STEVE SISOLAK
Governor

Deonne E. Contine
Board Chair

STATE OF NEVADA
PUBLIC EMPLOYEES' BENEFITS PROGRAM
901 S. Stewart Street, Suite 1001 | Carson City, Nevada 89701
Telephone 775-684-7000 | 1-800-326-5496 | Fax 775-684-7028
www.pebp.state.nv.us

URAC ACCREDITED
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Expires 04/01/2021

DAMON HAYCOCK
Executive Officer

MEETING NOTICE AND AGENDA

Name of Organization:	Public Employees' Benefits Program Board
Date and Time of Meeting:	September 26, 2019 9:00 a.m.
Place of Meeting:	The Legislative Building 401 South Carson Street, Room #1214 Carson City, NV 89701
Video Conferencing:	The Grant Sawyer State Office Building 555 East Washington Avenue, Room #4412 Las Vegas, NV 89101
Streaming Website:	www.pebp.state.nv.us

AGENDA

1. Open Meeting: Roll Call

2. Public Comment

   Public comment will be taken during this agenda item. No action may be taken on any matter raised under this item unless the matter is included on a future agenda as an item on which action may be taken. Persons making public comments to the Board will be taken under advisement but will not be answered during the meeting. Comments may be limited to three minutes per person at the discretion of the chairperson. Additional three minute comment periods may be allowed on individual agenda items at the discretion of the chairperson. These additional comment periods shall be limited to comments relevant to the agenda item under consideration by the Board. Persons unable to attend the meeting and persons whose comments may extend past the three minute time limit may submit their public comment in writing to PEBP Attn: Laura Landry 901 S. Stewart St, Suite 1001 Carson City NV 89701, Fax: (775) 684-7028 or llandry@peb.nv.gov at least two business days prior to the meeting. Persons making public comment need to state and spell their name for the record at the beginning of their testimony.

3. PEBP Board disclosures for applicable Board meeting agenda items. (Brandee Mooneyhan, Deputy Attorney General) (Information/Discussion)

4. Consent Agenda (Deonne Contine, Board Chair) (**All Items for Possible Action**)

   Consent items will be considered together and acted on in one motion unless an item is removed to be considered separately by the Board.

   4.1 Approval of Action Minutes from the July 25, 2019 PEBP Board Meeting.

   4.2. Receipt of PEBP Chief Financial Officer annual reports for year ending June 30, 2019:
   - 4.2.1. Budget Report
   - 4.2.2. Utilization Report

   4.3. Receipt of annual vendor reports for timeframe July 1, 2018 - June 30, 2019:
   - 4.3.1. HealthSCOPE Benefits – Obesity Care Management Program
   - 4.3.2. Hometown Health Providers – Utilization and Large Case Management
   - 4.3.3. The Standard Insurance – Basic Life and Long Term Disability Insurance
   - 4.3.4. Willis Towers Watson's Individual Marketplace Quarterly Report for Q4, 2019

   4.4. Acceptance of Health Claim Auditors, Inc. quarterly audit of HealthSCOPE Benefits for the timeframe April 1, 2019 – June 30, 2019 to include: report from Health Claim Auditors; HealthSCOPE Benefits response to audit report; and acceptance of audit report findings and assessment of penalties, if applicable, in accordance with performance guarantees included in the contract pursuant to the recommendation of Health Claim Auditors.

5. Discussion and possible action to determine Plan Year 2021 (and beyond) disposition of the Unum contract for voluntary long-term care services to include: 1) extend the current contract an additional 4 years; 2) close the policy to new enrollees and continue payroll deductions for existing enrollees; or 3) allow the policy to terminate June 30, 2020 and current enrollees can elect continuation of coverage through direct billing. (Laura Rich, Operations Officer) (**For Possible Action**)

6. Discussion and possible action to approve an amendment to the Monreau Shepell eligibility and enrollment system contract to lower Per Employee Per Month (PEPM) fees from $1.78 to $1.50 beginning September 1, 2019 through the remainder of the contract. (Cari Eaton, Chief Financial Officer) (**For Possible Action)**

7. Presentation on the State of PEBP. (Damon Haycock, Executive Officer) (Information/Discussion)

8. Discussion and possible board direction regarding updating the PEBP Strategic Plan. (Damon Haycock, Executive Officer) (**For Possible Action**)

9. Discussion and possible action to update the PEBP Board's Duties, Policies and Procedures to align with legislative action during the 80th Legislative Session. (Damon Haycock, Executive Officer) (**For Possible Action**)

10. Discussion and possible action to review and approve the Morneau Shepell eligibility and enrollment system Performance Improvement Plan. (Morneau Shepell) (**For Possible Action**)

11. Discussion and possible direction from the Board to staff on potential program design changes for Plan Year 2021/2022/2023 for which the Board requests additional information and costs to be presented at the November 21, 2019 meeting. (Damon Haycock, Executive Officer) (**For Possible Action**)

12. Executive Officer Report. (Damon Haycock, Executive Officer) (Information/Discussion)

13. Public Comment

    Public comment will be taken during this agenda item. Comments may be limited to three minutes per person at the discretion of the chairperson. Persons making public comment need to state and spell their name for the record at the beginning of their testimony.

14. Adjournment

The supporting material to this agenda, also known as the Board Packet, is available, at no charge, on the PEBP website at www.pebp.state.nv.us/board.htm (under the Board Meeting date referenced above).
An item raised during a report or public comment may be discussed but may not be deliberated or acted upon unless it is on the agenda as an action item.
All times are approximate. The Board reserves the right to take items in a different order or to combine two or more agenda items for consideration to accomplish business in the most efficient manner. The Board may remove an item from the agenda or delay discussion relating to an item on the agenda at any time. The Board reserves the right to limit Internet broadcasting during portions of the meeting that need to be confidential or closed.
We are pleased to make reasonable efforts to assist and accommodate persons with physical disabilities who wish to attend the meeting. If special arrangements for the meeting are necessary, please notify the PEBP in writing, at 901 South Stewart Street, Suite 1001, Carson City, NV 89701, or call Laura Landry at (775) 684-7020 or (800) 326-5496, as soon as possible so that reasonable efforts can be made to accommodate the request.
Copies of both the PEBP Meeting Action Minutes and Meeting Transcripts are available for inspection, at no charge, at the PEBP Office, 901 South Stewart Street, Suite 1001, Carson City, Nevada, 89701 or on the PEBP website at www.pebp.state.nv.us. For additional information, contact Laura Landry at (775) 684-7020 or (800) 326-5496.
Notice of this meeting was posted on or before 9:00 a.m. on the third working day before the meeting at the following locations: NEVADA STATE LIBRARY & ARCHIVE, 100 N. Stewart St, Carson City; BLASDEL BUILDING, 209 East Musser Street, Carson City; PUBLIC EMPLOYEES' BENEFITS PROGRAM, 901 South Stewart Street, Suite 1001, Carson City; THE GRANT SAWYER STATE OFFICE BUILDING, 555 East Washington Avenue, Las Vegas; THE LEGISLATIVE BUILDING, 401 South Carson Street, Carson City, and on the PEBP website at www.pebp.state.nv.us, also posted to the

public notice website for meetings at www.leg.state.nv.us/App/Notice and https://notice.nv.gov. In addition, the agenda was mailed to groups and individuals as requested.

1.

1. Open Meeting; Roll Call

2.

2. Public Comment

3.

3. PEBP Board disclosures for applicable Board meeting agenda items. (Brandee Mooneyhan, Deputy Attorney General)
(Information/Discussion)

4.

4. Consent Agenda (Deonne Contine, Board Chair) (**All Items for Possible Action**)

   Consent items will be considered together and acted on in one motion unless an item is removed to be considered separately by the Board.

   4.1 Approval of Action Minutes from the July 25, 2019 PEBP Board Meeting.

   4.2. Receipt of PEBP Chief Financial Officer annual reports for year ending June 30, 2019:

   4.2.1. Budget Report

   4.2.2. Utilization Report

   4.3. Receipt of annual vendor reports for timeframe July 1, 2018 - June 30, 2019:

   4.3.1. HealthSCOPE Benefits – Obesity Care Management Program

   4.3.2. Hometown Health Providers – Utilization and Large Case Management

   4.3.3. The Standard Insurance – Basic Life and Long Term Disability Insurance

   4.3.4. Willis Towers Watson's Individual Marketplace Quarterly Report for Q4, 2019

   4.4. Acceptance of Health Claim Auditors, Inc. quarterly audit of HealthSCOPE Benefits for the timeframe April 1, 2019 – June 30, 2019 to include: report from Health Claim Auditors; HealthSCOPE Benefits response to audit report; and acceptance of audit report findings and assessment of penalties, if applicable, in accordance with performance guarantees included in the contract pursuant to the recommendation of Health Claim Auditors.

4.1.

4. Consent Agenda (Deonne Contine, Board Chair) (**All Items for Possible Action**)

   4.1 Approval of Action Minutes from the July 25, 2019 PEBP Board Meeting.

STATE OF NEVADA
PUBLIC EMPLOYEES' BENEFITS PROGRAM
BOARD MEETING

The Legislative Building
401 South Carson Street, Room #1214
Carson City, NV 89701

ACTION MINUTES (Subject to Board Approval)
July 25, 2019

MEMBERS PRESENT IN CARSON CITY:
Ms. Deonne Contine, Board Chair
Mr. Don Bailey, Vice-Chair
Ms. Mandy Hagler, Member
Ms. Leah Lamborn, Member
Mr. John Packham, Member
Mr. Tom Verducci, Member

MEMBERS PRESENT IN LAS VEGAS:
Ms. Linda Fox, Member
Ms. Jet Mitchell, Member
Ms. Christine Zack, Member

FOR THE BOARD: Ms. Brandee Mooneyhan, Deputy Attorney General

FOR STAFF:
Mr. Damon Haycock, Executive Officer
Ms. Cari Eaton, Chief Financial Officer
Ms. Laura Rich, Operations Officer
Ms. Nancy Spinelli, Quality Control Officer
Ms. Laura Landry, Executive Assistant

1. Open Meeting: Roll Call
   Chair Contine opened the meeting at 9:00 a.m.

2. Public Comment
   Public Comment in Carson City:
   - Kent Ervin – Nevada Faculty Alliance
   - Susan Gaskill – PEBP Participant
   - Deonne Contine – Board Chair - introduced new PEBP Board Member Jet Mitchell

   Public Comment in Las Vegas:
   - There was no public comment in Las Vegas.

3. PEBP Board disclosures for applicable Board meeting agenda items. (Brandee Mooneyhan, Deputy Attorney General) (Information/Discussion)

4. Consent Agenda (Deonne Contine, Board Chair) (**All Items for Possible Action**)

   Consent items will be considered together and acted on in one motion unless an item is removed to be considered separately by the Board.

   4.1. Approval of Action Minutes from the April 29, 2019 PEBP Board Meeting.

   4.2. Approval of Action Minutes from the May 23, 2019 PEBP Board Meeting.

   4.3. Receipt of quarterly staff reports for the period ending March 31, 2019:

   4.3.1. PEBP Chief Financial Officer Reports

   4.3.1.1. Budget Report

   4.3.1.2. Utilization Report

   4.4. Receipt of quarterly vendor reports for the period ending March 31, 2019:

   4.4.1. HealthSCOPE Benefits – Obesity Care Management Program

   4.4.2. Hometown Health Providers – Utilization and Large Case Management

   4.4.3. The Standard Insurance – Basic Life and Long-Term Disability Insurance

   4.4.4. Towers Watson's One Exchange – Medicare Exchange

   4.5. Accept the Fiscal Year 2019 Other Post-Employment Benefits (OPEB) valuation prepared by Aon in conformance with the Governmental Accounting Standards Board (GASB) requirements.

BOARD ACTION ON ITEM 4.
MOTION: Motion to approve the consent agenda in its entirety.
BY: Member Christine Zack
SECOND: Member Don Bailey
VOTE: Unanimous; the motion carried.

5. Health Claim Auditors, Inc. quarterly audit of HealthSCOPE Benefits for the timeframe January 1, 2019 – March 31, 2019: (1) Report from Health Claim Auditors; (2) HealthSCOPE Benefits response to audit report; and (3) for possible action to accept audit report findings and assess penalties, if applicable, in accordance with the performance guarantees included in the contract pursuant to the recommendation of Health Claim Auditors. (**For Possible Action**)

BOARD ACTION ON ITEM 5.
MOTION: Motion to approve the auditor's report and wave the associated penalties.
BY: Member Tom Verducci
SECOND: Member Mandy Hagler
IN FAVOR: Chair Deonne Contine, Vice Chair Don Bailey, Member Mandy Hagler, Member John Packham, Member Tom Verducci, Member Christine Zack

OPPOSED: Member Linda Fox, Member Leah Lamborn, Member Jet Mitchell

VOTE: Six in favor, three opposed; the motion carried.

6. Discussion and update on PEBP's Open Enrollment results for Plan Year 2020. (Laura Rich, Operations Officer) (Information/Discussion)

7. Discussion and possible action to approve a retroactive amendment with HealthSCOPE Benefits for lowered cost out-of-state medical network services available to members on the Consumer Driven Health Plan (CDHP) and Exclusive Provider Options (EPO) plan. (Cari Eaton, Chief Financial Officer) (**For Possible Action**)

BOARD ACTION ON ITEM 7.
MOTION: Motion to approve a retroactive amendment with HealthSCOPE Benefits for lower cost out-of-state medical network services.
BY: Member Christine Zack
SECOND: Member Leah Lamborn
VOTE: Unanimous; the motion carried.

8. Discussion, update and possible action on the 80th Legislative Session with Board approval to opt-in to emergency service reimbursement provisions of AB 469 and update plan benefits for CDHP and EPO members on January 1, 2020 in accordance with AB 472 for the addition of gestation carrier maternity services. (Damon Haycock, Executive Officer) (**For Possible Action**)

BOARD ACTION ON ITEM 8.
MOTION: Motion to participate in the provision of AB 469 and align maternity benefits with AB 472.
BY: Member Tom Verducci
SECOND: Member Don Bailey
VOTE: Unanimous; the motion carried.

9. Election of Board Vice-Chair pursuant to Nevada Administrative Code (NAC) 287.172. Eligible candidates are Don Bailey, Sr., Linda Fox, Leah Lamborn, John Packham, Mandy Hagler, Tom Verducci, and Christine Zack. (Deonne Contine, Board Chair) (**For Possible Action**)

BOARD ACTION ON ITEM 9.

MOTION: Motion to appoint Tom Verducci as Vice-Chair
BY: Member Don Bailey
SECOND: No Second

MOTION: Motion to appoint Linda Fox as Vice-Chair
BY: Member Christine Zack
SECOND: Member Leah Lamborn
IN FAVOR: Chair Deonne Contine, Member Linda Fox, Member Mandy Hagler, Member Leah Lamborn, Member Jet Mitchell, Member John Packham, Member Tom Verducci, Member Christine Zack
OPPOSED: Member Don Bailey
VOTE: Eight in favor, one opposed; the motion carried.

10. Public Comment

Public Comment in Carson City:

- Marlene Lockard - Retired Public Employees of Nevada (RPEN)
- Kent Ervin – Nevada Faculty Alliance
- Peggy Lear Bowen - Retiree Participant (See Exhibit A for comments)

Public Comment in Las Vegas:

- There was no public comment in Las Vegas.

11. Adjournment

- Chair Contine Adjourned the meeting at 10:42 AM

Exhibit A

These remarks are presented as transcribed by Capitol Reporters.

AGENDA ITEM 10 - PUBLIC COMMENT FROM MS. BOWEN:

MS. BOWEN: Good morning and afternoon and thank you for all your hard work. My name and words for the record Peggy, P-e-g-g-y Lear, L-e-a-r Bowen, B-o-w-e-n. A couple of thank you thank you for doing some many wonderful things and going to such great efforts. Damon, you should be congratulated on eliminating the computer from a great deal of things, but it sounds to me that what the computer is still being required of people because it's still being required that you have to come in and use the PEBP Board computer, the PEBP computer to input and do the surveys, not the surveys but the other requirements to prove that you exist. And that little part about Medicare and if Medicare and workers' comp is involved, errors have been made in regards to all of a sudden Medicare is cutting off services because they think it's a workers' comp program, and we need to make sure that the doctors' recordings and the use of that number, that coding number is -- meets the requirements so that there's not the denials that have been taking place. A small caveat that I've had a stroke, a heat stroke and a concussion and post traumatic since we last talked so I'm trying to go with my notes so things are not so convoluted and taken care of for you. So the important things are there were no meetings held for the retirees that are people who are currently in the system. I showed up at several of the meetings that were noticed by the postcards and by the letters and everything else, and I was asked what are you doing here? This isn't for you. And I said, well, where are the meetings to find out what the changes are in the program and what we're going to do so we know which programs we want to opt into or opt out of. So we need to have actual meetings for those who are already in the system, and the documents had to be done, as I was saying on PEBP computers so it's within the system regarding open enrollment and answering those questions. One thing that has not been brought up and hasn't been talked about is there was a requirement that a study be done as to what your members want, not just from department head meetings, not just by other entities but surveys of every single entity involved in this program to find out what their needs are, what they need to do, what -- and do them in the groups of the members of the departments not just the department head, you know, doing things but meetings for present employees to talk about what benefits they need in their individual departments because different departments have different needs. If you're the department of wildlife and fishing and hunting, you have different needs than the firefighters or the police. You have different needs, point made. You need to survey the members by groups as to what it is they need, and you also need to survey what the facilities needs, the facility committee, all of those wonderful computers and things that you said that you wanted to buy and pay for in interim finance and you got money for that, the buildings don't have the power, the plug-ins to support those computers. So we need to have facilities committees included and do a really thorough survey of each entity so that you have it all correct. Highway patrol needs more patrol cars. The facilities committee doesn't need more patrol cars. That's why simply break it down, and you still -- we got rid of the requirements for people to go in and answer all sorts of hoops and things to get on the program, and that was good that, but it's nowhere stated exactly that you need in order to qualify and maintain and keep your program that you need a physical -- you need your annual physical. You need your dental visit. You need your eye exam, and you need your blood work, and those things are in place so that you know those people exist and you don't -- And thank you for getting rid of the requirements about knowing what the programs about, but you --

CHAIRWOMAN CONTINE: Ms. Bowen, I'm going to ask you to wrap it up now. You're at about four minutes.
MS. BOWEN: Okay. Thank you. I apologize. Just please have meetings for retirees. Please have no computers required anywhere, anywhere. Oh, and the mammograms, that was it. We need to have included in what you're doing and saying that the -- that doctor follow-up because it's automatic now for most places for the 3D mammogram. So we had it that you have got to have two mammograms. What we need is a third provision to say follow-up as doctor recommended if you need a third mammogram or other types of -- other types of treatment regarding your mammograms, and that has been left out of the plans.
CHAIRWOMAN CONTINE: Okay. Thank you.
MS. BOWEN: Thank you, and thank you for all your hard work and have a great day.

4.2.

4. Consent Agenda (Deonne Contine, Board Chair) (**All Items for Possible Action**)

   Consent items will be considered together and acted on in one motion unless an item is removed to be considered separately by the Board.

   4.2. Receipt of PEBP Chief Financial Officer annual reports for year ending June 30, 2019:

      4.2.1. Budget Report

      4.2.2. Utilization Report

4.2.1.

4. Consent Agenda (Deonne Contine, Board Chair) (**All Items for Possible Action**)

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      4.2.1. Budget Report

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Executive Officer

AGENDA ITEM

[X] Action Item
[ ] Information Only

Date: September 26, 2019

Item Number: IV.II.I.

Title: Chief Financial Officer Budget Report

Summary

This report addresses the Operational Budget as of June 30, 2019 to include:

1. Budget Status
2. Budget Totals
3. Claims Summary

Budget Account 1338 – Operational Budget – Shown below is a summary of the operational budget account status as of June 30, 2019 with comparisons to the same period in Fiscal Year 2018. The budget status is reported on a cash basis and does not include incurred expenses and income owed to the fund.

The budget status report reflects actual income of $372.9 million as of June 30, 2019 compared to $354.2 million as of June 30, 2018 or an increase of 5.3%. Total expenses for the period have increased by $3 million or 0.8% for the same period.

The budget status report shows Realized Funding Available (cash) at $149.5 million. This compares to $124.6 million for last year. After subtracting $51.8 million for reserves for Incurred but not Reported (IBNR) claims, $39.9 million for the Catastrophic Reserve and $31.7 million for the HRA Reserve, the remaining balance is $26.2 million in Excess reserves. The table below reflects the actual revenue and expenditures for the period.

Operational Budget 1338						
	FISCAL YEAR 2019			FISCAL YEAR 2018		
	Actual as of 6/30/2019	Work Program	Percent	Actual as of 6/30/2018	Fiscal Year 2018 Close	Percent
Beginning Cash	143,129,728	143,129,728	100%	134,046,196	134,046,196	100%
Premium Income	360,793,540	384,570,407	94%	345,226,653	365,798,560	94%
All Other Income	12,203,752	1,884,806	647%	8,957,279	55,678,580	16%
Total Income	372,997,292	386,455,213	97%	354,183,931	421,477,139	84%
Personnel Services	2,630,988	2,787,950	94%	2,368,670	2,457,675	96%
Operating - Other than Personnel	2,103,793	2,580,922	82%	2,399,381	2,467,105	97%
Insurance Program Expenses	360,776,627	376,754,162	96%	357,789,976	360,212,838	99%
All Other Expenses	1,062,125	1,125,737	94%	1,001,384	1,007,397	99%
Total Expenses	366,573,534	383,248,771	96%	363,559,410	366,145,015	99%
Change in Cash	6,423,758	3,206,442		(9,375,478)	55,332,124	
REALIZED FUNDING AVAILABLE	149,553,486	146,336,170	102%	124,670,718	189,378,320	66%
Incurred But Not Reported Liability	(51,800,000)	(51,800,000)		(35,300,000)	(35,300,000)	
Catastrophic Reserve	(39,900,000)	(39,900,000)		(19,400,000)	(19,400,000)	
HRA Reserve	(31,676,056)	(31,676,056)		(30,167,672)	(30,167,672)	
NET REALIZED FUNDING AVAILABLE	26,177,430	22,960,114		39,803,046	104,510,648	

Current Budget Projections

The following table represents projections for FY 2019 based on data available as of June 30, 2019. The projection reflects total income to be less than budgeted by 1.7% ($520.3 million vs $529.6 million), total expenditures are projected to be less than budgeted by 3.4% ($370.1 million vs $383.2 million); total reserves are projected to be more than budgeted by 2.7% ($150.2 million vs $146.3 million).

Budgeted and Projected Income (Budget Account 1338)					
Description	**Budget**	**Actual 6/30/19**	**Projected**	**Difference**	
Carryforward	143,129,728	143,129,728	143,129,728	0	0.0%
State Subsidies	278,587,976	274,571,891	278,133,823	(454,153)	-0.2%
Non-State Subsidies	26,970,841	28,414,566	28,414,566	1,443,725	5.4%
Premium	79,011,590	57,807,083	57,807,083	(21,204,507)	-26.8%
All Other	1,884,806	12,203,752	12,896,429	11,011,623	584.2%
Total	529,584,941	516,127,020	520,381,628	(9,203,313)	-1.7%
Budgeted and Projected Expenses (Budget Account 1338)					
Description	**Budget**	**Actual 6/30/19**	**Projected**	**Difference**	
Operating	6,494,609	5,796,907	5,958,798	535,810	8.3%
State Employee Ins Cost	263,245,392	259,076,089	260,946,250	2,299,142	0.9%
State Retirees Ins Cost	53,764,043	50,571,877	50,936,656	2,827,387	5.3%
Non-State Employees Ins Cost	192,165	123,996	137,426	54,739	28.5%
Non-State Retirees Ins Cost	20,859,393	14,116,816	14,815,163	6,044,230	29.0%
State Medicare Ret Ins Cost	22,187,136	21,674,814	20,844,268	1,342,868	6.1%
Non-State Medicare Ret Ins Cost	16,506,033	15,213,035	16,474,099	31,934	0.2%
Total Insurance Costs	376,754,162	360,776,627	364,153,862	12,600,300	3.3%
Total Expenses	383,248,771	366,573,534	370,112,660	13,136,110	3.4%
Restricted Reserves	123,376,056	123,376,056	127,904,203	(4,528,147)	-3.7%
Excess Reserves for Benefit Enhancements	22,960,114	26,177,430	22,364,766	595,348	2.6%
Total Reserves	146,336,170	149,553,486	150,268,968	(3,932,798)	-2.7%
Total of Expenses and Reserves	529,584,941	516,127,020	520,381,628	9,203,312	1.7%

State Subsidies are projected to be less than the budgeted amount by $0.4 million (0.2%), Non-State Subsidies are projected to be more than budgeted by $1.4 million (5.4%), and Premium Income is projected to be less than budgeted by $21.2 million (26.8%). This overall decrease in projected revenue is due in part to a decrease in actual rates as compared to the budgeted rates as well as a decrease in average enrollment as compared to budgeted enrollment and a change in the mix of plan tiers. The mix of participants is as follows:

- 1.19% fewer state actives,
- 2.87% fewer state non-Medicare retirees,
- 11.1% fewer non-state actives,
- 6.07% fewer non-state, non-Medicare retirees
- 2.13% more state Medicare retirees, and
- 5.93% fewer non-state Medicare retirees.

Expenses for Fiscal Year 2019 are projected to be $13.1 million (3.4%) less than budgeted when changes to reserves are excluded. Operating expenses are projected to be less than budgeted by $0.5 million (8.3%). Employee and Retiree insurances costs are projected to be less than budgeted by $12.6 million (3.3%) when taken in total (see table above for specific information).

Total reserves for the year ending June 30, 2019 are projected to be $150.2 million. Reserves include $51.8 million for Incurred but not Reported (IBNR) claims, $39.9 million for the Catastrophic Reserve to insure plan solvency, $36.8 million in HRA reserves, and a balance in excess of the required reserves of $22.3 million.

Recommendations

None.

4.2.2.

4. Consent Agenda (Deonne Contine, Board Chair) (**All Items for Possible Action**)

   Consent items will be considered together and acted on in one motion unless an item is removed to be considered separately by the Board.

   4.2. Receipt of PEBP Chief Financial Officer annual reports for year ending June 30, 2019:

      4.2.2. Utilization Report

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Expires 04/01/2021

DAMON HAYCOCK
Executive Officer

AGENDA ITEM

[X] Action Item
[ ] Information Only

Date: September 26, 2019

Item Number: IV.II.II.

Title: Self-Funded CDHP and EPO Plan Utilization Report for the period ending June 30, 2019

This report addresses medical, dental, prescription drug and HSA/HRA utilization for the Plan Year ending June 30, 2019. Included are:

- Executive Summary – provides a utilization overview.
- HealthSCOPE CDHP Utilization Report – provides graphical supporting details for the information included in the Executive Summary.
- HealthSCOPE EPO Utilization Report – provides graphical supporting details for the information included in the Executive Summary.
- Express Scripts Utilization Report – provides details supporting the prescription drug information included in the Executive Summary.
- Health Plan of Nevada Utilization – see Appendix C for Plan Year 2019 utilization data.

Executive Summary

CONSUMER DRIVEN HEALTH PLAN (CDHP)

The Consumer Driven Health Plan (CDHP) experience for Q4 of Plan Year 2019 compared to Plan Year 2018 is summarized below.

- Population:
  - 1.8% increase for primary participants
  - 1.7% increase for primary participants plus dependents (members)
- Medical Cost:
  - 4.7% increase for primary participants
  - 4.4% increase for primary participants plus dependents (members)
- High Cost Claims:
  - There were 198 High Cost Claimants accounting for 20.7% of the total plan paid for Q4 in Plan Year 2019
  - 18.7% increase in High Cost Claimants per 1,000 members
  - 3.7% increase in average High Cost Claimant paid
- Top three highest cost clinical classifications include:
  - Neoplasms ($11.3 million) – 26.2% of paid claims
  - Injury and Poisoning ($6.5 million) – 15% of paid claims
  - Diseases of the Circulatory System ($5.5 million) – 12.7% of paid claims
- Emergency Room:
  - ER visits per 1,000 members decreased by 5.9%
  - Average paid per ER visit increased 5.5% from Q4 in Plan Year 2018
- Urgent Care:
  - Urgent Care visits per 1,000 members increased by 5.2%
  - Average paid per Urgent Care visit increased 2.3% from Q4 in Plan Year 2018
- Network Utilization:
  - 95.6% of claims are from In-Network providers
  - In-Network utilization decreased 0.8% from Plan Year 2018
  - In-Network discounts increased 1.1% from Plan Year 2018
- Preventive Services:
  - Overall Preventive Services Compliance Rates increased or remained within 3% from Plan Year 2018 in all categories
- Prescription Drug Utilization:
  - Overall:
    - Total Net Claims decreased 1.1%
    - Total Gross Claims Costs increased 6.2% ($2.8 million)
    - Average Total Cost per Claim increased 7.4%
      - From $89.14 to $95.72
  - Member:
    - Total Member Cost decreased 3.6%
    - Average Participant Share per Claim decreased 2.6%
    - Net Member PMPM decreased 5.2%
      - From $19.77 to $18.75

- Plan
  - Total Plan Cost increased 9%
  - Average Plan Share per Claim increased 10.2%
  - Net Plan PMPM increased 7.2%
    - From $70.79 to $75.88

PEBP PREMIER PLAN (EPO)

The PEBP Premier Plan (EPO) experience for Q4 of Plan Year 2019 is summarized below.

- Population:
  - Average of 4,653 primary participants
  - Average of 8,488 primary participants plus dependents (members)
- Medical Cost:
  - Primary participants cost $729 PEPM
  - Primary participants plus dependents (members) cost $400 PMPM
- High Cost Claims:
  - There were 39 High Cost Claimants accounting for 26.3% of the total plan paid for Q4 in Plan Year 2019
  - Total of 4.6 High Cost Claimants per 1,000 members
  - Total of $274,612 average High Cost Claimant paid
- Top three highest cost clinical classifications include:
  - Neoplasms ($1.9 million) – 18.5% of paid claims
  - Diseases of the Respiratory System ($1.8 million) – 17.1% of paid claims
  - Diseases of the Circulatory System ($1.2 million) – 12.1% of paid claims
- Emergency Room:
  - Total of 171 ER visits per 1,000 members
  - Average of $2,608 paid per ER visit
- Urgent Care:
  - Total of 288 Urgent Care visits per 1,000 members
  - Average of $140 paid per Urgent Care visit
- Network Utilization:
  - 98.3% of claims are from In-Network providers
- Preventive Services: Compliance %
  - Preventive Office Visit: 38.6%
  - Cholesterol Screening: 45.1%
  - Cervical Cancer Screening (Females 21-29) 29.7%
  - Cervical Cancer Screening (Females 30-65) 26.2%
  - Breast Cancer Screening (Females 40+) 45.7%
  - PSA (Prostate-specific antigen) Screening (Males 50+) 31.7%
  - Colorectal Screening (All 50+) 20.0%
- Prescription Drug Utilization (Compared to Q3 2019):
  - Overall:
    - Total Net Claims increased 0.1%
    - Total Gross Claims Costs increased 5.3% ($241k)
    - Average Total Cost per Claim increased 5.5%
      - From $107.66 to $113.53

- Member:
  - Total Member Cost decreased 15.3%
  - Average Participant Share per Claim decreased 15.2%
  - Net Member PMPM decreased 15.7%
    - From $22.48 to $18.96
- Plan
  - Total Plan Cost increased 8.4%
  - Average Plan Share per Claim increased 8.5%
  - Net Plan PMPM increased 7.9%
    - From $154.00 to $166.12

DENTAL PLAN

The Dental Plan experience for Q4 of Plan Year 2019 is summarized below.

- Dental Cost:
  - Total of $24,643,438 paid for Dental claims
    - Preventative claims account for 42.7% ($10.5 million)
    - Basic claims account for 29.6% ($7.2 million)
    - Major claims account for 20.2% ($4.9 million)
    - Periodontal claims account for 7.5% ($1.8 million)

HEALTH REIMBURSEMENT ARRANGEMENT

The table below provides a list of CDHP HRA account balances as of June 30, 2019.

HRA Account Balances as of June 30, 2019			
$Range	**# Accounts**	**Total Account Balance**	**Average Per Account Balance**
0	2,011	0	0
$.01 - $500.00	3,912	661,524	169
$500.01 - $1,000	1,750	1,250,374	714
$1,000.01 - $1,500	747	925,661	1,239
$1,500.01 - $2,000	423	734,090	1,735
$2,000.01 - $2,500	308	696,147	2,260
$2,500.01 - $3,000	260	714,795	2,749
$3,000.01 - $3,500	199	640,282	3,217
$3,500.01 - $4,000	154	576,440	3,743
$4,000.01 - $4,500	129	545,100	4,226
$4,500.01 - $5,000	138	654,249	4,741
$5,000.01 +	**808**	**5,953,923.27**	**7,368.72**
Total	**10,839**	**$ 13,352,585.85**	**$ 1,231.90**

CONCLUSION

The information in this report provides plan experience for the Consumer Driven Health Plan (CDHP) and the PEBP Premier Plan (EPO) for the fourth quarter of Plan Year 2019. The CDHP total plan paid costs increased 6.5% over Plan Year 2018. The EPO Plan, for its first year, ran better than expected. For HMO utilization and cost data please see the report provided in Appendix C.

PEBP staff and its partners continue to monitor data, research options and implement measures to provide cost savings to the plan while also providing the care our participants require.

Appendix A

Index of Tables
HealthSCOPE – CDHP Utilization Review for PEBP
July 1, 2018 – June 30, 2019

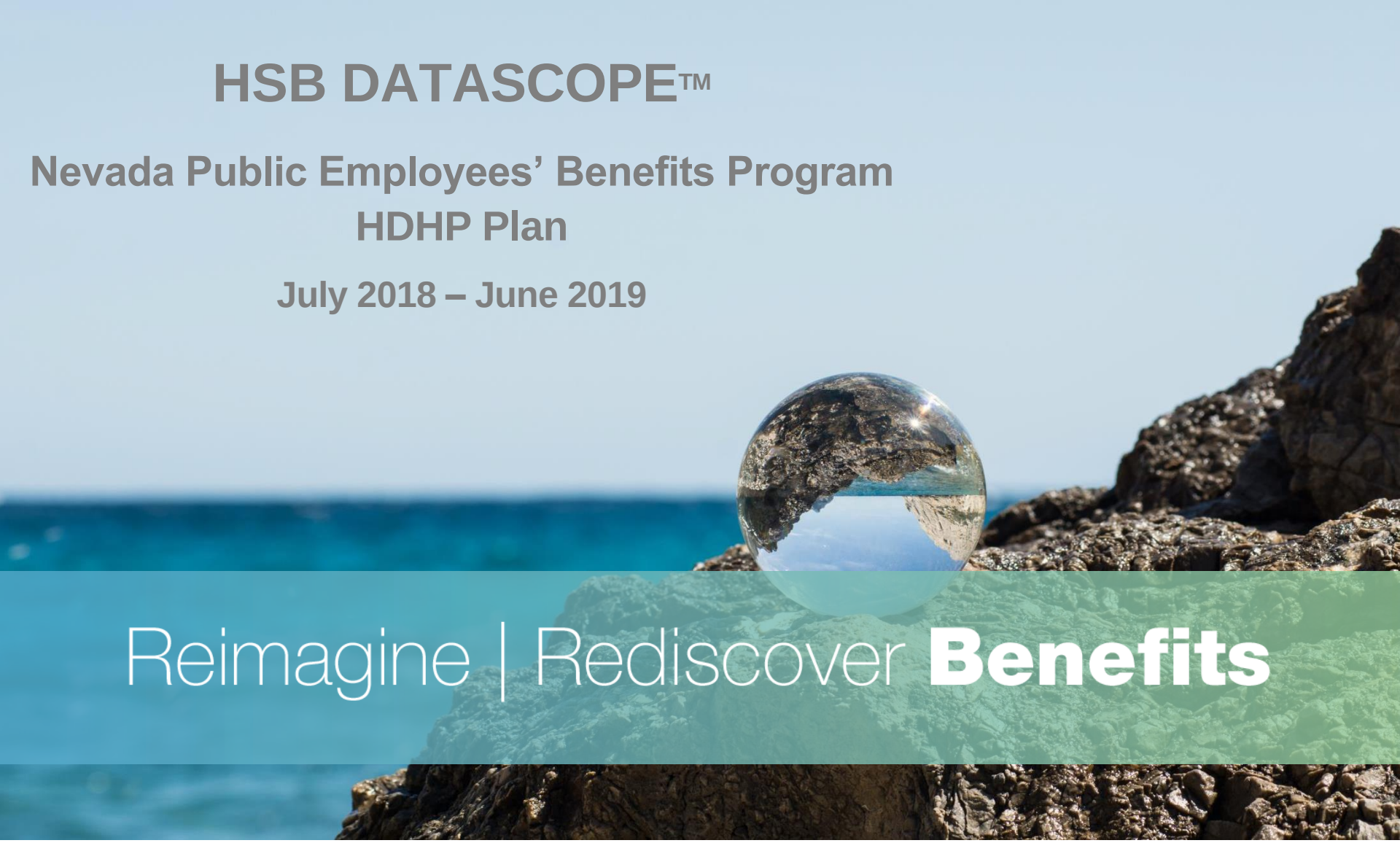
Appendix B

Index of Tables
HealthSCOPE – EPO Utilization Review for PEBP
July 1, 2018 – June 30, 2019

HSB DATASCOPE™

Nevada Public Employees' Benefits Program
HDHP Plan

July 2018 – June 2019



HealthSCOPE BENEFITS

Overview

- Total Medical Spend for PY19 was $133,179,670 of which 73.5% was spent in the State Active population. When compared to PY18, PY19 reflected an increase of 6.5% in plan spend.
  - When compared to PY17, PY19 reflected an increase of 8.7% in plan spend, with State Actives having an increase of 13.2%.
- On a PEPY basis, PY19 reflected an increase of 4.6% when compared to PY18. The largest group, State Actives, increased 3.8%.
  - When compared to PY17, PY19 reflected a increase in PEPY of 4.4%, with State Actives increasing by 6.9%.
- 86.0% of the Average Membership had paid Medical claims less than $2,500, with 17.7% of those having no claims paid at all during the reporting period.
- There were 198 High Cost Claimants (HCC's) over $100K, that account for 32.6% of the total spend. HCC's accounted for 27.7% of total spend during PY18, with 164 members hitting the $100K threshold. The largest claimant had a primary diagnosis in the Injury & Poisoning Grouper, with plan spend of $2,419,342.
- IP Paid per Admit was $21,100 which is an increase of 20.2% over PY18 Paid per Admit of $17,550.
- ER Paid per Visit is $2,025, which is an increase of 5.5% from PY18 ER Paid per Visit of $1,919.
- 95.6% of all Medical spend dollars were to In Network providers. The average In Network discount was 65.4%, which is slightly higher than PY18 discount of 64.3%.

Paid Claims by Age Group (p. 1 of 2)

Paid Claims by Age Group								
	PY18							
Age Range	Med Net Pay	Med PMPM	Rx Net Pay	Rx PMPM	Dental Net Pay	Dental PMPM	Net Pay	PMPM
<1	$ 5,529,148	$1,491	$ 20,282	$5	$ 3,855	$1	$ 5,553,285	$1,498
1	$ 775,797	$160	$ 12,089	$2	$ 46,864	$8	$ 834,750	$170
2 - 4	$ 1,179,040	$75	$ 71,885	$5	$ 395,902	$19	$ 1,646,827	$99
5 - 9	$ 1,555,560	$50	$ 224,318	$7	$ 1,245,177	$31	$ 3,025,055	$88
10 - 14	$ 2,621,977	$78	$ 336,346	$10	$ 1,230,918	$27	$ 4,189,241	$116
15 - 19	$ 3,355,137	$93	$ 761,868	$21	$ 1,461,638	$30	$ 5,578,643	$145
20 - 24	$ 4,161,697	$103	$ 904,576	$22	$ 1,037,960	$20	$ 6,104,233	$146
25 - 29	$ 4,111,542	$127	$ 692,524	$21	$ 964,543	$23	$ 5,768,609	$172
30 - 34	$ 5,522,890	$163	$ 921,359	$27	$ 1,198,065	$28	$ 7,642,314	$219
35 - 39	$ 6,406,372	$171	$ 1,719,643	$46	$ 1,383,893	$29	$ 9,509,908	$245
40 - 44	$ 6,454,899	$185	$ 1,844,666	$53	$ 1,353,595	$29	$ 9,653,160	$268
45 - 49	$ 9,559,650	$247	$ 3,042,544	$79	$ 1,613,583	$30	$ 14,215,777	$356
50 - 54	$ 12,917,061	$322	$ 4,911,765	$122	$ 1,867,773	$33	$ 19,696,599	$477
55 - 59	$ 15,619,711	$346	$ 5,287,501	$117	$ 2,287,808	$36	$ 23,195,020	$500
60 - 64	$ 31,443,977	$606	$ 8,036,483	$155	$ 2,755,825	$36	$ 42,236,285	$797
65+	$ 13,851,824	$538	$ 6,741,990	$262	$ 5,858,794	$39	$ 26,452,608	$840
Total	**$ 125,066,281**	**$ 248**	**$ 35,529,839**	**$ 70**	**$ 24,706,193**	**$ 31**	**$ 185,302,314**	**$ 349**

Paid Claims by Age Group (p. 2 of 2)

Paid Claims by Age Group																
	PY19														% Change	
Age Range	Med Net Pay		Med PMPM		Rx Net Pay		Rx PMPM		Dental Net Pay		Dental PMPM		Net Pay		PMPM		Net Pay	PMPM
<1	$	6,417,025	$	1,620	$	36,332	$	9	$	5,452	$	2	$	6,458,809	$	1,631	-14.0%	-8.2%
1	$	733,373	$	160	$	50,055	$	11	$	44,746	$	7	$	828,174	$	178	0.8%	-4.6%
2 - 4	$	1,140,806	$	71	$	79,418	$	5	$	413,256	$	20	$	1,633,480	$	96	0.8%	3.0%
5 - 9	$	1,641,304	$	53	$	329,398	$	11	$	1,235,087	$	30	$	3,205,789	$	94	-5.6%	-5.9%
10 - 14	$	3,730,705	$	110	$	382,089	$	11	$	1,225,296	$	26	$	5,338,091	$	148	-21.5%	-21.8%
15 - 19	$	4,689,885	$	129	$	903,369	$	25	$	1,470,160	$	29	$	7,063,413	$	184	-21.0%	-21.3%
20 - 24	$	6,492,186	$	158	$	909,269	$	22	$	975,767	$	18	$	8,377,222	$	199	-27.1%	-26.8%
25 - 29	$	4,642,212	$	139	$	904,592	$	27	$	970,627	$	23	$	6,517,431	$	189	-11.5%	-9.2%
30 - 34	$	7,033,160	$	199	$	1,443,219	$	41	$	1,139,314	$	25	$	9,615,693	$	266	-20.5%	-17.6%
35 - 39	$	6,909,105	$	175	$	1,637,414	$	42	$	1,346,222	$	27	$	9,892,742	$	243	-3.9%	0.8%
40 - 44	$	5,992,752	$	168	$	2,622,940	$	74	$	1,358,600	$	29	$	9,974,291	$	270	-3.2%	-1.0%
45 - 49	$	11,254,994	$	286	$	3,843,721	$	98	$	1,589,129	$	29	$	16,687,844	$	414	-14.8%	-13.8%
50 - 54	$	14,218,059	$	349	$	4,186,083	$	103	$	1,798,681	$	32	$	20,202,824	$	484	-2.5%	-1.4%
55 - 59	$	16,138,605	$	359	$	7,155,733	$	159	$	2,229,569	$	35	$	25,523,908	$	553	-9.1%	-9.6%
60 - 64	$	27,430,441	$	535	$	9,341,493	$	182	$	2,739,659	$	37	$	39,511,593	$	754	6.9%	5.7%
65+	$	14,715,057	$	547	$	5,889,932	$	219	$	6,101,872	$	39	$	26,706,862	$	805	-1.0%	4.3%
Total	**$**	**133,179,670**	**$**	**259**	**$**	**39,715,058**	**$**	**77**	**$**	**24,643,438**	**$**	**30**	**$**	**197,538,166**	**$**	**367**	**-6.2%**	**-4.9%**

Financial Summary (p. 1 of 2)

	Total				State Active				Non-State Active			
Summary	**PY17**	**PY18**	**PY19**	**Variance to PY18**	**PY17**	**PY18**	**PY19**	**Variance to PY18**	**PY17**	**PY18**	**PY19**	**Variance to PY18**
Enrollment												
Avg # Employees	22,628	23,155	23,569	1.8%	18,525	19,100	19,612	2.7%	5	4	4	-2.0%
Avg # Members	40,764	42,071	42,776	1.7%	35,124	36,389	37,138	2.1%	7	7	7	-1.1%
Ratio	1.8	1.8	1.8	-0.5%	1.9	1.9	1.9	-1.0%	1.5	1.7	1.8	1.2%
Financial Summary												
Gross Cost	$159,758,922	$164,211,622	$172,993,213	5.3%	$116,306,590	$123,145,285	$129,947,874	5.5%	$30,210	$42,221	$105,325	149.5%
Client Paid	$122,492,148	$125,066,281	$133,179,670	6.5%	$86,417,950	$91,783,613	$97,851,639	6.6%	$24,556	$32,607	$96,469	195.9%
Employee Paid	$37,266,774	$39,145,341	$39,813,543	1.7%	$29,888,640	$31,361,671	$32,096,235	2.3%	$5,654	$9,615	$8,857	-7.9%
Client Paid-PEPY	$5,413	$5,401	$5,651	4.6%	$4,665	$4,805	$4,989	3.8%	$5,170	$7,985	$24,117	202.0%
Client Paid-PMPY	$3,005	$2,973	$3,113	4.7%	$2,460	$2,522	$2,635	4.5%	$3,467	$4,603	$13,781	199.4%
Client Paid-PEPM	$451	$450	$471	4.7%	$389	$400	$416	4.0%	$431	$665	$2,010	202.3%
Client Paid-PMPM	$250	$248	$259	4.4%	$205	$210	$220	4.8%	$289	$384	$1,148	199.0%
High Cost Claimants (HCC's) > $100k												
# of HCC's	178	164	198	20.7%	90	108	124	14.8%	0	0	0	0.0%
HCC's / 1,000	4.4	3.9	4.6	18.7%	2.6	3.0	3.3	12.4%	0.0	0.0	0.0	0.0%
Avg HCC Paid	$198,331	$211,524	$219,374	3.7%	$188,569	$212,840	$218,720	2.8%	$0	$0	$0	0.0%
HCC's % of Plan Paid	28.8%	27.7%	32.6%	17.7%	19.6%	25.0%	27.7%	10.8%	0.0%	0.0%	0.0%	0.0%
Cost Distribution by Claim Type (PMPY)												
Facility Inpatient	$932	$900	$1,071	19.0%	$700	$719	$847	17.8%	$0	$0	$3,087	0.0%
Facility Outpatient	$973	$974	$925	-5.0%	$793	$814	$782	-3.9%	$1,345	$1,064	$6,561	516.6%
Physician	$1,013	$1,016	$1,045	2.9%	$901	$924	$948	2.6%	$1,937	$3,394	$4,006	18.0%
Other	$86	$82	$72	-12.2%	$66	$64	$58	-9.4%	$185	$146	$129	0.0%
Total	$3,005	$2,973	$3,113	4.7%	$2,460	$2,522	$2,635	4.5%	$3,467	$4,603	$13,781	199.4%
	Annualized	Annualized	Annualized		Annualized	Annualized	Annualized		Annualized	Annualized	Annualized	

Financial Summary (p. 2 of 2)

	State Retirees				Non-State Retirees				
Summary	**PY17**	**PY18**	**PY19**	**Variance to PY18**	**PY17**	**PY18**	**PY19**	**Variance to PY18**	**HSB Peer Index**
Enrollment									
Avg # Employees	3,095	3,165	3,224	1.9%	1,003	868	729	-16.0%	
Avg # Members	4,533	4,681	4,799	2.5%	1,101	958	832	-13.2%	
Ratio	1.5	1.5	1.5	0.7%	1.1	1.1	1.1	3.6%	1.8
Financial Summary									
Gross Cost	$30,476,360	$31,539,962	$34,175,219	8.4%	$12,945,763	$9,484,154	$8,764,794	-7.6%	
Client Paid	$24,783,105	$25,259,022	$27,761,940	9.9%	$11,266,537	$7,991,039	$7,469,622	-6.5%	
Employee Paid	$5,693,255	$6,280,940	$6,413,280	2.1%	$1,679,226	$1,493,115	$1,295,172	-13.3%	
Client Paid-PEPY	$8,007	$7,981	$8,612	7.9%	$11,238	$9,204	$10,246	11.3%	$6,209
Client Paid-PMPY	$5,468	$5,397	$5,785	7.2%	$10,233	$8,338	$8,983	7.7%	$3,437
Client Paid-PEPM	$667	$665	$718	8.0%	$936	$767	$854	11.3%	$517
Client Paid-PMPM	$456	$450	$482	7.1%	$853	$695	$749	7.8%	$286
High Cost Claimants (HCC's) > $100k									
# of HCC's	61	50	58	16.0%	27	18	16	-11.1%	
HCC's / 1,000	13.5	10.7	12.1	13.2%	24.5	18.8	19.2	2.5%	
Avg HCC Paid	$199,959	$169,470	$220,380	30.0%	$227,193	$179,428	$220,793	23.1%	
HCC's % of Plan Paid	49.2%	33.5%	46.0%	37.3%	54.4%	40.4%	47.3%	17.1%	
Cost Distribution by Claim Type (PMPY)									
Facility Inpatient	$1,992	$1,822	$2,155	18.3%	$3,983	$3,299	$4,794	45.3%	$1,057
Facility Outpatient	$1,778	$1,842	$1,787	-3.0%	$3,402	$2,839	$2,295	-19.2%	$1,145
Physician	$1,490	$1,521	$1,677	10.3%	$2,623	$2,073	$1,732	-16.4%	$1,122
Other	$208	$212	$166	-21.7%	$225	$127	$163	28.3%	$113
Total	$5,468	$5,397	$5,785	7.2%	$10,233	$8,338	$8,983	7.7%	$3,437
	Annualized	Annualized	Annualized		Annualized	Annualized	Annualized		

Paid Claims by Claim Type – State Participants

Net Paid Claims - Total State Participants	PY18				PY19				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical									
Inpatient	$ 31,368,709	$ 7,844,972	$ 1,849,402	$ 41,063,083	$ 36,705,959	$ 8,736,011	$ 2,660,713	$ 48,102,683	17.1%
Outpatient	$ 60,414,905	$ 13,698,539	$ 1,866,108	$ 75,979,552	$ 61,145,680	$ 14,375,822	$ 1,989,394	$ 77,510,895	2.0%
Total - Medical	$ 91,783,613	$ 21,543,511	$ 3,715,511	$ 117,042,635	$ 97,851,639	$ 23,111,833	$ 4,650,107	$ 125,613,579	7.3%
Dental	$ 17,102,914	$ 1,877,721	$ 494,557	$ 19,475,192	$ 16,845,534	$ 1,978,238	$ 510,673	$ 19,334,445	-0.7%
Dental Exchange	$ -	$ -	$ 2,649,933	$ 2,649,933	$ -	$ -	$ 2,870,635	$ 2,870,635	8.3%
Total	**$ 108,886,527**	**$ 23,421,232**	**$ 6,860,001**	**$ 139,167,760**	**$ 114,697,173**	**$ 25,090,071**	**$ 8,031,415**	**$ 147,818,659**	**6.2%**

Net Paid Claims - Per Participant per Month	PY18				PY19				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical	$ 400	$ 703	$ 507	$ 438	$ 416	$ 736	$ 637	$ 458	4.7%
Dental	$ 55	$ 47	$ 55	$ 54	$ 52	$ 49	$ 56	$ 52	-3.3%
Dental Exchange	$ -	$ -	$ 48	$ 48	$ -	$ -	$ 48	$ 48	-0.9%

Paid Claims by Claim Type – Non-State Participants

Net Paid Claims - Total Non-State Participants	PY18				PY19				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical									
Inpatient	$ -	$ 2,446,528	$ 1,025,118	$ 3,471,646	$ 25,103	$ 2,545,010	$ 1,671,607	$ 4,241,720	22.2%
Outpatient	$ 32,607	$ 4,060,837	$ 458,556	$ 4,552,000	$ 71,365	$ 2,739,008	$ 513,998	$ 3,324,371	-27.0%
Total - Medical	$ 32,607	$ 6,507,365	$ 1,483,675	$ 8,023,646	$ 96,469	$ 5,284,018	$ 2,185,605	$ 7,566,091	-5.7%
Dental	$ 2,777	$ 513,981	$ 208,643	$ 725,400	$ 2,943	$ 382,945	$ 203,655	$ 589,543	-18.7%
Dental Exchange	$ -	$ -	$ 1,855,668	$ 1,855,668	$ -	$ -	$ 1,848,816	$ 1,848,816	-0.4%
Total	**$ 35,383**	**$ 7,021,345**	**$ 3,547,985**	**$ 10,604,714**	**$ 99,412**	**$ 5,666,963**	**$ 4,238,075**	**$ 10,004,450**	**-5.7%**

Net Paid Claims - Per Participant per Month	PY18				PY19				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical	$ 665	$ 863	$ 515	$ 766	$ 2,010	$ 933	$ 709	$ 860	12.2%
Dental	$ 30	$ 40	$ 43	$ 41	$ 31	$ 40	$ 40	$ 40	-1.5%
Dental Exchange	$ -	$ -	$ 44	$ 44	$ -	$ -	$ 43	$ 43	-2.5%

Paid Claims by Claim Type – Total

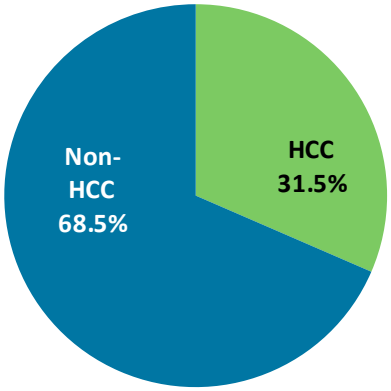
Net Paid Claims - Total Total Participants	PY18				PY19				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical									
Inpatient	$ 31,368,709	$ 10,291,500	$ 2,874,521	$ 44,534,729	$ 36,731,063	$ 11,281,021	$ 4,332,319	$ 52,344,403	17.5%
Outpatient	$ 60,447,511	$ 17,759,376	$ 2,324,665	$ 80,531,552	$ 61,217,045	$ 17,114,830	$ 2,503,392	$ 80,835,267	0.4%
Total - Medical	$ 91,816,220	$ 28,050,876	$ 5,199,186	$ 125,066,281	$ 97,948,107	$ 28,395,851	$ 6,835,711	$ 133,179,670	6.5%
Dental	$ 17,105,691	$ 2,391,702	$ 703,200	$ 20,200,592	$ 16,848,477	$ 2,361,183	$ 714,328	$ 19,923,988	-1.4%
Dental Exchange	$ -	$ -	$ 4,505,601	$ 4,505,601	$ -	$ -	$ 4,719,450	$ 4,719,450	4.7%
Total	**$ 108,921,911**	**$ 30,442,577**	**$ 10,407,986**	**$ 149,772,474**	**$ 114,796,585**	**$ 30,757,034**	**$ 12,269,490**	**$ 157,823,108**	**5.4%**

Net Paid Claims - Per Participant per Month	PY18				PY19				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	
Medical	$ 400	$ 734	$ 509	$ 450	$ 416	$ 766	$ 659	$ 471	4.6%
Dental	$ 55	$ 45	$ 51	$ 53	$ 52	$ 47	$ 51	$ 52	-3.1%
Dental Exchange	$ -	$ -	$ 46	$ 46	$ -	$ -	$ 46	$ 46	-1.4%

