Medicare Exchange

Health Reimbursement Arrangement

Audit Report

for

Nevada PUBLIC EMPLOYEES' BENEFITS PROGRAM

Conducted on

Willis Towers Watson

Audit Period:
PEBP Plan Year 2020

Submitted By:
Health Claim Auditors, Inc.

TABLE OF CONTENTS

State of NV. PEBP - Health Reimbursement Arrangement

Introduction

The State of Nevada Public Employees' Benefits Program (PEBP) requested Health Claim Auditors, Inc. (HCA) to conduct a Claims and System Audit on Willis Towers Watson (WTW), contracted with PEBP as the current contracted vendor for administration of the PEBP Medicare Exchange Health Reimbursement Arrangement (HRA) plan. This audit is conducted per The State of Nevada Division of Purchasing Request For Proposal (RFP) No. 1922.

WTW's subcontractor, PayFlex*, administrated the claims adjudication function for the Medicare Exchange HRA PEBP plan from July 2019 through March 2020 and Willis Towers Watson Benefits Accounts (WTWBA)** administrated claims from April 2020 through June 2020. Audits of both PayFlex and WTWBA were conducted on a remote basis due to the current Covid-19 situation in the United States.

***** PayFlex**,** an Aetna company, is a benefit administrator specializing in the administration of flexible spending accounts, health savings accounts, health reimbursement arrangements and COBRA administration.
**Willis Towers Watson Benefits Accounts is owned and operated by Willis Towers Watson.

HCA was provided with claim files from PayFlex and WTWBA of claims adjudicated for PEBP's Plan Year 2020 (July 2019 – June 2020). The files contained information pertinent to 355,652 HRA claims representing $45,383,247.08 in requested reimbursements. A claim is defined as each separate expense reimbursement request. Requests that contain multiple expenses (such as prescriptions) are separated and administered as separate claims.

This audit is to assure that WTWBA/PayFlex is doing an effective job of controlling claim costs while processing HRA claims accurately and within a reasonable period of time.

The preliminary report was presented to WTW for additional comments and responses on 08 October 2020. Additional comments/responses received from WTWBA/PayFlex are included within the report and identified in ***bold/italicized*** type. In situations where there is disagreement between HCA and the Administrator as to what constitutes an error, both sides are presented in the report. Final determination of error rests with the client.

Detailed data for each of the items displayed within the results, both statistical and non-statistical calculations, can be found in the Specific Claim Audit Details chapter, which begins on page 16.

A valid random selection of 400 claims plus no more than 200 bias* selected claims were identified for audit as per PEBP's agreement. Due to the split year of administrators processing PEBP claims, it was agreed to conduct the audit on a sample of 270 claims administrated by PayFlex, 130 claims administrated by WTWBA and combine the two for measurement(s) of the performance agreement language between PEBP and Willis Towers Watson.

*Bias claims are not part of the random selection but were selected manually and audited by HCA because of some "out of the ordinary" characteristic of the claim. Bias claims are not included within the statistical calculations for measurement of Performance Guaranteed categories within the Administration Agreement.

The valid random selections included claims from all categories adjudicated by PayFlex and WTWBA. These categories included, but were not limited to: 1) deductibles; 2) dental; 3) medical; 4) orthodontia; 5) over the counter; 6) premiums; 7) prescriptions; 8) vision and 9) hearing service claims.

The Claim Financial Precision provision in the Agreement defines the measurement of the "Total Amount Approved". The statistical calculations, as per Agreement for this category, includes the requested amount(s) from the participant minus any amounts denied by the administrator within the claim. The audit reviews all payments completed in response to the participant's request for the entire history of the claim up to and including the date the claim is audited.

EXECUTIVE SUMMARY OF FINDINGS

Guaranteed Performance Measurements - Audit Period: 01 July 2019 through 30 June 2020 (PEBP Plan Year 2020)

Metric	Guarantee Measurement	Actual	Pass/Fail
Claim Processing Turnaround Time	Processing will average two (2) business days or less. Additionally, 98% of all claims will be processed within five (5) business days.	.34 Bus. Days Aver. 99.0% w/in 5 Business Days	Pass Pass
Claim Processing Payment Precision	Processing average precision will be at least 98% or better.	98.5%	Pass
Claim Financial Payment Precision	Financial accuracy will be 98% or better	99.4%	Pass
Customer Service Abandon Rate	The percentage of incoming calls abandoned by participants be 5% or less	<5%	Pass
Customer Service Speed to Answer	Incoming telephone calls, on average, shall be answered within thirty (30) seconds.	<30 sec.	Pass
Reports	Reports will be available within ten (10) business days of the end of the period.	No Delays Noted	Pass
HRA Web Services	99% availability of web services for benefit information and HRA information exclusive of scheduled maintenance.	99.0% +	Pass
Disclosure of Subcontractors	Contractor shall not engage additional subcontractors to maintain PEBP data nor change the physical locations where PEBP data is maintained and/or stored without written authorization by PEBP.	No Exceptions Detected	TBD
Unauthorized Transfer of PEBP Data	All PEBP data will be stored, processed and maintained solely on currently designated servers and storage devices identified in this contract amendment and/or prior contract documents.	No Exceptions Detected	TBD
Speed to Respond to Issue(s)	98% of incoming participant issues are to be responded to within 48 Hours of receipt	100%	Pass
Issue Resolution	98% of incoming issues escalated are to be resolved within 30 business days	100%	Pass

