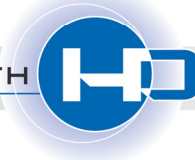


Complete Enrollment Validation

Presented by:
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Pioneering Specialists in Group Health Care Post-Payment Administration for 25 Years

- First with 100% claim audits
- Introduced the use of claim audits for recovery
- Originated linking of enrollment reconciliation with claim audits
- Started dependent eligibility audits 15 years ago
- Revolutionized data intake with payer-defined data – always successful
- Unblemished track record – no HIPAA violations or employee issues

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Why All the Fuss?

- Up to 10% of claim payments for non-existent employees.
- Up to 9% of claim payments after coverage termination.
- Up to 12% of ineligible dependents enrolled.
- Up to 10% of other coverage opportunities missed.
- Up to 10% of Medicare liability not known.
- Up to 15% of addresses wrong.

Enrollment errors increase costs 5% to 15% per year.

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My Plan Administrator Handles This. **WRONG**

- Every plan administrator when presented with an error in enrollment facts blames the self-funded plan.
- Plan administrators have a disincentive to manage enrollment since it both costs them more to do and can reduce their income.
- The responsibility for enrollment validation resides with the self-funded plan.

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I do annual Open Enrollments and did a Dependent Audit.

Aren't I Done?

NO

- Both are important.
- Neither are sufficient.

But I don't have enough time!

YES YOU DO.

- Reacting to enrollments issues is more disruptive.
- Costs of enrollment issues make it time well spent

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What	When
1. Information Verification	After Open Enrollment
2. Dependent Documentation	After Open Enrollment and With New Enrollee
3. Vendor Files Reconciliation (Individual and Cross-Files)	Monthly Data Files Quarterly Review Annual Audit
4. Claim Payment Confirmation	

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1. Information Verification

Done annually after open enrollment.

- Report results of open enrollment elections for confirmation.
- Sent to all enrollees with Response Required
- Verify all enrollment facts are current and correct.
- Confirm COB and Medicare facts.
- Correct and update enrollment facts.
- Communication reinforces value of benefits.
- Communication reinforces positive employee relations.

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2. Dependent Documentation

Initial

- Compile all existing dependent documentation.
- Scan documents and associate with enrollment record.

New Enrollee

- Confirm eligibility of dependents.
- Send documentation request to employees with new dependents.
- Response Required with Additional Documentation.

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2. Dependent Documentation

Annually with Information Verification

- Confirm any changes to dependent status
- Collect missing documentation.
- Enforce divorce decrees.
- Monitor 26+ eligibility.
- Identify other coverage for coordination (COB).
- Establish Medicare enrollment status.

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3A. Individual File Reconciliations

1. Benefit Record Keeper (BRK) reconciled to Employer “Payroll” Roster
2. BRK reconciled to Employer Retiree Rosters
3. Each Benefit Plan reconciled to BRK
 - Self-funded
 - HMO
 - RX
 - Others
4. COBRA election reconciled to BRK

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3A. Individual File Reconciliations

- Eligibility verification
- Employment/Retiree status verification
- Contract status verification
- Termination date verification
- COBRA verification
- Missed employee
- “Phantom” employee

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3B. Cross File Reconciliations

- BRK is “control”
- Each enrollment roster cross-referenced to BRK and to each other
 - Self-funded
 - HMO
 - RX
 - Others

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3B. Cross File Reconciliations

- Person enrolled in wrong plan
- Person enrolled in multiple plans
- Coverage status differences across plans
- Factual discrepancies across plans

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4. Claim Payment Confirmation

- Establish routine (monthly) claim data feeds with all payers.
- Apply new enrollment facts to historic annual baseline.
- Repeat analysis quarterly to monitor corrections.
- Include results in annual audit

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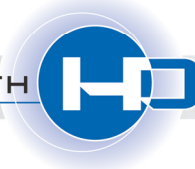
4. Claim Payment Confirmation

- Claimants not on employer/BRK roster
- Claimants not on payer roster
- Claims incurred outside periods of eligibility
- Claims incurred after termination
- Claims with COB opportunity
- Claims paid where Medicare is primary

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What It Takes

1. Have a plan.
2. Make this part of the benefit “routine”.
3. Stress Positive Value to the employee and their family in all communications.
4. Control data from all vendors.
5. Execute Validation steps 1-4.



Past Webinars Available for Download

Recordings of past webinars are available through **Si's Library** (www.healthdecisions.com/library) including:

- August, 2011 – New HIPAA Accounting Requirements
- July, 2011 – Dos and Don'ts of Competitive Bidding
- June, 2011 – You've Done a Dependent Audit. Now What?
- May, 2011 – Two Dozen Reasons for Claim Payment Error
- April, 2011 – How Does Your Plan Compare?
- March, 2011 – How Medicare Can Help Employer Health Plans
- February, 2011 – Administrative Fee Inflation
- January, 2011 – Planning for 2011

For More Information
Contact

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We offer no-cost consultations
to answer questions and discuss options.