Davis School District

Self-Insurance Review

December 2024

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December 20, 2024

Board of Education and Dr. Daniel Linford
Davis School District
779 McCormick Way
Layton, Utah 84041
Cc: Davis School District Audit Committee

Dear Board of Education and Dr. Daniel Linford,

We have completed our review of the Davis School District's Self Insurance Program. We want to thank you and the District employees for your assistance and support. Below is our report including details of work performed and results of review. The information within the report will be familiar as it includes the details that we covered in our discussion on December 20, 2024.

BDO USA, P.C.

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Background

Davis School District ("DSD" or "District") has implemented a self-insurance program for employee health benefits as a risk management strategy, setting aside funds to cover the healthcare expenses and potential losses, rather than purchasing insurance from third-party providers. A District Insurance Committee has been established, which includes representation from District administration personnel, support personnel (e.g., Human Resources), and teachers. The Committee oversees the program including, but not limited to, the selection of insurance carriers, review and approval of insurance plans, and monitoring of the program. DSD has contracted with GBS Benefits, a benefits consulting firm, as an advisor to assist in the selection of carriers, plans, and monitoring. DSD offers traditional and high deductible health plans to employees, through Aetna and Select Health as carriers. The medical and pharmacy related claims are managed by the following:

- Aetna serves as an Administrative Services Only (ASO) provider and processes medical claims as well as handling other administrative functions.
- Select Health serves as a Third-Party Administrator (TPA) and processes medical claims, handles other administrative functions. In addition, Select Health monitors Select Health member claims for stop loss eligibility.
- Navitus serves as the Pharmacy Benefits Manager that processes pharmacy claims.

In addition, DSD has a stop loss insurance policy with Symetra to protect the District from significant loss by limiting financial exposure due to large claims. Under the policy, Symetra will cover the cost of claims in excess of a $275,000 deductible, per member, within the plan year. Stealth Partner Group is responsible for managing DSD's stop loss claims including monitoring of member claims to identify instances in which the deductible has been met, filing the claims with Symetra, and reimbursement to DSD.

Standards and Guidance

Our review was based on the Institute of Internal Auditor's (IIA) International Professional Practices Framework (IPPF), which includes the *Core Principles for the Professional Practice of Internal Auditing, Definition of Internal Auditing, Code of Ethics,* and the *International Standards for the Professional Practice of Internal Auditing (Standards)*.

Objective

The objective of the project was to perform a review of the Davis School District (DSD or the District) self-insurance program related to medical and prescription insurance including program governance, member claims, and stop loss claims management.

Scope

The scope of the project included a review of activity during the calendar years 2022 and 2023 as follows:

1. Governance: Through inquiry with DSD Personnel, determined if clear, written policies and procedures are in place for all aspects of the self-insurance program, including claims management, reserve funding, risk management, monitoring of Third-Party Service Providers, and program performance monitoring.
2. Member claims: Reviewed a sample of claims processed by Aetna, Select Health, and Navitus, including paid claims and denials to determine if claims were processed timely and accurately in accordance with the plan.
3. Stop-Loss Claims Management performed by Stealth Partner Group:
    - Performed an analysis to determine if stop-loss claims were submitted timely for instances which met the stop-loss threshold.
    - Reviewed a sample of stop-loss claims, including paid claims and denials to determine if claims were processed timely and accurately in accordance with the plan.

Summary of our Results

Appendix A includes details of the work performed and results of the review, and third-party responses (if applicable).

APPENDIX A
Work Performed, Results, and Responses

1. Review of Program Governance

Objective:

Determine if clear, written policies and procedures are in place for all aspects of the self-insurance program, including claims management, reserve funding, risk management, monitoring of Third-Party Service Providers, and program performance monitoring.

Work Performed and Summary of Results:

Through inquiry with the DSD District Administrator, BDO determined that there are no policies or procedures in place surrounding the self-insurance program.

Recommendation:

BDO recommends that the District document and implement governance documentation for the self-insurance program including, but not limited to, the following:

- Insurance Committee Charter
- Policies and / or procedures including expectations and responsibilities for the following:
    - Governance including oversight of the program
    - Claims management
    - Reserve funding
    - Risk management
    - Monitoring of third-party service providers
    - Monitoring of program performance

Management Response:

The District will look at processes and procedures to address these recommendations and create appropriate documentation.

2a. Review of Claims Processed by Aetna

Objective:

Review a sample of claims processed by Aetna, including paid claims and denials to determine if claims were processed timely and accurately in accordance with the plan.

Work Performed and Summary of Results:

BDO reviewed a sample of 25 claims paid during the plan years of 2022 and 2023 to determine if they were adjudicated in accordance with the plan documents. The sample selection included:

- 14 fully paid
- Seven substantially paid, partially denied
- Four fully denied

This included a review of the claims, explanation of benefits (EOB), and other supporting documentation to determine mathematical accuracy of the EOB, accurate calculation of member copays, and appropriateness of denied claim lines. In addition, BDO observed provider contracts for 15 of the 21 samples to determine if the allowed amounts paid to the provider was accurate. This sample size was limited to 15 at the request of Aetna, due to confidentiality of the provider contracts.

