STEVE SISOLAK
Governor

LAURA FREED
Board Chair

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

ACCREDITED
CORE
Expires 04/01/2021

LAURA RICH
Executive Officer

MEETING NOTICE AND AGENDA

Name of Organization:	Public Employees' Benefits Program Board
Date and Time of Meeting:	November 23, 2020 9:00 a.m.
Place of Meeting:	Pursuant to the Governor's Emergency Directives 006, and 029, this meeting will be conducted via video- and tele-conference only. This meeting can be viewed live over the Internet on the PEBP YouTube channel at https://youtu.be/ir-eaoCDRV8

Members of the public are encouraged to submit public comment in writing by emailing wlunz@peb.nv.gov at least two business days prior to the meeting.

To listen to and view the PEBP Board Meeting please click on the YouTube Link located in "Place of Meeting" field above.

There are two agenda items designated for public comment. If you wish to provide verbal public comment during those agenda items, please follow the instructions below:

Option #1 **Join the webinar as an attendee https://zoom.us/j/94593766075 . This link is only for those who want to make public comment. If you are just listening to the webinar, please use the YouTube Link located in the "Place of Meeting" field above.**

Option #2 **Dial: (669) 900-6833. When prompted to provide your Meeting ID, please enter: 945 9376 6075 then press #. When prompted for a Participant ID, please enter #.**

Participants that call in will be muted until it is time for public comment. A moderator will then unmute callers one at a time for public comment.

To resolve any issues related to dialing in to provide public comment for this meeting, please call (775) 684-7016 or email wlunz@peb.nv.gov

Meeting materials can be accessed here: https://pebp.state.nv.us/meetings-events/board-meetings/

AGENDA

1. Open Meeting; Roll Call

2. Public Comment

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

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

4. Consent Agenda (Laura Freed, 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 September 24, 2020 PEBP Board Meeting.

   4.2 Health Claim Auditors, Inc. quarterly audit of HealthSCOPE Benefits for the timeframe July 1, 2020 – September 30, 2020: (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.

   4.3 Health Claim Auditors, Inc. annual audit of Willis Towers Watson's OneExchange for the timeframe July 1, 2019 – June 30, 2020: (1) Report from Health Claim Auditors; (2) Willis Towers Watson's response to audit report; and (3) for possible action to accept audit report findings and assess penalties, if applicable, in accordance with the performance guarantees included in the contract pursuant to the recommendation of Health Claim Auditors.

   4.4 Receipt of the PEBP Biennial Legal Compliance Review report performed by Aon.

   4.5 Receipt of the Casey, Neilon & Associates Audited Financial Statements of PEBP for Fiscal Year 2020.

5. Discussion and possible action to approve a 6-year contract beginning January 1, 2022 with LSI for an Enrollment and Eligibility Benefits System. Pursuant to NRS 287.04345(4), the PEBP Board may close a portion of this item to review the results of the evaluation of proposals for the contract; no action will be taken during any closed portion of the session (Cari Eaton, Chief Financial Officer)**(For Possible Action)**
6. Discussion and possible action to approve American Health Holding contract amendment addressing temporary ownership of toll-free number. (Cari Eaton, Chief Financial Officer)**(For Possible Action)**
7. Executive Officer Report (Laura Rich, Executive Officer) (Information/Discussion)
8. Discussion and possible action regarding Plan Year 2022 Plan Design Recommendations (July 1, 2021 – June 30, 2022) and FY22/23 Budget Reserve Proposals. Including but not limited to the following: (Laura Rich, Executive Officer) **(All Items for Possible Action)**
    - 8.1 Core Plan Design of CHDP, EPO and Low Deductible Plans
    - 8.2 Possible Changes to Payments of Out-of-Network Billed Charges
    - 8.3 Possible Implementation of Smart 90 to EPO
    - 8.4 Possible Implementation of Express Advantage Network to CHDP, EPO, and Low Deductible Plan.
    - 8.5 Possible Reductions to Medicare Health Reimbursement Arrangement (HRA) contributions.
    - 8.6 Possible Reductions in or Elimination of Basic Life Insurance Benefit
    - 8.7 Possible Reductions in or Elimination of Long-Term Disability Benefit
    - 8.8 Possible Elimination of Medicare Part B Subsidy
    - 8.9 Possible Elimination of Retiree Dependent Subsidies
    - 8.10 Possible Unbundling of Dental Premium
    - 8.11 Possible Increases in Premiums to Achieve Necessary Budget Reserve Requirements
    - 8.12 Possible Transition of Non-Medicare Retirees to the Silver State Health Insurance Exchange
9. 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.

10. 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/meetings-events/board-/meetings (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.
We are pleased to make reasonable efforts to assist and accommodate persons with physical disabilities who wish to participate in the meeting. If special arrangements for the meeting are necessary, please notify the PEBP in writing, at 901 South Stewart Street, Suite 1001, Carson City, NV 89701, or call Wendi Lunz at (775) 684-7020 or (800) 326-5496, as soon as possible so that reasonable efforts can be made to accommodate the request.
Copies of both the PEBP Meeting Action Minutes and Meeting Transcripts, if such transcripts are prepared, are available for inspection, at no charge, at the PEBP Office, 901 South Stewart Street, Suite 1001, Carson City, Nevada, 89701 or on the PEBP website at www.pebp.state.nv.us. For additional information, contact Wendi Lunz at (775) 684-7020 or (800) 326-5496.
Notice of this meeting was posted on or before 9:00 a.m. on the third working day before the meeting on the PEBP website at www.pebp.state.nv.us, and also posted to the public notice website for meetings at https://notice.nv.gov. In addition, the agenda was mailed to groups and individuals as requested.

1.

1. Open Meeting; Roll Call

2.

2. Public Comment

3.

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

4.

4. Consent Agenda (Laura Freed, 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 September 24, 2020 PEBP Board Meeting.

   4.2 Health Claim Auditors, Inc. quarterly audit of HealthSCOPE Benefits for the timeframe July 1, 2020 – September 30, 2020: (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.

   4.3 Health Claim Auditors, Inc. annual audit of Willis Towers Watson's OneExchange for the timeframe July 1, 2019 – June 30, 2020: (1) Report from Health Claim Auditors; (2) Willis Towers Watson's response to audit report; and (3) for possible action to accept audit report findings and assess penalties, if applicable, in accordance with the performance guarantees included in the contract pursuant to the recommendation of Health Claim Auditors.

   4.4 Receipt of the PEBP Biennial Legal Compliance Review report performed by Aon.

   4.5 Receipt of the Casey, Neilon & Associates Audited Financial Statements of PEBP for Fiscal Year 2020.

4.1

4. Consent Agenda (Laura Freed, Board Chair) (**All Items for Possible Action**)

4.1 Approval of Action Minutes from the September 24, 2020 PEBP Board Meeting.

STATE OF NEVADA
PUBLIC EMPLOYEES' BENEFITS PROGRAM
BOARD MEETING

Video/Telephonic Open Meeting
Carson City and Las Vegas, NV

ACTION MINUTES (Subject to Board Approval)
September 24, 2020

MEMBERS PRESENT VIA TELECONFERENCE:	Ms. Laura Freed, Board Chair Ms. Linda Fox, Vice Chair Ms. Michelle Kelley, Member Mr. Don Bailey, Member Mr. Tom Verducci, Member Mr. David Smith, Member Ms. Jennifer Krupp, Member Ms. Betsy Aiello, Member Dr. Marsha Urban, Member
FOR THE BOARD:	Ms. Brandee Mooneyhan, Deputy Attorney General
FOR STAFF:	Ms. Laura Rich, Executive Officer Mr. Nik Proper, Operations Officer Ms. Cari Eaton, Chief Financial Officer Mr. Brett Harvey, Chief Information Officer Ms. Nancy Spinelli, Quality Control Officer Ms. Wendi Lunz, Executive Assistant

1. Open Meeting; Roll Call

    - Board Chair Freed opened the meeting at 9:00 a.m.

2. Public Comment
    - Kent Ervin – Nevada Faculty Alliance
    - Kevin Ranft – AFSCME
    - Priscilla Maloney – AFSCME
    - Marlene Lockard – RPEN

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

4. Consent Agenda (Laura Freed, Board Chair) (**All Items for Possible Action**)

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

    4.1 Approval of Action Minutes from the July 23, 2020 PEBP Board Meeting

    4.2 Receipt of quarterly staff reports for the period ending June 30, 2020:

        4.2.1 Budget Report

        4.2.2 Utilization Report

    4.3 Receipt of quarterly vendor reports for the period ending June 30, 2020:

        4.3.1 HealthSCOPE Benefits – Obesity Care Management

        4.3.2 HealthSCOPE Benefits – Diabetes Care Management

        4.3.3 American Health Holdings – Utilization and Large Case Management

        4.3.4 The Standard Insurance – Basic Life and Long-Term Disability Insurance

        4.3.5 Willis Towers Watson's Individual Marketplace Enrollment and Performance Report

        4.3.6 Hometown Health Providers and Sierra Healthcare Options – PPO Network

        4.3.7 HealthPlan of Nevada, Inc. – Southern Nevada HMO

        4.3.8 Doctor on Demand Engagement Report through July 2020

4.4 Acceptance of Health Claim Auditors, Inc. quarterly audit of HealthSCOPE Benefits for the timeframe April 1, 2020 – June 30, 2020 to include: report from Health Claim Auditors; HealthSCOPE Benefits response to audit report; and acceptance of audit report findings and assessment of penalties, if applicable, in accordance with performance guarantees included in the contract pursuant to the recommendation of Health Claim Auditors.

4.5 American Health Holding Contract Amendment addressing temporary ownership of toll-free number.

4.6 Accept the Fiscal Year 2020 Other Post-Employment Benefits (OPEB) valuation prepared by Aon in conformance with the Governmental Accounting Standards Board (GASB) requirements.

BOARD ACTION ON ITEM 4
MOTION: Motion to approve everything in Item Four except for 4.2.1 and 4.5
BY: Vice Chair Linda Fox
SECOND: Member Don Bailey
VOTE: Unanimous; the motion carried

BOARD ACTION ON ITEM 4.5
MOTION: Motion to not approve the contract amendment
BY: Member David Smith
SECOND: Vice Chair Linda Fox
VOTE: Unanimous; the motion carried

BOARD ACTION ON ITEM 4.2.1
MOTION: Motion to approve the budget report
BY: Member Don Bailey
SECOND: Vice Chair Linda Fox
VOTE: Unanimous; the motion carried

5. Presentation on Ethics in Government (Yvonne Nevarez-Goodson, Executive Director, Nevada Commission on Ethics) (Information/Discussion)
6. Presentation on the Open Meeting Law (Brandee Mooneyhan, Deputy Attorney General, Nevada Attorney General's Office) (Information/Discussion)
7. Executive Officer Report (Laura Rich, Executive Officer) (Information/Discussion)
8. Discussion and Possible Action on Proposed changes to Healthcare Blue Book rewards payments (Laura Rich, Executive Officer) (**For Possible Action**)

BOARD ACTION ON ITEM 8

MOTION: Motion to approve the recommendation to change the rewards payments for Healthcare Blue Book so the rewards happen only when members search for that qualifying procedure and subsequently choose a green provider to perform that same procedure effective in the next plan year which would be plan year '22.
BY: Member Tim Lindley
SECOND: Member Michelle Kelley
VOTE: Unanimous; the motion carried (Member Don Bailey absent from vote**)**

9. Discussion and Possible Action regarding Legislative Commission's Audit Subcommittee Audit Findings and Corrective Action Plan (Laura Rich, Executive Officer) (**For Possible Action**)

BOARD ACTION ON ITEM 9

MOTION: Motion to accept the affirmative action plan and endorse ideas that there is to be a board subcommittee with not too many members that would violate the open meeting law, to review policies and procedures to ensure that they perform to state laws and procurement.
BY: Member Michelle Kelley
SECOND: Member Marsha Urban
VOTE: 6-yes, 1-no; the motion carried (Member Don Bailey absent from vote**)**

10. Discussion and Possible Action on Solicitation for PEBP Auditor (Laura Rich, Executive Officer) (**For Possible Action**)

BOARD ACTION ON ITEM 10

MOTION: Motion to solicit for PEBP Auditor
BY: Member Tom Verducci
SECOND: Member Don Bailey
VOTE: Unanimous; the motion carried

11. Presentation on COVID-19 modeling update (Stephanie Messier, Aon) (Information/Discussion)

12. Public Comment

- No Public Comment

13. Adjournment

- Board Chair Freed adjourned the meeting at 2:12 p.m.

4.2

4. Consent Agenda (Laura Freed, Board Chair) (**All Items for Possible Action**)

4.2 Health Claim Auditors, Inc. quarterly audit of HealthSCOPE Benefits for the timeframe July 1, 2020 – September 30, 2020: (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.

Claims and System Audit Report

for

Nevada PUBLIC EMPLOYEES' BENEFITS PROGRAM

PEBP

Health Matters.

Audit Period: PEBP Plan Year 2021, Quarter One
July, August and September 2020

Audited Vendor:

HealthSCOPE BENEFITS

Healthy People
Healthy Business
Healthy Futures

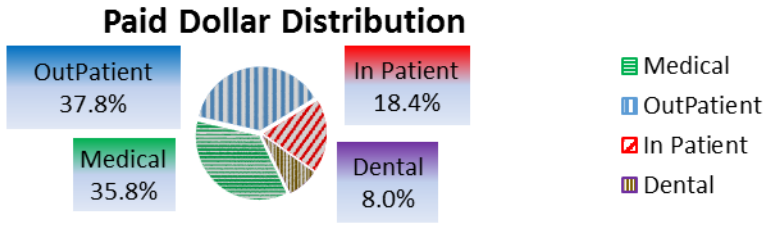
Submitted By:
Health Claim Auditors, Inc.
October 2020

TABLE OF CONTENTS

EXECUTIVE SUMMARY

Audited Random Selection Data

Total number of claims: 500
Total Charge Value of random selection: $1,078,508.48
Total Paid Value of random selection: $ 265,073.23



Performance Guaranteed Metric Results

Metric	Guarantee Measurement	Actual	Pass/Fail
Payment Accuracy	≥ 98% of claims audited are to be paid accurately	99.0%	Pass
Financial Accuracy	≥ 99% of the dollars paid for the audited claims is to be paid accurately	99.6%	Pass
Claim Processing Turnaround Time	- 99% of all claims are to be processed within 30 days.	99.9%	Pass
Customer Service	-Telephone Response Time: ≤ 30 seconds. -Telephone Abandonment Rate: ≤ 2%. -First Call Resolution: ≥ 95%	6 sec. 0.20% 95.3%	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.

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 25.

Charge denied in error; Supporting reference nos. 041, 071, 222 and 435

Incorrect rate due to network re-pricing;
Supporting reference nos. 041, 171, 222 and 292

Claim not adjusted after requested information received;
Supporting reference nos. 008 and 095

Unbundled lab; Supporting reference nos. 025 and **192**

Incorrect bundling of CPT code; Supporting reference no. 066

Paid under incorrect network; Supporting reference no. 110

Multiple surgical reduction calculated incorrectly; Supporting ref. no. **174**

Incorrect allowable applied; Supporting reference no. 298

Routine paid as medical; Supporting reference no. 328

Multiple surgical reduction applied in error; Supporting reference no. **346**

Claim not applied to deductible; Supporting reference no. **442**

Copay applied in error; Supporting reference no. **465**

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 25.

Dental code D1999 for PPE (personal protective equipment) denied as not covered; Supporting reference nos. 395, 413, 430, 431 and 472

Previously paid dental code D1999 for PPE not reprocessed to deny;
Supporting reference nos. 044, 109 and 128

New lab fee schedule for Renown;
Supporting reference nos. 133, 224 and 385

CLAIM PROCEDURES/SYSTEM CAPABILITIES/SUPPORT DATA

Introduction

In October 2020, Health Claim Auditors, Inc. (HCA) performed a Claims and System Audit of HealthSCOPE Benefits (HealthSCOPE) on behalf of The State of Nevada Public Employees' Benefits Program (PEBP).

This audit was performed remotely 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 27 October 2020.

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 February 2019 to September 2020 and were processed by HealthSCOPE from 01 July 2020 through 30 September 2020 (PEBP's First Quarter Plan Year 2021). 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	$ 239,994.53	$ 94,938.49	35.8%	336
Outpt. Hospital	$ 450,589.88	$ 100,273.86	37.8%	61
Inpt. Hospital	$ 344,873.79	$ 48,667.64	18.4%	7
Dental	$ 43,050.28	$ 21,193.24	8.0%	96
TOTAL	**$1,078,508.48**	**$ 265,073.23**	**100%**	**500**

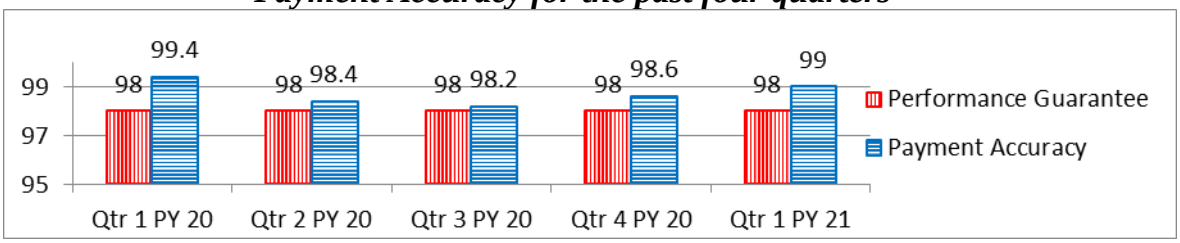
Payment Accuracy

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 99.0%.

Number of claims:	500
Number of claims paid incorrectly:	5
Percentage of claims paid incorrectly:	1.0%
Number of claims paid correctly:	495
Percentage of claims paid correctly:	99.0%

Payment Accuracy for the past four quarters



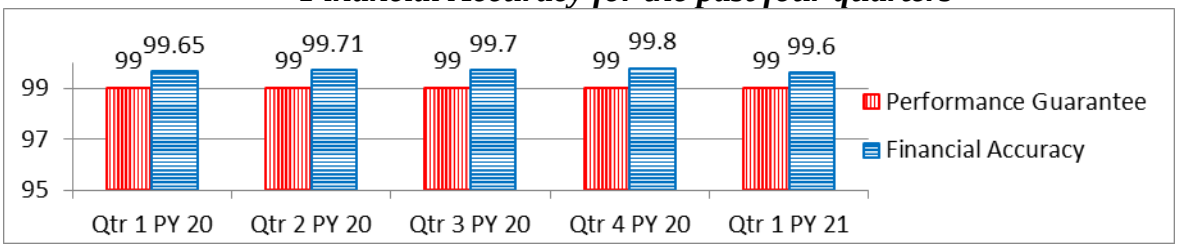
Financial Accuracy

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

The Financial Accuracy Percentage of paid dollars remitted correctly on the HealthSCOPE claims selected randomly for this audited quarter is 99.6%. This audit reflected nineteen and five tenths percent (19.5%) of the audited errors within the valid random selection were overpayments.

Paid dollars audited	$ 265,073.23
Amount of paid dollars remitted incorrectly	$ 1,013.66
Percentage of Dollars paid incorrectly	0.4%
Paid Dollars of claims paid correctly	$ 264,059.57
Percentage of Dollars Paid correctly	99.6%

Financial Accuracy for the past four quarters



Historical Statistical Data of Performance Guarantees

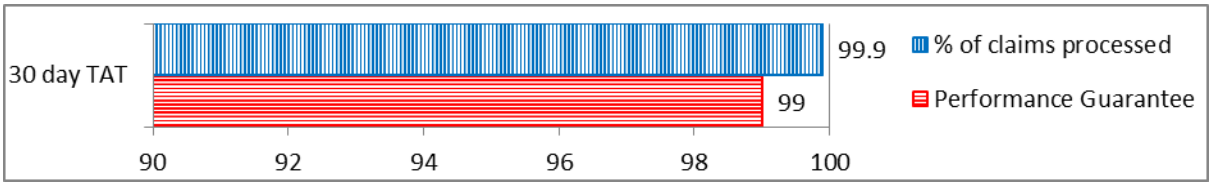
The following reflects the historical statistical data since the origin of PEBP medical claims administration by HealthSCOPE.

Period Audited	Payment Accuracy	Financial Accuracy	Turnaround Time	Telephone Response	Telephone Abandon Rate	First Call Resolution
1st Qtr PY 2012	95.7%	98.6%	7.6 days	:17	1.43%	N/A
2nd Qtr PY 2012	**93.3%**	**97.3%**	12.7 days	:12	1.16%	N/A
3rd Qtr PY 2012	**96.8%**	**98.6%**	3.7 days	:18	1.32%	N/A
4th Qtr PY 2012	**95.8%**	99.5%	11.4 days	:14	0.93%	N/A
1st Qtr PY 2013	97.2%	99.4%	10.4 days	:20	1.06%	N/A
2nd Qtr PY 2013	98.5%	99.3%	7.3 days	:11	0.87%	N/A
3rd Qtr PY 2013	98.0%	**95.7%**	6.4 days	:25	1.98%	N/A
4th Qtr PY 2013	98.4%	99.7%	6.2 days	:29	1.61%	N/A
1st Qtr PY 2014	98.8%	99.6%	5.4 days	:14	0.84%	N/A
2nd Qtr PY 2014	99.2%	99.2%	5.9 days	:29	1.96%	N/A
3rd Qtr PY 2014	98.0%	**98.5%**	5.2 days	**:30.5**	1.92%	N/A
4th Qtr PY 2014	99.0%	99.8%	4.4 days	:28	1.96%	N/A
1st Qtr PY 2015	98.8%	99.27%	4.9 days	:29.4	1.94%	N/A
2nd Qtr PY 2015	99.0%	99.35%	8.1 days	:22	1.18%	N/A
3rd Qtr PY 2015	98.6%	99.8%	5.9 days	:29.7	1.97%	N/A
4th Qtr PY 2015	99.6%	**95.6%**	4.9 days	:29.4	1.91%	N/A
1st Qtr PY 2016	99.0%	**98.9%**	4.8 days	:29.1	1.94%	N/A
2nd Qtr PY 2016	98.6%	99.7%	3.5 days	:24.0	1.14%	N/A
3rd Qtr PY 2016	98.8%	**98.53%**	5.3 days	:29.0	1.96%	N/A
4th Qtr PY 2016	99.0%	99.52%	6.3 days	:29.5	1.98%	N/A
1st Qtr PY 2017	99.0%	99.23%	6.6 days	:29.8	1.93%	N/A
2nd Qtr PY 2017	99.6%	99.78%	4.3 days	:29.3	1.96%	N/A
3rd Qtr PY 2017	98.2%	**93.83%**	3.7 days	:29.8	1.97%	N/A
4th Qtr PY 2017	99.0%	99.66%	4.6 days	:29.3	1.98%	N/A
1st Qtr PY 2018	99.2%	99.83%	4.4 days	:26.0	1.61%	98.79%
2nd Qtr PY 2018	99.6%	99.9%	4.3 days	:12.8	1.12%	98.28%
3rd Qtr PY 2018	98.6%	99.7%	3.5 days	:28.5	1.97%	98.65%
4th Qtr PY 2018	99.4%	99.5%	4.2 days	:21.0	1.50%	97.65%
1st Qtr PY 2019	98.8%	**98.2%**	5.4 days	:21.0	1.49%	97.85%
2nd Qtr PY 2019	99.6%	99.9%	5.6 days	:21.0	1.40%	97.18%
3rd Qtr PY 2019	98.4%	**98.31%**	5.8 days	:14.0	1.21%	95.89%
4th Qtr PY 2019	98.8%	99.30%	6.7 days	:14.0	1.09%	96.38%
1st Qtr PY 2020	99.4%	99.65%	7.1 days	:20.0	1.66%	95.03%
2nd Qtr PY 2020	98.4%	99.71%	5.0 days	:17.0	1.44%	95.89%
3rd Qtr PY 2020	98.2%	99.7%	4.1 days	:21.0	1.60%	96.25%
4th Qtr PY 2020	98.6%	99.8%	3.7 days	:05.0	0.11%	97.45%
1st Qtr PY 2021	**99.0%**	**99.6%**	**3.5 days**	**:06.0**	**0.2%**	**95.3%**

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 99.9% 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 3.5 days.

Turnaround Time Measurements



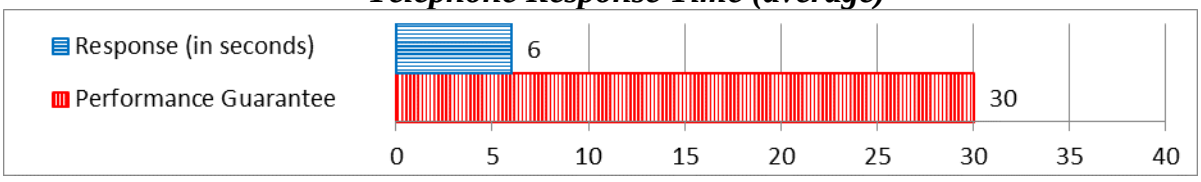
The turnaround time, measured only from the random selected claims, for Medical claims 7.6 calendar days, Out Patient Hospital claims was 9.2 calendar days, In Patient Hospital claims was 2.6 calendar days and Dental claims was 1.1 calendar days.

During the audit period of 01 July 2020 – 30 September 2020, HealthSCOPE had received 1,416 PEBP e-mail inquiries for information via the internet. The average turnaround time for these inquiries was calculated at approximately 7 hours.

Customer Service Satisfaction

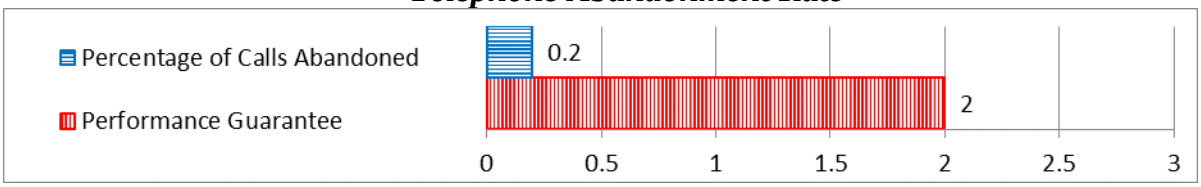
Per the Service Performance Standards and Financial Guarantees Agreement, the telephone response time reflects all calls must be answered within thirty (30) seconds or a penalty of one percent (1%) of Quarterly Administration fees for each second in non-compliance is to be applied. HCA has reviewed the appropriate report for the PEBP first fiscal quarter Plan Year 2021, which revealed the average incoming answer speed to be 6 seconds (0:6.0). The telephone response time was 7 seconds for July 2020, 5 seconds for August 2020 and 5 seconds for September 2020.

Telephone Response Time (average)



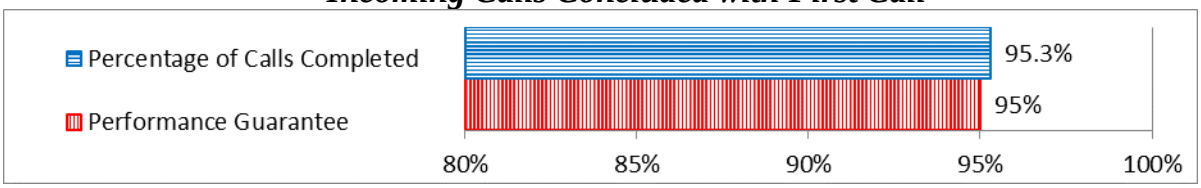
Per the Service Performance Standards and Financial Guarantees Agreement, the abandonment rate must be under two percent (2%) of total calls or a penalty of one percent (1%) of Quarterly Administration fees for each percentage point or fraction thereof in non-compliance is to be applied. HCA has reviewed the appropriate report for the PEBP first fiscal quarter Plan Year 2021, which revealed the abandoned calls ratio to be 0.20%. The telephone abandonment rate was 0.3% for July 2020, 0.1% for August 2020 and 0.1% for September 2020.

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 first fiscal quarter Plan Year 2021, which revealed that HealthSCOPE documented 95.3% 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 nineteen (19) 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 3,704 claims representing $ 18,954,858.43.

