Niagara Region

Internal Audit

Employee Extended Health Benefit Claims Audit

Operating Unit: Niagara Region

Date of Audit: September 2017 to August 2019

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EXECUTIVE SUMMARY

BACKGROUND

In accordance with the 2019 Audit Plan, Internal Audit (IA) performed a comprehensive review of the Employee Extended Health Benefits Plan (benefits). The audit was conducted within professional standards published by the Institute of Internal Auditors.

The purpose of the audit was to provide assurance to Senior Management and the Niagara Region Audit Committee that benefits plans being delivered through a contractual relationship with a third party provider has effective oversight and design to ensure cost efficiency and a sound control framework. This included a review of appropriate contract terminology, various design plans and usage rates which included testing of claims to ensure appropriate approval procedures are followed.

To complete this audit IA engaged the consulting services of MNP Consulting to analyze two years of claims data to identify potential issues and recommend a potential sample to be used by IA staff for in-depth fieldwork testing.

The methodology used by IA included a review of relevant documentation, analysis of financial data, interviews with key individuals, internally and externally, involved in the benefits program and re-performance of certain procedures.

SCOPE

A risk based auditing approach was used to determine the scope of the audit. The following processes, procedures and items were considered in scope:

- Risk identification and assessment of the various benefit plans available and delivered through third party providers;
- Review of extended health benefits contracts, policies, operating procedures, benefit plans including training and communication materials;
- Interviews and process walkthrough with key staff involved in extended health benefits to determine their roles, responsibilities, and oversight methodology;
- Consultative meeting and interviews with third party health claims administrators and Co-Source partner;
- Evaluation of internal processes and procedures related to contract oversight and enforcement;
- Analytical review of metrics used to monitor extended health benefits and report on operational performance and;
- Detailed testing of a sample of benefit claims to assess whether claims are being adjudicated in accordance with the provisions laid out in the benefit plan.

INTERNAL AUDIT FINDINGS

The audit of the Employee Extended Health Benefits Plan was driven by several high profile audits completed in other jurisdictions, most notably within the Greater Toronto Area (GTA). In general, the findings in those audits revealed a poorly designed benefit plan and an ineffective control framework administered by third party providers that did not prevent excessive claims fraud. Internal Audit engaged the external consulting services of MNP Canada to conduct data analytics, review the plan design controls and provide an overall report on the control framework managing extended health benefits.

This audit tested the benefits control framework at three different levels:

- Contract administration and oversight specifically focussing upon the working relationship between Total Rewards office staff and Green Shield Canada (GSC). The audit briefly touched on the analytical work completed by AON Canada.
- Administration and claim adjudication procedures in place at Green Shield Canada which included in depth testing of a sample of claims as identified by MNP Canada.
- Plan design as part of an overall wellness strategy endorsed by Senior Management and approved by Council

Overall, very few of the issues and claims manipulation schemes found in other jurisdictions were evident in Niagara. Limit controls placed on many services and annual service limits effectively reduces the financial benefits staff would gain from abusing the benefit plan or colluding with providers to contravene the intent of the plan design. In addition, the administration and adjudication process managed by Green Shield Canada is elaborate and effective in limiting staff's ability to commit fraud.

Plan design is effective from a control perspective, but as noted by the MNP report, Niagara should conduct a strategic review of the benefits plan to ensure it is meeting the changing needs of staff in a cost effective manner. In addition, Niagara currently manages 27 different benefit classes with several differences and commonalities between each class. The reason for the different benefit classes are explained in Observation 1 of the audit. While Green Shield Canada is able to build sufficient automated controls to manage the unique nature of each plan, reducing the number of classes would support improved administration and reduce complexity in maintaining the classes.

Contract administration and oversight is effective at managing overall costs and ensuring Green Shield Canada is meeting its contractual obligations. However, as noted by MNP, Total Rewards staff within Human Resources Division can provide greater value by conducting ongoing analytical review of employee and vendor trends. These trends can identify potential areas of claims pressures by either staff or providers or it could identify usage rates that needs to be addressed in future plan design changes. Continuous and ongoing internal reviews may be still be beneficial to support a regular cycle of monitoring and inform bargaining/plan design efforts.

Niagara has engaged the services of AON Canada to conduct analytical reviews on the service usage. AON provides professional services related to both insured and Health and Dental benefit annual renewals, including reviewing claim trends by benefit type and employee class. Risk analysis of pooled insurance for large medical claims is also completed, recommending different strategies to manage risks and costs. In addition, AON completes a review of each insured benefit (i.e. Life Insurance and LTD) by class, analyzes proposed rate changes and negotiates with the insurer on the Region's behalf. AON directly assists with ad-hoc insurance reviews and projects such as supporting collective bargaining strategies and plan design reviews.

During the conduct of the fieldwork for this audit, Niagara Region was required to sign a non-disclosure agreement (NDA) with GSC ensuring the privacy and confidentiality of employee information and GSC proprietary business systems. This NDA applied to all staff and consultants. Internal Audit staff did not have access to employee names or numbers. To protect staff identity, GSC created proxy employee numbers to facilitate data analytics.