Trends/Issues

The audit revealed the following issues or trends detected from the random selection and bias selected claims. Please note: the reference numbers in **bold type** are claims from the random selection and are included within the statistical calculations. Reference numbers in normal type were identified as issues in bias claims as defined earlier and are not included within the statistical calculations of this audit. Specific information regarding supporting reference numbers can be found in the Audit Results Section in numerical sequence, which begins on page 16.

Administrated by PayFlex

Incorrect denial remark code used; Supporting reference no. **010**

Charge denied in error; Supporting reference no. **125**

Charge should have been denied for request of itemized statement; Supporting reference no. **147**

The audit revealed the following issues, which appear to be administered properly by One Exchange but should be brought to client attention for proper notification or verification. Specific information regarding supporting reference numbers can be found in the Audit Results Section in numerical sequence, which begins on page 16.

Charge denied that appears to be a copay but amount requested is outside of $5.00 - $50.00 copay rule; Supporting reference no. 017

Willis Towers Watson Benefits Accounts

Premium amount entered for wrong year; Supporting reference no. **12W**

Claim processed with wrong coverage period; Supporting reference no. **78W**

Incorrect date of service entered; Supporting reference no. **128W**

The audit revealed the following issues, which appear to be administered properly by Via Benefits but should be brought to client attention for proper notification or verification. Specific information regarding supporting reference numbers can be found in the Audit Results Section in numerical sequence, which begins on page 16.

Previous overpayment was offset on current claim; Supporting reference no. 7W

Four (4) different items on one receipt not processed separately; Supporting reference no. 98W

RX pick up receipt date used versus actual fill date; Supporting reference no. 107W

Historical Statistics

The following reflects the historical statistical data since the origin of PEBP Health Reimbursement Arrangement (HRA) claims administration by WTW. The entries designated in **bold red type** are measurable categories below the Service Performance Guarantees Agreement.

Period Audited	Payment Accuracy	Financial Accuracy	Turnaround Time	Telephone Response	Telephone Abandon Rate
Plan Year 2012	**91.6%**	NA	1.2 days	0:19	1.07%
Plan Year 2013	98.7%	99.2%	1.1 days	0:15	0.94%
Plan Year 2014	98.2%	99.3%	1.3 days	0:19	1.30%
Plan Year 2015	98.0%	98.5%	1.3 days	0:24	1.47%
Plan Year 2016	98.7%	99.58%	1.1 days	**1:50**	4.15%
Plan Year 2017	**96.0%**	**96.36%**	0.59 days	**0:46**	2.7%
Plan Year 2018	**97.0%**	**95.59%**	0.91 days	0:28	1.53%
Plan Year 2019	98.0%	98.8%	0.36 days	0:13	0.93%
Plan Year 2020	98.5%	99.4%	0.34 days	0.19	1.15%

Other Audit Findings/Observations

WTW, originally contracted with PEBP as Extend Health, has been the administrator of Health Reimbursement Arrangement (HRA) claims for the PEBP retirees since July 2011.

HCA recognizes the numerous improvements in system edits, policies and procedures specifically instituted in PEBP Plan Years 2019 and 2020. The following issues are considered worthy of current importance:

Overpayments

Last year's audit reflected a total of 1,549 identified overpayments with a value of $910,634.07 uncollected for the PEBP Plan Years of 2011 through 2019. Utilizing the data provided from WTW for both years, HCA calculates the collection of 2011-2019 overpayments to be $194,252.49 [$910,634.07 (reported last year) minus $716,381.58 (reported this year)] plus any successful collections for the PEBP Plan Year 2020 + 2021 to date.

Validation of Carrier Commissions

During the September 17, 2015 PEBP Board of Directors meeting, the WTW representative was quoted that the average annual amount of commission that we receive for each individual that is enrolled is $300. PEBP has requested that HCA report the commissions earned by Willis Towers Watson for each audited period thereafter.

The statement received from Willis Towers Watson reflects that they received a total of $ 3,526,330 in commissions for PEBP's participation during PEBP Plan Year 2020.

Conclusion

- Findings and observations of this audit recognize the numerous improvements to internal operational policies and procedures as well as Explanation of Payment (EOP) improvements instituted by Willis Towers Watson Benefits Accounts within this past year have greatly improved the accuracy and PEBP member understanding and satisfaction of the HRA processes.
- It is HCA's unbiased opinion that metric measurements for this audited period were equal to or better than the agreed values within the Service Performance Standards Related to HRA Services Agreement (Agreement), Attachment N, with no exclusions.
- HCA is requesting that PEBP verify the receipt of funds for the collection of identified overpayments as calculated from the WTW data provided. HCA estimates the collections received from October 2019 (last audit) the current date for all overpayments (PEBP Plan Years 2011 – current) should exceed $200,000.00.