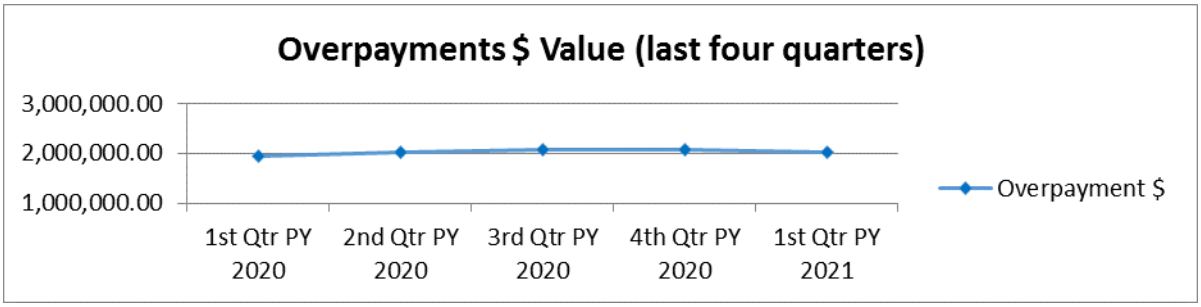
Audit Period	Total Number of Claims	Charge Amount Value of Soft Edits
1st Qtr PY 2012	2,607	$ 7,544,177.55
2nd Qtr PY 2012	4,068	$10,697,954.53
3rd Qtr PY 2012	1,536	$ 6,472,249.56
4th Qtr PY 2012	559	$ 2,205,318.16
1st Qtr PY 2013	1,053	$ 3,413,738.12
2nd Qtr PY 2013	1,107	$ 5,019,961.70
3rd Qtr PY 2013	1,023	$ 4,179,542.34
4th Qtr PY 2013	1,094	$ 3,049,481.74
1st Qtr PY 2014	1,389	$ 3,853,629.07
2nd Qtr PY 2014	1,157	$ 2,510,539.33
3rd Qtr PY 2014	1,621	$ 7,873,432.21
4th Qtr PY 2014	1.487	$ 4,665,197.77
1st Qtr PY 2015	1,404	$ 5,901,903.17
2nd Qtr PY 2015	1,668	$ 6,930,288.41
3rd Qtr PY 2015	2,897	$10,800,874.08
4th Qtr PY 2015	2,498	$10,685,255.24
1st Qtr PY 2016	3,071	$13,027,717.82
2nd Qtr PY 2016	2,543	$13,547,682.34
3rd Qtr PY 2016	2,871	$10,360,017.78
4th Qtr PY 2016	3,107	$15,262,995.27
1st Qtr PY 2017	2,580	$ 8,558,641.28
2nd Qtr PY 2017	3,876	$15,960,661.94
3rd Qtr PY 2017	3,696	$18,864,824.74
4th Qtr PY 2017	4,768	$20,217,736.28
1st Qtr PY 2018	3,926	$15,683,180.63
2nd Qtr PY 2018	4,073	$20,576,701.38
3rd Qtr PY 2018	4,144	$17,375,843.66
4th Qtr PY 2018	4,544	$21,591,987.11
1st Qtr PY 2019	4,624	$24,992,938.88
2nd Qtr PY 2019	5,558	$36,168,714.98
3rd Qtr PY 2019	5,476	$25,662,843.33
4th Qtr PY 2019	5,248	$24,848,496.79
1st Qtr PY 2020	4,992	$24,614,175.86
2nd Qtr PY 2020	4,275	$22,248,300.62
3rd Qtr PY 2020	4,521	$25,612,307.44
4th Qtr PY 2020	3,909	$17,472,693.36
1st Qtr PY 2021	**3,704**	**$18,954,858.43**

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 $2,025,429.09 (a decrease of $34,042.67 from the previous quarter). 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	$ 97,205.75
- Fiscal Year 2013	$ 139,547.51
- Fiscal Year 2014	$ 60,343.20
- Fiscal Year 2015	$ 131,185.64
- Fiscal Year 2016	$ 181,254.09
- Fiscal Year 2017	$ 99,488.19
- Fiscal Year 2018	$ 324,610.16
- Fiscal Year 2019	$ 147,702.21
- Fiscal Year 2020	$ 391,459.84
- Fiscal Year 2021 (to date)	$ 452,632.50
TOTAL	$2,025,429.09



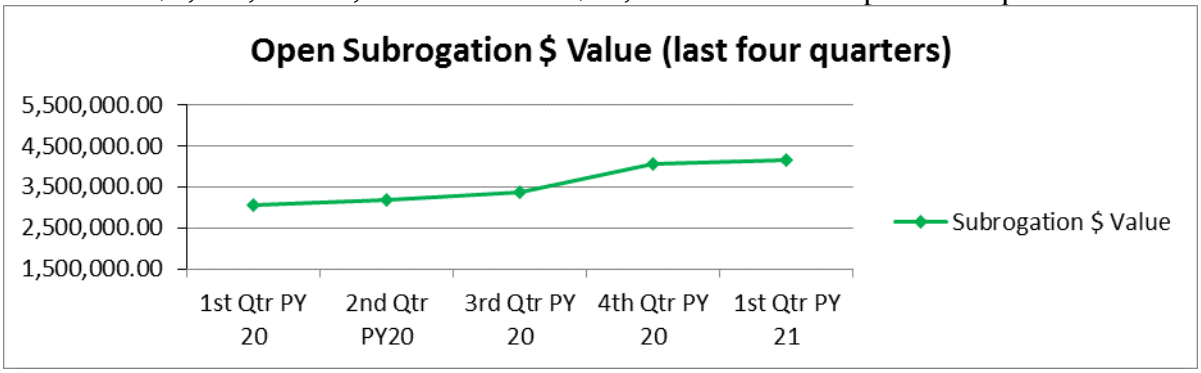
Of the 1,369 most current (Plan Year 2020 + 2021 to date) identified outstanding overpayments (HSB only), 61% were found to be caused by external sources that are not a cause of the HealthSCOPE adjudication processes. Breakout of the HealthSCOPE's most current overpayments (by claim count) are listed by reason as follows:

30.70%	Corrected HTH Network Pricing
13.82%	Incorrect Benefit Applied
12.50%	Provider caused, rebilled, charges billed in error, corrected EOB
10.16%	Incorrect Rate Applied
9.65%	Retro termination
5.48%	No COB on file
4.02%	SHO Pricing Correction
2.78%	Duplicate
1.24%	Processed under the incorrect provider
1.17%	COB incorrectly calculated or not applied
1.17%	Previous Information Received
0.88%	Paid NON PPO as PPO
0.73%	Adjusted after Medical Review
0.73%	Category error
0.66%	Service not covered
0.58%	Pharmacy Deductible Error
0.44%	Processed under incorrect patient
0.37%	Same Day Void
0.37%	Pre-Certification Error
0.37%	Incorrect Assignment Applied
0.29%	Stop Payment
0.22%	Benefit Clarification
0.22%	Subrogation error
0.22%	Entry Error
0.22%	Paid PPO provider as NON PPO
0.22%	Aetna network Pricing
0.22%	Eligibility Error
0.15%	Paid over Maximum
0.15%	Undefined Code
0.15%	Rebundle Error
0.07%	System Error
0.07%	Interim Billing

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 $4,136,270.06; an increase of $86,948.80 from the previous quarter.



Reports received from HealthSCOPE reflect that subrogation recoveries for the audited period was $258,603.34. After contingency fees were paid, PEBP received $199,417.68.

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 fifty (50) active members and thirty-five (35) dependents for a total of 85 active participants, who have obtained this level of plan payment participation representing an accrued dollar paid amount of $117,397,565.60.

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 Supervisors; total of 2 individuals;
- Claims Analysts, 15 individuals;
- Eligibility Director;
- Eligibility Specialists; 2 individuals;
- Customer Service Vice President;
- Customer Service Director;
- Customer Service Representatives, **CHANGED**, 3 added and 2 removed for a total of 19 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

The following section displays HealthSCOPE policies, procedures and system capabilities as they pertain to adjudication of PEBP claims. Due that system edit and functions do not change frequently, the following section appears only in the first quarter audit each Plan Year.

Eligibility

The HealthSCOPE system systematically denies claims for services rendered prior to or after the effective date.

The HealthSCOPE system systematically adjudicates claims pertinent to the date of service for those claims received prior to or after any benefit changes.

The HealthSCOPE system has the capability to load by line of coverage tiers (i.e.: single medical/family dental, etc.).

HealthSCOPE can, if requested, request divorce decrees or court orders for those dependents of divorced or separated parents.

The HealthSCOPE system will enforce IRS regulations if the Plan Document does not require stricter requirements.

Disabled (handicapped) dependent status is determined by PEBP when a covered dependent child has reached the age of 26, which would terminate his/her status as a dependent. HealthSCOPE can determine disabled dependent status with internal medical personnel if required.

HealthSCOPE has stated that they would not ever add a member dependent without PEBP authorization.

HealthSCOPE stated that the turnaround time to add or delete a member's eligibility is within 24 hours of receipt.

If a member is terminated retroactively, HealthSCOPE will review that member's claim history to determine any overpayments for possible recoveries and proceed per PEBP instructions.

Deductibles, Out-of-Pocket and Benefit Maximums

The HealthSCOPE system is capable of separate PPO and Non PPO accumulators.

All deductibles, out-of-pocket expenses and most benefit maximums are tracked by the HealthSCOPE system.

The HealthSCOPE system contains automated carry over deductible features if necessary.

HealthSCOPE system contains integrated deductibles for dental and medical claims.

HealthSCOPE does have experience of applying the Prescription Drug and Medical claims deductibles as reflected within the PEBP SPD.

Unbundling/Rebundling

The HealthSCOPE system can systematically edit to identify laboratory, diagnostic and radiology charges that have been unbundled and billed separately.

The HealthSCOPE system has the electronic capacity to match multiple claims in history for application of the unbundling edit.

The HealthSCOPE system systematically soft edits for multiple surgical guidelines, for those situations where a surgeon is billing for more than one (1) surgical procedure during the same operative session. The HealthSCOPE system has the capacity to match claims in history for application of the multiple procedure reduction edit.

For Network providers and Non-PPO providers where multiple surgical procedures have been performed, the HealthSCOPE system will electronically adjudicate and apply 100% of the Reasonable and Customary (R&C) or the provider specific fee schedule amount for the major procedure, 50% of the R&C or network fee schedule amount for subsequent procedures or any deviation designed by the network contract. This application is conducted manually with HealthSCOPE. The system can calculate the claim by global or individual allowance accounting.

For Network providers and Non-PPO providers where bilateral surgical procedures have been performed, the HealthSCOPE system will not electronically adjudicate to allow 100% of the Reasonable and Customary (R&C) or the provider specific fee schedule amount for the major procedure and 50% of the R&C or network fee schedule amount for the secondary procedure. This application is manually applied.

HealthSCOPE manually breaks this issue into separate line services for adjudication.
The HealthSCOPE system is automated to identify pre/post operative care related to surgical procedures.

The HealthSCOPE system denies incidental procedures when in relation to primary procedures.

The HealthSCOPE system systematically identifies claims that contain a same day procedure (procedures that are not customarily billed on the same day as a surgical procedure) unless billed under the same provider.

HealthSCOPE will allow the doctor to bill the initial obstetrical diagnostic office visit. The subsequent visits are paid and then manually tracked and applied to the global obstetrical fee. Reasonable and Customary (R&C) allowance or network fee schedule amount is applied to the global obstetrical fee. Obstetrical lab and diagnostic procedures are allowed to be billed separately.

Concurrent Care

The HealthSCOPE system is not automated to identify situations where more than one (1) physician is billing for services during the same time period for the same diagnosis. The claims analysts rely on the system's possible duplicate edit to detect this situation.

Code Creeping

The HealthSCOPE system is automated to identify code creeping. An example of this occurs when a physician is consistently billing for an initial or new patient office/hospital visit when services performed are actually rendered for a subsequent or established patient visit.

Procedure, Diagnosis and Place of Service

The HealthSCOPE system is automated to determine the correct usage of the Current Procedural Terminology (CPT) code. The system is automated to edit if the patient's age or gender does not concur with the (CPT) code.

The HealthSCOPE system edits if multiple CPT codes that are billed on the same claim don't belong together.

The HealthSCOPE system is automated to identify if the place of service does not concur with the (CPT) code.

The HealthSCOPE system is also automated to edit if a diagnosis does not concur with the (CPT) code.

The HealthSCOPE system has the capability to edit for routine/medical diagnosis' to determine which benefits are allowable under routine versus medical.

Experimental and Cosmetic Procedures

The HealthSCOPE system is automated to assist processors in identifying those procedures that are or could be cosmetic. Analysts are also trained to identify these claims. These procedures can also be identified during the pre-certification process.

The HealthSCOPE system can be programmed to systematic hold or deny these types of claims, depending upon plan election.

Medical Necessity/Potential Abuse Guidelines and Procedures

The HealthSCOPE system is automated to determine the appropriateness of an assistant surgeon based on the surgery performed. These claims can be pended or denied, depending upon the plan election.

The HealthSCOPE system is automated to determine the appropriateness of an anesthesiologist based on the service performed. These claims can be held or denied, depending upon the plan election.

The HealthSCOPE system is not automated to determine if anesthesia is billed by both the hospital and anesthesiologist under both a revenue code and separate CPT service code.

HealthSCOPE determines medical necessity for the rental or purchase of durable medical equipment (DME) by prescription from a physician or internal Medical Reviewers.

Rental cost of DME is tracked up to the purchase price by HealthSCOPE to assure that PEBP will pay no more for rental than it would if this equipment had been purchased. HealthSCOPE tracks this issue on a manual basis within their system.

HealthSCOPE investigates to determine if a prescription is a federal legend drug. They utilize the Medi-Span database for this procedure.

Claims involving chiropractic care, physical therapy are determined for medical necessity by HealthSCOPE. Therapeutic treatment needs to be rendered by a licensed physical therapist. Treatment must be commonly and customarily recognized as appropriate within the doctor's profession.

Per HealthSCOPE, medical necessity for infusion services are usually determined by Utilization Review but can be determined internally if necessary.

The HealthSCOPE system can comply with authorization, repricing and all requirements as they pertain to adjudication of Mental Health claims.

HealthSCOPE does execute on a regular basis, daily exception reports, which are run for supervisors to review edits that are overridden.

The HealthSCOPE system has the capability to identify repeat tests being done by both primary physicians and specialists.

Patterns of Care and Treatment for Physicians

HealthSCOPE has the capability to conduct evaluations of patterns of care of physicians on patient outcome studies (success) for various procedures and communicate facts to physicians to eliminate unnecessary or ineffective care or disclose potential fraud or trends of fraud.

Mandatory Outpatient/Inpatient Procedures

The HealthSCOPE system is not automated to determine those procedures that do not require hospitalization. Pre-certification is required for an inpatient stay and many surgical procedures, of which, most procedures will be identified at that time.

Duplicate Claim Edits

The HealthSCOPE system is automated to identify duplicate claims. The HealthSCOPE system will "soft" edit a claim under partial match and a "hard" edit under exact match circumstances. The following criteria are matches: Date of Service, CPT including modifier and Provider tax identification number.

In the event of multiple provider submissions, the PEBP member will receive an Explanation of Benefits (EOB) for all claims paid.

Adjusted Claims

In the event that a claim was previously paid and an adjustment is made to the original adjudication, the HealthSCOPE system will assign a "claim identification number" to the adjustment that reflects the original paid claim. HealthSCOPE links the original with the adjusted claim(s) with a notation on subsequent claim screens.

Hospital and Other Discounts

HealthSCOPE can automate all PPO Provider discounts including per diem and Diagnosis Related Group (DRG) arrangements.

HealthSCOPE stated that PPO (Preferred Provider Organization) provider rates which can be obtained can be repriced in-house.

If a network has negotiated a prompt payment discount, the HealthSCOPE system is programmed to apply the discount.

Attempts to negotiate non-PPO provider discounts are conducted by HealthSCOPE's vendors, with contingencies as reported within the response to RFP 1893. PEBP can set this issue at as low as $0 for HealthSCOPE.

HealthSCOPE declared that they do not collect any year end settlements, rebates, etc. other than those declared within their response(s) to RFP 1893.

HealthSCOPE stated that they would review and disclose any provider discount contracts relative to PEBP claims for the absence of any "Hold Harmless" language as an aid in protecting PEBP members.

Hospital Bills (UB-92) and Audits

HealthSCOPE requires itemized hospital bills to determine non-covered items. Itemization for all hospital bills over $100,000.00 is required by HealthSCOPE to determine non-covered items.

The HealthSCOPE system utilizes revenue codes when processing hospital bills.

HealthSCOPE has an internal hospital audit program in place. All non-PPO claims over $50,000.00 are sent for audit. HealthSCOPE also stated that some claims are audited through their external audit process. HealthSCOPE is willing to accept any amount PEBP determines as a minimum for this issue. Contingency fees and administrator percentage shares are disclosed within their responses to RFP 1983.

Filing Limitations

The HealthSCOPE system can systematically apply the appropriate standard filing limitation for submitting all claims. The standard filing limitation for submitting claims for PEBP is twelve (12) months after date of service.

Unprocessed Claims Procedures

Unprocessed claims are logged on the HealthSCOPE system for verification of receipt. HealthSCOPE has paper claims scanned and entered into their adjudication system within twenty four (24) hours of receipt.

HealthSCOPE stated that this process and data entry will be conducted by individuals within the continental United States. HealthSCOPE stated that they do utilize a company that conducts this process outside the United Sates, however, has ensured that PEBP data stays on shore.

Reasonable/Customary and Maximum Allowances

HealthSCOPE is utilizing R&C allowances for non-network providers. HealthSCOPE is utilizing R&C data for medical claims at the seventieth (70^{th}) percentile. Out of Network dental providers are paid using the same allowables as in-network dental providers, subject to the appropriate geographic location rates.

R&C is applied utilizing the date of service and geographical location (zip code). R&C data is updated four times per year by HealthSCOPE, last updated in August 2020.

HealthSCOPE does not have separate R&C schedules for Facilities versus Professional services, however, HealthSCOPE uses a vendor that can apply reductions for Non PPO facilities.

HealthSCOPE will pay medical claims at the appropriate network negotiated rates. Non network providers and non- negotiated services will be paid at the lesser of the MDR rate at the percentile chosen by the PEBP plan or the billed amount. Dental claims will be paid at the lesser of the MDR rate at the percentile chosen by the PEBP plan or the billed amount.

The HealthSCOPE system will pay the lower of charges or scheduled amount when contracts allow.

The HealthSCOPE system utilizes modifiers to determine R&C for professional and technical components for diagnostic, laboratory and radiological procedures.

Assistant surgical charges, when performed by MDs will be systematically calculated at no more than 20% of the R&C amount (or the network fee schedule) allowable for the surgeon's procedure performed.

HealthSCOPE will pay all related charges of an inpatient stay at the network level if a network hospital is utilized if the benefit plan dictates. This will be performed on a manual basis by HealthSCOPE.

HealthSCOPE is utilizing a form of R&C for Non-PPO Durable Medical Equipment (DME) claims when applicable.

In situations where the PEBP member has claims adjudicated under the PEBP Preferred Provider Organization (PPO) Exception Rule (50 mile rule), HealthSCOPE will identify these exceptions at the time of adjudication and pay within the Exception Rule per the PEBP Master Plan Document.

Membership Procedures

HealthSCOPE has the capabilities of electronic enrollment and re-enrollments. HealthSCOPE will add or cancel employee information onto their system within twenty four (24) hours.

Per HealthSCOPE, claims received for newborns can be paid and history tracked under their own name.

The HealthSCOPE system analysts have inquiry capability to view eligibility files only. They do not have the capability to make changes to eligibility information.

If an employee is terminated, the HealthSCOPE system will deny claims as not covered. An explanation of benefits is generated every time a claim is received after this date. HealthSCOPE will check for claims paid after this termination date.

Current historical eligibility information is stored on the HealthSCOPE system indefinitely.

COBRA Administration

COBRA administration is being done by PEBP. If elected, determination for benefits elected by individuals under COBRA administration rules can be done by HealthSCOPE.

The HealthSCOPE system can maintain an eligibility date that coincides with the premium "paid to" COBRA date. If the system detects an exception to the date, it forces human intervention. If the member is found to be terminated from COBRA, the claim is denied. The HealthSCOPE COBRA system is integrated with the claims administration system.

Provider Credentialing

Currently, providers are monitored by the PPO for credentialing. Claims received by providers not in the PPO network are verified as legitimate by HealthSCOPE.

HealthSCOPE will check legitimacy of the provider through the internet and alternate resources before payments are released.

Coordination of Benefits

Coordination of Benefits (COB) information is obtained via enrollment applications and claims displaying positive COB by HealthSCOPE.

HealthSCOPE states that all claims are investigated for COB information. HealthSCOPE's procedure for COB is to pursue then pay for all possible COB claims. Claims are denied until requested information is received. If a claim form displays that a spouse is employed, HealthSCOPE will send a COB questionnaire.

The HealthSCOPE system utilizes COB indicators, which will cause a warning edit to alert the processor to the presence of other insurance.

The HealthSCOPE system utilizes separate COB indicators for different lines of business, i.e. medical, dental, etc.

The HealthSCOPE system has electronic split indicators to assure the proper payment of claims received out of sequence and multiple positive COB periods.

Per HealthSCOPE, COB processing is performed by all claim processors.

The HealthSCOPE system can process claims utilizing a COB Credit Reserve program on a calendar year basis if required.

HealthSCOPE will utilize the primary carrier's discount when the discount is greater than the client's if by Plan design.

HealthSCOPE policies are to recover overpayments of past paid claims when COB is discovered after the fact.

Medicare

The HealthSCOPE system will alert the Processor when a member or dependent may be eligible for Medicare benefits. If an individual is age sixty-five (65) or older and Medicare may exist, active employment may be verified.

HealthSCOPE can present a report specific to active participants for verification to eligibility files when requested.

Controlling Possible Fraudulent Claims and Security Access

HealthSCOPE claims analysts have a payment authority of $15,000.00. HealthSCOPE Team Lead has an authority of $35,000.00 and the HealthSCOPE Claims Manager has an authority of $75,000.00. HealthSCOPE directors review claim payments in excess of $75,000.00.

Security logs are created and monitored by HealthSCOPE. HealthSCOPE system utilizes passwords, is monitored to restrict the use of certain system operations and can lockout unauthorized users.

The HealthSCOPE system can track activity by individuals to identify who handled a claim.

HealthSCOPE does currently offer website access to be used by clients for eligibility purposes.

Quality Control and Internal Audit

HealthSCOPE has a total of 125+ claim analysts in their Little Rock location. HealthSCOPE has 18 claims analysts dedicated to the PEBP account.

HealthSCOPE Claims Managers and Directors were found to be knowledgeable and possess extensive training. Discussions and tests of their working knowledge of adjudication processes and policies and procedures were positive. They were found to possess the ability to identify and defeat many adjudication potential "problem areas" defined with billing practices within the nation.

HealthSCOPE does not have internal audit personnel. They utilize an outside vendor that conducts a review of no less than 2% of their claims.

HealthSCOPE has formal training programs, where policies and procedures are taught. HealthSCOPE stated their training lasts four (4) weeks from the start. HealthSCOPE offers consistent ongoing training and identifies needs of specific individual training. Any needs are identified and supplied on an ongoing basis.

HealthSCOPE conducts audits on all processors. HealthSCOPE audits new analysts at 100% during their probationary period.

HealthSCOPE stated that experienced claim analysts will have the PEBP performance guarantee levels met for claims per person per month audited.

Records for all analysts are kept on a database for performance reference by HealthSCOPE.

HealthSCOPE has internal accuracy and production standards. HealthSCOPE's internal financial accuracy standard is 99.2% of paid claims and payment accuracy is 98%.

The production standard for HealthSCOPE experienced claims analysts is 150 - 175 medical/dental claims per day.

Internet Capabilities

HealthSCOPE does have internet capabilities to further extend membership and administrative service levels.

HealthSCOPE has internet sites provided for member information. These sites provide claim information, network provider identification and contact data.

HealthSCOPE internet sites were user friendly and easy to access. HealthSCOPE's site was checked for security processes of data protection and was found to be protected by member supplied passwords, etc.

HealthSCOPE has an internet site available for vendor information. These sites provide claim and benefit information, network rates and contact data.

Communication between Utilization Review (UR) and Claims Department

HealthSCOPE can currently accept communication between the UR and the claims department via electronic source. Information received regarding pre-certification, PCP references and Case Management can be entered on the system when received.

Precertification penalties for non-compliance will be manually applied by HealthSCOPE.

HealthSCOPE will apply the proper cutbacks to UR authorized number of service days if different than the number of billing days on a manual basis. HealthSCOPE verified that they will apply authorized number of service days according to PEBP's methodology.

HealthSCOPE analysts are trained to identify potential catastrophic cases and refer them to a Case Management program.

The HealthSCOPE system has the ability to communicate special instructions or negotiate arrangements/ discounts to the analysts through the notes.

PEBP's policy allows for a three (3) Level Appeal process. HealthSCOPE stated that they can apply this policy.

Claim Repricing Capabilities

HealthSCOPE is currently receiving network fee schedules and provider maintenance data electronically for internal claims repricing. HealthSCOPE has data loaded into their adjudication system within 24 hours of receiving.

HealthSCOPE currently is participating with multiple networks for repricing via the Electronic Data Interface (EDI) methodology.

Banking and Cash Flow

HealthSCOPE stated that they can accommodate PEBP's requirement for payment release frequency. HealthSCOPE stated that they could release payment checks the same date of final adjudication if before 10:00 AM.

HealthSCOPE is utilizing bulk checks for provider payments.

Reporting Capabilities

In addition to the standard AD HOC reporting, HealthSCOPE has the capability to develop and produce client-requested reports based on any information captured on the system.

HealthSCOPE stated that no additional charge would be applied for any requested report which is in the standard reporting.

General System

HealthSCOPE has been using the current system for twenty plus (20+) years. The current system has undergone many updates since its inception.

HealthSCOPE has the controls in place for the application of source coding enabling them to make client specific adjustments as necessary.

HealthSCOPE has written procedures in place for a formal Disaster Recovery program.

HealthSCOPE conducts daily system data backups, which are stored in a secure location off site.

HealthSCOPE stated that they have not experienced any significant downtime.

Security

This audit reviewed building security, the handling and security of sensitive documents and materials and the proper disposal of data for any potential data breaches. The audit also reviewed internal processes and potential exposure to possible fraudulent activity.

The HealthSCOPE office located in Little Rock, Arkansas was found to be secure during the last on-site visit in April 2020. All external ingress and egress locations were secured and locked. Entrance was made available to HealthSCOPE personnel by electronic pass keys. HCA entry beyond the reception area required assistance from official personnel. The facility work areas are monitored and recorded twenty four hours per day.

Sensitive data, specifically, member Personnel Health Information (PHI) of HealthSCOPE's clients was reviewed for security exposure practices. Any paper was found to be in secured areas and/or file cabinets when not in use.

Per Agreement, HealthSCOPE must provide all subcontractors that have access to PEBP member Personal Health Information (PHI) within 30 calendar days of said access or a penalty of 5.0% of rolling 12 months of administration fees will be applied for each violation.

Per Agreement, HealthSCOPE must remove PEBP member PHI from unauthorized/designated servers within 3 business days after they know or should have known using commercial reasonable efforts or a penalty of 5.0% of rolling 3 months of administration fees will be applied.

A review of the system server equipment for HealthSCOPE noted it was secured in a separate area under locked environments with appropriate fire suppression protections. Every attempt to access the adjudication system required appropriate security measures such as passcodes, etc.

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. 008 Medical HSB claim no.

NOT charged in statistical calculation. Note to client for information only.
Claim for anesthesia same DOS claim xxxxxx denied on 7/30/20 for accident info.
Claim xxxxxx paid on 7/27/30 for facility same DOS – per trns msgs "no subro"
Shouldn't claim xxxxxx for anesthesia have been paid?
HSB response: Yes, claim xxxxxx should have been paid. Injury released from possible subrogation.

Ref. No. 025 Medical HSB claim no.

NOT charged in statistical calculation. Note to client for information only.
Claim xxxxxx same DOS also from Quest paid on 7/6/20 contains:

80053	chg 88.07	allow/pd 18.58
84443	130.49	23.05
85025	45.50	10.66
		52.29

Shouldn't these codes have been re-bundled & paid as 80050?
HSB response: Yes, 36415, 80053, 84443 and 85025 should have been bundled to 80050.

Ref. No. 041 Outpatient Hospital HSB claim no.

NOT charged in statistical calculation. Note to client for information only.
Claim processed as allow 4845.25 denying REV 306 (U0003) charge $850.00 as not covered under contract w/HTH.
Shouldn't this charge have been paid?
(Note: This test now being required before having surgery)
HSB response: HTH originally repriced U0003 w/$0 allowed and claim paid on repricing they provided. Per recon xxxxx the procedure was priced incorrectly and the allowed should be $102.

Ref. No. 044 Dental HSB claim no.

NOT charged in statistical calculation. Note to client for information only.
Claim contains D1999 – PPE chg 15.00 allow 11.25 ded 11.25
Shouldn't this charge have been denied as not covered?
HSB response: PEBP will not require HSB to reprocess to deny D1999.
See attached email.
HCA Note: Attached email from PEBP dated October 20, 2020: "Please accept this email as confirmation that PEBP will not require HSB to reprocess the 4,000+ claims identified on the D1999 impact report.
In accordance with our discussion on 9/21/20, HSB will add coding to review every claim billed with this miscellaneous code going forward and deny PPE as a non-covered service."

Ref. No. 066 Outpatient Hospital HSB claim no.

