hms
Enterprising healthcare

Dependent Eligibility Verification

What You Need to Know and Why It Matters

Background

Dependent eligibility verification is a process that reviews the eligibility of the dependents enrolled on an organization's health benefit plan. This can be done retrospectively, as new dependents are added to the plan, or both. Essentially, the process involves:

1. Requesting employees provide documentation that proves their relationship to the dependents enrolled on their employer's health benefit plan; and
2. Verifying the relationship meets the definitions of eligible dependents under plan guidelines.

Employers typically conduct dependent eligibility verification on spouses, domestic partners, children, or other dependents included in the summary plan description or other plan documents. Verification offers employers several benefits, including the ability to achieve significant savings in their health spend.

This is why it's vitally important that employers understand their plan's definition of a dependent and that a dependent's status can change.

An organization can conduct a dependent eligibility verification itself, using internal resources and employees, but doing so requires a considerable allocation of time and preparation, including practical considerations like document storage and phone support. Most organizations choose a third-party vendor. The following information is based on an employer-vendor relationship.

Why conduct a dependent eligibility verification?

HMS has a history of completing more than 1,500 dependent eligibility verifications, reviewing more than 4.5 million dependents. From this experience, there are several common reasons an employer would conduct a dependent eligibility verification:

- Identify savings opportunities
- Preserve health benefits without raising an employee's out-of-pocket costs
- Enhance the employer's fiduciary oversight and management under ERISA or other compliance standards
- Validate information on file to accurately process health benefits in accordance with benefit designs
- Improve the current process of enrolling, re-enrolling, and processing family status changes
- Educate employees about the value of their benefit package

Employer savings opportunity

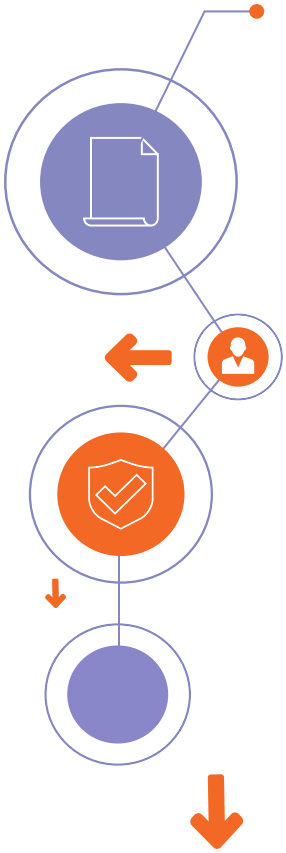
The table below is an example of the potential savings an organization can achieve with a dependent eligibility verification. It shows the average number of employees with dependents and the average number of enrolled dependents per employee. Applying these averages to an employer's own plan can help determine the impact a verification may have.

On average, a plan with 5,000 employees may typically experience:

- **8%:** Verified ineligible dependents
- **$3,500 per year:** Cost per member for medical and prescription coverage

Sample Savings

Employees with no dependents	2,500
Employees with dependents	2,500
Dependents	5,250
Ineligible Dependents	420
Approximate savings for an employer with 5,000 employees	$1.5 million



Four phases

1. Planning

An employer needs approximately 30 days to complete the planning necessary to initiate the dependent eligibility verification. Typical planning tasks include: identifying the review population, preparing communication, and building the web portals.

2. Verification

Verification may range from 25 to 45 days depending on the vendor, the type of verification selected, and the organization's goal. This is the core phase of the review. During this period, the vendor sends out a notification directly to plan members about the review, why it is being conducted, how the process works, where to go for additional information, what documents are needed, and how to submit documentation. Typically, the initial message is similar to this:

> "In an effort to preserve current employee and family health benefits, we will be conducting a dependent eligibility verification. This will ensure we are covering only those members that meet our eligibility rules under our summary plan description."

The employer should use all available media to reach as many employees as possible. This could include company internal communications such as a newsletter article, intranet notice, email, social media posting, video message, and a phone push. It is important to ensure that all employees are notified about the verification.

Further, the process of document submission should be made as simple as possible by offering multiple options: mail, fax or electronic. The best partners will also offer support of mobile devices. HMS has found that if multiple response options are available, 85% of participants can complete the process with a single attempt.