AUDIT FINDINGS – DETAIL

Other Customer Service Measurements

Per Agreement, WTW/PayFlex is to respond to 98% of participant escalated issues within 48 hours of receipt.
HCA Findings: The reporting for this issue reflected that WTW achieved a 100% rating for this issue.

Per Agreement, WTW/PayFlex is to resolve 98% of participant escalated issues within 30 business days of receipt.
HCA Findings: The reporting for this issue reflected that WTW achieved a 100% rating for this issue.

HCA requested a report that displays the percent of incoming participant issues that are resolved during the first incoming call.
HCA Findings: The reporting for this issue reflected that WTW achieved a 97.1% rating for the audited period (PEBP PY2020).

Current Overpayments

WTWBA reported a total current value of $761,302.31 in identified outstanding overpayments status that have an effect on 1,509 claims. This measurement decreased from the previous audit measurements and represents a decrease of $150,685.80 (16.5%) in identified overpayment dollars and a decrease of 263 (14.8%) effected PEBP claims.

The current 1,509 identified overpayments have accrued since July 2011 when this administrator was initially selected. Of the overpayments, measured by dollar(s), 88.9% are aged greater than two (2) years. The breakout of these overpayments is as follows:

Period	Value of Overpayments (This Year's Audit)
PEBP Plan Year 2011	$0
PEBP Plan Year 2012	$143,743.64
PEBP Plan Year 2013	$136,499.08
PEBP Plan Year 2014	$ 95,062.87
PEBP Plan Year 2015	$ 86,480.83
PEBP Plan Year 2016	$ 99,334.33
PEBP Plan Year 2017	$ 62,049.80
PEBP Plan Year 2018	$ 52,619.90
PEBP Plan Year 2019	$ 40,591.13
PEBP Plan Year 2020	$ 39,616.21
PEBP Plan Year 2021	$ 3,950.48
TOTAL	$759,948.27

Continued on next page…

Last year's audit reflected a total of 1,549 identified overpayments with a value of $910,634.07 uncollected for the PEBP Plan Years of 2011 through 2019. Utilizing the data provided from WTW for both years, HCA calculates the collection of years 2011-2019 overpayments to be $194,252.49 [$910,634.07 (reported last year) minus $716,381.58 (reported this year)] plus any successful collections for the PEBP Plan Year 2020 + 2021 to date.

Explanation of Payment (EOP)

WTW have made numerous additional changes and additions to their Explanation of Payment (EOP) forms provided to participants in compliance with recommendations from the previous audits.

During this audit, review of multiple participant communications to WTW/PayFlex including telephone calls, emails, etc. detected a common inquiry regarding their EOPs. The EOP displays certain accounting of their account identified as "roll-over". Since this is not essential information to the participant, HCA recommends that this data be eliminated, thereby, making the EOP briefer and less confusing to the participant(s).

Participant Funding

The audit reviewed the timing of the PEBP funding as it was made available to the participants. The following listing reflects the date that funds were available to participants during the period of July 2019 through June 2020:

*

Qualified Month	Date Funds Available		Qualified Month	Date Funds Available
July 2019*	28 June 2019		January 2020	31 December 2019
August 2019	31 July 2019		February 2020	31 January 2020
September 2019	31 August 2019		March 2020	28 February 2020
October 2019	28 September 2019		April 2020	03 April 2020
November 2019	31 October 2019		May 2020	01 May 2020
December 2019	27 November 2019		June 2020	01 June 2020

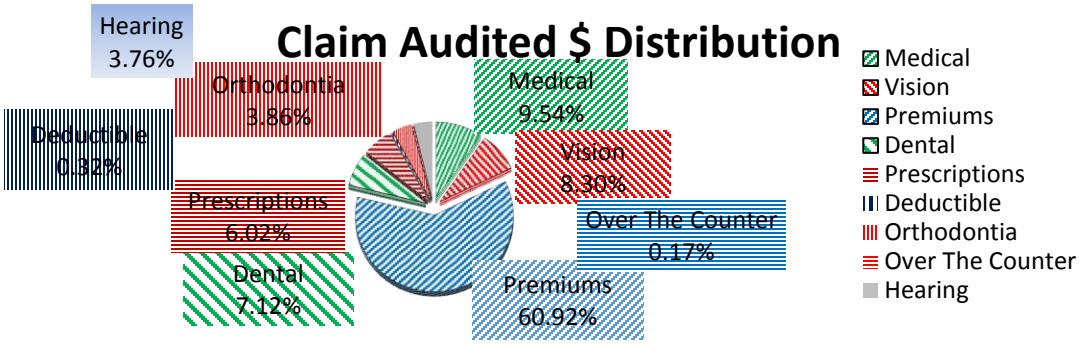
* Please note: A one (1) time fund deposit authorized by the PEBP Board of Directors was conducted in July 2019.