Within the review BDO noted errors for six of the 25 samples, including the following:

Type of Error	Samples with error			
	Total Samples	Resulted in Overpayment	Resulted in Underpayment	No Financial Impact
Allowed amount did not agree to the provider contract	2*	2*		
Inaccurate member copay	1	1		
Incorrect Denial Reason Code	1			1
Inaccurate accumulation of member out of pocket expense	1		1	
Total	5	3	1	1

* - One of the errors was identified by Aetna internal review processes and corrected prior to the audit.

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Details of Errors noted and Aetna Response:

Sample #	Type of Error	Description of Error	Impact	Aetna Response
5	Incorrect denial reason code	The claim sampled included 18 claim lines, two of which were denied with the incorrect denial reason. The denial reason applied was code V17, "The information previously requested from you for this claim from you was not received. This claim has been denied. The member is not responsible." However, through further review with BDO, Aetna noted that the line items should have been denied due incorrect coding. Although the incorrect denial reason was used, the line items were appropriately denied. The member and DSD were correctly charged.	No Financial Impact	Aetna agrees with this finding. This claim was originally pended for additional information. When this information was not received, within the specified time period, the claim was moved from a pended status to denied with action code V17 (requested information not received). Upon receipt of the requested information the claim was reprocessed, and the processor failed to remove the action code V17 from 2 of the lines. These lines were correctly denied; however, a separate action code related to the appropriate denial reason should have been used.
9	Inaccurate accumulation of member out of pocket expense	The member paid towards their out-of-pocket maximum per the EOB did not agree to the total of claims paid during the plan year. Per the EOB, the member paid a total of $3,500 towards their out of pocket for the plan year. However, through review of the claims data provided by Aetna and Navitus (the pharmacy claims administrator), BDO noted that the total member paid for the year was $3,508.44. The discrepancy was due to Navitus claim number 911093817 in the amount of $8.44 which was not included in the Aetna aggregation of claims towards their out-of-pocket maximum resulting in member overpayment and plan underpayment. Per Navitus research, the Claim appears in the RTA_CLAIMS_AUD table (meaning the transaction was sent to Aetna), but there is a Reject Code of 46 – Unknown Error. In addition, Navitus noted that Aetna is responsible for researching these errors to determine why the claim had an error. To date, Aetna has not explained the cause of the rejection.	Underpayment of $8.44	Aetna Agrees with this finding. The error occurred when the analyst failed to have a medical claim processed to offset the pharmacy overage. General Background Shared Accumulators This plan has external integration (aka shared accumulators) which is set up on the real time connection to share medical and pharmacy transactions. There is a percentage of claims that may pend for manual intervention. External Integration is a shared responsibility; Aetna is responsible for managing any pharmacy (RX) and/or behavioral health (BH) claims that pend and the other carriers (RX/BH) are responsible to review medical claims that may pend on their end. For Aetna, pended RX/BH claims are managed through inventory reports (crystal reports) that are supported by accumulator analysts. Due to the standard timing and the complexity of external integration, there are transaction codes aligned with inventory reports. This allows any transactions that require additional review or manual update to identified. There are many reasons why a transaction may need manual

Sample #	Type of Error	Description of Error	Impact	Aetna Response
				intervention, including but not limited to eligibility, over the limit, duplicate transaction, rework/OON claims and RX reversals without a positive RX claim. When a member is at their limits and an RX transaction applies that takes the member over their limit, Aetna intakes the transaction and applies the dollars to the file. The overage generates a transaction code 51/BC as an alert to the analyst that the file may be over the limit and requires manual intervention; therefore, the analyst needs to conduct a file review. During the course of the file review, the analyst will be able to identify (or work with the RX carrier to identify) the rationale for the overage. To offset the pharmacy overage, the Aetna analyst will have medical claims reprocessed; but if there are no medical claims to reprocess, Aetna will contact the PBM to have a refund issued to the member. Sample #9 Aetna agrees with an $8.44 overage. Aetna received the pharmacy transactions in the amount of $8.44, Vendor Clm# 2030400303142G dated 03/14/2023a code, but the claim pended for manual intervention with code 46. This pend code requires manual intervention from our daily inventory reports. Upon receipt of the code 46, the analyst should have added the dollars and sent a medical claim to offset the pharmacy overage; but there appears to have been an oversight. Upon receiving this audit inquiry, education was provided and will be reinforced during monthly coaching sessions. Aetna has adjusted the accumulator, and medical claim E8PC4RRQ100 was reprocessed on 11/02/2024. Additional benefits have been issued.
19	Allowed amount did not agree to the provider contract	The allowed amount per the EOB and paid to the provider did not agree to the provider contract.	Overpayment of $135.13	Aetna agrees

