

Reducing Healthcare Costs

for Employers

Employee Benefits Series

THOMPSON

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MHPA Realignment Will Cost Business \$100 Million in Year One

Employer plans will have to spend \$100 million in 2010 to change plan designs to comply with federal mental health parity rules, the government estimates. Of that, \$40 million will be spent unifying deductibles, copays and limitations, one of the rule's main new requirements.

Ongoing compliance over the next 10 years will cost businesses another \$100 million, say the U.S. departments that penned the rule: Labor, Treasury and Health and Human Services.

Group health plans may not impose separate deductibles or limitations for mental health and medical coverage, under the new rules. Plans that had separate deductibles and limits must start counting all covered medical, surgical, mental health and substance abuse claims against unified deductibles and limits, in categories such as inpatient and outpatient.

See *Mental Parity*, p. 4

Case Study

Health Plan Mixes Data Mining, Patient Interviews to Find Fraud

Provider fraud is rare. And it's difficult to uncover when the typical claim discrepancies are small and complicated. But with precision data mining technology that uncovers aberrant billing patterns, backed with tips from patients or whistleblowers, insurers and employers can build a case and reverse the damage caused by abusive or fraudulent claims.

Health Care Service Corp. (HCSC) of Chicago uses IBM's FAMS (Fraud and Abuse Management System (<https://www-304.ibm.com/businesscenter>) and SAS Enterprise Miner (<http://www.sas.com/technologies/analytics/datamining/miner>) to identify and then analyze billing patterns in cases of suspected fraud or billing errors. HCSC operates Blue Cross/Blue Shield plans covering 12.7 million lives in Illinois, Texas, New Mexico and Oklahoma.

"What FAMS does for us is provide us with the capability to do peer-to-peer comparisons, and based on what we find in those comparisons, we can use other tools to drill down more in claims data," says Sheri Farrar, executive director of HCSC's Special Investigations Department.

See *Fraud Discovery*, p. 2

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“Data analysis helps us focus on those providers where things don’t look quite right when you see overall data,” Farrar adds.

An investigator has to drill into data details and interview patients and providers to determine what the discrepancies truly mean, she says.

In one recent case, HCSC’s investigation into billing issues of a single allergist resulted in the allergy business being ordered to pay \$934,068 in restitution to Blue Cross/Blue Shield of Illinois (BCBSIL) and about 300 patients, as well as a \$1.58 million fine. BCBSIL received \$528,016 of the restitution money.

HCSC participated in this major fraud recovery in spite of the fact that the initial allegations against the allergist involved little money.

It started with a call from Federal Bureau of Investigation (FBI). The FBI had been informed by the Illinois Department of Insurance (IDI) that 30 people called its hotline about this one allergy practice. HCSC looked and found it too received five complaints about the allergist.

Sign 1: Patients Balance Billed

The allergist’s patients had noticed odd things on their bills. Their plan was supposed to cover all costs after copay. Yet the allergist continually billed them for the difference between what the insurer paid and what the allergist claimed were the charges, says Mone Petsod, a senior investigator with HCSC’s Special Investigations Department.

When patients declined to pay, the allergist’s office sent out bills with late payment charges. The bills became so complex that when Petsod examined some of them, even she couldn’t understand the rationale behind the provider charges.

Sign 2: Charges Unbundled

Another red flag was that the patients’ bills included supply charges, such as syringes, alcohol wipes and items that typically are not billed separately because they are supposed to be bundled into the procedure charges, Petsod notes. The allergist billed separately for the allergy serum, which was inappropriate for the procedure codes in question. “We have allowances for the price of those items in the treatment itself.”

Petsod ran a report using the FAMS and Enterprise Miner software, looking at all of the doctor’s data.

“The initial allegations didn’t involve a lot of money — no more than \$20,000 for the year,” Petsod says. “And, actually, the doctor’s billing didn’t stand out because our exposure to her was just average when compared with any Illinois allergist.”

But the details were telling: “When I looked at the claim data in detail, line-by-line, I found other billing issues that were different from other allergists,” she says. “The way the allergist billed for the procedure involving allergen extract was unusual.”

Typically, the ratio between the extract preparation and the actual extract administration is not large. But this particular allergist’s ratio was inconsistent with the norm.

Step 3: Patients Identify Abuses

Petsod’s next step was to interview 25 patients. “I asked them what exactly they were getting at each visit, how many shots per visit, how often they received bills, and how they were billed,” she says.

