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

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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:	September 24, 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/bogWJC1FdeA

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:

Dial: (669) 900-6833. When prompted to provide your Meeting ID, please enter: 921 1678 4439 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.state.nv.us at least two business days prior to the meeting. Persons making public comment need to state and spell their name for the record at the beginning of their testimony.

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

4. Consent Agenda (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.

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**)
9. Discussion and Possible Action regarding Legislative Commission's Audit Subcommittee Audit Findings and Corrective Action Plan (Laura Rich, Executive Officer) (**For Possible Action**)
10. Discussion and Possible Action on Solicitation for PEBP Auditor (Laura Rich, Executive Officer) (**For Possible Action**)
11. Presentation on COVID-19 modeling update (Stephanie Messier, Aon) (Information/Discussion)
12. 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.
13. 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**)

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4.1

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

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

STATE OF NEVADA
PUBLIC EMPLOYEES' BENEFITS PROGRAM
BOARD MEETING

Telephonic Open Meeting
Carson City and Las Vegas, NV

ACTION MINUTES (Subject to Board Approval)
July 23, 2020

MEMBERS PRESENT VIA TELECONFERENCE:	Ms. Laura Freed, Board Chair Ms. Linda Fox, Vice Chair Ms. Jet Mitchell, Member Mr. Don Bailey, Member Mr. Tom Verducci, Member Mr. David Smith, Member Ms. Jennifer Krupp, 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 9:04 a.m.

2. Public Comment
    - Priscilla Maloney – AFSCME
    - Kevin Ranft – AFSCME
    - Kent Ervin – Nevada Faculty Alliance
    - Doug Unger – UNLV Benefits Advisory Committee/UNLV Faculty Senate

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 May 28, 2020 PEBP Board Meeting

    4.2 Receipt of quarterly staff reports for the period ending March 31, 2020:

    4.2.1 Budget Report

    4.2.2 Utilization Report

    4.3 Receipt of quarterly vendor reports for the period ending March 31, 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 Towers Watson's One Exchange – Medicare Exchange

    4.3.6 Hometown Health Providers and Sierra Healthcare Options – PPO Network

    4.3.7 HealthPlan of Nevada, Inc. – Southern Nevada HMO

BOARD ACTION ON ITEM 4
MOTION: Motion to approve all but 4.2.1, 4.3.5 and 4.3.6.
BY: Member Jet Mitchell
SECOND: Vice Chair Linda Fox
VOTE: Unanimous; the motion carried

BOARD ACTION ON ITEM 4.2.1, 4.3.5 and 4.3.6
MOTION: Motion to accept reports under 4.2.1, 4.3.5, 4.3.6.
BY: Member Tom Verducci
SECOND: Vice Chair Linda Fox
VOTE: Unanimous; the motion carried

5. Election of Board Vice-Chair pursuant to Nevada Administrative Code (NAC) 287.172. Eligible candidates are Don Bailey, Sr., Linda Fox, Tom Verducci, Marsha Urban, Jennifer Krupp, David Smith and Jet Mitchell (Laura Freed, Board Chair) **(For Possible Action)**

BOARD ACTION ON ITEM 5
MOTION: Motion that Ms. Fox continue her service as Vice Chair for plan year '21.
BY: Member Jet Mitchell
SECOND: Member Marsha Urban
VOTE: Unanimous; the motion carried

6. Executive Officer Report (Laura Rich, Executive Officer) (Information/Discussion)
7. Discussion and Possible action of Legislative Counsel Bureau Audit Report and Corrective Action Plan (Laura Rich, Executive Officer) (**For Possible Action**)

BOARD ACTION ON ITEM 7
ITEM 7 WAS DEFERRED BECAUSE THE LCB AUDIT SUBCOMMITTEE THAT WAS SCHEDULED FOR JULY WAS PREEMPTED BY THE 31ST SPECIAL SESSION.

8. Presentation on results of Request for Information (RFI) for Actuarial Review Services and Benefits Management System (Laura Rich, Executive Officer) (Information/Discussion)
9. Discussion and Possible action of plan design changes to be considered for Fiscal Year 2022/2023 agency request budget submission (Laura Rich, Executive Officer) (**For Possible Action**)

BOARD ACTION ON ITEM 9 (1)
MOTION: Motion to instruct PEBP staff to build a budget for submission to the GFO on August 31st that includes and accounts for a PPO middle tier option.
BY: Vice Chair Linda Fox
SECOND: Member Jennifer Krupp
VOTE: Unanimous; the motion carried

BOARD ACTION ON ITEM 9 (2)
MOTION: Motion that PEBP submit an agency request budget that comports to the approximate five percent reduction reflected in Agenda Item Nine.
BY: Vice Chair Linda Fox
SECOND: Member Tom Verducci
VOTE: Unanimous; the motion carried

10. Discussion and Possible action of recommended policy changes to be considered for Plan Year 2022 (Laura Rich, Executive Officer) (**For Possible Action**)

BOARD ACTION ON ITEM 10 (1)

MOTION: Motion to accept staff's recommendation on underwriting all self-funded plans into one risk pool, but keeping the State and Non-State risk pools separate in conformance with statute.
BY: Vice Chair Linda Fox
SECOND: Member David Smith
VOTE: Unanimous; the motion carried

BOARD ACTION ON ITEM 10 (2)

MOTION: Motion to accept staff's recommendation to apply a single contribution strategy across all plans.
BY: Vice Chair Linda Fox
SECOND: Member Tom Verducci
VOTE: Unanimous; the motion carried

BOARD ACTION ON ITEM 10 (3)

MOTION: Motion to approve option number three, single amount per employee regardless of tier, as the established HSA/HRA funding strategy.
BY: Vice Chair Linda Fox
SECOND: Member Jet Mitchell
VOTE: Four in favor; Linda Fox, Marsha Urban, Jet Mitchell, David Smith
Three opposed; Don Bailey, Tom Verducci, Jennifer Krupp
Abstained; Chair Freed
The motion carried

BOARD ACTION ON ITEM 10 (4)

MOTION: Motion to accept staff's recommendation to accept streamlining the tiers by following more traditional actuarial underwriting process by using a per purchase settlement per month factor per claims, adding on admin fees per participant per month basis. Use one tier for all plans, products, State and Non-State, keeping this factor static for a two-year budget cycle at a minimum.
BY: Member Tom Verducci
SECOND: Member Don Bailey
VOTE: Unanimous; the motion carried

BOARD ACTION ON ITEM 10 (5)

MOTION: Motion to refer to excess reserves as differential cash account and to establish it on , at a point in time and this motion specifies August 31, and to utilize the differential cash account if it's positive for things that are not ongoing expenses of the plan subject to possible emergency circumstances that the Board might define.

BY: Member Tom Verducci

SECOND: Member David Smith

VOTE: Unanimous; the motion carried

11. Public Comment

- Marlene Lockard – RPEN
- Shaun Franklin-Sewell
- Kevin Ranft – AFSCME

12. Adjournment

- Board Chair Freed adjourned the meeting at 1:37 p.m.

4.2

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

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

        4.2.1 Budget Report

        4.2.2 Utilization Report

4.2.1

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

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

4.2.1 Budget Report

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LAURA RICH
Executive Officer

AGENDA ITEM

[X] Action Item
[ ] Information Only

Date: September 24, 2020

Item Number: IV.II.I

Title: Chief Financial Officer Budget Report

Summary

This report addresses the Operational Budget as of June 30, 2020 to include:

1. Budget Status
2. Budget Totals
3. Claims Summary
4. Differential Cash Available for FY 2021

Budget Account 1338 – Operational Budget – Shown below is a summary of the operational budget account status as of June 30, 2010 with comparisons to the same period in Fiscal Year 2019. The budget status is reported on a cash basis and does not include incurred expenses and income owed to the fund.

The budget status report reflects actual income of $370.1 million as of June 30, 2020 compared to $373.0 million as of June 30, 2019 or a decrease of 0.8%. Total expenses for the period have increased by $22.1 million or 6.0% for the same period.

The budget status report shows Realized Funding Available (cash) at $132.0 million. This compares to $150.0 million for last year. After subtracting $58.8 million for reserves for Incurred but not Reported (IBNR) claims, $24.2 million for the Catastrophic Reserve and $36.2 million for the HRA Reserve, the remaining balance is $12.5 million in Excess reserves. The table below reflects the actual revenue and expenditures for the period.

Operational Budget 1338

	FISCAL YEAR 2020			FISCAL YEAR 2019		
	Actual as of 6/30/2020	Work Program	Percent	Actual as of 6/30/2019	Fiscal Year 2019 Close	Percent
Beginning Cash	150,276,433	150,276,433	100%	143,129,728	143,129,728	100%
Premium Income	353,826,673	382,017,605	93%	360,793,540	363,123,752	99%
All Other Income	16,243,687	15,819,606	103%	12,203,752	13,001,438	94%
Total Income	370,070,360	397,837,211	93%	372,997,292	376,125,190	99%
Personnel Services	2,504,369	2,835,868	88%	2,630,988	2,721,398	97%
Operating - Other than Personnel	2,026,253	2,383,964	85%	2,103,793	2,142,352	98%
Insurance Program Expenses	383,531,409	416,502,437	92%	360,776,627	363,036,252	99%
All Other Expenses	606,816	669,431	91%	1,062,125	1,078,483	98%
Total Expenses	388,668,846	422,391,700	92%	366,573,534	368,978,485	99%
Change in Cash	(18,598,487)	(24,554,489)		6,423,758	7,146,705	
REALIZED FUNDING AVAILABLE	131,677,946	125,721,944	105%	149,553,486	150,276,433	100%
Incurred But Not Reported Liability	(58,790,000)	(58,790,000)		(51,800,000)	(51,800,000)	
Catastrophic Reserve	(24,201,541)	(24,201,541)		(39,900,000)	(39,900,000)	
HRA Reserve	(36,204,203)	(36,204,203)		(31,676,056)	(31,676,056)	
NET REALIZED FUNDING AVAILABLE	12,482,202	6,526,200		26,177,430	26,900,377	

Current Budget Projections

The following table represents projections for FY 2020 based on data available as of June 30, 2020. The projection reflects total income to be more than budgeted by 0.9% ($546.1 million vs $541.4 million), total expenditures are projected to be more than budgeted by 1.0% ($402 million vs $397.5 million); total reserves are projected to be more than budgeted by 0.3% ($144.4 million vs $143.9 million).

Budgeted and Projected Income (Budget Account 1338)					
Description	**Budget**	**Actual 6/30/20**	**Projected**	**Difference**	
Carryforward	150,276,433	150,276,433	150,276,433	0	0.0%
State Subsidies	286,540,424	267,802,656	292,590,729	6,050,305	2.1%
Non-State Subsidies	29,202,769	28,187,570	28,309,827	(892,942)	-3.1%
Premium	66,274,412	57,836,447	57,845,642	(8,428,770)	-12.7%
All Other	16,228,497	16,243,687	17,070,199	(525,926)	-3.2%
Total	548,522,535	520,346,793	546,092,831	(3,797,333)	-0.7%
Budgeted and Projected Expenses (Budget Account 1338)					
Description	**Budget**	**Actual 6/30/20**	**Projected**	**Difference**	
Operating	5,889,263	5,137,438	5,295,331	593,933	10.1%
State Employee Ins Cost	294,710,442	281,681,642	280,060,913	14,649,529	5.0%
State Retirees Ins Cost	66,274,434	54,814,711	58,257,984	8,016,450	12.1%
Non-State Employees Ins Cost	171,498	152,262	155,555	15,943	9.3%
Non-State Retirees Ins Cost	15,384,713	10,821,631	11,413,356	3,971,357	25.8%
State Medicare Ret Ins Cost	23,155,087	21,746,222	20,795,956	2,359,131	10.2%
Non-State Medicare Ret Ins Cost	16,806,263	14,314,940	15,572,408	1,233,855	7.3%
Total Insurance Costs	416,502,437	383,531,409	386,256,172	30,246,265	7.3%
Total Expenses	422,391,700	388,668,846	391,551,503	30,840,198	7.3%
Restricted Reserves	119,195,744	119,195,744	139,294,953	(20,099,209)	-16.9%
Differential Cash Available	6,526,200	12,482,202	15,246,375	(8,720,175)	-133.6%
Total Reserves	125,721,944	131,677,946	154,541,328	(28,819,384)	-22.9%
Total of Expenses and Reserves	548,113,644	520,346,793	546,092,831	2,020,814	0.4%

State Subsidies are projected to be more than the budgeted amount by $6.1 million (2.1%), Non-State Subsidies are projected to be less than budgeted by $0.1 million (3.1%), and Premium Income is projected to be less than budgeted by $8.4 million (12.7%). This overall decrease in budgeted revenue is due in part to a slight increase in actual rates as compared to the budgeted rates as well as a decrease in average enrollment as compared to budgeted enrollment and a change in the mix of plan tiers. The mix of participants is as follows:

- 0.47% fewer state actives,
- 0.64% fewer state non-Medicare retirees,
- 1.04% fewer non-state actives,
- 4.07% fewer non-state, non-Medicare retirees
- 2.23% fewer state Medicare retirees, and
- 2.61% fewer non-state Medicare retirees

Expenses for Fiscal Year 2020 are projected to be $30.8 million (7.3%) less than budgeted when changes to reserves are excluded. Operating expenses are projected to be less than budgeted by $0.6 million (10.1%). Employee and Retiree insurances costs are projected to be less than budgeted by $30.2 million (7.3%) when taken in total (see table above for specific information). The significant reduction in projected expenditures compared to the budget is substantially due to the claims suppression experienced between March and June during the COVID-19 shutdown.

Total reserves for the year ending June 30, 2020 are projected to be $154.5 million. Reserves include $58.8 million for Incurred but not Reported (IBNR) claims, $42.4 million for the Catastrophic Reserve to insure plan solvency, $38.1 million in HRA reserves, and a projected differential of cash available of $15.2 million.

Differential Cash Available for FY 2021

PEBP ended FY 2020 with $154.5 million of cash on hand to balance forward to FY 2021. The FY 2021 budget was built with a balance forward amount of $140 million. PEBP will submit work programs to transfer the additional cash authority from FY 2020 to FY 2021 and make necessary adjustments to the required reserve and claims category authority for FY 2021. Once all the adjustments are approved through the state budget process, PEBP is projecting a final differential cash available for FY 2021 of $8.3 million.

Recommendations

None.

4.2.2

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

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

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        4.2.2 Utilization Report

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Executive Officer

AGENDA ITEM

[X] Action Item
[ ] Information Only

Date: September 24, 2020

Item Number: IV.II.II

Title: Self-Funded CDHP and EPO Plan Utilization Report for the period ending June 30, 2020

This report addresses medical, dental, prescription drug and HSA/HRA utilization for the Plan Year ending June 30, 2020. Included are:

- Executive Summary – provides a utilization overview.
- HealthSCOPE CDHP Utilization Report – provides graphical supporting details for the information included in the Executive Summary.
- HealthSCOPE EPO Utilization Report – provides graphical supporting details for the information included in the Executive Summary.
- Express Scripts Utilization Report – provides details supporting the prescription drug information included in the Executive Summary.
- Health Plan of Nevada Utilization – see Appendix C for Plan Year 2020 utilization data.

Executive Summary

CONSUMER DRIVEN HEALTH PLAN (CDHP)

The Consumer Driven Health Plan (CDHP) experience for Q4 of Plan Year 2020 compared to Q4 of Plan Year 2019 is summarized below.

- Population:
  - 0.4% increase for primary participants
  - 0.2% increase for primary participants plus dependents (members)
- Medical Cost:
  - 7.4% increase for primary participants
  - 7.7% increase for primary participants plus dependents (members)
- High Cost Claims:
  - There were 206 High Cost Claimants accounting for 33.9% of the total plan paid for Q4 in Plan Year 2020
  - 4.2% increase in High Cost Claimants per 1,000 members
  - 7.9% increase in average cost of High Cost Claimant paid
- Top three highest cost clinical classifications include:
  - Neoplasms ($9.3 million) – 19.0% of paid claims
  - Injury and Poisoning ($8.1 million) – 16.6% of paid claims
  - Diseases of the Circulatory System ($7.8 million) – 16.0% of paid claims
- Emergency Room:
  - ER visits per 1,000 members had no change over Plan Year 2019
  - Average paid per ER visit increased 12.2%
- Urgent Care:
  - Urgent Care visits per 1,000 members increased by 2.9%
  - Average paid per Urgent Care visit increased 15.6%
- Network Utilization:
  - 95.9% of claims are from In-Network providers
  - Q4 of Plan Year 2020 In-Network utilization increased 0.3% over PY 2019
  - Q4 of Plan Year 2020 In-Network discounts decreased 0.4% over PY 2019
- Preventive Services:
  - Overall Preventive Services Compliance Rates decreased in 7 out of 9 categories from Plan Year 2019 between 0.2% - 2.7%.
- Prescription Drug Utilization:
  - Overall:
    - Total Net Claims increased 4.2%
    - Total Gross Claims Costs increased 2.5% ($1.2 million)
    - Average Total Cost per Claim decreased 1.6%
      - From $95.68 to $94.16
  - *Member:
    - Total Member Cost increased 29.4%
    - Average Participant Share per Claim increased 24.2%
    - Net Member PMPM increased 29.1%
      - From $18.66 to $24.10

- Plan
  - Total Plan Cost decreased 4.1%
  - Average Plan Share per Claim decreased 7.9%
  - Net Plan PMPM decreased 4.3%
    - From $75.94 to $72.67
  - Net Plan PMPM factoring rebates decreased 22.0%
    - From $68.50 to $53.40

*The primary reason for the increase in cost share has to do with the increase in Out-of-Pocket Protection dollars.

PEBP PREMIER PLAN (EPO)

The PEBP Premier Plan (EPO) experience for Q4 of Plan Year 2020 compared to the complete Plan Year 2019 is summarized below.

- Population:
  - 3.0% increase for primary participants
  - 3.3% increase for primary participants plus dependents (members)
- Medical Cost:
  - 19.9% increase for primary participants
  - 19.5% increase for primary participants plus dependents (members)
- High Cost Claims:
  - There were 51 High Cost Claimants accounting for 20.6% of the total plan paid for Q4 in Plan Year 2020
  - 26.7% increase in High Cost Claimants per 1,000 members (compared to PY19)
  - 21.7% decrease in average cost of High Cost Claimant paid
- Top three highest cost clinical classifications include:
  - Neoplasms ($1.7 million) – 16.3% of paid claims
  - Diseases of the Musculoskeletal System ($1.5 million) – 14.4% of paid claims
  - Diseases of the Blood ($1.0 million) – 9.9% of paid claims
- Emergency Room:
  - ER visits per 1,000 members increased by 26.9%
  - Average paid per ER visit increased by 1.6%
- Urgent Care:
  - Urgent Care visits per 1,000 members increased by 14.5%
  - Average paid per Urgent Care visit increased 11.4%
- Network Utilization:
  - 97.4% of claims are from In-Network providers
  - In-Network utilization decreased 0.9%
  - In-Network discounts decreased 0.7%
- Preventive Services:
  - Overall Preventive Services Compliance Rates increased from Plan Year 2019 in all categories.
- Prescription Drug Utilization:
  - Overall:
    - Total Net Claims increased 5.3%

        - Total Gross Claims Costs increased 19.5% ($3.3 million)
        - Average Total Cost per Claim increased 13.5%
            - From $102.48 to $116.29
    - Member:
        - Total Member Cost increased 8.6%
        - Average Participant Share per Claim increased 3.1%
        - Net Member PMPM increased 5.3%
            - From $23.96 to $25.23
    - Plan
        - Total Plan Cost increased 21.4%
        - Average Plan Share per Claim increased 15.2%
        - Net Plan PMPM increased 17.7%
            - From $141.47 to $166.45
        - Net Plan PMPM factoring rebates decreased 22.9%
            - From $168.36 to $129.78

DENTAL PLAN

The Dental Plan experience for Q4 of Plan Year 2020 is summarized below.

- Dental Cost:
    - Total of $23,061,804 paid for Dental claims
        - Preventative claims account for 42.0% ($9.7 million)
        - Basic claims account for 29.9% ($6.9 million)
        - Major claims account for 20.8% ($4.8 million)
        - Periodontal claims account for 7.2% ($1.7 million)

HEALTH REIMBURSEMENT ARRANGEMENT

The table below provides a list of CDHP HRA account balances as of June 30, 2020.

