AUDITOR GENERAL'S REPORT

Management of the City's Employee Extended Health and Dental Benefits

Phase Two: Ineffective Controls and Plan Design Leaving the City Vulnerable to Potential Benefit Abuse

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TABLE OF CONTENTS

EXECUTIVE SUMMARY **1**

BACKGROUND **10**

The City's Employee Health Benefits 12

Role of the Benefits Administrator 14

How We Conducted this Audit 16

AUDIT RESULTS **17**

A. Limited System Capacity to Detect Provider Fraud **17**

A.1 Provider Fraud is Common 17

A.2 Benefits Administrator Did Not Track Provider Information on Almost All Health Claims 18

A.3 Limited Ability to Detect Suspect Providers 19

B. Administrator Controls Were Either Not Fully Applied or Insufficient **21**

B.1 Prepayment Claim Audit Was Not Applied to City Claims 22

B.2 Limited Post-Payment Controls 24

C. Overpayment and Potential Overutilization **27**

C.1 Orthotics and Orthopedic Shoes 27

C.2 Compression Stockings 33

C.3 Medical Braces 36

C.4 Physiotherapy 38

C.5 Other Professional Services and Private Duty Nursing 42

D. Closer Monitoring of Plan Administrator Required **46**

CONCLUSION **49**

AUDIT OBJECTIVES, SCOPE AND METHODOLOGY **51**

APPENDIX 1: Management's Response to the Auditor General's Audit of Management of the City's Employee Extended Health and Dental Benefits, Phase Two **53**

EXECUTIVE SUMMARY

Approximately 80,000 individuals are eligible for coverage

The City provides health benefits to its employees and retirees as well as to their spouses and eligible dependents. For the year 2015, 80,059 individuals were eligible for coverage.

In 2015 the City spent approximately $229 million to provide employee benefits including health, dental, long term disability and employee life insurance, of which approximately $56 million was for extended health care benefits (excluding drug benefits).

The City's benefits plan is self-insured

For the majority of extended health benefits, the City is self-insured under an Administrative Services Only (ASO) contract, which means the City bears the cost of its employee health claims in addition to fees paid to an external benefits administrator.

Extended health Care benefits are covered 100% by the City

Extended health care benefits are covered one hundred per cent by the City. Examples of main health benefit categories are:

- Orthotics and orthopedic shoes;
- Medical supplies and equipment;
- Professional services provided by chiropractors, massage therapists, psychologists, podiatrists, physiotherapists; and
- Vision and hearing.

Manulife was the City's benefits administrator for the years from 2000 to 2016. Our audit included a review of claim data from January 2013 to December 2015 during which Manulife was the City's benefits administrator. Green Shield Canada became the City's benefits administrator for health and dental benefits effective January 1, 2017.

Manulife was the City's benefits administrator and the foremost line of defense

Acting as an agent for the City, Manulife was responsible for claims adjudication, monitoring, issuing payments, fraud prevention and detection, and investigative services. It is the City's foremost line of defense in ensuring that benefit claims paid are accurate, in accordance with its benefit plans, and are for legitimate health reasons.

Manulife was not responsible for the City's plan design

Equally important is the City's own benefits plan design. The current benefits plans are a result of collective agreement negotiations with various employee groups. City staff overseeing the health benefits program need to ensure the plan design is cost effective while providing a reasonable level of health benefits for employees.

Our key audit findings pertain to both the administrator's functions and controls, and the City's plan design.

Certain TTC claimants and a supplier were found involved in a multi-million dollar fraud

As with any program of this size and complexity, numerous risks exist to the program including fraud, waste, and abuse of employee benefits. A recent example is the multi-million dollar fraud investigation at the Toronto Transit Commission (TTC) where employees provided health claims for reimbursement whereby no product or service, e.g. orthotics, compression hose and sleeves were obtained, or where receipt amounts were inflated. The value of the loss from this incident is estimated to be as high as $6 million. Manulife was the benefit administrator in that case.

During our on-site file review, we observed that Manulife's claims adjudicators generally obtained the required supporting documentation, and individual claims were appropriately declined for reasons such as missing documentation.

Our key audit findings, based on an analysis of claim data for the years 2013 to 2015 and a review of a selected sample of files, are summarized as follows:

Limited System Capacity to Detect Provider Fraud

Manulife is supposed to have sophisticated and powerful analytical tools to detect provider and individual fraud and abuse

One of the City requirements during the 2011 RFP process was for the administrator to maintain "*sophisticated tools to analyze and identify unusual claims trends indicating possible fraud or abuse*".

In Manulife's bid proposal, which forms part of the contractual agreement, it stated that it possessed powerful tools to analyse data and identify *"unusual trends and patterns, allowing for the detection of fraud and abuse at a provider or individual member level*".

Manulife also emphasized in its published brochure entitled "Fraud and Abuse Prevention" that it has sophisticated technology to review claim history of the service provider or supplier, and billing habits of the health provider.

Manulife did not track the provider information on City's claims

In actuality, for the vast majority of City's claims, Manulife did not systematically track any provider[1] information for the City's claims during the entire contractual period from 2012 to 2016. Consequently we were not able to carry out the basic analytical steps to systematically identify suspicious cases, exceptions or anomalies.

Among a small selected sample of claims we reviewed, we identified two medical supplies and equipment providers with suspicious activities. In accordance with our audit agreement with Manulife, we have referred these two providers to Manulife for investigation. Subsequently, Manulife then indicated that these two providers were already under investigation, but declined to provide us any details of the investigations.

[1] The term provider refers to those providing products or services to City claimants, including medical and health suppliers and health practitioners.

Key Administrator Controls Were Either Not Fully Applied or Insufficient

Standard adjudication process consists of a prepayment audit

We are not able to discuss Manulife's specific adjudication process for the City's claims because Manulife deemed the information proprietary. Based on its published materials, in general, Manulife's standard adjudication process consists of a prepayment audit and a post payment verification. We believe these should be applicable to processing the City's claims.

The standard process was not applied to City of Toronto claims

During our file review we learned that the standard prepayment process was not being applied to the City's claims. In our subsequent discussion with Manulife management, they stated that they acted on a direction from City staff in 2005 to forego this process for the City's supplier claims (e.g. providers supplying orthotics, orthopedic shoes or medical braces). City management, however, denied providing such a direction.

The financial impact could be significant

The impact of forgoing the standard and critical prepayment process on City's claims could be substantial. The City might have been exposed to significant risk of reimbursing inappropriate or fraudulent benefit claims, potentially costing millions over ten years from 2006 to 2016.

Audit findings limited due to lack of critical information

In our data analysis and file review, we identified a number of overpayments and unusual or excessive claims. Our audit findings were however limited because of the lack of provider and other critical information available to us, which hampered our ability to fully apply standard data analytical tools. As a result, our audit procedure was conducted by manually reviewing a limited sample, and there could be many more unidentified instances.

Overpayments Due to Adjudication Errors

Benefit claim reimbursement should only be made in accordance with the City's benefit plans. Based on a review of a selected sample of claims, we have confirmed with Manulife the following instances where reimbursements to claimants exceeded the plan limits or maximum occurrences:

- 7 claimants whose benefit plans did not provide for orthotic or orthopedic shoes coverage were reimbursed for such benefits, totalling $3,700 in overpayments;

- 20 claimants were reimbursed for more than one pair of orthotics, orthopedic shoes or cost of modifications in a year exceeding the plan limit; total approximately $9,000 in overpayments;

- 4 claimants were found to be reimbursed for eight pairs of compression stockings instead of four pairs (plan limit); total approximately $4,000 in overpayments;

- Errors in administering the City's benefit provisions for professional services such as massage or chiropractic treatments, resulting in $58,000 in overpayments.

Instances of Potential Overutilization of Benefits

Some of the following instances of potential overutilization are likely a result of the City's unlimited plan coverage for certain health benefits. The City's plan design is not part of Manulife's administrative functions. However, analysis of excessive claims and unusual claim patterns to detect potential fraud is part of an administrator's contractual responsibilities.

Dependents under 19 have unlimited coverage for orthotics and orthopedic shoes

Dependents aged 18 or younger have unlimited coverage for orthotic and orthopedic shoes under the City's benefit plans. In 2015, the costs for orthotic and orthopedic shoe claims from 1,547 dependents 18 or younger amounted to $1.3 million, averaging $840 per claimant. Specific instances noted include:

Instances of potential over-utilization in orthotic claims

- 41 dependents aged 18 or younger claimed between six and ten pairs of orthotics in a year; each received between $3,000 and $5,000 of benefit reimbursement in one year.

- 35 employees received $10,000 or more in orthotic benefits for their dependents over the three years, for instance:

    - One employee with three dependents was reimbursed $28,500 for close to 60 pairs of orthotics for the dependents; and

    - Another employee with two dependents was reimbursed approximately $20,000 for close to 40 pairs of orthotics over three years.

Compression stocking and medical brace claims

Compression stockings and medical braces are other areas that are vulnerable to benefit overutilization. The City paid approximately $3 million per year for compression stockings (up to four pairs per person per year), and $1.3 million for medical braces (unlimited coverage).

- In 2015, over 2,000 individuals were each reimbursed for $1,000 or more for compression stockings.

- 9 families (including the employees, their spouses and eligible dependents) with three of more members each made claims for compression stockings, receiving between $7,000 and $12,000 over the three-year period.

- 124 dependents aged 18 or younger were reimbursed for compression stockings.

- About 100 individuals were each reimbursed for $2,000 or more for braces in 2015.

- 9 families (consisting of two or more members) appeared to claim an unusually large number of braces over the three years and received reimbursement ranging from $13,000 to $38,000.

Physiotherapy is the most costly extended health benefit for the City, averaging $10 million per year

Physiotherapy is the City's most costly extended health benefit category averaging approximately $10 million in annual benefit cost. Most retirees under grandfathered benefit plans and three active employee groups[2], as well as their spouses and eligible dependents, are allowed unlimited coverage for physiotherapy. All other employee groups are usually limited to $2,000 per year.

To be eligible for reimbursement, a claimant only needs to submit an invoice from a licensed physiotherapist; a physician's prescription is not required.

When a benefit category has unlimited coverage, the risk of potential abuse increases. We noted some instances where the reimbursed costs to individual members appear high. For instance:

- 17 individuals each received $10,000 or more in physiotherapy reimbursement in at least a year between 2013 and 2015.

- Seven families (employees and their spouses and at least two eligible dependents) in which each member claimed physiotherapy benefits in at least a year. Each of these employees received more than $10,000 in reimbursement in at least a year, with two of them exceeding $20,000.

Paramedical services by chiropractors, registered massage therapists and osteopaths

The annual benefit cost for other professional services and private duty nursing was approximately $12 million. Examples of unusual instances are:

- A family of six received massage therapy on the same day on six different occasions within ten weeks, receiving about $3,000 in reimbursement. On each date the family claimed a total of 5.5 hours of massages, each signed off by the same massage therapist.