Sample #	Type of Error	Description of Error	Impact	Aetna Response
		Per review of the provider contract with Aetna, the allowed amount paid to the provider should have been 58% of the total billed charges. However, the provider was paid approximately 80% of the total billed charges. Per Aetna, this claim was reprocessed on 10/22/2024, after identification within this audit, and a reimbursement has been requested from the provider.		The error occurred when the processor committed a mathematical error in calculating the negotiated amount. We are unable to pursue overpayment recovery. The provider has an overpayment recovery contractual agreement for a look back period of 12 months from the claim payment date. The claim payment was issued on 12/29/2022 and overpayment recovery was initiated on 10/22/2024 which is more than 12 months from the claim payment date.
24	Allowed amount did not agree to the provider contract	The allowed amount per the EOB and paid to the provider did not agree to the provider contract. Per review of the provider contract with Aetna, a deviation agreement for ER charges, the allowed amount paid to the provider should have been 85% of the total billed charges. However, the provider was paid 100% of the total billed charges. Through additional discussion with Aetna and observation of claims records, BDO validated that this error was identified by Aetna and corrected as part of an internal review of the claim. The claim was reprocessed on 2/23/2023.	Overpayment of $14,611.61	Aetna agrees with this finding. The error occurred when the processor failed to review the provider's contract deviations and paid the claim at 100% of the billed charges. This was identified and reprocessed, prior to the audit, on February 24, 2023. Overpayment was recovered on 09/28/2023.

2b. Review of Claims Processed by Select Health

Objective:

Review a sample of claims processed by Select Health, including paid claims and denials to determine if claims were processed timely and accurately in accordance with the plan.

Work Performed and Summary of Results:

BDO reviewed a sample of 25 claims paid during the plan years of 2022 and 2023 to determine if they were adjudicated in accordance with the plan documents. The sample selection included:

- 21 paid claims
- Four claims with -0- paid (The population did not include any identifier of denied claims, therefore BDO selected a sample of claims with no payment)

This included a review of the claims, explanation of benefits (EOB), and other supporting documentation to determine mathematical accuracy of the EOB, accurate calculation of member copays, and appropriateness of denied claim lines. In addition, BDO observed provider contracts for 4 of the 21 paid samples to determine if the allowed amounts paid to the provider was accurate. This sample size was limited to 4 at the request of Select Health, due to confidentiality of the provider contracts.

No errors related to the accuracy of claims processing were noted in the review.

During review of claim details for Select Health members, including both medical claims administered by Select Health and pharmacy claims administered by Navitus, BDO identified two instances in which the Select Health Summary of Benefits and Coverage (SBC) was inconsistent with Navitus Requirements Document for pharmacy benefits.

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Details of Errors noted and Select Health Response:

Sample #	Type of Error	Description of Error	Impact	Select Health Response
Select Health Sample 3, 4, 8, 12, & 13 Navitus Sample 21	Pharmacy Deductible Not Accurately included on the Traditional Plan SBC	The member, or family on the plan, paid a deductible for pharmacy in the amount of $100. However, there is no pharmacy specific deductible included in the 2022 or 2023 Schedule of Benefits and Coverage (SBC), which Select Health is responsible for creating. Per GBS, and review of the 2021 Select Health Traditional plan SBC, the $100 deductible was in place in 2021 during the Navitus implementation. Because the pharmacy benefits have not changed since that time, Select Health has been instructed to carry over the benefits in the SBC. This deductible was erroneously left off the 2022 and 2023 SBCs. The district creates their own open enrollment materials and benefit guides but were informed that the $100 Rx deductible was listed for both carriers in 2022 and 2023. Further, the $100 pharmacy deductible it is included on the Aetna SBCs and the pharmacy details for Aetna and Select Health should mirror each other. The DSD District Administrator confirmed that the plans should mirror each other, and that $100 pharmacy deductible is appropriate. Further, BDO was provided with the plan comparisons which were provided to DSD employees during open enrollment, which included the $100 pharmacy deductible for the Select Health Traditional plan. BDO notes that the deductible should be included in the SBC in future plan years for transparency to the members.	No Financial Impact	Terms of the Administrative Services Agreement with Davis School District note that Select Health provides a sample Summary of Benefits and Coverage (SBC) with information for benefits administered by Select Health and that an employer has responsibility to assess the SBC. As a courtesy, the 2022 SBC provided by Select Health included pharmacy benefit information despite Select Health no longer administering pharmacy benefits for the plan. Select Health supplied sample SBCs for 2022 through 2024 for employer and advisor review. Select Health received indication by email each year that the sample SBC was acceptable. Select Health will update the SBC to reflect the $100 pharmacy deductible. Davis School District will be responsible for review of the SBC for accuracy.

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Sample #	Type of Error	Description of Error	Impact	Select Health Response
Navitus Sample 2	Retail and Mail Order Copays Not Clearly Defined in Traditional Plan or High Deductible Plan SBCs	The claim was for a 90-day supply of a tier 2 maintenance drug filled at a retail pharmacy. Per the Select Health Traditional Plan SBC, for tier 2 maintenance (preferred brand drugs) the copay should be $60, however a $90 copay was applied. Per Navitus, and further review of the plan requirements document, it was noted that the prescriptions filled at a retail pharmacy have a $30 pay for a 30-day supply. Therefore, Navitus appropriately applied a $90 copay for three prescriptions with 30-day supply. Further, through review of the SBC and plan requirements, BDO noted that the copays for "maintenance" outlined in the SBC are related to copays for prescriptions filled through the mail order pharmacy. The SBC should be updated to accurately reflect these as such, for transparency to the members.	No Financial Impact	Terms of the Administrative Services Agreement with Davis School District note that Select Health provides a sample Summary of Benefits and Coverage (SBC) with information for benefits administered by Select Health and that an employer has responsibility to assess the SBC. As a courtesy, the 2022 SBC provided by Select Health included pharmacy benefit information despite Select Health no longer administering pharmacy benefits for the plan. Select Health supplied sample SBCs for 2022 through 2024 for employer and advisor review. Select Health received indication by email each year that the sample SBC was acceptable. Select Health will update the SBC to clarify the copays for retail pharmacies and mail order. Davis School District will be responsible for review of the SBC for accuracy.