HRA Account Balances as of June 30, 2020			
$Range	**# Accounts**	**Total Account Balance**	**Average Per Account Balance**
0	1,762	0	0
$.01 - $500.00	3,082	578,244	199
$500.01 - $1,000	1,522	1,075,568	709
$1,000.01 - $1,500	1,459	1,765,969	1,211
$1,500.01 - $2,000	746	1,296,768	1,735
$2,000.01 - $2,500	464	1,044,103	2,245
$2,500.01 - $3,000	266	730,290	2,742
$3,000.01 - $3,500	202	652,601	3,230
$3,500.01 - $4,000	198	740,031	3,730
$4,000.01 - $4,500	150	633,271	4,218
$4,500.01 - $5,000	110	521,550	4,727
$5,000.01 +	**856**	**6,651,480**	**223,219**
Total	**10,817**	**$ 15,689,873.97**	**$ 1,450.48**

CONCLUSION

The information in this report provides plan experience for the Consumer Driven Health Plan (CDHP) and the PEBP Premier Plan (EPO) for Plan Year 2020. The CDHP total plan paid costs increased 7.9% over Plan Year 2019. The EPO total plan paid costs increased 23.4% over Plan Year 2019. For HMO utilization and cost data please see the report provided in Appendix C.

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

Appendix A

Index of Tables
HealthSCOPE – CDHP Utilization Review for PEBP
July 1, 2019 – June 30, 2020

HSB DATASCOPE™

Nevada Public Employees' Benefits Program
HDHP Plan

July 2019 – June 2020

HealthSCOPE BENEFITS

Overview

- Total Medical Spend for PY20 was $143,667,208 of which 73.8% was spent in the State Active population. When compared to PY19, PY20 reflected an increase of 7.9% in plan spend, with State Actives having an increase of 8.4%.
  - When compared to PY18, PY20 reflected an increase of 14.9% in plan spend, with State Actives having an increase of 15.6%.
- On a PEPY basis, PY20 reflected an increase of 7.4% when compared to PY19. The largest group, State Actives, increased 7.4%.
  - When compared to PY18, PY20 reflected a increase in PEPY of 12.4%, with State Actives increasing by 11.5%.
- 85.3% of the Average Membership had paid Medical claims less than $2,500, with 17.7% of those having no claims paid at all during the reporting period.
- There were 206 High Cost Claimants (HCC's) over $100K, that accounted for 33.9% of the total spend. HCC's accounted for 32.6% of total spend during PY19, with 198 members hitting the $100K threshold. The largest claimant had a primary diagnosis in the Injury and Poisoning Grouper, with plan spend of $4,934,099.
- IP Paid per Admit was $20,998 which is on track with PY19 of $21,100.
- ER Paid per Visit is $2,273, which is an increase of 12.2% from PY19 ER Paid per Visit of $2,025.
- 95.9% of all Medical spend dollars were to In Network providers. The average In Network discount was 65.3%, which is slightly lower than PY19 discount of 65.4%.

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

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

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

Paid Claims by Age Group																
	PY20														% Change	
Age Range	Med Net Pay		Med PMPM		Rx Net Pay		Rx PMPM		Dental Net Pay		Dental PMPM		Net Pay		PMPM		Net Pay	PMPM
<1	$	6,794,610	$	1,627	$	63,607	$	15	$	12,587	$	2	$	6,870,804	$	1,644	6.4%	0.8%
1	$	841,639	$	180	$	29,308	$	6	$	43,114	$	6	$	914,061	$	193	10.4%	8.2%
2 - 4	$	1,280,257	$	80	$	569,167	$	36	$	368,411	$	17	$	2,217,834	$	132	35.8%	38.0%
5 - 9	$	1,504,049	$	49	$	147,265	$	5	$	1,172,971	$	28	$	2,824,285	$	82	-11.9%	-12.3%
10 - 14	$	3,568,831	$	104	$	523,976	$	15	$	1,150,189	$	24	$	5,242,995	$	144	-1.8%	-2.6%
15 - 19	$	5,395,888	$	149	$	905,365	$	25	$	1,396,753	$	28	$	7,698,006	$	202	9.0%	10.0%
20 - 24	$	5,813,187	$	142	$	1,028,701	$	25	$	945,369	$	17	$	7,787,257	$	184	-7.0%	-7.3%
25 - 29	$	5,710,701	$	171	$	1,201,788	$	36	$	921,117	$	22	$	7,833,606	$	230	20.2%	21.3%
30 - 34	$	7,718,900	$	214	$	1,693,247	$	47	$	1,072,181	$	23	$	10,484,328	$	283	9.0%	6.7%
35 - 39	$	6,714,047	$	168	$	3,530,405	$	88	$	1,243,787	$	24	$	11,488,239	$	280	16.1%	15.0%
40 - 44	$	7,995,208	$	219	$	2,334,383	$	64	$	1,292,574	$	26	$	11,622,166	$	309	16.5%	14.4%
45 - 49	$	10,751,419	$	277	$	3,460,559	$	89	$	1,478,697	$	27	$	15,690,675	$	393	-6.0%	-5.0%
50 - 54	$	12,184,580	$	300	$	4,605,442	$	113	$	1,652,154	$	29	$	18,442,177	$	442	-8.7%	-8.6%
55 - 59	$	17,462,073	$	392	$	6,399,544	$	144	$	1,991,457	$	32	$	25,853,074	$	568	1.3%	2.7%
60 - 64	$	33,725,255	$	675	$	7,928,803	$	159	$	2,450,819	$	35	$	44,104,877	$	868	11.6%	15.1%
65+	$	16,206,562	$	582	$	5,055,571	$	182	$	5,869,624	$	37	$	27,131,757	$	801	1.6%	-0.5%
Total	**$**	**143,667,208**	**$**	**279**	**$**	**39,477,131**	**$**	**77**	**$**	**23,061,804**	**$**	**28**	**$**	**206,206,141**	**$**	**384**	**4.4%**	**4.6%**

Financial Summary - Prior Year comparison (p. 1 of 2)

	Total				State Active				Non-State Active			
Summary	**PY18**	**PY19**	**PY20**	**Variance to Prior Year**	**PY18**	**PY19**	**PY20**	**Variance to Prior Year**	**PY18**	**PY19**	**PY20**	**Variance to Prior Year**
Enrollment												
Avg # Employees	23,155	23,569	23,673	0.4%	19,100	19,612	19,809	1.0%	4	4	4	-4.3%
Avg # Members	42,071	42,776	42,865	0.2%	36,389	37,138	37,291	0.4%	7	7	7	-2.4%
Ratio	1.8	1.8	1.8	0.0%	1.9	1.9	1.9	-0.5%	1.7	1.8	1.8	1.7%
Financial Summary												
Gross Cost	$164,211,622	$172,993,213	$185,251,114	7.1%	$123,145,285	$129,947,874	$139,774,757	7.6%	$42,221	$105,325	$46,064	-56.3%
Client Paid	$125,066,281	$133,179,670	$143,667,208	7.9%	$91,783,613	$97,851,639	$106,095,205	8.4%	$32,607	$96,469	$35,053	-63.7%
Employee Paid	$39,145,341	$39,813,543	$41,583,906	4.4%	$31,361,671	$32,096,235	$33,679,553	4.9%	$9,615	$8,857	$11,011	24.3%
Client Paid-PEPY	$5,401	$5,651	$6,069	7.4%	$4,805	$4,989	$5,356	7.4%	$7,985	$24,117	$9,144	-62.1%
Client Paid-PMPY	$2,973	$3,113	$3,352	7.7%	$2,522	$2,635	$2,845	8.0%	$4,603	$13,781	$5,130	-62.8%
Client Paid-PEPM	$450	$471	$506	7.4%	$400	$416	$446	7.2%	$665	$2,010	$762	-62.1%
Client Paid-PMPM	$248	$259	$279	7.7%	$210	$220	$237	7.7%	$384	$1,148	$427	-62.8%
High Cost Claimants (HCC's) > $100k												
# of HCC's	164	198	206		108	124	151		0	0	0	
HCC's / 1,000	3.9	4.6	4.8		3.0	3.3	4.1		0.0	0.0	0.0	
Avg HCC Paid	$211,524	$219,374	$236,642	7.9%	$212,840	$218,720	$206,591	-5.5%	$0	$0	$0	0.0%
HCC's % of Plan Paid	27.7%	32.6%	33.9%	4.0%	25.0%	27.7%	29.4%	6.1%	0.0%	0.0%	0.0%	0.0%
Cost Distribution by Claim Type (PMPY)												
Facility Inpatient	$900	$1,071	$1,139	6.3%	$719	$847	$883	4.3%	$0	$3,087	$0	0.0%
Facility Outpatient	$974	$925	$1,040	12.4%	$814	$782	$880	12.5%	$1,064	$6,561	$2,087	-68.2%
Physician	$1,016	$1,045	$1,093	4.6%	$924	$948	$1,014	7.0%	$3,394	$4,006	$2,777	-30.7%
Other	$82	$72	$80	11.1%	$64	$58	$68	17.2%	$146	$129	$266	0.0%
Total	$2,973	$3,113	$3,352	7.7%	$2,522	$2,635	$2,845	8.0%	$4,603	$13,781	$5,130	-62.8%

Financial Summary - Prior Year comparison (p. 2 of 2)

	State Retirees				Non-State Retirees				
Summary	**PY18**	**PY19**	**PY20**	**Variance to Prior Year**	**PY18**	**PY19**	**PY20**	**Variance to Prior Year**	**HSB Peer Index**
Enrollment									
Avg # Employees	3,165	3,224	3,246	0.7%	868	729	615	-15.7%	
Avg # Members	4,681	4,799	4,858	1.2%	958	832	710	-14.6%	
Ratio	1.5	1.5	1.5	0.7%	1.1	1.1	1.2	1.8%	1.8
Financial Summary									
Gross Cost	$31,539,962	$34,175,219	$39,350,569	15.1%	$9,484,154	$8,764,794	$6,079,723	-30.6%	
Client Paid	$25,259,022	$27,761,940	$32,691,908	17.8%	$7,991,039	$7,469,622	$4,845,042	-35.1%	
Employee Paid	$6,280,940	$6,413,280	$6,658,661	3.8%	$1,493,115	$1,295,172	$1,234,681	-4.7%	
Client Paid-PEPY	$7,981	$8,612	$10,070	16.9%	$9,204	$10,246	$7,882	-23.1%	$6,209
Client Paid-PMPY	$5,397	$5,785	$6,730	16.3%	$8,338	$8,983	$6,821	-24.1%	$3,437
Client Paid-PEPM	$665	$718	$839	16.9%	$767	$854	$657	-23.1%	$517
Client Paid-PMPM	$450	$482	$561	16.4%	$695	$749	$568	-24.2%	$286
High Cost Claimants (HCC's) > $100k									
# of HCC's	50	58	60		18	16	8		
HCC's / 1,000	10.7	12.1	12.4		18.8	19.2	11.3		
Avg HCC Paid	$169,470	$220,380	$271,721	23.3%	$179,428	$220,793	$156,233	-29.2%	
HCC's % of Plan Paid	33.5%	46.0%	49.9%	8.5%	40.4%	47.3%	25.8%	-45.5%	
Cost Distribution by Claim Type (PMPY)									
Facility Inpatient	$1,822	$2,155	$2,853	32.4%	$3,299	$4,794	$2,835	-40.9%	$1,057
Facility Outpatient	$1,842	$1,787	$2,107	17.9%	$2,839	$2,295	$2,143	-6.6%	$1,145
Physician	$1,521	$1,677	$1,600	-4.6%	$2,073	$1,732	$1,745	0.8%	$1,122
Other	$212	$166	$170	2.4%	$127	$163	$98	-39.9%	$113
Total	$5,397	$5,785	$6,730	16.3%	$8,338	$8,983	$6,821	-24.1%	$3,437

Paid Claims by Claim Type – State Participants

Net Paid Claims - Total State Participants	PY19				PY20				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical									
Inpatient	$ 36,705,959	$ 8,736,011	$ 2,660,713	$ 48,102,683	$ 38,557,944	$ 12,386,833	$ 2,629,640	$ 53,574,416	11.4%
Outpatient	$ 61,145,680	$ 14,375,822	$ 1,989,394	$ 77,510,895	$ 67,537,260	$ 15,689,986	$ 1,985,449	$ 85,212,696	9.9%
Total - Medical	$ 97,851,639	$ 23,111,833	$ 4,650,107	$ 125,613,579	$ 106,095,205	$ 28,076,819	$ 4,615,089	$ 138,787,113	10.5%
Dental	$ 16,845,534	$ 1,978,238	$ 510,673	$ 19,334,445	$ 15,744,257	$ 1,851,687	$ 494,735	$ 18,090,679	-6.4%
Dental Exchange	$ -	$ -	$ 2,870,635	$ 2,870,635	$ -	$ -	$ 2,797,694	$ 2,797,694	-2.5%
Total	**$ 114,697,173**	**$ 25,090,071**	**$ 8,031,415**	**$ 147,818,659**	**$ 121,839,461**	**$ 29,928,507**	**$ 7,907,519**	**$ 159,675,486**	**8.0%**

Net Paid Claims - Per Participant per Month	PY19				PY20				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical	$ 416	$ 736	$ 637	$ 458	$ 446	$ 888	$ 630	$ 502	9.5%
Dental	$ 52	$ 49	$ 56	$ 52	$ 48	$ 46	$ 54	$ 48	-7.7%
Dental Exchange	$ -	$ -	$ 48	$ 48	$ -	$ -	$ 44	$ 44	-8.7%

Paid Claims by Claim Type – Non-State Participants

Net Paid Claims - Total Non-State Participants	PY19				PY20				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical									
Inpatient	$ 25,103	$ 2,545,010	$ 1,671,607	$ 4,241,720	$ 204	$ 702,380	$ 1,444,526	$ 2,147,110	-49.4%
Outpatient	$ 71,365	$ 2,739,008	$ 513,998	$ 3,324,371	$ 34,849	$ 2,057,080	$ 641,056	$ 2,732,985	-17.8%
Total - Medical	$ 96,469	$ 5,284,018	$ 2,185,605	$ 7,566,091	$ 35,053	$ 2,759,461	$ 2,085,582	$ 4,880,095	-35.5%
Dental	$ 2,943	$ 382,945	$ 203,655	$ 589,543	$ 2,486	$ 266,841	$ 203,135	$ 472,462	-19.9%
Dental Exchange	$ -	$ -	$ 1,848,816	$ 1,848,816	$ -	$ -	$ 1,700,969	$ 1,700,969	-8.0%
Total	**$ 99,412**	**$ 5,666,963**	**$ 4,238,075**	**$ 10,004,450**	**$ 37,539**	**$ 3,026,301**	**$ 3,989,685**	**$ 7,053,525**	**-29.5%**

Net Paid Claims - Per Participant per Month	PY19				PY20				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical	$ 2,010	$ 933	$ 709	$ 860	$ 762	$ 649	$ 667	$ 658	-23.5%
Dental	$ 31	$ 40	$ 40	$ 40	$ 26	$ 38	$ 40	$ 39	-2.9%
Dental Exchange	$ -	$ -	$ 43	$ 43	$ -	$ -	$ 40	$ 40	-8.0%

Paid Claims by Claim Type – Total

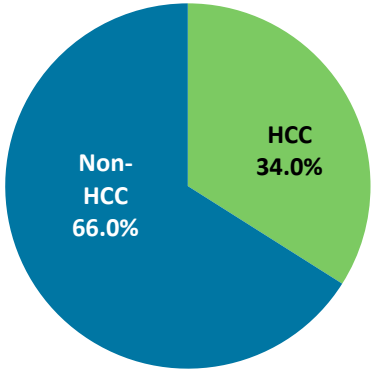
Net Paid Claims - Total Total Participants	PY19				PY20				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical									
Inpatient	$ 36,731,063	$ 11,281,021	$ 4,332,319	$ 52,344,403	$ 38,558,148	$ 13,089,213	$ 4,074,165	$ 55,721,526	6.5%
Outpatient	$ 61,217,045	$ 17,114,830	$ 2,503,392	$ 80,835,267	$ 67,572,109	$ 17,747,067	$ 2,626,505	$ 87,945,681	8.8%
Total - Medical	$ 97,948,107	$ 28,395,851	$ 6,835,711	$ 133,179,670	$ 106,130,257	$ 30,836,280	$ 6,700,671	$ 143,667,208	7.9%
Dental	$ 16,848,477	$ 2,361,183	$ 714,328	$ 19,923,988	$ 15,746,743	$ 2,118,528	$ 697,870	$ 18,563,141	-6.8%
Dental Exchange	$ -	$ -	$ 4,719,450	$ 4,719,450	$ -	$ -	$ 4,498,663	$ 4,498,663	-4.7%
Total	**$ 114,796,585**	**$ 30,757,034**	**$ 12,269,490**	**$ 157,823,108**	**$ 121,877,000**	**$ 32,954,808**	**$ 11,897,203**	**$ 166,729,012**	**5.6%**

Net Paid Claims - Per Participant per Month	PY19				PY20				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	
Medical	$416	$766	$659	$471	$ 446	$ 859	$ 641	$ 506	7.4%
Dental	$52	$47	$51	$52	$ 48	$ 44	$ 49	$ 48	-8.3%
Dental Exchange	$ -	$ -	$46	$46	$ -	$ -	$ 42	$ 42	-8.5%

Cost Distribution – Medical Claims

PY19							PY20					
Avg # of Members	% of Members	Total Paid	% of Paid	EE Paid	% EE Paid	Paid Claims Category	Avg # of Members	% of Members	Total Paid	% of Paid	EE Paid	% EE Paid
126	0.3%	$29,879,772	31.5%	$930,047	3.0%	$100,000.01 Plus	178	0.4%	$48,745,433	33.9%	$1,293,423	3.1%
155	0.4%	$12,088,256	12.7%	$937,359	3.0%	$50,000.01-$100,000.00	245	0.6%	$18,722,982	13.0%	$1,451,386	3.5%
278	0.6%	$10,600,684	11.2%	$1,499,833	4.8%	$25,000.01-$50,000.00	489	1.1%	$18,430,502	12.8%	$2,576,800	6.2%
925	2.2%	$15,297,595	16.1%	$4,264,775	13.6%	$10,000.01-$25,000.00	1,345	3.1%	$22,375,812	15.6%	$6,136,143	14.8%
1,268	3.0%	$9,481,845	10.0%	$4,091,426	13.0%	$5,000.01-$10,000.00	1,773	4.1%	$13,273,550	9.2%	$5,814,853	14.0%
1,600	3.7%	$6,115,622	6.4%	$3,673,869	11.7%	$2,500.01-$5,000.00	2,258	5.3%	$8,604,868	6.0%	$5,148,488	12.4%
22,307	52.2%	$11,366,963	12.0%	$13,326,359	42.5%	$0.01-$2,500.00	23,252	54.2%	$13,514,062	9.4%	$16,399,035	39.5%
6,455	15.1%	$0	0.0%	$2,632,908	8.4%	$0.00	5,748	13.4%	$0	0.0%	$2,763,779	6.6%
9,635	22.5%	$0	0.0%	$0	0.0%	No Claims	7,578	17.7%	$0	0.0%	$0	0.0%
42,747	**100.0%**	**$94,830,736**	**100.0%**	**$31,356,576**	**100.0%**		**42,865**	**100.0%**	**$143,667,208**	**100.0%**	**$41,583,906**	**100.0%**