BACKGROUND

Niagara Region's Employee Extended Health benefits plan is managed though the Total Rewards staff. The benefit plan has been administered through an Administrative Services Only (ASO) contract with Green Shield Canada since April 2008. In 2016, through Request for Proposal (RFP), the contract was again successfully awarded to Green Shield Canada and is subsequently renewed annually. Administration charges were secured at a locked in rate until 2022. Green Shield Canada manages, on behalf of the Region the following categories of services:

- Prescription Drugs,
- Dental, and
- Extended Health Services, which includes,
    - Hospital Accommodation,
    - Hearing Care,
    - Medical Items and Services,
    - Emergency Transportation
    - Private Duty Nursing in the Home,
    - Professional Services and,
    - Vision

Employees or their service providers submit all claims directly to GreenShield who are required to adjudicate each claim for legitimacy, approve the claim and disburse funds back to the employee or directly to the professional service provider. For the most part, the benefit fund is entirely employer funded, except for one employee group which has members contribute a small percentage. The Region submits a pre-determined premium amount per enrolled employee every month which is held by Green Shield Canada. Claims

reimbursements are then deducted from this amount as the year progresses with an annual reconciliation.

Green Shield Canada successfully took over Niagara's Extended Benefit plan in 2008. Through a successful second Request for Proposal (RFP) in 2016, GSC continued as the Niagara Region's benefit provider. As part of the contract for services GSC charges a set administrative percentage rate on paid claims. Internal Audit reviewed the financial terms of the contract with GSC and tested several payments, including annual reconciliations and found no issues with the disbursements.

In addition, the Region purchases pooled insurance protection from GSC, entitled Stop Loss, to manage the risk surrounding large medical claims. This insurance policy covers an employee's benefit claim costs over and above a set limit for drugs, dental and some health related products and services. In other words, if one employee (or collectively, with their dependents) incurs benefit claim costs above the established amount, the Stop Loss insurance policy would pay these additional costs, not the Region. The Stop Loss Rate fluctuates annually and is set in December for the following year. Again, Internal Audit reviewed the financial statements and payouts and determined no issues

The time period for this audit looked at claims and administration costs from the time period September 2017 to August 2018 indicated as 2018 in all the Tables and September 2018 to August 2019, indicated as 2019 in all the Tables.

Internal Audit appreciates the assistance and co-operation from the Total Rewards staff in supporting and actively participating in this audit.

OBSERVATIONS AND RECOMMENDATIONS

The following are all the observations from the audit along with recommendations and Management's Action Plans to address these issues. See Appendix I for the risk ranking justification.

Observation #1 – Niagara Region provides sound oversight of the benefits contract but can benefit through enhanced reporting and review of performance metrics.

Risk Ranking	LOW

The administration and management of the employee extended health benefits plan at Niagara Region falls under the responsibility of Total Rewards staff within Human Resources. Total Rewards works with its outsourced partner Green Shield Canada (GSC) to administer all facets of the employee extended health benefits plan. Niagara has negotiated unique benefit plans for its six bargaining groups as well as non-union staff. In addition, the corporation offers different benefit packages within the employee groups to full time, part time or contract employees. Total Rewards also manages benefit plans for retired employees. In total, there are 27 different benefit classes that the Region, along with GSC, manage.

Green Shield Canada uses the Advantage® system to adjudicate and process all claims. Advantage is a proprietary computer system that incorporates all the unique 'rules' related to the 27 different benefit classes to expedite and automate the adjudication process. As part of fieldwork for this audit, MNP Canada and the Internal Audit team visited GSC offices to meet with staff and observe the programming and operational components of the Advantage system. MNP concluded the following, "it is our view that the Advantage® system, if working in accordance with what we were advised, adequately processes claims submitted to ensure they are in accordance with the group benefit plan."

The myHR Employee Services Representatives at Niagara Region are responsible for the inputting and updating of eligible staff within the Green Shield Online Administration system. Changes to the rules and plan design features can only be done by GSC staff upon written request from Total Rewards staff, with several layers of approvals and quality control measures. The Advantage® system has robust controls embedded to proactively identify abnormal trends as well as various thresholds that would trigger an audit on a particular claim or provider. Internal Audit staff and MNP directly observed the system controls as described above.

In addition to the Advantage® system, GSC uses an investigative business model called Claim Watch to support its investigations and ongoing monitoring of employee and provider trends. This proactive system, utilizing enhanced artificial intelligence, identifies anomalies in claims through dozens of algorithm formulae. In addition, GSC receives updates from various

professional associations and regulatory bodies, such as the Ontario College of Pharmacy, to ensure that providers are actively registered and in good standing within their professions. Niagara has an audit rate of approximately 17 percent of claims, which is somewhat low based on industry standards. The reason for this is due to the tight plan design and Niagara being considered a low risk client by GSC.

