THE BURCHFIELD GROUP
an Aon company

PBM Benefit Audits: Understanding Health Plan Rights and Best Practices

January 14, 2020

1.800.778.1359
www.burchfieldgroup.com
5600 W 83rd Street, Suite 1100, Bloomington, MN 55437

The Burchfield Group, An Aon Company

The Burchfield Group

Brian Bullock, RPh, MBA
SVP, Health Plan

Kristin Gray
VP, Health Plan Consulting

Steve Baumgardner
VP, Health Plan Procurement and Consulting

Derek Frye, MBA
VP, Audit and Compliance

Diana Waldbillig
Consulting Analyst

Terri Poindexter
VP, Health Plan Consulting

Lynn Stauffer
Health Plan Audit Lead

The Burchfield Group: Health Plan Audit Team

150
AUDITS PER YEAR

98%
RETENTION RATE

OVER
3 Billion
Rx claims audited

LARGEST HP-DEDICATED AUDIT TEAM IN THE INDUSTRY

50
YEARLY HEALTH PLAN CLIENTS

HITRUST
CSF Certified
FOR THE SYSTEMS USED IN THE CONTEMPLATED SCOPE

2nd
LARGEST PROVIDER OF CMS COMPLIANCE / PROGRAM AUDIT SERVICES

60%
AUDITS WITH CONFIRMED ERRORS

Audit Service Overview

Vendor Oversight

- PBM audits
- Clinical vendor audits
- SNP vendor audits

- Financial audits
- Benefit audits (topic of this presentation)
- Rebate audits
- Performance guarantee audits
- PDE audits
- (and several other audit types)

Compliance

- Mock audits
- CMS data validation and pre-assessments
- CPE audits
- Independent validation audits
- Fraud, waste, and abuse audits

Operations

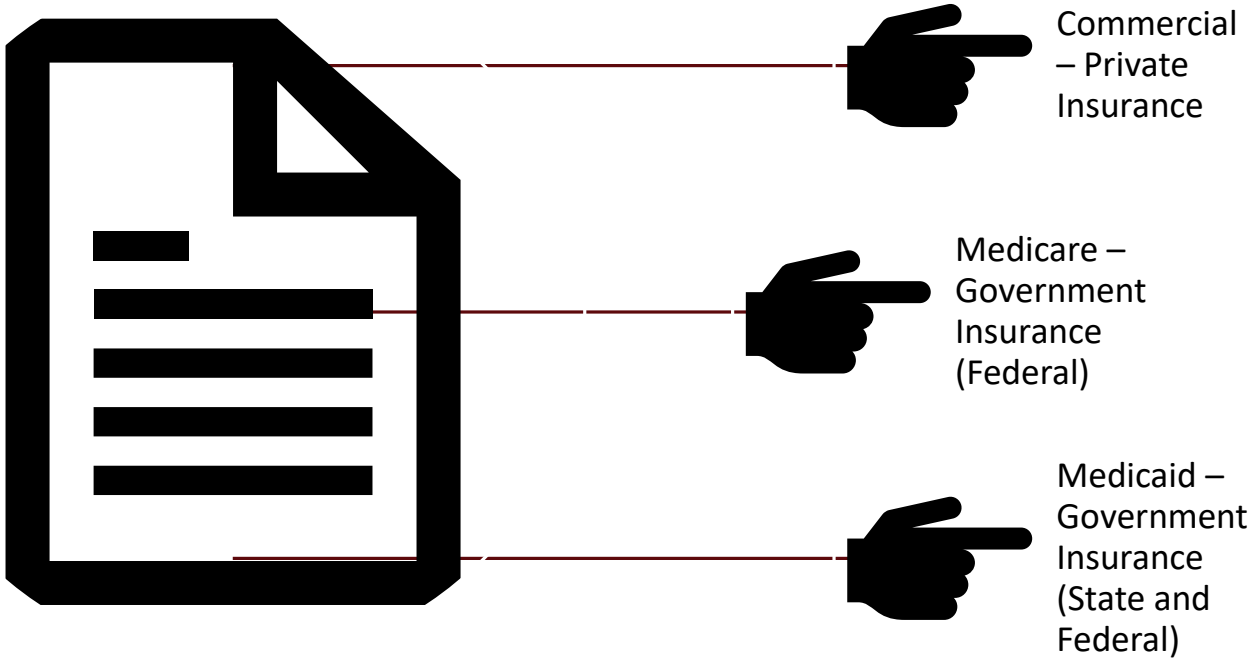
- Eligibility audits
- Utilization management audits
- Contract compliance reviews