Distribution of HCC Medical Claims Paid



HCC – High Cost Claimant over $100K

HCC's by AHRQ Clinical Classifications Chapter			
AHRQ Chapter	Patients	Total Paid	% Paid
(CCS NEO) Neoplasms	106	$9,271,619	19.0%
(CCS INJ) Injury, Poisoning and Certain Other Consequences of External Causes	106	$8,070,933	16.5%
(CCS CIR) Diseases of the Circulatory System	143	$7,798,145	16.0%
(CCS FAC) Factors Influencing Health Status and Contact with Health Services	193	$5,913,031	12.1%
(CCS PNL) Certain Conditions Originating in the Perinatal Period	17	$3,352,917	6.9%
(CCS MUS) Diseases of the Musculoskeletal System and Connective Tissue	122	$2,145,683	4.4%
(CCS INF) Certain Infectious and Parasitic Diseases	56	$1,841,910	3.8%
(CCS DIG) Diseases of the Digestive System	86	$1,753,568	3.6%
(CCS MBD) Mental, Behavioral and Neurodevelopmental Disorders	62	$1,727,992	3.5%
(CCS NVS) Diseases of the Nervous System	115	$1,465,646	3.0%
(CCS SYM) Symptoms, Signs and Abnormal Clinical and Laboratory Findings, Not Elsewhere	197	$1,300,367	2.7%
(CCS GEN) Diseases of the Genitourinary System	99	$1,190,993	2.4%
(CCS END) Endocrine, Nutritional and Metabolic Diseases	107	$946,417	1.9%
(CCS RSP) Diseases of the Respiratory System	115	$945,391	1.9%
(CCS MAL) Congenital Malformations, Deformations and Chromosomal Abnormalities	18	$507,819	1.0%
(CCS SKN) Diseases of the Skin and Subcutaneous Tissue	73	$257,447	0.5%
(CCS BLD) Diseases of the Blood and Blood Forming Organs and Certain Disorders Involving	64	$85,226	0.2%
(CCS PRG) Pregnancy, Childbirth and the Puerperium	1	$80,962	0.2%
All Others	121	$161,975	0.3%
Overall	**----**	**$48,818,044**	**100.0%**

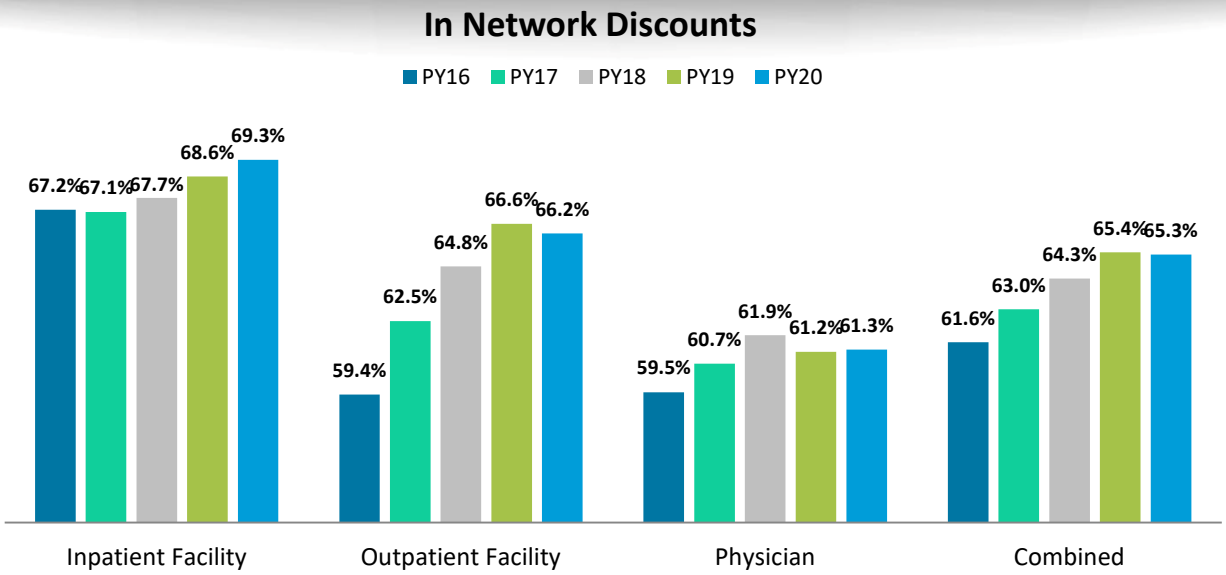
Utilization Summary (p. 1 of 2)

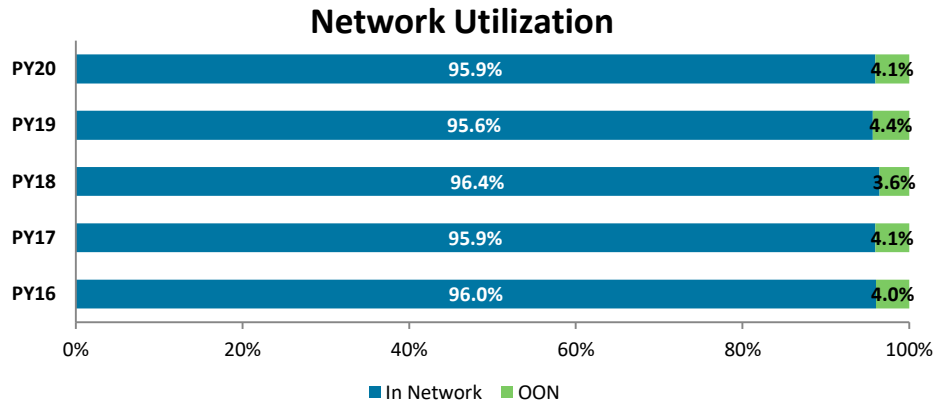
	Total				State Active				Non-State Active			
Summary	**PY18**	**PY19**	**PY20**	**Variance to Prior Year**	**PY18**	**PY19**	**PY20**	**Variance to Prior Year**	**PY18**	**PY19**	**PY20**	**Variance to Prior Year**
Inpatient Facility												
# of Admits	2,255	2,270	2,334		1,693	1,753	1,852		0	2	0	
# of Bed Days	10,294	14,341	12,517		7,217	8,989	9,285		0	8	0	
Paid Per Admit	$17,550	$21,100	$20,998	-0.5%	$16,350	$19,040	$18,016	-5.4%	$0	$10,803	$0	0.0%
Paid Per Day	$3,845	$3,340	$3,915	17.2%	$3,835	$3,713	$3,593	-3.2%	$0	$2,701	$0	0.0%
Admits Per 1,000	54	53	54	1.9%	47	47	50	6.4%	0	286	0	0.0%
Days Per 1,000	245	335	292	-12.8%	198	242	249	2.9%	0	1143	0	0.0%
Avg LOS	4.6	6.3	5.4	-14.3%	4.3	5.1	5.0	-2.0%	0	4	0	0.0%
Physician Office												
OV Utilization per Member	3.6	3.5	3.6	2.9%	3.3	3.3	3.4	3.0%	9	7.3	6.0	-17.8%
Avg Paid per OV	$48	$47	$47	0.0%	$47	$46	$47	2.2%	$84	$89	$74	-16.9%
Avg OV Paid per Member	$171	$167	$170	1.8%	$158	$154	$159	3.2%	$755	$652	$441	-32.4%
DX&L Utilization per Member	7.7	7.7	7.9	2.6%	7	7.1	7.3	2.8%	8.6	10.1	0	0.0%
Avg Paid per DX&L	$60	$64	$63	-1.6%	$57	$59	$59	0.0%	$48	$320	$0	0.0%
Avg DX&L Paid per Member	$461	$489	$492	0.6%	$400	$418	$436	4.3%	$412	$3,250	$0	0.0%
Emergency Room												
# of Visits	7,106	6,931	6,939		5,870	5,653	5,691		3	3	2	
# of Admits	1046	1096	1,033		745	796	750		0	1	0	
Visits Per Member	0.17	0.16	0.16	0.0%	0.16	0.15	0.15	0.0%	0.42	0.43	0.29	0.0%
Visits Per 1,000	169	162	162	0.0%	161	152	153	0.7%	424	429	293	0.0%
Avg Paid per Visit	$1,919	$2,025	$2,273	12.2%	$1,893	$1,992	$2,286	14.8%	$1,027	$1,280	$1,803	0.0%
Admits Per Visit	0.15	0.16	0.15	-6.3%	0.13	0.14	0.13	-7.1%	0.00	0.33	0.00	0.0%
Urgent Care												
# of Visits	9,817	10,472	10,800		8,774	9,389	9,767		2	6	2	
Visits Per Member	0.23	0.24	0.25	5.0%	0.24	0.25	0.26	4.8%	0.28	0.86	0.29	0.0%
Visits Per 1,000	233	245	252	2.9%	241	253	262	3.6%	282	857	286	0.0%
Avg Paid per Visit	$44	$45	$52	15.6%	$42	$43	$51	18.6%	$140	$114	$183	0.0%

Utilization Summary (p. 2 of 2)

	State Retirees				Non-State Retirees				
Summary	**PY18**	**PY19**	**PY20**	**Variance to Prior Year**	**PY18**	**PY19**	**PY20**	**Variance to Prior Year**	**HSB Peer Index**
Inpatient Facility									
# of Admits	422	402	372		140	113	110		
# of Bed Days	2,374	2,457	2,646		703	2,887	586		
Paid Per Admit	$20,299	$26,215	$36,220	38.2%	$23,788	$35,038	$19,737	-43.7%	$16,173
Paid Per Day	$3,608	$4,289	$5,092	18.7%	$4,737	$1,371	$3,705	170.2%	$3,708
Admits Per 1,000	90	84	77	-8.3%	146	136	155	14.0%	61
Days Per 1,000	507	512	545	6.4%	734	3,472	825	-76.2%	264
Avg LOS	5.6	6.1	7.1	16.4%	5	25.5	5.3	-79.2%	4.3
Physician Office									
OV Utilization per Member	5.0	4.9	4.9	0.0%	6.4	6.4	6.9	7.8%	3.3
Avg Paid per OV	$52	$52	$50	-3.8%	$41	$40	$36	-10.0%	$50
Avg OV Paid per Member	$258	$254	$245	-3.5%	$265	$256	$250	-2.3%	$167
DX&L Utilization per Member	11.1	11	11	0.0%	14.5	13.6	13.3	-2.2%	8.3
Avg Paid per DX&L	$75	$85	$80	-5.9%	$64	$78	$58	-25.6%	$67
Avg DX&L Paid per Member	$838	$932	$882	-5.4%	$930	$1,067	$767	-28.1%	$554
Emergency Room									
# of Visits	960	996	993		469	279	253		
# of Admits	229	227	214		72	72	69		
Visits Per Member	0.21	0.21	0.20	-4.8%	0.49	0.34	0.36	5.9%	0.17
Visits Per 1,000	205	208	204	-1.9%	489	336	356	6.0%	174
Avg Paid per Visit	$2,097	$2,244	$2,419	7.8%	$1,113	$1,905	$1,459	-23.4%	$1,684
Admits Per Visit	0.24	0.23	0.22	-4.3%	0.15	0.26	0.27	3.8%	0.14
Urgent Care									
# of Visits	845	908	880		196	169	151		
Visits Per Member	0.18	0.19	0.18	-4.6%	0.20	0.20	0.21	4.1%	0.24
Visits Per 1,000	181	189	181	-4.1%	205	203	208	2.6%	242
Avg Paid per Visit	$63	$69	$70	1.4%	$58	$55	$40	-27.3%	$74

Provider Network Summary



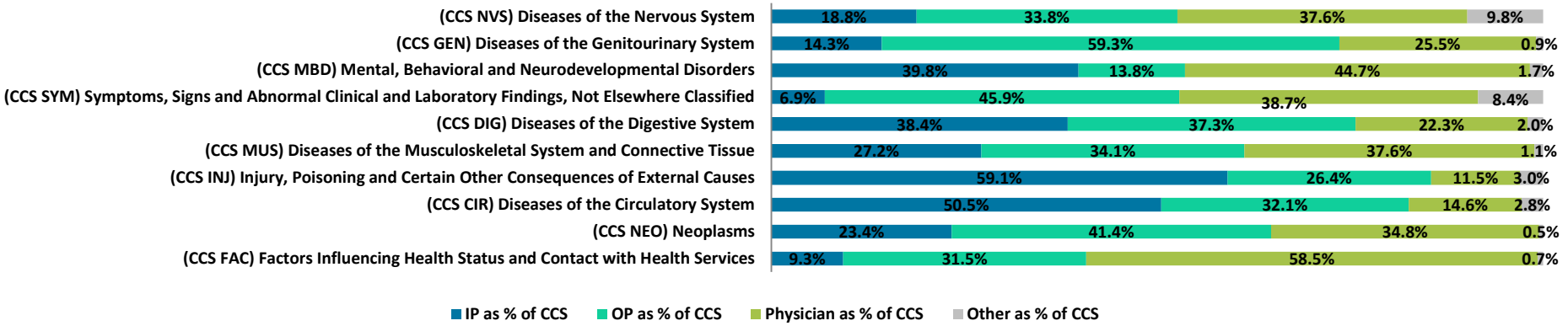


AHRQ* Clinical Classifications Summary

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

AHRQ Clinical Classifications Chapter	Total Paid	% Paid	Insured	Spouse	Child	Male	Female
(CCS FAC) Factors Influencing Health Status and Contact with Health Services	$17,695,136	12.3%	$11,086,099	$2,791,492	$3,817,546	$6,622,000	$11,073,137
(CCS NEO) Neoplasms	$16,574,671	11.5%	$12,673,525	$3,552,601	$348,546	$7,096,058	$9,478,613
(CCS CIR) Diseases of the Circulatory System	$16,159,271	11.2%	$13,376,210	$2,463,912	$319,149	$8,181,210	$7,978,061
(CCS INJ) Injury, Poisoning and Certain Other Consequences of External Causes	$15,860,400	11.0%	$10,890,074	$1,937,992	$3,032,334	$5,685,023	$10,175,376
(CCS MUS) Diseases of the Musculoskeletal System and Connective Tissue	$14,204,121	9.9%	$9,041,905	$3,728,434	$1,433,782	$5,878,277	$8,325,844
(CCS DIG) Diseases of the Digestive System	$8,194,658	5.7%	$5,997,408	$1,244,041	$953,209	$4,087,044	$4,107,615
(CCS SYM) Symptoms, Signs and Abnormal Clinical and Laboratory Findings, Not Els	$7,408,676	5.2%	$4,735,502	$1,513,769	$1,159,406	$2,894,926	$4,513,750
(CCS MBD) Mental, Behavioral and Neurodevelopmental Disorders	$6,503,991	4.5%	$2,844,538	$684,825	$2,974,627	$3,267,881	$3,236,110
(CCS GEN) Diseases of the Genitourinary System	$6,243,889	4.3%	$4,536,744	$1,187,984	$519,161	$2,366,948	$3,876,941
(CCS NVS) Diseases of the Nervous System	$6,165,721	4.3%	$3,893,970	$1,188,871	$1,082,880	$2,552,986	$3,612,734
(CCS PNL) Certain Conditions Originating in the Perinatal Period	$4,967,103	3.5%	$8,032	$33,607	$4,925,464	$2,325,601	$2,641,502
(CCS RSP) Diseases of the Respiratory System	$4,731,690	3.3%	$2,652,377	$808,108	$1,271,204	$2,244,152	$2,487,538
(CCS PRG) Pregnancy, Childbirth and the Puerperium	$4,580,300	3.2%	$3,182,687	$1,281,260	$116,353	$1,430	$4,578,870
(CCS END) Endocrine, Nutritional and Metabolic Diseases	$4,237,589	2.9%	$2,991,858	$776,501	$469,230	$1,810,576	$2,427,013
(CCS INF) Certain Infectious and Parasitic Diseases	$3,723,422	2.6%	$2,587,244	$887,008	$249,171	$1,924,057	$1,799,365
(CCS EYE) Diseases of the Eye and Adnexa	$2,160,444	1.5%	$1,412,549	$490,074	$257,821	$884,298	$1,276,146
(CCS SKN) Diseases of the Skin and Subcutaneous Tissue	$1,371,173	1.0%	$895,575	$314,031	$161,568	$718,055	$653,118
(CCS MAL) Congenital Malformations, Deformations and Chromosomal Abnormaliti	$1,325,534	0.9%	$283,752	$42,546	$999,236	$677,188	$648,347
(CCS BLD) Diseases of the Blood and Blood Forming Organs and Certain Disorders I	$794,857	0.6%	$491,596	$186,939	$116,323	$328,344	$466,513
(CCS EAR) Diseases of the Ear and Mastoid Process	$722,705	0.5%	$433,624	$70,378	$218,703	$349,407	$373,298
(CCS 18) Residual Codes; Unclassified; All E Codes [259. And 260.]	$37,093	0.0%	$22,150	$7,418	$7,525	$18,245	$18,848
(CCS EXT) External Causes of Morbidity	$4,762	0.0%	$1,499	$284	$2,979	$145	$4,618
Total	**$143,667,208**	**100.0%**	**$94,038,916**	**$25,192,076**	**$24,436,216**	**$59,913,851**	**$83,753,356**

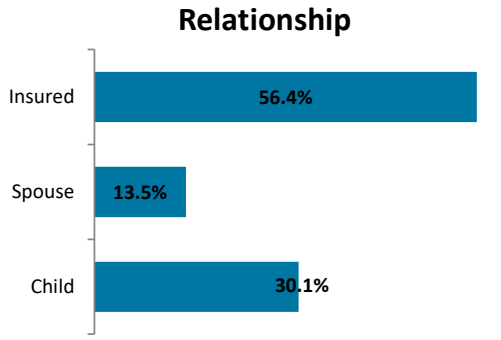
Top 10 Categories by Claim Type

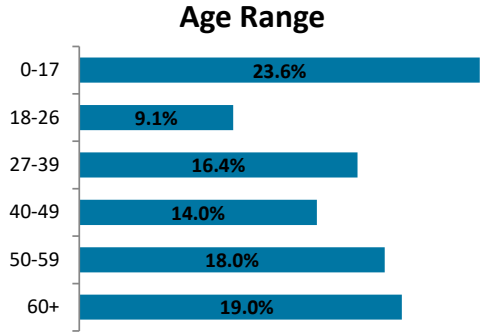


AHRQ Category – Factors Influencing Health Status and Contact with Health Services

Diagnosis Category	Patients	Claims	Total Paid	% Paid
Encounter For Antineoplastic Therapies	140	1,250	$5,243,543	29.6%
Medical Examination/Evaluation	18,450	37,093	$3,715,519	21.0%
Neoplasm-Related Encounters	7,156	14,706	$2,986,945	16.9%
Exposure, Encounters, Screening Or Contact With Infectious Disease	10,669	17,203	$2,037,857	11.5%
Other Aftercare Encounter	815	2,343	$942,961	5.3%
Contraceptive And Procreative Management	1,520	2,977	$695,213	3.9%
Other Specified Status	2,211	6,006	$508,216	2.9%
Personal/Family History Of Disease	1,252	2,206	$432,977	2.4%
Implant, Device Or Graft Related Encounter	839	2,645	$397,354	2.2%
Encounter For Prophylactic Or Other Procedures	188	264	$312,791	1.8%
Encounter For Observation And Examination For Conditions Ruled Out (	2,884	4,195	$139,345	0.8%
Organ Transplant Status	49	498	$101,480	0.6%
Other Specified Encounters And Counseling	530	1,137	$72,532	0.4%
Acquired Absence Of Limb Or Organ	64	134	$69,090	0.4%
Encounter For Prophylactic Measures (Excludes Immunization)	33	45	$14,110	0.1%
Socioeconomic/Psychosocial Factors	40	136	$7,810	0.0%
Encounter For Administrative Purposes	191	252	$7,809	0.0%
Lifestyle/Life Management Factors	110	181	$4,279	0.0%
Encounter For Mental Health Conditions	278	316	$1,940	0.0%
Screening For Neurocognitive Or Neurodevelopmental Condition	48	71	$1,531	0.0%
Carrier Status	17	32	$1,021	0.0%
No Immunization Or Underimmunization	18	31	$500	0.0%
Counseling Related To Sexual Behavior Or Orientation	6	9	$265	0.0%
Resistance To Antimicrobial Drugs	1	2	$49	0.0%
Overall	**----**	**----**	**$17,695,136**	**100.0%**

