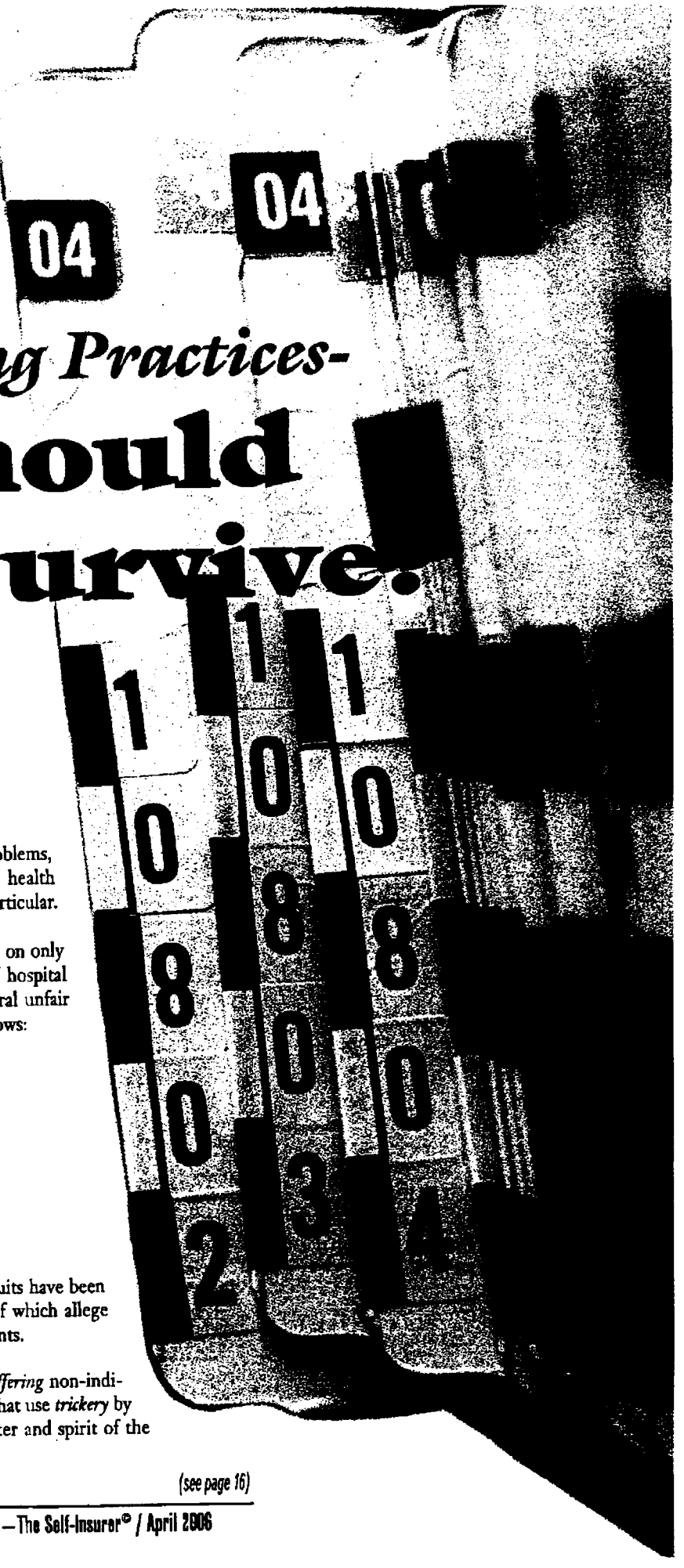
Conclusions

The writer is concerned with these class action law suits for the following reasons:

1. They will not go away and will eventually end up on the Supreme Court with an uncertain conclusion. This we do not need with our many present challenges.
2. The class action suits might be modified to include a restraint of trade infraction as one of their complaints.
3. The multiple class actions joined with the consensus that our present hospital billing system is in disrepair could be one more argument for Congress to go to a single payer system.

Editors note: The following article presents an interesting view on this subject that we felt we should share with our readers. The opinions reached are those of the author alone and do not imply any opinion on the part of the officers, directors or members of SIIA or the SIPC.

Hospital Billing Practices- Can/Should They Survive?



By Carlton Harker, FSA, MAAA

Introduction

I enumerate in Exhibit A some of our current problems, which impact unfavorably on employer-financed health care plans in general and/or self-funded plans in particular.

Since I am limited in space, I will offer a brief critique on only one of these problems, namely the current spate of hospital billing class action lawsuits and possible state or federal unfair competition issues. My critique will be offered as follows:

- Understanding the litigation
- Unfair competition aspects of the problem
- Participant involvement
- Suggested solution
- Conclusion.

Understanding the Litigation

Overview

It has been reported that as many as 48 class action suits have been filed against approximately 370 hospitals nearly all of which allege billing abuses involving non-indigent uninsured patients.

The emotional issues are generally stressed. The *suffering* non-indigent uninsured is *fleeced* by the *bloated*-rich hospitals that use *trickery* by their *overpaid* hospital officers all contrary to the letter and spirit of the hospital's tax-exempt mandates.

(see page 16)

Hospital Billing Practices - Can/Should They Survive (continued from page 7)

It has been reported that the IRS is, or soon might be, conducting an investigation into the tax-status of some of these nonprofit hospitals.

Typical Class Action Suit

The typical class action suit complains that uninsured patients at a nonprofit hospital were victims of a scheme by which they were billed much higher charges than those for either Medicare-paid or employer-paid patients. Being non-indigent, such patients failed to qualify as charity patients. As a result, such patients were presented with bills far in excess of what would be deemed fair or reasonable.

Specific alleged infractions of the law generally include:

- Violation of the state's unfair trade practice laws
- Not following letter and spirit of the hospital's IRC §501(c)(3) mandates
- Federal Emergency Medical Treatment and Active Labor Act violations
- Breach of contract, unjust enrichment, civil conspiracy, concealed action, etc.

Relevant Rhetoric is Ugly

Charges being leveled against the hospitals, outside of the courtroom, are becoming rather strident. Some samples:

1. "Billing abuses and wrongdoings are widespread throughout the nonprofit hospital industry."
2. "We are becoming painfully aware that many nonprofit hospitals, benefiting from the cross-pollination of information from the AHA are not meeting the needs of the communities they serve but rather are catering to the special interest groups."

Response of the Hospitals

The hospitals have been offering a calm, lucid and effective defense to date.

Comments

I am concerned with these class action lawsuits for the following reasons:

1. They will not go away and will eventually end up in the Supreme Court (in all likelihood) with an unpredictable conclusion. This we do not need with our many present challenges.
2. The class action suits might be modified to include price discrimination and/or restraint of trade infractions as a part of their complaints.
3. These multiple class actions joined with the consensus that our present hospital billing system is in disrepair could be one more argument for Congress to adopt a single payer system.
4. Hospitals could be financially harmed in a significant way.

Unfair Competition Aspects of the Problem

It appears to me that there is a problem with hospital bill pricing but many of the class action suits do not stress the real problem; i.e., unfair competition (or possibly antitrust) infractions. I suggest that the matter be viewed from three perspectives:

1. The rule
2. The activity
3. The infraction.

The Rule

Our primary focus is on 15 USC ch. 2 §45 which forbids unfair methods of competition or unfair/deceptive acts or practices which affect commerce. Our lesser interest is on 15 USC ch. 1 §§1 and 13 which address the possible antitrust implications of the price discrimination.

The Activity

Hospital A, profit or nonprofit, has a chargemaster, which declares a market basket of procedures to be a $8,000 in value and for which the hospitals cost is $5,000; the hospital is reimbursed as follows:

Medicare	$4,500
Blue Cross	6,000
Network A	6,500
Network B	7,000
Network C	7,500
Non-indigent uninsured	9,500
Indigent uninsured	0

The Infraction

When the *activity* is measured against the *rule*, we find the following:

Price discrimination in products and services. There is price discrimination (and potential unfair competition) without any need for discussion.

Economic justification of such discrimination. I would believe that the hospital discounts typically given from its chargemaster cannot be economically justified.

Restraint of trade as an end result or motive. Either (a) there is a free and open competitive environment for the consumer with ample marketplace choices in which event it may be argued that the consumer is not harmed by the choices made, or (b) the consumer is so constrained that there are no ample marketplace choices in which event it may be argued that the consumer may be harmed by the choices offered. I believe that (b) is the correct choice for these reasons:

1. The consumer may obtain health care only through the consumer's physician because of the nature of the relationship, the nature of the disease or similar reasons.
2. The consumer may obtain health care only through Hospital A; the consumer has no choice in where the hospi-

tal care is given because the physician has practice privileges only in Hospital A.

3. On hospital admission, the consumer is powerless to bargain for prices, argue for *most-favored nation* terms, be offered network choices, etc. The consumer signs a *blank check* to Hospital A to pay what Hospital A says will be the charges. Such consumer has no access to a *sticker price* and is figuratively in the financial clutches of Hospital A.

Over-arching and compelling reason. In light of Hospital A's conflicted interests with Medicare Outlier adjustments, recovery from Medicaid filings and for-poverty care reimbursement, it is doubtful that Hospital A is due much slack should the unfair competition decision go against it.

Participant Involvement

One young couple found out the hard way that a hospital may be a dangerous place. The facts were these:

1. Rather than use a network hospital, the couple opted to use a more convenient out-of-network hospital for their maternity stay.
2. Their preemie proved to be costly for its 20-day stay with a resulting hospital bill of $900,000 of which only $650,000 was accepted by the plan as reasonable and customary.
3. The hospital insisted on balance billing so as to gain the financial advantage with the hospital's Medicare Outlier filing (and other advantages relative to charity charge-offs).
4. The preemie did not survive leaving the couple with both a child loss and a bankruptcy filing.

Thus it is that hospitals are marvelous centers for healing but they can also (a) bankrupt you and (b) give you health problems that you did not have when you were admitted (staph, e.g.).

Suggested Solution

It is my suggestion that the laws or regulation of each state which presently govern hospitals be modified so as to accomplish at least two things:

1. An annual report, jointly-prepared by an independent accountant *and* an independent economist, which would show, for an industry-accepted market basket of hospital procedures the following data:
   a. Hospital-Specific Data

• Chargemaster	$8,000
• Hospital costs	5,000

   b. Market basket-Specific Charges

Payer-Network	Actual	Cost Justified
Medicare	$4500	$6,000
Blue Cross	6000	6500
Network A	6500	7000
Network B	7000	7200
Network C	7500	7800
Uninsured		
Non-indigent	8500	8000
Indigent	0	0

2. An amendment to the financial responsibility provision of the Consent to Treatment Contract might read as follows:

I have received a certified statement of hospital charges for a market basket of hospital procedures; I understand the basis of my charges will be according to my billing class which is Network A.

My financial obligation will be determined by the actual services provided by the hospital but the basis of such determination (when applied to such market basket of services) will be the actual charges of $6,500 which compares to the Hospital sticker price of $8,000.

Conclusions

My critique, skimpy though it is, permits me to make a few conclusions:

1. We must take these class actions seriously because they offer the single-payer advocates a good argument for their agenda.
2. The real problem, not generally grasped, is that our oligopolistic hospital industry cannot sustain the unfair competition activities introduced in the last decade under the name of managed care. We must with some haste either (a) make the hospital industry more competitive or (b) modify their pricing practices. Only (b) has any reasonable hope for success, in my judgement.
3. Prospective patients should realize that the Consent to Treatment Agreement could be the cause of their bankruptcy or worse.