Cost Distribution – Medical Claims

PY18							PY19					
Avg # of Members	% of Members	Total Paid	% of Paid	EE Paid	% EE Paid	Paid Claims Category	Avg # of Members	% of Members	Total Paid	% of Paid	EE Paid	% EE Paid
143	0.3%	$34,689,929	27.7%	$907,245	2.3%	$100,000.01 Plus	176	0.4%	$43,435,833	32.6%	$1,456,122	3.7%
247	0.6%	$18,837,261	15.1%	$1,319,075	3.4%	$50,000.01-$100,000.00	213	0.5%	$16,804,113	12.6%	$1,274,376	3.2%
434	1.0%	$16,460,523	13.2%	$2,432,236	6.2%	$25,000.01-$50,000.00	455	1.1%	$17,387,019	13.1%	$2,453,060	6.2%
1,259	3.0%	$20,503,517	16.4%	$5,795,615	14.8%	$10,000.01-$25,000.00	1,266	3.0%	$21,003,923	15.8%	$5,830,862	14.6%
1,728	4.1%	$13,022,293	10.4%	$5,653,910	14.4%	$5,000.01-$10,000.00	1,675	3.9%	$12,738,499	9.6%	$5,498,850	13.8%
2,188	5.2%	$8,263,831	6.6%	$5,056,299	12.9%	$2,500.01-$5,000.00	2,182	5.1%	$8,284,816	6.2%	$4,935,634	12.4%
23,353	55.5%	$13,288,926	10.6%	$15,471,147	39.5%	$0.01-$2,500.00	23,701	55.4%	$13,525,467	10.2%	$15,881,281	40.0%
5,470	13.0%	$0	0.0%	$2,509,816	6.4%	$0.00	5,515	12.9%	$0	0.0%	$2,483,360	6.2%
7,249	17.2%	$0	0.0%	$0	0.0%	No Claims	7,592	17.7%	$0	0.0%	$0	0.0%
42,071	**100.0%**	**$125,066,281**	**100.0%**	**$39,145,341**	**100.0%**		**42,776**	**100.0%**	**$133,179,670**	**100.0%**	**$39,813,543**	**100.0%**

Distribution of HCC Medical Claims Paid



HCC – High Cost Claimant over $100K

HCC's by AHRQ Clinical Classifications Chapter			
AHRQ Chapter	Patients	Total Paid	% Paid
(CCS 2) Neoplasms	109	$11,380,138	26.2%
(CCS 16) Injury And Poisoning	103	$6,538,881	15.0%
(CCS 7) Diseases Of The Circulatory System	148	$5,513,457	12.7%
(CCS 15) Certain Conditions Originating In The Perinatal Period	14	$3,315,293	7.6%
(CCS 1) Infectious And Parasitic Diseases	114	$2,614,545	6.0%
(CCS 13) Diseases Of The Musculoskeletal System And Connective Tissue	129	$2,352,336	5.4%
(CCS 5) Mental Illness	67	$2,224,433	5.1%
(CCS 9) Diseases Of The Digestive System	110	$1,816,998	4.2%
(CCS 8) Diseases Of The Respiratory System	140	$1,459,027	3.4%
(CCS 6) Diseases Of The Nervous System And Sense Organs	146	$1,244,917	2.9%
(CCS 10) Diseases Of The Genitourinary System	100	$1,169,223	2.7%
(CCS 17) Symptoms; Signs; And Ill-Defined Conditions And Factors Influencing Health Status	191	$1,083,627	2.5%
(CCS 3) Endocrine; Nutritional; And Metabolic Diseases And Immunity Disorders	125	$786,015	1.8%
(CCS 18) Residual Codes; Unclassified; All E Codes [259. And 260.]	123	$644,969	1.5%
(CCS 14) Congenital Anomalies	22	$572,484	1.3%
(CCS 12) Diseases Of The Skin And Subcutaneous Tissue	90	$310,676	0.7%
(CCS 4) Diseases Of The Blood And Blood-Forming Organs	66	$236,411	0.5%
(CCS 11) Complications Of Pregnancy; Childbirth; And The Puerperium	5	$221,825	0.5%
Overall	**----**	**$43,485,256**	**100.0%**

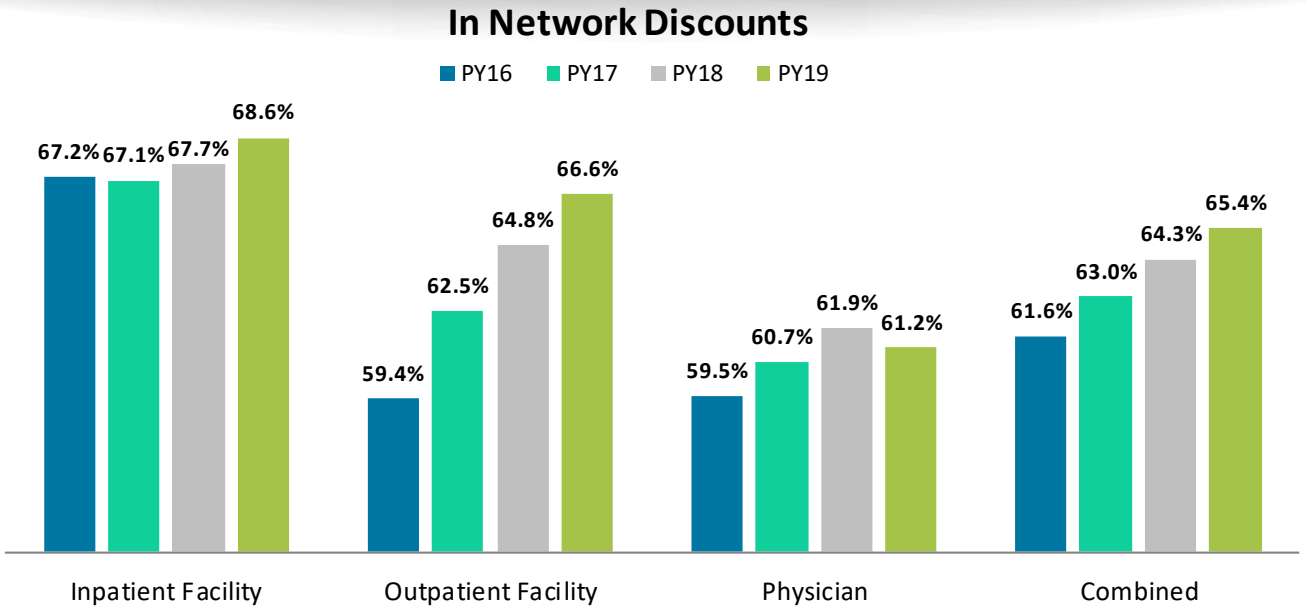
Utilization Summary (p. 1 of 2)

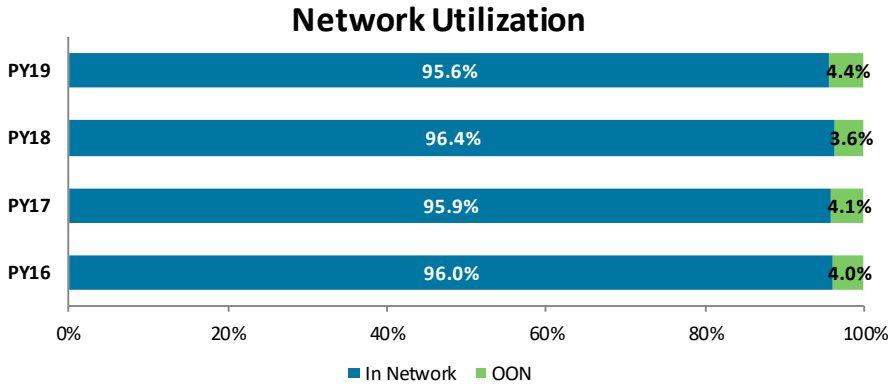
	Total				State Active				Non-State Active			
Summary	**PY17**	**PY18**	**PY19**	**Variance to PY18**	**PY17**	**PY18**	**PY19**	**Variance to PY18**	**PY17**	**PY18**	**PY19**	**Variance to PY18**
Inpatient Facility												
# of Admits	2,171	2,255	2,270		1,598	1,693	1,753		0	0	2	
# of Bed Days	10,475	10,294	14,341		6,878	7,217	8,989		0	0	8	
Paid Per Admit	$17,869	$17,550	$21,100	20.2%	$15,914	$16,350	$19,040	16.5%	$0	$0	$10,803	0.0%
Paid Per Day	$3,703	$3,845	$3,340	-13.1%	$3,697	$3,835	$3,713	-3.2%	$0	$0	$2,701	0.0%
Admits Per 1,000	53	54	53	-1.9%	45	47	47	0.0%	0	0	286	0.0%
Days Per 1,000	257	245	335	36.7%	196	198	242	22.2%	0	0	1143	0.0%
Avg LOS	4.8	4.6	6.3	37.0%	4.3	4.3	5.1	18.6%	0	0	4	0.0%
Physician Office												
OV Utilization per Member	3.6	3.6	3.5	-2.8%	3.3	3.3	3.3	0.0%	6.1	9.0	7.3	-18.9%
Avg Paid per OV	$47	$48	$47	-2.1%	$46	$47	$46	-2.1%	$68	$84	$89	0.0%
Avg OV Paid per Member	$168	$171	$167	-2.3%	$152	$158	$154	-2.5%	$413	$755	$652	0.0%
DX&L Utilization per Member	7.5	7.7	7.7	0.0%	6.9	7	7.1	1.4%	13.3	8.6	10.1	0.0%
Avg Paid per DX&L	$63	$60	$64	6.7%	$59	$57	$59	3.5%	$68	$48	$320	0.0%
Avg DX&L Paid per Member	$474	$461	$489	6.1%	$403	$400	$418	4.5%	$906	$412	$3,250	0.0%
Emergency Room												
# of Visits	6,379	7,106	6,931		5,153	5,870	5,653		4	3	3	
# of Admits	987	1046	1,096		648	745	796		0	0	1	
Visits Per Member	0.16	0.17	0.16	-5.9%	0.15	0.16	0.15	-6.3%	0.56	0.42	0.43	0.0%
Visits Per 1,000	156	169	162	-4.1%	147	161	152	-5.6%	565	424	429	0.0%
Avg Paid per Visit	$1,931	$1,919	$2,025	5.5%	$1,896	$1,893	$1,992	5.2%	$1,990	$1,027	$1,280	0.0%
Admits Per Visit	0.15	0.15	0.16	6.7%	0.13	0.13	0.14	7.7%	0.00	0.00	0.33	0.0%
Urgent Care												
# of Visits	9,953	9,817	10,472		8,940	8,774	9,389		5	2	6	
Visits Per Member	0.24	0.23	0.24	4.3%	0.25	0.24	0.25	4.2%	0.71	0.28	0.86	207.1%
Visits Per 1,000	244	233	245	5.2%	255	241	253	5.0%	706	282	857	203.9%
Avg Paid per Visit	$45	$44	$45	2.3%	$42	$42	$43	2.4%	$83	$140	$114	0.0%
	Annualized	Annualized	Annualized		Annualized	Annualized	Annualized		Annualized	Annualized	Annualized	

Utilization Summary (p. 2 of 2)

	State Retirees				Non-State Retirees				
Summary	**PY17**	**PY18**	**PY19**	**Variance to PY18**	**PY17**	**PY18**	**PY19**	**Variance to PY18**	**HSB Peer Index**
Inpatient Facility									
# of Admits	403	422	402		170	140	113		
# of Bed Days	2,373	2,374	2,457		1,224	703	2,887		
Paid Per Admit	$21,800	$20,299	$26,215	29.1%	$26,933	$23,788	$35,038	47.3%	$16,173
Paid Per Day	$3,702	$3,608	$4,289	18.9%	$3,741	$4,737	$1,371	-71.1%	$3,708
Admits Per 1,000	89	90	84	-6.7%	154	146	136	-6.8%	61
Days Per 1,000	524	507	512	1.0%	1,112	734	3,472	373.0%	264
Avg LOS	5.9	5.6	6.1	8.9%	7.2	5.0	25.5	410.0%	4.3
Physician Office									
OV Utilization per Member	5.0	5.0	4.9	-2.0%	6.6	6.4	6.4	0.0%	3.3
Avg Paid per OV	$52	$52	$52	0.0%	$45	$41	$40	-2.4%	$50
Avg OV Paid per Member	$264	$258	$254	-1.6%	$296	$265	$256	-3.4%	$167
DX&L Utilization per Member	10.6	11.1	11	-0.9%	14.5	14.5	13.6	-6.2%	8.3
Avg Paid per DX&L	$79	$75	$85	13.3%	$85	$64	$78	21.9%	$67
Avg DX&L Paid per Member	$838	$838	$932	11.2%	$1,234	$930	$1,067	14.7%	$554
Emergency Room									
# of Visits	891	960	996		331	469	279		
# of Admits	238	229	227		101	72	72		
Visits Per Member	0.2	0.21	0.21	0.0%	0.3	0.49	0.34	-30.6%	0.17
Visits Per 1,000	197	205	208	1.5%	301	489	336	-31.3%	174
Avg Paid per Visit	$2,029	$2,097	$2,244	7.0%	$2,212	$1,113	$1,905	71.2%	$1,684
Admits Per Visit	0.27	0.24	0.23	-4.2%	0.31	0.15	0.26	73.3%	0.14
Urgent Care									
# of Visits	766	845	908		242	196	169		
Visits Per Member	0.17	0.18	0.19	5.6%	0.22	0.20	0.20	0.0%	0.24
Visits Per 1,000	169	181	189	4.4%	220	205	203	-1.0%	242
Avg Paid per Visit	$72	$63	$69	9.5%	$77	$58	$55	-5.2%	$74
	Annualized	Annualized	Annualized		Annualized	Annualized	Annualized		

Provider Network Summary



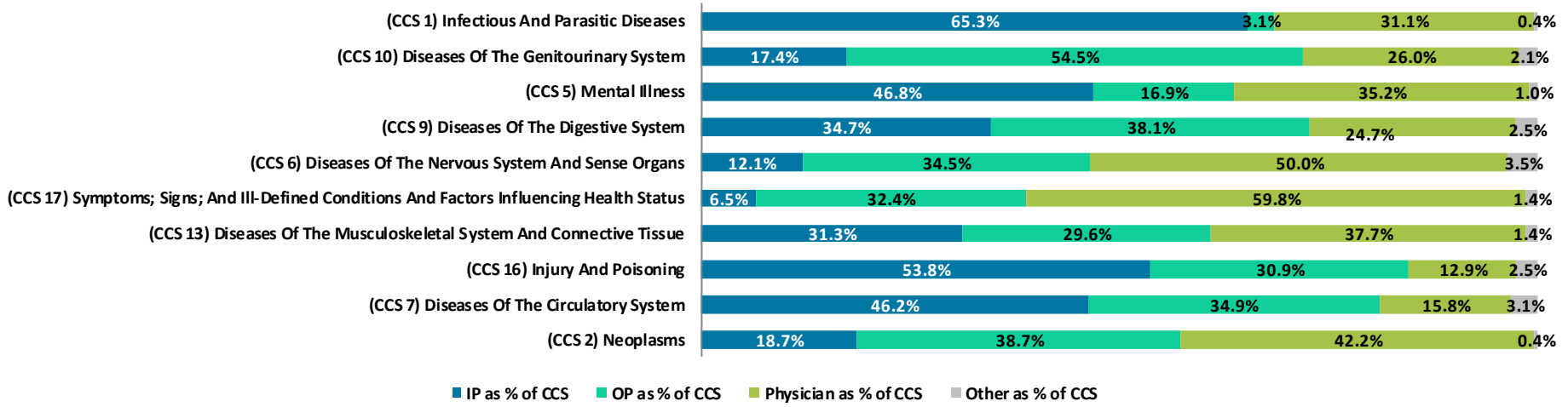


AHRQ* Clinical Classifications Summary

*Developed at the Agency for Healthcare Research and Quality (AHRQ), the Clinical Classifications Software (CCS) is a tool for clustering patient diagnoses and procedures into a manageable number of clinically meaningful categories.

AHRQ Clinical Classifications Chapter	Total Paid	% Paid	Insured	Spouse	Child	Male	Female
(CCS 2) Neoplasms	$19,385,424	15.8%	$15,988,203	$3,017,587	$379,635	$8,888,474	$10,496,950
(CCS 7) Diseases Of The Circulatory System	$14,340,484	10.4%	$10,376,046	$3,220,172	$744,266	$7,521,272	$6,819,212
(CCS 16) Injury And Poisoning	$13,701,239	10.2%	$8,424,573	$1,147,915	$4,128,751	$9,213,489	$4,487,750
(CCS 13) Diseases Of The Musculoskeletal System And Connective Tissue	$13,572,375	9.2%	$9,321,649	$2,720,050	$1,530,676	$5,723,339	$7,849,037
(CCS 17) Symptoms; Signs; And Ill-Defined Conditions And Factors Influencing Healt	$11,722,768	8.9%	$7,637,119	$1,834,688	$2,250,961	$4,204,266	$7,518,502
(CCS 6) Diseases Of The Nervous System And Sense Organs	$8,495,814	6.4%	$5,477,733	$1,615,009	$1,403,073	$3,193,876	$5,301,939
(CCS 9) Diseases Of The Digestive System	$8,010,086	6.3%	$5,863,723	$1,098,331	$1,048,031	$3,520,990	$4,489,096
(CCS 5) Mental Illness	$6,733,975	5.0%	$2,793,296	$928,417	$3,012,262	$3,231,667	$3,502,309
(CCS 10) Diseases Of The Genitourinary System	$6,037,245	4.9%	$4,029,478	$1,100,714	$907,053	$2,423,372	$3,613,873
(CCS 1) Infectious And Parasitic Diseases	$5,729,425	4.5%	$3,519,680	$800,498	$1,409,246	$3,125,344	$2,604,080
(CCS 8) Diseases Of The Respiratory System	$5,699,872	3.9%	$3,074,900	$995,109	$1,629,862	$2,984,643	$2,715,229
(CCS 11) Complications Of Pregnancy; Childbirth; And The Puerperium	$4,913,813	3.7%	$3,262,566	$1,380,032	$271,215	$19,434	$4,894,379
(CCS 15) Certain Conditions Originating In The Perinatal Period	$4,774,874	3.6%	$11,397	$3,086	$4,760,392	$2,845,736	$1,929,137
(CCS 3) Endocrine; Nutritional; And Metabolic Diseases And Immunity Disorders	$4,214,666	3.3%	$3,110,556	$571,464	$532,645	$1,700,576	$2,514,089
(CCS 18) Residual Codes; Unclassified; All E Codes [259. And 260.]	$2,316,634	1.1%	$1,739,360	$297,625	$279,648	$1,055,538	$1,261,096
(CCS 12) Diseases Of The Skin And Subcutaneous Tissue	$1,420,529	1.0%	$1,040,393	$215,339	$164,797	$860,615	$559,914
(CCS 14) Congenital Anomalies	$1,202,086	0.9%	$358,530	$10,041	$833,515	$753,538	$448,548
(CCS 4) Diseases Of The Blood And Blood-Forming Organs	$908,361	0.7%	$702,995	$102,420	$102,946	$258,097	$650,263
Total	**$133,179,670**	**100.0%**	**$86,732,197**	**$21,058,498**	**$25,388,974**	**$61,524,266**	**$71,655,403**

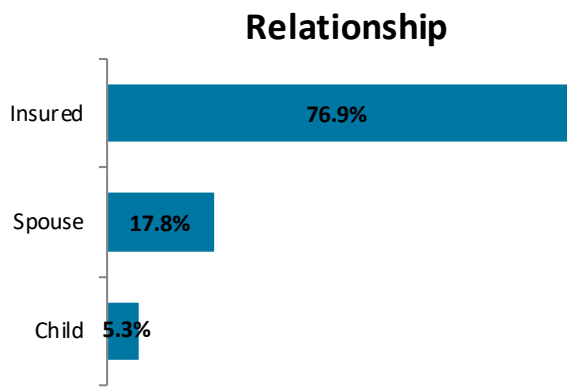
Top 10 Categories by Claim Type

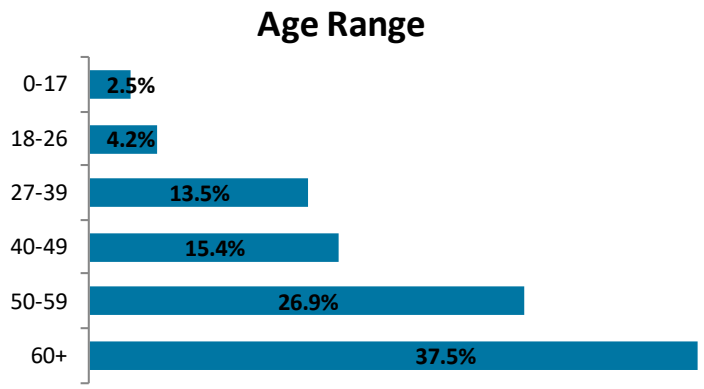


AHRQ Category - Neoplasms

Diagnosis Category	Patients	Claims	Total Paid	% Paid
Cancer Of Breast [24.]	335	4,513	$2,863,496	14.8%
Cancer Of Lymphatic And Hematopoietic Tissue	119	2,178	$2,745,361	14.2%
Cancer Of Skin	618	2,211	$2,418,369	12.5%
Maintenance Chemotherapy; Radiotherapy [45.]	112	784	$2,416,626	12.5%
Benign Neoplasms	2,933	5,815	$2,021,396	10.4%
Cancer; Other Primary	223	2,132	$1,813,901	9.4%
Other Gastrointestinal Cancer	41	759	$897,522	4.6%
Colorectal Cancer	85	962	$882,476	4.6%
Secondary Malignancies [42.]	125	857	$747,192	3.9%
Cancer Of Uterus And Cervix	263	888	$582,840	3.0%
Neoplasms Of Unspecified Nature Or Uncertain Behavior [44.]	2,115	3,808	$492,070	2.5%
Cancer Of Male Genital Organs	166	1,080	$410,288	2.1%
Cancer Of Ovary And Other Female Genital Organs	54	425	$324,359	1.7%
Cancer Of Bronchus; Lung [19.]	42	413	$320,406	1.7%
Malignant Neoplasm Without Specification Of Site [43.]	28	177	$227,252	1.2%
Cancer Of Urinary Organs	70	484	$221,871	1.1%
Overall	**----**	**----**	**$19,385,424**	**100.0%**

*Patient and claim counts are unique only within the category

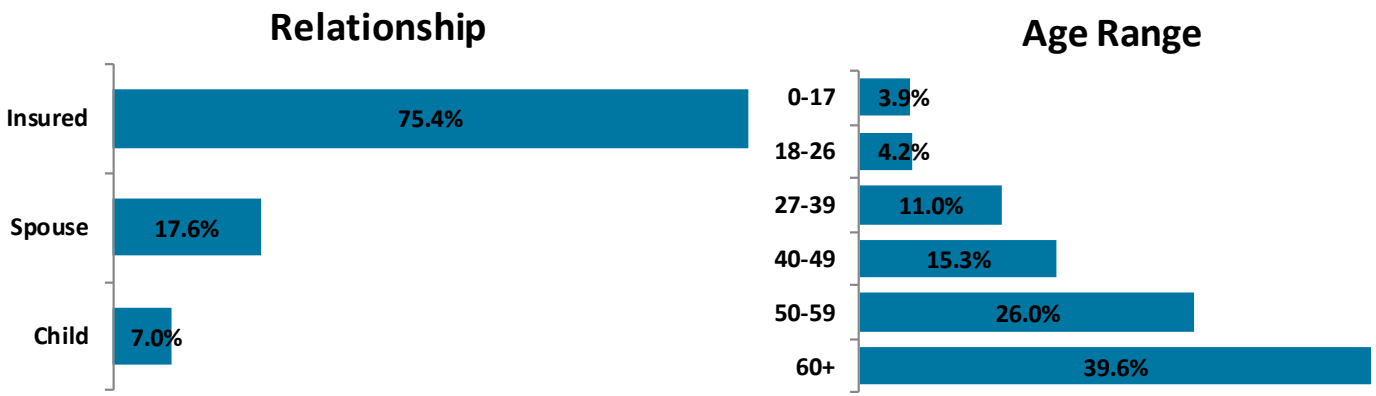




AHRQ Category – Diseases of the Circulatory System

Diagnosis Category	Patients	Claims	Total Paid	% Paid
Diseases Of The Heart	3,787	17,014	$9,753,365	68.0%
Cerebrovascular Disease	446	1,938	$1,813,411	12.6%
Diseases Of Veins And Lymphatics	743	2,493	$1,111,920	7.8%
Hypertension	3,777	9,028	$957,219	6.7%
Diseases Of Arteries; Arterioles; And Capillaries	925	1,738	$704,569	4.9%
Overall	**----**	**----**	**$14,340,484**	**100.0%**

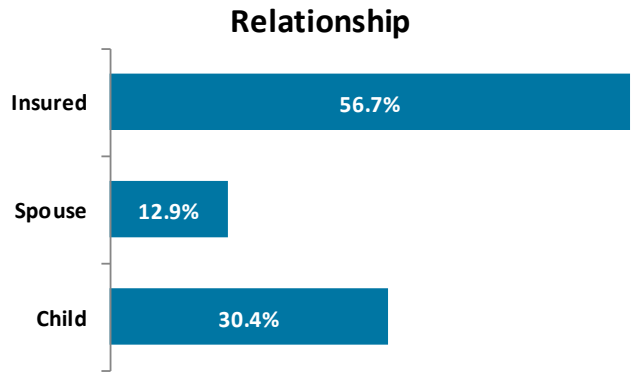
*Patient and claim counts are unique only within the category

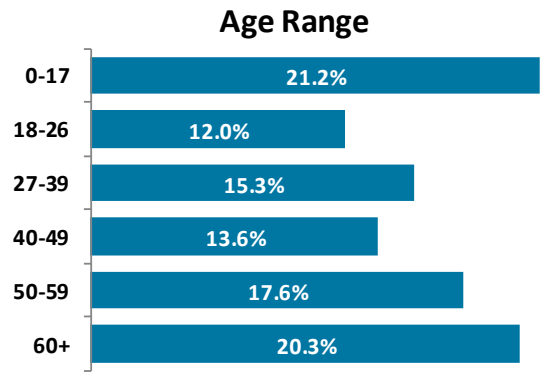


AHRQ Category – Injury & Poisoning

Diagnosis Category	Patients	Claims	Total Paid	% Paid
Complications	643	2,451	$4,551,857	33.2%
Fractures	965	6,858	$2,891,862	21.1%
Intracranial Injury [233.]	162	730	$1,589,887	11.6%
Open Wounds	849	2,217	$1,305,564	9.5%
Sprains And Strains [232.]	1,693	6,452	$1,110,915	8.1%
Joint Disorders And Dislocations; Trauma-Related [225.]	780	3,548	$935,487	6.8%
Other Injuries And Conditions Due To External Causes [244.]	1,547	3,018	$584,271	4.3%
Superficial Injury; Contusion [239.]	902	1,655	$282,672	2.1%
Crushing Injury Or Internal Injury [234.]	72	234	$205,583	1.5%
Spinal Cord Injury [227.]	11	110	$113,965	0.8%
Poisoning	110	234	$83,294	0.6%
Burns [240.]	60	179	$45,883	0.3%
	----	----	$13,701,239	100.0%

*Patient and claim counts are unique only within the category

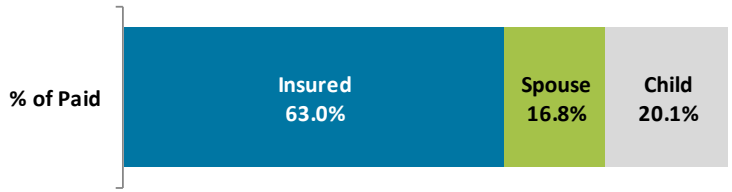


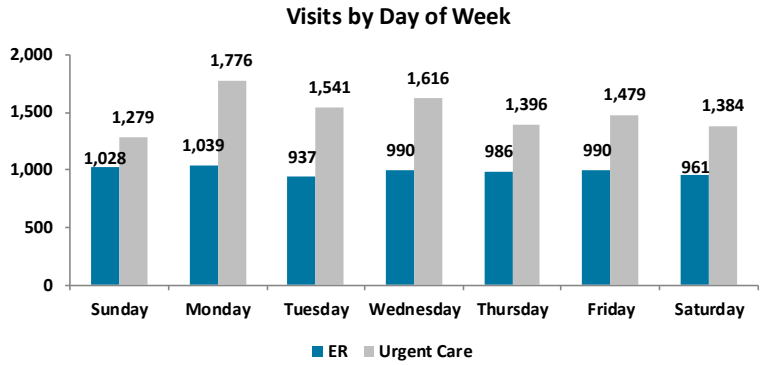


Emergency Room / Urgent Care Summary

	PY18		PY19		HSB Peer Index	
ER/Urgent Care	**ER**	**Urgent Care**	**ER**	**Urgent Care**	**ER**	**Urgent Care**
Number of Visits	7,106	9,817	6,931	10,471		
Number of Admits	1,046	----	1,096	----		
Visits Per Member	0.17	0.23	0.16	0.24	0.17	0.24
Visits/1000 Members	169	233	162	245	174	242
Avg Paid Per Visit	$1,918	$44	$2,025	$45	$1,684	$74
Admits per Visit	0.15	----	0.16	----	0.14	
% of Visits with HSB ER Dx	76.1%	----	76.9%	----		
% of Visits with a Physician OV*	76.7%	71.8%	77.0%	72.6%		
Total Plan Paid	**$13,628,487**	**$431,822**	**$14,021,480**	**$473,014**		

*looks back 12 months from ER visit



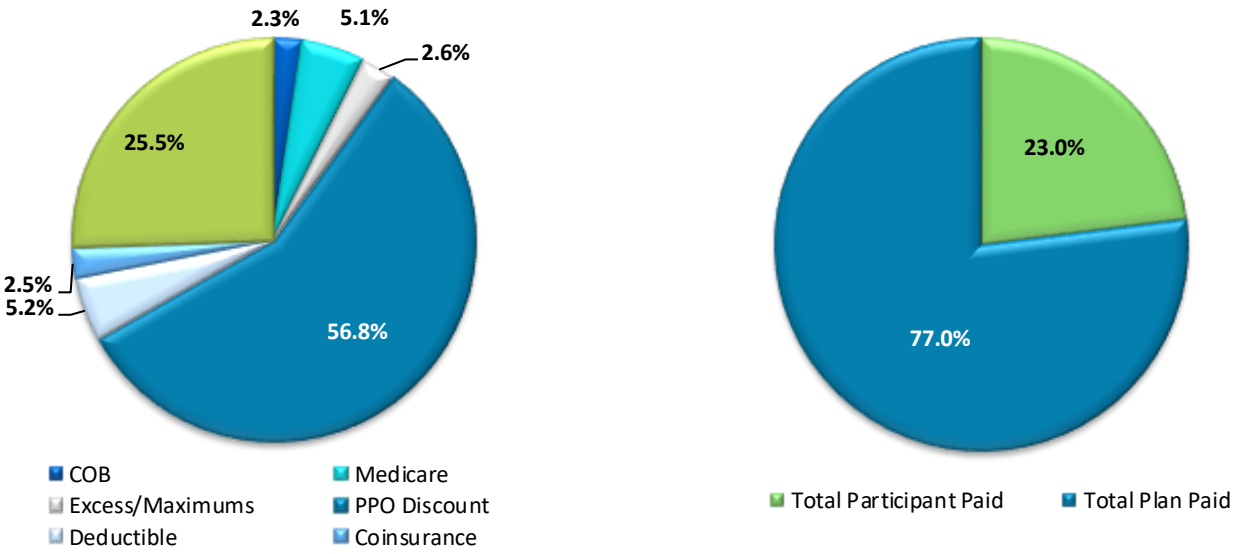


ER / UC Visits by Relationship						
Relationship	**ER**	**Per 1,000**	**Urgent Care**	**Per 1,000**	**Total**	**Per 1,000**
Insured	4,027	171	6,164	262	10,191	433
Spouse	1,061	193	1,264	230	2,325	423
Child	1,843	135	3,043	223	4,886	357
Total	**6,931**	**162**	**10,471**	**245**	**17,402**	**408**

Savings Summary – Medical Claims

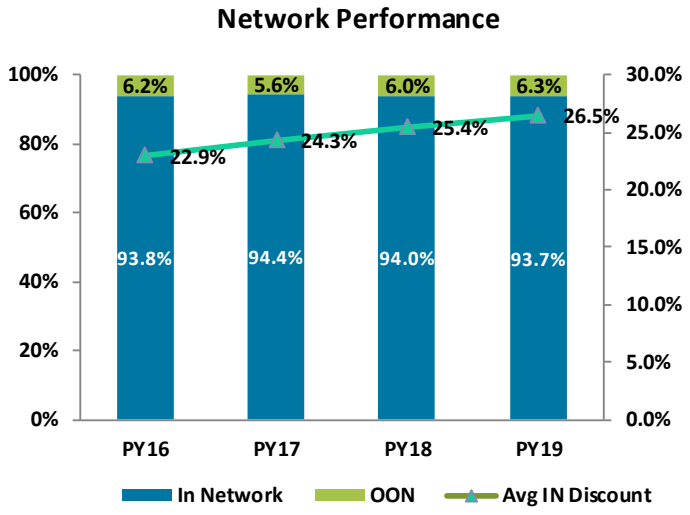
Description	Dollars	PPPM	% of Eligible
Eligible Charges	$521,636,791	$1,844	100.0%
COB	$11,997,892	$42	2.3%
Medicare	$26,487,675	$94	5.1%
Excess/Maximums	$13,801,977	$49	2.6%
PPO Discount	$296,356,034	$1,048	56.8%
Deductible	$27,003,220	$95	5.2%
Coinsurance	$12,810,323	$45	2.5%
Total Participant Paid	**$39,813,543**	**$141**	**7.6%**
Total Plan Paid	**$133,179,670**	**$471**	**25.5%**

Total Participant Paid - PY18	**$141**
Total Plan Paid - PY18	**$450**

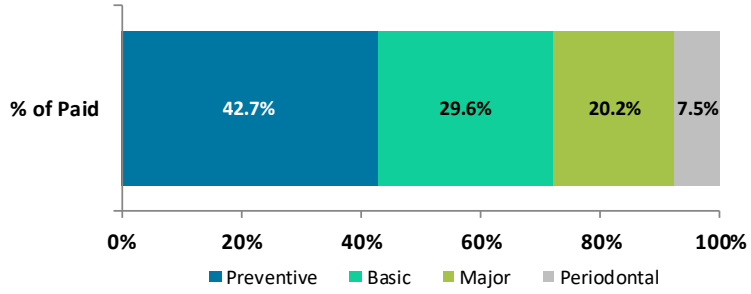


Dental Claims Analysis

Cost Distribution								
Paid Claims Category	Avg # of Members	% of Members	# Claims	# of Claims	Total Paid	% of Paid	Total EE Paid	% of EE Paid
$1,000.01 Plus	6,970	10.3%	35,338	25.2%	$10,624,178	43.1%	$6,571,080	57.9%
$750.01-$1,000.00	2,944	4.3%	12,167	8.7%	$2,617,580	10.6%	$1,325,695	11.7%
$500.01-$750.00	4,994	7.4%	18,454	13.2%	$3,142,638	12.8%	$1,364,549	12.0%
$250.01-$500.00	15,776	23.3%	46,243	33.0%	$5,602,392	22.7%	$1,266,931	11.2%
$0.01-$250.00	15,551	22.9%	27,596	19.7%	$2,656,650	10.8%	$810,596	7.1%
$0.00	402	0.6%	490	0.3%	$0	0.0%	$18,218	0.2%
No Claims	21,147	31.2%	0	0.0%	$0	0.0%	$0	0.0%
Total	**67,785**	**100.0%**	**140,288**	**100.0%**	**$24,643,438**	**100.0%**	**$11,357,070**	**100.0%**



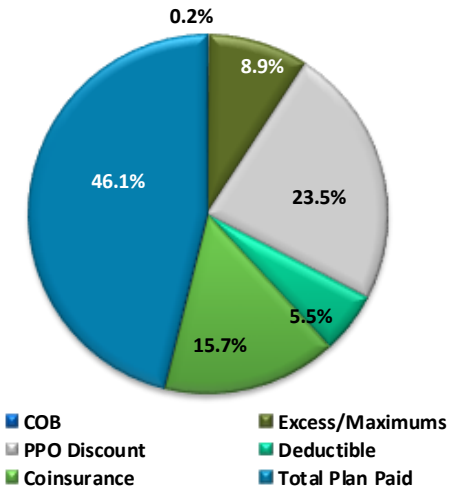
Claim Category	Total Paid	% of Paid
Preventive	$10,524,728	42.7%
Basic	$7,287,125	29.6%
Major	$4,984,909	20.2%
Periodontal	$1,846,675	7.5%
Total	**$24,643,438**	**100.0%**

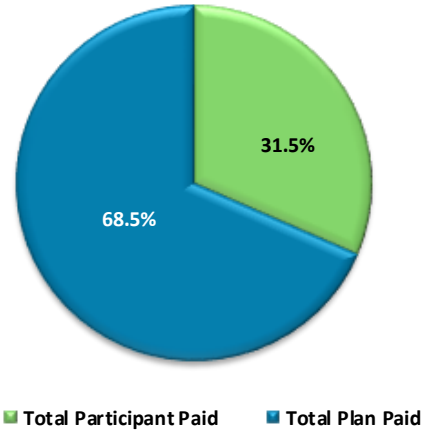


Savings Summary – Dental Claims

Description	Dollars	PPPM	% of Eligible
Eligible Charges	$53,448,740	$66	100.0%
COB	$126,217	$0	0.2%
Excess/Maximums	$4,776,955	$6	8.9%
PPO Discount	$12,545,059	$15	23.5%
Deductible	$2,954,152	$4	5.5%
Coinsurance	$8,402,917	$10	15.7%
Total Participant Paid	**$11,357,069**	**$14**	**21.2%**
Total Plan Paid	**$24,643,438**	**$30**	**46.1%**

Total Participant Paid - PY18	**$14**
Total Plan Paid - PY18	**$31**





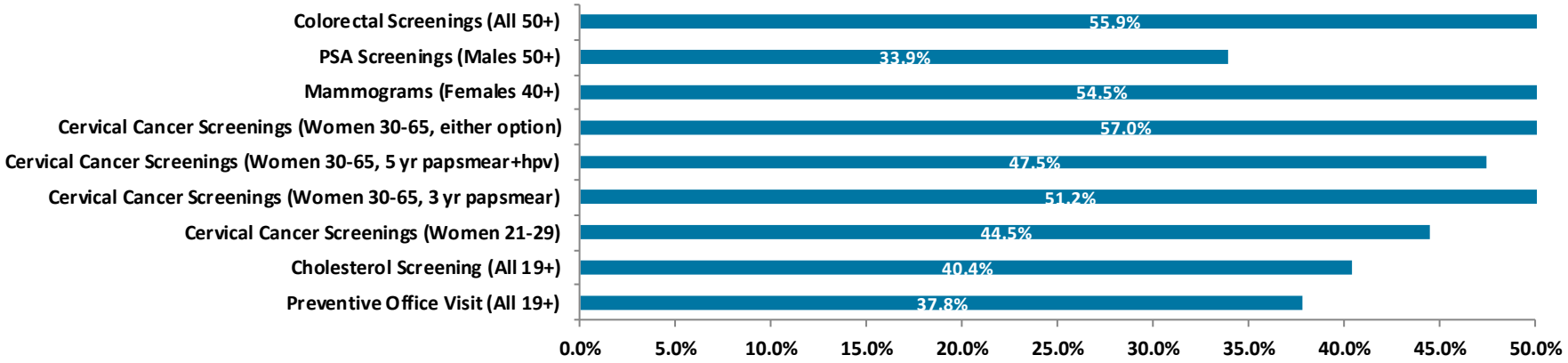
Preventive Services Compliance

*Based on 15 mo. of utilization/12 mo. paid data on members with 9 mo. of service or greater;

Colorectal screenings look back to July 2011.

	Female			Male			Total		
Service	**Eligible**	**Compliant**	**% Compliant**	**Eligible**	**Compliant**	**% Compliant**	**Eligible**	**Compliant**	**% Compliant**
Preventive Office Visit (All 19+)	17,285	8,608	49.8%	15,213	3,682	24.2%	32,498	12,289	37.8%
Cholesterol Screening (All 19+)	17,285	7,623	44.1%	15,213	5,522	36.3%	32,498	13,145	40.4%
Cervical Cancer Screenings (Women 21-29)	2,740	1,219	44.5%	----	----	----	2,740	1,219	44.5%
Cervical Cancer Screenings (Women 30-65, 3 yr papsmear)	13,050	6,682	51.2%	----	----	----	13,050	6,682	51.2%
Cervical Cancer Screenings (Women 30-65, 5 yr papsmear+hpv)	13,050	6,199	47.5%	----	----	----	13,050	6,199	47.5%
Cervical Cancer Screenings (Women 30-65, either option)	13,050	7,439	57.0%	----	----	----	13,050	7,439	57.0%
Mammograms (Females 40+)	10,739	5,853	54.5%	----	----	----	10,739	5,853	54.5%
PSA Screenings (Males 50+)	----	----	----	6,386	2,165	33.9%	6,386	2,165	33.9%
Colorectal Screenings (All 50+)	7,455	4,309	57.8%	6,386	3,423	53.6%	13,841	7,732	55.9%

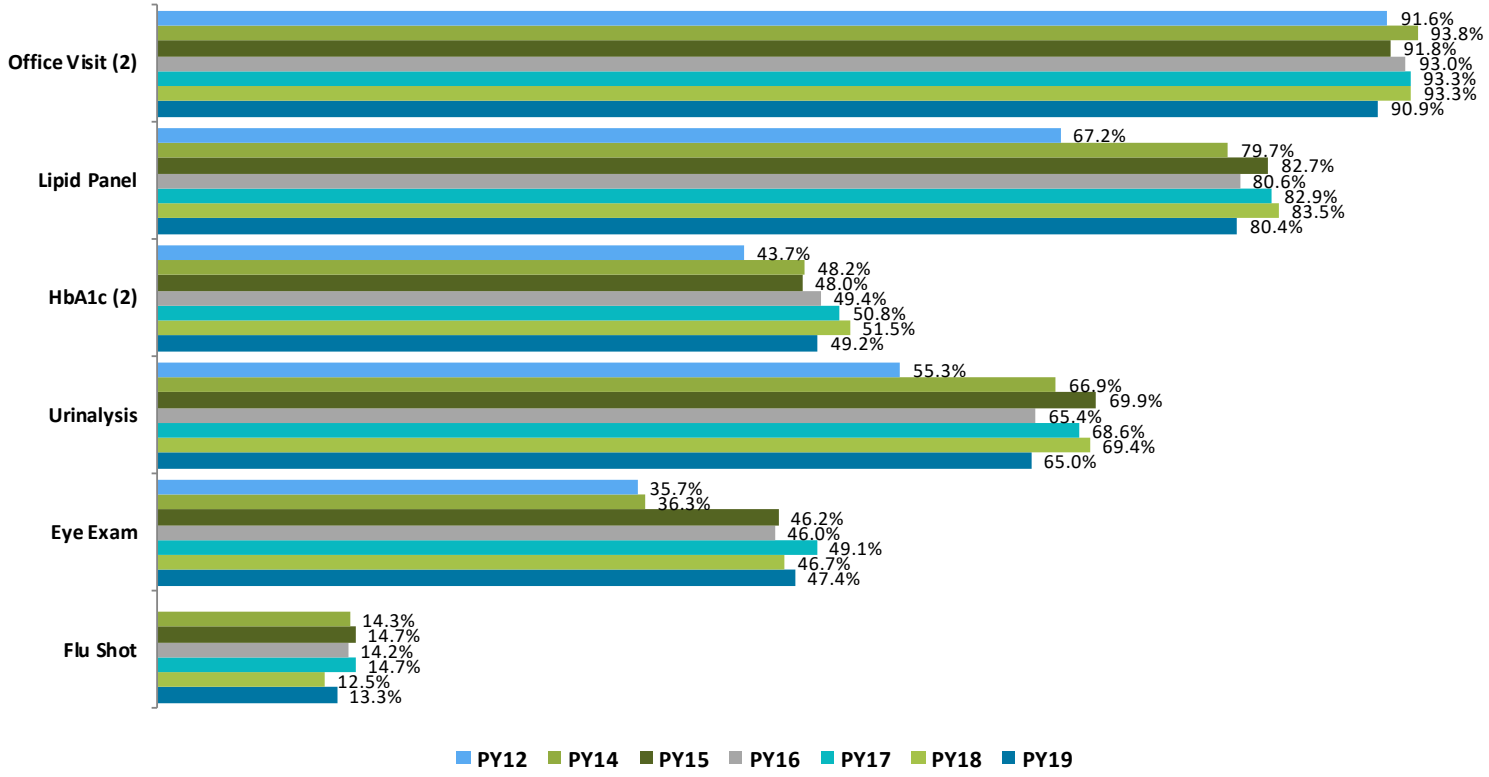
Overall Preventive Services Compliance Rates



Diabetic Disease Compliance

*Based on 15 mo. of utilization/12 mo. paid data on members with 9 mo. of service or greater;

Diabetic Population								
Year	PY12	PY13	PY14	PY15	PY16	PY17	PY18	PY19
Members	1,651	1,643	1,555	1,676	1,693	1,704	1,747	1,838

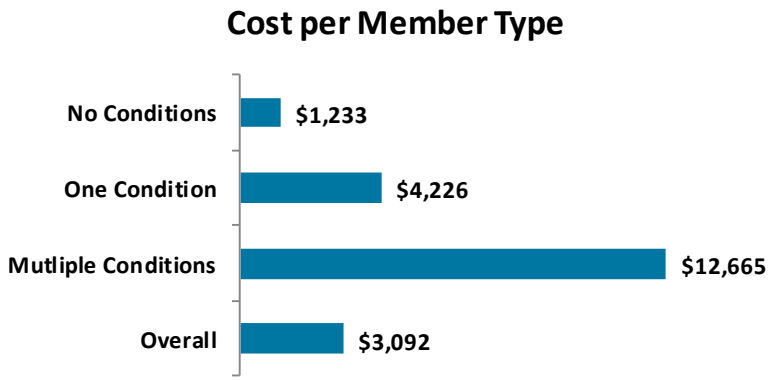


Chronic Conditions Summary

*Based on 15 mo. of utilization/12 mo. paid data on members with 9 mo. of service or greater;

Condition	Total Members	Avg Members	Per 1,000	Avg Age	Total Cost	Average Cost	Compliance Rate	Compliance Measure
Asthma	1,167	1,091	27	37	$7,234,553	$6,199	99.0%	1 Office Visit
Cancer	1,341	1,259	31	58	$29,620,560	$22,088	----	----
Chronic Kidney Disease	326	4,051	100	52	$43,731,678	$10,268	----	----
Chronic Obstructive Pulmonary Disease (COPD)	270	253	6	60	$6,201,189	$22,967	95.9%	1 Office Visit
Congestive Heart Failure (CHF)	139	128	3	61	$7,182,906	$51,676	12.9%	1 Office Visit, 1 Lipid Profile, 1 Wellness Visit
Coronary Artery Disease (CAD)	617	596	14	62	$11,272,341	$18,270	25.1%	1 Office Visit, 1 Lipid Profile, 1 Wellness Visit
Depression	1,426	1,317	33	41	$10,871,047	$7,623	95.7%	1 Office Visit
Diabetes	1,838	1,734	43	56	$17,094,838	$9,301	21.1%	2 Office Visits, 1 Lipid Profile, 2 HbA1c's, 1 Urinalysis, 1 Eye Exam, 1 Flu Shot
Hyperlipidemia	3,218	3,096	76	54	$15,682,988	$4,874	42.4%	1 Office Visit, 1 Lipid Profile, 1 Wellness Visit
Hypertension	3,580	3,403	84	57	$30,518,883	$8,525	27.9%	1 Office Visit, 1 Lipid Profile, 1 Wellness Visit
Obesity	786	309	8	61	$7,357,327	$22,568	----	----

# of Conditions	Avg Members	Average Age	Relationship		
			Insured	Spouse	Child
No Conditions	29,281	31	47.1%	11.9%	41.0%
One Condition	8,653	46	70.8%	16.3%	12.9%
Multiple Conditions	4,663	56	79.4%	18.0%	2.6%
Overall	**42,596**	**36**	**54.6%**	**13.3%**	**32.1%**



Public Employees' Benefits Program - RX Costs

PY 2019 - Quarter Ending June 30, 2019

Express Scripts

Membership Summary	4Q FY2019	4Q FY2018	Difference	% Change
			Membership Summary	
Member Count (Membership)	42,767	42,072	695	1.7%
Utilizing Member Count (Patients)	30,881	30,385	496	1.6%
Percent Utilizing (Utilization)	72.2%	72.2%	(0.00)	0.0%
Claim Summary			**Claims Summary**	
Net Claims (Total Rx's)	507,355	512,914	(5,559)	-1.1%
Claims per Elig Member per Month (Claims PMPM)	0.99	1.02	(0.03)	-2.9%
Total Claims for Generic (Generic Rx)	439,347	443,579	(4,232.00)	-1.0%
Total Claims for Brand (Brand Rx)	68,008	69,335	(1,327.00)	-1.9%
Total Claims for Brand w/Gen Equiv (Multisource Brand Claims)	8,121	8,391	(270.00)	-3.2%
Total Non-Specialty Claims	503,236	509,198	(5,962.00)	-1.2%
Total Specialty Claims	4,119	3,716	403.00	10.8%
Generic % of Total Claims (GFR)	**86.6%**	**86.5%**	0.00	0.1%
Generic Effective Rate (GCR)	**98.2%**	**98.1%**	0.00	0.0%
Mail Order Claims	66,786	62,648	4,138.00	6.6%
Mail Penetration Rate*	15.0%	13.9%	0.01	1.1%
Claims Cost Summary			**Claims Cost Summary**	
Total Prescription Cost (Total Gross Cost)	$48,565,119.00	$45,721,943.00	$2,843,176.00	6.2%
Total Generic Gross Cost	$9,949,262.00	$9,974,122.00	($24,860.00)	-0.2%
Total Brand Gross Cost	$38,615,857.00	$35,747,821.00	$2,868,036.00	8.0%
Total MSB Gross Cost	$1,333,924.00	$1,039,940.00	$293,984.00	28.3%
Total Ingredient Cost	$48,197,024.00	$45,432,679.00	$2,764,345.00	6.1%
Total Dispensing Fee	$350,687.00	$270,702.00	$79,985.00	29.5%
Total Other (e.g. tax)	$17,408.00	$18,562.00	($1,154.00)	-6.2%
Avg Total Cost per Claim (Gross Cost/Rx)	$95.72	$89.14	$6.58	7.4%
Avg Total Cost for Generic (Gross Cost/Generic Rx)	$22.65	$22.49	$0.16	0.7%
Avg Total Cost for Brand (Gross Cost/Brand Rx)	$567.81	$515.58	$52.23	10.1%
Avg Total Cost for MSB (MSB Gross Cost/MSB ARx)	$164.26	$123.94	$40.32	32.5%
Member Cost Summary			**Member Cost Summary**	
Total Member Cost	**$9,623,391.00**	**$9,983,613.00**	($360,222.00)	-3.6%
Total Copay	$4,581,675.00	$4,590,152.00	($8,477.00)	-0.2%
Total Deductible	$5,041,716.00	$5,393,461.00	($351,745.00)	-6.5%
Avg Copay per Claim (Copay/Rx)	$9.03	$8.95	$0.08	0.9%
Avg Participant Share per Claim (Copay+Deductible/RX)	**$18.97**	**$19.46**	**($0.50)**	**-2.6%**
Avg Copay for Generic (Copay/Generic Rx)	$9.03	$9.63	($0.60)	-6.2%
Avg Copay for Brand (Copay/Brand Rx)	$83.20	$82.41	$0.79	1.0%
Avg Copay for Brand w/ Generic Equiv (Copay/Multisource Rx)	$64.64	$68.06	($3.42)	-5.0%
Net PMPM (Participant Cost PMPM)	**$18.75**	**$19.77**	($1.02)	-5.2%
Copay % of Total Prescription Cost (Member Cost Share %)	19.8%	21.8%	-2.0%	-9.3%
Plan Cost Summary			**Plan Cost Summary**	
Total Plan Cost (Plan Cost)	**$38,941,729.00**	**$35,738,330.00**	**$3,203,399.00**	**9.0%**
Total Non-Specialty Cost (Non-Specialty Plan Cost)	$17,912,047.00	$17,158,105.00	$753,942.00	4.4%
Total Specialty Drug Cost (Specialty Plan Cost)	$21,029,682.00	$18,580,224.00	$2,449,458.00	13.2%
Avg Plan Cost per Claim (Plan Cost/Rx)	**$76.75**	**$69.68**	$7.08	10.2%
Avg Plan Cost for Generic (Plan Cost/Generic Rx)	$13.62	$12.86	$0.76	5.9%
Avg Plan Cost for Brand (Plan Cost/Brand Rx)	$484.61	$433.18	$51.43	11.9%
Avg Plan Cost for MSB (MSB Plan Cost/MSB ARx)	$99.61	$55.88	$43.73	78.3%
Net PMPM (Plan Cost PMPM)	**$75.88**	**$70.79**	**$5.09**	**7.2%**
PMPM for Specialty Only (Specialty PMPM)	$40.98	$36.80	$4.18	11.4%
PMPM without Specialty (Non-Specialty PMPM)	$34.90	$33.99	$0.91	2.7%

HSB DATASCOPE™

Nevada Public Employees' Benefits Program
EPO Plan

July 2018 – June 2019

HealthSCOPE BENEFITS

Overview

- Total Medical Spend for PY19 was $40,764,731 with an annualized plan cost per employee per year of $8,745. This is 40.8% above the HSB Book of Business Index.
  - IP Cost per Admit is $20,294 which is 26.1% higher than the HSB Index.
  - ER Cost per Visit is $4,151 which is 11.9% higher than the HSB Index.
- Employees shared in 9.6% of the medical cost.
- Inpatient facility costs were 40.5% of the plan spend.
- For the reporting period, 11.0% of members did not incur cost to the plan. Of that, 10.8% of total members did not have any claims paid by the plan at all during the reporting period.
- 39 members exceeded the $100k high cost threshold during the reporting period, which accounted for 23.0% of the plan spend. The highest diagnosis category was Neoplasms, accounting for 18.5% of the high cost claimant dollars.
- Total spending with in-network providers was 98.3%. The overall in-network discount was 58.0%.

