STEVE SISOLAK
Governor

Deonne E. Contine
Board Chair

STATE OF NEVADA
PUBLIC EMPLOYEES' BENEFITS PROGRAM
901 S. Stewart Street, Suite 1001 | Carson City, Nevada 89701
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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:	May 23, 2019 9:00 a.m.
Place of Meeting:	The Richard H. Bryan Building 901 South Stewart Street, Suite 1002 Carson City, Nevada 89701
Video Conferencing:	University of Nevada Las Vegas 4505 S. Maryland Parkway, System Computing Services Bldg, Room 102 Las Vegas, NV
Streaming Website:	www.pebp.state.nv.us

AGENDA

1. Open Meeting: Roll Call

2. Public Comment

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

3. PEBP Board disclosures for applicable Board meeting agenda items. (Brandee Mooneyhan, Deputy Attorney General) (Information/Discussion)
4. Approval of Action Minutes from the March 28, 2019 PEBP Board Meeting. (Deonne Contine, Board Chair) (**For Possible Action**)
5. Health Claim Auditors, Inc. quarterly audit of HealthSCOPE Benefits for the timeframe January 1, 2019 – March 31, 2019: (1) Report from Health Claim Auditors; (2) HealthSCOPE Benefits response to audit report; and (3) for possible action to accept audit report findings and assess penalties, if applicable, in accordance with the performance guarantees included in the contract pursuant to the recommendation of Health Claim Auditors. (**For Possible Action**)
6. Discussion and possible action to allow and approve PEBP to finalize Plan Year 2020 rates and participant premiums upon final decision by the Nevada Legislature to approve employer contributions (subsidy) at PEBP's budget closing hearing. (Damon Haycock, Executive Officer) (**For Possible Corrective Action**)
7. Discussion and possible action to delay the start of Open Enrollment from May 1st, 2019 to May 20th, 2019 and extend the end of Open Enrollment from May 31st, 2019 to June 7th, 2019 for Plan Year 2020 (July 1, 2019 – June 30, 2020). (Damon Haycock, Executive Officer) (**For Possible Corrective Action**)
8. Discussion and possible action regarding approval of PEBP contract amendments beginning Plan Year 2021 (July 1, 2020):

    8.1 Extend the HealthSCOPE Benefits contract to provide Flexible Spending Account (FSA) services for an additional 2 years through June 30, 2022.

    8.2 Extend the Unum contract to provide voluntary long-term care services for an additional 4 years through June 30, 2024; assess if Unum can join PEBP's voluntary platform through PEBP's vendor; or allow the Unum contract to expire without renewal on June 30, 2020.

    (Cari Eaton, Chief Financial Officer)(**For Possible Action**)
9. Update on PEBP's Fiscal Year 2020/2021 Budget Closing hearings at the 80th Legislative Session. (Cari Eaton, Chief Financial Officer) (Information/Discussion)
10. Discussion and possible action regarding American Cancer Society age and frequency recommendations for colonoscopies and the United States Preventive Services Task Force (USPSTF) age and frequency guidelines for mammograms for both the Consumer Driven Health Plan (CDHP) and Exclusive Provider Organization (EPO) plans for Plan Year 2020. (Nancy Spinelli, Quality Control Officer) (**For Possible Action**)
11. Executive Officer Report. (Damon Haycock, Executive Officer) (Information/Discussion)
12. Discussion and possible action regarding potential Board position, recommendations, and direction to staff about 2019 Legislative Bills that may impact PEBP, including the following:

    * Assembly Bill 185

* Assembly Bill 469

(Damon Haycock, Executive Officer) **(For Possible Action)**

13. Public Comment

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

14. Adjournment

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

1.

1. Open Meeting; Roll Call

2.

2. Public Comment

3.

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

4.

4. Approval of Action Minutes from the March 28, 2019 PEBP Board Meeting. (Deonne Contine, Board Chair) (For Possible Action)

STATE OF NEVADA
PUBLIC EMPLOYEES' BENEFITS PROGRAM
BOARD MEETING

The Richard H. Bryan Building
901 South Stewart Street, Suite 1002
Carson City, Nevada 89701
Video conferenced to:
Nevada State Business Center 3300 West Sahara Avenue,
Tahoe Room, Suite 430
Las Vegas, Nevada 89102

ACTION MINUTES (Subject to Board Approval)
March 28, 2019

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

1. Open Meeting: Roll Call
   Chair Deonne Contine opened the meeting at 9:01 a.m.

2. Public Comment

   Public Comment in Carson City:

   - Kyle Dalpey – Nevada System of Higher Education
   - Nancy Jones – Douglas County resident

   Public Comment in Las Vegas:

   - Tondra De – Administrative Faculty member, UNLV
   - Richard Hinkley – State of Nevada employee

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 January 24, 2019 PEBP Board Meeting.

   4.2. Acceptance of Health Claim Auditors' quarterly audit findings for HealthSCOPE Benefits for the timeframe of October 1, 2018 – December 31, 2018.

   4.3. Acceptance of Health Claim Auditors' annual audit findings for Express Scripts, Inc. (ESI) for the PEBP Plan Year 2018 (July 1, 2017 – June 30, 2018).

   4.4. Acceptance of PEBP vendor quarterly reports for the timeframe of October 1, 2018 – December 31, 2018.

   4.4.1. Hometown Health Case/Utilization Management report

   4.4.2. HealthSCOPE Obesity Care Management Program enrollment & utilization

   4.4.3. The Standard Basic Life and Long Term Disability data & performance report

   4.4.4. The Standard Voluntary Life and Short Term Disability data & performance report

   4.4.5. Willis Towers Watson's Individual Marketplace Enrollment & Performance Report

4.5. Acceptance of the PEBP Chief Financial Officer quarterly reports for the period ending December 31, 2018.

4.5.1. Budget Report

4.5.2. Utilization Report

4.6. Receipt of the federally mandated Summaries of Benefits and Coverage documents effective July 1, 2019 for individual coverage and family coverage for PEBP's Consumer Driven Health Plan (CDHP) and PEBP's Premier Plan (Exclusive Provider Organization – EPO).

Chair Contine suggested to take item 4.1. for approval of the January 24, 2019 Board meeting action minutes separately as she had not yet been appointed to the board at the time of the previous meeting.

BOARD ACTION ON ITEM 4.2. THROUGH 4.6. -

MOTION: Motion to approve the consent agenda with the exception of the action minutes from the January 24th, 2019 meeting.
BY: Member Christine Zack
SECOND: Member Tom Verducci
VOTE: Unanimous; the motion carried.

BOARD ACTION ON ITEM 4.1. -

MOTION: Motion to approve the action minutes from the January 24, 2019 PEBP Board meeting.
BY: Member Christine Zack
SECOND: Member Leah Lamborn
VOTE: Unanimous; the motion carried. (Chair Contine abstained)

5. Discussion and possible action regarding an update to PEBP's Voluntary Benefit Platform implementation, to include an update by the Nevada Division of Insurance on vendor compliance with insurance law requirements to offer voluntary benefits in Nevada. (Laura Rich, Operations Officer) (**For Possible Action**)

PUBLIC COMMENT ON ITEM 5. -

Public Comment in Carson City:

- There was no public comment in Carson City.

Public Comment in Las Vegas:

- Vicky Cameron - Retired Public Employees of Nevada (RPEN)

BOARD ACTION ON ITEM 5. -

MOTION: Motion to accept staff's recommendation to approve the Aflac accident, critical care policies to be offered as a voluntary benefit to retirees on a Voluntary Benefit Platform.
BY: Member Tom Verducci
SECOND: Member Leah Lamborn
VOTE: Unanimous; the motion carried

6. Discussion and possible action regarding approval of PEBP contract amendments beginning Plan Year 2020 (July 1, 2019):

6.1. Amend the Morneau Shepell eligibility and enrollment contract to add language authorizing the contractor to coordinate payroll deductions for voluntary benefits;

PUBLIC COMMENT ON ITEM 6.1. -

Public Comment in Carson City:

- There was no public comment in Carson City.

Public Comment in Las Vegas:

- There was no public comment in Las Vegas.

BOARD ACTION ON ITEM 6.1. -

MOTION: Motion to amend the Morneau Shepell eligibility and enrollment contract to add language authorizing the contractor payroll deductions for voluntary benefits.
BY: Member Christine Zack
SECOND: Member Leah Lamborn
VOTE: Unanimous; the motion carried

6.2. Amend the HealthSCOPE Benefits Third Party Administration (TPA) contract to reduce TPA collection of fees, subrogation recoveries, and provider refunds;

PUBLIC COMMENT ON ITEM 6.2. -

Public Comment in Carson City:

- Priscilla Maloney - Representative of AFSCME retirees

Public Comment in Las Vegas:

- There was no public comment in Las Vegas.

BOARD ACTION ON ITEM 6.2. -
MOTION: Motion to amend the HealthSCOPE Benefits Third Party Administration Contract for TPA collection of fees, subrogation recoveries and provider refunds.
BY: Member Christine Zack
SECOND: Member Leah Lamborn
VOTE: Unanimous; the motion carried

6.3. Amend the Express Scripts, Inc. Pharmacy Benefits Manager contract to reduce administrative fees and implement greater drug discounts and guaranteed drug rebates;

PUBLIC COMMENT ON ITEM 6.3. -
Public Comment in Carson City:

- There was no public comment in Carson City.

Public Comment in Las Vegas:

- There was no public comment in Las Vegas.

BOARD ACTION ON ITEM 6.3. -
MOTION: Motion to amend the Express Scripts Pharmacy Benefits Manager Contract to reduce administrative fees and implement greater drug discounts and guarantee drug rebates.
BY: Member Christine Zack
SECOND: Member Leah Lamborn
VOTE: Unanimous; the motion carried

6.4. Extend and amend the Extend Health (Willis Towers Watson) Medicare Exchange contract to provide services for an additional 5 years through 2025 and eliminate administration fees beginning July 1, 2019. (Cari Eaton, Chief Financial Officer) (**For Possible Action**)

PUBLIC COMMENT ON ITEM 6.4. -
Public Comment in Carson City:

- There was no public comment in Carson City.

Public Comment in Las Vegas:

- There was no public comment in Las Vegas.

BOARD ACTION ON ITEM 6.4. -
MOTION: Motion to accept staff's recommendation, authorize staff to complete a contract amendment between PEBP and Willis Towers Watson Extend Health for Medicare Exchange services and Contract Number 16468 to eliminate fees and extend through June 30, 2025.
BY: Member Tom Verducci
SECOND: Member Mandy Hagler
VOTE: Unanimous; the motion carried.

7. Discussion and possible action regarding changes to Plan Year 2020 Consumer Driven Health Plan (CDHP) plan design to include: reducing deductibles and out-of-pocket maximums; increasing dental benefit maximums; and eliminating annual vision exam copays. (Damon Haycock, Executive Officer) (**For Possible Action**)

PUBLIC COMMENT ON ITEM 7. -

Public Comment in Carson City:

- Doug Unger - Chair, Faculty Senate Nevada System of Higher Education
- Kent Ervin – Nevada Faculty Alliance
- Terri Laird – Executive Director of RPEN
- Priscilla Maloney - Representative of AFSCME retirees

Public Comment in Las Vegas:

- There was no public comment in Las Vegas.