Exhibit A

List of Some of Our Current Problems

- Growing consensus is that our health care system is broken; burdens on employers are becoming unsustainable; health care costs are estimated to be 20% of GDP by 2015.
- Managed care as a cost control mechanism has collapsed.
- Hospital administrators are openly admitting that their billing systems are broken, perhaps beyond repair.

(see page 18)

Hospital Billing Practices - Can/Should They Survive (continued from page 17)

- Hoped-for patient-protection and tort reform legislation is not on the horizon.
- The number and aggressiveness of vendors each with their own song and conflicted interests are increasing.
- Ravages created by the proliferating hospital billing class actions lawsuits might become comparable to the tobacco-litigation industry problems.
- The general health financing industry attitude is that it is above the reach of the antitrust laws.
- To-date, stop-loss has not self-corrected many of its inherent drawbacks thereby making it part of the problem rather than part of the solution.
- New paradigm of consumer-controlled care is not being taken seriously in that such will only work if the system is competitive which is not a reasonable expectation.
- Upcoming baby-boomer financial demands will add to the costs. Exponential technical advances all with much higher costs will add to the costs.
- Cost-shifting by Medicare to the private system (lowering hospital reimbursements, e.g.) will accelerate as Medicare Part D costs are felt. Accelerating cost-shifting as the rolls of the uninsured increase will be expected.
- The government reserve requirements for retirees (GASB 43 and GASB 45) will be a train wreck financially adding to our numerous other problems.

That's my opinion. To share yours, contact the Editorial Dept. listed on page 1.

Carlton Harker, FSA, MAAA is a well known and respected member of the self-funding community and has been an active participant in the Self-Insurance Institute of America's educational programs for many years. In addition to authoring numerous books on a diversity of subjects related to self-funded health care, Carlton has appeared as a speaker and panel member at various industry educational functions. Harker has appeared as an expert witness in many hearings and trials. Mr. Harker is the Principal of Self-Funding Actuarial Services, 8025 North Point Blvd., Suite 207 W., Winston-Salem, NC 27106. (tel) 336-759-2035, (fax) (336)892-0392, or via e-mail at harker2@eartblink.net He maintains a web site at www.self-fundhealth.com

Bundled Vendor Services and Possible Unfair Methods of Competition

Introduction

This brief critique examines the federal unfair methods of competition issues with respect to bundled, or combined, vendor services which might possibly be in violation of certain federal or state laws. The concern of the writer is that such possibility might become a reality thereby offering proponents of a single-payer health system an additional argument therefore. A relatively simple solution to such potential problem is suggested; i.e., a special-purpose audit, selectively made, which would demonstrate compliance with both the spirit and letter of applicable federal and state laws. This critique is limited to general asset self-funded plans where the only claims under scrutiny are hospital-related.

The critique is in these parts:

Problem
Discussion
Solution
Exhibits
A – Definitions
B – Illustration of Possible Infractions

Italicized words are defined in Exhibit A

Problem

When any of the four *vendor*-provided *functions* to a self-funded health *plan* are provided in *combination* (i.e., *bundled* there exists the *possibility* of *unfair competition* as contemplated by *state* or *federal laws*. Potential unfair methods competition exists because of the presence of *conflicted interest* (disclosed or otherwise) with such combined vendors. Where the four vendors are each freestanding, no conflicted interest is deemed possible.

If a *special-purpose audit* is made of the activities of the *combined* vendors, it may well be demonstrated that, as a result of the conflicted-interest of the vendors, an unfair method of competition did, in fact occur. If such is shown to be the case, an *FTC* investigation might be made at the instigation of: (a) interested parties (*regulators,* e.g.); (b) aggrieved parties (*providers*, e.g.) (c) any of the four vendors not involved with, but harmed by, such alleged discrimination and (d) *plan sponsors*. It is important to note that plan *beneficiaries* are not involved in that the unfair methods of competition under discussion do not typically afflict plan benefits. Examples of infractions which arise from conflicted interest and which may likely be unfairly competitive are illustrated in Exhibit B, attached.

The infractions alleged to be unfair methods competition which are set forth in Exhibit B may or may not be found by the FTC to be such depending on facts and circumstances. These are the Type B infractions shown in the Definitions-Federal Laws. Such infractions may be corrected by the FTC without civil or criminal penalties to the miscreant(s). However, an act may be a Type B and also a Type A infraction in which event the miscreant(s) may have to face the draconian antitrust penalties (most particularly the treble damage award where the damages are usually the creations of hired economists).

Discussion

Additional topic-related comments are as following:

1. *Producers*, while significant to the care and upkeep of the plans, do not have sufficient impact on the unfair competition aspects thereof to be a factor and therefore do not enter the critique.
2. Central to the writer's thesis is the following assertion:
   - With an *oligopolistic* economic environment such as hospital services…
   - Any significant unfair competition infraction…
   - That does not have an economic justification…
   - Might be deemed a violation of certain federal laws…
   - Unless otherwise shown to be pro-competitive by applying the rule of reason test.
3. Miscreant practices are primarily unfair methods of competition or unfair or deceptive practices in nature; they are secondarily (if at all) monopolistic on trade-restraining in nature. Rules of interpretation used with infractions of the *Clayton Act* will usually be used with unfair methods of competition infractions, however.
4. *MGUs* do not gain a place in the critique because they are an extension (or alter ego) of the stop-loss carrier.

Solution

The vendors, who are bundled or in combination for plan services, have a choice between the following two options as regards the acquisition of a special-purpose audit:

- Do not acquire such audit and rely on their actions being immune from any challenge.
- Acquire an audit, correct/amend any instances of unfair methods of competition to the extent possible, and enjoy the comfort of a likely legal safe harbor.

Facts and circumstances will dictate the more prudent course of action in each instance.

It is the assertion of the writer that, while Exhibit B shows instances where conflicted interests might lead to indefensible unfair methods of competition and/or unfair/deceptive practices which would probably fail the rule of reason test, the majority of such vendor combinations are likely above reproach as respects such activities.

Exhibit A

Definitions

Beneficiaries mean all covered persons.

Bundling* and *Combining are essentially synonymous; such may occur between corporate entities or divisions or by tying arrangements.

Chargemaster means the hospital's posted *sticker price* for its charges prior to discounts.

Clayton Act as amended by the Robinson-Patman Act, in brief, is part of the Federal Antitrust law and says, in effect:

- Do not – discriminate in prices (Act applies only to commodities and not to services)…
- Unless – it can be justified economically…
- Or if – it can be shown convincingly that its goal, or result, was anti-competitive…
- Unless if – it can be shown to be pro-competition by the rule of reason test.

Combination means the 11 ways by which the four vendors may be connected or bundled together taking them either two, three or four at a time; i.e.:

- MCO-UR
- MCO-TPA
- MCO-SL
- TPA-SL
- TPA-UR
- SL-UR
- SL-UR-TPA
- SL-UR-MCO
- SL-TPA-MCO
- TPA-MCO-UR
- UR-MCO-TPA-SL

Conflicted Interest exists where the adjudicating-vendor has a financial interest (direct or indirect) in the outcome.

Federal Law includes the following:

A. **Antitrust Laws**

- 15 USC ch.1 §§1 and 2 (Sherman Act which deals with monopolies and restraint of trade)
- 15USC ch.1 §13 (Clayton Act as amended by Robinson-Patman Act) which deals with commodity price discrimination.

B. **Unfair Competition Law**

- 15USC ch.2 §45 which deals with unfair methods competition and unfair or deceptive practices.

Any violation of (A) is automatically a violation of (B); any violation of (B) may or may not be a violation of (A).

FTC means Federal Trade Commission which is the federal agency designated to administer the relevant laws.

Functions mean the vendor services whether provided by (a) affiliates or subsidiaries, (b) vendor divisions or (c) contractual arrangements.

MGU means managing general underwriter.

Oligopolistic means an economic environment with only a few producers so that some, but not all, of the evils of monopoly are found.

Plan is limited to a self-funded plan, whether ERISA-exempt or not, and funded by the general assets of the plan sponsor.

Plan Sponsor means the employer; (i.e., excludes MEWAs and similar).

Possibility means any such alleged acts of unfair competition must be (a) shown to be such, (i.e., rule of reason) and not (b) assumed to be such (i.e., per se rule).

Producers mean agents, brokers, consultants and risk managers.

Providers mean hospitals only; this critique excludes physicians which should be considered using different standards.

Regulators mean the Department of Justice or the Federal Trade Commission or comparable state offices.

Special-purpose Audits means any audit which specifically targets price and service discrimination as contemplated by applicable federal laws. Other plan-related audits (IRS/DOL Form 5500 audit; employer or TPA internal audit; stop-loss audit; regulatory audit; e.g.) have no standing. Focus of the special-purpose audit must be on unfair method of competition, unfair/deceptive practices or restraint of trade issues.

State law, comparable to the federal law as regards to unfair methods of competition but is not discussed in this brief critique.

Unfair Method of Competition means an act among persons, corporation or partnerships which involves interstate commerce, as determined by the FTC, the courts and common sense to be such. Unfair method of Competition includes any acts which are either unfair or deceptive.

Vendors mean any of the following entities (each of which is publicly-regulated):

- Claims and recordkeeping firm or function (TPA, e.g.)

- MCO (managed care organization) or the network manager
- Stop-loss (SL), carrier (or it's alter ego, the MGU)
- UR (utilization review), firm and more particularly the case management function thereof.

Exhibit B

Illustration of Possible Infractions

We consider four employers:

- Each has a medical plan with identical benefits.
- Each plan uses a set of four vendors (stop-loss, MCO, UR and TPA) with each set consisting of different vendors.
- Each of the employers has a covered person who intends to use ABC Mercy Hospital; the four covered persons are identical in all particulars and have identical health problems.
- The stop-loss terms for each of the four plans are the same.
- ABC has posted a $125,000 chargemaster fee for the Medicaid procedure and offers a 20% discount to all four plans.
- The plans are all single-employer, self-funded general asset, ERISA-governed medical plans.

The only difference is that for Employer A, the vendors are totally independent, while for Employer B-D, the vendors are tied together either by ownership or by contract in some significant way.

Analysis of Cost Distributions

	Plan A	Plan B	Plan C	Plan D
Hospital Charge				
Gross Charge	$125,000	$150,000	$125,000	$100,000
Discount	25,000	0	25,000	20,000
Balance Billing	0	0	0	20,000
Net Charge	100,000	150,000	100,000	100,000
Financed as Follows				
Employer	$75,000	$75,000	$28,000	$75,000
Participant	2,000	2,000	2,000	2,000
Stop-loss Carrier	23,000	73,000	0	3,000
Total	100,000	150,000	100,000	80,000

Notes

The net charge is the legal liability of the covered person as contemplated by IRC §105.

Plan Differences
A-All four vendors are independent.
B-MCO, UR and TPA are combined.
C-Stop-loss and TPA are combined.
D-MCO and UR are combined.

Explanation of Why Cost Distribution Varies

Plan A
With all four vendors being independent, this is the correct distribution of costs.