*Patient and claim counts are unique only within the category

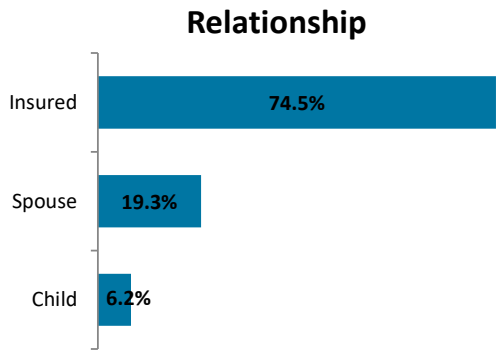


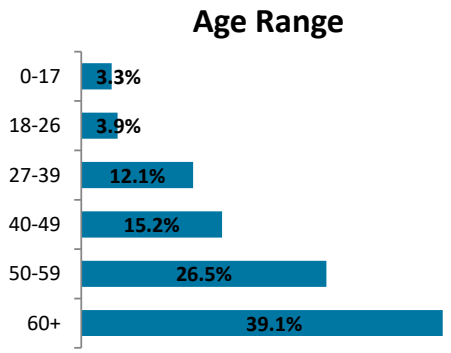


AHRQ Category – Neoplasms

Diagnosis Category	Patients	Claims	Total Paid	% Paid
Breast Cancer - All Other Types	306	3,603	$2,340,418	14.1%
Benign Neoplasms	2761	5,626	$1,938,043	11.7%
Male Reproductive System Cancers - Prostate	152	1,662	$1,266,445	7.6%
Nervous System Cancers - Brain	24	475	$1,115,466	6.7%
Secondary Malignancies	109	601	$1,102,019	6.6%
Multiple Myeloma	19	741	$942,102	5.7%
Skin Cancers - Melanoma	76	456	$899,750	5.4%
Gastrointestinal Cancers - Colorectal	67	986	$656,918	4.0%
Non-Hodgkin Lymphoma	51	638	$656,235	4.0%
Respiratory Cancers	35	662	$535,261	3.2%
Head And Neck Cancers - Lip And Oral Cavity	25	285	$419,225	2.5%
Neoplasms Of Unspecified Nature Or Uncertain Behavior	2,155	3,898	$384,222	2.3%
Urinary System Cancers - Bladder	37	448	$373,537	2.3%
Leukemia - Acute Myeloid Leukemia (Aml)	4	153	$364,096	2.2%
Malignant Neuroendocrine Tumors	15	205	$349,509	2.1%
Gastrointestinal Cancers - All Other Types	5	114	$329,013	2.0%
Female Reproductive System Cancers - Uterus	10	134	$284,072	1.7%
Breast Cancer - Ductal Carcinoma In Situ (Dcis)	46	324	$281,301	1.7%
Endocrine System Cancers - Pancreas	13	288	$220,416	1.3%
Endocrine System Cancers - Thyroid	106	569	$194,686	1.2%
Conditions Due To Neoplasm Or The Treatment Of Neoplasm	41	153	$182,823	1.1%
Female Reproductive System Cancers - Cervix	25	145	$173,158	1.0%
Female Reproductive System Cancers - Ovary	32	290	$164,528	1.0%
Urinary System Cancers - Kidney	26	124	$143,608	0.9%
Skin Cancers - Basal Cell Carcinoma	320	754	$139,239	0.8%
Gastrointestinal Cancers - Stomach	8	33	$127,160	0.8%
Female Reproductive System Cancers - Endometrium	39	246	$122,781	0.7%
Hodgkin Lymphoma	10	99	$94,115	0.6%
Head And Neck Cancers - All Other Types	12	72	$93,716	0.6%
Gastrointestinal Cancers - Liver	10	157	$92,194	0.6%
All Others	421	1,920	$588,614	3.6%
Overall	**----**	**----**	**$16,574,671**	**100.0%**

*Patient and claim counts are unique only within the category

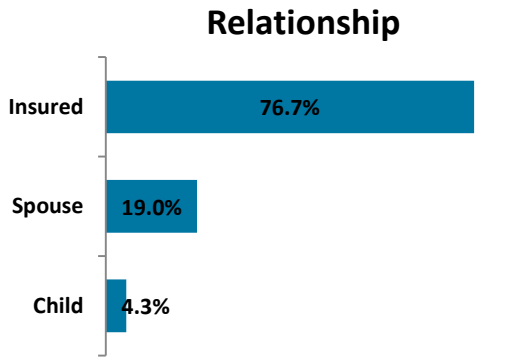


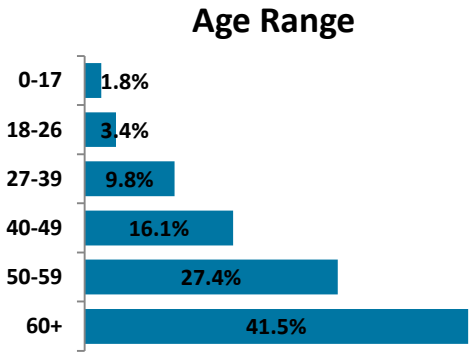


AHRQ Category – Diseases of the Circulatory System

Diagnosis Category	Patients	Claims	Total Paid	% Paid
Cardiac Dysrhythmias	686	2,682	$3,110,614	19.2%
Nonspecific Chest Pain	1,897	4,922	$1,777,493	11.0%
Coronary Atherosclerosis And Other Heart Disease	651	2,287	$1,764,110	10.9%
Heart Failure	199	1,226	$1,604,248	9.9%
Nonrheumatic And Unspecified Valve Disorders	350	856	$1,353,462	8.4%
Acute Myocardial Infarction	103	531	$1,249,272	7.7%
Acute Hemorrhagic Cerebrovascular Disease	38	428	$818,865	5.1%
Cerebral Infarction	131	678	$533,332	3.3%
Acute Phlebitis; Thrombophlebitis And Thromboembolism	173	595	$509,558	3.2%
Essential Hypertension	3,852	8,769	$429,572	2.7%
Aortic; Peripheral; And Visceral Artery Aneurysms	70	212	$333,957	2.1%
Acute Pulmonary Embolism	80	352	$331,791	2.1%
Sequela Of Cerebral Infarction And Other Cerebrovascular Disease	43	294	$243,942	1.5%
Varicose Veins Of Lower Extremity	178	592	$232,567	1.4%
Conduction Disorders	196	505	$185,316	1.1%
Other And Ill-Defined Cerebrovascular Disease	103	231	$180,937	1.1%
Sequela Of Hemorrhagic Cerebrovascular Disease	6	16	$179,391	1.1%
Myocarditis And Cardiomyopathy	92	326	$146,710	0.9%
Cardiac Arrest And Ventricular Fibrillation	30	77	$141,207	0.9%
Peripheral And Visceral Vascular Disease	219	495	$124,929	0.8%
Pericarditis And Pericardial Disease	31	106	$116,220	0.7%
Hypertension With Complications And Secondary Hypertension	143	262	$99,631	0.6%
Chronic Rheumatic Heart Disease	234	293	$99,608	0.6%
Postthrombotic Syndrome And Venous Insufficiency/Hypertension	109	304	$74,818	0.5%
Endocarditis And Endocardial Disease	13	158	$72,162	0.4%
Occlusion Or Stenosis Of Precerebral Or Cerebral Arteries Without Infarction	180	304	$66,537	0.4%
Pulmonary Heart Disease	52	230	$66,302	0.4%
Other Specified Diseases Of Veins And Lymphatics	115	360	$60,389	0.4%
Chronic Phlebitis; Thrombophlebitis And Thromboembolism	23	49	$58,437	0.4%
Other Specified And Unspecified Circulatory Disease	106	173	$46,699	0.3%
Gangrene	9	26	$34,458	0.2%
Other And Ill-Defined Heart Disease	167	240	$31,416	0.2%
Postprocedural Or Postoperative Circulatory System Complication	20	70	$29,213	0.2%
Hypotension	79	147	$24,908	0.2%
Aortic And Peripheral Arterial Embolism Or Thrombosis	33	62	$11,579	0.1%
Acute Rheumatic Heart Disease	4	12	$10,598	0.1%
Arterial Dissections	12	25	$4,986	0.0%
Complications Of Acute Myocardial Infarction	2	2	$38	0.0%
Diseases Of The Heart	3	6	$0	0.0%
Hypertension	3	4	$0	0.0%
Overall	**----**	**----**	**$16,159,271**	**100.0%**

*Patient and claim counts are unique only within the category

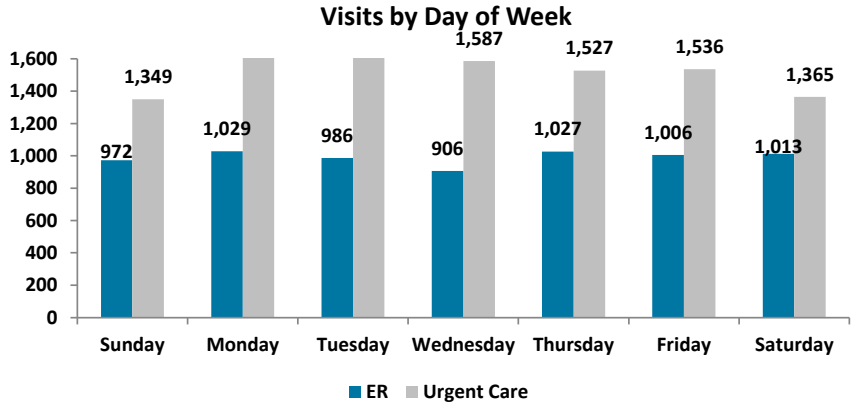


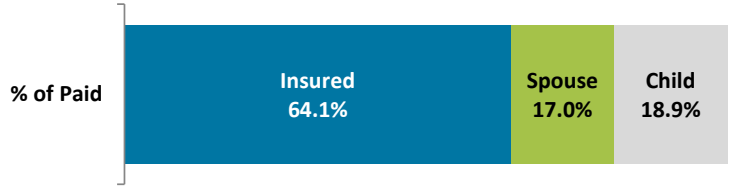


Emergency Room / Urgent Care Summary

	PY19		PY20		HSB Peer Index	
ER/Urgent Care	**ER**	**Urgent Care**	**ER**	**Urgent Care**	**ER**	**Urgent Care**
Number of Visits	6,931	10,471	6,939	10,800		
Number of Admits	1,096	----	1,033	----		
Visits Per Member	0.16	0.24	0.16	0.25	0.17	0.24
Visits/1000 Members	162	245	162	252	174	242
Avg Paid Per Visit	$2,025	$45	$2,273	$52	$1,684	$74
Admits per Visit	0.16	----	0.15	----	0.14	
% of Visits with HSB ER Dx	76.9%	----	77.7%	----		
% of Visits with a Physician OV*	77.0%	72.6%	77.0%	72.6%		
Total Plan Paid	**$14,021,480**	**$473,014**	**$15,775,565**	**$564,993**		

*looks back 12 months from ER visit



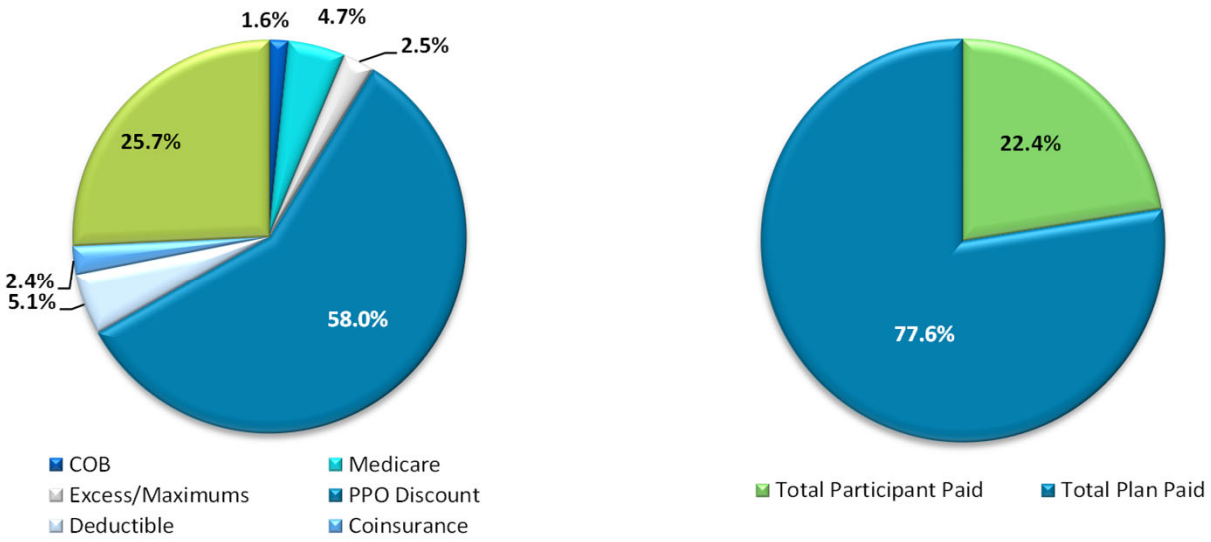


ER / UC Visits by Relationship						
Relationship	**ER**	**Per 1,000**	**Urgent Care**	**Per 1,000**	**Total**	**Per 1,000**
Insured	4,047	171	6,472	273	10,519	444
Spouse	1,100	199	1,212	219	2,312	418
Child	1,792	131	3,116	228	4,908	359
Total	**6,939**	**162**	**10,800**	**252**	**17,739**	**414**

Savings Summary – Medical Claims

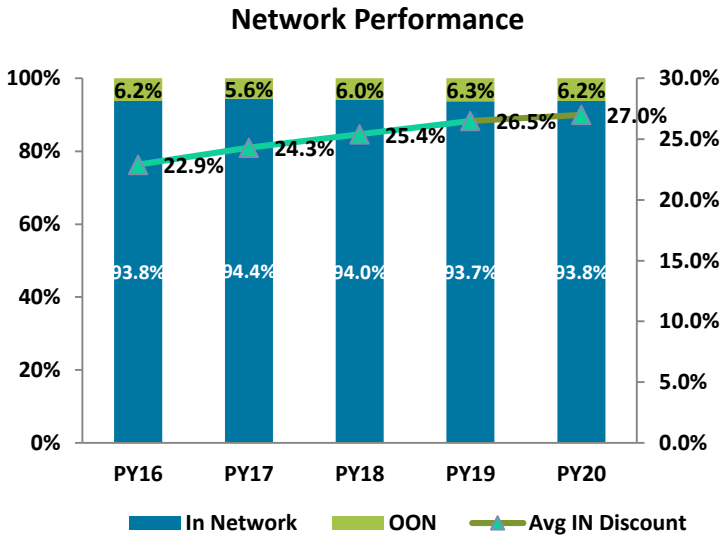
Description	Dollars	PPPM	% of Eligible
Eligible Charges	$558,209,333	$1,965	100.0%
COB	$8,999,752	$32	1.6%
Medicare	$26,173,982	$92	4.7%
Excess/Maximums	$14,045,333	$49	2.5%
PPO Discount	$323,739,152	$1,140	58.0%
Deductible	$28,371,961	$100	5.1%
Coinsurance	$13,211,946	$47	2.4%
Total Participant Paid	**$41,583,907**	**$146**	**7.4%**
Total Plan Paid	**$143,667,208**	**$506**	**25.7%**

Total Participant Paid - PY19	**$141**
Total Plan Paid - PY19	**$471**

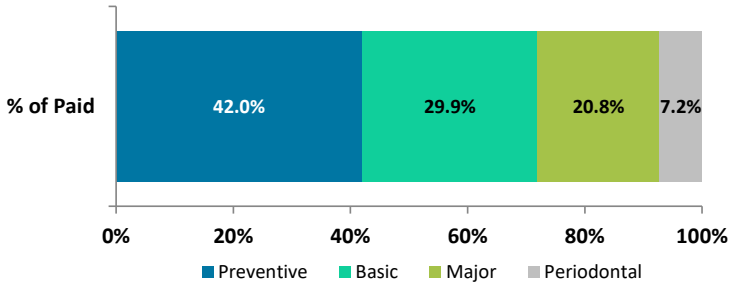


Dental Claims Analysis

Cost Distribution								
Paid Claims Category	Avg # of Members	% of Members	# Claims	# of Claims	Total Paid	% of Paid	Total EE Paid	% of EE Paid
$1,000.01 Plus	6,501	9.5%	31,324	24.8%	$9,961,699	43.2%	$6,211,288	57.3%
$750.01-$1,000.00	2,703	3.9%	10,638	8.4%	$2,412,326	10.5%	$1,263,367	11.7%
$500.01-$750.00	4,640	6.8%	16,312	12.9%	$2,922,745	12.7%	$1,301,385	12.0%
$250.01-$500.00	14,323	20.9%	39,785	31.5%	$5,066,792	22.0%	$1,213,807	11.2%
$0.01-$250.00	17,069	24.9%	27,560	21.8%	$2,698,243	11.8%	$821,591	7.6%
$0.00	545	0.8%	661	0.5%	$0	0.0%	$24,579	0.2%
No Claims	22,897	33.3%	0	0.0%	$0	0.0%	$0	0.0%
Total	**68,678**	**100.0%**	**126,280**	**100.0%**	**$23,061,804**	**100.0%**	**$10,836,018**	**100.0%**



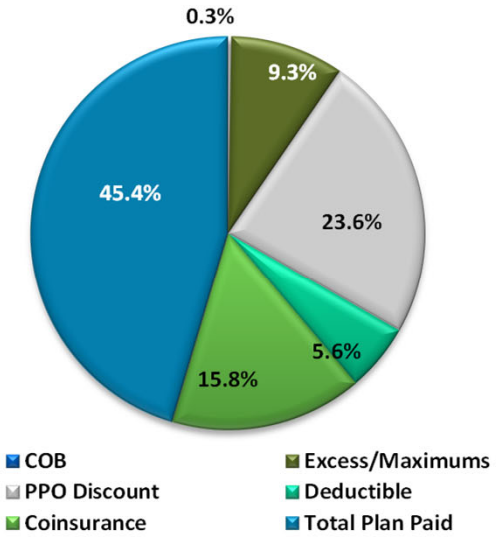
Claim Category	Total Paid	% of Paid
Preventive	$9,694,451	42.0%
Basic	$6,898,776	29.9%
Major	$4,800,105	20.8%
Periodontal	$1,668,472	7.2%
Total	**$23,061,804**	**100.0%**

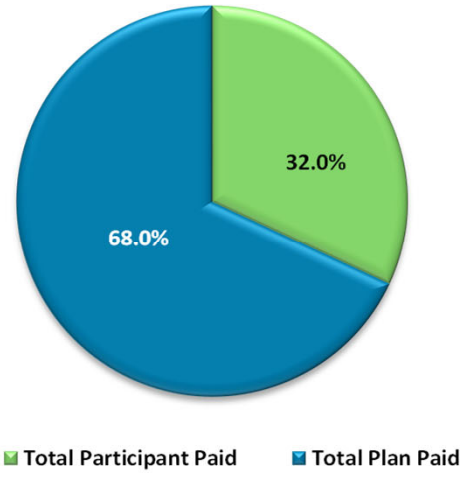


Savings Summary – Dental Claims

Description	Dollars	PPPM	% of Eligible
Eligible Charges	$50,776,544	$102	100.0%
COB	$132,712	$0	0.3%
Excess/Maximums	$4,739,547	$10	9.3%
PPO Discount	$12,006,462	$24	23.6%
Deductible	$2,827,661	$6	5.6%
Coinsurance	$8,008,357	$16	15.8%
Total Participant Paid	**$10,836,018**	**$22**	**21.3%**
Total Plan Paid	**$23,061,804**	**$46**	**45.4%**

Total Participant Paid - PY19	**$14**
Total Plan Paid - PY19	**$30**





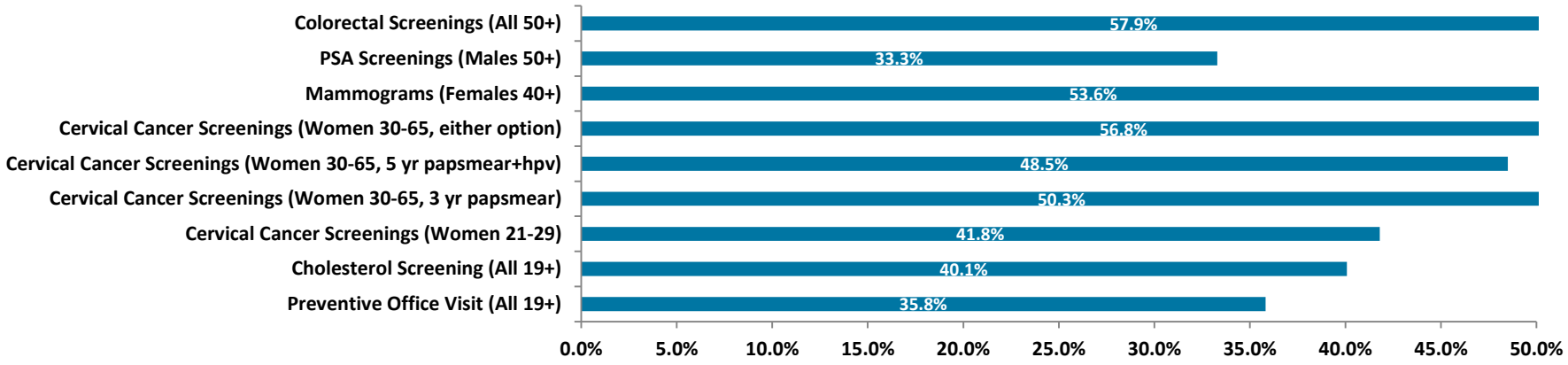
Preventive Services Compliance

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

Colorectal screenings look back to July 2011.