2c. Review of Claims Processed by Navitus

Objective:

Review a sample of claims processed by Navitus, including paid claims and denials to determine if claims were processed timely and accurately in accordance with the plan.

Work Performed and Summary of Results:

BDO reviewed a sample of 25 claims paid during the plan years of 2022 and 2023 to determine if they were adjudicated in accordance with the plan documents. The sample selection included:

- 17 paid claims
  - 14 electronically submitted and processed
  - 3 manual claims
- Eight denied (rejected)

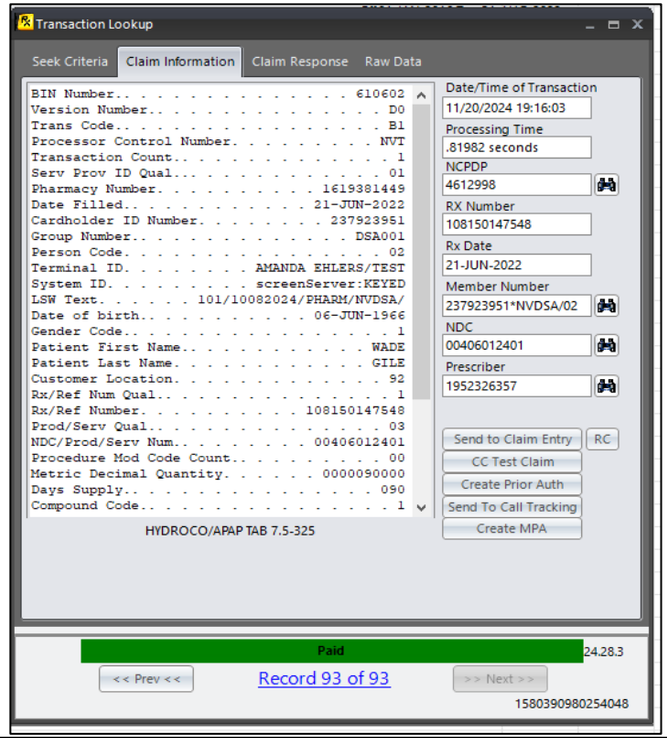
This included a review of the claims detail, observation of adjudication detail in NCRx (Navitus claims processing system), and other supporting documentation to determine mathematical accuracy of the claim adjudication, accurate calculation of member copays, and appropriateness of denied claim lines. In addition, BDO observed provider contracts for the 10 of the 17 paid claims to determine if the allowed amounts paid to the provider was accurate. BDO did not observe contracts for 7 of the samples for one of the following reasons:

- The claim was from a non-participating pharmacy
- The claim was originally paid by another provider, and submitted to Navitus for reimbursement (no pharmacy contract)
- The claim was later reversed

Within the review BDO noted errors for six of the 25 samples, including the following:

Type of Error	Samples with error			
	Total Samples	Potential Overpayment	Potential Underpayment	No Financial Impact
Unable to validate the amount paid	1		1	
Unable to validate the copay applied	1			1
Claim processed and paid twice	1	1		
Inappropriate Denial	3		2	1
Total	6	1	3	2

Detailed of Errors noted and Aetna Response:

Sample #	Type of Error	Description of Error	Potential Impact	Navitus Response
2	Inappropriate Denial	A line item on the manual claims inappropriately denied by Navitus. The manual claim included 8 lines, 2 of which were denied. One line was appropriately denied because it was a repackaged drug which is not covered under the plan. The other line, in the amount of $15.21, was inappropriately denied by Navitus. Per discussion with Navitus, this error has since been corrected and the claim line has been paid. BDO notes that the member met their out-of-pocket max during the processing of this claim. Therefore, the full allowed amount of for this claim line should have been paid by the plan.	Underpayment of $15.21	Upon further review, the Hydrocodone - Acetamin 7.5-32 was not a repackaged drug; reprocessed on 11/20/24 and it has been paid. See screen shot below. The claim for Prazosin 2 MG capsule that rejected for repackaged product stands based on input from many different business areas at Navitus. 
12	Inappropriate Denial	The claim was inappropriately denied on 10/5/2023 at the point of service (at the pharmacy). Per discussion with Navitus, bad data that was applied to the NCRx production	Underpayment of $56.87	Member's claim rejected on 10/5 due to the negative-MPA being reactivated from the NCRx Production Environment update. No additional claim was reprocessed by pharmacy on

Sample #	Type of Error	Description of Error	Potential Impact	Navitus Response
		environment impacted the claim adjudication process and caused this claim to be denied. The issue with the bad data was released on 10:00 am on 10/5/2023 and a fix was implemented in the system to resolve the issue at 1:44 pm that same day. BDO notes that the next month's supply of the prescription appears to have been processed without issue. The impact of this inappropriate denial is based on the review of claims processed and paid for this drug before and after this denied claim. Assuming the member filled this prescription the member should have paid a $15 copay with the plan covering $56.87.		or around that date. The 9/23 and 11/11 claims were the only claims initiated by pharmacy for this product around the 10/5 date.