Paid Claims by Age Group

Paid Claims by Age Group										
	PY19									
Age Range	Med Net Pay		Med PMPM		Rx Net Pay		Rx PMPM		Net Pay		PMPM	
<1	$	1,874,215	$	1,698	$	9,149	$	8	$	1,883,364	$	1,706
1	$	264,791	$	245	$	14,535	$	13	$	279,326	$	259
2 - 4	$	372,210	$	117	$	14,845	$	5	$	387,055	$	122
5 - 9	$	502,906	$	81	$	95,811	$	16	$	598,717	$	97
10 - 14	$	1,277,258	$	167	$	244,065	$	32	$	1,521,323	$	198
15 - 19	$	1,537,283	$	186	$	292,943	$	35	$	1,830,226	$	222
20 - 24	$	1,082,265	$	156	$	409,392	$	59	$	1,491,657	$	215
25 - 29	$	1,215,987	$	295	$	301,168	$	73	$	1,517,155	$	369
30 - 34	$	2,784,920	$	515	$	341,212	$	63	$	3,126,132	$	578
35 - 39	$	2,361,827	$	366	$	734,028	$	114	$	3,095,855	$	480
40 - 44	$	2,437,647	$	381	$	784,468	$	123	$	3,222,115	$	504
45 - 49	$	2,770,287	$	331	$	1,525,758	$	182	$	4,296,045	$	513
50 - 54	$	5,152,391	$	559	$	2,107,261	$	229	$	7,259,652	$	788
55 - 59	$	5,436,354	$	503	$	2,751,284	$	254	$	8,187,638	$	757
60 - 64	$	9,774,054	$	815	$	3,034,480	$	253	$	12,808,534	$	1,067
65+	$	1,920,336	$	395	$	1,343,189	$	276	$	3,263,525	$	672
Total	**$**	**40,764,731**	**$**	**400**	**$**	**14,003,588**	**$**	**137**	**$**	**54,768,319**	**$**	**537**

Financial Summary

	Total	State Active	Non-State Active	State Retirees	Non-State Retirees	
Summary	**PY19**	**PY19**	**PY19**	**PY19**	**PY19**	**HSB Peer Index**
Enrollment						
Avg # Employees	4,653	3,878	4	599	181	
Avg # Members	8,488	7,445	5	826	227	
Ratio	1.8	1.9	1.3	1.4	1.3	1.8
Financial Summary						
Gross Cost	$45,094,672	$35,711,039	$45,961	$7,418,807	$1,918,864	
Client Paid	$40,764,731	$32,097,283	$40,931	$6,863,148	$1,763,370	
Employee Paid	$4,329,941	$3,613,757	$5,030	$555,659	$155,495	
Client Paid-PEPY	$8,745	$8,277	$10,233	$11,461	$9,769	$6,209
Client Paid-PMPY	$4,794	$4,311	$8,186	$8,313	$7,777	$3,437
Client Paid-PEPM	$729	$690	$853	$955	$814	$517
Client Paid-PMPM	$400	$359	$682	$693	$648	$286
High Cost Claimants (HCC's) > $100k						
# of HCC's	39	27	0	9	3	
HCC's / 1,000	4.6	3.6	0.0	10.9	13.2	
Avg HCC Paid	$274,612	$246,453	$0	$339,256	$334,114	
HCC's % of Plan Paid	26.3%	20.7%	0.0%	44.5%	56.8%	
Cost Distribution by Claim Type (PMPY)						
Facility Inpatient	$1,218	$944	$3,360	$3,028	$3,554	$1,057
Facility Outpatient	$1,506	$1,395	$1,369	$2,243	$2,477	$1,145
Physician	$1,923	$1,844	$3,030	$2,713	$1,587	$1,122
Other	$148	$127	$427	$328	$158	$113
Total	$4,794	$4,311	$8,186	$8,313	$7,777	$3,437
	Annualized	Annualized	Annualized	Annualized	Annualized	

Paid Claims by Claim Type – State Participants

Net Paid Claims - Total State Participants	PY19			
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total
Medical				
Inpatient	$ 8,762,274	$ 2,599,386	$ 160,727	$ 11,522,387
Outpatient	$ 23,335,008	$ 3,620,613	$ 482,422	$ 27,438,043
Total - Medical	**$ 32,097,283**	**$ 6,219,999**	**$ 643,149**	**$ 38,960,431**

Net Paid Claims - Per Participant per Month	PY19			
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total
Medical	$ 690	$ 1,018	$ 596	$ 725

Paid Claims by Claim Type – Non-State Participants

Net Paid Claims - Total Non-State Participants	PY19			
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total
Medical				
Inpatient	$ 23,542	$ 854,839	$ 10,077	$ 888,459
Outpatient	$ 17,389	$ 754,444	$ 144,009	$ 915,842
Total - Medical	**$ 40,931**	**$ 1,609,283**	**$ 154,087**	**$ 1,804,301**

Net Paid Claims - Per Participant per Month	PY19			
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total
Medical	$ 853	$ 1,048	$ 242	$ 813

Paid Claims by Claim Type – Total

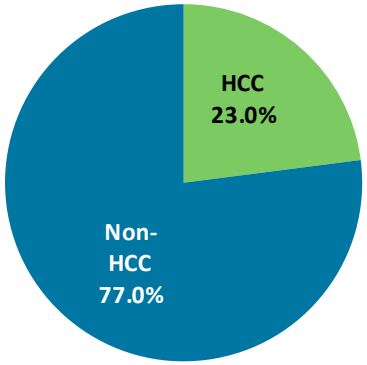
Net Paid Claims - Total Total Participants	PY19			
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total
Medical				
Inpatient	$ 8,785,816	$ 3,454,225	$ 170,805	$ 12,410,846
Outpatient	$ 23,352,397	$ 4,375,057	$ 626,431	$ 28,353,885
Total - Medical	**$ 32,138,214**	**$ 7,829,282**	**$ 797,236**	**$ 40,764,731**

Net Paid Claims - Per Participant per Month	PY19			
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total
Medical	$ 690	$ 1,024	$ 465	$ 729

Cost Distribution – Medical Claims

	PY19					
Paid Claims Category	Avg # of Members	% of Members	Total Paid	% of Paid	EE Paid	% EE Paid
$100,000.01 Plus	32	0.4%	$10,660,448	26.2%	$223,955	5.2%
$50,000.01-$100,000.00	63	0.7%	$4,489,989	11.0%	$285,075	6.6%
$25,000.01-$50,000.00	148	1.7%	$5,378,700	13.2%	$370,909	8.6%
$10,000.01-$25,000.00	489	5.7%	$7,901,863	19.4%	$770,638	17.8%
$5,000.01-$10,000.00	592	7.0%	$4,367,753	10.7%	$713,266	16.5%
$2,500.01-$5,000.00	935	11.0%	$3,470,368	8.5%	$766,356	17.7%
$0.01-$2,500.00	5,310	62.5%	$4,495,610	11.0%	$1,195,579	27.6%
$0.00	16	0.2%	$0	0.0%	$4,162	0.1%
No Claims	918	10.8%	$0	0.0%	$0	0.0%
	8,503	**100.0%**	**$40,764,731**	**100.0%**	**$4,329,941**	**100.0%**

Distribution of HCC Medical Claims Paid



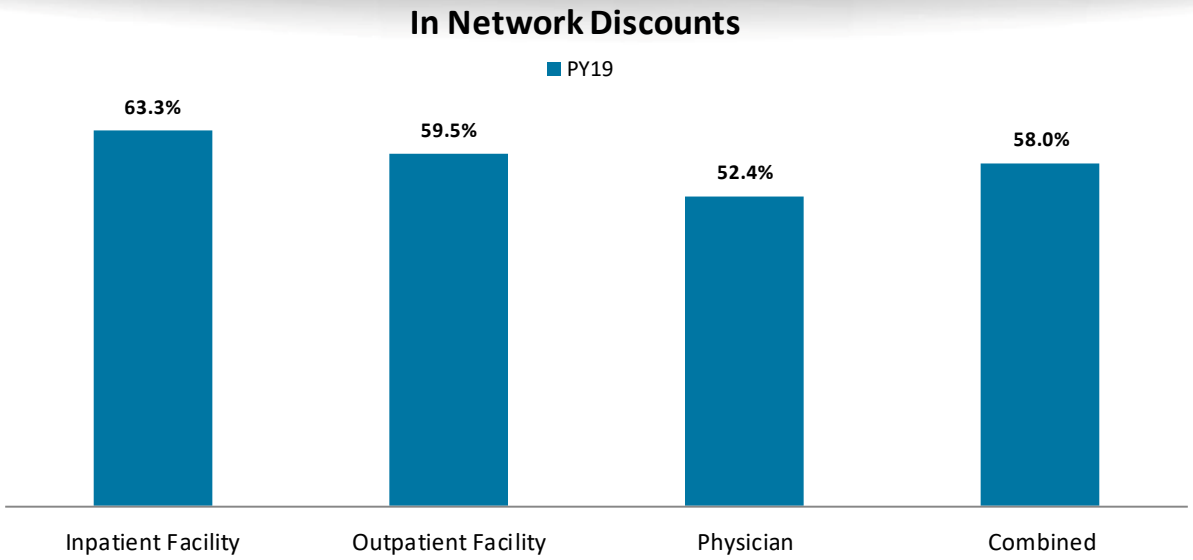
HCC – High Cost Claimant over $100K

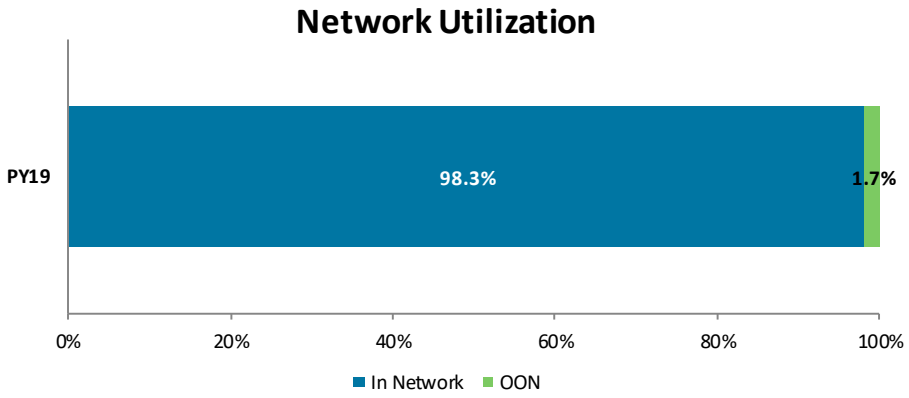
HCC's by AHRQ Clinical Classifications Chapter			
AHRQ Chapter	Patients	Total Paid	% Paid
(CCS 2) Neoplasms	19	$1,974,808	18.5%
(CCS 8) Diseases Of The Respiratory System	32	$1,827,802	17.1%
(CCS 7) Diseases Of The Circulatory System	23	$1,285,819	12.1%
(CCS 3) Endocrine; Nutritional; And Metabolic Diseases And Immunity Disorders	21	$1,181,115	11.1%
(CCS 14) Congenital Anomalies	6	$832,441	7.8%
(CCS 13) Diseases Of The Musculoskeletal System And Connective Tissue	23	$778,560	7.3%
(CCS 15) Certain Conditions Originating In The Perinatal Period	5	$537,259	5.0%
(CCS 4) Diseases Of The Blood And Blood-Forming Organs	11	$467,435	4.4%
(CCS 16) Injury And Poisoning	18	$409,857	3.8%
(CCS 1) Infectious And Parasitic Diseases	23	$310,450	2.9%
(CCS 5) Mental Illness	13	$270,964	2.5%
(CCS 10) Diseases Of The Genitourinary System	16	$171,450	1.6%
(CCS 18) Residual Codes; Unclassified; All E Codes [259. And 260.]	25	$166,903	1.6%
(CCS 17) Symptoms; Signs; And Ill-Defined Conditions And Factors Influencing Health Status	38	$159,168	1.5%
(CCS 11) Complications Of Pregnancy; Childbirth; And The Puerperium	2	$107,456	1.0%
(CCS 9) Diseases Of The Digestive System	19	$87,918	0.8%
(CCS 6) Diseases Of The Nervous System And Sense Organs	25	$82,256	0.8%
(CCS 12) Diseases Of The Skin And Subcutaneous Tissue	9	$8,975	0.1%
Overall	**----**	**$10,660,634**	**100.0%**

Utilization Summary

Summary	Total PY19	State Active PY19	Non-State Active PY19	State Retirees PY19	Non-State Retirees PY19	HSB Peer Index
Inpatient Facility						
# of Admits	507	441	1	52	13	
# of Bed Days	2,491	2,026	2	361	102	
Paid Per Admit	$20,394	$15,930	$16,801	$47,923	$61,977	$16,173
Paid Per Day	$4,151	$3,468	$8,401	$6,903	$7,899	$3,708
Admits Per 1,000	60	59	200	63	57	61
Days Per 1,000	293	272	400	437	450	264
Avg LOS	4.9	4.6	2	6.9	7.8	4.3
Physician Office						
OV Utilization per Member	4.4	4.2	5.6	5.6	5.0	3.3
Avg Paid per OV	$94	$95	$105	$85	$86	$50
Avg OV Paid per Member	$410	$402	$587	$473	$431	$167
DX&L Utilization per Member	8.9	8.4	14	12.1	12.2	8.3
Avg Paid per DX&L	$78	$75	$106	$88	$104	$67
Avg DX&L Paid per Member	$690	$629	$1,491	$1,069	$1,274	$554
Emergency Room						
# of Visits	1,453	1,261	0	158	94	
# of Admits	192	154	0	30	8	
Visits Per Member	0.17	0.17	0	0.19	0.41	0.17
Visits Per 1,000	171	169	0	191	415	174
Avg Paid per Visit	$2,608	$2,546	$0	$2,991	$1,195	$1,684
Admits Per Visit	0.13	0.12	0.00	0.19	0.09	0.14
Urgent Care						
# of Visits	2,450	2,232	0	158	60	
Visits Per Member	0.29	0.30	0.00	0.19	0.26	0.24
Visits Per 1,000	288	300	0	191	265	242
Avg Paid per Visit	$140	$140	$0	$154	$96	$74
	Annualized	Annualized	Annualized	Annualized	Annualized	

Provider Network Summary



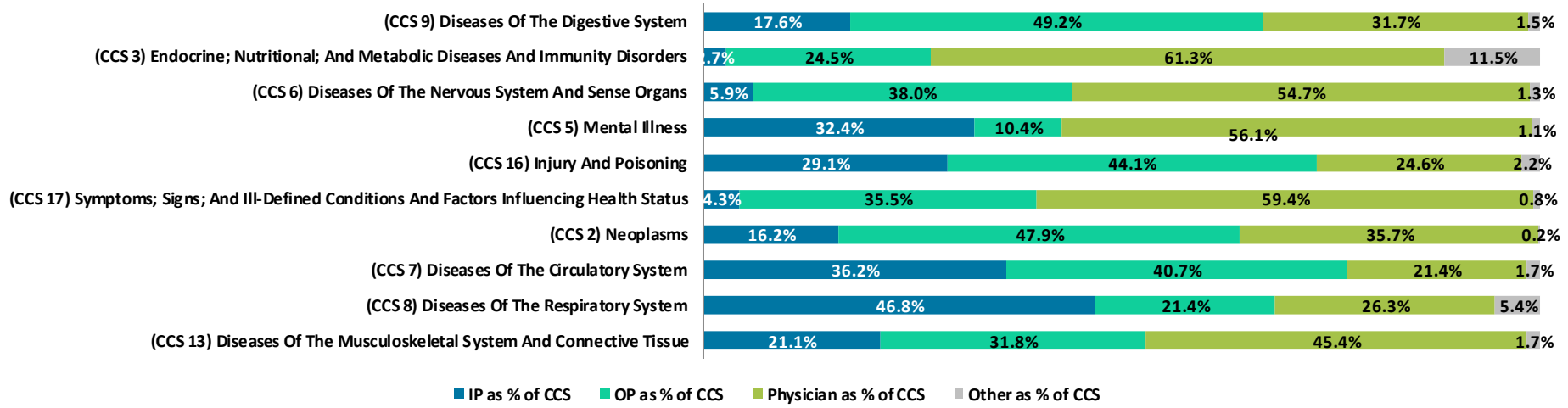


AHRQ* Clinical Classifications Summary

*Developed at the Agency for Healthcare Research and Quality (AHRQ), the Clinical Classifications Software (CCS) is a tool for clustering patient diagnoses and procedures into a manageable number of clinically meaningful categories.

AHRQ Clinical Classifications Chapter	Total Paid	% Paid	Insured	Spouse	Child	Male	Female
(CCS 13) Diseases Of The Musculoskeletal System And Connective Tissue	$5,068,002	12.4%	$3,855,270	$998,372	$214,360	$1,637,256	$3,430,745
(CCS 8) Diseases Of The Respiratory System	$4,002,541	9.8%	$1,704,161	$1,634,071	$664,310	$2,564,599	$1,437,943
(CCS 7) Diseases Of The Circulatory System	$3,801,288	9.3%	$3,033,036	$683,029	$85,223	$2,413,067	$1,388,221
(CCS 2) Neoplasms	$3,495,545	8.6%	$2,782,661	$672,259	$40,625	$1,448,690	$2,046,855
(CCS 17) Symptoms; Signs; And Ill-Defined Conditions And Factors Influencing Healt	$3,207,621	7.9%	$2,022,594	$423,167	$761,861	$1,005,552	$2,202,069
(CCS 16) Injury And Poisoning	$2,646,864	6.5%	$1,726,268	$390,271	$530,325	$1,338,806	$1,308,058
(CCS 5) Mental Illness	$2,642,295	6.5%	$1,183,655	$228,776	$1,229,864	$987,050	$1,655,245
(CCS 6) Diseases Of The Nervous System And Sense Organs	$2,566,706	6.3%	$1,682,267	$436,410	$448,030	$862,859	$1,703,847
(CCS 3) Endocrine; Nutritional; And Metabolic Diseases And Immunity Disorders	$2,411,462	5.9%	$1,887,247	$173,735	$350,480	$761,010	$1,650,451
(CCS 9) Diseases Of The Digestive System	$2,065,063	5.1%	$1,558,034	$212,174	$294,855	$819,094	$1,245,969
(CCS 10) Diseases Of The Genitourinary System	$1,958,080	4.8%	$1,493,037	$260,933	$204,111	$605,398	$1,352,683
(CCS 11) Complications Of Pregnancy; Childbirth; And The Puerperium	$1,654,660	4.1%	$1,229,023	$315,347	$110,290	$6,987	$1,647,673
(CCS 14) Congenital Anomalies	$1,180,411	2.9%	$360,128	$5,669	$814,614	$1,020,608	$159,803
(CCS 18) Residual Codes; Unclassified; All E Codes [259. And 260.]	$1,045,826	2.6%	$821,212	$190,688	$33,926	$571,395	$474,432
(CCS 1) Infectious And Parasitic Diseases	$1,040,562	2.6%	$680,405	$48,364	$311,792	$521,467	$519,095
(CCS 15) Certain Conditions Originating In The Perinatal Period	$940,464	2.3%	$657	$266	$939,540	$522,268	$418,196
(CCS 4) Diseases Of The Blood And Blood-Forming Organs	$580,144	1.4%	$103,606	$474,675	$1,864	$37,541	$542,603
(CCS 12) Diseases Of The Skin And Subcutaneous Tissue	$457,196	1.1%	$331,545	$71,718	$53,933	$190,657	$266,539
Total	**$40,764,731**	**100.0%**	**$26,454,807**	**$7,219,924**	**$7,090,001**	**$17,314,303**	**$23,450,428**

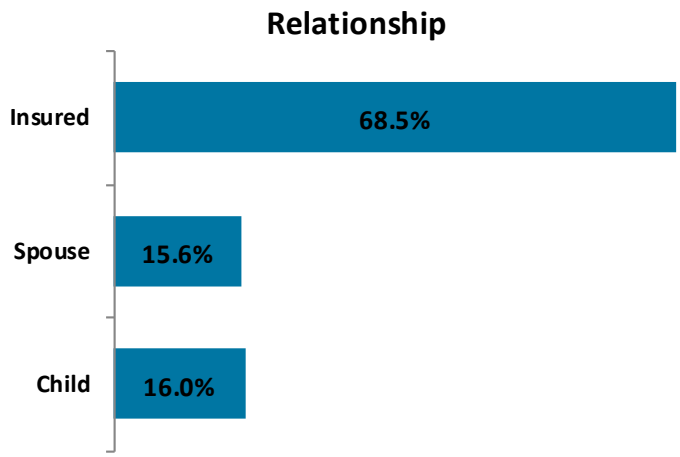
Top 10 Categories by Claim Type

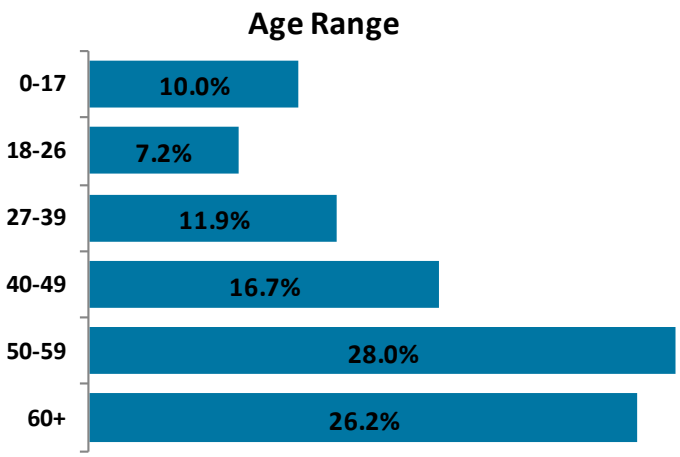


AHRQ Category – Diseases of the Musculoskeletal System & Connective Tissue

Diagnosis Category	Patients	Claims	Total Paid	% Paid
Spondylosis; Intervertebral Disc Disorders; Other Back Problems [205.]	1,182	8,646	$2,111,471	41.7%
Infective Arthritis And Osteomyelitis (Except That Caused By Tb Or Std) [201.]	10	154	$15,893	0.3%
Non-Traumatic Joint Disorders	1,281	6,612	$1,377,656	27.2%
Other Connective Tissue Disease [211.]	1,132	3,994	$763,036	15.1%
Other Bone Disease And Musculoskeletal Deformities [212.]	461	2,151	$131,387	2.6%
Pathological Fracture [207.]	7	35	$76,788	1.5%
Osteoporosis [206.]	52	92	$20,716	0.4%
Acquired Deformities	189	653	$491,358	9.7%
Systemic Lupus Erythematosus And Connective Tissue Disorders [210.]	29	152	$79,697	1.6%
	----	----	$5,068,002	100.0%

*Patient and claim counts are unique only within the category

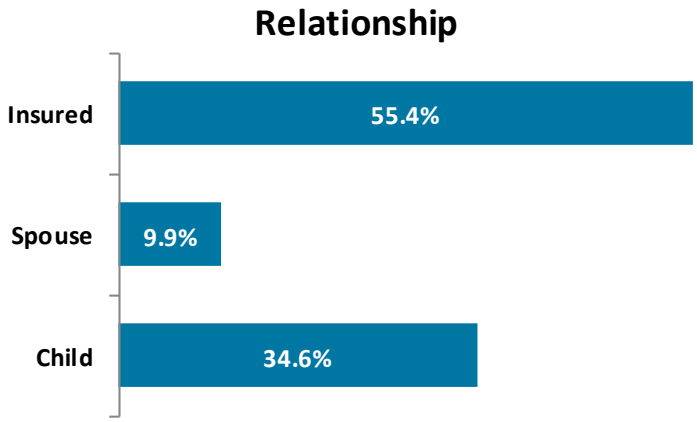


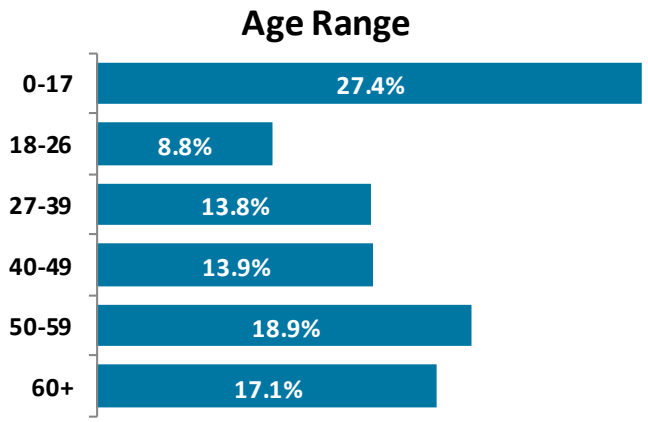


AHRQ Category – Diseases of the Respiratory System

Diagnosis Category	Patients	Claims	Total Paid	% Paid
Lung Disease Due To External Agents [132.]	3	7	$1,230,943	30.8%
Respiratory Infections	2,117	4,074	$943,440	23.6%
Other Lower Respiratory Disease [133.]	929	2,330	$654,647	16.4%
Other Upper Respiratory Disease [134.]	670	3,766	$396,480	9.9%
Respiratory Failure; Insufficiency; Arrest (Adult) [131.]	38	352	$350,582	8.8%
Pleurisy; Pneumothorax; Pulmonary Collapse [130.]	45	198	$151,933	3.8%
Asthma [128.]	384	943	$148,095	3.7%
Chronic Obstructive Pulmonary Disease And Bronchiectasis [127.]	245	571	$107,835	2.7%
Aspiration Pneumonitis; Food/Vomitus [129.]	1	3	$18,588	0.5%
	----	----	$4,002,541	100.0%

*Patient and claim counts are unique only within the category

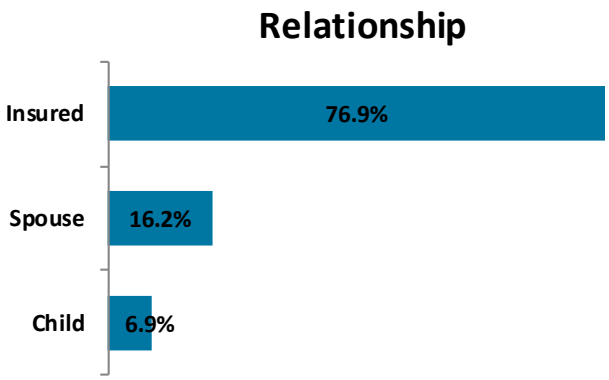


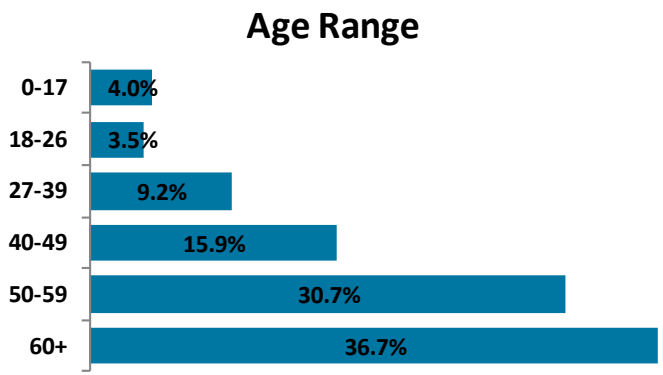


AHRQ Category – Diseases of the Circulatory System

Diagnosis Category	Patients	Claims	Total Paid	% Paid
Diseases Of The Heart	797	3,435	$2,858,485	75.2%
Diseases Of Arteries; Arterioles; And Capillaries	174	338	$135,452	3.6%
Hypertension	778	1,657	$314,001	8.3%
Cerebrovascular Disease	86	445	$392,949	10.3%
Diseases Of Veins And Lymphatics	161	439	$100,401	2.6%
Overall	**----**	**----**	**$3,801,288**	**100.0%**

*Patient and claim counts are unique only within the category

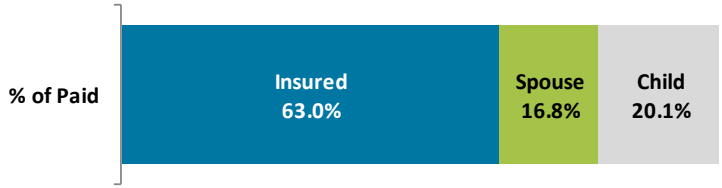


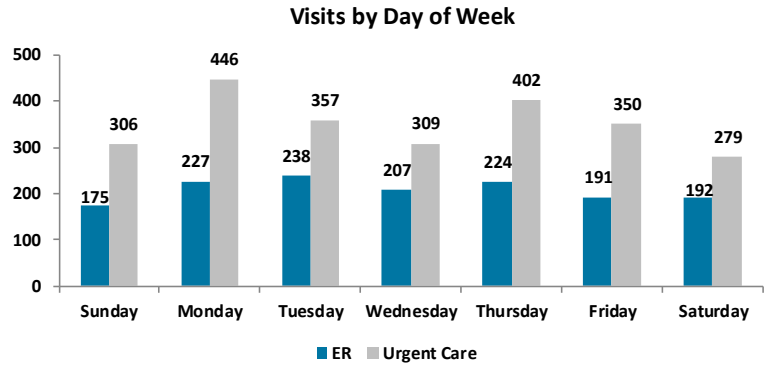


Emergency Room / Urgent Care Summary

	PY19		HSB Peer Index	
ER/Urgent Care	ER	Urgent Care	ER	Urgent Care
Number of Visits	1,454	2,449		
Number of Admits	192	----		
Visits Per Member	0.17	0.29	0.17	0.24
Visits/1000 Members	171	288	174	242
Avg Paid Per Visit	$2,606	$139	$1,684	$74
Admits per Visit	0.13	----	0.14	
% of Visits with HSB ER Dx	79.4%	----		
% of Visits with a Physician OV*	67.9%	67.3%		
Total Plan Paid	**$3,788,451**	**$341,606**		

*looks back 12 months from ER visit





ER / UC Visits by Relationship						
Relationship	ER	Per 1,000	Urgent Care	Per 1,000	Total	Per 1,000
Insured	845	181	1,341	288	2,186	469
Spouse	171	182	277	295	448	478
Child	438	151	831	286	1,269	436
Total	**1,454**	**171**	**2,449**	**288**	**3,903**	**459**

Savings Summary – Medical Claims

Description	Dollars	PPPM	% of Eligible
Eligible Charges	$105,121,708	$1,879	100.0%
COB	$989,134	$18	0.9%
Medicare	$1,398,546	$25	1.3%
Excess/Maximums	$767,339	$14	0.7%
PPO Discount	$56,872,017	$1,017	54.1%
Deductible	$4,329,870	$77	4.1%
Coinsurance	$71	$0	0.0%
Total Participant Paid	**$4,329,941**	**$77**	**4.1%**
Total Plan Paid	**$40,764,731**	**$729**	**38.8%**

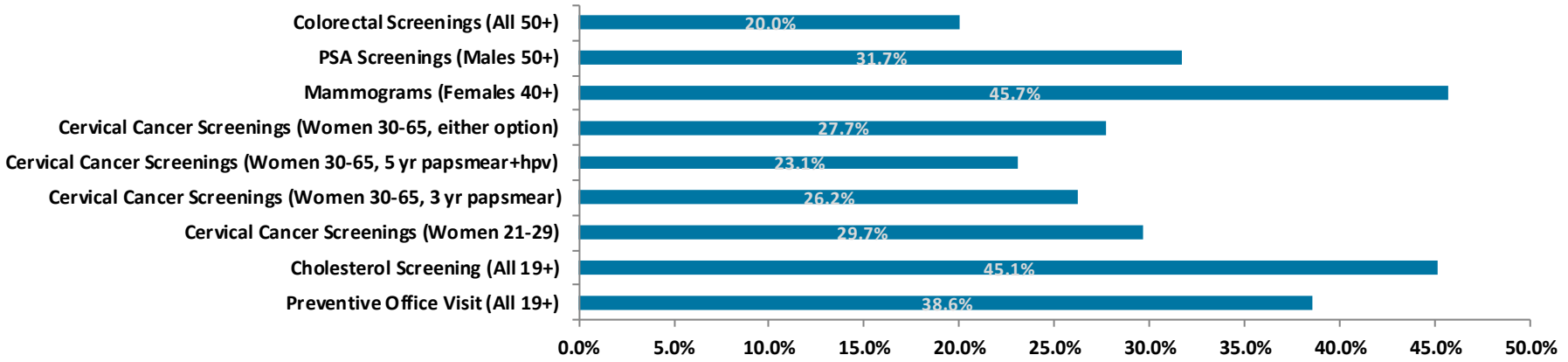
Preventive Services Compliance

*Based on 15 mo. of utilization/12 mo. paid data on members with 9 mo. of service or greater;

Colorectal screenings look back to July 2011.

	Female			Male			Total		
Service	Eligible	Compliant	% Compliant	Eligible	Compliant	% Compliant	Eligible	Compliant	% Compliant
Preventive Office Visit (All 19+)	3,484	1,697	48.7%	2,609	655	25.1%	6,093	2,352	38.6%
Cholesterol Screening (All 19+)	3,484	1,634	46.9%	2,609	1,114	42.7%	6,093	2,748	45.1%
Cervical Cancer Screenings (Women 21-29)	407	121	29.7%	----	----	----	407	121	29.7%
Cervical Cancer Screenings (Women 30-65, 3 yr papsmear)	2,780	728	26.2%	----	----	----	2,780	728	26.2%
Cervical Cancer Screenings (Women 30-65, 5 yr papsmear+hpv)	2,780	642	23.1%	----	----	----	2,780	642	23.1%
Cervical Cancer Screenings (Women 30-65, either option)	2,780	770	27.7%	----	----	----	2,780	770	27.7%
Mammograms (Females 40+)	2,363	1,080	45.7%	----	----	----	2,363	1,080	45.7%
PSA Screenings (Males 50+)	----	----	----	1,314	417	31.7%	1,314	417	31.7%
Colorectal Screenings (All 50+)	1,707	345	20.2%	134	24	17.8%	1,841	369	20.0%

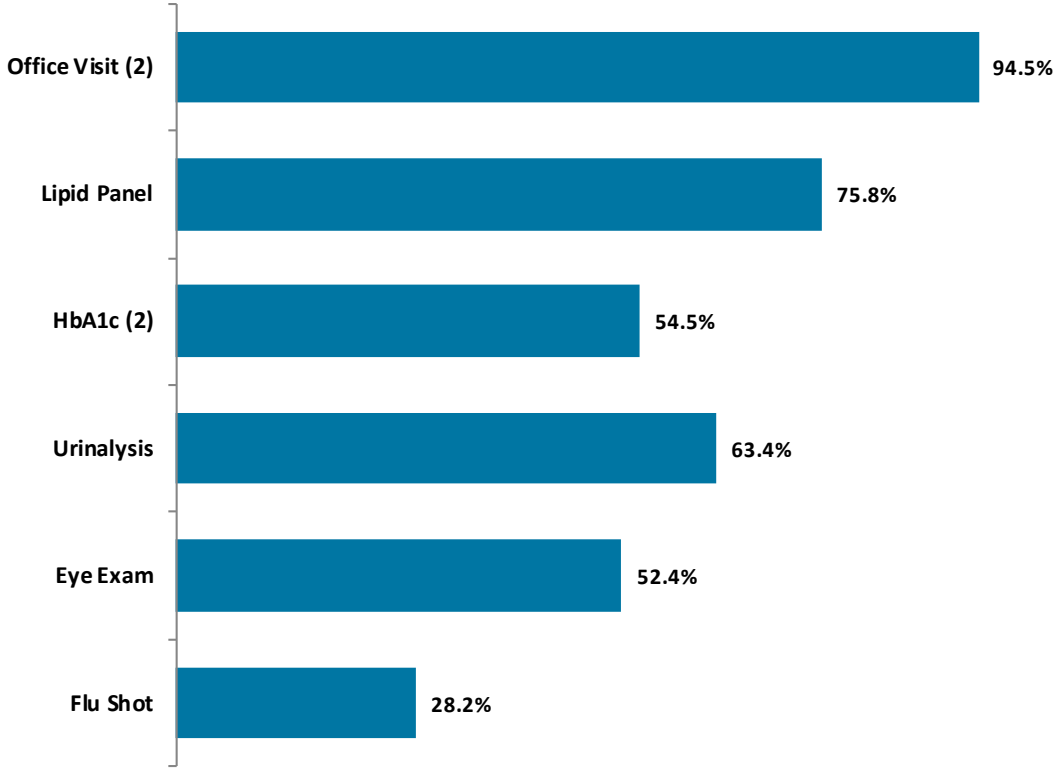
Overall Preventive Services Compliance Rates



Diabetic Disease Compliance

*Based on 15 mo. of utilization/12 mo. paid data on members with 9 mo. of service or greater;

Diabetic Population	
Year	PY19
Members	525

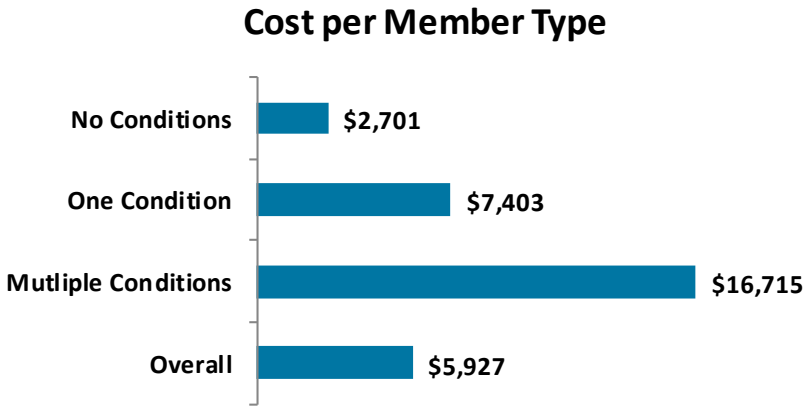


Chronic Conditions Summary

*Based on 15 mo. of utilization/12 mo. paid data on members with 9 mo. of service or greater;

Condition	Total Members	Avg Members	Per 1,000	Avg Age	Total Cost	Average Cost	Compliance Rate	Compliance Measure
Asthma	380	296	55	38	$2,502,009	$6,584	99.5%	1 Office Visit
Cancer	268	204	39	58	$5,751,343	$21,460	----	----
Chronic Kidney Disease	63	47	9	57	$1,172,554	$18,612	----	----
Chronic Obstructive Pulmonary Disease (COPD)	88	66	13	61	$1,603,683	$18,224	97.7%	1 Office Visit
Congestive Heart Failure (CHF)	30	23	4	54	$3,510,687	$117,023	13.3%	1 Office Visit, 1 Lipid Profile, 1 Wellness Visit
Coronary Artery Disease (CAD)	113	86	16	61	$1,815,600	$16,067	20.4%	1 Office Visit, 1 Lipid Profile, 1 Wellness Visit
Depression	534	409	78	41	$4,609,713	$8,632	96.6%	1 Office Visit
Diabetes	525	403	76	55	$4,075,533	$7,763	24.8%	2 Office Visits, 1 Lipid Profile, 2 HbA1c's, 1 Urinalysis, 1 Eye Exam, 1 Flu Shot
Hyperlipidemia	671	521	98	55	$6,357,924	$9,475	32.6%	1 Office Visit, 1 Lipid Profile, 1 Wellness Visit
Hypertension	763	588	111	56	$6,795,985	$8,907	24.8%	1 Office Visit, 1 Lipid Profile, 1 Wellness Visit
Obesity	237	182	35	47	$2,113,089	$8,916	0.0%	----

# of Conditions	Avg Members	Average Age	Relationship		
			Insured	Spouse	Child
No Conditions	4,189	30	42.7%	9.4%	47.8%
One Condition	1,654	46	69.5%	14.0%	16.5%
Multiple Conditions	1,026	54	80.8%	16.2%	3.0%
Overall	**6,869**	**37**	**54.2%**	**11.4%**	**34.4%**



Public Employees' Benefits Program - RX Costs

PY 2019 - Quarter Ending June 30, 2019

Express Scripts

Membership Summary	4Q FY2019 EPO	3Q FY2019 EPO	Difference	% Change
			Membership Summary	
Member Count (Membership)	8,548	8,509	39	0.5%
Utilizing Member Count (Patients)	5,105	5,254	(149)	-2.8%
Percent Utilizing (Utilization)	59.7%	61.7%	(0)	-3.3%
Claim Summary			**Claims Summary**	
Net Claims (Total Rx's)	41,804	41,845	(41)	-0.1%
Claims per Elig Member per Month (Claims PMPM)	1.63	1.64	(0.01)	-0.6%
Total Claims for Generic (Generic Rx)	36,358	36,732	(374.00)	-1.0%
Total Claims for Brand (Brand Rx)	5,446	5,113	333.00	6.5%
Total Claims for Brand w/Gen Equiv (Multisource Brand Claims)	622	628	(6.00)	-1.0%
Total Non-Specialty Claims	41,442	41,526	(84.00)	-0.2%
Total Specialty Claims	362	319	43.00	13.5%
Generic % of Total Claims (GFR)	**87.0%**	**87.8%**	(0.01)	-0.9%
Generic Effective Rate (GCR)	**98.3%**	**98.3%**	(0.00)	0.0%
Mail Order Claims	3,744	3,462	282.00	8.1%
Mail Penetration Rate*	9.8%	9.2%	0.01	0.6%
Claims Cost Summary			**Claims Cost Summary**	
Total Prescription Cost (Total Gross Cost)	$4,746,089.94	$4,505,116.48	$240,973.46	5.3%
Total Generic Gross Cost	$1,071,973.29	$1,062,245.44	$9,727.85	0.9%
Total Brand Gross Cost	$3,674,116.65	$3,442,871.04	$231,245.61	6.7%
Total MSB Gross Cost	$136,091.52	$101,524.51	$34,567.01	34.0%
Total Ingredient Cost	$4,730,804.29	$4,488,844.44	$241,959.85	5.4%
Total Dispensing Fee	$14,494.13	$15,586.75	($1,092.62)	-7.0%
Total Other (e.g. tax)	$791.52	$685.29	$106.23	15.5%
Avg Total Cost per Claim (Gross Cost/Rx)	**$113.53**	**$107.66**	$5.87	5.5%
Avg Total Cost for Generic (Gross Cost/Generic Rx)	$130.54	$122.65	$7.89	6.4%
Avg Total Cost for Brand (Gross Cost/Brand Rx)	$196.84	$207.75	($10.91)	-5.3%
Avg Total Cost for MSB (MSB Gross Cost/MSB ARx)	$5,550.03	$5,482.28	$67.75	1.2%
Member Cost Summary			**Member Cost Summary**	
Total Member Cost	**$486,097.89**	**$573,851.40**	($87,753.51)	-15.3%
Total Copay	$486,097.89	$573,851.40	($87,753.51)	-15.3%
Total Deductible	$0.00	$0.00	$0.00	0.0%
Avg Copay per Claim (Copay/Rx)	$11.63	$13.71	($2.09)	-15.2%
Avg Participant Share per Claim (Copay+Deductible/RX)	**$11.63**	**$13.71**	**($2.09)**	**-15.2%**
Avg Copay for Generic (Copay/Generic Rx)	$6.03	$6.30	($0.27)	-4.3%
Avg Copay for Brand (Copay/Brand Rx)	$48.99	$66.99	($18.00)	-26.9%
Avg Copay for Brand w/ Generic Equiv (Copay/Multisource Rx)	$26.35	$25.06	$1.29	5.1%
Net PMPM (Participant Cost PMPM)	**$18.96**	**$22.48**	($3.52)	-15.7%
Copay % of Total Prescription Cost (Member Cost Share %)	10.2%	12.7%	-2.5%	-19.6%
Plan Cost Summary			**Plan Cost Summary**	
Total Plan Cost (Plan Cost)	**$4,259,992.00**	**$3,931,265.00**	**$328,727.00**	**8.4%**
Total Non-Specialty Cost (Non-Specialty Plan Cost)	$2,374,759.00	$2,234,557.00	$140,202.00	6.3%
Total Specialty Drug Cost (Specialty Plan Cost)	$1,885,233.00	$1,696,709.00	$188,524.00	11.1%
Avg Plan Cost per Claim (Plan Cost/Rx)	**$101.90**	**$93.95**	$7.96	8.5%
Avg Plan Cost for Generic (Plan Cost/Generic Rx)	$23.45	$22.62	$0.83	3.7%
Avg Plan Cost for Brand (Plan Cost/Brand Rx)	$625.65	$606.37	$19.28	3.2%
Avg Plan Cost for MSB (MSB Plan Cost/MSB ARx)	$179.23	$136.61	$42.62	31.2%
Net PMPM (Plan Cost PMPM)	**$166.12**	**$154.00**	**$12.12**	**7.9%**
PMPM for Specialty Only (Specialty PMPM)	$73.52	$66.47	$7.05	10.6%
PMPM without Specialty (Non-Specialty PMPM)	$92.60	$87.54	$5.06	5.8%

Quarterly Health Plan Performance Review
Prepared For PEBP

State of Nevada

Reporting Period:
07/2018 thru 06/2019 – Current Period
07/2017 thru 06/2018 – Prior Period

HEALTH PLAN OF NEVADA
A UnitedHealthcare Company

35+ years experience caring for Nevadans and their families

Member Centered Solutions

Access to Southwest Medical/OptumCare

Cost Structure & Network Strength

Local Service & Wellness Resources

On-Site Hospital Case Managers

Our Care Delivery Assets in Nevada

- ✓ 40 OptumCare locations and expanding
- ✓ Over 400 providers practicing evidence-based medicine
- ✓ 6 high acuity urgent cares
- ✓ Patient portal with e-visit capabilities
- ✓ Robust integrated EMR
- ✓ Access to schedule, renew script and view test results
- ✓ 7 convenient care walk-in locations
- ✓ 2 ambulatory surgery centers
- ✓ Brand new 55,000 sq ft state-of-the-art cancer center
- ✓ Saturday appointments with primary care

Enhancements Made for Your Members

- ✓ Adding new and more ways for your members to receive the care they need when they need it
- ✓ Expansion of specialty network in these areas: pulmonary, allergy, dermatology, general surgery, orthotics & prosthetic vendors
- ✓ Real Appeal weight loss program
- ✓ Dispatch Health to provide at home urgent visits
- ✓ Medicine on The Move in your community
- ✓ $0 telemedicine visits for your members
- ✓ Pilot on continuous glucose monitoring for diabetics to improve outcomes and management of medication

Key Performance Indicators

Demographics & Cost Data

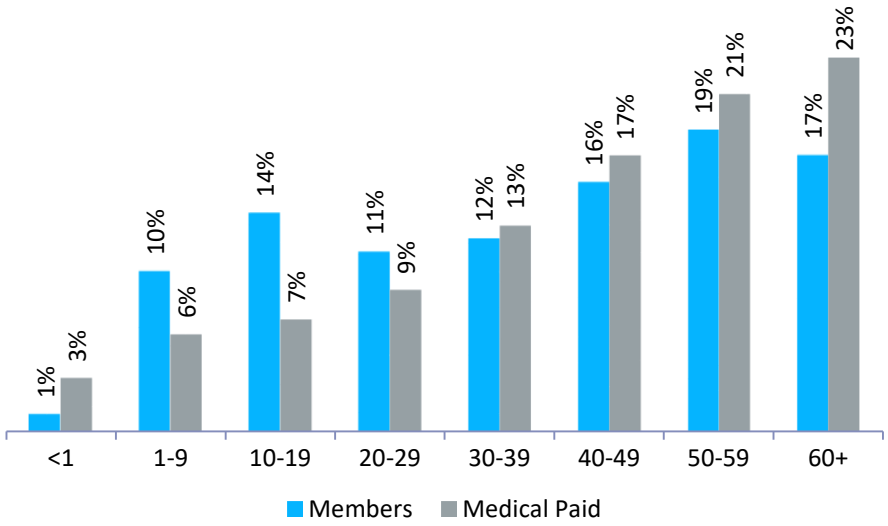
Data Definitions:

- **Prior Period** - July 1, 2017 through June 30, 2018
- **Current Period** - July 1, 2018 through June 30, 2019

Demographic Overview

HEALTH PLAN OF NEVADA
A UnitedHealthcare Company

	Prior	Current	Δ	Peer	Δ
Employees	3,971	3,884	-2.2%		
Average Age	49.6	49.4	-0.3%	44.2	11.7%
% Female	61.0%	61.6%	1.1%	50.5%	22.1%
Membership	6,802	6,700	-1.5%		
Average Age	38.3	37.9	-1.0%	35.1	8.0%
% Female	57.2%	56.9%	-0.5%	51.5%	10.6%
% Female (20 -44)	18.1%	18.4%	1.4%	21.2%	-13.5%
% Children (<18)	21.1%	21.8%	3.0%	21.6%	0.9%
% Dependents (18-25)	11.3%	11.3%	-0.2%	12.4%	-8.5%
Average Family Size	1.71	1.72	0.7%	1.81	-4.4%
Age Gender Factor	1.21	1.20	-0.6%	1.05	14.2%
HHS Population Risk Factor	1.76	1.31	-25.7%	1.04	25.8%



Population Insights

Membership decreased -**1.5%** to **6,700** covered under the medical plan for this period

Females are **56.9%** of membership driving **61.4%** of spend

Age 40+ are **51.8%** of members and drive **61.8%** of spend

HHS Risk Factor decreased -**25.7%** from prior period, but is still **25.8%** higher than Peer

Financial Highlights

HEALTH PLAN OF NEVADA
A UnitedHealthcare Company

Financial

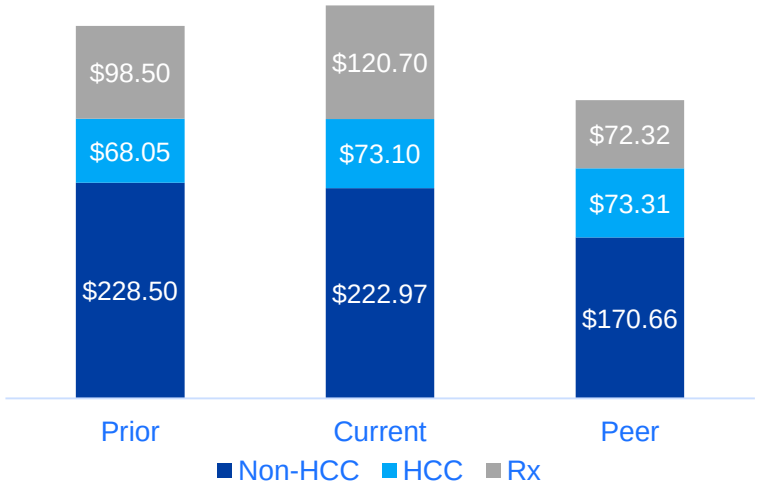
	Prior	Current	Δ		Peer	Δ
Net Paid PMPM	$296.55	$296.07	-0.2%	▼	$243.97	21.4%
Non-Catastrophic	$228.50	$222.97	-2.4%	▼	$170.66	30.6%
Catastrophic	$68.05	$73.10	7.4%	▲	$73.31	-0.3%
Plan Cost Share	75.1%	71.0%	-5.4%		77.1%	-7.9%
Pharmacy PMPM	$98.50	$120.70	22.5%	▲	$72.32	66.9%

Catastrophic

Catastrophic Cases	52	54	3.8%	▲		
% of Members	0.55%	0.62%	14%		0.51%	22.7%
Average Net Paid	$110,934	$116,473	5.0%	▲	$127,229	-8.5%
% of Dollars as High Cost	17.9%	18.8%	4.9%		24.4%	-23.1%

Trends Period over Period

- Medical PMPM Trend: **-0.2 %**
- Rx PMPM Trend: **22.5%**
- Combined PMPM trend: **5.5%**



Emergency Room/Urgent Services

HEALTH PLAN OF NEVADA
A UnitedHealthcare Company

	Prior	Current	Δ	Peer	Δ
ER Visits	826	724	-12.4%	14,211	
ER Net Paid / Visit	$2,627	$2,729	3.9%	$2,454	11.2%
ER Visits per K	121	108	-11.1%	63	71.3%
UC Visits	4,536	4,485	-1.1%	72,246	
UC Net Paid / Visit	$93	$95	2.2%	$92	4.0%
UC Visits per K	667	669	0.4%	400	67.4%

ER and Urgent Care Overview

- Number of free-standing emergency rooms growing in Nevada
- ER per 1000 utilization is lower in current period by **-12.4%**
- Average Net paid per Visit for ER increased 3.9%, more emergent cases.
- Urgent Care utilization stayed relatively flat from prior period.

Top 10 ER Diagnosis by Spend	ER Visits
Abdominal Pain	43
Nonspecific Chest Pain	36
Spondylosis; Intervertebral Disc Disorders	27
Cardiac Dysrhythmias	18
Other Complications Of Pregnancy	22
Urinary Tract Infections	23
Superficial Injury; Contusion	25
Sprains And Strains	24
Dizziness Or Vertigo	16
Headache; Including Migraine	20

On-Demand Care Services

HEALTH PLAN OF NEVADA
A UnitedHealthcare Company

ADVICE NURSE for care guidance, treatment alternatives and options

24/7

VIRTUAL VISITS through NowClinic to see a provider from any location

Advice Nurse Utilization

Prior	Current
354	313

NowClinic Visits

Prior	Current
691	501

Top Outcomes of Advice Nurse Call	Prior	Current
Sent to Urgent Care	118	118
Scheduled Appointment with Provider	64	51
Provided Self-Care Options	60	48
Sent to Emergency Room	44	35
Information or Advice Only	17	26
Other	51	35

High Cost Claimant (HCC) Data

HEALTH PLAN OF NEVADA
A UnitedHealthcare Company

Overview of High Cost Claimants

HCC Summary	Prior	Current	Δ	Peer	Δ
High Cost Members (>= $50,000)	52	54	3.8%		
HCC's per 1,000	5.48	6.23	13.7%	5.08	22.7%
% of Members as High Cost	0.55%	0.62%	13.7%	0.51%	22.7%
% of Dollars as High Cost	17.9%	18.8%	4.9%	24.4%	-23.1%
HHS Risk Score	32.08	17.61	-45.1%	20.83	-15.4%
High Cost Claimant Average Cost	**$110,934**	**$116,473**	**5.0%**	**$127,229**	**-8.5%**
High Cost Claimant Average Med Cost	$106,813	$108,838	1.9%	$120,812	-9.9%
High Cost Claimant Average Rx Cost	$4,120	$7,635	85.3%	$6,418	19.0%

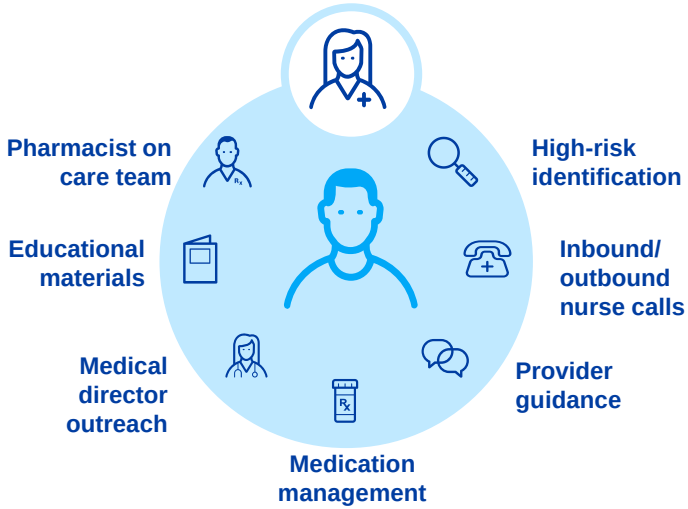
- HCC Defined as $50,000+ in spend during measurement period
- High cost claimant paid dollars accounts for **4.9%** of total medical spend in the current period
- More complex cases caused an increase in the average cost per claim by **5.0%**

High Cost Claimant (HCC) Details

HEALTH PLAN OF NEVADA
A UnitedHealthcare Company

Largest 10 Cases by Paid in Current Period

Case #	AHRQ Category Description	Relationship	Paid	Eligible
1	Rehabilitation care; fitting of prostheses; and adjustment of devices	Subscriber	$271,900.18	Yes
2	Acute myocardial infarction	Subscriber	$265,300.75	Yes
3	Complication of device; implant or graft	Spouse	$244,750.67	Yes
4	Fracture of lower limb	Subscriber	$242,029.75	Yes
5	Cancer of pancreas	Subscriber	$229,670.84	Yes
6	Other nutritional; endocrine; and metabolic disorders	Spouse	$210,499.38	Yes
7	Cardiac and circulatory congenital anomalies	Dependent	$206,051.30	Yes
8	Heart valve disorders	Spouse	$198,044.19	No
9	Coagulation and hemorrhagic disorders	Subscriber	$188,776.19	Yes
10	Other liver diseases	Spouse	$174,525.40	Yes



- Care management team engagement
- 9 of the 10 high cost claimants are currently eligible
- Largest claimant is under $300,000
- Medical management works to ensure services are medically necessary and received at the appropriate level

Pharmacy Data

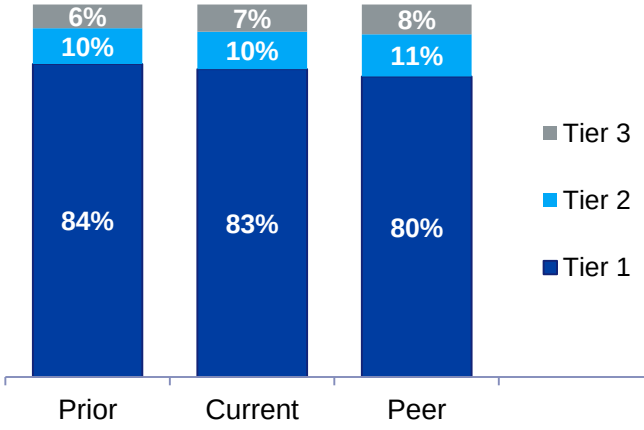
HEALTH PLAN OF NEVADA
A UnitedHealthcare Company

	Prior	Current	Δ	Peer	Δ
Enrolled Members	6,802	6,700	-1.5%		
Average Prescriptions PMPY	17.6	17.7	0.6%	10.7	64.7%
Formulary Rate	94.4%	93.4%	-1.0%	92.1%	1.4%
Generic Use Rate	88.2%	87.4%	-0.9%	87.2%	0.2%
Generic Substitution Rate	97.4%	97.3%	0.0%	96.4%	1.0%
Employee Cost Share PMPM	$24.66	$20.08	-18.6%	$12.62	59.1%
Avg Net Paid per Prescription	$67.29	$81.99	21.8%	$80.89	1.4%
Net Paid PMPM	$98.50	$120.70	22.5%	$72.32	66.9%

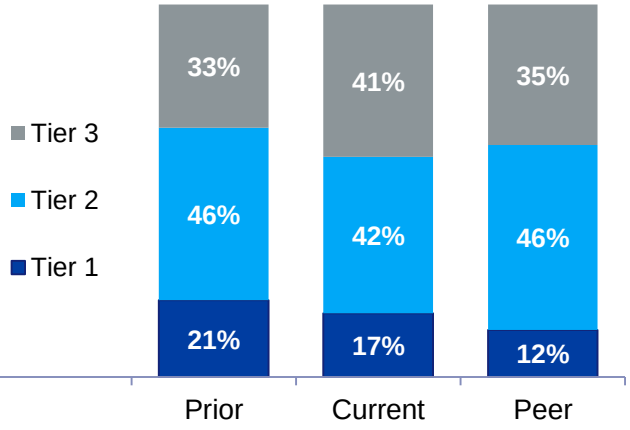
Pharmacy PMPM trend is 22.5%

- Average net paid per script increased **21.8%**
- 83% of prescriptions were in Tier 1 and drove only **17.0%** of spend
- Tier 3 spend increased **23.7%** from prior period
- Kalydeco(Cystic Fibrosis Rx) spend increased 90% on a PMPM

Prescriptions by Tier

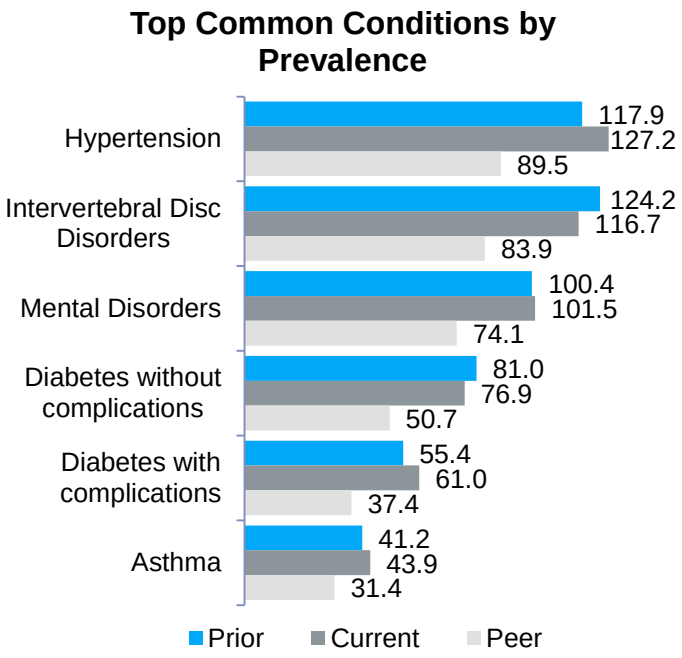


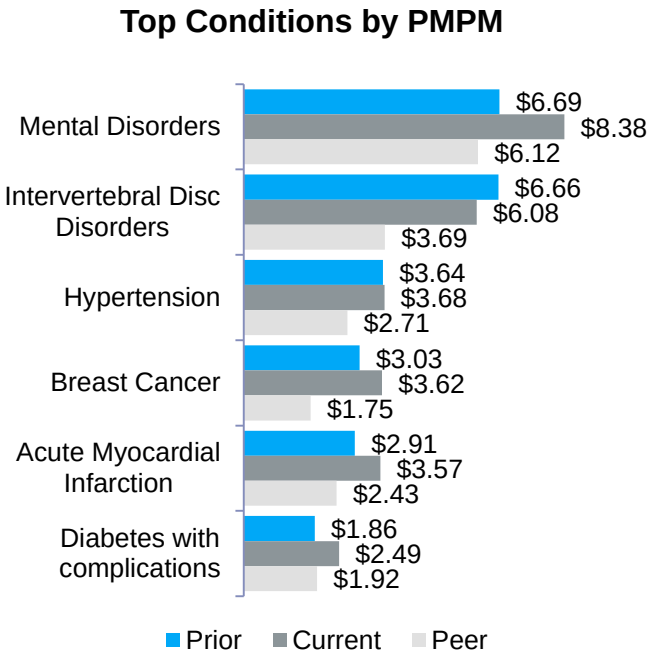
Net Paid by Tier



Common Diagnosis Categories

HEALTH PLAN OF NEVADA
A UnitedHealthcare Company





- Hypertension, Intervertebral Disc Disorders, and Mental Disorders are the most prevalent clinical conditions within the population.
- Prevalence of Hypertension and Mental Disorders increased from prior period
- Net paid for Mental Disorders increased **25.3%** year over year
- **13.7%** of claimants have a diabetes diagnosis -
  - Increase of **10.1%** prevalence of Diabetes with complications and a **34.1%** increase in spend
- Chronic illnesses are driving the top common conditions

4.3.

