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

Beverly Romeo-Beehler, CPA, CMA, B.B.A., JD, ICD.D, CFF
Auditor General

Jane Ying, CPA, CMA, CIA, CGAP, MHSc
Assistant Auditor General

Celia Yeung, CPA, CA
Senior Audit Manager

Auditor General's Office
Integrity, Excellence and Innovation
Background

- The City is self-insured
- Extended health care benefits cost $56 million in 2015, up 68% from 2006
- 80,000 individuals eligible for benefits coverage
- Manulife has been the City’s benefits administrator from 2000 to 2016
Background

Costs for extended health benefits

Year

Source: City PPEB Division
Background

Top Extended Health Benefits in 2015

- Physiotherapy - $11M
- Vision - $8M
- Orthotics/orthopedics - $7M
- Massages - $6M
- Stockings - $3M
Audit Timeline

LTD Benefits Phase 1: City Management 2015
LTD Phase 2: Adjudication and Oversight 2016
Extended Health Phase 1: Drug Claims 2016
Extended Health Phase 2: Medical Supplies and Professional Services 2017
Two Components of Program Management

Plan Design

- Responsibility of PPEB management (with advice from administrator)
- Based on the Collective Agreements
- Dictate the eligible benefits coverage limits, and required documentation
- Limit opportunity for waste and abuse

Adjudication and Monitoring

- Primary responsibility of benefits administrator (with oversight from City management):
  - Verify eligibility and accuracy of claims
  - Ongoing monitoring to determine emerging trends and issues
- Prevent and detect fraud
Audit Findings

Three major types of findings:

#1
Ineffective controls and monitoring

#2
Potential cases of waste and abuse

#3
Overpayments due to adjudication errors
#1 – Ineffective Controls and Monitoring

- No systematic tracking of provider information
  - Lack of ability to conduct basic analysis
  - Limited capacity to identify unusual trends and patterns to detect abuse and fraud

- AGO identified two providers with suspicious activities from a limited sample
#1 – Ineffective controls and monitoring (cont’d)

- A prepayment audit process was not applied to the City since 2006
  - This was part of the benefits administrator’s standard controls
  - As a result, the City could be exposed to risk of paying inappropriate or fraudulent claims for 10 years
Basic Types of Benefit Fraud

- Provider fraud
- Plan member fraud
- Provider and plan member collusion
- For example, the latest TTC fraud involving a health supply provider
#2 – Potential Cases of Waste and Abuse

Orthotics and Orthopedic Shoes:

- Unlimited coverage for dependents aged 18 and under

  - 41 dependents claimed between 6 and 10 pairs of orthotics in a year → $3,000 and $5,000 per year

- One dependent claimed modifications on 7 pairs of orthopedic shoes and 4 pairs of orthotics in 2015 → $5,800 in a year

- One employee with three dependents claimed close to 60 pairs of orthotics for the dependents and another 6 pairs for the couple → $31,500 over three years
#2 – Potential Cases of Waste and Abuse

Compression Stockings

- Plan limit of up to 4 pairs per person per year

9 families made claims for each of their 3+ members, each family receiving between $7,000 and $12,000 over the three-year period

124 dependents aged 18 or younger were reimbursed for compression stockings
#2 – Potential Cases of Waste and Abuse

Medical Braces

- Plan limit has unlimited coverage

9 families appeared to claim an unusually large number of medical braces, receiving between $13,000 and $38,000 over three years.

- In one family, the employee claimed 7 braces, the spouse claimed 5, and each of the two dependents claimed 4 over the three years → $38,000 in benefit payments.
#2 – Potential Cases of Waste and Abuse

**Physiotherapy**

- Most employees are limited to $2,000 per year. Three groups had unlimited coverage.
- 17 individuals claimed $10,000 or more within a year
- A family of five each submitted claims for every member, receiving $70,000 over 3 years
- A family where the employee and spouse both claimed:
  - The employee → ~145 visits/year → $34,000 over 3 years
  - The spouse → ~110 visits/year → $25,000 over 3 years
#2 – Potential Cases of Waste and Abuse

Other Professional Services

- 55 families of five or more members each claimed the same service on the same day

  A family of six each received massage therapy totalling 5.5 hours on the same day, all signed off by the same therapist. This occurred six times within 10 weeks, totalling $3,000.

- 13 individuals claimed 3+ types of services (e.g. massage, physiotherapy, chiropractic and/or osteopathy) on the same day
Audit Findings – Overpayments

- Overpayments found from a limited sample

<table>
<thead>
<tr>
<th>Benefit Categories</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Orthotics &amp; orthopedics</td>
<td>$12,700</td>
</tr>
<tr>
<td>Compression stockings</td>
<td>4,000</td>
</tr>
<tr>
<td>Professional services</td>
<td>58,000</td>
</tr>
<tr>
<td><strong>Total Overpayment</strong></td>
<td><strong>$74,700</strong></td>
</tr>
</tbody>
</table>

- More instances likely remain undetected
Summary – Going Forward

► Clarify the City’s provisions and strengthen communication with the benefits administrator;

► Perform more effective claim analysis; and

► Continue to reduce the City’s risk exposure by tightening its plan design.
Conclusion

► Management has agreed to all 16 recommendations

► Previous Auditor General’s recommendations were considered by City management when it elected the new benefits administrator for the 2017 to 2021 contract.