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Sample #	Type of Error	Description of Error	Potential Impact	Navitus Response
16	BDO Unable to Validate the Amount Paid	A discrepancy between the manual claim and amount paid was identified and not explained by Navitus. A manual claim was submitted by the member to have Navitus reimburse their secondary insurance for 47 prescriptions, totaling $16,667.29 which had been paid by the secondary insurance. Supporting documentation for this claim, included: • A report of prescriptions totaling $16,667.29. • For a subset of the prescriptions, the member completed and signed prescription drug claim forms totaling $13,528.87. • Pharmacy printouts from two pharmacies, including prescriptions totaling $9,970.49. Navitus reimbursed the secondary insurance $6,597.51. Through further review of the documentation with Navitus, BDO noted the following: • Six of the prescriptions on the claim were denied. • Per Navitus, only prescriptions on the pharmacy printouts would be processed. BDO noted that the total of prescriptions on the pharmacy printouts, excluding the rejected items, was $9,867.78. A variance exists between the total of prescriptions between the pharmacy printouts and the total paid per Navitus in the amount of $3,270.27 which Navitus has not explained. Therefore, BDO was unable to validate the amount paid.	Underpayment of $3,270.27	The first 85 pages of the member's submission are irrelevant. The dollar amounts the member correlated with specific RX numbers do not match. The letter from Public Employees Health Plan does not have an accurate dollar amount that is supported by the printouts. The letter indicates $16,667.29 as the balance owed. The printouts illustrate that $9828.04 is the balance owed. Since the claims for the member were processed by Navitus in 2022, Navitus is unable to access the actual claims that were in the system. The check issued by Navitus was $6,597.51. Upon review of the medications submitted and the client's formulary, these items can be concluded to identify the discrepancy between the balance owed and the actual amount of the check sent to Public Employees Health Plan. Colchicine is not a formulary drug. Levothyroxine is a not a formulary drug. Navitus is unable to determine exact dollar amounts paid on the claims due to the system limitation of the claims being archived. A call was placed to Public Health Employees Plan on 11/21/2024 and the agent confirmed there is no balance owed by Navitus for this member.

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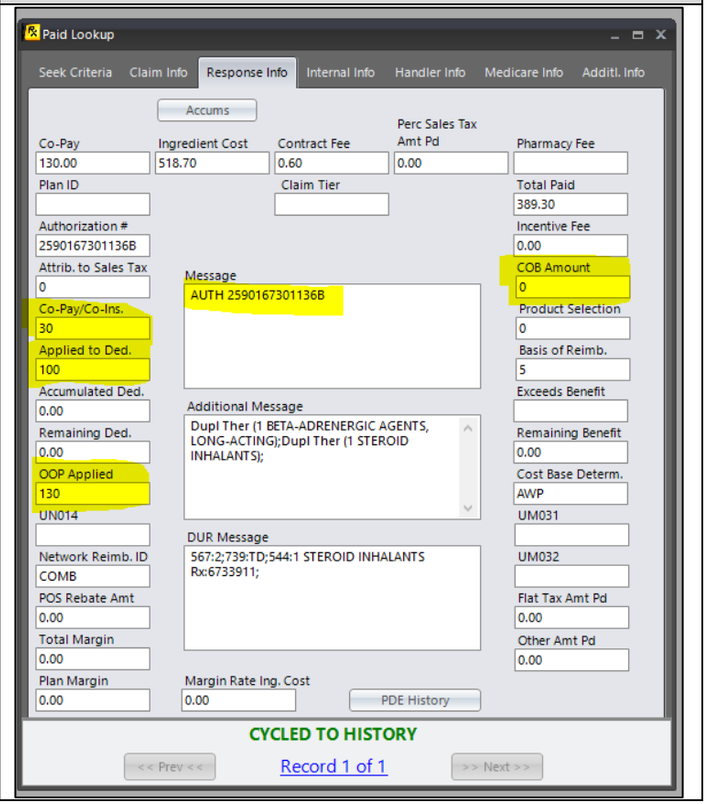
Sample #	Type of Error	Description of Error	Potential Impact	Navitus Response
19	BDO was Unable to Validate the Copay Applied	Claim was for a specialty drug. Per the SBC and pharmacy plan requirements document, a $100 copay is required for a specialty drug, however a 30% copay was charged, totaling $7,707.28. Per discussion with Navitus, the 30% copay was applied due to the use of a copay assistance program, Specialty Access. Per Navitus, there is a process to pursue alternate funding for certain specialty drugs including a free drug program. If the member isn't eligible for the free drug, they member receives copay assistance, and the 30% copay was the best percentage to optimize the copay assistance. However, Navitus was unable to provide documentation to support the determination of the 30% copay. BDO notes that this claim was later reversed at the request of the pharmacy, therefore no financial impact.	No Financial Impact	Please see embedded Specialty Access Program Addendum (contract addendum) and Copay Max Plus Addendum for documentation of the programs.  Davis School District Specialty Access Prog  Copay Max Plus Addendum_Davis.pdf
21	Claim was Processed and Paid Twice	The claim selected was processed and paid twice (first payment was $389.30 and second payment was $100). Per Navitus, this claim was processed twice due to the COB flag of S on member's eligibility file. This flag indicates a second, active coverage and was programmed for situations where member and their spouse are both cardholders under the same plan. The claim can be processed twice for the same member ID including: • First under the member as the primary cardholder, and • Second under the spouse as primary card holder. BDO was unable to validate this explanation through review of the claims data, as both records were recorded for the same member and there was no indication that the second processing of the claim was related to their spouse being a primary cardholder. In addition, through inquiry with Davis School District Human Resources and observation of the employee insurance details, BDO determined that the member's spouse was not an	Overpayment of $100	The initial claim processes without member having met any of their $100 deductible. The first, primary claim sees member pay $100 towards deductible and the expected $30 copay for a Tier-2 drug. The additional claim is run as a secondary claim to the primary. In this case, member's deductible is now met. Client covered $389.30 on the initial claim, which shows as a COB amount on this secondary claim. Member now pays the additional $30 for the expected Tier 2 copay, with plan then covering again the remaining amount of the claim. See screen prints below. **Claim Authorization Number 2590167301136B:**