She learned the allergist’s office was billing patients for the balance of charges, despite this going against the insurer’s contract with the allergist.

“They kept repeatedly billing, duplicating charges for services and then later added on additional fees for late payments,” Petsod says, partly due to syringes or allergen extract that shouldn’t have been billed separately in the first place. “We talked to the provider and hit a road block because the office’s biller was her husband, and he didn’t let us speak with the doctor herself.”

The investigation revealed that what initially seemed like a small-dollar amount actually was huge because the allergist had billed people for far more units of allergens than were actually administered, Petsod says.

See *Fraud Discovery*, p. 8

Reducing Healthcare Costs for Employers

DIRECTOR OF PUBLISHING: **LUIS HERNANDEZ**

ASSOCIATE PUBLISHER: **GWEN COFIELD**

EDITOR: **TODD LEEUWENBURGH**

REPORTERS: **MARLA DURBEN HIRSCH, MELINDA YOUNG**

DESKTOP PUBLISHER: **JASON PEACO**

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Getting More Bang for Your TPA Buck: Questions Employers Should Ask Before Paying

Employers are changing how they conduct due diligence on third-party administrators (TPAs), evaluating them not just on the cost of their services, but on the TPA's ability to expand or adjust services later and its ability to provide more comprehensive programs.

“Historically employers looked primarily at the cost of services. But now employers are looking at the rising costs and asking TPAs about their results and what they're doing to better manage their risk,” explains Joe Manheim, president of benefits administration for TriZetto in Naperville, Ill. Since health benefits are a company's second-highest cost after payroll, health management costs becomes a critical factor in a company's ability to compete, he adds.

Employers are also demanding more transparency from TPAs, particularly on what goes into fees the plan pays the TPA. Plans are scrutinizing line items for unexplained expenses and comparing bills from month to month and year to year, according to Joseph Paduda, principal, Health Strategy Associates, Madison, Conn.

Many TPAs are transforming ... from a commodity based vendor model to one of more of a risk manager, says Manheim. “The world is changing. TPAs need to change [their practice and structures] with it — to accommodate their employers,” he explains.

Question TPA's Operations

Employers should “get in the weeds” and ask some specific questions of a TPA they're working with or thinking of engaging, experts say. They include:

- **Can the TPA offer more complex benefits than merely processing claims?** If an employer wants to add to its plan design, such as adding wellness programs or disease management, now or down the road, the TPA needs to be able to handle the changes or else run the risk that the employer will go elsewhere for its TPA needs, warns Manheim.
- **Can the TPA improve the plan design by aligning incentives?** Out-of-sync incentives can increase health care costs. For instance, the employer may cover preventive care, such as mammograms or immunizations, but if the employee must pay a high copayment for the privilege, she may not take advantage of the preventive care, which can backfire when she gets sick, says Manheim. TPAs should be looking out for that.
- **Is there a broker fee included in the TPA fee?** Sometimes the broker is getting a cut of the TPA's per

member per month (pmpm) fee paid by the employer. However, since brokers typically get paid by commission, also paying them a cut means that they're getting paid twice, warns attorney Catherine Stowers, with Krieg Devault in Indianapolis. Employers should not be paying for that. “You need to ask what the elements of the pmpm fee are,” she suggests.

- **How efficient is the TPA's operation?** The more efficient and integrated the TPA's processes and tools, the better it will operate, which means reduced costs for employers, says Manheim. For example, if the TPA is part of a national network of highly qualified providers, employees are likely to remain in-network for health care services, but also to obtain higher-quality care.
- **What kind of reports can the TPA generate?** TPAs should be able to provide data and report so that it can be analyzed and the plan design changed, if necessary. For example, if the TPA can monitor trends regarding patients with chronic diseases, it may determine that the employer would benefit from adding nurse coaching to reduce those long term costs, says Manheim.
- **How does the TPA handle subrogation?** Some TPAs are better at pursuing and winning third-party recoveries from employees who have been reimbursed for medical claims from other insurers, such as automobile insurance companies. “If a TPA is not identifying these claims and notifying the plan sponsor, then money is lost on the back end,” says Stowers. Some TPAs handle these claims in-house, others use law firms or subrogation companies, but the TPA should spell out how these cases will be covered.
- **Will the TPA keep the employer in compliance with applicable regulatory requirements?** Employers often rely on their TPAs to ensure that their ERISA, U.S. Department of Labor and other forms and filings are compliant, but they are sometimes deficient, warns Stowers. Some TPAs handling employers' IRS Form 5500 filings don't file on time. The employer runs the risk of fines and penalties down the road, she notes.
- **What is the TPA doing to transition to the HIPAA 5010 standards and ICD-10 diagnosis codes?** These billing mandates become effective in 2012. “If the TPA's system can't become compliant,

See *TPA Costs*, p. 8

Despite concerns about the “cost of converting systems to permit unified deductibles,” the three agencies said “prohibiting separately accumulating financial restrictions and quantitative treatment limitations is more consistent with the policy goals that led to the enactment of [the Mental Health Parity and Addiction Equity Act of 2008] MHPAEA.”