BOARD ACTION ON ITEM 7. -

MOTION: Motion to not initiate any enhancements to the CDHP at this time, and instead to defer the discussion on these enhancements to the August 2019 strategic planning session.
BY: Member Christine Zack
SECOND: Member Leah Lamborn
IN FAVOR: Chair Deonne Contine, Member Linda Fox, Member Mandy Hagler, Member Leah Lamborn, Member Tom Verducci, Member Christine Zack
OPPOSED: Member John Packham
VOTE: Six in favor, one opposed; the motion carried.

8. Discussion regarding future Consumer Driven Health Plan (CDHP) and Exclusive Provider Organization (EPO) plan in-state network strategies for improving access and choice to healthcare providers. (Damon Haycock, Executive Officer) (Information/Discussion)

9. Discussion and possible action to include approving Plan Year 2020 (July 1, 2019 – June 30, 2020) rates for State and Non-State employees, retirees, and their dependents for the Statewide Consumer Driven Health Plan (CDHP); southern Nevada Health Maintenance Organization (HMO) Plan; and the northern and rural Nevada PEBP Premier (Exclusive Provider Organization - EPO) Plan. (Damon Haycock, Executive Officer) **(For Possible Action)**.

PUBLIC COMMENT ON ITEM 9. -

Public Comment in Carson City:

- Peggy Lear Bowen - Retiree Participant (See Exhibit A for comments)
- Kent Ervin – Nevada Faculty Alliance
- Doug Unger - Chair, Faculty Senate Nevada System of Higher Education
- Terri Laird – Executive Director of RPEN

Public Comment in Las Vegas:

- There was no public comment in Las Vegas.

BOARD ACTION ON ITEM 9. -

MOTION: Motion accept staff's recommendation for option number two and allow staff to make all the technical changes they need to make.
BY: Member Christine Zack
SECOND: Member Tom Verducci
VOTE: Unanimous; the motion carried

10. Approval of the proposed changes to the CDHP and EPO Master Plan Documents for Plan Year 2020 (July 1, 2019 – June 30, 2020) for medical, dental, life, and long term disability benefits, for enrollment and eligibility rules, and for privacy and security requirements, to reflect previously approved plan design modifications, changes in legislative or regulatory requirements, and technical corrections or updates. (Nancy Spinelli, Quality Control Officer) **(For Possible Action)**

PUBLIC COMMENT ON ITEM 10. -

Public Comment in Carson City:

- Priscilla Maloney - Representative of AFSCME retirees
- Kent Ervin – Nevada Faculty Alliance
- Terri Laird – Executive Director of RPEN
- Peggy Lear Bowen - Retiree Participant (See Exhibit A for comments)
- Michelle Kelly – Nevada System of Higher Education

Public Comment in Las Vegas:

- There was no public comment in Las Vegas.

BOARD ACTION ON ITEM 10 -

MOTION: Motion to approve and go forward with numbers three, dental, life and long term disability master plan document, number four, health and welfare wrap plan document, number five, Medicare Exchange HRA summary plan description. Number six, flexible spending account summary plan description. Number seven, PEBP enrollment and eligibility master plan document as is. I would like to include in the motion that we approve, number one, the Premier Plan Master Plan document with the exception of removing outpatient from Item E, hospice services and the inclusion of next Board meeting for number D's and E's that we know exactly what the American Cancer Society age and frequency recommendation is and also what for Number E what they USPSTF age and frequency guidelines are and then approve and add to that number two for the CDHP medical, vision and prescription drug master plan document with the same requirement, and I think the item numbers are different but just knowing what the American Cancer Society and the USPSTF guidelines are.

BY: Member Leah Lamborn

SECOND: Member Christine Zack

VOTE: Unanimous; the motion carried

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

12. Discussion and possible action regarding potential Board position, recommendations, and direction to staff about 2019 Legislative Bills that may impact PEBP, including the following:

    * Assembly Bills

    * Senate Bills

    * Bill Draft Requests

    (Damon Haycock, Executive Officer) **(For Possible Action)**

PUBLIC COMMENT ON ITEM 12.-

Public Comment in Carson City:

- There was no public comment in Carson City.

Public Comment in Las Vegas:

- There was no public comment in Las Vegas.

BOARD ACTION ON ITEM 12 –

- No action taken.

13. Public Comment

Public Comment in Carson City:

- Peggy Lear Bowen - Retiree Participant (See Exhibit A for comments)

Public Comment in Las Vegas:

- There was no public comment in Las Vegas.

14. Adjournment

Chair Contine adjourned the meeting at 1:55 p.m.

Exhibit A

These remarks are presented as transcribed by Capitol Reporters.

AGENDA ITEM 9 - PUBLIC COMMENT FROM MS. BOWEN:

MS. BOWEN: My name and words for the record Peggy, P-e-g-g-y space Lear, L-e-a-r space Bowen, B-o-w-e-n, b as in boy. I have several comments, but I need to bring this back to the fact that this has never been put out to bid. The -- way back in 2011 and prior to that that we need to have in order to get the best bang for our buck, not to discuss just what -- what Hometown Health and the others are doing, but we literally need to talk about going out to bid and having a fair and open transparent situation. I would like to put the group on notice that I do believe that we are in potential violation of not exactly the law but the intent of the law for the open meeting that in order for people to attend this meeting, I don't believe the Governor or based on what I'm seeing and how it's being done, I don't believe anyone can access this meeting from outside of this room, and I don't believe that the packets could be mailed because no money has been provided for the mailing of packets the way they used to be given to every department head so the department would have input as to what the employees, active employees needed for their insurance benefit and what the retired employees need for their insurance benefits and for the orphans, which is the nickname I gave to those who said we didn't fit here, we didn't fit here but we're part of the insurance because the school district, being involved in the school district. And I know there's a three-minute time limit and I appreciate that but, in fact, your survey, I was never surveyed. Your survey was sent to certain people as determined by whoever sent out the survey. What was supposed to take place is they were to get a group together to put together the survey questions because it's what you ask and what response, and I don't believe that the benefits and what is being -- what has been going on has been -- it's not misrepresented based on the survey that went out, but I don't think it was the survey of the entire population, and you can send it with the PERS check or however you want to, that avenue is open to you to ask people what it is they want for their insurance. And -- and if you're asking us to pay for things and be part of things in the premium things, then you should ask us what it is we want, what it is we need and not focus just on what the pharmaceuticals are doing. And I think that way too much orientation toward Renown which does a good job but the point is there are people who are living three miles from Churchill County Hospital. It's not the expense of the program you should consider. It's the expense to us that travel, the getting the rooms to put up the family, the doing everything coming back and forth and what those hospitals were actually offering and were discounted and to be included and to look at what Southern Nevada wanted in regards to more equalization and more standardization. Thank you very much, and I assume I've just met my time limit.

CHAIRWOMAN CONTINE: Well, I was just going to say we're talking about the rate item and I just didn't want you to run out of time if you had anything to say about the rate.

MS. BOWEN: So the rates themselves are not as accurate as they seem. They thought they took care of the problems with the orphans which the legislature did the best to do. But when it comes to adding different things and making available the dental program and the hearing aid and all that kind of stuff --

CHAIRWOMAN CONTINE: Okay.

MS. BOWEN: What we have here is an insurance company whom holds into trust or holds into reserve -- I'm sorry, I've had a concussion and a minor stroke, and I'm doing the best I can. The

reserves keep going no matter what. take a look at those reserves that continue to grow and the person who holds the reserve, the company that holds the reserve is getting the interest on the reserves, and it just sort of works out that the interest that -- the amount of money that Aon and everybody would have earned is getting it in interest on the reserves instead of the state taking back their own program and handling it for themselves and make it Nevada's again instead of insurance companies making the profits instead of your employees having the benefits of their monies and what it is earning. Nevada needs to take back Nevada's program. Thank you very much.

AGENDA ITEM 10 - PUBLIC COMMENT FROM MS. BOWEN:
MS. BOWEN: My name and words for the record, P-e-g-g-y, Peggy space Lear, L-e-a-r space Bowen, B as in boy o-w-e-n. I have a couple of concerns, one about the mammogram and if you go in and have your mammogram done and if the doctor can't read it or requires more input to that with an additional mammogram, a lot of people are not getting the second mammogram, not even going in for the first mammogram because they feel they are being held responsible to pay for that second mammogram based on limits and things like that. And it would be really appreciated if we thank you, thank you, thank you for all of the work you did to get the 3D mammograms accepted and the mammogram of the day now for most places but not all places, so you need to remember that it's to include mammogram 3D if the first one was not a 3D. And, secondly, you need to have something within this provision that if the doctor requires you to have more work done that it should be covered at 100 percent. It is not the patient who is asking and going in and requiring more mammograms, but it is the doctor states as needed to please include that in the benefit would be very helpful. To -- for the obesity program, you have not incorporated anywhere in your program any means or mechanism for the disabled. I know that with four foot and ankle surgeries and three knee surgeries, I don't walk as fast and I don't do this much, and I can go around Virginia Lake as many times as you want, and I can climb the steps and go to the gym and be in the obesity program all you want, but you're discriminating against me because of my disability. Wait a minute, Ms. Spearman gave me a different terminology. My -- I'm not disabled. I am differently abled and the accommodations that my doctor and I follow following my doctor's recommendations should a -- should allow for whatever the weight is that if I'm following my doctor's recommendations for doing the best I can for my abilities hat you shouldn't discriminate against me and make me pay more because I'm not meeting your obesity requirements. I can eat your food however you want me to. It won't make any difference. I can eat -- I can starve to death. It won't make any difference. If I can't walk or I can't do that which would allow weight loss but I'm doing everything the doctor says for me to do in the conditions that I have, four foot and ankle surgeries, three knee surgeries, severed -- there's one bone that works and one that doesn't, it impacts on how my weight is, and I should not be discriminated by your policy, by the policy that you have created or by the insurance companies that you accept regarding that. When a pre-approval to go into an emergency room or not or what's going on there, you've heard my story before, but my point is that if a drug is prescribed by -- a drug is recommended by a -- by a doctor, I need an Epipen because I'm allergic to bees, wasps and any other critters that bite. And if that Epipen gets used because I was bitten by a wasp and went to emergency room and the emergency room wouldn't prescribe an Epipen, finally they did, and I went. And the pharmacist says, well, if you get the prescription pre-approved then it's $300 instead of $800. We need those prescriptions not to need pre-approval as such. And when you're going to the emergency room or any other state, the only way they would have covered the