	Female			Male			Total		
Service	Eligible	Compliant	% Compliant	Eligible	Compliant	% Compliant	Eligible	Compliant	% Compliant
Preventive Office Visit (All 19+)	17,321	8,124	46.9%	15,205	3,528	23.2%	32,526	11,651	35.8%
Cholesterol Screening (All 19+)	17,321	7,483	43.2%	15,205	5,550	36.5%	32,526	13,032	40.1%
Cervical Cancer Screenings (Women 21-29)	2,766	1,156	41.8%	----	----	----	2,766	1,156	41.8%
Cervical Cancer Screenings (Women 30-65, 3 yr papsmear)	13,039	6,559	50.3%	----	----	----	13,039	6,559	50.3%
Cervical Cancer Screenings (Women 30-65, 5 yr papsmear+hpv)	13,039	6,324	48.5%	----	----	----	13,039	6,324	48.5%
Cervical Cancer Screenings (Women 30-65, either option)	13,039	7,406	56.8%	----	----	----	13,039	7,406	56.8%
Mammograms (Females 40+)	10,667	5,718	53.6%	----	----	----	10,667	5,718	53.6%
PSA Screenings (Males 50+)	----	----	----	6,401	2,132	33.3%	6,401	2,132	33.3%
Colorectal Screenings (All 50+)	7,353	4,404	59.9%	6,401	3,553	55.5%	13,754	7,957	57.9%

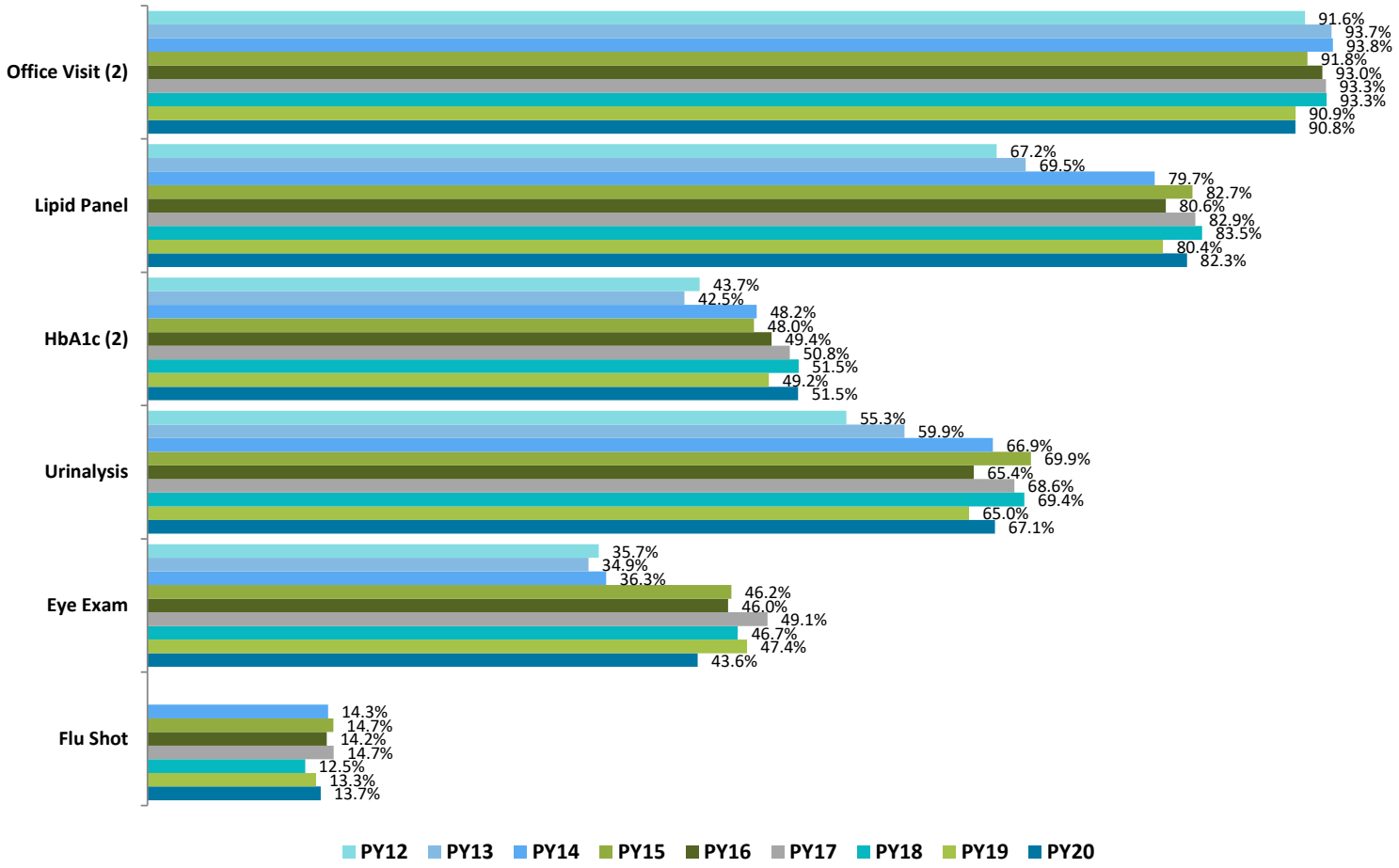
Overall Preventive Services Compliance Rates



Diabetic Disease Compliance

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

Diabetic Population									
Year	PY12	PY13	PY14	PY15	PY16	PY17	PY18	PY19	PY20
Members	1,651	1,643	1,555	1,676	1,693	1,704	1,747	1,838	1,876

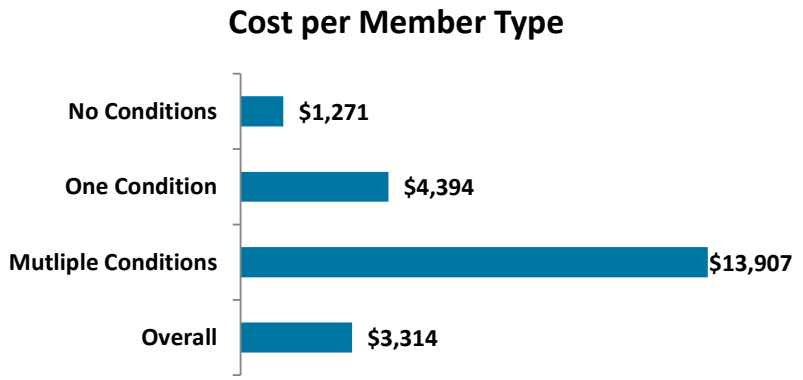


Chronic Conditions Summary

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

Condition	Total Members	Avg Members	Per 1,000	Avg Age	Total Cost	Average Cost	Compliance Rate	Compliance Measure
Asthma	1,237	1,170	29	38	$6,999,235	$5,658	99.3%	1 Office Visit
Cancer	1,356	1,285	32	59	$31,494,154	$23,226	----	----
Chronic Kidney Disease	332	309	8	60	$7,057,790	$21,258	----	----
Chronic Obstructive Pulmonary Disease (COPD)	262	245	6	59	$5,801,582	$22,143	98.9%	1 Office Visit
Congestive Heart Failure (CHF)	164	147	4	62	$14,684,237	$89,538	15.2%	1 Office Visit, 1 Lipid Profile, 1 Wellness Visit
Coronary Artery Disease (CAD)	635	599	15	62	$11,358,137	$17,887	22.0%	1 Office Visit, 1 Lipid Profile, 1 Wellness Visit
Depression	1,547	1,448	36	40	$17,432,117	$11,268	95.3%	1 Office Visit
Diabetes	1,876	1,763	44	56	$15,926,494	$8,490	20.1%	2 Office Visits, 1 Lipid Profile, 2 HbA1c's, 1 Urinalysis, 1 Eye Exam, 1 Flu Shot
Hyperlipidemia	3,222	3,104	75	54	$21,496,183	$6,672	39.4%	1 Office Visit, 1 Lipid Profile, 1 Wellness Visit
Hypertension	3,747	3,554	87	57	$38,458,575	$10,264	27.4%	1 Office Visit, 1 Lipid Profile, 1 Wellness Visit
Obesity	881	832	21	44	$5,881,677	$6,676	----	----

# of Conditions	Avg Members	Average Age	Relationship		
			Insured	Spouse	Child
No Conditions	29,274	31	47.3%	11.8%	40.9%
One Condition	8,820	46	70.4%	16.2%	13.4%
Multiple Conditions	4,748	56	78.2%	19.1%	2.7%
Overall	**42,842**	**36**	**54.7%**	**13.4%**	**32.0%**



Public Employees' Benefits Program - RX Costs
PY 2020 - Quarter Ending June 30, 2020

Express Scripts

Membership Summary	4Q FY2020	4Q FY2019	Difference	% Change
			Membership Summary	
Member Count (Membership)	42,860	42,767	93	0.2%
Utilizing Member Count (Patients)	30,898	30,892	6	0.0%
Percent Utilizing (Utilization)	72.1%	72.2%	(0.00)	-0.2%

Claim Summary			Claims Summary	
Net Claims (Total Rx's)	528,538	507,442	21,096	4.2%
Claims per Elig Member per Month (Claims PMPM)	1.03	0.99	0.04	4.0%
Total Claims for Generic (Generic Rx)	460,353	439,537	20,816.00	4.7%
Total Claims for Brand (Brand Rx)	68,185	67,905	280.00	0.4%
Total Claims for Brand w/Gen Equiv (Multisource Brand Claims)	8,527	8,120	407.00	5.0%
Total Non-Specialty Claims	522,302	501,486	20,816.00	4.2%
Total Specialty Claims	6,236	5,956	280.00	4.7%
Generic % of Total Claims (GFR)	**87.1%**	**86.6%**	0.00	0.6%
Generic Effective Rate (GCR)	**98.2%**	**98.2%**	(0.00)	0.0%
Mail Order Claims	98,209	66,787	31,422.00	47.0%
Mail Penetration Rate*	20.2%	14.8%	0.05	5.4%

Claims Cost Summary			Claims Cost Summary	
Total Prescription Cost (Total Gross Cost)	$49,767,182.00	$48,551,146.00	$1,216,036.00	2.5%
Total Generic Gross Cost	$8,025,545.00	$9,949,865.00	($1,924,320.00)	-19.3%
Total Brand Gross Cost	$41,741,637.00	$38,601,281.00	$3,140,356.00	8.1%
Total MSB Gross Cost	$1,668,251.00	$1,333,062.00	$335,189.00	25.1%
Total Ingredient Cost	$49,438,797.00	$48,183,051.00	$1,255,746.00	2.6%
Total Dispensing Fee	$308,172.00	$350,687.00	($42,515.00)	-12.1%
Total Other (e.g. tax)	$20,213.00	$17,408.00	$2,805.00	16.1%
Avg Total Cost per Claim (Gross Cost/Rx)	**$94.16**	**$95.68**	($1.52)	-1.6%
Avg Total Cost for Generic (Gross Cost/Generic Rx)	$17.43	$22.64	($5.21)	-23.0%
Avg Total Cost for Brand (Gross Cost/Brand Rx)	$612.18	$568.46	$43.72	7.7%
Avg Total Cost for MSB (MSB Gross Cost/MSB ARx)	$195.64	$164.17	$31.47	19.2%

Member Cost Summary			Member Cost Summary	
Total Member Cost	**$12,392,589.00**	**$9,576,190.00**	$2,816,399.00	29.4%
Total Copay	$6,737,994.00	$4,533,965.00	$2,204,029.00	48.6%
Total Deductible	$5,654,595.00	$5,042,225.00	$612,370.00	12.1%
Avg Copay per Claim (Copay/Rx)	$12.75	$8.93	$3.81	42.7%
Avg Participant Share per Claim (Copay+Deductible/RX)	**$23.45**	**$18.87**	**$4.58**	**24.2%**
Avg Copay for Generic (Copay/Generic Rx)	$8.10	$9.02	($0.92)	-10.2%
Avg Copay for Brand (Copay/Brand Rx)	$127.04	$82.63	$44.41	53.7%
Avg Copay for Brand w/ Generic Equiv (Copay/Multisource Rx)	$63.73	$64.55	($0.82)	-1.3%
Net PMPM (Participant Cost PMPM)	**$24.10**	**$18.66**	$5.44	29.1%
Copay % of Total Prescription Cost (Member Cost Share %)	24.9%	19.7%	5.2%	26.2%

Plan Cost Summary			Plan Cost Summary	
Total Plan Cost (Plan Cost)	**$37,374,593.00**	**$38,974,956.00**	**($1,600,363.00)**	**-4.1%**
Total Non-Specialty Cost (Non-Specialty Plan Cost)	$13,586,360.00	$16,333,510.00	($2,747,150.00)	-16.8%
Total Specialty Drug Cost (Specialty Plan Cost)	$23,788,233.00	$22,641,446.00	$1,146,787.00	5.1%
Avg Plan Cost per Claim (Plan Cost/Rx)	**$70.71**	**$76.81**	($6.09)	-7.9%
Avg Plan Cost for Generic (Plan Cost/Generic Rx)	$9.33	$13.62	($4.29)	-31.5%
Avg Plan Cost for Brand (Plan Cost/Brand Rx)	$485.14	$485.83	($0.69)	-0.1%
Avg Plan Cost for MSB (MSB Plan Cost/MSB ARx)	$131.91	$99.62	$32.29	32.4%
Net PMPM (Plan Cost PMPM)	**$72.67**	**$75.94**	**($3.28)**	**-4.3%**
PMPM for Specialty Only (Specialty PMPM)	$46.25	$44.12	$2.13	4.8%
PMPM without Specialty (Non-Specialty PMPM)	$26.42	$31.83	($5.41)	-17.0%
Rebates (Q1-Q4 FY2020 actual)	$9,876,814.94	$3,827,465.06	$6,049,349.88	158.1%
Net PMPM (Plan Cost PMPM factoring Rebates)	**$53.40**	**$68.50**	**($15.09)**	**-22.0%**
PMPM for Specialty Only (Specialty PMPM)	$40.11	$39.12	$0.99	2.5%
PMPM without Specialty (Non-Specialty PMPM)	$14.12	$20.02	($5.90)	-29.5%

Appendix B

Index of Tables
HealthSCOPE – EPO Utilization Review for PEBP
July 1, 2019 – June 30, 2020

HSB DATASCOPE™

Nevada Public Employees' Benefits Program
EPO Plan

July 2019 – June 2020

HealthSCOPE BENEFITS

Overview

- Total Medical Spend for PY20 was $50,293,887 with a plan cost per employee per year of $10,492. This is an increase of 20.0% when compared to PY19.
  - IP Cost per Admit is $14,091 which is 30.9% lower than PY19.
  - ER Cost per Visit is $2,649 which is on track with PY19.
- Employees shared in 9.4% of the medical cost.
- Inpatient facility costs were 20.4% of the plan spend.
- 67.1% of the Average Membership had paid Medical claims less than $2,500, with 8.9% of those having no claims paid at all during the reporting period.
- 51 members exceeded the $100k high cost threshold during the reporting period, which accounted for 20.6% of the plan spend. The highest diagnosis category was Neoplasms, accounting for 16.3% of the high cost claimant dollars.
- Total spending with in-network providers was 97.4%. The overall in-network discount was 57.3%.

Paid Claims by Age Group

Paid Claims by Age Group																
	PY19						PY20						% Change	
Age Range	Med Net Pay	Med PMPM	Rx Net Pay	Rx PMPM	Net Pay	PMPM	Med Net Pay	Med PMPM	Rx Net Pay	Rx PMPM	Net Pay	PMPM	Net Pay	PMPM
<1	$ 1,874,215	$ 1,698	$ 9,149	$ 8	$ 1,883,364	$ 1,706	$ 2,065,664	$ 1,523	$ 43,610	$ 32	$ 2,109,274	$ 1,556	12.0%	-8.8%
1	$ 264,791	$ 245	$ 14,535	$ 13	$ 279,326	$ 259	$ 322,038	$ 280	$ 10,151	$ 9	$ 332,189	$ 288	18.9%	11.5%
2 - 4	$ 372,210	$ 117	$ 14,845	$ 5	$ 387,055	$ 122	$ 499,290	$ 143	$ 21,093	$ 6	$ 520,383	$ 150	34.4%	22.9%
5 - 9	$ 502,906	$ 81	$ 95,811	$ 16	$ 598,717	$ 97	$ 671,109	$ 108	$ 118,472	$ 19	$ 789,581	$ 128	31.9%	31.6%
10 - 14	$ 1,277,258	$ 167	$ 244,065	$ 32	$ 1,521,323	$ 198	$ 1,496,169	$ 195	$ 261,037	$ 34	$ 1,757,206	$ 228	15.5%	15.1%
15 - 19	$ 1,537,283	$ 186	$ 292,943	$ 35	$ 1,830,226	$ 222	$ 2,508,550	$ 293	$ 365,029	$ 43	$ 2,873,579	$ 336	57.0%	51.5%
20 - 24	$ 1,082,265	$ 156	$ 409,392	$ 59	$ 1,491,657	$ 215	$ 1,896,090	$ 253	$ 649,773	$ 87	$ 2,545,863	$ 340	70.7%	57.8%
25 - 29	$ 1,215,987	$ 295	$ 301,168	$ 73	$ 1,517,155	$ 369	$ 1,399,255	$ 312	$ 448,440	$ 100	$ 1,847,695	$ 412	21.8%	11.7%
30 - 34	$ 2,784,920	$ 515	$ 341,212	$ 63	$ 3,126,132	$ 578	$ 2,810,656	$ 487	$ 384,069	$ 67	$ 3,194,725	$ 553	2.2%	-4.2%
35 - 39	$ 2,361,827	$ 366	$ 734,028	$ 114	$ 3,095,855	$ 480	$ 3,816,160	$ 559	$ 872,086	$ 128	$ 4,688,246	$ 687	51.4%	43.2%
40 - 44	$ 2,437,647	$ 381	$ 784,468	$ 123	$ 3,222,115	$ 504	$ 3,025,413	$ 449	$ 1,471,349	$ 218	$ 4,496,762	$ 667	39.6%	32.4%
45 - 49	$ 2,770,287	$ 331	$ 1,525,758	$ 182	$ 4,296,045	$ 513	$ 4,355,742	$ 514	$ 1,557,551	$ 184	$ 5,913,293	$ 698	37.6%	36.1%
50 - 54	$ 5,152,391	$ 559	$ 2,107,261	$ 229	$ 7,259,652	$ 788	$ 5,252,965	$ 547	$ 2,521,204	$ 263	$ 7,774,169	$ 810	7.1%	2.8%
55 - 59	$ 5,436,354	$ 503	$ 2,751,284	$ 254	$ 8,187,638	$ 757	$ 7,388,691	$ 691	$ 3,451,241	$ 323	$ 10,839,932	$ 1,014	32.4%	33.9%
60 - 64	$ 9,774,054	$ 815	$ 3,034,480	$ 253	$ 12,808,534	$ 1,067	$ 9,642,859	$ 815	$ 4,337,100	$ 367	$ 13,979,959	$ 1,182	9.1%	10.7%
65+	$ 1,920,336	$ 395	$ 1,343,189	$ 276	$ 3,263,525	$ 672	$ 3,143,235	$ 644	$ 1,712,534	$ 351	$ 4,855,769	$ 994	48.8%	48.1%
Total	**$ 40,764,731**	**$ 400**	**$ 14,003,588**	**$ 137**	**$54,768,319**	**$ 537**	**$ 50,293,887**	**$ 478**	**$ 18,224,739**	**$ 173**	**$ 68,518,625**	**$ 651**	**25.1%**	**21.3%**

Financial Summary (p. 1 of 2)