NOT charged in statistical calculation. Note to client for information only.
Originally claim paid on 4/21/20 under xxxxxx as:
allow 5608.51 copay 5000 pd 5108.51
Audited is adjusted claim on 7/6/20 to pay an additional 365.04
allow 5973.55 copay 500 pd 5473.55
Per trns msgs appears system bundled REV 260, CPT 96374 in error?
HSB response: Claim suspended for examiner to review. The examiner should have overrode edit and allowed as 96374 was billed appropriately.

Ref. No. 071 Outpatient Hospital HSB claim no.

NOT charged in statistical calculation. Note to client for information only.
Originally claim paid on 5/28/20 under xxxxxx paying 74.02 denying REV 301, CPT 80050
Audited is adjustment on 7/7/20 to now pay an additional 30.51.
Appears charge denied in error?
HSB response: 80050 should not have denied on original claim.

Ref. No. 095 Medical HSB claim no.

NOT charged in statistical calculation. Note to client for information only.
Claim xxxxxx DOS 6/20/20 for K0001-RR charge 112.00 denied on 7/1/20 for purchase price.
Purchase price received & all other DOS except for 6/20 have been paid.
Shouldn't this claim have also been adjusted & paid?
HSB response: Claim xxxxxx should have been adjusted and denied indicating purchase price met.

Ref. No. 109 Dental HSB claim no.

NOT charged in statistical calculation. Note to client for information only.
Claim contains D1999 – PPE
chg 25.00 allow 18.75 (x80%) paid 15.00
Shouldn't this charge have been denied as not covered?
HSB response: PEBP will not require HSB to reprocess to deny D1999.
See attached email.
HCA Note: Attached email from PEBP dated October 20, 2020: "Please accept this email as confirmation that PEBP will not require HSB to reprocess the 4,000+ claims identified on the D1999 impact report.
In accordance with our discussion on 9/21/20, HSB will add coding to review every claim billed with this miscellaneous code going forward and deny PPE as a non-covered service."

Ref. No. 110 Medical HSB claim no.

NOT charged in statistical calculation. Note to client for information only.
Originally claim paid on 3/2/19 under xxxxxx paid as:
99214 chg 150.00 allow 50 paid 40
90833 150.00 0.00 0.00
Audited is adjustment on 7/14/20 to now pay as:
90833 allow 25.00 paid 20.00
99214 45.00 36.00
56.00 – 48.00 = 8.00 additional paid
Per trns msgs paid under incorrect network – used HTH versus BHO
HSB response: The following claims corrected on 7/14/20 with correct pricing (Network): xxxxxx – 3/15/19, xxxxxx – 1/18/19, xxxxxx – 2/15/19. DOS 1/18/19 originally paid $80 under claim xxxxxx, when adjusted under xxxxxx paid $72 creating $8 overpayment. When claim xxxxxx paid for DOS 2/15/19 $8 of the $16 payable applied to offset overpayment.

Ref. No. 128 Dental HSB claim no.

NOT charged in statistical calculation. Note to client for information only.
Claim contains D1999 – PPE
chg 20.00 allow 16.00 ded 9.00 paid 5.60
Shouldn't this charge have been denied as not covered?
HSB response: PEBP will not require HSB to reprocess to deny D1999.
See attached email.
HCA Note: Attached email from PEBP dated October 20, 2020: "Please accept this email as confirmation that PEBP will not require HSB to reprocess the 4,000+ claims identified on the D1999 impact report.
In accordance with our discussion on 9/21/20, HSB will add coding to review every claim billed with this miscellaneous code going forward and deny PPE as a non-covered service."

Ref. No. 133 Outpatient Hospital HSB claim no.

NOT charged in statistical calculation. Note to client for information only.
Provider - Renown
Claim paid as:

Rev 300	36415	allow/pd 2.40	Per fee schedule allow 1.13
301	80053	11.59	15.82
301	80061	14.70	15.82
301	84153	20.18	19.65
302	86780	14.53	14.13
302	86803	15.66	13.00
305	85025	8.53	11.30
306	87340	11.34	10.74
306	87389	26.42	25.99
306	87491	38.51	37.29
306	87591	38.51	37.29
307	81003	2.46	1.70
		204.83	215.73

Claim for HM. Appears to be underpaid.
HSB response: Per HTH priced correctly. Please see attached.
HCA Note: Per attached from HTH: "contracted lab fee schedule 80% 2017 CMS Lab fee schedule with a 12% default."

Ref. No. 171 Medical HSB claim no.

NOT charged in statistical calculation. Note to client for information only.
Originally paid on 11/22/19 under xxxxxx paid as:
allow 1818.24 paid 1600.05
Audited is adjustment on 7/27/20 to pay additional 896.26
allow now 2714.50 paid 2496.31
HTH corrected pricing per trns msgs
HSB response: Yes, HTH repriced the claim on 7-2-20 with allowed of $2714.50.

Ref. No. 174 Medical HSB claim no.

Overpayment - $11.67
Claim paid as:

52001	chg 580.00	allow 260.41	(x80%) pd	208.33
52235	565.00	339.00	"	271.20
99222	280.00	168.00	"	134.40
				613.93

1) Per trns msgs allow for 52235 is $364.32. Why was claim processed with allow of $339.00?
2) Why was allow for 52001 calculated as:
52001 allow 362.59 – 52000 allow 102.18 = 260.41

Continued on next page….

HSB response: See attached pricing information. Overpaid by $11.67.
HCA Note: Per attached: "52235 & 52001 have a multiple procedure indicator of 3, not 2. These two procedures are endoscopic and the multiple procedure reduction calculates differently if they share an endoscopic base code. 52235 & 52001 share a common endoscopic base code of 52000. Calculates as follows:
52001 – Highest value endoscopy, allow 100% of PPO allowed = $348.00
52235 – 2nd highest values procedure will be PPO allowed for 52235 of $339.00 less than the PPO allowed for common endo base code 52000 $102.18 = $236.82. Total allow after reduction is $752.82, paying at 80% = $602.26.

Ref. No. 192 Medical HSB claim no.
Overpayment - $4.23

Claim contains:		chg		allow/paid
	80053	30.00		13.20
	84443	50.00		21.00
	85025	22.00		9.71
				43.91

Shouldn't these charges have been re-bundled & paid as 80050?
HSB response: Yes, 36415, 80053, 34443, 85025 should bundle to 80050 allowing $39.68.

Ref. No. 222 Outpatient Hospital HSB claim no.
NOT charged in statistical calculation. Note to client for information only.
Claim contains Rev 306, CPT 86769 chg 436.00 – denied as not covered
1) Since this is a covid test shouldn't this charge have been paid?
2) Does Renown have a fee schedule amount for this lab CPT?
HSB response: Per HTH, priced incorrectly and corrected pricing will be returned in 48 hours. 86769 allowed = $52.32.

Ref. No. 224 Outpatient Hospital HSB claim no.
NOT charged in statistical calculation. Note to client for information only.
Provider – Renown

Claim paid as:			chg	allow/pd
Rev 300	36415		26.00	2.40
301	80048		72.00	9.28
305	85027		55.00	7.10
				18.78

Per lab fee schedule shouldn't claim have paid as:

36415	allow/pd 1.13
80048	12.43
85027	10.17
	23.73

HSB response: Per HTH priced correctly. See attached.
HCA Note: Per attached from HTH: "Contract rate for lab services 80% 2017 CMS lab fee schedule with a 12% default".

Ref. No. 292 Medical HSB claim no.

NOT charged in statistical calculation. Note to client for information only.
Claim xxxxxx – inpatient hospital 7/15-7/16/20 at St Rose Siena paid as:
1 day at 6097.00
Rev 636 59.27
6156.27 allow
Shouldn't allow have been:
DRG 807 – 1 day x 6097.00 = 6097.00
Rev 636 270.00 x 24.2% = 65.34
6162.34 allow
HSB response: Incorrect rates provided by SHO. See attached email.
$6162.34 is correct allowable.
HCA Note: Per attached email dated September 24, 2020: "We did finally receive the rates that are to be effective 1/1/2020 thru 12/31/2020."

Ref. No. 298 Medical HSB claim no.

NOT charged in statistical calculation. Note to client for information only.
Claim originally paid 5/6/20 under xxxxxx as: allow/paid 737.50
Audited is adjusted on 8/18/20 to now pay as:
allow/paid 1192.50 with additional 455.00 paid
Per trns msgs S9364 allow is 150.00 versus 85.00 used to originally calculate.
When did HSB receive corrected pricing info from SHO?
HSB response: Original claim paid with incorrect calculations. During a routine audit this claim was identified and corrected. This was not the result of an updated SHO fee schedule.

Ref. No. 328 Medical HSB claim no.

NOT charged in statistical calculation. Note to client for information only.
Audited claim pd as: HM 00811-AA allow/paid 360.00
1) Claim xxxxxx for ASC Durango Surg Ctr denied as not covered.
2) Surgeon claim xxxxxx paid on 10/5/20 to deductible.
HSB response: The facility claim denied because there are no OON wellness benefits. Surgeon claim xxxxxx should pay as wellness based on facility claim DX.

Ref. No. 346 Medical HSB claim no.

Underpayment - $315.63

Claim paid as:	93655	allow 394.54	paid 315.63
	93656	2077.12	1661.70
	93613	549.53	439.62
	93623	291.59	233.27
	93662	256.16	204.93

Per trns msgs "No MPR". CPT 93655 is an add-on code

Shouldn't allow for 93655 have been 789.07 and not cut back for MPR at 50%?

HSB response: Agree, 93655 is an add on code and should not have been reduced.

Ref. No. 385 Outpatient Hospital HSB claim no.

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

Provider – Renown

Claim pd as:	36415	chg 26	allow/pd 2.40	Per fee schedule 1.13
	80197	117	15.07	17.52
	82043	49	6.34	7.35
	82306	252	32.17	40.68
	82570	44	5.68	6.78
	82570	44	5.68	6.78
	83735	57	7.35	7.91
	83970	351	45.30	48.03
	84156	31	4.02	6.22
	85025	66	8.53	11.30
	81003	19	2.46	1.70
			135.30	155.40

Appears claim underpaid?

HSB response: Disagree, claim paid correctly per HTH. See attached.

HCA Note: Per attached from HTH: "Contract rate for lab services 80% 2017 CMS lab fee schedule with a 12% default".

Ref. No. 395 Dental HSB claim no.

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

D1110	chg 98	allow/paid 93.00
D1206	34	34.00
D1999	15	0.00

Shouldn't D1999 have paid at 80% after deductible?

HSB response: D1999 was billed for PPE "personal protective equipment" and is non-covered. See attached email from PEBP.

HCA Note: Per PEBP email dated September 4, 2020: "If PPE is considered an administrative cost, it is not an allowable expense under the plan."

Ref No. 413 Dental HSB claim no.

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

D0140	chg 72	allow 48.00		paid 38.40
D0220	31	20.00		16.00
D0460	57	31.00	ded 25	3.00
D1999	10	0.00		0.00

Shouldn't D1999 have paid at 80% after deductible?

HSB response: D1999 was billed for PPE "personal protective equipment" and is non-covered. See attached email from PEBP.

HCA Note: Per PEBP email dated September 4, 2020: "If PPE is considered an administrative cost, it is not an allowable expense under the plan."

Ref. No. 430 Dental HSB claim no.

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

D0140	chg 81.00	allow/ded 69.00	
D0220	32.00	25.00	
D1999	15.00	0.00	

Shouldn't D1999 have paid at 80% after deductible?

HSB response: D1999 was billed for PPE "personal protective equipment" and is non-covered. See attached email from PEBP.

HCA Note: Per PEBP email dated September 4, 2020: "If PPE is considered an administrative cost, it is not an allowable expense under the plan."

Ref. No. 431 Dental HSB claim no.

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

D0120	chg 52.00	allow/paid 48.00	
D1120	70.00	67.00	
D1206	39.00	32.00	
D1999	10.00	0.00	

Shouldn't D1999 have paid at 80% after deductible?

HSB response: D1999 was billed for PPE "personal protective equipment" and is non-covered. See attached email from PEBP.

HCA Note: Per PEBP email dated September 4, 2020: "If PPE is considered an administrative cost, it is not an allowable expense under the plan."

Ref. No. 435 Outpatient Hospital HSB claim no.

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

Audited claim for Rev 320 – 77003-TC chg 1062.39

Claim xxxxxx same DOS 77003-26 chg 160.98 denied as "add-on code should not be reported without primary procedure"

This is the reading of 77003. Shouldn't this claim have been paid?

HSB response: Yes, claim xxxxxx, 77003-26 should have paid.

Ref. No. 442 Medical HSB claim no.

Overpayment - $182.13
Claim contains 96374, 96375, 96361-59, J1170, J1170-JW, J1885, J3480 and J7042.
OOP not met. Why is claim paying at 100%?
HSB response: Claim should have applied to deductible.

Ref. No. 465 Inpatient Hospital HSB claim no.

Underpayment - $500.00
Claim for DOS 7/1/20-7/20/20 paid as: allow 15,000 – 500 copay = 14,500.00 paid
Claim xxxxxx same provider paid on 9/17/20 for DOS 5/30-6/30/20 also has 500 copay applied.
Since audited claim is continuation of stay on claim xxxxxx, shouldn't no copay have applied? Underpaid 500.00
HSB response: Disagree, $500 copay assessed correctly based on new plan year and new maximum OOP accumulation period.
HCA Note: Per MPD Premier Plan copay of "$500 per admission" applies to Acute Care Hospital Admission. Patient was in for one admission in the same hospital from 5/30/20 to 7/20/20.

Ref. No. 472 Dental HSB claim no.

NOT charged in statistical calculation. Note to client for information only.
D0110 chg 115.00 allow/paid 93.00
D1999 10.00 0.00
Shouldn't D1999 have paid at 80% after deductible?
HSB response: D1999 was billed for PPE "personal protective equipment" and is non-covered. See attached email from PEBP.
HCA Note: Per PEBP email dated September 4, 2020: "If PPE is considered an administrative cost, it is not an allowable expense under the plan."

27 Corporate Hill
Little Rock, AR 72205

November 9, 2020

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

Subject: Audit Results July 1, 2020 –September 30, 2020

Dear Public Employees' Benefits Program (PEBP) Board:

HealthSCOPE Benefits appreciates the opportunity to respond to the audit performed by Health Claim Auditors for the first quarter of Plan Year 2021. The audit included 500 claims with paid amounts totaling $265,073.23.

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

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

We are very pleased with cost containment measures we are able to provide on the PEBP account. We saved an additional $731K through non-network negotiations, subrogation, clinical edits and transplant savings in the first quarter of PY2021.

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

4.3

4. Consent Agenda (Laura Freed, Board Chair) (**All Items for Possible Action**)

4.3 Health Claim Auditors, Inc. annual audit of Willis Towers Watson's OneExchange for the timeframe July 1, 2019 – June 30, 2020: (1) Report from Health Claim Auditors; (2) Willis Towers Watson's response to audit report; and (3) for possible action to accept audit report findings and assess penalties, if applicable, in accordance with the performance guarantees included in the contract pursuant to the recommendation of Health Claim Auditors.

Medicare Exchange

Health Reimbursement Arrangement

Audit Report

for

Nevada PUBLIC EMPLOYEES' BENEFITS PROGRAM

Conducted on

Willis Towers Watson

Audit Period:
PEBP Plan Year 2020

Submitted By:
Health Claim Auditors, Inc.

TABLE OF CONTENTS

State of NV. PEBP - Health Reimbursement Arrangement

Introduction

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

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

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

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

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

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

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

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

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

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

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

EXECUTIVE SUMMARY OF FINDINGS

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

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

Trends/Issues

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

Administrated by PayFlex

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

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

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

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

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

Willis Towers Watson Benefits Accounts

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

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

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

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

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

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

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

Historical Statistics

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

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

Other Audit Findings/Observations

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

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

Overpayments

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

Validation of Carrier Commissions

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

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

Conclusion

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

AUDIT FINDINGS – DETAIL

Other Customer Service Measurements

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

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

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

Current Overpayments

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

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

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

Continued on next page…

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

Explanation of Payment (EOP)

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

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

Participant Funding

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

*

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

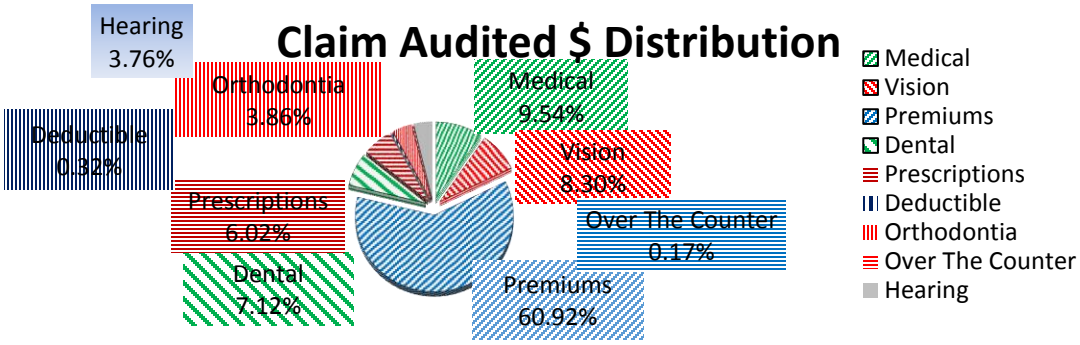
* Please note: A one (1) time fund deposit authorized by the PEBP Board of Directors was conducted in July 2019.

Breakout of Claims Audited

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

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

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



Participant Survey

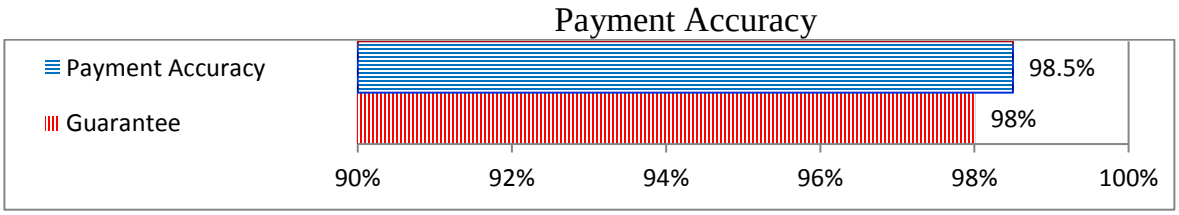
HCA requested the results of any Customer Surveys conducted within the audited period. Note: The client trend report categories changed for quarters three and four. Results supplied are as follows:

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

Payment Accuracy

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

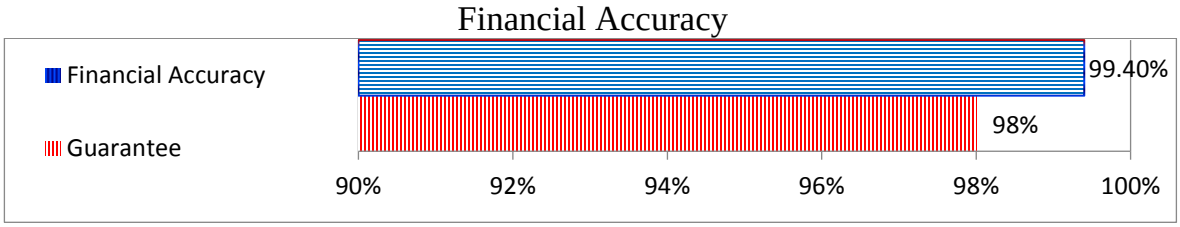
The Payment Accuracy Percentage of the number of claims paid correctly from the WTW (PayFlex + WTWBA) random selections for this audited period is 98.5%.



Financial Accuracy

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

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



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

Turnaround Time

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

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

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

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

Policy, Procedures and System

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Phase Expectations

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

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

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

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

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

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

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

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

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

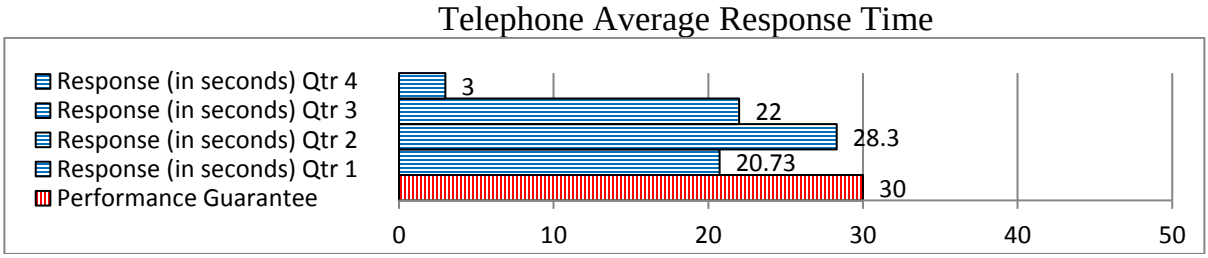
HCA is requested that WTWBA please verify by statement the following:

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

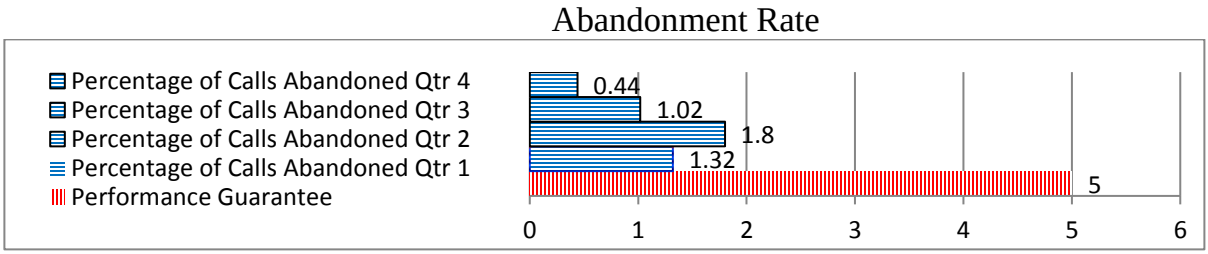
WTWBA response: It has been verified that WTW has fulfilled its obligations per the contract.

Customer Service

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



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



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

Reporting

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

Standard:
Ledger Summary
Production Payment Register
Deposit Summary
Payment Summary

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

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

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

SPECIFIC AUDIT RESULTS

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

Ref. No. 010 One Exchange claim no.

Over/Underpayment - $0.00

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

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

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

Ref. No. 017 One Exchange claim no.

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

Ref. No. 125 One Exchange claim no.

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

Ref. No. 147 One Exchange claim no.

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

Ref. No. 7W Via Benefits claim no.

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

Ref. No. 12W Via Benefits claim no.

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

Ref. No. 78W Via Benefits claim no.

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

Ref. No. 98W Via Benefits claim no.

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

Ref. No. 107W Via Benefits claim no.

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

Ref. No. 128W Via Benefits claim no.

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

4.4

4. Consent Agenda (Laura Freed, Board Chair) (**All Items for Possible Action**)

4.4 Receipt of the PEBP Biennial Legal Compliance Review report performed by Aon.

Empower Results®

October 28, 2020

Ms. Laura Rich
Executive Director
State of Nevada
Public Employees' Benefits Program
901 S. Stewart Street, Suite 1001
Carson City, NV 89701

Subject: Final Compliance Review Report for PEBP Plan Year 2020

Dear Laura,

Enclosed please find our final compliance review report for PEBP Plan Year 2020. Please do not hesitate to contact me if you would like to discuss any aspect of the report.

Sincerely,

Aon Consulting, Inc.

Rachel Arnedt

Enclosure
By UPS
cc: Ms. Stephanie Messier, Aon

Public Employees' Benefits Program

Biennial Compliance Review

Review Period July 2019-June 2020 ("PY 2020")

FINAL REPORT

November 2, 2020

Empower Results®

Report Contents

SECTION A: INTRODUCTION

This compliance review is being undertaken pursuant to Nevada Revised Statute ("NRS") 287.025(2)(b), which requires a biennial review of the Public Employees' Benefits Program ("PEBP") to determine whether the PEBP complies with federal and state laws relating to taxes and employee benefits. Accordingly, Aon performed a review of certain plan documents and administration processes provided by PEBP to verify that procedures have been implemented to enable PEBP to comply with applicable federal and state laws.

Our compliance review is based on documents received, statutes, and regulations as existing and in effect for PEBP's July 1, 2019—June 30, 2020 plan year ("PY 2020"), unless otherwise noted ("Review Period"). We requested from PEBP staff members certain documents and answers to specific questions relevant to PEBP during the Review Period. As noted in the Work Order Request ("Work Order"), our transactional review was specifically limited to targeted questions on administration of changes in status, special enrollment periods, and issuance of applicable COBRA notices. We did not attempt to verify actual administration of PEBP through sampling techniques, discussions with third party vendors/administrators, or otherwise. In addition, we did not perform any claim audits related to PEBP, or consider issues related to payroll practices, workers' compensation, unemployment compensation, classification of employees, or other non-benefits-related aspects of any federal or state law.

This Report outlines the results of Aon's review and summarizes our findings and recommendations to address certain document compliance issues that we have identified as a result of our compliance review. Any consulting advice we provide is intended to assist PEBP in determining how best to comply with applicable requirements relating to PEBP's compliance with federal and state laws. Nevertheless, Aon does not engage in the practice of law, and the consulting advice we provide is not, and is not intended to be, legal advice. Accordingly, this Report should be reviewed with PEBP's legal counsel.

Although we identified certain compliance issues relating to PEBP, our Report should not be relied upon to identify all possible weaknesses in internal controls, errors, irregularities, or illegal acts, or to identify all possible violations of the NRS, Nevada Administrative Code ("NAC"), the Internal Revenue Code (the "Code"), Public Health Service Act ("PHSA"), the Employee Retirement Income Security Act of 1974 as amended ("ERISA") (in relevant part as made applicable through the PHSA), Internal Revenue Service ("IRS"), regulations, or other technical pronouncements as we did not perform a transactional operational compliance review of PEBP. We interpreted compliance requirements in a manner we believe to be reasonable. However, we cannot guarantee that government agencies, courts, or participants will agree with our interpretation, or that PEBP would be in compliance with all applicable laws, regulations, rules, or other governmental pronouncements if PEBP implemented all of our recommendations.

We would be pleased to discuss this Report and our recommendations with you in further detail. If you have any questions, please contact Rachel Arnedt at 203.584.2913.

SECTION B: EXECUTIVE SUMMARY

Overall, PEBP has done an excellent job in ensuring that its documents and procedures comply with applicable federal and state laws.

However, as is typical with reviews of this magnitude, we did note a few areas that could be enhanced to better meet federal and/or state law requirements. The following summarizes our significant findings. Please refer to Sections E and F for a detailed description of the findings and required courses of action.

Federal Law Issues—Current

Medicare Secondary Payer

- PEBP terminates retiree eligibility for its active plans when retirees reach Medicare eligible age and requires Medicare eligible retirees to enroll in the Medicare HRA plan. Medicare Secondary Payer rules prohibit *active* plans from basing plan eligibility on Medicare eligibility. PEBP will remedy this by creating a mirror plan and documentation for early retirees only.

Required Notices in General

- PEBP has switched to the PY 2020 Benefit Guide and that Guide doesn't have as many notices in it as were available in prior years. PEBP mails the Benefit Guide to new hires and retirees at initial enrollment. It is unclear how widely its notices are being distributed compared to prior years.

Electronic Disclosure of Important Notices to Spouses, Other Beneficiaries, and Employees without Routine Computer Access at Work

- PEBP should continue to work toward a system change that will allow it to get written consent to receive electronic notices from retirees and others without work access, as well as keep multiple addresses on file (e.g., COBRA, where spouse has different address from employee) to send separate notices to them when needed.

Federal Law—Future Considerations

Patient Protection and Affordable Care Act of 2010 ("PPACA")

- PEBP should continue monitoring the status of PPACA provisions and lawsuits pertaining to PPACA to determine whether any changes (e.g., repeal or replacement provisions) become effective that would necessitate changes to PEBP's plans. In particular, PEBP should monitor the Supreme Court case (arguments for which will be held in mid-November 2020) regarding the constitutionality of the ACA.
- Employer reporting of health insurance information to government and participants on Forms 1094-C and 1095-C continues; monitor for any changes in requirements.
- PEBP should continue monitoring of changes to HHS/Health Resources and Services Administration ("HRSA") preventive task force guidelines and make respective plan changes from time to time.
- If PEBP determines it is still a covered entity under the revised definition, PEBP should continue monitoring for additional Section 1557 nondiscrimination guidance given the litigation regarding the recent final regulations and make respective plan changes from time to time.
- PEBP should develop necessary forms and procedures to comply with PPACA quality of care reports (requirement delayed).

SECTION B: EXECUTIVE SUMMARY (CONT'D)

- PEBP should monitor, perform testing, develop a strategy, and make any necessary plan design changes needed to comply with insured nondiscrimination testing (guidance still pending and not in effect).

State Law Issues

None.

SECTION C: FACTS AND ASSUMPTIONS

The following facts and assumptions were relied upon in performing our review and preparing this Report:

All documents and data received (see Section D), as well as any information conveyed to us orally, are accurate and were in effect during the Review Period.