Receiving and Monitoring Reports

According to GSC's bid, they included the following clause, "Niagara Region has been a key GSC client for many years, and we are committed to ensuring your needs are always met. We're taking this opportunity to reconfirm that commitment, and we would be happy to establish a Service Level Agreement (SLA) that includes customized metrics according to your needs." Internal Audit, along with MNP reviewed several of the reports that GSC has available to for their clients via their administration portal.

The administration portal provides direct access to dozens of reports generated by GSC within a secure web interface. Examples of reports include claim volumes and high level details, health provider summaries and employee enrollment details. Financial reconciliations are provided annually directly by GSC. Within the RFP and contract with GSC, Niagara has always retained a right to audit clause which was never utilized until this audit engagement.

Internal Audit, along with MNP, reviewed some of the existing reports and identified potential areas that should be considered:

- Delisted provider reports – a report that details claim activities prior to the delisting that would allow Niagara to proactively identify and plan for similar trends. This report will allow Total Rewards, along with GSC, to establish identifiers that can be monitored and to proactively minimize various fraudulent activities and maintain cost effectiveness.
- Multi-family member claims – while many, possibly all of the claims, are legitimate and adjudicated appropriately, audits from other jurisdictions have shown that multi-family claims is a 'red-flag' that should be monitored. Specifically, in other jurisdictions, claims for multi-family members around similar dates has shown a direct correlation to improper claim issues. The annual and per visit limits within the Niagara plan reduces the risk of fraud, but when combining totals from multiple family members, the materiality increases and the potential for abuse increases as well.
- Reports for employee groups – a report that monitors claim volumes by employee groups already exists at a high level. This report could be improved to detail employee group activities down to the product/service and provider level. In audits from other organizations, and trends viewed in Niagara, employees are quickly attracted to fraudulent providers. By monitoring short term spikes in volumes based on employee group or provider, Total Rewards, along with GSC, can proactively identify activities that require an intervention.

- Customized performance metrics – some of the metrics that should be requested and monitored regularly include financial and non-financial statistics. Much of the analytics is currently performed by AON Canada and that relationship should not be terminated. GSC should also be reporting on the success of their own internal operational customer service metrics as they impact Niagara, such as, timeliness of adjudication process, payment processing duration and time period for appeals. Finally, Total Rewards should be reviewing usage statistics to determine demand levels for all services. Specifically, the focus should be on service levels with an aim to ensure that staff are able to access services that are in high demand that supports a healthy lifestyle and continuous and uninterrupted work due to illness.

Implication

Without sound data analytics and reports Niagara may not be identifying potential issues proactively to maintain costs at an effective level.

Without a robust set of performance metrics, developed through input and consensus of the various employee groups, Niagara cannot be assured that it is effectively meeting the needs of employees with regard to its enhanced benefits plan.

Recommendation

1. Human Resources should review and prioritize its current population of reports from GSC to identify more data-driven reports to proactively identify employee claim activity such as multi-family transactions, employee group trends and delisted provider activity trends.

2. Human Resources should coordinate with GSC to develop, monitor and report on customer service performance metrics to ensure GSC is meeting expected performance and operational targets.

Management Action Plan

Person(s) Responsible Linda Gigliotti/Kristen Angrilli

Completion Date Ongoing

1. Management supports the importance of monitoring data-driven reports to appropriately manage employee claim activity, and also stresses the importance of balancing this activity to monitor potential misuse or fraudulent activity with the necessity to respect employee privacy. Currently, management is satisfied that GSC is monitoring and reporting delisted providers quarterly and provides to Niagara Region to determine if any local providers are delisted, and further provides Audit Advisories if any claim activity is occurring with a provider that is being delisted. Management have actively participated in program reviews offered by GSC for the purposes of cost containment, such as offering

biosimilar drugs. In consultation with Total Rewards staff, AON Canada also performs a deep dive of employee claims to assess overall cost containment related to plan design and activities which includes some detailed data not available to Niagara Region as the employer, loss ratios (revenue vs. expenses), rate setting guidelines and trends. Human Resources does not duplicate those same activities, but does review several additional audit reports and data points to routinely review billings and claims activities on a regular basis. Given the positive findings of this comprehensive review performed by the internal audit group, the strategy in place does appear to have effect. Having said that, Management requested and obtained a full listing of available reports from GSC to assess and determine if any additional available reporting would be of further assistance in more routinely reviewing employee group trends. Effective immediately, any findings related to employee group trends identified with new reports, will be leveraged in addition to existing reports being utilized, and any findings will be used to further assist with collective bargaining and annual/regular reviews.

2. Management does meet annually with GSC to review service levels, claims trends and other proactive trends relevant in the market (ex. biosimilar pharmaceuticals, infant chiropractic research, etc.) In addition, regular ongoing discussions occur with GSC on an ad-hoc basis to deal with all issues of claim and/or rare service level complaints that arise. While Management is satisfied with current customer service performance deliverables, following receipt of this audit Management worked with GSC to formalize a quarterly dashboard of performance standard measures, relevant stats and claim trends against agreed upon contractual service level deliverables (GreenShield Commitment).