Learning Objectives

- What is a benefit audit?
- Do I have a right to audit my benefits?
- What are the reasons I need to conduct a benefit audit?

Business Products

- Health Insurance Lines of Business



Benefit Plan Design Offerings

- Health Maintenance Organization (HMO) Plan
- Preferred Provider Organization (PPO) Plan
- Exclusive Provider Organization (EPO) Plan
- Consumer-Driven Health Plan (CDHP)
- High Deductible Health Plan (HDHP)
  - Includes integrated medical accumulators
- Medicare Advantage Prescription Drug (MAPD) Plan
- Medicare Prescription Drug Plan (PDP)
- Medicare Employer Group Waiver Plan (EGWP)

Typical Formulary Drug Coverage

- Open
  - All drugs are covered
- 2-Tier
  - Preferred generic drugs (lowest tier)
  - Generic and brand drugs
- 3-Tier
  - Preferred generic drugs
  - Generic drugs
  - Preferred brand drugs
- 4-Tier
  - Preferred generic drugs
  - Generic drugs
  - Preferred brand drugs
  - Non-preferred drugs
- 5-Tier
  - Preferred generic drugs
  - Generic drugs
  - Preferred brand drugs
  - Non-preferred drugs
  - Specialty drugs (highest tier)

Benefit Audit Overview

There are 4 major components reviewed in a benefit audit.

Your auditor should review 100% of claims.

Benefit Plan Design Implemented by PBM	Member Accumulators Tracked by PBM	Formulary Drugs Administered by PBM	Clinical Utilization Management Applied by PBM
• Copayments/Coinsurance • Benefit exclusions	• Deductibles • Coverage gaps • Maximum out-of-pocket/integrated medical accumulators • Catastrophic coverage	• Drug tiers • Drug exclusions	• Prior authorizations • Quantity limits • Step therapies

PBM Audit Rights

- PBM Contracts
  - Include rights to audit Rx claims (usually called a “claims audit”)
  - Allow retrospective look-back period within 1-2 years of current plan year
  - Clarify PBM obligations during audits
    - Delivery timelines (30 days to deliver all audit data is standard)
    - Response timelines (30 days to respond to all discrepant samples is standard)
    - Formal report response timelines (30 days to respond in writing is standard)
  - Allow for external audit vendors to conduct audits

Top Reasons to Conduct a Benefit Audit

Challenges

- Plan set up
- Plan changes

Compliance

- Local/State regulation
- Federal regulation

Contract

- Due diligence
- Efficacy

Benefit Audit Finding Examples

Typical findings

- 92% of benefit audits Aon conducted in the last 6 months identified collectable ($$$ impact) findings, resulting in member/plan over/underpayments (in some cases, up to millions of dollars of impact).

Benefit Audit Finding Examples

Top findings observed in Burchfield's benefit audits

- Incorrect copay/coinsurance applied on claim (occurs in approx. 80% of audits)

1. Failure to process claim with the correct formulary drug tier
2. Incorrect plan setup during implementation
3. Plan/coding changes that subsequently caused processing issues
4. Undocumented/missing plan benefit intent
5. Inappropriate processing of low income cost-sharing (LICS) levels.
6. Failure to apply dispensed as written (DAW) penalties
7. Coverage of excluded benefits/drugs
8. Application of incorrect prior authorization changed intended copay

Benefit Plan Error – Plan A

Benefit setup

- Plan A had coinsurance levels for members with a minimum copay for certain tier drugs.