- 13 individuals claimed three or more different types of services (e.g. massage, physiotherapy, chiropractic and/or osteopathy) on the same day on five or more occasions in a year.

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[2] Firefighters Association, Toronto Community Housing Corporation Access Housing ($2,000 limit effective August 1, 2016), and employees who were on LTD benefits as of April 4, 2012.

We recognize that there may be legitimate reasons for the above instances. Nonetheless, in our view, they are unusual cases that should have been identified and examined further.

Opportunities to Improve Oversight and Benefit Plan Design

Although the administrator manages the adjudication process, PPEB retains overall responsibility

While the primary responsibility to adjudicate and monitor claims lies with the administrator, the City's Pension, Payroll and Employee Benefits Division (PPEB) still retains ultimate responsibility for oversight of the employee benefits program. Over the course of the audit, we observed that in several areas PPEB staff did not have a clear understanding of how Manulife interpreted or executed the City's plan requirements.

In addition, benefit plan design should enable the City to provide intended benefits to its employees, without exposing itself to unreasonable or excessive costs. In some cases the lack of any specification leaves the plan at the mercy of the market. We recommend the City consider the following plan design changes:

Setting reasonable quantity and price limits in benefit plan to help reduce unnecessary cost and risk of abuse

- Establish a reasonable annual quantity or dollar limit for orthotic and orthopedic shoes coverage for dependents 18 years old or younger;
- Establish a reasonable annual quantity limit for medical brace;
- Reassess the provision of unlimited physiotherapy coverage for certain employee groups; and
- Where the benefits administrator has no Reasonable and Customary charges, establish a reasonable contractual limit or unit cost for all extended health coverage including orthotics, orthopedic shoes, compression stockings, and medical braces.

Conclusion

This report contains 16 recommendations to help improve controls and administration of the City’s extended health benefits program.

City needs to ensure adequate controls and monitoring of benefit claims

Overall, we found the controls and monitoring of the City's benefit claims ineffective in identifying unusual patterns or potential frauds. Potential benefit abuse or fraud might not have been detected due to the lack of critical claim information and the administrator forgoing a standard audit process for the City's claims.

City management, who retains overall responsibility for the program, should further strengthen their oversight by establishing clear understanding of the benefit administrator's actual adjudication practices, as well as performing more effective claim data analysis and implementing periodic third-party audits.

To reduce annual benefit cost and the risk of benefit abuse, we recommend several changes to the City's benefit plan design. As well, the City should establish reasonable quantity and price limits for items such as compression stockings and medical braces.

The City has recently contracted a new benefits administrator and this presents an opportunity to strengthen its benefits program and reduce its risk exposure moving forward.

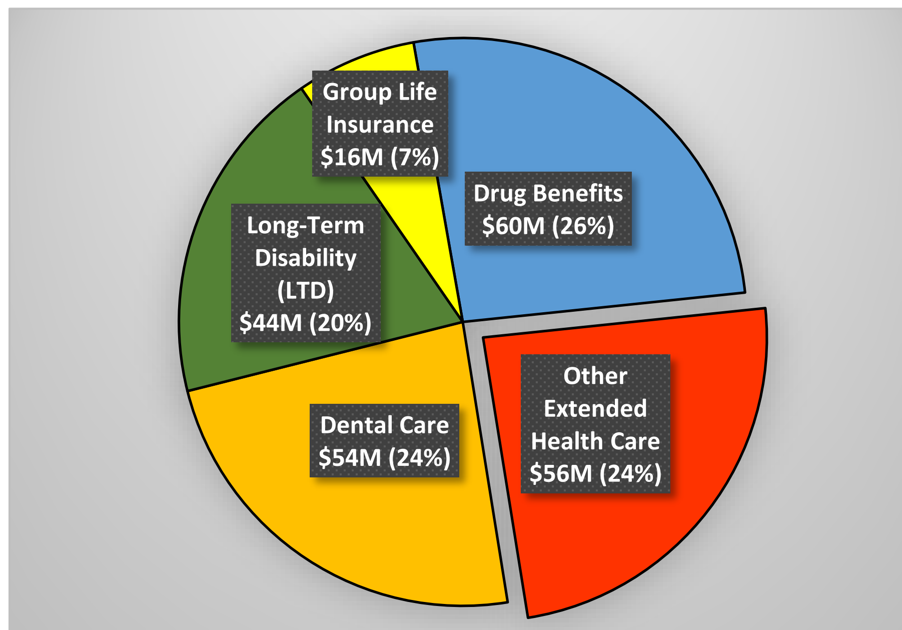
We express our appreciation for the co-operation and assistance we received from management and staff of Manulife, and the City's Pension, Payroll and Employee Benefits Division.

BACKGROUND

Employee benefits cost $229 million in 2015

In 2015 the City spent approximately $229 million to provide employee benefits including health, dental, group life insurance and Long-Term Disability (LTD) benefits coverage. Figure 1 shows the spending breakdown of these benefits. Over the past 10 years, there has been an increase of 68 per cent in the cost of extended health care benefits (excluding drug benefits), from $33 million in 2006 to $56 million in 2015.

Figure 1: Breakdown of 2015 employee benefit costs



Source: Pension, Payroll and Employee Benefits Division

The City pays for the benefits itself

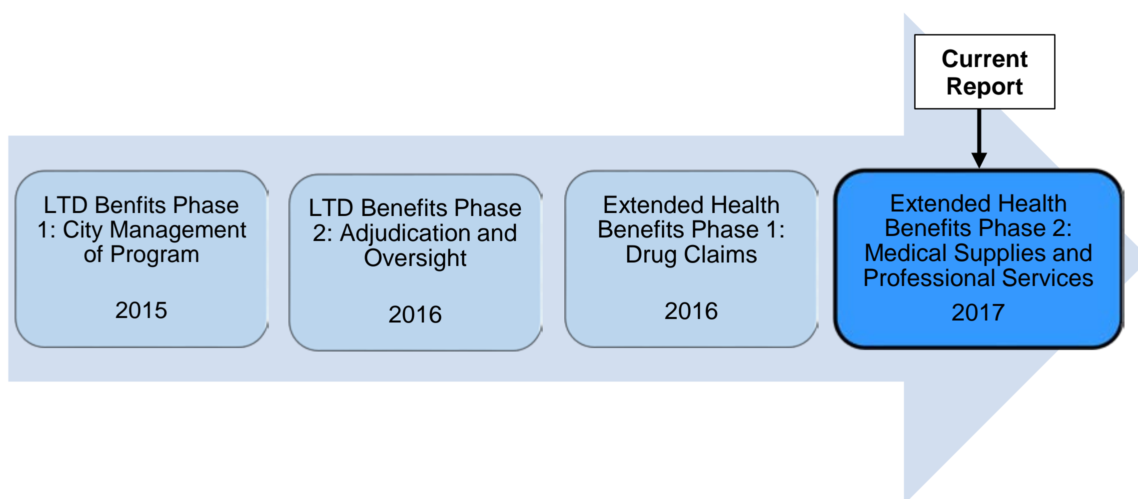
For the majority of extended health benefits, the City provides the benefits through an Administrative Service Only (ASO) contract. The only exceptions are out-of-country and private duty nursing which are insured on a premium basis.

Under an ASO contract, the City is self-insured, which means it bears the cost of its claims in addition to fees paid to the external benefits administrator. The reimbursement to claimants is made out of a City's funding float.

Audit is part of a broader plan to improve benefits administration

Given the significant expenses involved, it is imperative to the City that its benefit programs are managed cost effectively and in a manner most suited to accomplish its intended objectives. The current audit report addresses extended health care benefits, and is the latest component in the AGO's multi-year plan to assist the City in achieving value for money in its overall benefits program (Figure 2).

Figure 2: Progression of Auditor General's audits on employee health benefits, 2015 to 2017



Audit was divided into two phases

Phase One of the extended health benefits audit focused on Drug Benefits, and an audit report was issued in October 2016: http://www.toronto.ca/legdocs/mmis/2016/au/bgrd/backgroundfile-97612.pdf

Phase Two of this audit, the subject of this report, focused on extended health care benefits such as orthotics, compression stockings, physiotherapy, massages, and chiropractic treatments.

A Phase Three audit on dental benefits was originally planned for 2017. Given the expiry of the City’s contract with Manulife by the end of 2016, it will not be practical to commence Phase Three when Manulife is no longer obligated to assist the audit. As such Phase Three will not proceed as planned.

The City's Employee Health Benefits

The City provides extended health benefits to its employees, spouses and eligible dependents, and retirees

The City provides coverage to its employees and retirees, as well as to their spouses and eligible dependents in accordance with City policies and collective agreements. Part-time employees may opt-in to the program by paying the full premium or a pro-rated portion of the premium based on hours worked.

For the year 2015, 80,059 individuals were eligible for the City health benefits plans. Table 1 shows the breakdown of these individuals:

Approximately 80,000 individuals are eligible for coverage

Table 1: Number of Individuals Covered under the City Benefits Plans for Year 2015

	Number of Individuals	Percentage of Total
Employees	25,506	32%
Spouses	23,986	30%
Dependents	21,442	27%
Subtotal – individuals under active employee health plans	70,934	89%
Retirees	9,125	11%
Total number of eligible individuals	80,059	100%

Source: AGO calculated based on information provided by PPEB

Different waiting periods and coverage for employees

Non-union permanent employees, firefighters, and elected officials are entitled to employee health benefits on the first day of employment. Employees under different unions have various waiting periods before they are entitled for coverage.

Retirees are covered up to the age of 65, with the exception of those with grand-parented post-65 retiree benefits from their former municipalities.

Cost and Types of Benefits

Extended health care benefits are covered one hundred per cent by the City, subject to various per-instance and cumulative limits specified in the benefit plans. In 2015 the cost of these claims totalled $56 million, including approximately $6 million of taxes and administrative fees paid to Manulife. Extended health care benefits include the following:

Table 2: Extended Health Care Benefit Claims by Category

Benefit Category	Total Reimbursed in 2015 ($M)	% of Total Benefits	Fee Structure
Medical Supplies and Equipment			
Orthotics and Orthopedic Shoes	6.8	13.7%	ASO
Stockings	3.3	6.6%	ASO
Braces	1.3	2.6%	ASO
Other Medical Supplies and Equipment	2.5	5.0%	ASO
Professional Services			
Physiotherapist	$10.9	21.9%	ASO
Masseur	6.4	12.9%	ASO
Chiropractor	2.9	5.9%	ASO
Private Duty Nursing	0.4	0.8%	Premium
Other Professional Services	2.6	5.2%	ASO
Vision	7.9	15.8%	ASO
Hospital	2.9	5.9%	ASO
Emergency Out-of-Country	1.8	3.6%	Premium
Total Benefits	**$49.7**	**100.0%**	
Administrative Fees and Taxes	5.8		
Total	**$55.5**		

Source: AGO calculated from 2015 claims data

Inherent Risks of the Benefits Program

Health benefits are a vital component of compensation package

Extended health benefits are a vital component in the City's overall compensation package as it assists the City in attracting talent and maintaining a healthy and productive workforce. However, the provision of these benefits must be closely monitored given the risks of excessive utilization and benefits abuse.

