

Audits

Employer Audits

In General

With larger employer clients, the TPA 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 TPA's service.

When the employer wishes such an audit performed, it is done by one of these type of 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 errors in the 1%-3% 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 are any, in the TPA's benefit administration as regards:

- Training of examiners
- Quality control
- Internal audits
- Cost-containment
- Management reports
- Discipline of UCR standards
- COB/Subrogation investigations.

Results of Employer-Sponsored Audits

The results, typical of such audits, are these:

- Errors may be classed as confirmed (certain) or disputed (undocumented).
- TPA firm making the errors may be held accountable under E&O for many of the errors found.
- Fully computerized systems have fewer errors than fully manual systems.
- It is absolutely essential to have the names of all covered dependents.
- Need for provider audit was crucial in the areas of chiropractic and therapy benefits.
- TPA, as a result of such audit, established its own internal audit.
- Too little investigation was made to discern COB cutback.
- Too many small bills were being processed. Participants might be encouraged to hold back small bills until some limit reached: deductible, or \$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 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 were commonly found.
- Most TPA systems were weak.
- Often reports were confusing or misleading.
- TPA instructions were seen in some audits to be weak or nonexistent.
- Frequent inconsistencies between the plan document and the booklet were seen.
- Missing claim files were found in some audits.
- Lack of structure in the examiner's mind as to what is meant by *medical necessity* was occasionally seen.
- Often TPA was not aggressive in its investigations.
- Cost-containment provisions were too sophisticated for many TPAs.

Features of Audits

A carefully designed audit should do the following:

- 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, such as physicians, fourth-party review, firms, etc.

- Review forms, reports, EOBs, etc.

Specific Areas of the 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, end stage renal disease?

Audit Report

The audit report will usually consist of these parts:

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

Employee Audit

Many plans have as a cost-containment provision, an inducement to the participant to audit the hospital bill with the understanding that any demonstrable savings to the plan will be shared with the participant up to a 50% maximum not to exceed \$500, e.g. Complexities of such audit bonus programs are extensive but not further discussed herein.

Independent Accountant's Audit

An independent accountant will audit a health and welfare plan for one of two reasons:

- For purposes of the Annual Report (Form 5500)
- For purposes of meeting certain requirements relative to jointly trustee plans.

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

Auditing Requirement of the Annual Report

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

- Any plan filing a Form 5500, which uses a trust, of any form, 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 an auditor's opinion if there are no plan assets of any amount.

Audits are not required for any plan, trustee or not, whose purpose 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 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 claimant's 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.

Department of Labor Audit

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 a new audit program known as an 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, which began in 1990, 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 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 (IRS) keypunches 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 IRS forwards computer tapes containing all of the data to the department. The data for all plans (900,000) are then subjected to a comprehensive automated review using specialized targeting criteria. The department believes that this new 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, for the first time, all annual reports will be 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 IRS, financial regulatory agencies, state insurance departments, and other leads. Cases are also based upon referrals to field offices from the IRS.

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 plans 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 a 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 that involve service providers can be identified by the department. 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 field.

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 pursuing those cases that involve the most serious violations and that 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.

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.

Targeting

In developing priorities for meeting the investigative objectives, the following factors are considered by each area office as well as by the IRS 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 about 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 report
- Comparison of data from ERISA database to data merged or generated from other database befitting the criteria under review or investigation 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 OIG, 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.