Generally, the PEBP-sponsored health and welfare benefit plans that are subject to this review are those reflected in the Master Plan Documents and the FSA SPD:

- Self-funded PEBP Consumer Driven Health Plan
- Self-funded Prescription Drug Benefits
- Self-funded PEBP PPO Dental Plan
- Health Care Flexible Spending Account
- Dependent Care Flexible Spending Account

To the extent that the Federal and/or State of Nevada laws noted in the bullet points below are applicable, the following PEBP health and welfare benefit plans were also included:

- Life Insurance Plan
- Long-Term Disability Plan
- Voluntary elective products/benefits offered under PEBP (Flex Plan, Long-Term Care, Short-Term Disability, and Supplemental Life Insurance)

PEBP is not involved in the administration of the Employee Assistance Program (EAP); therefore, any analysis related to the EAP is outside the scope of this Report.

There were also documents that were provided during our previous review(s) that were still effective during this Review Period. To the extent that applicable statutes had not been subsequently amended, we relied on our prior findings for our current review, assuming they would be still applicable.

The PEBP health and welfare benefit plans listed above were reviewed for compliance with the following federal laws:

- Americans with Disability Act of 1990 and the Americans with Disability Act Amendments Act of 2008 (together "ADA")
- Age Discrimination in Employment Act of 1967 ("ADEA")
- Children's Health Insurance Program Reconciliation Act of 2009 ("CHIPRA")
- COBRA (as made applicable through Section 300bb of the Public Health Service Act)
- Coronavirus Aid, Relief, and Economic Security Act ("CARES Act")
- Executive Order 11246 (re: nondiscrimination on the basis of sex)
- Family and Medical Leave Act of 1993 ("FMLA")
- Families First Coronavirus Response Act ("FFCRA")
- Genetic Information Nondiscrimination Act of 2008 ("GINA")
- Gulf Opportunity Zone Act of 2005 ("GO")
- Heroes Earnings Assistance and Relief Tax Act of 2008 ("HEART")

SECTION C: FACTS AND ASSUMPTIONS (CONT'D)

- Health Insurance Portability and Accountability Act of 1996 ("HIPAA") benefit provisions for HIPAA privacy and data security provisions, including HITECH (note that our review did not include a review for compliance with HIPAA's Electronic Data Interchange ("EDI") regulations)
- Medicare Secondary Payer ("MSP") requirements
- The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 ("Medicare Part D Requirements")
- Mental Health Parity Act ("MHPA") and Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 ("MHPAEA")
- Michelle's Law of 2008
- National Defense Authorization Act of 2008 ("NDAA")
- Newborns' and Mothers' Protection Act of 1996 ("NMHPA")
- Patient Protection and Affordable Care Act of 2010 ("PPACA")
- Pregnancy Discrimination Act ("PDA")
- QMCSOs
- Rehabilitation Act of 1973
- Social Security Act Health Insurance ("Medicare"), including Medicare Part D
- Title VII of the Civil Rights Act of 1964
- Uniformed Services Employment and Reemployment Rights Act of 1964 ("USERRA")
- Women's Health & Cancer Rights Act of 1998 ("WHCRA")
- Code Section 125 Cafeteria Plan rules

SECTION C: FACTS AND ASSUMPTIONS (CONT'D)

The PEBP health and welfare plans listed above were reviewed for document compliance with the certain Nevada state law requirements in the following areas. This listing reflects the impact of several new and revised pieces of legislation subsequent to our previous review that may have impacted PEBP benefits and administration:

- Eligibility and Participation
  - NAC 287.035, 287.085, 287.095, 287.100, 287.135, 287.150, 287.310, 287.3105, 287.311, 287.312, 287.3105, 287.3125, 287.313, 287.314, 287.317, 287.318, 287.319, 287.320, 287.355, 287.357, 287.359, 287.361, 287.363, 287.365, 287.367, 287.368, 287.369, 287.371, 287.373, 287.375, 287.376, 287.379, 287.381, 287.383, 287.385, 287.386, 287.387, 287.389, 287.400, 287.510, 287.515, 287.520, 287.530
  - NRS 287.010, 287.020, 287.021, 287.025, 287.040, 287.045,287.0467, 287.0475, 287.0477, 287.0479, 689B.033
- Retirees
  - NAC 287.530, 287.540, 287.542, 287.544, 287.546, 287.548
  - NRS 287.0205, 287.023, 287.024, 287.0406, 287.0436, 287.043, 287.046, 287.047, 287.0475
- Benefit Coverage
  - NAC 287.100
  - NRS 287,010, 287.0205, 287.027, 287.0272, 287.0274, 287.0276, 287.0278, 287.040, 287.04062, 287.0433, 287.04335, 287.0467, 287.0485, 287.287, 689A.0447, 683A.0879, 683A.330, 689A.417, 689B.0306, 689B.0362, 689B.069, 689B.255, 689B.275, 689B.330, 689B.283, 689B.287, 689B.0362, 689B.425, 689B.500, 689B.550, 689C.159, 689C. 190, 689C.193, 689C.198, 689C.220, 689C.425, 689C.17335, 695A.188, 695B.193, 695B.2505, 695B.2555, 695C.050, 695C.173, 695C.185, 695C.207, 695C.330, 695G.150, 695G.160, 695G.162, 695G.164, 695G.1645, 695G.1665, 695G.167, 695G.170-695G.172, 695G.173, 695G.177, and 695G.405
- Premium and Funding
  - NAC 287.420-287.490, 287.760-287.792
  - NRS 287.015, 287.017, 287.043, 287.0434, 287.0435, 287.0436, 287.04362, 287.04364, 287.04385, 287.0439, 287.044, 287.0445, 287.046
- Subrogation (NRS 287.0465) (as amended)
- Orientation Program (NAC 287.314 and 287.317)
- Agency Participation and Administration
  - NAC 287.310, 287.320, and 287.355-287.389
  - NRS 287.010 and 287.020
- Board Authority and Duties
  - NAC 287.170-287.196
  - NRS 287.0402, 287.04062, 287.041, 287.0415, 287.0424, 287.0426, 287.043, 287.04335, 287.0434, 287.04366, and 287.0487
- Executive Branch Reporting Requirements (NRS 287.0425)
- Claims and Appeals Procedures

SECTION C: FACTS AND ASSUMPTIONS (CONT'D)

  - NAC 287.610-287.695 and 287.750
  - NRS 287.043, 287.04335, 689B.255, 695G.200, 695G.210, 695G.220, 695G.230, 695G.241-695G.300, and 695G.310
- Notice Requirements (NRS 695G.210 and 695G.230)
- Family and Medical Leave (NAC 284.52315, 284.5237, 284.52345, 284.581, 284.5811, and 284.5813)
- Leave of Absence for Military Duty (NAC 281.145, and 284.5875; NRS 284.359)
- Audit Requirements (NRS 287.0425 (1)(a), (b))

SECTION D: DOCUMENTS REVIEWED

In performing our review of the PEBP health and welfare plans, we reviewed the following documents during this review period:

- PEBP to Aon Work Order Request (2020)
- Plan Documents:
  - PEBP Master Plan Document ("MPD") for Enrollment and Eligibility: Plan Year ("PY") 2020
  - PEBP MPD for the Consumer Driven Health Plan for Medical, Vision and Prescription Drug Benefits and Summary of Benefits for Health Savings Account, Health Reimbursement Account PY 2020
  - PEBP MPD for the Self-Funded PEBP PPO Dental Plan and Summary of Benefits for Life and Long-Term Disability Insurance PY 2020
  - Qualifying Life Event Guide (April 2019)
  - PEBP Section 125 Health and Welfare Benefits Plan Document PY 2020
- Plan Summaries
  - PEBP Plan Year 2020 Benefit Guide
  - PEBP CDHP SBC (Individual) PY 2020
  - PEBP CDHP SBC (Family) PY 2020
  - PEBP CDHP Glossary of Health Coverage and Medical Terms
  - Medicare Exchange Health Reimbursement Arrangement Summary PY 2020
  - HealthSCOPE Flexible Spending Accounts ("FSA"), Health Care (Medical) FSA, Dependent Care FSA, Limited Purpose/Scope FSA Summary Plan Description and Employee Enrollment PY 2020
  - HSA/HRA Supplemental Funding FAQs PY 2020
  - PEBP Health Plan Comparison PY 2020
- PEBP Consumer Driven Health Plan Documents
- HealthSCOPE Documents:
  - Benefits Subrogation Letters

SECTION D: DOCUMENTS REVIEWED (CONT'D)

- State of Nevada/PEBP Handbooks and Manuals
  - State of Nevada Employee Handbook (Revised 1/18/2018)
  - State of NV State Administrative Manual (Revised 11/2018)
- Enrollment Materials
  - Plan Year 2020 Benefit Guide
  - Plan Year 2020 Medicare Guide
  - Enrollment & Eligibility MPD PY 2020
  - Certification of Disabled Dependent Child (PY 2020)
  - Legal Guardianship Certification (8/2019)
- COBRA-Related Documents:
  - Initial COBRA Notice (Revised 8/2020)
  - COBRA Address Notification Form (Revised 10/2013)
  - Sample COBRA Election Notice (Dated 11/17/16)
  - COBRA Confirmation of Enrollment (Dated 11/18/16)
  - COBRA Premium Notice – Past Due (undated)
  - COBRA Termination Notices (Dated 10/31/16)
  - COBRA Rates PY 2020
- Other Notices:
  - Qualified Medical Child Support Order Notification
  - Notification of Retiree Turning 65
  - FMLA Notice
  - Marketplace Notice – Eligible Employees
  - Marketplace Notice – Ineligible Employees
  - PEBP CDHP Medicare Part D Notice Actives PY 2020
  - PEBP CDHP Medicare Part D Notice Retirees PY 2020
  - USERRA/Military Leave Related Notices

SECTION D: DOCUMENTS REVIEWED (CONT'D)

  - Newborn and Mother's Health Protection Act Notice
  - Women's Health and Cancer Rights Act
  - SBC Availability Notice
  - CHIP Notice
  - Section 1557 Nondiscrimination Notice
- Local Government Entity Application Instructions for Coverage under Public Employees' Benefits Program (Health Insurance) (Revised 6/2016)
- PEBP Policies and Procedures
  - Accounting Unit
  - Appeals and Complaints Policies and Procedures (3/19/2018)
  - Privacy Policies and Procedures (7/1/2016)
  - Non-State Agency Application Procedures (last updated in 2001)
  - Local Government Entity Application (dated 6/2016)
- HIPAA Privacy and Security-Related Documents:
  - PEBP Master Plan Document for the HIPAA Privacy and Security Requirements for PEBP Health Benefits PY 2018
  - HIPAA Privacy Notice (Effective July 1, 2015)
  - Privacy & Security of Protected & Personal Health Information (PHI) (Originated 9/17/2003, Last Updated 7/1/2016), including Attachments A through F
  - HIPAA Privacy and Data Security Training: PEBP Board and Staff (August 2017)
  - Template Business Associate Agreement
  - Current Business Associate Agreements with:
    - Casey, Neilon and Associates LLC (Effective March 26, 2013)
    - Express Scripts, Inc. ("Upon BOE Approval")
    - Health Claim Auditors, Inc. (Effective July 1, 2016)
    - HealthSCOPE Benefits, Inc. (Effective July 1, 2016)
    - Hometown Health Providers ("Upon BOE Approval")
    - Morneau Shepell (Effective July 1, 2016)

SECTION D: DOCUMENTS REVIEWED (CONT'D)

  - Towers Watson / Delaware Inc. (Effective July 1, 2018)

- PY20 Rates – Effective 7/1/2019
- PEBP Board Action Minutes
  - January 24, 2019
  - March 7, 2019
  - March 28, 2019
  - April 29, 2019
  - May 23, 2019
  - July 25, 2019
  - September 26, 2019
  - November 21, 2019
  - December 20, 2019
  - January 23, 2020
  - March 3, 2020
  - March 31, 2020
  - April 9, 2020
  - April 27, 2020
  - May 28, 2020

- PEBP Board and Agency Duties, Policies and Procedures (9/2019 (draft))

SECTION E: SUMMARY OF FINDINGS—FEDERAL LAW REQUIREMENTS

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SECTION E: SUMMARY OF FINDINGS—FEDERAL LAW REQUIREMENTS (CONT'D)

SECTION E: SUMMARY OF FINDINGS—FEDERAL LAW REQUIREMENTS (CONT'D)

FEDERAL STATUTE	DOCUMENTS REVIEWED	FINDINGS	COURSE OF ACTION REQUIRED	PEBP ACTION
Americans with Disabilities Act of 1990, as amended ("ADA")	▪ Reviewed Master Plan Documents ("MPDs"), Section 125 Health and Welfare Benefits Plan Document ("Section 125 Document"), and Flexible Spending Account Summary Plan Description ("FSA SPD"). ▪ Reviewed Employee Handbook and State Administrative Manual.	▪ EEOC regulations under the ADA and GINA, since partially vacated, would have applied to PEBP starting 7/1/2017 if PEBP had a wellness program that collected employee health information as a condition for receiving incentives. ▪ PEBP does not have a wellness program that collects employee health information, and so this new requirement does not apply to PEBP.	▪ None.	
Age Discrimination in Employment Act of 1967	▪ Reviewed MPDs, Section 125 Document, and FSA SPD. ▪ Reviewed Employee Handbook and State Administrative Manual. ▪ Reviewed Group Life Insurance Certificates. ▪ Reviewed Group Long Term Disability Insurance Certificates.	▪ No exceptions noted.	▪ None.	
Children's Health Insurance Program Reconciliation Act of 2009 ("CHIPRA")	▪ Reviewed MPDs, Section 125 Document, and FSA SPD. ▪ Reviewed Employee Handbook.	▪ CHIPRA Notice is currently not being distributed by PEBP; the obligation to distribute is on the employer (i.e., Agencies). ▪ Aon sent PEBP a copy of the most recent model CHIPRA notice on December 15, 2016. ▪ As confirmed by PEBP in document request, the Agencies retained the responsibility to distribute the notice for PY 2020. PEBP will distribute the CHIPRA notice starting PY 2021 in the Benefit Guide.	▪ None.	

SECTION E: SUMMARY OF FINDINGS—FEDERAL LAW REQUIREMENTS (CONT'D)

FEDERAL STATUTE	DOCUMENTS REVIEWED	FINDINGS	COURSE OF ACTION REQUIRED	PEBP ACTION
Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA")	▪ Reviewed MPDs. ▪ Reviewed Section 125 Document. ▪ Reviewed Plan Year 2020 Benefits Guide and Plan Year 2020 Medicare Guide. ▪ Reviewed FSA SPD. ▪ Reviewed COBRA Election Notice. ▪ Reviewed COBRA Premium Notice – Past Due. ▪ Reviewed PEBP Bad Debt and Collections Procedures.	▪ COBRA General (Initial) Notice. ▪ PEBP updated COBRA General Notice in August 2020 to incorporate Medicare coordination language from the new model notice published by the DOL in May 2020. ▪ Plan Year 2020 Benefits Guide contains COBRA overview and a link to the General Notice. PEBP does not obtain consent from employees or spouses for electronic disclosure of important documents including COBRA notices. (PEBP intends to add capability to obtain consent electronically in future system upgrades.) ▪ Linking to the COBRA General Notice is an electronic disclosure of the General Notice to employees and spouses. PEBP may electronically disclose the General Notice to an employee without consent only if: • The employee has the ability to access the documents at any location where the employee is reasonably expected to perform employment duties, and • The employee's access to the electronic system is an integral part of their employment duties. To furnish the General Notice to employees without such access to the electronic system, and to all spouses of employees, PEBP must obtain the consent of the employee or spouse. ▪ PEPB will incorporate the COBRA General Notice, along with other required notices, into the E&E MPD and mail the E&E MPD annually.	▪ Mail COBRA General Notice to employees and spouses who have not provided consent for electronic disclosure. ▪ If a second address is known for a spouse, mail COBRA General Notice to that second address when capable.	▪ PEBP agrees with this finding and PEBP will work with the new eligibility and enrollment system vendor for potential system changes to obtain participant consent to receive electronic notices and the ability to maintain multiple address on file for COBRA participants ▪ PEBP will also incorporate the COBRA General Notice into the E&E MPD and mail the E&E MPD annually.

SECTION E: SUMMARY OF FINDINGS—FEDERAL LAW REQUIREMENTS (CONT'D)

FEDERAL STATUTE	DOCUMENTS REVIEWED	FINDINGS	COURSE OF ACTION REQUIRED	PEBP ACTION
COBRA (cont'd)		▪ Retirees in the Medicare Exchange HRA are not eligible for COBRA in the event of the employer's bankruptcy. Medicare Exchange Health Reimbursement Arrangement SPD does not address COBRA.	▪ Revise Medicare Exchange Health Reimbursement Arrangement SPD to include COBRA eligibility in the event of an employer bankruptcy.	▪ PEBP agrees with this finding and will add the language.
		▪ The Enrollment and Eligibility MPD refers to a section called "When COBRA Continuation Coverage May Be Cut Short" for an explanation of when the plan may terminate COBRA prior to the end of the maximum period of coverage. There is no section entitled "When COBRA Continuation Coverage May Be Cut Short," and this information is not provided in this MPD.	▪ Add a section "When COBRA Continuation Coverage May Be Cut Short" to Enrollment and Eligibility MPD after "Maximum Period of COBRA Continuation Coverage."	▪ PEBP agrees with this finding and will add the language.
		▪ <u>Notification to PEBP of Qualifying Events.</u> ▪ As confirmed by PEBP, the Agencies notify PEBP regarding the terminations of employment and reductions in hours. PEBP is unable to control timing of notifications by the Agencies. Agencies are responsible for employee portion of the premium if PEBP is not notified timely.	▪ None.	
		▪ <u>Election Notice.</u> ▪ If the Election Notice has been unchanged, then the COBRA Election Notice contains language regarding HIPAA Creditable Coverage notices which should be removed. ▪ Distribution of Election Notice: Per confirmation by PEBP, PEBP typically sends out the COBRA Election Notice within 5 working days after receipt of notification of a qualifying event from the Agency. PEBP is unable to control any potential delay by the Agencies in notifying PEBP of the qualifying event.	▪ Remove references to HIPAA Creditable Coverage notices in the COBRA Election Notice.	▪ PEBP agrees with this finding and will remove the HIPAA Creditable Coverage notice language.
		▪ <u>Notice of Termination of COBRA Coverage</u>. ▪ No exceptions noted.	▪ None.	
		▪ <u>Notice of COBRA Premiums Short by Insignificant Amount.</u>	▪ None.	

SECTION E: SUMMARY OF FINDINGS—FEDERAL LAW REQUIREMENTS (CONT'D)

FEDERAL STATUTE	DOCUMENTS REVIEWED	FINDINGS	COURSE OF ACTION REQUIRED	PEBP ACTION
COBRA (cont'd)		▪ The 2014 report suggested adding COBRA shortfall language to the standard Collections notice issued by PEBP Accounting Unit. ▪ Aon provided sample language on December 15, 2016. ▪ Per discussion with PEBP on January 20, 2017, PEBP believes that the collections process and existing language in Collections notice is sufficient and that explicit COBRA shortfall language is unnecessary in the standard Collections notice issued by the PEBP Accounting Unit. ▪ PEBP stated in its response to summary questions dated October 7, 2020 that PEBP will add shortfall language to COBRA Premium Notice – Past Due notice. The proposed shortfall language is not appropriate for qualified beneficiary communications. Aon instead recommends including the following phrase: "If your payment is not significantly short of the due amount, PEBP will contact you to allow you to complete the payment."	▪ Revise COBRA Premium Notice – Past Due with the shorter shortfall statement.	▪ PEBP agrees with this and will modify the COBRA Premium Notice – Past Due accordingly.
Executive Order 11246	▪ Reviewed MPDs, Section 125 Document, and FSA SPD. ▪ Reviewed Group Life Insurance Certificates. ▪ Reviewed Group Long Term Disability Insurance Certificates.	▪ No exceptions noted.	▪ None.	
Family and Medical Leave Act of 1993 ("FMLA")	▪ Reviewed MPDs, Section 125 Document, and FSA SPD. ▪ Reviewed Employee Handbook. ▪ FMLA Notice.	▪ No exception noted.	▪ None.	

SECTION E: SUMMARY OF FINDINGS—FEDERAL LAW REQUIREMENTS (CONT'D)

FEDERAL STATUTE	DOCUMENTS REVIEWED	FINDINGS	COURSE OF ACTION REQUIRED	PEBP ACTION
Families First Coronavirus Response Act ("FFCRA"), as amended by the Coronavirus Aid, Relief, and Economic Security Act ("CARES Act") and IRS Notices 2020-29 & 2020-30	▪ Reviewed MPDs, Section 125 Document, and FSA SPD.	▪ FFCRA requires group health plans to cover USPSTF recommended items, including a COVID-19 vaccine, within 15 business days of adoption by the USPSTF. CDHP MPD and Premium Plan MPD should make such preventive service coverage explicit. ▪ FSA SPD will need to be updated for $550 carryover. ▪ OTC medicines need to be updated.	▪ Amend CDHP MPD and Premier EPO Plan MPD to explicitly cover USPSTF-recommended COVID services, including a vaccine, within 15 business days of adoption of recommendation by USPSTF. ▪ Update FSA SPD accordingly.	▪ PEBP agrees with this finding and will make the required amendments to the CDHP MPD and Premier EPO Plan MPD. ▪ PEBP agrees with this finding and will make the required amendments to the FSA SPD.
Genetic Information Nondiscrimination Act of 2008 ("GINA")	▪ Reviewed MPDs.	▪ No exception noted.	▪ None.	
Gulf Opportunity Zone Act of 2005 ("GO Act")	▪ Reviewed MPDs.	▪ No exception noted.	▪ None.	
Heroes Earnings Assistance and Relief Tax Act of 2008 ("HEART")	▪ Reviewed FSA SPD. ▪ Reviewed FSA Enrollment Form. ▪ Reviewed Employee Handbook.	▪ No exceptions noted.	▪ None.	

SECTION E: SUMMARY OF FINDINGS—FEDERAL LAW REQUIREMENTS (CONT'D)

FEDERAL STATUTE	DOCUMENTS REVIEWED	FINDINGS	COURSE OF ACTION REQUIRED	PEBP ACTION
HIPAA Benefit Provisions	▪ Reviewed Plan Year 2020 Benefit Guide and Plan Year 2020 Medicare Guide. ▪ Reviewed MPDs, Section 125 Document, and FSA SPD. ▪ Reviewed Qualifying Life Status Event document.	▪ The Enrollment and Eligibility MPD and Qualifying Life Status Event documents describe the HIPAA Special Enrollment rights for those who lose CHIPRA coverage or for those who lose Medicaid coverage. ▪ The Enrollment and Eligibility MPD and Qualifying Life Status Event document do not permit a special enrollment for those that lose eligibility for individual coverage in the public Exchange. However, in practice, PEBP allows individuals to enroll in PEBP coverage if they lose individual coverage. ▪ The following documents have a HIPAA Special Enrollment Rights notice: Enrollment and Eligibility MPD. The Section 125 Document has a section regarding "Special Enrollment" with the language of a HIPAA Special Enrollment Rights notice, but the term "HIPAA Special Enrollment" is not used. PEBP will begin to mail E&E MPD annually to ensure provision of required notices, including notice of Special Enrollment rights. ▪ Qualifying Life Status Event document states that participants need to provide PEBP with a Creditable Coverage Certificate when trying to enroll during Dependent Loses Coverage and Loss of Coverage for Dependent Children under Medicaid or Nevada Check Up.	▪ None. ▪ None. ▪ None. ▪ Remove references to "Creditable Coverage Certificates."	▪ PEBP agrees with this finding and will remove references to Creditable Coverage Certificates.

HIPAA Privacy and Data Security Provisions	▪ Reviewed HIPAA Privacy Notice.
	▪ Reviewed MPD, HIPAA Privacy and Security Policies and Procedures, and July 2019 training materials as provided by Aon to PEBP.
	▪ Reviewed HIPAA Training Log.
		▪ <u>Training</u>.
		  ▪ PEBP staff receives annual training and has a good understanding of the HIPAA rules and regulations and are very sensitive to the privacy and security of PEBP health information.
		  ▪ Training Log ("Board and Staff HIPAA Attestation") indicates training was received September and October of 2019 and between February and October 2020.
			▪ None.	

SECTION E: SUMMARY OF FINDINGS—FEDERAL LAW REQUIREMENTS (CONT'D)

FEDERAL STATUTE	DOCUMENTS REVIEWED	FINDINGS	COURSE OF ACTION REQUIRED	PEBP ACTION
HIPAA Privacy and Data Security Provisions (cont'd)		▪ HIPAA Privacy Officer. ▪ Identified in the HIPAA Privacy and Security Policies and Procedures as Quality Control Officer. ▪ Identified in the HIPAA Privacy Notice (also identified as contact person). ▪ Identified in the July 2019 HIPAA Privacy and Data Security Training as Quality Control Officer.	▪ None.	
	▪ Reviewed HIPAA Privacy Notice.	▪ HIPAA Privacy Notice. ▪ Notice was updated in 2016.	▪ None.	
	▪ Reviewed MPDs, Section 125 Document, and FSA SPD.	▪ HIPAA Notice of Privacy Practices is not provided in any MPDs, but the FSA SPD has a large portion of the Notice under General Notices.	▪ Delete the remaining portion of the Notice of Privacy Practices in the FSA SPD.	▪ PEBP agrees with this finding and will amend the FSA SPD accordingly.
	▪ Reviewed Plan Year 2020 Benefit Guide and Plan Year 2020 Medicare Guide.	▪ Plan Year 2020 Benefit Guide and Plan Year 2020 Medicare Guide contain paragraph on HIPAA Privacy Practices with a description of how to obtain a copy of the notice.	▪ None.	
		▪ Notice of Privacy Practices under Mandatory Notices section of website links to same Notice of Privacy Practices as other plan documents.	▪ None.	
	▪ Reviewed MPDs, Section 125 Document, and FSA SPD.	▪ Protected Information Access Levels. ▪ The PEBP Protected Information Access Levels per position chart, which lists the access levels for employees who are authorized to view PHI/PII, is found in: • The 2019 HIPAA Privacy and Data Security Training materials; and • The HIPAA Privacy and Security Policies and Procedures (1/23/2019).	▪ Reconcile the titles and levels of access between the training the Policies and Procedures (likely updating the training).	▪ PEBP agrees with this finding and will review the titles and update the appropriate documents to match.

SECTION E: SUMMARY OF FINDINGS—FEDERAL LAW REQUIREMENTS (CONT'D)

FEDERAL STATUTE	DOCUMENTS REVIEWED	FINDINGS	COURSE OF ACTION REQUIRED	PEBP ACTION
HIPAA Privacy and Data Security Provisions (cont'd)	▪ Reviewed HIPAA Privacy and Security Policies and Procedures.	▪ There are discrepancies between the training materials and the Policies and Procedures: • Chief Financial Officer's level • Title: Chief Information Officer or Information Technology Officer • Management Analyst II's level • Program Officer III's level • Titles and levels of Member Services Administrative Assistant, Eligibility Administrative Assistant ▪ HIPAA Data Security Compliance. ▪ PEBP's Health Plan Auditor had completed a security review in 2010, 2014, and 2016 (per August 2016 report submitted by Health Claim Auditors, Inc. ("HCA")). Per HCA August 2016 report, HCA's audit observed PEBP internal policies and procedures under HIPAA; the review included some areas (administrative, physical, and technical safeguards) required by the HIPAA data security regulations. ▪ Per the PY 2016 report, PEBP believes they are in compliance for HIPAA. ▪ At the time of the last review, PEBP indicated that HCA was scheduled to conduct another audit. Although that audit is outside the scope of this review timeframe, PEBP should review the results of the HCA audit and take action as needed. Per conference call on September 15, 2020, PEBP confirmed that the scheduled audit did not occur. Per PEBP response to further summary questions, PEBP will conduct a HIPAA audit in the fall of 2021. ▪ HIPAA Security Officer is identified in the HIPAA Privacy and Security Policies and Procedures as Information Technology Officer and in the July 2019 HIPAA Training as the Chief Information Officer.	▪ Update training to reconcile HIPAA Security Officer title.	▪ PEBP agrees with this finding and will update the training.