Plan B
With the MCO, UR and TPA acting in concert, ABC agrees with the MCO and the UR that the case is best provided in another hospital. Therefore, the covered person is sent to another with the consent of such person being obtained in some manner.

Plan C
The stop-loss carrier and the TPA ***claims game*** so that the paid claims straddle the plan year so that the $98,000 benefit is paid in such a manner that the employer has to meet the two specifics and not the one specific. Depending on numerous factors, this activity may or may not gain the McCarran-Ferguson safe harbor. Even if such safe harbor is available, there is the likelihood that the state's fair trade practices would apply.

Plan D

The UR, MCO and stop-loss carrier are connected so that ABC will necessarily acquiesce to the accepted charges by the reasonable and customary provisions of the plan which will be $100,000 and not $125,000. ABC is presumed to insist on balance-billing to the covered person. Such person has no recourse but to accept such balance billing because of the terms of the consent to treatment agreement executed by the covered person.

Commentary to Exhibit B

It is the assertion of the writer that the infractions above-sited have the potential for being FTC-determined violations of the "unfair methods of competition and for unfair acts and deceptive practices" provisions of the FTCAct (15USC ch.2§45) depending on the facts and circumstances surrounding such activities. It is also the assertion of the writer that such activities might also be in restraint of trade or monopolistic but leaves that issue for others to ponder.

Of interest in that analysis are the following comments:

- As far as the writer can discern the three infractions, above-cited, do not violate any state insurance statutes or ERISA. Nor have such infractions, been acknowledged to exist by any regulatory body (state or federal).
- With each of the three infractions cited, there exists a conflicted interest on the part of the vendors. While not dispositive of a wrongdoing, the presence of such conflicted interest is a danger-signal to possible trouble.
- The Exhibit cites three infractions; there are, of course, numerous instances of other infractions but are not discussed because of space limitations.

Special Purpose Audit

Overview

This Audit has the single purpose of determining whether any acts of any health plan vendors or providers might be deemed unfair methods of competition or unfair acts or deceptive practices as contemplated by relevant state or federal laws. While the health care plan is the enterprise engaging the parties to the audit, the focus of the Audit is on vendor or provider activity which is only tangential to the subject health plan. That is, ERISA infractions are not the target of the Audit.

The Audit is presented in these parts:

- Parties
- Purpose
- Scope
- Auditor
- Results/Commentary
- **Appendices**
  Sources of Information
  Unfair and Deceptive Practices
  Description of Potential Infractions

Parties

The Parties to this Audit are as follows:

Plan Sponsor means

Health Plan means

Providers means

Producers mean

Stop-loss (S-L) Carrier means

Utilization Review (UR) means

Managed Care Organization (MCO) means

Claims and Recordkeeping Administrator **(TPA)** means

Managing General Underwriter (MGU) means

Auditor means

The *Audit Sponsor* means _____. Such entity, unless otherwise shown, has financial responsibility for the Audit.

Purpose

The Report must make clear in its narrative as to whether the purpose of the Audit is to be:

- **Precautionary**
  This purpose is of the nature of an internal or prophylactic audit. Any infractions would be corrected so that the Audit Sponsor has the comfort of a *clean bill* of *health.*
- **External**
  This purpose is of the nature of an outside or regulatory audit. Any infractions might be used against the party (or Parties) involved.

The purpose of the Audit is to assert, positively or negatively, as follows:

- Because of potential conflicted interests…
- Certain named parties, individually or in concert…
- Did commit certain acts or follow certain practices….
- Which might possibly violate the statutory or common-law meaning of "unfair methods of competition and/or unfair or deceptive acts or practices"…
- Where such alleged infractions are set forth and discussed in the Audit Report…
- Following the instructions, appendices and agreements attached hereto.

Scope

The Scope of the Audit is to provide detailed responses to the following questions:

Hospital Billing
Did any hospital provider have a billing practice whereby its variations from a chargemaster are not economically justifiable? Explain.

Bundled Services
Are any of the four major vendors (UR,, TPA, S-L, MCO) tied together (by ownership, contract or otherwise) in a combination of either two, three or four in a manner whereby potential conflicted interest exists? If such response is yes, are any of the potential acts deemed to be unfair methods of competition or unfair or deceptive acts or practices? Explain.

Other Issues

To what extent, if any, might an act, identified as a potential unfair method of competition or unfair or deceptive act or practice, also be an incipient act of restraining trade or creating a monopoly? Explain.

Auditor

The Auditor uses the following professional skills in the preparation of the Report:

___ Claims processing and recordkeeping
___ Accounting
___ Actuarial
___ Economic
___ Legal
___ Other.

The Auditor may be guided in its conduct of the Audit by the items set forth or referenced on the Appendices. The Auditor may find it needful to *subcontract* some of the special questions to professional skills not available through the Auditor (economist, attorney, actuary, e.g.). The actuary might be helpful if issues of pricing are germane. The Auditor must profess independence and the report, including the opinion of any contributing specialist professionals, must be acceptable as an independent report.

Results/Commentary

The text of the Audit Report is provided here.

Appendices

Sources of Information

- www.antitrusthealth.com
- FTC Web Site
- State Attorneys General.

Description of Potential Infractions

Attached hereto is a sample listing of most of the possible infractions which should gain the attention of the Auditor.

Unfair and Deceptive Practices

Attached hereto is a brief critique of the statutory and/or common-law meaning of this term.

Unfair and Deceptive Practices

Statutory Background

The United States Code (15 USC §45(a)(1)) declares as illegal the following:

1. Unfair methods of competition…
2. Unfair or deceptive acts or practices…
3. Which affect commerce.

The *litmus test* of whether an act is an unfair method of competition is three-fold:

1. Is commerce affected?
2. Is competition substantially lessoned?
3. Is there a tendency for a monopoly to be created?

This is ultimately a judicial and not an administrative decision.

The *litmus test* of whether an act or practice is unfair or deceptive is as follows:

1. Is commerce affected?
2. **General Questions**
   a. Is public policy offended?
   b. Is the act characterized by any of the following, e.g.:
      - Immoral
      - Libelous
      - Unethical
      - Illegal
      - Oppressive
      - High pressure
      - Unscrupulous
      - Fraudulent
      - Injurious to the general public.
   c. Without regard to any acts, are there any unfair provisions in any contracts of adhesion?
3. **Specific Questions**
   a. Are services of A passed off as services of B?
   b. Does the act cause the likelihood of confusion or misunderstanding as to the source, sponsorship, approval or certification of services?
   c. Does the act cause the likelihood of confusion or misunderstanding as to affiliation, connection or association with, or certification by, another?
   d. Does the act use deceptive representations or designations of origin in connection with the services?
   e. Does the act represent that the services have sponsorship approval, characteristics, ingredients, uses, benefits or qualities that they do not have or that an entity has a sponsorship, approval, status, affiliations or connection that it does not have?

f. Does the act represent that the services are of a particular standard, quality or grade, if, in fact, they are of another?
g. Does the act create the likelihood of confusion or misunderstanding?

Traditional and Common-Law Meanings

Unfair Competition

This is a widely-used term that has gained a place in common-law.

General Use
Any dishonest or fraudulent act in trade or commercial rivalry.
Particular Use (Example)
The practice of substituting one's own goods or services for those of another by capitalizing on such other firm's reputation, name, etc. that is, infringement of trade-name or similar.

Unfair competition is a tort involving the misappropriation for commercial advantage of a benefit or right belonging to another. It is the simulation by Firm A of certain product or service characteristics of its competitor, Firm B, such as trade names, materials, services, etc. Thereby falsely inducing the purchase of goods or services. This act has the common-law name of *passing off*. In brief it is the selling of another firm's services or products as one's own.

Unfair competition includes the following:

- Deceitful advertising
- Bribery of employees
- Secret rebates and/or concessions.

The true test of unfair competition is, when comparing the two products or services, that:

- Perfect simulation need not be achieved.
- Similarity is all that is needed to make the act unfair.

Unfair Methods of Competition

This term is unique with the FTC Act (15 USC§45) and is more broad than the term unfair competition. The term, by design, is not defined but its meaning is to be a function of the following:

- Particular instance…
- Particular competitive condition…
- Specific and substantial public interest…

All supported by evidence provided.

The concept of unfair methods of competition was not to restrict fair and free competition among honorable opponents, nor was it to give license to acts heretofore deemed immoral, unethical or against public policy.

Description of Potential Infractions

Several examples of activities which would likely be deemed unfair trade practices characterized by both bundling and conflicted interest are these:

Instance Number One
The TPA is combined with an MCO which also provides its own UR services. A covered person with a serous health problem, capped by an outlier provision, presents a serious financial problem to the network hospital. The solution is to get the person's consent and by air ambulance ship such patient to a non-network hospital. The stop-loss carrier will doubtless be apoplectic but it will necessarily have to pay the higher charges.

Instance Number Two
The TPA and the stop-loss carrier are combined and stop-loss benefits are easily manipulated by simple claims gaming. The employer likely is not aware of such activity.

Instance Number Three
The MCO, TPA, and stop-loss carrier are combined and aggressively slash the hospitals submitted charges. The hospital must acquiesce but recovers much of the cost direct by means of the Medicare Outlier and charity recovery relief.

Instance Number Four
Hospital billing practice of making undisclosed and chaotic or discriminatory variations from its chargemaster with the Medicare Outlier conflicted interest.

Health Plan Audit

Introduction

This health plan audit critique briefly reviews several of the underlying issues and considerations as follows:

Part A – General Considerations

- Meaning of audit
- Outline of a typical health plan audit
- Audit firm and its services
- Sampling techniques used in Auditing
- Aggressive marketing by audit firms.

Part B – Description of the Major Types of Audits

- Department of Labor Audit
- Internal Revenue Service Audit
- TPA Internal Audit
- Provider Audit
- Stop-Loss Audit
- IRS/DOL Form 5500 Audit
- Managed Care – Related Audit
- Physician Retrospective Audit
- Activity – Specific Audit.

Part C – Special Purpose Audits

- Economic Considerations

Part A - General Considerations

Meaning of Audit

The audit, in general, is the review, accounting, critique, etc. of transactions or activities after they have occurred. It excludes any involvement with such transactions during their occurrence.

Outline of a Typical Health Plan Audit

Goals and objectives

The overall objective of an audit is to assess the performance of a vendor in the administration of the plan sponsor's group health plans. The audit seeks to accomplish one or more of the following specific goals:

- Assess effectiveness of the vendors' policies, procedures, and internal controls
- Verify participant eligibility
- Verify that claims are for eligible dependents
- Verify that claims are paid in accordance with the plan documents
- Assess accuracy of COB procedures
- Verify validity of covered diagnoses
- Identify incidents and dollar volume of duplicate payments
- Test benefit calculations relative to application of correct (CPT) codes network provider discounts, UCR limits, deductibles and copayments and plan limits
- Measure timeliness of claims payments
- Confirm procedures are in place relative to pended claims
- Evaluate effectiveness of utilization review protocols
- Assess effectiveness of large case management and its integration with claims processing system
- Review high cost claims relative to financial and coding accuracy and coordination with case management programs.

Scope of Audit

An audit can include one or more of the following elements:

Medical Claim Adjudication Review. This is a review of a statistically-valid sample of claims.