Observation #2 – The adjudication and processing of claims by GreenShield is sound as per the design plan, and Total Rewards staff should continue to work with GSC to ensure that benefit coverages are understood by all staff and potential anomaly areas are satisfactorily examined.

Risk Ranking	MEDIUM

Internal Audit engaged the services of MNP Consulting to perform the following activities:

- Review the oversight and administrative management of the Niagara Region benefit plan by focusing upon the functions performed internally by Total Rewards staff and the contracted activities of GSC staff;
- Conduct data analytics on aggregated source data to identify potential trends, utilization patterns, potential risk areas and support the determination of a sample of claims to be tested further at GSC headquarters; and,
- Develop recommendations for improving the overall internal control environment and the plan design framework.

Following the completion of MNP's data analysis, Internal Audit conducted further testing of a sample of claims at the GSC office in Windsor, Ontario to ensure compliance and to test for potential anomalies identified by MNP.

MNP conducted data analysis on a 24-month period of time based on contract periods, specifically from September 2017 to August 2019. Over that period eligible staff were approved for over $18M in benefit claims as shown on Table 1 below.

TABLE 1 – Summary of Claims by Dollar Value

Service	2017-2018	2018-2019	Total*	Percent
Drug	$3,960,493	$4,053,516	$8,014,009	42.64%
Dental	$3,323,916	$3,464,221	$6,788,137	36.12%
Paramedical Services	$690,181	$776,937	$1,467,118	7.81%
Medical Items	$509,302	$432,894	$942,196	5.01%
Vision	$677,235	$687,149	$1,364,385	7.26%
Accommodation	$57,390	$89,737	$147,127	0.78%
Audio	$29,265	$28,243	$57,507	0.31%
Out of Province	$6,077	$3,283	$9,360	0.05%
Medical Transportation	$2,498	$1,800	$4,298	0.02%
Total	$9,256,356	$9,537,780	$18,794,136	100.00%

*Total includes claims that were auto-coordinated and paid through Health Care Spending Account. For claims that starts and ends within Health Care Spending Account, additional $54,708 and $74,598 were paid in the two plan years respectively.

MNP then proceeded to conduct analytics on various trends, specifically, total claim patterns by employee, claims by various expense categories as listed above and high risk expenses within the categories as well (i.e. within drugs they looked at expenses related to opioids, stimulants and sedatives to determine unusual trends) and claims by vendors for several of the categories.

Claims by Employees – MNP identified the highest claimants by dollar value over the two-year study period. Further testing on these individuals allowed MNP to conclude that all claims were valid and related to specific illnesses. They then looked at employees with the highest volume of claims to determine the types of claims they are submitting for. All claims were adjudicated appropriately by GSC. The second highest claimant was part of Internal Audit's sample for additional detailed testing for drug claims.

Claims by Drug Categories – MNP analyzed the total claims by dollar amount for opioids, sedatives and stimulants. As controlled medications, these three categories are considered the highest risk for potential abuse as validated in audit reports from other jurisdictions. Several other drugs are available to staff through the benefit plan but these would be considered low risk and pose little threat of employee abuse. To conduct this testing MNP looked at eligible drugs under Niagara Region's plan by Drug Identification Number (DIN) for the three main categories listed above. All data analytics were for the two-year period of study as mentioned previously.

Table 2 – Drug Claims by Dollar Value and Claim Volumes

	Dollar Value			Claim Volumes		
	2018	**2019**	**Total**	**2018**	**2019**	**Total**
Opioids	$73,984	$69,092	$143,076	5,261	5,529	10,790
Sedatives	$17,283	$16,724	$34,007	2,338	2,215	4,553
Stimulants	$19,684	$31,173	$50,857	785	880	1,665

For opioids, MNP identified three individuals that exceeded $7,000 in approved claims and several more between $4,000 and $7,000. The total claim amounts for sedatives and stimulants is significantly lower with one claimant in each category exceeding $3,500. For sedatives, only two people exceeded $1,000. Examples of sedatives include Clonazepam and Lorezepam. For stimulants, all employees are under $2,500 except for the one mentioned above. While stimulants such as Viagra and Cialis was an area of abuse found in other audits reviewed, Niagara did not find such issues due to the plan design which does not reimburse many of those same stimulants.

For the three drug categories, Internal Audit staff conducted in depth testing of approved claims and controls within the Advantage system to determine if any controls were circumvented to allow for higher than normal claim amounts. Based on audits from other jurisdictions, the following fraud schemes were identified and tested for:

- Double doctoring – claimants receiving prescriptions from more than one doctor within a very short period of time and having all prescriptions filled
- Double pharmacy – claimants taking the same prescription to multiple pharmacies within a very short period of time and have the prescription successfully dispensed
- By-passing the refill rate and frequency – claimants that have prescriptions with no prescribed refill rate or frequency. It should be noted that many physicians and pharmacies follow the Canadian Guidelines for Safe and Effective Use of Opioids which recommends safe opioid volumes and dispensing rates.