SECTION E: SUMMARY OF FINDINGS—FEDERAL LAW REQUIREMENTS (CONT'D)

FEDERAL STATUTE	DOCUMENTS REVIEWED	FINDINGS	COURSE OF ACTION REQUIRED	PEBP ACTION
HIPAA Privacy and Data Security Provisions (cont'd)	▪ Reviewed HIPAA Privacy and Security Policies and Procedures.	▪ <u>HIPAA Privacy and Security Policies and Procedures</u>: ▪ Following 2014 report, PEBP created MPD for HIPAA Privacy and Security Requirements which describes how PHI may be accessed, used or disclosed by the PEBP Workforce, and updated HIPAA Privacy and Security of Protected Health Information (PHI) policies and procedures document as of 7/1/2017, which describe HIPAA requirements at a high level. ▪ Per 2014 report, the HIPAA Privacy and Security of Protected Health Information (PHI) policies and procedures were substantially updated in 2013. • Incorporate a summary of HITECH changes to HIPAA rules and refer to the HITECH revisions published in January 2013. • Describe the HIPAA Data Security standards and specifications at a high level. ▪ 2019 HIPAA Privacy and Security Policies and Procedures incorporate detailed procedures for determining breaches and notification of breaches.	▪ Proofread the document, which appears to have misplaced headers and some redundant sections.	▪ PEBP agrees with this finding and will revise the document.
	▪ Reviewed Release of Information Authorization Form.	▪ On January 27, 2017, Aon provided the following to PEBP: (1) updated signature language for Attachment B "Release of Information Authorization Form" to address personal representative of individual; and (2) sample Table of Contents for HIPAA Privacy and Security of Protected Health Information (PHI) policies and procedures. PEBP added this language in April 2019. ▪ If PEPB uses the Release of Information Authorization Form to request an individual to authorize release, the Form must also include language informing the individual that PEBP may not condition treatment, payment, enrollment, or eligibility for benefits in the PEBP health plan upon the individual signing the authorization form.	▪ If PEBP requests authorization, add statement that PEBP does not condition treatment, payment, enrollment, or eligibility for benefits upon individual signing authorization.	▪ PEBP agrees with this finding and will revise the Release of Information Authorization Form accordingly.

SECTION E: SUMMARY OF FINDINGS—FEDERAL LAW REQUIREMENTS (CONT'D)

FEDERAL STATUTE	DOCUMENTS REVIEWED	FINDINGS	COURSE OF ACTION REQUIRED	PEBP ACTION
HIPAA Privacy and Data Security Provisions (cont'd)	▪ Reviewed Business Associate Agreements. ▪ Reviewed Template Business Associate Agreement.	▪ Business Associate Agreements ("BAA"). ▪ The BAA with Express Scripts, Inc., signed by both parties in 2018, is effective "upon BOE approval." In 2018 PEBP confirmed that its BAA with ESI is effective July 12, 2018. ▪ The BAA with Hometown Health Providers, signed by both parties in 2018, is effective "upon BOE approval." BOE approved Amendment #3 to contract 3100/15510 which incorporates the BAA as Attachment DD. ▪ We are unable to independently confirm that every business associate of PEBP has been identified.		▪ PEBP agrees with this finding and has confirmed that the BAA has been executed.
		▪ PEBP confirmed that they have HIPAA BAAs with appropriate PEBP vendors. PEBP provided that other vendors or entities that could be potential business associates (such as photocopier providers, on-site contractors, facsimile machine providers, document storage and disposal (paper or electronic)) would be handled as part of an overall state-wide contract.	▪ None.	
		▪ Template BAA has all necessary provisions.		
		▪ General Observations.		
		▪ PEBP states that an independent audit occurs that involves IT. PEBP confirmed in a conference call on September 15, 2020 that the IT Security Audit was completed on February 18, 2020.	▪ None.	
Code Section 125—Pre-Tax and Election Changes	▪ Reviewed MPDs, Section 125 Health and Welfare Benefits Plan Document, and FSA SPD.	▪ Article 6.1 of the Section 125 Health and Welfare Benefits Plan Document includes the Medicare Exchange benefit which is not offered through the cafeteria plan. The Medicare Exchange benefit is an HRA funded solely by the former employer.	▪ Remove Medicare Exchange benefit from Article 6 of the Section 125 Health and Welfare Benefits Plan Document.	▪ PEBP agrees with this finding and will remove Article 6 from the Section 125 Health and Welfare Benefits Plan Document.
		▪ PEBP confirmed that a change in elections is allowed only when eligibility for coverage is affected, and that the change is due to and consistent with the change in status.	▪ None.	

SECTION E: SUMMARY OF FINDINGS—FEDERAL LAW REQUIREMENTS (CONT'D)

FEDERAL STATUTE	DOCUMENTS REVIEWED	FINDINGS	COURSE OF ACTION REQUIRED	PEBP ACTION
Code Section 125—Pre-Tax and Election Changes (cont'd)	▪ Reviewed Qualifying Life Status Events document.	▪ Qualifying Life Status Events document states that, in the event of a marriage, coverage for newly-added spouse begins first day of the month concurrent with or following marriage. This can result in retroactive election changes if the employee notifies PEBP of the marriage within 60 days but after the first of the month concurrent with or following the date of marriage. Retroactive election changes are only allowed for birth, adoption, or placement for adoption events. All other events must have prospective election changes from the date of the event or the date of notification to the plan, whichever is later.	▪ Begin coverage on the first of the month concurrent with or following the date of marriage or the date the employee notifies the plan of the marriage, whichever is later.	▪ PEBP agrees with this finding and will take the recommended action.
Medicare Secondary Payer Requirements	▪ Reviewed MPDs.	▪ The active plan requires retirees and retiree dependents to be covered under the Medicare HRA when Medicare-eligible.	▪ Create a second plan for retirees that mirrors the active plan and has its own, separate plan documentation.	▪ PEBP agrees with this finding and will take the recommended action.
Medicare Part D Requirements	▪ Reviewed Medicare Part D Notices.	▪ Medicare Part D Notices are posted on PEBP's website (dated July 1, 2019) under "Mandatory Notices." Per PEBP response to summary questions dated October 7, 2020, notices are distributed to all participants annually in July. ▪ Per PEBP response to summary questions dated October 7, 2020, PEBP confirmed that it performs Medicare Part D reporting to CMS within 60 days following the beginning of each plan year.	▪ None. ▪ None.	
Mental Health Parity and Addiction Equity Act ("MHPAEA")	▪ Reviewed MPDs and Section 125 Document.	▪ No exceptions noted.	▪ None.	
Michelle's Law	▪ Reviewed MPDs and Section 125 Document. ▪ Reviewed Plan Year 2020 Benefit Guide and Plan Year 2020 Medicare Guide.	▪ No exceptions noted.	▪ None.	
National Defense Authorization Act of 2008 ("NDAA")	▪ Reviewed MPDs and Section 125 Document. ▪ Reviewed Employee Handbook.	▪ No exceptions noted.	▪ None.	

SECTION E: SUMMARY OF FINDINGS—FEDERAL LAW REQUIREMENTS (CONT'D)

FEDERAL STATUTE	DOCUMENTS REVIEWED	FINDINGS	COURSE OF ACTION REQUIRED	PEBP ACTION
Newborns' and Mothers' Health Protection Act of 1996 ("NMHPA")	▪ Reviewed MPDs, Section 125 Document, and FSA SPD. ▪ Reviewed Plan Year 2020 Benefit Guide and Plan Year 2020 Medicare Guide.	▪ No exceptions noted.	▪ None.	
Patient Protection and Affordable Care Act of 2010 ("PPACA")	▪ Reviewed MPDs, Section 125 Document, and FSA SPD. ▪ Reviewed Plan Year 2020 Benefit Guide and Plan Year 2020 Medicare Guide. ▪ Reviewed PEBP Appeals and Complaints Policies and Procedures. ▪ Reviewed Employee Handbook.	▪ <u>PPACA Reporting</u>. ▪ PEBP performs PPACA reporting in-house after Morneau Shepell collects the necessary data, as confirmed by PEBP in response to summary questions dated October 7, 2020. ▪ <u>Claims and Appeals</u>. ▪ Enrollment and Eligibility MPD. • MPD still excludes eligibility appeals but Appeals and Complaints Policies and Procedures includes eligibility appeals. ▪ Notice of Adverse Benefit Determinations. • Aon did not receive nor review adverse benefit determination notices sent by PEBP or TPA. • Aon confirmed with HSB in email dated 8/13/2018 that the adverse benefit determination notices are sent in a culturally and linguistically appropriate manner.	▪ None—continue existing process. ▪ None. ▪ Revise Enrollment and Eligibility MPD to explicitly state eligibility decisions are subject to appeals. ▪ None. ▪ None.	▪ PEBP agrees with this action and will make the appropriate revision to the Eligibility & Enrollment MPD.

SECTION E: SUMMARY OF FINDINGS—FEDERAL LAW REQUIREMENTS (CONT'D)

FEDERAL STATUTE	DOCUMENTS REVIEWED	FINDINGS	COURSE OF ACTION REQUIRED	PEBP ACTION
PPACA (cont'd)		• Aon confirmed with HSB in email dated 8/13/2018 that the notices sent by PEBP or TPA comply the content requirement include information sufficient to identify the claim involved, the reason(s) for the adverse benefit determination as well as a description of the plan's or issuer's standard, if any, that was used in denying the claim, provide a description of available internal appeals and external review processes, including information regarding how to initiate an appeal, and disclose the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman.	▪ None.	
		▪ Employer Mandate. ▪ Agencies are responsible for counting hours and determining who is a full-time employee eligible for coverage. Agencies then feed that information to PEBP. ▪ Medical coverage offered meets the minimum value standard and is affordable (monthly contribution amount for employee-only coverage in the lowest cost plan is below Federal Poverty Line), as set forth in the Marketplace Notice – Eligible Employees.	▪ None—continue the existing course of action. ▪ None.	
		▪ Fees. ▪ PCORI fee for the self-insured health plan(s) was paid in July 2019 and July 2020, as confirmed on the conference call of September 15, 2020.	▪ None.	
		▪ Marketplace Notices. ▪ Eligible and ineligible for health coverage notices are being provided annually to all payroll centers at the various agencies. The Agency should provide the applicable notice within 7 days of hire date.	▪ None.	
		▪ Preventive Care. ▪ CDHP MPD and Wellness Guide incorporate latest guidance regarding preventive services without cost-sharing.	▪ None. ▪ None.	

SECTION E: SUMMARY OF FINDINGS—FEDERAL LAW REQUIREMENTS (CONT'D)

FEDERAL STATUTE	DOCUMENTS REVIEWED	FINDINGS	COURSE OF ACTION REQUIRED	PEBP ACTION
PPACA (cont'd)		▪ Out-of-Pocket Maximums. ▪ CDHP complies with PPACA and IRS limits for maximum out-of-pocket limits. ▪ Section 1557 Nondiscrimination. ▪ The Section 1557 notice requirement has been revoked in new final rule published by HHS. There is ongoing litigation over the final rule, but the repealed notice requirement is not affected by the litigation. ▪ The Section 1557 notice is included in the following documents: Enrollment and Eligibility MPD; 2020 Plan Year Benefit Guide, 2020 Plan Year Medicare Guide. ▪ PEBP medical plans cover gender dysphoria. ▪ Summaries of Benefit and Coverage (SBCs). ▪ SBCs are posted on the PEBP website. ▪ Per email dated December 19, 2016, and conference call of 8/3/2018, PEBP does not provide hard copies of the SBC to new hires or special enrollees. SBC is referenced in the 2020 Plan Year Benefit Guide but is not included. ▪ Per email dated December 19, 2016, PEBP provides SBC within 7 business days upon request. ▪ SBC notice of availability is not in the 2020 Plan Year Benefit Guide but there is language directing participants to the PEBP website. ▪ SBCs use current (updated) SBC template. ▪ Dental. ▪ Based on documentation reviewed, self-insured dental coverage does not appear to be an excepted benefit as it is: (1) bundled with medical coverage for active employees; and (2) the claims administrator for both dental and medical coverage is HealthSCOPE. PEBP discussed with legal counsel and determined that the dental plan is an excepted benefit.	▪ None. ▪ None. ▪ None. ▪ None. ▪ None.	
Pregnancy Discrimination Act ("PDA")	▪ Reviewed MPDs and Section 125 Document.	▪ No exceptions noted.	▪ None.	

SECTION E: SUMMARY OF FINDINGS—FEDERAL LAW REQUIREMENTS (CONT'D)

FEDERAL STATUTE	DOCUMENTS REVIEWED	FINDINGS	COURSE OF ACTION REQUIRED	PEBP ACTION
QMCSOs	▪ Reviewed MPDs Section 125 Document, and FSA SPD.	▪ No exceptions noted.	▪ None.	
Rehabilitation Act of 1973	▪ Reviewed MPDs Section 125 Document, and FSA SPD. ▪ Reviewed Employee Handbook.	▪ No exceptions noted.	▪ None.	
Social Security Act Health Insurance ("Medicare")	▪ Reviewed Medicare Part D Notice.	▪ No exceptions noted.	▪ None.	
Title VII of the Civil Rights Act of 1964	▪ Reviewed MPDs Section 125 Document, and FSA SPD. ▪ Reviewed Employee Handbook.	▪ No exceptions noted.	▪ None.	
Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA")	▪ Reviewed MPDs, Section 125 Document, and FSA SPD. ▪ Reviewed Employee Handbook. ▪ Reviewed Military Leave Notice.	▪ No exceptions noted.	▪ None.	
Women's Health and Cancer Rights Act of 1998 ("WHCRA")	▪ Reviewed MPDs, Section 125 Document, and FSA SPD. ▪ Review 2020 Plan Year Benefit Guide and 2020 Plan Year Medicare Guide.	▪ No exceptions noted. ▪ PEBP will incorporate WHCRA notice in E&E MPD and mail the E&E MPD annually.	▪ None.	

SECTION F: SUMMARY OF FINDINGS—STATE LAW REQUIREMENTS

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SECTION F: SUMMARY OF FINDINGS—STATE LAW REQUIREMENTS (CONT'D)

SECTION F: SUMMARY OF FINDINGS—STATE LAW REQUIREMENTS (CONT'D)

STATE STATUTE	PROCEDURES PERFORMED	FINDINGS	COURSE OF ACTION REQUIRED	PEBP ACTION
Eligibility and Participation: Definition of "Dependent" NAC 287.035 NAC 287.311 NAC 287.312 NAC 287.3125 NAC 287.313 NRS 689B.035	▪ Reviewed Master Plan Documents ("MPD"). ▪ Reviewed Open Enrollment Guide. ▪ Reviewed Section 125 Document. ▪ Reviewed PEBP Health & Welfare Wrap Plan.	▪ No exceptions noted.	▪ None.	
Eligibility and Participation: Definition of "Domestic Partner" NAC 287.035	▪ Reviewed MPDs. ▪ Reviewed Section 125 Document. ▪ Reviewed Open Enrollment Guide. ▪ Reviewed PEBP Health & Welfare Wrap Plan.	▪ No exceptions noted.	▪ None.	
Eligibility and Participation: Definition of "Participant" NAC 287.095 NAC 287.135 NAC 287.150 NAC 287.313	▪ Reviewed MPDs. ▪ Reviewed Open Enrollment Guide. ▪ Reviewed Section 125 Document. ▪ Reviewed Employee Handbook.	▪ No exceptions noted.	▪ None.	
Eligibility and Participation: Definition of "Full-Time Employment" and Eligibility Waiting Periods NRS 287.045 NAC 287.150 NAC 287.313	▪ Reviewed MPDs. ▪ Reviewed Open Enrollment Guide. ▪ Reviewed Employee Handbook. ▪ Reviewed Section 125 Document. ▪ Reviewed PEBP Health & Welfare Wrap Plan.	▪ No exceptions noted.	▪ None.	

SECTION F: SUMMARY OF FINDINGS—STATE LAW REQUIREMENTS (CONT'D)

STATE STATUTE	PROCEDURES PERFORMED	FINDINGS	COURSE OF ACTION REQUIRED	PEBP ACTION
Eligibility and Participation: Retirees NAC 287.135 NAC 287.440 NAC 287.530 NAC 287.540 NAC 287.542 NAC 287.544 NAC 287.546 NAC 287.548 NRS 287.0406 NRS 287.0436 NRS 287.046 NRS 287.023 NRS 287.047 NRS 287.043	▪ Reviewed MPDs. ▪ Reviewed PEBP Board and Agency Duties, Policies and Procedures ("Board Procedures"). ▪ Reviewed Open Enrollment Guide. ▪ Reviewed Employee Handbook. ▪ Reviewed PEBP Health & Welfare Wrap Plan.	▪ No exceptions noted.	▪ None.	
Eligibility and Participation: Seasonal Employees and Employees on a Biennial Plan NAC 287.095 NAC 287.150 NRS 287.0467	▪ Reviewed MPDs. ▪ Reviewed Open Enrollment Guide. ▪ Reviewed Employee Handbook.	▪ No exceptions noted.	▪ None.	
Eligibility and Participation: Rehired Employees NAC 287.510 NAC 287.515 NRS 287.043	▪ Reviewed MPDs. ▪ Reviewed Open Enrollment Guide. ▪ Reviewed Employee Handbook.	▪ No exceptions noted.	▪ None.	
Eligibility and Participation: Individual as Both Employee and Dependent NAC 287.520 NRS 287.043	▪ Reviewed MPDs. ▪ Reviewed Open Enrollment Guide. ▪ Reviewed Employee Handbook.	▪ No exceptions noted.	▪ None	

SECTION F: SUMMARY OF FINDINGS—STATE LAW REQUIREMENTS (CONT'D)

STATE STATUTE	PROCEDURES PERFORMED	FINDINGS	COURSE OF ACTION REQUIRED	PEBP ACTION
Eligibility and Participation: Surviving Spouse/ Dependents NAC 287.530 NRS 287.021 NRS 287.0475 NRS 287.0477	▪ Reviewed MPDs. ▪ Reviewed Open Enrollment Guide. ▪ Reviewed Employee Handbook.	▪ No exceptions noted.	▪ None.	
Eligibility and Participation: Surviving Spouse/Child of a Police Officer, Firemen or Volunteer Firemen Killed in the Line of Duty NRS 287.0477 NRS 287.021	▪ Reviewed MPDs. ▪ Reviewed Open Enrollment Guide. ▪ Reviewed Employee Handbook.	▪ No exceptions noted.	▪ None.	
Eligibility and Participation: Coverage of Newly Born and Adopted Children NRS 689B.033 NRS 287.04335	▪ Reviewed MPDs. ▪ Reviewed Open Enrollment Guide. ▪ Reviewed Employee Handbook.	▪ No exceptions noted.	▪ None.	

SECTION F: SUMMARY OF FINDINGS—STATE LAW REQUIREMENTS (CONT'D)

STATE STATUTE	PROCEDURES PERFORMED	FINDINGS	COURSE OF ACTION REQUIRED	PEBP ACTION
Eligibility and Participation: Applications for Participation in PEBP by Local Government Agencies NAC 287.310 NRS 287.010 NRS 287.017 NRS 287.025.1(a) NRS 287.040	▪ Reviewed Local Government Entity Application Instructions. ▪ Reviewed MPDs.	▪ In the 2014 and PY 2016 reports, Aon recommended that Quality Control procedures be developed to reflect PEBP's responsibilities regarding administration of the application process and responsibilities to the local government agencies, including the requirements of NAC 287.310(3), regarding providing a claims history report upon request and NAC 287.310(1), regarding the calculation of the nonrefundable fee to be deposited into the Fund for the PEBP. ▪ Aon again notes that the instructions are missing the provisions required by NAC 287.310 that the local governmental agency group must provide a statement that all terminal fees and costs associated with the previous health plan will be paid by that local governmental agency group. Further, the instructions state that a claims report will be provided to local agencies upon leaving the program; however, the statute states that this report should be provided at any time, within 90 days after receipt of the written request, with a charge to the agency for the cost of providing the report. Per PEBP during PY 2016 review, PEBP treats the application instructions as its procedures. Per PEBP conference call 8/3/2018 and 9/15/2020, PEBP confirmed the same process and treats the application instructions as its procedures. PEBP will update instructions if needed.	▪ None. ▪ None.	
Eligibility and Participation: Orientation Program NAC 287.314 NAC 287.317	▪ Reviewed MPDs. ▪ Reviewed Open Enrollment Guide.	▪ No exceptions noted.	▪ None.	

SECTION F: SUMMARY OF FINDINGS—STATE LAW REQUIREMENTS (CONT'D)

STATE STATUTE	PROCEDURES PERFORMED	FINDINGS	COURSE OF ACTION REQUIRED	PEBP ACTION
Eligibility and Participation: Terminating Interlocal Contract and Withdrawing from Program NAC 287.320 NAC 287.355 NAC 287.357 NAC 287.359 NAC 287.361 NAC 287.363 NAC 287.367 NAC 287.369 NRS 287.0479	▪ Reviewed MPDs. ▪ Reviewed Local Government Agency Application Instructions.	▪ Per conference call during PY 2016 review, there were then no opt-out plans maintained by local government agencies. Per conference call with PEBP on 8/3/2018 and 9/15/2020, there are still no opt-out plans.	▪ None.	
Eligibility and Participation: Opt-out Plan Administration NAC 287.371 NAC 287.373 NAC 287.375 NAC 287.379 NAC 287.381 NAC 287.383 NAC 287.385 NAC 287.387 NAC 287.389 NRS 287.010	▪ Reviewed MPDs.	▪ Per conference call during PY 2016 review, there were then no opt-out plans maintained by local government agencies. Per conference call with PEBP on 8/3/2018 and 9/15/2020, there are still no opt-out plans.	▪ None.	
Eligibility and Participation Definition of "Open Enrollment" NAC 287.085	▪ Reviewed MPDs. ▪ Reviewed Open Enrollment Guide.	▪ No exceptions noted.	▪ None.	
Benefits Coverage: Definition of "Plan Year" NAC 287.100	▪ Reviewed MPDs. ▪ Reviewed Open Enrollment Guide.	▪ No exceptions noted.	▪ None.	

SECTION F: SUMMARY OF FINDINGS—STATE LAW REQUIREMENTS (CONT'D)

STATE STATUTE	PROCEDURES PERFORMED	FINDINGS	COURSE OF ACTION REQUIRED	PEBP ACTION
Benefits Coverage NRS 287.0433 NRS 287.04062 NRS 695G.160 NRS 287.0485	▪ Reviewed MPDs. ▪ Reviewed Employee Handbook.	▪ No exceptions noted.	▪ None.	
Benefits Coverage: Reinstatement of Coverage by Retired Public Officer, Employee or Surviving Spouse NRS 287.0205 NRS 287.0475	▪ Reviewed MPDs.	▪ This provision relates to self-insured opt-out plans maintained by local governmental agencies. Per conference call with PEBP on 8/3/2018 and 9/15/2020, there are still no opt-out plans.	▪ None (outside scope of review).	
Benefits Coverage: Human Papillomavirus Vaccination, Screening for Colorectal Cancer, Screening for Prostate Cancer, and Screening for and Diagnosis and Treatment of Autism Spectrum Disorders NRS 287.027 NRS 287.0274 NRS 287.0276	▪ Reviewed MPDs.	▪ Relates to self-insured opt-out plans maintained by local governmental agencies. Per conference call with PEBP on 8/3/2018 and 9/15/2020, there are still no opt-out plans.	▪ None (outside scope of review).	

SECTION F: SUMMARY OF FINDINGS—STATE LAW REQUIREMENTS (CONT'D)

STATE STATUTE	PROCEDURES PERFORMED	FINDINGS	COURSE OF ACTION REQUIRED	PEBP ACTION
Benefits Coverage: Oral Chemotherapy Parity NRS 287.0278 NRS 287.04335 NRS 695G.167	▪ Reviewed MPDs.	▪ Under NRS 287.04335, NRS 695G.167 is made applicable to self-insured health plans. ▪ Applies to health plans providing coverage for both chemotherapy administered intravenously or by injection and orally administered chemotherapy. Monetary limits for orally administered chemotherapy must not be less favorable from other types of chemotherapy. A health plan is prohibited from meeting parity requirement by decreasing monetary limits (e.g., OOPs) for chemotherapy. A health plan that is not an HDHP is also prohibited from requiring copayment, deductible or coinsurance amount for orally administered chemotherapy in a combined amount that is more than $100 per prescription. NRS 287.0278 and NRS 695G.167 contain similar provisions regarding coverage for chemotherapy administered orally. ▪ Both MPDs indicate that the health plans cover orally administered chemotherapy.	▪ None.	
Benefits: Coverage: Services Provided Through Telehealth NRS 695G.162 NRS 287.04335	▪ Reviewed MPDs. ▪ Reviewed Open Enrollment Guide.	▪ The NRS generally requires insurance to cover telehealth services to the same extent as services provided in-person or by other means. ▪ MPDs reflect COVID-19 related telemedicine provisions.	▪ None.	
Benefits: Coverage: Continued Medical Treatment NRS 695G.164 NRS 287.04335	▪ Reviewed MPDs.	▪ No exceptions noted.	▪ None.	

SECTION F: SUMMARY OF FINDINGS—STATE LAW REQUIREMENTS (CONT'D)

STATE STATUTE	PROCEDURES PERFORMED	FINDINGS	COURSE OF ACTION REQUIRED	PEBP ACTION
Benefits Coverage: Autism Spectrum Disorders NRS 695G.1645 NRS 287.0276 NRS 287.04335	▪ Reviewed MPDs.	▪ No exceptions noted.	▪ None.	
Benefits Coverage: Medically Necessary Emergency Services NRS 695G.170 NRS 287.04335	▪ Reviewed MPDs.	▪ No exceptions noted.	▪ None.	
Benefits Coverage: Required Provision Concerning Coverage for Human Papillomavirus Vaccine NRS 695G.171 NRS 287.0272 NRS 287.04335	▪ Reviewed MPDs.	▪ No exceptions noted.	▪ None.	
Benefits Coverage: Treatment Received as Part of a Clinical Trial or Study NRS 695G.173 NRS 689B.0306 NRS 287.04335	▪ Reviewed MPDs.	▪ No exceptions noted.	▪ None.	
Benefits Coverage: Required Provisions for Prescription Drugs Irregularly Dispensed for Synchronization of Chronic Medications NRS 695G.1665 NRS 287.04335	▪ Reviewed MPDs.	▪ No exceptions noted. ▪ Aon confirmed via email from ESI on10/13/2020 that PEBP complies with HRS 695G. 1665 and NRS 287.04335 for 2020 as in prior plan years.	▪ None.	

SECTION F: SUMMARY OF FINDINGS—STATE LAW REQUIREMENTS (CONT'D)

STATE STATUTE	PROCEDURES PERFORMED	FINDINGS	COURSE OF ACTION REQUIRED	PEBP ACTION
Benefits Coverage: Required Provisions for Early Refills of Topical Ophthalmic Products NRS 695G.172 NRS 287.04335	▪ Reviewed MPDs.	▪ No exceptions noted. ▪ Aon confirmed via email from ESI on 10/13/2020 that PEBP complies with NRS695G.172 and NRS 287.04335 for 2020 as in prior plan years.	▪ None.	
Benefits Coverage: Required Provisions for Coverage for Prostate Cancer Screening NRS 695G.177 NRS 287.0274 NRS 287.04335	▪ Reviewed MPDs.	▪ No exceptions noted. ▪ MPDs make clear that this benefit is covered as preventive care service.	▪ None.	
Benefits Coverage: Claims Involving Intoxication NRS 689B.287 NRS 695G.405	▪ Reviewed MPDs.	▪ No exceptions noted.	▪ None.	
Benefits Coverage: Hearing Aid Coverage for Children NRS 689B.330 NRS 689B.425 NRS 695C.050 NRS 695C.330 NRS 287.010	▪ Reviewed MPDs.	▪ No exceptions noted.	▪ None.	
Benefits Coverage: Sickle Cell Anemia Treatment NRS 689A.330 NRS 689C.425 NRS 695C.050 NRS 287.010 NRS 287.04335	▪ Reviewed MPDs.	▪ No exceptions noted.	▪ None.	

SECTION F: SUMMARY OF FINDINGS—STATE LAW REQUIREMENTS (CONT'D)

STATE STATUTE	PROCEDURES PERFORMED	FINDINGS	COURSE OF ACTION REQUIRED	PEBP ACTION
Benefits Coverage: Gestational Maternity Care NRS 689A.330 NRS 689C.425 NRS 695C.050 NRS 695C.330 NRS 287.04335	▪ Reviewed MPDs.	▪ No exceptions noted.	▪ None.	
Benefits Coverage: Billing for Certain Medically Necessary Emergency Services NRS 683A.0879 NRS 689B.255 NRS 695A.188 NRS 695B.2505 NRS 695C.185	▪ Reviewed MPDs.	▪ No exceptions noted.	▪ None.	
Benefits Coverage: Prescription Drug Coverage under Medicaid and CHIP NRS 287.010 NRS 287.287 NRS 287.040 NRS 287.0433 NRS 683.178	▪ Reviewed MPDs.	▪ No exceptions noted. ▪ Per section 28.5, PEBP may use the list of preferred prescription drugs developed by HHS as its formulary and obtain prescription drugs through the purchasing agreements negotiated by HHS.	▪ None.	