- Findings generally include payment accuracy, financial accuracy, procedural accuracy and turnaround time.

- Results are compared to performance guarantee and industry standards for the category.

- Findings include:
  - Incorrect data entry
  - Incorrect benefit level
  - Incorrect fee allowance
  - Incorrect provider information
  - Misapplication of copayment
  - Denial of eligible expenses
  - Benefit limitation exceeded
  - Incorrect denial code
  - Eligibility discrepancy.

Operational Assessment. This is a review of the administrator's policies, practices and procedures. Findings of the assessment address such things as:

- Effectiveness of duplicate edit system logic
- Scope of internal eligibility audits
- Phone monitoring system (i.e., speed in answering calls, dropped calls, etc.)
- Percentage of internally-audited claims relative to prevailing practice
- Definitions and calculations used relative to industry standards.

Electronic Review. This is a 100% review of all claims paid in a given period in order to detect duplicate claims. Findings include details about duplicate claims payment such as:

- Number of claims potentially paid in error
- Potential dollars paid in error
- Profile of factors causing duplicate payments (i.e., multiple claims from the same providers with different tax IDs or different provider addresses).

High Dollar Claims Review. This is a focused audit on selected claims exceeding a specified dollar amount (i.e., claims greater than $50,000). Examples of findings in a high value claims audit include:

- Inaccurate application of pre-certification penalty
- Incorrect fee allowance because the claim was paid by applying the incorrect discount
- Claim processed with the incorrect procedural code.

Vendors

A claims audit requires highly specialized subject matter expertise. Proposals should be obtained from at least two qualified vendors.

Audit Process

The plan sponsor determines the key goals of the audit and requests proposals from at least two vendors. The successful bidder conducts the audit and reviews its findings with the administrator. The review with the vendor assures that the vendor is afforded the opportunity to refute and/or explain the findings. The final report includes the audit methodology and the findings along with any actionable recommendations. The plan sponsor and its consultant use the audit report to develop an action plan to correct any systemic problems, adjust the performance guarantees to align more closely with industry standards where appropriate and establish a performance baseline against which to measure future results.

The cost of a comprehensive claim audit can be surprisingly high. Budgetary considerations can influence whether or not the audit is conducted and, if so, the available budget helps define the specific scope of any audit. Prior to commissioning an audit, the plan sponsor should review current service levels and results of any internal audits conducted by the vendor. This exercise will help with a *go/no* go decision on an independent audit. The exercise will also be instructive in determining the scope of any independent audit.

Audit Firm and Its Services

In General

The typical audit firm (excluding the accountant firm) offers these services:

1. Claims Operations Review
2. Administrative Operations Review
3. Special Class Evaluations
4. Statistical Analysis
5. Selective Claims Assessments
6. Random Claims Evaluations
7. Eligibility Review
8. Stop-Loss Review
9. Litigation Support
10. Fraud Investigations
11. Operational Controls Reviews
12. Follow-Up Evaluations.

A brief discussion these services follows.

Claims Operations Review

This involves an on-site visit by the auditor to the TPA's offices to review the TPA's administration procedures. Attention will typically be given to the following:

- Security of data
- Segregation of systems functions (processing v. eligibility, e.g.)

- Claim control (TPA internal checks and balances)
- Refund or returned check control
- Ancillary claims payment financial controls
- Quality of pended/denied/appealed disciplines
- Fraud control
- Overpayments procedures.

Administrative Operations Evaluations

This audit focuses on the TPA's control and accuracy of its services. Such targeted services include, but are not limited to the following:

- Invoice of TPA's fees
- Quality of data for regulatory filings
- Accounting correctness
- Accuracy and timeliness of bank reconciliations
- Controls over checks, signature plates and wire transfer authority
- Handling of stop-loss transactions, premium billings, contribution accounting, COBRA billing and cash collection procedures.

Other areas selected by the plan sponsor may be added.

Special Claims Evaluations

Certain large and troublesome types of claims are targeted for special analysis. Subrogation and Medicare secondary claims e.g. These types of claims have a higher than average *returns on audit-time invested.*

Statistical Analysis

By this methodology, the audit will focus on a small (150-300 randomly – selected claims, e.g.) sampling of claims and from such draw conclusions regarding the entire population of claims.

Selective Claims Assessments

Plan sponsors often request or direct that the auditor make a special audit in certain pre-audit identified problem areas.

Random Claims Evaluations

This is the processing of translating the results of the audit sample into meaningful information:

- Statistically – valid weighted averages of claims accuracy and production results
- Contracting TPA results against industry averages
- Areas of potential cost savings.

Eligibility Reviews

This is a particularly critical area since more claim errors are from eligibility errors than from processing errors.

Stop-Loss Review

A commonly – found error alleged by auditors in the promotions of their audit services is in stop-loss. Errors with stop-loss contribute greatly to self-funded plan litigations and can be very costly. Good procedures can be enormously effective and vice versa.

Litigation Support

This is essentially a case-related expert witness services or more commonly a case-related consulting (or ad/hoc) service.

Fraud Investigation

Health care fraud as a *thief in the night* is large (and getting larger) in scope and costs. It is not easy to detect and often requires involved and sophisticated detective work. Such is typically the service of the auditor.

Operational Controls Reviews

This includes discuss of the AICPA SAS 70 TPA internal audit procedures, quality of TPA accounting procedures and any accountant – provided audits or reviews.

Follow-up Evaluations

The audit as a snap/shot is useful but when followed with a measurement recommendations, etc., becomes even more useful.

Compensation of Audit Firm

The audit firm is typically paid as (a) percent of savings and (b) consulting fee. This difficult question of auditor compensation is further discussed elsewhere in this critique.

Sampling Techniques Used in Auditing

The sampling technique employed was as follows:

- Uses the characteristics of the claim population to determine the amount needed to sample for statistically-reliable results.
- Stratifies the claim population using a critical variable – the claim paid amount.
- Isolates zero dollar claims to examine the effectiveness of system-based edits (e.g., duplicate claims, deductible application).
- Allocates the sample to account for the variability and the number of claims in each stratum.
- Ensures the selection of all high cost claims – where the opportunity for large dollar errors is great (in this audit all claims with payments above a pre-set amount were selected to be certain that these large payments were handled correctly).
- Uses the sample claim results to provide a statistically valid estimate of the TPA's performance for the entire claims population during the audit period.

Aggressive Marketing by Audit Firms

Audit firms (excluding most accounting firms) have become very aggressive in the marketing of their services. These audit firms are typically fourth-party audit firms or consulting firms which have added the audit diversion to their menu of services.

- They stress both claims and eligibility as topics for audit.
- They stress savings to the plan sponsor and *imply* the likelihood of the present TPA not doing its job properly.

Some of the *teaser* questions posed to the plan sponsor to attract the attention of the plan sponsor are:

- How to monitor vendor performance? Are appropriate benefit limitations and maximums applied? Are coordination-of benefits provisions enforced? Are claims paid only on behalf of eligible participants?
- What industry standards are and how to hold your vendors to them?
- Which reports to request from vendors to uncover the accuracy of your plan's claims payments?
- What are best practices for communicating dependent eligibility? Is it clear to employees who are eligible for health plan coverage? What about under COBRA?
- What information can and should you ask your employees for?
- Conduct eligibility audits: What to look for and what to do if you find ineligible dependents enrolled?
- What are the pros and cons, legal issues, and how-to's of random eligibility audits?

Another way which such firms attract the attention of the plan sponsor is to address issues of the overall performance of the plan's vendors. Such audits are typically in four parts.

- Traditional claims audit activities (such as claims and eligibility audits and operational assessments)
- Implementation or administration audits
- Customer service audits
- Provider audits.

The auditor will usually stress how the audit firm can assist the plan sponsor in comparing its performance with industry standards. The audit can assist the plan sponsor in improving plan administration. Also, audits are useful to clients who need to complete a due diligence process, or who wish to understand and solve service issues. Audits also are helpful in comparing an administrator's performance to service guarantees or to develop new service guarantees.

Part B - Description of the Major Types of Audits

Background

The Congress Reorganization Plan No. 4 of 1978 divided the regulation of ERISA into these areas:

DOL. Authority over fiduciary responsibility and prohibited transactions as well as reporting and disclosure matters.

IRS. Authority over participation, funding and vesting.

Justice Department. Major criminal activities with ERISA plans lie with the Justice Department; minor jurisdictional or criminal matters remain with the Inspector General of the DOL.

Controller of the Currency. Any banking matters are under this Department's control.

Securities and Exchange Commission. This Department has control over registered investment advisors.

The primary investigation and enforcement activities are carried out by the DOL.

Authority for Audits

Both the Department of Labor and the Internal Revenue Service have the legal authority to perform audits. This authority is found in ERISA. These audits are normally aimed at items not directly affecting the plan supervisor's benefit administration but benefit administration may be part of the audit. Knowledge of such audits, however, is useful to the benefit administration of self funded plans. The DOL has been given the primary authority to audit by Regulations.

The DOL may delegate its audit functions to other agencies – the Controller of the Currency, e.g.; the DOL may subpoena all relevant records; the DOL may enter and inspect as well as subpoena.

Any inquiry as to actual or contemplated violation is acceptable. An audit done for political harassment, intimidation or in bad faith is not acceptable. Virtually no restraint on DOL's audit or investigative powers is to be found.

There are very few standards which the DOL must follow in its audits. The DOL may only *allege* that there *may* be a violation to investigate. The DOL does not have the burden of showing probable cause or, that a law has actually been violated. The DOL has only the need to show reasonable cause, probable jurisdiction or probable success to

perform its audit. Power to inspect exceeds any federal privacy guidelines as to business records.

Department of Labor Audit

Introduction

In response to the call for more enforcement to curb *fraud and abuse* in the employee benefit area, the Pension and Welfare Benefit Administration of the Department of Labor has implemented an audit program known a *ERISA Enforcement Strategy Implementation Plan.* The purpose of the audit program is to provide direction and focus to the Department's efforts so that the largest number of participants and amount of plan assets may be protected, given the Department's available resources.

The implementation of the audit program requires the blending of two specific ingredients. The first is substantive and involves the content and conduct of actual audits themselves. The second is the management of the program, involving those support functions that the Department of Labor provides to maximize the effectiveness of the first ingredient. These support functions include strategic planning, effective targeting, training, standardized audit procedures, the imposition of appropriate sanctions, and meaningful public disclosure of program accomplishments.

Audit Techniques

The first part of the audit program outlines the techniques that auditors will use to achieve compliance with the fiduciary responsibility requirements. About 50% of the Department of Labor's audit resources are devoted to investigation of *significant issues,* i.e., specific areas that have the highest potential for abuse. About 15% of its investigative resources are devoted to fostering voluntary compliance. And the remaining 35% of its investigative resources are devoted to audits of plans with known or suspected violations, investigations of cross-sections of the employee benefit universe, and criminal investigations.

Significant Issues

The *significant issue* approach is implemented in order to focus the Department's resources into specific areas. Under this approach, 50% of the Department's fiduciary investigative time is devoted to abusive practices in two areas: service providers to welfare plans, and financial institutions that provide services to pension plans. The remaining 50% of fiduciary audit time is used to conduct audits of a cross-section of the employee benefit plan universe - both by size and type of plan - and to conduct criminal investigations. It is anticipated that 15% of available auditor time will be devoted to responding to the needs of the public both directly and through their congressional representatives, to case development, and to nonfiduciary investigations such as reporting and disclosure.