Internal Audit tested the three areas listed above, among other things, and conducted interviews with GSC staff, including its in-house pharmacist. The sample was based proportionately on the volume of claims and dollar value. Audit testing did not reveal any circumvention of system controls. Specifically, audit testing found no instances of double doctoring or double pharmacy with regard to the dispensing of controlled medications beyond the prescribed levels. As noted by MNP, the Advantage system has sound and effective controls that would proactively identify and prevent a claimant from being approved beyond the prescribed parameters. In addition, the system identifies similar prescriptions from multiple providers effectively reducing the possibility of the first two testing areas noted above. Finally, through analytical testing of all claims MNP and Internal Audit did not find any cases where claimants exceeded Health Canada standards for prescription drugs.

For high volume claimants, Internal Audit interviewed GSC pharmacists to determine if there were any unusual trends that may contravene Canadian Medical Association or the Ontario Pharmaceutical Association recommended practices. It was noted that the dispensing rates were compliant and considered best practices. It was also noted Niagara Region's current plan design is effective in supporting staff medical concerns.

Claims by Medical Items – MNP focused on equipment claims that would be considered highest risk, specifically orthopedic shoes, orthotics, compression socks, and braces. High risk is based on several factors including audit reports from other jurisdictions, the number of delisted providers across Ontario and even in Niagara and the overall high dollar amount provided under the plan design can be considered a material amount for fraud to occur.

Table 3 – Medical Items by Dollar Value and Claim Volumes

	Dollar Values			Claims		
	2018	**2019**	**Total**	**2018**	**2019**	**Total**
Custom-made Foot Orthotics	$237,339	$187,935	$425,273	713	575	1,288
Medical Services Includes Eye Examination	$77,679	$83,019	$160,697	1,277	1,360	2,637
Braces	$43,516	$51,413	$94,929	195	193	388

	Dollar Values			Claims		
Compression Stockings	$88,619	$38,142	$126,761	201	140	341
Respiratory / Cardiology	$25,762	$24,604	$50,366	113	120	233
Others	$36,388	$47,781	$84,169	228	264	492
Total	$509,302	$432,894	$942,196	2,727	2,652	5,379

Testing occurred at a couple different levels. MNP and Internal Audit conducted extensive data analytics to determine employees, vendors and even employee group trends focusing on high dollar amounts and volume of claims. Secondly, Internal Audit tested a sample of claims in depth based on the highest users and providers.

From an analytics perspective Table 3 above shows a large decrease in orthotics and compression stockings from 2018 to 2019. While the 24-month trend shows a significant decrease in orthotic claim values, the previous two years (2016 and 2017) were closer to the 2019 levels. Many factors may contribute to the decrease for orthotics including three delisted providers in early 2019. Testing found that one of the delisted providers had paid claims for $47,110 for a 12-month period in 2017-2018. For the next six months, from September 2018 to March 2019 when the same provider was delisted, they were responsible for $46,645 in claims. It is not possible to determine the percent of claims that were incentivized against GSC policy, but the large spike in claims led to an investigation from GSC and eventual delisting.

This also demonstrates, as was shown in other jurisdictions, how fraudulent providers become an attractor for staff in a very short period of time. Among the fraud schemes that occur are ‘bonusing’ or gifting to clients from providers. In other words, employees receive products that are not eligible under Niagara Region’s benefit plan as an incentive to purchase an allowable product. Providers may escalate the price of the eligible product to compensate for the non-eligible product.

For compression stockings, in 2018 GSC altered its reasonable and customary reimbursement levels depending on the length of the stocking and began requiring more information to adjudicate such claims. These changes significantly impacted reimbursement dollar amounts due to altered levels and the number of submitted and approved claims.

For the two-year period under study, the top two claimants under medical equipment was for items not on the list detailed in the table above. All other claimants over a threshold established at $5,000 for employee, spouse and dependent were for one or a combination of items listed. Detailed testing revealed the following:

- The audit found no indication that required rules and documentation were circumvented reinforcing the effectiveness of the Advantage system and GSC adjudicators;
- For one of the delisted providers seven claims for orthotics were tested from different individuals, each having the exact same diagnosis;
- The majority of staff tested all received multiple products from the same provider usually for more than one family member;
- For orthotics, GSC requires thorough documentation including a medical prescription and significant lab documentation from providers prior to approval, minimizing the opportunity for fraud;
- For braces, GSC requires a medical prescription and diagnosis demonstrating need;
- The clarity around the type and dollar amount provided for braces is confusing and has room for improvement given the amount that is available to staff; and,
- The audit found some minor instances of staff converging and favouring one provider, although there was no fraudulent activity necessarily detected. The audit also noted that several providers were delisted, based on regular audit and investigation protocols, possibly triggered by claim spikes which raised red flags at GSC.

Claims by Paramedical Services – Paramedical, or often referred to as Professional Services, includes, among other things, massage, chiropractor, physiotherapy, podiatrist, naturopath, speech therapist and psychological services.