	Total			State Active			Non-State Active		
Summary	**PY19**	**PY20**	**Variance to Prior Year**	**PY19**	**PY20**	**Variance to Prior Year**	**PY19**	**PY20**	**Variance to Prior Year**
Enrollment									
Avg # Employees	4,653	4,794	3.0%	3,878	4,054	4.5%	4	4	0.0%
Avg # Members	8,488	8,768	3.3%	7,445	7,768	4.3%	5	5	0.0%
Ratio	1.8	1.8	0.5%	1.9	1.9	0.0%	1.3	1.3	0.0%
Financial Summary									
Gross Cost	$45,094,672	$55,523,229	23.1%	$35,711,039	$45,961,999	28.7%	$45,961	$70,916	54.3%
Client Paid	$40,764,731	$50,293,887	23.4%	$32,097,283	$41,579,805	29.5%	$40,931	$65,329	59.6%
Employee Paid	$4,329,941	$5,229,342	20.8%	$3,613,757	$4,382,194	21.3%	$5,030	$5,587	11.1%
Client Paid-PEPY	$8,745	$10,492	20.0%	$8,277	$10,256	23.9%	$10,233	$16,332	59.6%
Client Paid-PMPY	$4,794	$5,736	19.6%	$4,311	$5,352	24.1%	$8,186	$13,066	59.6%
Client Paid-PEPM	$729	$874	19.9%	$690	$855	23.9%	$853	$1,361	59.6%
Client Paid-PMPM	$400	$478	19.5%	$359	$446	24.2%	$682	$1,089	59.7%
High Cost Claimants (HCC's) > $100k									
# of HCC's	39	51	30.8%	27	40	48.1%	0	0	0.0%
HCC's / 1,000	4.6	5.8	26.7%	3.6	5.2	42.0%	0.0	0.0	0.0%
Avg HCC Paid	$274,612	$202,775	-26.2%	$246,453	$179,535	-27.2%	$0	$0	0.0%
HCC's % of Plan Paid	26.3%	20.6%	-21.7%	20.7%	17.3%	-16.4%	0.0%	0.0%	0.0%
Cost Distribution by Claim Type (PMPY)									
Facility Inpatient	$1,218	$1,169	-4.0%	$944	$1,036	9.7%	$3,360	$2,928	-12.9%
Facility Outpatient	$1,506	$1,832	21.6%	$1,395	$1,693	21.4%	$1,369	$4,817	251.9%
Physician	$1,923	$2,541	32.1%	$1,844	$2,461	33.5%	$3,030	$5,153	70.1%
Other	$148	$194	31.1%	$127	$163	28.3%	$427	$168	-60.7%
Total	$4,794	$5,736	19.6%	$4,311	$5,352	24.1%	$8,186	$13,066	59.6%

Financial Summary (p. 2 of 2)

	State Retirees			Non-State Retirees			
Summary	**PY19**	**PY20**	**Variance to Prior Year**	**PY19**	**PY20**	**Variance to Prior Year**	**HSB Peer Index**
Enrollment							
Avg # Employees	599	588	-1.8%	181	148	-18.2%	
Avg # Members	826	807	-2.3%	227	188	-17.3%	
Ratio	1.4	1.4	-0.7%	1.3	1.3	0.8%	1.8
Financial Summary							
Gross Cost	$7,418,807	$8,514,643	14.8%	$1,918,864	$975,672	-49.2%	
Client Paid	$6,863,148	$7,803,114	13.7%	$1,763,370	$845,639	-52.0%	
Employee Paid	$555,659	$711,529	28.1%	$155,495	$130,033	-16.4%	
Client Paid-PEPY	$11,461	$13,272	15.8%	$9,769	$5,730	-41.3%	$6,209
Client Paid-PMPY	$8,313	$9,674	16.4%	$7,777	$4,508	-42.0%	$3,437
Client Paid-PEPM	$955	$1,106	15.8%	$814	$477	-41.4%	$517
Client Paid-PMPM	$693	$806	16.3%	$648	$376	-42.0%	$286
High Cost Claimants (HCC's) > $100k							
# of HCC's	9	18	100.0%	3	0	0.0%	
HCC's / 1,000	10.9	22.3	104.7%	13.2	0.0	0.0%	
Avg HCC Paid	$339,256	$175,561	-48.3%	$334,114	$0	0.0%	
HCC's % of Plan Paid	44.5%	40.5%	-9.0%	56.8%	0.0%	0.0%	
Cost Distribution by Claim Type (PMPY)							
Facility Inpatient	$3,028	$2,529	-16.5%	$3,554	$787	-77.9%	$1,057
Facility Outpatient	$2,243	$3,276	46.1%	$2,477	$1,314	-47.0%	$1,145
Physician	$2,713	$3,385	24.8%	$1,587	$2,165	36.4%	$1,122
Other	$328	$484	47.6%	$158	$242	53.2%	$113
Total	$8,313	$9,674	16.4%	$7,777	$4,508	-42.0%	$3,437

Paid Claims by Claim Type – State Participants

Net Paid Claims - Total State Participants	PY19				PY20				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical									
Inpatient	$ 8,762,274	$ 2,599,386	$ 160,727	$ 11,522,387	$ 10,464,957	$ 2,021,740	$ 396,512	$ 12,883,209	11.8%
Outpatient	$ 23,335,008	$ 3,620,613	$ 482,422	$ 27,438,043	$ 31,114,848	$ 4,575,830	$ 809,032	$ 36,499,709	33.0%
Total - Medical	**$ 32,097,283**	**$ 6,219,999**	**$ 643,149**	**$ 38,960,431**	**$ 41,579,805**	**$ 6,597,569**	**$ 1,205,544**	**$ 49,382,919**	**26.8%**

Net Paid Claims - Per Participant per Month	PY19				PY20				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical	$ 690	$ 1,018	$ 596	$ 725	$ 855	$ 1,092	$ 1,190	$ 887	22.3%

Paid Claims by Claim Type – Non-State Participants

Net Paid Claims - Total Non-State Participants	PY19				PY20				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical									
Inpatient	$ 23,542	$ 854,839	$ 10,077	$ 888,459	$ 22,498	$ 49,975	$ 123,810	$ 196,283	-77.9%
Outpatient	$ 17,389	$ 754,444	$ 144,009	$ 915,842	$ 42,831	$ 562,214	$ 109,640	$ 714,685	-22.0%
Total - Medical	**$ 40,931**	**$ 1,609,283**	**$ 154,087**	**$ 1,804,301**	**$ 65,329**	**$ 612,189**	**$ 233,450**	**$ 910,968**	**-49.5%**

Net Paid Claims - Per Participant per Month	PY19				PY20				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical	$ 853	$ 1,048	$ 242	$ 813	$ 1,361	$ 544	$ 362	$ 501	-38.4%

Paid Claims by Claim Type – Total

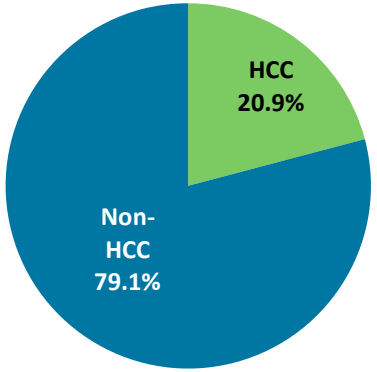
Net Paid Claims - Total Total Participants	PY19				PY20				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical									
Inpatient	$ 8,785,816	$ 3,454,225	$ 170,805	$ 12,410,846	$ 10,487,455	$ 2,071,715	$ 520,322	$ 13,079,492	5.4%
Outpatient	$ 23,352,397	$ 4,375,057	$ 626,431	$ 28,353,885	$ 31,157,679	$ 5,138,044	$ 918,672	$ 37,214,394	31.2%
Total - Medical	**$ 32,138,214**	**$ 7,829,282**	**$ 797,236**	**$ 40,764,731**	**$ 41,645,134**	**$ 7,209,759**	**$ 1,438,994**	**$ 50,293,887**	**23.4%**

Net Paid Claims - Per Participant per Month	PY19				PY20				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical	$ 690	$ 1,024	$ 465	$ 729	$ 855	$ 1,006	$ 868	$ 874	20.0%

Cost Distribution – Medical Claims

PY19							PY20					
Avg # of Members	% of Members	Total Paid	% of Paid	EE Paid	% EE Paid	Paid Claims Category	Avg # of Members	% of Members	Total Paid	% of Paid	EE Paid	% EE Paid
32	0.4%	$10,660,448	26.2%	$223,955	5.2%	$100,000.01 Plus	44	0.5%	$10,340,819	20.6%	$390,985	7.5%
63	0.7%	$4,489,989	11.0%	$285,075	6.6%	$50,000.01-$100,000.00	88	1.0%	$6,373,247	12.7%	$358,697	6.9%
148	1.7%	$5,378,700	13.2%	$370,909	8.6%	$25,000.01-$50,000.00	225	2.6%	$8,154,879	16.2%	$555,463	10.6%
489	5.7%	$7,901,863	19.4%	$770,638	17.8%	$10,000.01-$25,000.00	677	7.7%	$11,069,243	22.0%	$1,103,842	21.1%
592	7.0%	$4,367,753	10.7%	$713,266	16.5%	$5,000.01-$10,000.00	709	8.1%	$5,306,235	10.6%	$742,035	14.2%
935	11.0%	$3,470,368	8.5%	$766,356	17.7%	$2,500.01-$5,000.00	1,148	13.1%	$4,313,452	8.6%	$963,451	18.4%
5,310	62.5%	$4,495,610	11.0%	$1,195,579	27.6%	$0.01-$2,500.00	5,073	57.9%	$4,736,011	9.4%	$1,110,286	21.3%
16	0.2%	$0	0.0%	$4,162	0.1%	$0.00	23	0.3%	$0	0.0%	$4,582	0.1%
918	10.8%	$0	0.0%	$0	0.0%	No Claims	780	8.9%	$0	0.0%	$0	0.0%
8,503	**100.0%**	**$40,764,731**	**100.0%**	**$4,329,941**	**100.0%**		**8,768**	**100.0%**	**$50,293,887**	**100.0%**	**$5,229,342**	**100.0%**

Distribution of HCC Medical Claims Paid



HCC – High Cost Claimant over $100K

HCC's by AHRQ Clinical Classifications Chapter			
AHRQ Chapter	Patients	Total Paid	% Paid
(CCS NEO) Neoplasms	22	$1,712,149	16.3%
(CCS MUS) Diseases of the Musculoskeletal System and Connective Tissue	34	$1,513,584	14.4%
(CCS BLD) Diseases of the Blood and Blood Forming Organs and Certain Disorders Involving	20	$1,039,769	9.9%
(CCS END) Endocrine, Nutritional and Metabolic Diseases	30	$909,798	8.7%
(CCS PNL) Certain Conditions Originating in the Perinatal Period	4	$873,604	8.3%
(CCS INJ) Injury, Poisoning and Certain Other Consequences of External Causes	25	$591,383	5.6%
(CCS NVS) Diseases of the Nervous System	27	$567,721	5.4%
(CCS RSP) Diseases of the Respiratory System	33	$531,746	5.1%
(CCS INF) Certain Infectious and Parasitic Diseases	11	$526,511	5.0%
(CCS GEN) Diseases of the Genitourinary System	26	$432,586	4.1%
(CCS CIR) Diseases of the Circulatory System	33	$428,660	4.1%
(CCS MBD) Mental, Behavioral and Neurodevelopmental Disorders	23	$393,320	3.7%
(CCS DIG) Diseases of the Digestive System	25	$393,229	3.7%
(CCS FAC) Factors Influencing Health Status and Contact with Health Services	47	$206,240	2.0%
(CCS SYM) Symptoms, Signs and Abnormal Clinical and Laboratory Findings, Not Elsewhere	46	$163,487	1.6%
(CCS MAL) Congenital Malformations, Deformations and Chromosomal Abnormalities	7	$24,986	0.2%
(CCS EYE) Diseases of the Eye and Adnexa	23	$16,615	0.2%
(CCS SKN) Diseases of the Skin and Subcutaneous Tissue	21	$15,744	0.1%
All Others	121	$161,975	1.5%
Overall	**----**	**$10,503,107**	**100.0%**

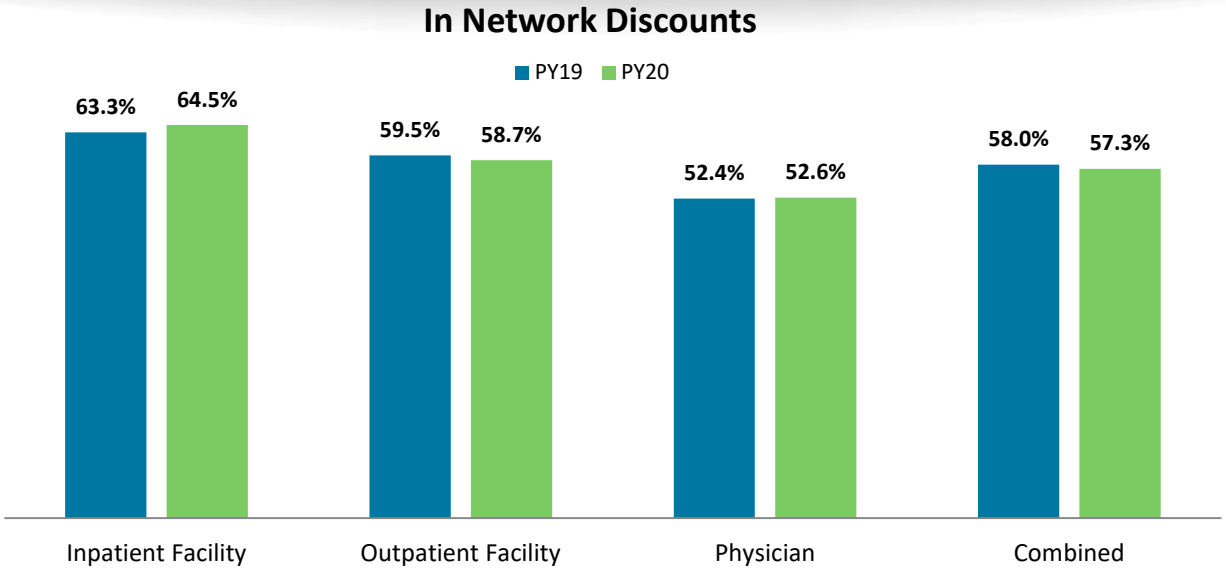
Utilization Summary (p. 1 of 2)

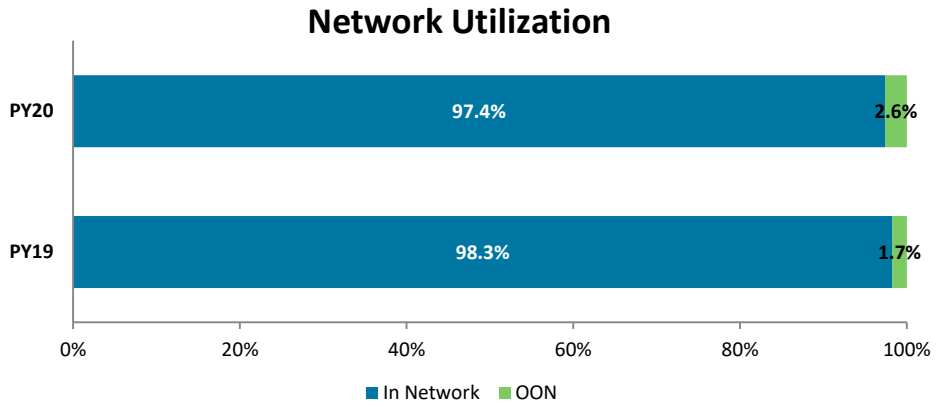
	Total			State Active			Non-State Active		
Summary	**PY19**	**PY20**	**Variance to Prior Year**	**PY19**	**PY20**	**Variance to Prior Year**	**PY19**	**PY20**	**Variance to Prior Year**
Inpatient Facility									
# of Admits	507	725	43.0%	441	616	39.7%	1	1	0.0%
# of Bed Days	2,491	3,388	36.0%	2,026	2,777	37.1%	2	2	0.0%
Paid Per Admit	$20,394	$14,091	-30.9%	$15,930	$13,098	-17.8%	$16,801	$14,640	-12.9%
Paid Per Day	$4,151	$3,015	-27.4%	$3,468	$2,905	-16.2%	$8,401	$7,320	-12.9%
Admits Per 1,000	60	83	38.3%	59	79	33.9%	200	200	0.0%
Days Per 1,000	293	386	31.7%	272	357	31.3%	400	400	0.0%
Avg LOS	4.9	4.7	-4.1%	4.6	4.5	-2.2%	2.0	2.0	0.0%
Physician Office									
OV Utilization per Member	4.4	5.1	15.9%	4.2	4.9	16.7%	5.6	8.6	53.6%
Avg Paid per OV	$94	$100	6.4%	$95	$102	7.4%	$105	$90	-14.3%
Avg OV Paid per Member	$410	$514	25.4%	$402	$503	25.1%	$587	$776	32.2%
DX&L Utilization per Member	8.9	10.4	16.9%	8.4	9.8	16.7%	14	17.6	25.7%
Avg Paid per DX&L	$78	$76	-2.6%	$75	$77	2.7%	$106	$90	-15.1%
Avg DX&L Paid per Member	$690	$791	14.6%	$629	$756	20.2%	$1,491	$1,582	6.1%
Emergency Room									
# of Visits	1,453	1,903	31.0%	1,261	1,618	28.3%	0	2	0.0%
# of Admits	192	309	60.9%	154	234	51.9%	0	0	0.0%
Visits Per Member	0.17	0.22	27.7%	0.17	0.21	22.5%	0	0.40	0.0%
Visits Per 1,000	171	217	26.9%	169	208	23.2%	0	400	0.0%
Avg Paid per Visit	$2,608	$2,649	1.6%	$2,546	$2,734	7.4%	$0	$2,405	0.0%
Admits Per Visit	0.13	0.16	24.9%	0.12	0.14	20.5%	0.00	0.00	0.0%
Urgent Care									
# of Visits	2,450	2,892	18.0%	2,232	2,644	18.5%	0	0	0.0%
Visits Per Member	0.29	0.33	13.7%	0.30	0.34	13.5%	0.00	0.00	0.0%
Visits Per 1,000	288	330	14.5%	300	340	13.5%	0	0	0.0%
Avg Paid per Visit	$140	$156	11.4%	$140	$158	12.9%	$0	$0	0.0%

Utilization Summary (p. 2 of 2)

	State Retirees			Non-State Retirees			
Summary	**PY19**	**PY20**	**Variance to Prior Year**	**PY19**	**PY20**	**Variance to Prior Year**	**HSB Peer Index**
Inpatient Facility							
# of Admits	52	95	82.7%	13	13	0.0%	
# of Bed Days	361	453	25.5%	102	156	52.9%	
Paid Per Admit	$47,923	$20,902	-56.4%	$61,977	$11,362	-81.7%	$16,173
Paid Per Day	$6,903	$4,383	-36.5%	$7,899	$947	-88.0%	$3,708
Admits Per 1,000	63	118	87.3%	57	69	21.1%	61
Days Per 1,000	437	562	28.6%	450	832	84.9%	264
Avg LOS	6.9	4.8	-30.4%	7.8	12.0	53.8%	4.3
Physician Office							
OV Utilization per Member	5.6	7.0	25.0%	5.0	6.1	22.0%	3.3
Avg Paid per OV	$85	$89	4.7%	$86	$79	-8.1%	$50
Avg OV Paid per Member	$473	$622	31.5%	$431	$477	10.7%	$167
DX&L Utilization per Member	12.1	15	24.0%	12.2	13.9	13.9%	8.3
Avg Paid per DX&L	$88	$71	-19.3%	$104	$75	-27.9%	$67
Avg DX&L Paid per Member	$1,069	$1,065	-0.4%	$1,274	$1,047	-17.8%	$554
Emergency Room							
# of Visits	158	249	57.6%	94	34	-63.8%	
# of Admits	30	68	126.7%	8	7	-12.5%	
Visits Per Member	0.19	0.31	62.5%	0.41	0.18	-55.8%	0.17
Visits Per 1,000	191	309	61.6%	415	181	-56.3%	174
Avg Paid per Visit	$2,991	$2,281	-23.7%	$1,195	$1,300	8.8%	$1,684
Admits Per Visit	0.19	0.27	43.7%	0.09	0.21	128.8%	0.14
Urgent Care							
# of Visits	158	189	19.6%	60	59	-1.7%	
Visits Per Member	0.19	0.23	23.3%	0.26	0.31	21.0%	0.24
Visits Per 1,000	191	234	22.7%	265	315	18.7%	242
Avg Paid per Visit	$154	$153	-0.6%	$96	$97	1.0%	$74