Epipen is if I had been admitted to the hospital, and I didn't -- I didn't need anything that needed admission at that point for that situation. Later, I fell and had a concussion and -- and I was taken by ambulance to the hospital and because they would not determine or state that I had a concussion except they released me with concussion protocol to go home and be by myself and then if I passed out there and died is because they wouldn't admit me. This pre-admit approval that you have incorporated is keeping patients from going in, keeping patients from get prescriptions. And for the mammogram, I have to tell you that it's keeping people from getting the initial mammogram because they don't want to know if there's something else and they can't afford the second one. We just simply need it as doctor recommended on each of those. And pre-approval for medications, we need to have that stopped in the sense of what's required in a doctor recommended as recommended by doctor. We need you to do that. Thank you very much. Thank you for all you do, and thank you for giving up this day, and Happy Easter coming up. Please because it's so important. Mr. Damon Haycock, for whatever reason, and I didn't hear it discussed today but I was late because I had a doctor's appointment. The -- the use of a computer to be able to access any of these programs and be accepted in these programs and required, the only reason that the computer is involved in a person becoming part of the program, the PEBP program is so that you can have certain, do they know about your program.
And little old ladies and others and the poor, this discriminates against the elderly and the poor, actual discrimination. You need to eliminate the requirement. You did earlier, thank you very much, but you need to eliminate the requirement that we have to sign-in on your computers in order to be enrolled in -- Damon, please help me with the name.
MR. HAYCOCK: Doctor on Demand.
MS. BOWEN: Doctor on Demand. Thank you very much. We have people, we need the computer requirement that discriminates against the elderly and poor removed because all that program does is tell you what the program is. You shouldn't keep us from using the program because we don't know about the program. Obviously, if this is how you know you're not sending the -- this is how a person knows they are not sending checks to people that don't exist anymore. If we go to the doctor and we have our physical, if we have our blood work done, if we have our, there are four things, physical, blood work, Damon, would you help me once more, please.
MS. SPINELLI: Labs and dental.
MS. BOWEN: Labs and?
MS. SPINELLI: Dental.
MS. BOWEN: And dental done then you know we exist. We don't -- we should not have to be enrolled with, touch or have to deal with computers because our elderly are not accessing this program because they don't have computers. They don't use computers nor do the poor. They rather use three or four or $500 for a computer to put food on their table and roofs over their head and clothes on their back.
CHAIRWOMAN CONTINE: Thank you.
MS. BOWEN: So please eliminate the Doctor on
Demand requirement from anything to do with any participation. We beg of you get the computer off our back and get us back to dealing with our doctors and our health and living well and long, and then we won't be using your insurance program. Thank you very much, and Happy Easter.

AGENDA ITEM 13 - PUBLIC COMMENT FROM MS. BOWEN:
MS. BOWEN: My name and my words for the record
P-e-g-g-y space Lear, L-e-a-r space Bowen, B-o-w-e-n space. We need to -- once again, people are not accessing and utilizing our insurance because of the computer component. We need to have the Doctor on Demand not a requirement for being a participant in anything. We need to have you accept, I put stars here so I would do it. Regarding the contraceptives network, I believe that Viagra is covered and yet there are things about birth control that are not being covered. If you cover one, you cover both. It's all equal access or equal input, however you want to word it. Both those drugs are covered at 100 percent without any limitation on how old. We have people getting pregnant, family members getting pregnant at 14, 15. We need to be able to access contraceptives. As far as colonoscopies and mammograms, we have people dying from lung cancer, breast cancer, colon cancer, polyps that had they been discovered at an earlier age, then they could have been dealt with, and so we need that age limit not to be -- not to have an age limit on being able to have a colonoscopy as needed as recommended by doctors in that way. And the same thing with mammograms, I have a strong history of breast cancer within my family. Every single woman on my mother's side of the family have died with relationship to cancers and breast cancer and that being found, and the sooner that I can have follow-up that I can have mammograms done and not limit. You know, people die at 14, 15 years old from breast cancer. Children's cancer units, we want to eliminate children's cancer, and the children of your members should be included in being able to get those mammograms and get those colonoscopies much earlier because the disease by the time we get to be old enough we'll probably going to be dead. And when they just did my colonoscopy, they discovered a polyp, and so what am I supposed to do now? I've had my colonoscopy. There's a polyp, and I need somebody to be able to go in and be able to go back into that colonoscopy and get that polyp out of there so I don't die from cancer down in that area. It's high risk. We just need you to get the age requirements removed in what you're doing, and we need to get that Doctor on Demand, get the computer out of it. You know, we're using it if we do the four catchups and, gosh, there was one more, and I'm being apologetic.
CHAIRWOMAN CONTINE: I think we're going to wrap
MS. BOWEN: Okay. Just wrap it up.
CHAIRWOMAN CONTINE: Happy Easter.
MS. BOWEN: Thank you very much and thank you for being so consistent. But anything to do with PEBP and access to this plan or anything to do with PEBP at all, please remove the computer requirements. You don't need us to not sit home, Ms. Margi Prum (phonetic), and die of something because she didn't go back and redo the things so you know where she is or how she's doing or she knows about your plan. And the survey, who did you survey? And make it a true survey so you know what the members need and want and not just surveyed by random members. Did you get a survey? Did you get a survey? Did I get a survey? I don't know about you, but I know I didn't get one, and he said all were surveyed. And, I'm sorry, Damon, I didn't mean it to sound quite like that.
MR. HAYCOCK: That's okay.
MS. BOWEN: But that's how it is and have a great day.

5.

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

Claims and System Audit Report

for

Nevada PUBLIC EMPLOYEES' BENEFITS PROGRAM

PEBP

Health Matters.

Audit Period: PEBP Plan Year 2019, Quarter Three
January, February and March 2019

Audited Vendor:

HealthSCOPE BENEFITS

Healthy People
Healthy Business
Healthy Futures

Submitted By:
Health Claim Auditors, Inc.
April 2019

TABLE OF CONTENTS

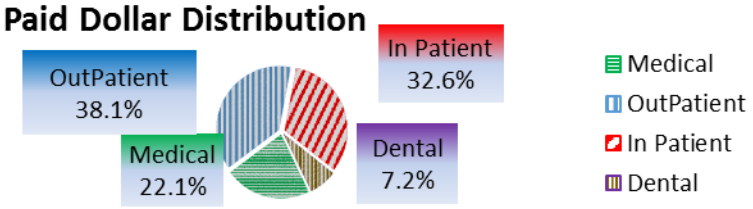
The following categories are reviewed each quarterly audit, however, because of their constant properties, the detail of each category will only be displayed within the first quarter audit of the PEBP fiscal year unless a change or defect is detected:

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

EXECUTIVE SUMMARY

Audited Random Selection Data

Total number of claims: 500
Total Charge Value of random selection: $ 861,484.92
Total Paid Value of random selection: $ 273,007.02



Performance Guaranteed Metric Results

Metric	Guarantee Measurement	Actual	Pass/Fail
Payment Accuracy	≥ 98% of claims audited are to be paid accurately	98.4%	Pass
Financial Accuracy	≥ 99% of the dollars paid for the audited claims is to be paid accurately	98.31%	Fail
Claim Processing Turnaround Time	- 99% of all claims are to be processed within 30 days.	99.6%	Pass
Customer Service	-Telephone Response Time: ≤ 30 seconds. -Telephone Abandonment Rate: ≤ 2%. -First Call Resolution: ≥ 95%	14 sec. 1.21% 95.9%	Pass Pass Pass
Data Reporting	-100% of standard reports w/in 10 bus. days -Annual/Regulatory Documents w/in 10 business days of Plan Year end	No Exceptions Noted	Pass
Disclosure of Subcontractors	-Report access of PEBP data within 30 c. days -Removal of PEBP member PHI within 3 business days after knowledge	No Exceptions Noted	Pass

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

Previous Recommendation(s)

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

Previous Findings

End Stage Renal Disease

Previous detected an issue concerning errors with the payment of participant claims with diagnosis (DX) of End Stage Renal Disease (ESRD) where claims were found to be Medicare eligible and requesting in excess of $450,000 in overpayments. HCA has conducted follow-up focus audits and verified that the majority of these overpayments have been collected. HCA recommends that PEBP consider language within the Plan Specific Plan Document (SPD) that addresses the enrollment of participants Medicare eligible with an ESRD DX.

Current/Updated Findings

1) **Letters of Authorizations**

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

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

2) **Repricing by Hometown Health**

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

Trends/Issues

The audit revealed the following issues or trends detected from the random selection and bias selected claims. Please note: the reference numbers in **bold type** are claims from the random selection and are included within the statistical calculations. Reference numbers in normal type were identified as issues in bias claims as defined earlier and are not included within the statistical calculations of this audit. Specific information regarding supporting reference numbers can be found in the Audit Results Section in numerical sequence, which begins on page 15.

Incorrect rate due to network re-pricing;
Supporting reference nos. 005, 232, 242 and 260

Incorrect rate; Supporting reference nos. **082,** 495 and 505

Copay not applied; Supporting reference nos. **105, 149** and **328**

Copay applied in error; Supporting reference no. **032**

Incorrect copay applied; Supporting reference no. **114**

Claim paid at incorrect coinsurance; Supporting reference no. **219**

Incorrect calculation of payment on adjustment;
Supporting reference no. **414**

The audit revealed the following issues, which appear to be administered properly by HSB but should be brought to client attention for proper notification or verification. Specific information regarding supporting reference numbers can be found in the Audit Results Section in numerical sequence, which begins on page 15.

Programming issue with Quest Labs not being allowed under SHO contract; Supporting reference no. 229

Final clarification for 2018 Valley Health System contract percentage change received 10/18/18; Supporting reference no. 307

Accessories for denied DME not also denied;
Supporting reference no. 220

CLAIM PROCEDURES/SYSTEM CAPABILITIES/SUPPORT DATA

Introduction

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

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

Breakdown of Claims Audited

The individual claims audited were randomly selected from PEBP's claims listings as supplied by HealthSCOPE. These claims had dates of service ranging from January 2018 to March 2019 and were processed by HealthSCOPE from 01 January 2019 through 31 March 2019 (PEBP's Third Quarter Plan Year 2019). These claims were stratified by dollar volume to assure that HCA audited all types of claims. The audit also includes large dollar paid amounts that are considered as bias* selected claims.

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

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

Type of Service	Charge Amount	Paid Amount	Paid Distribution	No. of Claims
Medical	$ 191,534.01	$ 60,395.70	22.1%	332
Outpt. Hospital	$ 336,334.11	$ 104,063.61	38.1%	67
Inpt. Hospital	$ 298,357.45	$ 88,864.91	32.6%	5
Dental	$ 35,259.35	$ 19,682.80	7.2%	96
TOTAL	**$ 861,484.92**	**$ 273,007.02**	**100%**	**500**

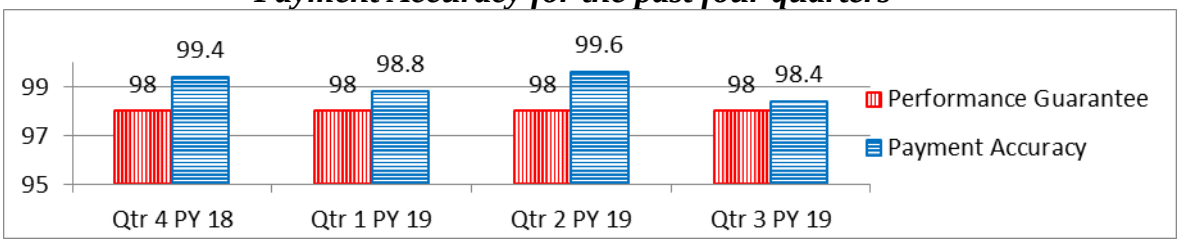
Payment Accuracy

Per PEBP, the Service Performance Standards and Financial Guarantees Agreement for the payment accuracy is to be 98% or above of claims adjudicated are to be paid correctly or a penalty of 2.5% of Quarterly Administration Fees for each percentage (%) point, or fraction thereof, below performance guarantee is to be applied. Payment Accuracy is calculated by dividing the total number of claims not containing payment errors in the audit period by the number of claims audited within the random selection.