On the other hand, the government does not predict that the rule will appreciably spur consumption of mental health and substance-abuse services.

Rule Expands Parity Requirements

The rule interprets MHPAEA, which, among other things, extended 1996 Mental Health Parity Act’s (MHPA) requirements to “substance use disorder” benefits as well as mental health benefits.

The act took effect Jan. 1, 2010, for calendar year plans, so technically the rule is in effect, but the government will not enforce the rule until July 2010.

The parity rule does not actually require group health plans to offer mental health benefits. But for plans that do, “financial requirements” and “treatment limitations” for mental health and substance use disorder benefits may not be more restrictive than the “predominant” such provisions for medical and surgical benefits.

The rule applies to plans sponsored by private and public-sector employers with more than 50 employees, including self-insured and fully insured arrangements. It also applies to health insurance issuers that sell coverage to employers with more than 50 employees.

Feds Predict Modest Hike in Utilization

A big question is whether the rule will spur utilization of mental health and substance abuse benefits, premium increases and make coverage unaffordable. “The rules can have a dramatic impact, especially on substance abuse treatment,” says attorney John Klein, with Ohrenstein & Brown, Garden City, N.Y.

The rule, however, says the increases in utilization may be negligible, if one factors in a return on investment through better overall health. Cost impact will be muted also because parity will occur in the context of managed care. For example, the impact of mental health parity in the Federal Employees Benefit Program was negligible, according to studies cited by the rule.

And data from states with mental health parity laws indicate minimal increases in consumption of mental health and substance-abuse services resulting from parity, the rule noted.

Compliance Obligations

Apart from aggregating cost-sharing and limitations data, compliance will impose other costs. Other potentially costly plan changes include:

- **Plans cannot exclude substance abuse benefits if they cover mental health.** Plans must reimburse substance abuse benefits under the same plan rules as mental health. Plans must count such services in aggregate lifetime and annual dollar limits, together with medical/surgical benefits, under the MHPAEA.
- **Plans will have to remove specialty care copays** for visits to mental health care providers. Plans will need to reimburse most mental health visits as primary care, with lower copays for members making such visits. The regulators noted that charging higher copays to mental health providers was a device to steer patients away from them.
- **PBM deductibles and limits must be counted.** If drugs are managed separately from the plan, the two sets of deductibles and limitations, must be pooled into one total. Tiering of drugs, deductibles and limits by pharmacy benefit managers are allowed, but must not be used to discriminate against mental-health benefits, the rule states.
- **Group plans must explain denials of payment for mental health services** to plan participants and beneficiaries on request.
- **Plans that use a separate company for (carve out) mental health administration** will have to build interfaces to receive data from the mental health benefits administrator.
- **Plans can’t use any of these common plan management tools in a way that discriminates against mental health** (or substance-abuse) services: medical management standards, medical necessity or experimental/investigative service designations; formulary design for prescription drugs; standards for provider inclusion in networks — including reimbursement rates; methods for determining usual, customary and reasonable charges; refusal to pay for higher-cost therapies until it can be shown that a lower-cost alternative was tried (step therapy); and exclusions based on failure to complete a course of treatment.

The government will accept comments until May 3, 2010 on specific topics, such as whether substance abuse disorder treatment should be a required benefit in all treatment settings. (To do so, go to <http://www.regulations.gov>.)

See *Mental Parity*, p. 5

Exception If Parity Costs More Than Two Percent

The MHPA contains exceptions for small employers and in situations where complying would increase plan costs by more than two percent in the first year.

- **Small employer exemption.** The MHPA does not apply to any group health plan or coverage of any employer that employed an average of between 2 and 50 employees on business days during the preceding calendar year, and that employs at least two employees on the first day of the plan year.
- **Increased cost exemption.** The rule does not apply to a group health plan or group health coverage if applying the parity provisions increase plan or coverage costs by 2 percent in the first year and 1 percent in subsequent years. But plans cannot use the exception for two consecutive years.