Identified findings

- Prescription drug claims for these drug tiers did not process with the minimum copay requirements. Instead, only coinsurance levels were applied.
- The impact was some members did not pay their share of the coinsurance, i.e., the minimum copay when the total gross cost was less than the benefit minimum amount required.
- Plan A paid tens of thousands of dollars more for these claims than they should have.

Resolution

- PBM stated the root cause of this error was due to incorrect setup of this benefit at implementation.
- PBM corrected its system to reflect the stated minimum copay and ran a claims analysis to determine financial impact (member underpayment/plan overpayment).

Benefit Plan Error – Plan B

Benefit setup

- Plan B low income cost-sharing levels (LICS) for low income subsidy (LIS) members were set up to apply the applicable annual Centers for Medicare and Medicaid Services (CMS) thresholds and LICS copays for that benefit year.

Identified findings

- LICS prescription drug claims for LIS members processed with the incorrect LICS level copays.
- The impact was some LIS members did not pay the correct LICS level copays for that applicable benefit year.
- Members paid thousands of dollars more for these claims than they should have.

Resolution

- PBM stated the root cause of this error was due to incorrect system coding. Previous plan year's LICS level copays were set up instead of the subsequent year's LICS copay levels.
- PBM corrected its system to reflect the correct plan year LICS level copays and ran a claims analysis to determine financial impact (member overpayment/plan underpayment). Claims were reversed and reprocessed with updated prescription drug event records (PDEs) resubmitted to CMS.

Benefit Plan Error – Plan C

Benefit setup

- Plan C covered compound drug claims only if all ingredients within that compound were considered covered (no exclusions).

Identified findings

- All compound prescription drug claims that had at least one excluded ingredient was still processed and considered covered.
- The impact was some members received compound benefits beyond the plan's intent.
- Plan C paid millions of dollars for these claims that should have been excluded from coverage.

Resolution

- PBM stated the root cause of this error was due to incorrect setup of compound inclusion/exclusion lists.
- PBM corrected its system to reflect the correct inclusion/exclusion lists and ran a claims analysis to determine financial impact (member underpayment/plan overpayment).