The Payment Accuracy Percentage of the number of claims paid correctly from the HealthSCOPE random selection for this audited quarter is 98.2%.

Number of claims:	500
Number of claims paid incorrectly:	8
Percentage of claims paid incorrectly:	1.60%
Number of claims paid correctly:	492
Percentage of claims paid correctly:	98.40%

Payment Accuracy for the past four quarters



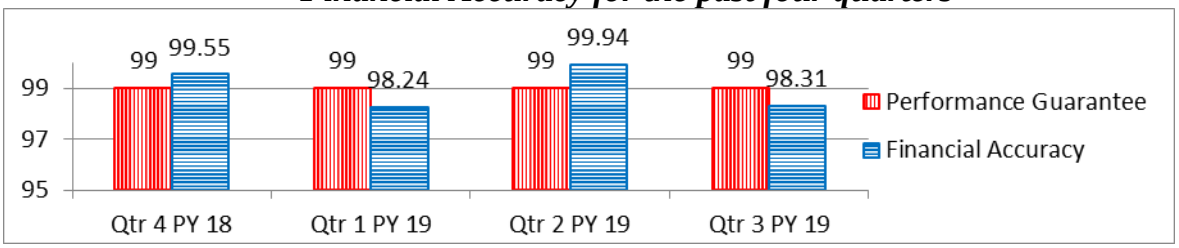
Financial Accuracy

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

The Financial Accuracy Percentage of paid dollars remitted correctly on the HealthSCOPE claims selected randomly for this audited quarter is 98.31%. This audit reflected seventy-two and five tenths percent (72.5%) of the audited errors within the valid random selection were overpayments.

Paid dollars audited	$ 273,007.02
Amount of paid dollars remitted incorrectly	$ 4,618.10
Percentage of Dollars paid incorrectly	1.69%
Paid Dollars of claims paid correctly	$ 268,388.92
Percentage of Dollars Paid correctly	98.31%

Financial Accuracy for the past four quarters



Historical Statistical Data of Performance Guarantees

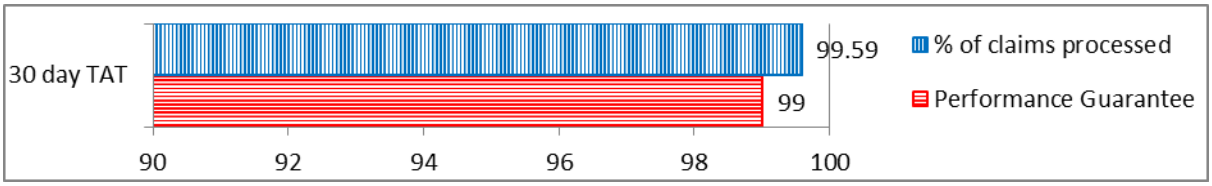
The following reflects the historical statistical data since the origin of PEBP medical claims administration by HealthSCOPE. The entries designated in **bold red type** are measurable categories with underperformance of the Service Performance Guarantees Agreement.

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

Turnaround Time

Per the Service Performance Standards and Financial Guarantees Agreement, the turnaround time for payments of claims is measured in calendar days from the date HealthSCOPE receives the claim until the date of process. Ninety nine percent (99%) of complete claims adjudicated are to be processed within thirty (30) calendar days, excluding federal holidays, or a penalty of two percent (2.0%) of Quarterly Administration fees for each two and a half percent (2.5%) of non-compliance complete claims is to be applied. HCA had requested the report that reflects the measurement of this issue. This report reflected that 99.59% of "complete" claims were processed within 30 calendar days, in compliance with the performance guarantee. This report also displayed the total turnaround process time for all claims at 5.8 days.

Turnaround Time Measurements



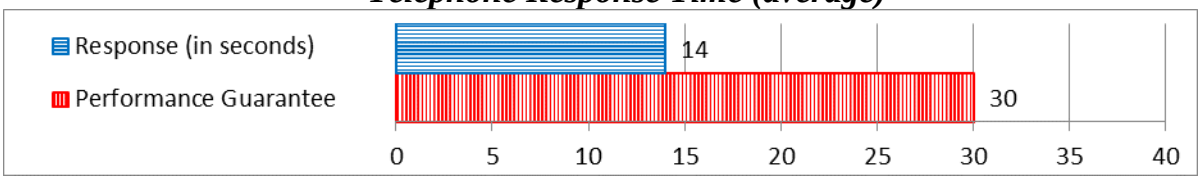
The turnaround time, measured only from the random selected claims, for Medical claims was 13.6 calendar days, Out Patient Hospital claims was 14.6 calendar days, In Patient Hospital claims was 11.8 calendar days and Dental claims was 1.9 calendar days.

During the audit period of 01 January 2019 to 31 March 2019, HealthSCOPE had received 1,030 PEBP e-mail inquiries for information via the internet. The average turnaround time for these inquiries was calculated at approximately 7.0 hours.

Customer Service Satisfaction

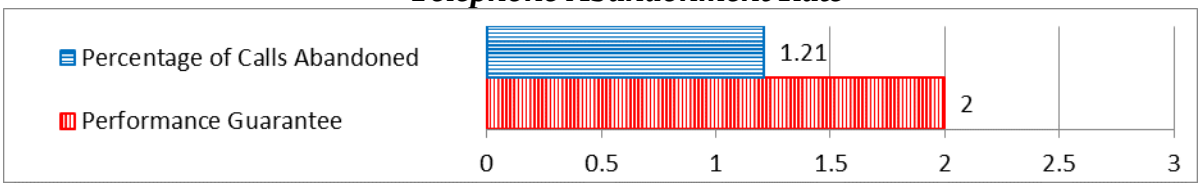
Per the Service Performance Standards and Financial Guarantees Agreement, the telephone response time reflects all calls must be answered within thirty (30) seconds or a penalty of one percent (1%) of Quarterly Administration fees for each second in non-compliance is to be applied. HCA has reviewed the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

Telephone Response Time (average)



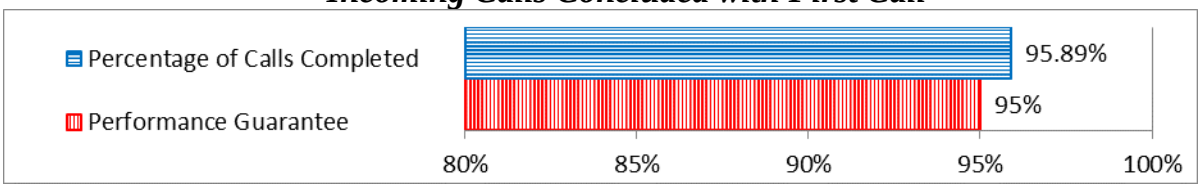
Per the Service Performance Standards and Financial Guarantees Agreement, the abandonment rate must be under two percent (2%) of total calls or a penalty of one percent (1%) of Quarterly Administration fees for each percentage point or fraction thereof in non-compliance is to be applied. HCA has reviewed the appropriate report for the PEBP third fiscal quarter Plan Year 2019, which revealed the abandoned calls ratio to be 1.21%. The telephone abandonment rate was 1.11% for January 2019, 1.37% for February 2019 and 1.18% for March 2019.

Telephone Abandonment Rate



Per the Service Performance Standards and Financial Guarantees Agreement, ninety five percent (95%) of incoming PEBP member problems must be resolved to conclusion on the first call or a penalty of one percent (1%) of Quarterly Administration fees for non-compliance is to be applied. HCA has reviewed the appropriate report for the PEBP third fiscal quarter Plan Year 2019, which revealed that HealthSCOPE documented 95.89% of incoming calls were brought to completion on the first call.

Incoming Calls Concluded with First Call



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

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

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

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

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

HealthSCOPE's telephone conversations are documented for future reference.

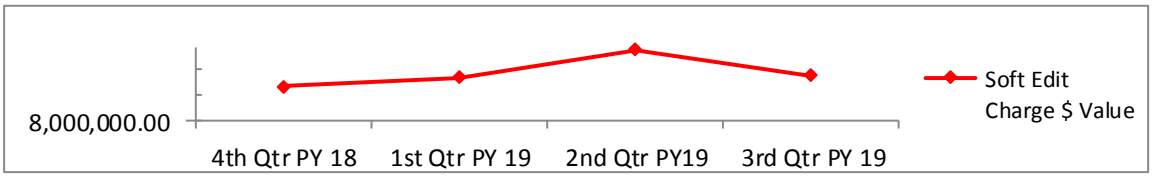
HealthSCOPE does have an audit process for Customer Service Representatives.

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

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

Soft Denied Claims

The audit identifies the volume of claims adjudicated and placed in a "soft denied" status. HCA recognizes and respects the need to place certain claims in a soft denied status such as claims that require additional information or special calculation of payment. It is important to include this data within this report to disclose the outstanding unpaid claims that could create an artificial debit/savings during the time that these claims were adjudicated. Note: The measurement of this data was provided as a "snapshot" report. The report reflected the "soft edit" amounts as they were reported on the specific day that the report was recorded. The report for the current claims placed in a "soft denied" status reflect a total of 5,476 claims representing $ 25,662,843.33.



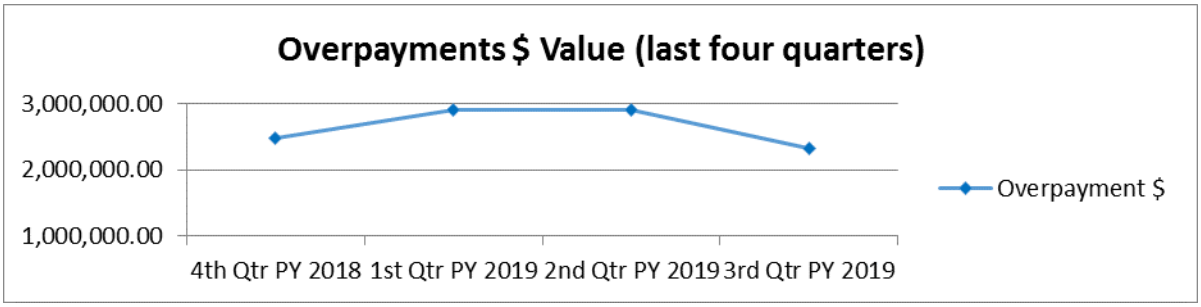
Audit Period	Total Number of Claims	Charge Amount Value of Soft Edits
1st Qtr PY 2012	2,607	$ 7,544,177.55
2nd Qtr PY 2012	4,068	$10,697,954.53
3rd Qtr PY 2012	1,536	$ 6,472,249.56
4th Qtr PY 2012	559	$ 2,205,318.16
1st Qtr PY 2013	1,053	$ 3,413,738.12
2nd Qtr PY 2013	1,107	$ 5,019,961.70
3rd Qtr PY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

Overpayments

HCA requested an overpayment report that reflects the identified current outstanding overpayments incurred since the beginning of the contract period with HealthSCOPE. This report reflected a current total potential recovery value of $2,322,865.51 (a decrease of $575,663.88). Detailed information regarding outstanding overpayments can be reviewed in a separate Supplemental Report, which for confidentiality purposes, is not included in this report but is made available to PEBP staff should they request it.