Sample #	Type of Error	Description of Error	Potential Impact	Navitus Response
		employee of the District and a dependent on the employee's plan only.		

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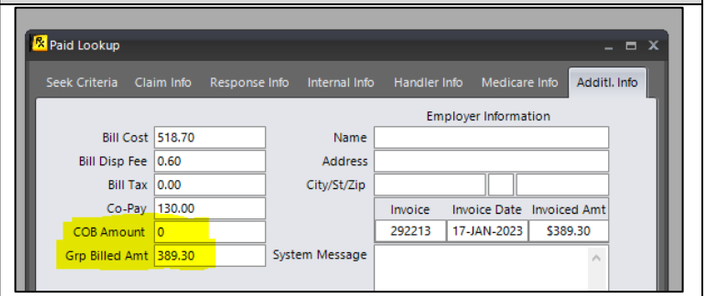
Sample #	Type of Error	Description of Error	Potential Impact	Navitus Response
				 **Claim Authorization Number 2588637301139B:**

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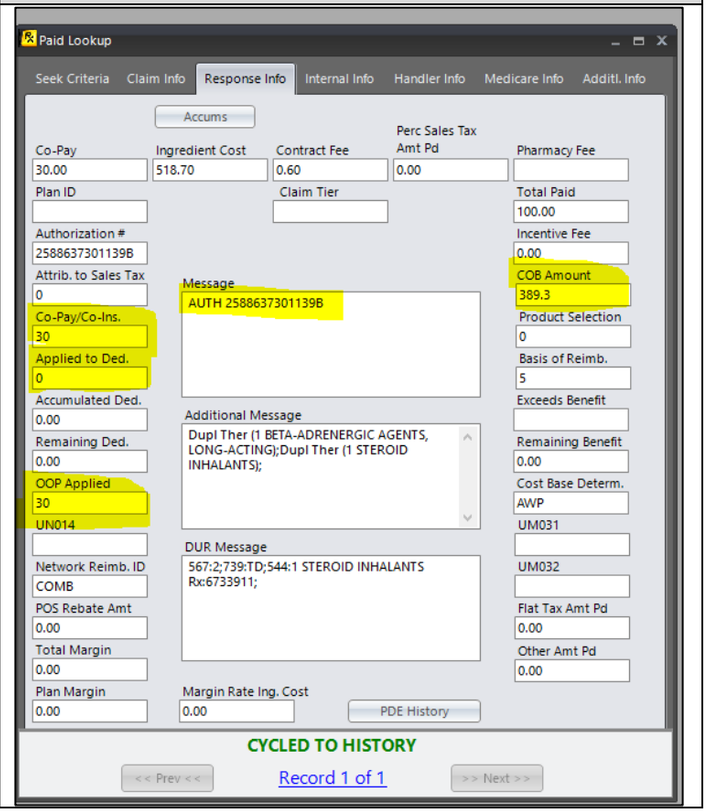
Sample #	Type of Error	Description of Error	Potential Impact	Navitus Response
				

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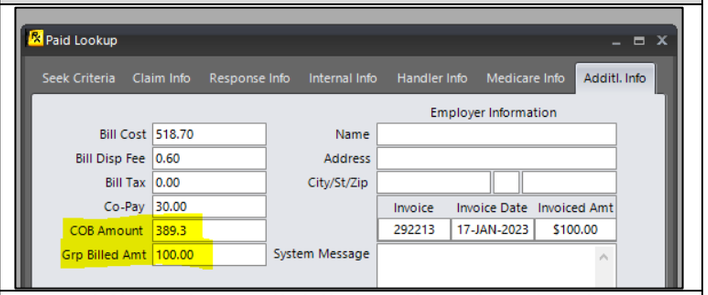
Sample #	Type of Error	Description of Error	Potential Impact	Navitus Response
				