Plan Designs Threatened

Employers will need to sit down with their plan administrators and TPAs and see what changes are needed to bring their current plans into compliance, and if additional changes are necessary or preferable.

For instance, an employee assistance program (EAP) may need to drop its requirement that employees be evaluated under the EAP and/or exhaust EAP benefits before they receive mental health benefits, since now a similar limitation must be applied for medical/surgical benefits, which isn't very feasible, says Kay Pestaina, vice president and senior health compliance specialist, The Segal Company, Washington, D.C. "An EAP program may no longer be a [cost effective] silver bullet," she warns.

Employers do have some choices, but none of them are optimum, and all involve a cost/benefit analysis:

- **Drop mental health and substance abuse coverage entirely.** "If you offer it, you must have parity, but the law doesn't mandate that you must offer it," explains Klein. However, if you drop this coverage, you face an administrative burden of changing summary plan descriptions, notifying beneficiaries, and so on. Not offering mental health/substance abuse disorder benefits also can set an employer up for higher medical charges, since mental problems often go hand in hand with physical problems like high blood pressure and smoking-related illnesses. It can also affect employees' productivity and well being. "Treating mental health and substance abuse is preventative," reminds Pestaina.

- **Decrease medical/surgical benefits to such a level that parity is achieved.** This would also require a plan change that would trigger notification and other duties. While this is an option, "that's not the point of this law," says Pestaina.
- **Do a little of both.** An employer can add some mental health/substance abuse disorder benefits and lower medical/surgical ones, such as increasing copayments, notes Klein.
- **Apply for an exception from parity.** An employer can apply for an exception if compliance with the parity rules results in cost increases exceeding 2 percent. However, a plan can only qualify for this exception in alternating years, so this option isn't feasible in the long term, says attorney Seth Perretta, with Davis & Harman in Washington, D.C.

TIP: Employers/plan sponsors should also factor in state-law requirements when evaluating their plans in light of the new parity rules. "Many state laws require some mental health benefit, so a plan may not be able to avoid it," explains Pestaina.

Luckily, it's estimated that the costs of complying with the rules are not as significant as originally feared. "Most employees use none at all [of these benefits] or get treatment on a less formal basis, like the family practitioner treating depression," says Klein. The rules indicate that adding benefits to achieve this parity would be about \$1.83 per person per year for employers, he says. "The percentage of people who would be availing themselves of longer term care is just 2 percent of the population. Mental health is not a big figure in overall health care spending," he notes.

However, the government may not have taken into account the costs of increased medical management for mental health and substance abuse disorders, such as the application of utilization review and prior approval requirements, warns Pestaina.

Employers probably won't engage in a lot of jockeying to avoid this law, especially considering that much of these costs are noninvasive and comparatively less expensive than procedures such as CT scans. "For every dollar invested in substance abuse benefits, the return on investment (ROI) is \$10. That's an ROI of 1,000%," says Klein.

Perretta also predicts that employers may pass the costs of parity on to plan members in the form of higher premiums. "Cash strapped employers are unlikely to want to subsidize the premium cost increases mandated by parity," he explains. 📌

Employers May Be Able to Save Thousands By Evaluating Drug-management Charges

If you haven't looked at your health plan's pharmacy benefit manager (PBM) charges lately, you're probably paying too much. As medical costs rise, pharmacy expenditures could be low-hanging fruit for cost cutting.

For example, the 5,000-employee Manatee School District in Bradenton, Fla., saved \$470,000 in drug expenses after a thorough review of its PBM spending. It did that after hiring a pharmacy benefit attorney and renegotiating its contract with a large PBM, says Forrest Branscomb, Manatee's director of risk management.

The first step to achieving this kind of cost savings is to use data mining software to capture pharmacy expenses.


"Data mining software shows you on a daily basis exactly what you're spending and for what," he says. "You can get that information from your PBM, but it'll be in the format that they want to show you, and it might not be timely."

The quickest way to save money is to identify high mark-ups on generic drugs. Branscomb hired a consultant who analyzed the district's drug spending and showed him how the PBM was charging the district far more for some generic drugs than what an employee would pay out of pocket at a discount retailer like Wal-Mart, Costco's, Kmart, Target, or even some grocery store chains.