3. Grace/Appeals

The average grace/appeals phase is 15 to 20 days, and it begins at the conclusion of the verification period. This time allows for additional outreach to maximize employee response rates. Organizations should work closely with their vendor to coordinate emails, phone calls, and other communication alternatives that will increase response rates and reduce true appeals after coverage has been terminated.

After the grace/appeals period is over, it is reasonable to expect 1.5% of dependents who have been removed may ultimately be reinstated on the plan. This is usually because they have located missing documents or have realized the consequences of not responding by the required deadline.

4. Follow-through

When the verification is complete, the vendor should provide the employer with a file of dependents who may be considered ineligible. The file should indicate dependents who voluntarily self-reported their ineligibility, those who partially submitted data but did not fully comply, and those who did not submit any information for consideration. At this point, the employer should proceed to remove these dependents from the appropriate health plans.

Once an employer processes the termination transactions and notifies the employees and their dependents of their removal, there will likely be appeals.

On a case-by-case basis, management and human resources typically consider if a dependent should be put back on a plan. Experienced vendors offer a service that handles post-termination appeals as an option to the verification.

This reinstatement period usually runs an additional 30 days after terminating the ineligible dependents. It may or may not run concurrently with the original verification.

Resolving common issues

After the verification is complete, a small percentage of terminated dependents will continue to send paperwork to the vendor. The vendor should notify the member they will not act on these documents and should point them to their human resources department.

HMS recommends employers terminate coverage on those dependents who have voluntarily identified themselves as ineligible and those who have not responded to the verification request.

What about dependents who have not responded to the verification request? HMS recommends employers terminate coverage on those dependents who have voluntarily identified themselves as ineligible and those who have not responded to the verification request. By terminating only the voluntarily reported dependents, the employer could unintentionally send a message to employees that there is no need to respond to future verifications.

On average, 5% of the dependents do not respond to the verification process. About 1.5% of dependents are reinstated on the plan within 60 days of verification.

Preparing for a dependent eligibility verification

After choosing a vendor, an employer can prepare for a dependent eligibility verification by taking these steps:

- Educate management about the objectives of the verification and how they can help ensure its success.
- Train the human resources team to understand their role and establish proper protocols. Even with the vendor handling most of the customer service, the employer will receive questions, complaints, and appeals the human resources team will need to address.
- Work with the vendor on all communications to plan members, including advance notification of the upcoming verification. Make sure all messages are clear and concise to improve the response rate, decrease member complaints, and ease the work of human resources.
- Notify the vendor of any security protocols and vendor requirements as soon as possible to avoid delays.
- Prepare to follow the agreed-on timeline. An interrupted timeline affects the vendor's resources, including the call center, auditors, or project management support. Interruptions could have a negative impact on the quality of the verification and the results.
- Provide eligibility definitions and summary plan description to the vendor.
- Finalize communications to employees and the transmission of appropriate data files.

Contributing factors for savings

The amount of money an organization saves by conducting a dependent eligibility verification depends on several variables:

1. Industry

The employer's industry will likely impact the number of dependents enrolled in the plan and the cost per member.

Industries and employers with a higher degree of turnover typically have a greater potential for savings. For example, a technology company may have a smaller percentage of employees with dependents due to the lower average age of employees.

Unions and federal employers may have a higher dependent ratio due to negotiated contract provisions that allow expanded eligibility. Thus, they may have a higher dependent count per employee (2.5:1 vs. 2:1).

2. Process

The verification process itself can impact the results in several ways:

- The number of communications to employees should be scaled for the length of the verification. Too few will mean a poor response rate, and too many will cause diminished returns – and might irritate employees.
- The employer should send at least three communications to employees to achieve a reasonable response rate.
- The employer should collaborate with the vendor to determine the frequency and content of the communications.

3. Response rate

The percentage of employees responding with documentation is critical to the success of the dependent eligibility verification.

The goal is to achieve a high response rate — above 95% — to minimize appeals and complaints. The higher the response rate, the more credible the projected savings. If the response rate is low — 80% or below — the employer could have a high number of appeals and complaints by employees whose dependents have been removed from the plan.

4. Timeframe

The timeframe of the verification could impact both the results and the cost.

If too little time is allowed, employers will probably have a low response rate and a high number of complaints and costly appeals. If the process is too long, an employer could be paying for unnecessary elements and may experience employee irritation.

5. Communication

The clarity of communications can significantly affect the results of the verification.

