



STATE OF WISCONSIN
Department of Employee Trust Funds

Eric O. Stanchfield
SECRETARY

801 W Badger Road
PO Box 7931
Madison WI 53707-7931

1-877-533-5020 (toll free)
Fax (608) 267-4549
TTY (608) 267-0676
<http://etf.wi.gov>

CORRESPONDENCE MEMORANDUM

DATE: January 23, 2007
TO: Group Insurance Board
FROM: Arlene Larson, Manager
Self-Insured Health Plans
SUBJECT: Third Party Due Diligence Audit of Blue Cross & Blue Shield of Wisconsin

The Department of Employee Trust Funds (ETF) retained Claim Technologies Incorporated (CTI) to conduct a due diligence audit of Blue Cross & Blue Shield of Wisconsin's (BCBSWI) administration of the self-insured plans for the calendar years 2004 and 2005, including run-out¹ through April 30, 2006. CTI has completed its audit and has submitted the attached report. BCBSWI's response is also attached.

Staff has discussed the findings with the parties and offers comments on the results, below. Staff has shared pertinent information from the CTI report with WPS Health Insurance (WPS), the current administrator, and is discussing the remarks and recommendations with them to enhance its administration of the program.

The CTI report and BCBSWI letter is provided for the Board's information only. No action is required.

ETF requested the due diligence audit of CTI to verify that BCBSWI had administered the self-funded medical plans in accordance with the contract during its final two years, including the first four months of a 12 month period of run-out. This period of run-out was chosen as the Board's actuary stated that most run-out claims would be paid by April of 2006. The audit examined claims payment to identify procedural deficiencies, but offered no recommendations for BCBSWI process improvements as BCBSWI is longer the administrator. Instead, areas of concern are directed to WPS for consideration of future administration.

CTI audited 13 control risk categories. In six, CTI found that BCBSWI had handled the category appropriately. In the remainder, CTI found areas of concern that were not significant. BCBSWI has indicated that it agrees with some of CTI's findings, but questions others due to interpretation of the data and policy. Staff has worked with BCBSWI and WPS to assure that all identified issues are addressed. The major findings are as follows:

¹Run-out occurs when an administrator is paid to continue to process claims that were incurred prior to cancellation of a self-funded insurance product, but adjudicated after the cancellation date. BCBSWI coverage was cancelled January 1, 2006. BCBSWI was hired to run-out any claims incurred prior to January 1, 2006, during the calendar year of 2006. The run-out agreement ended December 31, 2006.

Reviewed and approved by Tom Korpady, Division of Insurance Services.

Signature

Date

Board	Mtg Date	Item #
GIB	2/13/2007	3

1. CTI found that BCBSWI's systems for controlling duplicate payments were performing well. However, CTI found overpayments worth \$7,257 on nine cases, and potentially two more cases worth \$1,256. BCBSWI responded that they agree that six of these cases were duplicates due to human error and they have been corrected. BCBSWI contests the other three cases, providing information that they were not duplicates. **Staff agrees with BCBSWI's assessment of the nine cases.**
2. CTI reviewed data to determine if claims had been paid during any lapses in our member's coverage. They identified ten potential cases. Two cases were selected for analysis. One case had \$35,784 paid and, upon investigation, it was found that there had not been a lapse in coverage. The second case found that \$319 had been paid during a lapse in coverage. **Staff will discuss eligibility and claim payment with WPS to avoid future payments during a lapse in coverage.**
3. CTI found overpayments of claims for 37 members after their termination date worth \$15,953. CTI's analysis reviewed the initial processing of any claim after the date of cancellation, without reviewing later adjustments. It should be noted that the State's current enrollment process from the employers, through ETF and to the health plans, does result in some retroactive additions and cancellations. Thus, CTI may have noted an overpayment in the audit for members who were retroactively cancelled and had claims paid, but these claims were later recouped appropriately. BCBSWI indicates that for nine of the 37 members, a cancellation notification was sent to BCBSWI from ETF after the date of claim payment, and timely retroactive adjustments to recoup the payment had been made. Further, for seven, BCBSWI explains that it handled the claims appropriately and no recoupment was necessary. However, BCBSWI agrees on the remaining 21 cases that human error was made. BCBSWI performed an additional review and it will reimburse the Trust Fund for \$6,924.76 for claims paid in error. **Staff will monitor recovery and is discussing this eligibility transmission finding with WPS to enhance future administration.**
4. CTI reviewed 124 claimants with over \$100,000 paid to determine if Large Claims Case Management had been appropriately applied. CTI expressed concern over one case worth \$104,898 for a brain tumor beginning in December 2005. In the case, CTI found that BCBSWI did not open a file upon receipt of claims. In addition, CTI found no evidence that BCBSWI shared claim information with WPS to allow them to manage the case. BCBSWI replied that the claims began to be received in January of 2006 and, per the cut-over agreement, it was instructed not to open files on cases after December 31, 2005. Further, BCBSWI states that it did send claim history amounts to WPS for this individual or any others. WPS did perform case management on this case in 2006. **Staff feels that this case was handed over appropriately by BCBSWI.**
5. CTI found, during analysis of policy exclusions, an issue where BCBSWI paid for eye refractions when accompanied by a claim with a medical diagnosis for non-SMP plans. The contract is silent on refractions except for under SMP, where they are allowable.

Typically, refractions are only provided in order to prescribe glasses. Coverage for glasses or contacts is excluded under the contract. It is uncommon that a refraction is required for the treatment of an illness or injury. BCBSWI responds that since our contract is silent on refractions, BCBSWI relied on its administrative policy, which allows payment for refractions when provided in conjunction with a visit for a medical, not routine, diagnosis. **Staff has**

found that each of the 6,598 refraction claims that were paid would have to be reviewed to better determine if the refraction was performed to check for a loss of visual field for a medical condition, or for a routine check. The average cost per refraction claim is approximately \$26.00. The administrative cost to review and recoup on a claim is much higher than \$26.00. It should be noted that under the current contract with WPS, any overpayment of \$50 or less would not be recovered due to a lack of cost effectiveness. Therefore, staff feels that any recovery effort for inappropriately paid refractions would not be cost effective and should not be pursued. Staff is discussing the refraction issue with the new administrator for future contract clarification.

6. CTI reviewed 26 cases that had more than \$30,000 paid where it determined that there was a potential for subrogation and third party recovery. CTI tested eight of these cases and found that BCBSWI handled seven of the eight appropriately. CTI expressed concern however about the handling of a claim incurred in December of 2005 which ultimately cost the program \$417,872. CTI was concerned that WPS was not notified in a timely fashion about this claim for possible subrogation. BCBSWI states that the first claims for a fractured ankle in that case arrived at BCBSWI in January 2006 when the cut-over agreement prohibited it from opening new subrogation cases. **Staff requested more information from BCBSWI and was subsequently notified that the injury happened in the home so there was no third-party liability or work-related injury. Claims data had been sent to WPS regarding the claim cost. Staff determined the claim was handled according to the terms of the cut-over agreement.**

7. CTI reviewed claims for treatment of diagnoses that may have been incurred as a result of work-related injuries. It identified 37 cases with greater than \$15,000 paid, and tested six identified cases. CTI found that BCBSWI had not investigated one of the six. BCBSWI responded that they did not investigate the sixth case due to the diagnosis of a ventral hernia. BCBSWI's medical policy lists this diagnosis as related to a surgical incision and not to a work-related injury. **Staff concurs with BCBSWI's determination.**