As with any program of this size and complexity, numerous inherent risks exist to threaten the integrity and financial viability of the program. We highlight some of the major risk factors below:

Risk of claimants in collusion with providers

- Orthotics claims have seen continuous growth across the health insurance industry, and is a challenge not unique to the City. The Toronto Transit Commission (TTC) is currently investigating a fraud whereby employees submitted claims to Manulife for reimbursement but no product or service, e.g. orthotics, compression hose and sleeves were obtained, or where receipt amounts were inflated. The value of the loss is estimated to be as high as $6 million just from this one provider. As of February 2017, 73 employees have been dismissed and the investigation is still ongoing.

Significant increase in massage therapy benefit cost across the industry

- The use of professional services has proven to be a popular benefit, costing the City $23 million in 2015. Based on our review of literature, this area has also seen a dramatic increase across the industry, with massage therapy showing the sharpest growth.

City has complex benefit provisions

- The City's current benefit provisions are the result of decades of collective negotiations efforts with its various labour groups, with some inherited and grandfathered from pre-amalgamation jurisdictions. As a result, provisions are complex and can vary widely for the same type of benefit between different employee groups.

Given all the risks involved and the significant costs incurred every year, the role of the benefits administrator becomes vital in protecting the City's best interests.

Role of the Benefits Administrator

The benefits administrator is the City's main line of defense

The Pension, Payroll and Employee Benefits Division (PPEB) is responsible for oversight of the employee benefits program including extended health care. The responsibility for claims adjudication, monitoring, issuance of claim payments, prevention and detection of fraud or abuse, as well as investigative services lies with the benefits administrator and not PPEB.

The administrator is the City's main line of defense in ensuring that claims reimbursed are reasonable, accurate, and in accordance with the administration contract and the City's Collective Agreements.

Manulife was the City's benefits administrator

Manulife, acting as an agent for the City, was the City's benefits administrator for the years 2000 to 2016. Its last contract with the City covered the five-year period 2012 to 2016, with the City paying an administrative fee of 1.65 per cent of total claims paid.

Starting in 2017 Green Shield became the City's current benefits administrator for health and dental benefits covering a five-year period 2017 to 2021. At the time of our audit, the contract with Green Shield was still being finalized.

Our description of the adjudication processes is based on discussions and fieldwork conducted with Manulife, which was the benefits administrator for the period reviewed (2013-2015).

Submitting a Claim

Majority of claims are submitted on paper

Manulife introduced eClaims in March 2014, which allows health care providers to submit claims directly to Manulife on the member's behalf. However, it is still relatively new and for the period reviewed the vast majority (over 95 per cent) of claims were submitted on paper by the City's plan members.

Claimants are required to provide documentation indicating the date, amount, provider, and item or service claimed in all instances. Additional requirements such as physician's referral or medical diagnosis vary by the type of benefit and employee group.

Reasonable and Customary Charges

Reasonable and Customary charges protect the City from inflated prices

Health insurance carriers including Manulife commonly establish Reasonable and Customary charges for certain benefit types, for example, a predetermined amount for a pair of orthotics. A fee is considered to be Reasonable and Customary if it is within the usual range of charges for the same services performed by other providers practising in the same geographic area. Individual claims will not be reimbursed beyond the Reasonable and Customary charge, even where the benefit is stated to be 100 per cent covered.

Reasonable and Customary charges are an important control to protect the City from excessive cost on a single item or service. The City may also direct the benefits administrator to apply its own per-occurrence or unit limits for specific benefit types.

How We Conducted this Audit

A detailed description of our audit scope and methodology is provided in the last section of this report.

Our primary audit work consisted of a detailed analysis of extended health claims and an on-site review of selected claim records in the presence of Manulife staff. No personally identifiable information was obtained by the Auditor General's Office during the audit, either in the data analysis or follow up inquiries to Manulife.

Audit scope limitation

As discussed in Section A.3, due to the lack of provider information available, we were not able to carry out basic analytical steps to systematically identify exceptions or anomalies, nor could we perform further steps to extrapolate other relevant exceptions from Manulife's data. Consequently, we could only identify exceptions through a manual review of a small number of claims, and hence cannot determine the total volume or amount of potential losses.

Our sample was not selected by random and therefore the related results are not representative of the population of claims.

AUDIT RESULTS

Based on our review of a small selected sample of claims, we found that the administrator's files generally contain the required documents such as physician's notes and invoices.

Our review focused on five major types of claims: orthotics and orthopedic shoes, compression stockings, medical braces, professional services, and eye glasses. Among them, we did not find any significant issues from our review of eye glasses.

For the remaining four types examined, we noted overpayments exceeding benefit plan limits, signs of red flags for overutilization or potential abuse, and gaps in the plan design that will expose the City to unnecessary financial risk. We also noted significant issues in overall controls and ability to detect potential abuse or fraud.

This section of the report contains the findings from our audit work followed by specific recommendations.

A. Limited System Capacity to Detect Provider Fraud

A.1 Provider Fraud is Common

Research shows that 2 to 10% of healthcare dollars are lost to fraud

According to research, provider fraud is common and can result in significant costs to an organization by just a few individual providers engaging in the act of fraud.

It is estimated that two to ten per cent of all healthcare dollars are lost to fraud[3]. There are three basic types of benefits fraud: provider fraud, plan member fraud, and provider and plan member collusion[4].

Provider and plan member frauds happen when either party intentionally submits false or misleading information for their own personal gain. Collusion happens when both the provider and plan member work together to intentionally submit false or misleading information for mutual gain.

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[3] Canadian Life and Health Insurance Association, https://www.clhia.ca/antifraud
[4] "Benefits Fraud: Shrink the Risk/Gain Group Plan Sustainability", Sun Life Financial

Among the various fraud schemes, provider fraud is the more prevalent type[5], such as billing for services not rendered, treating outside one's scope of practice, and billing through someone else's licence number. The above referenced recent benefit fraud investigation involving TTC employees and a medical supplies and equipment provider is one example of provider and plan member collusion fraud.

Even when frauds are perpetrated by only a small number of providers and claimants, they can result in significant expense increases to an organization. As a result, having the effective techniques and tools to deter and detect all types of frauds is crucial to any benefits plan.

A.2 Benefits Administrator Did Not Track Provider Information on Almost All Health Claims

In order to be able to identify potential fraud involving providers, a benefits administrator needs to, at a minimum, keep track of basic provider information on all claims processed in its system such as supplier and practitioner names, therapist registration number, and location of practice in order to perform basic analysis.

Manulife did not systematically track provider information for the City's claims

Our review of Manulife's claim processes and claims data, however, found that provider information was not systematically tracked for the vast majority of the City's claims processed during the entire contractual period from 2012 to 2016. Where needed, adjudicators or investigators manually refer to individual files to retrieve image scans or hard copies of documentation to obtain the information.

The City's 2010 RFP for the employee benefit plans administrator had specific requirements for the plan administrator to fulfill, including requirements to:

[5] "It's More Common than you Think", Tech Issue 2015, Benefits Canada

- "*…have the ability to detect service providers who may be over-prescribing …treatments to insureds*"; and

- *maintain* "*sophisticated tools to analyze and identify unusual claims trends indicating possible fraud or abuse*".

Manulife is supposed to have sophisticated and powerful analytical tool to detect provider and individual fraud and abuse

In Manulife's bid proposal to the City for the 2012-2016 contract (which forms part of the contractual agreement), it stated it complied with the RFP requirements and that it possessed:

"*Sophisticated technology to monitor both individual and provider history. [It uses] powerful risk based scoring algorithms to analyze the data and identify unusual trends and patterns, allowing for the detection of fraud and abuse at a provider or individual member level*".

Furthermore, it also stated that its analytical tools can identify *"provider and plan member fraud and abuse that exist or are emerging*".

In response to our audit findings for the lack of provider information, Manulife indicated that it "*did not commit to a full provider registry as it was not a specific requirement of the RFP*."

A.3 Limited Ability to Detect Suspect Providers

In our view, the lack of systematic provider information on all City's claims processed prevented the benefit administrator from performing basic analysis on a provider basis to detect unusual trends or patterns.

Exceptions identified are based on a small sample

The lack of provider information also hampered our ability to analyse claims by providers. Instead, we had to resort to manually retrieving and reviewing a small sample of claim files with assistance from Manulife staff. Consequently, we believe there will be more exceptions that have not been identified in the audit.

Based on our review of a small selected sample of claims, we identified two medical supplies and equipment providers with suspicious activities.

In light of our level of concern, these two providers have been referred to Manulife for investigation in accordance with our audit agreement with Manulife.

After we have referred the cases to Manulife, it then indicated that these two providers were already under investigation, but declined to provide us any details of their investigations.

Two suppliers have been referred for investigation

Due to the lack of provider information available, we were not able to quantify how many other claims were from these two suspicious providers or the amount of at risk dollars for the City.

The lack of information also limited our analysis to identify other similarly suspect providers. Our request for Manulife to input provider information for all City claims processed from 2013 to 2015 was denied by Manulife management.

Recommendations:

1. **City Council request the Treasurer to make a request to Manulife to input the provider information including the name of provider, location, and therapist registration number, for all City's health claims processed and reimbursed in the period 2013 to 2015 to enable proper analysis to be performed to confirm validity of claims.**

2. **City Council request the Treasurer to ensure the plan administrator has adequate tools, controls and adjudication processes in place to identify unusual trends and patterns, and to detect and prevent fraud and abuse at both the provider and individual plan member level. This should include establishing predetermined criteria with the plan administrator for identification of unusual trends and patterns, and requesting periodic reports back from the plan administrator on actions taken.**

B. Administrator Controls Were Either Not Fully Applied or Insufficient

Manulife's standard adjudication process

We are not able to discuss Manulife's specific adjudication process for the City's claims because Manulife deemed the information proprietary.