4. Consent Agenda (Deonne Contine, Board Chair) (**All Items for Possible Action**)

   Consent items will be considered together and acted on in one motion unless an item is removed to be considered separately by the Board.

   4.3. Receipt of annual vendor reports for timeframe July 1, 2018 - June 30, 2019:

      4.3.1. HealthSCOPE Benefits – Obesity Care Management Program

      4.3.2. Hometown Health Providers – Utilization and Large Case Management

      4.3.3. The Standard Insurance – Basic Life and Long Term Disability Insurance

      4.3.4. Willis Towers Watson's Individual Marketplace Quarterly Report for Q4, 2019

4.3.1.

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   4.3. Receipt of annual vendor reports for timeframe July 1, 2018 - June 30, 2019:

      4.3.1. HealthSCOPE Benefits – Obesity Care Management Program

HSB DATASCOPE™

Obesity Care Management Report

Nevada Public Employees' Benefits Program

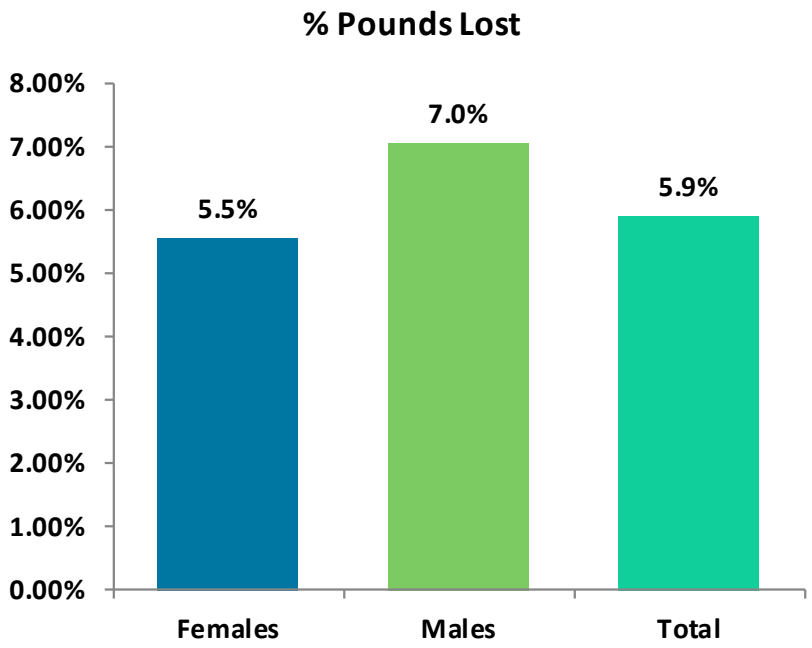
July 2018 – March 2019

HealthSCOPE BENEFITS

Obesity Care Management Overview

*Non-Participant is defined as a member who has been diagnosed with obesity in the past 12 months, but is not enrolled in the program

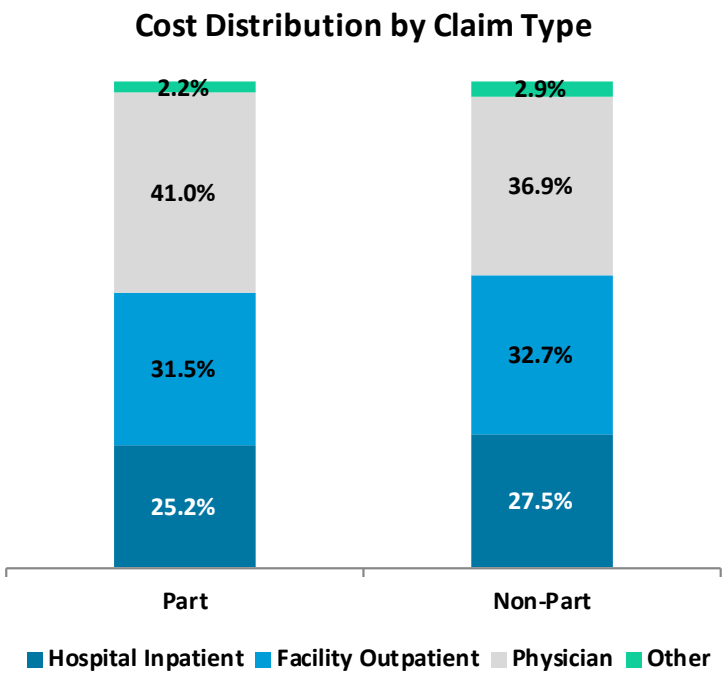
PEBP PY19			
Weight Management Summary	**Females**	**Males**	**Total**
# Mbrs Enrolled in Program	932	244	1,176
Average # Lbs. Lost	12.3	15.3	12.9
Total # Lbs. Lost	11,483.0	3,725.3	15,208.3
% Lbs. Lost	5.5%	7.0%	5.9%
Average Cost/ Member	$5,057	$3,950	$4,827



Obesity Care Management – Financial Summary

Summary	Participants	Non-Participants	Variance
Enrollment			
Avg # Employees	1,002	549	82.3%
Avg # Members	1,105	742	49.0%
Member/Employee Ratio	1.1	1.4	-18.5%
Financial Summary			
Gross Cost	$7,179,386	$6,274,283	
Client Paid	$5,677,347	$5,106,389	
Employee Paid	$1,502,040	$1,167,894	
Client Paid-PEPY	$5,669	$9,296	-39.0%
Client Paid-PMPY	$5,139	$6,885	-25.4%
Client Paid-PEPM	$472	$775	-39.1%
Client Paid-PMPM	$428	$574	-25.4%
High Cost Claimants (HCC's) > $100k			
# of HCC's	8	8	
HCC's / 1,000	7.2	10.8	0.0%
Avg HCC Paid	$134,774	$148,805	0.0%
HCC's % of Plan Paid	19.0%	23.3%	0.0%
Cost Distribution - PMPY			
Hospital Inpatient	$1,296	$1,895	-31.6%
Facility Outpatient	$1,621	$2,249	-27.9%
Physician	$2,106	$2,543	-17.2%
Other	$115	$198	-41.9%
Total	$5,139	$6,885	-25.4%

*Non-Participant is defined as a member who has been diagnosed with obesity in the past 12 months, but is not enrolled in the program



Obesity Care Management – Utilization Summary

*Non-Participant is defined as a member who has been diagnosed with obesity in the past 12 months, but is not enrolled in the program

Summary	Participants	Non-Participants	Variance
Inpatient Facility			
# of Admits	89	69	
# of Bed Days	385	310	
Paid Per Admit	$15,639	$20,366	-23.2%
Paid Per Day	$3,615	$4,533	-20.3%
Admits Per 1,000	81	93	-12.9%
Days Per 1,000	348	418	-16.7%
Avg LOS	4.3	4.5	-4.4%
Physician Office			
OV Utilization per Member	9.4	7.9	19.0%
Avg Paid per OV	$79	$65	21.5%
Avg OV Paid per Member	$746	$520	43.5%
DX&L Utilization per Member	15.1	17.6	-14.2%
Avg Paid per DX&L	$66	$61	8.2%
Avg DX&L Paid per Member	$993	$1,078	-7.9%
Emergency Room			
# of Visits	292	222	
# of Admits	48	38	
Visits Per Member	0.26	0.30	-13.3%
Visits Per 1,000	264	299	-11.7%
Avg Paid per Visit	$2,341	$2,481	-5.6%
Admits Per Visit	0.16	0.17	-5.9%
Urgent Care			
# of Visits	528	350	
Visits Per Member	0.48	0.47	2.1%
Visits Per 1,000	478	472	1.3%
Avg Paid per Visit	$51	$96	-46.9%

4.3.2.

4. Consent Agenda (Deonne Contine, Board Chair) (**All Items for Possible Action**)

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   4.3. Receipt of annual vendor reports for timeframe July 1, 2018 - June 30, 2019:

      4.3.2. Hometown Health Providers – Utilization and Large Case Management

Hometown Health

Quarterly Update for CDHP PPO Plan 4Q FY 2019 (04/01/2019 - 06/30/2019)

Nevada PUBLIC EMPLOYEES' BENEFITS PROGRAM

PEBP

Health Matters.

Report Table of Contents

Case Management – Executive Summary

Case management (CM) is a voluntary process where the clinical professionals at the utilization management company work with patients and their family members, caregivers and other health care providers to assist with coordination of various medical treatment needs of patients. Case management services are particularly helpful when a plan participant (patient) needs complex, costly and/or high-technology services such as those related to organ and tissue transplants, certain cancer treatments, serious head injuries, hospice care or certain behavioral health issues.

Active Cases: For Q4 2019, 787 clients were identified through prior authorization and referral processes for screening by staff. Of those, 63 members met preliminary criteria for enrollment into the Case Management (CM) program and 48 accepted, representing 76.1% of eligible cases screened. Cases are identified from pre-certifications as well as potential high cost and trigger diagnosis reports.

	Screened	Eligible	Enrolled	%
Current Quarter 04/01/2019 to 06/30/2019	787	63	48	76.1%
Previous Quarters 07/01/2018 to 03/31/2019	2112	452	363	80.3%
Screened Plan Year 2018 07/01/2018 to 06/30/2019	2899	515	411	79.8%

For the current quarter, of the 787 clients screened:

- 567 discharged patients were managed and transitioned through case management to alternate levels of care or discharged home on an independent basis. 48 cases were actually managed in the post-discharge setting.

- 63 members met preliminary criteria for enrollment into CM. 48 members elected to participate in the CM program. 15 members were not enrolled due to various factors related to lack of MD referrals, end of life issues, declined consents, and other social behavior influences.

- In addition to 48 new cases, 302 extended cases were carried over from previous monitoring periods, bringing total enrollment for the quarter to 350 with typical case duration of 9 months to 2 years as members regain function and stabilize or their condition deteriorates.

Case Management – Executive Summary (continued)

The majority of clients referred to CM continues to be from the Utilization Review nurses at time of referral, time of hospital admission, or time of transition to an alternate level of care. These referrals make up 75% of the referrals to Case Management. 25% of the cases screened came from physicians, plan referrals, specialty clinics and other health care facilities.

Case management estimated cost savings is $619,006.00 for the Fourth quarter of Plan Year 2019. Additional savings will be realized under Healthscope for the early intervention and referrals/resources channeled to in-network provider services.

Conclusion

During the Fourth quarter of Plan Year 2019, 787 unique members were screened for possible case management intervention. Of the 787, 63 members met preliminary criteria for enrollment into CM and 48 members (76.1%) elected to enroll in the program.

Case Management – Referral Reason Report

	Quarterly 04/01/2019 to 06/30/2019	Year to Date 7/1/2018 to 06/30/2019
CM Trigger List	787	2899
High Dollar	Included in Trigger List	Included in Trigger List
High Risk	Included in Trigger List	Included in Trigger List
Other		
Totals	**787**	**2899**

Case Type – Summary Report

	Quarterly 04/01/2019 to 06/30/2019					Year to Date 07/01/2018 to 06/30/2019				
	New Cases Opened	Full Cases Opened	Benefit Mgmt	LOAs	Totals	New Cases Opened	Full Cases Opened	Benefit Mgmt	LOAs	Totals
Bariatric	8	43	3		**54**	36	139	59		**234**
LCM	35	190	83		**308**	307	662	300		**1269**
BH/CHEM	3	53	16		**72**	59	129	73		**261**
Transplant	2	16	3		**21**	9	65	104		**178**
Other										
Totals	**48**	**302**	**105**		**455**	**411**	**995**	**536**	**17**	**1942**
Total Open Cases	**350**									

Case Management – Summary Report

Report Glossary:

New Cases Opened:
Number of cases opened to full (traditional) case management within the period.

Full Cases Opened
Number of existing cases carried over from previous reporting periods remaining active during current reporting period. (Excludes new cases opened within period).

Benefit Management Cases:
Referrals for simple discharge planning, resources, brief education, CM consults, etc. within the period.

LOAs
Extra-contractual agreements executed within the period.

Case Management – Saving Detail for Open & Closed Cases

04/01/2019 to 06/30/2019						
Case Type	Care Level Status	Vendor Negotiations	Averted Adm Savings	Change in Level of Care	Proposed Alternative Plan	Total Savings
LCM	Closed			$ 64,400		$ 64,400
LCM	Active		$ 39,499			$ 39,499
LCM	Active			$ 36,400		$ 36,400
LCM	Active		$ 33,749			$ 33,749
LCM	Active			$ 30,800		$ 30,800
LCM	Closed		$ 29,520			$ 29,520
LCM	Active			$ 26,400		$ 26,400
BH/CHEM	Closed			$ 26,070		$ 26,070
LCM	Active		$ 24,491			$ 24,491
LCM	Active		$ 24,164			$ 24,164
LCM	Active		$ 24,156			$ 24,156
LCM	Closed			$ 17,600		$ 17,600
LCM	Active		$ 16,940			$ 16,940
LCM	Closed			$ 15,400		$ 15,400
LCM	Closed			$ 13,600		$ 13,600

Case Management – Saving Detail for Open & Closed Cases (Continued)

04/01/2019 to 06/30/2019						
Case Type	**Care Level Status**	**Vendor Negotiations**	**Averted Adm Savings**	**Change in Level of Care**	**Proposed Alternative Plan**	**Total Savings**
LCM	Active		$ 9,250	$ 4,200		$ 13,450
LCM	Active			$ 13,400		$ 13,400
LCM	Closed			$ 12,800		$ 12,800
BH/CHEM	Active			$ 11,880		$ 11,880
BH/CHEM	Closed			$ 11,500		$ 11,500
LCM	Active			$ 11,400		$ 11,400
LCM	Active			$ 8,800		$ 8,800
LCM	Closed		$ 8,400			$ 8,400
BH/CHEM	Active			$ 8,250		$ 8,250
BH/CHEM	Active			$ 7,680		$ 7,680
LCM	Closed		$ 7,450			$ 7,450
LCM	Active		$ 7,400			$ 7,400
BH/CHEM	Active		$ 6,806			$ 6,806
LCM	Active		$ 6,600			$ 6,600
LCM	Active			$ 6,400		$ 6,400

Case Management – Saving Detail for Open & Closed Cases (Continued)

04/01/2019 to 06/30/2019						
Case Type	**Care Level Status**	**Vendor Negotiations**	**Averted Adm Savings**	**Change in Level of Care**	**Proposed Alternative Plan**	**Total Savings**
BH/CHEM	Active			$ 6,300		$ 6,300
LCM	Active		$ 5,850			$ 5,850
BH/CHEM	Active		$ 4,712			$ 4,712
BH/CHEM	Active			$ 4,712		$ 4,712
LCM	Active			$ 4,000		$ 4,000
BH/CHEM	Active		$ 3,906			$ 3,906
BH/CHEM	Active		$ 3,850			$ 3,850
BH/CHEM	Active			$ 3,800		$ 3,800
BH/CHEM	Closed		$ 3,510			$ 3,510
BH/CHEM	Active		$ 810	$ 2,640		$ 3,450
BH/CHEM	Active		$ 2,160	$150		$ 2,310
LCM	Active		$ 1,800			$ 1,800
BH/CHEM	Active		$ 1,572			$ 1,572
BH/CHEM	Active		$ 775			$ 775
BH/CHEM	Active		$774			$ 774

Case Management – Saving Detail for Open & Closed Cases (Continued)

04/01/2019 to 06/30/2019						
Case Type	**Care Level Status**	**Vendor Negotiations**	**Averted Adm Savings**	**Change in Level of Care**	**Proposed Alternative Plan**	**Total Savings**
BH/CHEM	Closed		$ 664			$ 664
BH/CHEM	Active		$ 620			$ 620
LCM	Active			$ 600		$ 600
LCM	Active			$ 396		$ 396
Quarterly Savings by Type			$269,428	$349,578		
Total Quarterly Savings Q4 2019						$619,006
Q1 + Q2 + Q3 2019 Savings						$3,047,648
Year To Date ROI						$3,666,654

Utilization Management – Executive Summary

The PEBP Consumer Driven Health Plan (CDHP) requires participants to obtain a pre-certification for certain medical services such as inpatient hospital admissions, skilled nursing facility admissions and bariatric weight loss surgeries. This requirement is also referred to as utilization management, utilization review, concurrent and retrospective review. The purpose of utilization management is to evaluate the appropriateness, the medical need and efficiency of certain healthcare services and procedures.

Inpatient Utilization Overview:

Based on the Fourth quarter, the PEBP population was 42,925 (average monthly lives for the quarter). Fourth quarter data shows 569 member admissions and 567 member discharges. Discharges for the fourth quarter were 13.23 members per thousand lives managed. Discharges annualized were 52.91 members per thousand lives managed. Bed days for the fourth quarter were 76.07 members per thousand lives managed. Bed days annualized were 304.07 members per thousand lives managed. The average length of stay was 6.14 days.

Inpatient Authorization and Denials:

The data show 567 authorized admissions were discharged in the quarter. General Med/Surg discharges composed the majority of all discharges with 427(75%), Mother and Newborn 77 (14%), Mental Health 30 (5%), Rehab 16 (3%), Skilled Nursing 9 (2%), and NICU with 8 (1%) total discharges.

Quarter/Year	General Med/Surg	Mother & Newborn	Mental Health	Rehab	Skilled Nursing	NICU
4Q 2019	427 75%	77 14%	30 5%	16 3%	9 2%	8 1%

Fourth quarter data shows 10 admission denials for a total of 15 denial days.
All 10 admit(s) with 15 day(s) were "*DENIED NOT COVERED BY PLAN*"

Utilization Management – Executive Summary (Continued)

Reviewing Discharges by Specialty for the this Quarter:

- **General Med/Surg** discharges were 427, with a total of 1,981 authorized days and an average LOS of 4.64 days. Bed days of 46.19 per thousand lives managed for the quarter *(annualized 184.63 per thousand),* and 9.97 members discharged per thousand of lives managed for the quarter *(annualized 39.87 per thousand).*

- **Mother & Newborn** discharges were 77, with a total of 194 authorized days and an average LOS of 2.39 days. Bed days of 4.30 per thousand lives managed for the quarter *(annualized 17.19 per thousand)* and 1.80 members were discharged per thousand lives managed for the quarter *(annualized 7.18 per thousand).*

- **Mental Health** discharges were 30, with a total of 194 authorized days and an average LOS of 6.47 days. Bed days of 4.55 per thousand lives managed for the quarter *(annualized 18.19 per thousand)* and 0.70 members were discharged per thousand lives managed for the quarter *(annualized 2.79 per thousand).*

- **Rehab** discharges were 16, with a total of 275 authorized days and an average LOS of 17.19 days. Bed days of 6.45 per thousand lives managed for the quarter *(annualized 25.78 per thousand)* and 0.37 members were discharged per thousand lives managed for the quarter *(annualized 1.50 per thousand).*

- **Skilled Nursing** discharges were 9, with a total of 229 authorized days and an average LOS of 25.44 days. Bed days of 7.90 per thousand lives managed for the quarter *(annualized 31.60 per thousand)* and 0.31 members were discharged per thousand lives managed for the quarter *(annualized 1.25 per thousand).*

- **NICU** discharges were 8, with a total of 203 authorized days and an average LOS of 25.38 days. Bed days of 4.75 per thousand lives managed for the quarter *(annualized 18.97 per thousand)* and 0.19 members were discharged per thousand lives managed for the quarter *(annualized 0.75 per thousand).*

Utilization Management – Executive Summary (Continued)

Age and Gender Distribution:
Fourth quarter discharges show 28.7% of the members discharged fall in the age bracket of 50-64. Overall women make-up 64.02% of all discharges in this quarter.

Out-Patient Utilization and Denials *(Services Include: Ambulatory Services, Diagnostic, Dialysis, Durable Medical Equipment, Home Health, Hospice, Infusion, Medical Office Visits, Pharmaceutical services, Medical Transportation, Mental Health Outpatient, Rehabilitation, Outpatient Surgery, Infusion, Transplant, Prenatal Care)***:**

Fourth quarter outpatient utilization consisted of 1,932 requests for services authorized. Authorizations for services are as follows: Outpatient Surgical Services composed 65.01% of total requests. Durable Medical Equipment composed 13.35% of total requests. Medical Office Services requests composed 10.71% of total requests. Infusion Services composed 4.92 %. Ambulatory Services composed 3.11% and Medical Transportation composed 0.88% of total request. The remaining requests composed 2.01% of total requests and include: Mental Health and Substance Abuse, Outpatient Rehabilitative Therapy Services, Outpatient Mental Health, Outpatient Transplant Services, Dialysis Services, Home Health Services, Hospice Services, Obstetrical, and Medical Pharmaceutical Services (0.67%, 0.36%, 0.26%, 0.21%, 0.21%, 0.10%, 0.10%, 0.05% and 0.05% respectively).

There were 27 outpatient requests for services denied during this quarter of FY 2019. The requests included 1 for ***Ambulatory Services***, 1 for ***Durable Medical Equipment (DME),*** 7 for ***Medical Office Services*** *and* 1 for ***Outpatient Surgical Services*** were denied as "Not Covered by Plan". 2 for ***Ambulatory Services***, 11 for ***Durable Medical Equipment (DME),*** 1 for ***Outpatient Surgical Services***, ***and*** 1 for ***Mental Health & Substance Abuse*** were "Denied Not Medically Necessary". Lastly, 2 for ***Outpatient Surgical Services*** was denied as "Experimental Svcs EXC".

Estimated savings provided do not include denials of coverage for services designated as non covered in the PEBP Master Plan document or potential savings from Letters of Agreement negotiated by Hometown health, but administered by PEBP and Healthscope.

Inpatient Utilization

4th Quarter Plan Year 2019 04/01/2019 - 06/30/2019			
Average Population	**42,925**	Quarterly Discharges Per Thousand	**13.24**
Total Discharges	**567**	Quarterly Bed Days Per Thousand	**76.07**
Days Approved	**3,066**		
Total Reviews Performed			
Admissions	**567**		
Concurrent	**328**		
Retrospective	**241**		

*The above table provides an overview of inpatient pre-certification/authorizations.

Inpatient Authorizations & Denials

4th Quarter Plan Year 2019
04/01/2019 - 06/30/2019

Admissions	Total	General Med/Surg	Mother & Newborn	Mental Health	Rehab	Skilled Nursing	NICU	
# of Discharges	567	427	77	30	16	9	8	
Quarterly Discharges per 1000	13.34	9.97	1.80	0.70	0.37	0.31	0.19	

Total Denied

Denials	Surgical	Medical	Detox	Obstetrical	Rehab	Skiilled Nursing Facility	Observation	Total
Total Number of Denied Requests	**0**	**1**	**0**	**8**	**0**	**0**	**1**	**10**
Denied, Not Medically Necessary	0	0	0	0	0	0	0	**0**
Denied, Not Covered by Plan	0	1	0	8	0	0	1	**10**
Denied, Member Exceeds Max Limits	0	0	0	0	0	0	0	**0**

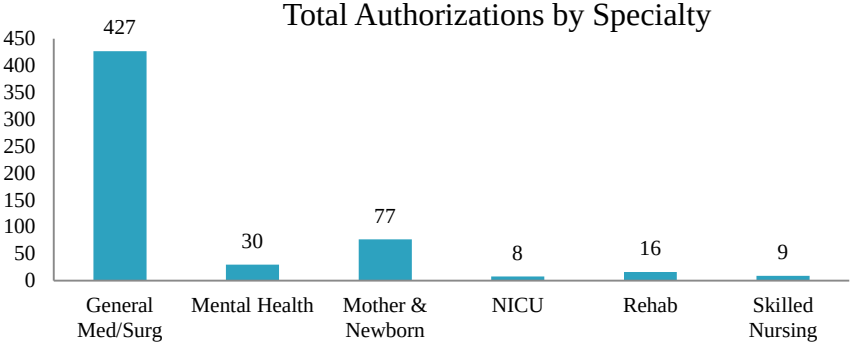
*The above tables provide an overview of inpatient authorization by utilization data. Total denied days are derived from prospective and concurrent reviews.

Inpatient Discharge Information

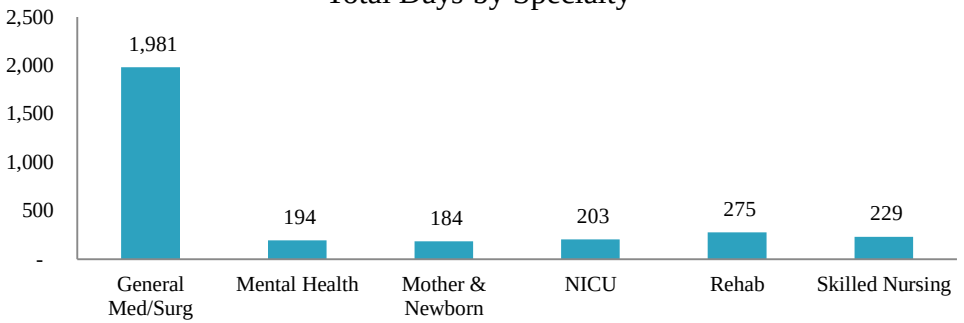
4th Quarter Plan Year 2019 04/01/2019 - 06/30/2019					
Discharges by Specialty	Total Auths	Total Days	Average LOS	Quarterly Beddays/1,000	Quarterly Discharges/1,000
General Med/Surg	427	1,981	4.64	46.19	9.97
Mother & Newborn	77	184	2.39	4.30	7.18
Mental Health	30	194	6.47	3.60	2.79
Rehab	16	275	17.19	6.45	1.49
Skilled Nursing	9	229	25.44	7.90	1.25
NICU	8	203	25.38	4.75	0.75

*The above tables provide an overview of discharges by category and as a whole, in addition the table provides a further breakout of the medical category. Graphic representation of Discharges by specialty is located on pages 17 through 18 of this report.

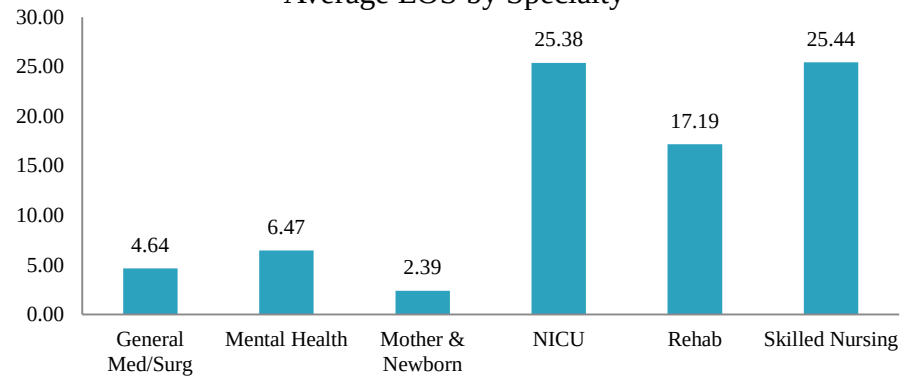
Total Authorizations by Specialty



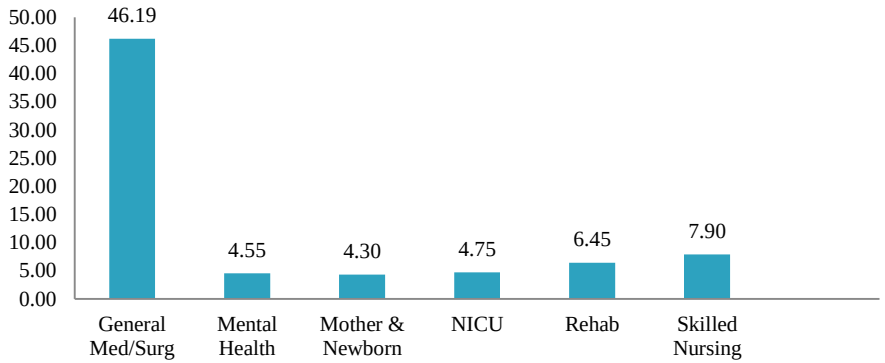
Total Days by Specialty



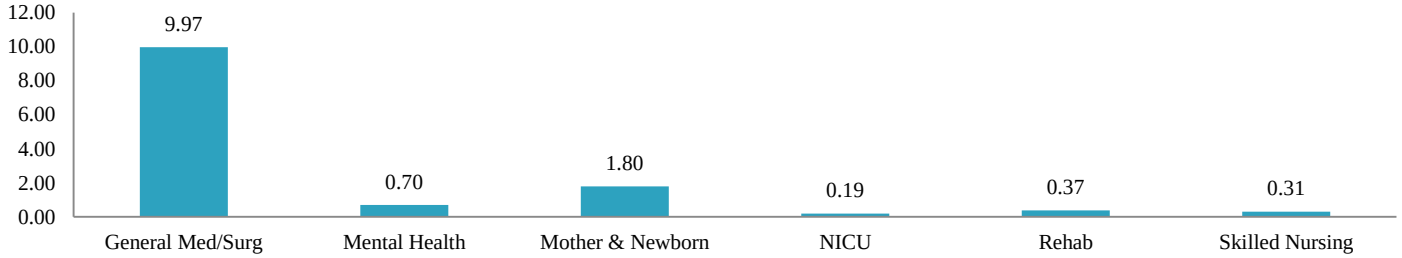
Average LOS by Specialty



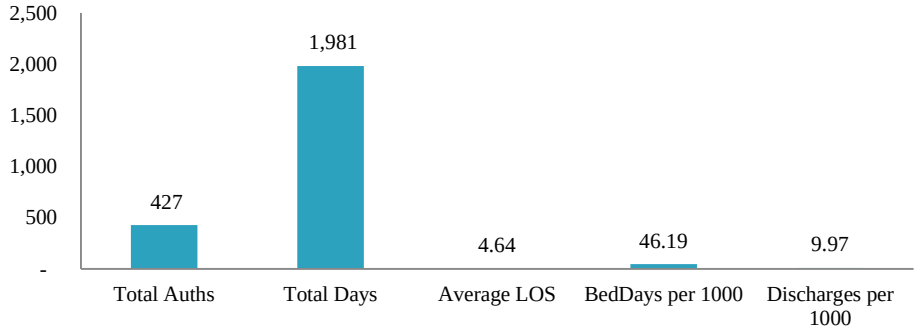
Average Bed Days per Thousand



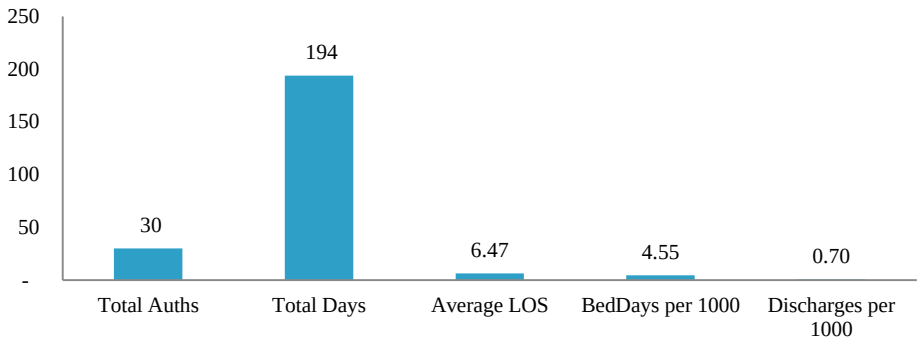
Discharges per Thousand



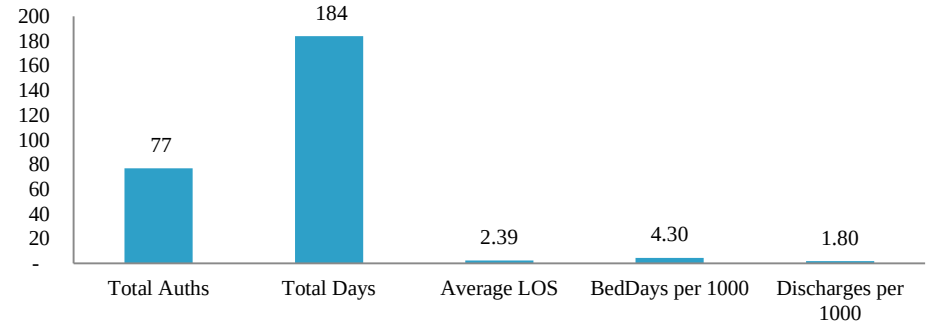
General Med/Surg



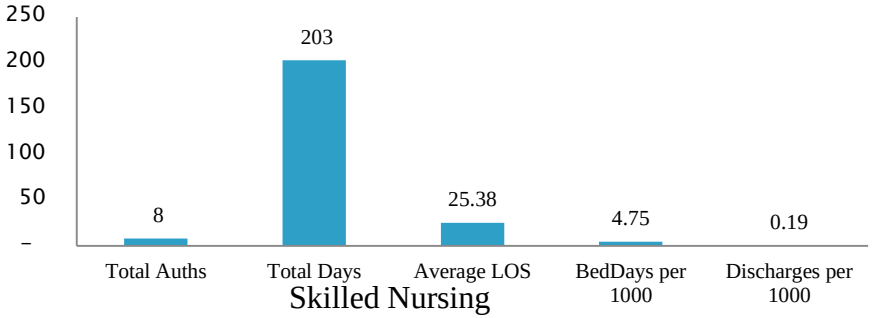
Mental Health



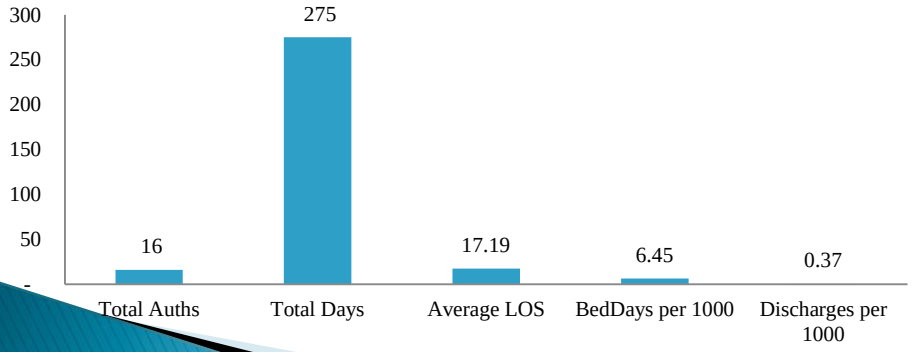
Mother & Newborn



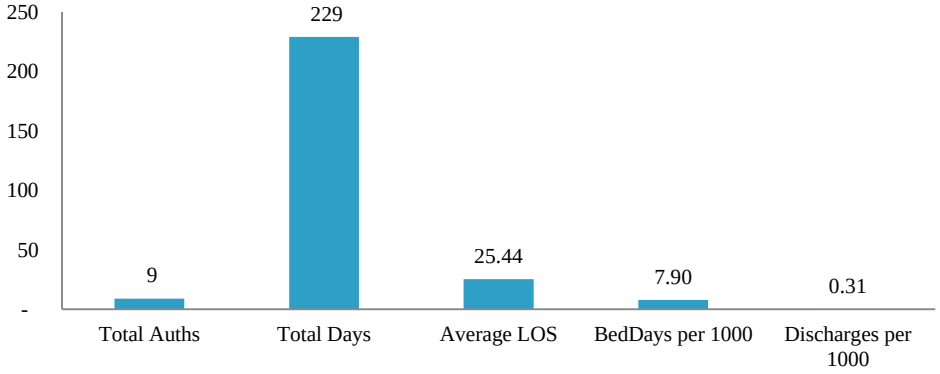
NICU



Rehab

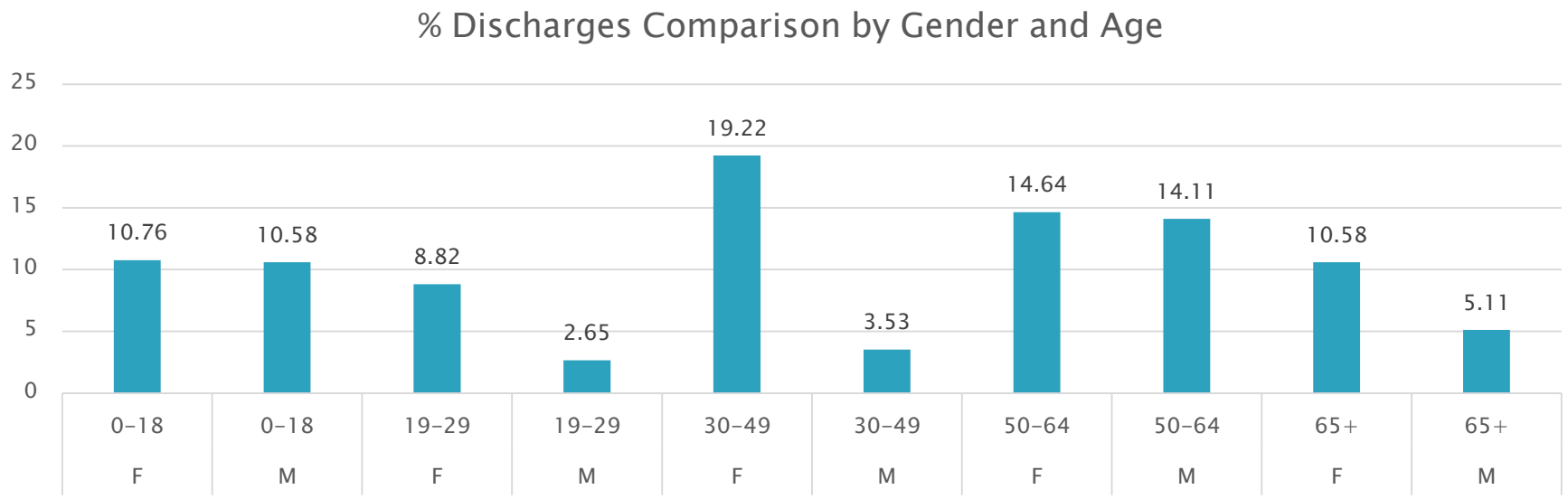


Skilled Nursing



Age & Gender Distribution

	Age Categories					
	0 - 18	19 - 29	30 - 49	50 - 64	65+	Total
Female	61	50	109	83	60	363
Male	60	15	20	80	29	204
Total	**121**	**65**	**129**	**163**	**89**	**567**
Total (%)	**21**	**11**	**23**	**29**	**16**	**100**



*The above table provides a breakout of discharged members by age categories, the above graph provides a comparison of male to female discharges in the same age categories.

Outpatient Authorizations & Denials

4th Quarter Plan Year 2019 04/01/2019 - 06/30/2019 Authorizations	
OUTPATIENT SURGICAL SERVICES	1256
DURABLE MEDICAL EQUIPMENT	258
MEDICAL OFFICE SERVICES	207
INFUSION SERVICES, EQUIPMENT AND SUPPLIES	95
AMBULATORY SERVICES	60
MEDICAL TRANSPORTATION SERVICES	17
MENTAL HEALTH & SUBSTANCE ABUSE	13
OUTPATIENT REHABILITATIVE THERAPY SERVICE	7
OUTPATIENT MENTAL HEALTH SERVICES	5
OUTPATIENT TRANSPLANT SERVICES	4
DIALYSIS SERVICES	4
HOME HEALTH SERVICES	2
HOSPICE SERVICES	2
OBSTETRICAL	1
MEDICAL PHARMACEUTICAL SERVICES	1
Totals	**1928**

Denials	Ambulatory Services	Outpatient	Medical Office Services	DME	Mental Health & Substance Abuse	Total
Denied, Not Medically Necessary	2	1	0	11	1	15
Denied, Not Covered by Plan	1	1	7	1	0	10
Denied, Experimental SVCS EXC	0	2	0	0	0	2
Total Number of Denied Requests	**3**	**4**	**7**	**12**	**1**	**27**

Appendix A

Medical Discharges by Facility and Level of Care

BARTON MEMORIAL HOSPITAL	1	1	Acute	1
BHC FAIRFAX HOSPITALINC	1	6	Mental Health	6
BLOUNT MEMORIAL HOSPITAL	1	1	Acute	1
CARSON NURSING &REHAB C	1	45	SNF	45
CARSON TAHOE BEHAVIORAL HLTH SVCS	8	46	Mental Health	6
CARSON TAHOE REGIONAL MEDICAL CTR	90	228	Acute	3
CARSON TAHOE SIERRASURGERY	1	2	Acute	2
CARSON VALLEY MEDICAL CENTER	1	1	Acute	1
CEDAR SINAI MED CTR	1	2	Acute	2
CENTENNIAL HILLS HOSPITAL MED CTR	29	102	Acute	4
COMPLEX CARE HOSPITAL AT TENAYA	2	60	Acute	30
CONTINUECARE HOSP OFCARSON TAHOE	1	28	Acute	28
DESERT PARKWAY BEHAVIORAL HEALTH	4	15	Mental Health	4
DESERT SPRINGS HOSPITAL	7	60	Acute	9
EMORY UNIVERSITY HOSPITAL MIDTOWN	1	1	Acute	1
ENCOMPASS HEALTH REHAB HOSP OF LV	1	7	Rehab	7
ENCOMPASS REHAB HOSPOF HENDERSON	6	149	Rehab	25
ENLOE MEDICAL CENTER	1	1	Acute	1
GRANT MEDICAL CENTER	1	1	Acute	1
HENDERSON HOSPITAL	10	30	Acute	3
HORIZON SPECIALTY HOSPITAL	1	38	Acute	38
HUMBOLDT GENERAL HOSPITAL	1	3	Acute	3
JCL DV HOSPITAL	1	4	Acute	4
KINDRED HOSPITAL LASVEGAS FLAMINGO	1	57	Acute	57
KINDRED HOSPITAL LASVEGAS FLAMINGO	1	43	SNF	43
KINDRED TRANS CARE AND REHAB	1	31	Acute	31
KINDRED TRANS CARE AND REHAB	2	49	SNF	25
LAS VEGAS RECOVERY CENTER	1	7	Mental Health	7
LIFE CARE CENTER OFRENO	3	69	SNF	23
LUCILE SALTER PACKARD CHILDRENS HOSLPITA	2	6	Acute	3
MAYO CLINIC HOSPITALROCHESTER	1	5	Acute	5
MERCY MEDICAL CENTER	2	5	Acute	3
MONTEVISTA HOSPITAL	1	4	Mental Health	4
MOUNTAIN VIEW HOSPITAL	14	54	Acute	4

Facility	Total Admits	Total Days	Level Of Care	ALOS by Level of Care
MOUNTAIN VIEW HOSPITAL	1	8	Rehab	8
NATHAN ADELSON HOSPICE	1	4	Acute	4
NORTH VISTA HOSPITAL	6	8	Acute	1
NORTHEASTERN NEV R/H	7	14	Acute	2
NORTHERN NV MEDICAL	3	4	Acute	1
ORMSBY POST ACUTE REHAB	1	7	SNF	7
PROVIDENCE MEDFORD MEDICAL CEN	1	6	Acute	6
PROVIDENCE MEDFORD MEDICAL CEN	1	8	Rehab	8
RECOVERY WAYS DENALILLC	1	7	Mental Health	7
RENO BEHAVIORAL HEALTHCARE HOSP	1	2	Acute	2
RENO BEHAVIORAL HEALTHCARE HOSP	7	28	Mental Health	4
RENOWN REGIONAL MEDICAL CENTER	111	554	Acute	5
RENOWN REHAB HOSPITAL	4	45	Rehab	11
RENOWN SOUTH MEADOWS	16	21	Acute	1
REVIVE DETOX	1	6	Mental Health	6
RONALD REAGAN UCLA MEDICAL CENTER	3	6	Acute	2
SAINT BARNABAS MEDICAL CENTER	1	3	Acute	3
SALINAS VALLEY MEMORIAL HOSPITAL	1	3	Acute	3
SEVEN HILLS BEHAVIORAL INSTITUTE	1	4	Mental Health	4
SHRINERS HOSPITALS FOR CHILDREN CA	1	1	Acute	1
SIERRA RIDGE HEALTHAND WELLNESS	1	21	SNF	21
SOUTHERN HILLS HOSPITAL	10	39	Acute	4
SPRING MOUNTAIN TREATMENT CENTER	1	4	Acute	4
SPRING MOUNTAIN TREATMENT CENTER	2	7	Mental Health	4
SPRING VALLEY HOSPITAL MEDICAL CTR	17	101	Acute	6
ST LUKES HOSPITAL	1	1	Acute	1
ST LUKES MAGIC VALLEY RMC HOSPITAL	1	1	Acute	1
ST MARKS HOSPITAL	1	7	Acute	7
ST MARYS REGIONAL MED CTR	3	8	Acute	3
ST ROSE DOMINICAN BLUE DIAMOND	1	5	Acute	5
ST ROSE DOMINICAN SAN MARTIN CAMPUS	6	27	Acute	5
ST ROSE DOMINICAN SIENA	42	116	Acute	3
STANFORD MEDICAL CENTER	3	31	Acute	10

Facility	Total Admits	Total Days	Level Of Care	ALOS by Level of Care
SUMMERLIN HOSPITAL MEDICAL CENTER	45	144	Acute	3
SUMMERLIN HOSPITAL MEDICAL CENTER	1	11	Rehab	11
SUNRISE HOSPITAL & MED CTR-REHAB	1	1	Acute	1
SUNRISE HOSPITAL & MEDICAL CTR	9	40	Acute	4
SUTTER MEMORIAL HOSPITAL	1	7	Acute	7
SUTTER ROSEVILLE MEDICAL	1	22	Acute	22
TAHOE FOREST HOSPITAL	2	2	Acute	1
THE DESERT HOPE TREATMENT CENTER	1	7	Mental Health	7
U OF U HOSPITAL CLINICS	6	27	Acute	5
U OF U HOSPITAL CLINICS	1	8	Rehab	8
U OF U HUNTSMAN CANCER INSTITUTE	1	4	Acute	4
UC DAVIS MEDICAL CENTER	3	68	Acute	23
UC IRVINE MEDICAL CENTER	2	4	Acute	2
UC IRVINE MEDICAL CENTER	1	5	Rehab	5
UCSD MEDICAL CENTER	1	4	Acute	4
UCSF MEDICAL CENTER	1	1	Acute	1
UNIV OF WISCONSIN HOSPITAL	2	12	Acute	6
UNIVERSITY MEDICAL CENTER-LV	15	69	Acute	5
UNIVERSITY OF WASHINGTON MED CTR	1	3	Acute	3
VA SOUTHERN NEVADA	2	4	Acute	2
VALLEY DETOX	1	5	Mental Health	5
VALLEY HOSPITAL MEDICAL CENTER	4	30	Acute	8
VANDERBILT UNIV MEDCTR	1	2	Acute	2
WAUKESHA MEMORIAL HOSPITAL	1	7	Acute	7
WEST HILLS HOSPITAL-NV	1	5	Mental Health	5
WILLIAM BEE RIRIE HOSPITAL	4	6	Acute	1.5

Performance Standards & Guarantees – Self Reported

4th Quarter Plan Year 2018 04/01/2018 – 06/30/2018		
Service Performance Standard (Metric)	Guarantee Measurement	Pass/Fail
I. Quarterly and annual management reports	**100%** - Delivery of Quarterly reports within 45 days of end of reporting period as established by PEBP.	Pass
II. Notification of potential high expense cases*	**95.0%** - Designated PEBP staff will be notified within 5 business days of the UM vendors initial notification of requested service.	Pass
III. Pre-certification information shall be provided to PEBP's Fourth party administrator	**98%** - Pre-certification requests from healthcare providers shall be communicated to PEBP's Fourth party administrator using an approved method e.g. electronically, within 5 business days of UM completing pre-certification determination.	Pass
IV. Concurrent hospital review	**98%** - Concurrent hospital reviews shall be completed and communicated using an approved method e.g. electronically within 5 business days of determination decision.	Pass

*High expense case is defined as a single-claim or treatment plan expected to exceed $1,000,000.

Hometown Health

Quarterly Update for PREMIER EPO PLAN Q4 FY 2019 (04/01/2019 - 06/30/2019)

Nevada PUBLIC EMPLOYEES' BENEFITS PROGRAM

PEBP

Health Matters.

Report Table of Contents

Case Management – Executive Summary

Case management (CM) is a voluntary process where the clinical professionals at the utilization management company work with patients and their family members, caregivers and other health care providers to assist with coordination of various medical treatment needs of patients. Case management services are particularly helpful when a plan participant (patient) needs complex, costly and/or high-technology services such as those related to organ and tissue transplants, certain cancer treatments, serious head injuries, hospice care or certain behavioral health issues.

Active Cases: For Q4 2019, 189 clients were identified through prior authorization and referral processes for screening by staff. Of those, 16 members met preliminary criteria for enrollment into the Case Management (CM) program and 13 accepted, representing 81.2% of eligible cases screened. Cases are identified from pre-certifications as well as potential high cost and trigger diagnosis reports.

	Screened	Eligible	Enrolled	%
Current Quarter 04/01/2019 to 06/30/2019	189	16	13	81.2%
Previous Quarters 07/01/2018 to 03/31/2019	643	163	127	77.9%
Screened Plan Year 2018 07/01/2018 to 06/30/2019	832	179	140	78.2%

For the current quarter, of the 189 clients screened:

- 142 discharged patients were managed and transitioned through case management to alternate levels of care or discharged home on an independent basis. 13 cases were actually managed in the post-discharge setting.

- 16 members met preliminary criteria for enrollment into CM. 13 members elected to participate in the CM program. 3 members were not enrolled due to various factors related to lack of MD referrals, end of life issues, declined consents, and other social behavior influences.

- In addition to 13 new cases, 53 extended cases were carried over from previous monitoring periods, bringing total enrollment for the quarter to 66 with typical case duration of 9 months to 2 years as members regain function and stabilize or their condition deteriorates.

Case Management – Executive Summary (continued)

The majority of clients referred to CM continues to be from the Utilization Review nurses at time of referral, time of hospital admission, or time of transition to an alternate level of care. These referrals make up 75% of the referrals to Case Management. 25% of the cases screened came from physicians, plan referrals, specialty clinics and other health care facilities.

Case management estimated cost savings is $91,860 for the Fourth quarter of Plan Year 2019. Additional savings will be realized under Healthscope for the early intervention and referrals/resources channeled to in-network provider services.

Conclusion

During the Fourth quarter of Plan Year 2019, 189 unique members were screened for possible case management intervention. Of the 189, 16 members met preliminary criteria for enrollment into CM and 13 members (81.2%) elected to enroll in the program.

Case Management – Referral Reason Report

	Quarterly 04/01/2019 to 06/30/2019	Year to Date 7/1/2018 to 06/30/2019
CM Trigger List	189	832
High Dollar	Included in Trigger List	Included in Trigger List
High Risk	Included in Trigger List	Included in Trigger List
Other		
Totals	**189**	**832**

Case Type – Summary Report

	Quarterly 04/01/2019 to 06/30/2019					Year to Date 07/01/2018 to 06/30/2019				
	New Cases Opened	Full Cases Opened	Benefit Mgmt	LOAs	Totals	New Cases Opened	Full Cases Opened	Benefit Mgmt	LOAs	Totals
Bariatric	7	21	4		**32**	30	58	16		**104**
LCM	6	17	14		**37**	88	129	56		**273**
BH/CHEM	0	12	3		**15**	17	52	15		**84**
Transplant	0	3	1		**4**	5	12	12		**29**
Other										
Totals	**13**	**53**	**22**	**0**	**88**	**140**	**251**	**99**	**17**	**490**
Total Open Cases	**66**									

Case Management – Summary Report

Report Glossary:

New Cases Opened:
Number of cases opened to full (traditional) case management within the period.

Full Cases Opened
Number of existing cases carried over from previous reporting periods remaining active during current reporting period. (Excludes new cases opened within period).