SECTION F: SUMMARY OF FINDINGS—STATE LAW REQUIREMENTS (CONT'D)

STATE STATUTE	PROCEDURES PERFORMED	FINDINGS	COURSE OF ACTION REQUIRED	PEBP ACTION
Benefits Coverage: Coverage Regardless of Health Status NRS 689A.330 NRS 689A.417 NRS 689B.069 NRS 689B.275 NRS 689B.500 NRS 689B.550 NRS 689C.159 NRS 689C.190 NRS 689C.193 NRS 689C.198 NRS 689C.220 NRS 695B.193 NRS 695B.2555 NRS 695C.050 NRS 695C.173 NRS 695C.207 NRS 287.010 NRS 287.04335	▪ Reviewed MPDs.	▪ No exceptions noted.	▪ None.	
Funding Requirements: Non-retiree plans NRS 287.0435 NRS 287.0434 NRS 287.043 NRS 287.046	▪ Reviewed MPDs. ▪ Reviewed Board Procedures. ▪ Reviewed Employee Handbook.	▪ No exceptions noted.	▪ None.	

SECTION F: SUMMARY OF FINDINGS—STATE LAW REQUIREMENTS (CONT'D)

STATE STATUTE	PROCEDURES PERFORMED	FINDINGS	COURSE OF ACTION REQUIRED	PEBP ACTION
Funding Requirements: Retiree Plans NAC 287.485 NAC 287.490 NRS 287.017 NRS 287.043 NRS 287.0434 NRS 287.0436 NRS 287.04362 NRS 287.04364 NRS 287.046	▪ Reviewed MPDs. ▪ Reviewed Board Procedures. ▪ Reviewed Open Enrollment Guide.	▪ No exceptions noted.	▪ None.	

Funding Requirements: Payment of Premiums
NAC 287.420
NRS 287.04385
NRS 287.043
NRS 287.044
	▪ Reviewed MPDs.
	▪ Reviewed Board Procedures.
	▪ Reviewed Local Government Agency Application Instructions.
		▪ NAC 287.420 provides penalties to be assessed in the event of nonpayment by the participating public agency.
		▪ In previous reviews, Aon was told that specific procedures exist regarding the billing and payment of premiums by participating employers to the PEBP.
		  ▪ Accounting Unit Policies and Procedures, Collections and Bad Debt Write-Off, provides a process overview and procedures for collection of past due group accounts.
		  ▪ Per conference call with PEBP on December 20, 2016, and again in conference call on 8/3/2018, PEBP provided that procedures: (1) exist for billing/monitoring invoicing of local government entities; and (2) identify who is responsible for payment of invoices. PEBP provided that they would send procedures to Aon, and PEBP provided local government agency application instructions. These instructions did not address the above-referenced procedures. Aon requested copy of procedures on January 13, 2017. Per conference call with PEBP on January 20, 2017, PEBP: (1) confirmed that the same procedures apply to local government entities; and (2) provided that they identify by role (other than by name) who is responsible for payment of invoices. Per conference call on September 15, 2020, PEBP confirmed no changes.
			▪ None.	

SECTION F: SUMMARY OF FINDINGS—STATE LAW REQUIREMENTS (CONT'D)

STATE STATUTE	PROCEDURES PERFORMED	FINDINGS	COURSE OF ACTION REQUIRED	PEBP ACTION
Funding Requirements: Direct Payment of Premiums for Retirees, LOAs Without Pay and LOAs due to Work Injury NAC 287.430 NAC 287.440 NAC 287.450 NAC 287.460 NRS 287.043 NRS 287.046 NRS 287.0439 NRS 287.0445	▪ Reviewed MPDs. ▪ Reviewed Section 125 Document. ▪ Reviewed Employee Handbook. ▪ Reviewed Open Enrollment Guide.	▪ No exceptions noted.	▪ None.	
Funding Requirements: Procedures Regarding Handling Over/ Underpayments of Premiums NAC 287.470 NRS 287.043	▪ Reviewed MPDs. ▪ Reviewed Section 125 Document. ▪ Reviewed PEBP Health & Welfare Wrap Plan.	▪ Not clear from MPDs whether in the event of an underpayment of premiums, PEBP notifies the applicable entity. Per conference call with PEBP on December 20, 2016, PEBP described their collections process. In the event of an underpayment of premiums, PEBP notifies the applicable entity. In the event of an overpayment of premiums, it is a net-pay situation; the next month's premium is reduced by a certain amount. Confirmed again with PEBP in conference call of 8/3/2018. ▪ Confirmed again on conference call of September 15, 2020.	▪ None.	
Subrogation to Rights of Officer, Employee or Dependent NRS 287.0465	▪ Reviewed MPDs. ▪ Reviewed PEBP Health & Welfare Wrap Plan.	▪ No exceptions noted.	▪ None.	
Claims and Appeals Procedures NAC 287.610 NAC 287.620 NAC 287.660 NAC 287.670 NAC 287.680 NAC 287.690 NRS 287.043 NRS 287.04335 NRS 689B.255	▪ Reviewed MPDs. ▪ Reviewed Section 125 Document. ▪ Reviewed PEBP appeals procedures. ▪ Reviewed PEBP Health & Welfare Wrap Plan.	▪ No exceptions noted.	▪ None.	

SECTION F: SUMMARY OF FINDINGS—STATE LAW REQUIREMENTS (CONT'D)

STATE STATUTE	PROCEDURES PERFORMED	FINDINGS	COURSE OF ACTION REQUIRED	PEBP ACTION
Claims and Appeals Procedures: Complaint System; Notice Requirements to Insured NAC 287.750 NRS 695G.200 NRS 695G.220 NRS 695G.230 NRS 287.04335	▪ Reviewed MPDs. ▪ Reviewed PEBP appeals procedures.	▪ No exceptions noted.	▪ None.	
Claims and Appeals Procedures: Notice to Insured; Expedited Review Process NRS 695G.210 NRS 695G.230 NRS 287.04335	▪ Reviewed MPDs. ▪ Reviewed PEBP appeals procedures.	▪ No exceptions noted.	▪ None.	
Claims and Appeals Procedures: External Review Process NRS 695G.241 NRS 695G.300 NRS 695G.310 NRS 287.04335	▪ Reviewed MPDs. ▪ Reviewed PEBP appeals procedures.	▪ No exceptions noted.	▪ None.	
Family Medical Leave Provisions NAC 284.52345 NAC 284.581 NAC 284.5811 NAC 284.5813 NAC 284.52315 NAC 284.5237	▪ Reviewed MPDs. ▪ Reviewed FMLA procedures. ▪ Reviewed Employee Handbook. ▪ Reviewed PEBP Health & Welfare Wrap Plan.	▪ No exceptions noted.	▪ None.	
Leave of Absence for Military Duty NAC 281.145 NAC 284.5875	▪ Reviewed MPDs. ▪ Reviewed Employee Handbook. ▪ Reviewed PEBP Health & Welfare Wrap Plan.	▪ No exceptions noted.	▪ None.	

SECTION F: SUMMARY OF FINDINGS—STATE LAW REQUIREMENTS (CONT'D)

STATE STATUTE	PROCEDURES PERFORMED	FINDINGS	COURSE OF ACTION REQUIRED	PEBP ACTION
PEBP Board Authority and Duties NRS 287.04062 NRS 287.0415 NRS 287.0424 NRS 287.0426 NRS 287.043 NRS 287.0487 NRS 287.04335 NRS 287.0402 NRS 287.041 NRS 287.0434	▪ Reviewed Board Procedures. ▪ Reviewed MPDs. ▪ Reviewed PEBP Quality Control Contracts Policies and Procedures.	▪ No exceptions noted.	▪ None.	
Miscellaneous NAC 287.005 NAC 287.145	▪ Reviewed MPDs.	▪ No exceptions noted.	▪ None.	

By: _____

Name: Rachel Arnedt

Title: VP, Health Solutions Legal Consulting Group

Date: 10/29/2020

4.5

4. Consent Agenda (Laura Freed, Board Chair) (**All Items for Possible Action**)

4.5 Receipt of the Casey, Neilon & Associates Audited Financial Statements of PEBP for Fiscal Year 2020.

CASEY NEILON

November 16, 2020

To the Board of the Public Employees' Benefits Program

We have audited the financial statements of the State Retirees' Health and Welfare Benefits Fund of the Public Employees' Benefits Program (the "Fund") for the year ended June 30, 2020. Professional standards require that we provide you with information about our responsibilities under generally accepted auditing standards, *Government Auditing Standards*, as well as certain information related to the planned scope and timing of our audit. We have communicated such information in our letter to you dated September 28, 2020. Professional standards also require that we communicate to you the following information related to our audit.

Significant Audit Matters

Qualitative Aspects of Accounting Practices

Management is responsible for the selection and use of appropriate accounting policies. The significant accounting policies used by the Fund are described in Note 1 to the financial statements. No new accounting policies were adopted and the application of existing policies was not changed during 2020. We noted no transactions entered into by the Fund during the year for which there is a lack of authoritative guidance or consensus. All significant transactions have been recognized in the financial statements in the proper period.

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

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

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

> The disclosure of the OPEB liability and activities in Note 2 to the financial statements because of the material changes in the estimated OPEB liability calculations made under GASB 74.

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

Difficulties Encountered in Performing the Audit

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

Corrected and Uncorrected Misstatements

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

Disagreements with Management

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

Management Representations

We have requested certain representations from management that are included in the management representation letter dated November 16, 2020.

Management Consultations with Other Independent Accountants

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

Other Audit Findings or Issues

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

Other Matters

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

Restriction on Use

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

Very truly yours,

Casey Neilon

Casey Neilon

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

JUNE 30, 2020 AND 2019

STATE OF NEVADA
STATE RETIREES' HEALTH & WELFARE BENEFITS FUND
PUBLIC EMPLOYEES' BENEFITS PROGRAM
JUNE 30, 2020 AND 2019

TABLE OF CONTENTS

Casey Neilon
Accountants and Advisors

INDEPENDENT AUDITOR'S REPORT

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

Report on the Financial Statements

We have audited the accompanying financial statements of the State Retirees' Health & Welfare Benefits Fund, Public Employees' Benefits Program of the State of Nevada, as of and for the years ended June 30, 2020 and 2019, and the related notes to the financial statements, which collectively comprise the State Retirees' Health & Welfare Benefits Fund, Public Employees' Benefits Program of the State of Nevada's basic financial statements as listed in the table of contents.

Management's Responsibility for the Financial Statements

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

Auditor's Responsibility

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

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

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

Opinion

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of the State Retirees' Health & Welfare Benefits Fund, Public Employees' Benefits Program of the State of Nevada as of June 30, 2020 and 2019, and the changes in fiduciary net position thereof for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Emphasis of a Matter

As discussed in Note 1, the financial statements of the State Retirees' Health & Welfare Benefits Fund, Public Employees' Benefits Program of the State of Nevada are intended to present the net position, and changes in net position of the program. They do not purport to, and do not, present fairly the financial position of the State of Nevada, as of June 30, 2020 and 2019, and the changes in its net position, for the years then ended, in conformity with

accounting principles generally accepted in the United States of America. Our opinion is not modified with respect to this matter.

Other Matters – Required Supplementary Information

Accounting principles generally accepted in the United States of America require that the Schedule of Changes in Net OPEB Liability and Related Ratios and the Schedule of Contributions on pages 13 and 14 be presented to supplement the basic financial statements. Such information, although not a part of the basic financial statements, is required by the Governmental Accounting Standards Board, who considers it to be an essential part of financial reporting for placing the basic financial statements in an appropriate operational, economic, or historical context. We have applied certain limited procedures to the required supplementary information in accordance with auditing standards generally accepted in the United States of America, which consisted of inquiries of management about the methods of preparing the information and comparing the information for consistency with management's response to our inquiries, the basic financial statements, and other knowledge we obtained during our audit of the basic financial statements. We do not express an opinion or provide any assurance on the information because the limited procedures do not provide us with sufficient evidence to express an opinion or provide any assurance.

Other Reporting Required by Government Auditing Standards

In accordance with *Government Auditing Standards*, we have also issued our report dated November 16, 2020 on our consideration of the State Retirees' Health & Welfare Benefits Fund, Public Employees' Benefits Program of the State of Nevada's internal control over financial reporting and on our tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements and other matters. The purpose of that report is solely to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing, and not to provide an opinion on the effectiveness of the State Retirees' Health & Welfare Benefits Fund's internal control over financial reporting or on compliance. That report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering the State Retirees' Health & Welfare Benefits Fund, Public Employees' Benefits Program of the State of Nevada's internal control over financial reporting and compliance.

Casey Neilon

Casey Neilon, Inc.
Carson City, Nevada
November 16, 2020

STATE OF NEVADA
STATE RETIREES' HEALTH & WELFARE BENEFITS FUND
STATEMENTS OF FIDUCIARY NET POSITION
JUNE 30, 2020 AND 2019

	2020	2019
ASSETS		
Cash with treasurer	$ 2,570,445	$ 480,301
Intergovernmental receivable	22,806	15,103
Due from other funds	130,776	167,754
Due from component unit	1,480,374	1,411,976
Investments at fair value	1,843,713	1,728,842
Total Assets	6,048,114	3,803,976
LIABILITIES		
Due to other funds	11,699,729	3,572,579
Total Liabilities	11,699,729	3,572,579
NET POSITION		
Net position restricted for other postemployment benefits	$ (5,651,615)	$ 231,397

See accompanying notes.

STATE OF NEVADA
STATE RETIREES' HEALTH & WELFARE BENEFITS FUND
STATEMENTS OF CHANGES IN FIDUCIARY NET POSITION
FOR THE YEARS ENDED JUNE 30, 2020 AND 2019

	2020	2019
ADDITIONS		
Contributions		
Employer contributions	$ 43,881,808	$ 40,942,430
Investment income		
Interest and dividends	100,811	80,098
Net appreciation in fair value of investments	103,941	101,793
Investment expense	(474)	(453)
Net investment income	204,278	181,438
Total additions	44,086,086	41,123,868
DEDUCTIONS		
Benefit payments	49,969,098	42,489,798
Total deductions	49,969,098	42,489,798
NET INCREASE (DECREASE) IN FIDUCIARY NET POSITION	(5,883,012)	(1,365,930)
NET POSITION:		
Beginning of year	231,397	1,597,327
End of year	$ (5,651,615)	$ 231,397

See accompanying notes.

STATE OF NEVADA
STATE RETIREES' HEALTH & WELFARE
BENEFITS FUND
PUBLIC EMPLOYEES' BENEFITS PROGRAM
NOTES TO FINANCIAL STATEMENTS
JUNE 30, 2020 AND 2019

NOTE 1 - Summary of Significant Accounting Policies:

Reporting Entity:

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

Basis of Accounting:

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

Method Used to Value Investments:

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

Plan Description and Contribution Information:

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

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

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

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

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

Plan Description and Contribution Information (continued):

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

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

Contributions to the fund are paid by the State of Nevada through an assessment of actual payroll paid by each State entity. The assessment is set by the Governor's Finance Office based on an amount provided by the Legislature each biennium in session law. The assessment was 2.34% and 2.34% of actual payroll for the years ending June 30, 2020 and 2019, respectively. Benefits are paid to the Public Employees' Benefits Program Self Insurance Trust Fund as necessary to offset retiree premiums pursuant to NRS 287.046. Funds not required to pay benefits are invested in the Retiree Benefits Investment Fund established pursuant to NRS 355.220 or are held in the State of Nevada general portfolio pursuant to NRS 226.110 as approved in the legislatively approved budget. Administrative costs of the Retirees' Fund are absorbed by the Self Insurance Trust Fund.

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

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

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

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

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

Recently Issued Accounting Pronouncements:

GASB Statement No. 84, *Fiduciary Activities* (GASB 84) establishes criteria for identifying fiduciary activities of all state and local governments. This statement also provides for recognition of a liability to the beneficiaries in a fiduciary fund when an event has occurred that compels the government to disburse fiduciary resources. The requirements of this Statement are effective for reporting periods beginning after December 15, 2019. It is not clear at this point how this will impact the financial statements as of June 30, 2020.

NOTE 2 – Net OPEB Liability:

Funding Status and Funding Progress

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

Net OPEB Liability of the Retirees' Fund

The components of the net OPEB liability of the Retiree's Fund at June 30, 2020 and 2019, were as follows:

	2020 (in thousands)	2019 (in thousands)
Total OPEB liability	$ 1,393,813	$ 1,325,980
Plan fiduciary net position	(231)	(1,597)
Net OPEB liability	1,393,582	1,324,383
Plan fiduciary net position as a percentage of total OPEB liability	0%	0%
OPEB expense	$ 75,973	$ 70,466

NOTE 2 – Net OPEB Liability (continued):

Actuarial Assumptions

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

Inflation	2.50%
Salary Increases	Dependent upon pension system ranging from 1.00% to 10.65%, including inflation.
Discount Rate	3.51%, Based on Bond Buyer General Obligation 20-Bond Municipal Bond Index
Healthcare cost trend rates	For medical prescription drug benefits the current amount is 6.50% and decreases to 4.5% long-term trend rate after six years. For dental benefits and Part B Premiums the trend rate is 4.00% and 4.50%, respectively.
Actuarial method	Entry Age Normal Level % of Pay

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

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

As the Retirees' Fund is funded on a pay-as-you-go basis, the discounted rate is equal to the Bond Buyer General Obligation 20-Bond Municipal Bond Index rate of 3.51%.

Discount rate

The discount rate basis under GASB 74 is required to be consistent with a 20-Year Municipal Bond Index. The Bond Buyer General Obligation 20-Bond Municipal Bond Index is used for the determination of the discount rate.

The discount rates used for fiscal years ended June 30, 2020 and 2019 are 3.51% and 3.87%, respectively.

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

The following presents the net OPEB liability of the Retirees' Fund, as well as what the Retirees' Fund's net OPEB liability would be if it were calculated using a discount rate that is 1-percentage-point lower (2.51 percent) or 1-percentage-point higher (4.51 percent) than the current discount rate:

	1% Decrease (2.51%) (in thousands)	Discount Rate (3.51%) (in thousands)	1% Decrease (4.51%) (in thousands)
Total OPEB Liability (Ending)	$ 1,536,767	$ 1,393,813	$ 1,269,786
Plan Fiduciary Net Posistion (Ending)	(231)	(231)	(231)
Net OPEB Liability (Ending)	$ 1,536,536	$ 1,393,582	$ 1,269,555

NOTE 2 – Net OPEB Liability (continued):

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

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

	1% Decrease (in thousands)	Trend Rates (in thousands)	1% Decrease (in thousands)
Total OPEB Liability (Ending)	$ 1,293,175	$ 1,393,813	$ 1,513,360
Plan Fiduciary Net Posistion (Ending)	(231)	(231)	(231)
Net OPEB Liability (Ending)	$ 1,292,944	$ 1,393,582	$ 1,513,129

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

	2020	2019
Cash:		
Deposits with State Treasurer:		
State Treasurer's Investment Pool	$ 2,541,127	$ 479,096
GASB 31 adjustment	29,318	1,205
Total Cash and Deposits	$ 2,570,445	$ 480,301

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

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

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

A copy of the State of Nevada Comprehensive Annual Financial Report can be obtained online at https://controller.nv.gov/FinRpts/CAFR/CAFR/.

NOTE 4 – Interfund Balances:

Interfund balances at June 30, 2020 and 2019 consisted of the following:

	2020	2019
Due to fiduciary fund from:		
General funds	$ 125,626	$ 152,832
Internal service funds	5,150	6,574
Trust funds	-	8,348
Total due to fiduciary fund from other funds	$ 130,776	$ 167,754
Due to fiduciary fund from:		
All others	$ 1,480,374	$ 1,411,976
Total due to fiduciary fund from component units	$ 1,480,374	$ 1,411,976
Due from fiduciary fund:		
Internal service funds	$ 11,699,729	$ 3,572,579
Total due to internal service funds from fiduciary fund	$ 11,699,729	$ 3,572,579

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

NOTE 5 - Retirement Benefits Investment Fund:

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

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

NOTE 6 - Fair Value:

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

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

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

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

The following table presents fair value measurements as of June 30, 2020:

	Level 1
U.S treasury securities and equities	$ 1,843,713
Total investments	$ 1,843,713

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

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

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

NOTE 7 – Subsequent Events:

Management has evaluated the activities and transactions subsequent to June 30, 2020 to determine the need for any adjustments to and disclosure within the financial statements for the year ended June 30, 2020. Management has evaluated subsequent events through November 16, 2020, the date which the financial statements were available to be issued.

The Retirees' Fund is responding to the recent COVID-19 outbreak with a measured, practical response. As of the date of this report, the Retirees' Fund is able to perform necessary business functions however, the extent of future financial impact and duration cannot be reasonably estimated at this time.

STATE OF NEVADA
STATE RETIREES' HEALTH & WELFARE BENEFITS FUND
PUBLIC EMPLOYEES' BENEFITS FUND
REQUIRED SUPPLEMENTARY INFORMATION
JUNE 30, 2020 AND 2019

SCHEDULE OF CHANGES IN NET OPEB LIABILITY AND RELATED RATIOS

Last Ten Fiscal Years* (Unaudited)

	Fiscal Year Ending June 30,			
	2020	**2019**	**2018**	**2017**
	(in thousands)			
Total OPEB Liability				
Service cost	$ 51,349	$ 51,882	$ 59,309	$ 49,794
Interest cost	52,488	47,795	39,469	45,361
Changes of benefit terms	-	-	-	-
Differences between expected and actual experiences	(31,485)	-	-	-
Changes of assumptions	37,971	(36,851)	(102,300)	123,519
Gross benefit payments	(42,490)	(39,710)	(38,069)	(35,932)
Net change in total OPEB liability	67,833	23,116	(41,591)	182,742
Total OPEB liability - beginning	1,325,980	1,302,864	1,344,455	1,161,713
Total OPEB liability - ending	$ 1,393,813	$ 1,325,980	$ 1,302,864	$ 1,344,455
Plan Fiduciary Net Position				
Contributions: Employer	$ 40,943	$ 39,669	$ 38,049	$ 32,213
Contributions: Member	-	-	-	-
Net investment income	181	162	164	55
Gross benefit payments	(42,490)	(39,710)	(38,069)	(35,932)
Administrative expenses	-	-	-	-
Other	-	-	-	-
Net change in plan fiduciary net position	(1,366)	121	144	(3,664)
Plan fiduciary net position - beginning	1,597	1,476	1,332	4,996
Plan fiduciary net position - ending	$ 231	$ 1,597	$ 1,476	$ 1,332
Net OPEB liability - ending	$ 1,393,582	$ 1,324,383	$ 1,301,388	$ 1,343,123
Net position as a percentage of OPEB liability	0%	0%	0%	0%
Covered employee payroll	$ 1,991,456	$ 1,890,946	$ 1,663,856	$ 1,627,517
Net OPEB liability as a percentage of payroll	70%	70%	78%	83%

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

Notes to Schedule:

Plan Changes: None

Assumption Changes: The valuation reflects a change of assumption in that the discount rate used at June 30, 2018 was 3.87% and the discount rate used at June 30, 2019 was 3.51%.

STATE OF NEVADA
STATE RETIREES' HEALTH & WELFARE BENEFITS FUND
PUBLIC EMPLOYEES' BENEFITS FUND
REQUIRED SUPPLEMENTARY INFORMATION
JUNE 30, 2020 AND 2019

SCHEDULE OF CONTRIBUTIONS

Last Ten Fiscal Years* (Unaudited)

	Fiscal Year Ending June 30,			
	2020	**2019**	**2018**	**2017**
	(in thousands			
Actuarially determined contribution	N/A	N/A	N/A	N/A
Contributions made in relation to the actuarially determined contribution	N/A	N/A	N/A	N/A
Contribution deficiency (excess)	N/A	N/A	N/A	N/A
Covered employee payroll **	$ 1,991,456	$ 1,890,946	$ 1,663,856	$ 1,627,517
Contributions as a percentage of payroll	N/A	N/A	N/A	N/A

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

Notes to Schedule

Valuation Date	January 1, 2018

Methods and assumptions used to determine contribution rates:

Actuarial Cost Method	Entry Age Normal - Level % of Salary
Asset Valuation Method	Market Value of Assets
Retirement Age***	Varies by age and service
Mortality	Headcount-weighted RP-2014 table projected to 2020 with Scale MP-2016

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

Casey Neilon
Accountants and Advisors

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

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

We have audited, in accordance with the auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards* issued by the Comptroller General of the United States, the financial statements of the State Retirees' Health & Welfare Benefits Fund, Public Employees' Benefits Program of the State of Nevada, as of and for the year ended June 30, 2020, and the related notes to the financial statements, which comprise the State Retirees' Health & Welfare Benefits Fund, Public Employees' Benefits Programs basic financial statements, and have issued our report thereon dated November 16, 2020.

Internal Control over Financial Reporting

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

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

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

Compliance and Other Matters

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

Purpose of this Report

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

Casey Neilon

Carson City, Nevada
November 16, 2020

CASEY NEILON

November 16, 2020

To the Board of the Public Employees' Benefits Program

We have audited the financial statements of the Self Insurance Trust Fund of the Public Employees' Benefits Program (the "Fund") for the year ended June 30, 2020. Professional standards require that we provide you with information about our responsibilities under generally accepted auditing standards and *Government Auditing Standards*, as well as certain information related to the planned scope and timing of our audit. We have communicated such information in our engagement letter to you dated September 28, 2020. Professional standards also require that we communicate to you the following information related to our audit.

Significant Audit Findings

Qualitative Aspects of Accounting Practices

Management is responsible for the selection and use of appropriate accounting policies. The significant accounting policies used by the Fund are described in Note 1 to the financial statements. We noted no new accounting policies were adopted and the application of existing policies was not changed during 2020. We noted no transactions entered into by the Fund during the year for which there is a lack of authoritative guidance or consensus. All significant transactions have been recognized in the financial statements in the proper period.

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

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

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

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

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

Difficulties Encountered in Performing the Audit

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

Corrected and Uncorrected Misstatements

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

Disagreements with Management

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

Management Representations

We have requested certain representations from management that are included in the management representation letter dated November 16, 2020.

Management Consultations with Other Independent Accountants

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

Other Audit Findings or Issues

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

Other Matters

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

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

Very truly yours,

Casey Neilon

Casey Neilon

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

JUNE 30, 2020 AND 2019

STATE OF NEVADA
SELF INSURANCE TRUST FUND
PUBLIC EMPLOYEES' BENEFITS PROGRAM
JUNE 30, 2020 AND 2019

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Casey Neilon
Accountants and Advisors

INDEPENDENT AUDITOR'S REPORT

To the Board of the
Public Employees' Benefits Program

Report on the Financial Statements

We have audited the accompanying financial statements of the Self Insurance Trust Fund, Public Employees' Benefits Program of the State of Nevada, as of and for the years ended June 30, 2020 and 2019, and the related notes to the financial statements, which collectively comprise the Self Insurance Trust Fund, Public Employees' Benefits Program of the State of Nevada's basic financial statements as listed in the table of contents.

Management's Responsibility for the Financial Statements

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

Auditor's Responsibility

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

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

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

Opinion

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of the Self Insurance Trust Fund, Public Employees' Benefits Program of the State of Nevada as of June 30, 2020 and 2019, and the changes in financial position and, cash flows thereof for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Emphasis of a Matter

As discussed in Note 1, the financial statements of the Self Insurance Trust Fund, Public Employees' Benefits Program of the State of Nevada are intended to present the financial position, the changes in financial position, and the cash flows of only that portion of the activities of the State of Nevada that is attributable to transactions of the Fund. They do not purport to, and do not, present fairly the financial position of the State of Nevada as of June 30, 2020 and 2019, the changes in its financial position, or, where applicable, its cash flows for the years then ended, in conformity with accounting principles generally accepted in the United States of America. Our opinion is not modified with respect to this matter.

Other Matters

Required Supplementary Information

Accounting principles generally accepted in the United States of America require that the pension and other post-employment benefits information on pages 19-20 and 21-22 be presented to supplement the basic financial statements. Such information, although not a part of the basic financial statements, is required by the Governmental Accounting Standards Board, who considers it to be an essential part of financial reporting for placing the basic financial statements in an appropriate operational, economic, or historical context. We have applied certain limited procedures to the required supplementary information in accordance with auditing standards generally accepted in the United States of America, which consisted of inquiries of management about the methods of preparing the information and comparing the information for consistency with management's responses to our inquiries, the basic financial statements, and other knowledge we obtained during our audit of the basic financial statements. We do not express an opinion or provide any assurance on this required information because the limited procedures do not provide us with sufficient evidence to express an opinion or provide any assurance.

Other Reporting Required by Government Auditing Standards

In accordance with *Government Auditing Standards*, we have also issued our report dated November 16, 2020 on our consideration of the Self Insurance Trust Fund, Public Employees' Benefits Program of the State of Nevada's internal control over financial reporting and on our tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements and other matters. The purpose of that report is to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing, and not to provide an opinion on the effectiveness of the Self Insurance Trust Fund, Public Employees' Benefit Program of the State of Nevada internal control over financial reporting or on compliance. That report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering the Self Insurance Trust Fund, Public Employees' Benefits Program of the State of Nevada's internal control over financial reporting and compliance.

