Claim Administration Audit

HEALTH REIMBURSEMENT ARRANGEMENT

State of Nevada Public Employees' Benefits Program Health Reimbursement Arrangement Plan

Administered by Via Benefits from Willis Towers Watson

Audit Period: July 1, 2023 through June 30, 2024
Plan Year 2024

Presented to

State of Nevada Public Employees' Benefits Program

November 21, 2024

CLAIM TECHNOLOGIES INCORPORATED

PART OF THE BROWN & BROWN TEAM

Proprietary and Confidential

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EXECUTIVE SUMMARY

This Comprehensive Audit Report is a compilation of the detailed information, findings, and conclusions drawn from Claim Technologies Incorporated's (CTI's) audit of Via Benefits from Willis Towers Watson's administration of the State of Nevada Public Employees' Benefits Program (PEBP) Medicare Exchange Health Reimbursement Arrangement (HRA) plan.

Scope

CTI performed an audit of Via Benefits' administration of the PEBP HRA for the period of July 1, 2023 through June 30, 2024 (plan year 2024). The population of claims and amount paid during the audit period was taken from the paid claim file provided by Via Benefits.

Health Reimbursement Arrangement (HRA)	
Total Paid Amount	$18,931,372
Total Number of Claims Paid/Denied/Adjusted	191,726

The audit included the following components which are described in more detail in the following pages.

- Operational Review
- Random Sample Audit
- Eligibility Verification

Auditor's Opinion

Based on these findings, and in CTI's opinion:

1. Via Benefits again improved service to PEBP's members and exceeded all performance guarantees for FY2024.
2. Although Via Benefits provided good service to PEBP's members, CTI recommends the following area for improvement:
    - Provide claim processors with coaching on the errors identified during the audit.

Summary of Via Benefits Guarantee Measurements

Based on CTI's Random Sample Audit results, Via Benefits met all three of the annual metrics for PEBP in plan year 2024.

FY 2024 Annual Metrics	Guarantee	Met/Not Met	Penalty
Claim Financial Precision	98%	Met–99.00%	$0
Claim Processing Payment Precision	98%	Met 99.00%	$0
Claim Processing Turnaround Time	Average 2 business days	Met – 0.44 days	$0
		Total Penalty	$0

AUDIT OBJECTIVES

This report contains CTI's findings from our audit of Via Benefits from Willis Towers Watson (Via Benefits) administration of the State of Nevada Public Employees' Benefits Program (PEBP) Medicare Exchange Health Reimbursement Arrangement (HRA) plan. We provide this report to PEBP, the plan sponsor, and Via Benefits, the claim administrator. A copy of Via Benefits' response to these findings can be found in the Appendix of this report.

CTI conducted the audit according to accepted standards and procedures for claim audits in the health insurance industry. We based our audit findings on the data and information provided by PEBP and Via Benefits. The validity of our findings relies on the accuracy and completeness of that information. We planned and performed the audit to obtain reasonable assurance claims were adjudicated according to the terms of the contract between Via Benefits and PEBP.

CTI specializes in the audit and control of health plan claim administration. Accordingly, the statements we make relate narrowly and specifically to the overall effectiveness of policies, procedures, and systems Via Benefits used to pay PEBP's claims during the audit period. While performing the audit, CTI complied with all confidentiality, non-disclosure, and conflict of interest requirements and did not receive anything of value or any benefit of any kind other than agreed upon audit fees.

The objectives of CTI's audit of Via Benefits' claim administration were to determine whether:

- Via Benefits followed the terms of its contract with PEBP;
- Via Benefits paid claims according to the provisions of the plan documents and if those provisions were clear and consistent; and
- members were eligible for PEBP's benefits at the time a service paid by Via Benefits was incurred.

OPERATIONAL REVIEW

Objectives

CTI's Operational Review evaluates Via Benefits' claims system, staffing, and procedures related to administration including enrollment, customer service, and overpayment recovery. We also used the Operational Review to verify compliance with contract terms and in support of our Random Sample Audit activities.

Scope

The scope of our review included:

1. Claim administrator information
    - Insurance and bonding
    - Conflicts of interest
    - Performance standards
    - Business continuity planning
    - System software
    - Offsite claim administration
2. Claim funding:
    - Claim funding mechanism
    - Check processing and security
3. Claim adjudication, customer service, and eligibility maintenance procedures:
    - Contributions and rollovers
    - Claim processing
    - Customer service call and inquiry handling
    - Overpayment and adjustments
    - System security
4. Privacy and security compliance

Methodology

CTI used an Operational Review Questionnaire to gather information from Via Benefits. We reviewed Via Benefits' responses and any supporting documentation supplied to gain an understanding of the procedures, staffing, and systems used to administer the PEBP's HRA plan. This allowed us to conduct the audit more effectively.

Findings

We observed the following from Via Benefit's response to the operational review questionnaire:

- Via Benefits indicated it maintained levels and types of insurance reasonable and customary for a health services organization with comparable size and market presence.
- Willis Towers Watson (WTW), parent company of Via Benefits, reported that it had been audited by KPMG LLP, for compliance with the standards of the American Institute of Certified Public Accountants through the issuance of a Service Organization Controls (SOC) 1 Report and provided CTI a copy of the report.