Benefit Management Cases:
Referrals for simple discharge planning, resources, brief education, CM consults, etc. within the period.

LOAs
Extra-contractual agreements executed within the period.

Case Management – Saving Detail for Open & Closed Cases (Continued)

04/01/2019 to 6/30/2019						
Case Type	**Care Level Status**	**Vendor Negotiations**	**Averted Adm Savings**	**Change in Level of Care**	**Proposed Alternative Plan**	**Total Savings**
BH/CHEM	Active			$ 24,750		$ 24,750
LCM	Active			$ 23,800		$ 23,800
BH/CHEM	Active			$ 18,150		$ 18,150
BH/CHEM	Active			$ 17,160		$ 17,160
LCM	Active			$ 8,000		$ 8,000
Quarterly Savings by Type				$91,860		
Total Quarterly Savings Q3 2019						$91,860
Q1 + Q2 +3 2019 Savings						$496,010
Year To Date ROI						$587,870

Utilization Management – Executive Summary

The PEBP Consumer Driven Health Plan (CDHP) requires participants to obtain a pre-certification for certain medical services such as inpatient hospital admissions, skilled nursing facility admissions and bariatric weight loss surgeries. This requirement is also referred to as utilization management, utilization review, concurrent and retrospective review. The purpose of utilization management is to evaluate the appropriateness, the medical need and efficiency of certain healthcare services and procedures.

Inpatient Utilization Overview:

Based on the Fourth quarter, the PEBP population was 8,713 (average monthly lives for the quarter). Fourth quarter data shows 142 member admissions and 142 member discharges. Discharges for the fourth quarter were 16.35 members per thousand lives managed. Discharges annualized were 65.35 members per thousand lives managed. Bed days for the fourth quarter were 70.07 members per thousand lives managed. Bed days annualized were 280.07 members per thousand lives managed. The average length of stay was 4.30 days.

Inpatient Authorization and Denials:

The data show 142 authorized admissions were discharged in the quarter. General Med/Surg discharges composed the majority of all discharges with 92 (65%), Mother and Newborn 22 (15%), Mental Health 17 (12%), NICU 4 (3%), Rehab 4 (3%), and NICU with 3 (2%) total discharges.

Quarter/Year	General Med/Surg	Mother & Newborn	Mental Health	NICU	Rehab	Skilled Nursing
4Q 2019	92 65%	22 15%	17 12%	4 3%	4 3%	3 2%

Fourth quarter data shows 0 admission denials for a total of 0 denial days.

Utilization Management – Executive Summary (Continued)

Reviewing Discharges by Specialty for the this Quarter:

- **General Med/Surg** discharges were 92, with a total of 275 authorized days and an average LOS of 2.99 days. Bed days of 31.63 per thousand lives managed for the quarter *(annualized 126.43 per thousand)*, and 10.58 members discharged per thousand of lives managed for the quarter *(annualized 42.29 per thousand).*

- **Mother & Newborn** discharges were 22, with a total of 57 authorized days and an average LOS of 2.59 days. Bed days of 6.56 per thousand lives managed for the quarter *(annualized 26.21 per thousand)* and 2.54 members were discharged per thousand lives managed for the quarter *(annualized 10.17 per thousand).*

- **Mental Health** discharges were 17, with a total of 113 authorized days and an average LOS of 6.65 days. Bed days of 12.86 per thousand lives managed for the quarter *(annualized 51.88 per thousand)* and 1.96 members were discharged per thousand lives managed for the quarter *(annualized 7.85 per thousand).*

- **NICU** discharges were 4, with a total of 98 authorized days and an average LOS of 24.50 days. Bed days of 11.26 per thousand lives managed for the quarter *(annualized 45.02 per thousand)* and 0.46 members were discharged per thousand lives managed for the quarter *(annualized 1.83 per thousand).*

- **Rehab** discharges were 4, with a total of 19 authorized days and an average LOS of 4.75 days. Bed days of 3.32 per thousand lives managed for the quarter *(annualized 13.28 per thousand)* and 0.70 members were discharged per thousand lives managed for the quarter *(annualized 2.80 per thousand).*

- **Skilled Nursing** discharges were 3, with a total of 32 authorized days and an average LOS of 10.67 days. Bed days of 10.79 per thousand lives managed for the quarter *(annualized 43.14 per thousand)* and 1.01 members were discharged per thousand lives managed for the quarter *(annualized 4.04 per thousand).*

Utilization Management – Executive Summary (Continued)

Age and Gender Distribution:
Fourth quarter discharges show 30.28% of the members discharged fall in the age bracket of 50-64. Overall women make-up 59.15% of all discharges in this quarter.

Out-Patient Utilization and Denials *(Services Include: Ambulatory Services, Diagnostic, Dialysis, Durable Medical Equipment, Home Health, Hospice, Infusion, Medical Office Visits, Pharmaceutical services, Medical Transportation, Mental Health Outpatient, Rehabilitation, Outpatient Surgery, Infusion, Transplant, Prenatal Care)***:**

Fourth quarter outpatient utilization consisted of 1,127 requests for services authorized. Authorizations for services are as follows: Medical Office Services requests composed 34.78% of total requests. Outpatient Surgical Services composed 28.04% of total requests. Durable Medical Equipment composed 24.93% of total requests. Outpatient Rehabilitative Therapy Services composed 5.50% of total requests. Infusion Services composed 1.77 % of total requests. Ambulatory Services composed 1.69% and Home Health Services composed 0.98% of total request. The remaining requests composed 2.21% of total requests and include: Outpatient Mental Health, Wound Care Services, Cardiac Rehabilitation Services, Mental Health and Substance Abuse, Medical Pharmaceutical Services, Dialysis Services, Hospice Services, Outpatient Substance Abus53and Outpatient Transplant Services(0.66%, 0.44%, 0.44%, 0.44%, 0.09%, 0.09%, 0.09% and 0.09% respectively).

There were 21 outpatient requests for services denied during this quarter of FY 2019. The requests included 4 for ***Durable Medical Equipment (DME),*** 4 for ***Medical Office Services*** *and* 2 for ***Outpatient Surgical Services*** were denied as "Not Covered by Plan". 2 for ***Durable Medical Equipment (DME)*** were "Denied Not Medically Necessary"**.** 1 for ***Durable Medical Equipment (DME)*** 3 for ***Outpatient Surgical Services***, ***and*** *4* for ***Medical Office Services*** were denied as "Service Out Plan". Lastly, 1 for ***Durable Medical Equipment (DME)*** was denied as "Authorization Insufficient Medical Information".

Estimated savings provided do not include denials of coverage for services designated as non covered in the PEBP Master Plan document or potential savings from Letters of Agreement negotiated by Hometown health, but administered by PEBP and Healthscope.

Inpatient Utilization

4th Quarter Plan Year 2019 04/01/2019 - 06/30/2019			
Average Population	**8,713**	Quarterly Discharges Per Thousand	**17.26**
Total Discharges	**142**	Quarterly Bed Days Per Thousand	**68.98**
Days Approved	**594**		
Total Reviews Performed			
Admissions	**142**		
Concurrent	**87**		
Retrospective	**55**		

*The above table provides an overview of inpatient pre-certification/authorizations.

Inpatient Authorizations & Denials

Admissions	Total	General Med/Surg	Mother & Newborn	Mental Health	NICU	Rehab	Skilled Nursing	
# of Discharges	142	92	22	17	4	4	3	
Quarterly Discharges per 1000	17.26	10.58	2.54	1.96	0.46	0.70	1.01	

Denials	Total Denied							
	Surgical	Medical	Detox	Obstetrical	Rehab	Skiilled Nursing Facility	Observation	Total
Total Number of Denied Requests	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Denied, Not Medically Necessary	0	0	0	0	0	0	0	**0**
Denied, Not Covered by Plan	0	0	0	0	0	0	0	**0**
Denied, Member Exceeds Max Limits	0	0	0	0	0	0	0	**0**

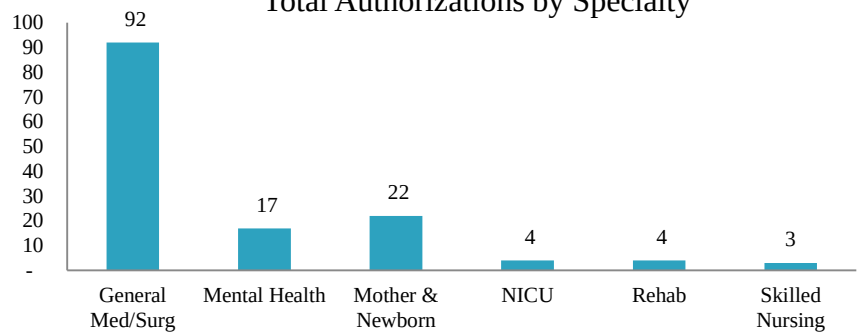
*The above tables provide an overview of inpatient authorization by utilization data. Total denied days are derived from prospective and concurrent reviews.

Inpatient Discharge Information

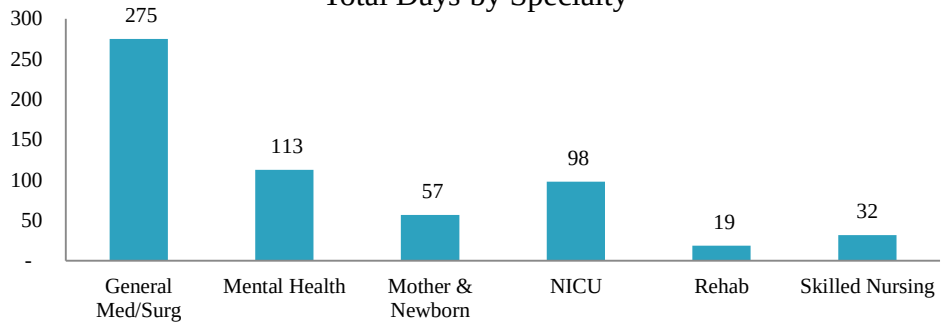
4th Quarter Plan Year 2019 04/01/2019 - 06/30/2019					
Discharges by Specialty	Total Auths	Total Days	Average LOS	Quarterly Beddays/1,000	Quarterly Discharges/1,000
General Med/Surg	92	275	2.99	31.63	10.58
Mother & Newborn	22	57	2.59	6.56	2.54
Mental Health	17	113	6.65	12.98	1.96
NICU	4	98	24.50	11.26	0.46
Rehab	4	19	4.75	3.32	0.70
Skilled Nursing	3	32	10.67	10.79	1.01

*The above tables provide an overview of discharges by category and as a whole, in addition the table provides a further breakout of the medical category. Graphic representation of Discharges by specialty is located on pages 17 through 18 of this report.

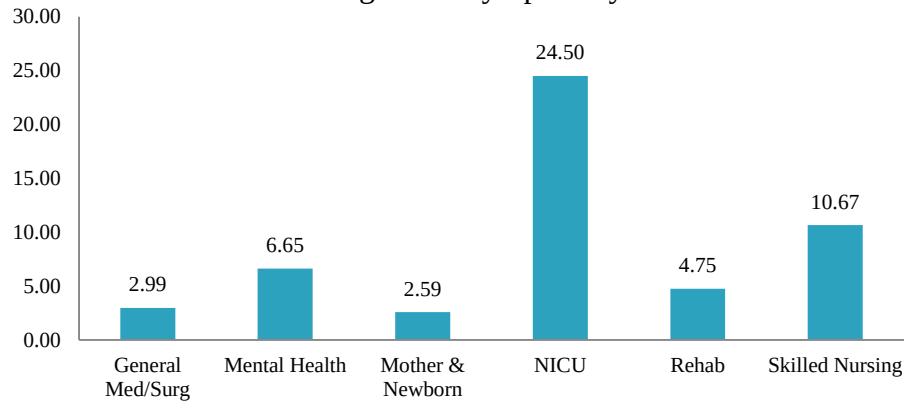
Total Authorizations by Specialty



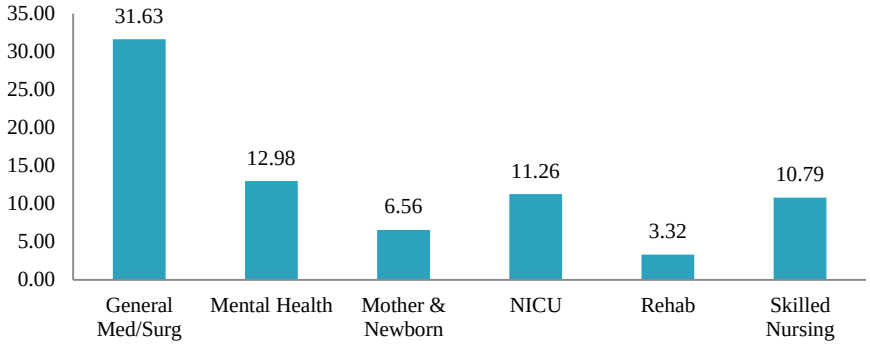
Total Days by Specialty



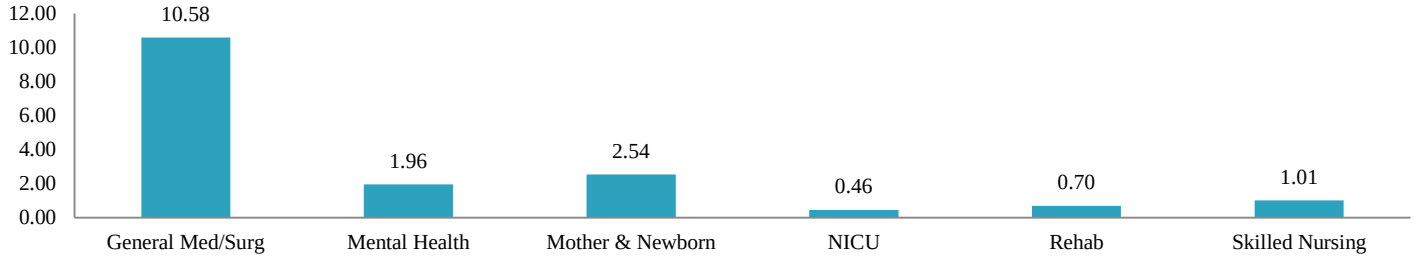
Average LOS by Specialty



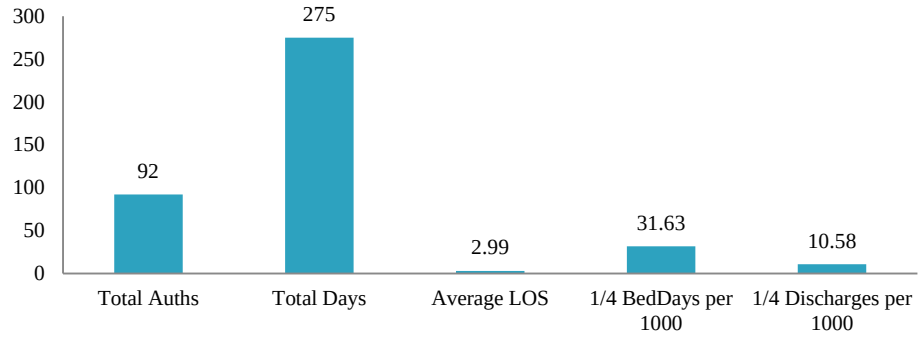
Average Bed Days per Thousand



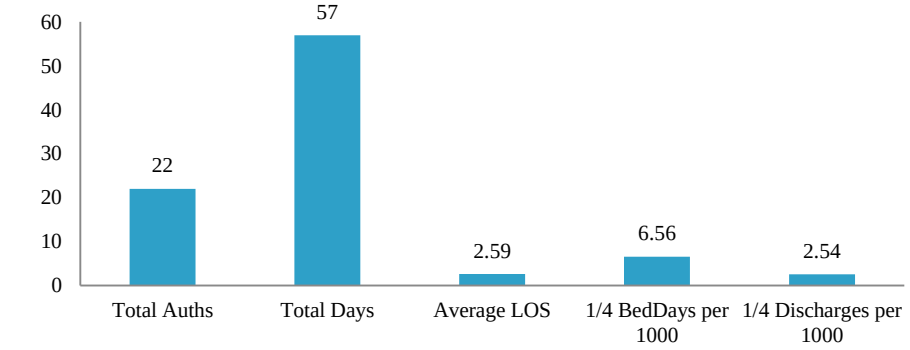
Discharges per Thousand



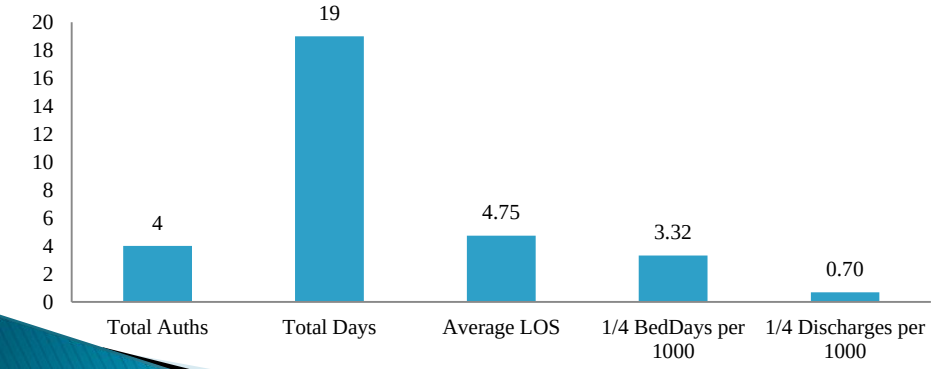
General Med/Surg



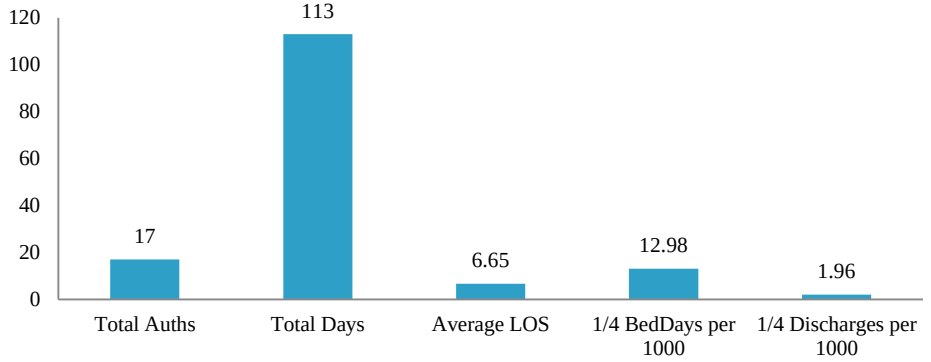
Mother & Newborn



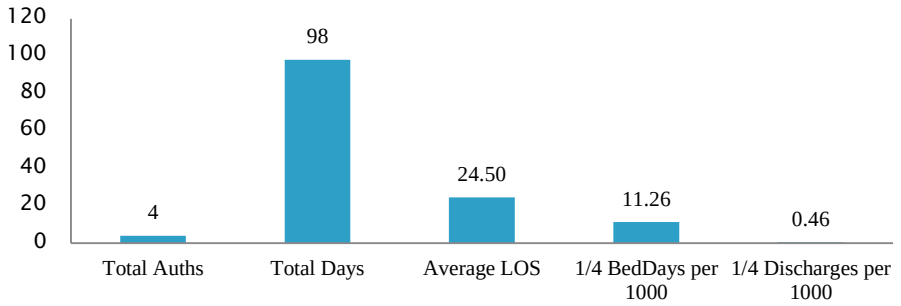
Rehab



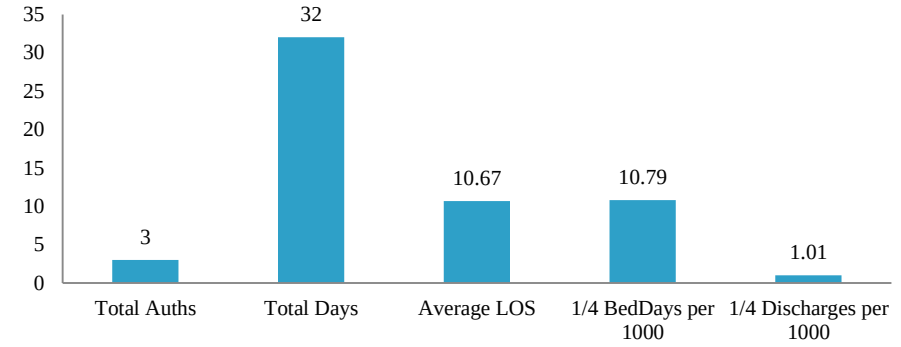
Mental Health



NICU

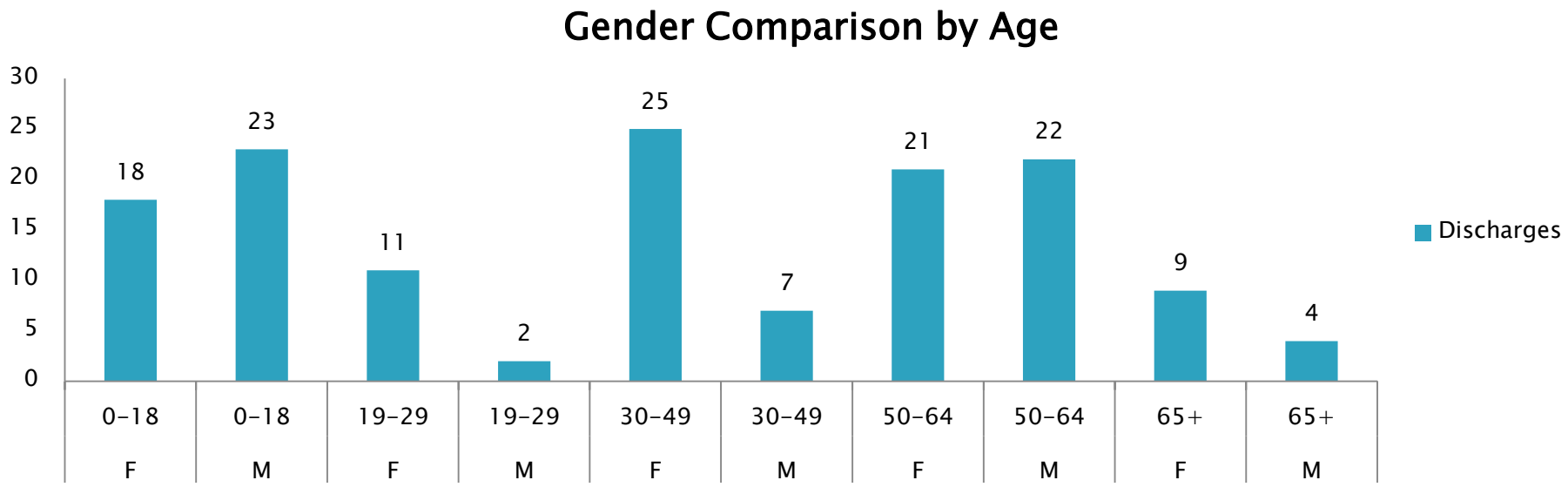


Skilled Nursing



Age & Gender Distribution

	Age Categories					
	0 - 18	19 - 29	30 - 49	50 - 64	65+	Total
Female	18	11	25	21	9	84
Male	23	2	7	22	4	58
Total	**41**	**13**	**32**	**43**	**13**	**142**
Total (%)	**29**	**9**	**23**	**30**	**9**	**100**



*The above table provides a breakout of discharged members by age categories, the above graph provides a comparison of male to female discharges in the same age categories.

Outpatient Authorizations & Denials

04/01/2019 - 06/30/2019 Authorizations	
MEDICAL OFFICE SERVICES	392
OUTPATIENT SURGICAL SERVICES	316
DURABLE MEDICAL EQUIPMENT	281
OUTPATIENT REHABILITATIVE THERAPY SERVICE	62
INFUSION SERVICES, EQUIPMENT AND SUPPLIES	20
AMBULATORY SERVICES	19
HOME HEALTH SERVICES	11
OUTPATIENT MENTAL HEALTH SERVICES	6
WOUND CARE SERVICES	5
CARDIAC REHABILITATION SERVICES	5
MENTAL HEALTH & SUBSTANCE ABUSE PARTIAL	5
MEDICAL PHARMACEUTICAL SERVICES	1
DIALYSIS SERVICES	1
HOSPICE SERVICES	1
OUTPATIENT SUBSTANCE ABUSE SERVICES	1
OUTPATIENT TRANSPLANT SERVICES	1
Totals	**1127**

Ambulatory

Denials	Ambulatory Services	Outpatient	Medical Office Services	DME	Mental Health & Substance Abuse	Total
Denied, Not Medically Necessary	0	0	0	2	0	2
Denied, Not Covered by Plan	0	2	4	4	0	10
Denied Authorization Insufficient Medical Information	0	0	0	1	0	1
Denied Service Out of Plan	0	3	4	1	0	8
Total Number of Denied Requests	**0**	**2**	**4**	**7**	**0**	**13**

Appendix A

Medical Discharges by Facility and Level of Care

Facility	Total Admits	Total Days	Level Of Care	ALOS by Level of Care
BANNER CHURCHILL COMMUNITY HOSP	1	1	Acute	1
CARSON NURSING &REHAB C	2	21	SNF	11
CARSON TAHOE BEHAVIORAL HLTH SVCS	6	57	Mental Health	10
CARSON TAHOE REGIONAL MEDICAL CTR	32	81	Acute	3
CARSON TAHOE REGIONAL MEDICAL CTR	1	4	Mental Health	4
LUCILE SALTER PACKARD CHILDRENS HOSLPITA	1	5	Acute	5
NORTHEASTERN NEV R/H	4	8	Acute	2
PERSHING GENERAL HOSPITAL	1	18	SNF	18
RENO BEHAVIORAL HEALTHCARE HOSP	6	42	Mental Health	7
RENOWN REGIONAL MEDICAL CENTER	67	278	Acute	4
RENOWN REHAB HOSPITAL	3	18	Rehab	6
RENOWN SOUTH MEADOWS	8	13	Acute	2
RONALD REAGAN UCLA MEDICAL CENTER	1	1	Acute	1
SUNRISE HOSPITAL & MEDICAL CTR	1	6	Acute	6
SUTTER GENERAL HOSPITAL	1	6	Acute	6
SUTTER ROSEVILLE MEDICAL	1	10	Rehab	10
U OF U HOSPITAL CLINICS	1	2	Acute	2
UTAH VALLEY REGIONALMEDICAL CENTER	1	1	Acute	1
WEST HILLS HOSPITAL-NV	4	10	Mental Health	3

Performance Standards & Guarantees – Self Reported

4th Quarter Plan Year 2018 04/01/2018 – 06/30/2018		
Service Performance Standard (Metric)	Guarantee Measurement	Pass/Fail
I. Quarterly and annual management reports	**100%** - Delivery of Quarterly reports within 45 days of end of reporting period as established by PEBP.	Pass
II. Notification of potential high expense cases*	**95.0%** - Designated PEBP staff will be notified within 5 business days of the UM vendors initial notification of requested service.	Pass
III. Pre-certification information shall be provided to PEBP's Fourth party administrator	**98%** - Pre-certification requests from healthcare providers shall be communicated to PEBP's Fourth party administrator using an approved method e.g. electronically, within 5 business days of UM completing pre-certification determination.	Pass
IV. Concurrent hospital review	**98%** - Concurrent hospital reviews shall be completed and communicated using an approved method e.g. electronically within 5 business days of determination decision.	Pass

*High expense case is defined as a single-claim or treatment plan expected to exceed $1,000,000.

4.3.3.

4. Consent Agenda (Deonne Contine, Board Chair) (**All Items for Possible Action**)

   Consent items will be considered together and acted on in one motion unless an item is removed to be considered separately by the Board.

   4.3. Receipt of annual vendor reports for timeframe July 1, 2018 - June 30, 2019:

      4.3.3. The Standard Insurance – Basic Life and Long Term Disability Insurance

The Standard

Quarterly Report: Basic Life Insurance and Long Term Disability:
Quarter Ending
June 30, 2019

Report Table of Contents

Basic Life Insurance & Long Term Disability Executive Summary

Most Recent Five Plan Years: July 01, 2014 to June 30, 2019

This is the final report for the 2018-19 plan year, providing updated information for the period beginning July 1, 2014 and ending June 30, 2019.

Basic Life

Basic Life claim incidence and loss ratios were up in the 2018-19 plan year compared to the prior plan year. Incidence (page 4) was up slightly for actives (1.5 compared to 1.3/1,000) and retirees (14.8 compared to 14.3). The loss ratios (page 5) for actives and retirees were both up, actives slightly at 28% compared to 23% last year and retirees significantly at 315% compared to 267%. The overall loss ratio for Basic Life was up considerably, 93% compared to 79% last year. The Basic Life plan suffered a loss of $651,000 for the plan year, driven by increased claims and the 5% rate reduction that went into effect July 1, 2018.

One interesting note for this plan year is incidence and loss ratio for non-state retirees (page 6). For the first time in a number of years, the loss ratio for non-state retirees was higher than the ration for state retirees, 330% compared to 308% for state retirees.

Long Term Disability

LTD claim incidence (page 7) is reported on an incurred basis; claims are charged to the plan year in which disability began. While we don't have complete information, it appears the 2018-19 plan year will see a slight increase in incidence. While incidence is up slightly, it is still very much in line with plan expectations.

LTD loss ratios (page 8) are reported on a cash basis, without regard for incurred date. The ratio for the 2018-19 plan year (42%) was up over the 2017-18 plan year (31%). Though it's up, it's still within plan expectations, much like the incidence result, .

For the 2018-19 plan year, LTD premium exceeded claims and expenses by $1.3 million, reducing the all year's deficit to $3.5 million.

Basic Life Insurance Claims by Plan Year and Participant Type

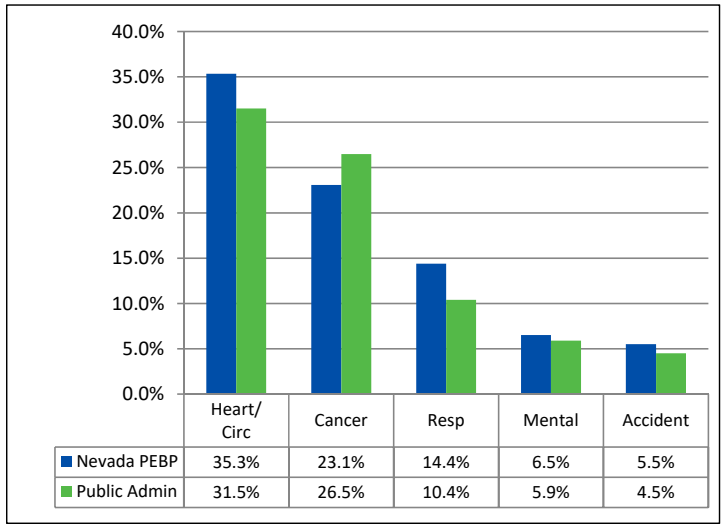
Most Recent Five Plan Years: July 01, 2014 to June 30, 2019

	From Jul-14 Through Jun-15		From Jul-15 Through Jun-16		From Jul-16 Through Jun-17		From Jul-17 Through Jun-18		From Jul-18 Through Jun-19	
Participant Type	**Count**	**Inc./ 1000**	**Count**	**Inc./ 1000**	**Count**	**Inc./ 1000**	**Count**	**Inc./ 1000**	**Count**	**Inc./ 1000**
Actives	39	1.7	41	1.7	51	2.0	41	1.6	41	1.5
Retirees	268	19.2	270	18.3	320	21.5	293	19.3	232	14.8
Totals	**307**	**8.3**	**311**	**7.9**	**371**	**9.3**	**334**	**8.1**	**273**	**6.5**

Basic Life Insurance Claims by Diagnostic Category

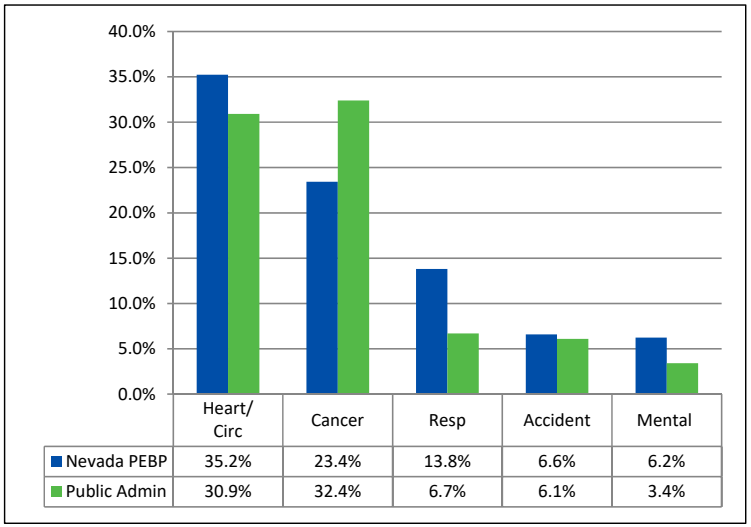
Public Admin benchmark is from SIC book of business for most recent 5 calendar years

Top Five Diagnostic Categories by Incidence



	Heart/ Circ	Cancer	Resp	Mental	Accident
Nevada PEBP	35.3%	23.1%	14.4%	6.5%	5.5%
Public Admin	31.5%	26.5%	10.4%	5.9%	4.5%

Top Five Diagnostic Categories by Liability

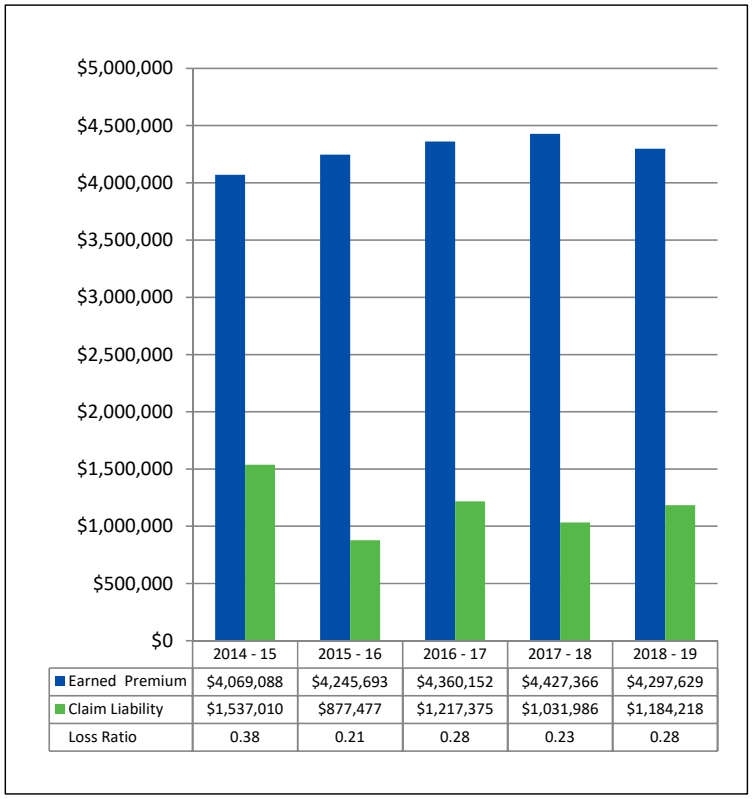


	Heart/ Circ	Cancer	Resp	Accident	Mental
Nevada PEBP	35.2%	23.4%	13.8%	6.6%	6.2%
Public Admin	30.9%	32.4%	6.7%	6.1%	3.4%

Basic Life Insurance Earned Premiums & Liability by Participant Type

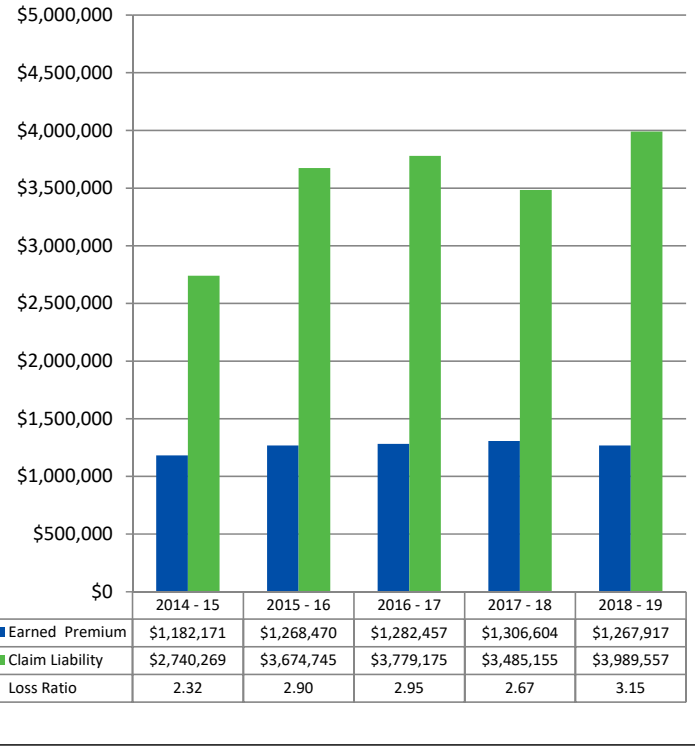
Most Recent Five Plan Years: July 01, 2014 to June 30, 2019

Active Participants



	2014 - 15	2015 - 16	2016 - 17	2017 - 18	2018 - 19
Earned Premium	$4,069,088	$4,245,693	$4,360,152	$4,427,366	$4,297,629
Claim Liability	$1,537,010	$877,477	$1,217,375	$1,031,986	$1,184,218
Loss Ratio	0.38	0.21	0.28	0.23	0.28

Retired Participants

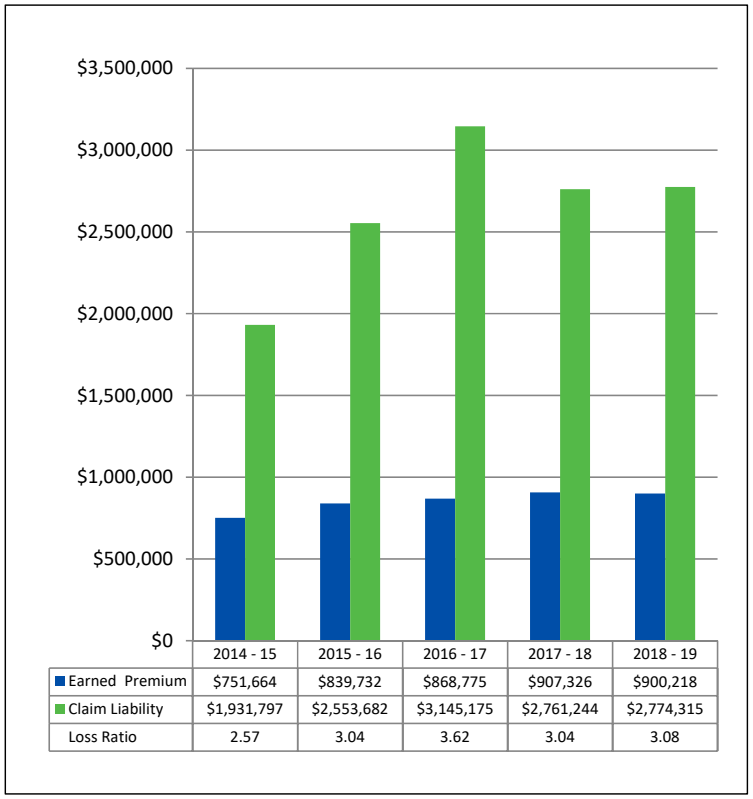


	2014 - 15	2015 - 16	2016 - 17	2017 - 18	2018 - 19
Earned Premium	$1,182,171	$1,268,470	$1,282,457	$1,306,604	$1,267,917
Claim Liability	$2,740,269	$3,674,745	$3,779,175	$3,485,155	$3,989,557
Loss Ratio	2.32	2.90	2.95	2.67	3.15

Basic Life Retiree Insurance Earned Premiums & Liability by Participant Type

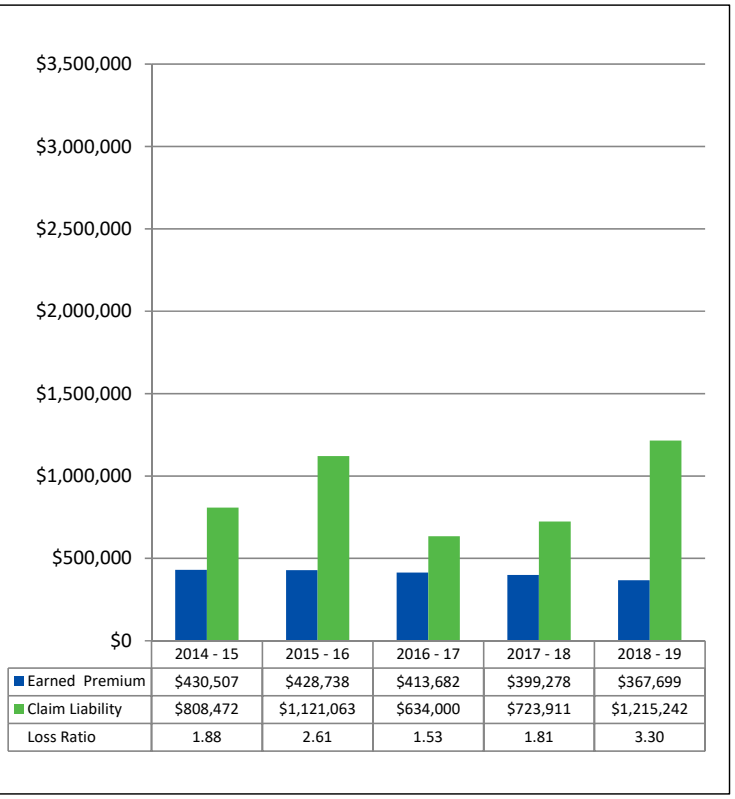
Most Recent Five Plan Years: July 01, 2014 to June 30, 2019

State Retired Participants



	2014 - 15	2015 - 16	2016 - 17	2017 - 18	2018 - 19
Earned Premium	$751,664	$839,732	$868,775	$907,326	$900,218
Claim Liability	$1,931,797	$2,553,682	$3,145,175	$2,761,244	$2,774,315
Loss Ratio	2.57	3.04	3.62	3.04	3.08

Non-State Retired Participants



	2014 - 15	2015 - 16	2016 - 17	2017 - 18	2018 - 19
Earned Premium	$430,507	$428,738	$413,682	$399,278	$367,699
Claim Liability	$808,472	$1,121,063	$634,000	$723,911	$1,215,242
Loss Ratio	1.88	2.61	1.53	1.81	3.30

Long Term Disability Claims by Plan Year

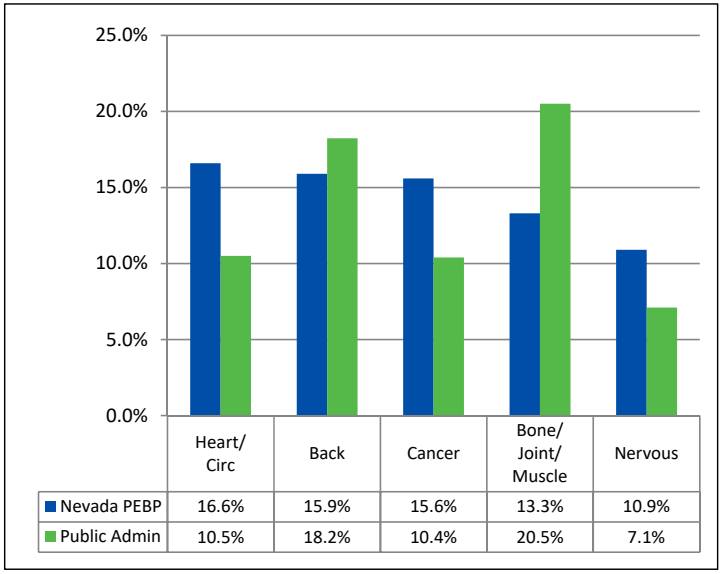
Most Recent Five Plan Years: July 01, 2014 to June 30, 2019

	From Jul-14 Through Jun-15		From Jul-15 Through Jun-16		From Jul-16 Through Jun-17		From Jul-17 Through Jun-18		From Jul-18 Through Jun-19	
	Count	Inc./ 1000	Count	Inc./ 1000	Count	Inc./ 1000	Count	Inc./ 1000	Count	Inc./ 1000
LTD Claims	47	2.0	28	1.1	36	1.4	29	1.1	15	0.6

Long Term Disability Claims by Diagnostic Category

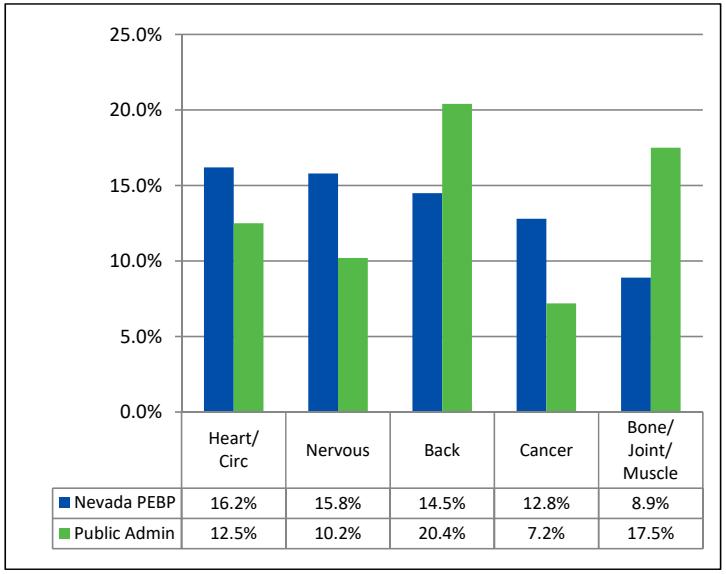
Public Admin benchmark is from SIC book of business for most recent 5 calendar years

Top Five Diagnostic Categories by Incidence



	Heart/ Circ	Back	Cancer	Bone/ Joint/ Muscle	Nervous
Nevada PEBP	16.6%	15.9%	15.6%	13.3%	10.9%
Public Admin	10.5%	18.2%	10.4%	20.5%	7.1%

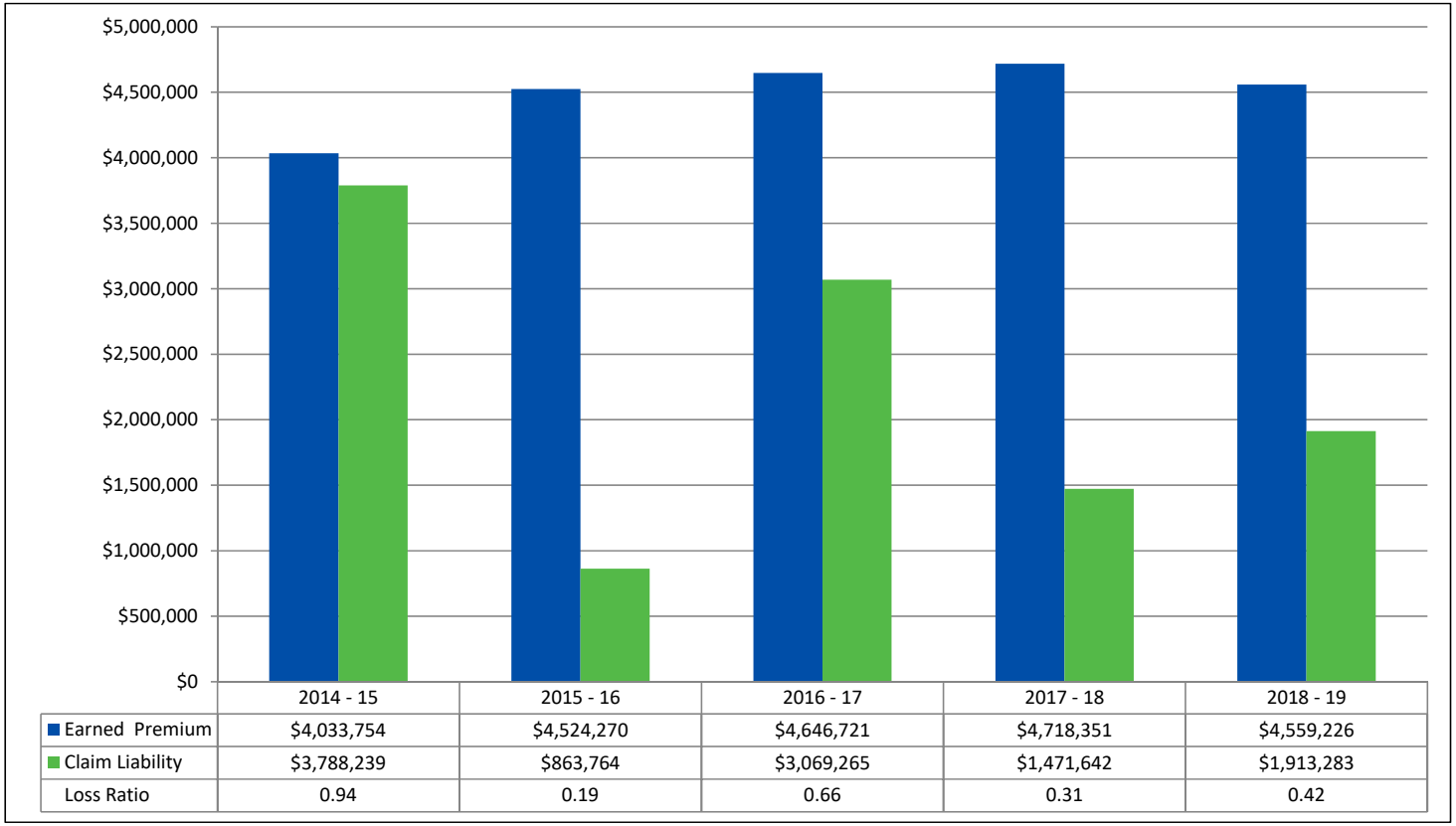
Top Five Diagnostic Categories by Liability



	Heart/ Circ	Nervous	Back	Cancer	Bone/ Joint/ Muscle
Nevada PEBP	16.2%	15.8%	14.5%	12.8%	8.9%
Public Admin	12.5%	10.2%	20.4%	7.2%	17.5%

Long Term Disability Earned Premiums & Liability

Most Recent Five Plan Years: July 01, 2014 to June 30, 2019



	2014 - 15	2015 - 16	2016 - 17	2017 - 18	2018 - 19
Earned Premium	$4,033,754	$4,524,270	$4,646,721	$4,718,351	$4,559,226
Claim Liability	$3,788,239	$863,764	$3,069,265	$1,471,642	$1,913,283
Loss Ratio	0.94	0.19	0.66	0.31	0.42

Claim Appeals

Quarterly Update for Plan Year to Date July 01, 2018 to June 30, 2019

	In Process	Decision Upheld	Decision Overturned	Total
Claim Appeals				
Life Insurance Claims	0	2	0	2
Long-Term Disability Claims	0	2	3	5
Short-Term Disability Claims	0	0	0	0
Total Appeals	**0**	**4**	**3**	**7**

4.3.4.

4. Consent Agenda (Deonne Contine, Board Chair) (**All Items for Possible Action**)

   Consent items will be considered together and acted on in one motion unless an item is removed to be considered separately by the Board.

   4.3. Receipt of annual vendor reports for timeframe July 1, 2018 - June 30, 2019:

      4.3.4. Willis Towers Watson's Individual Marketplace Quarterly Report for Q4, 2019

Nevada Public Employees Benefit Program

Quarterly Update – 4th Quarter Plan Year 2019

Willis Towers Watson's Individual Marketplace

August 13, 2019

The Public Employees Benefit Program Executive Dashboard

Quarterly Update – 4th Quarter Plan Year 2019

Executive Summary

Plan Enrollment:

- At the end of Q4 2019, PEBP's total enrollment into Medicare policies through Willis Towers Watson's Individual Marketplace increased to 12,764. Since inception, 100 carriers have been selected by PEBP's retirees with current enrollment in 1,210 different plans.
- Medicare Supplement (MS) plan selection remained consistent at 80% of the total population with the majority of participants selecting AARP and Anthem BCBS of Nevada as their insurer; each carrier holds plans for 6,392 and 2,049 enrollees respectively. The average monthly premium cost for MS plans remained consistent at $147.
- The percentage of Medicare Advantage (MA or MAPD) plans selected remaining consistent at 20%. Top MA carriers include Hometown Health Plan with 1,335 individual plan selections and Humana with 379 individual plan selections. The average monthly premium cost to PEBP participants is $28.

Customer Satisfaction:

- Q4 2019, PEBP participant satisfaction with Enrollment Calls had an average satisfaction score result of 4.8 out of 5.0 based on 78 surveys returned.
- For Q3 2019, the average satisfaction score results were 4.4 out of 5.0. For Q4 2019, the score was 4.4 with 223 survey responses.
- The combined average satisfaction score for Enrollment Calls and Service Calls was 4.5 out of 5.0 for Q4 2019.
- For Funding Calls, PEBP customer satisfaction was 4.1 out of 5.0. This was a decrease when compared to Q3 2019. There were 146 survey responses in Q3 compared to 140 survey responses for Q4.

Health Reimbursement Arrangement:

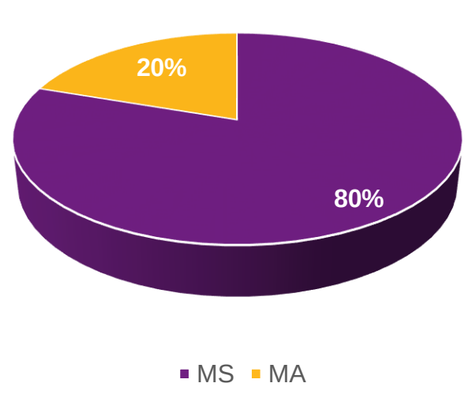
- At the end of Q4 2019 there were 12,422 Health Reimbursement Arrangement (HRA) accounts for PEBP participants.
- There were 85,109 claims submitted against the HRA for reimbursement in Q4, with 82.7% being submitted via Auto-Reimbursement, meaning that participants did not have to manually submit 70,410 claims for Premium Reimbursement.
- The total reimbursement amount processed for Q4 was $7,204,139.

Summary of Retiree Decisions and Costs

Retiree Plan Selection Through 6/30/2019		Previous Qtr
Total enrolled through individual marketplace	12,764	12,731
Number of carriers**	100	100
Number of plans**	1,210	1,204

Plan Type Selection Through 6/30/2019		Previous Qtr
Medicare Advantage (MA, MAPD)	2,525	2,520
Medicare Supplement (MS)	10,240	10,212

Medical Enrollment



"The percentage of Medicare Advantage plans selected by PEBP's retiree population is now slightly below the average for Willis Towers Watson's Book of Business.

Plan Type	Number Enrolled	Average Premium
Medicare Supplement	10,240	$147
Medicare Advantage (MA,MAPD)	2,525	$0 / $28
Part D drug coverage	8,544	$26
Dental coverage	1,129	$36
Vision coverage	1,872	$14

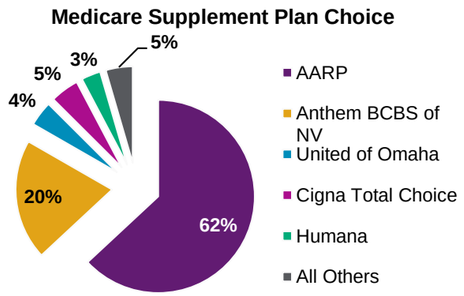
** Reflects total carriers and plans that PEBP participants have enrolled in nationwide, since inception.