24	Inappropriate Denial	The claim was inappropriately denied due to a keying error in the Navitus NCRx claims system. The claim was initially processed and paid by the State of Utah Medicaid, which was the member's secondary insurance. It was submitted to Navitus, as the primary payer, for reimbursement as a manual claim. The claim was entered into NCRx and denied with the rejection code "PHARMACY NOT CONTRACTED WITH PLAN/PROCESSOR ON DATE OF SERVICE". Per Navitus and review of the claims system, a dummy pharmacy was set up in to allow this claim to process. However, the pharmacy creation date was incorrectly keyed as January 28, 2022. Because the claim date was October 21, 2021, the claim was rejected. This claim was reprocessed on 8/5/2024 based on further review during this audit. The was no financial impact of this inappropriate denial. At the time the claim was reprocessed, it was determined that the member would have been responsible for the full claim value due to copay and a dispense as written (DAW) penalty. Therefore, Medicaid was not reimbursed for the claim payment.	No Financial Impact	Pay and Chase claim - all dollars apply to Out of Pocket (OOP). For a Tier 3 brand name drug, member will have to pay copay and DAW penalty since they are not getting the generic. If the member would have used Navitus benefits at the pharmacy, their expected copay would have been the copay plus DAW penalty. In this scenario, the copay would have been $50, but since the contracted rate for the medication was less; the copay was $39.48 plus the DAW penalty of $317.58. See screen print below for Retail Copay Detail. The Point of Sale (POS) claim was run through the State Medicaid Program. They then find out the member had other insurance primary over Medicaid through Navitus. Navitus processes the claim using the alpha character nabp (lockbox) to pay back the state. Our claim adjudicates at lesser of logic, which is what Navitus would have paid at POS compared to the Medicaid payment, those dollars are then reimbursed to the lockbox. The pharmacy remains whole and is never touched. Also, claims are processed against the member's benefit plan design. If all dollars apply towards the MOOPs, then the state would not get any dollars back, unless they decide to ask the member for those dollars.

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Sample #	Type of Error	Description of Error	Potential Impact	Navitus Response
				Retail Copay Detail

Description	Tier	Day Supply 1-30	Day Su
DSD - Copay Plans	1	$15	
Comments:			
DSD - Copay Plans	2	$30	
Comments:			
DSD - Copay Plans	3	$50	
Comments:			
DSD - HDHP Plans	1	$7	
Comments:			
DSD - HDHP Plans	2	$21	
Comments:			
DSD - HDHP Plans	3	$42	
Comments:			

3. Review Stop Loss Claims Managed by Stealth Partner Group

Objective:

- Perform an analysis to determine if stop-loss claims were submitted timely for instances which met the stop-loss threshold.
- Review a sample of stop-loss claims, including paid claims and denials to determine if claims were processed timely and accurately in accordance with the plan.

Work Performed and Summary of Results:

Analysis to Determine if Stop Loss Claims were Submitted Timely

Utilizing claims data received from Aetna, Select Health and Navitus, BDO independently aggregated the total value of medical and pharmacy claims paid for each member during the 2022 and 2023 plan years. For each member that had aggregated paid claims exceeding the $275,000 stop loss deductible, BDO compared the total of paid claims to the Stop Loss Summary Report maintained by Stealth Partner Group (Stealth) to determine if a stop loss claims had been filed completely and timely.

Within the review, BDO noted that paid claims exceeded the deductible for 13 members for the 2022 plan year and 14 members for the 2023 plan year. While each member did have stop loss claims filed for the plan year totaling 43 filings processed for 2022 and 54 filings processed for 2023, there were discrepancies in the value of claims eligible for stop loss related to 9 members for 2022 and 8 members for 2023, a total of 17 instances out of the 97 filings processed. Through review of these discrepancies with Stealth, BDO determined that stop loss claims were not completely or timely filed in six instances. The remaining 11 instances require additional research and review. A summary of the discrepancies is included below:

Type of Error or Discrepancy	Total Discrepancies	Discrepancies Related to Aetna Members		Discrepancies Related to Select Health Members	
		2022	2023	2022	2023
Stop Loss Claims were not Completely and Timely Filed	6	0	1	5	0
Inconsistency in Data provided to Stealth and BDO Leading to Variance in Total Value of Medical or Pharmacy Claims Eligible for Stop Loss	11	2	7	2	0
Total	17	2	8	7	0

Review a Sample of Stop Loss Claims Filed

BDO reviewed a sample of 10 stop loss claims filed during the plan years 2022 and 2023 to determine if claims were processed timely and accurately in accordance with the plan. The sample selection included:

- Seven fully paid claims
- Two claims substantially paid, partially denied
- One denied claim

This included a review of the claim forms, supporting claim, a copy of the reimbursement check received or explanation of reimbursement, and documentation of communication between Stealth and Symetra for any claims that required discussion of the determination.

No errors were noted within the review.