Breakout of Claims Audited

The individual claim requests audited were randomly selected from PEBP's claims listings as supplied by WTW. The detail claims listing supplied, reflected each separate service as a claim. These claims were processed by WTW/PayFlex from 01 July 2019 through 30 June 2020. These claims were stratified by dollar volume to assure that HCA audited all types of claims.

The breakdown of the 400 random selected claims is as follows:

Type of Service	Requested Amount	Audited (Req – Denied)	Paid Amount
Medical	$ 6,064.71	$ 5,606.21	$ 4,410.58
Dental	$ 4,409.10	$ 4,183.10	$ 4,274.90
Vision	$ 5,574.06	$ 4,881.16	$ 4,531.16
Premiums	$ 38,054.59	$ 35,807.03	$ 12,390.20
Prescription	$ 4,232.11	$ 3,535.97	$ 2,841.61
Deductible	$ 330.49	$ 189.41	$ 189.41
Over The Counter	$ 152.01	$ 99.57	$ 99.57
Orthodontia	$ 2,269.13	$ 2,269.13	$ 100.00
Hearing	$ 2,208.00	$ 2,208.00	$ 2,007.23
TOTAL	**$ 63,294.20**	**$ 58,779.58**	**$ 30,844.66**



Participant Survey

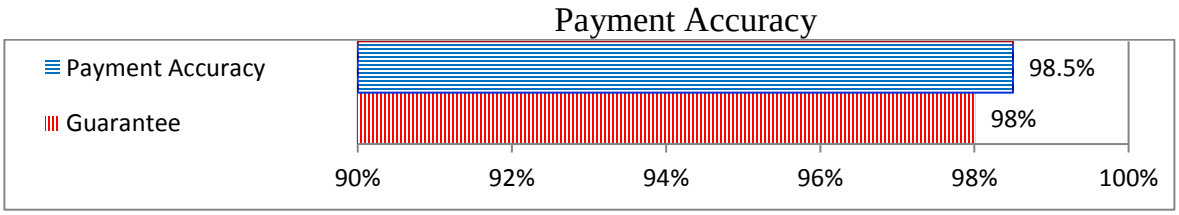
HCA requested the results of any Customer Surveys conducted within the audited period. Note: The client trend report categories changed for quarters three and four. Results supplied are as follows:

Category	Qtr One	Qtr Two	Qtr Three	Qtr Four
Completed Surveys	217	76	45	42
Overall Service Satisfaction	4.3 of 5	3.9 of 5	4.1 of 5	4.5 of 5
CSR OSAT	4.5 of 5	4.1 of 5	4.1 of 5	4.6 of 5
BA OSAT			4.8 of 5	4.8 of 5
Resolve Issue on Call	80.8%	76.7%		
% BA Answered all Questions			100%	100%
Recommend (NPS)	49	22		
Satisfaction with Wait Time	4.3 of 5	3.9 of 5	4.1 of 5	4.6 of 5
Work with CSR again?	88.7%	86.3%		
Enrollment Process Satisfaction			5.0 of 5	4.3 of 5
% Surveys with Alerts			20.0	7.1
Plan Selection Confidence			5.0 of 5	4.7 of 5
Satisfaction w/ time to complete enroll			4.7 of 5	4.0 of 5

Payment Accuracy

Per agreement, payment accuracy for the randomly selected claims should be 98% or above. Payment accuracy is defined as a claim that was processed for payment without a payment or non-payment error. Payment Accuracy is calculated by dividing the total number of claims not containing payment errors in the audit period by the number of claims audited within the random selection.

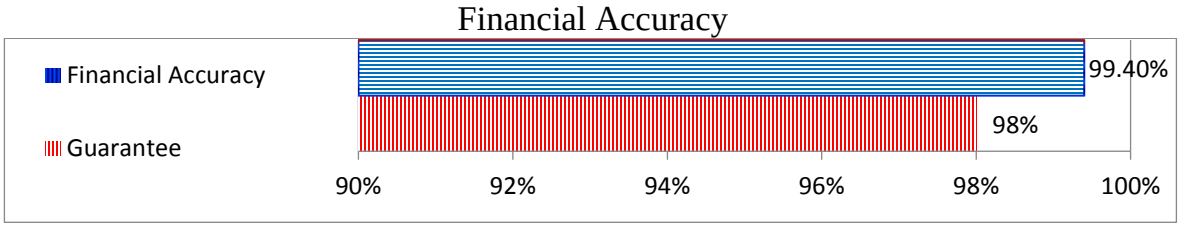
The Payment Accuracy Percentage of the number of claims paid correctly from the WTW (PayFlex + WTWBA) random selections for this audited period is 98.5%.