The Department targets its investigations from a number of sources including, most importantly, the Form 5500 annual reports. The Internal Revenue Service inputs the data from these reports and subjects it to a comprehensive series of automated edit tests, which identify deficient filings and generate correspondence to the filer requesting that the deficiency be corrected. Civil penalties of up to $1,000 per day may be assessed if after three rounds of correspondence a deficiency remains.

Once the automated edit checks are complete, the Internal Revenue Service forwards computer tapes containing all of the data to the Department. The data for all plans are then subjected to a comprehensive automated review using specialized targeting criteria. The Department believes that this system is a major step forward. Prior to its implementation this year, the Department was only able to review a small proportion of all plans. Now, all annual reports are being screened for accuracy and completeness, and subject to computer targeting.

The Department developed these targeting techniques from experience in auditing ERISA violations. Annual reports that contain information that may be indicative of a violation are identified through this process for a follow-up determination by the appropriate field office as to whether an audit should be open.

This sophisticated automation system permits all plan filing to be reviewed, and information on the investigations that are undertaken to be maintained on computer. This will enable the Department to strengthen considerably the deterrent effect of its enforcement program, better manage cases, and evaluate the results of targeting and investigative techniques.

It will also improve the timeliness of the review of Forms 5500. Financial information included on the annual return relates to transactions that actually occurred as much as 20 months previously. However, the automated system ensures that further delays will not result by giving the Department's access to the information contained on Form 5500 within 60 to 90 days after a completed Form 5500 is filed.

The Department targets additional cases for audit in a variety of ways. Many cases are based upon leads gathered from individual field office initiated projects. Other sources of cases are information and complaints provided by participants, referrals from the Internal Revenue Service, financial regulatory agencies, state insurance departments, and other leads. Cases are also based upon referrals to field offices from the Internal Revenue Service.

Finally, the Department is developing a set of legislative proposals to enhance its enforcement program. Generally, these proposals are intended to improve the quality of pension plan audits, to create incentives for participants and beneficiaries to exercise their private rights of action under ERISA, and to strengthen disincentives for unlawful behavior.

Service Providers

As a result of the success of the Department and other law enforcement agencies auditing, detecting, and correcting significant fiduciary ERISA violations involving investment practices of pension plans, there has been a change in emphasis over the last several years by those individuals who seek to use employee benefit plans to benefit themselves and their associates at the expense of plan participants and their beneficiaries. Many of these new practices involve service provider arrangements with welfare plan under which certain service providers and subcontractors enrich themselves at plan expense by providing no services, unnecessary services or duplicative services. The net effect of these practices is that money that could otherwise be used to increase benefits or to reduce cost of administration is, in fact, being wasted.

A service provider is any person or entity who provides service, directly or indirectly, to an employee benefit plan for compensation. There are in excess of 100,000 plans with more than 100 participants. Most of these plans, or their sponsors, pay compensation to at least one service provider. Among the most intensive users of service providers are Taft-Hartley welfare plans. Because most of these plans are multiemployer plans that have no single plan sponsor to assume the administrative expenses, most service providers to these plans are paid by the plan themselves.

The proper operation of Taft-Hartley welfare plans requires the services of numerous professionals, both to perform the duties that plan trustees are unable to undertake personally as well as to provide benefits to participants. Examples of the first type of service providers include claims processors, contract administrators, attorneys, accountants, and consultants. Examples of the second type include providers of dental, vision, medical, or legal services to plan participants.

The focus of the Department service provider audits is on abuses committed by the actual providers of specific services to welfare plans, rather than on the plan themselves. In most cases, a given service provider will service several employee benefit welfare plans and the corrections of abusive practices will have a much greater impact than if audit activities had been concentrated on just one plan.

Each audit is conducted to determine:

- Whether any legitimate service is being rendered on behalf of the plan or its participants.
- Whether the service is necessary to the administration of the plan or payment of benefits.
- Whether the service is being duplicated by other service providers.
- Whether the cost of providing the service is reasonable under the circumstances.

A number of different types of abuses can be identified by the Department that involve service providers. These include, but are not limited to:

- The payment by plans of large sums of money for the provision of benefits to a very few participants.

- The hiring of individuals as consultants through an arrangement with plan officials who receive money for no services rendered.
- The purchase of inappropriate or unnecessary expensive insurance products for plan participants.
- The receipt of excessive or duplicative administrative fees.
- The payment of kickbacks to plan fiduciaries by service providers.
- The retention of parties in interest to provide services not exempt by ERISA §408.

The Department's objectives involving audit of abuse practices by service providers are as follows:

- To identify and to conduct investigations of those service providers who have the most potential for abuse.
- To establish a presence in the service provider field nationwide by identifying and conducting audits of at least one major service provider in each of the 50 states.
- To establish a presence in areas of high concentration of providers of service to employee benefit plans by identifying and conducting investigations of at least one major service provider in each of the 20 major population centers in the country.
- To establish a presence in the entire service provider community by identifying and conducting investigations of service providers based on size and type of service.
- To identify ERISA violations and to obtain correction of those violations.
- To develop data through audits of service providers that will form a basis for establishing targeting guidelines and for use in pursuing, when violations exist, the correction of those violations.
- To ensure the most widespread possible dissemination of knowledge of Departmental correction of employee benefit plan abuses through publicity, speeches, etc.

Targeting

Each area office will be directed to identify service providers within their jurisdiction both geographically and by type of provider. The following methods will be used by the Department in targeting service providers:

- Access of all Schedule C filings to Form 5500s processed on the Department's ERISA Access System, making it easier to target service providers.
- Computer generated reports from Form 5500 filing of service providers servicing multiple plans.
- Computer generated reports from Form 5500 filing analyzing plan administrative expenses.
- Computer generated reports from Form 5500 filing for various specific health and welfare plans, including: (a) prepaid legal, (b) dental, and (c) vision plans.
- Office intelligence files including case files that have identified potential problem areas with service providers.

- Contracts with other state and federal governmental agencies to identify potential abusive service providers - contract will include FBI, Office of the Inspector General, Department of Justice, and State Insurance Commissioners.
- Any congressional subcommittee hearing transcripts that may identify potential abusive service providers.
- Interviews with individuals, companies, and others who might have knowledge of violations in the service provider held.

Investigative Activity

Because of the very large size of the plan universe, it is important that enforcement resources be directed to those areas where abusive practices are most prevalent and serious. The key element is for the audit results to provide genuine protection in situations in which a significant amount of funds were or would be lost or are at risk. Priorities are established for determining which cases to pursue, placing emphasis on two related considerations.

One relates to pursing those cases that involve the most serious violations and which lead to remedies that restore or safeguard substantial amounts of assets affecting large numbers of participants and beneficiaries. The other consideration is to provide an impact beyond the immediate plan either through the issue or entity involved, or through the magnitude or nature of the remedy achieved.

Area offices are directed to conduct a balanced program regarding the types and sizes of plans audited, and their geographic locations. In addition, there is a balance in terms of the types of issues investigated, such as prudence, diversification and prohibited transactions. The types and sizes of plans where abusive practices exist and investigations are most warranted vary among and within area offices, depending on plan universe characteristics obtained from Form 5500 data and other factors.

Objectives

The objectives of this portion of the Department's program are as follows:

- To provide protection for the greatest number of participants and the amounts of plan assets given the resources available to do the job through effective utilization of the case selection process.
- To concentrate available resources on those individuals and organizations who through their past conduct have shown that they require closer scrutiny.
- To utilize a systematic program to ensure that remaining Department audit resources provide, to the greatest extent possible, an enforcement presence over the entire geographic jurisdiction and employee plan universe of each area office.
- To be responsive to participant complaints and other public inquiries.
- To respond to referrals of information from federal and state regulatory and enforcement agencies.

- Each area office plans for and conducts investigations in specifically identified geographical areas, and plans for and conducts investigations in predetermined categories of plans by type and size.

Targeting

In developing priorities for meeting the investigative objectives, the following factors are considered by each area office as well as by the Internal Revenue Service in targeting cases:

- Preventing the wasting of plan assets.
- Obtaining restitution on behalf of employee benefit plans.
- Removing harmful individuals from contact with plans through both civil measures and criminal sanctions.
- Establishing legal precedent for the guidance of the public.
- Enlisting the assistance of others, such as plan accountants, in Department enforcement efforts.
- Encouraging private initiative as contemplated by ERISA by fostering greater awareness by plan participants of their rights and increasing their ability to obtain meaningful information abut their plans.
- Public assistance.
- Promoting legislative and public awareness of the Department's enforcement efforts, and seeking legislative and regulatory solutions to enforcement problems.

Methods of Targeting

Specific cases consistent with the above factors are selected by the Department using the following targeting methods:

- Plan directories for each area office's jurisdiction based on its designated geographical territories, participant size, and asset dollar size.
- Specifically designed Form 5500 computer based targeting reports.
- Comparison of data from ERISA database to data merged or generated from other database befitting the criteria under review or investigation.
- Continued review of significant answers to Form 5500 narrative questions that will warrant further inquiry by the appropriate field office for investigation.
- Targeting techniques to measure whether plan assets are adequately diversified as to decrease the risk of losses to the plan using investment strategies.
- Specific *on line* targeting for special plan characteristics.
- Information from the Department's Office of Exemption Determinations and Office of Regulations and Interpretations, such as exemption applications and related comments.
- Complaints of abuse in employee benefit plans from participants, trustees, and interested third parties.

- Information from other federal and state agencies including Office of the Inspector General, FBI, and state insurance commissioners.

Criminal Investigations

The Department obtains audit leads for criminal investigations from many sources including reviews of Forms 5500, civil investigations, contacts with other law enforcement agencies and the U.S. attorneys, informants, media, etc. The Department's enforcement strategy involves considering whether there are possible criminal aspects to any of its civil investigations and, if so, to pursue criminal investigative authority from the appropriate U.S. Attorney and seek criminal indictments and convictions where the facts indicate. In this regard, the Department will develop and maintain close contacts and coordination with other law enforcement agencies, and seek to enhance the ability of its investigators to conduct criminal investigations.

While ERISA provides for a system of administrative penalties, civil actions, and criminal sanctions, there are a number of provisions in the U.S. Criminal Code under which violators can be prosecuted for certain activity involving employee benefit plans. For example, thefts or embezzlements from employee benefit plans are covered under the Code; the making of false statements and concealment of facts in relation to documents required by ERISA are covered by the Code; the offer, acceptance or solicitation of funds to influence the operation of employee benefit plans is also covered by the Code.

The Comprehensive Crime Control Act of 1984 clarified the Department's criminal investigative authority by expressly conferring upon the Secretary the direct responsibility and authority to detect, investigate and refer, where appropriate, criminal violations of Title I of ERISA as well as other related federal laws.

The Department's policy is to seek the appropriate enforcement remedy under the facts and circumstances as they are developed in each investigation. In certain instances, potential improper conduct will be investigated under a civil investigation that will be conducted and, if the nature of the violations indicates criminal misconduct, then the case will also be referred to the U.S. Attorney for criminal prosecution. In some instances, a civil and criminal investigation **will** be conducted at the same sight. In other instances, the investigation may be conducted as a criminal investigation only.

