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

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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:	November 21, 2019 8:30 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
Video 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. 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: Wendi Lunz 901 S. Stewart St, Suite 1001 Carson City NV 89701, Fax: (775) 684-7028 or wlunz@peb.state.nv.us 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 the Action Minutes from the September 26, 2019 PEBP Board Meeting.

4.2. Health Claim Auditors, Inc. annual audit of Willis Towers Watson's OneExchange for the timeframe July 1, 2018 – June 30, 2019: (1) Report from Health Claim Auditors; (2) Willis Towers Watson's 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.

4.3. Receipt of the Casey, Neilon & Associates Audited Financial Statements of PEBP for Fiscal Year 2019.

4.4. Approval of the updated PEBP Strategic Plan.

5. Update on the Morneau Shepell Performance Improvement Plan (Morneau Shepell) (Information/Discussion)

6. Presentation on the development and history of PEBP's Incurred But Not Paid (IBNP), Catastrophic, and Health Reimbursement Arrangement (HRA) reserves. (Aon and Cari Eaton, Chief Financial Officer) (Information/Discussion)

7. Discussion and possible action regarding proposed plan design changes for Plan Year 2021 (July 1, 2020 – June 30, 2021), including but not limited to the following:
   - Possible implementation of narrow pharmacy network for 90-day prescriptions on the EPO plan;
   - Possible implementation of a second opinion program for CDHP high cost high value healthcare;
   - Possible implementation of a Chronic Kidney Disease management program on the CDHP;
   - Possible increases to CDHP HSA/HRA enhanced employer contributions;
   - Possible implementation of additional Centers of Excellence for members on the CDHP and EPO plan;
   - Possible reduction to CDHP deductibles and out-of-pocket maximums;
   - Possible elimination of the $25 copay for annual vision exams;
   - Possible increases to the dental benefit maximums of the CDHP, EPO, HMO, and Medicare Exchange participants;
   - Possible inclusion of recent IRS approved drugs to PEBP's Preventive Drug List on the CDHP; and
   - Additional benefit design inclusions/exclusions/alterations to meet projected budget needs.

   (Damon Haycock, Executive Officer) (**All Items for Possible Action**)

8. Discussion and possible action to approve benefit changes for Plan Year 2021 to PEBP's Master Plan Documents for the CDHP and Premier (EPO) plans. (Damon Haycock, Executive Officer) (**For Possible Action**)

9. Discussion on PEBP's FY 2022/2023 budget development and direction to staff on budget enhancements for submission of PEBP's biennial budget August 2020. (Damon Haycock, Executive Officer) (**For Possible Action**)

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

11. 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.

12. 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 Wendi Lunz 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 Wendi Lunz 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 & ARCHIVES, 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 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 the Action Minutes from the September 26, 2019 PEBP Board Meeting.

   4.2. Health Claim Auditors, Inc. annual audit of Willis Towers Watson's OneExchange for the timeframe July 1, 2018 – June 30, 2019: (1) Report from Health Claim Auditors; (2) Willis Towers Watson's 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.

   4.3. Receipt of the Casey, Neilon & Associates Audited Financial Statements of PEBP for Fiscal Year 2019.

   4.4. Approval of the updated PEBP Strategic Plan.

4.1.

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   4.1. Approval of the Action Minutes from the September 26, 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)
September 26, 2019

MEMBERS PRESENT IN CARSON CITY:	Ms. Deonne Contine, Board Chair Ms. Leah Lamborn, Member Mr. John Packham, Member Mr. Tom Verducci, Member
MEMBERS PRESENT IN LAS VEGAS:	Ms. Linda Fox, Vice Chair Ms. Jet Mitchell, Member
MEMBERS EXCUSED:	Mr. Don Bailey, Member Ms. Mandy Hagler, 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 Las Vegas:
   - Douglas Unger – Employee benefits representative UNLV Faculty Senate
   - Public Comment in Carson City:
     - Kent Ervin - Nevada Faculty Alliance
     - Marlene Lockard – Retired Public Employees of Nevada
     - Priscilla Malony – AFSCME
     - Nikki Pecorino - UNUM

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.

BOARD ACTION ON ITEM 4.
MOTION: Motion to approve the consent agenda except for Item 4.2.1
BY: Member John Packham
SECOND: Member Leah Lamborn
VOTE: Unanimous; the motion carried.

BOARD ACTION ON ITEM 4.2.1.
MOTION: Motion to approve the budget report Item 4.2.1.
BY: Member Tom Verducci
SECOND: Member John Packham
VOTE: Unanimous; the motion carried.

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**)

BOARD ACTION ON ITEM 5.
MOTION: Motion to go with option three and terminate the contract as of June 30, 2020
BY: Member Leah Lamborn
SECOND: Member John Packham
IN FAVOR: Chair Deonne Contine, Vice Chair Linda Fox, Member Leah Lamborn, Member John Packham, Member Tom Verducci
OPPOSED: Member Jet Mitchell
VOTE: Five in favor, one opposed; the motion carried.

6. Discussion and possible action to approve an amendment to the Morneau 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)**

BOARD ACTION ON ITEM 6.
MOTION: Motion that PEBP recommends the Board authorize staff to complete a contract amendment between PEBP and Morneau Shepell to provide an enrollment an eligibility system for all PEBP plan participants in Contract Number 15941 to reduce fees through the term of the contract.
BY: Member Tom Verducci
SECOND: Member John Packham
VOTE: Unanimous; the motion carried.

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**)

BOARD ACTION ON ITEM 8.

- No action taken. Executive Officer to finalize and bring back to November 21, 2019 Board Meeting.

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**)

BOARD ACTION ON ITEM 9.

MOTION: Motion to approve the updates to PEBP Board's Duties, Policies and Procedures
BY: Member Tom Verducci
SECOND: Member John Packham
VOTE: Unanimous; the motion carried.

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

BOARD ACTION ON ITEM 10.

MOTION: Motion to approve the Morneau Shepell eligibility enrollment system performance improvement plan with the date change (typo) from 1-31-19 to 1-31-20.
BY: Member John Packham
SECOND: Member Jet Mitchell
VOTE: Unanimous; the motion carried.

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**)

Member John Packham requested that AON provide a report on how the IBNR and catastrophic reserves are set at the November Board Meeting.

BOARD ACTION ON ITEM 11.

MOTION: Motion to provide further analysis of the requests from UNLV Faculty Senate and the NFA, further analysis of Shot-Term Potential Strategies 1, 2, and 3 per the report, and investigate where using Centers of Excellence would be cost effective and provide better health outcomes for PEBP members.
BY: Member Jet Mitchell
SECOND: Member Leah Lamborn
VOTE: Unanimous; the motion carried.

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.

Public Comment in Carson City:

- Marlene Lockard - Retired Public Employees of Nevada (RPEN)
- Priscilla Malony – AFSCME

Public Comment in Las Vegas:

- Doug Unger – UNLV Faculty Senate

14. Adjournment

- Chair Contine Adjourned the meeting at 12:03 PM

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. Health Claim Auditors, Inc. annual audit of Willis Towers Watson’s OneExchange for the timeframe July 1, 2018 – June 30, 2019: (1) Report from Health Claim Auditors; (2) Willis Towers Watson's 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.

Medicare Exchange

Health Reimbursement Arrangement

Audit Report

for

Nevada PUBLIC EMPLOYEES' BENEFITS PROGRAM

Conducted on

Willis Towers Watson

Audit Period:
PEBP Plan Year 2019

Submitted By:
Health Claim Auditors, Inc.

TABLE OF CONTENTS

State of NV. PEBP - Health Reimbursement Arrangement

Introduction

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

WTW's subcontractor, PayFlex*, administrates the claims adjudication function for the Medicare Exchange HRA PEBP plan. The onsite portion of the audit was conducted in September 2019 at the PayFlex location in Omaha, Nebraska.

***** PayFlex**,** an Aetna company, is a benefit administrator specializing in the administration of flexible spending accounts, health savings accounts, health reimbursement arrangements and COBRA administration.

HCA was provided with a claim file from PayFlex of claims adjudicated for PEBP's Plan Year 2019 (July 2018 – June 2019). The file contained information pertinent to 313,779 HRA claims representing $36,375,928.79 in requested reimbursements. A claim is defined as each separate expense reimbursement request. Requests that contain multiple expenses (such as prescriptions) are separated and administered as separate claims.

The purpose of the audit was to assure that WTW/PayFlex is doing an effective job of controlling claim costs while processing HRA claims accurately and within a reasonable period of time.

The preliminary report was presented to WTW for additional comments and responses on 19 September 2019. Additional comments/responses received from WTW/PayFlex are included within the report and identified in ***bold/italicized*** type. In situations where there is disagreement between HCA and the Administrator as to what constitutes an error, both sides are presented in the report. Final determination of error rests with the client. The statistical effect on the Financial Accuracy measurement for each error is displayed in the HCA note immediately after the WTW comment.

Detailed data for each of the items displayed within the results, both statistical and non-statistical calculations, can be found in the Specific Claim Audit Details chapter of this report, which begins on page 17.

A valid random selection of 400 claims plus no more than 200 bias* selected claims were identified for audit as per agreement. *Bias claims are not part of the random selection but were selected manually and audited by HCA because of some "out of the ordinary" characteristic of the claim. Bias claims are not included within the statistical calculations for measurement of Performance Guaranteed categories within the Administration Agreement.
The valid random selection included claims from all categories adjudicated by PayFlex. These categories included, but were not limited to: 1) deductibles; 2) dental; 3) medical; 4) orthodontia; 5) over the counter; 6) premiums; 7) prescriptions and 8) vision claims.

The Claim Financial Precision provision in the Agreement defines the measurement of the "Total Amount Approved". The statistical calculations for this category includes all payments completed for the participant's request for the entire history of the claim up to the date the claim is audited.

EXECUTIVE SUMMARY OF FINDINGS

Guaranteed Performance Measurements - Audit Period: 01 July 2018 through 30 June 2019 (PEBP Plan Year 2019)

Metric	Guarantee Measurement	Actual	Pass/Fail
Claim Processing Turnaround Time	Processing will average two (2) business days or less. Additionally, 98% of all claims will be processed within five (5) business days.	.036 Bus. Days Aver. 99.5% w/in 5 Business Days	Pass Pass
Claim Processing Payment Precision	Processing average precision will be at least 98% or better.	98.0%*	Pass*
Claim Financial Payment Precision	Financial accuracy will be 98% or better	98.8%**	Pass**
Customer Service Abandon Rate	The percentage of incoming calls abandoned by participants be 5% or less	<5%	Pass
Customer Service Speed to Answer	Incoming telephone calls, on average, shall be answered within thirty (30) seconds.	<30 sec.	Pass
Reports	Reports will be available within ten (10) business days of the end of the period.	No Delays Noted	Pass
HRA Web Services	99% availability of web services for benefit information and HRA information exclusive of scheduled maintenance.	99.0% +	Pass
Disclosure of Subcontractors	Contractor shall not engage additional subcontractors to maintain PEBP data nor change the physical locations where PEBP data is maintained and/or stored without written authorization by PEBP.	No Exceptions Detected	Pass
Unauthorized Transfer of PEBP Data	All PEBP data will be stored, processed and maintained solely on currently designated servers and storage devices identified in this contract amendment and/or prior contract documents.	No Exceptions Detected	Pass
Speed to Respond to Issue(s)	98% of incoming participant issues are to be responded to within 48 Hours of receipt	100%	Pass
Issue Resolution	98% of incoming issues escalated are to be resolved within 30 business days	100%	Pass

*** This category includes disputed errors by Willis Towers Watson. Please refer to next page. WTW comment: WTW agrees to 99%**

****This category includes disputed error by Willis Towers Watson. Please refer to next page. WTW comment: WTW agrees to 99.5%**

* Disputed claims within the Performance Guarantee Statistics

HCA conducts the audit as per standards set forth within documented agreements between the client and administrator. HCA has received rebuttals from WTW/PayFlex for claims charged as errors within this report that they believe should not be calculated as an error. HCA has reviewed the rebuttals and maintains the following as errors. In situations where there is disagreement between HCA and the Administrator as to what constitutes an error, both sides are presented below and also within each specific claim information within the report.

1) Ref. No. 142, $100.00 underpayment. This claim requested reimbursement of the participant's $100 payment to the provider. The statement provided displayed the charge amount, cash discount and payment amount. Claim was denied for insurance EOB, however, the audit observed multiple claims within this participant's file that were reimbursed before this claim with the exact data supplied.

2) Ref. No. 157, $44.32 underpayment. The participant requested reimbursement for the amount of patient responsibility paid. They provided invoice reflecting balance due and provider statement including DOS, service description (OV), Hometown Health insurance discount for plan, copay, Hometown Health insurance payment and coinsurance amount. Claim was denied requesting EOB as expense may be eligible for insurance benefits, however, HCA observed that the participant provided all required data.

3) Ref. No. 166, Overpayment - $140.00. The member submitted a receipt for patient copay for MRI of $140.00. Receipt reflects payment date 8/1/18, however does not display the date of service. Claim was reimbursed due that the Claim PDF reflects the MRI copayment to be $140.00, however, the receipt of payment date was utilized as the date of service because TWT states "copays are typically pre-paid at the time of service prior to the service for that day". It is the auditor's opinion that this claim should have been denied for additional information as 1) copayments are many times paid at a different date of the service date and 2) this scenario does not comply with TWT's policy as responded to other claims within this audit, i.e. ref. no. 360 TWT response "According to our Med-10 copay rule, we use receipts/payment receipts as the date of service as long as they are within our $5-$50 copay amounts".

4) Ref. No. 288, Overpayment - $164.51. This claim is for a prescription drug received 10/9/18 paid with DOS 9/25/18 for 164.54. Review of documentation (for above claim) shows RX was for 164.51 with a fill date of 9/24/18 but cash register receipt date of 9/25 was used to process claim and incorrect RX amount (164.54 versus 164.51) entered and paid. When audited claim came along (processed 3/26/19) system did not edit for duplicate and audited claim should have been denied.
   TWT states "Audited claim was processed correctly. The biased claim was processed by another examiner using the 9/25/18 date of service which made the $164.51 not catch in the duplicate logic check".
   HCA finds that the audited claim is a duplicate payment of original payment.

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 14.

Duplicate premium paid; Supporting reference nos. **177, 217** and 287

Duplicate payment; Supporting reference no. **288**

Incorrect date of service entered; Supporting reference nos. 062 and **289**

Claim incorrectly denied; Supporting reference nos. **142** and **157**

Paid without proper documentation of date of service;
Supporting reference nos. **166** and 360

Claim incorrectly denied due to claim system functionality;
Supporting reference no. 144

Copay reimbursement incorrectly denied; Supporting reference no. **171**

Incorrect amount reimbursed; Supporting reference no. 333

The audit revealed the following issues, which appear to be administered properly by One Exchange but should be brought to client attention for proper notification or verification. Specific information regarding supporting reference numbers can be found in the Audit Results Section in numerical sequence, which begins on page 14.

Claim for same date of service both paid and denied on same EOP;
Supporting reference nos. 144, 175 and 189

Proof of liability only required on 213(d) expenses;
Supporting reference nos. 078 and 091

PEBP eligibility issue; Supporting reference no. 237

Denial of claim nor call made to member to clarify premium reimbursement request; Supporting reference no. 247

Request for copayment using receipt date versus date of service if amount is $5.00 to $50.00; Supporting reference no. 360

Historical Statistics

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

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

* and **, please refer to notes on page 2

Other Audit Findings/Observations

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

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

- Overpayments

  It is HCA's opinion that overpayments remain a serious issue as new identified overpayments are greater than successful collections. Overpayments were found to be $910,634.07 at the end of Plan Year 2019 representing 1,772 claims.

  This measurement increased from the previous audit measurements and represents an increase of $108,178.60 (13.5%) in identified overpayment dollars and an increase of 223 (14.4%) effected PEBP claims.

  Collections for overpayments become very difficult to collect when they age more than two (2) years. Currently, of the 1,772 claims, 1,389 (78%) claims representing $703,644.75 in overpayments are greater than two (2) years of age.

  Due to the significant increase in overpayments for the audited period, HCA requested a report that displays the reason for each overpayment to determine cause(s). This report displayed the quantity of the following reasons:

Reason	Quantity	% of Total
Death	853	48.14%
Disenrolled	537	30.30%
Eligibility Change	209	11.79%
Incorrect Reinbursement	173	9.76%

- Date of Service (DOS) Entries
  An issue detected in previous audits concerned the date of service entries into the PayFlex system. Multiple duplicate of payment errors were detected previously due to the lack of entry of the exact date(s) of coverage. This year's audit reflect that PayFlex has applied a "real time" duplicate edit and instituted a change in the entry of multiple month premium requests that allows greater accuracy in detecting possible duplicate submissions of reimbursement(s). PayFlex also stated that they will be instituting a change in the entry of multiple month premium requests. They stated that the current policies of breaking multiple month premium requests into separate month entries will be expanded to include those requested from third parties. It is our opinion that this will also greatly improve the function of the system edits and also advance the reduction of duplicate payments.

Validation of Carrier Commissions

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

The statement received from Willis Towers Watson reflects that they received a total of $3,335,425.37 in commissions for PEBP Plan Year 2019.

Conclusion

- Findings and observations of this audit recognize the numerous improvements to internal operational polices and procedures as well as Explanation of Payment (EOP) improvements instituted by Willis Towers Watson and PayFlex within this past year have greatly improved the accuracy and PEBP member understanding and satisfaction of the HRA processes.
- It is HCA's unbiased opinion that metric measurements for this audited period were equal to or better than the agreed values within the Service Performance Standards Related to HRA Services Agreement (Agreement), Attachment N, with no exclusions.
- Identified overpayments have increased to $910,634.07 with a volume of 1,772 claims. HCA is recommending that WTW maintain providing a report to PEBP that displays the cause/reason for each overpayment and provide an operational process to collect these overpayments. HCA also recommends that this process include reporting to help quantify and/or aid in identifying the responsible party of the overpayment.

AUDIT FINDINGS – DETAIL

Other Customer Service Measurements

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

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

HCA requested a report that displays the percent of incoming participant issues that are resolved during the first incoming call.
HCA Findings: The reporting for this issue reflected that WTW achieved a 98% rating for the first PEBP quarter, 99% for the PEBP second quarter, 96% for the PEBP third quarter and 97% for the PEBP fourth quarter resulting in an annual performance of 97.6%.

Current Overpayments

WTW reported a total value of $910,634.07 in identified outstanding overpayments status that have an effect on 1,772 claims. This measurement increased from the previous audit measurements and represents an increase of $108,178.60 (13.5%) in identified overpayment dollars and an increase of 223 (14.4%) effected PEBP claims.

The current 1,772 identified overpayments have accrued since July 2011 when this administrator was initially selected. Of the overpayments, 1,389 (78%) are aged greater than two (2) years. The breakout of these overpayments is as follows:

Period	Number of Overpayments	Value of Overpayments
PEBP Plan Year 2011	8	$ 799.32
PEBP Plan Year 2012	82	$ 38,257.44
PEBP Plan Year 2013	26	$ 43,340.48
PEBP Plan Year 2014	549	$244,634.32
PEBP Plan Year 2015	226	$129,047.30
PEBP Plan Year 2016	194	$110,831.56
PEBP Plan Year 2017	304	$136,734.33
PEBP Plan Year 2018	170	$ 80,517.98
PEBP Plan Year 2019	213	$126,471.34
TOTAL	1,772	$910,634.07

Explanation of Payment (EOP)

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

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

Participant Funding

The audit reviewed the timing of the PEBP funding as it was made available to the participants. The following listing reflects the date that funds were available to participants during the period of July 2017 through June 2018:

Qualified Month	Date Funds Available		Qualified Month	Date Funds Available
July 2018*	June 28, 2018		January 2019	December 31, 2018
August 2018	July 31, 2018		February 2019	January 31, 2019
September 2018	August 31, 2018		March 2019	February 28, 2019
October 2018	Sept. 28, 2018		April 2019	March 29, 2019
November 2018	October 31, 2018		May 2019	April 30, 2019
December 2018	Nov. 31, 2018		June 2019	May 31, 2019

* Please note: A one (1) time fund deposit authorized by the PEBP Board of Directors was conducted in July 2018.

Participant Survey

HCA requested the results of any Customer Surveys conducted within the audited period. Results supplied as following:

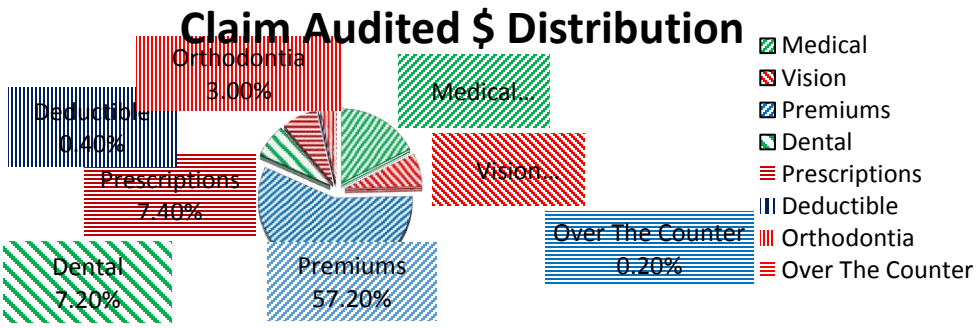
Category	Qtr One	Qtr Two	Qtr Three	Qtr Four
Completed Surveys	72	105	146	147
Overall Service Satisfaction	3.9 of 5	4.1 of 5	4.3 of 5	4.1 of 5
CSR OSAT	4.1 of 5	4.3 of 5	4.3 of 5	4.3 of 5
CSR Care/Concern	1.0			
Resolve Issue on Call	70%	75.5%	78.9%	71.3%
Recommend (NPS)	14	38	42	32
Satisfaction with Wait Time	3.8 of 5	4.2 of 5	4.2 of 5	4.0 of 5
CSR Ability to Find Solution	1.0			
Work with CSR again?	84.3%	84.3%	85.3%	83.6%

Breakdown of Claims Audited

The individual claim requests audited were randomly selected from PEBP's claims listings as supplied by WTW. The detail claims listing supplied, reflected each separate service as a claim. These claims were processed by WTW/PayFlex from 01 July 2018 through 30 June 2019. These claims were stratified by dollar volume to assure that HCA audited all types of claims.

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

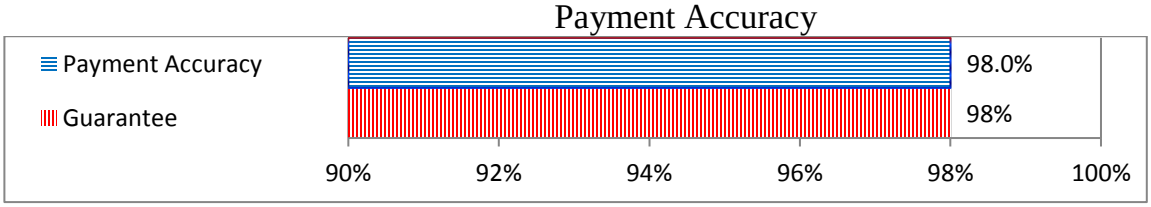
Type of Service	Requested Amount	Audited (Req – Denied)	Paid Amount
Medical	$ 13,443.75	$ 12,310.87	$ 12,018.48
Dental	$ 11,314.10	$ 5,140.10	$ 5,140.10
Vision	$ 5,127.89	$ 5,127.89	$ 5,127.89
Premiums	$ 41,496.05	$ 40,542.05	$ 16,044.51
Prescription	$ 5,313.17	$ 5,265.74	$ 4,359.60
Deductible	$ 322.23	$ 317.23	$ 317.23
Over The Counter	$ 101.05	$ 92.45	$ 67.57
Orthodontia	$ 2,118.00	$ 2,118.00	$ 2,118.00
Dependent	$ 13.41	$ 0.00	$ 0.00
TOTAL	**$ 79,249.65**	**$ 70,914.33**	**$ 45,193.38**



Payment Accuracy

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

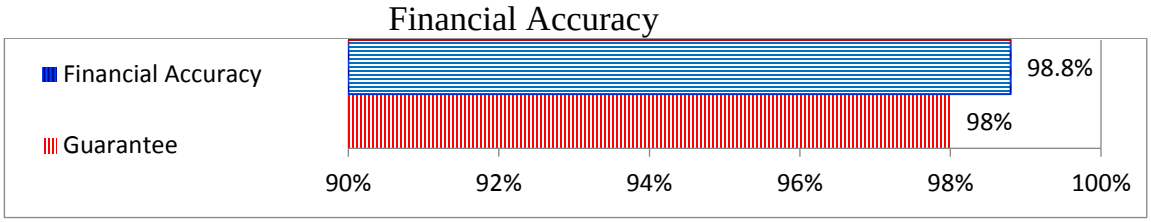
The Payment Accuracy Percentage of the number of claims paid correctly from the WTW random selection for this audited period is 98.0%. Please refer to Disputed Claims section on page 3.



Financial Accuracy

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

The Financial Accuracy Percentage of the number of claims paid correctly from the WTW random selection for this audited period is 98.8%. Please refer to Disputed Claims section on page 3.



Statistical calculations for the metric measurement of the Performance Guarantees are calculated of the claims adjudicated from the period of 01 July 2018 through 30 June 2019 (PEBP Plan Year 2019). Specific audit error findings and issues can be reviewed within the Specific Claim Audit Detail section of this report, which begins on page 14.

Turnaround Time

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

HCA requested a lag report from PayFlex that displayed the processing turnaround times. This report reflected that the audited period turnaround time for processing claims was 0.24 days within quarter one, 0.57 days within quarter two, 0.48 days within quarter three and 0.14 days within quarter four reflecting that the 2 business days performance guarantee was met.