Financial Accuracy

Per agreement, financial accuracy for the randomly selected claims should be 98% or above. Financial accuracy is defined as total absolute value (overpayments and underpayments) as difference of the correct payment amount. The payment amount is defined, by agreement, as the full requested amount minus any denied amount. Financial Accuracy is calculated by dividing the total dollar amount of claims not containing payment errors in the audit period by the dollar amount of claims audited within the random selection.

The Financial Accuracy Percentage of the number of claims paid correctly from the WTW (PayFlex + WTWBA) random selection for this audited period is 99.4%.



Statistical calculations for the metric measurement of the Performance Guarantees are calculated of the claims adjudicated from the period of 01 July 2019 through 30 June 2020 (PEBP Plan Year 2020). Specific audit error findings and issues can be reviewed within the Specific Claim Audit Detail section of this report, which begins on page 16.

Turnaround Time

Turnaround time for claim payments is measured in business days from the date WTWBA/PayFlex receives the claim to the date the claim was processed and also from the date received to the date of payment. Per agreement, all claims in aggregate will be processed within an average of two (2) business days and 98% of all claims will be processed within five (5) business days.

HCA requested a lag report from PayFlex that displayed the processing turnaround times. This report reflected that the audited period turnaround time for processing claims was 0.40 days within quarter one, 0.16 days within quarter two, 0.54 days within quarter three and 0.24 days within quarter four reflecting that the 2 business days performance guarantee was met.

The random selection was tested for the average turnaround with a result of 0.5 business days and 99.0% were processed with five (5) business days. It is HCA's opinion that TWT is in compliance with the performance guarantees for turnaround times.

During the audited period, WTW received a total of 719 Emails from participants to the Email team seeking information. The average time to respond to these emails was approximately 45 hours.

Policy, Procedures and System

WTW receives the funding and eligibility data directly from PEBP and relays this information to WTWBA on a regular basis.

WTW applies received funding and eligibility data weekly, every Thursday. WTW stated that they are moving toward updating eligibility daily. Allocations are applied to the HRA's by the first of the month. Participants with retroactive qualification will receive their allocation on the next weekly file following qualification.

Claims are received at the WTWBA by mail, facsimile and other third party requestors such as insurance carriers. WTWBA stated that all claims received from PEBP participants are scanned into the system the date they are received and assigned a document identification number.

Claims are transferred and archived into the WTWBA adjudication system within forty-eight (48) hours of receipt.

WTWBA has a two (2) level appeal process for claims questioned by PEBP participants. If the two appeals are exhausted, the participant has the right for a third level appeal. When this level is achieved, the claim is sent to the client for final disposition.

WTWBA stated that they have internal written Standard Operating Procedures (SOP). These SOPs include but are not limited to:

1) Standard requirements for documentation from PEBP participants for payment of premiums, prescriptions and medical reimbursement requests;
2) Standard operations requirements of WTWBA associates for all processes from receipt of the request to payment.

State of Nevada PEBP claims are processed by the onshore claims processing team. All processors have either claim processing or a health care background. Senior and junior processors have been with WTWBA for three to four years. Newer processors have been processing claims for more than a year. There are currently four (4) dedicated senior and junior processors assigned to adjudicate State of Nevada claims.

Associates undergo a two-week classroom training session. The classroom portion is divided in two parts with the first week focusing on concepts, while the second week introduces associates to the Acclaim system with prior concepts being tied to actual processing examples. The classroom portion is structured in a top down approach starting with foundational information and progresses into more detailed topics. These topics are reinforced with activities, knowledge checks (quizzes), assessments, and real-life documentation examples.

Following the two-week classroom training and system introduction, associates will begin a nine-week certification process split into three phases. Each phase includes increasing production and quality requirements while carefully monitoring quality and providing feedback.

The certification phases will allow associates to apply the knowledge learned in Classroom Training, SOPs, and examples to real world, production claims. Associates will be audited at 100% throughout the certification period and will be expected to meet specific benchmarks at each phase in order to progress.

All claims processed will be production claims, however, they are all pended, reviewed, and released by experienced auditors. This protects participants from any adverse processing decisions, allows real-world processing experience to the new hire, and provides a method of direct feedback on incorrect decision making. Associates are expected to meet expectations by phase. Associates are considered "certified" if they meet any of the following criteria by the end of certification.

Associates are expected to meet expectations by phase. Associates are considered "certified" if they meet any of the following criteria by the end of certification:

- Meets expectations in 4 of 6 weeks in phases 2-3
- Meets all Phase 3 expectations
- Meets all expectations in all phases

All associates' metrics are reviewed and discussed by the management team and input is provided on each individual's performance, risks, and observations.