- The business continuity plan provided by Via Benefits included two approaches to data protection: 1) continuous off-site replication to a second, geographically distant location and, 2) the use of daily backups of files and databases.
- Via Benefits indicated no claim processing functions, member services, or provider services were outsourced.
- Refunds and return checks were forwarded to PEBP to deposit to PEBP's bank account.
- Via Benefits indicated PEBP provided the allocation amount for which participants were eligible. Effective May 31, 2021, PEBP implemented an $8,000 cap on the available balance.
- Via Benefits indicated loss of HRA eligibility was the biggest reason for a claim overpayment. Via Benefits did not provide an HRA overpayment report for FY2024.
- Customer service operations were available via phone Monday through Friday from 5:00 AM to 4:00 PM PST.
- The member online portal allowed claim submission, check claim status, check participant balances, supporting documents submittal, and viewing of historical information.
- Via Benefits communicated with account holders via mail or email. It provided digital newsletters approximately every two months, a one-time enrollment guide mailing when a participant aged into Medicare, and a one-time HRA welcome packet mailing upon initial qualification.
- Via Benefits reported it used secure system passwords and system authorization, as well as separation of duties for system security. It also limited access to eligibility maintenance and claim adjudication.
- Via Benefits' internal system control document provided a thorough overview including detail on data entry logic, duplicate logic, and overpayment logic as examples.
- Web-based security and compliance training was provided to Via Benefits staff within 90 days after hire and then annually thereafter.
- Via Benefits reported there were no privacy or security breaches identified during the audit period.

Performance Guarantee Validation

As part of CTI's audit of PEBP, we reviewed the Performance Guarantees included in its contract with Via Benefits. The self-reported results for plan year 2024 follow.

Metric and Service Objective	Actual	Met/ Not Met
Reports Annual Review: Reports provided within 15 days.	All reports delivered within 15 days	Met
HRA Web Services Annual Review: 99% availability of web services for benefit information and HRA information exclusive of scheduled maintenance.	99.98%	Met
Customer Service Abandon Rate Annual Review: The percentage of incoming calls abandoned by participants be 5% or less.	2.37%	Met
Customer Service Speed to Answer Quarter Review: Incoming telephone calls answered in less than or equal to: Ninety seconds in Q1 PY 2024 Five minutes in Q2 PY 2024 Two minutes in Q3 PY 2024 Ninety seconds in Q4 PY 2024	 Q1 PY 2024 – 0:10 Q2 PY 2024 – 1:28 Q3 PY 2024 – 0:26 Q4 PY 2024 – 0:10	Met
Customer Satisfaction Quarter Review: At least 80% of participants surveyed will be satisfied with services.	Q1 PY 2024 – 92.31% Q2 PY 2024 – 87.47% Q3 PY 2024 – 92.12% Q4 PY 2024 – 90.48%	Met
Disclosure of Subcontractors Per Violation: additional subcontractors shall not be engaged, unless at least 60 days prior notice to the engagement of a new subcontractor.	100%	Met
Unauthorize Transfer of Data Per Violation: All data will be stored, processed, and maintained on designated servers. Any changes must have 60 days notification.	100%	Met

RANDOM SAMPLE AUDIT

Objective

The objective of the Random Sample Audit was to identify any administrative process deficiencies in PEBP's health reimbursement arrangement claims.

Scope

The Random Sample Audit included a random sample of 200 HRA claims paid or denied during the audit period. Via Benefits' performance was measured for the following key performance categories:

- Claim Financial Precision
- Claim Processing Payment Precision

We also measured claim turnaround time, a commonly relied upon performance measure.

Methodology

The Random Sample Audit was conducted remotely at CTI's Des Moines, Iowa office. A CTI auditor reviewed each sample claim selected to determine if it was paid or processed correctly based on member eligibility or plan provisions as defined in the plan documents or amendments.

CTI cited errors when a sampled claim was determined to have been paid or processed incorrectly. Payment errors were observed based on how the selected claim was paid and the information Via Benefits had at the time the transaction was processed.

Findings

CTI defines claim financial precision as the total correct claim payments made compared to the total dollars of correct claim payments that should have been made for the audit sample. Claim processing payment precision is defined as the total number of payments made correctly without a payment or nonpayment error compared to the total number of payments issued. The sampled claims were selected from the PEBP HRA claims processed during the 2024 plan year.

Via Benefits did meet the performance guarantees for claim financial precision, claim processing payment precision, and claim turnaround time.

Note: A summary of each finding follows the chart below.

Performance Measure	Claims Sampled		Sampled Claims with Errors		Results
	Claims	Dollars Paid	Claims	Dollars Paid	
Claim Financial Precision	200	$18,509.50	2	$184.70	99.00%
Claim Processing Payment Precision	200		2		99.00%
Claim Turnaround Time	Average 2 business days				0.44 days

Random Sample Findings Detail Report			
Audit Number	**Over/(Under) Paid**	**Via Benefits Response**	**CTI's Conclusion**
Duplicate Payment			
1017	$174.70	Agree.	Procedural error and overpayment remain. The claim was a duplicate payment.
Paid Ineligible Procedure			
1007	$10.00	Agree.	Procedural error and overpayment remain. An ineligible charge on the claim submission was paid.