The random selection was tested for the average turnaround with a result of 0.8 business days and 99.5% were processed with five (5) business days. It is HCA's opinion that TWT is in compliance with the performance guarantees for turnaround times.

During the audited period, WTW received a total of 803 Emails from participants to the Email team seeking information. The average time to respond to these emails was within 14 hours.

Policy, Procedures and System

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

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

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

Claims are transferred and archived into the PayFlex adjudication system, Complete Benefit Administration System CBAS) within forty-eight (48) hours of receipt. PayFlex has utilized this system since 2006 and owns the key for any program changes.

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

PayFlex stated that they have internal written Standard Operating Procedures (SOP). HCA reviewed these SOPs during the on-site portion of the audit:

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

PayFlex stated that they have over fifty (50) experienced processors for requests received in the Omaha, Nebraska facility. PayFlex stated that PEBP has no dedicated processors assigned to their account, however, PayFlex has designated 27 examiners to adjudicate the WTW client claims.

Initial processor training lasts from two (2) weeks to six (6) months depending on the individual. PayFlex stated that they conduct internal audits on all processors. New processors have 100% audit until the supervisor is satisfied with their performance. Experienced processors have four (4) claim lines audited per every three hundred and fifty (350) lines processed.

WTW stated that they have over one thousand (1,000) Customer Service Representatives that address all incoming inquiries from client participants.

PayFlex also stated that they have over eighty (80) Customer Service Representatives to provide services to their clients. Both WTW and PayFlex stated that no Customer Service Representatives are dedicated to the PEBP plan.

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

WTW response: Subcontractor Entity Name

- ***Bancorps***
- ***Datamark***
- ***DestinationRx, Inc.***
- ***IC Group***
- ***InMoment, Inc.***
- ***Language Line Services, Inc.***
- ***Oracle America (Through the end of 2018)***
- ***Flexential (Formally Peak 10, Inc.)***
- ***Pegasystems***
- ***PNC Bank***
- ***Rastar/Sun Litho***
- ***TargetSmart (formerly WayPoint)***
- ***Zelis Healthcare (formerly Strenuus, LLC):***

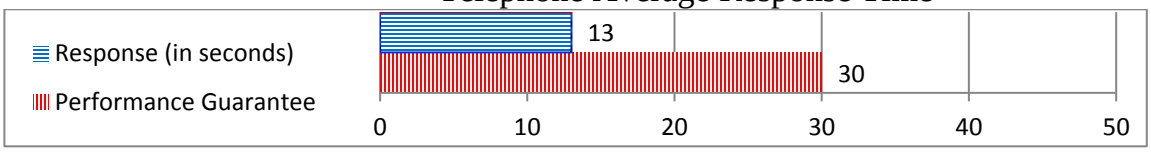
HCA requested that WTW please verify if any of these entities were NOT supplied to PEBP as subcontractor vendors previous to this audit report disclosure.

WTW/PayFlex comment: "I searched and did not find any PEBP incidents in this timeframe (or any.)"

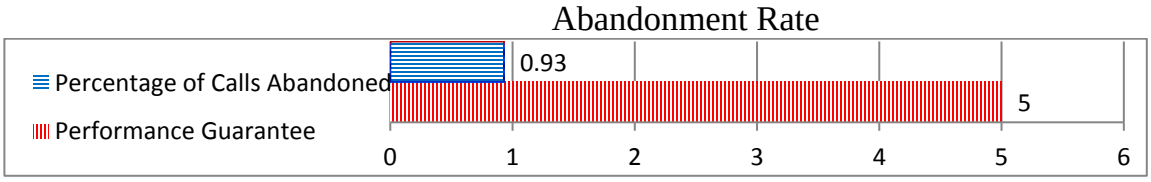
Customer Service

Per agreement, the average incoming telephone response time should be within thirty (30) seconds or less. The reports supplied by WTW reflected that the average answer speed for all incoming calls during the period of 01 July 2018 through 30 June 2019 was 13.0 seconds (0:13.0). The average response time for Quarter One was 6.4 seconds, 12.9 seconds for Quarter Two, 13.0 seconds for Quarter Three and 20.2 seconds for Quarter Four.

Telephone Average Response Time



Per agreement, the abandonment rate must be under five percent (5%) of total incoming. HCA has reviewed the appropriate report for the audited period, which revealed the abandoned calls ratio to be 0.93% for the period of 01 July 2018 through 30 June 2019 (period measurable against the Performance Agreement). The average abandonment rate for Quarter One was 0.79%, 1.76% for Quarter Two, 0.89% for Quarter Three and 1.23% for Quarter Four.



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

Reporting

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

Standard:
Ledger Summary
Production Payment Register
Deposit Summary
Payment Summary

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

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

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

SPECIFIC AUDIT RESULTS

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

Ref. No. 062 One Exchange claim no.

NOT charged in statistical calculation. Note to client for information only.
Member submitted 2 prepayments of 2200.00. One receipt date of 6/12/18 and another with receipt date of 7/26/18.
Shouldn't audited claim have used receipt date of 7/26/18 versus 8/7/18?
(Note: Other prepayment paid used receipt date of 6/12/18 versus 6/26/18 claim ID xxxxxx)
One Exchange response: Based on date of service of 8-7-18 this claim was processed correctly. We use incurred date instead of prepaid date.
HCA Note: Based on response that would make claim ID xxxxxx date of service used incorrect.

Ref. No. 078 One Exchange claim no.

NOT charged in statistical calculation. Note to client for information only.
Patient requested:
DOS 7/17/18 Type Medical Amt of request 50.00
8/7/18 Medical 30.38
Receipt submitted reflects $50.00 payment to provider on 7/17/18.
Total billed for DOS 7/17/18: $761.00
Sr Care Plus Contract Adj: - 431.00
Sequestration Reduction: - 1.23
Sr Care Plus Payment: - 59.98
Bill reflects $30.38 patient responsibility balance. System does not reflect any payments etc. of the $30.38 but patient was reimbursed $30.38 under DOS 7/17/18.
Should the $30.38 payment have been denied until proof of payment was received?
One Exchange response: Proof of liability is only required on 213(d) expenses. Proof of payment is not needed.
HCA Note: Charge balance minus deductions do not add up – Total charges for DOS $761.00 minus payment from client 50.00, contract adjustment 413.41, Sequestration from Senior Care Plus 1.23 and payment from Senior Care Plus 59.98. $761.00 - $524.62 = $236.38.

Ref. No. 091 One Exchange claim no.

NOT charged in statistical calculation. Note to client for information only.
Patient requested 1219.00 on 10/8/18 & reimbursed 1219.00 on 10/9/18.
Web request for DOS 7/23/18 for 1219.00. EOP dated 10/10/18.
Patient submitted provider's statement of 7/23/18 for D2750 & D2950 for 1219.00 amount due. System did not display a receipt, method of payment, etc. for payment by patient.
Should this claim have been denied for proof of payment?
One Exchange response: We require proof of liability only for 213(d) expenses. Proof of payment is not required. There is no mention of insurance so the whole dental expanse would be the member's liability.

Ref. No. 142 One Exchange claim no.

Underpayment - $100.00
Patient submitted billing for medical services:
DOS 8/07/18 office visit charged at 157.00
Statement reflects payment from patient at $100.00. Statement also reflects discount adjustment at $57.00. Cash discount adjustment occurs when services are not covered by insurance.
Request was denied for insurance EOB. Should the claim have been paid with statement as evidence?
One Exchange response: This was properly denied HI. Because there was proof of medical pg 5 insurance (Health Plan of NV MCR) within the document, the claim must be denied for needing an insurance denial or insurance payment. The expense must be reimbursed from all other sources before it can be reimbursed through their account.
PayFlex 09/24/19: Disagree with underpayment. In PayFlex claims workbook scenario Med-1, it states that we are to consider all documentation with the medical claim as a whole. If insurance shows on one bill and not on another, the claim not showing insurance should be denied for the insurance EOB.
HCA Note: Exact info supplied for DOS 7/13/17 & 12/5/17 and paid without denial – exact statement, provider, comments, etc. Please refer to Disputed Claim section located on page 3.

Ref. No. 144 One Exchange claim no.

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

EOP:

Premium 9/1/18 requested 151.61, paid 151.61

10/1/18	151.61	151.61
11/1/18	151.61	151.61

Premium 9/1/18 requested 151.61 denied – proof of payment needed

10/1/18	151.61 denied – proof of payment needed
11/1/18	151.61 denied – proof of payment needed

Premium 1/1/19 requested 271.00 denied – invoice needed

Premium 7/1/18	134.00 denied – n/c must be w/in period of cov
8/1/18	134.00 denied – " "
9/1/18	134.00 denied – " "
10/1/18	134.00 denied – " "
11/1/18	134.00 denied – " "

Please explain this info on same EOP.

1) 151.61/mo premium for 9/1/18, 10/1/18 & 11/1/18 first ones paid, second ones are denied for proof of payment. Why the duplication – request does not reflect a spouse, etc.

2) Premiums dated 7/1/18 through 11/1/18 reflect not covered during this period. Funding and payment of other claims reflect she is covered. Please explain why the denial of these claims.

One Exchange response: Processed 11-19-18 12:56 – rec'd 17 page fax clm xxxxxx. Processed 11-19-18 12:55 received 3 page fax. Claim form, fax coversheet & Anthem BCBS 2019 $151.61 payment letter.

1) 2 claims were received. Clm xxxxxx only received 3 page fax properly denied. Processed 11-19-18 12:55. Clm xxxxxx received 17 page fax. Processed 11-19-18 12:56.

2) Recurring claim form received for 7-1-18 to 12-31-18. Member's effective date was 9-1-18 (after 7-1-18). The way that cbas currently functions is to look at the from or begin date of he claim (7-1-18). Since that date was before 9-1-18, cbas system denied the whole claim as GL. On 12-13-18 after receiving a request from a phone call, the claims for 9-1-18, 10-1-18, 11-1-18 & 12-1-18 were released to the member. This is bias because it is not within the scope of claim xxxxxx selected for the audit.

Ref. No. 157 One Exchange claim no.

Underpayment - $44.32

Member is requesting 44.32 for 44.32 patient responsibility paid on 11/28/18.

Member provided 1) invoice reflecting 44.32 balance due, 2) provider Statement including DOS, service description (OV), Hometown Health discount for plan, copay, Hometown Health insurance payment (9/24/18) and coinsurance amount.

Claim was denied requesting EOB as expense may be eligible for insurance benefits. Since all data was submitted w/insurance discount, payment, etc. shouldn't this claim/request have been paid?

One Exchange response: This was properly denied due to page 14 showing $908 in insurance pending. The Hometown Health Plan insurance payment and insurance write off do not specifically link with the 8-29-18 date of service. The insurance payment could have been for a previous balance. Since the $908 pending insurance is more than the 8-29-18 $332 services we do not feel safe in assuming.

PayFlex 09/24/19: Disagree with underpayment. Anytime there is evidence of insurance, we must check to see if there is pending insurance, estimated insurance or proof that insurance was filed. If the itemized statement does not show complete insurance payments, we can't assume that insurance is finished paying on any of the services.

HCA Note: Statement reflects DOS clearly as 8/29/18 & associated info is under 8/29/18 DOS: OV charge 332.00

Copay	(5.68)
Hometown Health Plan	(16.15)
Insurance write off	(265.85)
Balance	44.32 patient responsibility

Other claims paid from this date (i.e. dental, etc.) all critical info on statement. Auditor's opinion that this should have been reimbursed. Please refer to Disputed Claim section located on page 3.

Ref. No. 166 One Exchange claim no.

Overpayment - $140.00

This member submitted a receipt for patient copay for MRI of $140.00. Receipt reflects payment date 8/1/18, however does not display the date of service. Should this claim be denied for additional info (i.e. DOS)?

One Exchange response: In combining the annual notice of changes from Page 14 along with page 10 showing patient name, provider name, type of service (MRI), date of service (8-1-18), dollar amount $140 that matches the $140 copay from page 14, this was eligible to pay.

PayFlex 09/24/19: Disagree with overpayment. Page 10 of Claim PDF shows MRI $140, Page 14 shows MRI copays are $140. Copays are typically pre-paid at the time of service prior to the service for that day. This follows our scenario Med-11 from our claims' workbook.

HCA Note: Only docs received for audited claim – receipt w/MRI $140.00 – name of member but only date is date of payment – no display with date of service. (Admin assuming date is of DOS versus payment date. Other receipts from same provider display "copayment for today's visit". Audited receipt has no DOS. Please refer to Disputed Claim section on page 3.

Ref. No. 171 One Exchange claim no.

Underpayment - $80.00

$80 denied for additional info

Per documentation this is "ER at Aliante Copay" which appears to be paid at time of ER visit on 12/9/18. Documentation does include patient name. Appears this is sufficient documentation so should claim have been paid?

One Exchange response: This was properly denied as prepayment. There is not an admission or discharge date listed. Also, the total billed amount and insurance payments are missing. The receipt states pending final bill.

HCA Note: Other claims in random with receipts for copayments without total billed charges are accepted as sufficient documentation and claims paid.

PayFlex 09/24/19: Agree with underpayment. Claim will be corrected.

Ref. No. 175 One Exchange claim no.

NOT charged in statistical calculation. Note to client for information only. Member requested reimbursement of 160.58. Documentation shows 2 RXs for 21.82 and 138.76 (totaling 160.58).
Why was there an additional line of 160.58 denied for documentation as this was the total for the 2 RXs submitted & paid?
One Exchange response: From page 1 of the documentation the member submitted their express claim twice so it was processed twice.

Ref. No. 177 One Exchange claim no.

Overpayment - $105.12
Reimbursement request for: 1/1/19 $30.10, 1/1/19 $105.12 and 1/1/19 $202.00
Documentation received shows $30.10 for Humana premium for 1/1/19-1/31/19, $105.12 for United Healthcare coverage for 1/1/19 and Medicare Part B for $189.60 for 1/1/19-1/31/19 & Medicare Part D for 12.40 for same time period totaling $202.00 for Medicare.
1) 1st EOP shows payment for 105.52 for January premium and 30.10 for January premium with partial payment for 105.12 of 21.28. Second EOP dated 7/1/19 shows remaining payment for 105.12 of 83.84 and partial payment of 156.16 for 189.60 Medicare charge.
Appears the request for United Healthcare premium paid twice (105.52 and 105.12) – TPD and mail.
NOT charged in statistical calculation. Note to client for information only.
2) Appears Humana premium 30.10 for 1/1/19 paid by TPD on 1/15/19 claim xxxxxx and by mail submission on claim xxxxxx on 6/3/19. duplicate payment made for this premium. Also appears dup payment of 30.10 also paid for 2/1/19 DOS.
One Exchange response: 1) Claim xxxxxx $105.12 paid in error.
2) Is bias and not part of xxxxxx selection.
PayFlex 09/24/19: Agree to overpayment. Claim has been denied.

Ref. No. 189 One Exchange claim no.

NOT charged in statistical calculation. Note to client for information only.
EOP shows payment of requested 3 RX charges and then denials of same 3 charges for additional information. Why are charges denied after being paid?
One Exchange response: Claim was received twice via fax. 1st fax only had claim form. 2nd fax had claim form and documentation (4 pages). The charges were not denied after being paid. This was processed properly.

Ref. No. 217 One Exchange claim no.

Overpayment - $175.20

This member requested Medicare Part B claims for Jan 2018 – Jan 2019 $12,440.80/yr with monthly breakouts & receipts. Jan 2019 request is for $176.20.

Audited claim paid 175.20 for 1/1/19 billing – docs in system display each month billing, payment etc. Other claim for 1/1/19 billing under Medicare is paid at 175.20 and all supporting documents are exactly as audited claim. Appears as a duplicate payment?

One Exchange response: I agree to the $175.20 overpayment.

PayFlex 09/24/19: Agree to overpayment. Claim has been denied.

Ref. No. 237 One Exchange claim no.

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

Member requested $50.00 copay for echocardiogram service.

Member has continual coverage & funding however, the EOP for this claim states that "This expense is not eligible for reimbursement and has been denied. Expenses must be incurred during your period of coverage. Incurred is based on the date of service."

Was this EOP sent to the member with incorrect explanation?

One Exchange response: This is not a processing error. Cbas system denied the claim as no coverage on date of service on 2-8-19. A file was loaded on 2-14-19 that had cbas re-evaluate and release the claim for payment.

However, the claim hasn't paid because it is awaiting additional contributions. On 12-20-18 a file changed the plan year expiration of the member's account from 6/30/19 to 12-31-18. On 2-14-19 a file changed the plan year expiration from 12-31-18 back to 6-30-19.

Ref. No. 247 One Exchange claim no.

NOT charged in statistical calculation. Note to client for information only.
Member sent Web request for premium. Web request displayed only DOS of 1/1/18 for premium and amount of $900.00. Member provided form SSA-1099 which reflects $1,548.00 deducted for Medicare B.
Payflex applied request for period of 1/1/18-7/1/18 for Medicare B at 129.00/mo. Jan & Feb 2018 were denied for timely filing since request was received 2/13/19.
Should this claim have been denied or a call to member inquiring their intent or qualify their request?
System reflects member called in July 2019 re: direct deposit only.
Request could be interpreted numerous ways - $900.00 request divided by 12 months = 75.00/mo, etc.
One Exchange response: Standard express claim 1-1-18 $900 1099 states $1,548 for 2018 which breaks down to $129 per month. Our processes are to enter the premium amount until you go over the requested amount, which was done. Our claim department does not call members. We were following procedure on this claim.

Ref. No. 287 One Exchange claim no.

NOT charged in statistical calculation. Note to client for information only.
Also paid on same claim ID was reimbursement for 3/1/19 medical premium of 45.00. Review of history shows TPD for same DOS, type of premium & charge (45.00) was received prior to above claim and was paid
Appears claim detail #xxxxxx should have been denied as previously paid.
One Exchange response: Claim xxxxxx was paid correctly. Claim xxxxxx is bias and not related to xxxxxx.

Ref. No. 288 One Exchange claim no.

Overpayment - $164.51

Claim xxxxxx received 10/9/18 paid as RX with DOS 9/25/18 for 164.54
Review of documentation (for above claim) shows RX was for 164.51
with a fill date of 9/24/18 but cash register receipt date of 9/25 was used to
process claim and incorrect RX amount (164.54 versus 164.51) entered
and paid.
When audited claim came along (processed 3/26/19) system did not edit
for dup when it should have & audited claim should have been denied.
One Exchange response: Claim xxxxxx was properly processed. Claim
xxxxxx is bias.
PayFlex 09/24/19: Disagree with overpayment of audited claim. Audited claim was
processed correctly. The biased claim was processed by another examiner using the
9/25/18 date of service which made the $164.51 not catch in the duplicate logic check.
HCA note: HCA finds that the audited claim is a duplicate payment of original payment.

Ref. No. 289 One Exchange claim no.

Over/Underpayment - $0.00

Claim entered & paid with DOS of 12/13/18. Correct DOS per
documentation is 12/31/18. Incorrect date entered.
One Exchange response: I agree to this date of service error.
PayFlex 09/24/19: Agree to DOS error.

Ref. No. 333 One Exchange claim no.

NOT charged in statistical calculation. Note to client for information only.
Claim xxxxxx, DOS 7/1/19 member provided statement that reflects
member paid 116.00, requested 126.00 & was approved for 126.00.
Statement verifies that member paid the 116.00 but United Healthcare
payment was 126.00. Shouldn't approval of reimbursement be 116.00
versus 126.00?
One Exchange response: Claim xxxxxx is bias and not related to claim
Xxxxxx, corrected.

NOT charged in statistical calculation. Note to client for information only.
Receipt reflects that this is "pt copay" $15.00 however, what is actual DOS? Receipt is dated 4/9/19 but we do not know is that is also the DOS.
(Note: Several receipts form this same provider all with similar info except for DOS 3/26/19 receipt which states "copayment for today's visit")
Shouldn't we have denied this $15 charge to verify actual DOS?
One Exchange response: We allow payment receipts for copays and use the payment date as date of service according to our multiple date of service (on TPD) table. This was processed correctly.
HCA Note: Using receipt date does not allow the system to edit correctly for potential duplicates.
PayFlex 09/24/19: Disagree with overpayment. According to our Med-10 copay rule, we use receipts/payment receipts as the date of service as long as they are within our $5-$50 copay amounts.
HCA note: HCA requests verification from PEBP for application of receipt date for Date of Service if request for reimbursement represents a copayment amount between $5.00 to $50.00.

EXHIBIT A

Understanding Your Explanation of Payment (EOP) Statements

Understanding Your

Explanation of Payment (EOP) Statements

Each time Extend Health processes a reimbursement claim that you or your insurance carrier has submitted you will receive an Explanation of Payment (EOP) statement.

Each EOP statement will include a summary of your paid claims, your available funding balance, and the amounts you have been reimbursed for. In the case of denied claims, your EOP will list the reason for denial. If a claim is denied, you may be required to take action in order to receive reimbursement for the claim, such as resubmitting paperwork or providing additional documentation. Most importantly, if you have not opted to receive reimbursement by direct deposit, your EOP statement may be accompanied by your reimbursement check.

Your EOP statements will be sent to you with the same frequency you submit claims. If you have provided your email address to Extend Health, expect to receive your EOP statements by email. If you have not provided an email address, your EOP statements will arrive in the mail. To change your statement delivery method, call Extend Health at the phone number printed in your Welcome Letter.

If you have signed up for automatic reimbursement, your insurance carrier will submit reimbursement claims on your behalf, meaning you will receive EOP statements without having filed a claim. You may also receive an EOP for a claim not previously paid in full. If you submit a claim and do not have sufficient funds, your claim will be held until funds become available. The claim may then be approved and an EOP provided.

How to read an EOP statement

Your EOP statement is divided into two sections: "Your Account Balance After This Payment" and "This Payment Includes." The "Your Account Balance" section includes:

1. **Account Name:** This is the specific name of your funding program. The year contained in parenthesis is the current plan year of your program.
2. **Contributions:** The amount deposited into your funding program by your former benefits provider as of the date of the EOP statement.
3. **Total Paid:** The total amount you have been paid for approved claims during the current plan year. The total paid amount includes the amount paid as of this statement, shown under "Amt This Payment" (#5).
4. **Available Balance:** The amount available for future claim requests.
5. **Amt This Payment:** The amount paid this statement by check or direct deposit. If you do not have direct deposit with Extend Health, a check will be attached to your EOP statement.
6. **Total Amount:** The amount you requested for reimbursement.

(continued on reverse)

7 Account Name	8 Expense Type	9 Service Dates Begin	End	This Payment Includes 10 Amt Requested	11 Amt Paid	12 Amt Denied	13 Claim #	14 Amt This Payment
(2012) Health Reimburseme	Premium	08/01/2012	08/01/2012	$15.10	$15.10	$0.00	167103600	$15.10
							Total:	$15.10

The second section of your EOP statement, "This Payment Includes" provides the following information:

7. **Account Name:** This is the specific name of your funding program. The year contained in parenthesis is the current plan year of your program.

8. **Expense Type:** Expenses are organized by categories. The category of the expense you submitted is listed here.

9. **Service Dates (Beginning and Ending):** These dates represent the date the service was received, not the date the expense was paid. Reimbursement for premiums generally list the first day of the month as both the start and end date.

10. **Amt Requested:** The amount requested for reimbursement. For premiums, this will generally be the entire premium amount.

11. **Amt Paid:** The amount of the claim that is eligible for reimbursement.

12. **Amt Denied:** The amount of the claim that is not eligible for reimbursement. You will see a reason for the denial, if applicable.

13. **Claim #:** A system generated number to identify your claim.

14. **Amt This Payment:** The amount paid to you by check or direct deposit. If you do not have direct deposit with Extend Health, a check will be attached to your EOP.

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 the Casey, Neilon & Associates Audited Financial Statements of PEBP for Fiscal Year 2019.

CASEY NEILON

November 1, 2019

To the Board of the Public Employees' Benefits Program

We have audited the financial statements of the Self Insurance Trust Fund of the Public Employees' Benefits Program (SITF) for the year ended June 30, 2019. Professional standards require that we provide you with information about our responsibilities under generally accepted auditing standards and *Government Auditing Standards*, as well as certain information related to the planned scope and timing of our audit. We have communicated such information in our engagement letter to you dated September 5, 2019. Professional standards also require that we communicate to you the following information related to our audit.

Significant Audit Findings

Qualitative Aspects of Accounting Practices

Management is responsible for the selection and use of appropriate accounting policies. The significant accounting policies used by SITF are described in Note 1 to the financial statements. We noted no new accounting policies were adopted and the application of existing policies was not changed during 2019. We noted no transactions entered into by SITF during the year for which there is a lack of authoritative guidance or consensus. All significant transactions have been recognized in the financial statements in the proper period.

Accounting estimates are an integral part of the financial statements prepared by management and are based on management's knowledge and experience about past and current events and assumptions about future events. Certain accounting estimates are particularly sensitive because of their significance to the financial statements and because of the possibility that future events affecting them may differ significantly from those expected. The most sensitive estimates affecting SITF's financial statements were:

> Management's estimate of the reserve for loss and loss adjustment expense is based on claims incurred but not reported during the policy period. This was supported by an actuarial opinion, and meets the standards required by generally accepted accounting principles. We evaluated the key factors and assumptions used to develop the reserve for unpaid loss and loss adjustment expense in determining that it is reasonable in relation to the financial statements taken as a whole.
>
> Management's estimate of the reserve for loss and loss adjustment expense includes the unused portion of the Health Reimbursement Account (HRA) component of the Consumer Driven Health Plan (CDHP) and the Medicare Exchange.
>
> Management's estimate of the Express Scripts (account 1600) and Medicare D (account 1679) accounts receivable is based on average of cash received during the fiscal year and average number of participants. We evaluated the key factors and assumptions used to develop the receivable estimate in determining that it is reasonable in relation to the financial statements taken as a whole.

