

IOWA STATE UNIVERSITY

Internal Audit Report

Executive Summary

Employee Medical Benefit Claims

June 18, 2004

Report Distribution

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Introduction

The University has contracted with two third party administrators (TPAs) to provide a network of physicians, hospitals, and pharmacies for health care goods and services. The ISU Medical Plan consists of three options for health care coverage:

ISU Indemnity Plan - Wellmark BlueCross BlueShield of Iowa

ISU Preferred Provider Organization (PPO) Plan - Wellmark BlueCross BlueShield of Iowa

ISU Health Maintenance Organization (HMO) Plan - Health Alliance Medical Plans, Inc.

These plans cover medical claim payments for the faculty, staff, and supervisory merit employee classifications.

The TPAs provide claims administration, network maintenance, utilization review and credentialing, case management, membership and eligibility functions, customer service lines, provider relations and contracting and stops loss coverage.

ISU must directly reimburse on a weekly basis Health Alliance and Wellmark for the cost of all covered claims incurred by plan members. An average weekly reimbursement to the vendors for covered medical expenses is \$600,000. Annually, ISU pays approximately \$31,000,000 for covered health care goods and services.

ISU Human Resource Services (HRS) benefits personnel requested this audit to contribute to their evaluation of TPA services and performance.

Scope and Objectives

The scope of the audit included review of membership records and paid claims in the ISU Medical Plan (i.e. the Indemnity, PPO, and HMO plans). We examined claims paid during the following time periods:

Wellmark – Claims incurred July 1, 2002 through June 30, 2003. We performed additional review of annual out of pocket maximums for claims incurred January 1, 2003 through December 31, 2003 and paid through March 31, 2004.

Health Alliance – Claims incurred for the service dates January 1, 2003 through December 31, 2003 and paid through March 31, 2004.

Our audit objectives were to evaluate the accuracy of TPA claim processing and assess the need for additional controls or contract terms that would reduce the occurrence of errors. We met with ISU Human Resource Services staff to review potential errors identified and determine whether further investigation by the TPAs was warranted. We then worked with the TPAs to verify potential errors identified during testing. Audit testing for each plan included review for the following:

- Duplicate payments
- Non-allowable payments
- Exceeding annual or lifetime out of pocket maximums
- Claims for non-members
- Subrogation

Observations

Our audit observations reflect on the services and performance of the TPAs with whom ISU contracts for the administration of employee medical benefits. However, Internal Audit has no jurisdiction over the TPAs' claim processing. The Detailed Observations and Management's Action Plans section of this report describes our observations and the actions ISU Human Resource Services will take in an effort to improve TPA claim processing services:

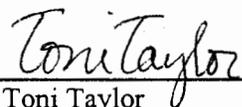
1. Indemnity and PPO Plans
2. HMO Plan

Management's Action Plans

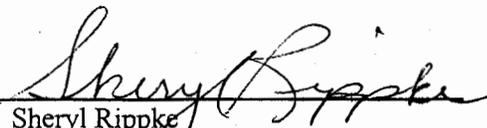
We discussed with management our audit observations and recommendations for remedial action. We then assisted management in developing their action plans and establishing target dates for implementation. For specific claim errors, we relied on ISU Human Resources staff to determine any corrective action.

For the reported observations, management's responsibility is to take appropriate action, and Internal Audit's responsibility is to monitor the status of implementation. Internal Audit will, therefore, initiate a follow-up review in May 2005. At that time, we will ask management to provide documentation describing the actions implemented or, alternatively, their acceptance of the risks of not taking action.

Completed by:


Toni Taylor
Auditor

Approved by:


Sheryl Rippke
Director of Internal Audit

Internal Audit Report
Detailed Observations and Management's Action Plans
Employee Medical Benefit Claims
June 18, 2004

Observation 1: Indemnity and PPO Plans

As the TPA, Wellmark maintains the detailed records for membership and claims processing. We requested a data download of membership and paid claims for the time period, July 1, 2002 through June 30, 2003; the population included 192,792 original claims. Membership headcounts as of July 2002 were 1,232 Indemnity plan members and 2,421 PPO plan members. Our observations regarding the administration of the Indemnity and PPO plans follow:

- a. We experienced a significant delay in receiving the membership and paid claims download from Wellmark. There was an 18-week delay between initial contact with Wellmark personnel and receipt of requested data. For all subsequent requests we defined "requested by" dates and timeliness was much improved.
- b. Duplicates – We selected claims from the download that included the same individual, the same date of service, and same procedure but different claim numbers. We identified 3,072 claims as potential duplicate payments. After consultation with ISU Human Resources staff, we requested Wellmark review 1,050 of the potential duplicate claims. Wellmark reviewed the 1050 claims and verified that 76 claims were indeed duplicate claims with a dollar impact of approximately \$4,000. ISU Human Resource staff indicated the number of errors was a concern.