The Department conducts its criminal enforcement program by decentralizing to the largest extent possible, to field managers the decision making and conduct of criminal investigations. Field office managers consult with the local U.S. Attorney, at the beginning of any criminal investigation, to obtain a delegation of specific directions as may be necessary.

In a number of instances, the Department conducts joint investigations with other agencies such as the Office of Labor Racketeering, the Office of Labor Management Standards, the FBI, the U.S. Postal Inspectors, and other pertinent state and federal law enforcement agencies. This team approach brings together the abilities and backgrounds that may be particularly necessary for any individual investigation.

To further its criminal strategy, the Department will establish a position of Criminal Coordinator within the Office of Enforcement to be held by an individual who has had extensive criminal investigative experience in the area of complex financial crimes. This Coordinator will oversee the implementation of the Department's criminal enforcement activities, coordinate with other agencies within and without the Department including the FBI and the Department of Justice and various U.S. Attorneys, provide guidance to field office auditors for criminal case referrals, ensure that appropriate criminal audit training is provided to enforcement staff, and consider whether the criminal enforcement actions are initiated as appropriate based upon facts obtained in civil investigations.

DOL – Requested Audit Items

These are the items usually required for review by the Department of Labor auditors in a Plan Supervisor audit:

1. Listing of all employee benefit plans for which the Plan Supervisor has provided services for the past two years.
2. Listing of all ERISA-related employee benefit plans for which the Plan Supervisor has performed services for the past two years.
3. Organizational chart of the Plan Supervisor firm along with a listing of directors, officers and principal employees.
4. Organizational chart of the Plan Supervisor firm, with ownership information, along with a listing of parent/holding companies subsidiaries of affiliates related to the Plan Supervisor.
5. All contracts between the Plan Supervisor and the identified ERISA-related employee benefit plans.
6. A copy of all standard Plan Supervisor contract or administrative agreement with the ERISA-related plans.
7. A copy of the Plan Supervisor's license to conduct business in their home office state and/or other states, including licensing information on any Plan Supervisor employee who is/was an insurance agent/broker.
8. The Plan Supervisor's fee schedule for services provided to ERISA-related employee benefit plans.
9. All Plan Supervisor contracts and/or administrative agreements with the following insurance providers/companies.
10. Information on the administrative fees charged by the insurance providers/companies servicing the ERISA-related employee benefit plans.
11. All contracts with subcontractors who provide services for the Plan Supervisor for the benefit of the ERISA-related employee benefit plans, including but not limited to consultants, computer services, insurance brokers/agents, etc.

12. The Plan Supervisor's financial statements for past two years, along with any reports on the activities of the Plan Supervisor issued by third parties such as annual audited financial statements, commentary reports by external auditors, reports prepared by outside monitoring firms by the ERISA-related plans, or examination reports by governmental agencies.
13. The Plan Supervisor's cash receipts and cash disbursements journals.
14. A listing of the types of financial and other pertinent records maintained by the Plan Supervisor and the ERISA-related plans such as *claims turn-around* and experience reports provided to the plans or the plan sponsors.
15. All reports or analyses prepared by or for plan officials regarding the performance of the Plan Supervisor.
16. The Plan Supervisor's correspondence files related to the ERISA-related plans.
17. The Plan Supervisor's Board of Directors meeting minutes.
18. Plan SPD's and evidence that they were filed with the Department of Labor.
19. Form 5500 for past two or three years.
20. Plan documents with language currently reflective or recently enacted legislation.

Internal Revenue Service Audit

Those items which directly impact on IRS's sphere of interest are subjects of an IRS audit.

- Review of who is actually participating in the plan.
- Are rules being followed if plan is trusteed with a 501(c)(9) or 419A trust?
- Are non-eligible persons enjoying participation (self-employed, board members, etc)?
- Rules relative single employer plans and joint-trusteed plans may differ.

Generally,
a person is an employee under common law tests which include the following:

- Employer has the right to and does in fact exercise control and authority over such person's work.
- Such person usually does his work so supervised as a business practice in the particular geographic area in question.
- Work being done is part of the employer's regular business.
- Person is paid either hourly or salaried, not on a commission, bonus, piece work, etc.
- Person uses the employee's tool or equipment and/or place of work.

Self-employed persons have consistently been denied participation.

In no event will the definition of an employee be extended to include the following:

- Proprietors
- Partners
- Independent contractors
- Owner-operators.

An interesting question arises where the plan is negotiated for employees by the union but some employees decline union membership. Must such non-union employee be offered participation? Several courts held that such participation had to be offered to the non-union employees.

The IRS also has an interest in auditing these matters:

- Acceptable level of participation
- Trust filings
- Cafeteria plan violations
- Discriminatory benefits

Employer-Arranged Audit

In General

With larger employer clients, the Plan Supervisor may expect occasional employer-sponsored audits for these reasons:

- Good business practices on part of employer
- Improved services through the *sentinel effect.*
- Objective evaluation of the Plan Supervisor's service.

When the employer wishes such an audit performed, it is done by one of these type firms:

- Consulting firm (actuarial e.g.)
- Fourth party medical review firm
- Accounting firm.

Errors of a procedural or payment nature are discerned; most audits pick up erroers in the 1-2% range.

Three audit patterns are found:

- General assessment of performance
- Dollar value of errors
- Selective or target audit (COB, e.g.).

The auditor must be knowledgeable as to the subject matter to be audited.

The audit will spot deficiencies, if there is any in the Plan Supervisor's benefit administration as regards:

- Training of examiners
- Quality control
- Internal audits
- Cost containment
- Management reports
- Discipline of UCR standards

- COB/Subrogation investigations.

Results from Employer-Sponsored Audits

The results, typical of such audits, are these:

- Errors are classed as confirmed (certain) or disputed (undocumented).
- Plan Supervisor firm making the errors may be held accountable for many of these errors found.
- Fully computerized systems have fewer errors than fully manual systems.
- It is absolutely essential; to have names of all covered dependents and not just children.
- Need for provider audit was crucial in the areas of chiropractic and therapy benefits.
- Plan Supervisor as a result of such audit established it s own internal audit.
- Too little investigation to discern COB cutback.
- Too many small bills were being processed. Participants encouraged to hold back small bills until some limit reached: deductible, on $X or even to the end of the Benefit Year.
- Inconsistencies in benefit practices between employer branch offices. Local plants in too many instances were intruding or overriding normal industry practices. Central control and administration is essential.
- Most audits found slow turnaround time. Difficulty with slow turnaround time was its compounding effect: more phone calls and more errors/confusion with duplicate bills.
- Confusion over plan interpretation commonly found.
- Many Plan Supervisor systems were weak.
- Often reports were confusing or misleading.
- Plan Supervisor instructions were seen in some audits to be weak or nonexistent.
- Frequent inconsistencies between the plan document and the booklet was seen.
- Missing claim files found in some audits.
- Lack of structure in the examiner's mind as to what is meant by *medical necessity.*
- Often Plan Supervisor was not aggressive in its investigations.
- Cost containment provisions were too sophisticated for many Plan Supervisors.

Features of the Audit

A carefully designed audit should include these features:

- Examine procedures and work flow.
- Evaluate personnel for adequacy of training and supervision.
- Look at ongoing educational programs.
- Review computer and procedure manual.
- Check efficiency of internal audit controls. Examine security disciplines.

- Determine usefulness or need for outside professionals - physicians, fourth party review, etc.
- Review forms, reports, EOB's, etc.

Specific Areas of Audit

An auditor will examine these specific questions:

- Patient actually a covered person?
- Coding accurate?
- Balances correct (deductible, out-of-pocket, inside limits, etc.)
- Any duplicate payments?
- Plan provisions properly interpreted?
- Possible preexisting conditions investigated?
- COB/subrogation properly handled?
- Areas of UCR and medical necessity applied properly?
- Files properly documented?
- Assigned benefits handled properly?
- Compliance with federal standards as regards COBRA, maternity, endstage renal?

Audit Report

The audit report will usually consist of these parts:

- General identification of data
- Goal of audit stated
- Description of sample
- Summary of findings
- Detailed list of errors
- Comments and recommendations.

TPA Internal Audit

General

An ongoing obligation, the Plan Supervisor should have a regular program of internal audit as a safeguard against an external audit. An external audit will routinely come about in two ways:

- Stop-loss carrier audit when an aggregate claim is presented.
- Independent accountant audit as a part of a compliance program or at the request of the employer.

Overview of Audit Program

A reasonable checklist to be followed by the plan supervisor in performing an internal audit is as follows:

- *Is Covered Person Eligible?*
  Effective date, COBRA dates, termination dates, change of status dates, age and hours requirements, definitions (dependent child, e.g.) should be considered.
- *Is Late Applicant Information Correct?*
  Material misrepresentation may mislead coverage.
- *Preexisting a Possibility?*
  Was claim adequately investigated? Is condition a potential preexisting condition? Was a physician consulted?
- *Is COB a Possibility?*
  Was question answered on submission form? Are copies of bills found? Are bills submitted well after the incurred date? Has employer been asked?
- *Is the Cause a Possible Workers' Compensation Claim?*
  Is document workers' compensation-exclusion or non-occupational? Has claim been reasonably investigated? Has employer been consulted?
- *Are charges within UCR Guidelines?*
  What UCR guidelines are followed? Were geography, multiple procedures considered?
- *Were Contract Provisions Followed?*
  Any Errors with Stop-Loss Benefits?
  Are accumulations accurate? Are dates acceptable as to terms of stop-loss (12/12, 14/12, 12/15, etc.)
- *Are Files in Acceptable Order?*
  Complete, orderly, duplicates marked, telephone calls documented, etc.
- *Legal Compliance Followed?*
  Are all state laws and federal laws obeyed? Medicare is usually secondary; Plan Supervisor must be properly licensed where required, etc.
- *Are Acts of Examiner Acceptable?*
  Ate calculations correct? Are duplicates clearly indicated? Is coding complete and correct? Are out-of-pocket and excess loss accumulations done

accurately? Are all bills properly included? Are noncovered items denied? Are unrelated bills properly excluded? Have appropriate investigations been done? Are correct release of information statements in the file?

- *Are Acts of Plan Supervisor Acceptable?*
  Are claim forms properly completed and signed? Is diagnosis clearly shown? If claim delayed or denied were proper procedures followed? Are all definitions properly met? Are provider assignments appropriately honored? Were claims authority rules properly followed?
- *Federal Mandates*
  Were federal mandates follows? Examples include COBRA, HIPAA, ADA, etc.

Provider Audit

In General

The goal of the Provider Audit Program is to proactively analyze claims data and confirm that claim submissions accurately represent the services provided to Plan members, and to ensure that billing is conducted in accordance with Current Procedural Terminology (CPT) guidelines and other applicable standards, rules, laws, regulations, contract provisions, policies and procedures.

As part of an ongoing program to provide outstanding customer service and cost-effective medical care and as a supplement to other subject Health Plan initiatives, such as the Utilization Management Program the objective of the Provider Audit Program is to ensure that the Subject Health Plan fulfills its responsibility to its risk sharing partners and/or enrollees and/or Plan sponsors by identifying and recovering inaccurate which are a result of inadvertent or intentional provider actions or misrepresentations.