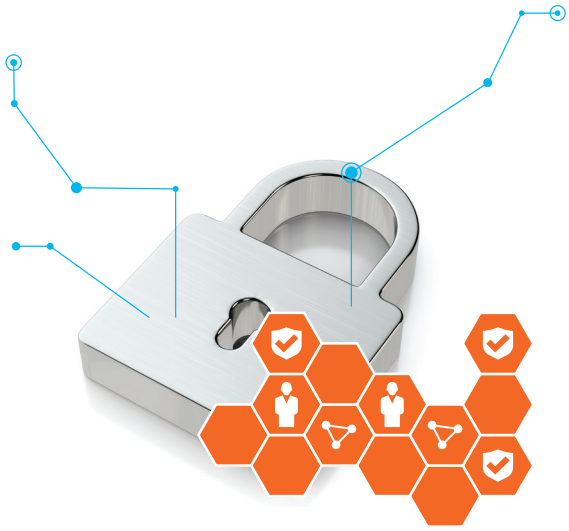
Mailing envelopes should show the organization's logo to ensure that employees read the communication. The vendor should use all available media to reach employees and increase the response rate. Employees should have a variety of ways to respond. The best vendors enable employees to respond using mobile technology because it has been proven to be one of the most effective ways of member compliance and response to the verification.

Choosing the right vendor

Since a dependent eligibility verification can have a considerable impact on employees' lives and can certainly affect their opinion of the company, it is important to choose a vendor that understands an organization's culture and needs.

Key considerations include:

- **Experience.** Work with an experienced vendor who is experienced and has references to validate results. Vendors who shortcut the process or charge below-market fees may create higher member dissatisfaction and a lower response rate. Look for a vendor with proven results.
- **Process.** Discuss timeline, communication, and employee education, as all can impact response rates.
- **Priorities.** The vendor should focus on the verification, not on add-on services. Some vendors perform verifications as a way to offer members other products, such as voluntary benefits. This can be disruptive and diminish the ability to conduct a high quality verification with minimum employee abrasion.
- **Flexibility.** Best-in-class vendors offer many types of products to suit a client's specific needs, rather than a one-size-fits-all approach. Some vendors may offer only retrospective verifications; others may offer services for new hires.
- **Capability.** Vendors who provide the ability to collect a wider range of information can add value to the review process. This information could include social security numbers, attestations for smoking cessations, and affidavits of working spouses.
- **Systems and document submission.** The vendor should offer robust systems that allow employers and employees to track documents and identify resources. Vendors should also allow employees several options for submitting data.
- **Timing.** Employers typically want to perform verifications right after open enrollment. This is valid, as companies can use this time to process new employees and family status changes. However, verifications performed outside of the open enrollment period can maximize immediate savings and reduce the number of ineligible transactions that occur during open enrollment.
- **References.** Ask vendors specific questions about the process, including what the typical response rate is and how many communications are used to achieve it.
- **Security.** The vendor should have the appropriate certifications and meets or surpasses industry standards regarding secure processes and staffing. The sensitive data from a verification requires specific handling and storage standards.



- **Exceptions.** Employers who want to make exceptions to plan definitions should discuss these with the vendor prior to project implementation. Exceptions may include special handling for executives, excluding dependents who have had previous verifications, or other exceptions.
- **Internal resources.** Know the internal resources required for a successful verification. In addition to planning, most verifications require between 10 to 20 hours of work from human resources staff, or more hours for larger organizations. As a rule of thumb, employers with less than 50,000 members can plan for five hours of work for every 2,500 members covered. Employers also need to involve the information technology team or enrollment vendor to obtain the necessary data files and the legal department to review the contract.

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New developments

Using a $3,500 member-per-year average savings model, every ineligible member costs an organization approximately $292 a month. Employers who want to prevent unnecessary spending are conducting more frequent verifications to ensure ineligible dependents are not continually added to the health benefit plan.

To meet this need, enrollment companies and some vendors have created point-of-enrollment solutions to verify all new dependents at the time of enrollment. With this integrated verification approach, the vendor requests documents and verifies eligibility before or soon after the dependent is enrolled in the plan.

The point-of-enrollment process helps minimize the number of ineligible dependents added to the plan, but it does not eliminate the need to conduct reviews retrospectively, as relationship statuses change.