The Public Employees Benefit Program Executive Dashboard

Quarterly Update – 4th Quarter Plan Year 2019

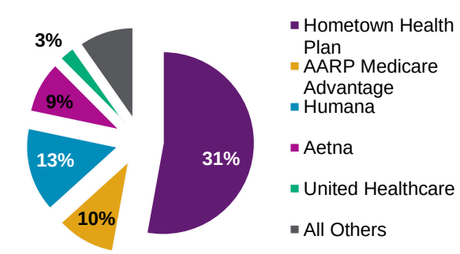
Summary of Retiree Carrier Choice

Top Medicare Supplement Plans	Total
AARP	6,392
Anthem BCBS of NV	2,049
United of Omaha	423
Cigna Total Choice	486
Humana	327



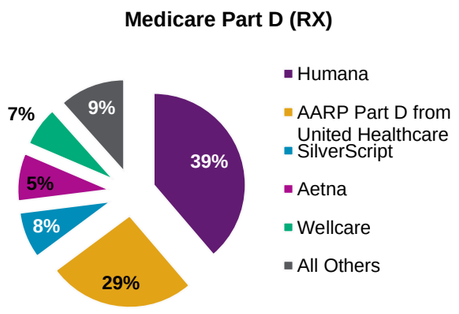
Cost Data For MS Plans	Cost
Minimum	$22
Average	$147
Median	$143
Maximum	$411

Top Medicare Advantage Plans	Total
Hometown Health Plan	1,335
Humana	379
AARP Medicare Advantage	263
Aetna	233
United Healthcare	69



Cost Data For MA Plans	Cost
Minimum	$0
Average	$28
Median	$0
Maximum	$223

Top Medicare Part D (RX)	Total
Humana	3,287
AARP Part D from United Healthcare	2,207
SilverScript	683
Aetna	771
WellCare	674



Cost Data For Part D (RX)	Cost
Minimum	$10
Average	$27
Median	$23
Maximum	$130

The Public Employees Benefit Program Executive Dashboard

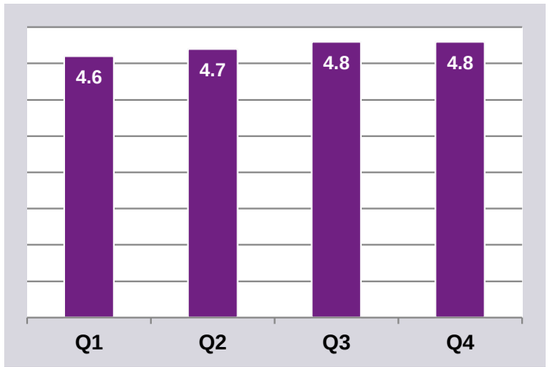
Quarterly Update – 4th Quarter Plan Year 2019

Customer Service – Voice of the Customer (VoC)

Individual Marketplace conducts phone and email surveys of all participant transactions. Each survey contains approximately 12-16 questions. Responses are scanned by IBM Mindshare Analytics which expose trends within an hour, alerting Individual Marketplace of issues and allowing for real-time feedback and adjustments

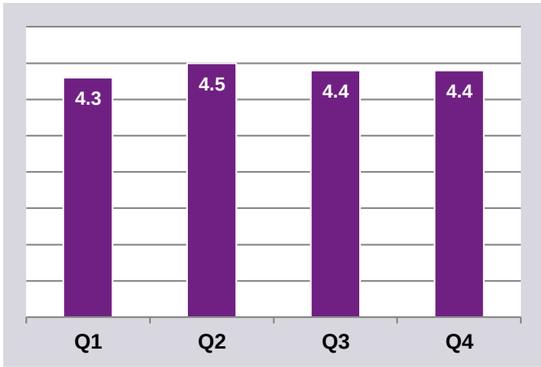
Q4 Enrollment Satisfaction

CSAT score	Count	%
5	67	86%
4	6	8%
3	5	6%
2	0	0%
1	0	0%
	78	**100%**



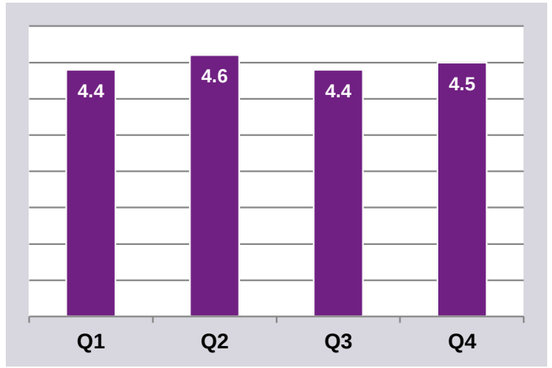
Q4 Service Satisfaction

CSAT score	Count	%
5	151	68%
4	36	16%
3	15	7%
2	8	4%
1	13	6%
	223	**100%**



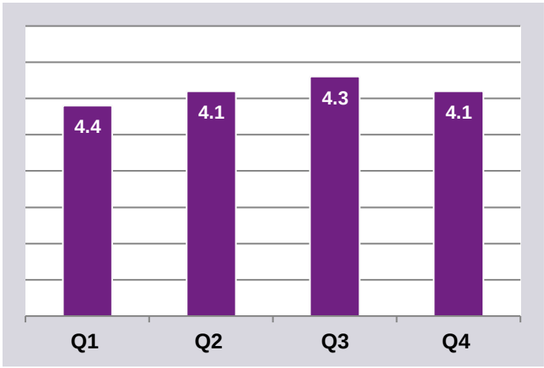
Q4 Enrollment & Service Combined

CSAT score	Count	%
5	218	72%
4	42	14%
3	20	7%
2	8	3%
1	13	4%
	301	**100%**



Q4 HRA Satisfaction

CSAT score	Count	%
5	77	55%
4	27	19%
3	17	12%
2	10	7%
1	9	6%
	140	**100%**

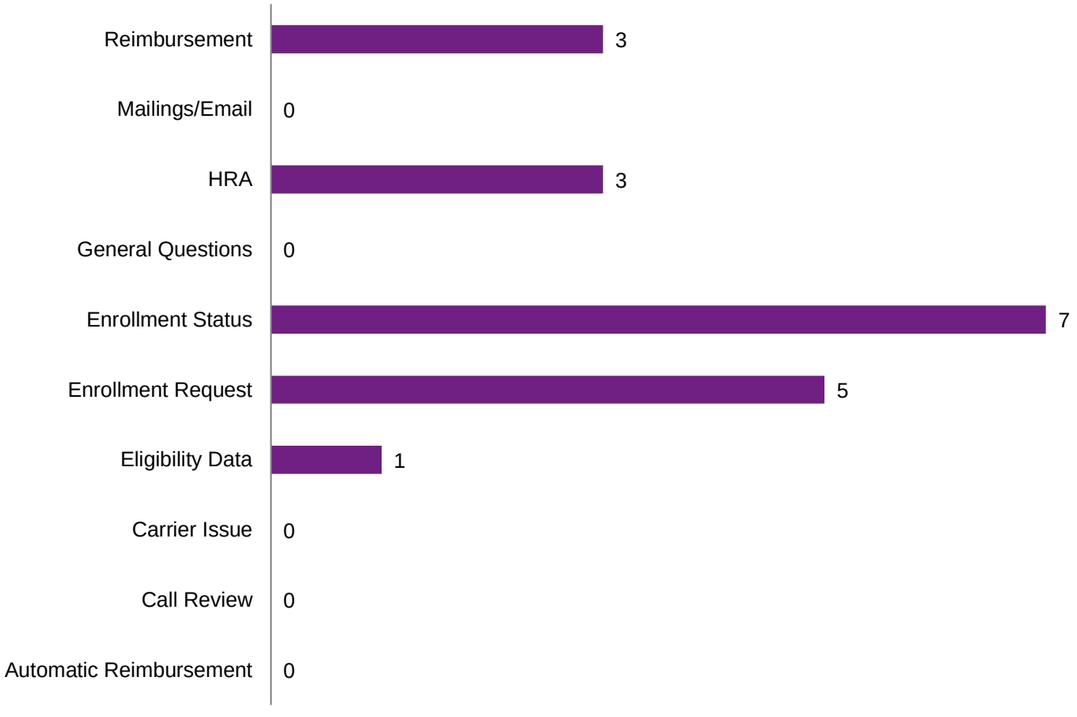


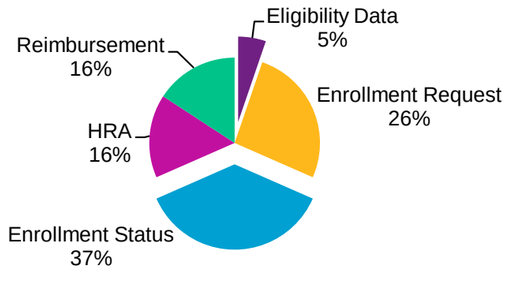
The Public Employees Benefit Program Executive Dashboard

Quarterly Update – 4th Quarter Plan Year 2019

Customer Service – Issues Log Resolution

Each quarter a certain number of participant inquiries are received by both PEBP and Willis Towers Watson that require escalation to Individual Marketplace Issues Log. Items on the Issues Log are carefully evaluated and continuously monitored by seasoned Willis Towers Watson staff until resolution is reached. The total number of inquiries reviewed during Q4-PY19 is 19 and are associated with the following categories:





Health Reimbursement Account (HRA)

Claim Activity for the Qtr.	Total
HRA accounts	12,422
Number of claims paid	85,109
Accounts with no balance	6,359
Claims paid amount	$7,204,139.18

Claims By Source	Total
A/R file	70,410
Mail	11,226
Web	3,473

Call Category	Total
General / Instructional	923
Denial Reason Explanation	121
Other	85
Overpayment	47
Date EFT / Mail Issued	33

The Public Employees Benefit Program Executive Dashboard

Quarterly Update – 4th Quarter Plan Year 2019

Performance Guarantees*

Category	Commitment	Outcome	PG MET
Claims turnaround time	≤ 2 days	0.14 Days	Yes
Claim financial accuracy	≥ 98%	99.26%	Yes
Claim processing financial accuracy	≥ 98%	98.49%	Yes
HRA call center abandon rate	≤ 5%	1.23%	Yes
HRA customer service - avg. speed to answer	≤ 30 seconds	20.2 Seconds	Yes
Reports	≤ 10 business days	As Scheduled	Yes
HRA web services	≥ 99%	>99%	Yes
Benefits admin customer service avg. speed to answer Q4	≤ 5 minutes	15 Seconds	Yes

*Please note that the performance guarantees are ultimately measured based on the annual audit period.

The Public Employees Benefit Program Executive Dashboard

Quarterly Update – 4th Quarter Plan Year 2019

Operations Report

Fall Retiree Meetings:

The Fall Retiree Meetings will be held on October 9, 10, and 11 in Las Vegas, Carson City, and Reno. At each location there will be two meetings per day with the morning meeting focusing on participants aging-in to Medicare and the afternoon meeting focusing on the HRA for those that are already Medicare eligible. Nevada PEBP will mail a communication to participants in the area of these meetings in September.

Date	Location
October 9	College of Southern Nevada North Las Vegas Campus Horn Theatre 3200 E. Cheyenne Ave North Las Vegas, NV 89030
October 10	Nevada Army National Guard Auditorium 2460 Fairview Dr. Carson City, NV 89701
October 11	Truckee Meadows Community College Sierra Building, Room 105 7000 Dandini Boulevard Reno, NV 89512

Communications:

Below is information on communications that are currently in process or will be coming up.

- Fall Newsletter
  - This communication is sent to participants via mail and is targeted to be sent out starting the week of August 26. The intent of this communication is to educate participants on different areas like Annual Enrollment, Medicare, HRA, Direct Deposit, and Auto-Reimbursement functionality.
- Fall Balance Reminder
  - This communication reminds participants of the balance in their HRA if they have not had any claims processed in the last 90 days. It is mailed to participants starting in mid-September.

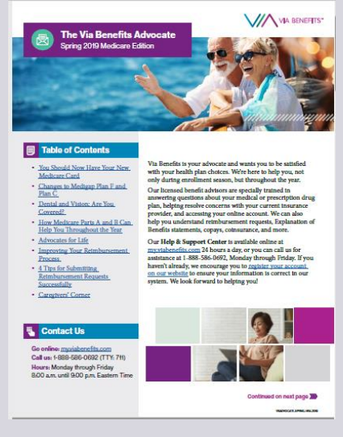

The Via Benefits Advocate
Spring 2019 Medicare Edition

Table of Contents

- You Should Now Have Your New Medicare Card
- Changes to Medigap Plan F and Plan C
- Dental and Vision: Are You Covered?
- How Medicare Parts A and B Can Help You Throughout the Year
- Advocates for Life
- Improving Your Reimbursement Process
- 4 Tips for Submitting Reimbursement Requests Successfully
- Caregivers' Corner

Contact Us

Via Benefits is your advocate and wants you to be satisfied with your health plan choices. We're here to help you, not only during enrollment season, but throughout the year.

Our licensed benefit advisors are specially trained in answering questions about your medical or prescription drug plan, helping resolve concerns with your current insurance provider, and accessing your online account. We can also help you understand reimbursement requests, Explanation of Benefits statements, copays, coinsurance, and more.

Our **Help & Support Center** is available online at myviabenefits.com 24 hours a day, or you can call us for assistance at 1-888-586-0692, Monday through Friday. If you haven't already, we encourage you to register your account on our website to ensure your information is correct in our system. We look forward to helping you!

Continued on next page

The Public Employees Benefit Program Executive Dashboard

Quarterly Update – 4th Quarter Plan Year 2019

Nevada PEBP Historical Call Statistics

The below charts reflect the historical call statistics for Nevada PEBP for 2019.

Month	Average Wait Time	Total Calls	Abandoned Calls	Average Handle Time	Outreach Attempts
January	1m 10s	2,623	89	22m 17s	356
February	24s	1,732	11	22m 23s	160
March	14s	1,584	5	23m 24s	228
April	14s	1,602	6	24m 00s	230
May	15s	1,780	3	24m 41s	192
June	15s	1,475	4	26m 58s	201
July	15s	2,070	3	25m 38s	227
August					
September					
October					
November					
December					

The Public Employees Benefit Program Executive Dashboard

Quarterly Update – 4th Quarter Plan Year 2019

Nevada PEBP Historical Call Statistics

The below charts reflect the historical call statistics for Nevada PEBP for 2018.

Month	Average Wait Time	Total Calls	Abandoned Calls	Average Handle Time	Outreach Attempts
January	03m 32s	2,671	223	21m 39s	266
February	25s	1,890	8	18m 01s	318
March	22s	2,001	13	19m 03s	354
April	13s	1,750	7	21m 01s	170
May	14s	1,653	3	22m 45s	192
June	13s	1,615	8	23m 47s	329
July	16s	1,589	2	25m 18s	282
August	15s	1,379	0	26m 19s	224
September	15s	1,686	1	22m 56s	336
October	37s	2,484	36	29m 16s	357
November	33s	2,441	23	32m 10s	271
December	34s	2,241	24	25m 27s	322

4.4.

4. Consent Agenda (Deonne Contine, Board Chair) (**All Items for Possible Action**)

    4.4. Acceptance of Health Claim Auditors, Inc. quarterly audit of HealthSCOPE Benefits for the timeframe April 1, 2019 – June 30, 2019 to include: report from Health Claim Auditors; HealthSCOPE Benefits response to audit report; and acceptance of audit report findings and assessment of penalties, if applicable, in accordance with performance guarantees included in the contract pursuant to the recommendation of Health Claim Auditors.

Claims and System Audit Report

for

Nevada PUBLIC EMPLOYEES' BENEFITS PROGRAM

PEBP

Health Matters.

Audit Period: PEBP Plan Year 2019, Quarter Four
April, May and June 2019

Audited Vendor:

HealthSCOPE BENEFITS

Healthy People
Healthy Business
Healthy Futures

Submitted By:
Health Claim Auditors, Inc.
September 2019

TABLE OF CONTENTS

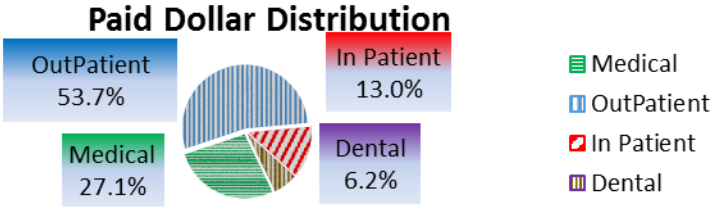
The following categories are reviewed each quarterly audit, however, because of their constant properties, the detail of each category will only be displayed within the first quarter audit of the PEBP fiscal year unless a change or defect is detected:

*HSB System	*HSB Policy/Procedure
*Eligibility	*Deductibles, Benefit Maximums
*Unbundling/Rebundling	*Concurrent Care
*Code Creeping	*Procedure, Diagnosis, Place of Service
*Experimental/Cosmetic Proc	*Medical Necessity Guidelines
*Patterns of Care	*Mandatory Outpatient/Inpatient Procedures
*Duplicate Claim Edits	*Adjusted Claims
*Hospital Discounts	*Hospital Bills and Audits
*Filing Limitation	*Unprocessed Claim Procedures
*R&C/Maximum Allowance	*Membership Procedures
*COBRA	*Provider Credentialing
*Coordination of Benefits	*Medicare
*Controlling Possible Fraud	*Security Access
*Quality Control/Internal Audit	*Internet Capabilities
*Communication, U/R and Claims Depts.	
*Claim Repricing	*Banking and Cash Flow
*Reporting Capabilities	*General System

EXECUTIVE SUMMARY

Audited Random Selection Data

Total number of claims: 500
Total Charge Value of random selection: $ 940,574.45
Total Paid Value of random selection: $ 276,915.57



Performance Guaranteed Metric Results

Metric	Guarantee Measurement	Actual	Pass/Fail
Payment Accuracy	≥ 98% of claims audited are to be paid accurately	98.8%	Pass
Financial Accuracy	≥ 99% of the dollars paid for the audited claims is to be paid accurately	99.30%	Pass
Claim Processing Turnaround Time	- 99% of all claims are to be processed within 30 days.	99.27%	Pass
Customer Service	-Telephone Response Time: ≤ 30 seconds. -Telephone Abandonment Rate: ≤ 2%. -First Call Resolution: ≥ 95%	14 sec. 1.09% 96.38%	Pass Pass Pass
Data Reporting	-100% of standard reports w/in 10 bus. days -Annual/Regulatory Documents w/in 10 business days of Plan Year end	No Exceptions Noted	Pass
Disclosure of Subcontractors	-Report access of PEBP data within 30 c. days -Removal of PEBP member PHI within 3 business days after knowledge	No Exceptions Noted	Pass

The following notations within the Executive Summary section are reported as follow up to previous findings and/or issues considered as an "outlier" of findings typically detected within the PEBP quarterly audits which require attention and/or acknowledgement for possible action(s).

Previous Recommendation(s)

HCA is pleased to report that all previous recommendations accepted by the PEBP Board of Directors has been implemented and/or in the process of application.

Current/Updated Findings

1) Savings Realized from PEBP Renown Hospital Neutral Negotiation(s)

In early 2018, the PEBP Executive Officer negotiated with Renown Hospital to maintain a "no financial increase" to services rendered to PEBP participants for the period of 01 May 2018 through 31 December 2019. This contract adjustment was approved by the PEBP Board of Directors in April 2018.

The Renown Hospital contract allows the Charge Master billings to be changed effective 01 May of each year. Most Inpatient rates are fixed, however, the majority of outpatient services are reimbursed on a percentage-off of billed charges basis. In order to maintain neutrality from one year to the next, HCA audits the Charge Master changes for each revenue code and obtains approval from the PEBP Executive Officer for application of repricing for claims with the new discount rates. HCA immediately audits the claim files at HealthSCOPE to ensure the new rates are utilized for repricing of claims.

During, the audit conducted this month (July 2019), HCA detected that the new rate(s) were not utilized in the repricing of PEBP claims incurred 01 May 2019 and later until mid-July 2019. HCA requested a response from Hometown Health regarding their intent to adjust these claims for accuracy. Hometown Health responded that 1,214 claims were affected and they will reprice and provide HealthSCOPE with each correction.

The Renown Hospital Charge Master was increased by 4.7% for the period of 01 May 2018 – 30 April 2019 and 2.49% for the period of 01 May 2019 forward. HCA has calculated the savings experienced by PEBP due to the negotiations for financial neutrality of the Renown Hospital services rendered to PEBP participants since 01 May 2018 to be in excess of $1,619,500.00.

2) **Letters of Authorizations**

HTH contracting department may have some excluded services within their contracts that could be covered under "blanket" Letter of Authorizations (LOAs) that the claims repricing personnel and HSB are not provided.

This audit detected claims in which it was discovered that HTH has negotiated rates documented with LOAs for provider service(s) that would normally be edited as denied or inclusive and paid at $0 (i.e. CPT 99070, supplies and materials).
Providers with rendered services under this circumstance are requesting that PEBP pay for said services as they are listed on their negotiated contract(s) and have been denied by HSB within their normal adjudication processes. It is HCA's recommendation that PEBP support the HSB system adjudication edits as they are universally accepted within the industry. Providers that are entitled to payment(s) for services within denied or inclusive codes will need to correctly recode said services for proper reimbursement(s). It is also HCA's recommendation, that HTH document negotiated rates for PEBP claims within a contract versus a LOA.

3) **Repricing by Hometown Health**

Audits have detected a trend in which the allowable rates repriced by Hometown Health and provided to HSB for adjudication of PPO claims are incorrect. Examples of this audit include claims repriced as "NON PPO" causing HSB to apply Usual & Customary (U&C) rates. Other examples are hospital claims with surgical services where the surgical add-on allowable is not applied as per contract agreement.

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.

Incorrect rate due to network re-pricing;
Supporting reference nos. 143, 454 and 503

Multiple Surgical reduction not applied;
Supporting reference nos. **049** and **055**

Incorrect network used;
Supporting reference no. **058**

Multiple Surgical Guidelines calculated incorrectly;
Supporting reference no. 104B

Incorrect rate;
Supporting reference no. 170

Medical claim paid as preventive;
Supporting reference no. **172**

Bilateral surgery calculated incorrectly;
Supporting reference no. **214**

Unbundled lab;
Supporting reference no. **269**

PA penalty not applied;
Supporting reference no. 344

Claim denied in error due to network returning claim as non PPO;
Supporting reference no. 418

The audit revealed the following issues, which appear to be administered properly by HSB 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.

Inpatient copay not applied to newborn services;
Supporting reference nos. 504 and 507

Telemedicine Doctor on Demand claim paid at 80% versus copay;
Supporting reference no. 116

Specialist copay applied for entire visit/services;
Supporting reference no. 135

DME requires PA for "cost" = charge greater than $100.00;
Supporting reference no. 344

Renown claim to be adjusted to pay at rates effective in June 2019;
Supporting reference no. 371

Specialty Imaging and Diagnostic Testing copay applied per test;
Supporting reference no. 399

CPT 92014 with routine vision diagnosis applied medical specialist copay versus vision copay;
Supporting reference no. 412

All Other (Non-Specialty) Imaging and Diagnostic Testing (including X-rays and ultrasounds) copay taken per date of service;
Supporting reference no. 477

CLAIM PROCEDURES/SYSTEM CAPABILITIES/SUPPORT DATA

Introduction

In July 2019, Health Claim Auditors, Inc. (HCA) performed a Claims and System Audit of HealthSCOPE Benefits (HealthSCOPE) located in Little Rock, Arkansas on behalf of The State of Nevada Public Employees' Benefits Program (PEBP).

This audit was performed by collecting information to assure that HealthSCOPE is doing an effective job of controlling claim costs while paying claims accurately within a reasonable period of time. This report was presented to HealthSCOPE for any additional comments and responses on 25 July 2019.

Breakdown of Claims Audited

The individual claims audited were randomly selected from PEBP's claims listings as supplied by HealthSCOPE. These claims had dates of service ranging from March 2018 to June 2019 and were processed by HealthSCOPE from 01 April 2019 through 30 June 2019 (PEBP's Fourth Quarter Plan Year 2019). These claims were stratified by dollar volume to assure that HCA audited all types of claims. The audit also includes large dollar paid amounts that are considered as bias* selected claims.

*Bias claims are not part of the random selection but were audited by HCA because of some "out of the ordinary" characteristic of the claim. There are multiple criteria to identify the "out of the ordinary" characteristics. Examples are duplicates, CPT up coding, exceeding benefit limits, etc.

The breakdown of the 500 random selected claims audited is as follows:

Type of Service	Charge Amount	Paid Amount	Paid Distribution	No. of Claims
Medical	$ 211,536.17	$ 74,979.14	27.1%	321
Outpt. Hospital	$ 450,869.24	$ 148,933.00	53.7%	80
Inpt. Hospital	$ 241,778.54	$ 35,947.24	13.0%	5
Dental	$ 36,390.50	$ 17,056.19	6.2%	94
TOTAL	**$ 940,574.45**	**$ 276,915.57**	**100%**	**500**

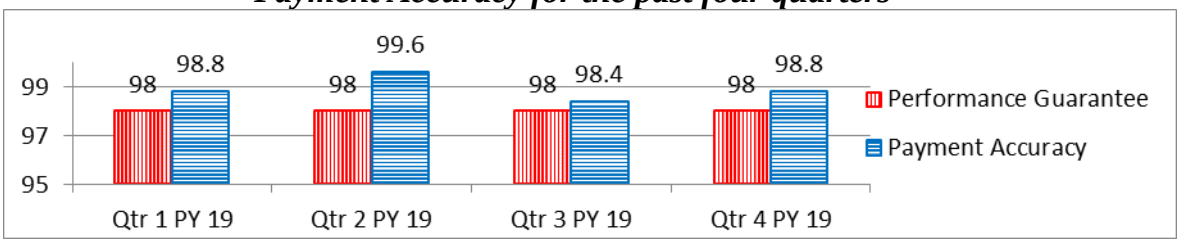
Payment Accuracy

Per PEBP, the Service Performance Standards and Financial Guarantees Agreement for the payment accuracy is to be 98% or above of claims adjudicated are to be paid correctly or a penalty of 2.5% of Quarterly Administration Fees for each percentage (%) point, or fraction thereof, below performance guarantee is to be applied. 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 HealthSCOPE random selection for this audited quarter is 98.8%.

Number of claims:	500
Number of claims paid incorrectly:	6
Percentage of claims paid incorrectly:	1.2%
Number of claims paid correctly:	494
Percentage of claims paid correctly:	98.8%

Payment Accuracy for the past four quarters



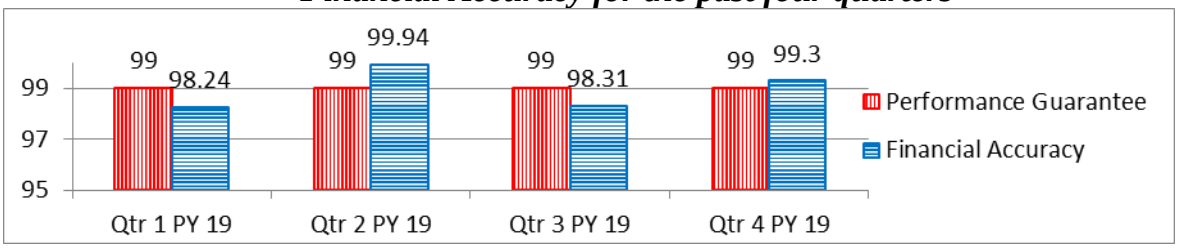
Financial Accuracy

Per PEBP, the Service Performance Standards and Financial Guarantees Agreement for the financial accuracy of the total dollars paid for claims adjudicated is to be paid correctly at 99% or above or a penalty of 2.5% of Quarterly Administration Fees for each percentage (%) point, or fraction thereof, below performance guarantee is to be applied. Financial Accuracy is calculated by dividing the total audited dollars paid correctly by the total audited dollars processed within the random selection.

The Financial Accuracy Percentage of paid dollars remitted correctly on the HealthSCOPE claims selected randomly for this audited quarter is 99.30%. This audit reflected twenty and six tenths percent (20.6%) of the audited errors within the valid random selection were overpayments.

Paid dollars audited	$ 276,915.57
Amount of paid dollars remitted incorrectly	$ 1,928.04
Percentage of Dollars paid incorrectly	0.70%
Paid Dollars of claims paid correctly	$ 274,987.53
Percentage of Dollars Paid correctly	99.30%

Financial Accuracy for the past four quarters



Historical Statistical Data of Performance Guarantees

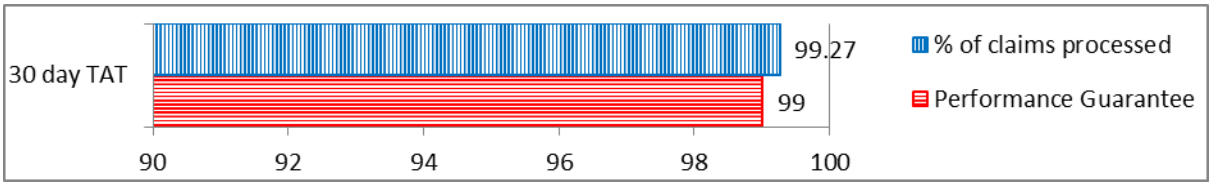
The following reflects the historical statistical data since the origin of PEBP medical claims administration by HealthSCOPE. The entries designated in **bold red type** are measurable categories with underperformance of the Service Performance Guarantees Agreement.

Period Audited	Payment Accuracy	Financial Accuracy	Turnaround Time	Telephone Response	Telephone Abandon Rate	First Call Resolution
1st Qtr PY 2012	95.7%	98.6%	7.6 days	:17	1.43%	N/A
2nd Qtr PY 2012	**93.3%**	**97.3%**	12.7 days	:12	1.16%	N/A
3rd Qtr PY 2012	**96.8%**	**98.6%**	3.7 days	:18	1.32%	N/A
4th Qtr PY 2012	**95.8%**	99.5%	11.4 days	:14	0.93%	N/A
1st Qtr PY 2013	97.2%	99.4%	10.4 days	:20	1.06%	N/A
2nd Qtr PY 2013	98.5%	99.3%	7.3 days	:11	0.87%	N/A
3rd Qtr PY 2013	98.0%	**95.7%**	6.4 days	:25	1.98%	N/A
4th Qtr PY 2013	98.4%	99.7%	6.2 days	:29	1.61%	N/A
1st Qtr PY 2014	98.8%	99.6%	5.4 days	:14	0.84%	N/A
2nd Qtr PY 2014	99.2%	99.2%	5.9 days	:29	1.96%	N/A
3rd Qtr PY 2014	98.0%	**98.5%**	5.2 days	**:30.5**	1.92%	N/A
4th Qtr PY 2014	99.0%	99.8%	4.4 days	:28	1.96%	N/A
1st Qtr PY 2015	98.8%	99.27%	4.9 days	:29.4	1.94%	N/A
2nd Qtr PY 2015	99.0%	99.35%	8.1 days	:22	1.18%	N/A
3rd Qtr PY 2015	98.6%	99.8%	5.9 days	:29.7	1.97%	N/A
4th Qtr PY 2015	99.6%	**95.6%**	4.9 days	:29.4	1.91%	N/A
1st Qtr PY 2016	99.0%	**98.9%**	4.8 days	:29.1	1.94%	N/A
2nd Qtr PY 2016	98.6%	99.7%	3.5 days	:24.0	1.14%	N/A
3rd Qtr PY 2016	98.8%	**98.53%**	5.3 days	:29.0	1.96%	N/A
4th Qtr PY 2016	99.0%	99.52%	6.3 days	:29.5	1.98%	N/A
1st Qtr PY 2017	99.0%	99.23%	6.6 days	:29.8	1.93%	N/A
2nd Qtr PY 2017	99.6%	99.78%	4.3 days	:29.3	1.96%	N/A
3rd Qtr PY 2017	98.2%	**93.83%**	3.7 days	:29.8	1.97%	N/A
4th Qtr PY 2017	99.0%	99.66%	4.6 days	:29.3	1.98%	N/A
1st Qtr PY 2018	99.2%	99.83%	4.4 days	:26.0	1.61%	98.79%
2nd Qtr PY 2018	99.6%	99.9%	4.3 days	:12.8	1.12%	98.28%
3rd Qtr PY 2018	98.6%	99.7%	3.5 days	:28.5	1.97%	98.65%
4th Qtr PY 2018	99.4%	99.5%	4.2 days	:21.0	1.50%	97.65%
1st Qtr PY 2019	98.8%	**98.2%**	5.4 days	:21.0	1.49%	97.85%
2nd Qtr PY 2019	99.6%	99.9%	5.6 days	:21.0	1.40%	97.18%
3rd Qtr PY 2019	98.4%	**98.31%**	5.8 days	:14.0	1.21%	95.89%
4th Qtr PY 2019	**98.8%**	**99.30%**	**6.7 days**	**:14.0**	**1.09%**	**96.38%**

Turnaround Time

Per the Service Performance Standards and Financial Guarantees Agreement, the turnaround time for payments of claims is measured in calendar days from the date HealthSCOPE receives the claim until the date of process. Ninety nine percent (99%) of complete claims adjudicated are to be processed within thirty (30) calendar days, excluding federal holidays, or a penalty of two percent (2.0%) of Quarterly Administration fees for each two and a half percent (2.5%) of non-compliance complete claims is to be applied. HCA had requested the report that reflects the measurement of this issue. This report reflected that 99.27% of "complete" claims were processed within 30 calendar days, in compliance with the performance guarantee. This report also displayed the total turnaround process time for all claims at 6.7 days.

Turnaround Time Measurements



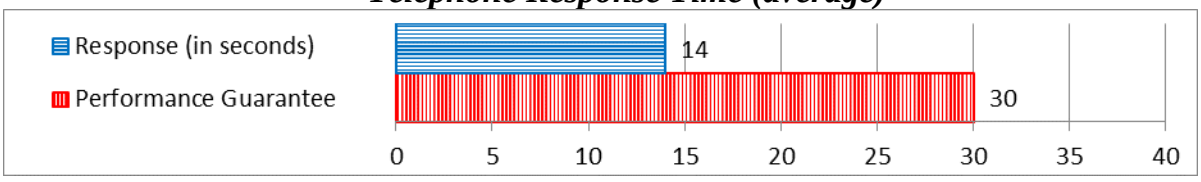
The turnaround time, measured only from the random selected claims, for Medical claims was 16.2 calendar days, Out Patient Hospital claims was 14.7 calendar days, In Patient Hospital claims was 16.4 calendar days and Dental claims was 2.1 calendar days.

During the audit period of 01 April 2019 to 30 June 2019, HealthSCOPE had received 1,241 PEBP e-mail inquiries for information via the internet. The average turnaround time for these inquiries was calculated at approximately 7.0 hours.

Customer Service Satisfaction

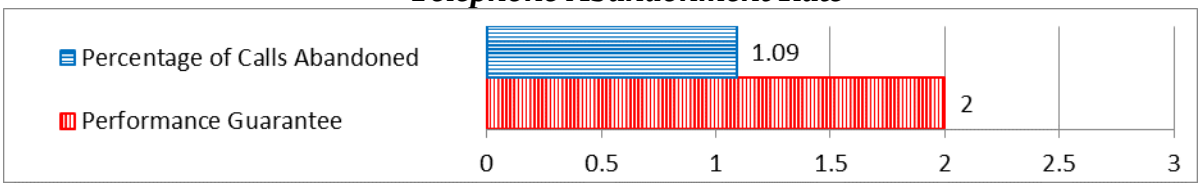
Per the Service Performance Standards and Financial Guarantees Agreement, the telephone response time reflects all calls must be answered within thirty (30) seconds or a penalty of one percent (1%) of Quarterly Administration fees for each second in non-compliance is to be applied. HCA has reviewed the appropriate report for the PEBP fourth fiscal quarter Plan Year 2019, which revealed the average incoming answer speed to be 14.0 seconds (0:14.0). The telephone response time was 14 seconds for April 2019, 13 seconds for May 2019 and 15 seconds for June 2019.

Telephone Response Time (average)



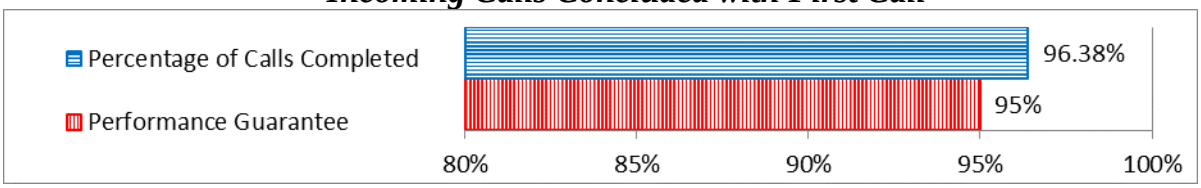
Per the Service Performance Standards and Financial Guarantees Agreement, the abandonment rate must be under two percent (2%) of total calls or a penalty of one percent (1%) of Quarterly Administration fees for each percentage point or fraction thereof in non-compliance is to be applied. HCA has reviewed the appropriate report for the PEBP fourth fiscal quarter Plan Year 2019, which revealed the abandoned calls ratio to be 1.09%. The telephone abandonment rate was 1.13% for April 2019, 0.92% for May 2019 and 1.22% for June 2019.

Telephone Abandonment Rate



Per the Service Performance Standards and Financial Guarantees Agreement, ninety five percent (95%) of incoming PEBP member problems must be resolved to conclusion on the first call or a penalty of one percent (1%) of Quarterly Administration fees for non-compliance is to be applied. HCA has reviewed the appropriate report for the PEBP fourth fiscal quarter Plan Year 2019, which revealed that HealthSCOPE documented 96.38% of incoming calls were brought to completion on the first call.

Incoming Calls Concluded with First Call



HealthSCOPE has eighty plus (80+) Customer Service Reps (CSRs), of which, the majority are in the Little Rock office with an average of eight (8) years experience.

Health SCOPE currently has eighteen (18) CSRs dedicated to the PEBP plan.

HealthSCOPE stated that customer service hours of operation will be applied to PEBP direction for proper service levels.

Benefit data is supplied by electronic documentation so that the analyst may explain benefit information to clients, members and providers by HealthSCOPE.

HealthSCOPE stated that the customer service representatives will not have the ability to make system changes.

HealthSCOPE's telephone conversations are documented for future reference.

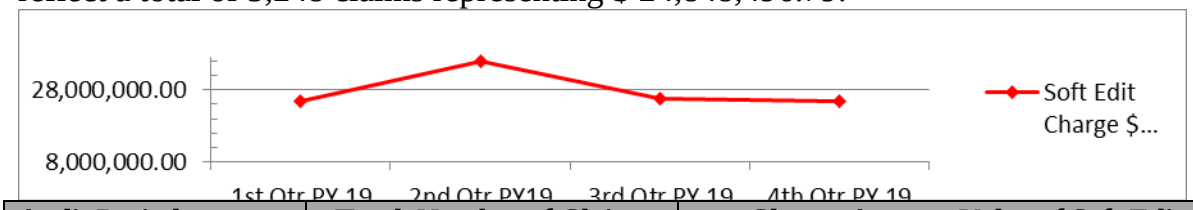
HealthSCOPE does have an audit process for Customer Service Representatives.

HealthSCOPE is able to monitor trends/errors found through Customer Service.

HealthSCOPE can conduct customer service satisfaction surveys to determine employee satisfaction of claims administration and service upon client request.

Soft Denied Claims

The audit identifies the volume of claims adjudicated and placed in a "soft denied" status. HCA recognizes and respects the need to place certain claims in a soft denied status such as claims that require additional information or special calculation of payment. It is important to include this data within this report to disclose the outstanding unpaid claims that could create an artificial debit/savings during the time that these claims were adjudicated. Note: The measurement of this data was provided as a "snapshot" report. The report reflected the "soft edit" amounts as they were reported on the specific day that the report was recorded. The report for the current claims placed in a "soft denied" status reflect a total of 5,248 claims representing $ 24,848,496.79.



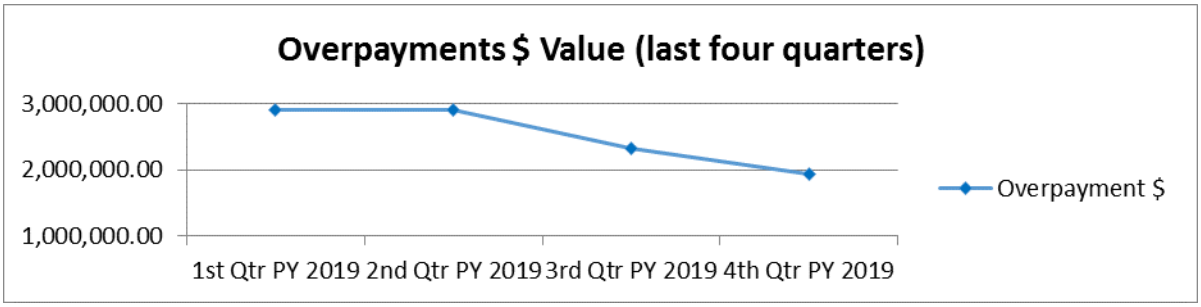
Audit Period	Total Number of Claims	Charge Amount Value of Soft Edits
1st Qtr PY 2012	2,607	$ 7,544,177.55
2nd Qtr PY 2012	4,068	$10,697,954.53
3rd Qtr PY 2012	1,536	$ 6,472,249.56
4th Qtr PY 2012	559	$ 2,205,318.16
1st Qtr PY 2013	1,053	$ 3,413,738.12
2nd Qtr PY 2013	1,107	$ 5,019,961.70
3rd Qtr PY 2013	1,023	$ 4,179,542.34
4th Qtr PY 2013	1,094	$ 3,049,481.74
1st Qtr PY 2014	1,389	$ 3,853,629.07
2nd Qtr PY 2014	1,157	$ 2,510,539.33
3rd Qtr PY 2014	1,621	$ 7,873,432.21
4th Qtr PY 2014	1.487	$ 4,665,197.77
1st Qtr PY 2015	1,404	$ 5,901,903.17
2nd Qtr PY 2015	1,668	$ 6,930,288.41
3rd Qtr PY 2015	2,897	$10,800,874.08
4th Qtr PY 2015	2,498	$10,685,255.24
1st Qtr PY 2016	3,071	$13,027,717.82
2nd Qtr PY 2016	2,543	$13,547,682.34
3rd Qtr PY 2016	2,871	$10,360,017.78
4th Qtr PY 2016	3,107	$15,262,995.27
1st Qtr PY 2017	2,580	$ 8,558,641.28
2nd Qtr PY 2017	3,876	$15,960,661.94
3rd Qtr PY 2017	3,696	$18,864,824.74
4th Qtr PY 2017	4,768	$20,217,736.28
1st Qtr PY 2018	3,926	$15,683,180.63
2nd Qtr PY 2018	4,073	$20,576,701.38
3rd Qtr PY 2018	4,144	$17,375,843.66
4th Qtr PY 2018	4,544	$21,591,987.11
1st Qtr PY 2019	4,624	$24,992,938.88
2nd Qtr PY 2019	5,558	$36,168,714.98
3rd Qtr PY 2019	5,476	$25,662,843.33
4th Qtr PY 2019	**5,248**	**$24,848,496.79**

Overpayments

HCA requested an overpayment report that reflects the identified current outstanding overpayments incurred since the beginning of the contract period with HealthSCOPE. This report reflected a current total potential recovery value of $1,940,930.88 (a decrease of $381,934.63). Detailed information regarding outstanding overpayments can be reviewed in a separate Supplemental Report, which for confidentiality purposes, is not included in this report but is made available to PEBP staff should they request it.

HSB's policy is to keep all identified overpayments active for potential recoupment(s The breakout of overpayments identified by the year paid are as follows:

Period	Due/Potential Recovery
- Fiscal Year 2012	$ 112,168.53
- Fiscal Year 2013	$ 160,772.50
- Fiscal Year 2014	$ 67,040.20
- Fiscal Year 2015	$ 186,963.44
- Fiscal Year 2016	$ 204,124.78
- Fiscal Year 2017	$ 133,766.26
- Fiscal Year 2018	$ 448,848.40
- Fiscal Year 2019	$ 627,246.77
TOTAL	$1,940,930.88



Of the 1,237 most current (Plan Year 2019) identified outstanding overpayments (HSB only), 71% were found to be caused by external sources that are not a cause of the HealthSCOPE adjudication processes. Breakout of the HealthSCOPE's most current (PY19) overpayments (by claim count) are listed by reason as follows:

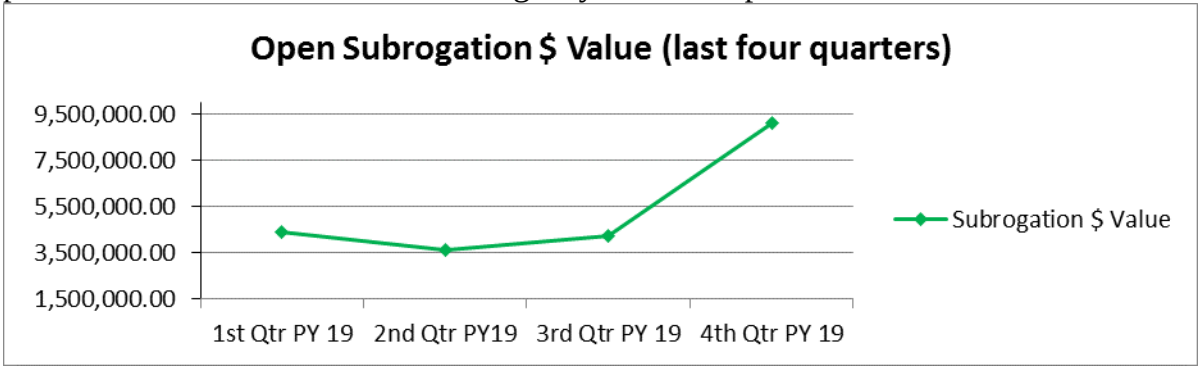
25.08%	SHO Pricing Correction
18.06%	No COB on file
14.68%	Incorrect Benefit Applied
11.29%	Provider caused, rebilled, charges billed in error, corrected EOB
8.63%	Corrected HTH Network Pricing
6.94%	Retro termination
3.06%	Incorrect Rate Applied
2.58%	Duplicate
2.18%	COB incorrectly calculated or not applied
1.05%	Paid in excess of max limit
0.97%	Previous Information Received
0.81%	Service not covered
0.73%	Category error
0.56%	Adjusted after medical review
0.48%	Processed under the incorrect provider
0.48%	Paid NON PPO as PPO
0.48%	Incorrect assignment applied
0.24%	Stop Payment
0.24%	Processed under incorrect patient
0.16%	Pharmacy claim deductible/Co-Insurance error
0.16%	Pre-Certification
0.16%	Eligibility
0.16%	Benefit Clarification
0.16%	Asst Surgeon paid as Surgeon
0.16%	Subrogation error
0.16%	Entry Error
0.16%	Denied in Error
0.08%	Paid PPO provider as NON PPO
0.08%	Multiple Surgery Reduction not applied

Subrogation

HCA requested a subrogation report that can be reviewed in a separate Supplemental Report, which for confidentiality purposes is not included in this report. It is made available to PEBP staff should they request it.

This report reflects open subrogation claims representing a current potential recovery amount of $9,082,279.44; an increase of $4,834,158.53 from the previous quarter. HCA note: this significant increase is due to the addition of six (6) claims with possible recoupment(s) of greater than $1,000,000.00 each.

Reports received from HealthSCOPE reflect that subrogation recoveries for the audited period was $78,211.63. After contingency fees were paid, PEBP received $58,658.73.



HealthSCOPE system will apply a pursue and pay subrogation policy as directed by PEBP. Per HealthSCOPE, subrogation is determined and pursued on all claims where the total amount paid equals to or exceeds $1000 (one thousand).

HealthSCOPE does identify possible subrogation cases internally. HealthSCOPE utilizes a third party vendor for recovery of monies. Vendors are paid a contingency of which the administrator receives a portion of and disclosed within RFP 1983 for Third Party Claims Administration.

HealthSCOPE does not conduct auditing of outstanding subrogation cases sent to their vendors, but sends any cases not picked up by the main vendor to another vendor for review.

HealthSCOPE depends on the external vendors to conduct the appropriate International Classification of Diseases (ICD) sweep checks for subrogation detections. HealthSCOPE is currently utilizing the new ICD-10 conversions and the coding has been completed within their system.

Per HealthSCOPE, claims related to Worker's Compensation are denied.

Recoupment and payments for subrogation claims are assigned as directed by PEBP.

High Dollar Claimants

Per the request of PEBP staff, HCA has requested a report to identify the number of active, retiree or COBRA elected participants or dependents who have obtained a plan paid level of $750,000.00 or greater.

This report reflected thirty-five (35) active members and thirty-five (35) dependents for a total of 65 active participants, who have obtained this level of plan payment participation representing an accrued dollar paid amount of $94,011,457.38.

Personnel

The audit included a review of the HealthSCOPE personnel dedicated or assigned to PEBP. The current Organization Chart for individuals assigned to the PEBP plan, is, with changes, as follows:

- State of Nevada Manager;
- Vice President – Quality Assurance;
- Sr. Vice President Operations Customer Care;
- Executive Account Manager;
- Client Relations Manager;
- Financial Operations Director;
- Provider Maintenance Specialist;
- Financial Analysts, 3 individuals;
- Funding Supervisor;
- Claims Administration Manager;
- Claims Administration Supervisor;
- Claims Analysts, **CHANGE**, 3 individuals added for a total of 15 individuals;
- Eligibility Director;
- Eligibility Supervisor;
- Customer Service Vice President;
- Customer Service Director;
- Customer Service Representatives, **CHANGE**, 2 individuals added and 2 removed for a total of 18 individuals;
- Scanning Services Manager;
- Recoveries Manager;
- Recoveries Specialists, 2 individuals;
- Vice President Data Services;
- Senior Data Analyst;
- Chief Information Officer;
- Data Architect
- Computer Domain Hosting (CDH) Services Manager;
- Sr. Vice President-Legal and Compliance;
- COBRA Service Manager;
- Customer Care Supervisor;
- Customer Care Representatives, 3 individuals.

HealthSCOPE POLICY/PROCEDURES/SYSTEM CAPABILITIES

This section details the HealthSCOPE adjudication system capabilities and operations as they pertain to the PEBP Health Plan. These operations typically do not change on a regular basis and remain redundant within subsequent audit reports, thereby, are only displayed within the first quarterly audit report for the fiscal year. The quarterly audit includes the review of the following operations, however, if any changes or defects are identified, they will be reported immediately within the audited period report:

- HealthSCOPE Policy/Procedures
- Eligibility
- Deductibles, Out-of-Pocket and Benefit Maximums
- Unbundling/Rebundling
- Concurrent Care
- Code Creeping
- Procedure, Diagnosis and Place of Service
- Experimental and Cosmetic Procedures
- Medical Necessity/Potential Abuse Guidelines and Procedures
- Patterns of Care and Treatment for Physicians
- Mandatory Outpatient/Inpatient Procedures
- Duplicate Claim Edits
- Adjusted Claims
- Hospital and Other Discounts
- Hospital Bills (UB-92) and Audits
- Filing Limitations
- Unprocessed Claims Procedures
- Reasonable/Customary and Maximum Allowances
- Membership Procedures
- COBRA Administration
- Provider Credentialing
- Coordination of Benefits
- Medicare
- Controlling Possible Fraudulent Claims and Security Access
- Quality Control and Internal Audit
- Internet Capabilities
- Communication between Utilization Review (UR) and Claims Department
- Claim Repricing Capabilities
- Banking and Cash Flow
- Reporting Capabilities
- General System
- Security

HCA CLAIM AUDIT PROCEDURES

HCA selects a valid random sampling of claims from the client's current detailed claims listings. The third party administrator is advised of the audit and requested to provide either limited system access or paper reproduction of the entire file associated with each random claim.

Each random claim and file is reviewed comparing eligibility and benefits to information provided by the client. Third party administrator personnel are questioned regarding any discrepancies. Entire files are reviewed to assure the client that deductibles, out-of-pockets benefit maximums and related claims are processed correctly. This allows HCA to verify all details of the client's benefit plan.

Audit statistics involve only those claims chosen in the random selection. If a randomly selected claim HealthSCOPE been recalculated or corrected prior to the release of the random selection for the audit, an error was not charged for the original miscalculation. HCA will, at its opinion, comment on any claim in the random claim history to illustrate situations it feels the client should be aware of or specific areas requiring definition.

A payment error is charged when an error identified in claim processing results in an under/ overpayment or a check being paid to the wrong party. Assignment errors are considered payment errors since the plan could be liable for payment to the correct party.

In situations where there is disagreement between HCA and the third party administrator as to what constitutes an error, both sides are presented in the report. Final determination of error rests with the client.

AUDIT RESULTS

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

Ref. No. 049 Medical HSB claim no.

Overpayment - $9.78

51741	chg 200.00	allow/pd 88.07	
51798.59	120.00	19.57	
81002	15.00	3.70	
		111.34	

Multiple surgical reduction was not applied to 51798 service. Should it have been?

HSB response: No overpayment. Processed correctly per NCCI edits. CPT 51798 excluded from reduction.

HCA Note: Per AMA guidelines – 51798 is not an add-on code and should be reduced per multiple surgical guidelines.

Ref. No. 055 Medical HSB claim no.

Overpayment - $123.92
43248 chg 700.00 allow/pd 247.83
Claim xxxxxx same DOS, provider: 45378 chg 750.00 allow/pd 574.05
Claim xxxxxx same DOS, provider: 43239.59 chg 670 allow/pd 351.27
Since all services conducted by same provider, same DOS, shouldn't audited claim have been reduced for multiple surgical reductions?
HSB response: Agree that xxxxxx (biased) & xxxxxx (audited clm) should have been reduced for multiple surgery. It appears analyst overrode the system edits and did not apply cuts. $123.92 OP.

Ref. No. 058 Outpatient Hospital HSB claim no.

Underpayment - $1,530.14
Claim was allowed at 1117.86 under the XXXXXX contract.
Per agreement & during this DOS, XXXXXX hospitals paid under xxxxx contract. Should payment be $2648.00 versus $1117.86?
HSB response: The claim was processed with the better Statewide PPO network discount but agree the discount should have been applied.

Ref. No. 104 Outpatient Hospital HSB claim no.

NOT charged in statistical calculation. Note to client for information only.
Provider: Renown
Paid at 100% = 2191.00

REV 370	Charge	2360.00
250		1010.25
258		14.00
260		1221.00
272		15196.00
300		48.00
301		482.00
305-312		1817.00
360 – 43281		1959.00
360 – 43659		1959.00
360 – 47379		1959.00
460 – 94760		181.00
636		332.75
710		2559.00
762		2296.00

Repriced at 2,191.08 allowable. Please have HTH explain the repricing of this claim. Could not match w/contract.
HSB response: Per HTH priced correctly. Breakdown attached shows: Lab services 177.41, Carve out Rev 636, 42% = 143.97, Observation 133.55 per unit x 14 = 1869.70. Total allow = 2191.08.

Ref. No. 104B Outpatient Hospital HSB claim no.

NOT charged in statistical calculation. Note to client for information only.
Claim xxxxxx DOS 4/27/18 surgeon's bill:

43848.52	chg 5316.00	repriced 4500.00	allowed 2250.00
43281.51	12407.00	1329.00	664.50
47001	351.00	159.03	159.03
			3073.53
			614.71 coins
			2458.82 paid

Claim repriced by HTH. We reduced 43848 & 43281 for multiple surgical reduction. Should the 43848 be primary & paid at 100% of repricing (4500.00) and then both 43281 & 47001 be reduced by 50% for MPR?
HSB response: Agree. Multiple surgery was calculated incorrectly. $1,800 UP
Correct calculation should be:

43848	repriced 4500.00	allow 4500.00
43281	1329.00	664.50
47001	159.03	159.03 (add-on)
		5323.53
		1064.71 coins
		4258.82 – prev pd 2458.82=1800.00

Ref. No. 116 Medical HSB claim no.

NOT charged in statistical calculation. Note to client for information only.
Provider: Doctor on Demand
99213 chg 49.00 x 80% = 39.20
Please provide SPD language for benefit application of Doctor on Demand. 2019 SPD states "You pay after deductible: $49 for primary care visit." Under "Telemedicine" except Doctor on Demand states "80% after Plan Year Deductible."
HSB response: Claim processed correctly. PEBP's intent is to still apply ded/coins to apply towards MAX OOP. See attached e-mail.
HCA Note: Attached e-mail states: "PEBP Quality Control Officer states, PEBP's intent for Doctor on Demand CDHP PPO claims is to apply deductible, coinsurance and OOP max per the plan guidelines for PY19 and PY20. She will review and clarify language in the MPD for the future."

Ref. No. 135 Medical HSB claim no.

NOT charged in statistical calculation. Note to client for information only.
Claim paid as: 73590 chg 84 allow 40.00 copay 40.00 pd 0.00
73610 98 44.80 5.00 39.80
99213 138 45.00 45.00
Should $45 specialist copay have also been applied to the specialist office visit (99213)? SPD unclear if both "office visit" and "all other (non -specialty) imaging and diagnostic testing" copays should apply if both services are being done on same day.
HSB response: Per PEBP, $45.00 copay for entire visit/services.

Ref. No. 143 Medical HSB claim no.