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

Period	Due/Potential Recovery
- Fiscal Year 2012	$ 126,872.76
- Fiscal Year 2013	$ 192,584.73
- Fiscal Year 2014	$ 91,077.33
- Fiscal Year 2015	$ 210,833.02
- Fiscal Year 2016	$ 230,377.03
- Fiscal Year 2017	$ 213,224.61
- Fiscal Year 2018	$ 563,101.17
- Fiscal Year 2019	$ 694,794.86
TOTAL	$2,322,865.51



Of the 2,402 most current (Plan Year 2019) identified outstanding overpayments (HSB only), 76% were found to be caused by external sources that are not a cause of the HealthSCOPE adjudication processes. Breakout of the HealthSCOPE's most current (PY19) overpayments (by claim count) are listed by reason as follows:

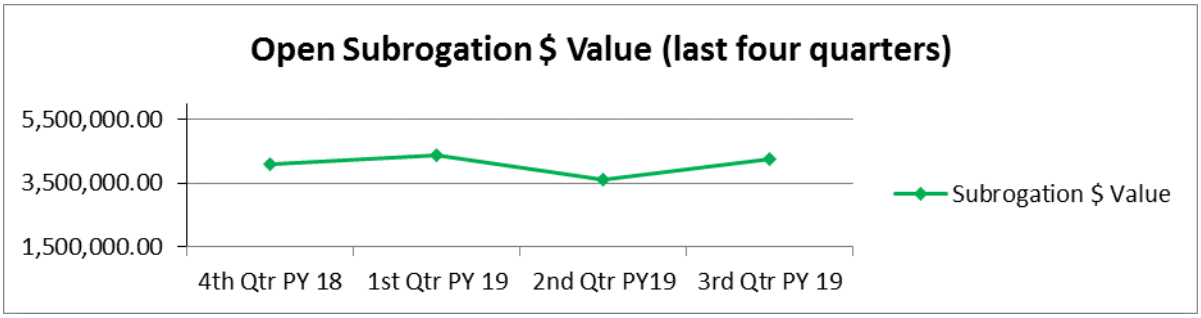
26.60%	SHO Pricing Correction
12.17%	Provider caused, rebilled, charges billed in error, corrected EOB
11.42%	Previous Information Received
10.71%	No COB on file
10.59%	Incorrect Benefit Applied
8.80%	Corrected HTH Network Pricing
7.25%	Retro termination
5.92%	Incorrect Rate Applied
1.50%	Duplicate
0.66%	Service not covered
0.62%	Pharmacy claim deductible/Co-Insurance error
0.50%	COB incorrectly calculated or not applied
0.41%	Paid in excess of max limit
0.37%	Pre-Certification
0.33%	Adjusted after medical review
0.29%	Processed under the incorrect provider
0.25%	Industrial and/or possible Workers Compensation claim
0.25%	Paid NON PPO as PPO
0.25%	Stop Payment
0.20%	Incorrect assignment applied
0.20%	Eligibility
0.17%	Benefit Clarification
0.08%	Processed under incorrect patient
0.08%	Paid PPO provider as NON PPO
0.08%	Asst Surgeon paid as Surgeon
0.04%	Subrogation error
0.04%	Entry Error
0.04%	Aetna Correction
0.04%	Appeal
0.04%	Denied in Error

Subrogation

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

This report reflects open subrogation claims representing a current potential recovery amount of $4,248,120.91; an increase of $638,815.75 from the previous quarter.

Reports received from HealthSCOPE reflect that subrogation recoveries for the audited period was $569,919.62. After contingency fees were paid, PEBP received $416,346.87.



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

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

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

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

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

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

High Dollar Claimants

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

This report reflected thirty-six (36) active members and twenty-seven (27) dependents for a total of 63 active participants, who have obtained this level of plan payment participation representing an accrued dollar paid amount of $84,132,919.45.

Personnel

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

- State of Nevada Manager;
- Vice President – Quality Assurance;
- Sr. Vice President Operations Customer Care;
- Executive Account Manager;
- Client Relations Manager;
- Financial Operations Director;
- Provider Maintenance Specialist;
- Financial Analysts, 3 individuals;
- Funding Supervisor;
- Claims Administration Manager;
- Claims Administration Supervisor;
- Claims Analysts, **CHANGE**, 2 individuals added for a total of 14 individuals;
- Eligibility Director;
- Eligibility Supervisor;
- Customer Service Vice President;
- Customer Service Director;
- Customer Service Representatives, **CHANGE**, 1 individual added and 1 removed for a total of 18 individuals;
- Scanning Services Manager;
- Recoveries Manager;
- Recoveries Specialists, 2 individuals;
- Vice President Data Services;
- Senior Data Analyst;
- Chief Information Officer;
- Data Architect
- Computer Domain Hosting (CDH) Services Manager;
- Sr. Vice President-Legal and Compliance;
- COBRA Service Manager;
- Customer Care Supervisor;
- Customer Care Representatives, 3 individuals.

HealthSCOPE POLICY/PROCEDURES/SYSTEM CAPABILITIES

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

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

HCA CLAIM AUDIT PROCEDURES

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

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

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

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

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

AUDIT RESULTS

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

Ref. No. 005 Medical HSB claim no.

NOT charged in statistical calculation. Note to client for information only.
A7030 chg 171.50
A7035 38.50
Originally paid claim at 100% with no discount on 11/30/18
Adjusted claim on 1/5/19 to allow: A7030 = 108.28
A7035 = 22.81
Was original claim repriced by HTH with no discount and reflected as Non-PPO?
HSB response: Yes. Original claim returned by HTH as non-par.

Ref. No. 032 Medical HSB claim no.

Underpayment - $75.00

Audited claim is for physician's charges:

DOS 11/26 77427 chg 571.00 allow 249.15

11/21-11/30 77014.26 x 5 days chg 199.00 ea allow 59.18 ea

$75.00 copay applied

Claim xxxxxx for hospital services is for 77336 & 77386. The $75.00 copayment was applied to each day of radiation treatment.

Should the $75.00 copay have been applied to the hospital claim or the audited claim for the same date of service with both for radiation treatment?

HSB response: No copay should only be applied once. Agree audited claim underpaid $75.00.

Ref. No. 082 Medical HSB claim no.

Underpayment - $1,166.04

S9480 chg 1000 ea allow 166.87 ea pd 83.49 ea

File reflects 45 billings from this provider originating on 2/26/18 through 4/4/19. All had significant discounting applied except claim xxxxxx DOS 7/3/18-7/9/18, S9480 x 4 charged 4000.00 allowed 3400.00 paid 1700.00

EOB states discount from same three Rivers Provider Network

Should claim xxxxxx have been paid at $333.96 versus $1700.00?

HSB response: Per Zelis (audited) claim xxxxx priced incorrectly – correct allowed $3400.00 & attached. Claim xxxxxx priced correctly.

HCA Note: Per attached both claims were priced by network at $3400.00 for four (4) dates of service.

Ref. No. 105 Medical HSB claim no.

Overpayment - $25.00

99214	chg 370.00	allow 241.00	pd 241.00	excess 129.00
96127-59	50.00	50.00	50.00	

Shouldn't $25 OV copay have been applied?

HSB response: Agree. Claim should have taken $25.00 copay.

Ref. No. 114 Outpatient Hospital HSB claim no.
Underpayment - $30.00
REV 305, CPT 85610 chg 58.00 allow 3.39 pd 3.39
761, 99212 209.00 93.84 93.84
Claim adjusted on 2/20/19 under xxxxxx to now pay as:
REV 305 allow 3.39 pd 3.39
761 93.84 copay 75.00 18.84
Appears to be taking "All Other (Non-Specialty) Imaging and Diagnostic Testing (including x-rays and ultrasounds) services provided in hospital outpatient setting" copay.
Charges are for lab (which has a $0 copay) and hospital outpatient treatment room. Please explain why claim was adjusted to take $75 copay as it appears audited claim was paid correctly.
(Note: Multiple claims in history for these services from this provider, some taking $75 copay, some taking $45 copay)
HSB response: $45.00 copay is correct as facility is billing 99212-OV.
UP $30.00 on Txxxxxx.

Ref. No. 149 Outpatient Hospital HSB claim no.
Overpayment - $75.00
76536.TC chg 818.00 allow 801.64 pd 801.64
Shouldn't the $75.00 copay have been applied?
HSB response: Agree. Claim should have taken $75.00 copay. OP $75.00.

Ref. No. 219 Medical HSB claim no.
Overpayment - $114.65
93000 chg 80.00 allow 32.37 pd 32.37
99204.25 340.00 82.28 82.28
Please explain why this claim paid at 100%. (OOP not met & related facility claim applied to deductible)
HSB response: Analyst error. Wrong category chosen. OP $114.65.

Ref. No. 220 Medical HSB claim no.
NOT charged in statistical calculation. Note to client for information only.
A6550 chg 89.70 allow/pd 31.47
A7000 153.00 7.30
This claim is for accessories for E2402 & was received 1/29/19
Claim xxxxxx is same DOS, same provider for E2402 (Neg press wound therapy electrical pump). Claim denied as not authorized. Charge 5278.69 and was received on 1/29/19.
Since pump denied as not authorized, shouldn't audited claim for pump accessories also be denied?
HSB response: Audited claim is for medical supplies and paid w/o auth because billed charges did not exceed $1000.00. No error.
HCA note: it is the auditor's opinion that if the pump was denied, all supporting materials of the pump should have also been denied.

Ref. No. 223 Outpatient Hospital HSB claim no.

NOT charged in statistical calculation. Note to client for information only.
REV 730, 93005.59 chg 443.79 allow/pd 332.84
Audited claim adjudicated with HTH network discount
Claim xxxxxx same provider & TIN, same DOS is being sent to Aetna for repricing. Charge 7756.63.
Shouldn't audited claim have also been sent to Aetna for repricing discounts?
HSB response: HTH priced both claims. Due to billed charges on biased Txxxxxx, claim sent to Aetna for pricing comparison. No error.

Ref. No. 229 Medical HSB claim no.

NOT charged in statistical calculation. Note to client for information only.
Claim is from provider Quest Labs. Numerous random claims are for Quest processed in late January & early February 2019. All were delayed for payment for SHO pricing correction. Was there a issue w/SHO contract pricing during this time? (Note: HCA ref nos. 225 – 231)
HSB response: Quest Diagnostics is dual contracted. Programming changed to not allow as SHO in error. This issue was corrected & reports ran to rework impacted claims. All adjustments completed prior to audit. No error.

Ref. No. 232 Medical HSB claim no.