Provider Network Summary



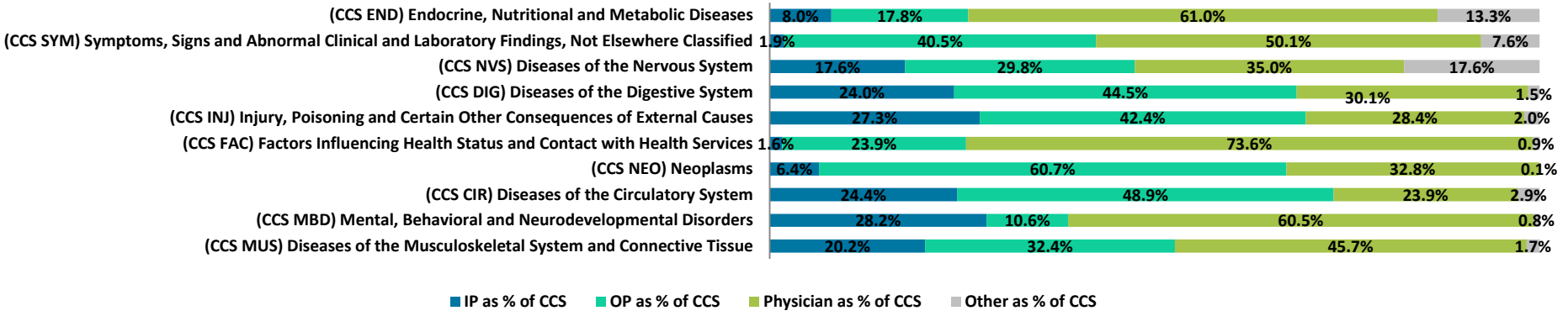


AHRQ* Clinical Classifications Summary

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

AHRQ Clinical Classifications Chapter	Total Paid	% Paid	Insured	Spouse	Child	Male	Female
(CCS MUS) Diseases of the Musculoskeletal System and Connective Tissue	$7,537,314	15.0%	$4,596,657	$2,196,439	$744,217	$3,723,514	$3,813,799
(CCS MBD) Mental, Behavioral and Neurodevelopmental Disorders	$3,666,794	7.3%	$1,930,564	$341,449	$1,394,781	$1,163,738	$2,503,056
(CCS CIR) Diseases of the Circulatory System	$3,649,144	7.3%	$2,770,280	$686,128	$192,736	$1,893,625	$1,755,519
(CCS NEO) Neoplasms	$3,633,436	7.2%	$3,007,104	$565,876	$60,456	$827,182	$2,806,254
(CCS FAC) Factors Influencing Health Status and Contact with Health Services	$3,503,371	7.0%	$1,989,071	$418,317	$1,095,983	$1,154,236	$2,349,135
(CCS INJ) Injury, Poisoning and Certain Other Consequences of External Causes	$3,452,461	6.9%	$1,953,469	$567,705	$931,287	$1,848,393	$1,604,068
(CCS DIG) Diseases of the Digestive System	$3,249,784	6.5%	$2,308,725	$524,525	$416,534	$1,425,956	$1,823,828
(CCS NVS) Diseases of the Nervous System	$2,923,621	5.8%	$1,854,354	$708,606	$360,660	$1,323,043	$1,600,578
(CCS SYM) Symptoms, Signs and Abnormal Clinical and Laboratory Findings, Not Els	$2,884,829	5.7%	$1,897,131	$391,735	$595,964	$1,100,225	$1,784,604
(CCS END) Endocrine, Nutritional and Metabolic Diseases	$2,721,088	5.4%	$2,141,105	$382,825	$197,158	$961,902	$1,759,186
(CCS RSP) Diseases of the Respiratory System	$2,467,306	4.9%	$1,557,728	$233,126	$676,452	$1,117,156	$1,350,150
(CCS GEN) Diseases of the Genitourinary System	$2,286,018	4.5%	$1,745,642	$332,052	$208,324	$816,521	$1,469,497
(CCS PRG) Pregnancy, Childbirth and the Puerperium	$1,952,793	3.9%	$1,587,278	$257,988	$107,527	$0	$1,952,793
(CCS PNL) Certain Conditions Originating in the Perinatal Period	$1,458,620	2.9%	$12,789	$225	$1,445,606	$316,856	$1,141,764
(CCS BLD) Diseases of the Blood and Blood Forming Organs and Certain Disorders I	$1,227,353	2.4%	$391,362	$817,301	$18,691	$262,356	$964,997
(CCS EYE) Diseases of the Eye and Adnexa	$1,107,868	2.2%	$810,482	$114,212	$183,174	$438,084	$669,784
(CCS INF) Certain Infectious and Parasitic Diseases	$1,076,215	2.1%	$794,435	$114,405	$167,374	$649,770	$426,444
(CCS SKN) Diseases of the Skin and Subcutaneous Tissue	$776,632	1.5%	$464,671	$171,260	$140,701	$320,134	$456,498
(CCS MAL) Congenital Malformations, Deformations and Chromosomal Abnormalit	$347,101	0.7%	$22,610	$17,351	$307,140	$214,709	$132,392
(CCS EAR) Diseases of the Ear and Mastoid Process	$340,964	0.7%	$135,588	$37,850	$167,526	$158,238	$182,726
(CCS 18) Residual Codes; Unclassified; All E Codes [259. And 260.]	$30,645	0.1%	$7,581	$11,557	$11,507	$8,606	$22,039
(CCS EXT) External Causes of Morbidity	$531	0.0%	$145	$0	$386	$0	$531
Total	$50,293,887	100.0%	$31,812,846	$8,824,174	$8,937,625	$19,342,691	$30,231,954

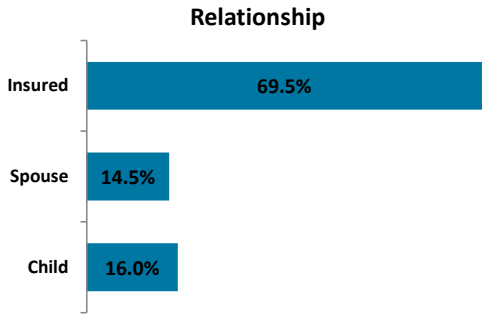
Top 10 Categories by Claim Type

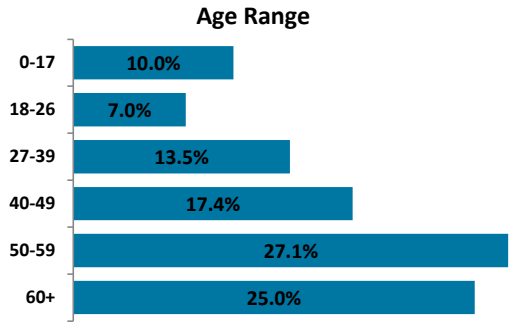


AHRQ Category – Diseases of the Musculoskeletal System & Connective Tissue

Diagnosis Category	Patients	Claims	Total Paid	% Paid
Spondylopathies/Spondyloarthropathy (Including Infective)	1,048	7,423	$2,699,026	35.8%
Osteoarthritis	482	1,729	$1,138,065	15.1%
Musculoskeletal Pain, Not Low Back Pain	1,855	8,805	$911,730	12.1%
Tendon And Synovial Disorders	331	1,445	$498,488	6.6%
Scoliosis And Other Postural Dorsopathic Deformities	50	186	$364,020	4.8%
Other Specified Joint Disorders	225	807	$286,736	3.8%
Other Specified Connective Tissue Disease	548	1,492	$277,629	3.7%
Low Back Pain	549	2,510	$227,671	3.0%
Rheumatoid Arthritis And Related Disease	81	349	$162,828	2.2%
Systemic Lupus Erythematosus And Connective Tissue Disorders	58	267	$157,455	2.1%
Acquired Foot Deformities	112	290	$153,667	2.0%
Disorders Of Jaw	27	173	$150,406	2.0%
Postprocedural Or Postoperative Musculoskeletal System Complication	49	434	$138,609	1.8%
Osteoporosis	67	154	$123,477	1.6%
Muscle Disorders	56	197	$54,500	0.7%
Biomechanical Lesions	409	2,215	$53,845	0.7%
Osteomyelitis	11	78	$34,455	0.5%
Other Specified Bone Disease And Musculoskeletal Deformities	118	216	$32,726	0.4%
Infective Arthritis	4	46	$20,238	0.3%
Acquired Deformities (Excluding Foot)	29	75	$19,464	0.3%
Stress Fracture, Initial Encounter	15	27	$16,956	0.2%
Gout	55	101	$8,681	0.1%
Neurogenic/Neuropathic Arthropathy	3	22	$2,834	0.0%
Pathological Fracture, Subsequent Encounter	4	5	$2,340	0.0%
Traumatic Arthropathy	3	6	$629	0.0%
Juvenile Arthritis	1	3	$317	0.0%
Pathological, Stress And Atypical Fractures, Sequela	1	1	$166	0.0%
Crystal Arthropathies (Excluding Gout)	1	2	$107	0.0%
Stress Fracture, Subsequent Encounter	1	1	$80	0.0%
Musculoskeletal Abscess	1	1	$71	0.0%
Immune-Mediated/Reactive Arthropathies	1	4	$59	0.0%
Aseptic Necrosis And Osteonecrosis	1	1	$37	0.0%
Other Bone Disease And Musculoskeletal Deformities [212.]	3	4	$0	0.0%
	----	----	$7,537,314	100.0%

*Patient and claim counts are unique only within the category

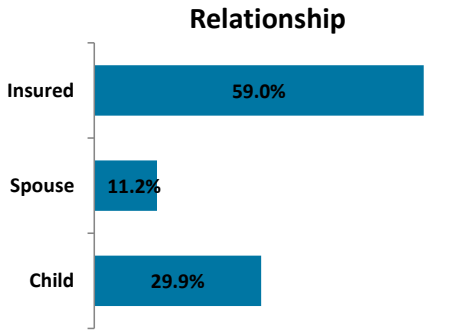


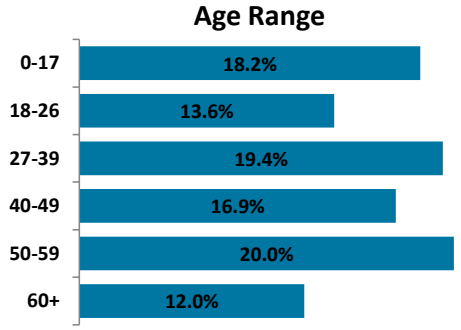


AHRQ Category – Mental, Behavioral, and Neurodevelopment Disorders

Diagnosis Category	Patients	Claims	Total Paid	% Paid
Depressive Disorders	630	4,819	$1,025,617	28.0%
Trauma- And Stressor-Related Disorders	537	4,107	$574,777	15.7%
Alcohol-Related Disorders	54	349	$469,602	12.8%
Anxiety And Fear-Related Disorders	686	3,189	$467,377	12.7%
Neurodevelopmental Disorders	265	1,966	$250,330	6.8%
Bipolar And Related Disorders	114	943	$174,732	4.8%
Miscellaneous Mental And Behavioral Disorders/Conditions	35	125	$169,316	4.6%
Feeding And Eating Disorders	16	211	$111,225	3.0%
Other Specified And Unspecified Mood Disorders	36	172	$102,544	2.8%
Opioid-Related Disorders	23	229	$93,424	2.5%
Suicidal Ideation/Attempt/Intentional Self-Harm	31	84	$65,719	1.8%
Schizophrenia Spectrum And Other Psychotic Disorders	24	188	$40,789	1.1%
Obsessive-Compulsive And Related Disorders	22	258	$34,766	0.9%
Mental And Substance Use Disorders In Remission	77	238	$31,975	0.9%
Other Specified Substance-Related Disorders	24	73	$14,105	0.4%
Disruptive, Impulse-Control And Conduct Disorders	15	51	$11,581	0.3%
Cannabis-Related Disorders	9	18	$8,666	0.2%
Somatic Disorders	34	59	$7,969	0.2%
Stimulant-Related Disorders	6	29	$6,579	0.2%
Tobacco-Related Disorders	46	74	$4,296	0.1%
Personality Disorders	8	22	$1,259	0.0%
Suicide Attempt/Intentional Self-Harm; Subsequent Encounter	1	1	$146	0.0%
Hallucinogen-Related Disorders	1	1	$0	0.0%
	----	----	$3,666,794	100.0%

*Patient and claim counts are unique only within the category

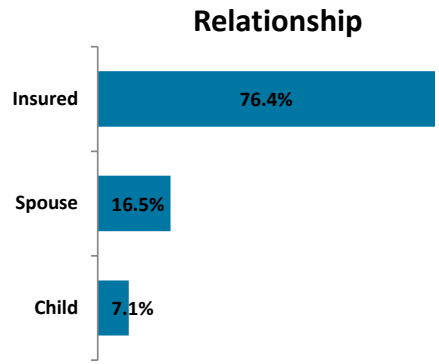


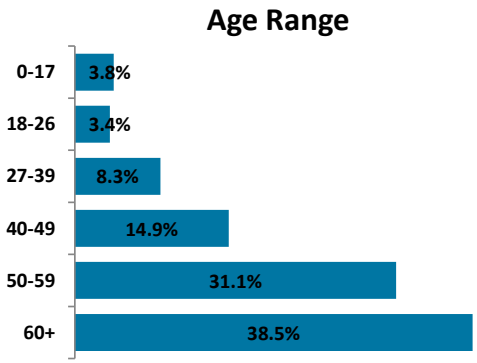


AHRQ Category – Diseases of the Circulatory System

Diagnosis Category	Patients	Claims	Total Paid	% Paid
Cardiac Dysrhythmias	186	872	$1,014,880	27.8%
Nonspecific Chest Pain	412	1,161	$724,886	19.9%
Coronary Atherosclerosis And Other Heart Disease	139	353	$214,860	5.9%
Essential Hypertension	853	1,744	$211,406	5.8%
Nonrheumatic And Unspecified Valve Disorders	78	181	$209,277	5.7%
Acute Myocardial Infarction	23	103	$196,541	5.4%
Heart Failure	42	213	$132,385	3.6%
Peripheral And Visceral Vascular Disease	54	111	$111,729	3.1%
Varicose Veins Of Lower Extremity	47	161	$106,057	2.9%
Acute Phlebitis; Thrombophlebitis And Thromboembolism	41	154	$102,310	2.8%
Cerebral Infarction	35	128	$69,310	1.9%
Aortic; Peripheral; And Visceral Artery Aneurysms	19	56	$59,701	1.6%
Other Specified Diseases Of Veins And Lymphatics	26	84	$57,733	1.6%
Chronic Phlebitis; Thrombophlebitis And Thromboembolism	8	26	$48,431	1.3%
Hypertension With Complications And Secondary Hypertension	30	59	$39,833	1.1%
Postthrombotic Syndrome And Venous Insufficiency/Hypertension	25	50	$34,715	1.0%
Acute Pulmonary Embolism	20	66	$34,555	0.9%
Sequela Of Cerebral Infarction And Other Cerebrovascular Disease	6	23	$32,509	0.9%
Chronic Rheumatic Heart Disease	17	23	$31,235	0.9%
Acute Hemorrhagic Cerebrovascular Disease	5	13	$30,519	0.8%
Occlusion Or Stenosis Of Precerebral Or Cerebral Arteries Without Infarction	47	93	$23,207	0.6%
Myocarditis And Cardiomyopathy	26	83	$21,005	0.6%
Other And Ill-Defined Cerebrovascular Disease	27	51	$19,016	0.5%
Other And Ill-Defined Heart Disease	41	61	$18,028	0.5%
Cardiac Arrest And Ventricular Fibrillation	5	41	$16,927	0.5%
Other Specified And Unspecified Circulatory Disease	29	53	$15,563	0.4%
Hypotension	14	40	$14,623	0.4%
Conduction Disorders	53	105	$14,233	0.4%
Pericarditis And Pericardial Disease	9	22	$13,190	0.4%
Aortic And Peripheral Arterial Embolism Or Thrombosis	17	22	$12,822	0.4%
Pulmonary Heart Disease	11	22	$12,755	0.3%
Sequela Of Hemorrhagic Cerebrovascular Disease	1	3	$4,569	0.1%
Postprocedural Or Postoperative Circulatory System Complication	1	1	$217	0.0%
Endocarditis And Endocardial Disease	1	1	$90	0.0%
Gangrene	2	3	$30	0.0%
Complications Of Acute Myocardial Infarction	1	1	$0	0.0%
Overall	**----**	**----**	**$3,649,144**	**100.0%**

*Patient and claim counts are unique only within the category

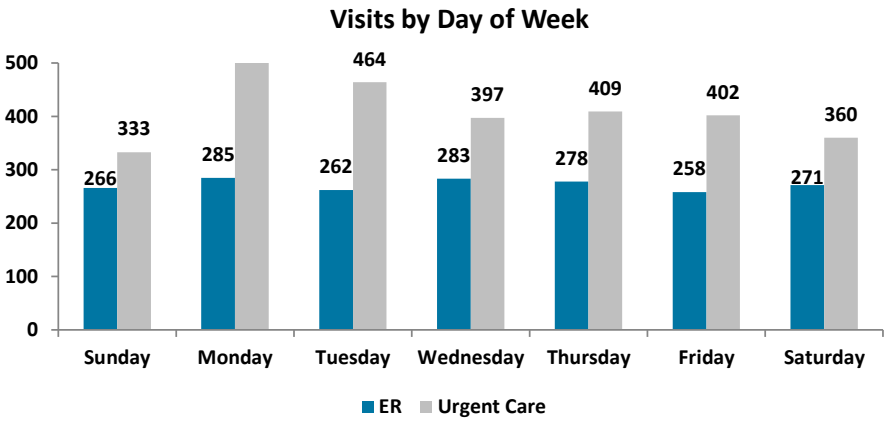


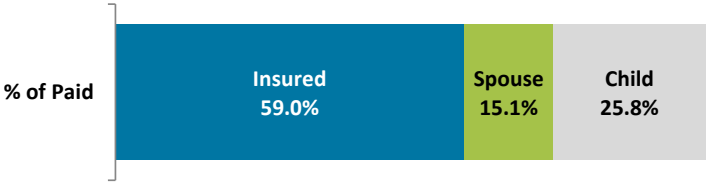


Emergency Room / Urgent Care Summary

	PY19		PY20		HSB Peer Index	
ER/Urgent Care	**ER**	**Urgent Care**	**ER**	**Urgent Care**	**ER**	**Urgent Care**
Number of Visits	1,454	2,449	1,903	2,892		
Number of Admits	192	----	309	----		
Visits Per Member	0.17	0.29	0.22	0.33	0.17	0.24
Visits/1000 Members	171	288	217	330	174	242
Avg Paid Per Visit	$2,606	$139	$2,649	$156	$1,684	$74
Admits per Visit	0.13	----	0.16	----	0.14	
% of Visits with HSB ER Dx	79.4%	----	80.1%	----		
% of Visits with a Physician OV*	67.9%	67.3%	85.5%	81.9%		
Total Plan Paid	**$3,788,451**	**$341,606**	**$5,040,452**	**$452,314**		

*looks back 12 months from ER visit



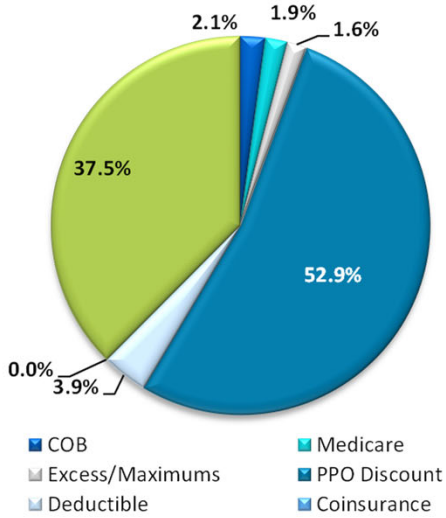


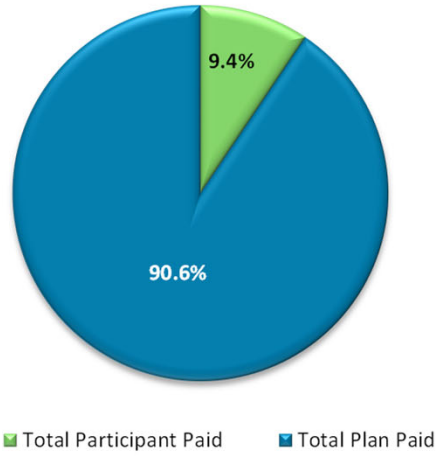
ER / UC Visits by Relationship						
Relationship	**ER**	**Per 1,000**	**Urgent Care**	**Per 1,000**	**Total**	**Per 1,000**
Insured	1,100	229	1,673	349	2,773	578
Spouse	242	253	282	294	524	547
Child	561	186	937	311	1,498	497
Total	**1,903**	**217**	**2,892**	**330**	**4,795**	**547**