Annual out of pocket maximums – Subscribers of the Wellmark plans are subject to an annual "out of pocket" maximum of \$1,500. We identified 72 subscribers who appeared to have paid more than the \$1,500 for medical services. We requested Wellmark evaluate the appropriateness of the amounts paid. The results from Wellmark indicate that the limit was not properly applied for ten subscribers.

Dependent eligibility – University and Wellmark membership records for dependents over age 19 were compared for agreement. Wellmark records include 173 dependents over age 19 who are not in the corresponding University records. University records include 696 dependents over age 19 who are not in the corresponding Wellmark records.

Tier coverage type – University employees must select a tier coverage type such as subscriber only, family, subscriber and spouse, or subscriber and children. Claims were selected from the download which would be unallowed based on tier coverage type. In doing this test, we identified former plan members with claims paid after their plan termination date. We requested Wellmark evaluate the appropriateness of claims paid for these individuals. Wellmark reported that the majority of the claims for these individuals were valid, but four former members' claims should not have been paid due to dates of service after the termination date. This error occurred due to changes in tier coverage types.

Subrogation – Subrogation is the assumption by a third party (as a second creditor or an insurance company) of another's legal right to collect a debt or damages. Members must notify the TPA if they

have the potential right to receive payment from someone else. Currently the TPA will ask the members for confirmation that a claim is not subject to subrogation.

Potential subrogation claims of approximately one million dollars were selected based on common procedure and diagnosis codes for accidents. After consultation with ISU Human Resource staff, we selected the five members with claims paid over \$30,000 and requested Wellmark to determine whether the claims had been investigated for possible subrogation. An investigation was not performed for one member identified as is required based on the procedure and diagnosis codes on the claims. Investigations for the remaining four were conducted.

Management's Action Plan:

- a. We will discuss with Wellmark the need for timely information. Definitive timelines will be established for future reporting requests.

Target for Completion: ongoing
Follow up contact: Diane Muncrief

- b. Duplicates - We will work with Wellmark to determine the cause of errors identified and whether a change in processing is needed. Our first step in this process will be a site visit which includes an education in claims processing and operational procedures currently in place at Wellmark.

Target for Completion: August 6, 2004
Follow up contact: Diane Muncrief

Dependent Eligibility - We will work with Wellmark and our current Administrative Technology Services resources to develop a process to more accurately address dependent and tier coverage changes.

Target for Completion: April 29, 2005
Follow up contact: Diane Muncrief

Performance standards will be reviewed on an annual basis and documentation will be requested prior to acceptance of the yearly Operational Performance Standards Guarantee report from Wellmark.

Target for Completion: August 2, 2004 and annually thereafter
Follow up contact: Diane Muncrief

We will test paid claims and membership periodically. HRS processes for tracking membership, eligibility and contract performance will be adjusted to enhance monitoring of the TPA's services.

Target for Completion: ongoing
Follow up contact: Diane Muncrief/Tim Ashley

Observation 2: HMO Plan

As the TPA, Health Alliance maintains the detailed records for membership and claims processing. We requested a data download of membership and paid claims for the service dates January 1, 2003 through December 31, 2003 and paid through March 31, 2004. The population included 81,482 claims and the membership headcount as of January 2003 was 1,825 members. Our observations regarding the administration of the HMO plan follow:

- a. Duplicates – We selected claims from the download that included the same individual, the same date of service, and same procedure but with different claim numbers. We identified 584 claims as potential duplicate payments; we then requested Health Alliance investigate those identified. Health Alliance verified that 10 claims were duplicate payments with a total value of \$868.

Dependent eligibility – University and Health Alliance membership records for dependents over age 19 were compared for agreement. Health Alliance records include 94 dependents over age 19 who are not in the corresponding University records. University records include 46 dependents over age 19 who are not in the corresponding Health Alliance records.

- b. Tier coverage type – University employees must select a tier coverage type such as subscriber only, family, subscriber and spouse, or subscriber and children. Health Alliance does not capture this information with the claims data. We were unable to test for claims that would be non-covered based the tier coverage type (for example, a spouse claim on a subscriber only policy) or termination date.

Management's Action Plan:

- a. We will work with Health Alliance to determine the cause of errors identified and whether a change in processing is needed. We will work with Health Alliance on error corrections as well.

Target for Completion: August 13, 2004

Follow up contact: Diane Muncrief

We will test paid claims and membership periodically. HRS processes for tracking membership, eligibility and contract performance will be adjusted to enhance monitoring of the TPA's services.

Target for Completion: ongoing

Follow up contact: Diane Muncrief/Tim Ashley

- b. Tier coverage type - We will work with Health Alliance and our current Administrative Technology Services resources to develop a process to more accurately address dependent and tier coverage changes.

Target for Completion: March 2, 2005

Follow up contact: Diane Muncrief