The estimate of the net pension liability is determined by an actuarial valuation and is reported by Nevada PERS. The employer allocation percentage of the net pension liability was based on the total contributions due on wages paid during the measurement period. Each employer's proportion of the net pension liability is based on their combined employer and member contributions relative to the total combined employer and member contributions for all employers for the period ended June 30, 2019. It is further allocated by the Controller's office for each Fund that is covered by the State of Nevada.

The estimate of the net OPEB liability is determined by an actuarial valuation and was provided by the Public Employee Benefits Program.

Certain financial statement disclosures are particularly sensitive because of their significance to financial statement users. The most sensitive disclosures affecting the financial statements were:

The disclosure of pension liabilities and activities in Note 4 to the financial statements because of the material changes and estimates that have occurred with the implementation of the new Governmental Accounting Standards Board Statements relating to pensions in the current year.

The disclosure of the OPEB liability and activities in Note 5 to the financial statements because of the material changes and estimates that have occurred with the implementation of the new Governmental Accounting Standards Board Statements relating to other post-employment retirement benefits in the current year.

The disclosure of the unpaid claims liabilities and reserves in Note 7 to the financial statements because these numbers are based on actuarial opinions and estimates and have a material impact on the financials statements. These accruals are estimates which if there were material changes occur to the estimates there could be material changes to the financial statements.

The financial statement disclosures are neutral, consistent, and clear.

Difficulties Encountered in Performing the Audit

We encountered no significant difficulties in dealing with management in performing and completing our audit.

Corrected and Uncorrected Misstatements

Professional standards require us to accumulate all known and likely misstatements identified during the audit, other than those that are clearly trivial, and communicate them to the appropriate level of management. Management has corrected all such misstatements. In addition, none of the misstatements detected as a result of audit procedures and corrected by management were material, either individually or in the aggregate, to each opinion unit's financial statements taken as a whole.

Disagreements with Management

For purposes of this letter, a disagreement with management is a financial accounting, reporting, or auditing matter, whether or not resolved to our satisfaction, that could be significant to the financial statements or the auditor's report. We are pleased to report that no such disagreements arose during the course of our audit.

Management Representations

We have requested certain representations from management that are included in the management representation letter dated November 1, 2019.

Management Consultations with Other Independent Accountants

In some cases, management may decide to consult with other accountants about auditing and accounting matters, similar to obtaining a "second opinion" on certain situations. If a consultation involves application of an accounting principle to SITF's financial statements or a determination of the type of auditor's opinion that may be expressed on those statements, our professional standards require the consulting accountant to check with us to determine that the consultant has all the relevant facts. To our knowledge, there were no such consultations with other accountants.

Other Audit Findings or Issues

We generally discuss a variety of matters, including the application of accounting principles and auditing standards, with management each year prior to retention as SITF's auditors. However, these discussions occurred in the normal course of our professional relationship and our responses were not a condition to our retention.

Other Matters

We applied certain limited procedures to the pension and other post-employment benefits schedules of information, which are required supplementary information (RSI) that supplements the basic financial statements. Our procedures consisted of inquiries of management regarding the methods of preparing the information and comparing the information for consistency with management's responses to our inquiries, the basic financial statements, and other knowledge we obtained during our audit of the basic financial statements. We did not audit the RSI and do not express an opinion or provide any assurance on the RSI.

This information is intended solely for the use of the Public Employees' Benefits Program, its Board and its management and is not intended to be, and should not be, used by anyone other than these specified parties.

Very truly yours,

Casey Neilon

Casey Neilon

STATE OF NEVADA
SELF INSURANCE TRUST FUND
PUBLIC EMPLOYEES' BENEFITS PROGRAM

JUNE 30, 2019 AND 2018

STATE OF NEVADA
SELF INSURANCE TRUST FUND
PUBLIC EMPLOYEES' BENEFITS PROGRAM
JUNE 30, 2019 AND 2018

TABLE OF CONTENTS

Casey Neilon
Accountants and Advisors

INDEPENDENT AUDITOR'S REPORT

To the Board of the
Public Employees' Benefits Program

Report on the Financial Statements

We have audited the accompanying financial statements of the Self Insurance Trust Fund, Public Employees' Benefits Program of the State of Nevada, as of and for the years ended June 30, 2019 and 2018, and the related notes to the financial statements, which collectively comprise the Self Insurance Trust Fund, Public Employees' Benefits Program of the State of Nevada's basic financial statements as listed in the table of contents.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of the Self Insurance Trust Fund, Public Employees' Benefits Program of the State of Nevada as of June 30, 2019 and 2018, and the changes in financial position and, cash flows thereof for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Emphasis of a Matter

As discussed in Note 1, the financial statements of the Self Insurance Trust Fund, Public Employees' Benefits Program of the State of Nevada are intended to present the financial position, the changes in financial position, and the cash flows of only that portion of the activities of the State of Nevada that is attributable to transactions of the Fund. They do not purport to, and do not, present fairly the financial position of the State of Nevada as of June 30, 2019 and 2018, the changes in its financial position, or, where applicable, its cash flows for the years then ended, in conformity with accounting principles generally accepted in the United States of America. Our opinion is not modified with respect to this matter.

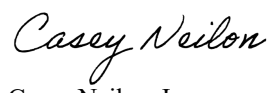
Other Matters

Required Supplementary Information

Accounting principles generally accepted in the United States of America require that the pension and other post-employment benefits information on pages 20-23, be presented to supplement the basic financial statements. Such information, although not a part of the basic financial statements, is required by the Governmental Accounting Standards Board, who considers it to be an essential part of financial reporting for placing the basic financial statements in an appropriate operational, economic, or historical context. We have applied certain limited procedures to the required supplementary information in accordance with auditing standards generally accepted in the United States of America, which consisted of inquiries of management about the methods of preparing the information and comparing the information for consistency with management's responses to our inquiries, the basic financial statements, and other knowledge we obtained during our audit of the basic financial statements. We do not express an opinion or provide any assurance on this required information because the limited procedures do not provide us with sufficient evidence to express an opinion or provide any assurance.

Other Reporting Required by Government Auditing Standards

In accordance with *Government Auditing Standards*, we have also issued our report dated November 1, 2019 on our consideration of the Self Insurance Trust Fund, Public Employees' Benefits Program of the State of Nevada's internal control over financial reporting and on our tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements and other matters. The purpose of that report is to describe the scope of our testing of internal control over financial reporting and the results of that testing, and not to provide an opinion on internal control over financial reporting or on compliance. That report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering the Self Insurance Trust Fund, Public Employees' Benefits Program of the State of Nevada's internal control over financial reporting and compliance.



Casey Neilon, Inc.
Carson City, Nevada
November 1, 2019

STATE OF NEVADA
SELF INSURANCE TRUST FUND
PUBLIC EMPLOYEES' BENEFITS PROGRAM
STATEMENTS OF NET POSITION
JUNE 30, 2019 AND 2018

	2019	2018
ASSETS		
Current assets:		
Cash and cash equivalents	$ 155,908,618	$ 140,029,596
Prepaid insurance	3,611	-
Receivables:		
Accounts receivable, net	6,106,065	2,864,110
Intergovernmental receivable	2,419,215	6,717,562
Due from other funds	5,230,821	6,188,275
Due from component units, net	19,210	939,496
Total Current Assets	169,687,540	156,739,039
Capital assets:		
Property and equipment	466,100	466,100
Less: Accumulated depreciation	(411,151)	(369,138)
Total Capital Assets (net of accumulated depreciation)	54,949	96,962
Total Assets	169,742,489	156,836,001
Deferred outflows of resources:		
Pension related amounts	641,824	572,133
OPEB related amounts	44,268	39,801
Total Deferred Outflows of Resources	686,092	611,934
LIABILITIES		
Current liabilities:		
Bank overdraft	3,829,541	2,419,159
Accounts payable	4,274,803	1,736,131
Accrued payroll and related liabilities	87,285	91,013
Due to other funds	25,334	16,562
Unearned revenue	3,662,898	48,916
Compensated absences	163,215	157,495
Reserve for losses	94,881,428	71,683,258
Total Current Liabilities	106,924,504	76,152,534
Noncurrent liabilities:		
Compensated absences	54,490	66,215
Net pension obligation	3,547,239	3,361,917
Net OPEB liability	1,417,507	1,339,747
Total Noncurrent Liabilities	5,019,236	4,767,879
Total Liabilities	111,943,740	80,920,413
Deferred inflows of resources:		
Pension related amounts	257,269	255,633
OPEB related amounts	95,047	83,387
Total Deferred Inflows of Resources	352,316	339,020
NET POSITION		
Invested in capital assets	54,949	96,962
Restricted expendable - losses	58,077,576	76,091,540
Total Net Position	$ 58,132,525	$ 76,188,502

See accompanying notes.

STATE OF NEVADA
SELF INSURANCE TRUST FUND
PUBLIC EMPLOYEES' BENEFITS PROGRAM
STATEMENTS OF REVENUES, EXPENSES AND CHANGES IN FUND NET POSITION
FOR THE YEARS ENDED JUNE 30, 2019 AND 2018

	2019	2018
OPERATING REVENUES:		
Insurance premiums	$ 357,432,206	$ 362,340,352
Other	1,902	1,683
Total Operating Revenues	357,434,108	362,342,035
OPERATING EXPENSES:		
Salaries and benefits	2,910,928	2,206,566
Operating	3,398,726	3,878,955
Claims expense	314,546,591	227,862,964
Depreciation	42,013	41,586
Insurance premiums and contractual obligations	59,318,572	125,492,052
Total Operating Expenses	380,216,830	359,482,123
Operating Income	(22,782,722)	2,859,912
NONOPERATING REVENUES (EXPENSES):		
Investment income	1,694,774	(938,598)
Interest income	3,031,971	1,535,420
Total Nonoperating Revenues	4,726,745	596,822
CHANGE IN NET POSITION	(18,055,977)	3,456,734
NET POSITION		
Beginning of year	76,188,502	72,731,768
End of year	$ 58,132,525	$ 76,188,502

See accompanying notes.

STATE OF NEVADA
SELF INSURANCE TRUST FUND
PUBLIC EMPLOYEES' BENEFITS PROGRAM
STATEMENTS OF CASH FLOWS
FOR THE YEARS ENDED JUNE 30, 2019 AND 2018

	2019	2018
CASH FLOWS FROM OPERATING ACTIVITIES:		
Receipts from customers and users	$ 29,482,963	$ 51,785,881
Receipts for interfund services provided	322,062,620	300,422,806
Receipts from component units	13,588,561	15,384,957
Payments to suppliers, other governments and beneficiaries	(349,437,609)	(354,337,303)
Payments to employees	(2,718,441)	(2,445,449)
Payments for interfund services used	(1,298,678)	(1,098,176)
Net Cash Provided by Operating Activities	11,679,416	9,712,716
CASH FLOWS FROM CAPITAL AND RELATED FINANCING ACTIVITIES:		
Purchase of capital assets	-	(12,773)
Net Cash Used by Financing Activities	-	(12,773)
CASH FLOWS FROM INVESTING ACTIVITIES		
Interest on investments	4,199,606	274,125
Net Cash Provided by Investing Activities	4,199,606	274,125
Net Increase in Cash and Cash Equivalents	15,879,022	9,974,068
Cash and cash equivalents, July 1	140,029,596	130,055,528
Cash and cash equivalents, June 30	$ 155,908,618	$ 140,029,596
RECONCILIATION OF OPERATING INCOME (LOSS) TO NET CASH USED BY OPERATING ACTIVITIES:		
Operating income	$ (22,782,722)	$ 2,859,912
Adjustments to reconcile operating income to net cash used by operating activities:		
Depreciation	42,013	41,586
Allowance for doubtful accounts	(3,592)	3,607
Changes in assets and liabilities:		
(Increase) decrease in receivables	3,464,863	4,325,284
(Increase) decrease in prepaid expenses	(3,611)	-
(Increase) decrease in deferred outflows	(74,158)	(16,556)
Increase (decrease) in payables and accruals	30,760,245	2,766,476
Increase (decrease) in net pension obligation	185,322	(271,871)
Increase (decrease) in net OPEB liability	77,760	(42,965)
Increase (decrease) in deferred inflows	13,296	47,243
Total Adjustments	34,462,138	6,852,804
Net Cash Provided by Operating Activities	$ 11,679,416	$ 9,712,716

See accompanying notes.

NOTE 1 - Summary of Significant Accounting Policies:

The financial statements of the Self Insurance Trust Fund, Public Employees' Benefits Program ("PEBP") of the State of Nevada ("Self Insurance Trust Fund") have been prepared in conformity with accounting principles generally accepted in the United States of America (USGAAP) as applied to governmental units. The Governmental Accounting Standards Board (GASB) is the accepted standard-setting body for establishing governmental accounting and financial reporting principles. A summary of the Self Insurance Trust Fund's significant accounting policies applied in the preparation of the accompanying financial statements is presented below.

Plan Description:

The Self Insurance Trust Fund was created in 1983 by the Nevada Legislature to administer group health, life and disability insurance for covered employees, both active and retired, of the State, and certain other participating public employers within the State of Nevada. All public employers in the State are eligible to participate in the activities of the Self Insurance Trust Fund and currently, in addition to the State, there were four public employers participating at June 30, 2019 whose employees are covered under the plan. Additionally, all retirees of public employers contracted with PEBP to provide coverage to their employees are eligible to join the program subsequent to their retirement. Public employers are required to subsidize their retirees who participate in the plan in the same manner the State subsidizes its retirees. Currently, the State, the Nevada System of Higher Education and 165 public employers within the State of Nevada are billed for retiree subsidies. The Self Insurance Trust Fund provides medical, dental, vision, long-term disability, mental health, substance abuse, and life insurance benefits. The Self Insurance Trust Fund is overseen by the Public Employees' Benefits Program Board. The Board is composed of ten members, nine members appointed by the Governor, and the Director of the Department of Administration or their designee.

The Self Insurance Trust Fund is self-insured for medical, dental, vision, mental health and substance abuse benefits and also offers fully insured HMO products. Long-term disability and life insurance benefits are fully insured by outside carriers. For the self-insured benefits, rate-setting policies have been established after consultation with an actuary. The participating public employers, with the exception of the State, are not subject to supplemental assessment in the event of deficiencies.

PEBP has instituted a Consumer Driven Health Plan (CDHP) with Health Savings Account (HSA) and Health Reimbursement Account (HRA) components. The HSA component is designed for eligible active employee's where the HRA component is for retirees and surviving spouses, domestic partners and certain employees enrolled in the CDHP.

PEBP has also implemented an individual market Medicare exchange where retirees eligible for Medicare purchase individual coverage on the private market with an HRA component to reimburse retirees for insurance premiums and other out of pocket expenses.

In fiscal year 2019 PEBP implemented an Exclusive Provider Organization (EPO) plan. The plan is self-insured and employees were eligible to elect this plan as of July 1, 2018.

Reporting Entity:

Governmental accounting and financial reporting principles require that basic financial statements be presented for governmental entities which present financial statements in accordance with generally accepted accounting principles. The accompanying financial statements are not intended to present the combined financial activities of the State of Nevada taken as a whole, but are intended only to present the financial position, results of operations, and cash flows of the Self Insurance Trust Fund.

NOTE 1 - Summary of Significant Accounting Policies (continued):

Fund Accounting:
The operations of the Self Insurance Trust Fund, a proprietary fund (internal service fund), are accounted for by a separate set of self-balancing accounts that comprise its assets, liabilities, net position, revenues, and expenses. The Self Insurance Trust Fund is used to account for the services provided to the employees and retirees of the State of Nevada and other governmental units under the programs administered by management.

Basis of Accounting:
The Self Insurance Trust Fund maintains its accounting records on the accrual basis of accounting as defined by the Governmental Accounting Standards Board ("GASB"). Under this method, revenues are recognized at the time they are earned and expenses are recognized when the related liabilities are incurred regardless of the timing of cash flows.

The Self Insurance Trust Fund is reported using the economic resources measurement focus. The revenues derived from current operations are generally intended to provide those resources necessary to maintain continued delivery of such services in the future. Net positions greater or lesser than those required to support ongoing operations are moderated by adjustments of future charge rates appropriate to accomplish the long-term cost recovery objectives of the Self Insurance Trust Fund.

Internal Service Funds distinguish operating revenues and expenses from nonoperating items. Operating revenues and expenses result from providing services in connection with providing group health, life and disability insurance. Operating expenses include the cost of services, administrative expenses and depreciation on capital assets. All revenues and expenses not meeting this definition are reported as nonoperating revenues and expenses.

Cash Equivalents:
For the purpose of presentation in the Self Insurance Trust Fund's financial statements, cash equivalents are short-term, highly liquid investments that are both (a) readily convertible to known amounts of cash and (b) so near to maturity that they present insignificant risk of changes in value due to changing interest rates.

Receivables:
Insurance premiums due through June 30 but remitted after that date are recorded as receivables or due from other funds, component units or governments in the financial statements.

The third party administrator that processes claims payments on behalf of the Self Insurance Trust Fund has identified overpayments in the amount of $1,940,931 and $2,479,714 as of June 30, 2019 and 2018, respectively. Overpayments are followed up on every 30 days until recovery is made. These amounts have not been accrued as a receivable on the statement of net assets, but are recorded as a reduction to claims expense in the period in which recovery is received. Collection attempts cease when the overpayment is greater than 4 years old.

The Self Insurance Trust Fund administers an additional pass-through budget account, the Active Employee Group Insurance Subsidy (AEGIS) budget account. This budget account is utilized for recording the payments made by the state and received by the Self Insurance Trust Fund on behalf of active employees. Agencies contribute a fixed dollar amount per employee into this budget account. However, insurance premiums are earned by the main operating budget account in accordance with the PEBP approved rate for insurance coverage for the plan and tier to which each employee belonged. The difference between cash contributions and revenue recognition resulted in a surplus of contributions over premiums of $3,122,265 and a shortage of contributions over premiums of $(2,413,913) for the years ended June 30, 2019 and 2018, respectively. These amounts were allocated among all state entities that paid the AEGIS subsidy proportionate to their size and were included in the subsequent year's budget.

NOTE 1 - Summary of Significant Accounting Policies (continued):

Receivables (continued):
The Self Insurance Trust Fund considers $274,123 and $277,715 in participant premiums as uncollectible as of June 30, 2019 and 2018, respectively. Pursuant to NRS 353C.220, only accounts that have been approved by the State of Nevada Board of Examiners may be written off. Of the uncollectible premiums listed above, $0 and $0 were approved for write-off by the State of Nevada Board of Examiners as of June 30, 2019 and 2018, respectively. The State has a policy in which all uncollectible amounts are remitted to the State Controller's Office for continued collection attempts and are eventually written off. In accordance with this policy, the Self Insurance Trust Fund created an allowance to account for the remaining uncollectible amounts that have been remitted to the State Controller's Office, but not yet been approved by the State of Nevada Board of Examiners for write off.

Property and Equipment:
Fixed assets are capitalized and depreciated using the straight line method of depreciation over the assets' estimated useful lives ranging from three to ten years. Capital acquisitions for the years ended June 30, 2019 and 2018 were $0 and $12,773, respectively. Capital dispositions for the years ended June 30, 2019 and 2018 were $0 and $12,899, respectively.

Estimated Claims:
The Self Insurance Trust Fund contracted with Aon, a provider of consulting and actuarial services, to estimate its liability for incurred but not reported claims, claims reported but not yet paid and administrative expenses expected to be incurred in conjunction with processing incurred but not reported claims as of June 30, 2019 and 2018, respectively. This liability is estimated by the actuary based on industry trends and claims lag information reported by the third party administrator. Such liabilities are necessarily based on estimates, and, while management believes the amount is adequate, the ultimate liability may be in excess of, or less than, the amounts provided. The methods for making such estimates and for establishing the resulting liability are reviewed on an annual basis and any adjustments are currently reflected in net income from operations.

Included in the estimated claims is the liability for the unused portion of the HRA component of the CDHP and the Medicare exchange. The Fund contracted with HealthSCOPE and Willis Towers Watson, respectively, to administer these programs and the liabilities are provided by each.

Compensated Absences:
A liability for compensated absences relating to services already rendered and that are not contingent on a specified event is accrued as employees earn the rights to the benefits. Compensated absences relating to future services or that are contingent on a specified event will be accounted for in the period those services are rendered or those events take place. Annual and sick leave benefits not used as earned accumulate to be carried over to the next year, except that annual leave in excess of 240 hours (30 days) per employee is forfeited each December 31.

Accumulated annual leave and compensatory time are payable upon termination, retirement, or death. Unused sick leave may be partially compensated at that time according to formulas established by the Department of Administration. The Self Insurance Trust Fund reports accrued compensated absences as a liability.

Pensions:
For purposes of measuring the net pension liability and deferred outflows/inflows of resources related to pensions, and pension expense, information about the fiduciary net position of the Public Employees' Retirement System of Nevada (PERS) plan (Plan) and additions to/deductions from the Plan's fiduciary net position have been determined on the same basis as they are reported by PERS. For this purpose, benefit payments (including refunds of employee contributions) are recognized when due and payable in accordance with the benefit terms. Investments are reported at fair value.

NOTE 1 - Summary of Significant Accounting Policies (continued):

Post Employment Benefits Other Than Pensions (OPEB):
For purposes of measuring the net OPEB liability, deferred outflows/inflows of resources related to OPEB and OPEB expense, information about the fiduciary net position of the State Retirees' Health and Welfare Benefits Fund, Public Employees' Benefits Program (PEBP) and additions to/deductions PEBP's fiduciary net position have been determined on the same basis as they are reported by PEBP. For this purpose, PEBP recognizes benefit payments when due and payable in accordance with the benefit terms.

Deferred Outflows/Inflows of Resources:
In addition to assets, the Statements of Net Position include a separate section for deferred outflows of resources. This separate financial statement element represents a consumption of net position that applies to future periods and will not be recognized as an outflow of resources until then. Self Insurance Trust Fund has pension related deferred outflows that qualify for reporting in this category. Pension related deferred outflows of resources are discussed in depth in Note 4.

In addition to liabilities, the Statements of Net Position include a separate section for deferred inflows of resources. This separate financial statement element represents an acquisition of net position that applies to future periods and will not be recognized as an inflow of resources until that time. Self Insurance Trust Fund has pension related deferred inflows that qualify for reporting in this category. Pension related deferred inflows of resources are discussed in depth in Note 4.

Net Position:
Net position presents the difference between assets plus deferred outflows of resources and liabilities plus deferred inflows of resources in the statement of net position. Net position invested in capital assets are net of accumulated depreciation and reduced by the outstanding balances of any borrowings used for the acquisition, construction or improvements of those assets. Restricted net position results when constraints placed on net asset use are either externally imposed by creditors, grantors, contributors and the like, or imposed by law through constitutional provisions or enabling legislation. Management determined that the net position at year end should be restricted for future claims payments due to legal restrictions on the use of the funds.

Operating and Non-operating Revenues and Expenses:
Revenues and expenses are classified as operating if they result from providing services and producing and delivering goods. They also include other events that are not defined as capital and related financing, noncapital financing, or investing activities. Contracts representing an exchange transaction are considered operating revenues.

Revenues and expenses are classified as non-operating if they result from capital and related financing, noncapital financing, or investing activities. Appropriations received to finance operating deficits are classified as noncapital financing activities; therefore, they are reported as non-operating revenues. Contracts representing non-exchange receipts are treated as non-operating revenues.

Reinsurance:
The Self Insurance Trust Fund does not carry any reinsurance policies.

Reclassifications:
Certain accounts in the prior-year financial statements have been reclassified for comparative purposes to conform with the presentation in the current-year financial statements.

NOTE 1 - Summary of Significant Accounting Policies (continued):

Use of Estimates:
The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and the disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

Recently Issued Accounting Pronouncements (Not Yet Adopted):
In January 2017, GASB issued Statement No. 84, *Fiduciary Activities* (GASB 84). This statement addresses the identification and presentation of fiduciary activities for accounting and financial reporting purposes. GASB 84 is effective for fiscal years beginning after December 15, 2018. It is not clear at this point how this will impact the financial statements as of June 30, 2020.

Recently Adopted Accounting Pronouncements:
In June 2015, GASB issued Statement No. 75, *Accounting and Financial Reporting for Postemployment Benefits other than Pensions* (GASB 75), which improves accounting and financial reporting by state and local governments for postemployment benefits other than pensions (other postemployment benefits or OPEB). It also improves information provided by state and local governmental employers about financial support for OPEB that is provided by other entities. GASB 75 is effective for fiscal years beginning after June 15, 2017. The Fund implemented this pronouncement during 2018, the results of which were changes to the reporting format of the financial statements, additional footnote disclosures, and changes to the required supplementary schedules from what was presented in prior years.

In March 2017, the GASB issued Statement No. 85, *Omnibus 2017* (GASB 85). This statement addresses a variety of topics including issues related to blending component units, goodwill, fair value measurement and application, and postemployment benefits. The requirements of this statement will enhance consistency in the application and financial reporting requirements. Consistent reporting will improve the usefulness of information for users of state and local government financial statements. This statement was effective June 15, 2017.

NOTE 2 - Compliance with Nevada Revised Statutes and the Nevada Administrative Code:

The Self Insurance Trust Fund conformed to all significant statutory constraints on its financial administration during the year.