The following is a general description of Manulife's adjudication process based on its published materials[6,7]. One would expect the same or similar processes should be applied to the City's claims:

Manulife has a standard "prepayment audit"

- Manulife operates a fraud prevention program that protects plan sponsors (i.e. employers) by performing "*prepayment audits and post payment investigations."*
- Manulife uses "*prepayment claim audits*" when "*claims may be questionable"* and "*audit letters – asking clients to confirm what services they have received – are routinely issued where providers show unusual billing patterns.*"
- These prepayment claim audits mean "*questionable claims are not paid and the plan is protected from incurring the expense.*"
- Manulife describes its prepayment claim audits as "*significant resources to detect and respond to claims abuse patterns.*"

Prepayment audit is a critical means to flag suspicious providers

Given that Manulife has no systematic provider information on the vast majority of City's claims processed (discussed in the previous section), it had no means to systematically flag claims associated with suspicious providers. Its standard prepayment audit process is therefore particularly critical to the adjudication of City's claims.

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[6] "Employee Benefit News", Vol. 7 Issue 3, Manulife Financial

[7] "Group Benefits Fraud and Abuse Prevention", Manulife Financial, http://manulifebank.ca/wps/wcm/connect/76dc2e3b-749f-464f-ac81-e1de86f91192/preventinge.pdf?MOD=AJPERES&CACHEID=76dc2e3b-749f-464f-ac81-e1de86f91192

B.1 Prepayment Claim Audit Was Not Applied to City Claims

During our on-site file review, Manulife staff members involved in claim adjudication and investigation confirmed that the prepayment claim audit was not being applied to City claims. This means that claims originating from suspicious practitioners or suppliers were not subject to additional verification prior to issuing payments to claimants.

In our subsequent discussions with Manulife management staff, they confirmed that the prepayment audit process was not being applied for medical supplies claims (orthotics, braces, etc.). However, they indicated that the process for practitioner claims (massages, physiotherapy, etc.) remained in place. No evidence has been provided to date to support this statement.

According to Manulife, City staff in 2005 instructed it to stop applying the prepayment audit to City claims

We were advised by Manulife that the prepayment audit was originally in place, and that it acted on a direction provided by the City in 2005 to forego this process.

Management denied providing this direction

However, the City's PPEB management disputed Manulife's assertion. Table 3 provides a summary of the conflicting information from Manulife and City staff:

Table 3: A summary of conflicting information from Manulife and City staff regarding discontinuation of the standard prepayment audit process for City's claims

	What we learned from our on-site file review from Manulife's staff	Manulife management's response to audit query	City management's response to audit query
Did Manulife apply the prepayment process to City's claims?	Did not apply to any City claims.	Applied to claims from practitioners (e.g. massages) but not from suppliers (e.g. orthotics).	With the exception of firefighters' orthotic claims, not aware that it was not applied until being informed by the Auditor General's staff.
Why or why not?	A direction from City staff in 2006 to forgo the process for firefighters' orthotic claims, and subsequent verbal direction from the City staff to expand to all other City claims.	A direction from City staff in 2005 to forgo the process for medical supplies claims (including orthotics as well as other supplies).	City staff only directed Manulife to change the process for firefighters' orthotic claims. No other direction was given to Manulife for other claims.
What did the documents provided to audit staff show?	A 2006 email from City staff requesting Manulife to forgo prepayment process for firefighters' orthotic claims. No other evidence to support that City asked to expand this to other claims beyond firefighters' orthotic claims.	A 2005 internal Manulife email and subsequent emails with City staff, none of which support a City direction to forgo the process to all claims.	Provided correspondence relating to implementation of the new firefighters' process. No record of other written direction was provided to the audit.

No evidence to support City staff provided such a direction

Based on our review, we are of the opinion that no credible evidence was provided by Manulife that substantiates a City direction to discontinue the prepayment process for all claims. Furthermore, given that this is such a key control, in our view, one would expect that Manulife would confirm such an important direction in writing with City staff when commencing a new five-year (2012-2016) ASO contract with the City. Manulife indicated that the practice was a continuation from the prior contract, hence no confirmation was needed.

Prepayment audit of the City's hospital and dental claims resulted in high decline rates and cost savings

Although Manulife ceased applying its standard prepayment audit process to the City's extended health claims, it continued to apply the audit process to the City's dental and hospital benefits, and provided quarterly prepayment savings reports to PPEB.

According to the prepayment savings reports, Manulife performed 709 hospital claim prepayment audits in 2015, resulting in 341 declined claims (48 per cent denial rate) for a total savings of $537,168. In the same year, 460 dental claim prepayment audits were performed resulting in 279 declines (60 per cent denial rate), for a total savings of $109,485.

Other than the hospital and dental claims, City PPEB staff advised that they have never received any prepayment savings reports from Manulife on other extended health claims.

Inappropriate or fraudulent provider claims might not have been identified, potentially costing the City millions in benefit payments since 2006

The City's claims for practitioner services and medical supplies for three years from 2013 to 2015 totalled $125 million. Based on the high decline rates for the hospital and dental claims that were subject to prepayment audits, it is reasonable to say that had Manulife applied its standard prepayment audit to the City's extended health claims, a considerable number of claims from suspicious providers might have been declined.

By not applying the standard and critical prepayment process to the City's health claims, the City might be exposed to significant risk of reimbursing inappropriate or fraudulent health claims for the 10-year period from 2006 to 2016, potentially resulting in millions of unnecessary benefit costs.

B.2 Limited Post-Payment Controls

Post-payment reviews performed based on risk factors

Other than the prepayment audit process described, Manulife selects on a regular basis a number of claimants across its client base (including non-City claimants) for post-payment verification review. Claimants are selected based on a proprietary set of risk factors.

Only a Small Number of City's Claimants Were Flagged for Verification

Post-payment review did identify few incidences of fraud over the years

This post-payment verification process did over the years identify a few false claims. For example, through the process Manulife identified, investigated, and reported that a City employee submitted falsified receipts for health benefits in 2016.

Only a small number of City's claimants were selected for post payment review

However, since selection for the post-payment verification process was spread across all of Manulife's clients, the proportion of City's claimants reviewed was low. For the three-year period 2013 to 2015, Manulife processed approximately 1.2 million health claims submitted by about 70,000 City plan members. During this same period, Manulife selected 309, or less than 0.5 per cent of all City's claimants for a post payment verification review. Sixty (60) per cent of these reviews focused on physiotherapy claims.

Of the 309 claimants reviewed, Manulife declined claims from two claimants and referred three to the police for submitting false claims. For the remainder of the claimants reviewed, their claims were validated through contacting the providers, or flagged for future monitoring.

Provider fraud is not likely be detected from the existing verification process

Aside from the issue described above, the process of contacting the provider to validate claims could be effective in identifying cases where the claimant was at fault, but would not detect provider fraud or collusion between providers and plan members. In Manulife's published brochure, it recognizes that one of the most common type of fraud being "*exaggerated and fake claims submitted by service providers*[8]".

In order to detect such cases, provider information over a larger number of claims would be required, such as through an analysis of provider patterns, comparisons or outliers.

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[8] "Group Benefits Fraud and Abuse Prevention", Manulife Financial, accessed March 2017. https://www.manulife.ca/wps/wcm/connect/76dc2e3b-749f-464f-ac81-e1de86f91192/preventinge.pdf?MOD=AJPERES&CACHEID=76dc2e3b-749f-464f-ac81-e1de86f91192

Very few fraud cases were reported

For the years 2013, 2014, and 2015, the number of fraud reported by Manulife to the City was seven, zero, and one respectively.

Ineffective orthotic questionnaire process

Questionnaire introduced on a post-payment basis, different from City direction

During the audit we learned that a verification questionnaire for City's orthotics claim was introduced to replace the prepayment audit process for orthotics. Manulife would send a questionnaire to selected employees after reimbursing the claim to ask for additional information.

Manulife advised that this process was applied City-wide on a post-payment basis. However, PPEB management stated that the orthotic questionnaire was expected to be applied prior to reimbursing the claim, with the exception of the firefighters' employee group.

No consequences for plan members ignoring the questionnaire

However, Manulife advised that the questionnaire was not being enforced. In other words, claimants who responded with insufficient information, were late in replying, or ignored the request altogether would have no consequence. Steps such as clawing back the reimbursement or suspension of future claims were not applied to employees who did not fully respond to the questionnaire. According to Manulife staff, the questionnaire response rate has been very low. Factoring in all of the above, the orthotic questionnaire is not an effective control to detect inappropriate claims.

According to Manulife, City staff directed Manulife not to undertake any further follow-up action on the questionnaires sent. Management indicated that this was correct for only one specific employee group.

Recommendation:

3. **City Council request the Treasurer to ensure all key changes to the City's health benefits plan administration are clearly communicated and documented by City staff, and retained in accordance with the City record retention policy. When a major change to the benefit plan is made, the Treasurer should ensure the change is implemented by the benefits administrator according to the City's direction.**

C. Overpayment and Potential Overutilization

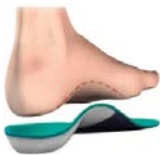
Manulife's claims adjudication was generally in accordance with benefit provisions

During our file review we observed that Manulife's claims adjudication was generally in accordance with the City's benefit provisions:

- Required supporting documentation was obtained (invoices, physician's referral etc.);
- Adjudicators were appropriately declining claims based on individual issues observed (e.g. lack of documentation submitted); and
- Age limits were applied appropriately.

However, we have identified instances of overpayment and potential overutilization, highlighted in the following sections below. All of the overpayments identified have been verified and acknowledged by Manulife.

C.1 Orthotics and Orthopedic Shoes



Orthotics refers to corrective devices worn inside a shoe. Orthopedic shoes are shoes specifically designed, such as extra depth or extra wide widths, to provide support and relief to the foot.

Most members can claim up to one pair per year

As shown in Table 4 the City benefit plans cover the cost of one pair of orthotics per year for most employee groups.

For orthopedic shoes coverage, certain employee groups have the coverage for purchasing a pair of orthopedic shoes and modification cost to regular footwear or orthopedic shoes. For other employee groups, their coverages are limited to modification cost only. See Table 5 for plan limit details. Dependents at the age of 18 and under have unlimited coverage for orthotics and orthopedic shoes for all active benefit plans and the majority of retiree plans.

Table 4: Coverage and document requirements for orthotics claims for major employee groups

	Non-union staff	Local 416	Local 79
Plan Limit	One pair per year		
Plan Limit for dependents 18 & under	Unlimited		
Reasonable & Customary Charge	$500 (Most active union employee groups exempt)		
Requirement	Referral by a Physician, Podiatrist, or Chiropodist and a diagnosis by way of biomechanical examination is required to establish medical necessity.		

Table 5: Coverage and document requirements for orthopedic shoes claims for major employee groups

	Non-union staff	Local 416	Local 79*	Firefighters
Plan Limit	Either modification** to and/or purchase of one pair per two years			One pair per year
Modification cost vs. Cost of shoes**	Modification only	Purchase and modification	Modification only	Purchase and modification
Plan Limit for dependents 18 & under	Unlimited			
Reasonable & Customary charge	$250 for the cost of orthopedic shoes. No R&C for modification costs.			
Requirement	Referral from a Physician and a diagnosis by way of biomechanical examination is required to establish medical necessity.			