Casey Neilon

Casey Neilon, Inc.
Carson City, Nevada
November 16, 2020

STATE OF NEVADA
SELF INSURANCE TRUST FUND
PUBLIC EMPLOYEES' BENEFITS PROGRAM
STATEMENTS OF NET POSITION
JUNE 30, 2020 AND 2019

	2020	2019
ASSETS		
Current assets:		
Cash and cash equivalents	$ 159,637,188	$ 155,908,618
Prepaid insurance	3,202	3,611
Receivables:		
Accounts receivable, net	6,055,621	6,106,065
Intergovernmental receivable	8,911,233	2,419,215
Due from other funds	12,732,822	5,230,821
Due from component units, net	4,567	19,210
Total Current Assets	187,344,633	169,687,540
Capital assets:		
Property and equipment	461,025	466,100
Less: Accumulated depreciation	(435,940)	(411,151)
Total Capital Assets (net of accumulated depreciation)	25,085	54,949
Total Assets	187,369,718	169,742,489
Deferred outflows of resources:		
Pension related amounts	663,273	641,824
OPEB related amounts	69,742	44,268
Total Deferred Outflows of Resources	733,015	686,092
LIABILITIES		
Current liabilities:		
Bank overdraft	3,428,332	3,829,541
Accounts payable	1,409,272	4,274,803
Accrued payroll and related liabilities	98,393	87,285
Due to other funds	20,435	25,334
Unearned revenue	3,489,755	3,662,898
Compensated absences	156,804	163,215
Reserve for losses	89,702,313	94,881,428
Total Current Liabilities	98,305,304	106,924,504
Noncurrent liabilities:		
Compensated absences	38,259	54,490
Net pension obligation	3,833,649	3,547,239
Net OPEB liability	1,301,204	1,417,507
Total Noncurrent Liabilities	5,173,112	5,019,236
Total Liabilities	103,478,416	111,943,740
Deferred inflows of resources:		
Pension related amounts	362,280	257,269
OPEB related amounts	79,050	95,047
Total Deferred Inflows of Resources	441,330	352,316
NET POSITION		
Invested in capital assets	25,085	54,949
Restricted expendable - losses	84,157,902	58,077,576
Total Net Position	$ 84,182,987	$ 58,132,525

See accompanying notes.

STATE OF NEVADA
SELF INSURANCE TRUST FUND
PUBLIC EMPLOYEES' BENEFITS PROGRAM
STATEMENTS OF REVENUES, EXPENSES AND CHANGES IN FUND NET POSITION
FOR THE YEARS ENDED JUNE 30, 2020 AND 2019

	2020	2019
OPERATING REVENUES:		
Insurance premiums	$ 391,121,895	$ 357,432,206
Other	5,520	1,902
Total Operating Revenues	391,127,415	357,434,108
OPERATING EXPENSES:		
Salaries and benefits	2,793,277	2,910,928
Operating	2,356,630	3,398,726
Claims expense	303,888,916	314,546,591
Depreciation	40,542	42,013
Insurance premiums and contractual obligations	59,748,805	59,318,572
Total Operating Expenses	368,828,170	380,216,830
Operating Income (Loss)	22,299,245	(22,782,722)
NONOPERATING REVENUES (EXPENSES):		
Investment income	1,407,557	1,694,774
Interest income	2,343,660	3,031,971
Total Nonoperating Revenues	3,751,217	4,726,745
CHANGE IN NET POSITION	26,050,462	(18,055,977)
NET POSITION		
Beginning of year	58,132,525	76,188,502
End of year	$ 84,182,987	$ 58,132,525

See accompanying notes.

STATE OF NEVADA
SELF INSURANCE TRUST FUND
PUBLIC EMPLOYEES' BENEFITS PROGRAM
STATEMENTS OF CASH FLOWS
FOR THE YEARS ENDED JUNE 30, 2020 AND 2019

	2020	2019
CASH FLOWS FROM OPERATING ACTIVITIES:		
Receipts from customers and users	$ 73,055,552	$ 29,482,963
Receipts for interfund services provided	296,430,133	322,062,620
Receipts from component units	13,822,120	13,588,561
Payments to suppliers, other governments and beneficiaries	(380,396,574)	(349,437,609)
Payments to employees	(2,592,613)	(2,718,441)
Payments for interfund services used	(865,561)	(1,298,678)
Net Cash Provided by Operating Activities	(546,943)	11,679,416
CASH FLOWS FROM CAPITAL AND RELATED FINANCING ACTIVITIES:		
Purchase of capital assets	(10,678)	-
Net Cash Used by Financing Activities	(10,678)	-
CASH FLOWS FROM INVESTING ACTIVITIES		
Interest on investments	4,286,191	4,199,606
Net Cash Provided by Investing Activities	4,286,191	4,199,606
Net Increase in Cash and Cash Equivalents	3,728,570	15,879,022
Cash and cash equivalents, July 1	155,908,618	140,029,596
Cash and cash equivalents, June 30	$ 159,637,188	$ 155,908,618
RECONCILIATION OF OPERATING INCOME (LOSS) TO NET CASH USED BY OPERATING ACTIVITIES:		
Operating income	$ 22,299,245	$ (22,782,722)
Adjustments to reconcile operating income to net cash used by operating activities:		
Depreciation	40,542	42,013
Allowance for doubtful accounts	3,595	(3,592)
Changes in assets and liabilities:		
(Increase) decrease in receivables	(14,467,501)	3,464,863
(Increase) decrease in prepaid expenses	409	(3,611)
(Increase) decrease in deferred outflows	(46,923)	(74,158)
Increase (decrease) in payables and accruals	(8,462,288)	27,146,263
Increase (decrease) in unearned revenue	(173,143)	3,613,982
Increase (decrease) in net pension obligation	286,410	185,322
Increase (decrease) in net OPEB liability	(116,303)	77,760
Increase (decrease) in deferred inflows	89,014	13,296
Total Adjustments	(22,846,188)	34,462,138
Net Cash Provided by Operating Activities	$ (546,943)	$ 11,679,416

See accompanying notes.

NOTE 1 - Summary of Significant Accounting Policies:

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

Plan Description:
The Self Insurance Trust Fund was created in 1983 by the Nevada Legislature to administer group health, life and disability insurance for covered employees, both active and retired, of the State, and certain other participating public employers within the State of Nevada. All public employers in the State are eligible to participate in the activities of the Self Insurance Trust Fund and currently, in addition to the State, there were four public employers participating at June 30, 2020 whose employees are covered under the plan. Additionally, all retirees of public employers contracted with PEBP to provide coverage to their employees are eligible to join the program subsequent to their retirement. Public employers are required to subsidize their retirees who participate in the plan in the same manner the State subsidizes its retirees. Currently, the State, the Nevada System of Higher Education and 165 public employers within the State of Nevada are billed for retiree subsidies. The Self Insurance Trust Fund provides medical, dental, vision, long-term disability, mental health, substance abuse, and life insurance benefits. The Self Insurance Trust Fund is overseen by the Public Employees' Benefits Program Board. The Board is composed of ten members, nine members appointed by the Governor, and the Director of the Department of Administration or their designee.

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

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

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

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

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

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

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

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

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

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

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

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

The third party administrator that processes claims payments on behalf of the Self Insurance Trust Fund has identified overpayments in the amount of $2,059,472 and $1,940,931 as of June 30, 2020 and 2019, respectively. Overpayments are followed up on every 30 days until recovery is made. These amounts have not been accrued as a receivable on the statement of net assets, but are recorded as a reduction to claims expense in the period in which recovery is received. Collection attempts cease when the overpayment is greater than 4 years old.

The Self Insurance Trust Fund administers an additional pass-through budget account, the Active Employee Group Insurance Subsidy (AEGIS) budget account. This budget account is utilized for recording the payments made by the state and received by the Self Insurance Trust Fund on behalf of active employees. Agencies contribute a fixed dollar amount per employee into this budget account. However, insurance premiums are earned by the main operating budget account in accordance with the PEBP approved rate for insurance coverage for the plan and tier to which each employee belonged. The difference between cash contributions and revenue recognition resulted in a surplus of contributions over premiums of $3,196,058 and $3,122,265 for the years ended June 30, 2020 and 2019, respectively. These amounts were allocated among all state entities that paid the AEGIS subsidy proportionate to their size and were included in the subsequent year's budget.

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

Receivables (continued):
The Self Insurance Trust Fund considers $277,718 and $274,123 in participant premiums as uncollectible as of June 30, 2020 and 2019, respectively. Pursuant to NRS 353C.220, only accounts that have been approved by the State of Nevada Board of Examiners may be written off. Of the uncollectible premiums listed above, $0 and $0 were approved for write-off by the State of Nevada Board of Examiners as of June 30, 2020 and 2019, respectively. The State has a policy in which all uncollectible amounts are remitted to the State Controller's Office for continued collection attempts and are eventually written off. In accordance with this policy, the Self Insurance Trust Fund created an allowance to account for the remaining uncollectible amounts that have been remitted to the State Controller's Office, but not yet been approved by the State of Nevada Board of Examiners for write off.

Property and Equipment:
Fixed assets are capitalized and depreciated using the straight line method of depreciation over the assets' estimated useful lives ranging from three to ten years. Capital acquisitions for the years ended June 30, 2020 and 2019 were $10,678 and $0, respectively. Capital dispositions for the years ended June 30, 2020 and 2019 were $15,753 and $0, respectively.

Estimated Claims:
The Self Insurance Trust Fund contracted with Aon, a provider of consulting and actuarial services, to estimate its liability for incurred but not reported claims, claims reported but not yet paid and administrative expenses expected to be incurred in conjunction with processing incurred but not reported claims as of June 30, 2020 and 2019, respectively. This liability is estimated by the actuary based on industry trends and claims lag information reported by the third party administrator. Such liabilities are necessarily based on estimates, and, while management believes the amount is adequate, the ultimate liability may be in excess of, or less than, the amounts provided. The methods for making such estimates and for establishing the resulting liability are reviewed on an annual basis and any adjustments are currently reflected in net income from operations.

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

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

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

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

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

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

Deferred Outflows/Inflows of Resources:
In addition to assets, the Statements of Net Position include a separate section for deferred outflows of resources. This separate financial statement element represents a consumption of net position that applies to future periods and will not be recognized as an outflow of resources until then. Self Insurance Trust Fund has pension and OPEB related deferred outflows that qualify for reporting in this category. Pension and OPEB related deferred outflows of resources are discussed in depth in Note 4 and 5, respectively.

In addition to liabilities, the Statements of Net Position include a separate section for deferred inflows of resources. This separate financial statement element represents an acquisition of net position that applies to future periods and will not be recognized as an inflow of resources until that time. Self Insurance Trust Fund has pension and OPEB related deferred inflows that qualify for reporting in this category. Pension and OPEB related deferred inflows of resources are discussed in depth in Note 4 and 5, respectively.

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

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

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

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

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

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

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

Recently Issued Accounting Pronouncements (Not Yet Adopted):
In January 2017, GASB issued Statement No. 84, *Fiduciary Activities* (GASB 84). This statement addresses the identification and presentation of fiduciary activities for accounting and financial reporting purposes. GASB 84 is effective for fiscal years beginning after December 15, 2019. It is not clear at this point how this will impact the financial statements as of June 30, 2020.

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

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

NOTE 3 - Cash and Deposits as of June 30:

	2020	2019
Cash:		
Operating checking account	$ (3,428,332)	$ (3,829,541)
Deposits with State Treasurer:		
State Treasurer's Investment Pool	157,843,151	155,522,138
GASB 31 adjustment	1,794,037	386,480
Total Deposits with State Treasurer	159,637,188	155,908,618
Total Cash and Deposits	$156,208,856	$152,079,077

The Self Insurance Trust Fund has three checking accounts with Wells Fargo Bank at June 30, 2020 and 2019. These accounts contain $1,171,735 and $1,058,501 in stale outstanding checks for the years ended June 30, 2020 and 2019, respectively. Additionally, certain Bank of America and Wells Fargo Bank zero balance accounts were closed in previous fiscal years. These closed accounts contain $48,637 and $301,826 in stale outstanding checks as of June 30, 2020 and 2019, respectively. Checks presented for payment from the closed accounts are rejected by the bank, voided, and reissued by the Self Insurance Trust Fund using the controlled disbursement account. The controlled disbursement account is funded only when checks are presented for payment. The negative balance represents outstanding checks issued that have not been presented for payment. In accordance with NRS 353.140, the Self Insurance Trust Fund honors outstanding stale warrants presented for payment within six years from the date of origination. For insurance and collateral purposes, the account is commingled with all of the cash accounts of the State of Nevada. All cash and deposits are recorded at fair value.

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

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

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

A copy of the State of Nevada Comprehensive Annual Financial Report can be obtained online at https://controller.nv.gov/FinRpts/CAFR/CAFR/.

NOTE 4 - Pension Plan:

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

Funding Policy. Plan members' benefits are funded under one of two methods. Under the employer paid contribution plan, the Self Insurance Trust Fund is required to contribute all amounts due under the plan. The rate for those contributions was 29.25%, 28.00% and 28.00% for regular members on all covered payroll for the years ended June 30, 2020, 2019 and 2018, respectively. The second funding mechanism for providing benefits is the employer/employee paid contribution plan. Under this method, employees are required to contribute a percentage of their compensation to the plan while the Self Insurance Trust Fund is required to match that contribution. The rate for regular employees under this plan was 15.25%, 14.50% and 14.50% for the years ended June 30, 2020, 2019 and 2018, respectively. The contribution requirements of plan members and the Self Insurance Trust Fund are established by NRS Chapter 286. The funding may only be amended through legislation. The Self Insurance Trust Fund's contributions to PERS for the years ended June 30, 2020, 2019, and 2018 were $270,646, $241,299, and 226,892, respectively, equal to the required contributions for the year.

Pension Liability. At June 30, 2020 and 2019 the Self Insurance Trust Fund reported a liability of $3,833,649 and $3,547,239, respectively, for its proportionate share of the net pension liability. The net pension liability was measured as of June 30, 2019 and 2018, and the total pension liability used to calculate the net pension liability was determined by an actuarial valuation as of that date. The Self Insurance Trust Fund's proportion of the net pension liability is based on their combined employer and member contributions relative to the total combined employer and member contributions for all employers for the period ended June 30, 2020 and 2019. The Self Insurance Trust Fund's proportionate share is approximately 0.028% and 0.026% as of June 30, 2020 and 2019, respectively.

Pension Expense, Deferred Outflows of Resources and Deferred Inflows of Resources Related to Pensions. As of June 30, 2020 and 2019, the total employer pension expense is $637,076 and $387,713, respectively. Amounts totaling $267,388 resulting from Fund contributions subsequent to the measurement date will be recognized as a reduction of the net pension liability in the year ended June 30, 2021. At June 30, 2020 and 2019, the Self Insurance Trust Fund reported deferred outflows of resources and deferred inflows of resources related to pensions from the following sources:

NOTE 4 - Pension Plan (continued):

	2020		2019	
	Deferred Outflows of Resources	Deferred Inflows of Resources	Deferred Outflows of Resources	Deferred Inflows of Resources
Differences between expected and actual experience	$ 143,758	$ 110,577	$ 111,125	$ 164,653
Change of assumptions	156,014	-	186,917	-
Net difference between projected and actual earnings on investments	-	190,710	-	16,888
Changes in proportion and differences between actual contributions and proportionate share of contributions	96,113	60,993	72,852	75,728
System contributions subsequent to the measurement date	267,388	-	270,930	-
Totals	$ 663,273	$ 362,280	$ 641,824	$ 257,269

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

Year ended June 30:	Amount
2021	$ 10,797
2022	(72,742)
2023	19,984
2024	24,755
2025	14,069
2026	1,622
	$ (1,515)

The net difference between projected and actual investment earnings on pension plan investments will be recognized over five years, all the other above deferred outflows and deferred inflows will be recognized over the average expected remaining service lives, which was 6.18 years for the measurement period ending June 30, 2019.

Reconciliation of Net Pension Liability	2020	2019
Beginning net pension liability	$ 3,547,239	$ 3,361,917
Pension expense	637,076	387,713
Employer contributions	(270,646)	(241,299)
Net deferred (inflows)/outflows	(80,020)	38,908
Ending net pension liabilities	$ 3,833,649	$ 3,547,239

NOTE 4 - Pension Plan (continued):

Actuarial Assumptions. The Fund's net pension liability was measured as of June 30, 2019 and 2018 and the total pension liability used to calculate the net pension liability was determined by an actuarial valuation as of that date. The total pension lability was determined using the following actuarial assumptions, applied to all periods included in the measurement, unless otherwise specified:

Inflation	2.75%
Productivity pay increase	0.50%
Projected salary increase	Regular: 4.25% to 9.15%, depending on service Rates include inflation and productivity increases
Investment rate of return	7.50%
Other assumptions	Same as those used in the June 30, 2019 funding actuarial valuation

Actuarial assumptions used in the June 30, 2019 valuation were based on the results of the experience study for the period July 1, 2012 through June 30, 2016.

Investment Policy. The following was the Retirement Board's adopted policy target asset allocation as of June 30, 2019:

Asset Class	Target Allocation	Long-Term Geometric Expected Real Rate of Return*
U.S. stocks	42%	5.50%
International stocks	18%	5.50%
U.S. bonds	28%	0.75%
Private markets	12%	6.65%

*As of June 30, 2019, PERs' long-term inflation assumption was 2.75%.

Discount Rate and Pension Liability Discount Rate Sensitivity. The following presents the net pension liability of the PERS as of June 30, 2019, calculated using the discount rate of 7.50%, as well as what the PERS net pension liability would be if it were calculated using a discount rate that is 1 percentage-point lower (6.5%) or 1 percentage-point higher (8.50%) than the current discount rate:

	1% Decrease in Discount Rate (6.50%)	Discount Rate (7.50%)	1% Increase in Discount Rate (8.50%)
Net Pension Liability	$ 5,935,939	$ 3,833,649	$ 2,086,109

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

NOTE 5 – Other Post Employment Retirement Benefits:

Plan Description. Employees of the State, who meet the eligibility requirements for retirement, have the option upon retirement to continue group insurance pursuant to NAC 287.530. NRS 287.046 requires the State to pay an amount toward the cost of the premiums for most persons retired from state service. Retirees assume any portion of the premium not covered by the State. The State allocates funds for payment of post retirement insurance benefits as a percentage of budgeted payrolls to all State agencies.

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

The cost of the employer contribution is recognized in the year the costs are charged. No unused funds are carried forward to the next fiscal year.

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

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

Contributions. Per NRS 287 contribution requirements of the participating entities and covered employees are established and may be amended by the PEBP Board. The Fund's contractually required contribution for the years ended June 30, 2020 and 2019 were $41,705 and $44,268, respectively, actuarially determined as an amount that is expected to finance the costs of benefits earned by employees during the year. Employees are not required to contribute to the OPEB plan.

OPEB Liabilities, OPEB Expenses, and Deferred Outflows of Resources and Deferred Inflows of Resources Related to OPEB. At June 30, 2020 and 2019, the Fund reported a liability of $1,301,204 and $1,417,507, respectively, for its proportionate share of the collective net OPEB liability. The collective net OPEB liability was measured as of January 1, 2019, and the total OPEB liability used to calculate the collective net OPEB liability was determined by an actuarial valuation as of that date. The Fund's proportion of the collective net OPEB liability was based on a projection of the Fund's long-term share of contributions to the OPEB plan relative to the projected contributions of all participating entities, actuarially determined. For the year ended June 30, 2020 and 2019, respectively, the Fund's proportion was 0.0934% and 0.1070%.

The components of the net OPEB liability at June 30, 2020 and 2019 were as follows:

	2020	2019
Total OPEB liability	$1,301,420	$ 1,419,217
Plan fiduciary net position	(216)	(1,710)
Net OPEB liability	$1,301,204	$ 1,417,507

For the years ended June 30, 2020 and 2019, respectively, the Fund recognized OPEB expense of ($122,109) and $131,880. At June 30, 2020 and 2019, the Fund Reported deferred outflows of resources and deferred inflows of resources related to OPEB for the following sources:

	2020		2019	
	Deferred Outflows of Resources	Deferred Inflows of Resources	Deferred Outflows of Resources	Deferred Resources
Changes of assumptions	$ 28,037	$ 55,581	$ -	$ 94,871
Net difference between projected and actual earnings on OPEB plan investments	-	23,469	-	176
Fund contributions subsequent to the measurement date	41,705	-	44,268	-
	$ 69,742	$ 79,050	$ 44,268	$ 95,047

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

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

Year ending June 30,	Amount
2021	$ (25,987)
2022	(21,590)
2023	(4,396)
2024	960
	$ (51,013)

Actuarial Assumptions. The total OPEB liability in the June 30, 2020 actuarial valuation was determined using the following actuarial assumptions, applied to all periods included in the measurement, unless otherwise specified:

Inflation	2.50%
Salary Increases	Dependent upon pension system ranging from 1.00% to 10.65%, including inflation.
Discount Rate	3.51%, Based on Bond Buyer General Obligation 20-Bond Municipal Bond Index
Healthcare cost trend rates	For medical prescription drug benefits the current amount is 6.50% and decreases to 4.5% long-term trend rate after six years. For dental benefits and Part B Premiums the trend rate is 4.00% and 4.50%, respectively.
Actuarial method	Entry Age Normal Level % of Pay

Mortality rates were based on the Headcount-weighted RP-2014 Employee table projected to 2020 with Scale MP-2016 for pre-retirement participants, Headcount-weighted RP-2014 Healthy Annuitant table projected to 2020 with Scale MP-2016, set forward one year for spouses and beneficiaries for post-retirement participants and Headcount-weighted RP-2014 Disabled Retiree table, set forward four years for disabled participants.

The actuarial assumptions used in the June 30, 2020 valuation were based on the results of an actuarial experience study for the period July 1, 2017 to June 30, 2018. As a result of the 2018 actuarial experience study, the expectation of life after disability was adjusted in the January 1, 2018 actuarial valuation to more closely reflect actual experience.

Discount rate. The discount rate basis under GASB 75 is required to be consistent with a 20-Year Municipal Bond Index. The Bond Buyer General Obligation 20-Bond Municipal Bond Index is used for the determination of the discount rate.

Sensitivity of the Net OPEB Liability to Changes in the Discount Rate. The following presents the net OPEB liability of the Retirees' Fund, as well as what the Retirees' Fund's net OPEB liability would be if it were calculated using a discount rate that is 1-percentage-point lower (2.51 percent) or 1-percentage-point higher (4.51 percent) than the current discount rate:

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

	1% Decrease in Discount Rate 2.51%	Discount Rate 3.51%	1% Increase in Discount Rate 4.51%
Total OPEB Liability	$ 1,434,897	$ 1,301,420	$ 1,185,615
Plan Fiduciary Net Position	(216)	(216)	(216)
Net OPEB Liability	$ 1,434,681	$ 1,301,204	$ 1,185,399

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

	1% Decrease in	Health Care Cost	1% Increase in
Total OPEB Liability	$ 1,207,454	$ 1,301,420	$ 1,413,042
Plan Fiduciary Net Position	(216)	(216)	(216)
Net OPEB Liability	$ 1,207,238	$ 1,301,204	$ 1,412,826

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

NOTE 6 - Commitments:

The Self Insurance Trust Fund is committed to the following contracts or policies after June 30, 2020:

Contractor	Contract Rate	Expiration Date
American Health Holding, Inc.	Varies by case volume	6/30/23
Aon Hewitt	Hourly rate	6/30/22
Casey Neilon, Inc.	Hourly rate	12/31/21
Diversified Dental Services	Per participant per month	6/30/21
Express Scripts	Per participant per month admin fee, claims costs	6/30/22
Health Claim Auditors	Based on a per audit fee for each quarterly audit	9/30/22
Health Plan of Nevada (HMO)	Varies by tier	6/30/21
HealthSCOPE Benefits (FSA)	Varies by service	6/30/22
HealthSCOPE Benefits (PPO)	Varies by service	6/30/22
HealthSCOPE Benefits (TPA)	Varies by service	6/30/22
HealthSCOPE Dental	Varies by service	6/30/22
Hometown Health Providers (PPO)	Varies by tier	6/30/21
KPS3	Monthly fee	6/30/21
Morneau Shepell	Per participant per month fee for services rendered	12/31/23
The Standard Insurance	Varies	6/30/22
Towers Watson	Per HRA Account per month	6/30/25
UNUM	Varies by type of insurance selected by participant	6/30/20

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

NOTE 7 - Risk Management:

Estimated Claims Liabilities:

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

Unpaid Claims Liabilities:

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

Unpaid Claims Liabilities:

	2020	2019
Reserve for claims balance		
Beginning balance	$ 58,790,000	$ 37,568,000
Claims and changes in estimates	258,939,546	274,535,662
Claims payments	(266,215,546)	(253,313,662)
Ending balance reserve for claims balance	$ 51,514,000	$ 58,790,000
HRA Liability		
Beginning balance	$ 36,091,428	$ 34,115,258
Incurred	44,596,089	42,537,462
Paid	(42,499,204)	(40,561,292)
Ending balance HRA liability	$ 38,188,313	$ 36,091,428
Ending Balance	$ 89,702,313	$ 94,881,428

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

NOTE 8 – Contingencies:

Contingent Liabilities

In accordance with NRS 353.140, the Self Insurance Trust Fund honors outstanding stale warrants presented for payment within six years from the date of origination. Management has estimated the total amount of outstanding stale warrants less than six years old to be $1,220,373 and $1,360,327 as of June 30, 2020 and June 30, 2019, respectively. Management has assessed that it is not probable that these warrants will be presented for payment during the statutory time frame. However these warrants will continue to be recorded as a liability as after the statutory six year period the funds will be turned over to the Nevada State Treasurer as unclaimed property.

NOTE 9 – Subsequent Events:

Management has evaluated the activities and transactions subsequent to June 30, 2020 to determine the need for any adjustments to and disclosure within the financial statements for the year ended June 30, 2020. Management has evaluated subsequent events through November 13, 2020, the date which the financial statements were available to be issued.

The Fund is responding to the recent COVID-19 outbreak with a measured, practical response. As of the date of this report, the Fund is able to perform necessary business functions however, the extent of future financial impact and duration cannot be reasonably estimated at this time.

STATE OF NEVADA
SELF INSURANCE TRUST FUND
PUBLIC EMPLOYEES' BENEFITS FUND
REQUIRED SUPPLEMENTARY INFORMATION - PENSION
JUNE 30, 2020 AND 2019

SCHEDULE OF CHANGES IN NET PENSION LIABILITY

(Last Ten Fiscal Years*)

	Measurement Dates					
	2019	**2018**	**2017**	**2016**	**2015**	**2014**
Proportion of the net pension liability (asset)	0.0281%	0.0260%	0.0253%	0.0270%	0.0262%	0.0254%
Proportion share of the net pension liability (asset)	$ 3,833,649	$ 3,547,239	$ 3,361,917	$ 3,633,788	$ 3,003,622	$ 2,681,426
Proportion share of covered-employee payroll	$ 1,907,119	$ 1,692,314	$ 1,578,012	$ 1,641,897	$ 1,507,312	$ 1,451,686
Proportionate share of the net pension liability (asset) as a percentage of its covered-employee payroll	201.02%	209.61%	213.05%	221.32%	199.27%	184.71%
Plan fiduciary net position as a percentage of the total pension liability	76.46%	75.24%	74.42%	72.23%	75.13%	76.31%

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

STATE OF NEVADA
SELF INSURANCE TRUST FUND
PUBLIC EMPLOYEES' BENEFITS FUND
REQUIRED SUPPLEMENTARY INFORMATION - PENSION
JUNE 30, 2020 AND 2019

SCHEDULE OF CONTRIBUTIONS

(Last Ten Fiscal Years*)

	Measurement Dates					
	2020	**2019**	**2018**	**2017**	**2016**	**2015**
Contractually required contributions	$ 267,388	$ 270,930	$ 241,784	$ 220,384	$ 228,943	$ 281,658
Contributions in relation to those contractually required	(267,388)	(270,930)	(226,892)	(220,384)	(228,943)	(281,658)
Contribution deficiency	$ -	$ -	$ -	$ -	$ -	$ -
Fund's covered-employee payroll	$ 1,532,510	$ 1,684,981	$ 1,509,506	$ 1,374,657	$ 1,333,326	$ 1,344,932
Contributions as a percentage of covered-employee payroll	17.45%	16.08%	16.02%	16.03%	17.17%	20.94%

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

STATE OF NEVADA
SELF INSURANCE TRUST FUND
PUBLIC EMPLOYEES' BENEFITS FUND
REQUIRED SUPPLEMENTARY INFORMATION - OPEB
JUNE 30, 2020 AND 2019

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

(Last Ten Fiscal Years*)

	Measurement Date		
	2019	**2018**	**2017**
Proportion of the Net OPEB Liability (Asset)	9.3400%	0.1070%	0.1029%
Proportionate share of the Net OPEB Liability (Asset)	$ 1,301,204	$ 1,417,507	$ 1,339,747
Proportionate share of covered payroll	$ 1,911,007	$ 2,023,909	$ 1,712,899
Proportionate Share of the Net OPEB Liability (Asset) as a percentage of covered payroll	68.09%	70.04%	78.22%
Plan Fiduciary Net Position as a percentage of the total Net OPEB Liability	0.02%	0.12%	0.11%

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

STATE OF NEVADA
SELF INSURANCE TRUST FUND
PUBLIC EMPLOYEES' BENEFITS FUND
REQUIRED SUPPLEMENTARY INFORMATION - OPEB
JUNE 30, 2020 AND 2019

SCHEDULE OF THE FUND CONTRIBUTIONS

(Last Ten Fiscal Years*)

	2020	2019	2018
Contractually required contributions	$ 41,705	$ 44,268	$ 39,801
Contributions	41,705	44,268	39,801
Contribution deficiency (excess)	$ -	$ -	$ -
Fund's covered payroll	$ 1,532,510	$ 1,684,981	$ 1,509,506
Contributions as a percentage of covered payroll	2.72%	2.63%	2.64%

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

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

To the Board of the
Public Employees' Benefits Program

We have audited, in accordance with the auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards* issued by the Comptroller General of the United States, the basic financial statements of the Self Insurance Trust Fund, Public Employees' Benefits Program of the State of Nevada, as of and for the year ended June 30, 2020, and the related notes to the financial statements, which comprise the Self Insurance Trust Fund, Public Employees' Benefits Programs basic financial statements, and have issued our report thereon dated November 16, 2020.