NOT charged in statistical calculation. Note to client for information only.
Claim originally paid on 2/8/19 as:
11102 chg 203.84 allow 0.00 pd 0.00
17000 156.02 93.36 74.69
17003 43.62 28.50 22.80
Audited claim is adjusted claim to pay additional 45.39 – now paying 11102 as allow 56.74 x 80%
Appears HTH repricing was incorrect on original processing?
HSB response: Yes, it was repriced incorrectly. Originally allowed 0 for 17003. Claim repriced by HTH & claim adjusted.

Ref. No. 170 Medical HSB claim no.

NOT charged in statistical calculation. Note to client for information only.
Multiple claims for PT from Full Range Physical Therapy all billed with CPTs 97010, 97014, 97016, 97110 and 97140 total charge 203.00.
Appears allowable may be flat rate of $100/visit.
Some claims paid as $100 x 80% = 80.00 pd (i.e. clm xxxxxx DOS 5/2/19 paid on 6/4/19) and others paid as allow 95.08 x 80% = 76.06 combining one of the codes into another (i.e. clm xxxxxx DOS 3/29/19 paid on 4/23/19). Shouldn't all claims be paid w/global fee of $100 ay 80%?
HSB response: Agree. All claims should have allowed $100.00 global pricing per visit.

Ref. No. 172 Medical HSB claim no.

Overpayment - $102.28
Claim paid as HM at 100%. Diagnoses are medical (N182, E559, E1129 and N2582). Shouldn't these services have paid as medical and gone toward deductible? (588.25 ded satisfied out of 1500.00)
HSB response: Agree. Analyst error. Should be at 80% = $20.46 OP.
HCA Note: Charges are for lab services which is subject to the calendar year deductible which has not been satisfied. Therefore, $102.28 should have gone toward the deductible versus being paid.

Ref. No. 214 Medical HSB claim no.

Overpayment - $157.95

31237.50.58 chg 2035.00 allow 592.31 (x80%) pd 473.85

Claim xxxxxx exact service, same provider, DOS 5/10/19:

31237.50.58 chg 2035.00 allow 394.87 (x80%) pd 315.90

Please provide the allowable for 31237 for this provider on 4/5/19 without any modifiers.

HSB response: Base allowable is $263.25 x 150% = 394.81. Claim overpaid 157.95.

Ref. No. 269 Medical HSB claim no.

Overpayment - $3.97

Audited claim paid as: 80053 chg 88.07 allow/pd 18.58

80061	154.85	18.37
84443	130.49	23.05
87389	108.16	33.02

Claim xxxxxx same DOS, DX & provider:

85025 chg 45.50 allow/pd 10.66

86592 49.00 5.86

1) Shouldn't 80053, 84443 & 85025 have been rebundled & paid as 80050? (Paid 52.29 for 3 codes)

2) Please advise what allowable for 80050 for this DOS would be.

HSB response: Yes, claims xxxxxx & xxxxxx should have been bundled for 80053, 84443 & 85025 into 80050. SHO allowed is 48.32 for 80050. $3.97 OP.

Ref. No. 344 Medical HSB claim no.

NOT charged in statistical calculation. Note to client for information only.

E0562 chg 28.37 allow 19.87

E0601 150.00 73.74

178.37 93.61

1) Claim was denied for no PA. Per SPD all DME with a cost greater than $100 requires a PA. Does the term "cost" refer to charge amount or allowed amount?

2) File reflects no PA's. DOS 3/8/19, same provider, same services paid the E0562. Should this also have been denied as the audited claim was?

HSB response: Cost is based on billed charges, actual cost to purchase E0562 exceeds $100.00. This item is also oxygen related equipment and requires prior authorization per MPD.

Ref. No. 371 Outpatient Hospital HSB claim no.

NOT charged in statistical calculation. Note to client for information only.
Provider – Renown, DOS 5/12/19
Claim paid as: Rev 250 chg 8.00 x 46.19% = 3.70
320 623.00 x 42.35% = 263.84
450 2883.00 x 39.33% = 1133.88
636 5.00 x 42% = 2.10
Total allow = 1403.52 – ded 749.31 x 80% = 523.37 paid on 6/13/19
Claim was paid with rates effective 5/1/19 at the time but as of the end of June 2019 contract was amended and claim would have paid as:
Rev 250 chg 8.00 x 46.0% = 3.68
320 623.00 x 42.0% = 261.66
450 2883.00 x 42.0% = 1210.86
636 5.00 x 42.0% = 2.10
Total allow = 1478.30 – ded 749.31 x 80% = 583.19 payable
Will this claim be adjusted for the newer rates?
HSB response: Copy of original HTH pricing attached, along with reply to recon request. Claim repriced based on contract revisions today 7-16-19 and will be adjusted.

Ref. No. 399 Outpatient Hospital HSB claim no.

NOT charged in statistical calculation. Note to client for information only.
72141.TC chg 890.00 allow 436.10 copay 250.00 pd 186.10
72146.TC 890.00 436.10 250.00 186.10
Per EPO SPD MRI's have $250.00 copayment. Since the SPD is not clear on whether $250.00 copay is applied per test or per visit, does HSB have any documented clarification?
HSB response: $250 copay per test. See -email dated 8/22/18 confirming PEBP's intent. Claim processed correctly.
HCA Note: E-mail states: "Three separate charges."

Ref. No. 412 Vision HSB claim no.

NOT charged in statistical calculation. Note to client for information only.
DX: H5213 – Myopia & H52223 – regular astigmatism bilateral

92014	chg 150.00	allow 150.00
92015	65.00	45.00
92310	150.00	0.00
	365.00	195.00 – 45.00 copay = 150.00 paid

Shouldn't Category be Vision versus Illness & copay be $10.00 versus $45.00?
HSB response: Claim processed correctly applying $45 copay. Did not bill for routine eye exam S0620 or S0621.
HCA note: This is an EPO plan claim. DX is for routine optical myopia and astigmatism and services are ophthalmological services (92014) and refractive state determination (92015). HCA requests verification from PEBP for this benefit application.

Ref. No. 418 Medical HSB claim no.

NOT charged in statistical calculation. Note to client for information only. This is an EPO member claim.
97012 chg 35.00, 97032 chg 35.00, 98940 chg 65.00, 98943 chg 40.00
Claim denied payment as was not authorized.
Claim xxxxxx same provider, same services, DOS 6/6/19 also did not obtain PA was paid at 22.59 (67.59 – 45 copay). Should this claim also have been denied?
HSB response: Claim xxxxxx was denied because HTH originally returned claim as non par. They have now repriced this claim.

Ref. No. 454 Medical HSB claim no.

NOT charged in statistical calculation. Note to client for information only.
Originally paid on 2/13/19 under claim xxxxxx as:
99223 chg 435.00 allow/pd 128.25
Audited claim is adjustment to pay an additional 139.21 as allow is now 267.46.
Appears HTH submitted corrected repricing.
HSB response: Yes. HTH repriced claim on 5/23/19.

Ref. No. 477 Outpatient Hospital HSB claim no.

NOT charged in statistical calculation. Note to client for information only.
73564.LT chg 295.00 allow 144.55
76705.TC 419.00 205.31
349.86 – 75.00 copay = 274.86 paid
SPD states x-rays & ultrasounds are $75.00 copay when services provided in a hospital outpatient setting. Should a $75.00 copay be applied to each service or $75 for visit?
HSB response: PEBP's intent is one copay = $75.00 for OP diagnostic testing per DOS. See attached e-mail. Claim paid correctly.
HCA Note: E-mail states: "The member should only be charged one copayment."

Ref. No. 503 Inpatient Hospital HSB claim no.

NOT charged in statistical calculation. Note to client for information only.
Provider – Sunrise Hospital
DRG – 220, billed 612,285.00
Per contract DRG 220w/Rev code 203 is 37% billed charges
612,285.00 x 37% = 226,545.45, allowed was 228,107.61
Should allowable be 226,545.45 versus 228,107.61?
Note: Originally paid incorrectly at 83,878.70, missed carveout w/DRG and rev code exception
HSB response: Claim priced correctly per HTH.
Rev 278 42,719 x 40% = 17087.60
390 1778.50 x 20% = 355.70
636 19,431 x 40% = 7772.40
Remaining 548,356.50 x 37% = 202,891.90

Ref. No. 504 Inpatient Hospital HSB claim no.

NOT charged in statistical calculation. Note to client for information only.
Allowed/pd 115,579.24 (newborn claim)
Why wasn't a copay of $500 applied?
HSB response: See attached e-mail, per PEBP newborn hospital claim only assessed copay if newborn is discharged then readmitted. Claim processed correctly.
HCA Note: Attached e-mail states: "only if baby discharges and returns."

Ref. No. 507 Inpatient Hospital HSB claim no.

NOT charged in statistical calculation. Note to client for information only.
Allowed/pd 115,435.18 (newborn claim)
Why wasn't a copay of $500 applied?
HSB response: See attached e-mail, per PEBP newborn hospital claim only assessed copay if newborn is discharged then readmitted. Claim processed correctly.
HCA Note: Attached e-mail states: "only if baby discharges and returns."

27 Corporate Hill
Little Rock, AR 72205

August 16, 2019

Public Employees' Benefits Program Board
State of Nevada
901 Stewart Street, Suite 1001
Carson City, NV 89701

Subject: Audit Results April 1, 2019 – June 30, 2019

Dear Public Employees' Benefits Program (PEBP) Board:

HealthSCOPE Benefits appreciates the opportunity to respond to the audit performed by Health Claim Auditors for the fourth quarter of Plan Year 2019. The audit included 500 claims with paid amounts totaling $276,915.57

HealthSCOPE Benefits is extremely pleased to have met all performance guarantees for this audit period.

We strive to have the highest possible quality and we continue to review quality improvement opportunities within our organization and our vendor partners.

We are very pleased with cost containment measures we are able to provide on the PEBP account. We saved PEBP an additional $3.3M through non-network negotiations, subrogation, clinical edits and transplant savings in the fourth quarter of Plan Year 2019.

We appreciate the quarterly audit process and the interaction between Health Claims Auditors, PEBP, and HealthSCOPE Benefits as it provides for continuous improvement in our service.

Sincerely,

Mary Catherine Person
President

5.

5. Discussion and possible action to determine Plan Year 2021 (and beyond) disposition of the Unum contract for voluntary long-term care services to include: 1) extend the current contract an additional 4 years; 2) close the policy to new enrollees and continue payroll deductions for existing enrollees; or 3) allow the policy to terminate June 30, 2020 and current enrollees can elect continuation of coverage through direct billing. (Laura Rich, Operations Officer) (**For Possible Action**)

STEVE SISOLAK
Governor

Deonne E. Contine
Board Chair

STATE OF NEVADA
PUBLIC EMPLOYEES' BENEFITS PROGRAM
901 S. Stewart Street, Suite 1001 | Carson City, Nevada 89701
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Expires 04/01/2021

DAMON HAYCOCK
Executive Officer

AGENDA ITEM

[X] Action Item
[ ] Information Only

Date: September 26, 2019

Item Number: V

Title: UNUM Voluntary Long-Term Care Contract

BACKGROUND

UNUM has provided group voluntary long-term care (LTC) insurance to eligible PEBP participants since 2001. In 2013, Unum's contract with PEBP terminated and because of changes in the market and long-term viability of this benefit, carriers stopped offering group LTC policies to large employers on a voluntary basis. As a result, a solicitation waiver was granted in 2014 that allowed PEBP to waive the solicitation process and sign a six-year contract with UNUM. That contract expires June 30, 2020.

On September 27, 2018, the Board approved a two-year amendment to the Morneau Shepell contract which included a new fully integrated voluntary benefit platform. The transition to this platform eliminated much of PEBP's administrative load related to voluntary products. Although PEBP retains the authority to offer any voluntary products approved by the Board, PEBP no longer maintains direct relationships or contracts with each individual voluntary product provider. Eliminating the need to go through a separate procurement process and manage specific contracts with individual vendors enables PEBP to be able to offer a larger variety of voluntary products to its members.

With the exception of UNUM, PEBP cancelled all contracts related to voluntary products beginning July 1, 2019. Existing and new vendors instead contracted directly with Morneau Shepell's subcontracted voluntary benefits platform vendor, Corestream and each of these products are currently offered to members to enroll in through the member portal. Due to technical limitations and the lack of approval from its broker, UNUM was unable to integrate enrollment on to PEBP's voluntary benefits platform. Currently, UNUM's LTC product is displayed on the platform but members do not have the ability to enroll in the product nor can the various pay centers leverage the single payroll deduction process that is managed by Corestream.

REPORT

ENROLLMENT AND UTILIZATION

PEBP participants can purchase a LTC policy without evidence of insurability within the first 60 days of becoming benefit eligible. UNUM reports ~40% of applicants who apply outside of this time frame are declined due to medical underwriting.

Currently, 320 employees are participating in active LTC payroll deductions across several pay centers. The bulk of this enrollment occurred early on, as only 24 total applications for LTC have been submitted since January 2018. Of those 24, 7 policies were issued in 2018 and 11 in 2019. This is likely due to the dramatic rate increases that LTC products have experienced in more recent years. The Nevada Division of Insurance determines the acceptable and fair rates for all companies who offer LTC products, and since 2014, the DOI has approved 10%+ rate increases annually. Rates for members who purchase an LTC policy after January 1, 2020 will be a minimum of 15% more expensive, and in some cases up to 40% more expensive than the 2019 rates.

In addition to the low participation rate, UNUM reports PEBP members have paid approximately $7.5 million in premiums since the inception of the contract but UNUM has only paid out $2.6 million in claims.

OPTIONS

1) Extend the current contract an additional 4 years.

    - This option presents no impact to existing members participating in this product.
    - Pay centers would be required to manage separate payroll deduction processes.
    - Administrative and contract oversight would remain with PEBP.
    - Low new enrollment in this product.
    - With all other voluntary products being offered through the platform, this exception can create some confusion for members. Additionally, UNUM will be excluded in the products that are marketed to members by Corestream.

2) Close the policy to new enrollees and continue payroll deductions for existing enrollees.

    - This option presents no impact to existing members.
    - Due to the substantial increases in premium costs of this policy and the low recent enrollment rate, it is unlikely there will be significant future enrollment in this product.
    - Maintaining separate payroll deductions for existing policy holders while closing the policy creates a long-term burden on the pay centers since there is no established “end” date for these deductions.

3) Allow the policy to terminate June 30, 2020 and current enrollees can elect continuation of coverage through direct billing.

- This option creates minimal impact to existing members. Allowing the policy to terminate would trigger a conversion option which would grant policy holders 60 days to transition to direct bill. The plan design and premiums would remain the same and would be a similar process used when members who terminate state employment wish to keep their LTC policy active.
- Eliminates the burden of managing separate payroll deductions by the pay centers.
- Eliminates PEBP's direct administrative oversight of voluntary products.
- Continues to allow UNUM the opportunity to explore a transition to the voluntary benefits platform to offer LTC and/or other voluntary products. It is possible for UNUM to accomplish this by June 30, 2020 and create a seamless transition that would eliminate any impact to existing members.

RECOMMENDATION

PEBP recommends option 3 above. This product experiences significant rate increases annually and new utilization is low. Last year the PEBP board established the voluntary benefits policy of using a single partner on a single platform. Therefore for consistency, PEBP also recommends allowing UNUM to work with Corestream for inclusion on the platform moving forward.

6.

6. Discussion and possible action to approve an amendment to the Monreau Shepell eligibility and enrollment system contract to lower Per Employee Per Month (PEPM) fees from $1.78 to $1.50 beginning September 1, 2019 through the remainder of the contract. (Cari Eaton, Chief Financial Officer) (**For Possible Action)**

STEVE SISOLAK
Governor

Deonne Contine
Board Chair

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Expires 04/01/2021

DAMON HAYCOCK
Executive Officer

AGENDA ITEM

[X] Action Item
[ ] Information Only

Date: September 26, 2019

Item Number: VI

Title: Contract Amendment Report – Morneau Shepell

SUMMARY

This report requests the Board authorize staff to complete a contract amendment between PEBP and Morneau Shepell to provide an enrollment and eligibility system for all PEBP plan participants at a reduced rate effective September 2019.

REPORT

MORNEAU SHEPELL

On July 26, 2018, the Board approved a two-year extension (through 2023) with Morneau Shepell for an enhanced eligibility system. An Open Enrollment Update Report was provided to the Board at the July 25, 2019 meeting. Page 4 of that report indicated that Morneau Shepell would reduce the PPPM fees in response to the new enrollment tool and voluntary benefits platform rollout. Morneau Shepell has agreed to reduce the administrative fees from $1.78 PPPM to $1.50 PPPM beginning September 2019.

This reduction to the administrative fees is projected to save PEBP approximately $670,000 through the term of the contract.

Fee Type	Pre-Amendment Projected Cost	Post-Amendment Projected Cost	Total Projected Savings
Morneau Administrative Fees – FY 20	$956,949	$831,507	$125,443
Morneau Administrative Fees – FY 21	$970,665	$817,977	$152,689
Morneau Administrative Fees – FY 22	$984,764	$829,858	$154,907
Morneau Administrative Fees – FY 23	$999,251	$842,066	$157,186
Morneau Administrative Fees – FY 24 (June-Dec)	$507,066	$427,303	$79,763
TOTAL	**$4,418,697**	**$3,748,709**	**$669,987**

RECOMMENDATION

PEBP recommends the Board authorize staff to complete a contract amendment between PEBP and Morneau Shepell to provide an enrollment and eligibility system for all PEBP plan participants in contract # 15941 to reduce fees through the term of the contract.

7.

7. Presentation on the State of PEBP. (Damon Haycock, Executive Officer) (Information/Discussion)

STEVE SISOLAK
Governor

Deonne E. Contine
Board Chair

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DAMON HAYCOCK
Executive Officer

PLAN YEAR 2019 REPORT TO PARTICIPANTS AND STAKEHOLDERS

PURPOSE, MISSION, VISION AND VALUES

PURPOSE

The Public Employees' Benefits Program (PEBP) administers a group health and life insurance program which offers comprehensive medical, prescription drug, dental, vision, life, and long-term disability insurance. Our organization is responsible for designing and managing a quality health care program for approximately 43,000 primary participants and 27,000 covered dependents, totaling over 70,000 lives.

MISSION

Provide employees, retirees, and their families with access to high quality benefits at affordable prices.

VISION

PEBP will be a member focused, nationally recognized, affordable program of employer sponsored benefits serving employees, retirees, their families and the Nevada taxpayer.

VALUES

- Service
- Innovation
- Accountability
- Transparency
- Fairness
- Integrity
- Compassion
- Sustainability
- Collaboration

PLAN YEAR 2019 OVERVIEW

PEBP continued to provide a Consumer Driven Health Plan (CDHP) alongside one regional Health Maintenance Organization (HMO) plan and one new self-funded regional Exclusive Provider Organization (EPO) plan for active employees and non-Medicare retirees while covering Medicare retirees through an individual market exchange.

PROGRAM ENROLLMENT

As of June 30, 2019, the following enrollment was recorded:

Plan	Employees	Pre-Medicare Retirees	Dependents	Total Lives
CDHP	19,675	3,862	18,989	42,526
EPO – North	3,893	759	3,837	8,489
Health Plan of Nevada (HMO – South)	3,292	554	2,792	6,638
Total Pre-Medicare Lives	26,860	5,175	25,618	57,653
Medicare Enrollment	**Employees**	**Medicare Retirees**	**Medicare Dependents**	**Total**
Medicare Exchange (Via Benefits)	0	12,365	1,736	14,101
Tricare	0	174	23	197
Total *	**26,860 Employees**	**17,714 Retirees**	**27,377 Dependents**	**71,951 Covered Lives**

**PEBP's total program is split 60% Employees / 40% Retirees (Pre-Medicare + Medicare)*

PEBP'S SELF-INSURED CDHP

ENROLLMENT

Looking at average enrollment throughout Plan Year 2019 (versus a snapshot near the end of the plan year shown above), the CDHP experienced the following:

1. 2.7% increase in State Employees (from 19,100 to 19,612) with 2.1% increase in total lives (from 36,389 to 37,138).
2. No change in Non-State Employees (4 each year) with flat covered lives (7 each year).
3. 1.9% increase in State Retirees (from 3,165 to 3,224) with 2.5% increase in covered lives (from 4,681 to 4,799).
4. 16.0% decrease in Non-State Retirees (868 to 729) with 13.2% decrease in covered lives (from 958 to 832).

UTILIZATION AND COST

The CDHP experienced increased (4.7%) medical costs on a per employee/retiree per month (PEPM) basis in Plan Year 2019 (PY19) versus Plan Year 2018 going from $450 in 2018 to $471 in 2019. A slightly smaller increase (4.4%) was experienced when factoring in all the dependents on a per member per month basis (PMPM) going from $248 to $259. The increased utilization was directly related to an increase of 34 High Cost Claimants (+20.7%) from the previous year. PEBP defines High Cost Claimants as members with claims greater than $100,000. The average High Cost Claimant paid amount was $219,374, and 34 claims x $219,374 = $7.5 million, so without these claims, the plan would have realized small increases in total overall costs but increased enrollment resulting in approximately 1.2% decrease (negative trend).

In pharmacy coverage, the PEPM increased moderately (+9.0%) from $70.79 in Plan Year 2018 to $75.88 in Plan Year 2019. When factoring in drug rebates earned in that time frame (not necessarily realized as there is an approximate 180-day lag in receiving rebates), the PEPM increased only 5.1% going from $55.94 in 2018 to $58.80 in Plan Year 2019. Those rebates equated to just over $8.7 million (a $1.3 million (16.9%) increase over 2018). The increased costs in pharmacy coverage are attributed to specialty drugs as that high trend (9%) was offset by negative trend (-0.5%) in non-specialty drugs.

NEW PROGRAMS & SERVICES

The PEBP Board approved a new online transparency service through Healthcare Bluebook. This service utilized PEBP claims data and national quality standards to highlight low cost high quality providers of care for PEBP members. Some of those services were so variable that PEBP provided incentive checks to members who selected the lower cost options to drive utilization. Over the course of the year, there were 77,125 provider searches conducted on the website, 4,770 guided tours, and $26,550 in incentive checks sent to members who selected high quality low cost providers.

To combat rising pharmacy costs, the PEBP Board also approved the implementation of a voluntary narrow pharmacy network for 90-day drug fills at select retail pharmacies and mail order services.

PEBP also implemented incentivized enhanced HSA/HRA funding tied to requirements. In Plan Year 2018, those requirements included preventive annual doctor and dentist visits, lab work, and a teeth cleaning. In 2019, the Board approved splitting the funding to preventive care and enrollment in online tools (Dr. on Demand and Healthcare Bluebook) to expose as many members as possible to these cost saving services. PEBP also implemented a 3-dimensional (3D) mammography preventive benefit paid by the plan at 100%.

CONTINUED PROGRAMS & SERVICES

The PEBP Board approved utilizing excess reserves to continue to provide a higher level of life insurance ($25,000 employee / $12,500 retiree), an enhanced HSA/HRA benefit of $200 (see above for specifics), and the administrative fees associated with the Medicare Exchange HRA and life insurance premiums for Medicare retirees.

PEBP'S SELF-INSURED EPO

In November 2018, PEBP was faced with a significant regional HMO premium increase (13%). The PEBP budget was approved by the Legislature with a 4% inflation, so the larger portion of the increased premiums would be absorbed by PEBP members. After significant analysis was completed, PEBP presented and the Board approved a self-insured PEBP managed Exclusive Provider Organization (EPO) plan to replace the northern Nevada HMO for Plan Year 2019. PEBP's HMO/EPO rates were blended and the result was a 8% decrease overall.

PEBP patterned the EPO plan closely to the outgoing HMO plan to ensure minimum disruption for those members. PEBP's enrollment and utilization during the first year of the EPO plan are described below.

ENROLLMENT

Looking at average enrollment throughout Plan Year 2019 (versus a snapshot near the end of the plan year shown above), the EPO experienced the following:

1. State Employees: 3,878
2. Non-State Employees: 4
3. State Retirees: 599
4. Non-State Retirees: 181
5. Dependents: 3,835
6. Total Covered Lives: 8,488

UTILIZATION AND COST

The EPO experienced medical costs on a per employee/retiree per month (PEPM) basis in Plan Year 2019 (PY19) of $729. When factoring in all the dependents on a per member per month basis (PMPM), the costs were $400. High Cost Claimants were high at 39, averaging the same per capita as the CDHP of 4.6 per 1,000. The plan paid a higher average for these High Cost Claimants at $274,612 per claim versus the CDHP of $219,374 per claim.

In pharmacy coverage, the EPO costs were much higher than the CDHP with a PEPM of $141.58 reduced by rebates ($3.35 million) to $108.71. Highest utilization was attributed to specialty drugs by the state retiree population.

PEBP will be able to report on year-over-year trend for this EPO plan next September after we close out Plan Year 2020 (Year 2).

ACCOMPLISHMENTS

STRATEGIC PLANNING

PEBP successfully held its second annual Strategic Planning Session in August 2018. In November 2018, the Board approved the revised Strategic Plan. PEBP's updated Strategic Plan is located on our website in the "About Us" section available from the top menu of every webpage.

Three simple yet purposeful overall strategies continued to guide the Program:

1. Improve access to care;
2. Improve the member experience; and
3. Reduce costs to the Program

Every PEBP staff recommendation is framed within those overall strategies, and specific strategies were developed in the areas of program administration, transparency, collaboration and communication. For Plan Year 2019, PEBP met almost all of the strategic objectives set out from the plan.

2018 MEMBER SATISFACTION SURVEY

In October through December 2018, PEBP conducted a satisfaction survey to gauge firsthand knowledge of our membership. In this survey, PEBP asked a series of customer satisfaction questions, and of the responses, participants rated PEBP between 7.34 and 8.28 (up from 6.88 and 8.01 in 2017) on a scale of 1 (not satisfied) to 10 (extremely satisfied).

The highest rating (10 – extremely satisfied) had the most responses, and some positive results can be seen below:

- Prompt follow-up of requests: 70% of responses scored between 8-10
- Communication on benefits: 66% of responses scored between 8-10
- Quality of information PEPB provides: 71% of responses scored between 8-10
- Quality of customer service at PEBP: 75% of responses scored between 8-10
- Training and Education at PEBP: 59% of responses scored between 8-10
- Benefit information available: 63% of responses scored between 8-10

Compared to last year, all of these results are an increase of 4-9% per category.

PEBP continues to prioritize training, education and communication of our benefits. We want to see those lower results increase again next year.

AMERICAN BUSINESS AWARD – 2ND YEAR IN A ROW

In May 2019, PEBP was selected from nominations nationwide as winner of a top-ranking award from the 17th annual American Business Awards. PEBP was selected as winner of a Gold Stevie Award in the category of Organization of the Year - Non-Profit or Government - Large category

for the second year in a row. We are excited to continue receiving accolades by national organizations.

CONTRACTING

American Health Holdings
PEBP entered into a new contract with American Health Holdings for Utilization Management / Large Case Management (UM/CM) for services beginning Plan Year 2020 (July 1, 2019). The former UM/CM contract was held by Hometown Health Providers who elected not to rebid on the solicitation when their contract term expired.

Express Scripts
PEBP performed a market check on our Pharmacy Benefits Manager, Express Scripts in early 2018 resulting in annual savings and increased rebates totaling over $5 million.

HealthSCOPE Benefits
PEBP renegotiated fees with our Third Party Administrator lowering the Per Employee Per Month costs from $14.50 to $13.95, reduced subrogation fees from 35% recovery to 18%, and enhanced recovery fees from 25% to 22% of savings. Total annual savings were $277,500 per year.

Willis Towers Watson
PEBP extended the contract for Medicare Exchange services to Medicare eligible retirees out to 2025 and eliminated all Health Reimbursement Account (HRA) fees starting July 1, 2019. This extension saves PEBP approximately $240,000 per year.

Morneau Shepell
PEBP extended the Morneau Shepell contract for eligibility and enrollment services to include for Plan Year 2020 the implementation of an upgraded member portal and a seamless integration of a third-party voluntary benefit platform offering expanded benefits to members.

The Standard
PEBP canceled the Voluntary Life and Short-Term Disability contract as these products and services were shifted to Morneau Shepell's Voluntary Benefit platform (see above).

CUSTOMER SERVICE

Phone Calls, Walk-ins, and Emails
PEBP received approximately 46,000 phone calls in Plan Year 2019 – an increase of almost 5,000 calls over Plan Year 2018. The average time to answer calls was almost 43 seconds and the abandoned call rate was 2.55%. These figures rose from Plan Year 2018 primarily due to a pushed out Open Enrollment to respond to Legislative approval of employer contributions and rate setting, a new member facing portal which created questions, and a cadre of additional voluntary benefits requiring additional communication to members.

The average time to answer calls was 13 seconds greater than industry standards (43 seconds versus 30 seconds) and the abandoned call rate exceeded industry standards and the performance guarantees included in our vendor contracts (3% respectively). PEBP also received 1,153 total walk-ins during the same time period. In addition to phone calls, members also contact PEBP member services through email via the PEBP website. In Plan Year 2019, PEBP received over 19,600 emails which was almost 2,000 more than the previous year.

In-person Education and Outreach

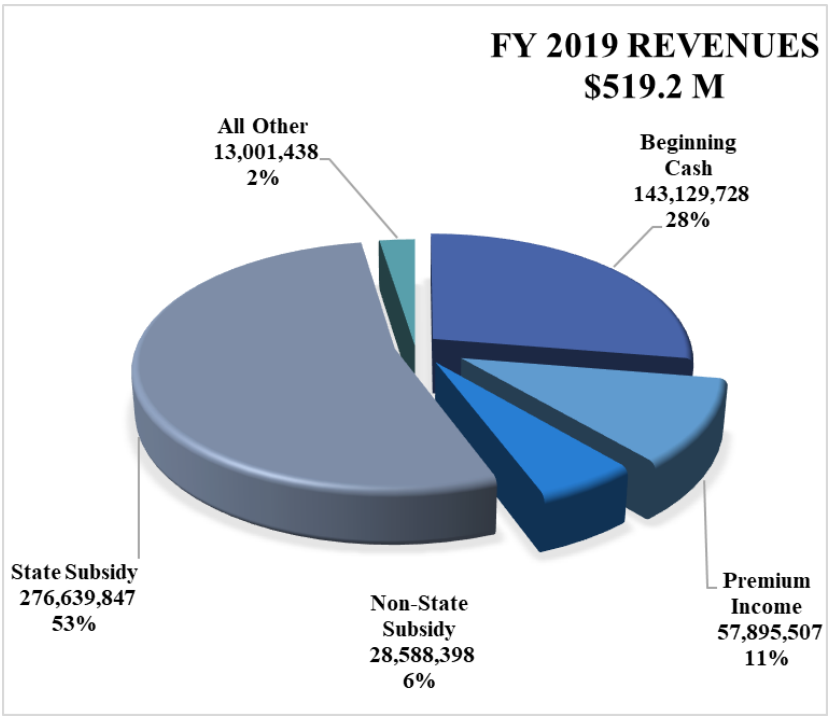
During the month of May, 492 state employees attended a series of open enrollment meetings across the state hosted by PEBP staff and vendors. In addition, 64 employees attended via the new interactive webinar based presentations. The presentation material was also made available on the PEBP website in order to make it accessible to those who could not attend.

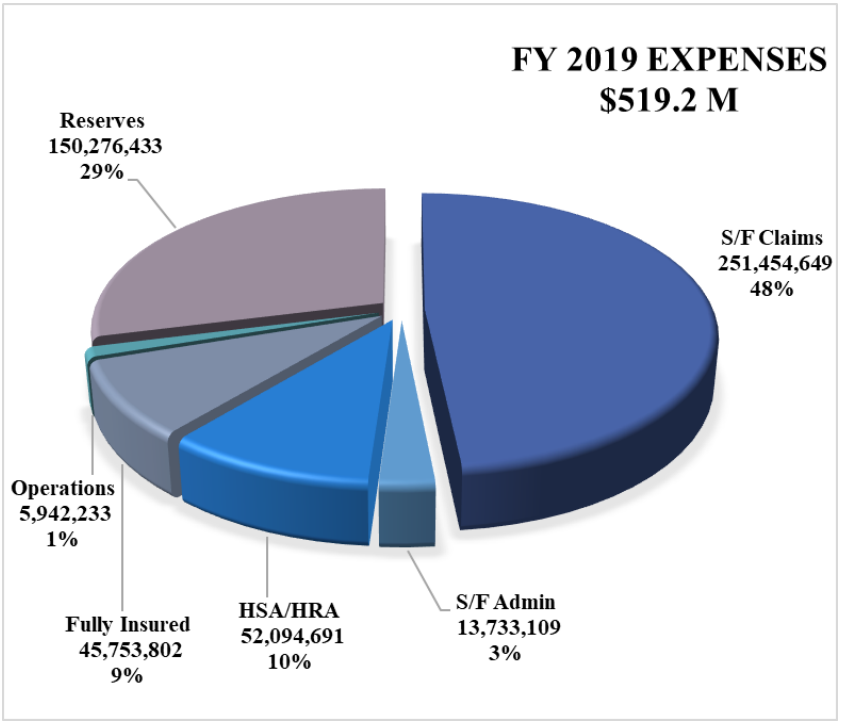
FISCAL YEAR PERFORMANCE INDICATORS

PEBP did not meet our stated goals last year but we did come close. Appeals increased and we attribute that to adding a new plan in northern Nevada. Our other ratios were all within 1% except generic drug utilization, however, PEBP has had a generic-over-brand drug policy for years to keep generic drug utilization as high as possible.

Performance Measures	Goal	Actual
Expense Ratio	4.15%	4.63%
Claims Loss Ratio	98.66%	97.31%
Generic Drug Utilization	92.59%	85.64%
Medical In-Network Utilization	96.4%	95.6%
Dental In-Network Utilization	94%	93.7%
Appeals per 1,000 Participants	0.21	0.34

PROGRAM FINANCES





2019 FINANCIAL OVERVIEW

The Program continues to maintain financial solvency with fully funded Incurred But Not Paid (IBNP) reserves for each of the last fourteen plan years and a fully funded Catastrophic reserve for each of the last twelve plan years. As of June 30, 2019, there were 26.1 million dollars in the Program above those required reserve levels on a budgetary basis (cash as opposed to accrual).

PEBP derived its revenue in Fiscal Year 2019 from four primary sources: State Subsidies (53%); Employee and Retiree Premium (11%), Non-State Employer Contributions which includes the SB522 supplemental subsidy (6%), other revenue to include prescription rebates (3%), and funds carried forward from Previous Years (28%).

Program revenues can only be spent on Program expenses. In Fiscal Year 2019, the expenses of the Program were: Self-Funded Administration, Claims and Health Savings Accounts and Health Reimbursement Arrangement Contributions (61%), Fully Insured Premiums (9%), and Agency Operations (1%). The balance, approximately 29%, was reserved and carried forward to Fiscal Year 2020.

RESERVE UTILIZATION

The conservative financial policies advocated by the actuarial consultants and adopted by the Board, the adoption of plan design changes when necessary to balance increasing medical costs, and the responsible funding of benefit enhancements ensure the plan is run in a fiscally prudent manner. As part of the annual rate setting process, the Board determines how to utilize any reserves accumulated in excess of those actuarially required to maintain the financial solvency of the Program.

In November 2017, the Board approved the Plan Benefit Design for Plan Year 2019 (beginning July 1, 2018). The rates were approved in March 2018 and included the continuation of the following enhancements:

- Medicare Exchange Life Insurance Premiums ($0.4 million);
- Medicare Exchange HRA Administrative Fees ($0.4 million);
- CDHP HSA/HRA Enhanced Funding ($4.7 million); and
- Increase basic group life insurance benefit from $10k to $25k for employees and from $5k to $12.5k for retirees ($3.6 million)

The Board also approved additional uses of excess reserves for Plan Year 2019 for enhanced benefits:

- 3-Dimensional Mammography paid as a preventive benefit ($200k);
- One-time $2/month/year-of-service supplemental HRA funding for Medicare retirees ($5.4 million)

FUTURE CHALLENGES

THE RISE OF HIGH COST CLAIMANTS

In Plan Year 2019, PEBP experienced a significant increase in High Cost Claimants (members with claims ≥ $100,000). Many of these claims are directly related to chronic disease and many of these members are on PEBP's large case management program. As PEBP looks to control costs and help these members through these critical issues, it will be equally important to address health issues to prevent and avoid these claims moving forward. Many programs and services exist to prevent and treat chronic disease and PEBP can explore these opportunities for long-term success.

CONTINUED INCREASES TO SPECIALTY DRUGS

In Plan Year 2019, PEBP again experienced high trend with regards to specialty drug utilization. High cost drugs continue to flood the market and new conditions for older high cost drugs are approved daily. With the federal government limiting certain cost containment programs like PEBP's new Plan Year 2020 copay accumulator program, the solutions and opportunities to mitigate these high costs grow smaller and smaller each year. PEBP will need to continue to research and analyze options to ensure the high costs of drugs don't lead the program to a point of eventual insolvency.

8.

8. Discussion and possible board direction regarding updating the PEBP Strategic Plan. (Damon Haycock, Executive Officer) (**For Possible Action**)

STEVE SISOLAK
Governor

Deonne E. Contine
Board Chair

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DAMON HAYCOCK
Executive Officer

PEBP STRATEGIC PLAN

Drafted: September 26, 2019

BACKGROUND

The Public Employees' Benefits Program (PEBP) administers a group health, life insurance program which offers comprehensive medical, prescription drug, dental, vision, life, and long-term disability insurance. Our organization is responsible for designing and managing a quality health care program for approximately 43,000 primary participants and 28,000 covered dependents, totaling over 71,000 lives.

PEBP is governed by a ten member Board. The PEBP Board consists of members appointed by the Governor, including an Executive Officer who directs the program and serves at the pleasure of the Board. PEBP works to ensure the PEBP Board consists of members with varied and relevant education and professional backgrounds. The Board's purpose is to adopt regulations, Nevada Administrative Code (NAC), enforcement, and policy for the agency. The Board approves plan benefit designs for health plans and annual rates for all programs and services sponsored by the program.

Funding for PEBP operations and insurance plans comes primarily from participant and employer contributions. PEBP submits its funding and operational requirements to the legislature as part of the biennial budget. Upon approval, each participating employer is assessed an amount to contribute toward both the active-employee and retiree health plans.

PEBP employees a staff of 34 full-time employees. Operations include quality control, accounting, member services and eligibility, public information, and information technology.

MISSION

Provide employees, retirees, and their families with access to high quality benefits at affordable prices.

VISION

PEBP will be a member focused, strategic, innovative, nationally recognized, affordable program of employer sponsored benefits serving employees, retirees, their families and the Nevada taxpayer through continuous evaluation and improvement.

VALUES

- Service
- Innovation
- Accountability
- Transparency
- Fairness
- Integrity
- Compassion
- Sustainability
- Collaboration
- Health Improvement

GOALS

- Program Administration
    1. Position the Program to be able to pivot on federal and state healthcare rulemaking
    2. Ensure long-term Program solvency and sustainability
    3. Balance the needs and desires of the employer, the employee/retiree, and the NV taxpayer
    4. Consistently evolve and modernize
    5. Develop and provide benefits desired by the employers and members
    6. Improve member experience
    7. Acknowledge and address the disparity between northern, southern and rural Nevada
- Transparency
    1. Consistently provide reporting on utilization, finances, and policy decisions
    2. Showcase plan design and rate approvals publicly in an easy-to-understand format
    3. Commit to Program transparency tools
- Collaboration
    1. Coordinate policy with stakeholders (Legislature, Executive Branch, Advocacy Groups)
    2. Develop program strategy by aligning agendas
    3. Evolve the Program through partnership with current and future vendors/partners
    4. Encourage communication and coordination between partners
- Communications
    1. Maximize utilization of multiple communication channels
    2. Review/update and coordinate a comprehensive multi-partner communications plan
    3. Develop communication strategies balancing digital, person-to-person and cost resources

SWOT ANALYSIS

- Strengths
    - Supportive Board
    - Plan solvency (CDHP) and long-term sustainability (CDHP, Exchange)
    - Available excess reserves
    - Innovative
    - Transparency
    - Strong relationships with advocacy groups
    - Strong agency units: Operations, Finance, Quality Control & Information Technology
    - Negotiating contracts
    - National recognition
- Weaknesses
    - One-size-fits-all design (statewide plan design but regional risk pools and models of care)
    - Cannot make changes rapidly (BOE, IFC, Budget Office, Legislature, Board schedules, etc.)

- No direct access to drafting BDRs (must be included in the Governor's 110)
- ~~Reaching all members consistently~~ Struggling eligibility and enrollment system
- Board lost final approval for employer contributions, rates, and excess reserve utilization

- Opportunities
  - Member tools (~~online decision support,~~ disease management program enhancements, implement more digital member applications)
  - Increase access to care (~~direct hospital contracting, increase network providers,~~ increase voluntary benefit offerings~~, coordinating assets with HPN, leverage more Centers of Excellence, improve disease management~~ increase voluntary benefit offerings, revisit PPO network contracting)
  - Innovation (~~system upgrades, ERP system, voluntary benefit platform, digital member applications,~~ new/expanded plan offerings (3rd tier plan, statewide EPO, transform EPO into low deductible PPO), leverage higher education resources)
  - Cost containment (mandatory Smart90 Rx network (EPO), ~~more PAs,~~ more Reference Based Pricing~~, direct contracting with providers~~)
  - Bring back wellness program(s)
  - ~~Improve communications (modernize guides, revamp HMO reporting, coordinate distribution with partners)~~
- Threats
  - ~~New Administration in 2019 (supportive?)~~
  - Policy decision making potentially influenced by political decision making
  - Member entitlement to previous plan benefit levels
  - Federal rulemaking (ACA survive? Cadillac Tax?)

Commented [DH1]: System needs to work out current bugs before enhancing tools further.

Commented [DH2]: PEBP is coordinating better with current networks to ensure a comprehensive level of providers and fair pricing exists.

Commented [DH3]: PEBP continues to research coordination and collaboration with HPN but we have no direct strategy to implement this year.

Commented [DH4]: PEBP researched utilizing more Centers of Excellence, however, it may mean sending more members out-of-state for services available in-state causing issue for Nevada providers.

Commented [DH5]: Many of these already occurred or in progress. ERP system approved by 80th Legislative Session

Commented [DH6]: Explored and negotiated cost containment on current hospital contracts.

Commented [DH7]: Complete and ongoing

NEVADA PUBLIC EMPLOYEES' BENEFITS PROGRAM

Access. Quality. Affordability.

OVERALL STRATEGY

1. Increase Access to Care
2. Improve the Member Experience
3. Reduce Costs to the Program

SPECIFIC STRATEGIES

- Program Administration
  1. Position the Program to be able to pivot on federal and state healthcare rulemaking
     Strategy: Maintain sufficient reserves, review all laws for impact, retain enough delegated authority from the Board to address rules, implement appropriate regulations
  2. Ensure long-term Program solvency and sustainability
     Strategy: Maintain sufficient reserves, implement cost-containment activities every year to reduce trend/inflation, ~~approve rates with gradual changes versus sharp impacts,~~ and maintain appropriate staffing levels to meet needs
  3. Balance the needs and desires of the employer, the employee/retiree, and the NV taxpayer
     Strategy: Implement only value-added benefits, require ROI where appropriate, invest in program infrastructure, evaluate all options rigorously, and leverage interns where applicable
  4. Consistently evolve and innovate
     Strategy: Stay abreast of the marketplace, upgrade system functionality regularly, implement tools to improve stakeholder experience, invest in the program infrastructure~~, research and catalog a comprehensive set of digital solutions for evaluation and implementation, and improve real-time data sharing~~
  5. Develop and provide benefits desired by the employers and members
     Strategy: Research benefit offerings and present viable options, prioritize ~~–~~access to care, provide added value benefits, and evaluate benefits annually
  6. Improve member experience
     Strategy: Increase value added tools, communicate benefit changes thoroughly and timely alignment with partner communications, incentivize good behavior, ~~revamp member dashboard,~~ increase benefit offerings
  7. ~~Acknowledge and address the disparity between northern, southern and rural Nevada~~
     ~~*Strategy:* Analyze cost factors and access to care, evaluate alternatives to "one-size-fits-all," continue to close the gap between marketplaces~~
- Transparency
  1. Consistently provide reporting on utilization, finances, and policy decisions
     Strategy: Continue Board reporting, IRBC reporting, update website regularly with reports, implement new report formats
  2. Showcase plan design and rate approvals publicly in an easy-to-understand format
     Strategy: Develop simple value added plan design review and approval, develop simple value added rate review and approval
  3. Commit to Program transparency tools
     Strategy: Continue to provide stakeholder access to data~~, improve HMO reporting data to include more program results~~
- Collaboration
  1. Coordinate policy with stakeholders (Legislature, Executive Branch, Advocacy Groups)

Commented [DH8]: No longer allowed by Legislature

Commented [DH9]: Completed and ongoing

Commented [DH10]: Completed 2020 Open Enrollment

Commented [DH11]: Completed and ongoing. Lowering rates on EPO has led to lowering rates on HPN's HMO

Commented [DH12]: Completed 3rd quarter reporting Plan Year 2019.

Strategy: Continue bimonthly meetings with RPEN and AFSCME, provide updates to LCB as needed, provide updates to Governor's Office as ~~scheduled~~requested

2. Develop program strategy by aligning agendas
   Strategy: Obtain input from stakeholders prior to accepting strategic plan, incorporate legislative and executive branch requests in program strategy
3. Evolve the Program through partnership with current and future vendors/partners
   Strategy: Obtain input from vendors/partners, develop a roadmap of program improvements and quality improvement strategies
4. Encourage communication and coordination between partners
   Strategy: Open up direct communication between partners, allow for coordinated solution building, create opportunities for teamwork and coordination

- Communications
  1. Maximize utilization of multiple communication channels
     Strategy: Continue to ~~M~~modernize communications, coordinate communications efforts with partners, leverage digital solutions where appropriate
  2. Formalize and review/update communications plan
     Strategy: Review plan annually, develop a multi-partner communications schedule, emphasize in-person education, continue to implement more webinars/trainings online
  3. Engage subject matter experts to improve communication to members and other stakeholders
     Strategy: Continue to ~~R~~research communications material of other states, coordinate strategies with partners

STEVE SISOLAK
Governor

Deonne E. Contine
Board Chair

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Expires 04/01/2021

DAMON HAYCOCK
Executive Officer

2019 PEBP Strategic Planning Session

Dates: August 7-8, 2019
Location: South Lake Tahoe, CA

Attendees:

- American Health Holdings
- AON
- Express Scripts
- HealthSCOPE Benefits
- Health Plan of Nevada
- Hometown Health Providers
- Morneau Shepell
- Willis Towers Watson
- PEBP Board Members (Day 1: Tom Verducci, Linda Fox, Jet Mitchell, John Packham; Day 2: Linda Fox, Jet Mitchell, John Packham, Deonne Contine)
- Attorney General's Office
- PEBP Executive Staff

Executive Summary:
Day 1 – Discussed end-of-year statistics and success in meeting previous year's strategic goals. Discussed multiple opportunities for both short and long term strategic initiatives moving forward.
Day 2 – Prioritized recommended strategies to present to the Board at the September Board meeting. Assigned tasks to partners to flesh out initiatives.

Strategic Plan Update:
Attached is the 2018 Strategic Plan with transparent changes detailed in the document. A clean version will be provided for final approval at the November PEBP Board meeting.

Specific Strategies:
Plan Years 2021/2022/2023

Background:
During the 80th Legislative Session, the Nevada Legislature approved PEBP's biennial budget (Fiscal Year 2020 / 2021) with three new inclusions:

1. The specific employer contribution (% of rates per plan per tier)
2. The overall rates (by default in approving the employer contribution); and
3. Any use of accumulated excess reserves for benefit changes/additions

These additions to PEBP's budget approval process present an environment that will be split into short-term (next plan year) and longer term (Plan Years 2022 and 2023) to coincide with Legislative approval of plan changes.

Short-Term Potential Strategies (Plan Year 2021):

1. Adding the Smart90 network requirements (voluntary or mandatory) to the EPO plan to be consistent with the CDHP. This is a pharmacy benefit cost-saving activity that saves both the member and the plan and can be implemented without excess reserve utilization.
2. Implement second opinions for high cost high value healthcare (example: oncology diagnosis). Both the Mayo and Cleveland Clinics report misdiagnosis is a leading cause of high cost unnecessary healthcare. The cost to pay an entity to provide these services can be offset by the reduced cost of claims for unnecessary services resulting in no utilization of excess reserves.
3. Chronic Kidney Disease (CKD) management program to assist members and reduce costs to the plan. American Health Holdings and HealthSCOPE Benefits can put together a coordinated program to address one of PEBP's highest costs chronic diseases ($43.7 million on the CDHP and $1.2 million on the EPO). This program would need to be developed with a 1:1+ ROI the first year to avoid excess reserve utilization.

Long-Term Potential Strategies (Plan Year 2022/2023):

1. Providing tiered coinsurance within the PPO networks. Based on cost and quality, PEBP can reimburse PPO network providers a higher plan coinsurance percentage (85%, 90%, etc.) or a lower coinsurance percentage (75%, 70%, etc.) and the member pays the difference. This should steer members to lower cost high quality providers while saving both the plan and the member. Both the SHO and HTH networks have this provision available today in some form.
2. Implement a Save-On Pharmacy program. Today PEBP has a copay accumulator program that disallows pharmacy manufacturer coupons from applying to the annual medical/RX accumulators (deductibles and out-of-pocket maximums). Per the federal Department of Health and Human Services (DHHS), starting next year these types of programs can only exist if a generic drug is offered. Since most of the high cost drugs do not have generics, this could effectively shut down this cost saving activity for PEBP next year. An alternative to remove drugs with copay cards out of the formulary, adjust the copay to the coupon amount, and collect maximum revenue from manufacturers. This reduces the member copay out-of-pocket to **zero**.
3. Implement additional disease management programs (enhanced Diabetes Care Management, Hypertension, etc.). These may or may not increase costs based on program ROI requirements.
4. Allow orthodontia to be included as part of the maximum dental benefit of $1,500. This will drive additional utilization (costs) and therefore can be presented to the Legislature in Plan Years 2022/2023 as a budget enhancement.
5. Alternative income-based sliding scale premium design. Those who make more pay more in monthly premiums. The overall rates and employer contributions would not change – only the member's monthly premiums would adjust based on income. This could be administratively challenging pending the employers' ability to apply income programming to the deductions.

Conclusion:

The short-term potential strategies could be easily implemented next year with no need to obtain IFC approval. The longer-term strategies can be built as budget enhancement units next year when PEBP submits its agency request budget on August 31, 2020. Additional opportunities and strategies can be built for the budget enhancement process as requested.

Recommendation:

PEBP recommends the Board review and provide input to the 2019 Strategic Plan. PEBP also recommends the Board review and approve any/all/different strategies for both short-term and long-term initiatives.

9.

9. Discussion and possible action to update the PEBP Board's Duties, Policies and Procedures to align with legislative action during the 80th Legislative Session. (Damon Haycock, Executive Officer) (**For Possible Action**)

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STEVE SISOLAK
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Executive Officer

NEVADA PUBLIC EMPLOYEES' BENEFITS PROGRAM

DEONNE CONTINE
Board Chair

PUBLIC EMPLOYEES' BENEFITS PROGRAM

BOARD AND AGENCY

Duties, Policies and Procedures

~~Novem~~September 201~~7~~9

TABLE OF CONTENTS

I. INTRODUCTION

Nevada Revised Statutes (NRS) (http://www.leg.state.nv.us/NRS/NRS-287.html) Chapter 287 Section 041 subsection 1 creates the Public Employees' Benefits Program (PEBP) Board (Board) ~~which~~to establish~~es~~ and carry~~ies~~ out a Program for health, life, and ~~health-related~~other voluntary insurance benefits.

The Board has adopted the following Duties, Policies and Procedures for general direction, information, and guidance of the Program. The Duties, Policies and Procedures may be amended, varied, or temporarily suspended at the discretion of the Board by motion passed in an open meeting.

A comprehensive fiduciary policy provides the Program with functional guidelines within which to operate. The Program is accountable to the Participants and the Public. Board Members, and agency employees must be willing to perform their responsibilities that preclude and inhibit misconduct, eliminate waste of resources, and embrace the concepts of sound cost effective measures.

GUIDING PRINCIPLES OF HEALTH CARE BENEFITS ADMINISTRATION

Service to the participants of the Program is the primary function of the Board and the Agency. Board members are fiduciaries who are to act for the exclusive benefit of the participants. Board members will act with integrity, objectivity, independence, prudence and due care.

II. GOVERNANCE

The policy is designed to enable Board members and agency employees to seek counsel, to remain inquisitive, and to exercise their functions with the prudence demanded of them in the public sector.

Board members are entrusted with the responsibility of exercising their duties in a manner that ensures the efficient and effective administration of the Program in compliance with all applicable Federal and State laws and regulations, including those relating to ethics (NRS Chapter 281A) and the Nevada Open Meeting Law (NRS Chapter 241).

FRAMEWORK:

- "Board" means the PEBP Board members
- "Agency" means the PEBP agency and its employees
- "Program" means both the Board and the Agency

A. BOARD RESPONSIBILITIES

Board members are entrusted with the responsibility of ensuring efficient administration of the program in accordance with all applicable laws and regulations, and shall:

1. Be responsible for adopting the Mission Statement, Values, Goals and Objectives (i.e., the Strategic Plan) of the Program.
2. Provide health care, life insurance, and other voluntary insurance benefits in a responsible manner balancing the needs of the State, Plan participants and the taxpaying community. Benefit changes may be considered by the Board based upon recommendations from individual Board members, the Agency or from the public.
3. Adopt sound actuarial and accounting standards and appropriate internal controls.
4. Review and revise Duties, Policies and Procedures regarding matters that are not specifically enumerated in statute or regulation as needed.
5. Take a position on any proposed legislative matters affecting the Program and direct Agency employees to make that position known to the Legislature. During the legislative session, the Board authorizes the Executive Officer to take a position of "neutral" on any new bill affecting the Program by default. This allows for rapid response to legislative committee meetings scheduled prior to a Board vote. The Board can revise the default position at the next Board meeting.
6. Prior to the commencement of each biennial legislative session, review and approve the framework for the biennial budget to be submitted to the Governor's office.
7. Employ and appoint an Executive Officer, subject to the approval of the Governor, to oversee the day-to-day operations of the Program in accordance with NRS 287.0424.
8. Delegate to the Executive Officer the authority to manage the Program within the parameters defined by the Board.
9. Evaluate the Executive Officer as needed in a public forum adhering to all applicable open meeting law requirements.
10. The Director of the Department of Administration appoints the Quality Control Officer for the Program. The Director shall define the duties of the Quality Control Officer with the concurrence of the Board. The Quality Control Officer serves at the pleasure of the Director.

B. BOARD MEMBER CONDUCT

Individual Board members shall:

1. Prepare for and attend Board meetings.
2. Refrain from making commitments to any individual or entity regarding any matter that is scheduled for consideration by the Board.

3. Not communicate with the press or plan participants on behalf of the Board.
4. Be ~~E~~encouraged to obtain continuing education credits pertaining to the administration of group benefits for public employees as funding is available.
5. Conduct their affairs in such a manner that they always represent the best interest of the Board. To fulfill these functions satisfactorily, individual Board members must exercise utmost judgment, discretion, and tact in order to ensure good public relations, and to avoid any possible misunderstanding regarding actions as an individual as opposed to actions as a Board member.
6. Not act in any official capacity on behalf of the Board except as directed by Board action.
7. Refrain from performing any function delegated or normally assigned to Agency employees.
8. Not obligate expenses on behalf of the Agency without following the Agency procedures.
9. Direct their inquiries and requests for information which may occur outside of a Board meeting to the Agency through the Executive Officer. A request that requires significant Agency resources, as determined by the Executive Officer, must be approved by the Board Chair~~man~~ before the staff shall be required to act upon the request.

C. BOARD MEETINGS

Board meetings shall be held in accordance with NRS Chapter 287 Section 0415. The Board shall conduct business in accordance with Nevada Administrative Codes (NAC) Chapter 287 Sections 170 - 176, (http://www.leg.state.nv.us/NAC/NAC-287.html), the Nevada Open Meeting Law (NRS Chapter 241), federal and state statutory and regulatory provisions and current Duties, Policies and Procedures, as applicable.