NOTE 3 - Cash and Deposits as of June 30:

	2019	2018
Cash:		
Operating checking account	$ (3,829,541)	$ (2,419,159)
Deposits with State Treasurer:		
State Treasurer's Investment Pool	155,522,138	141,337,890
GASB 31 adjustment	386,480	(1,308,294)
Total Deposits with State Treasurer	155,908,618	140,029,596
Total Cash and Deposits	$ 152,079,077	$ 137,610,437

NOTE 3 - Cash and Deposits as of June 30 (continued):

The Self Insurance Trust Fund has three checking accounts with Wells Fargo Bank at June 30, 2019 and 2018. These accounts contain $1,058,501 and $814,584 in stale outstanding checks for the years ended June 30, 2019 and 2018, respectively. Additionally, certain Bank of America and Wells Fargo Bank zero balance accounts were closed in previous fiscal years. These closed accounts contain $301,826 and $474,162 in stale outstanding checks as of June 30, 2019 and 2018, respectively. Checks presented for payment from the closed accounts are rejected by the bank, voided, and reissued by the Self Insurance Trust Fund using the controlled disbursement account. The controlled disbursement account is funded only when checks are presented for payment. The negative balance represents outstanding checks issued that have not been presented for payment. In accordance with NRS 353.140, the Self Insurance Trust Fund honors outstanding stale warrants presented for payment within six years from the date of origination. For insurance and collateral purposes, the account is commingled with all of the cash accounts of the State of Nevada. All cash and deposits are recorded at fair value.

Nevada Revised Statutes direct the Office of the State Treasurer to deposit funds into any state, or national bank, credit union or savings and loan association covered by federal depository insurance. For those deposits over and above the federal depository insurance maximum balance, sufficient collateral must be held by the financial institution to protect the State of Nevada against loss. The pooled collateral for the deposits program maintains a 102% pledge collateral for all public deposits.

NRS 355.140 details the types of securities in which the State may invest. In general, authorized investments include: certificates of deposit, asset-backed securities, bankers' acceptances and commercial paper, collateralized mortgage obligations, corporate notes, money market funds whose policies meet the criteria set forth in the statute, United States treasury securities and specific securities implicitly guaranteed by the federal government. Additionally, the State may invest in limited types of repurchase agreements; however, statutes generally prohibit the State from entering into reverse-repurchase agreements.

A copy of the State of Nevada Comprehensive Annual Financial Report can be obtained online at http://controller.nv.gov/FinancialReports/CAFR_Download_Page.html.

NOTE 4 - Pension Plan:

Plan Description. The Self Insurance Trust Fund contributes to the PERS, a cost sharing, multiple employers, defined benefit plan administered by the Public Employees' Retirement System of the State of Nevada. PERS provides retirement benefits, disability benefits, and death benefits, including annual cost of living adjustments, to plan members and their beneficiaries. Chapter 286 of the Nevada Revised Statutes establishes the benefit provisions provided to the participants of PERS. These benefit provisions may only be amended through legislation. A publicly available financial report that includes financial statements and required supplementary information for PERS may be obtained by writing to the Public Employees' Retirement System of the State of Nevada, 693 West Nye Lane, Carson City, NV 89703-1599 or by calling (775) 687-4200.

NOTE 4 - Pension Plan (continued):

Funding Policy. Plan members' benefits are funded under one of two methods. Under the employer paid contribution plan, the Self Insurance Trust Fund is required to contribute all amounts due under the plan. The rate for those contributions was 28.00%, 28.00% and 28.00% for regular members on all covered payroll for the years ended June 30, 2019, 2018 and 2017, respectively. The second funding mechanism for providing benefits is the employer/employee paid contribution plan. Under this method, employees are required to contribute a percentage of their compensation to the plan while the Self Insurance Trust Fund is required to match that contribution. The rate for regular employees under this plan was 14.50%, 14.50% and 14.50% for the years ended June 30, 2019, 2018 and 2017, respectively. The contribution requirements of plan members and the Self Insurance Trust Fund are established by NRS Chapter 286. The funding may only be amended through legislation. The Self Insurance Trust Fund's contributions to PERS for the years ended June 30, 2019, 2018, and 2017 were $241,299, $226,892, and 314,930, respectively, equal to the required contributions for the year.

Pension Liability. At June 30, 2019 and 2018 the Self Insurance Trust Fund reported a liability of $3,547,239 and $3,361,917, respectively, for its proportionate share of the net pension liability. The net pension liability was measured as of June 30, 2018 and 2017, and the total pension liability used to calculate the net pension liability was determined by an actuarial valuation as of that date. Self Insurance Trust Fund's proportion of the net pension liability is based on their combined employer and member contributions relative to the total combined employer and member contributions for all employers for the period ended June 30, 2019 and 2018. The Self Insurance Trust Fund's proportionate share is approximately 0.026% and 0.025% as of June 30, 2019 and 2018, respectively.

Pension Expense, Deferred Outflows of Resources and Deferred Inflows of Resources Related to Pensions. As of June 30, 2019 and 2018, the total employer pension expense is $387,713 and $(73,667), respectively. Amounts totaling $270,930 resulting from Fund contributions subsequent to the measurement date will be recognized as a reduction of the net pension liability in the year ended June 30, 2020. At June 30, 2019 and 2018, the Self Insurance Trust Fund reported deferred outflows of resources and deferred inflows of resources related to pensions from the following sources:

	2019		2018	
	Deferred Outflows of Resources	Deferred Inflows of Resources	Deferred Outflows of Resources	Deferred Inflows of Resources
Differences between expected and actual experience	$ 111,125	$ 164,653	$ -	$ 220,610
Change of assumptions	186,917	-	223,031	-
Net difference between projected and actual earnings on investments	-	16,888	21,828	-
Changes in proportion and differences between actual contributions and proportionate share of contributions	72,852	75,728	85,490	35,023
System contributions subsequent to the measurement date	270,930	-	241,784	-
Totals	$ 641,824	$ 257,269	$ 572,133	$ 255,633

NOTE 4 - Pension Plan (continued):

Amounts reported as deferred outflows of resources and deferred inflows of resources related to pensions, without regard to the contributions subsequent to the measurement date and changes in proportion and differences between actual contributions and proportionate share of contributions, are expected to be recognized in pension expense as follows:

Year ended June 30:	Amount
2020	$ 81,193
2021	21,625
2022	(55,663)
2023	30,125
2024	34,539
2025	4,682
	$ 116,501

The net difference between projected and actual investment earnings on pension plan investments will be recognized over five years, all the other above deferred outflows and deferred inflows will be recognized over the average expected remaining service lives, which was 6.22 years for the measurement period ending June 30, 2018.

Reconciliation of Net Pension Liability	2019	2018
Beginning net pension liability	$ 3,361,917	$ 3,633,788
Pension expense	387,713	(73,667)
Employer contributions	(241,299)	(226,892)
Net deferred (inflows)/outflows	38,908	28,688
Ending net pension liabilities	$ 3,547,239	$ 3,361,917

Actuarial Assumptions. The Fund's net pension liability was measured as of June 30, 2018 and 2017 and the total pension liability used to calculate the net pension liability was determined by an actuarial valuation as of that date. The total pension lability was determined using the following actuarial assumptions, applied to all periods included in the measurement, unless otherwise specified:

Inflation	2.75%
Payroll growth	5.00%, including inflation
Investment rate of return	7.50%
Productivity pay increase	0.50%
Projected salary increase	Regular: 4.25% to 9.15%, depending on service Rates include inflation and productivity increases
Consumer Price Index	2.75%
Other assumptions	Same as those used in the June 30, 2018 funding actuarial valuation

Actuarial assumptions used in the June 30, 2018 valuation were based on the results of the experience review completed in 2017.

NOTE 4 - Pension Plan (continued):

Investment Policy. The following was the Retirement Board's adopted policy target asset allocation as of June 30, 2018:

Asset Class	Target Allocation	Long-Term Geometric Expected Real Rate of Return*
Domestic stocks	42%	5.50%
International stocks	18%	5.75%
U.S. bonds	30%	0.25%
Private markets	10%	6.80%

*As of June 30, 2018, PERs' long-term inflation assumption was 2.75%.

Discount Rate and Pension Liability Discount Rate Sensitivity. The following presents the net pension liability of the PERS as of June 30, 2018, calculated using the discount rate of 7.50%, as well as what the PERS net pension liability would be if it were calculated using a discount rate that is 1 percentage-point lower (6.5%) or 1 percentage-point higher (8.50%) than the current discount rate:

	1% Decrease in Discount Rate (6.50%)	Discount Rate (7.50%)	1% Increase in Discount Rate (8.50%)
Net Pension Liability	$ 5,409,402	$ 3,547,239	$ 1,999,897

Pension Plan Fiduciary Net Position. Additional information supporting the Schedule of Employer Allocations and the Schedule of Pension Amounts by Employer is located in the PERS Comprehensive Annual Financial Report (CAFR) available on the PERS website at www.nvpers.org under Quick Links – Publications.

NOTE 5 – Other Post Employment Retirement Benefits:

Plan Description. Employees of the State, who meet the eligibility requirements for retirement, have the option upon retirement to continue group insurance pursuant to NAC 287.530. NRS 287.046 requires the State to pay an amount toward the cost of the premiums for most persons retired from state service. Retirees assume any portion of the premium not covered by the State. The State allocates funds for payment of post retirement insurance benefits as a percentage of budgeted payrolls to all State agencies. The cost of the employer contribution is recognized in the year the costs are charged. No unused funds are carried forward to the next fiscal year.

The Public Employees Benefit Program administers these benefits as a multiple employer cost sharing plan. The State Retirees' Health and Welfare Benefits Trust Fund has been created to provide benefits to retirees and their beneficiaries.

Benefits. The Public Employees Benefit Program provides medical, dental, vision, mental health and substance abuse and also offers fully insured HMO products. Long-term disability and life insurance benefits are fully insured by outside carriers.

NOTE 5 – Other Post Employment Retirement Benefits (continued):

Contributions. Per NRS 287 contribution requirements of the participating entities and covered employees are established and may be amended by the PEBP Board. The Fund's contractually required contribution for the year ended June 30, 2019 was $44,268, actuarially determined as an amount that is expected to finance the costs of benefits earned by employees during the year. Employees are not required to contribute to the OPEB plan.

OPEB Liabilities, OPEB Expenses, and Deferred Outflows of Resources and Deferred Inflows of Resources Related to OPEB. At June 30, 2019 and 2018, the Fund reported a liability of $1,417,507 and $1,339,747, respectively, for its proportionate share of the collective net OPEB liability. The collective net OPEB liability was measured as of January 1, 2018, and the total OPEB liability used to calculate the collective net OPEB liability was determined by an actuarial valuation as of that date. The Fund's proportion of the collective net OPEB liability was based on a projection of the Fund's long-term share of contributions to the OPEB plan relative to the projected contributions of all participating entities, actuarially determined. For the year ended June 30, 2019 and 2018, respectively, the Fund's proportion was 0.1070% and 0.1029%.

The components of the net OPEB liability at June 30, 2019 and 2018 were as follows:

	2019	2018
Total OPEB liability	$ 1,419,217	$ 1,341,267
Plan fiduciary net position	(1,710)	(1,520)
Net OPEB liability	$ 1,417,507	$ 1,339,747

For the years ended June 30, 2019 and 2018, respectively, the Fund recognized OPEB expense of $131,880 and $79,592. At June 30, 2019 and 2018, the Fund Reported deferred outflows of resources and deferred inflows of resources related to OPEB for the following sources:

	2019		2018	
	Deferred Outflows of Resources	Deferred Inflows of Resources	Deferred Outflows of Resources	Deferred Inflows of Resources
Changes of assumptions	$ -	$ 94,871	$ -	$ 83,282
Net difference between projected and actual earnings on OPEB plan investments	-	176	-	105
Fund contributions subsequent to the measurement date	44,268	-	39,801	-
	$ 44,268	$ 95,047	$ 39,801	$ 83,387

NOTE 5 – Other Post Employment Retirement Benefits (continued):

OPEB Liabilities, OPEB Expenses, and Deferred Outflows of Resources and Deferred Inflows of Resources Related to OPEB (continued). Other amounts reported as deferred outflows of resources and deferred inflows of resources related to OPEB will recognized in OPEB expense as follows:

Year ending June 30,	Amount
2020	$ (31,209)
2021	(31,209)
2022	(26,169)
2023	(6,460)
	$ (95,047)

Actuarial Assumptions. The total OPEB liability in the January 1, 2018 actuarial valuation was determined using the following actuarial assumptions, applied to all periods included in the measurement, unless otherwise specified:

Discount Rate	3.87%, Based on Bond Buyer General Obligation 20-Year Municipal Bond Index
Inflation	2.50%
Salary Increases	Dependent on years of service ranging from 1.00% to 10.65%, including inflation
Healthcare Trend Rate	For medical and prescription drug benefits, this amount initially is at 7.00% and decreases to a 4.75% long-term rate after six years. For dental benefits, and medical Part B premiums, this trend rate is 4.00% and 4.50%, respectively.

Mortality rates were based on the RP-2000 Combined Healthy Mortality Table projected to 2014 with Scale AA for regular participants, set back one year for females, RP-2000 Combined Healthy Mortality Table projected to 2014 with scale AA for Fire and Police, set forward one year, and RP-2000 Disabled Retiree Mortality Table projected to 2014 with scale AA for disabled participants, set forward three years.

The actuarial assumptions used in the January 1, 2018 valuation were based on the results of an actuarial experience study for the period July 1, 2017 to June 30, 2018. As a result of the 2018 actuarial experience study, the expectation of life after disability was adjusted in the January 1, 2018 actuarial valuation to more closely reflect actual experience.

Discount rate. The discount rate basis under GASB 75 is required to be consistent with a 20-Year Municipal Bond Index. The Bond Buyer General Obligation 20-Bond Municipal Bond Index is used for the determination of the discount rate. The assets in the trust as of June 30, 2018 are less than the expected benefit payments in the first year; therefore, the crossover period is assumed to be in the first year, which provides additional support for continuing the discount rate at the 20-Year Municipal Bond Index rate.

NOTE 5 – Other Post Employment Retirement Benefits (continued):

Sensitivity of the Net OPEB Liability to Changes in the Discount Rate. The following presents the net OPEB liability of the Retirees' Fund, as well as what the Retirees' Fund's net OPEB liability would be if it were calculated using a discount rate that is 1-percentage-point lower (2.87 percent) or 1-percentage-point higher (4.87 percent) than the current discount rate:

	1% Decrease in Discount Rate 2.87%	Discount Rate 3.87%	1% Increase in Discount Rate 4.87%
Total OPEB Liability	$ 1,563,552	$ 1,419,217	$ 1,293,779
Plan Fiduciary Net Position	(1,710)	(1,710)	(1,710)
Net OPEB Liability	$ 1,561,842	$ 1,417,507	$ 1,292,069

Sensitivity of the Net OPEB Liability to Changes in the Healthcare Cost Trend Rates. The following presents the net OPEB liability of the Retirees' Fund, as well as what the Retirees' Fund liability would be if it were using healthcare cost trend rates that are 1-percentage-point lower or 1-percentage-point higher than the current healthcare cost trend rates:

	1% Decrease in	Health Care Cost	1% Increase in
Total OPEB Liability	$ 1,323,914	$ 1,419,217	$ 1,531,727
Plan Fiduciary Net Position	(1,710)	(1,710)	(1,710)
Net OPEB Liability	$ 1,322,204	$ 1,417,507	$ 1,530,017

OPEB plan fiduciary net position. Detailed information about the OPEB plan's fiduciary net position is available in the separately issued PEBP financial report.

NOTE 6 - Commitments:

The Self Insurance Trust Fund is committed to the following contracts or policies after June 30, 2019:

Contractor	Contract Rate	Expiration Date
American Health Holding, Inc.	Varies by case volume	6/30/23
Aon Hewitt	Hourly rate	6/30/22
Casey Neilon, Inc.	Hourly rate	12/31/21
Diversified Dental Services	per participant per month	6/30/21
Express Scripts	Per participant per month admin fee, claims costs	6/30/22
Health Claim Auditors	Based on a per audit fee for each quarterly audit	9/30/22
Health Plan of Nevada (HMO)	Varies by tier	6/30/21
HealtchSCOPE Benefits (FSA)	Varies by service	6/30/20
HealthSCOPE Benefits (PPO)	Varies by service	7/30/22
HealthSCOPE Benefits (TPA)	Varies by service	6/30/22
HealthSCOPE Dental	Varies by service	6/30/22
Hometown Health Plan (HMO)	Varies by tier	6/30/21
Hometown Health Providers (UM)	Varies by service	6/30/19
Hometown Health Providers (PPO)	Varies by tier	6/30/21
Liberty Mutual Group	Varies by type of insurance selected by participant	6/30/19
Morneau Shepell	per participant per month fee for services rendered	12/31/23
The Standard Insurance	Varies	6/30/23
Towers Watson	per HRA Account per month	6/30/20
UNUM	Varies by type of insurance selected by participant	6/30/20

The above contracts include varying termination provisions that allow termination without cause with notice required between 30 and 180 days prior to the date of termination.

NOTE 7 - Risk Management:

Estimated Claims Liabilities:

The management of the Self Insurance Trust Fund establishes claims liabilities based on estimates of the ultimate cost of claims (including future claim adjustment expenses) that have been reported but not settled, and of claims that have been incurred but not reported and the unused portion of the HRA liability. Because actual claims costs depend on such complex factors as inflation, changes in doctrines of legal liability and damage awards, the process used in computing claims liabilities does not necessarily result in an exact amount. Typically, after consultation with an actuary, claims liabilities are recomputed annually using a variety of actuarial and statistical techniques to produce current estimates that reflect recent settlements, claim frequency and other economic and social factors. A provision for inflation in the calculation of estimated future claims costs is implicit in the calculation, because reliance is placed both on actual historical data that reflect past inflation and on other factors that are considered to be appropriate modifiers of past experience. Adjustments to claims liabilities are charged or credited to expense in the periods in which claims are made.

Unpaid Claims Liabilities:

As discussed above, management established a liability for both reported and unreported insured events, which includes estimates of both future payments of losses and related claim adjustment expenses. The following presents changes in those aggregate liabilities for the Self Insurance Trust Fund during the past two years.

NOTE 7 - Risk Management (continued):

Unpaid Claims Liabilities:

	2019	2018
Reserve for claims balance		
Beginning balance	$ 37,568,000	$ 33,422,000
Claims and changes in estimates	274,535,662	188,873,648
Claims payments	(253,313,662)	(184,727,648)
Ending balance reserve for claims balance	$ 58,790,000	$ 37,568,000
HRA Liability		
Beginning balance	$ 34,115,258	$ 35,246,573
Incurred	42,537,462	36,624,429
Paid	(40,561,292)	(37,755,744)
Ending balance HRA liability	$ 36,091,428	$ 34,115,258
Ending Balance	$ 94,881,428	$ 71,683,258

These unpaid claims liabilities are all for the self-funded medical, dental, vision and prescription drug benefits and the CDHP and Medicare exchange HRAs.

NOTE 8 – Contingencies:

Contingent Liabilities

In accordance with NRS 353.140, the Self Insurance Trust Fund honors outstanding stale warrants presented for payment within six years from the date of origination. Management has estimated the total amount of outstanding stale warrants less than six years old to be $1,360,327 and $1,288,946 as of June 30, 2019 and June 30, 2018, respectively. Management has assessed that it is not probable that these warrants will be presented for payment during the statutory time frame. However these warrants will continue to be recorded as a liability as after the statutory six year period the funds will be turned over to the Nevada State Treasurer as unclaimed property.

NOTE 9 – Subsequent Events:

Management has evaluated subsequent events through November 1, 2019, the date which the financial statements were available to be issued.

STATE OF NEVADA
SELF INSURANCE TRUST FUND
PUBLIC EMPLOYEES' BENEFITS FUND
REQUIRED SUPPLEMENTARY INFORMATION - PENSION
JUNE 30, 2019 AND 2018

SCHEDULE OF CHANGES IN NET PENSION LIABILITY

(Last Ten Fiscal Years*)

	Measurement Dates				
	2018	**2017**	**2016**	**2015**	**2014**
Proportion of the net pension liability (asset)	0.0260%	0.0253%	0.0270%	0.0262%	0.0254%
Proportion share of the net pension liability (asset)	$ 3,547,239	$ 3,361,917	$ 3,633,788	$ 3,003,622	$ 2,681,426
Proportion share of covered-employee payroll	$ 1,692,314	$ 1,578,012	$ 1,641,897	$ 1,507,312	$ 1,451,686
Proportionate share of the net pension liability (asset) as a percentage of its covered-employee payroll	209.61%	213.05%	221.32%	199.27%	184.71%
Plan fiduciary net position as a percentage of the total pension liability	75.24%	74.42%	72.23%	75.13%	76.31%

*Only five years of information is available due to reporting changes related to the implementation of GASB 68 implementation effective fiscal year 2015.

STATE OF NEVADA
SELF INSURANCE TRUST FUND
PUBLIC EMPLOYEES' BENEFITS FUND
REQUIRED SUPPLEMENTARY INFORMATION - PENSION
JUNE 30, 2019 AND 2018

SCHEDULE OF CONTRIBUTIONS

(Last Ten Fiscal Years*)

	Measurement Dates				
	2019	**2018**	**2017**	**2016**	**2015**
Contractually required contributions	$ 270,930	$ 241,784	$ 220,384	$ 228,943	$ 281,658
Contributions in relation to those contractually required	(270,930)	(241,784)	(220,384)	(228,943)	(281,658)
Contribution deficiency	$ -	$ -	$ -	$ -	$ -
Fund's covered-employee payroll	$ 1,684,981	$ 1,509,506	$ 1,374,657	$ 1,333,326	$ 1,344,932
Contributions as a percentage of covered-employee payroll	16.08%	16.02%	16.03%	17.17%	20.94%

*Only five years of information is available due to reporting changes related to the implementation of GASB 68 implementation effective fiscal year 2015.

STATE OF NEVADA
SELF INSURANCE TRUST FUND
PUBLIC EMPLOYEES' BENEFITS FUND
REQUIRED SUPPLEMENTARY INFORMATION - OPEB
JUNE 30, 2019 AND 2018

SCHEDULE OF THE FUND'S PROPORTIONATE SHARE OF THE NET OPEB LIABILITY

(Last Ten Fiscal Years*)

	Measurement Date	
	2019	**2018**
Proportion of the Net OPEB Liability (Asset)	0.1070%	0.1029%
Proportionate share of the Net OPEB Liability (Asset)	$ 1,417,507	$ 1,339,747
Proportionate share of covered payroll	$ 1,780,851	$ 1,712,897
Proportionate Share of the Net OPEB Liability (Asset) as a percentage of covered payroll	79.60%	78.22%
Plan Fiduciary Net Position as a percentage of the total Net OPEB Liability	0.12%	0.11%

* Only two years of information is available due to reporting changes related to the implementation of GASB 75 effective fiscal year 2018.

STATE OF NEVADA
SELF INSURANCE TRUST FUND
PUBLIC EMPLOYEES' BENEFITS FUND
REQUIRED SUPPLEMENTARY INFORMATION - OPEB
JUNE 30, 2019 AND 2018

SCHEDULE OF THE FUND CONTRIBUTIONS

(Last Ten Fiscal Years*)

	2019	2018
Contractually required contributions	$ 44,268	$ 39,801
Contributions	44,268	39,801
Contribution deficiency (excess)	$ -	$ -
Fund's covered payroll	$ 1,684,981	$ 1,509,506
Contributions as a percentage of covered payroll	2.63%	2.64%

* Only two years of information is available due to reporting changes related to the implementation of GASB 75 effective fiscal year 2018.

INDEPENDENT AUDITOR'S REPORT ON INTERNAL CONTROL OVER FINANCIAL REPORTING AND ON COMPLIANCE AND OTHER MATTERS BASED ON AN AUDIT OF FINANCIAL STATEMENTS PERFORMED IN ACCORDANCE WITH *GOVERNMENT AUDITING STANDARDS*

To the Board of the
Public Employees' Benefits Program

We have audited, in accordance with the auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards* issued by the Comptroller General of the United States, the basic financial statements of the Self Insurance Trust Fund, Public Employees' Benefits Program of the State of Nevada, as of and for the year ended June 30, 2019, and the related notes to the financial statements, which collectively comprise the Self Insurance Trust Fund, Public Employees' Benefits Programs basic financial statements, and have issued our report thereon dated November 1, 2019.

Internal Control over Financial Reporting

In planning and performing our audit of the financial statements, we considered the Self Insurance Trust Fund, Public Employees' Benefits Program's internal control over financial reporting (internal control) to determine the audit procedures that are appropriate in the circumstances for the purpose of expressing our opinions on the financial statements, but not for the purpose of expressing an opinion on the effectiveness of the Self Insurance Trust Fund, Public Employees' Benefits Programs internal control. Accordingly, we do not express an opinion on the effectiveness of the Self Insurance Trust Fund, Public Employees' Benefits Program's internal control.

A *deficiency in internal control* exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, misstatements on a timely basis. A *material weakness* is a deficiency, or a combination of deficiencies, in internal control, such that there is a reasonable possibility that a material misstatement of the entity's financial statements will not be prevented, or detected and corrected on a timely basis. A *significant deficiency* is a deficiency, or a combination of deficiencies, in internal control that is less severe than a material weakness, yet important enough to merit attention by those charged with governance.

Our consideration of internal control was for the limited purpose described in the first paragraph of this section and was not designed to identify all deficiencies in internal control that might be material weaknesses or, significant deficiencies. Given these limitations, during our audit we did not identify any deficiencies in internal control that we consider to be material weaknesses. However, material weaknesses may exist that have not been identified.

Compliance and Other Matters

As part of obtaining reasonable assurance about whether the Self Insurance Trust Fund, Public Employees' Benefits Program's financial statements are free from material misstatement, we performed tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements, noncompliance with which could have a direct and material effect on the determination of financial statement amounts. However, providing an opinion on compliance with those provisions was not an objective of our audit, and accordingly, we do not express such an opinion. The results of our tests disclosed no instances of noncompliance or other matters that are required to be reported under *Government Auditing Standards*.

Purpose of this Report

The purpose of this report is solely to describe the scope of our testing of internal control and compliance and the results of that testing, and not to provide an opinion on the effectiveness of the entity's internal control or on compliance. This report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering the entity's internal control and compliance. Accordingly, this communication is not suitable for any other purpose.