Phase Expectations

Phase	Week	Production Target	Financial Accuracy	Payment Accuracy	Process Accuracy	Audit Threshold
One	3	15	90.0%	80.0%	80.0%	$0
	4	25	92.0%	85.0%	85.0%	$0
	5	30	94.0%	90.0%	90.0%	$0
Two	6	35	96.0%	92.0%	92.0%	$0
	7	45	97.0%	94.0%	94.0%	$0
	8	50	98.0%	96.0%	96.0%	$0
Three	9	55	99.0%	98.0%	98.0%	$100
	10	60	99.0%	98.0%	98.0%	$100

In order to process claims, a prerequisite of any claim role is to have a user level access with a configured threshold. For claims processors specifically, there are currently several user accesses levels that are used:

User Access Level	Use	Tenure/Experience	Threshold
Claims Level 01 – Processor (Trainee)	Applied to new hires, processors being cross-trained on new processes, performance management (improvement plans), etc.	• New hire pre-certification (3 months)	$0.00 (all claims will be pended)
Claims Level 02 – Processor (Junior)	Applied to entry level processors after meeting quality and certification requirements.	• Successful completion of new hire certification	$500.00
Claims Level 03 – Processor (Senior)	Applied to more tenured processors who have consistently met quality, have increased production requirements, and increased responsibilities.	• Minimum experience of 3 years • Quality met consistently for 12 months prior to promotion	$1,000.00
Claims Level 04 – Mentor	Applied to Team Leads and Auditors.	• Minimum experience of 3 years • Quality met consistently for 12 months prior to promotion	$2,500.00
Claims Level 05 – Manager	Applied to Claims Operations and Quality Managers	• Role based experience	$5,000.00

After processors are configured in the system with an appropriate threshold, their claims will automatically pend. Processors review and adjudicate their assigned claims as normal. The system logic would be applied and for any claims that are pended, they are flagged both visually in Acclaim (the claim turns blue) and with a unique status (QA Pend) within the data tables to allow for reporting later.

Claims are adjudicated daily and pended immediately after adjudication. As part of broader inventory management, a report is circulated approximately hourly that includes aging and pending claims. Auditors are required to review the hourly emails and audit the pended claims. The Quality Manager is responsible for ensuring the timely release of all pended claims so as not to negatively impact Turn Around Time (TAT). The majority of claims pended are released the same day.

WTWBA stated that they have 818 Customer Service Representatives to provide services to their clients and will be hiring for another four (4) classes. WTWBA stated that no Customer Service Representatives are dedicated to the PEBP plan.

HCA had requested a written response from WTWBA and/or PayFlex that any and all PEBP Personal Health Information (PHI) was retained with secured practices within their operating systems and that no PHI was shared, transferred or obtained to any other entity other than WTW or PayFlex, including any subcontracted or entities that have acquired their businesses since the authorization of their vendor contract with PEBP. HCA will redact the names of these subcontractors for confidentiality purposes within the final report.

WTW response: Subcontractors Entity Name during PEBP's PY 2020:

Subcontractor Entity Name	**Description of Services**
DestinationRx, Inc.	Prescription drug information for website tools
Datamark, Inc.	Mailroom and Data Entry
Flexential (formerly Peak 10, Inc.)	Data Center
HealthSherpa	Enhanced Direct Enrollment and Plan Shopping, Quoting, and Enrollment for IFP plans
IC Group	Printing, distribution, and/or check writing services
Infutor Data Solutions, LLC	Data accuracy and contract verification services
InMoment, Inc.	Participant feedback survey assistance
Language Line Services, Inc.	Language translation assistance services
National Benefit Services, LLC	COBRA administration
Pegasystems, Inc.	Ticketing and tracking services for customer and retiree issues/escalations
PNC Bank	Banking Solution
Qualfon Data Services Group, LLC	Provides phone based service center staff who assist participants in completing applications for individual insurance policies
Sun Print Solutions	Printing, distribution, and/or check writing services
Zelis Healthcare (formerly Strenuus, LLC)	Physician data for website tools

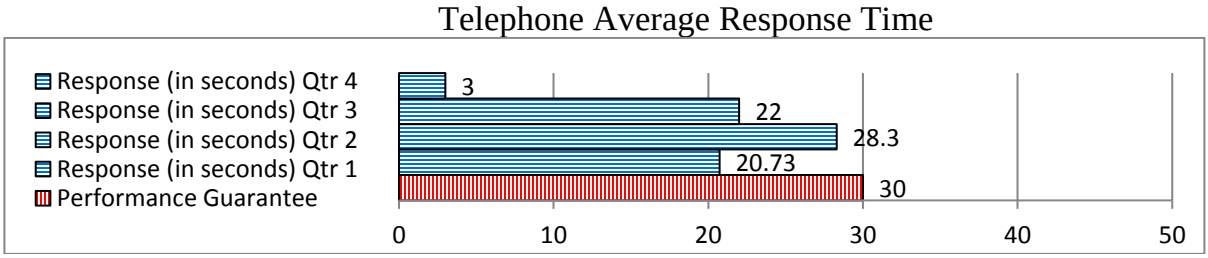
HCA is requested that WTWBA please verify by statement the following:

1) if any of these entities were NOT supplied/disclosed to PEBP as subcontractor vendors previous to this audit report disclosure;
2) that all PEBP data was stored, processed and maintained solely on currently designated servers and storage devices identified in the PEBP contract amendment and/or prior contract documents.