NOT charged in statistical calculation. Note to client for information only.
99396 chg 259.00 allow/pd 118.00
Claim adjusted under xxxxxx on 3/25/19 to now pay as: allow/pd 55.68
Per Trns Msg "corrected fees"
Previous claim in 2017 claim xxxxxx DOS 9/2/17 same provider/service paid 55.68
Why was audited claim priced & paid at 118.00?
HSB response: We received an ACT form for this provider in Oct 2018. At that time the fee schedule was changed to manual in error. This caused the old pricing for provider to be used to price claim. This was corrected & reports ran to correct claims. These were adjusted prior to audit. No error.

Ref. No. 242 Medical HSB claim no.

NOT charged in statistical calculation. Note to client for information only.
Paid as: 11102 chg 203.84 allow 0.00 pd 0.00
99203 222.36 125.38 ded 125.38 pd 0.00
Claim adjusted on 3/1/19 under claim xxxxxx to now pay as:
11102 allow 113.47 ded 113.47
99203 125.38 125.38
Per Trns Msg: corrected HTH pricing received
Appears HTH repriced 11102 originally at $0?
HSB response: Yes HTH originally allowed $0. Corrected pricing received from HTH on report dated 2-28-19 to allow $113.47. See Txxxxxx.
No error.

Ref. No. 260 Medical HSB claim no.

NOT charged in statistical calculation. Note to client for information only.
Originally paid 1/4/19 under xxxxxx as:
96402 chg 95.00 allow 41.22 copay 41.22 pd 0.00
J1950 3500.00 1193.67 33.78 1159.89
75.00
Audited is adjusted claim to pay additional 101.34 – now pd as:
96402 allow 41.22 copay 41.22 pd 0.00
J1950 1295.01 33.78 1261.23
Appears HTH original repricing incorrect?
HSB response: HTH original pricing was incorrect. They corrected pricing on 1/7/19. No error.

Ref. No. 307 Outpatient Hospital HSB claim no.

NOT charged in statistical calculation. Note to client for information only.
Provider – Centennial Hills (Valley Health System)
Originally paid 2/5/18 under claim xxxxxx taking 65% discount:
ER allow 695.80 paid 556.64
Audited claim is adjustment on 2/19/19 to now pay with 66% discount:
ER allow 675.92 paid 540.74
When was HSB notified of contract change on these services?
HSB response: Final clarification was received 10/18/18.

Ref. No. 328 Outpatient Hospital HSB claim no.

Overpayment - $75.00
REV 920 CPT 93971 – RT Duplex scan of extremity veins unilateral or unlimited
Paid as: allow/paid 570.56
Appears to be Non-Specialty Imaging & Diagnostic Testing done in hospital outpatient setting. Shouldn't $75 copay have been applied?
HSB response: Agree. $75.00 overpaid.

Ref. No. 414 Medical HSB claim no.

Overpayment - $3,057.41
Claim originally paid 10/15/18 under xxxxxx paying as:
J1569 allow 3821.76 paid 3057.41
(Suspense Memo #3 shows AC = 3683.64)
Audited claim is adjustment to pay as:
J1569 allow 3683.25 at 100%
1) Since we had already paid 3057.41, shouldn't we have only paid an additional 625.84 on audited?
2) Why did we not used the allowed of 3683.64 on original processing?
HSB response: 1) Yes. 52) We should have used 3683.64 when claim originally processed, not 3821.76. Analyst error when claim for DOS 8/15/18 was reconsidered upon receipt of provider inquiry.

Ref. No. 495 Medical HSB claim no.

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

97010	chg 25.00	allow 11.12
97110	100.00	44.44
97140	100.00	44.44
	225.00	100.00 x 80% = 80.00 – prev pd 71.10 = 8.90

Original claim paid 71.10 on 11/12/18. Audited claim is adjustment to allow global fee of $100.00 on 3/27/19.
HSB response: Claim adjusted to allow 100.00 global fee making additional payment of 8.91. No error.

Ref. No. 505 Inpatient Hospital HSB claim no.

NOT charged in statistical calculation. Note to client for information only.
Provider – Sunrise Hospital
This inpatient hospital claim repriced as:
DRG 229 (day 1-6) = 52,733.00
Add'l days 12 x 2965 = 35,580.00
Rev 278, 8217 x 40% = 3286.80
Rev 390, 4893 x 20% = 978.60
Rev 636, 23,459 x 40% = 9383.60
101,962.00 – 500 copay = 101,462.00 pd 2/1/19
Contract states: Pediatric rates when DRG 229 with revenue code 203 are present on bill/UB: Other Cardiothoracic (MS-DRG 229) is 37% of billed charges. Should allowable have been:

Carve outs: Rev 278, 8217.00 x 40% = 3286.80
390, 4893.00 x 20% = 978.60
636, 23459.00 x 40% = 9383.60
36,569.00
Balance 1,280,129.00 x 37% = 473,647.73
487,296.73
Should allowable have been 487,296.73 versus 101,962.00?
(Note: MSI repriced 2/1/19)
HSB response: Pediatric Cardiology rates were not applied to pricing. We had received call on 3/26/19 prior to audit and were working with HTH on getting corrected pricing to correct the claim. Corrected pricing was received on 4/4/19, validated and claim reprocessed on 4/17/19.

27 Corporate Hill
Little Rock, AR 72205

May 10, 2019

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

Subject: Audit Results January 1, 2019 – March 31, 2019

Dear Public Employees' Benefits Program (PEBP) Board:

HealthSCOPE Benefits appreciates the opportunity to respond to the audit performed by Health Claim Auditors for the third quarter of Plan Year 2019. The audit included 500 claims with paid amounts totaling $273,007.02

HealthSCOPE Benefits is extremely disappointed to have missed the financial accuracy percentage for this audit period. We take the quality of our work very seriously and strive for perfection.

We continue to review quality improvement opportunities within our organization and our vendor partners. Based on our review, we have implemented the following quality control measures:

Item (1)
HealthSCOPE Benefits will conduct training classes and continuing education courses for the Claims staff to continue to stress quality goals and review of provider billing practices.

Item (2)
HealthSCOPE Benefits has requested an internal audit on the EPO Premier Plan copay structure and we will make the appropriate benefit programming changes based on the outcome of our Quality Assurance audit.

We are very pleased with cost containment measures we are able to provide on the PEBP account. We saved PEBP an additional $1.6M through non-network negotiations, subrogation, clinical edits and transplant savings in the third quarter of Plan Year 2019.

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

Sincerely,

Mary Catherine Person
President & Co-CEO

6.

6. Discussion and possible action to allow and approve PEBP to finalize Plan Year 2020 rates and participant premiums upon final decision by the Nevada Legislature to approve employer contributions (subsidy) at PEBP's budget closing hearing. (Damon Haycock, Executive Officer) (For Possible Corrective 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: April 29, 2019

Item Number: VI

Title: Finalizing Plan Year 2020 Rates and Premiums

REPORT

LEGISLATURE APPROVED CONTRIBUTIONS (SUBSIDY)

The Nevada Legislature is scheduled to approve PEBP's biennial budget for Fiscal Year 2020 and 2021 in subcommittee on May 1, 2019 and full committee on May 4, 2019. There are still decisions to make on the employer contribution (subsidy) which will affect the participant premiums starting July 1, 2019.

The PEBP Board approved Plan Year 2020 rates and premiums at the March 28, 2019 Board meeting. The Board also approved PEBP to make "technical adjustments" to those rates as needed.

PEBP's budget must be approved by the Legislature. Therefore, PEBP requests the Board designate legislative budget approval as a "technical adjustment" allowing PEBP to revise Plan Year 2020 rates and premiums in accordance with legislative appropriations.

RECOMMENDATION

PEBP recommends the Board authorize PEBP to make technical adjustments to the Plan Year 2020 rates and premiums based on legislative decision-making on PEBP's Fiscal Year 2020 budget.

7.

7. Discussion and possible action to delay the start of Open Enrollment from May 1st, 2019 to May 20th, 2019 and extend the end of Open Enrollment from May 31st, 2019 to June 7th, 2019 for Plan Year 2020 (July 1, 2019 – June 30, 2020). (Damon Haycock, Executive Officer) (For Possible Corrective Action)

STEVE SISOLAK
Governor

Deonne E. Contine
Board Chair

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DAMON HAYCOCK
Executive Officer

AGENDA ITEM

[X] Action Item
[ ] Information Only

Date: April 29, 2019

Item Number: VII

Title: Revising Open Enrollment for Plan Year 2020

REPORT

DELAYING & EXTENDING PY2020 OPEN ENROLLMENT

The Nevada Legislature is scheduled to approve PEBP's biennial budget for Fiscal Year 2020 and 2021 in subcommittee on May 1, 2019 and full committee on May 4, 2019. There are still decisions to make on the employer contribution (subsidy) which will affect the participant premiums starting July 1, 2019.

Per NRS 287.043:
In establishing and carrying out the Program, the Board shall:

1. Provide public notice in writing of any proposed changes in rates or coverage to each participating public agency that may be affected by the changes. Notice must be provided at least 30 days before the effective date of the changes.
2. If a proposed change is a change in the premium or contribution charged for, or coverage of, health insurance, provide written notice of the proposed change to all participants in the Program. The notice must be provided at least 30 days before the date on which a participant in the Program is required to select or change the participant's policy of health insurance.

Current policy specifies Open Enrollment to occur between May 1st – 31st each year. Due to the statutory requirements for 30 day noticing, PEBP would need to post and notice rate changes no later than May 1, 2019. Therefore, PEBP is recommending the Open Enrollment time frame be altered this year to allow for the following:

1. Legislature approval of PEBP's employer contribution (subsidy) on May 1 and May 4, 2019
2. Posting and noticing of final rates and participant premiums no later than May 8 (30 days prior to June 7 end of Open Enrollment)
3. Loading and testing rates within PEBP's eligibility system May 4 – May 19, 2019

4. Plan Selection for participants May 20 – June 7, 2019
5. Supporting Documentation due to PEBP by June 15, 2019
6. PEBP processing of enrollments from May 20 – third week of June
7. Vendors receive enrollment files third week of June
8. Vendors enroll members and setup HSA/HRA funding for July 1

RECOMMENDATION

PEBP recommends revising Open Enrollment this year to May 20, 2019 – June 7, 2019.

8.

8. Discussion and possible action regarding approval of PEBP contract amendments beginning Plan Year 2021 (July 1, 2020):

   8.1 Extend the HealthSCOPE Benefits contract to provide Flexible Spending Account (FSA) services for an additional 2 years through June 30, 2022.

   8.2 Extend the Unum contract to provide voluntary long-term care services for an additional 4 years through June 30, 2024; assess if Unum can join PEBP's voluntary platform through PEBP's vendor; or allow the Unum contract to expire without renewal on June 30, 2020.

   (Cari Eaton, Chief Financial Officer)(For Possible Action)

8.1.

8. Discussion and possible action regarding approval of PEBP contract amendments beginning Plan Year 2021 (July 1, 2020):

   8.1. Extend the HealthSCOPE Benefits contract to provide Flexible Spending Account (FSA) services for an additional 2 years through June 30, 2022.