* One pair per year, with purchases of orthopedic shoes allowed, for a small number of employees on LTD benefits

** Cost to modify off-the-shelf orthopedic shoes or regular footwear

Source: Manulife Plan Documents and City Collective Agreements

Physician referral only needed once per lifetime

To claim for orthotic and orthopedic shoes, a plan member is required to submit to Manulife:

- a referral from a physician, a podiatrist, or a chiropodist,
- an invoice from the supplier, and
- results of a biomechanical assessment and gait analysis.

Per Manulife, the physician or specialist referral was needed only once for life time. However, when we discussed this with PPEB management, they were unaware of this and indicated that they expected such referral would be required once per year.

Overpayments due to adjudication errors

Our ability to efficiently review the claim data was limited by the lack of basic information

Since the City's benefit limits are based on quantity (i.e. number of pairs), we expected that this information will be systematically tracked in a benefits administrator's system. The data we received did not have the quantity information that would allow us to efficiently confirm compliance with benefit limits or identify exceptions.

To carry out our audit procedure, we had to manually review individual files and scanned invoices to count and calculate the number of pairs reimbursed based on the purchase costs on invoices. Consequently, we could only review a small number of files from a limited number of employee groups.

A number of overpayments were identified from reviewing a small sample of claims

The following overpayments were identified based on our review of a small sample of claims between 2013 and 2015:

- Seven claimants from two employee groups[9] were reimbursed a total of approximately $3,700 for orthotics or orthopedic shoes despite not having coverage.

[9] The two groups are under part-time CUPE Local 79 Unit B.

- Our analysis identified 201 active plan members who submitted multiple orthotics claims. Manulife confirmed that 17 of them were reimbursed for more than one pair of orthotics in a year exceeding the plan limit, totalling $7,725 in overpayments. As our sample is small compared to the population of orthotic claims, there may be more overpaid claims that were not identified by our audit procedure.

- Our analysis found 115 claimants with a high amount of orthopedic shoes claims. For the plan members who are entitled to one pair of orthopedic shoes, Manulife confirmed three of them were reimbursed in excess of the plan coverage, resulting in overpayments of about $1,300. Again due to our small sample size, there are likely to be additional overpaid claims that have not been identified.

Potential waste and abuse from dependent claims

$1.3 million a year for orthotics and orthopedic shoe claims from dependents

Dependents aged 18 or younger have unlimited coverage for orthotic and orthopedic shoes under the City's benefit plans. In 2015, the costs for orthotic and orthopedic shoe coverage for dependents aged 18 or younger amounted to $1.3 million from 1,547 dependents who submitted claims.

From our review of 2013 to 2015 data, we noted many instances indicative of potential benefit waste or abuse. A highlight of some of these instances is provided below:

Some dependents claimed up to ten pairs per year

- 41 dependents aged 18 or younger claimed between six and ten pairs of orthotics[10] in a year; the yearly cost of reimbursement ranged from $3,000 to $5,000 per dependent.

  - In one particular case, an employee with two dependents each was reimbursed approximately $5,000 for 10 pairs of orthotics in 2015.

A number of employees with multiple dependents 18 or younger submitted a large number of orthotic claims for their children. For example:

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[10] *Estimated based on total reimbursed cost and Reasonable and Customary charge per pair.*

- 35 employees received $10,000 or more in orthotic benefits for their dependents over the three years 2013 to 2015.

A family claimed 66 pairs over three years

  - One employee with three dependents was reimbursed $28,500 for close to 60 pairs of orthotics[10] for the dependents over three years. The employee and spouse were also reimbursed for six pairs of orthotics (the maximum covered by the benefit plans) during the same period. In total, the employee was reimbursed $31,500 during the three year period. The employee started claiming orthotics for the dependents since year 2008.

  - Another employee with two dependents was reimbursed approximately $20,000 for close to 40 pairs of orthotics[10] over three years. The employee and spouse were also reimbursed for three pairs of orthotics during the same period.

Of all the cases highlighted above, one dependent was reviewed by Manulife and a verification call was made to the provider.

In addition to orthotics, coverage for orthopedic shoes and modifications for these shoes are also unlimited for dependents 18 years or younger.

Due to the limited information on records, there was no efficient way to separate the cost of purchasing orthopedic shoes from the cost of modifications to regular footwear or off-the-shelf orthopedic shoes. As such, our observations were based on reviewing three claim files with high reimbursement cost, and we noted:

One dependent claimed 4 pairs of orthotics and modification of 7 pairs of orthopedic shoes in a year

- One claimed modifications on three pairs of orthopedic shoes and was reimbursed for over $1,000. The other two each claimed modifications on at least six pairs of orthopedic shoes in a year for over $2,500 in benefits reimbursement.

- One dependent, in particular, was reimbursed approximately $3,800 for modifications on seven pairs of orthopedic shoes and $2,000 for four pairs of orthotics in 2015. The other two dependents of the employee also claimed orthotics and orthopedic shoe modifications in the same year. The total orthotics and orthopedic shoes reimbursement to the employee was $15,350 in 2015.

None of the above cases were selected by Manulife for further review. Manulife indicated that it adjudicated claims in alignment with the City's plan design as required under the contract.

Age appropriateness of claims was not considered

Our review also identified that 76 dependents under the age of five claimed orthotics during the review period. According to Manulife, age appropriateness is not considered a risk factor in their adjudication process. However, based on the educational materials posted on Manulife's website[11], "custom-made orthotics for children under 5 are highly uncommon. Skeletal or soft tissue injuries that require orthotic treatment don't usually present themselves until a person is older".

Manulife stated it was obligated to approve these claims due to the City's unlimited coverage

In response to our findings regarding claims from dependents, Manulife indicated that although they were aware of probable overutilization in the City's dependent claims, it was obligated to approve these claims as long as the required documents were submitted because of the unlimited coverage in the City's benefit plans.

In our view, since the City's benefit plans provide unlimited coverage for dependents, this poses a higher risk for the City and makes it more vulnerable to benefit waste and abuse. Extra due diligence should be applied to these claims.

[11] "Buying custom-made orthotics – what you need to know", Manulife Financial, https://www.manulife.ca/wps/wcm/connect/bfb196a9-9068-4bc1-8c07-0b0cf7f3cc88/Orthotics_memberguide.pdf?MOD=AJPERES&CACHEID=bfb196a9-9068-4bc1-8c07-0b0cf7f3cc88

Orthotics benefit is an area with significant risk

Unlimited dependent coverage, recent orthotics fraud detected involving Toronto Transit Commission employees, no systematic tracking of provider information, and the lack of a prepayment audit step, are all factors that point to significant risk in this area.

City's benefits plan design is unclear and should have limits in place

City Management and Manulife interprets provision differently

City Management's expectation is that modifications to orthopedic or regular shoes are only covered for one time on one pair. However, the City's plan documents are not explicit in this requirement and Manulife adjudicated claims on the interpretation that there were no limits to the number of modifications as long as it is for the same pair. As a result, among a small sample of claims we reviewed, we noted a number of them were reimbursed for multiple shoe modifications contrary to the City's understanding.

Orthotics plan is generous compared to other jurisdictions

Compared with other jurisdictions, the City's orthotic and orthopedic shoe coverage is unique and in our view, overly generous. We reviewed benefit plans for nine other municipal, provincial and federal jurisdictions and all of them have a dollar limit in place.

Additionally, coverage for dependents is limited for all but two of the comparators. For example, the TTC limits its dependents under age 19 to one pair of orthotics, and up to maximum of three pairs of orthopedic shoes per 12 months. If the City's coverage for dependents aged 18 and younger is limited to two pairs per year for orthotics, it is estimated that the City can reduce the benefits cost by $0.5 million per year while still providing a reasonable level of benefits.

C.2 Compression Stockings

$3 million per year for compression stockings

Compression stockings are garments designed to treat venous conditions through aiding blood circulation around the leg. The City pays approximately $3 million for compression stockings claims each year. In 2015, over 760 individual members were each reimbursed for $1,000 or more for this benefit.

Limited to four pairs per year

Table 6 shows the City benefit provisions for compression stockings. For most employee groups, benefits are limited to four pairs of compression stockings or surgical hoses per year.

Table 6: Benefit coverage and required documentation for compression stockings claims

	Non-union	Local 416	Local 79	Retirees
Plan limit per person per year	4 pairs			
Reasonable & Customary charge	None			
Requirement	Referral from physician required once every 12 months to establish medical necessity.			

Source: Manulife Plan Documents and City Collective Agreements

Overpayments due to adjudication errors

Our data analysis identified 2,223 claimants with relatively high claim amounts for compression stockings. Out of this list, Manulife chose and reviewed 57 of them and confirmed four were found to be reimbursed for eight pairs, resulting in $4,000 in overpayments.

Quantity claimed is not tracked

For the same system issue discussed above, we could only cover a limited sample in our review and there are likely more overpayments, particularly among the remaining 2,166 claimants on our initial list to Manulife.

Potential benefit waste and abuse

We noted the following instances of potential benefit abuse:

- 124 dependents aged 18 or younger were reimbursed for compression stockings over the three years.
  - More specifically, five dependents under the age of 10 each claimed $95 to $1,600 over the three years, including a four-year-old dependent who was reimbursed $800.

  Of these 124 claimants, none was selected by Manulife for further review.

- Nine employees' families with three or more members each made claims for compression stockings; each employee received between $7,000 and $12,000 over the three-year period.

Insufficient detail in supporting documentation

While invoices were on file for the cases we reviewed, they often do not include sufficient details such as model and style of stocking purchased, and whether the item was off-the-shelf or custom made. Given the wide range of pricing depending on the type of stockings, this information would assist the adjudicator to assess the reasonableness of the claim.

No dollar limit to avoid overpricing of stockings claimed

Plan specifies quantify covered but not price

Manulife did not have Reasonable and Customary charges for stockings during the review period 2013-2015. Our review found the cost varied widely from $200 to almost $400 per pair for the same pressure level. By comparison, a pair of off-the-shelf compression stockings for the same pressure level has a general retail price of about $20 to $200.

Given the significant annual benefit costs for stockings, the City should ensure the benefits administrator has a Reasonable and Customary charge or where there is none, consider implementing a maximum cost per pair to avoid over pricing by suppliers.

In March 2016, the City adopted Manulife's 2016 guideline on compression stockings to tighten the requirements for reimbursement, including only reimbursing higher gradient stockings, and requiring more details on invoices and diagnosis information from physicians.

C.3 Medical Braces

$1.3 million in braces claimed in 2015

Medical braces are used to treat various conditions, providing support to the arms, legs, neck or back. In 2015, the City paid approximately $1.3 million for medical braces to 2,400 individual claimants, averaging $542 per claimant. About 100 of these claimants were each reimbursed $2,000 or more, accounting for more than a quarter of the total cost of braces to the City.