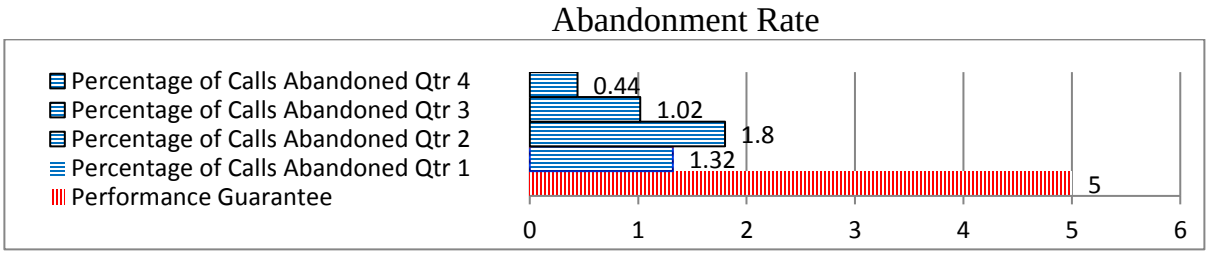
WTWBA response: It has been verified that WTW has fulfilled its obligations per the contract.

Customer Service

Per agreement, the average incoming telephone response time should be within thirty (30) seconds or less. The reports supplied by WTWBA reflected that the average answer speed for all incoming calls during the period of Quarter One for both Onshore and Offshore was 20.73 seconds, 28.3 seconds for Quarter Two, 22.0 seconds for Quarter Three and 3.0 seconds for Quarter Four, all in compliance and within the performance guarantees.



Per agreement, the abandonment rate must be under five percent (5%) of total incoming. HCA has reviewed the appropriate report for the audited period, which revealed the abandoned calls ratio for Quarter One was 1.32%, 1.80% for Quarter Two, 1.02% for Quarter Three and 0.44% for Quarter Four.



Please note: WTW utilizes an Integrated Telephone System and these customer service performances are measurements after the participant completes the integrated inquiries that aid in the directing of the call.

Reporting

Per Agreement, the following reports will be available within ten (10) business days of the end of the reporting period if requested or scheduled by the last day of the reporting period or later if agreed to by PEBP. Analyses of data or custom reports are excluded.

Standard:
Ledger Summary
Production Payment Register
Deposit Summary
Payment Summary

Optional:
Employer Funding Summary
Employer Funding Detail Report
Overpaid Employees Report

Quarterly:
S.C.O.R.E. Analysis
Account utilization
Claim information
Direct Deposit

Benefit Reports (Included in the quarterly board presentation):
Retiree Enrollment Decisions
Retiree Premium Costs
Retiree Survey Results
Benefit Customer Service Matrices
Issue Resolution Summary
Quarterly board presentations will be provided fifteen (15) business days prior to the quarterly board meeting where it is scheduled for presentation.

SPECIFIC AUDIT RESULTS

Listed below are the errors or issues of discussion found by this audit while processing the claims for PEBP Exchange HRA Plan.

Ref. No. 010 One Exchange claim no.

Over/Underpayment - $0.00

Claim denied for additional info as prepaid expense not eligible. Documentation shows payment as well as delivery receipt both dated 5/23/19. Claim should have been paid. One Exchange response: Denied correctly by PayFlex. Member was required to pay before they received their product and the billed amount was an estimate as they were unsure if insurance would pay or how much insurance would pay. Documentation for this expense was received on pages 9& 10. The examiner denied the claim as HM prepayment because of the wording on page 9 "We are committed to informing you of the anticipated financial cost to you for out healthcare services, before they are rendered to you. You are responsible for payment of you co-insurance and/or any unmet annual deductible and non-covered service before delivery." The receipt goes on to state "This is an estimate based on information we obtained from your insurance provider. If the amount collected/paid is determined to be insufficient, you will be billed. Payment of the unpaid balance will be due and payable within 30 days from the date of invoice. Any refund due because of your overpayment will be distributed 30-45 days after your insurance has paid their portion of your claim. The examiner followed G-10 per our workbook:

Scenario #	Scenario Description	How to handle		Other information
		Allow	Deny/Not paid	
	pre-determination of benefits or pre-payment (pre-paid) for services eligible for reimbursement?	incurred and is billed separately before the actual birth	with the following expenses): • OB/GYN fees for pre-child birth • Chiropractors for entire year of adjustments • Health club/Gym memberships ✓ Pre-treatment estimates (primarily with dental claims) **Possible remark code(s):** HM	

HCA Note: Documentation for this expense was also on page 11, the Delivery Receipt, which states "I acknowledge that on today's date, I have received the referenced componentry utilized in the fabrication and reimbursement of my devise." The Delivery receipt shows the device type and is dated 5/23/2019. Due to language on page 10 regarding possible insurance payment, HCA agrees that claim should have been denied. However, claim was denied with incorrect remark as services were received and paid for on 5/23/2019. Claim should have been denied for insurance payment information.