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Detailed of Errors noted and Stealth Response:

Type of Error or Discrepancy	Description of Error or Discrepancy	Potential Impact	Stealth Partner Group (Stealth) Response
Aetna Members - Stop Loss Claims were not Timely Filed	Stop loss claims were not timely filed for an Aetna member for the 2023 plan year. Total medical claims paid for this Aetna member prior to December 31, 2023 totaled $10,202.66. Per discussion with Stealth, and review of the current Stop Loss Summary Report, the related stop loss claim was not filed with Symetra until September 2024 (prior to identification in the audit).	Delayed Reimbursement (less than 1 year) of $10,202.66	This stop loss claim was delayed because Stealth and Aetna begin monitoring medical claims for stop loss once they reach 50% of the deductible. This delay is expected. The process to monitor medical claims at once they reach 50% of the deductible is a standard process for instances in which there is an Administrative Services Only (ASO) entity, such as Aetna, with an independent Pharmacy Benefits Manager, such as Navitus. Stealth receives claims detail from both Aetna and Navitus, monitors the value of claims, and submits the stop loss claims to Symetra. An ASO's standard reporting provided to Stealth is generated at 50% of the deductible. It takes time for the ASO to generate and ad hoc report. Stealth generated the initial request for the ad hoc report in June, Aetna provided the report in August, and the related stop loss claim was filed and reimbursed in September.
Select Health Members - Stop Loss Claims were not Completely and Timely Filed	Stop loss claims were not completely filed for five Select Health members for the 2022 plan year, including: • Stop loss claims were not filed for any medical claims paid related to four Select Health members, totaling $122,128.73. • A stop loss claim was not filed for a medical claim paid related to one Select Health member, totaling $520.11. This error was identified during the audit, and Stealth has since filed stop loss claims with Symetra.	Delayed Reimbursement (more than 1 year) of $122,648.84	These stop loss claims were not submitted timely because Stealth and Select Health begin monitoring medical claims for stop loss once they reach 50% of the deductible. Select Health is a Third-Party Administrator (TPA). As a TPA, Select Health compiles the stop loss claims and sends it to Stealth for review and submission to Symetra. Stealth receives the claims filing from Select Health and claims detail from Navitus, monitors the value of claims, and submits the stop loss claims to Symetra. A TPA's standard reporting provided to Stealth is generated at 50% of the deductible for monitoring and claims filings are generated at 100% of the deductible. In the instances identified, Stealth submitted claims for the pharmacy from Navitus, however overlooked the medical claims because they were below 50% of the deductible. Once identified, Stealth worked with Select Health to generate filings and get the amounts reimbursed by Symetra.

Type of Error or Discrepancy	Description of Error or Discrepancy	Potential Impact	Stealth Partner Group (Stealth) Response
			Stealth has developed and is continuing to evolve tools to monitor medical claims and pharmacy claims in aggregate to determine when the number of claims paid meets the stop loss deductible despite reporting threshold restrictions in order to ensure stop loss claims are filed completely and timely.
Aetna Members - Inconsistency in Data provided to Stealth and BDO Leading to Variance in Total Value of Medical or Pharmacy Claims Eligible for Stop Loss	During review of the claims data provided by Aetna and Navitus, for claims activity for Aetna members, BDO noted inconsistencies between the data provided to BDO and the data provided to Stealth. For the 2022 stop loss plan year, BDO noted inconsistencies between the information provided to BDO and Stealth for two members: • 2021 claim activity occurring during 2022 plan year which would have been considered under the stop loss policy's gapless parameters and pharmacy claim which wasn't included in the data that Stealth had received. • 2022 claim activity / adjustments that weren't included in the data stealth had received. For the 2023 stop loss plan year BDO noted inconsistencies between the information provided to BDO and Stealth for seven members: • 2022 claim activity occurring during 2023 plan year which would have been considered under the stop loss policy's gapless parameters and pharmacy claim which wasn't included in the data that Stealth had received. • 2023 claim activity / adjustments that weren't included in the data stealth had received. With the assumption that that the data provided to BDO is accurate and complete, these inconsistencies result in a potential over reimbursement in stop loss claims in the amount of $41,024.45 for 2022 and $47,396.22 for 2023.	Over Reimbursement of $88,420.67	Stealth will work with Aetna and Navitus to determine the cause of inconsistencies in the data received, obtain the accurate information from Select Health, and ensure that adjustments to stop loss claims are filed (as needed).
Select Health Members - Inconsistency in Data provided to Stealth and BDO Leading to Variance in Total Value of Medical or	During review of the 2022 claims data provided by Select Health and Navitus, for Select Health members, BDO noted inconsistencies between the information provided to BDO and Stealth for two members. These inconsistencies included the following: • 2021 claim activity occurring during 2022 which would have been considered under the stop loss policies gapless parameters.	Over Reimbursement of $773.66	Stealth will work with Select Health to determine the cause of inconsistencies in the data received, obtain the accurate information from Select Health, and ensure that adjustments to stop loss claims are filed (as needed).

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Type of Error or Discrepancy	Description of Error or Discrepancy	Potential Impact	Stealth Partner Group (Stealth) Response
Pharmacy Claims Eligible for Stop Loss	• A 2022 pharmacy claim which wasn't included in the data that Stealth had received. With the assumption that that the data provided to BDO is accurate and complete, these inconsistencies result in a potential over reimbursement in stop loss claims.		