Casey Neilon

Carson City, Nevada
November 1, 2019

CASEY NEILON

November 1, 2019

To the Board of the Public Employees' Benefits Program

We have audited the financial statements of the State Retirees' Health and Welfare Benefits Fund of the Public Employees' Benefits Program (SRHWF) for the year ended June 30, 2019. Professional standards require that we provide you with information about our responsibilities under generally accepted auditing standards, *Government Auditing Standard* as well as certain information related to the planned scope and timing of our audit. We have communicated such information in our letter to you dated September 5, 2019. Professional standards also require that we communicate to you the following information related to our audit.

Significant Audit Findings

Qualitative Aspects of Accounting Practices

Management is responsible for the selection and use of appropriate accounting policies. The significant accounting policies used by SRHWF are described in Note 1 to the financial statements. We noted no new accounting policies were adopted and the application of existing policies was not changed during 2019. We noted no transactions entered into by SRHWF during the year for which there is a lack of authoritative guidance or consensus. All significant transactions have been recognized in the financial statements in the proper period.

Accounting estimates are an integral part of the financial statements prepared by management and are based on management's knowledge and experience about past and current events and assumptions about future events. Certain accounting estimates are particularly sensitive because of their significance to the financial statements and because of the possibility that future events affecting them may differ significantly from those expected. The most sensitive estimate affecting the SRHWF financial statements was:

> The funding status of the plan and the actuarial accrued liability is based on an actuarial analysis of the estimated liability for post retirement benefits other than pensions. We evaluated the key factors and assumptions used by the actuary in developing this analysis and the resulting disclosures in determining if the information is reasonable in relation to the financial statements taken as a whole.

Certain financial statement disclosures are particularly sensitive because of their significance to financial statement users. The most sensitive estimate affecting the financial statements was:

> The disclosure of the OPEB liability and activities in Note 2 to the financial statements because of the material changes in the estimated OPEB liability calculations made under GASB 75.

The financial statement disclosures are neutral, consistent, and clear.

Difficulties Encountered in Performing the Audit

We encountered no significant difficulties in dealing with management in performing and completing our audit.

Corrected and Uncorrected Misstatements

Professional standards require us to accumulate all known and likely misstatements identified during the audit, other than those that are clearly trivial, and communicate them to the appropriate level of management. Management has corrected all such misstatements. In addition, none of the misstatements detected as a result of audit procedures and corrected by management were material, either individually or in the aggregate, to each opinion unit's financial statements taken as a whole.

Disagreements with Management

For purposes of this letter, a disagreement with management is a financial accounting, reporting, or auditing matter, whether or not resolved to our satisfaction, that could be significant to the financial statements or the auditor's report. We are pleased to report that no such disagreements arose during the course of our audit.

Management Representations

We have requested certain representations from management that are included in the management representation letter dated November 1, 2019.

Management Consultations with Other Independent Accountants

In some cases, management may decide to consult with other accountants about auditing and accounting matters, similar to obtaining a "second opinion" on certain situations. If a consultation involves application of an accounting principle to Public Employees' Benefits Program's financial statements or a determination of the type of auditor's opinion that may be expressed on those statements, our professional standards require the consulting accountant to check with us to determine that the consultant has all the relevant facts. To our knowledge, there were no such consultations with other accountants.

Other Audit Findings or Issues

We generally discuss a variety of matters, including the application of accounting principles and auditing standards, with management each year prior to retention as Public Employees' Benefits Program's auditors. However, these discussions occurred in the normal course of our professional relationship and our responses were not a condition to our retention.

Other Matters

We applied certain limited procedures to the Schedule of Changes in Net OPEB Liability and Related Ratios and the Schedule of Contributions which are required supplementary information (RSI) that supplements the basic financial statements. Our procedures consisted of inquiries of management regarding the methods of preparing the information and comparing the information for consistency with management's responses to our inquiries, the basic financial statements, and other knowledge we obtained during our audit of the basic financial statements. We did not audit the RSI and do not express an opinion or provide any assurance on the RSI.

Restriction on Use

This information is intended solely for the use of the Public Employees' Benefits Program, its Board and its management and is not intended to be, and should not be, used by anyone other than these specified parties.

Very truly yours,

Casey Neilon

Casey Neilon, Inc.

STATE OF NEVADA
STATE RETIREES' HEALTH & WELFARE BENEFITS FUND
PUBLIC EMPLOYEES' BENEFITS PROGRAM

JUNE 30, 2019 AND 2018

STATE OF NEVADA
STATE RETIREES' HEALTH & WELFARE
BENEFITS FUND
PUBLIC EMPLOYEES' BENEFITS PROGRAM
JUNE 30, 2019 AND 2018

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Casey Neilon
Accountants and Advisors

INDEPENDENT AUDITOR'S REPORT

To the Board of the
Public Employees' Benefits Program, State of Nevada

Report on the Financial Statements

We have audited the accompanying financial statements of the State Retirees' Health & Welfare Benefits Fund, Public Employees' Benefits Program of the State of Nevada, as of and for the years ended June 30, 2019 and 2018, and the related notes to the financial statements, which collectively comprise the basic financial statements as listed in the table of contents.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of the State Retirees' Health & Welfare Benefits Fund, Public Employees' Benefits Program of the State of Nevada as of June 30, 2019 and 2018, and the changes in fiduciary net position thereof for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Emphasis of a Matter

As discussed in Note 1, the financial statements of the State Retirees' Health & Welfare Benefits Fund, Public Employees' Benefits Program of the State of Nevada are intended to present the net position, and changes in net position of the program. They do not purport to, and do not, present fairly the financial position of the State of Nevada, as of June 30, 2019 and 2018, and the changes in its net position, for the years then ended, in conformity with accounting principles generally accepted in the United States of America. Our opinion is not modified with respect to this matter.

Other Matters – Required Supplementary Information

Accounting principles generally accepted in the United States of America require that the Schedule of Changes in Net OPEB Liability and Related Ratios and the Schedule of Contributions be presented to supplement the basic financial statements. Such information, although not a part of the basic financial statements, is required by the Governmental Accounting Standards Board, who considers it to be an essential part of financial reporting for placing the basic financial statements in an appropriate operational, economic, or historical context. We have applied certain limited procedures to the required supplementary information in accordance with auditing standards generally accepted in the United States of America, which consisted of inquiries of management about the methods of preparing the information and comparing the information for consistency with management's response to our inquiries, the basic financial statements, and other knowledge we obtained during our audit of the basic financial statements. We do not express an opinion or provide any assurance on the information because the limited procedures do not provide us with sufficient evidence to express an opinion or provide any assurance.

Other Reporting Required by Government Auditing Standards

In accordance with *Government Auditing Standards*, we have also issued our report dated November 1, 2019 on our consideration of the State Retirees' Health & Welfare Benefits Fund, Public Employees' Benefits Program of the State of Nevada's internal control over financial reporting and on our tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements and other matters. The purpose of that report is to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing, and not to provide an opinion on the effectiveness of the State Retirees' Health & Welfare Benefits Fund's internal control over financial reporting or on compliance. That report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering the State Retirees' Health & Welfare Benefits Fund, Public Employees' Benefits Program of the State of Nevada's internal control over financial reporting and compliance.

Casey Neilon

Casey Neilon, Inc.
Carson City, Nevada
November 1, 2019

STATE OF NEVADA
STATE RETIREES' HEALTH & WELFARE BENEFITS FUND
STATEMENTS OF FIDUCIARY NET POSITION
JUNE 30, 2019 AND 2018

	2019	2018
ASSETS		
Cash with treasurer	$ 480,301	$ 2,304,640
Intergovernmental receivable	15,103	13,806
Due from other funds	167,754	170,250
Due from component unit	1,411,976	1,286,771
Investments at fair value	1,728,842	1,602,029
Total Assets	3,803,976	5,377,496
LIABILITIES		
Due to other funds	3,572,579	3,780,169
Total Liabilities	3,572,579	3,780,169
NET POSITION		
Net position restricted for other postemployment benefits	$ 231,397	$ 1,597,327

See accompanying notes.

STATE OF NEVADA
STATE RETIREES' HEALTH & WELFARE BENEFITS FUND
STATEMENTS OF CHANGES IN FIDUCIARY NET POSITION
FOR THE YEARS ENDED JUNE 30, 2019 AND 2018

	2019	2018
ADDITIONS		
Contributions		
Employer contributions	$ 40,942,430	$ 39,668,884
Investment income		
Interest and dividends	80,098	78,210
Net appreciation in fair value of investments	101,793	84,595
Investment expense	(453)	(372)
Net investment income	181,438	162,433
Total additions	41,123,868	39,831,317
DEDUCTIONS		
Benefit payments	42,489,798	39,710,152
Total deductions	42,489,798	39,710,152
NET INCREASE (DECREASE) IN FIDUCIARY NET POSITION	(1,365,930)	121,165
NET POSITION:		
Beginning of year	1,597,327	1,476,162
End of year	$ 231,397	$ 1,597,327

See accompanying notes.

STATE OF NEVADA
STATE RETIREES' HEALTH & WELFARE
BENEFITS FUND
PUBLIC EMPLOYEES' BENEFITS PROGRAM
NOTES TO FINANCIAL STATEMENTS
JUNE 30, 2019 AND 2018

NOTE 1 - Summary of Significant Accounting Policies:

Reporting Entity:

The financial statements of the State Retirees' Health and Welfare Benefits Fund, Public Employees' Benefits Program ("PEBP") of the State of Nevada ("Retirees' Fund") have been prepared in conformity with accounting principles generally accepted in the United States of America (US GAAP) as applied to governmental units. The Governmental Accounting Standards Board (GASB) is the accepted standard-setting body for establishing governmental accounting and financial reporting principles. A summary of the Retirees' Fund's significant accounting policies applied in the preparation of the accompanying financial statements is presented below.

Basis of Accounting:

The financial statements of the Retirees' Fund have been prepared using the accrual basis of accounting and the economic resources measurement focus. Employer contributions are recognized when due and the employer has made a formal commitment to provide the contributions. Benefits and refunds are recognized when due and payable in accordance with the terms of the plan. The Retirees' Fund does not receive member contributions. The Retirees' Fund is accounted for as a fiduciary fund that is administered as an irrevocable trust fund.

Method Used to Value Investments:

Investments are reported at fair value, which for the Retirees' Fund is determined by the Retirement Benefits Investment Fund.

Plan Description and Contribution Information:

The State Retirees' Health and Welfare Benefits Fund was created in 2007 by the Nevada Legislature to account for the financial assets designated to offset the portion of current and future costs of health and welfare benefits paid on behalf of state retirees. The Retirees' Fund is a multiple employer cost sharing defined postemployment benefit plan run by the PEBP Board. The Retirees' Fund provides benefits other than pensions to eligible retirees and their dependents through the payment of subsidies to PEBP which administers a group health and life insurance program.

Pursuant to NRS 287.023 and NRS 287.046, the following individuals and their dependents are eligible to receive benefits from the Retirees' Fund:

Any PEBP covered retiree with state service whose last employer was the state or a participating local government entity and who:

- Has at least five years of public service and who was initially hired by the state prior to January 1, 2010; or
- Has at least fifteen years of public service and who was initially hired by the state on or after January 1, 2010, but before January 1, 2012; or
- Has at least five years of public service, who has a disability and who was initially hired by the state on or after January 1, 2010, but before January 1, 2012; or
- Any PEBP covered retirees with state service whose last employer was not the state or a participating local government entity and who has been continuously covered under PEBP as a retiree since November 30, 2008.

NOTE 1 - Summary of Significant Accounting Policies (continued):

Plan Description and Contribution Information (continued):

State service is defined as employment with any Nevada State agency, the Nevada System of Higher Education and any State Board or Commission. Participating local government entity is defined as a county, school district, municipal corporation, political subdivision, public corporation or other local governmental agency that has an agreement in effect with PEBP to provide health coverage for its active employees.

The money in the Retirees' Fund belongs to the officers, employees and retirees of the State of Nevada in aggregate; neither the State nor the governing body of any county, school district, municipal corporation, political subdivision, public corporation or other local governmental agency of the State, nor any single officer, employee or retiree of any such entity has any right to the money in the Retirees' Fund. Pursuant to NRS 287.0425, the Executive Officer reports information regarding the Retirees' Fund annually to the Governor's Finance Office and the Nevada Legislature. The Retirees' Fund is governed by NRS 287.0436 through NRS 287.04364.

Contributions to the fund are paid by the State of Nevada through an assessment of actual payroll paid by each State entity. The assessment is set by the Governor's Finance Office based on an amount provided by the Legislature each biennium in session law. The assessment was 2.34% and 2.35% of actual payroll for the years ending June 30, 2019 and 2018, respectively. Benefits are paid to the Public Employees' Benefits Program Self Insurance Trust Fund as necessary to offset retiree premiums pursuant to NRS 287.046. Funds not required to pay benefits are invested in the Retiree Benefits Investment Fund established pursuant to NRS 355.220 or are held in the State of Nevada general portfolio pursuant to NRS 226.110 as approved in the legislatively approved budget. Administrative costs of the Retirees' Fund are absorbed by the Self Insurance Trust Fund.

State active employee and retiree enrollment and inactive members consisted of the following as of the actuarial valuation date:

Active Plan Members*	13,190
Inactive Plan Members or Beneficiaries Currently Receiving Benefit**	12,551
Inactive Plan Members Entitles to but Not Yet Receiving Benefit Payments**	2,272
Total Plan Members	28,013

*Active counts reflect those hired prior to January 1. 2012
**Inactive counts include terminated vested participants and reflect State retirees only.

The Retirees' Fund is governed by the Public Employees Benefits Program Board of Trustees which consists of ten members who are appointed by the Governor of the State of Nevada. Each appointee represents a specific class of public employees and retirees including the Nevada System of Higher Education, retired public employees, state employees, and local government employees. Additionally, two members must have substantial and demonstrated experience in risk management, health care administration, or employee benefits programs. One member must be employed in a managerial capacity for the Nevada State Department of Administration. These requirements are all in accordance with NRS 287.041.

NOTE 1 - Summary of Significant Accounting Policies (continued):

Recently Issued Accounting Pronouncements (Not Yet Adopted):

In January 2017, GASB issued Statement No. 84, *Fiduciary Activities* (GASB 84). This statement addresses the identification and presentation of fiduciary activities for accounting and financial reporting purposes. GASB 84 is effective for fiscal years beginning after December 15, 2018. It is not clear at this point how this will impact the financial statements as of June 30, 2020.

NOTE 2 – Net OPEB Liability:

Funding Status and Funding Progress

The projections of the net OPEB liability are based on the substantive plan (the plan as understood by the employer and plan members) and included the types of benefits provided at the time of each valuation and the historical pattern of sharing of benefit costs between the employer and plan members to that point. The projection of the net OPEB liability does not explicitly incorporate the potential effects of legal or contractual funding limitations on the pattern of cost-sharing between the employer and plan members in the future. The actuarial methods and assumptions used include techniques that are designed to reduce the effects of short-term volatility in actuarial estimated liabilities and the actuarial value of assets, consistent with the long-term perspective of the calculations. However, the preparation of any estimate of future post-employment costs require consideration of a broad array of complex social and economic events. Future changes in the healthcare reform, changes in reimbursement methodology, the emergence of new and expensive medical procedures and prescription drug options, changes in the investment rate of return and other matters increase the level of uncertainty of such estimates. As such, the estimate of post-employment program costs contains considerable uncertainty and variability and actual experience may vary significantly by the current estimated net OPEB liability.

Net OPEB Liability of the Retirees' Fund

The components of the net OPEB liability of the Retiree's Fund at June 30, 2019 and 2018, were as follows:

	2019 (in thousands)	2018 (in thousands)
Total OPEB liability	$ 1,325,980	$ 1,302,864
Plan fiduciary net position	(1,597)	(1,476)
Net OPEB liability	1,324,383	1,301,388
Plan fiduciary net position as a percentage of total OPEB liability	0%	0%
OPEB expense	$ 70,466	$ 77,313

NOTE 2 – Net OPEB Liability (continued):

Actuarial Assumptions

The total OPEB liability was determined by an actuarial valuation as of June 30, 2018, using the following actuarial assumptions, applied to all periods included in the measurement, unless otherwise specified:

Inflation	2.50%
Salary Increases	Dependent upon pension system ranging from 1.00% to 10.65%, including inflation.
Discount Rate	3.87%, Based on Bond Buyer General Obligation 20-Bond Municipal Bond Index
Healthcare cost trend rates	For medical prescription drug benefits the current amount is 7.00% and decreases to 4.75% long-term trend rate after six years. For dental benefits and Part B Premiums the trend rate is 4.00% and 4.50% respectively.
Actuarial method	Entry Age Normal Level % of Pay

Mortality rates were based on the RP-2000 Combined Healthy Mortality Table projected to 2014 with Scale AA for regular participants, set back one year for females and RP-2000 Combined Healthy Mortality Table projected to 2014 with scale AA for Fire and Police, set forward one year.

The actuarial assumptions used in the January 1, 2018 valuation were based on the results of an actuarial experience study for the period July 1, 2017 to June 30, 2018.

As the Retirees' Fund is funded on a pay-as-you-go basis, the discounted rate is equal to the Bond Buyer General Obligation 20-Bond Municipal Bond Index rate of 3.87%.

Discount rate

The discount rate basis under GASB 74 is required to be consistent with a 20-Year Municipal Bond Index. The Bond Buyer General Obligation 20-Bond Municipal Bond Index is used for the determination of the discount rate. The assets in the trust as of June 30, 2018 are less than the expected benefit payments in the first year; therefore, the crossover period is assumed to be in the first year, which provides additional support for continuing the discount rate at the 20-Year Municipal Bond Index rate.

NOTE 2 – Net OPEB Liability (continued):

Discount rate (continued)

The discount rates used for fiscal years ended June 30, 2019 and 2018 are 3.87% and 3.58%, respectively.

Sensitivity of the Net OPEB Liability to Changes in the Discount Rate

The following presents the net OPEB liability of the Retirees' Fund, as well as what the Retirees' Fund's net OPEB liability would be if it were calculated using a discount rate that is 1-percentage-point lower (2.87 percent) or 1-percentage-point higher (4.87 percent) than the current discount rate:

	1% Decrease (2.87%) (in thousands)	Discount Rate (3.87%) (in thousands)	1% Decrease (4.87%) (in thousands)
Total OPEB Liability (Ending)	$ 1,460,832	$ 1,325,980	$ 1,208,782
Plan Fiduciary Net Posistion (Ending)	(1,597)	(1,597)	(1,597)
Net OPEB Liability (Ending)	$ 1,459,235	$ 1,324,383	$ 1,207,185

Sensitivity of the Net OPEB Liability to Changes in the Healthcare Cost Trend Rates

The following presents the net OPEB liability of the Retirees' Fund, as well as what the Retirees' Fund liability would be if it were using healthcare cost trend rates that are 1-percentage-point lower or 1-percentage-point higher than the current healthcare cost trend rates:

	1% Decrease (in thousands)	Trend Rates (in thousands)	1% Decrease (in thousands)
Total OPEB Liability (Ending)	$ 1,236,938	$ 1,325,980	$ 1,431,098
Plan Fiduciary Net Posistion (Ending)	(1,597)	(1,597)	(1,597)
Net OPEB Liability (Ending)	$ 1,235,341	$ 1,324,383	$ 1,429,501

NOTE 3 - Cash and Deposits with the State Treasurer as of June 30:

	2019	2018
Cash:		
Deposits with State Treasurer:		
State Treasurer's Investment Pool	$ 479,096	$ 2,317,697
GASB 31 adjustment	1,205	(13,057)
Total Cash and Deposits	$ 480,301	$ 2,304,640

The Nevada Revised Statutes direct the Office of the State Treasurer to deposit funds into any state, or national bank, credit union or savings and loan association covered by federal depository insurance. For those deposits over and above the federal depository insurance maximum balance, sufficient collateral must be held by the financial institution to protect the State of Nevada against loss. The pooled collateral for deposits program maintains a 102% pledge collateral for all public deposits.

NOTE 3 - Cash and Deposits with the State Treasurer as of June 30 (continued):

NRS 355.140 details the types of securities in which the State may invest. In general, authorized investments include: certificates of deposit, asset-backed securities, bankers' acceptances and commercial paper, collateralized mortgage obligations, corporate notes, money market funds whose policies meet the criteria set forth in the statute, United States treasury securities and specific securities implicitly guaranteed by the federal government. Additionally, the State may invest in limited types of repurchase agreements; however, statutes generally prohibit the State from entering into reverse-repurchase agreements.

A copy of the State of Nevada Comprehensive Annual Financial Report can be obtained online at http://controller.nv.gov/FinancialReports/CAFR_Download_Page.html.

NOTE 4 – Interfund Balances:

Interfund balances at June 30, 2019 and 2018 consisted of the following:

	2019	2018
Due to fiduciary fund from:		
General funds	$ 152,832	$ 153,555
Internal service funds	6,574	8,333
Trust funds	8,348	8,362
Total due to fiduciary fund from other funds	$ 167,754	$ 170,250
Due to fiduciary fund from:		
All others	$ 1,411,976	$ 1,286,771
Total due to fiduciary fund from component units	$ 1,411,976	$ 1,286,771
Due from fiduciary fund:		
Internal service funds	$ 3,572,579	$ 3,780,169
Total due to internal service funds from fiduciary fund	$ 3,572,579	$ 3,780,169

These balances resulted from the time lag between the dates that (1) interfund contributions are provided or benefit payments occur, (2) transactions are recorded in the accounting system, and (3) payments between funds are made.

NOTE 5 - Retirement Benefits Investment Fund:

The Nevada Legislature established the Retirement Benefits Investment Fund (RBIF) with an effective date of July 1, 2007. The purpose of the Fund is to invest contributions made by participating public entities, as defined by NRS 355.220 to enable such entities to support financing of other post employment benefits at some time in the future. Per NRS 355.220(2) monies received by the RBIF from participating entities are held for investment purposes only and not in any fiduciary capacity. Each participating entity acts as fiduciary for its particular share of the Fund. NRS 355.220(2) requires that any money in the Fund must be invested in the same manner as money in the Public Employees' Retirement System of Nevada (PERS) Investment Fund is invested. The PERS Investment Fund is governed primarily by the "prudent person" standard as set forth in NRS 286.682, which authorizes the Retirement Board to invest PERS' funds in "every kind of investment which persons of prudence, discretion and intelligence acquire or retain for their own account." PERS has established limits on the concentration of investments in any single issuer or class of issuer or managed by a single investment firm. In general, the authorized investments include: fixed income, both US comingled and non-US comingled; domestic, international and comingled equity; money market funds; and short-term investments.

RBIF is designed to value participants' shares in the Fund according to the contributions of each entity, and accordingly, earnings (including realized and unrealized gains and losses, interest, and other income) and expenses are allocated to each entity in proportion to the participant's share in the Fund. The financial statements of the RBIF were audited in accordance with auditing standards generally accepted in the United States of America and can be obtained from the Public Employees' Retirement System, 693 West Nye Lane, Carson City, Nevada 89703.

NOTE 6 - Fair Value:

The Retirees' Fund holds investments that are measured at fair value on a recurring basis. The Retirees' Fund categorizes its fair value measurements within the fair value hierarchy established by generally accepted accounting principles. Investments measured and reported at fair value using Level inputs are classified and disclosed in one of the following categories:

Level 1 – Quoted prices are available in active markets for identical investments as of the reporting date. The types of investments included in Level 1 include U.S. Treasuries securities and listed equities.

Level 2 – Quoted prices for similar instruments in active markets; quoted prices for identical or similar instruments in markets that are not active; and model-driven valuations in which all significant inputs and significant value drivers are observable.

Level 3 – Valuations derived from valuation techniques in which significant inputs or significant value drivers are unobservable.

NOTE 6 - Fair Value (continued):

The following table presents fair value measurements as of June 30, 2019:

	Level 1
U.S treasury securities and equities	$ 1,728,842
Total investments	$ 1,728,842

The following table presents fair value measurements as of June 30, 2018:

	Level 1
U.S treasury securities and equities	$ 1,602,029
Total investments	$ 1,602,029

Debt and equity securities classified in Level 1 of the fair value hierarchy are valued using prices quoted in active markets for those securities. All investments are classified in Level 1.

NOTE 7 – Subsequent Events:

Management has evaluated subsequent events through November 1, 2019, the date which the financial statements were available to be issued.

STATE OF NEVADA
STATE RETIREES' HEALTH & WELFARE BENEFITS FUND
PUBLIC EMPLOYEES' BENEFITS FUND
REQUIRED SUPPLEMENTARY INFORMATION
JUNE 30, 2019 AND 2018

SCHEDULE OF CHANGES IN NET OPEB LIABILITY AND RELATED RATIOS

Last Ten Fiscal Years* (Unaudited)

	Fiscal Year Ending June 30,		
	2019 (in thousands)	**2018** (in thousands)	**2017** (in thousands)
Total OPEB Liability			
Service cost	$ 51,882	$ 59,309	$ 49,794
Interest cost	47,795	39,469	45,361
Changes of benefit terms	-	-	-
Differences between expected and actual experiences	-	-	-
Changes of assumptions	(36,851)	(102,300)	123,519
Gross benefit payments	(39,710)	(38,069)	(35,932)
Net change in total OPEB liability	23,116	(41,591)	182,742
Total OPEB liability - beginning	1,302,864	1,344,455	1,161,713
Total OPEB liability - ending	$ 1,325,980	$ 1,302,864	$ 1,344,455
Plan Fiduciary Net Position			
Contributions: Employer	$ 39,669	$ 38,049	$ 32,213
Contributions: Member	-	-	-
Net investment income	162	164	55
Gross benefit payments	(39,710)	(38,069)	(35,932)
Administrative expenses	-	-	-
Other	-	-	-
Net change in plan fiduciary net position	121	144	(3,664)
Plan fiduciary net position - beginning	1,476	1,332	4,996
Plan fiduciary net position - ending	$ 1,597	$ 1,476	$ 1,332
Net OPEB liability - ending	$ 1,324,383	$ 1,301,388	$ 1,343,123
Net position as a percentage of OPEB liability	0%	0%	0%
Covered employee payroll	$ 1,780,851	$ 1,663,856	$ 1,627,517
Net OPEB liability as a percentage of payroll	74%	78%	83%

* Only three years of information is available due to reporting changes related to the implementation of GASB 75 effective fiscal year 2018.