Table 4 – Professional Services by Dollar Value

	2018	2019	Total
Massage Therapist	$319,967	$362,454	$682,421
Chiropractor	$197,733	$223,871	$421,604
Physiotherapist	$112,640	$121,686	$234,326
Naturopath	$23,800	$23,868	$47,668
Psychologist	$16,857	$33,509	$50,365
Other*	$19,184	$11,550	$30,734
Total	$690,181	$776,937	$1,467,118

**Includes speech therapist, acupuncturist, osteopath, podiatrist and dental accident*

As Table 4 details, the amount allocated to paramedical services has increased over the study period by approximately $87,000. For most of these services listed, a physician referral is not required (physician referral is required for speech language pathologist) and in most cases the providers are able to direct bill on behalf of Niagara Region staff. The Advantage® system does not require service providers to upload receipts or other documentation demonstrating work performed unless randomly audited by GSC. Alternatively, for providers that do not have direct billing privileges to GSC, staff can submit a claim online and are only required to submit documentation if GSC selects that claim for an audit.

Niagara Region benefit plans have several different limits, based on per visit and an annual basis. While the negotiated limits vary based on benefit class, they provide an effective control to prevent fraud and collusion among employees and service providers. In addition to the limits, GSC applies reasonable and customary charge limits based on the various types of services which ensures costs for services and products are monitored and controlled within industry standards.

In several audits reviewed from other jurisdictions, paramedical services were abused due to the lack of per visit limits and either no or very high annual limit. Given the plan design limits that Niagara Region has put in place the potential for abuse is greatly reduced. Internal Audit testing at GSC offices revealed no instance of claims being inappropriately adjudicated. In addition, MNP data analytics found, "that there were no claims that exceeded the per visit limit for massages, chiropractic, physiotherapy…" The Advantage® system has access to various professional organizations to ensure that provider's registration is valid and current.

Claims by Vision – Vision benefits range from $350-$450 every two years based on employee group. This total does not include eye exams which was captured under medical items. Table 5 details benefit expenses directly attributable to vision care for the study period. As is shown the costs and number of claims has remained steady over the study period. MNP Consulting did not have any findings related to claims exceeding their limit values over the study period.

Table 5 – Vision Care by Dollar Value and Number of Claims

	2,018		2019	
Glasses	$638,717	2,203	$640,894	2,167
Contact Lenses	$37,295	254	$43,754	289
Other*	$1,224	5	$2,501	8
Total	$677,235	2,462	$687,149	2,464

**Including generally excluded vision services such as laser eye surgery*

Within the study period two optical retailers in Niagara have been delisted by GSC (one in February 2019 and the other in March 2019) convincing Internal Audit staff to continue testing vision benefits from a claims perspective. For 18 months (all within the study period) prior to delisting, both providers combined accounted for $143,053 or 10% of all vision claim dollars within Niagara Region. One of the vendors was the top selling retailer to Niagara Region employees while the other was fourth highest. As noted earlier, it is very difficult to determine what percent of the total sales can be classified as fraudulent.

The sample of claims tested by Internal Audit while at GSC offices revealed that very little documentation is requested from GSC to verify the claims. In other words, providers and claimants are not mandatorily required to upload prescriptions, dispensing date or a detailed breakdown of charges. In addition, in 45 out of 47 claims tested the maximum amount was requested and approved by GSC. Without sufficient documentation it is difficult to determine

the accuracy of invoices or if opticians are 'gifting' clients with additional non-prescriptions products such as sunglasses.

Vision claims account for approximately 1.86% of the total amount of Niagara Region claims yet represent about 7% of dollar value. Although the dollar value claimed slightly decreased from 2018 to 2019, industry numbers indicate a slight increase for vision care. In speaking with staff within the GSC investigations team, vision is an area of focus for them as the number of claims and providers is increasing.

Claims by Health Care Spending Account (HCSA) – Non-union staff are provided with an additional $600 HCSA that can be applied towards any eligible expense. Eligible expenses for employees or dependent(s) include those that qualify for medical expense tax credits under the Canada Revenue Agency (CRA) Income Tax guidelines. In most cases, the HCSA is used to either acquire certain products that are not part of the current Niagara Region offerings, i.e. osteopath services, or to allocate funds towards a Regionally-approved service after the limit has been exhausted.

Table 6 – HCSA Only and Auto-Coordinated Claims

	Dollar Values			Claims		
	HCSA Only	Auto-Coordinated	Total	HCSA Only	Auto-Coordinated	Total
2018	$54,708	$85,688	$140,396	672	2,473	3,145
2019	$74,598	$129,425	$204,024	794	3,543	4,337

In 2019, the HCSA amount per full time, non-union employee increased from $300 to $600. Due to that plan change the overall amount spent on HSCA claims increased from $140,396 in 2018 to $204,024 in 2019. For reimbursement under HCSA claims must be submitted by an employee, not a provider. HCSA claims can initiate from several streams:

- Financial top up to a traditional claim whereby the maximum allowance has been exhausted;
- Coordination and top up from a traditional claim from a secondary provider; and,
- A claim that starts and ends within HCSA. (Shown as HCSA Only Claims in Table 6).