Ref. No. 017 One Exchange claim no.

NOT charged in statistical calculation. Note to client for information only.
As part of submittal : charge for DOS 5/10 was paid with documentation of payment receipt and after visit summary.
Audited claim for DOS 6/10 for $90 had the exact same documentation.
Why was claim denied?
One Exchange response: Denied correctly per PayFlex. The service on 5/10/19 was for $30 which falls under our copay rule. The $90 expense in the audited line was over $50 so the copay rule did not apply. We require an itemized statement.

Ref. No. 125 One Exchange claim no.

Underpayment - $51.99
Charge not paid – requested letter of medical necessity
RX for insulin purchased on same DOS. Per receipt description (BD Ult III Mini) these are needles/syringes used for diabetes.
(FSA eligible per receipt)
Shouldn't this charge have been paid versus denied?
One Exchange response: PayFlex agrees this was denied in error - $51.99.
The CVS pharmacy receipt stated BD ULTIII MINI3/16 100 $51.99T.
At the bottom of the receipt it shows $56.28 ($51.99 + 8.25% tax) as health care eligible. When we google this it comes up with BD Ultra Fine Pen needles Mini (insulin syringes).

Ref. No. 147 One Exchange claim no.

Overpayment - $20.00
Only documentation is cash register receipt which does not indicate patient name, date of service or services.
Should this charge have been denied for additional info?
One Exchange response: PayFlex agrees this was paid in error - $20.00.
Approved $20 from Sierra Eye Associates credit card slip. Copay rule does not apply to vision expense. This should have been denied for itemized statement.

Ref. No. 7W Via Benefits claim no.

NOT charged in statistical calculation. Note to client for information only.
Amount requested $23.00, offset by $3.20, we paid $19.80
Claim for Pass Thru Premium. Why was claim offset by $3.20?
Via Benefits response: The overpayment stem from Claim ID: xxxxx in the amount of $52.40. The subsequent claims were used to offset the overpayment including Claim ID: xxxxxx, xxxxxx, and xxxxxx. $3.20 was used to satisfy the remaining overpayment balance.

Ref. No. 12W Via Benefits claim no.

Overpayment - $135.50
Appears this premium was paid on 4/9/20 but is now showing as an overpayment. How did the overpayment occur?
Via Benefits response: Claim has been marked as overpayment during an internal audit. The premium amount was entered for the wrong year. The correction claim was entered under Transaction: xxxxxx/Expense ID xxxxxx.

Ref. No. 78W Via Benefits claim no.

Overpayment - $108.45
Premium reimbursement paid 8/3/2020
System now reflects overpayment made & was recovered by offset on 8/25/20. How did overpayment occur?
Via Benefits response: Claim was processed with the wrong coverage period. During audit, the error was identified and adjusted for the correct coverage period.

Ref. No. 98W Via Benefits claim no.

NOT charged in statistical calculation. Note to client for information only.
4 different items on receipt totaling 141.41.
(17.96 + 27.?? + 13.?? + 83.?? – cannot read receipt clearly)
Shouldn't these items have been processed separately in order to avoid a possible duplicate being processed?
Via Benefits response: We have established a clubbing rule to help increase efficiency and decrease the number of error occurrences, which allows the processors to combine all of the expense within a receipt to one claim line vs entering multiple claims. This policy helps drive consistency to avoid duplicate payments and decrease the risk of entry errors by minimizing the number of claim entries.

Ref. No. 107W Via Benefits claim no.

NOT charged in statistical calculation. Note to client for information only.
Date used to process is 3/14/20 date RX was picked up & paid.
Actual fill date of RX appears to be 3/13/20.
Shouldn't we have used the actual filled date in order to prevent duplication?
Via Benefits response: The prescription is filled by the pharmacist and the fill date is the date that is on the prescription, but the participant may not pick it up right away. When the participant does pick it up, a receipt is generated and pick up date is printed date on the receipt. The actions mentioned are to provide consistency in data entry.

Ref. No. 128W Via Benefits claim no.

Over/Underpayment - $0.00
Total requested $1279.25 (only paid $283.34 to date)
Per claim form dates of service are 2/6-28/2020 for managed care coinsurance. DOS used for processing is the date of letter from provider requesting payment.
We should have denied for further info requesting actual dates of service.
Why did we not request EOB from insurance?
WTW response: Agree. The wrong date of service was entered for this claim. As mentioned on the claim form, the processor should have entered 2/6/2020 as indicated in rehab center statement. EOB is not required, because we are able to determine the expense was incurred with the statement provided along with the letter from the facility and proof of payment (indication that the services were rendered).
Action item: Date of service will be updated.