The City's benefit plans do not specify the coverage limit for medical braces. Table 7 summarizes the benefit provisions below:

Table 7: Benefit coverage and required documentation for medical braces

	Non-union	Local 416	Local 79	Retirees
Plan limit per person per year	No limit			
Reasonable & Customary charge	None			
Requirement	Prescription from a physician is required to establish medical necessity			

Source: Manulife Plan Documents and City Collective Agreements

<u>Lack of details on physician notes and invoices to facilitate adjudication</u>

Insufficient information is retained for analysis

While all of the claims we reviewed contain the required physician notes and invoices on file, we found that many of these documents contain insufficient information to allow for a meaningful and detailed assessment of claim legitimacy. For example:

- In six physician notes for four claimants we reviewed, the physician only indicated the need for braces without providing information on the diagnosis or medical reason;
- Invoices do not always specify whether the items purchased were off-the-shelf or custom made; prices vary significantly between the two.

Instances of potential waste or abuse of benefits

- Nine employees and their families (consisting of two or more members) appeared to claim an unusually large number of braces over the three years and received reimbursement ranging from $13,000 to $38,000.

  - In particular, in one family, the employee claimed seven braces, the spouse claimed five braces, and each of the two dependents claimed four braces over the three years, amounting to approximately $38,000 in benefit payments.

  - In two cases, both the employee and spouse each claimed two or more braces every year for three consecutive years. Total reimbursement for one couple was $13,000, and the other couple was $27,000 over the three years.

Of these nine cases highlighted above, none of them were selected by Manulife for further review. While these claims might be for legitimate health reasons, in our view, further review should have been conducted by Manulife.

City's unlimited benefit plans design

No dollar or quantity limits specified

There is no Reasonable and Customary charge for braces and no dollar or quantity limit is specified by the City's benefit plans. City's plan members can claim an unlimited number of braces each year as long as the claim is accompanied with a physician's prescription and a supplier invoice. For example, three individuals were reimbursed for sacral braces within five months of their previous claim.

Additionally, the cost of claims vary widely for the same type of brace. From our review of a small sample, we noted:

Wide range of prices

- Sacral braces ranged from $475 to $1,500; and
- Knee braces ranged from $1,300 to $2,000.

Since the demand for braces is high and the price for the same type could vary significantly, it is important and would limit the financial risk of the City to set a reasonable price limit for this type of benefit.

C.4 Physiotherapy

$23 million in 2015 for paramedical services and private duty nursing

The City's benefit plans cover professional services provided by licensed practitioners (chiropractors, registered massage therapists, speech therapists, podiatrists, physiotherapists, psychologists, etc.) as well as private duty nursing. Annual limits are granted for each member of a family, and a physician's referral is not required to claim these benefits except for massage therapist for certain employee groups. The 2015 benefit cost for professional services and private duty nursing was approximately $23 million.

Physiotherapy is the most costly extended health benefit for the City

Physiotherapy is the City's most costly extended health benefit category, costing on average $10 million per year in benefit reimbursements.

Over the past few years, City staff had taken steps to reduce the benefit cost through collective agreement negotiations. In 2012 the City further reduced the number of employee groups with unlimited physiotherapy coverage.

Three employee groups continue to have unlimited coverage

For the three-year period under review, the majority of employee groups were limited to an annual $2,000 benefit coverage for physiotherapy. Most retirees under grandparented benefit plans and three employee groups under active plans[12] continue to have unlimited coverage. The unlimited coverage also extends to these employees' spouses and eligible dependents. Table 8 outlines the physiotherapy provisions for the City's major employee groups.

[12] Firefighters Association, Toronto Community Housing Corporation Access Housing ($2,000 limit effective August 1, 2016), and employees who were on LTD benefits as of April 4, 2012.

Table 8: Benefit coverage and required documentation for physiotherapy

	Non-union	Local 416	Local 79 *	Firefighters	Retirees
Plan Limit per person per benefit year	$2,000			Unlimited	Unlimited for most of the employee groups under grandparented plans
Reasonable & Customary Charge	Initial Assessment $134; Following Sessions $84 each (Does not apply to employees under part time Local 79 Unit B)				
Requirement	Doctor's referral not required. Physiotherapist must be licensed or registered.				

* Employees on LTD benefits as of April 4, 2012 have unlimited physio coverage while in receipt of LTD benefits. Upon termination of LTD benefits, they will be subject to the $2,000 limit

A physician prescription is not required

To submit a physiotherapy claim, plan members are required to provide an invoice from a licensed physiotherapist, but a physician prescription is not required.

Unlimited coverage with a lack of prescription requirement increase the City's risk exposure

We recognize that the provision of unlimited physiotherapy coverage to firefighters, and retirees may be desirable due to the occupational and health needs of these groups, and that these provisions are stipulated in the Collective Agreements. Nonetheless, the combination of unlimited coverage and no requirement for physician prescription increases the City's risk exposure to reimbursing unnecessary claims and potential benefit abuse.

Audit scope limitation

Our audit results are limited by the lack of access to claim documents

We conducted a detailed analysis of the physiotherapy claim data after our on-site file review at Manulife and requested Manulife to provide supporting documents (such as redacted invoices) for a selected sample of claims. Manulife declined, citing the expiry of its contract with the City. Consequently, we could not comment on whether there are any missing supporting documents or irregularities on invoices, and the following observations were made solely based on data analysis.

Unlimited physiotherapy coverage may expose the City to excessive claims

Of the total benefit cost for physiotherapy between 2013 and 2015, $12 million was reimbursement paid to members with unlimited coverage, and $18 million to members with the $2,000 annual limit.

In 2015, 583 plan members or 16 per cent of those with unlimited physiotherapy coverage, claimed more than $2,000 a year. In our analysis of claim data from 2013 to 2015, we noted:

- 17 plan members each received $10,000 or more for physiotherapy reimbursement in at least a year.

    - One employee submitted claims for approximately 145 treatment visits and was reimbursed over $10,000 each consecutive year, totalling approximately $34,000 over three years. The spouse also claimed an average of 110 physiotherapy visits per year, receiving a total of $25,000 during the same period.

    - One retiree claimed over 180 physiotherapy visits in 2013 then increased to over 200 visits in 2015. In total the employee was reimbursed approximately $39,000 over three years.

- Out of the above 17 cases, eight of them were selected by Manulife for review.

Seven families (employees and their spouses and at least two eligible dependents) in which each member claimed physiotherapy benefits in at least a year. Each of these employees received more than $10,000 in reimbursement in at least a year, with two of them exceeding $20,000. In particular:

- A family of five (an active employee and four family members) each submitted physiotherapy claims and in total received about $23,000 each consecutive year, totalling $70,000 over the three years.

Claims might be legitimate for health needs but should be examined further

It is important to point out that frequent physiotherapy claims with high dollar amount of reimbursement by themselves are not indicative of excess or abuse; these claims might be for legitimate health needs. However, the claim patterns by claimant and provider, along with the supporting documents, should be examined further to ensure they are for necessary health reasons, the intent of the City's benefits plan.

City's benefit plans design should be re-assessed

Based on a review of physiotherapy benefit provisions of ten other municipal, provincial and federal jurisdictions, we noted the following:

- Four organizations provided unlimited physiotherapy, although three of them will only reimburse up to a contractual per visit limit;

- Six organizations used annual limits ranging from $800 to $1,500, sometimes on top of a contractual per-visit limit (ranging from $25 to $35), or imposing a combined annual maximum with other services such as massages.

The City's coverage compares generously to other jurisdictions

In general, even for the employee groups with limited $2,000 annual coverage, the City's plan compares generously to all but one of the other organizations. This may be an area where a further reduction in benefit cost is possible while still providing a reasonable coverage for the majority of employees and their spouses and eligible dependents.

We do not have specific information on other jurisdictions' physiotherapy coverage specifically for their firefighters and retirees to make a direct comparison with the City. City staff should obtain further information for benchmarking purpose for this particular area of benefit provision.

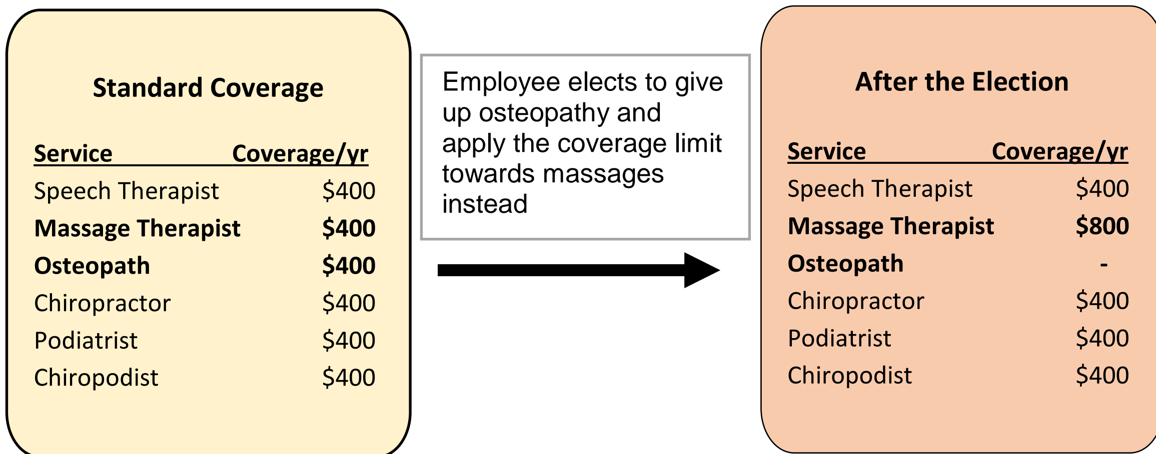
C.5 Other Professional Services and Private Duty Nursing

Overpayments and ineligible claims due to adjudication errors

Employees may double coverage on one service at the expense of another

The City's benefit plans for the majority of employee groups contain a "double up" provision for six professional services, namely speech therapy, massage, osteopath, chiropractor, podiatrist, and chiropodist. Under this provision, a plan member is allowed to forego the coverage of one selected service in order to double the coverage amount for another service. Figure 3 provides an example of this provision. The plan member can change the election from year to year.

Figure 3: Example of "double up" provision for professional services



Overpayments and ineligible claims found

The following adjudication errors were observed with regards to this "double up" provision or with application of the plan maximum limit:

- The "double up" option was discontinued for several employee groups in January 2013 as a result of plan changes. However, this change was not captured by Manulife resulting in 263 members continuing to make this election;

- Six plan members were able to receive double the coverage amount for two services instead of one; and

- 82 claimants were reimbursed more than the plan maximum limit, either for a single paramedical practitioner service or with the above election in place.