For the first two streams listed above, either GSC or the secondary provider may have requested documentation to verify the claim and possibly even audited the claim. Audit testing has shown that the degree of due diligence to substantiate claims is significantly reduced for HCSA claims than regular claims. In other words, for many regular claims submitted by staff documentation must be uploaded while for HCSA submitted claims for similar services or products, there is no online prompt requesting documentation. GSC can audit a claim once it has been submitted but it does not request documentation upfront. The administrative rules and adjudication process is reduced for HCSA claims to align with the CRA guidelines. Finally, according to GSC, the audit rate for HCSA claims is approximately

5%. This may be due to the diligence provided in the first two claim initiating streams depicted above.

Implication

Total Rewards, has insufficient capacity to review ongoing claim data analytics to proactively identify potential areas of fraud.

Insufficient documentation requirements for vision claims, combined with limited data analytics, may contribute fraudulent claims and future cost escalations.

Reduced claims audit and claims documentation for HCSA related claims may result in employee abuse through fraudulent claims.

Recommendation

1. Total Rewards should review the number and quality of reports it receives to improve the ability to proactively identify potential fraudulent activity.

2. Total Rewards should consult with GSC at increasing documentation levels for vision related claims to minimize the potential for 'gifting' or false claims from providers and employees

3. Total Rewards should consult with GSC to improve the due diligence, documentation required and audit rate related to HCSA claims.

Management Action Plan

Person(s) Responsible Linda Gigliotti
Kristen Angrilli

Completion Date Ongoing

1. Management is pleased with the overall positive findings in this report, and the current strategies in place with the provider, benefits consulting agency, and internally in Human Resources. Having said that, and as stated in response to Observation #1, Management is fully supportive of further reviewing additional reporting available by GSC to identify any additional opportunities for employee group trends that do not duplicate efforts already in place and appropriately respect privacy requirements. Management has already begun this process and will immediately implement any reasonable findings.

2. Management understands the opportunity for potential misuse of vision related claims based on lump sum coverage as opposed to a requirement for prescription level

reporting on claim submission. It is important to note however that any change to plan design would need to be considered as a negotiated item and be addressed through collective bargaining. Management is reviewing with Labour Relations the potential to update plan design to require a change to lens prescription vs. a fixed two year lump sum for vision coverage, however it is understood that any change to plan design through collective bargaining would be addressed on a case by case basis for each of 6 union employee groups, and if proposed requires union agreement through the collective bargaining to achieve. Protocols are already firmly in place that any proposed changes to plan design balance cost containment, value, need, administration, overall wellness and affordability.

3. As noted in the audit, HCSA benefits are currently only available to non-union employees with a cap of $600 per year for eligible expenses. This represents approximately 2% of overall health/dental claims, and given that approximately 82% of those claims are further auto coordinated as part of a top-up of another health/dental claim, these claims are subject to the same scrutiny as the related non HCSA claims (ex. using HCSA as a top-up of a dental claim to make up the difference between current ODA rate vs. plan prior year ODA rate, is still subject to the same scrutiny for claim coverage eligibility as part of the original dental claim). Furthermore, HCSA claims still experience an additional 5% audit rate. Finally, of the total dollars allocated towards HCSA in 2019, only 55% of the allocated funds were actually paid as eligible claims further indicating a low risk of misuse. Given the overall low risk and dollar value, and attempting to balance the needs for convenience and efficiency of the HCSA plan, Management views the level of existing audit and documentation in place for HCSA as reasonable and effective.

Observation #3 – The benefit plan design, along with the number of benefit classes has evolved over the years to the point where corporate and employee needs may need to be reconsidered and incorporated into an overall change initiative.

Risk Ranking	LOW

MNP worked with Jackson and Associates (J&A), a benefits consultant, to recommend industry trends Niagara Region should potentially consider to reduce administration costs while satisfying employee needs. The scope of work for MNP Consulting, with J&A support included:

- Providing advice on administrative solutions and modern trends on benefit plan designs, and
- Make recommendations and highlight employee benefit oversight practices through benchmarking, researching industry and employment trends.

MNP provided a briefing and shared their final report with staff from Total Rewards and others within Human Resources. A summary of observations and recommendations is below.

- Niagara Region should receive and review regular reports from GSC based on high volume providers/suppliers to ensure processing accuracy and develop or update a preferred provider network for staff;
- Review the drug formulary as Niagara Region's drug claim rates are slightly higher than similar comparators. This observation can be considered in conjunction with later recommendations on transitioning to a wellness strategy and vision;
- Total Rewards should request and receive detailed reports for medical items broken down by individual items instead of summaries to allow for greater comparisons and trend analysis;
- Niagara Region should conduct analysis, annually or biennially, of outlier providers and employees to detect potential fraudulent activity;
- Streamline the number of benefit classes to reduce overall administration costs. A reduction in benefit classes can make Niagara more attractive to benefit carriers, potentially lowering ASO costs, reducing internal administrative costs and the re-allocation of resources towards optimizing benefits for employees;
- Employee groups are individually focused on employee health and mental wellbeing. Niagara Region should work with the various groups to develop an overall mission and vision that focuses on wellness and promotion of a healthy lifestyle;
- The Wellness approach must be collaborative in nature, ensuring that all groups are represented and consensus is achieved with a well defined conflict resolution process;
- Total Rewards will need to monitor closely program changes and report semi-annually or annually to the employee groups demonstrating the changes that occurred and potential benefits achieved to the corporation and for the employees.