Additional Observations

During the Random Sample Audit, CTI's auditor observed the following procedures or situations that may not have caused an error on the sampled claim but may impact future claims or overall quality of service.

Audit Number	Observation
1011, 1092, 1122	Via Benefits' protocol is to process claims as one payment for multiple receipts. Best practice is to separate individual claims to identify and prevent duplicate payments. In the samples cited, multiple receipts were combined into one claim.

ELIGIBILITY VERIFICATION

CTI electronically compared dates of service to PEBP's electronic eligibility file received from TELUS Health. The screening revealed that some services were paid during the audit period for potentially ineligible claimants. The output was provided to TELUS Health for their review and comment. At this time, potentially overpaid amounts have been flagged into one of the following categories:

Description	Claim Lines	Members	*Paid Amount
Member Not on File	326	27	$42,871.38
Incurred After Member Benefit End Date	201	71	$26,095.24
TOTALS	**527**	**98**	**$68,966.62**

**CTI notes that 0.36% of PEBP's total medical spend processed by Via Benefits was identified as paid for members who may not have been eligible for coverage. These results are within the norm of less than 0.5% CTI generally reports.*

PLAN YEAR 2024 RECOMMENDATIONS

CTI has the following recommendations based on the findings of the Plan Year 2024 audit of Via Benefits:

1. Via Benefits should coach its claims processors on errors identified during the audit including:
    - Duplicate payments
    - Payment of ineligible expenses

CONCLUSION

Via Benefits met the performance metrics for claim financial precision, claim processing payment precision, and claim turnaround time for FY2024.

We consider it a privilege to have worked for, and with, your staff and administrator. Thank you for choosing CTI.

APPENDIX – ADMINISTRATOR RESPONSE TO INITIAL REPORT

Additional information submitted to CTI from the administrator in response to the initial report is reviewed and observations may be removed prior to the final report being published. While a removed observation will not be included in the final report, it may be referenced in the administrator's response to the initial report.

October 10, 2024

State of Nevada Public Employees Benefits Program:

On behalf of Willis Towers Watson (WTW) regarding the draft report of the Audit of the State of Nevada Public Employees' Benefits Program Health Savings Account and Health Reimbursement Arrangement for the period of July 2023-June 2024 please see our response to the report and the auditors recommendations below:

Observation:

Below is our logic and rules on why we combined the claim into one claim line instead of multiple lines:

The term, "Clubbing," refers to combining multiple expense amounts and/or dates of service found on supporting documentation and entering them into one claim line instead of several individual claim lines in CPI.

Required Information:

In order to "Club," expenses, the requirements below must be met. Eligible Health Care Expenses that are on the same document (EOB, receipt, statement, or invoice) and meet the criteria below, must be clubbed into one claim line entry if applicable.

Expenses must be fore the same person (participant or dependent)

- Expenses must be on the same document (Please note that multiple individual strips or receipts that are put on one piece of paper should not be clubbed)
- Expenses must be for the same provider
- Expenses must be fore same Category/Claim Type
- Expenses must be fore the same calendar year

Guidance:

Common documentation that can be used to club expenses:

- Prescriptions
  - Cash register receipts (Meaning all eligible items contained in one receipt should be clubbed including tax on those items if applicable)
  - Ledgers from the pharmacy
- Dental Expenses
  - Invoice
  - Statement
  - Ledger
  - EOB
- Medical Expenses

- EOB
- Invoice
- Statement
- Ledger

Claim Entry Instructions:

- If there are multiple years on the same document, do not enter a line that crosses plan years when clubbing.
  - Processor must enter a clubbed line for expenses within the same year.
    - For example, if the ledger has dates from 2017 and 2018 – processor would club all expenses for 2017 and enter into one claim line and then enter a second line for expenses from 2018.
- If the required information listed above is not met, do not club the lines. Enter the Health Care Expenses on individual claim lines per claim processing guidelines.

Recommendations:

1. Via Benefits should coach its claims processors on errors identified during the audit including:
   - Duplicate payments
   - Payment of ineligible expenses

WTW Response:

WTW's Claims Manager has confirmed that claim processors are coached on all identified errors, and we have shared the report broadly with the onshore team.

In conclusion this audit has provided valuable insights. We are confident the recommendations outlined in this report will contribute to the continued success of service to the participants. We appreciate the cooperation demonstrated by Claim Technologies Incorporated on behalf of the State of Nevada Public Employees' Benefits Program. We look forward to our continued partnership.

Claim Technologies Incorporated representatives may from time to time provide observations regarding certain tax and legal requirements including the requirements of federal and state health care reform legislation. These observations are based on our good-faith interpretation of laws and regulations currently in effect and are not intended to be a substitute for legal or tax advice. Please contact your legal counsel and tax accountant for advice regarding legal and tax requirements.

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