In total, these errors resulted in $58,000 in overpayments of paramedical practitioner service claims over the three years from 2013 to 2015.

Provision was adjudicated manually by Manulife

The double coverage option is a provision unique to the City, which Manulife verified manually when adjudicating its claims. This unique provision likely contributed to an increased risk of error.

Instances of unusual claims patterns

From our data analysis and detailed review of claims reimbursed between 2013 and 2015, we noted the following instances of red flags:

Multiple family members claimed the same service in one day

- 55 families of five or more members each claimed the same paramedical service on the same day. Three families did this at least eight times in a year. For instance:

    - A family of six each claimed physiotherapy on the same day on nine different occasions within two months in a year, receiving $6,410.

    - Another family of six received massage therapy on the same day on six different occasions within ten weeks, receiving about $3,000. On each date the family claimed a total of 5.5 hours of massages, each signed off by the same massage therapist.

- 13 individuals claimed three or more different types of services (e.g. massage, physiotherapy, chiropractic and/or osteopathy) on the same day on five or more occasions in a year.

Family members claimed coverage maximums in chronological order

- Out of a sample of 10 families, two were found to be claiming maximum paramedical practitioner services in chronological order. For instance, in one family the spouse first maximized his/her osteopath benefit coverage in January, followed by their child during February and March, then followed by the employee in April and May.

Out of the above examples, only one of them was selected by Manulife for its post payment review. Due to the high risk and large volume of these claims, closer monitoring should have been in place to ensure the claims were accurate and appropriate.

<u>No formal policy governing waiver of benefit limits</u>

City retains the right to waive coverage limits for individual members

The City retains the right to authorize Manulife to waive specific coverage limits for individual plan members, for reasons such as under extenuating medical circumstances. Such exceptions should be granted by the proper authority and documented.

Our review of high dollar claims noted the following:

Limits were waived with no documentation

- One claimant received about $346,000 for private duty nursing over three years. The note provided by Manulife does not indicate if this is a grandfathered case and does not specify who from the City granted the approval. We were informed by PPEB that this is a grandfathered case but no supporting documentation was retained.

- A Manulife customer service representative approved a claimant for a one-time allowance to exceed the physiotherapy limit by $465. Neither the reason nor any City authorization was documented on file.

While the number of such instances is low, each exception can represent a significant and often recurring cost. Thus, it is important that the rationale behind each waiver be documented and accounted for. To ensure each exemption is granted in a fair and equitable manner with valid rationale and authorization, the City should establish a formal policy governing waiver of benefit limits.

Recommendations:

4. City Council request the Treasurer to:

a. review the instances of benefit overpayments identified in the Auditor General's Phase Two audit of extended health benefit claims,

b. where feasible identify other instances of overpayments, and

c. recover the overpayments from plan members or the Benefits Plan Administrator where feasible.

5. City Council request the Treasurer to consider establishing a reasonable quantity limit for orthotics and orthopedic shoes benefits for dependents aged 18 or younger and for medical braces.

6. City Council request the Treasurer to review and initiate changes to the City's extended health benefits provisions to ensure benefit plans clearly articulate what expenses are eligible and covered by the City, including the coverage for modifications to orthopedic shoes.

7. City Council request the Treasurer to ensure the City's employee health benefit provisions are implemented in accordance with City's intentions and collective agreements, and that the plan administrator's interpretation of benefit provisions is in line with City intentions.

8. City Council request the Treasurer to consider unifying, where possible, the employee health benefit provisions in various collective agreements such that both the City's oversight of benefits and the benefit administrator's claim adjudication can be performed in a more effective and efficient manner.

9. City Council request the Treasurer to consider setting a reasonable contractual limit or unit cost on health benefits, particularly when the Plan Administrator does not have a Reasonable and Customary charge in place.

10. City Council request the Treasurer to ensure that the current employee health benefit plan administrator's adjudication processes include an assessment on age reasonableness for health claims.

11. City Council request the Treasurer to assess the reasonableness and appropriateness of the City's physiotherapy benefit provisions, taking into account the financial impact and the City's comparability to other jurisdictions.

12. City Council request the Treasurer to put in place a written policy and procedure on granting of exception cases for employee health benefits. The reason, type of benefit, and period in effect should be documented and retained.

D. Closer Monitoring of Plan Administrator Required

Although the administrator manages the adjudication process, PPEB retains overall responsibility

While the primary responsibility to adjudicate and monitor claims lies with the administrator, the City's PPEB still retains ultimate accountability for oversight of the employee benefits program and plan design. Over the course of the audit, we observed that in several areas PPEB staff did not have a clear understanding of how Manulife interpreted or executed the City's plan requirements. Table 9 shows examples of discrepancies between PPEB management's understanding of certain benefit provisions and Manulife's actual adjudication practices.

Table 9: Examples of discrepancy between City management's understanding and actual practice

City Management Understanding	Actual Adjudication Practice by Manulife
Prepayment audits were being applied to all except firefighters' orthotics	Prepayment audits were stopped for supplier claims, possibly all
Manulife was collecting all information needed to perform its contractual obligations	Provider information was not tracked for the vast majority (95%) of claims
Discontinue the "double-up" option for paramedical practitioner services for certain employee groups	Instructions were not consistently carried out for all affected groups
Physician referrals for orthotics and orthopedic shoes should be required once per year	Referrals only required once per lifetime
Modifications to regular or orthopedic shoes should be limited to one occurrence per pair	Multiple modifications allowed on the same pair of shoes

In addition, on an annual basis, PPEB staff conducts analysis of claim payments. However, this is only performed on identifying claimants with high physiotherapy reimbursements for follow up with Manulife. This review does not involve other types of health claim including the benefits that are known with common areas of concern.

The City has not exercised its right to engage an independent auditor to verify effectiveness of claims administration services

According to the contractual document, the City "shall have the right to audit its RFP Carrier's [Manulife] claims operation through a third person and have access to the claims systems for that purpose." During the contract period from 2012 to 2016, the City did not exercise its right to engage an independent auditor to audit Manulife's claims operation to verify effectiveness of claims administration services and performance as stipulated in the ASO contract. In particular, with the City's complex benefit provisions, it is prudent to obtain assurance that the administrator's system codes align with the provisions.

Some of the audit observations could have been identified and addressed earlier

Some of the issues observed may have come to light earlier if management undertook a closer examination of information or lack of information from Manulife. For example, management receives raw claims data from Manulife periodically. Had the data been closely examined by staff, it should have been apparent the critical "provider" information was missing.

In addition, management should have been querying Manulife to understand what types of analysis it performs, especially when Manulife specified in its proposal that it would identify unusual trend and patterns using analysis. This would ensure that between the two parties sufficient review is present to address all agreed pertinent risks.

The fee structure in the ASO contract means that the administration fee increases in proportion to the claims paid. While there is no evidence that this has influenced the actions of either the past or current administrator, due diligence should always be maintained to ensure that the administrator is acting appropriately as an agent for the City.

Recommendations:

13. **City Council request the Treasurer to engage an external auditor to conduct an initial audit on the new plan administrator's adjudication system to ensure the coding aligns with benefit provisions. Periodic audits should also be performed on the effectiveness of the administrator's adjudication and monitoring processes.**

14. **City Council request the Treasurer to conduct, on a regular basis, detailed reviews of health benefit claims history by high risk categories that are commonly subjected to misuse or abuse.**

15. **City Council request the Treasurer to ensure emerging risks and issues in the employee health benefits program are identified and adequately addressed by the benefits administrator in a timely manner.**

Recommended changes and observations may be beneficial to other City agencies

Since both Toronto Transit Commission and the Toronto Police Services Board use the same benefits administrator as the City, they may consider and adopt the applicable audit recommendations to help improve its oversight of the benefits program.

Recommendation:

16. City Council request the City Manager to forward this audit report to the respective Board of the Toronto Transit Commission and the Toronto Police Service for their review and consideration of the applicability of the audit recommendations in their own employee health benefit program.

CONCLUSION

This report contains 16 recommendations to improve controls and administration

This report contains 16 recommendations to help improve controls and administration of the City's extended health benefits program.

Overall, we found the controls and monitoring of the City's benefit claims ineffective in identifying unusual patterns or potential frauds. Potential benefit abuse or fraud might not have been detected due to the lack of critical claim information, and forgoing a standard audit process for the City's claims.

City management, who retains overall responsibility for the program, should further strengthen their oversight by establishing clear understanding of the benefit administrator's actual adjudication practices, as well as performing more effective claim data analysis and implementing periodic third-party audits.

To reduce annual benefit cost and the risk of benefit abuse, we recommend several changes to the City's benefit plan design. The City should, where feasible, discontinue the unlimited benefit coverage for orthotics and orthopedic shoes for dependents under 19, unlimited coverage for medical braces, and unlimited physiotherapy coverage currently available for a few employee groups. As well, the City should establish reasonable quantity or price limits for items such as compression stockings and medical braces.

The City has recently contracted a new benefits administrator and this presents an opportunity to strengthen its benefits program and reduce its risk exposure moving forward.

AUDIT OBJECTIVES, SCOPE AND METHODOLOGY

This audit was part of the Auditor General's 2016 audit plan

The Auditor General's Office initiated an audit of the management of the City's employee health and dental benefits claims in accordance with the Auditor General's 2016 Audit Work Plan.

Under the authority of the City of Toronto Act, the Auditor General conducted an analysis of claims data

In accordance with subsection 179(2) of the *City of Toronto Act, 2006,* the Auditor General is entitled to access the records belonging to or used by the City to perform her work. The Auditor General, under the City of Toronto Act, has the statutory authority to conduct an independent audit of the City's management of health benefits claims and claim records.

The audit was divided into two phases

The audit was divided into two separate phases. Phase One focused on drug benefits in the City and was presented to the Audit Committee on October 28, 2016. Subsequent to Phase One, a confidentiality agreement was signed between the Auditor General's Office and Manulife which allowed us to gain access to claim records and related adjudication information for review. A supplementary report which contains further observations pursuant to specific Phase One findings will be released later in 2017.

Phase Two focused on extended health care benefits

Phase Two of the audit focused on extended health care benefits not reviewed during Phase One. Our objective was to assess whether the City's Pension, Payroll and Employee Benefits Division (PPEB) has effective systems and procedures in place to:

- Manage employee extended health benefits in a cost effective manner;
- Ensure the City receives effective and timely claims administrative services for benefits; and
- Monitor the benefits plan administrator's performance for effectiveness and compliance with the contract.

The audit included work in the following areas:

- Extended health claims data and statistics;
- City policies, procedures, guidelines, negotiated agreements, Request for Proposal and contract agreements relating to extended health benefits;
- Management and oversight of benefit plans and performance of Manulife; and
- Manulife's claims adjudication and ongoing monitoring processes in documents supplied to City staff.

Claims data over three years from January 2013 to December 2015 was reviewed.