Notes to Schedule:

Plan Changes: None

Assumption Changes: The valuation reflects a change of assumption in that the discount rate used at June 30, 2017 was 3.58% and the discount rate used at June 30, 2018 was 3.87%.

STATE OF NEVADA
STATE RETIREES' HEALTH & WELFARE BENEFITS FUND
PUBLIC EMPLOYEES' BENEFITS FUND
REQUIRED SUPPLEMENTARY INFORMATION
JUNE 30, 2019 AND 2018

SCHEDULE OF CONTRIBUTIONS

Last Ten Fiscal Years* (Unaudited)

	Fiscal Year Ending June 30,		
	2019 (in thousands	**2018** (in thousands)	**2017** (in thousands)
Actuarially determined contribution	N/A	N/A	N/A
Contributions made in relation o the actuarially determined contribution	N/A	N/A	N/A
Contribution deficiency (excess)	N/A	N/A	N/A
Covered employee payroll **	$ 1,780,851	$ 1,663,856	$ 1,627,517
Contributions as a percentage of payroll	N/A	N/A	N/A

* Only three years of information is available due to reporting changes related to the implementation of GASB 75 effective fiscal year 2018.
** Covered payroll for all fiscal years were provided by the State.

Notes to Schedule

Valuation Date	January 1, 2018
Methods and assumptions used to determine contribution rates:	
Actuarial Cost Method	Entry Age Normal - Level % of Salary
Asset Valuation Method	Market Value of Assets
Retirement Age***	Varies by age and service
Mortality	Regular: RP-2000 Combined Healthy Mortality projected to 2014 with Scale AA, set back one year for females
	Police/Fire: RP-2000 Combined Health Mortality projected to 2014 with Scale AA, set forward one year

*** Weighted average retirement age based on January 1, 2018 census data and retirement rates provided in the "Actuarial Assumptions and Methods" section of the report.

Casey Neilon
Accountants and Advisors

INDEPENDENT AUDITOR'S REPORT ON INTERNAL CONTROL OVER FINANCIAL REPORTING AND ON COMPLIANCE AND OTHER MATTERS BASED ON AN AUDIT OF FINANCIAL STATEMENTS PERFORMED IN ACCORDANCE WITH *GOVERNMENT AUDITING STANDARDS*

To the Board of the
Public Employees' Benefits Program, State of Nevada

We have audited, in accordance with the auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards* issued by the Comptroller General of the United States, the financial statements of the State Retirees' Health & Welfare Benefits Fund, Public Employees' Benefits Program of the State of Nevada, as of and for the year ended June 30, 2019, and the related notes to the financial statements, which collectively comprise the State Retirees' Health & Welfare Benefits Fund, Public Employees' Benefits Programs basic financial statements, and have issued our report thereon dated November 1, 2019.

Internal Control over Financial Reporting

In planning and performing our audit of the financial statements, we considered the State Retirees' Health & Welfare Benefits Fund, Public Employees' Benefits Program's internal control over financial reporting (internal control) to determine the audit procedures that are appropriate in the circumstances for the purpose of expressing our opinion on the financial statements, but not for the purpose of expressing an opinion on the effectiveness of the State Retirees' Health & Welfare Benefits Fund, Public Employees' Benefits Programs internal control. Accordingly, we do not express an opinion on the effectiveness of the State Retirees' Health & Welfare Benefits Fund, Public Employees' Benefits Program's internal control.

A *deficiency in internal control* exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, misstatements on a timely basis. A *material weakness* is a deficiency, or a combination of deficiencies, in internal control, such that there is a reasonable possibility that a material misstatement of the entity's financial statements will not be prevented, or detected and corrected on a timely basis. A *significant deficiency* is a deficiency, or a combination of deficiencies, in internal control that is less severe than a material weakness, yet important enough to merit attention by those charged with governance.

Our consideration of internal control was for the limited purpose described in the first paragraph of this section and was not designed to identify all deficiencies in internal control that might be material weaknesses or, significant deficiencies. Given these limitations, during our audit we did not identify any deficiencies in internal control that we consider to be material weaknesses. However, material weaknesses may exist that have not been identified.

Compliance and Other Matters

As part of obtaining reasonable assurance about whether the State Retirees' Health & Welfare Benefits Fund, Public Employees' Benefits Program's financial statements are free from material misstatement, we performed tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements, noncompliance with which could have a direct and material effect on the determination of financial statement amounts. However, providing an opinion on compliance with those provisions was not an objective of our audit, and accordingly, we do not express such an opinion. The results of our tests disclosed no instances of noncompliance or other matters that are required to be reported under *Government Auditing Standards*.

Purpose of this Report

The purpose of this report is solely to describe the scope of our testing of internal control and compliance and the results of that testing, and not to provide an opinion on the effectiveness of the entity's internal control or on compliance. This report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering the entity's internal control and compliance. Accordingly, this communication is not suitable for any other purpose.

Casey Neilon

Carson City, Nevada
November 1, 2019

4.4.

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.

   4.4. Approval of the updated PEBP Strategic Plan.

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

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CORE
Expires 04/01/2021

DAMON HAYCOCK
Executive Officer

PEBP Strategic Plan

November 21, 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 a comprehensive 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)

    - Incomplete eligibility and enrollment system
    - Board loss of final approval for employer contributions, rates, and excess reserve utilization
- Opportunities
    - Additional member tools (disease management program enhancements, implement more digital member applications)
    - Increase access to care (research additional voluntary benefit offerings, revisit PPO network contracting)
    - Additional innovation (evaluate new/expanded plan offerings such as a 3rd tier PPO plan, statewide EPO plan, or transform the EPO into a low deductible PPO; leverage higher education resources)
    - Cost containment (evaluate mandatory Smart90 Rx network for the EPO plan, evaluate additional Reference Based Pricing options)
    - Research and evaluate wellness program(s)
- Threats
    - Policy decision making potentially influenced by political decision making
    - Member entitlement to previous plan benefit levels
    - Federal rulemaking (ACA survive? Cadillac Tax?)

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, 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
    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
    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, increase benefit offerings
    7. Acknowledge and address the disparity between northern, southern and rural Nevada
       Strategy: Continue to 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, showcase provider cost and quality for member decision-making
- Collaboration
    1. Coordinate policy with stakeholders (Legislature, Executive Branch, Advocacy Groups)
       Strategy: Continue bimonthly meetings with RPEN, AFSCME and NFA, provide updates to LCB as needed, provide updates to Governor's Office as 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: Continue to 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 modernize communications, coordinate communications efforts with partners, leverage digital solutions where appropriate
  2. Review and update a comprehensive communications plan
     Strategy: Review plan annually, develop a multi-partner communications schedule, emphasize in-person education, continue to implement more webinars/trainings online
  3. Develop communication strategies balancing digital, person-to-person and cost resources
     Strategy: Continue to research communications opportunities and coordinate strategies with partners

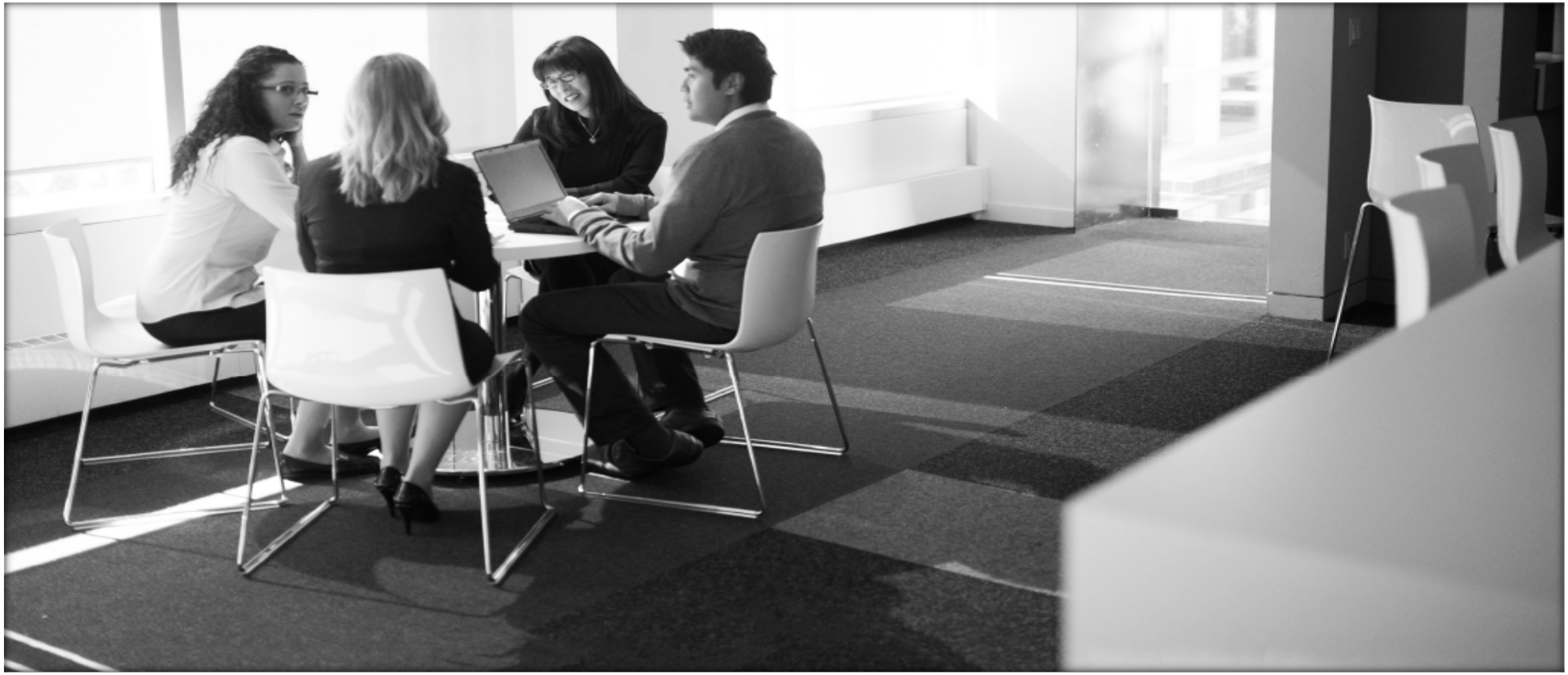
5.

5. Update on the Morneau Shepell Performance Improvement Plan (Morneau Shepell) (Information/Discussion)

PEBP

Update on Morneau Shepell Performance Improvement Plan

2019-11-14



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 User Experience) 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 User Acceptance Testing (UAT) wasn't parallel to production experience leading	High	Issues with participant website capabilities which triggered calls	Increased call and operational workload	Impact on KPIs

		to unanticipated production issues				
Resulting Issues						
Ref	**Issue**	**Details**	**Impact**	**Participant impact**	**Staff impact**	**Leadership**
4	Site access issues	Inconsistencies in behavior 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	User Experience (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	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,	Increased call volumes, reduced visibility	Increased call volumes and cancelled VB policies impacting VB revenue

				where did my old policy go?		
Ref	**Issue**	**Details**	**Impact**	**Participant impact**	**Staff impact**	**Leadership**
7	Rules for medical benefit 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 leading to calls to PEBP and submission of documents	Increased call volumes; increased 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 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 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

Morneau Shepell has made significant progress on these items since we began this work in September. For the 10 Key Performance Plan items listed below:

- 9 are On Track for completion by the Target Resolution Date
- 1 is temporarily in an At Risk status (item #4) but is expected to be completed on time

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	10/14/19	11/5/19* 2/27/20*	**On Track** *11/29/19 – Revised date. Completing the analysis and review of documentation takes slightly longer *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 – Completed review of errors and issues *12/4/19 - target resolution date dependent on the size & scope of corrections required

	Issue	Proposed Actions	Success Measures	Start Date	Target Resolution Date	Status
						Target resolution date in process of being confirmed
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** Analysis of data interfaces completed. Determined areas that present opportunities for file validation improvement. Work in progress.
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	**At Risk** Analysis of the backlog issues completed and implemented plan to address them May require additional time to address all the issues due to complexity and number of items
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**

	Issue	Proposed Actions	Success Measures	Start Date	Target Resolution Date	Status
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	11/1/19* 2/28/20*	**On Track** *11/1/19 – Completed analysis & review of documentation *2/28/20 - target resolution date dependent on the size & scope of changes required
7	Complete the decommissioning of AX	• Evaluate de-coupling AX from HRIS interface initiative & complete the implementation & conversion process	• Elimination of reliance on AX • Sign-off on new solution after stabilization period	In Progress	1/1/20*	**On Track** * Rolled out to production on 4-Nov-2019 Final batch extraction and import will be tied to the HRIS project go live as it is dependent on the paper documents to stop being processed through AX system
8	Complete the HRIS interface initiative	• Complete the implementation of the HRIS files from Workday and Central Payroll • Roll-out the administrator portal to enable on-line collection of hires, status changes, and data updates to other Pay Centers	• Testing completed with successful pass of test cases • Interface code error free in production	In Progress	3/31/20	**On Track**

	Issue	Proposed Actions	Success Measures	Start Date	Target Resolution Date	Status
			• Reduction in operational team work effort			
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** * Based on the recent joint discussions, target resolution date is dependent on the optimization of user experience decoupling solution
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

Morneau Shepell has made significant progress on these items since we began this work in September. For the 8 items listed below:

- 3 have been Completed
- 5 are On Track for completion by the Target Resolution Date

	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	**Completed**
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	9/30/19	12/6/19	**On Track** • Added resource to reduce key person dependencies • Introduce on-site support for triaging issues and working with PEBP on performance plan • Implemented plan to improve turnaround on reviewing and triaging AV tickets – under monitoring

	Issue	Proposed Actions	Success Measures	Start Date	Target Resolution Date	Status
			managed effectively			
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 consequences when requirements change	9/16/19	10/11/19	**Completed**
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

	Issue	Proposed Actions	Success Measures	Start Date	Target Resolution Date	Status
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	**Completed**
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 production on a piecemeal basis	• Reduced errors & issues related to product or configuration changes	9/30/19	2/3/20	**On Track**
8	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**

6.

6. Presentation on the development and history of PEBP's Incurred But Not Paid (IBNP), Catastrophic, and Health Reimbursement Arrangement (HRA) reserves. (Aon and Cari Eaton, Chief Financial Officer) (Information/Discussion)

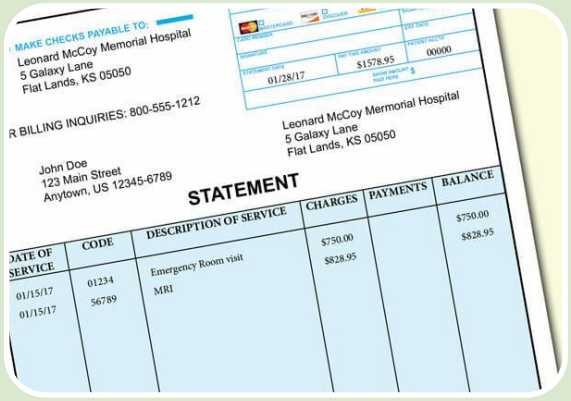
Public Employees' Benefits Program
IBNP and Catastrophic Reserve Summary

Prepared by Aon
Health Solutions

November 2019 Board Meeting

Empower Results®

Today's Agenda


MAKE CHECKS PAYABLE TO:
Leonard McCoy Memorial Hospital
5 Galaxy Lane
Flat Lands, KS 05050

R BILLING INQUIRIES: 800-555-1212

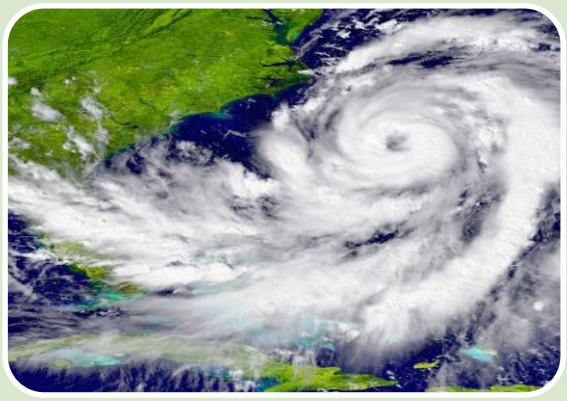
John Doe
123 Main Street
Anytown, US 12345-6789

Leonard McCoy Mermorial Hospital
5 Galaxy Lane
Flat Lands, KS 05050

01/28/17 $1578.95 00000

STATEMENT

DATE OF SERVICE	CODE	DESCRIPTION OF SERVICE	CHARGES	PAYMENTS	BALANCE
01/15/17	01234	Emergency Room visit	$750.00		$750.00
01/15/17	56789	MRI	$828.95		$828.95



Incurred But Not Paid (IBNP) Reserve

- Methodology
- Historical Results

Catastrophic/ Contingency Reserve

- Reasoning
- Methodology

Benchmarks/ Industry Best Practices

- What are other States doing?
- Other approaches PEBP could adopt?

PEBP also maintains a HRA Reserve that is calculated by PEBP Staff

Incurred But Not Paid (IBNP) Reserve

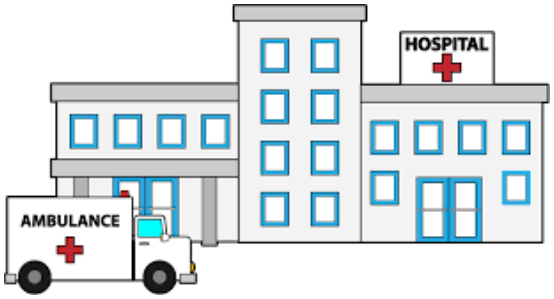
Incurred But Not Paid Reserve—
Reflects Timing Differences in Service Dates and Payment Dates

Incurred But Not Paid (IBNP) reserves account for projected amounts not yet paid by a claim administrator as of a specific valuation date for services incurred by plan members on or before the specific valuation date—see example below:

5/2/2019

"Incurred Date"

PEBP Employee leaves Hospital after a 2 day stay



6/30/2019

"Valuation Date"

– PEBP's Financial Plan Year end date and date at which reserve is calculated

8/10/2019

"Paid Date"

PEBP is notified of the claim by HSB and sends payment to the Hospital

First of Two Best Practice Methods Used in IBNP—Development

The **Development Method** projects historical *claim lag patterns* into the future to estimate IBNP using ***completion factors***

A claim lag "triangle" example is shown at right—array of dollars by incurred month and paid

We'll come back to the highlighted item in a few slides when we discuss IBNP margins

	Incurred			
Paid	Feb-18	Mar-18	Apr-18	May-18
Feb-18	1,055,000			
Mar-18	4,532,000	1,437,000		
Apr-18	1,689,000	4,876,000	1,866,000	
May-18	606,000	1,359,000	4,766,000	1,587,000
Jun-18	409,000	606,000	1,545,000	5,255,000
Jul-18	**1,330,000**	808,000	879,000	2,202,000
Aug-18	123,000	232,000	655,000	670,000
Sep-18	56,000	82,000	406,000	658,000
Oct-18	79,000	168,000	355,000	242,000
Nov-18	59,000	186,000	70,000	152,000
Dec-18	223,000	199,000	89,000	132,000
Jan-19	39,000	58,000	68,000	54,000
Feb-19	27,000	92,000	92,000	797,000
Mar-19	93,000	78,000	124,000	216,000
Apr-19	3,000	37,000	86,000	109,000
May-19	77,000	30,000	33,000	29,000
Jun-19	33,000	23,000	6,000	277,000
Total	**10,433,000**	**10,271,000**	**11,040,000**	**12,380,000**

Second of Two Best Practice Methods Used in IBNP—Projection

The **Projection Method** uses historical claims experience to establish a cost per member per month that is trended and applied to the more recent immature incurred months from the **Development Method** in order to come up with the **"Best Estimate"** IBNP

Step 1
- Summarize data by incurred month vs. paid month into a lag triangle

Step 2
- Smooth variations of the data

Step 3
- Calculate age-to-ultimate development factors (i.e. **completion factors**)

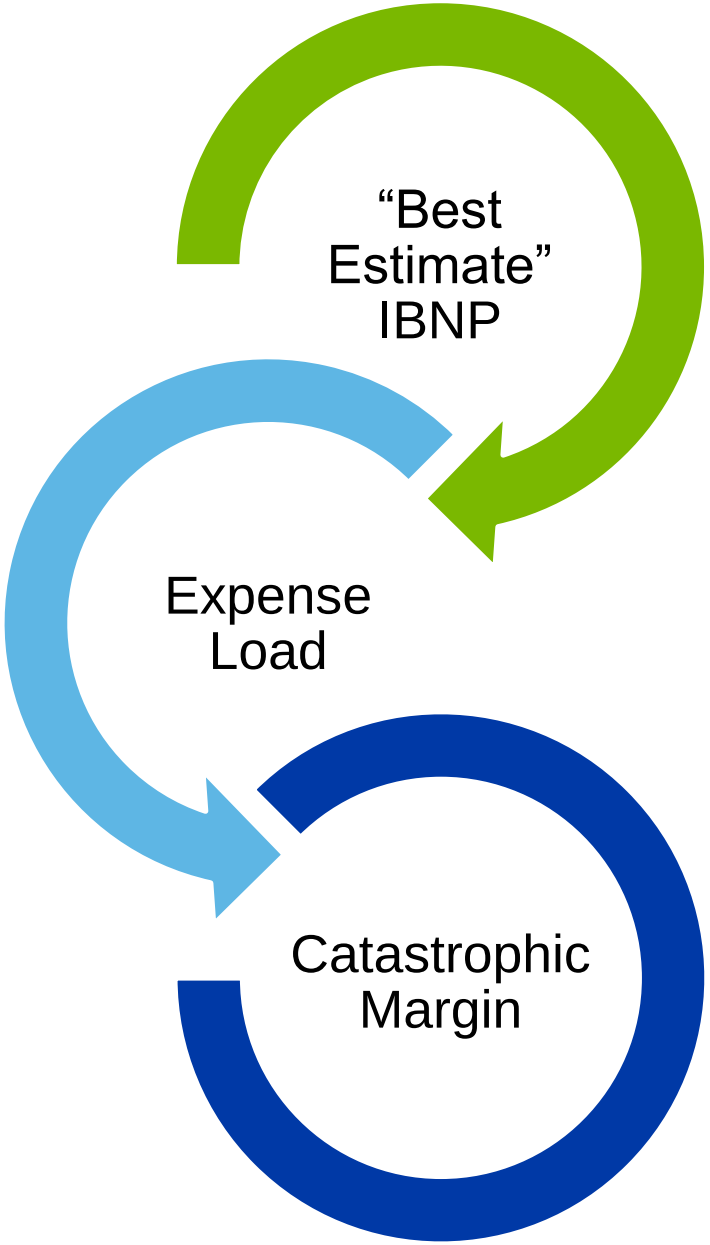
Step 4
- Divide each incurred month's cumulative paid claims by it's completion factor to get **fully incurred claims**

Step 5
- Subtract cumulative paid claims from the fully incurred claims to get the **unpaid claims liability (IBNP)**

Load Factors on “Best Estimate” IBNP Calculation—Expense and Margin Loads

For PEBP, an **Expense Load** is applied as a 1.025 factor to the “Best Estimate” IBNP—this provides for fees that would be charged for the plan administrator to process “run-out” claims if the plan were to be terminated

The PEBP Board has also elected to include a **Catastrophic Reserve Margin** on the IBNP at a 95% confidence interval to increase certainty that reserves are sufficient to meet claim run-out liabilities



Why Have a Catastrophic Reserve Margin in IBNP?