The areas reviewed by the Provider Audit Program include, but are not limited to, the following:

- Billing for services that were not provided
- Intentional misrepresentation
- Billing services at a higher level than which was rendered
- Failure to comply with the Contract/Health Services Agreement, Plan policies and procedures and/or other relevant guidelines, regulations or laws
- Inadequate documentations to support the services billed
- The deliberate performance of unwarranted or medically unnecessary services for the purpose of financial gain.

In connection with the provisions set forth in the Health Services Agreement (Contract) with the subject Plan, Plan providers shall:

- Provide or arrange for health services for members in an economic and efficient manner with professional standards of medical care generally accepted in the medical community at the time
- Provide or authorize for members only those services which are medically necessary
- Maintain complete and up-to-date medical records
- Participate in, and cooperate with, the Subject Health Plan's compliance-related activities and initiatives
- Bill in accordance with the American Medical Association's CPT guidelines
- Comply with all Subject Health Plan payment policies, including, but not limited to, policies contained in the Claims Manual.

In connection with the preceding provisions, Subject Health Plan's Provider Audit Program may:

- Audit providers
- Recover funds from providers who engage in improper and/or inappropriate billing practices. Although audits are usually based on claim submissions for up to a four-year period, audits and subsequent recoupment may extend back to the date on which the provider originally became contracted with the Subject Health Plan.
- Impose penalties and/or surcharges and/or interest charges in the settlement of audits
- Suspend future claim payments once improper billing practices are suspected
- Close the provider's panel or terminate the provider in addition to recovering overpayments of provider intentionally engages in improper billing practices
- Access medical records of past and present subject Health Plan members.

Hospital Audit

As discussed under stop-loss claims, the control of the hospital audit is preferably left with the stop-loss carrier. However, these are instances where a Plan Supervisor-ordered audit is in order; the usual practice will be for the Plan Supervisor to directly contract with a fourth party review company.

The early hospital audits required the audit before payment; than audits were allowed by hospital only if at least 90% of the bill was paid; currently many hospitals permit audits only if the entire bill is paid. Hospital have become less, not more cooperative, as regards such audits.

The audit seeks our two difficulties:

- Billings errors.
- Unsubstantiated errors.

In addition, charges of an apparent *not necessary, reasonable and customary nature* will be sought out.

When an audit is made, the employer/plan agrees to pay back to the hospital any *under charges*.

Examples of errors which might be discovered are these (review made from detailed hospital bill):

- Lab tests done more often than daily
- Blood charges without credit for replacement
- Frequent or questionable therapies (inhalation, twice daily to a younger person, e.g.)
- Charges appear excessive in amount as well as frequency

- Services are not consistent with diagnosis
- Charges are not adequately described
- Room and board charges are less than 50% of the total bill
- Excessive pharmacy charges
- Obvious arithmetic and computer errors
- A single high charge
- Length of stay beyond the PAS (Professional Activities Standards) Book standards
- Weekend admissions
- Prolonged stays for mental/nervous conditions
- Bills for *screening* and *admission* purposes not ordered by the physician
- Unique supply items or services
- *Case lot* purchase of a drug showing up in a high expense for one day
- Repeated and excessive X-rays.

There are other items of potential abuse which may be discerned for a hospital audit. These include the following:

- Hospitalization for diagnostic, custodial purposes; that is, stay not medically necessary
- Hospital work could have been outpatient or in a convalescent center
- Hospital history of errors or abuse.

In deliberating on whether or not an on-site audit is in order, several questions should be asked:

- Is there enough money involved? Breakpoint is over $10,000 in charges.
- Is patient still confined?
- Can bill questions be resolved by telephone?

If the detailed hospital bill suggests that an on-site audit be performed, these steps should be taken:

- Use telephone calls to the hospital to get as many of the questions resolved as soon as possible.
- For unresolved questions, contract with a fourth party audit firm.

The simplest way for the Plan Supervisor to handle the hospital audit matter is as follows:

- Send a detailed hospital bill to the excess loss carrier.
- The stop-loss carrier will review such bill and decide whether or not the bill is to be audited. If so, they will conduct the audit or job the audit to a fourth party firm for audit.

Guidelines for Successful Hospital Bill Audits

- Hospital work could have been outpatient or in a convalescent center
- Hospital history of errors or abuse.

In deliberating on whether or not an on-site audit is in order, several questions should be asked:

- Is there enough money involved? Breakpoint is over $10,000 in charges.
- Is patient still confined?
- Can bill questions be resolved by telephone?

If the detailed hospital bill suggests that an on-site audit be performed, these steps should be taken:

- Use telephone calls to the hospital to get as many of the questions resolved as soon as possible
- For unresolved questions, contract with a fourth party audit firm.

The simplest way for the Plan Supervisor to handle the hospital audit matter is as follows:

- Send a detailed hospital bill to the excess loss carrier.
- The stop-loss carrier will review such bill and decide whether or not the bill is to be audited. If so, they will conduct the audit or job the audit tot a fourth party firm for audit.

Guidelines for Successful Hospital Bill Audits

Guidelines of provider and plan sponsor groups would assist everyone to find hospital bill audits more acceptable. These are the guidelines:

Full Reporting. Whatever the original intended purpose of the audit, all parties agree that any identified overcharges and undercharges will be recognized, recorded, and presented in the audit process. This language addresses major concerns expressed in Senate hearing s concerning the alleged failure of certain firms to report hospital overcharges if they were hired to identify undercharges.

Promptness. All audits should be completed within six months of submission of a bill.

Payment Process. Despite a pending audit, players should pay a minimum of 90 percent of the covered benefit upon receipt of a bill. The audit should not be used as a process to delay payment.

Documentation. The medical records of most providers were not designed primarily to be billing record, the guidelines state. Thus, auditors should review other documents as well, including department logs, daily charge records, individual service tickets, and medical protocols.

Stop-Loss Audit

In General

When there is a stop-loss audit of any dollar consequence ($10,000 and over, e.g.), or when the stop-loss carrier has reason to be unsure as to the practices followed by the plan supervisor, there may be an audit.

There are many motivations by the stop-loss carrier to have audits. The stop-loss agreements are complex and easier to misunderstand. While the plan supervisor is top quality, there may be an examiner who is grossly undertrained. The fear of an audit puts the plan supervisor *on alert*. To the stop-loss carrier an aggregate claim is a big risk for a small premium.

Aggregate on-site audits are frequent; specific on-site audits are rare, and are usually done by the carrier by home office review of the actual claim file.

There are several goals to the audit. The accuracy of the benefit calculations must be established. All benefits must be within terms of agreement and plan. The plan supervisor must follow good administration practices.

The stop-loss carriers will usually do a pre-audit test (claims printout, check documents, etc.) This is followed by an on-site inspection. The audit concludes with a formal report.

The audit often will extend beyond the basic benefit examiner and worksheet functions, getting into such areas as documents, booklets, quality controls, training, recordkeeping, etc.

Usually the stop-loss carrier does its own audit; occasionally the carrier will hire a *fourth party audit* firm to do the work.

Red Flags for an Audit

In addition to an aggregate claim the stop-loss carrier may watch for other signs which would suggest an audit.

- Large and unexplained increase in paid claims
- Large claims without medical case management
- Numerous credits and refunds in directing payment errors
- Excessive complaints of the plan supervisor's service.

Physical Arrangements

The stop-loss carrier will provide a pre-audit plan which sets the time, place and length or time of the audit. The auditor will ask that certain files are made available. Access to the enrollment and change cards will be expected.

The plan supervisor will be well rewarded to have a quiet, reasonably private work area for the visiting auditor in order that the work be expedited.

Audit Process

Ideally the audit might proceed as follows:

- Auditor has a quiet place to work in the benefit administration department with all of the requested information awaiting when the audit begins.
- The audit has instant access to the examiners and supervisors and staff to get any questions answered on the spot.
- Audit confirms the correctness of any benefit discrepancy before it is *written up* to avoid audit comments which are not accurate.
- Auditor and plan supervisor essentially understand each other's position or point of view on the audit items to be written up. Contentions are expected and healthy but should be limited to accurate factual situations and not surmises or maybes.

Disability Benefits – Special Considerations

Where there are disability benefits to audited:

- Time limits in filing met?
- Dates of disability correct?
- Appropriate medical evidence of disability?
- OCC/NONOCC distinction clear?
- Social security offset if appropriate?
- *His v. Any* occupation definition followed?
- Claim large and/or ongoing?
- Rehabilitation appropriate?
- Meet disability guidelines as to duration?
- Forms accurately completed?

Audit Checklist

The auditor will have a checklist of items to be looked for.

- Payment accuracy
- Managed care rules not adhered to
- Coding correctness
- Turnaround time
- File correspondence indicating complaints

- UCR limitations
- File maintenance, record retention, document action, neatness, etc.
- Subrogation and COB
- The limits and exclusions
- Computer program errors.

Audit Report

Where the stop-loss carrier does the audit itself, the report will tend to be most brief and to the point. When the audit is done by a *fourth party* audit firm the report will tend to be detailed and expansive in its commentary and/or recommendations.

IRS/DOL Form 5500 Audit

In General

This is the so-called independent accountant audit.
An independent accountant will audit a health and welfare plan for one of three reasons:

- For purposes of the Annual Report (Form 5500)
- For purposes of meeting certain requirements relative to jointly trusted plans
- Special requirements for workers' compensation.

Since ERISA, most independent accountant audits are done solely to satisfy the requirements of the annual report.

Requirements of the Annual Report

These are the conditions where an independent accountants' opinion is required for a welfare plan:

- Any plan filing a Form 5500, which uses an IRC §501(c)(9) trust, regardless of the amount in trust
- Any plan filing a Form 5500, with plan assets of any amount. Form 5500 for general asset or unfunded plans do not require a auditor's opinion if there are no plan assets of any amount.

Audits are not required for any plan, trusted or not, whose purposes is solely to serve as conduits for insurance premiums. Where asset information is provided by a bank or insurance company, such assets need not be audited.

Benefit Portion of the Audit

The largest cost of a health and welfare or similar type health benefit plan is the participant's benefit costs. In expressing an opinion on the plan's financial statements, the independent accountants – as a part of the audit – are responsible for examining benefit costs to ensure that such payments are being made in accordance with the plan of benefits established by the board of trustees.

In larger plans, generally, one of the components of participant's benefit costs are self-funded claims. Under this arrangement, the plan insures or funds benefits for participants by setting aside funds and adjusting and paying claims under a schedule of benefits. If the plan has established such an arrangement, claims audits must be performed as part of the examination of benefit costs.

Reviewing the plan of benefits is the initial step in the claims audit process. There must be a clear understanding of the type and extent of the benefit to be paid. Computer claims processing systems must be tested for compliance with the plan benefits. (In the processing of claims, numerous plan interpretations are made for specific circumstances. It is imperative that these interpretations be documented so the same interpretation is made for the same set of circumstances).

Next, after the review of the plan of benefits, the auditor must trace and define the cycle through which the claim will proceed in order to be paid and verified. Generally, the cycle is as follows:

- Certification of participant's eligibility
- Adjustment of the claim
- Actual payment of the claim
- Periodic internal review of claims payments.