See *PBM Vigilance*, p. 7

Increase Generic Drug Utilization to Lower Costs

Savvy employers can take steps to reduce the use of brand name medications when a generic is available, such as:

- 1) **Ensure that plan design and formularies favor generic drug use.** Ask for reports of prescription drug use by your plan members to see if you (or they) can pinpoint areas where transitioning to generics would have significant impact on your costs. You may also want to ask for an analysis of drug utilization trends based on your industry or geography to see if that sheds light on generic use, suggests Richard Rubino, Senior VP for Finance and CFO of Medco in Franklin Lakes, N.J. "A plan design can be changed, even mid-contract," he points out.
- 2) **Make sure that copayments for generic drugs are significantly less than brand-name equivalents.** "There should be a meaningful financial incentive between generic and brand name," says Rubino. He suggests that copayments for: (1) generics be between \$5 and \$10; (2) preferred brand-name drugs be \$25 to \$50; and (3) non-formulary brand-name drugs be even higher.
- 3) **Inform employees and their dependents that generic versions are available.** Spread the word, via newsletter or other communication, that particular medications are going generic, and that filling prescriptions with generics can save them a lot of money. Make it clear that generics work like the brand name drug, and must meet the same quality and safety standards, says Ritu Malhotra, PharmD, with the Segal Company in Chicago. "This kind of 'Buy Generic' campaign is a win-win for both employers and employees," she notes. Your plan welcome kits should also contain this information, notes Rubino. In this vein, plans and insurers have been suggesting switching people from Lipitor (still on patent) to simvastatin (a generic statin sold exclusively as Zocor until 2007).
- 4) **Consider waiving copayments for generics for a short period.** For instance, you may waive copayments for generics for three to six months to incentivize patients to try the drug. "This is especially effective for those [taking maintenance drugs to treat] chronic conditions," says Malhotra.
- 5) **Encourage generics for the newly diagnosed.** Some health and self-insured plans have added "preferred drug step therapy" to their programs. When a patient is diagnosed with a new illness and put on a new medication, the patient starts with a generic version, assuming that one is available. If that medication is not effective, the brand name drug in the plan formulary is tried next. If that doesn't work, the drug is stepped up again to a brand name not in the formulary. "So at least the starting point is the generic. And most patients stay there," says Rubino.
- 6) **Remind employees to ask their physicians if generic drugs are available for their prescriptions.** Some people are wary about questioning their physicians, but they shouldn't be. "Don't just let a doctor write a prescription for a brand name drug if a generic is available," says Rubino. "Doctors are receptive to generic drugs, even though they get bombarded by brand name ads." 

For example, the PBM charges included a \$180 charge for 90 days of a generic statin drug. The employee paid a \$20 copay for the drug when it was filled, says Dan Ross, president of Med-Vision LLC of Tampa. Ross worked with Branscomb on identifying some of the easier ways to save health care costs.

“That same drug costs \$10 at Wal-Mart for a 90-day supply,” Ross says. “It’s incredible!”

In such cases, employers should attempt to renegotiate with the PBM. To do so, Manatee hired an attorney who understood the complex language and terms of PBM contracts, Branscomb says.

“You have to rely on experts because there are a lot of dollars out there that you can save,” he adds.

Although PBMs are resistant to renegotiating, the district was able to convince its PBM to adjust the percentages and redefine definitions for the remaining time on the contract, Branscomb notes.

The discrepancy between actual drug costs and what the typical PBM charges is a common problem for employers. And it’s the reason why increasing numbers of employers and others are asking for transparency in their interactions with PBMs.

Manatee likely will save even more in drug costs when the district’s current PBM contract comes up for renewal. The plan’s going to demand transparency on a variety of levels.

“We want to know where all the money is going, and you have to craft your contract to be very specific about that,” Branscomb says.

An expert attorney will assist the employer with writing a proposed contract for potential PBMs. The proposed contract will ask for transparency in fees and expenses, and the district would select the PBM that satisfies their contractual requirements, he adds.

Cutting the mark-up on generic drugs is one strategy, but employers can use others.

Employer Starts Own PBM

For instance, another common issue is that PBMs often have contracts with drug companies where they receive rebates for including particular brand-name drugs

on their formulary, explains Robert Carta, assistant vice president of the division of pharmacy services at Carolinas HealthCare System in Charlotte, N.C.

As a large health care system with in-house pharmacy expertise, Carolinas HealthCare was able to take the unusual move of starting its own PBM for the system’s 30,000 health plan members. By taking over the drug costs, the health system was able to save \$2.4 million within three years, Carta says.

Not only did the health system’s PBM eliminate the hidden cost of rebates and the huge mark-ups on generic drugs, but it was able to steer plan members toward cheaper generic drugs by making these available with no copay.