   (Cari Eaton, Chief Financial Officer)(For Possible Action)

STEVE SISOLAK
Governor

Deonne Contine
Board Chair

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Expires 04/01/2021

DAMON HAYCOCK
Executive Officer

AGENDA ITEM

[X] Action Item
[ ] Information Only

Date: May 23, 2019

Item Number: VIII.I

Title: Contract Extension Opportunities

SUMMARY

The purpose of this report is to request the Board's approval for a 2-year extension to the HealthSCOPE Benefits (Flexible Spending Account) contract.

REPORT

HEALTHSCOPE BENEFITS VOLUNTARY FSA SERVICES

PEBP entered into a 4-year contract with HealthSCOPE Benefits for voluntary Flexible Spending Account (FSA) services effective July 1, 2013 resulting from RFP # 3028. This contract has been extended through June 30, 2020. PEBP staff has negotiated a 2-year contract extension and reduction to FSA participant paid fees from $3.25 PEPM to $3.15 PEPM. The reduction of fees will be effective July 1, 2020 through the extended contract term of June 30, 2022.

RECOMMENDATION

PEBP recommends the Board authorize staff to complete a contract amendment between PEBP and HealthSCOPE Benefits for FSA services in contract # 14465 to reduce fees and extend through June 30, 2020.

8.2.

8. Discussion and possible action regarding approval of PEBP contract amendments beginning Plan Year 2021 (July 1, 2020):

   8.2. Extend the Unum contract to provide voluntary long-term care services for an additional 4 years through June 30, 2024; assess if Unum can join PEBP's voluntary platform through PEBP's vendor; or allow the Unum contract to expire without renewal on June 30, 2020.

   (Cari Eaton, Chief Financial Officer)(For Possible Action)

STEVE SISOLAK
Governor

Deonne Contine
Board Chair

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DAMON HAYCOCK
Executive Officer

AGENDA ITEM

[X] Action Item
[ ] Information Only

Date: May 23, 2019

Item Number: VIII.II

Title: Contract Extension Opportunities

SUMMARY

The purpose of this report is to request the Board's input and review possible contract opportunities for the UNUM Provident Corporation contract.

REPORT

UNUM VOLUNTARY LONG-TERM CARE (LTC) SERVICES

PEBP entered into a 6-year contract with UNUM for voluntary Long-Term Care (LTC) services effective June 12, 2014 resulting from a solicitation waiver. PEBP has had multiple contracts with UNUM since 2003. UNUM is working with Morneau and Corestream to be able to join the Voluntary Benefit Platform.

UNUM needs more time to determine if the transition to the Voluntary Benefit Platform is feasible. Staff has identified some potential options for the future of the UNUM contract:

1. Give UNUM more time to determine ability to join the Voluntary Benefit Platform and provide the Board with an update and recommendation at the September 26, 2019 board meeting.
2. Extend the UNUM contract for an additional 4 years through June 30, 2024. If UNUM is able to join the Voluntary Benefit Platform, cancel the contract at that time.
3. Cancel the contract effective June 30, 2020 even if UNUM is not able to join the Voluntary Benefit Platform. This will affect nearly 350 members that are accessing LTC services.

RECOMMENDATION

PEBP recommends the Board select Option 1 or Option 2 above to continue providing voluntary long-term care services to PEBP members.

9.

9. Update on PEBP's Fiscal Year 2020/2021 Budget Closing hearings at the 80th Legislative Session. (Cari Eaton, Chief Financial Officer) (Information/Discussion)

STEVE SISOLAK
Governor

Deonne Contine
Board Chair

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DAMON HAYCOCK
Executive Officer

AGENDA ITEM

☐ Action Item
☒ Information Only

Date: May 23, 2019

Item Number: IX

Title: Fiscal Year 2020 and 2021 Budget Closing Report

SUMMARY

The purpose of this report is to address the budget closing as recommended and approved by the Assembly Committee on Ways and Means and Senate Committee on Finance, Subcommittees on General Government and the Joint Committee of the Assembly Ways and Means and Senate Committee on Finance for Fiscal Years 2020 and 2021.

REPORT

The Subcommittees on General Government met on May 1, 2019 to discuss the closing of the Public Employees' Benefits Program (PEBP) budget. The subcommittee discussed several modifications to the PEBP budget; however, they took no action. The Assembly Committee on Ways and Means and Senate Committee on Finance met on May 6, 2019 and closed the PEBP budget with several modifications to the Governor's Recommended Budget. Those modifications are discussed below:

HSA/HRA CONTRIBUTIONS (CDHP)

The Governor's Recommended Budget included a $400 supplemental HSA/HRA contribution in FY20 and a $100 supplemental HSA/HRA contribution in FY21. The PEBP Board approved the $400 supplemental HSA/HRA contribution at the January 24, 2019 meeting. The contribution was approved for members to receive $200 with no requirements, $100 tied to preventive programs, and $100 tied to enrolling in Dr. on Demand and Healthcare Bluebook to be consistent with FY19.

The Assembly Committee on Ways and Means and Senate Committee on Finance voted to approve the $400 supplemental HSA/HRA contribution in FY20 to be funded by excess reserves without a requirement to complete activities to receive the additional funding as recommended by the Governor. The Assembly Committee on Ways and Means and Senate Committee on

Finance also voted to approve a supplemental HSA/HRA contribution in FY21 in the amount of $125 as included in the Governor's budget amendment.

Medicare Exchange HRA Contribution

The Assembly Committee on Ways and Means and Senate Committee on Finance voted to approve a Medicare Exchange HRA contribution in the amount of $13.00 per month per year of service for FY20 and FY21. This is consistent with the Governor's Recommended budget, Board approval and PEBP's original budget submission.

Employer Contribution

The PEBP Board set PY20 rates at the March 28, 2019 board meeting. Rates were set utilizing state contribution percentages that were higher than the percentages recommended in the Governors Recommended budget. The Assembly Committee on Ways and Means and Senate Committee on Finance were given several options and ultimately voted to set the State contribution percentages as outlined below.

Contribution Percentages				
	PY20 PEBP Board Approved (March 28, 2019)		PY20 & PY21 Committee Approved (May 6, 2019)	
Participant Type	**CDHP**	**HMO/EPO**	**CDHP**	**HMO/EPO**
State Active (Primary)	95.1%	82.6%	95%	83%
State Active (Dependent)	75.1%	62.6%	75%	63%
State Retiree (Non-Medicare 15YOS)	66.4%	53.9%	66%	54%
State Retiree (Non-Medicare Retiree Dependent)	46.4%	33.9%	46%	34%

The State contribution percentages determine the total state contribution revenue needed and are the basis for the Active Employee Group Insurance (AEGIS) and Retired Employee Group Insurance (REGI) amounts that were approved by the Assembly Committee on Ways and Means and Senate Committee on Finance as outlined below.

AEGIS & REGI Employer Contribution					
	FY 2020			FY 2021	
	Gov Rec	**Board Approved**	**Committee Approved***	**Gov Rec**	**Committee Approved***
AEGIS	$757.83	$747.75	$763.76	$785.63	$783.30
REGI	$522.68	$546.70	$553.78	$470.20	$478.15

**These figures will change slightly as technical adjustments are made. PEBP and LCB reviewed the rates and found slight changes were necessary.*

The State contribution percentages and AEGIS and REGI amounts affect the member premiums. The member premium changes are outlined below.

State Active Employees	Statewide PPO		Statewide HMO/EPO	
	Consumer Driven Health Plan		PEBP Premier Plan and HPN Plan	
Tier	PEBP Board Approved	Committee Approved	PEBP Board Approved	Committee Approved
Employee Only	31.73	30.95	137.31	137.47
Employee + Spouse	156.04	160.01	415.64	415.95
Employee + Child (ren)	82.41	82.97	274.84	275.84
Employee + Family	206.72	212.02	553.17	554.32

State & Non-State Retirees	Statewide PPO		Statewide HMO/EPO	
	Consumer Driven Health Plan		PEBP Premier Plan and HPN Plan	
Tier	PEBP Board Approved	Committee Approved	PEBP Board Approved	Committee Approved
Employee Only	199.56	203.33	354.17	362.56
Employee + Spouse	470.33	482.10	846.09	859.32
Employee + Child (ren)	309.96	315.68	597.24	609.39
Employee + Family	580.72	594.45	1,089.16	1,106.15

Note: Retiree rates shown above reflect 15 years of service.

BASE BUDGET ADJUSTMENTS

Minor amendments to the Governor's Recommended Budget were recommended and approved by the Assembly Committee on Ways and Means and Senate Committee on Finance as outlined below.

a. Medicare Exchange Retiree costs (HRA administration fees and Life Insurance premiums) were put back into the budget in FY20 and FY21.
b. Medicare Premium Credits were approved at $135.50 per month for FY20 and FY21.

PLAN INFLATION/TREND ADJUSTMENTS

The Assembly Committee on Ways and Means and Senate Committee on Finance approved adjustments to plan trend and inflation in both years of the biennium.

FY 2020 (as compared to FY2019)
Medical – Decreased from 3.7% to 1.63%
Prescription – Increased from 3.7% to 16.9%
Dental – Decreased from 3% to 0.13%
HMO/EPO – Remains the same at 3.7%

FY 2021 (as compared to FY2019)
Medical – Decreased from 7.5% to 5.33%
Prescription – Increased from 7.5% to 20.61%

Dental – Decreased from 6% to 3.13%
HMO/EPO – Decreased from 7.5% to 7.4%

PLAN ENROLLMENT ADJUSTMENTS

The Assembly Committee on Ways and Means and Senate Committee on Finance approved adjustments to enrollment due to updated projections.

State active employee enrollment is projected to increase by 1,062 individuals, or 4% to 27,644 over the biennium when compared to FY19 enrollments of 26,582. Non-Medicare eligible state retirees, who are enrolled in either the CDHP, HMO, or EPO, are projected to increase by 230, or 5.7% from 4,067 to 4,297.

Non-state active employee enrollments are projected to remain at 8 employees in each fiscal year. Non-state non-Medicare retiree enrollments are projected to decrease by 305 or 24.9% over the biennium to 922 by the end of FY21.

The state retirees who become Medicare-eligible and enroll in the Medicare Exchange are projected to increase by 853 retirees, or 12% from 7,133 in FY19 to 7,986 by the end of FY21. The non-state retirees who become Medicare-eligible and enroll in the Medicare Exchange are projected to increase by 189 retirees, or 3.6% from 5,275 in FY19 to 5,464 by the end of FY21.

BUDGET ENHANCEMENTS

The Assembly Committee on Ways and Means and Senate Committee on Finance approved enhancements to the budget as outlined below.

a. Funding for replacement equipment totaling $211,430 over the biennium.
b. Reclassification of the unclassified Financial Analyst position to a classified Administrative Services Officer 2 position effective October 1, 2019.

PLAN RESERVE LEVELS

The Assembly Committee on Ways and Means and Senate Committee on Finance approved adjustments to PEBP reserve categories as outlined below.

Plan Reserve Levels			
Reserve Category	**FY 2019 (YTD)**	**FY 2020**	**FY 2021**
HRA Reserves	$31.7 M	$33.8 M	$33.9 M
IBNR Reserves	$51.8 M	$54.4 M	$57.5 M
Catastrophic Reserves	$39.9 M	$42.8 M	$45.8 M
Excess Reserves	$23 M	$9 M	$0.5 M
Total Reserves	$146.4 M	$140 M	$137.7 M

EXCESS RESERVE AUTHORITY

The Assembly Committee on Ways and Means and Senate Committee on Finance voted to approve back language in the Authorization Act requiring PEBP to obtain Interim Finance Committee (IFC) approval prior to any allocation of excess reserves, projected or otherwise budgeted, regardless of purpose.