The Internal claims review is probably the most important step in the cycle. An internal claims review program should be a continuous, ongoing procedure.

Once the independent accountants have reviewed the plan of benefits and the processing cycle, including the internal review of claims payments, they will be prepared to begin their own audit of claims. Internal control strengths and weaknesses and the extent of the claims reviews by internal auditors will determine the extent and type of the audit sample. Generally, a stratified sampling of claims is the most efficient sampling technique, concentrating on the larger dollar claims. Nevertheless, block or specific problem sampling methods are appropriate if the initial systems review revealed weaknesses in certain areas or indicated special problems.

Independent accountants normally do not have the background or expertise to perform a detailed review of the claims adjustments procedure. Thus normal auditing procedures will include the following:

- Review of actual checks (drafts) written.
- Comparisons of payments to worksheets and supporting bills from the claimants' files.
- Confirmation of payments with participants and/or service providers.
- Verifications of the control sequence of paid checks (drafts).

If self-funded claims comprise a material part of the benefit costs, the independent accountant should consider engaging professional claims consultants to perform in-depth reviews of the claims selected as a sample. With the additional expertise of such professionals the value of the claims audit is increased.

Special Requirements for Workers Compensation

A risk management consulting firm recently critiqued the practices of some Plan Supervisor's who supervise the claims of Workers' Compensation. The results are not complimentary. This note should be carefully reviewed so that Plan Supervisors who supervise medical plans do not receive a similar audit. The general and particular results of the audit are set forth in the following paragraph

Results of one audit:

- Employers have become skeptical of both the abilities and the guarantees of the Plan Supervisor.
- Administrative imperfections were noted such as not returning phone calls.
- Some of the substantive errors are these.
    1. Medical bills not promptly paid.
    2. Record of losses not accurate.
    3. Compensation bills not promptly paid.
    4. Failure to report claims to state regulators or excess loss carriers.
    5. Failure to respond to regulator's inquiries.
    6. Failure to prepare required state forms.
    7. Failure to apply second injury recoveries.
    8. Failure to formally close a claim (leaving open the statute of limitations).
    9. Closing files too early jeopardizing legal status of claim.
    10. Overlooking the existence of aggregate or specific excess loss coverage.
    11. Simple instances of actual mispayment of claim.
    12. Failure to use outside adjusters properly.
    13. Underfunding cases which require sizable reserves.

While the subject is workers' compensation and not medical coverage, the concern of the Plan Supervisor to avoid such audits is obvious.

Managed Care – Related Audit

In General

While this topic specific audit is often done as part of the larger employer-arranged audit it is also found as a freestanding audit. It most generally audits the TPAs performance in the two areas.

- Provider bill repricing
- Out-of-network provider bills.

Provider Bill Repricing

Where the PPO network manager does the repricing there is no issue. It is where the TPA does the repricing that the question arises: how appropriate or accurate was the TPA in performing its task. The TPA may have a special procedure for doing an internal audit; the accountant may attempt to spot-check this activity; the employer arranged audit may include it as its checklist of potential problem areas. More often as not the activity is not examined. This offers a specialty audit firm to find an opportunity for a special service. It is reasonable that this activity be audited.

It is becoming common for TPA to be approached by such an audit firm with the offer of the firm to do such audit for the TPA on behalf of the TPA's client(s). To this offer the TPA has a range of options:

1. Say *no* to the offer because of one or some of these reasons:
   - No interest by the TPA.
   - TPA believes employer should arrange such audit.
   - Audit is being done at present by other firms or methods.
2. Say *yes* to the offer and offer such audit to the TPA's clients as an added TPA service

Physician Retrospective Audit

In General

A retrospective audit is a cost containment mechanism that health plans use to determine whether overpayments on claims have been made to a particular physician practice. These audits go beyond the usual and common practices related to recoupment of honestly-made mistaken (so-called clerical errors). Physicians are understandably concerned with such audits because of their administrative burdens and potential for litigations. The various physician organizations have dealt with this challenged and have formulated some guidelines relative thereto.

Physician Audits and Peer Review

Medical peer review, unlike retrospective audits, generally serves educational or other constructive functions. Its emphasis is on improving patient care. Retrospective audits are conducted to recoup payments that health plans have determined were made inappropriately. Generally, medical peer review sessions that fall within the scope of specific laws are confidential and any records, transcripts or individuals participating in the process are shielded from any subsequent litigation. All aspects of a retrospective audit, however, can be made part of any litigation

Targeting Physicians for Audits

The typical audit-alerts are these:

- Out-of-ordinary service items; an example would be over-utilization of care or services.
- Coding issues; computer-indicated flags of CPT or ICD codes e.g. would be an example.
- Extraordinary care issues; these would be flagged by the so-called modifiers.

Physicians Response to Prospective Audit

In preparation for such an audit, physicians will typically do the following:

- Make inquires if what are areas to be targeted for audit; review existing compliance guidelines, review existing contracts; consider employing legal counsel, e.g.
- Do what is possible to prepare for the audit by contacting the subject health plan(s), review all medical records, etc.

Activity – Specific Audit

Auditors may be engaged to audit certain specific activities with a greater intensity or purposes than would normally be the case. Several examples are these:

Example Number 1

Some plan function such as recordkeeping or some group of beneficiaries such as retirees or COBRAS.

Example Number 2

Some plan activity which may implicate plan parties with conflicted interest where the plan interests are subverted for the benefit of the vendors or plan sponsor. This would include but not be limited to fiduciary breaches.

Part C - Special Purpose Audits

Economic Considerations

This audit targets any possible antitrust infractions incidental to the activities of certain plan vendors. It offers a variety of new challenges.

The audit may be freestanding and/or ad hoc or may be an extension of one of the audits above-discussed. The audit may be economist-directed-actuary-directed or may be accountant-directed using an *expert* as the economist. Economist has no professional qualification as would an accountant (CPA), an actuary (FSA) or physician (MD).

Partie's who might be interested in acquiring such special purpose audit include the following:

- Regulators (FTC, e.g.)
- Plan sponsors
- Providers
- Vendor combinations (Stop-loss carrier with its own MCO, e.g.).

The economist, who is the *expert*, retained as part of the audit team should offer an opinion as follows:

- Did the audit indicate any instances in the activities under review which were discriminatory in price or service?
- May such identified instances of price or service discrimination be deemed to be economically justifiable?
- In any instance involving a price or service discrimination, was there demonstratable conflicted interest among the parties involved therewith?

Responses of the economist-auditor should be evidence-supported.

Suggested Self-Funded Health Plan Charges

Background

We have established in other sub-sites that unfair trade practices may appear as either (a) discriminatory hospital billing practices or (b) vendor bundling, each of which will introduce the possibility of conflicted interests. Also, that such unfair acts or practices will likely only be found (and proven) by means of a special-purpose audit with new professional skills added to the audit team.

The self-funded plan sponsor may wish to know what can be done to ameliorate the harm which *may* be inflicted by such potential unfair trade practices. This sub site offers a few suggestions which may (or should) be considered by such plan sponsor at once. The range of actions are these:

1. Amend such plan to disclose certain vendor bundling.
2. Encourage the regulation of hospital billing practices by the state.
3. Amend the plan sponsor's plan to define the hospital basis of charges.
4. Encourage the use of the special-purpose audits.
5. Promote Consumer-Driven Health Plans.
6. Amend the Administrative Agreement to show the relationship between the producer and TPA with regards to stop-loss.
7. Rely on competition.

Amend Plan to Disclose Certain Vendor Bundling

While vendor bundling may or may not affect the assets or benefits of the plan, either directly or indirectly, the existence of such bundling carries the possibility of conflicted interest which opens the opportunity to unfair trade acts or deceptive practices. There are four vendor services to be considered:

- Utilization Review Firm (UR)
- Managed Care Organization (Network Management) (MCO)
- Plan Supervisor (Claims Administration) (TPA)
- Stop-loss Carrier (SL).

While the SL agreement has the plan sponsor as applicant-owner-payer-beneficiary and is therefore not a plan asset, its relationship by bundling with other vendor services may

indirectly affect plan assets or benefits. For two reasons, it is grouped with the other vendor services.

The bundling of vendor services maybe as follows:

_____ **Two services**
_____ and _____.

_____ **Three services**
_____, _____ and _____.

_____ **Four services**
_____, _____, _____ and _____.

Encourage the Regulation Hospital Billing Practices by the State

All of the parties connected directly or indirectly with self-funded health plans (providers, producers, plan sponsors and vendors) should consent to what is obvious: i.e., because of the oligolopolistic nature of the hospital industry, regulation of billing practices by the state is necessary.

Amend Plan to Redefine Hospital Basic of Charges

For every inpatient stay by any covered person, this plan requires that the hospital's basis of charges be disclosed to such Covered Person by means of a Plan-Provided Hospital Disclosure of Charges Statement as near to the admission date as possible. Such Disclosure Statement shall show this information.

Basis of Hospital Charges
This health care plan will not reimburse for hospital charges which exceed the following:

In-Network Care
Those hospital charges established by the Network

Non-Network Care
Those hospital charges which exceed the particular selected basis below shown:
___ (105) % of Hospital's Chargemaster
___ (115) % of Hospital's Medicare Reimbursement including any outlier payment

___ 100% of state-provided basis of charges
___ (110) % of Hospital's publicly-disclosed charges
___ Other, as may be agreed up by the Plan and the Hospital.

Hospital charges mean the unit (sticker) price of the service and has no relationship to either the quantity or quality of such service.

Encourage the use of the Special-Purpose Audit

Every reasonable effort should be made by all parties connected with a self-funded health plan to assure the ready availability of special-purpose audit teams that can bring the needed and added dimensions to the audit assignment such as legal, economic and actuarial.

Promote Consumer-Driven Health Plans

While most students of health plans agree that the virtues of the CDHP paradigm are significant, the difficulty is that without price transparency, the success of such plans will be limited. As a tax-deferred retirement plan, such arrangement as the HSA is fine but as a cost containment tool it has limited effectiveness.

What is needed is a nationally-based software program which will make available such data as the following:

- Representative costs, by procedure, showing both (a) hospital and (b) physician costs.
- Representative costs, by procedure, showing on a national cost basis, the costs of the principal treatment options separate by type of provider.

Amend Administration Agreement to Show Relationship Between the Producer and the TPA with Regards to Stop-Loss

Notwithstanding the fact that (a) the stop-loss contract is not directly connected with the plan in that the plan sponsor is the owner-applicant-payer-beneficiary and (b) the only parties directly connected to the stop-loss are the carrier and the plan sponsor, there should be a liaison between the plan sponsor and the stop-loss carrier (i.e., either the producer or the TPA).

The Administrative Agreement should make clear that the vendor responsible to the plan sponsor for stop-loss related administration is indicated as follows:

___ TPA
___ Producer (agent, broker, consultant, etc.)
___ Other _____.

Rely on Competition

Each of the four major funding methods (fully insured, prepaid, HMO and self-funding) has its own set of skills and advantages. Each of the four should see the challenges set forth is this Web Site and accordingly seek and provide solutions. The market-share dominance of each of the four methods is, and should be, the goal. The writer might add "good luck to the winner".