Audit methodology

The audit methodology included:

- Review of the City's policies and benefits plans;
- Manulife's plan document;
- Review of literature and studies, and other audit reports relating to employee health benefits;
- Meetings and interviews with staff of Pension, Payroll and Employee Benefits Division,
- Meetings with Manulife staff;
- On-site review of a selected sample of claim records maintained by Manulife, followed by discussions with Manulife staff to understand the claim details.

Audit scope limitation

Due to the lack of systematic provider information on City's claims, we were not able to carry out the basic analytical steps to systematically identify exceptions or anomalies, nor could we perform further steps to extrapolate other relevant exceptions from Manulife's data. Consequently, we could only identify exceptions through a manual review of a small number of claims, and hence cannot determine the total volume or amount of potential losses.

Compliance with generally accepted government auditing standards

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

APPENDIX 1: Management's Response to the Auditor General's Audit of Management of the City's Employee Extended Health and Dental Benefits, Phase Two

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Recommendation 1: City Council request the Treasurer to make a request to Manulife to input the provider information including the name of provider, location, and therapist registration number, for all City's health claims processed and reimbursed in the period 2013 to 2015 to enable proper analysis to be performed to confirm validity of claims.

Management Response: ☒ Agree ☐ Disagree
Comments/Action Plan/Time Frame: Q3, 2017

The Treasurer will write to request Manulife to input the provider information including the name of provider, location, and therapist registration number, for all City's health claims processed and reimbursed in the period 2013 to 2015 to enable proper analysis to be performed to confirm validity of claims. Should this request not be successful, Manulife will be requested to review their systems to determine if there are alternate methods of reviewing claims for the years 2013 through 2016 to allow for the analysis.

Recommendation 2: City Council request the Treasurer to ensure the plan administrator has adequate tools, controls and adjudication processes in place to identify unusual trends and patterns, and to detect and prevent fraud and abuse at both the provider and individual plan member level. This should include establishing predetermined criteria with the plan administrator for identification of unusual trends and patterns, and requesting periodic reports back from the plan administrator on actions taken.

Management Response: ☒ Agree ☐ Disagree
Comments/Action Plan/Time Frame: Q2, 2017

The Director, Pension, Payroll & Employee Benefits will meet with the new benefits plan administrator to review and document that the administrator has adequate tools, controls and adjudication processes in place to identify unusual trends and patterns, and to detect and prevent fraud and abuse at both the provider and individual plan member level. This should include establishing predetermined criteria with the plan administrator for identification of unusual trends and patterns, and requesting periodic reports back from the plan administrator on actions taken.

Recommendation 3: City Council request the Treasurer to ensure all key changes to the City's health benefits plan administration are clearly communicated and documented by City staff, and retained in accordance with the City record retention policy. When a major change to the benefit plan is made, the Treasurer should ensure the change is implemented by the benefits administrator according to the City's direction.

Management Response: ☒ Agree ☐ Disagree
Comments/Action Plan/Time Frame: Q2, 2017

The Director of Pension, Payroll & Employee Benefits, in consultation with Employee & Labour Relations and Legal Services, will develop a protocol and process to be followed when considering changes to the City's health benefits and/or processes.

Such protocol will include: proper documentation of the issues and the recommended changes; the appropriate approval process; and the appropriate record retention of the documentation in accordance with the City retention by-laws.

The protocol will include provisions for the appropriate process for granting exceptions.

The protocol will also include follow-ups and checks to ensure the change is implemented by the benefits administrator according to the City's direction.

Recommendation 4: City Council request the Treasurer to:

a. review the instances of benefit overpayments identified in the Auditor General's Phase Two audit of extended health benefit claims,
b. where feasible identify other instances of overpayments, and
c. recover the overpayments from plan members or the Benefits Plan Administrator where feasible.

Management Response: ☒ Agree ☐ Disagree
Comments/Action Plan/Time Frame: Q3, 2017

The Director of Pension, Payroll & Employee Benefits will meet with Manulife in an effort to review the Auditor General's Phase 2 audit of extended health benefit claims between 2013 and 2015, and to determine any amounts applicable for 2016.

Where overpayments are identified, the Director of Pension, Payroll & Employee Benefits, in consultation with Employee & Labour Relations and Legal, will determine whether overpayment amounts are recoverable and, if so, take the appropriate steps with employees and Manulife to recover the funds.

Recommendation 5: City Council request the Treasurer to consider establishing a reasonable quantity limit for orthotics and orthopedic shoes benefits for dependents aged 18 or younger and for medical braces.

Management Response: ☒ Agree ☐ Disagree
Comments/Action Plan/Time Frame: On-going to next round of Collective Bargaining in 2019:

The Director of Pension, Payroll & Employee Benefits, in consultation with Employee & Labour Relations and Legal Services will:

a. Undertake a review of benefit plan coverages, industry comparators in 2017, discussions with the benefits plan administrator and consultants, and at least every five years thereafter, to consider opportunities for change to the City's coverage to provide cost-effective benefit plans.

b. Where opportunities are identified, determine the appropriate steps and action required to adjust plans, in accordance with the collective agreements, City policies and legal requirements.

Recommendation 6: City Council request the Treasurer to review and initiate changes to the City's extended health benefits provisions to ensure benefit plans clearly articulate what expenses are eligible and covered by the City, including the coverage for modifications to orthopedic shoes.

Management Response: ☒ Agree ☐ Disagree
Comments/Action Plan/Time Frame: Q4, 2017

The Director of Pension, Payroll & Employee Benefits, in consultation with an external consultant, Employee & Labour Relations, Legal Services and the benefits plan administrator will review the benefit plan provisions and ensure that they clearly articulate eligible coverage, as documented in the City's collective agreements and policies.

Recommendation 7: City Council request the Treasurer to ensure the City's employee health benefit provisions are implemented in accordance with City's intentions and collective agreements, and that the plan administrator's interpretation of benefit provisions is in line with City intentions.

Management Response: ☒ Agree ☐ Disagree
Comments/Action Plan/Time Frame: Q3, 2017

In the transition of the health and dental benefits to the new benefits plan administrator, the City has retained an external consultant to review and validate the mapping of the benefit plans to the new carrier and will review the plan documents/benefit booklets to ensure the carrier is administering the benefits in line with the collective agreements, City policy and the City's intentions.

Recommendation 8: City Council request the Treasurer to consider unifying, where possible, the employee health benefit provisions in various collective agreements such that both the City's oversight of benefits and the benefit administrator's claim adjudication can be performed in a more effective and efficient manner.

Management Response: ☒ Agree ☐ Disagree
Comments/Action Plan/Time Frame: Same as action plan for recommendation # 5.

Recommendation 9: City Council request the Treasurer to consider setting a reasonable contractual limit or unit cost on health benefits, particularly when the Plan Administrator does not have a Reasonable and Customary charge in place.

Management Response: ☒ Agree ☐ Disagree
Comments/Action Plan/Time Frame: Same as action plan for recommendation # 5.

Recommendation 10: City Council request the Treasurer to ensure that the current employee health benefit plan administrator's adjudication processes include an assessment on age reasonableness for health claims.

Management Response: ☒ Agree ☐ Disagree
Comments/Action Plan/Time Frame: Q3, 2017:

The Director, Pension, Payroll & Employee Benefits will meet with benefit plan administrator to the review the adjudication processes to ensure that age reasonableness assessments are in place for health claims that are consistent with the collective agreements and City policies.

Recommendation 11: City Council request the Treasurer to assess the reasonableness and appropriateness of the City's physiotherapy benefit provisions, taking into account the financial impact and the City's comparability to other jurisdictions.

Management Response: ☒ Agree ☐ Disagree
Comments/Action Plan/Time Frame: On-going to next round of Collective Bargaining in 2019:

The Director of Pension, Payroll & Employee Benefits, in consultation with Employee & Labour Relations and Legal Services will:

a. Undertake a review of physiotherapy coverages, industry comparators in 2017, discussions with the benefits plan administrator and consultants, and at least every five years thereafter, to consider opportunities for change to the City's coverage to provide cost-effective benefit plans.

b. Where opportunities are identified, determine the appropriate steps and action required to adjust plans, in accordance with the collective agreements, City policies and legal requirements.

Recommendation 12: City Council request the Treasurer to put in place a written policy and procedure on granting of exception cases for employee health benefits. The reason, type of benefit, and period in effect should be documented and retained.

Management Response: ☒ Agree ☐ Disagree
Comments/Action Plan/Time Frame: Same as action plan for recommendation # 3.

Recommendation 13: City Council request the Treasurer to engage an external auditor to conduct an initial audit on the new plan administrator's adjudication system to ensure the coding aligns with benefit provisions. Periodic audits should also be performed on the effectiveness of the administrator's adjudication and monitoring processes.

Management Response: ☒ Agree ☐ Disagree
Comments/Action Plan/Time Frame: Q4, 2017 and On-going

In the transition of the health and dental benefits to the new benefits plan administrator, the City has retained an external consultant to review and validate the mapping of the benefit plans and review the plan documents/benefit booklets.

Provisions were included in the current RFP to allow for the City to arrange for periodic audits, including by the Auditor General. The Director, Pension, Payroll & Employee Benefits will ensure that regular audits, as appropriate, are done during the five (5) year contract.

Recommendation 14: City Council request the Treasurer to conduct, on a regular basis, detailed reviews of health benefit claims history by high risk categories that are commonly subjected to misuse or abuse.

Management Response: ☒ Agree ☐ Disagree
Comments/Action Plan/Time Frame: Q4, 2017 and On-going

The Director, Pension, Payroll & Employee Benefits will on an annual basis, at a minimum, undertake a review of the claims data to identify high volume claims and consult with the carrier to ensure the claims are appropriate and in compliance with the City's benefit plans.

Recommendation 15: City Council request the Treasurer to ensure emerging risks and issues in the employee health benefits program are identified and adequately addressed by the benefits administrator in a timely manner.

Management Response: ☒ Agree ☐ Disagree
Comments/Action Plan/Time Frame: Q4, 2017 and On-Going

The Director, Pension, Payroll & Employee Benefits will implement a process with the benefits plan administrator to ensure that systems are in place and reports are provided on a regular basis to ensure emerging risks and issues in the employee health benefits program are identified and adequately addressed by the benefits administrator in a timely manner.

Recommendation 16: City Council request the City Manager to forward this audit report to the respective Board of the Toronto Transit Commission and the Toronto Police Service for their review and consideration of the applicability of the audit recommendations in their own employee health benefit program.

Management Response: ☒ Agree ☐ Disagree
Comments/Action Plan/Time Frame: Immediately After Council Approval

The City Manager will forward this audit report to the Toronto Transit Commission and to the Toronto Police Services Board for their respective review and consideration of the applicability of the audit recommendations in their own employee health benefit program.