Implication

By not consulting with the various employee groups and conducting a strategic planning review Total Rewards and Human Resources may not fully capitalize on potential operational and administrative opportunities:

- To improve its benefit plan for employees;
- Strengthen the overall plan design;
- Monitor employee and vendor trends; and,
- Streamline the number of benefit classes thus reducing the administration burden.

Recommendation

1. Total Rewards should review its current portfolio of reports received from GSC and identify, based on J&A observations, more detailed claim reporting that would support a proactive approach to monitoring employee and provider fraud. These reports will also lead to a Niagara-made preferred professional list.

2. Human Resources should review and work with various employee groups to reduce number of benefit classes.

3. Total Rewards, with the support of Human Resources and in consultation with the employee groups, should conduct a strategic review of the benefit plan to ensure it meets the changing needs of employees including a greater focus on wellness, mental health support and an overall healthy lifestyle.

Management Action Plan

Person Responsible Linda Gigliotti
Kristen Angrilli

Completion Date 1. Ongoing
2. End of Q2 2021
3. End of 2021

1. As stated in Observation #1 and #2, Management supports the need to review existing reports and in the spirit of effectiveness and efficiency, will not duplicate all of the reviews and audits already in place, but is reviewing the current availability of data to determine if any additional audits would garner an increase in the already high level of risk reduction in our plan designs and existing audits. Management does not however support leading to a preferred provider list, and instead wishes to promote choice in

our health care professionals and service providers, and contain cost and risk through prudent benefit plan design and cost containment measures.

2. Management acknowledges the current number of benefit classes that have been established over many years is the result of some past practices and not aligned with Niagara Region's current strategy due to potential impact to the overall plan marketability. Currently, the process of introducing new benefit classes has been contained for the past several years. The current strategy is also to look for opportunities to merge benefit classes, including the potential for Niagara Regional Housing benefits to merge with other similar/existing classes in future. Management also acknowledges however that the reduction of benefit classes is largely dependent on the collective bargaining process with its 6 union employee groups and would require a total compensation mandate that is properly funded to make any meaningful change in the total number of benefit classes. GSC has confirmed that in comparison to other municipal clients in their book of business, Niagara Region's number of classes are tightly managed and have no real bearing on overall pricing.

3. Management fully supports and endorses the importance of a Total Rewards Strategy as part of the broader People Strategy and overall health and wellness initiatives at Niagara Region. Management also understands this strategy needs to be revisited on a regular basis to ensure its ongoing value. To that end, a new Total Rewards Strategy is already part of the overall Human Resources 3-year plan and objective setting. The strategy will contemplate wellness, preventative health care, mental health, overall affordability and consumerism. A significant focus is placed on responding to changing trends with our providers, including our Employee and Family Assistance Plan providers, to provide education, awareness and communications for our employees that enhance physical, social and mental well-being. Niagara Region also introduced an Employee Engagement survey and program in 2019 to address and understand the needs of employees. Finally, in addition to capturing the needs of our non-union staff, as part of each round of collective bargaining, there is a proactive approach to understanding what priorities exist with each unique union employee group, and how those priorities can best be addressed through collective bargaining (for example, increased coverage for mental health benefits for paramedics to address evolving needs).

Appendix 1 - Rating Scale

Rating	Definition
CRITICAL	Requires immediate action by Senior Management to avert a severe/disastrous risk event in the near-term. Internal controls are deemed to be ineffective, absent or poorly designed. Management Actions Plans (MAP's) are to be implemented immediately to mitigate risk of substantial financial losses, business interruption, loss of reputation and/or environmental, public health & safety risk.
HIGH	Requires prompt action by Management to avert, reduce or transfer a major risk event. Internal controls are deemed to be ineffective, absent or poorly designed. MAP's should be implemented to mitigate the risk of financial losses, loss of reputation, address fraud issues or legal/regulatory non-compliance.
MEDIUM	Requires timely actions by Management to reduce risks to a low level. Internal controls are deemed to be ineffective or poorly designed. Management action is required, but is not immediate. Moderate financial losses, temporary/minor reputational impairment, lesser potential for fraud or regulatory non-compliance may occur without timely MAP's.
LOW	Management actions are recommended to address the weaknesses identified. Internal controls are operating effectively or partially address the control objective; however they may be poorly designed and/or operational inefficiencies exist which may result in an opportunity for improvement. Low risk events may cause operational inconvenience or minor financial losses.