“If I put Lipitor on the formulary, it might cost us \$3 a tablet when another statin is 2 cents a tablet,” Carta says. “Other PBMs might put Lipitor on the formulary because they get a \$2 rebate, but to us that’s still being charged 98 cents more per tablet.”

Ross recommends that smaller, fully insured employers use a similar strategy to reduce their drug costs: “We’d tell employees to go to Wal-Mart and buy the generic drugs, and then we’d pay them cash for the costs,” Ross says. “Even if you’re fully insured, this is hugely worth it.”

The discrepancy between actual drug costs and what the typical PBM charges is a common problem for employers. And it’s the reason why increasing numbers of employers and others are asking for transparency in their interactions with PBMs.

Rebate Transparency

For instance, First Service Administrators, Inc. (FSAI) of Lakeland, Fla., requires PBM contracts to be transparent with 100 percent of drug rebates going back to clients, says Kathleen Sullivan, RD, executive vice president of business solutions. FSAI is a health care benefits administrator for employers.

“There’s incredible abuse in mail-order programs, and that’s where they’re getting 50 percent of their profits,” Sullivan says. “Employers don’t see how these gross profits are driving a majority of their costs.” The first thing FSAI looks at when trying to cut an employer client’s costs is drug costs, she adds. “It’s the biggest opportunity for saving money right away,” Sullivan says.

Employers regardless of size can cut their drug costs if they take time to learn more about how the PBM system works, Ross notes. “There are some really progressive employers who are using data to make sure they’re getting exactly what they need and that they have no over-charges in pharmacy contracts,” he adds. 🏠

Fraud Discovery (continued from p. 2)

HCSC's investigations department learned that the insurer's provider affairs department had already spoken with the doctor's husband about improper billing and had taught him proper billing before the investigation started. The fact that HCSC could prove that it educated the doctor's billing agent meant this case would qualify as fraud, rather than a series of mistakes, Petsod notes. "So we reported our findings back to the FBI," she says.

Calling law enforcement is appropriate once a company has determined that a provider knew he or she was doing something inappropriate, Farrar says.

"One thing we did to mitigate our risk was to put the provider's claims on a pre-payment review, where each claim was stopped and reviewed by a doctor before they were paid," Farrar says. "We do that in some cases where we identify that a provider is doing something that causes risk to us or to our members."

The FBI investigation and pre-payment review continued for about a year.

Team Up With Other Payers

"There were Medicare claims affiliated with this practice, so the government went out to increase the exposure on this case by determining whether these billing discrepancies happened in other plans and with the government," Farrar says.

As a result, the doctor entered a guilty plea to a single misdemeanor count of balance billing Medicare patients and was sentenced on Feb. 4, 2008, to a \$10,000 fine and ordered to pay restitution. Her husband and office manager entered a guilty plea to a single count of felony health care fraud and received a nine-year prison sentence plus a \$100,000 fine.

About one-third of cases are found as a result of independent data mining, she adds. Most cases, however, rely on tips from patients and whistleblowers.

"You can't make an analysis based on one claim; you have to identify problems on a particular claim and then look for patterns of aberrant, broader billing problems," Farrar says. 📌

TPA Costs (continued from p. 3)

will it migrate to a platform that does, [and what will that cost the employer]," Manheim says.

- **Does the TPA conduct eligibility audits?** Eligibility audits will ferret out people who are not or are no longer eligible for coverage, such as dependents who have turned 18 and who are not full-time students. The TPA should be conducting or at least assisting with these audits, says Stowers.
- **How well does the TPA handle stop-loss and re-insurance?** "Ask how quickly the TPA files claims and administers this. If it's not done quickly, the employer can get stung [by missing filing deadlines]," says Manheim.
- **Are the managed care fees being charged reasonable?** Sometimes the fees the TPA pays a managed care plan for services get inflated, such as a too-high network access charges or unnecessary case management services, says Paduda. "Employers need to know where their money is going. Any employer not closely tracking the line items is setting itself up to be taken advantage of," he warns.
- **Is the TPA outsourcing services?** It often makes sense for TPAs to outsource services it doesn't provide, such as case management or electronic claims data generation, says Paduda. But the employer should know what is and isn't being

outsourced, and if the fees for that are reasonable, he says. "The contract between the TPA and the employer should say that the TPA agrees to disclose financial relationships that exist as a result of [or in furtherance of] this contract," he suggests. 📌

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