Benefit Administration Best Practices

Checklist of items plans should routinely monitor

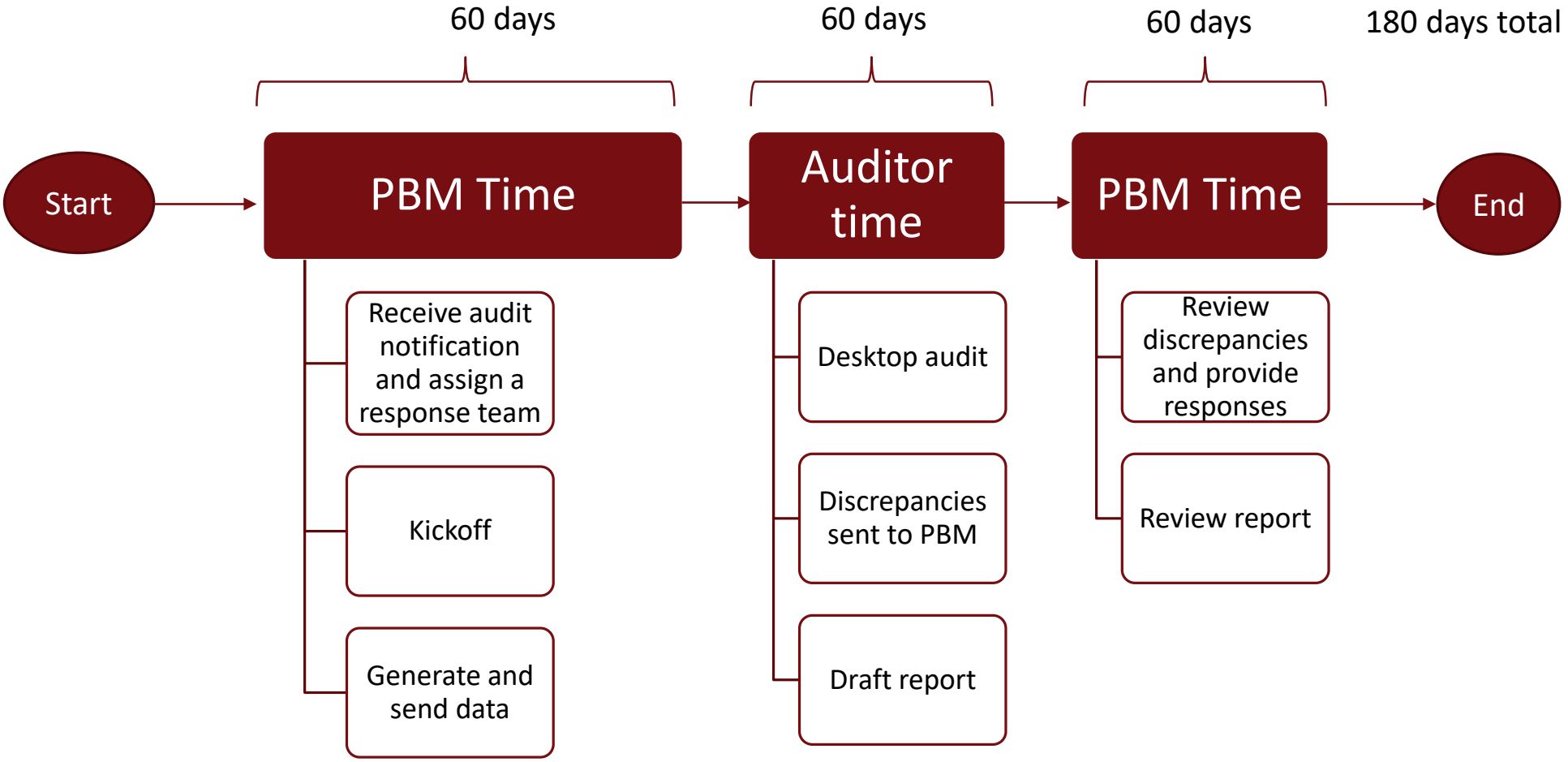
- Approvals for detailed benefit plan setup should be formally documented by and easily accessible to both plan and PBM.
- Customized benefits should be clearly communicated by plans and understood and documented by PBMs.
- Benefit errors identified by plans should be formally documented and shared with PBMs for their acknowledgement and corrective action (root cause, impact analysis).
- Benefit errors identified by PBMs should be formally documented (including corrective action) and shared with plans for their acknowledgement and tracking until they are completely resolved.
- All benefit documentation including corresponding formulary drug information should be archived and readily available to plans and external audit vendors for validation.

The Burchfield Group Best Practices

Audit Processes

- Assign a dedicated audit project owner to monitor audit progresses and provide routine status communications to clients.
- Conduct audits using sources of truth such as client signed/approved member benefit documentation, or explanation of coverage and summary plan designs.
- Present the audit report and results to clients detailing next and final steps to officially close out the audit.
- Track completion of findings to resolution via CAP process.

Benefit Audit Process – Typical Timeline



Open Questions & Our Contacts

Survey: PBM Benefit Audits – Understanding Health Plan Rights and Best Practices

Terri Poindexter

Vice President, Health Plan Consulting

651.895.9493

tpoindexter@burchfieldgroup.com

Kristin Gray

Vice President, Health Plan Consulting

612.618.2991

kgray@burchfieldgroup.com

Derek Frye

Practice Leader – Audit & Compliance

Lynn Stauffer

Audit Lead – Audit & Compliance

Website: www.burchfieldgroup.com