Conclusion

Further modifications to PEBP's budget will be made through technical adjustments as the money committees make final decisions regarding statewide cost allocations, pay raises, and draft and pass the appropriate enabling legislation to carry out the provisions of the budget.

10.

10. Discussion and possible action regarding American Cancer Society age and frequency recommendations for colonoscopies and the United States Preventive Services Task Force (USPSTF) age and frequency guidelines for mammograms for both the Consumer Driven Health Plan (CDHP) and Exclusive Provider Organization (EPO) plans for Plan Year 2020. (Nancy Spinelli, Quality Control Officer) (For Possible Action)

STEVE SISOLAK
Governor

Deonne Contine
Board Chair

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DAMON HAYCOCK
Executive Officer

AGENDA ITEM

[X] Action Item
[ ] Information Only

Date: May 23, 2019

Item Number: X

Title: Plan Year 2020 Preventive/Wellness Mammogram and Colonoscopy Screening Benefits

Summary

This report contains additional information regarding mammogram and colonoscopy screening wellness benefit for Plan Year 2020, as requested by the Board at the March 28, 2019 meeting.

Report

At the March 28, 2019 Board meeting, staff presented a summary of the recommended changes for the Plan Year 2020 Consumer Driven Health Plan (CDHP) and Premier EPO Plan (EPO) Master Plan Documents (MPD).

1. The Board requested clarification on the United States Preventive Services Task Force recommendation for screening mammograms.

Breast cancer screening	The USPSTF recommends screening mammography for women, with or without clinical breast examination, every 1 to 2 years for women age 40 years and older	B	September 2002†

Website: United States Preventive Services Task Force 2002 Release Date for breast cancer screening:
https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/#dag

Plan Year 2020 CDHP and Premier EPO Plan MPD as revised

The first 2-D or 3-D mammogram of the Plan Year is covered at 100% for women age 40 years and older, regardless of diagnosis, when performed in-network and in accordance with the U.S. Preventive Services Task Force and Section 2713(a)(5) of the Public Health Service Act and Section 9(h)(v)(229) of the 2015 Consolidated Appropriations Act, and the 2002 recommendation available at: https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/#dag

2. The Board requested clarification on the American Cancer Society's (AMS) colonoscopy screening recommendation.

The ACS qualified recommendation states adults age 45 and older with average risk of colorectal cancer should undergo screening at an interval of every 10 years. The ACS does not indicate a beginning age for individuals with high risk for colorectal cancer.

Staff, in collaboration with HealthSCOPE Benefits, proposed colonoscopy screening for individuals with high risk factors at age 40 to be covered under the wellness/preventive benefit.

Website: American Cancer Society Screening Guideline
https://www.cancer.org/content/dam/cancer-org/online-documents/en/pdf/infographics/colorectal-cancer-screening-guideline-for-men-and-women-at-average-risk.pdf

Plan Year 2020 CDHP and Premier EPO Plan MPD as revised

Colorectal cancer screening tests: covered at 100%, when provided in-network for adults aged 45 years and older who are at average risk of colorectal cancer in accordance with the American Cancer Society's qualified recommendations; or beginning at age 40 for members with a high-risk of colorectal cancer. For more information regarding colorectal screening guidelines, contact HealthSCOPE Benefits.

Recommendation

Staff requests Board approval for the revisions as presented at the March 28, 2019 Board meeting for mammogram and colonoscopy wellness/preventive screenings.

11.

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

STEVE SISOLAK
Governor

Deonne E. Contine
Board Chair

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DAMON HAYCOCK
Executive Officer

AGENDA ITEM

☐ Action Item

☒ Information Only

Date: May 23, 2019

Item Number: XI

Title: Executive Officer Report

SUMMARY

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

REPORT

ELIMINATION OF PY2020 ENHANCED HSA/HRA FUNDING REQUIREMENTS

As mentioned in the Budget Closing Report, The PEBP Board approved requirements to access HSA/HRA enhanced funding for Plan Year 2020 have been eliminated by the Legislature. These requirements include:

1. Annual preventive medical visit
2. Annual lab work
3. Annual preventive dental visit
4. A minimum of one annual teeth cleaning
5. Enrollment in Doctor on Demand, PEBP's telemedicine virtual visit provider
6. Completion of the online tour of Healthcare Bluebook, PEBP's online transparency provider

PEBP will continue to monitor utilization of these services and provide comparisons next year showing the impact of this decision.

INTERIM FINANCE COMMITTEE APPROVAL OF EXCESS RESERVE EXPENDITURES

PEBP's budget closed at the Assembly Committee on Ways and Means and Senate Finance Committee on May 6, 2019. Both committees approved language in the Authorizations Act requiring PEBP to "obtain Interim Finance Committee (IFC) approval prior to any allocation of excess reserves, projected or otherwise budgeted, regardless of purpose."

This adds an additional step to Plan Benefit Design Board approval and eliminates PEBP's ability to recommend, and the Board to approve, the use of excess reserves at the annual March rate setting meeting. It also prevents PEBP and the Board from adding requirements to the use of excess reserves unless IFC approves beforehand.

PEBP follows a traditional cyclical process each year, and with the new requirement to obtain IFC approval for excess reserve use, the process will change. PEBP will need to build in additional time sensitive steps to ensure the Board can recommend to the IFC the use(s) for excess reserves for the next plan year. Pending IFC agenda deadlines, PEBP may have 1 or 2 opportunities to gain IFC approval on excess reserves each year (January and/or March) for implementation July 1.

PEBP Wins Organization of the Year Again

On May 1, 2019, PEBP was informed we were selected from nominations nationwide as winner of a top-ranking award from the 17th annual American Business Awards. PEBP received a Gold Stevie Award for Organization of the Year – Non-Profit or Government – Large for a second year in a row. We are proud of the recognition and are excited to showcase Nevada again as a national leader in organizational accomplishments across both the public and private sector.

12.

12. Discussion and possible action regarding potential Board position, recommendations, and direction to staff about 2019 Legislative Bills that may impact PEBP, including the following:

    * Assembly Bill 185

    * Assembly Bill 469

    (Damon Haycock, Executive Officer) (For Possible Action)

PEBP Legislative Tracking
80th Legislative Session

Bill Number & Description	Impact to PEBP	Bill Status
AB185 (BDR 57-277) Providing for a study concerning certain health benefits. This bill proposes the following changes: • Requires the Board of the Public Employees' Benefits Program to conduct a study during the 2019-2021 interim concerning establishing pricing for the health benefits of public employees that is based on pricing for Medicare benefits. • The study must include, without limitation, consideration of the coverage and pricing of prescription drugs by Medicare and whether establishing Medicare-based pricing is beneficial for the employees of this State. • The Board shall utilize the staff of the Program to conduct the study. • On or before January 1, 2021, the Board shall submit a report of its findings and any recommendations to: (a) The Office of Finance in the Office of the Governor; and (b) The Director of the Legislative Counsel Bureau for transmittal to the 81st Session of the Nevada Legislature. **Effective Date:** July 1, 2019.	Requiring PEBP to conduct a study of the impact of using Medicare-based pricing. PEBP will need to work with our partners to reprice claims against Medicare allowable charges and develop a report for the Legislature. **Board Position** Neutral **Fiscal Note** When PEBP was asked about the potential costs of this study, the Board still maintained authority to utilize excess reserves. PEBP is confident there will be excess reserves to conduct this study and will need to get IFC approval after session.	2/18/19: Read first time. Referred to Committee on Commerce and labor. To Printer 2/19/19: From printer. To committee. 4/12/19: Amend, and do pass as amended. 4/22/19: From committee: Amend, and do pass as amended. Placed on Second Reading File. Notice of eligibility for exemption. Read second time. Amended (Amendment No. 503) Re-referred to Committee on Ways and means. Exemption effective. To printer. 4/23/19: From printer. To engrossment. Engrossed. First reprint. To committee.

PEBP Legislative Tracking
80th Legislative Session

Bill Number & Description	Impact to PEBP	Bill Status
AB469 (BDR 40-704) Revises provisions governing billing for certain medically necessary emergency services. The bill proposes the following changes: • Prohibits an out-of-network provider from charging a person covered by a policy of health insurance an amount for medically necessary emergency services that exceeds the copayment, coinsurance or deductible required by that policy. • Requires an out-of-network facility that provides medically necessary emergency services to a covered person to: notify the third party that provides coverage for the person that the person is receiving such services at the facility; and transfer the covered person to an in-network facility not later than 24 hours after the person's emergency medical condition is stabilized. • If an out-of-network provider did not have a contract as with the third party that provides coverage for the covered person as an in-network provider during that time, section 15 requires the third party to pay the provider an amount that the third party has determined to be fair and reasonable as payment for the medically necessary emergency services. If the provider does not accept the offer, section 15 requires the parties to submit the dispute to binding arbitration. • Amendment added changing it so PEBP is not required to pay doctors who terminate contracts the 109% and 115% and at most will pay the medical component of CPI, which today it is 2.3% unless PEBP (or its networks) terminate the provider contract for no-cause. • Section 18 was amended as a "may elect for the provisions of sections 2 to 19" for NRS 287.04052 and any other local	Amendment 587 approved April 22 provided further protections to plans like PEBP to ensure emergency providers do not terminate contracts for guaranteed increases in reimbursements. With this amendment, PEBP believes the risk of higher reimbursements is minimal while the advantage to protect member balance billing is significant. Furthermore, Amendment 694 approved May 13 added language allowing PEBP (and other entities) the ability to opt-in / opt-out of the requirements of this bill. PEBP believes there are only positive impacts remaining. **Board Position** Neutral. **Fiscal Note** Cannot be determined. (Previous fiscal note pulled due to change in amendments.)	3/25/19: Read first time. Referred to Committee on Health and Human Services. 4/12/19: Amend, and do pass as amended. 4/22/19: From committee: Amend, and do pass as amended. Placed on Second Reading File. Read second time. Amended. (Amend. No. 587.) To printer. 4/23/19: From printer. To engrossment. Engrossed. First reprint. Read third time. Passed, as amended. Title approved, as amended. (Yeas: 38, Nays: 3, Excused: 1.) To Senate. 4/24/19: In Senate. Read first time. Referred to Committee on Health and Human Services. To committee.

governmental agency which provides a system of health insurance. **Effective Date:** January 1, 2020		5/13/19: From committee. Amend, and do pass as amended. Placed on Second Reading File. Read second time. Amended. (Amendment No. 694) To printer. 5/14/19: From printer. To re-engrossment. Re-engrossed. Second reprint. Read third time. Passes, as amended. Title approved. (Yeas: 21, Nays: None.) To Assembly. In Assembly. Senate Amendment No. 694 concurred in. To enrollment. 5/15/19: Enrolled and delivered to Governor.

13.

13. Public Comment

14.

14. Adjournment