Internal Control over Financial Reporting

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

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

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

Compliance and Other Matters

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

Purpose of this Report

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

Casey Neilon

Carson City, Nevada
November 16, 2020

5.

5. Discussion and possible action to approve a 6-year contract beginning January 1, 2022 with LSI for an Enrollment and Eligibility Benefits System. Pursuant to NRS 287.04345(4), the PEBP Board may close a portion of this item to review the results of the evaluation of proposals for the contract; no action will be taken during any closed portion of the session (Cari Eaton, Chief Financial Officer)**(For Possible Action)**

STEVE SISOLAK
Governor

LAURA FREED
Board Chair

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LAURA RICH
Executive Officer

AGENDA ITEM

[X] Action Item
[ ] Information Only

Date: November 23, 2020

Item Number: V

Title: Ratification of Contract for Eligibility & Enrollment Benefits Management System - RFP 95PEBP-S1244

Report

On July 1, 2020, the Public Employees' Benefits Program released Request for Proposal (RFP) 95PEBP-S1244 for Eligibility & Enrollment Benefits Management System services. The following were some items important to PEBP in the consideration of the award of this contract:

PEBP is seeking a vendor with the capability of providing a comprehensive, user friendly system that is web enabled and SaaS based with an open architecture designed for easy migration to new technologies.

The high-level functionality of the system should include at a minimum, but not be limited to, the following:

- A solution providing core line-of-business functions, which include applications that permit the Agency to perform operations, including:
    - Determining member insurance eligibility in accordance with PEBP's eligibility plan rules;
    - Provide a sophisticated eligibility rules engine with automated solutions that increase efficiency in the administration of the plan;
    - Call center management tools;
    - Facilitating benefit enrollment including transfer of data from and to other internal systems, employers, and third-party administrators (TPAs);
    - Updating and maintaining coverage records;
    - The capability of billing premiums to multiple employers and pay centers, generating direct bills to all participants (including COBRA participants), and to administer all accounts receivable and payable while also being able to reconcile invoices with incoming payments;
    - Executing queries and other data extractions used to determine plan trends, usage patterns, and facilitate statistical analysis, etc.;

    - Integrated document management (including document production and retention);
    - System generated functions such as system generated letters to participants, and tasks for staff;
    - Ad hoc reporting capabilities.
- Web based access to the solution for PEBP staff, and Agency (pay center) Representatives;
- Web based, intuitive and comprehensive member solution providing a positive enrollment experience including single sign on integration;
- All required interfaces, including, but not limited to, interfaces between employers and TPAs;
- Mobile device accessibility
- Audit indicator capabilities such that a participant's account can be identified as to whether it has been audited, through what date, and by whom;
- Department-specific manuals and documentation for all system users, administrators, and developers; in addition to all baseline functionality, all such documentation must reflect the customized, as-built status of the solution; standard documentation reflecting only the vendor's un-customized base solution will not be accepted;
- Training for all system users, administrators, and developers– not only in application navigation and the use of screens and windows, but also in the use of the new solution to perform all their various job functions, processes, and sub-processes in the new environment;
- Any and all necessary software customizations to meet business and functionality requirements;
- Full implementation of the new solution (including as-built documentation of system design, database models, system configurations, and customizations);
- Project management services.

Vendor responses were scored based on the following criteria.

- Experience in Performance of Comparable Engagements
- Demonstrated Competence
- Expertise and Availability of Key Personnel
- Conformance with the Terms of the RFP
- Cost

On August 14, 2020, PEBP received six (6) proposals in response to RFP 95PEBP-S1244. The evaluation period began on August 15, 2020 and ended on September 11, 2020. The six-member evaluation committee included two PEBP Board members. Labyrinth Solutions, Inc. d/b/a LSI Consulting received the highest score by the evaluation committee. Some of the reasons provided by the individual evaluators for their scores were:

- Extensive and informative response
- Best technical requirements response
- Voluntary benefits platform included
- Smart21 existing state vendor with the ability to facilitate a smooth integration

- Some LSI Staff officed in Carson City

Although the proposal was submitted by LSI (as the system integrator), the actual eligibility and enrollment technology will be subcontracted to Benefit Focus.

The effective date of the contract is anticipated to be December 8, 2020 (upon BOE approval) through June 30, 2027 with an option to extend to June 30, 2029. Implementation will begin upon BOE approval while the services and associated fees are expected to begin on January 1, 2022 after implementation. The contract maximum is $ 6,849,000.

Recommendation

Ratify the evaluation committee's recommendation that a contract be approved with Labyrinth Solutions, Inc. d/b/a LSI Consulting to provide Eligibility & Enrollment Benefits Management System services beginning January 1, 2022.

6.

6. Discussion and possible action to approve American Health Holding contract amendment addressing temporary ownership of toll-free number. (Cari Eaton, Chief Financial Officer)**(For Possible Action)**

STEVE SISOLAK
Governor

LAURA FREED
Board Chair

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LAURA RICH
Executive Officer

AGENDA ITEM

[X] Action Item
[ ] Information Only

Date: November 23, 2020

Item Number: VI

Title: Contract Amendment Report

SUMMARY

This report requests the Board authorize staff to complete a contract amendment between PEBP and American Health Holdings Inc. to amend the negotiated items through the contract term.

REPORT

AMERICAN HEALTH HOLDINGS, INC.

PEBP contracted with American Health Holdings Inc. (AHH) for Utilization Management / Large Case Management (UMCM) Services which began February 12, 2019.

This contract amendment will add language to the Negotiated Items to allow AHH to put the PEBP owned toll free phone number in their name in order to pay the phone bill more efficiently. Upon termination of the contract, the phone line will be transferred back to PEBP. A performance guarantee of $100,000 will also be added to guarantee AHH will transfer the number.

Currently EITS is being charged $0.15 per minute and passing through those charges to AHH. Over the last year this phone line was charged approximately 21,970 minutes on average per month. AHH has a rate in place of $0.0088 per minute which would save AHH $2,320 per month on average.

Average Monthly EITS Charge - $3,295.46
Average Monthly Minutes - 21,970
Average Calculated AHH Charge - $193.33

RECOMMENDATION

PEBP recommends the Board authorize staff to complete a contract amendment between PEBP and American Health Holdings, Inc. for UMCM services in contract # 21376 to amend the negotiated items.

7.

7. Executive Officer Report (Laura Rich, Executive Officer) (Information/Discussion)

STEVE SISOLAK
Governor

LAURA FREED
Board Chair

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LAURA RICH
Executive Officer

AGENDA ITEM

☐ Action Item
☒ Information Only

Date: November 23, 2020

Item Number: VII

Title: Executive Officer Report

SUMMARY

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

REPORT

COVID-19 UPDATE

PEBP has been working with the Governor's Finance Office (GFO) to ensure the program's COVID-19 related expenditures are captured and reimbursement can be requested from the state's Coronavirus Relief Fund (CRF) allocations. As of November 12, PEBP has incurred almost $2.5M in COVID-19 related costs but is projected to incur approximately $4.7M by the end of December. Because CRF funds will expire at the end of the year, PEBP has submitted a work program requesting $4.7M in reimbursements to cover these projected costs. This is expected to be included as part of the December Interim Finance Committee (IFC) meeting agenda.

SCR10 – FEASIBILITY STUDY FOR A PUBLIC HEALTH INSURANCE OPTION

During the 2019 Legislative session, SCR10 was passed, directing the Legislative Commission to study the feasibility, viability and design of a public healthcare insurance plan offered through the Public Employees' Benefits Program to all Nevada residents (https://www.leg.state.nv.us/App/NELIS/REL/80th2019/Bill/7087/Text). In August 2020, PEBP and the Silver State Health Insurance Exchange (SSHIX) were approached by Manatt Health, the organization charged with conducting the feasibility study. Since then, both PEBP and SSHIX

have been working with Manatt and have provided information, data and feedback on possible options and solutions. Manatt is expected to provide a draft report on the findings of their analysis and potential solutions by the end of November and upon input and feedback from PEBP and other agencies, Manatt will finalize their study and deliver a final report to the Legislative Commission by the end of 2020. PEBP will continue to update the Board as more information becomes available on this study.

SOLICITATIONS UPDATE

Due to the enormous amount of time that must be dedicated - not just by PEBP staff and outside evaluators, but also by the Purchasing Division, many of the solicitations staff hoped to be able to bring to the Board in November will not be able to be presented until the January Board meeting, however PEBP is confident that all necessary contractual deadlines will be met and July 1, 2021 implementations will be achieved.

PEBP is pleased to announce successful negotiations for a new Enrollment and Eligibility system with the states' currently contracted Smart 21 vendor, LSI. LSI has partnered with Benefit Focus to offer an integrated enrollment and eligibility system that should seamlessly tie into the statewide system that is due to go live in 2021.

In addition, the Purchasing Division has issued letters of intent for the Medical Network, Dental Network and HMO contracts. PEBP is in the processes of negotiating each of these so that they can be presented at the January 2021 Board meeting and subsequently included in the Board of Examiners meeting for final approval in February.

The Health Plan Auditor RFP has been finalized and submitted to Purchasing for release and the Financial Auditor RFP is undergoing review and should be submitted to Purchasing by the end of the year.

OPERATIONS UPDATE

Flu Shots
As we have in previous years, PEBP hosted two flu shot clinics during the month of October – one in Carson City and one Las Vegas. Governor Sisolak attended the event in the Carson City location to show his support and stress the importance of flu shots during the pandemic. Although PEBP expected a significant decrease in participation due to a large number of employees working from home, we still had a surprisingly strong showing with almost 300 employees receiving flu shots in Carson City and 140 in Las Vegas – which is about 50% more than we saw in 2019.

Staffing
Staffing continues to be a challenge. Although PEBP received approval to staff several open positions, internal promotions created new vacancies and supervisors have found it challenging to fill several entry level vacancies. To date, the executive level CIO position, Management

Analyst III and two member services rep (AAIII) vacancies have been filled and there is one additional recruitment for an Eligibility Specialist (AAIV) in progress. PEBP has chosen not to submit Justification to Fill requests for several other positions that have been determined to not be vital at this time, such as a front desk receptionist. To date PEBP has 30 of 34 positions filled.

CONCLUSION

With all the upcoming changes to the core plan design and possible reductions to other benefits, PEBP expects a very busy year and will be depending on each and every one of our staff to ensure PEBP's 73,000+ members receive excellent service, care and attention.

8.

8. Discussion and possible action regarding Plan Year 2022 Plan Design Recommendations (July 1, 2021 – June 30, 2022) and FY22/23 Budget Reserve Proposals. Including but not limited to the following: (Laura Rich, Executive Officer) (**All Items for Possible Action**)

   8.1 Core Plan Design of CHDP, EPO and Low Deductible Plans

   8.2 Possible Changes to Payments of Out-of-Network Billed Charges

   8.3 Possible Implementation of Smart 90 to EPO

   8.4 Possible Implementation of Express Advantage Network to CHDP, EPO, and Low Deductible Plan.

   8.5 Possible Reductions to Medicare Health Reimbursement Arrangement (HRA) contributions.

   8.6 Possible Reductions in or Elimination of Basic Life Insurance Benefit

   8.7 Possible Reductions in or Elimination of Long-Term Disability Benefit

   8.8 Possible Elimination of Medicare Part B Subsidy

   8.9 Possible Elimination of Retiree Dependent Subsidies

   8.10 Possible Unbundling of Dental Premium

   8.11 Possible Increases in Premiums to Achieve Necessary Budget Reserve Requirements

   8.12 Possible Transition of Non-Medicare Retirees to the Silver State Health Insurance Exchange

STEVE SISOLAK
Governor

LAURA FREED
Board Chair

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LAURA RICH
Executive Officer

AGENDA ITEM

[X] Action Item
[ ] Information Only

Date: November 23, 2020

Item Number: VIII

Title: Plan Year 2022 Plan Design Recommendations and FY22/23 Budget Reserve Proposals

SUMMARY

This report provides information on the Plan Year 22 Plan Design recommendations to include 12% budget reserves for FY22.

BACKGROUND

Earlier this year, the Governor's Finance Office (GFO) requested agencies to submit budget reserves for Fiscal Years 2020 and 2021. PEBP was exempt from FY20 budget reserves but was able to achieve almost $25M in budget reserves for FY21, mainly by adjusting required reserve levels and contract adjustments. Additionally, agencies were originally asked to submit flat FY22/23 budgets, which for PEBP is automatically a 5% cut when trend is accounted for.

On November 3, 2020, the Governor's Finance Office (GFO) released a memo to state agency directors indicating that unfortunate economic conditions and declining revenues are expected in the next biennium. As a result, agencies are being asked to make necessary preparations by formulating and submitting proposed budget reserves of 12%. For PEBP, 12% is the equivalent of approximately $72M for the biennium. These reserve proposals are being used for budget planning purposes and may be adjusted when the Economic Forum releases the official forecast of future state General Fund revenues in December. The options presented in this report are for consideration not only for Plan Year 22 plan benefit design, but to be included, as necessary, in PEBP's FY22/23 agency request budget.

Each November, the PEBP Board discusses and approves the plan design for the following plan year so that in March, the approved plan design can be rated and premiums can be presented. At that point, all member material (including guides, master plan documents, website content, and member communications) is updated accordingly by staff in advance of open enrollment. The same approach is being proposed this year with an added element that will allow PEBP staff, in

coordination with GFO, to finalize a budget based on the forecasts presented by the Economic Forum in December. PEBP is proposing a menu of options to be considered in order to meet the budget reserve goal of 12%. Ranking the options in order of preference will reduce the need to call an emergency Board meeting (should the 12% goal change prior to January). It will allow PEBP to incorporate the necessary budgetary changes into the FY22/23 agency request budget and implement the changes accordingly in time for the upcoming Open Enrollment period.

Disclaimer: It is important to emphasize that although standard actuarial methodology has been applied to develop Plan Year 22 budget savings options and recommendations, the program has many outstanding variables that will ultimately play a critical role and affect the overall experience of the plan:

- Renewal of several major contracts
- COVID-19 costs
- Trend
- Introduction of new plan – unknown utilization
- Legislative Session

REPORT

8.1 PY2022 PROPOSED PLAN DESIGN

The grid below illustrates the plan design concept that the Board approved in July, including a new low deductible copay plan and modifications to the existing plans. The preliminary concept presented in July sought to meet the initial budget requirement, which required a reduction in benefits of approximately 5% in order to meet the required caps. Although the PEBP Board only approved the "concept" of the new plan design to ensure staff were able to incorporate the idea into the agencies budget submission, the specific plan details were not approved as plan design is historically presented and discussed each November. The intent was to present and approve the 5% reduced plan design, but the new budgetary goals required staff to make necessary adjustments to the original version. The grid below represents the adjusted benefit levels and illustrates a slightly leaner plan design than the original version presented to the Board in July.

	Modified CDHP		New Low Ded PPO w/ copay		EPO/HMO	
	PY21	Proposed PY22	PY21	Proposed PY22	PY21	Proposed PY22
Deductible (Individual w/in Family)	$1,500/$3,000 ($2,800)	$2,000/$4,000 ($2,850)		$1,000/$2,000 ($1,000)	$0	$500/$1,000 ($500)
OOP Max (Individual w/in Family)	$3,900/$7,800 ($6,850)	$6,000/$12,000 ($6,000)		$6,000/$12,000 ($6,000)	$7,150/$14,300 ($7,150)	$6,000/$12,000 ($6,000)
Coinsurance	20%	20%		20%	N/A	20%
Primary Care Visit	20% after ded.	20% after ded.		$30	$20	$25
Specialist Visit	20% after ded.	20% after ded.		$50	$40	$40
ER visit	20% after ded.	20% after ded.		$750	$500	ded + $750
UC Visit	20% after ded.	20% after ded.		$80	$30	$50
Inpatient Hospital	20% after ded.	20% after ded.		20% after ded.	$500	ded + $750
Outpatient Surgery	20% after ded.	20% after ded.		$500	$350	$350
RX						
Generic	20% after ded.	20% after ded.		$10	$10	$10
Formulary	20% after ded.	20% after ded.		$40	$40	$40
Non-formulary	20% after ded.	20% after ded.		$75	$75	$75
Specialty	20% after ded.	20% after ded.		30% after ded.	20%	30% after ded.
All other services	20% after ded.	20% after ded.		20% after ded.	Varies by service	20% after ded.
HSA employer contribution	$700 + $200/dep	$300		N/A	N/A	N/A
Actuarial Value	87.3%	78.4%		81.8%	92.0%	86.2%
Approximate EE only Rate	$43.94	**$44.60**		**$84.38**	$171.05	**$149.47**
Approx E + spouse Rate	$227.16	**$234.51**		**$314.07**	$517.57	**$444.26**
Approx E + Children Rate	$117.80	**$126.24**		**$180.94**	$343.23	**$270.45**
Approx E+Fam Rate	$301.01	**$272.74**		**$367.22**	$689.74	**$521.82**

*Rates are only an approximation based on above plan design and current experience through October 2020.

The plan design above, along with the assumption that PEBP will see a 2.5% reduction in headcount due to hiring freezes and the possibility of position eliminations, **achieves approximately $20.1M of the $36M necessary budget reserves for FY22.**

8.2 - 8.8

Since placing the burden entirely on plan design would decimate the plan, PEBP has completed analysis on a variety of other benefits that the Board will need to consider in order to make up the remaining $15.9M deficit:

Option	Detail	Savings	Rank
8.2 OON billed charges negotiated by using 140% Medicare model rather than Fair Health Standards.	Fair Health has historically been considered the claims payment markets' solution for the pricing of non-contracted providers. Fair Health maintains a database of billed charges by service code and zip code and determines typical charges for that service in that geographical area. This is referred to as the "Fair Health Usual & Customary charge." Since Medicare pricing is a controlled and equitable price point that takes into account geographic location. Moving to a referenced based value approach increases plan savings while using a value familiar to the provider community.	$1.9M	
8.3 Implement Smart 90 to EPO	In PY19, PEBP implemented Smart 90 to the CDHP on a voluntary basis and in PY20 it became mandatory. Smart 90 improves drug pricing on 90- day maintenance medications for	$500K	

and Low Deductible Plan	both the program and the member by narrowing the pharmacy network to Smart90 participating pharmacies. Although two major pharmacies are excluded from this network (CVS and Walgreens), all but 34 members will have access to a participating pharmacy within 4 miles of their home. Member savings = $317K		
8.4 Implement 30-day Express Advantage Network on CHDP, EPO and Low Deductible Plans	Similar to Smart 90, the Express Advantage Network improves drug pricing on 30-day prescriptions for both the member and the program by narrowing the pharmacy network to Express Advantage participating pharmacies. Although two major pharmacies are excluded from this network (CVS and Walgreens), all but 34 members (EPO) and 94 members (CDHP) will have access to a participating pharmacy within 4 miles of their home. Additionally, members have the option of continuing to fill their prescription at a non-participating pharmacy by paying an additional $10 to the price of their medications.	$900K	
8.5 Reductions to Medicare Health Reimbursement Arrangement (HRA) contributions	Option 1: Reduce from $13/YOS to $12 Option 2: Reduce from $13/YOS to $11	$1.7M $3.4M	
8.6 Reduction or Elimination of Basic Life Insurance Benefit	Current: $25k/Actives, $12,500/retirees Option 1: Reduce to $20k/Actives, $10k retirees Option 2: Reduce to $10k/Actives, $5k retirees Option 3: Eliminate *Total Claims in PY18: 41 actives, 294 retirees PY19: 47 actives, 273 retirees	 $1.3M $4.0M $7.0M	
8.7 Elimination of Long-Term Disability Benefit	Eliminate LTD benefit. This benefit is designed to help protect against a loss of income in the event of a disability that results in the ability to work for an extended period of time. *Utilization: PY19: 25, PY20: 21 *Total Active Claims: 117	$5.6M	
8.8 Elimination of Part B Subsidy	Retirees who are covered under PEBP plans (excluding Exchange) are required to purchase Medicare Part B. PEBP provides a Part B premium to offset this cost. Approximately 1100 members are receiving a $135.50 premium credit.	$1.7M	
8.9 Eliminating retiree dependent subsidies	Under this option, PEBP will continue to offer retiree dependent coverage, however dependents of retirees will no longer be subsidized by the plan. Dependent Coverage Count: 2106	$4.5M	
8.10 Unbundling of Dental Premium	Dental premiums are currently embedded into the overall premium. Members enrolling in a medical plan automatically receive dental coverage. This option separates the two premiums	$4.2M*	

	and allows members to opt out of dental or pay a separate premium to enroll into dental. Proposed premiums to enroll in dental: E only: $5, E+S: $10, E+C: $10, E+F: $15 **if 8.9 is prioritized before 8.10, then 8.10 savings is reduced to $2.6M*		
8.11 Premium increases	Meet budget reserve goal partially or entirely through increases in premiums.	Varies	
8.12 Possible transition of non-Medicare retirees to SSHIX	See details in section below	$12.6M	

8.12 POSSIBLE TRANSITION OF NON-MEDICARE RETIREES TO SILVER STATE HEALTH INSURANCE EXCHANGE

Similar to the actions PEBP took in 2011 as a result of the recession, this option will require retirees that are either not of Medicare age or do not qualify for Medicare to purchase coverage through Nevada's individual marketplace (Silver State Health Insurance Exchange (SSHIX)/Nevada Health Link).

Because retiree health care is expensive, many public sector employers have elected to no longer offer health coverage to retirees. In fact, during the 76th (2011) legislative session, the decision was made that employees hired after January 1, 2012 would no longer be eligible to receive a retiree health benefit subsidy. In many instances, those employers that do provide retiree benefits, have transitioned to providing retirees with financial assistance in the form of a Health Reimbursement Arrangement (HRA) contributions. Retirees can then seek and purchase their own health coverage and use their HRA to offset the cost of premiums and/or out-of-pocket costs. Leveraging Nevada's SSHIX will help reduce PEBP's costs while continuing to subsidize retirees with funding determined by their years of service.

Advantages	Disadvantages
Retirees will have access to more plan options.	Although the ACA has been upheld several times, the law is continuously being challenged.
Lower income retirees (<400% federal poverty level) may qualify for federal subsidies on the Exchange and have access to cheaper premiums and reduced out of pocket expenses than what they currently receive through PEBP. These federal subsidies would in many cases also be more advantageous than the HRA subsidy that would be provided by PEBP.	Although retirees in Clark/Nye County will experience less of an increase, premiums will likely increase for most retirees living in Nevada. Due to the high cost of care in the rurals and the age banding on the Exchange, those living in the rurals or higher income retirees (>400%FPL) will be the hardest hit. Their premiums and out of pocket costs will increase. The impact is unknown for retirees residing outside of Nevada as Exchange and

	Healthcare.gov plans and rates vary from state to state.
The Exchange can offer the services of brokers and navigators to help retirees located in Nevada transition.	This will require a significant undertaking by PEBP involving massive communication and planning. Should this option be leveraged, it is recommended it not be effective until PY23.
This option provides flexibility to the state to raise/reduce subsidies based on economic conditions.	This will require legislative changes.

Age Make-up of Non-Medicare Retirees

Years of Age	#
<45	19
46 – 55	714
56-65	3152
65+	1028
Total Non-Medicare members	4913

*692 members reside outside of Nevada.

Federal Poverty Level (FPL)

Household Size	100%	133%	138%	250%	400%
1	$12,760	$16,612	$17,236	$31,225	$51,040
2	$17,240	$22,490	$23,335	$42,275	$67,640
3	$21,720	$28,369	$29,435	$53,325	$85,320
4	$26,200	$34,248	$35,535	$64,375	$103,000
5	$30,680	$40,126	$41,634	$75,425	$120,680

Retiree Salaries

PEBP was unable to gather retiree income data on this population due to PERS confidentiality restrictions. Although not an indicator of actual retiree earnings, State of Nevada Department of Administration records show the median ending income of a retiree, within the past 5 years, is approximately $40,419.

As noted above, legislative changes would be necessary should this option be implemented. Although staff have not had the opportunity to vet this thoroughly through legal, two clear changes to statute have been identified:

1. NRS 287.043(2) states *"In establishing and carrying out the Program, the Board shall: (a) For the purpose of establishing actuarial data to determine rates and coverage for active and retired state officers and employees and their dependents, commingle the claims experience of such active and*

retired officers and employees and their dependents for whom the Program provides primary health insurance coverage into a single risk pool.

Since this option eliminates the need to determine rates and coverage for retirees and absent of claims, retirees would no longer be included in the single risk pool

2. NRS 287.046(5) states "*Except as otherwise provided in subsection 6, adjustments to the portion of the amount approved by the Legislature as described in subsection 2 to be paid by the Retirees' Fund for persons who retire on or after January 1, 1994, with state service must be as follows:*
(a) For each year of service less than 15 years, excluding service purchased pursuant to NRS 1A.310 or 286.300, the portion paid by the Retirees' Fund must be reduced by an amount equal to 7.5 percent of the base funding level defined by the Legislature. In no event may the adjustment exceed 75 percent of the base funding level defined by the Legislature.
(b) For each year of service greater than 15 years, excluding service purchased pursuant to NRS 1A.310 or 286.300, the portion paid by the Retirees' Fund must be increased by an amount equal to 7.5 percent of the base funding level defined by the Legislature. In no event may the adjustment exceed 37.5 percent of the base funding level defined by the Legislature."

Due to the overall higher premiums on the Exchange, PEBP is proposing a different funding methodology using increased subsidies for retirees:

	PY2021 Non Medicare State Retirees Current Employer Subsidy Monthly	
	CDHP Base Subsidy	EPO/HMO Base Subsidy
Retiree only	$393.72	$435.33
Retiree + Spouse	$636.04	$693.60
Retiree + Child(ren)	$495.52	$562.52
Retiree + Family	$737.84	$820.79

Current and Proposed Non-Medicare YOS Retiree Subsidies (Monthly)					
YOS	Current PY21	Retiree Only	Retiree+Spouse	Retiree+Child(ren	Retiree+Family
5	-$358.61	$160	$257	$204	$301
6	-$322.75	$208	$334	$266	$391
7	-$286.89	$256	$411	$327	$482
8	-$251.03	$304	$488	$388	$572

9	-$215.17	$352	$565	$449	$662
10	-$179.31	$400	$642	$511	$753
11	-$143.45	$448	$720	$572	$843
12	-$107.58	$497	$797	$633	$933
13	-$71.72	$545	$874	$695	$1,024
14	-$35.86	$593	$951	$756	$1,114
15	$0.00	$641	$1,028	$817	$1,204
16	$35.86	$689	$1,105	$878	$1,295
17	$71.72	$737	$1,182	$940	$1,385
18	$107.58	$785	$1,259	$1,001	$1,475
19	$143.45	$833	$1,336	$1,062	$1,566
20	$179.31	$881	$1,413	$1,123	$1,656

56 year-old retiree with 20 YOS living in:	PEBP Premium (CDHP)	Exchange Premium* w/ applied subsidy
Clark County	$54.28	$0
Carson City	$54.28	$315.78
Reno	$54.28	$163.35
Elko	$54.28	$537.98

**Gold level plan, $1,250/deductible, $5,900 OOPM, copay based for office visits/Rx, coinsurance based for procedures and specialty Rx.*

RECOMMENDATION:

1. Approve Plan Year 2022 Proposed Plan Benefit Design as illustrated in section 8.1
2. Rank options 8.2 – 8.12 in order of preference from most to least desirable for PY22 implementation as necessary to meet budgetary goals established by GFO for PY22.
3. Approve staff to implement budget reserve options in order of preference as necessary to meet budgetary goals established by GFO for FY22 and FY23.

9.

9. Public Comment

10.

10. Adjournment