Based on Recent PEBP Experience

- Large Claim of over $1M was incurred in February 2018 (PY18)
- Paid in July 2018 (PY19)
- Given how claims typically pay out in month 5 in this sample, our **"Best Estimate"** of July payments for February incurred claims would have been closer to $275k
- The Completion Factor method without any margin load would have been short by $1M

	Incurred			
Paid	Feb-18	Mar-18	Apr-18	May-18
Feb-18	1,055,000			
Mar-18	4,532,000	1,437,000		
Apr-18	1,689,000	4,876,000	1,866,000	
May-18	606,000	1,359,000	4,766,000	1,587,000
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Total	**10,433,000**	**10,271,000**	**11,040,000**	**12,380,000**

Historical Reserve Adequacy Study—Look Back Analysis

Reserve valuation contains an element of subjective Actuarial judgment

Each reserve method is built upon certain assumptions

It is important to see how accurate the original reserve estimate was when more data becomes available, we conduct this annually for PEBP as part of our **Look Back Analysis**

Valuation Dates	Actual Claims IBNP	Best Estimate IBNP	Total Loaded IBNP*	% Difference (Best Est. to Actual)	$ Difference (Best Est. to Actual)	Difference (Claims w/ Cat. Margin)
June 30-2012	$28.4M	$29.8M	$34.9M	4.7%	$1.34M	$5.6M
June 30-2013	$19.5M	$23.4M	$29.7M	20.1%	$3.92M	$9.5M
June 30-2014	$18.6M	$19.6M	$24.7M	5.2%	$0.97M	$5.5M
June 30-2015	$19.1M	$19.6M	$25.6M	2.4%	$0.46M	$5.9M
June 30-2016	$24.0M	$24.8M	$32.4M	3.2%	$0.77M	$7.8M
June 30-2017	$27.9M	$25.5M	$33.4M	-8.6%	($2.40M)	$4.8M
June 30-2018	$31.7M	$28.8M	$37.6M	-9.1%	($2.90M)	$5.0M

**Sum of Best Estimate IBNP reserve + Expense Margin + Catastrophic Margin*

Catastrophic Reserve
(also known as Contingency Reserves)

Catastrophic Reserve (also known as Contingency Reserve)

In addition to IBNP, many State benefit plans hold reserves in a separate fund known as a Contingency Reserve to cover any unforeseen insufficiencies that may develop in a given plan year from causes such as:

Trend Volatility

- Actual medical trend exceeding assumed medical trend in rate setting
- Utilization changes in medical/pharmacy services

Demographic Shifts

- Unplanned changes in plan membership via
  - Open enrollment
  - Significant onboarding/layoffs
  - Loss of a large employer group within the State

Claims Volatility

- Unexpected rise in catastrophic claimants
- Geographic health event risk – an epidemic or outbreak in Nevada's major metropolitan areas where employees are concentrated
- Previously unforeseen changes in provider reimbursement rates

Catastrophic Reserve (also known as Contingency Reserve)

In 2012, the PEBP Board tasked Aon with calculating a contingency reserve which became known as the **Catastrophic Reserve**, a separate and distinct fund from the catastrophic load on the IBNP and requested that this fund be established at a 95% confidence interval

- IBNP reserve provides for claim dollars attributable to services incurred on or prior to a specific valuation date, and paid after that measurement date, with margins covering potential large claim amounts to be paid after the valuation date that were not known as of the valuation date
- Catastrophic reserve protects from unforeseen events that could cause a large increase in aggregate claim dollars paid by the Plan beyond actuarial forecasts

Valuation Dates	Catastrophic Reserve
June 30-2012	$26.8M
June 30-2013	$27.8M
June 30-2014	$22.4M
June 30-2015	$23.9M
June 30-2016	$25.6M
June 30-2017	$25.8M
June 30-2018	$27.5M
June 30-2019	$31.0M/$11.4M*

**First year of EPO plan, CDHP/EPO figures reported separately*

Benchmarks and Industry Best Practices

Benchmark Data

What are other States/Public Entities doing?

- A 95% confidence margin was more common among Public Sector entities in 2010-2012 as a result of the economic downturn
- More recently, States and other Public Sector Entities have been engaging in discussions about changing their threshold and some have moved to lower confidence levels

What are other industries doing?

- Private Sector employer groups more typically include a 5%-15% margin on their IBNP, depending on their size and risk tolerance
- They typically do not hold a separate contingency reserve

State	Contingency Reserving Techniques
Arizona	1.5 months/47 days of claims, 75% confidence (set = IBNP reserve) https://benefitoptions.az.gov/sites/default/files/media/LEGI%20HITF%202016%20Annual%20Report.pdf
Oregon	10%-15% of annual expected claims https://apps.leg.state.or.us/liz/2018R1/Downloads/CommitteeMeetingDocument/147498
Three Aon State clients	Have a reserve policy that only consists of the IBNP reserve
Two Aon State clients	10% of claims
One Aon State client	200% of risk based capital
One Aon State client	60 days (2 months) of paid claims

Other Approaches for PEBP Consideration

- **Lowering margin on IBNP** to a 50% or 75% confidence interval

  Impact: Release of $6.6M - $11.0M in Reserves back to the Plan

- Lowering confidence interval on Catastrophic Reserves, holding **50 days** on hand instead of the current 60 days

  Impact: Release of $8.2M in Reserves back to the Plan

- Moving to a **Risk Based Capital (RBC)** approach for the Catastrophic Reserves, setting the threshold anywhere from 200% to 400% of Authorized Control Level

  Impact: Release $15.5M in Reserves back to the Plan at the 200% level

  Increase of $11.4M in Reserves at the 400% level

- Set Catastrophic Reserve at **10% of total claims paid** in the prior year

  Impact: Release $18.4M in Reserves back to the Plan

Ultimately, margin levels and methodologies are set at an organization's discretion based on that organization's specific risk tolerance

Appendix—
April 2019 Detailed Reserve Methodology Letter

Empower Results®

April 29th, 2019

Mr. Damon Haycock
Executive Officer
State of Nevada Public Employees' Benefits Program (PEBP)
901 S. Stewart Street, Suite 1001
Carson City, NV 89701

Subject: Incurred But Not Paid (IBNP) Liability and Catastrophic Reserves Development Methodologies

Dear Damon:

In response to the Legislative Counsel Bureau (LCB) audit request, Aon has outlined its IBNP and catastrophic reserves development methodologies and timeframes in this letter.

Reserve Development Timeframes

Annually, Aon provides IBNP and catastrophic reserves estimates with a valuation date of June 30 of that year to PEBP. The reserve estimates are provided twice a year: the reserves provided in February reflect data through January of that year, and the August reserve estimates reflect data through June. The February reserve estimates are used to provide PEBP with an early look of their projected June liabilities, as PEBP uses these projections for their budget projections in March. Since actual incurred claims data between February and June are not available when Aon sets the June 30 reserve in February, Aon projects February to June incurred claims and then applies completion factors to the projected incurred claims to calculate IBNP. PEBP requests an updated liability once actual June incurred claims data becomes available in July. Then, Aon refreshes reserves estimates as of June 30 with actual data and provides PEBP with updated estimates in August.

IBNP Actuarial Methods and Assumptions

IBNP liabilities for CDHP medical, dental, and CDHP prescription drug benefits were estimated based on the developmental method. The underlying principle of the developmental method is that the progression of claim payment follows runoff patterns that are assumed to remain stable over time. HealthSCOPE Benefits, Inc. and Express Scripts provided historical medical, dental, and prescription drug claim data summarized by incurred and paid period for the last 36 to 48 months. Claims were adjusted as necessary for actuarial factors such as plan design changes, outliers, and period weightings (i.e. more credibility on more current experience). Completion factors (percentage of incurred claims paid for each duration) were calculated based on historical runoff data. The results, produced by applying the developmental method, were then adjusted for months where data was deemed non-credible. These adjustments were made using the projection method, which is based on the change in costs per exposure unit over time.

The IBNP liability was further adjusted to reflect actuarial assumptions related to several factors/contingencies which could impact reserve adequacy. Such factors/contingencies include: changes in claim payment cycles, plan design, insurance carriers, large dollar shock claims, emerging claim trends, enrollment shifts, differences in the number of days in the projection period versus the baseline period, and other factors.

For the new EPO plan, Aon only had 7 months of incurred and paid claims between July 2018 and January 2019, which were not sufficient to produce credible completion factors for the developmental method. To estimate July 2018 to January 2019 completed incurred claims, Aon applied CDHP medical and Rx completion factors to the EPO incurred and paid claims, since the EPO claims are processed by the same vendors as the CDHP plan effective July 2018. The results were blended with the projection method, which was based on Hometown Health lag data through June 2018 adjusted for trend and vendor changes.

As mentioned previously, the lag data through the measurement date was not available for the February 2019 IBNP estimate with a valuation date of June 30, 2019. Therefore, we estimated incurred claims for the missing months using the projection method. We subsequently estimated IBNP by applying the developmental method (i.e., completion factors) to the incurred estimates for all months, including both historical and projected periods. The completion factors in this calculation were shifted to account for the number of months the IBNP is being projected. Please note that in projecting IBNP in this way, there is an added element of volatility since we are projecting monthly paid claims and not just incurred claims. Should actual paid claims for these months vary significantly from what was projected, this could have a meaningful impact on the resulting IBNP.

IBNP 95% Confidence Reserve Margin

The IBNP reserve is a best estimate of the outstanding liabilities of the plan. To be confident that the reserves are adequate to cover any outstanding liabilities, PEBP has requested that Aon calculate margin on the IBNP so that PEBP can be confident in 95% of scenarios the reserve estimate would be adequate for the actual runout.

The 95% confidence reserve margin was developed utilizing Aon's proprietary IBNP model. Completion factors by duration were calculated based on historical runout patterns. Aon then estimated the historical mean and standard deviation of the actual runout for each month which created enough data points to form a distribution. This distribution was then fit to a normal distribution based on the mean and standard deviation of the actual volatility in the runout. Based on a 95% confidence interval being requested, a 30% load on the IBNP is appropriate. We note that the runout on dental claims is more stable, but when combined with a more volatile medical experience, produced an aggregate 30% factor. We applied the 30% to both medical and dental for simplicity. It is more typical to see a load on the IBNP of 10% to 15% based on the client's risk tolerance and size of their population (employee counts greater than 100,000 which is far greater than the size of PEBP's plan).

Catastrophic Reserve Actuarial Method

The method used to create a catastrophic reserve will vary between organizations based on the organizations' risk tolerance, ability to withstand adverse deviations, and their ability to fund this reserve within their organizational constraints. For PEBP, Aon calculated a catastrophic reserve based on historical volatility in claims as well as accounting for systematic system risks such as underwriting, trend, and other macroeconomic risks. Aon's calculation resulted in using 17% of annual projected claims costs as the catastrophic reserve for PEBP. The 17% is based on the following components:

- Trend volatility 3-4% – This represents the variance between projected and actual trends. Every year we project the trend, but the actual trend deviates from projections. This is an estimation error that impacts the Monte Carlo claims simulations we performed for PEBP. Some common reasons for trends fluctuations are utilization changes, new specialty drugs, hospital consolidations, and regulatory changes. Recently, PEBP has experienced positive medical trend volatility, where trend has emerged 3-4% lower than projected. Though the medical trend has had a positive budgetary variance, there has also been an opposing negative Rx trend risk which is running at 5-10% above projection.

- Retiree/Non-State demographics 1.5-2.5% – The retiree and non-state populations are a worsening risk pool. Since non-state plans removed their active employees and left their less healthy pre-65 retirees with PEBP there isn't a "healthy" younger population to offset this older group. PEBP also covers State pre-65 retirees and post-65 retirees who did not pay into Medicare. They are the worst risk pool, as these retirees are older, most have multiple chronic conditions, and do not have Medicare coverage. In discussions with the state back in 2010, we determined it was prudent to add a load for them.

- Underwriting Risk 2-3% – In some years, the state enhances the benefit after Aon has already set the rates for PEBP. In that case, the rates Aon set were insufficient to cover the benefit enhancement. Therefore, we added a load to capture the cost of plan enhancement. Additionally, establishing new plans such as the EPO add an additional layer of uncertainty.

- Claims volatility from Monte Carlo simulation 4.5% – This load was developed from Aon's proprietary Monte Carlo simulation model. Fifty thousand iterations of claims simulations were conducted for PEBP's members. In each iteration, the model randomly selected claims for each PEBP member from a standard claim distribution that was calibrated to PEBP's claims level and demographic characteristics. Claims for each member were then aggregated in each of the 50,000 scenarios. These scenarios were used to calculate the average and standard deviation of PEBP's claims distribution, which was then used to generate the 95% confidence level of PEBP's claims. The additional cost of claims over average projected claims at the 97.5th percentile (upper bound of the 95% confidence level) represented about 4.5% of the average projected claims. Since Aon set rates for the average scenario at the PEBP Board's direction, a 4.5% load was added to make sure rates are sufficient under moderately adverse scenarios.

- Comorbidity Risk 2-3% - One limitation of the Monte Carlo simulation is that it assumes each member's claims are independently distributed. However, an epidemic or accident could easily affect various members at the same time. Therefore, Aon added a load to reflect the comorbidity risk among members.

We would like to note that a trend in public sector groups has been to adopt the National Association of Insurance Commissioner's (NAIC) guidelines of a Risk-Based Capital (RBC) model for insurance companies. The RBC model defines the capital that an insurance company needs to hold to remain solvent.

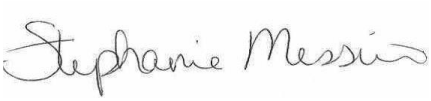
In the NAIC reserve methodology, underwriting risk is one of the key factors, which is a set percent based on the amount of claims an entity incurs: the higher the claims, the smaller the factor. Below is a summary of the factors:

	Underwriting Risk Load		
	Claims Range		
From	$0	$3,000,000	$25,000,000+
To	$3,000,000	$25,000,000	
Medical	15.00%	15.00%	9.00%
Dental/Vision	12.00%	7.60%	7.60%

Based on PEBP's medical/Rx claims distribution among the above brackets, the weighted average risk load is roughly 9.62% for PEBP. Many public entities are targeting 200%+ of the RBC requirement, which is about 19.24% based on just the underwriting risk factor alone. If PEBP were to adopt a similar methodology, depending on the RBC percentage that is targeted (i.e. 200%), it is likely the catastrophic reserve might be slightly higher than the 17% from the actuarial factors above.

We hope that this letter addresses the LCBs questions. Please let us know if further clarifications are needed or if a phone call or in-person meeting is desired.
Sincerely,

Aon Consulting, Inc.



Stephanie Messier, ASA, MAAA
Vice President

cc: Cari Eaton, CFO, Public Employees' Benefits Program
Shun Yu, Aon

Public Employees' Benefits Program

Health Reimbursement Arrangement (HRA)

Reserve History

Health Reimbursement Account (HRA) Overview

Consumer Driven Health Plan (CDHP) HRA

- Eligibility
  - Active Employees
    - Not Eligible for Health Savings Account (HSA)
    - Fail to elect HSA during open enrollment or initial election
  - Retirees
    - Any retiree on the CDHP
- Uses
  - Qualified medical expenses as defined by the IRS (Publication 502)
  - Tax free
- Timing
  - Lump Sum Contribution July each year
  - Contribution is pro-rated for participants with effective dates after July

Health Reimbursement Account (HRA) Overview Cont.

Medicare Exchange HRA

- Eligibility
  - Years of Service (YOS)
    - Any retiree on the Medicare Exchange with 5 or more YOS
- Uses
  - Qualified medical expenses as defined by the IRS (Publication 502 and 969)
  - May be used to reimburse Medicare, medical, dental, etc. premiums
- Timing
  - Monthly Per YOS Contribution
  - Contribution is pro-rated for participants with effective dates after July

Health Reimbursement Account (HRA) Reserve Policy

Policy

- It is the PEBP Board's policy to maintain a fully-funded HRA reserve based on the total balance remaining in all HRA accounts.

- PEBP maintains two separate HRA accounts for the CDHP and Medicare Exchange HRA funds. The total combined cash balance in those accounts as of June 30th should be the closing HRA reserve amount for each fiscal year.

- The Board has chosen many years to provide additional supplemental contributions to spend down excess reserves. Supplemental contributions directly impact HRA reserve growth.

Health Reimbursement Account (HRA) Enrollment History

PEBP HRA Enrollment History				
	CDHP Enrollment	Medicare Enrollment	Total Enrollment	Enrollment Change over Previous FY
FY 2012	10,758	8,655	19,413	
FY 2013	9,011	9,079	18,090	-1,323
FY 2014	8,597	9,646	18,243	153
FY 2015	8,359	10,341	18,700	457
FY 2016	8,577	10,879	19,456	756
FY 2017	8,817	11,252	20,069	613
FY 2018	8,868	11,741	20,609	540
FY 2019	8,869	12,234	21,103	494
FY 2020	8,730	12,636	21,366	263

Actual Enrollment as of July 1st

Health Reimbursement Account (HRA) Reserve History

CDHP HRA Contributions	
FY 2012	Base - $600 participant and $200 dependent Max $1,200
FY 2013	Base - $700 participant and $200 dependent Max $1,300; Supplemental $400 participant and $100 dependent Max $700
FY 2014	Base - $700 participant and $200 dependent Max $1,300; State Supplemental $697 participant and $215 dependent Max $1,342; Non-State Supplemental $400 participant and $100 dependent Max $700
FY 2015	Base - $700 participant and $200 dependent Max $1,300; Supplemental $400 participant and $100 dependent Max $700
FY 2016	Base - $700 participant and $200 dependent Max $1,300; Supplemental $400 participant and $100 dependent Max $700
FY 2017	Base - $700 participant and $200 dependent Max $1,300; Supplemental $400 participant and $100 dependent Max $700
FY 2018	Base - $700 participant and $200 dependent Max $1,300; Supplemental $200 participant tied to preventive program participation
FY 2019	Base - $700 participant and $200 dependent Max $1,300; Supplemental $200 participant tied to preventive program participation
FY 2020	Base - $700 participant and $200 dependent Max $1,300; Supplemental $400 participant

Medicare HRA Contributions	
FY 2012	$10 per month per YOS
FY 2013	$10 per month per YOS; Supplemental lump sum $2 per month per YOS
FY 2014	$11 per month per YOS; Supplemental lump sum $2 per month per YOS
FY 2015	$11 per month per YOS; Supplemental lump sum $2 per month per YOS
FY 2016	$11 per month per YOS; Supplemental lump sum $2 per month per YOS
FY 2017	$12 per month per YOS; Supplemental lump sum $2 per month per YOS
FY 2018	$12 per month per YOS
FY 2019	$12 per month per YOS; Supplemental $2 per month per YOS
FY 2020	$13 per month per YOS

Health Reimbursement Account (HRA) Reserve History Cont.

PEBP HRA Balance History					
	Leg Approved Budget	CDHP Actual	Medicare Actual	Total Actual	Budget vs Actual Variance
FY 2012	$ 2,060,000.00	$ 4,284,589.69	$ 3,852,453.16	$ 8,137,042.85	$ (6,077,042.85)
FY 2013	$ 2,152,000.00	$ 9,411,700.87	$ 5,774,021.11	$ 15,185,721.98	$ (13,033,721.98)
FY 2014	$ 18,555,521.00	$ 12,890,152.33	$ 9,569,828.51	$ 22,459,980.84	$ (3,904,459.84)
FY 2015	$ 22,266,600.00	$ 15,238,061.92	$ 13,479,493.67	$ 28,717,555.59	$ (6,450,955.59)
FY 2016	$ 31,298,890.00	$ 14,503,976.17	$ 16,087,564.81	$ 30,591,540.98	$ 707,349.02
FY 2017	$ 35,993,723.00	$ 15,557,757.19	$ 19,557,189.72	$ 35,114,946.91	$ 878,776.09
FY 2018	$ 30,167,672.00	$ 13,856,790.84	$ 20,423,104.48	$ 34,279,895.32	$ (4,112,223.32)
FY 2019	$ 31,676,056.00	$ 13,369,027.03	$ 22,835,175.60	$ 36,204,202.63	$ (4,528,146.63)
***FY 2020**	$ 36,204,203.00	$ 19,713,960.66	$ 22,358,030.64	$ 42,071,991.30	$ (5,867,788.30)

Actual amounts as of June 30th

** Actual amounts as of 9/30/2019*

Health Reimbursement Account (HRA) Conclusion

CDHP employees and retirees and Medicare Exchange retirees have been provided with a significant amount of funding to allow them to offset their medical expenses.

Reserves continue to grow each year because of additional contributions, enrollment growth, and participants not utilizing the funds that are available to them.

7.

7. Discussion and possible action regarding proposed plan design changes for Plan Year 2021 (July 1, 2020 – June30, 2021), including but not limited to the following:

- Possible implementation of narrow pharmacy network for 90-day prescriptions on the EPO plan;
- Possible implementation of a second opinion program for CDHP high cost high value healthcare;
- Possible implementation of a Chronic Kidney Disease management program on the CDHP;
- Possible increases to CDHP HSA/HRA enhanced employer contributions;
- Possible implementation of additional Centers of Excellence for members on the CDHP and EPO plan;
- Possible reduction to CDHP deductibles and out-of-pocket maximums;
- Possible elimination of the $25 copay for annual vision exams;
- Possible increases to the dental benefit maximums of the CDHP, EPO, HMO, and Medicare Exchange participants.
- Possible inclusion of recent IRS approved drugs to PEBP's Preventive Drug List on the CDHP; and
- Additional benefit design inclusions/exclusions/alterations to meet projected budget needs.

(Damon Haycock, Executive Officer) (**All Items 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
Telephone 775-684-7000 | 1-800-326-5496 | Fax 775-684-7028
www.pebp.state.nv.us

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Expires 04/01/2021

DAMON HAYCOCK
Executive Officer

AGENDA ITEM

[X] Action Item
[ ] Information Only

Date: November 21, 2019

Item Number: VII

Title: Plan Year 2021 Plan Benefit Design

SUMMARY

This report will provide the Board, participants, public, and other stakeholders information and recommendations for Plan Year 2021 Plan Benefit Design.

REPORT

At the September 26, 2019 Board meeting, PEBP provided the Board with opportunities for additional analysis regarding potential Plan Year 2021 (PY21) Benefit Design changes. Per the Board's direction, PEBP has conducted analysis and has made recommendations on each opportunity within the report.

EXCESS RESERVES

Excess reserves are a constant moving target as projected experience and costs throughout the plan year often differ from actual results. For the purposes of today's discussion, the same reserve reconciliation provided at the September 26, 2019 Board meeting is reprinted below:

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

Excess Reserve Reconciliation		
Type	**Amount**	**Comments**
Increased IBNR Reserve	($4,390,000)	Aon projected increased IBNR for the CDHP and EPO plans totaling $58,790,000.
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**

SMART90 PHARMACY NETWORK – EPO PLAN

PEBP implemented the Smart90 pharmacy network for 90-day fills of maintenance medication on a voluntary basis in Plan Year 2019 and a mandatory basis in Plan Year 2020 on the CDHP. Utilizing the Smart90 network in PY 2019 saved the plan $194,345.

When PEBP initiated the EPO plan in Plan Year 2019, we kept as many benefits and plan designs as possible resembling the outgoing HMO plan so we opted not to recommend this narrower network. Our Pharmacy Benefits Manager (PBM) analyzed the first years' claims and developed EPO Smart 90 network modeling for PY21. Since the EPO plan has a copay model for drugs (versus the CDHP's 20 % coinsurance), the analysis came back at a financial loss to the plan. PEBP and our PBM will continue to monitor opportunities to leverage this successful network in the future.

Our PBM did however analyze a mandatory mail order program for 90-day fills as a potential cost saving activity. There are two options available:

- *Exclusive Home Delivery* achieves the highest shift to home delivery at 65% and offers savings of $577,109
- *Select Home Delivery Incentive Choice* achieves a target home delivery rate of 57% and offers savings of $498,654

Note: Since the Retail 30-day (0-83 days) and Mail 90-day (84+ days) copays are aligned 1:2, more of the savings is distributed to the members than to PEBP. In both home delivery scenarios, plan savings primarily consist of Member Penalties. Therefore, some of the savings above is

derived from penalties assessed to members who choose not to follow a mandatory mail order program.

PEBP Recommendation: PEBP recommends making no changes to the pharmacy network for 90-day fills for PY21. Although there are potential savings making mail order mandatory to the EPO plan, the disruption to the members and the changes to their plan design may be viewed unfavorably as a benefit reduction for a higher premium health plan.

SECOND OPINION SERVICES – CDHP & EPO

PEBP and HealthSCOPE Benefits reviewed the options for second opinions services and after reviewing the data, there is an opportunity to provide a third party second option service to PEBP members. PEBP members today are seeking care in many places. Today, HealthSCOPE Benefits has agreements with the Mayo Clinic and Cleveland Clinic and those can be accessed at any time by PEBP for member specific second opinions. In addition, as a part of PEBP's access to the nationwide Aetna network, PEBP gets access to the Aetna Institutes of Excellence contracts. HealthSCOPE believes an approach where members can access a second opinion service, and PEBP is only charged based on the members who utilize it would be the best approach.

HealthSCOPE is recommending the utilization of 2nd.MD, a third-party vendor providing online and telephonic/video consultation with a nationwide top specialist within 3 – 5 days on average. This consultation provides expert medical opinions, treatment decision support, referrals to local high-value providers, and ongoing support. 2nd.MD offers expert opinion consults for all adult and pediatric specialties and sub-specialties. The top diagnostic categories for 2nd.MD expert opinions are Musculoskeletal (26%), Nervous System (10%), Oncology (9%), Digestive System (8%), Female Reproductive System (7%) and Circulatory System (6%). All others make up 34% of expert consults. In addition, 2nd.MD can steer members to any other vendors, narrow networks, Centers of Excellence, etc. offered by PEBP.

Through medical claims with HealthSCOPE, PEBP would pay just under $2,200 per consult, with an average savings of over $5,000 each occurrence. 2nd.MD will also guarantee a Return on Investment (ROI) of 1.25 to 1 utilizing the following:

- The episode of care (EOC) cost for the local recommendation
- The episode of care for the expert opinion
- What the member ultimately chose (97% of members follow the expert recommendation).

PEBP Recommendation: PEBP recommends implementing second opinion services though HealthSCOPE and 2nd.MD for PY 2021 as these services have a guaranteed return on investment and the enhancement will be viewed as a benefit increase.

CHRONIC KIDNEY DISEASE MANAGEMENT PILOT PROGRAM – CDHP & EPO

In Plan Year 2019, PEBP spent almost $7.4 million on the CDHP for 326 members with Chronic Kidney Disease. We spent another $1.2 million on the EPO plan for 63 members.

Chronic Kidney Disease refers to 5 stages of kidney damage, from very mild damage in stage 1 to complete kidney failure in stage 5, requiring dialysis and potential kidney transplants. The stages of kidney disease are based on how well the kidneys can filter waste and extra fluid out of the blood. In the early stages of kidney disease, kidneys are still able to filter out waste from the blood. In the later stages, kidneys must work harder to get rid of waste and may stop working altogether.

The way doctors measure how well kidneys filter waste from blood is by the estimated glomerular filtration rate, or eGFR. The eGFR is a number based on a blood test for creatinine, a waste product in your blood.