1. Any Board member may submit to the Executive Officer, or in his or her absence, the Operations Officer of the Program, a request for a matter to be placed on the agenda.
2. At the first meeting of each plan year, the Board will elect a Vice Chair. The Vice Chair shall serve as the Board Chair in the absence of the Board Chair.

D. EXECUTIVE OFFICER AND AGENCY ADMINISTRATION

The Executive Officer is appointed pursuant to NRS Chapter 287 Section 0424 and serves at the pleasure of the Board. The Executive Officer reports to the Board as a whole. Pursuant to NRS Chapter 287 Section 0424, the Executive Officer is delegated the responsibility to implement the plan of benefits, decisions, direction, internal controls and policies approved by the Board. Except as may otherwise be specified in plan documents approved

by the Board, the Executive Officer executes the authority of Plan Administrator as described in such documents.

1. The Board authorizes the Executive Officer or his/her designee to provide official press releases and to answer questions from the press and other news media.
2. The Board authorizes the Executive Officer or his/her designee to carry out administrative functions of the Agency, including but not limited to:
    a. Financial management of contribution/rate billing, accounts receivable, accounts payable and budgetary compliance.
    b. Management of Agency personnel, day-to-day operation and vendor performance matters.
    c. Interpretation of NRS and NAC in performing functions of the Agency.
    d. Approval of subrogation settlements and other financial settlements relating to claims processing.
    e. Representation of the Agency to other pertinent governmental bodies.
3. Consistent with Board policies and direction, the Agency shall work with the Governor's Finance Office and the Legislature to ensure that the Program is funded on an actuarially sound basis.
4. Ensuring the Agency notifies participants of health care benefit changes as approved by the Board.
5. As soon as practical, but within 120 days of the appointment of a new Board member, the Executive Officer shall provide the new Board member with a comprehensive orientation and overview of the Program which the new member shall acknowledge receipt by signing and dating the "Acknowledgment Form for Board Members". The orientation will include, at a minimum, the following:
    a. The history and overview of PEBP and the benefits administered by the Program including any special terminology generally used by the Program.
    b. The Board governance, including the Strategic Plan and these Duties, Policies and Procedures.
    c. A review of recent Board actions and precedents and current issues being considered by the Board.
    d. An overview of the funding and rate setting process.
    e. The continuing education opportunities for the member pending available funding.
6. The Executive Officer will also ensure these Duties, Policies and Procedures are provided to all employees upon approval of any changes by the Board and to new employees within 10 working days of their hire with the Agency. Employees will acknowledge receipt

and understanding by signing the "Acknowledgment Form for Employees."

7. The Executive Officer may obtain continuing education credits pertaining to the administration of group benefits for public employees as funding is available.
8. The Executive Officer will provide Agency employees with relevant education and training and will allow employees to attend training classes relating to the administration of health care benefits or to the employee's individual work assignments. The Executive Officer is responsible for setting the eligibility requirements for an employee to attend a training or other educational event and the appropriate reimbursement of cost and/or release time to be provided for the training within the budgetary limits established for the purpose of employee training.
9. The Executive Officer is responsible for interacting with the Executive and Legislative branches of government and shall work diligently and cooperate fully with both to provide any information desired in relation to the operations, functions, or status of the Program.
10. Responses to correspondence addressed to the Chair may be prepared by Executive Staff. Responses to correspondence addressed to the Board may be prepared and signed by Executive Staff on behalf of the Board.

E. ETHICS

The Board and agency employees must:

- Avoid the perception of misuse of influence;
- Be willing to adopt and abide by Duties, Policies and Procedures that preclude and inhibit misconduct;
- Eliminate the wasteful use of resources; and
- Embrace the concepts of sound cost effective measures.

Each Board Member and each member of the Executive Staff will read the most current Ethics Manual and sign an acknowledgement of their understanding of the ethics requirements upon appointment or hire and receive annual Ethics Training provided by the staff of the Commission on Ethics every subsequent year. The most current Ethics Manual may be found at:
http://ethics.nv.gov/uploadedFiles/ethicsnvgov/content/Resources/EthicsManual2014.pdf

In addition to the Ethics Manual and annual Ethics Training, Board members and agency employees will not:

1. Disclose information regarding business developments of a confidential nature received in the course of their duties except in the authorized performance of those duties.
2. Attempt to take advantage of confidential information received in the course of their duties for themselves or any third party.
3. Accept meals, travel, lodging or any other gift from any contractor bidding on an open Program RFP.

Business meetings, such as employee benefits orientations, open enrollment meetings, staff meetings, planning meetings, etc., may, in the interest of efficiency, be conducted at a contracted vendor's facility at no cost to the Agency as long as the expenses are customary and not intended to improperly influence a reasonable person.

If the Chair, Executive Officer, or assigned Deputy Attorney General cannot resolve ~~the~~an ethical question, the question should be referred to the Commission on Ethics:

Commission on Ethics
704 W. Nye Lane, Suite 204
Carson City, Nevada 89703
Telephone: 775-687-5469
Fax: 775-687-1279
Email: ncoe@ethics.nv.gov
Website: www.ethics.nv.gov

Nothing herein precludes a Board member from directly contacting the Commission on Ethics with a question about his or her ethical obligations as a Board member.

F. SEXUAL HARASSMENT

The Board hereby adopts and authorizes the Executive Officer to enforce the most current Policy Against Sexual Harassment and Discrimination approved by the Office of the Governor.

G. HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

Each Board member and agency employee must complete annual training regarding the privacy, protection and disclosure requirements of HIPAA.

Each Board member and agency employee shall sign a Confidentiality and Security Statement of Understanding upon appointment/hire.

H. TRAVEL POLICY

1. The authority for the travel policy is the State Administrative Manual (SAM) Sections 0200 and 1400. SAM can be found on the Governor's Finance Office's website.
2. Board members are subject to the same travel requirements as Agency employees and will receive a copy of the Travel Policy and Procedures during their orientation. The Travel Policy and Procedures outline the requirements for submitting travel requests, travel reimbursements and necessary supporting documentation.

III. CONTRACTS

A. PURPOSE, AUTHORITY, AND POLICY

1. The purpose of this policy is to establish procedures for new contracts and contract extensions which will be in accordance with the State Purchasing Act. http://www.leg.state.nv.us/NRS/NRS-333.html#NRS333Sec311
   The Nevada Administrative Code
   http://www.leg.state.nv.us/NAC/NAC-333.html and
   The State Administrative Manual
   http://budget.nv.gov/uploadedFiles/budgetnvgov/content/Governance/SAM.pdf

B. PROCUREMENT PROCESS

1. The Program is subject to the provisions of chapter 333 of NRS.
2. The Board shall act as the chief of the using agency for the purposes of NRS 333.335.
   a. The Board delegates the role as chief of the using agency to the Executive Officer.
3. If a committee to evaluate proposals for a contract for the Program is established pursuant to NRS 333.335, any number of members of the Board may be appointed to the evaluation committee. If one or more members of the Board are appointed to an evaluation committee:
   a. No action or deliberation regarding any business of the Board other than the confidential review of the proposals pursuant to NRS 333.335 may be taken or conducted by the evaluation committee.
   b. Except as otherwise provided above, a meeting of the evaluation committee is not subject to chapter 241 of NRS.
4. The Board shall review the results of any evaluation of proposals for a contract for the Program pursuant to NRS 333.335 in a closed meeting.

5. The Board shall take the following actions only in an open meeting:
   a. Award the contract pursuant to NRS 333.335;
   b. Cancel the request for proposals; or
   c. Modify and reissue the request for proposals.
6. Service performance standards and Financial Guarantees and/or Penalties will be included in all contracts. Specific standards, guarantees and penalties will depend upon the type of service(s) provided by vendor.
7. Contracts which are subject to an audit pursuant to the scope of work: the contracted auditor will conduct the audit in accordance with the schedule in the scope of work and provide the results to the Board at the next meeting after the conclusion of the audit and response from the vendor have been rendered.

IV. PREMIUMS AND CONTRIBUTIONS – RATE SETTING PROCESS

A. INTRODUCTION

PEBP sponsors both self-insured and fully-insured plans of benefits.

For benefit plans that are self-insured, the Board will annually establish plan contributions based on the recommendation of PEBP's contracted actuaries and sufficient to fund the plan(s) for the forthcoming plan year on an actuarially sound basis. Rates so established will be sufficient to fund anticipated paid claims as well as reserves. These reserves include Incurred but Not Reported (IBNR) claims, Health Reimbursement Arrangement (HRA) fund balances and a Catastrophic reserve.

For benefit plans that are fully insured, the Program will negotiate rates with insurance underwriters for the provision of benefits on the basis of equity to both the underwriters and to the Public Employees' Benefits Self-Insured Plan.

The Authority of the Board to establish rates are contained in NRS Chapter 287 Section 043 subsections 1 and 2 at the following link:
http://www.leg.state.nv.us/NRS/NRS-287.html#NRS287Sec043

B. RESERVE POLICY

PEBP will maintain fully-funded IBNR and Catastrophic Reserves as determined by plan actuaries using the confidence intervals and margins described herein and a fully-funded HRA Reserve based on the total balance remaining in all HRA accounts. ~~Excess reserves beyond those required to maintain fully-funded IBNR, Catastrophic and HRA Reserves may be used to pay for new programs and services, Program infrastructure~~

~~improvements, increased and/or new benefits, and rate mitigation.~~ Should the Catastrophic Reserve become underfunded or be forecast to be underfunded, the Executive Officer shall notify the Board at the next Board meeting.

The IBNR Reserves will be funded at a 95% confidence level to pay all known incurred claims. The Catastrophic Reserves will be funded at a 95% confidence level to meet unknown expenses which do not include IBNR. Both IBNR and Catastrophic Reserve levels will be recommended by PEBP's actuaries. The HRA Reserve will be funded to cover 100% of available balances.

Any cash-on-hand in addition to required reserves (IBNR, Catastrophic, and HRA) when the Program closes the fiscal year each year will be identified as "Excess Reserves." Per section 26 of Senate Bill 553 (2019) (~~T~~the Authorizations Act), "the Public Employees' Benefits Program, including, without limitation, the Board of the Public Employees' Benefits Program, shall not expend or otherwise obligate reserves, either realized or projected, in excess of the amounts authorized in section 1 of this act for purposes of changing the health benefits available to state and nonstate active employees, retirees and covered dependents over the 2019-2021 biennium without approval of the Interim Finance Committee upon the recommendation of the Governor."

C. DEFINITIONS

As used herein the following terms mean:

1. **Open Enrollment** – The period during which participants in the Program may select among all health benefit programs that are offered by PEBP or eligible individuals not currently enrolled in the Program may enroll for coverage.

2. **Participant Contribution** – The portion of the rate paid by participants.

3. **Plan Design** – The benefits provided to participants of the plan. This includes provider access, out-of-pocket expenses (deductibles, co-payments, and coinsurance), and lines of coverage (medical, dental, vision, life insurance, etc.). Plan design does not refer to the methodology used to determine rates.

4. **Plan Year** – The PEBP benefit plan year as approved by the Board.

5. **Premium** – The cost paid for fully-insured benefits (e.g. health maintenance organization membership, life insurance, etc.) as

determined by insurance companies contracted with by PEBP. Premiums are passed-through PEBP to the participants and employers.

6. **Rate** – The total monthly cost of coverage for a participant in a given plan option and tier.

7. **Rating Methodology** – The basis for allocating costs between plan options and participant tiers. This includes the application of claims commingling, coordination of benefits, predictive modeling, trend analysis, etc.

8. **Subsidy (Contribution)** – The amount paid by the employer or from Plan reserves towards the cost of PEBP benefits on behalf of participants. The subsidy is comprised of the following portions:
   a. Base Subsidy – For state employees, the portion of the rate paid by the employer pursuant to NRS 287.044. For retirees not on the Medicare Exchange, the portion of the rate paid by a retiree's previous employer(s) at 15 years of service pursuant to NRS 287.046.
   b. Years of Service (YOS) Subsidy – The adjustment to the Base Subsidy, for participants who retired on or after January 1, 1994, based on a retiree's YOS, paid by a retiree's previous employer(s) pursuant to NRS 287.046 and NRS 287.023(4)(b).

D. OVERVIEW OF THE BIENNIAL PROCESSES[1]

1. **Rate Setting** – Prior to the commencement of each plan year, the Board will establish rates based upon the recommendation of the Agency and PEBP's contracted actuaries based upon a variety of factors, including, but not limited to :
   a. Established plan designs
   b. Forecast claims costs for self-insured plan(s)
   c. Forecast premium costs for fully insured plan(s)
   d. Forecast fixed expenses from plan administrative vendors
   e. Forecast PEBP internal administrative expenses
   f. Forecast required adjustments to reserves
   g. Consideration of material demographic changes

2. **Plan Design** – The Board will identify the priorities for plan design (i.e. options for changes in the plan design). These priorities may

[1] As written, this process refers to the "normal" planning process for plan years starting July 1st and ending June 30th.

include scope of benefits offered by the plan and/or cost sharing methodologies between the Program and its participants. To the extent possible, cost estimates are presented at the same time as the plan design option for inclusion in the discussion. The Board can take into consideration all information provided by Program staff and consultants during the year, along with any other sources available to individual Board members.

The Board makes its initial determination regarding plan design changes not later than four to five months prior to Open Enrollment. Composite trend developed by the Plan actuaries is presented to the Board based on the final plan design changes. Final plan design is approved at the rate setting Board meeting to allow for flexibility and an opportunity to adjust rates at that meeting.

PEBP uses the approved plan design changes and rating methodologies to finalize the rates, subsidies, and participant contribution amounts. The final rates are then reviewed and approved by the Board approximately four to eight weeks prior to open enrollment.

3. **Strategic Planning** – The Board will review, revise and approve the program's Strategic Plan on an annual basis. The Strategic Plan will be the guiding document designed to assist the Board and the Agency develop and maintain a high quality program of benefits at affordable prices. Every effort will be made to review and approve the Strategic Plan prior to the initial annual plan benefit design approval meeting.

4. **Establishing the Legislative Agenda** –Using the strategic plan as a basis, any revisions required to the Nevada Revised Statutes (NRS) to implement the strategic plan will be identified. The Agency will present Bill Draft Request (BDR) recommendations to the Board every "even" numbered year and develop approved summaries and BDRs in accordance with State mandated schedules. Administrative departments are required to submit non-budgetary Legislative Summaries to the Governor's office by early April of each even numbered year. Upon approval of the Legislative Summary by the Governor's office, completed bill draft requests (BDRs) are due by June 1 of each even numbered year. Legislative Summaries and final non-budgetary BDRs will be approved by the Board prior to submission.

5. **Preparing the Biennial Budget Request** – Departments are required to submit their biennial budget requests no later than September 1 of each even numbered year. Using the strategic plan and the approved allocation methodologies found in Appendix A as a basis, staff preparation of the biennial budget request begins in the spring of each even numbered year. A framework for the budget request will be presented to the Board in late spring or early summer, with final approval required at the July or August Board meeting. Budgetary BDRs will be approved by the Board prior to submission on September 1.

6. **Program Reporting** – Per NRS 287.0425, the Executive Officer shall submit a report regarding the administration and operation of the Program to the Board and the Director of the Office of Finance, and to the Director of the Legislative Counsel Bureau for transmittal to the appropriate committees of the Legislature or, if the Legislature is not in regular session, to the Legislative Commission and the Interim Retirement and Benefits Committee of the Legislature created by NRS 218E.420. Additionally, the Board receives reports on a prescribed schedule to assist in strategic planning, decision-making, and program design. Below is a listing of the sources of information that will be considered by the Board when making all plan design and rate decisions, along with the timeframe of availability for each item. It is important to note that the information is provided to the Board throughout the year and is not limited to the Board meetings when rates are approved.
   a. Quarterly Vendor Reports – The reports provide utilization activity, participant contacts, provider updates, and other information applicable to each vendor's relationship with PEBP.
   b. Self-Insured Plan Utilization Reports – PEBP's Chief Financial Officer provides a utilization report for the self-funded plan on a quarterly basis. In addition, an annual utilization report is provided within 90 days following each plan year. The utilization report provides the following data for the entire plan:
      - √ Executive summary and trend analysis
      - √ Plan demographics
      - √ Paid claims by benefit
      - √ Medical claims paid for inpatient/outpatient services
      - √ Surplus and loss summaries broken down by state and non-state groups and active employees, non-Medicare retirees and Medicare retirees.
      - √ Costs by tier and age by medical, dental, prescription

- √ Network utilization and cost sharing
- √ Analysis of medical paid claims by major diagnostic category, large claims and prevalence
- √ Chronic conditions and wellness
- √ Analysis of prescription drug utilization

c. Disease management and wellness reports are made available to the Board in vendor quarterly reports. In addition, as each of these programs "mature", they will be analyzed by PEBP and PEBP's consultant on a cost / benefit basis and the results reported to the Board.

d. The results of any participant questionnaire will be reported to the Board as soon as practical upon compilation of the results.

7. **Projected Expenses and Rate Calculations** – Any change in methodology for projecting expenses (such as changing from claims trends to a predictive modeling approach) is to be reviewed and approved by the Board during strategic planning and plan design adoption actions. Rate calculations are to be completed by PEBP using the approved framework and rating methodology. The consultant/actuary firm is responsible for ensuring that industry standards are met for quality control and accuracy of the medical, prescription drug, and dental cost components for each plan year. PEBP staff will compare the projected expenses and rate calculations to the proposed budget and recommend any amendments to the proposed budget and/or plan design that are deemed appropriate. The rate methodology for each plan year shall be included in updates to these ~~d~~Duties, ~~p~~Policies~~,~~ and ~~p~~Procedures (see Appendix A).

Appendix A - Plan Year Rating Methodology

Rates are developed first by establishing the plan design. The second step is to project claims costs or premiums for each plan option (e.g. PPO self-funded, HMO, etc.) and participant tier (e.g. single, family, etc.). Finally, PEBP operating costs, administrative costs and reserve adjustments are applied to the various plan options to derive the final rates. Subsidies are applied to the appropriate rate resulting in the participant contribution. Unless otherwise approved by the Board, rates are to be calculated by staff using the following methods.

Plan Design

- Plan Selection Options (medical, prescription, and vision):
  - √ Preferred Provider Organization (PPO) Consumer Driven Health Plan (CDHP) (Base Plan) – self-funded
  - √ Exclusive Provider Organization (EPO) Premier Plan – self-insured
  - √ Health Maintenance Organization (HMO) Plans – fully insured
  - √ Individual Market Medicare Exchange (IMME) – fully insured; only for retirees and their dependents who are eligible for premium free Medicare Part A; Medicare retirees who qualify for the exchange are not eligible for any other PEBP coverage (other than dental) unless they cover a dependent who is not eligible for the IMME.

- Self-Funded Plan Designs: See Master Plan Documents for details.

- Benefits other than medical, prescription, and vision: See Master Plan Documents for details.
  - √ Dental - self-funded; voluntary for IMME retirees, mandatory for all other participants
  - √ Life Insurance - fully insured
  - √ Long Term Disability Insurance (LTD) – fully insured
  - √ Health Savings Account (HSA) – Active employees on the CDHP plan only; some eligibility restrictions apply. Plan contribution to be set by the Board each year; if no Board action, contribution is equal to prior year contribution. Employee contribution is voluntary.
  - √ Health Reimbursement Arrangement (HRA) – Retirees on the CDHP plan or active employees who do not have an HSA. Plan contribution on the CDHP is equal to the HSA contribution. Plan contribution on the Medicare Exchange is based on the retiree's years-of-service. There is no year over year carryover limit for unspent HRA funds in an individual's account. The Board will review the liability associated with unspent HRA funds each year.

- √ Flexible Spending Account (FSA) – IRS section 125 voluntary plan guaranteed by PEBP. For active employees only; employees with an HSA are not eligible for a Medical FSA.
- √ Additional Life Insurance – voluntary; fully insured
- √ Long Term Care – voluntary; fully insured
- √ Short Term Disability – voluntary; fully insured
- √ Homeowners and Automobile Insurance – voluntary; fully insured
- √ Accident/Indemnity – voluntary; fully insured
- √ Legal Support – voluntary, fully insured
- √ Identify Theft Protection – voluntary, fully insured
- √ Buy-Up Vision Insurance – voluntary; fully insured
- √ Pet Insurance – voluntary; fully insured

Cost Projections

- Commingling: Pursuant to NRS 287.043(2) and NRS 287.0434(3)(b), claims experience will be commingled for participants for whom the Program provides primary health insurance coverage in a single risk pool.

- Cost Projection Methodology: Predictive Modeling
  - √ In addition to taking traditional rating methodologies into consideration, such as demographics and claims experience, predictive modeling considers PEBP's actual disease states and medical conditions to add precision to actuarial projections
  - √ Medical diagnosis data is reviewed by certified clinicians, such as PEBP's Actuary's Medical Director and nursing staff.
  - √ PEBP's actuaries will develop rate cards so that there is 50% probability that the developed rates cover plan costs.

- Secondary Insurance Coordination: Standard Coordination of Benefits
  - √ PEBP plan pays the difference between the allowable cost of the health care services and supplies provided to the plan participants less whatever the primary plan paid for them.
  - √ The participant is still responsible for the annual PEBP plan deductible.

- Rate Structure: Separate rates are developed for each of the following groups (NRS 287.043(2)(a) and (b)):
  - √ State active employees and non-IMME retirees
  - √ Non-State active employees and non-IMME retirees

- Participant Tiers of Coverage: Four

- √ Single
- √ Single + Spouse
- √ Single + Child(ren)
- √ Single + Family (Spouse and one or more children)

Rate Development

- PEBP's actuaries and HMO vendors will develop costs in accordance with the plan design approved by the Board and in accordance with the methodologies found in the Cost Projections section above.

- Enrollment projections are based on the average change in enrollment over the past 4 years and assumptions approved by the Executive Officer.

- The following costs, revenues and reserve adjustments will be allocated equally to all active employees and non-IMME retirees:
  - √ Life insurance (per $1,000 of coverage)
  - √ Long Term Disability (active employees only)
  - √ PEBP operating costs
  - √ Contracted dental network and claims payment administrative fees
  - √ Miscellaneous Revenues (GL 4254)
  - √ Treasurer's Interest (GL 4326)
  - √ Cost of Medicare Part B premium credit (reduction to excess reserves, Category 86)
  - √ Projected credit due to NRS 287.046(4) (increase to excess reserves, Category 86)
  - √ IMME administrative costs for Health Reimbursement Arrangement
  - √ Life Insurance for IMME retirees

- The following costs, revenues and reserve adjustments will be allocated only to CDHP participants:
  - √ Contracted CDHP administrative fees
  - √ HSA/HRA plan contributions
  - √ CDHP Rx Rebates (GL 4218)
  - √ Adjustments to Catastrophic Reserves (Category 85) in accordance with reserve policies.

- IMME retirees will not be charged for PEBP operating costs, life insurance costs or HRA administration costs. The following costs will be allocated only to IMME retirees who choose PEBP dental coverage:
  - √ Contracted dental network and claims payment administrative fees

- Reserves
  - √ Catastrophic Reserves will be established at a level necessary to ensure plan solvency over the long term at a 95% confidence interval.
  - √ IBNR Reserves will be established at a level to achieve a 95% probability that all incurred claims can be paid.

- Participant contributions for HMO/EPO rates are blended between the northern EPO and southern HMOs after all of the above adjustments are applied. The blended HMO/EPO rate is based on the average cost of coverage by tier and projected enrollment. ~~The purpose of the following reserve adjustment is to offset errors in rate blending caused by variation in the estimated HMO enrollment for the current plan year. The adjustment will be allocated only to HMO participants:~~
- ~~Adjustments to the Excess Reserves (Category 86) in an amount that is equal to the difference between~~
- ~~The product of the projected HMO enrollment used to calculate the blended rates for the current plan year multiplied by the premiums charged by each HMO; and~~
- ~~The product of the latest projection for HMO enrollment for the current plan year multiplied by the premiums charged by each HMO.~~

Subsidy Allocation and Participant Contribution

- Base subsidy allocation
  - √ The employer subsidy percentages will be ~~determined~~recommended by the Board ~~at the rate setting Board meeting~~to the Governor during the Agency Request phase of the Biennial Budget. The ~~Agency will provide a recommendation in line with legislatively approved budgeted amounts to ensure the Program remains solvent in each year of the biennium~~ Legislature, through the Senate Finance Committee and Assembly Ways and Means Committee, will approve the final employer contribution percentages for each biennium when approving PEBP's biennial budget.
  - ~~√ Employer subsidy percentages for the primary insured in the non-base plans will be equal to the state subsidy percentages for the primary insured in the base plan less an amount approved by the Board.~~

- ~~√ State subsidy percentages for dependents will be equal to the state subsidy percentages for the primary insured in each plan less an amount approved by the Board~~
- √ Non-State Active Employee: Determined by employer
- √ Non-State Retiree: Determined by State Retiree amount (NRS 287.023(4)(b)) as set in session law and is based only upon years of service, regardless of plan selection or participant tier.

- Retiree Years of Service (YOS) subsidy adjustment to the base subsidy (NRS 287.046):
  - √ Retirees who retired prior to January 1, 1994: No adjustment.
  - √ Retirees who retired on or after January 1, 1994:
    - For each YOS less than 15, subtract 7.5% of the amount set in session law from the base subsidy.
    - For each YOS greater than 15, add 7.5% of the amount set in session law to the base subsidy (maximum, 20 YOS).
  - √ Retirees who were hired by their last employer on or after January 1, 2010 and who have less than 15 YOS do not receive a YOS or base subsidy.
  - √ Retirees who were hired by their last employer on or after January 1, 2012 do not receive a YOS or base subsidy.

- Medicare Part B premium credit – Retired primary participants enrolled in the Consumer Driven Health Plan, EPO or HMO plan with Medicare Part B coverage will receive a CDHP, EPO or HMO premium reduction as approved by the Board. In no case shall the premium contribution for an individual be less than zero.

10.

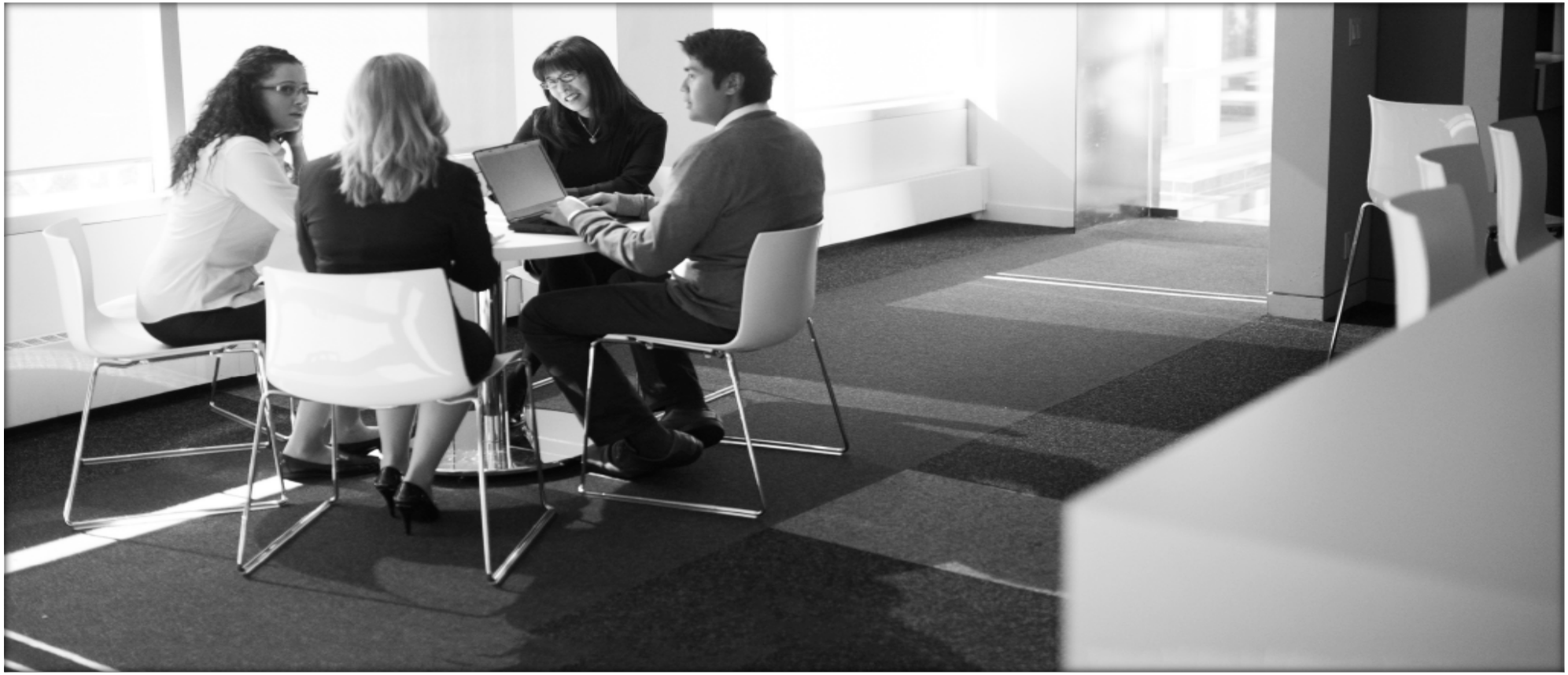
10. Discussion and possible action to review and approve the Morneau Shepell eligibility and enrollment system Performance Improvement Plan. (Morneau Shepell) (**For Possible Action**)

MORNEAU SHEPELL

PEBP

Performance Improvement Plan

September 26, 2019



Agenda

Background

In 2018/2019, Morneau Shepell and PEBP partnered to introduce a series of enhancements to the PEBP enrollment solution, including:

- Migration to a new portal platform (MyLife 2.0);
- Implementation of a new responsive enrollment tool;
- Integration of Voluntary Benefits (VB) supported by Corestream;
- Automation of event process where no documentation requirements exist;
- Decommissioning of OCR/Document Management in AX and replacement with Morneau Shepell's Kofax/FileNet solution;
- Introduction of HRIS files and on-line data updates for agency reps to automate data collection from upstream systems (WorkDay and Central Payroll).

The project was a significant undertaking for both organizations – in terms of time and importance to the overall relationship. Project management and resources were assigned and worked to deliver on all elements of the solution. Over the course of the project, some deliverables were added to the original scope with agreement from project leadership such as migration of the hosting environment to a US data center.

Additionally, some deliverables increased in complexity or encountered delays from parties outside both organizations and were de-prioritized on agreement with leadership with intent to deliver these at a later date:

- HRIS interface and on-line data updates for agency reps;
- Decommissioning of OCR/Document Management in AX.

In addition to the above, some elements (e.g. approach to integrating Voluntary Benefits) were simplified to help reduce risk. The result of this project flux was compressed time and attention to quality assurance which impacted the level of rigor applied to this phase of the process. As such, the system delivered for open enrollment was not fully compliant with all terms in Morneau Shepell's Contract Amendment #4.

The net result of these conditions impacted the quality of the delivered solution, which created impact on PEBP participants, PEBP & Morneau Shepell staff, and our leadership teams:

Ref	Issue	Details	Impact	Participant impact	Staff impact	Leadership
Key Contributing Factors						
1	Project governance approach	Plotting and management of critical path items, buffers, and trade-offs didn't adequately capture the impact of slippage in some deliverables, which resulted in trade-offs & some items being removed from initial launch	High	N/A	Increased churn in project and deliverable planning and associated uncertainty	Loss of confidence in overall project management discipline Loss of credibility with outside stakeholders (HRIS/payroll)
2	Compressed testing time	Compression of time available for testing all elements (including end-to-end impacts of changes beyond participant UX) compromised ability to validate all impacts of changes on overall operating environment	High	N/A	Significant churn and uncertainty at go-live, resulting in significant challenges during OE	Impact on KPIs and overall relationship
3	Environment management – issues promoting to production	Code and configuration sign-off in UAT wasn't parallel to production experience leading to unanticipated production issues	High	Issues with participant website capabilities which triggered calls and inability for some	Increased call and operational workload	Impact on KPIs

				members to enroll online.		
Resulting Issues						
Ref	**Issue**	**Details**	**Impact**	**Participant impact**	**Staff impact**	**Leadership**
4	Site access issues	Inconsistencies in behaviour of participant portal between browsers, and versions of browsers, leading to login problems & inconsistencies in user experience	Medium	Limited access to self-service & triggered outreach calls	Fielded additional call volume	Impact on KPIs
5	Vendor site integration issues	Intermittent issues with SSO to HealthScope (related primarily to HealthScope technology)	Medium	Limited access to self-service	Fielded additional call volume	
6	UX - VB integration approach	Difficult for participants to understand what's available, enroll, and view their products & deductions	High	Limited awareness of products, drives confusion	Increased call volumes to PEBP and other agency HR offices.	Reduced impact of VB purchases
6	VB transition approach	Mapping from old to new polices not well orchestrated, no planned conversion of carrier VB data at go-live, and change management wasn't comprehensive in approach	High	Confusion – e.g., what is this deduction, what's it for, what's the breakdown, where did my old policy go?	Increased call volumes, reduced visibility, added investigation and issue tracking	Increased call volumes and cancelled VB policies impacting VB revenue

Ref	Issue	Details	Impact	Participant impact	Staff impact	Leadership
7	Rules for medical applied to new VB products	Rule sets originally intended to support core medical elections (only) were not revisited as we added VB products	High	Confusion and errors leading to calls to PEBP and submission of documents	Increased call volumes; increased research and operational tasks	Increased workload for operational teams due to poor requirements definition process
8	Operational issue management & approach to firefighting	Issues lead to many on-the-fly workaround and firefight deployment / fixes that triggered other problems as these were made without considering impact on other elements of the solution (example = flagging auto-approval of events with EOI without consideration of other document requirements for same event).	High	Confusion and errors on what coverage was in-force and engagement to sort out what to do with errors	Significant churn & challenges in the support and operational teams leading to time-consuming investigation & rework	Impact on KPIs and overall relationship
9	Production instability during firefight support process	Rapid solutioning of workarounds and firefight deployments & bulk processes to deal with issues led to some additional unanticipated consequences	Medium	Issues with participant website capabilities which triggered enrollment issues and calls	Increased call and operational workload	Impact on KPIs and overall relationship

As we think through the performance improvement plan, a number of key areas which have led to our current state and which need to be addressed to future-proof the solution and working relationship need to be addressed. These are outside of the steps required

to catch up and regain stability and trust in the solution and prevent against future recurrence of issues. Key elements of our partnership model that we need to review include:

Item	Detail
Project management	Project plans need to reflect critical path, clear documentation of project scope to ensure clarity and agreement on deliverables, and include buffers. Project governance model needs to ensure identification and management of stakeholder impacts and input through the process.
Issue management	Our approach is too single threaded due to embedded knowledge with one person (Vanessa), which contributes to email escalations and churn
Interface validation	Not being done consistently for all interfaces - PEBP finds the issues & Vanessa then needs to research vs. Morneau Shepell ensuring quality and consistency of delivery
Solution design	Need to assign and retain a Solution Architect to ensure the end-to-end solution holds up and to re-involve when key elements of the solution or requirements change
Impact matrix	Need a formal matrix to help all team members understand what is impacted / what could break when a change is needed in one area of the solution
Quality control process	Need a more structured approach to quality management - for ongoing platform delivery, incremental changes & for large-scale ones. Test execution plans including matrix, cases, tactical plan, testing scope, support model, etc. Any significant UAT efforts (e.g. for OE) should be supported by Morneau Shepell staff on-site at PEBP.
Requirements management & change control	Need to review and update requirements document artifacts and validate with current system configuration and ensure that any changes to these are documented consistently & passed through a formal change control process.
Environment management	Need to ensure that all changes are tested and approved in UAT before promotion to production, and that production deployments are properly scheduled and validated.

	Client has limited testing in UAT as there are differences between UAT and production that they can't always explain. At OE, PEBP was comfortable in UAT but elements were missed in some production deployments. Issue of lack of test accounts in production that needs to be addressed.

Performance Plan Goal

PEBP desires a fully-integrated member facing intuitive portal that will improve the member experience enrolling in both standard medical offerings and Board-approved voluntary benefits. PEBP also desires an upgraded client-side system where manual processes conducted by PEBP staff are replaced with less risky, thoroughly tested and validated, automated processes for eligibility and enrollment in program services. Morneau Shepell shall create a fully integrated benefits platform incorporating voluntary benefits where possible into a dynamic, intuitive industry leading member portal and will streamline to the extent possible based on PEBP rules and procedure requirements, all in-scope client-side operations through collaboration with PEBP supported employers as well as strategic and robust automation of internal PEBP processes.

This document provides the scope and high-level plan to deliver to the above vision. Any additions or modifications to the scope of the performance improvement plan will be subject to change control process to ensure we are actively managing project risks associated with change to the scope documented herein.

Our goal is to deliver to PEBP's satisfaction on all elements contained in this Performance Improvement Plan by April 1, 2020. This includes both tactical fixes to the existing platform, along with improved approaches and methodologies to protect against recurrence of issues in our operational model and partnership. If Morneau Shepell does not deliver on the Performance Improvement Plan to PEBP's satisfaction as determined based on a set of metrics to be agreed to during the planning phase of this initiative and evaluated on completion of the initiative by PEBP's Executive Officer by April 1, 2020, beyond factors within our control, we acknowledge that PEBP may choose to: 1) develop a decommissioning plan to replace the system and terminate the contract early with no remaining financial responsibility to PEBP; 2) renegotiate contract terms and collaborate with Morneau Shepell on additional solutions; or 3) accept the system as-is and honor the remaining time and financial consideration as approved in the current contract amendment.

Key Performance Plan Items

We separate the performance improvement plan into two key areas – tactical (what we need to do to stabilize) and operational (what we need to do to future-proof our long-term relationship). Following are the recommended areas of focus for each:

Tactical areas of focus

	Issue	Proposed Actions	Success Measures	Start Date	Target Resolution Date	Status
1	Event processing rules configuration	• Review & revise documentation triggers to separate VB treatment from medical plan treatment	• Formal sign-off on rulesets & comprehensive testing to ensure accuracy	9/30/19	11/5/19* 2/28/20*	**On Track** *11/5/19 – Complete review of documentation *2/27/20 - target resolution date dependent on the size & scope of changes required
2	Event error & issue management	• Conduct structured audits to identify and support remediation of issues with event processing since April 15 (e.g. auto-approving events, EOI issues, etc.)	• Capture of all issues and impacted participants • Successful resolution of issues impacting participant accounts	10/7/19	11/7/19* 12/4/19*	**On Track** *11/7/19 – Complete review of errors and issues *12/4/19 - target resolution date dependent on the size & scope of corrections required
3	Interface management	• Assign an EDI team member to validate file contents, confirm delivery, and support research of any reported issues	• Elimination of errors in interface files prior to vendor distribution	10/7/19	12/16/19	**On Track**

	Issue	Proposed Actions	Success Measures	Start Date	Target Resolution Date	Status
4	Catch-up & management of other back-log issues	• Increase bench strength of issue research & support working team to reduce key person dependencies & increase throughput	• Increase speed and accuracy of requisite fixes	9/30/19	12/6/19	**On Track**
5	Optimize user experience for the participant portal	• Capture & address key areas of concern to simplify the user experience and optimize in terms of overall intuitiveness for the membership	• Reduced calls related to site navigation • Increased VB uptake	9/30/19	3/11/20	**On Track**
6	Stabilize VB benefits	• Ensure all products are configured and working properly and consistently • Introduce an escalation process to move VB-related issues from PEBP staff to Morneau Shepell's VB vendor – through the PEBP IVR tree or through warm-transfer	• Elimination of payroll agency concerns surrounding deductions; reduce calls and unnecessary work for PEBP staff	9/30/19	11/5/19* 2/28/20*	**On Track** *11/5/19 – Complete analysis & review of documentation *2/28/20 - target resolution date dependent on the size & scope of changes required
7	Complete the decommissioning of AX	• De-couple AX from HRIS interface initiative & complete the implementation & conversion process • Roll-out the administrator portal to	• Elimination of reliance on AX • Sign-off on new solution after stabilization period	In Progress	1/1/20*	**On Track** *Dependent on the decision to de-couple AX from the HRIS interface initiative

	Issue	Proposed Actions	Success Measures	Start Date	Target Resolution Date	Status
		enable on-line collection of hires, status changes, and data updates to all Pay Centers				
8	Complete the HRIS interface initiative	• Complete the implementation of the HRIS files from Workday and Central Payroll •	• Testing completed with successful pass of test cases • Interface code error free in production • Reduction in operational team work effort	In Progress	3/31/20	**On Track**
9	Formally market lifestyle VB products already in production	• Subject to Morneau Shepell and PEBP comfort that existing elections are working correctly, including payroll deductions, and are not causing unexpected issues for members and PEBP staff	• Formal marketing that Lifestyle products are available to PEBP members • Increased VB uptake	10/7/19	11/29/19	**On Track**

	Issue	Proposed Actions	Success Measures	Start Date	Target Resolution Date	Status
10	Enable self-service for retiring employees (previously deprioritized until after May 2019 launch)	• Create the ability for retiring employees to make their elections on-line (vs. the current paper-based approach)	• Elimination of paper from the retirement process • Increased efficiency for operational teams	11/4/19	2/28/20	**On Track**

Partnership & operational support optimization

	Issue	Proposed Actions	Success Measures	Start Date	Target Resolution Date	Status
1	Project management & governance	• Establish a formal governance structure (SC, working committee, reporting cadence) and project management approach for remediation project, key events (OE, upgrades, etc.) and ongoing	• PEBP approval of project governance model • Increased confidence in project outcomes	8/29/19	9/27/19	**On Track**

	Issue	Proposed Actions	Success Measures	Start Date	Target Resolution Date	Status
2	AV tickets and overall issues management	• Add resources to reduce key person dependencies & simplify triage model during catch-up phase • Introduce on-site support in triaging issues and working with PEBP on the performance plan • Improve turnaround on reviewing and triaging AV tickets & increase rigor in assigning and managing delivery to due dates	• Turnaround time for reported AV tickets • Capture of all requests via AV to ensure patterns are more easily recognized, root causes identified, and priorities managed effectively	9/30/19	12/6/19	**On Track**
3	Interface management	• Formalize the support structure for interface management & reduce dependency on PEBP	• Reduction of missed interface delivery timeframes • Reduction of interface issues	10/7/19	12/16/19	**On Track**
4	Solution design & continuity	• Assign a Solution Architect to support PEBP, including any significant future initiatives	• Improved cohesiveness of overall solution • Reduction in unintended	9/16/19	10/11/19	**On Track**

	Issue	Proposed Actions	Success Measures	Start Date	Target Resolution Date	Status
			consequences when requirements change			
5	Requirements management	• Review and update key requirements documents to ensure reflection of current state. Ensure future change requests are captured and change controlled	• PEBP sign-off on updated requirement artifacts	9/30/19	1/24/20* 3/18/20*	**On Track** *1/24/20 – Complete analysis & review of documentation *3/18/20 - target resolution date dependent on the size & scope of changes required
6	Change control	• Establish a formal change control process including impact identification (matrix), risk assessment, stakeholder impact, sign-offs / workflow, etc.	• Reduction in errors or differences in understanding when changes are made	9/3/19	10/8/19	**On Track**
7	Quality assurance	• Review and optimize the overall quality control process, including approach to test planning, test members, scenario management, and overall approach and accountabilities between Morneau Shepell and PEBP • Move to a more regimented schedule to batch fixes / releases vs. deploying to	• Reduced errors & issues related to product or configuration changes	9/30/19	2/3/20	**On Track**

	Issue	Proposed Actions	Success Measures	Start Date	Target Resolution Date	Status
		production on a piecemeal basis				
	Environment management	• Re-baseline UAT environment and develop overall approach to syncing between environments • Review deployment procedures & determine methods to ensure correct propagation between test and production environments	• Consistency between signed-off system and configuration in UAT vs. production	9/30/19	1/31/19	**On Track**

11.

11. Discussion and possible direction from the Board to staff on potential program design changes for Plan Year 2021/2022/2023 for which the Board requests additional information and costs to be presented at the November 21, 2019 meeting. (Damon Haycock, Executive Officer) (**For Possible Action**)

STEVE SISOLAK
Governor

Deonne E. Contine
Board Chair

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Expires 04/01/2021

DAMON HAYCOCK
Executive Officer

AGENDA ITEM

[X] Action Item
[ ] Information Only

Date: September 26, 2019

Item Number: XI

Title: Plan Benefit Design Opportunities

SUMMARY

This report will provide the Board, participants, and public information and recommendations for deeper analysis on program benefit design opportunities for Plan Year 2020.

REPORT

PEBP recently closed Fiscal Year 2019 and ended the year with more excess reserves than anticipated. PEBP experienced another good year with our self-insured Consumer Driven Health Plan (CDHP). For Plan Year 2019, the PEBP Board approved the utilization of known excess reserves to fund additional benefits at the March 2018 Board meeting.

The table below illustrates the new reality for available funding:

Excess Reserve Reconciliation		
Type	**Amount**	**Comments**
PY20 Starting Cash on Hand	$150,276,433	PY19 Ending Amount
PY20 HRA Reserve Budget	($33,820,094)	Legislatively Approved
PY20 IBNR Reserve Budget	($54,400,000)	Legislatively Approved
PY20 Cat Reserve Budget	($42,800,000)	Legislatively Approved
Increased HRA Reserve Budget	($2,384,109)	HRA balances as of June 30, 2019 totaling $36,204,203
Increased IBNR Reserve	($4,390,000)	Aon projected increased IBNR for the CDHP and EPO plans totaling $58,790,000.

Excess Reserve Reconciliation		
Type	**Amount**	**Comments**
Increased Cat Reserve	$400,000	Aon projected decreased Catastrophic for CDHP plus projected amount for new EPO plan totaling $42,400,000.
Remaining Available	**$12,882,230**	
PY 20 Legislative Approved Excess Reserve Spend	($9,600,207)	Approved by the Legislature during the 80th Session (includes $400 enhanced CDHP HSA/HRA funding, equipment replacement, personnel reclassification)
PY 21 Legislative Approved Excess Reserve Spend	($3,046,285)	Approved by the Legislature during the 80th Session (includes $125 enhanced CDHP HSA/HRA funding, equipment replacement, personnel reclassification)
Remaining Balance	**$235,738**	**Amount available for PY21**

Every year, PEBP brings the Board a table of categorized options to consider for further analysis by PEBP and our consultants. Due to the Legislative requirement to approve all excess reserve utilization for benefits, we have replaced the table with a short-term and long-term selection of opportunities. Please see on the following pages these opportunities to help guide the discussion.

RECOMMENDATION

PEBP staff recommend the Board select and approve analysis on activities outlined below and any others desired to prepare for and bring back recommendations to the Board at the November Board meeting for Plan Year 2021/2022/2023 plan benefit design approval.

Short-Term Potential Strategies (Plan Year 2021)

1. Adding the Smart90 network requirements (voluntary or mandatory) to the EPO plan to be consistent with the CDHP. This is a pharmacy benefit cost-saving activity that saves both the member and the plan and can be implemented without excess reserve utilization.

2. Implement second opinions for high cost high value healthcare (example: oncology diagnosis). Both the Mayo and Cleveland Clinics report misdiagnosis is a leading cause of high cost unnecessary healthcare. The cost to pay an entity to provide these services can be offset by the reduced cost of claims for unnecessary services resulting in no utilization of excess reserves.

3. Chronic Kidney Disease (CKD) management program to assist members and reduce costs to the plan. American Health Holdings and HealthSCOPE Benefits can put together a coordinated program to address one of PEBP's highest costs chronic diseases ($43.7 million on the CDHP and $1.2 million on the EPO). This program would need to be developed with a 1:1+ ROI the first year to avoid excess reserve utilization.

Long-Term Potential Strategies (Plan Year 2022/2023)

1. Providing tiered coinsurance within the PPO networks. Based on cost and quality, PEBP can reimburse PPO network providers a higher plan coinsurance percentage (85%, 90%, etc.) or a lower coinsurance percentage (75%, 70%, etc.) and the member pays the difference. This should steer members to lower cost high quality providers while saving both the plan and the member. Both the SHO and HTH networks have this provision available today in some form.

2. Implement a Save-On Pharmacy program. Today PEBP has a copay accumulator program that disallows pharmacy manufacturer coupons from applying to the annual medical/RX accumulators (deductibles and out-of-pocket maximums). Per the federal Department of Health and Human Services (DHHS), starting 2021 these types of programs can only exist if a generic drug is offered. Since most of the high cost drugs do not have generics, this could effectively shut down this cost saving activity for PEBP in the next few years. An alternative exists to remove drugs with copay cards out of the formulary, adjust the copay to the coupon amount, and collect maximum revenue from manufacturers. This reduces the member copay out-of-pocket to **zero** and maximizes PEBP's collection of manufacturer coupons.

3. Implement additional disease management programs (enhanced Diabetes Care Management, Hypertension, etc.). These may or may not increase costs based on program ROI requirements.

4. Allow orthodontia to be included as part of the maximum dental benefit of $1,500. This will drive additional utilization (costs) and therefore can be presented to the Legislature in Plan Years 2022/2023 as a budget enhancement.

5. Alternative income-based sliding scale premium design. Those who make more pay more in monthly premiums. The overall rates and employer contributions would not change – only the member's monthly premiums would adjust based on income. This could be administratively challenging pending the employers' and PEBP's ability to apply income programming to the deductions.

Advocate Requested Strategies (Plan Year 2021)

1. UNLV Faculty Senate and Employee Benefits Committee (see attached) requests in priority order increasing the dental maximum annual benefit $300 from $1,500 to $1,800. They also request lowering the deductibles for CDHP individuals $100 from $1,500 to $1,400 and $200 for families from $3,000 to $2,800. Both benefit increases will cost PEBP $1.7 -$1.8 million annually (per Nevada Faculty Alliance calculations). To meet this request, PEBP would need to:
    a. Project excess reserve funding sufficient to meet one or both requests; and
    b. Obtain approval from the Governor and Interim Finance Committee (IFC) of the Legislature to implement next year.

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August 28, 2019

TO: Deonne Contine, Board Chair, Public Employee Benefits Program
& Public Employee Benefits Program Board
& Executive Director, Damon Haycock

FROM: Douglas Unger, Post-Chair, Council of Faculty Senate Chairs
Nevada System of Higher Education; & Post-Chair, UNLV Faculty Senate

RE: Proposal from UNLV Committee on Employee Benefits for modest plan improvements

Dear Chair Contine, PEBP Board, and Director Haycock:

I am writing to you as a representative of the UNLV Faculty Senate tasked with employee benefits, and as a member of the UNLV Employee Benefits Committee.

Given that we have received some indications (without official confirmation until the quarterly report) that there may be significant additional accruals of excess reserves from CDHP (and other) premiums, we wish most cordially to propose for a PEBP Board item of discussion at the September Board meeting, and possible consideration at the November meeting, two modest improvements to the CDHP plan, in priority order, as follows:

1. Raising the Dental Maximum Benefit by $300 from $1500 to $1800. Rationale: our CDHP plan members have not seen a raise in dental benefits since the inception of the plan, and, over the past eight years, inflation in the costs of dental care have risen approximately 2.5% per year, on average (according to the Consumer Price Index). A modest adjustment in the benefit would help plan members to catch up at least somewhat with the increasing costs of dental care. According estimates by the Nevada Faculty Alliance (and confirmed last March by AON), such an increase in the Dental Plan Maximum should cost the plan less than $1 Million (by NFA calculations, $757,000). This modest improvement to our plan, we feel, would be a most welcome use of excess reserves for Nevada State Employees (if such excess reserves are, indeed, accruing). We also believe such an estimated amount would be a prudent use of accumulating excess reserves should the PEBP Board decide there are sufficient excess reserves already to cover any other contingencies.

2. Lowering the out-of-pocket deductibles for CDHP plan members $100 for individuals, from $1500 to $1400; and $200 for families, from $3000 to $2800. Rationale: these

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floor amounts would align the CDHP plan with the Internal Revenue Service announced HDHP plan lower limits for out-of-pocket deductibles, and make the plan more competitive with HDHP plans offered to employees of other states in the Western region. This relatively modest adjustment at the lower end of the cost scale would be most welcome to Nevada state employees, and we believe would begin to adjust the CDHP plan to be more affordable for those employees who most need and use medical care. Though we have not been able to do a precise calculation of the estimated cost of this modest adjustment, we estimate that it would be approximately $1 Million (or at most $1.1 Million). These figures are based on our rough adjustments of last year's $1350/$2700 estimates by the NFA and by AON. As with the Dental Maximum Benefit modest improvement, we believe this would also be a most welcome and prudent use of accumulating excess reserves.

Thank you for considering the discussion of these modest improvements to the CDHP plan at the September PEBP Board meeting, for possible action at the November meeting. Also, thank you for recalling and authorizing foundational research and work on a possible low-cost PPO third plan option (for Board consideration next year) announced at last March's meeting. We very strongly support offering a third plan choice to state employees, which would help align Nevada to the range of plans offered by most other states and/or university systems, and so would help our state to be more competitive for the hiring and retention of talented employees.

As ever, we very much appreciate your service, and the good care you take in the stewarding of our PEBP benefits.

With Very Best Wishes –

Post-Chair, UNLV Faculty Senate
Post-Chair, Council of Faculty Senate Chairs, NSHE

Douglas Unger
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12.

12. Executive Officer Report. (Damon Haycock, Executive Officer) (Information/Discussion)

STEVE SISOLAK
Governor

Deonne E. Contine
Board Chair

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Expires 04/01/2021

DAMON HAYCOCK
Executive Officer

AGENDA ITEM

☐ Action Item
☒ Information Only

Date: September 26, 2019

Item Number: XII

Title: Executive Officer Report

SUMMARY

This report will provide the Board, participants, public, and other stakeholders information on the overall activities of PEBP.

REPORT

URAC ACCREDITATION UPDATE

PEBP achieved URAC Core Accreditation on April 1, 2018. This accreditation marks PEBP's dedication to higher national quality standards and consistency with contracted partner requirements. PEBP was the first and only public sector employer sponsored program of benefits to receive this high honor. In August, PEBP reached out to URAC to discuss next steps for reaccreditation when our 3-year term expires (April 1, 2021). PEBP was informed URAC has changed the Core Accreditation program into a certificate series that no longer meets PEBP's desire to be an accredited program. The cost is the same, but requirements changed, and they no longer align with other national quality accreditation programs we require of our vendors.

The other national leader in healthcare accreditation is the National Committee for Quality Assurance (NCQA). PEBP approached NCQA when we explored accreditation options and at the time in 2017, NCQA did not have a program that fit PEBP. PEBP has reached out again to see if NCQA has (or is willing to develop) an accreditation process to continue PEBP's high quality standard. We will bring back to the Board any opportunities as they manifest.

MEDICARE EXCHANGE TPA TRANSITION – DELAYED

PEBP and Willis Towers Watson previously agreed to transition Third Party Administrator (TPA) Health Reimbursement Arrangement (HRA) services from their contractor Payflex to their internal benefits administration. This was in response to year-over-year failed financial

audits of Payflex. The original plan was to transition in November 2019, however, PEBP and Willis Towers Watson have agreed to delay this transition until March 2020. Payflex currently pays HRA claims through PEBP's bank account and Willis Towers Watson does not have that capability today. Willis Towers Watson will be building this functionality and the next major release date for implementation is March next year. PEBP will ensure Medicare exchange members will receive communication announcing this change closer to the March 2020 implementation on this transition.

BANNER CHURCHILL HOSPITAL

Banner Churchill Hospital is PEBP's only out-of-network hospital in Nevada. Banner's reimbursement rates traditionally are much higher than other hospitals in the region (Carson Tahoe, Renown, etc.) and they were removed per PEBP's request years ago from the PPO network for PEBP members. PEBP and Banner have tried to negotiate costs over the years yet have not been able to come to an agreement. PEBP has analyzed the costs thoroughly and believes there is an opportunity to bring Banner back as an in-network offering for emergency services. PEBP has reentered negotiations with Banner and we have agreed to pay them a fixed rate with the caveat their pricing does not increase for the next 3 years. These cost controls will ensure PEBP does not see year-over-year increased claims while protecting our members from costly balance bills. PEBP will develop a contract with Banner Churchill and provide it to the Board for review and approval once finalized.

13.

13. Public Comment

14.

14. Adjournment