The stages of kidney disease are based on the eGFR number:

- Stage 1 CKD: eGFR 90 or Greater
- Stage 2 CKD: eGFR Between 60 and 89
- Stage 3 CKD: eGFR Between 30 and 59
- Stage 4 CKD: eGFR Between 15 and 29
- Stage 5 CKD: eGFR Less than 15

HealthSCOPE and American Health Holdings (AHH), PEBP's Utilization Management/Case Management partner are recommending a Chronic Kidney Disease service to implement specialized case managers who perform medical necessity reviews, early identification, averted complications through member education, steerage to alternate care settings and member assistance for enrollment in dialysis. AHH will sign an agreement with HealthSCOPE (like new providers do today) and submit monthly service claims for these services with the costs (approximately $20,000/month) to be guaranteed on a 1:1 Return on Investment (ROI) utilizing the following metrics:

- Participating members separated by CKD stage will have their total medical costs compared against non-participating members (example: stage 3 versus stage 3)
- Where savings from participation are derived, those costs will offset the service claims of the program.
- If the savings are not greater than/equal to the total annual spend on the program, AHH will reimburse PEBP the difference (example: Total annual spend of $240,000 and total savings of $200,000. $240,000 - $200,000 = $40,000 payment back to PEBP).
- If the savings outweigh the total annual spend, PEBP will share 25% of the savings up to $100,000 of shared savings payments (example: Total annual spend of $240,000 resulting in total savings of $360,000. $360,000 - $240,000 = $120,000 x 25% = $30,000 shared savings payment back to AHH resulting in a $90,000 annual savings for PEBP).

PEBP Recommendation: PEBP recommends piloting these services in PY 2021 as the costs attributed to the additional oversight are guaranteed one-to-one and this enhancement will be viewed as a benefit increase.

CDHP HSA / HRA FUNDING

PEBP has provided a level of enhanced HSA/HRA funds to CDHP participants since the program incurred excess reserves. The following table shows current and Plan Year 2021 legislatively approved enhanced contributions to the HSA/HRA:

Plan Year	Individual Amount (Base)	Individual Amount (Enhanced)	Dependent Amount (Base)	Dependent Amount (Enhanced)
2020 (Current)	$700	$400	$200 / max 3	$0
2021 (Leg Approved)	$700	$125	$200 / max 3	$0

During the 80th Legislative Session, the Legislature approved PEBP's budget with a Plan Year 2021 CDHP enhanced HSA/HRA funding of $125 per primary participant. The costs for these benefits are included in the excess reserve reconciliation on page 1 of this report.

PEBP Recommendation: PEBP recommends approving the $125 enhanced individual HSA/HRA funding as approved by the Legislature for Plan Year 2021.

INCREASING THE UTILIZATION OF CENTERS OF EXCELLENCE – CDHP AND EPO

PEBP currently mandates Centers of Excellence for bariatric surgeries and transplants. The provider recommending the service works with PEBP's case management partner and third-party administrator to ensure the service is performed at an appropriate location. Case management and our third-party administrator will utilize national entities like Aetna and Cigna to research and reimburse Centers of Excellence across the nation for other non-mandated services.

PEBP can develop a program that incentivizes use of Centers of Excellence for specific services by increasing our reference-based pricing program to support those reimbursements and/or working with our online transparency vendor (Healthcare Bluebook) to showcase those facilities across the nation.

In a simpler fashion, PEBP can post listings of current Centers of Excellence and provide member education on the benefits of selecting those facilities for care. We can provide website content updates, post information in our quarterly newsletters, and/or work with our partners to send out notices by mail to members.

Pending the decision on second opinions above, PEBP can organically promote the increase utilization of Centers of Excellence through steerage as part of the second opinion process.

PEBP Recommendation: PEBP recommends increasing member education on the benefits of utilizing Centers of Excellence without changing the reimbursement model to steer members to these providers. If steerage through incentives or reference-based pricing is desirable, PEBP recommends revisiting reimbursement models as part of the FY 2022/2023 budget development

Reducing Deductibles and Out-of-Pocket Maximums – CDHP

PEBP's advocates requested PEBP and Aon analyze the projected increased costs of reducing deductibles and out-of-pocket maximums for members on the CDHP by $100 and $400 respectively. Aon provided the following:

Benefit Type	Benefit Level	Projected Annual Claims Cost	$ Increase in Claims Cost
Current	Deductible = $1,500 OOP Max = $3,900	$178,990,000	$0
Deductible Change (-$100)	Deductible = $1,400 OOP Max = $3,900	$179,800,000	$810,000
Out-of-Pocket Max (OOP) Change (-400)	Deductible = $1,500 OOP Max = $3,500	$180,770,000	$1,780,000
Deductible and OOP Max Change (-$100/-$400)	Deductible = $1,400 OOP Max = $3,500	$181,550,000	$2,560,000

PEBP Recommendation: PEBP recommends tabling this benefit increase to the FY 2022/2023 budget development due to current projected insufficient excess reserves.

Eliminating $25 Copay for Annual Vision Exams

In November 2016, the PEBP Board approved implementing a $25 copay for annual vision exams starting Plan Year 2018 to help offset the costs of other enhanced benefits. The following data showcases actual savings in PY18 and projected savings/costs in PY19 and PY20:

Plan Year	2018	2019	2020*	2021*
Eye Exams (CDHP)	10,982	10,793	10,836	**10,880**
Copay	$25	$25	$25	**$25**
Cost Savings	$272,625	$269,825	$270,904	**$271,988**

**2020 and 2021 are projected based on 2018 and 2019 data (increasing 0.4% each year).*

PEBP Recommendation: PEBP recommends tabling this benefit increase to the FY 2022/2023 budget development due to current projected insufficient excess reserves.

Increasing the Dental Benefit Annual Maximum

In 2011, PEBP developed the Consumer Driven Health Plan (CDHP) and changed the dental offering from an annual $1,500 maximum per individual to $1,000. In 2014, PEBP developed a 3-year plan to spend down excess reserves which included increasing the annual maximum dental benefit back to $1,500. In 2017, PEBP was able to restore this temporary enhanced dental benefit back to the base plan moving forward.

PEBP's actuaries (Aon) analyzed the projected costs if the Board chose to increase this benefit again utilizing increments to a maximum of $2,500:

Plan Design	Projected PY2021 Claims Cost	% Increase in Cost	$ Increase in Claims Cost
Current Dental PPO Design $1,500 Annual Max (PY 2020)	$26,160,000		
Increase Annual Max to $1,800	$27,040,000	3%	**$880,000**
Increase Annual Max to $2,000	$27,240,000	4%	**$1,080,000**
Increase Annual Max to $2,500	$27,360,000	4%	**$1,200,000**

PEBP Recommendation: PEBP recommends tabling this benefit increase to the FY 2022/2023 budget development due to current insufficient excess reserves.

INCREASING DRUGS ON PREVENTIVE DRUG LIST - CDHP

PEBP currently offer CDHP members access to a preventive drug list through our Pharmacy Benefits Manager (Express Scripts). Our list is customized as certain medications (like Diabetes medications) are removed because either our disease management programs offer a richer benefit (example $25 for insulin), or some associated equipment is paid for through the medical plan. In July 2019, the IRS issued an update expanding the list of preventive care benefits which could expand the offerings on PEBP's preventive drug list:

- Depression- Selective serotonin reuptake inhibitors (SSRIs)
- Inhaled corticosteroids
- Peak flow meters & Asthma Assistive Devices
- All diabetes medications and glucometers
- Blood pressure monitors

PEBP already covers inhaled corticosteroids on the current list, and diabetes medications and glucometers are provided through our Diabetes Care Management Program. Blood pressure monitors are available through the medical benefit today, so the only additions could be antidepressants and peak flow meters. Express Scripts looked at current utilization and projects $216,000 of additional costs per year (plus more if new people start using the benefit).

PEBP Recommendation: PEBP recommends tabling this benefit increase to the FY 2022/2023 budget development due to current insufficient excess reserves.

Summary of Recommendation

For Plan Year 2021, PEBP recommends 1) implementing second opinion services with 2nd.MD on the CDHP and EPO plans; 2) piloting chronic kidney disease services on the CDHP and EPO plans; 3) approving the $125 enhanced individual HSA/HRA funding as approved by the Legislature; 4) increasing member education on the benefits of utilizing Centers of Excellence; and 5) tabling all other analyzed enhanced benefits above for possible inclusion in the FY2022/2023 budget development.

UNLV | FACULTY SENATE

November 7, 2019

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

FROM: Douglas Unger, Post-Chair, Immediate Post-Chair, UNLV Faculty Senate; & member, UNLV Employee Benefits Committee

RE: Priorities for CDHP plan improvements, for possible action, or for legislative advocacy

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.

After some weeks of consultations with UNLV faculty, and coordinating with other faculty and state employee organizations, our Employee Benefits Committee at UNLV has set a series of what we believe are modest priorities for possible CDHP plan improvements. Given that the accrual of excess reserves is uncertain until reported in spring, please know we understand the necessary prudence the PEBP Board must exercise in considering any plan improvements that would require additional allocations of funds or the commitment of additional anticipated resources in the future. Nevertheless, we believe there are or should be resources enough available to consider possible action on at least one or more of these modest enhancement priorities, as follows:

1. Raising the Dental Maximum Benefit by $500 from $1500 to $2000. Rationale: our CDHP plan members have not seen a raise in dental benefits for, literally, decades. Indeed, the benefit maximum has remained the same for Nevada state employees for 30 years (the benefit was set at $1500 in 1989). This amounts to an effective reduction in dental coverage of 70.4% relative to the rising costs of dental care over the past 30 years, or a current benefit that is now approximately 29.6% of its original value for state employees (please see the calculator cited by the Nevada Faculty Alliance -- http://www.in2013dollars.com/Dental-services/price-inflation/1989-to-2019?amount=1500). This modest adjustment in the benefit would help plan members to catch up at least somewhat with the increasing costs of dental care. Our rough estimate of the additional PEBP allocation for such an enhancement is $983,000, or roughly less than $1,000,000.

2. Lowering the Out-of-Pocket-Maximum for CDHP plan members by $400 for individuals, from $3900 to $3500; and $800 for families, from $7800 to $7000. We believe lowering the maximum cost of healthcare services for the approximately 12% of Nevada state employees who regularly pay that maximum will benefit fellow employees who are most in need of relief, and would constitute the most ethical allocation of PEBP funds that is

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fitting and proper to the social and moral purpose of group health insurance. Furthermore, lowering Out-of-Pocket-Maximums to these levels will more closely approach the federally permissible amounts of $1350 for individuals and $2700 for families, and thus would re-shape the CDHP plan into one more competitive with comparable High Deductible Health Plans in the Western region. This would help our state with much-needed employee and faculty retention. Our rough estimates of the additional allocation needed for this enhancement is $1,780,000, or a cost of less than $2,000,000.

3. & 4. We recommend leaving the individual HSA/HRA contribution at the base $700 for individuals and raising the HSA/HRA Dependent contribution by $300 each for families (up to three dependents). The increased allocation for the Dependent contribution will, again, allocate PEBP resources to those who most need them, who are generally younger faculty and state employees with lower salaries who are raising families, for whom health care costs can be most burdensome and, in some cases, prohibitive to seeking care. We believe this re-allocation of resources within the CDHP plan would be of benefit to our state for the hiring of talented new employees and the retention of the most talented and promising into the future. Our estimates of the additional costs to PEBP of this new Dependent enhancement is $1,783,700, or less than $2,000,000.

5. Eliminating the $25 copay for the Preventative Vision exam, which would restore this modest benefit to pre-recession levels and would encourage more state employees to use it for preventative care. We believe that adding a cost to preventative care is counter-productive to the overall health of state employees. Copay elimination would bring the CDHP plan into a benefit mix more competitive with plans in the Western region. The estimated cost would be $283,000, or something less than $300,000.

Thank you for considering these modest improvements to the CDHP plan, in priority order, for possible action, or for inclusion as a significant plan members' group request for the budgeting process to be brought before the Nevada Legislature and the Governor's Office. We believe the requests taken individually, one by one, are modest ones; and taken together, we calculate the total additional resources required to be approximately $5,000,000, or even less. Please note that estimates of excess reserves potentially to be reported in spring (January, 2020) may very well amount to more than enough to fund these enhancements, which would be serendipitous indeed, and, we believe, the best use of our state health plan resources to improve the quality of life of Nevada employees.

Thank you for your service to our state, and for your good care in stewarding our PEBP benefits.

Douglas Unger
Post-Chair, UNLV Faculty Senate
Post-Chair, Council of Faculty Senate Chairs, NSHE
E-mail: douglas.unger@unlv.edu
Ph: 702-373-8853

UNLV | FACULTY SENATE

11-6-2019

From: UNLV Employee Benefits Committee & UNLV Faculty Senate Executive Committee – **PEBP Budget Priorities Request for CDHP plan**

(for possible action and/or Legislature consideration)

TO: PEBP Board, c/o Dionne Contine, Chair, & Damon Haycock, Executive Officer

Prioritized requests are in numerical order - (costs estimates based on sp. 2019 figures):

	Current		2020-21	Proposed - 2021-22		Costs
1-- Dental Maximum Annual Benefit	$1500	$0	$1500	$0	$2000	$933,00
2 -- Individual/Family Out-of-Pocket Maximum	$3900/$7800	$0	$3900/$7800	$0	$3500/$7000	$1,780,000
3 -- HSA/HRA base contribution	$700	$0	$850	$0	$700	$0
4 -- HSA/HRA dependent contribution	$200 each up to three	$0	$200 each up to three	$0	$300 each up to three	$1,783,700
5 -- Preventative Vision Exam	$25 copay	$0	$25 copay	$0	$0	$273,805

The three main enhancement requests are: 1) Dental Maximum Annual Benefit; 2) Individual /Family Out-of-Pocket Maximum; and 3) the HSA/HRA Dependent Contribution increase; then 4) elimination of Vision Exam copay.

Total UNLV requests (for possible action and/or to submit for consideration to the Legislature and Governor's Office) = $4, 769,000 (OR $5,000,000 if cost estimates increase over 2019).

8.

8. Discussion and possible action to approve benefit changes for Plan Year 2021 to PEBP's Master Plan Documents for the CDHP and Premier (EPO) plans. (Damon Haycock, Executive 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
Telephone 775-684-7000 | 1-800-326-5496 | Fax 775-684-7028
www.pebp.state.nv.us

ACCREDITED
CORE
Expires 04/01/2021

DAMON HAYCOCK
Executive Officer

AGENDA ITEM

[X] Action Item
[ ] Information Only

Date: November 21, 2019

Item Number: VIII

Title: Proposed revisions to the Plan Year 2020 Premier EPO and CDHP MPD Amendment Logs and to the Plan Year 2021 CDHP and Premier EPO Plan Master Plan Documents

SUMMARY

This report provides updates to the following:

- Plan Year 2020 Premier EPO and CDHP Amendment Logs
- Proposed changes for Plan Year 2021 CDHP and Premier EPO Plan Master Plan Documents

REPORT

SECTION 1

This section describes the revisions to the Plan Year 2020 Premier EPO CDHP Amendment Logs to incorporate the requirements of AB 472 (effective January 1, 2020) related to coverage for gestational carriers and AB 254 (effective October 1, 2019) related to coverage of sickle cell disease as passed during the 2019 legislative session.

Plan Year 2020 Premier EPO Plan Amendment Log

Benefit Limitations and Exclusions

Page 82: Fertility and Infertility Services: Except as otherwise specified in the *Schedule of Medical Benefits* section, all other costs incurred for reproduction by artificial means or assisted reproductive technology (such as in-vitro fertilization, or embryo transplants) except services directly related to artificial insemination services up to the maximum benefit limit are excluded.

This exclusion includes treatments, testing, services, supplies, devices, or drugs intended to produce a pregnancy; the promotion of fertility including, but not limited to, fertility

testing (except as otherwise covered and described above); serial ultrasounds; services to reverse voluntary surgically-induced infertility; reversal of surgical sterilization; any service, supply, or drug used in conjunction with or for the purpose of an artificially induced pregnancy, test-tube fertilization; the cost of donor sperm or eggs; in-vitro fertilization and embryo transfer or any artificial reproduction technology or the freezing of sperm or eggs or storage costs for frozen sperm, eggs, or embryos~~; maternity services related to a participant serving in the capacity of a surrogate mother~~, including, but not limited to, determining, evaluating, or enhancing the physical or psychological readiness for pregnancy, procedures to improve the participant's ability to become pregnant or to carry a pregnancy to term~~, or maternity services are excluded;~~ and any payment made by or on behalf of a participant who is contemplating or has entered into a contract for surrogacy to a provider or individual related to any services potentially included in the scope of surrogacy services; sperm donor for profit or prescription (infertility) drugs; or GIFT or ZIFT procedures, low tubal transfers, or donor egg retrieval are also excluded.

Key Terms and Definitions (new definitions)

Page 131: Gestational carrier: Gestational carrier means an adult woman who is not an intended parent and who enters into a gestational agreement to bear a child conceived using the gametes of other persons and not her own. NRS 126.580

Page 143: Sickle Cell Disease: An inherited disease caused by a mutation in a gene for hemoglobin in which red blood cells have an abnormal crescent shape that causes them to block small blood cells and die sooner than normal red blood cells and may include sickle cell disease, one or more variants or a combination thereof, as applicable. (AB254 Effective October 1, 2019).

Plan Year 2020 Consumer Driven Health Plan Amendment Log

Exclusions

Page 89: Fertility and Infertility Treatment: Expenses for the treatment of infertility, along with services to induce pregnancy (and complications thereof), including (but not limited to): services, prescription drugs, procedures or devices to achieve fertility, in vitro fertilization, low tubal transfer, artificial insemination, embryo transfer, gamete transfer, zygote transfer, ~~surrogate parenting,~~ donor egg/semen, cryostorage of egg or sperm, adoption, ovarian transplant, infertility donor expenses and reversal of sterilization procedures.

Page 91: Maternity/Family Planning:

- Contraception: Expenses related to prescription or non-prescription male contraceptive drugs and devices such as condoms.
- Termination of Pregnancy: Expenses for elective termination of pregnancy (abortion) unless the attending physician certifies the health of the mother would be endangered if the fetus were carried to term.
- Childbirth courses.

- Expenses related to delivery associated with a pregnant dependent child, except for expenses related to complications of pregnancy.
- ~~Expenses related to the maternity care and delivery expenses associated with a surrogate mother's pregnancy.~~
- Expenses related to cryo-storage of umbilical cord blood or other tissue or organs.
- For nondurable supplies.
- Reversal of prior sterilization procedures, including, but not limited to tubal ligation and vasectomy reversals.

Key Terms and Definitions (new definitions)

Page 133**:** **Gestational carrier:** Gestational carrier means an adult woman who is not an intended parent and who enters into a gestational agreement to bear a child conceived using the gametes of other persons and not her own. NRS 126.580

Page 147: **Sickle Cell Disease:** An inherited disease caused by a mutation in a gene for hemoglobin in which red blood cells have an abnormal crescent shape that causes them to block small blood cells and die sooner than normal red blood cells and may include sickle cell disease, one or more variants or a combination thereof, as applicable.

Recommendation:

PEBP staff requests approval to incorporate the revisions described in Section 1 into the Premier EPO Plan and CDHP Master Plan Document Amendment Logs for Plan Year 2020.

SECTION 2

This section describes the proposed changes to the CDHP and Premier EPO Plan Master Plan Documents for Plan Year 2021 effective July 1, 2020.

Gender Reassignment - Breast Augmentation Benefits for the CDHP and Premier EPO Plans

The CDHP and Premier EPO Plans provide coverage for gender reassignment surgery. Gender reassignment surgery is a term used for a series of surgical procedures and treatments by which a person's physical appearance and the function(s) of existing sexual characteristics are altered or even irreversibly changed to that of the opposite sex. Gender reassignment generally consists of several treatment plans, which include the diagnostic phase followed by continuous hormonal therapy. Gender reassignment surgery is covered by both the CDHP and the Premier EPO Plans when reassignment surgery is medically necessary and prior authorized by the UM company. When reviewing services for appropriateness of care and medical necessity, the UM company may refer to guidelines published by organizations such as the MCG Health LLC, Aetna Clinical Policy Bulletins and the World Professional Association for Transgender Health (WPATH) Standards of Care.

The purpose of this request is to amend the CDHP and EPO plan document language related to breast augmentation/mammoplasty to provide coverage for breast augmentation as a covered benefit only when 12 continuous months of hormonal (estrogen) therapy has failed to result in breast tissue growth of Tanner Stage 5 on the puberty scale, as determined by the provider, or the recipient has a medical contraindication to hormone therapy. The Plan Administrator will determine authorization and consent to care based on medical necessity.

This revision will remove the exclusion for medically necessary breast augmentation related to gender reassignment surgeries.

CDHP and Premier EPO Plans - Healthcare Bluebook Incentive Reward

Healthcare Bluebook (HCBB) provides incentive rewards via a paper check to CDHP and Premier EPO Plan participants for using certain high quality, low-cost providers for selective services. Two times per year, HCBB provides HealthSCOPE Benefits (HSB) and PEBP with a report that includes the unclaimed rewards. In lieu of having HCBB reissue the rewards at a cost of $35 per reissue, plus the cost of the reward, staff recommends inserting the following language regarding a 180 day timeframe from the date the check is issued to cash the reward check; reward checks that are not cashed within 180 days will be forfeited and the funds will be returned to the Plan.

Healthcare Bluebook Incentive Reward

Participants earning a monetary reward from Healthcare Bluebook will have 180 days from the date the check is issued to cash the reward check; reward checks that are not cashed within 180 days will be forfeited and the funds will be returned to the Plan.

CDHP - HSA and HRA Contributions

Staff receives inquiries from employees who while actively employed received their HSA or HRA contributions as a primary participants then subsequently terminate and later reinstate employment and coverage within the same plan year. Upon reinstatement, the employee is not eligible for additional prorated contributions as a primary participant but may receive prorated contributions when adding a new dependent. The following language clarifies that under no circumstances will a reinstated employee or reinstated dependent who received contributions in the plan year be eligible for additional prorated contributions upon reinstatement.

Under no circumstances will a participant or dependent who received contributions during the Plan Year be eligible for additional contributions due to reinstatement of coverage or changing from the CDHP with an HSA to the CDHP with an HRA or vice versa.

CDHP- HRA Contributions

Staff receives inquiries from CDHP participants regarding the reinstatement of HRA funds when an employee is terminated and subsequently reinstated in the same plan year.

The CDHP MPD does not include language to address the reinstatement of HRA funds within the same plan year; therefore, staff recommends the insertion of the following language:

Reinstated employees who return to active employment within the same Plan Year and who re-enroll in the CDHP HRA shall have their remaining HRA fund balance reinstated; however, any reinstated HRA funds may only be used for dates of service incurred while the employee is covered under the CDHP. Reinstated employees who re-enroll in the CDHP HRA more than one year after termination are not eligible for HRA balance reinstatement.

CDHP and Premier EPO Plan - Dental Anesthesia

The CDHP and the Premier EPO Plans cover facility fees and anesthesia associated with medically necessary dental services when the hospitalization is determined to be medically necessary to safeguard the health of the patient. The purpose of this request is to align the language in the CDHP and EPO MPDs to the language and age limits in the Premier EPO Plan MPD.

Plan Year 2020 Premier EPO Plan (current language)
Dental general anesthesia for a dependent child when services are rendered in a hospital or outpatient surgical facility, when enrolled dependent child is being referred because, in the opinion of the dentist, the child:

- Is under 18 and has a physical, mental, or medically compromising condition; or
- Is under age 18 and has dental needs for which local anesthesia is ineffective because of an acute infection, an anatomic anomaly or an allergy; or
- Is under age five (5).

Plan Year 2020 CDHP (current language)
Under certain circumstances the medical Plan will pay for the facility fees and anesthesia associated with medically necessary dental services if the utilization review company determines that hospitalization is medically necessary to safeguard the health of the patient during performance of dental services:

- Patient is a child under age seven (7) years and has been diagnosed with extensive dental decay substantiated by x-rays and narrative reporting provide by treating dentist, or
- Patient has a documented illness, such as hemophilia or prior tissue or organ transplant requiring a hospital environment to monitor vital signs; or
- Patient as a documented mental or physical impairment requiring general anesthesia in a hospital setting for the safety of the patient;
- No payment is extended toward the dentist or assistant dental provider under this Plan. Refer to the dental benefits described in the PEBP self-funded PPO Dental Plan Master Plan Document.

Plan Year 2021 CDHP and Premier EPO Plan (proposed language)

- Dental general anesthesia for a dependent child when services are rendered in a hospital or outpatient surgical facility, when enrolled dependent child is being referred because, in the opinion of the dentist, the child:
  - Is under 18 and has a physical, mental, or medically compromising condition; or
  - Is under age 18 and has dental needs for which local anesthesia is ineffective because of an acute infection, an anatomic anomaly or an allergy; or
  - Patient has a documented mental or physical impairment requiring general anesthesia for the safety of the patient;
  - Is under age seven (7) and diagnosed with extensive dental decay substantiated by x-rays and narrative reporting provided by treating dentist.
  - No payment is extended toward the dentist or assistant dental provider under this Plan. Refer to the dental benefits described in the PEBP self-funded PPO Dental Plan Master Plan Document.

Staff Recommendation:

- Staff requests approval for the Premier EPO and CDHP Plan Master Plan Document amendments described Sections 2 for Plan Year 2021, effective July 1, 2020.

- Staff requests approval to make any required technical changes to the Plan Year 2021 CDHP, Premier EPO and other Master Plan Documents for Board review and approval at the March 2020 meeting.

9.

9. Discussion on PEBP's FY 2022/2023 budget development and direction to staff on budget enhancements for submission of PEBP's biennial budget August 2020. (Damon Haycock, Executive Officer) (**For Possible Action**)

NO WRITTEN REPORT, FOR DISCUSSION ONLY

10.

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

NO WRITTEN REPORT, FOR DISCUSSION ONLY

11.

11. Public Comment

12.

12. Adjournment