Savings Summary – Medical Claims

Description	Dollars	PPPM	% of Eligible
Eligible Charges	$133,987,638	$2,329	100.0%
COB	$2,847,312	$49	2.1%
Medicare	$2,531,843	$44	1.9%
Excess/Maximums	$2,208,251	$38	1.6%
PPO Discount	$70,877,003	$1,232	52.9%
Deductible	$5,229,202	$91	3.9%
Coinsurance	$140	$0	0.0%
Total Participant Paid	**$5,229,342**	**$91**	**3.9%**
Total Plan Paid	**$50,293,887**	**$874**	**37.5%**

Total Participant Paid - PY19	**$77**
Total Plan Paid - PY19	**$729**





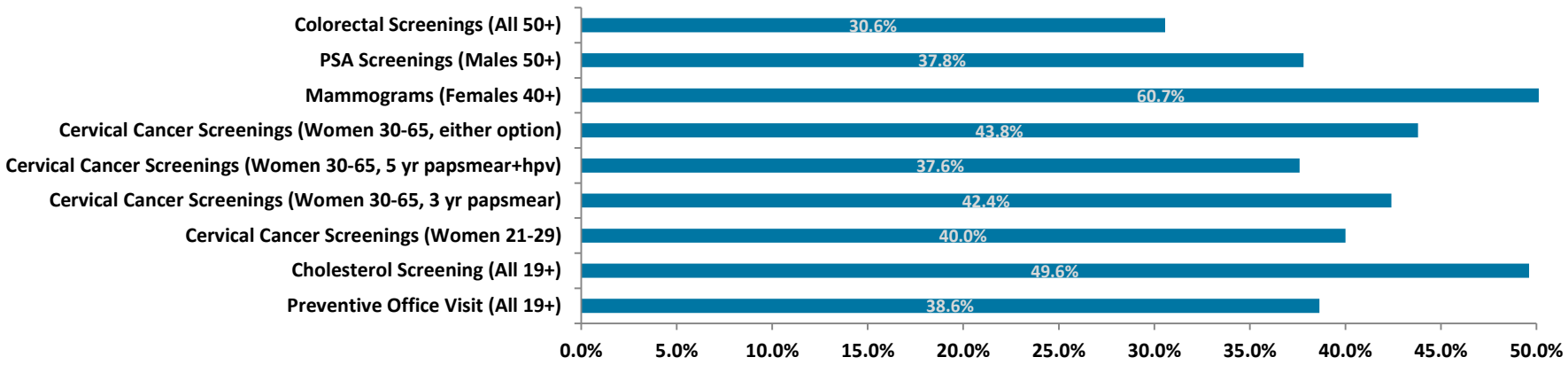
Preventive Services Compliance

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

Colorectal screenings look back to July 2011.

	Female			Male			Total		
Service	**Eligible**	**Compliant**	**% Compliant**	**Eligible**	**Compliant**	**% Compliant**	**Eligible**	**Compliant**	**% Compliant**
Preventive Office Visit (All 19+)	3,723	1,780	47.8%	2,763	727	26.3%	6,486	2,506	38.6%
Cholesterol Screening (All 19+)	3,723	1,902	51.1%	2,763	1,315	47.6%	6,486	3,218	49.6%
Cervical Cancer Screenings (Women 21-29)	462	185	40.0%	----	----	----	462	185	40.0%
Cervical Cancer Screenings (Women 30-65, 3 yr papsmear)	2,941	1,247	42.4%	----	----	----	2,941	1,247	42.4%
Cervical Cancer Screenings (Women 30-65, 5 yr papsmear+hpv)	2,941	1,106	37.6%	----	----	----	2,941	1,106	37.6%
Cervical Cancer Screenings (Women 30-65, either option)	2,941	1,288	43.8%	----	----	----	2,941	1,288	43.8%
Mammograms (Females 40+)	2,476	1,503	60.7%	----	----	----	2,476	1,503	60.7%
PSA Screenings (Males 50+)	----	----	----	1,361	514	37.8%	1,361	514	37.8%
Colorectal Screenings (All 50+)	1,764	584	33.1%	1,361	372	27.3%	3,125	955	30.6%

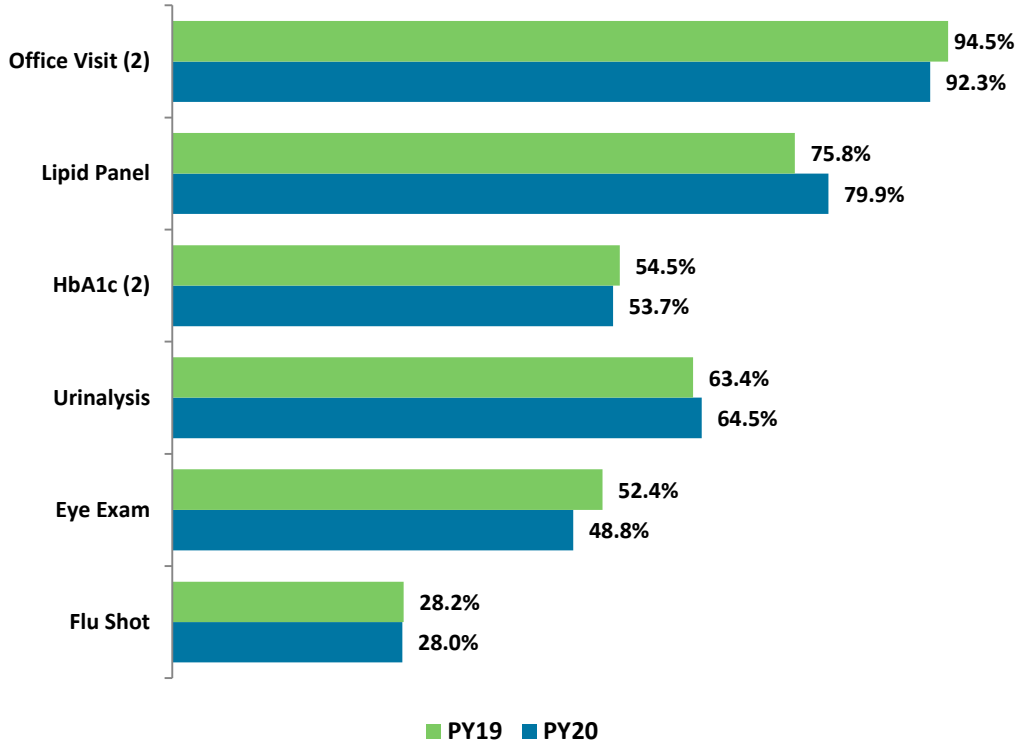
Overall Preventive Services Compliance Rates



Diabetic Disease Compliance

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

Diabetic Population		
Year	PY19	PY20
Members	525	569

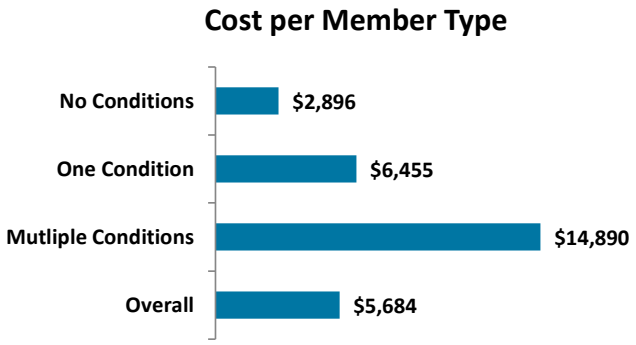


Chronic Conditions Summary

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

Condition	Total Members	Avg Members	Per 1,000	Avg Age	Total Cost	Average Cost	Compliance Rate	Compliance Measure
Asthma	405	386	46	38	$4,532,856	$11,192	99.8%	1 Office Visit
Cancer	303	285	35	58	$6,133,224	$20,242	----	----
Chronic Kidney Disease	72	67	8	57	$1,695,299	$23,546	----	----
Chronic Obstructive Pulmonary Disease (COPD)	88	84	10	60	$2,000,433	$22,732	98.9%	1 Office Visit
Congestive Heart Failure (CHF)	38	36	4	62	$1,606,586	$42,279	13.2%	1 Office Visit, 1 Lipid Profile, 1 Wellness Visit
Coronary Artery Disease (CAD)	134	126	15	61	$2,566,873	$19,156	17.9%	1 Office Visit, 1 Lipid Profile, 1 Wellness Visit
Depression	624	587	71	40	$6,539,935	$10,481	97.8%	1 Office Visit
Diabetes	557	518	64	55	$5,842,181	$10,489	21.9%	2 Office Visits, 1 Lipid Profile, 2 HbA1c's, 1 Urinalysis, 1 Eye Exam, 1 Flu Shot
Hyperlipidemia	703	668	80	55	$5,790,892	$8,237	33.1%	1 Office Visit, 1 Lipid Profile, 1 Wellness Visit
Hypertension	842	803	96	57	$9,814,868	$11,657	24.6%	1 Office Visit, 1 Lipid Profile, 1 Wellness Visit
Obesity	268	257	31	46	$2,364,221	$8,822	0.0%	----

# of Conditions	Avg Members	Average Age	Relationship		
			Insured	Spouse	Child
No Conditions	5,145	29	41.4%	9.5%	49.1%
One Condition	2,228	46	70.0%	14.0%	16.0%
Multiple Conditions	1,372	54	79.5%	16.5%	4.1%
Overall	**8,746**	**37**	**53.7%**	**11.6%**	**34.7%**



Public Employees' Benefits Program - RX Costs
PY 2020 - Quarter Ending June 30, 2020

Express Scripts

Membership Summary	4Q FY2020 EPO	4Q FY2019 EPO	Difference	% Change
			Membership Summary	
Member Count (Membership)	8,770	8,502	268	3.2%
Utilizing Member Count (Patients)	7,335	7,125	210	2.9%
Percent Utilizing (Utilization)	83.6%	83.8%	(0)	-0.2%
Claim Summary			**Claims Summary**	
Net Claims (Total Rx's)	173,467	164,703	8,764	5.3%
Claims per Elig Member per Month (Claims PMPM)	1.65	1.61	0.04	2.5%
Total Claims for Generic (Generic Rx)	149,919	142,994	6,925.00	4.8%
Total Claims for Brand (Brand Rx)	23,548	21,709	1,839.00	8.5%
Total Claims for Brand w/Gen Equiv (Multisource Brand Claims)	3,052	2,581	471.00	18.2%
Total Non-Specialty Claims	171,180	162,648	8,532.00	5.2%
Total Specialty Claims	2,287	2,055	232.00	11.3%
Generic % of Total Claims (GFR)	**86.4%**	**86.8%**	(0.00)	-0.5%
Generic Effective Rate (GCR)	**98.0%**	**98.2%**	(0.00)	-0.2%
Mail Order Claims	17,727	13,898	3,829.00	27.6%
Mail Penetration Rate*	11.3%	9.3%	0.02	2.0%
Claims Cost Summary			**Claims Cost Summary**	
Total Prescription Cost (Total Gross Cost)	$20,172,183.00	$16,878,075.00	$3,294,108.00	19.5%
Total Generic Gross Cost	$3,357,224.00	$3,937,390.00	($580,166.00)	-14.7%
Total Brand Gross Cost	$16,814,959.00	$12,940,685.00	$3,874,274.00	29.9%
Total MSB Gross Cost	$676,195.00	$428,203.00	$247,992.00	57.9%
Total Ingredient Cost	$20,093,269.00	$16,800,876.00	$3,292,393.00	19.6%
Total Dispensing Fee	$74,299.00	$74,791.00	($492.00)	-0.7%
Total Other (e.g. tax)	$4,616.00	$2,409.00	$2,207.00	91.6%
Avg Total Cost per Claim (Gross Cost/Rx)	**$116.29**	**$102.48**	$13.81	13.5%
Avg Total Cost for Generic (Gross Cost/Generic Rx)	$22.39	$27.54	($5.15)	-18.7%
Avg Total Cost for Brand (Gross Cost/Brand Rx)	$714.07	$596.10	$117.97	19.8%
Avg Total Cost for MSB (MSB Gross Cost/MSB ARx)	$221.56	$165.91	$55.65	33.5%
Member Cost Summary			**Member Cost Summary**	
Total Member Cost	**$2,655,465.00**	**$2,444,825.00**	$210,640.00	8.6%
Total Copay	$2,655,465.00	$2,444,825.00	$210,640.00	8.6%
Total Deductible	$0.00	$0.00	$0.00	0.0%
Avg Copay per Claim (Copay/Rx)	$15.31	$14.84	$0.46	3.1%
Avg Participant Share per Claim (Copay+Deductible/RX)	**$15.31**	**$14.84**	**$0.46**	**3.1%**
Avg Copay for Generic (Copay/Generic Rx)	$7.07	$6.27	$0.80	12.8%
Avg Copay for Brand (Copay/Brand Rx)	$67.75	$71.31	($3.56)	-5.0%
Avg Copay for Brand w/ Generic Equiv (Copay/Multisource Rx)	$27.49	$25.99	$1.50	5.8%
Net PMPM (Participant Cost PMPM)	**$25.23**	**$23.96**	$1.27	5.3%
Copay % of Total Prescription Cost (Member Cost Share %)	13.2%	14.5%	-1.3%	-9.1%
Plan Cost Summary			**Plan Cost Summary**	
Total Plan Cost (Plan Cost)	**$17,516,718.00**	**$14,433,250.00**	**$3,083,468.00**	**21.4%**
Total Non-Specialty Cost (Non-Specialty Plan Cost)	$8,049,281.00	$7,920,839.00	$128,442.00	1.6%
Total Specialty Drug Cost (Specialty Plan Cost)	$9,467,437.00	$6,512,411.00	$2,955,026.00	45.4%
Avg Plan Cost per Claim (Plan Cost/Rx)	**$100.98**	**$87.63**	$13.35	15.2%
Avg Plan Cost for Generic (Plan Cost/Generic Rx)	$15.32	$21.26	($5.94)	-27.9%
Avg Plan Cost for Brand (Plan Cost/Brand Rx)	$646.33	$524.79	$121.54	23.2%
Avg Plan Cost for MSB (MSB Plan Cost/MSB ARx)	$194.07	$139.91	$54.16	38.7%
Net PMPM (Plan Cost PMPM)	**$166.45**	**$141.47**	**$24.98**	**17.7%**
PMPM for Specialty Only (Specialty PMPM)	$89.96	$63.83	$26.13	40.9%
PMPM without Specialty (Non-Specialty PMPM)	$76.48	$77.64	($1.16)	-1.5%
Rebates (Q1-Q4 FY2020 actual)	$3,858,361.77	$1,508,587.15	**$2,349,774.62**	**155.8%**
Net PMPM (Plan Cost PMPM factoring Rebates)	**$129.78**	**$168.36**	**($38.58)**	**-22.9%**
PMPM for Specialty Only (Specialty PMPM)	$77.77	$54.70	$23.07	42.2%
PMPM without Specialty (Non-Specialty PMPM)	$50.28	$54.33	($4.05)	-7.5%

Appendix C

Index of Tables
Health Plan of Nevada –Utilization Review for PEBP
July 1, 2019 – June 30, 2020

KEY PERFORMANCE INDICATORS

PRESCRIPTION DRUG COSTS

Power Of Partnership.

Quarterly Health Plan Performance Review
Prepared for PEBP

Claims Data: July 1, 2019 – June 3 , 2020
Paid through July 31, 2020
30 day claims run out

State of Nevada

37 years experience caring for Nevadans and their families

Member Centered Solutions

Access to Southwest Medical/OptumCare

Cost Structure & Network Strength

Local Service & Wellness Resources

On-Site Hospital Case Managers

Our Care Delivery Assets in Nevada

- ✓ 45 OptumCare locations and expanding
- ✓ Over 450 providers practicing evidence-based medicine
- ✓ 6 high acuity urgent cares with home waiting room option
- ✓ Patient portal with e-visit capabilities
- ✓ Robust integrated EMR
- ✓ Access to schedule, renew script and view test results
- ✓ 7 convenient care walk-in locations
- ✓ 2 ambulatory surgery centers
- ✓ Brand new 55,000 sq ft state-of-the-art cancer center
- ✓ Saturday appointments with primary care

Enhancements Made for Your Members

- ✓ NowClinic and Walgreens now offering same-day medication delivery
- ✓ Added HCA hospitals and 17 Care Now Urgent Cares to the network
- ✓ Launched new HPN App
- ✓ Continued expansion of specialty network
- ✓ Real Appeal weight loss program
- ✓ Dispatch Health to provide at home urgent visits
- ✓ Pilot on continuous glucose monitoring for diabetics to improve outcomes and management of medication

Key Performance Indicators

Includes Demographics And Financials

Demographic and Financial Overview

UnitedHealthcare

Demographics

Membership	Age	Famiy size	Children <18	HHS Risk
Members: 6,871 Employees: 3,954	37.2	1.74	22.4%	1.76
Prior: 6,699 3,883	Prior : 37.9	Prior : 1.73	Prior: 21.8%	Prior: 1.72
	Norm: 36	Norm: 1.74	Norm: 20.5	Norm: 1.37
▲ 2.6%	▼ -1.7%	▲ 0.7%	▲ 3.2%	▲ 2.6%

Medical and Rx Spend

2.1%
Medical PMPM
$300.91
Prior $294.73
Norm: $246.92

Utilization
Inpatient: ▼ -8.0%
Outpatient: ▼ -12.5%
Professional: ▼ -1.3%

Spend
Inpatient: ▲ 5.4%
Outpatient: ▼ -3.4%
Professional: ▲ 11.2%

▲ 1.7%
Overall PMPM
$422.64
Prior: $415.44
Norm: $328.93

-0.3%
Specialty Rx
$60.22
Prior: $59.87
Norm: $35.78

0.8%
Avg. Scripts PMPY
17.8
Prior: 17.7
Norm: 11.4

0.9%
Rx PMPM
$121.74
Specialty Rx accounts for 49.4% of Rx Spend
Prior: $120.71
Norm: $82.01

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Medical and Rx Plan Experience

What Happened

Highlights of Utilization

Utilization Metric	Prior	Current	Δ
Physician Office Visits			
Per Member Per Year	2.0	2.0	-0.5%
Specialist Office Visits			
Per Member Per Year	4.9	4.9	-0.6%
Emergency Room			
ER Visits	742	732	-1.3%
ER Visits per K	110.8	106.6	-3.8%
Urgent Care			
UC Visits	4,258	3,801	-10.7%
UC Visits per K	635.6	553.2	-13.0%
OutPatient Surgery			
Facility	37.9	35.8	-5.6%
ASC	140.9	110.6	-21.5%
Inpatient Utilization			
Admissions Per K	65.8	60.5	-8.0%
Bed Days Per K	272.3	267.2	-1.9%
Average Length of Stay	4.1	4.4	6.7%
On Demand			
Now Clinic Visits	534	651	21.9%
TAN Calls	494	460	-6.9%

*Not representative of all Utilization

Highlights

- PCP and Specialist visits stayed flat on a PMPY basis year over year
- ER utilization decreased **-3.8%**,
  - Average Net Paid / Visit saw a slight increased **0.3%**
- Urgent Care Utilization decreased **-13.0%**
- Outpatient surgeries decreased at both facility and ASC settings
- Admits Per K decreased -**8.0%** from prior period, but ALOS increased **6.7%** due to more complex stays
- Increased Telehealth utilization
  - We will continue to see increases in these services as a result of COVID-19
  - *On Demand utilization is understated due to claims lag*

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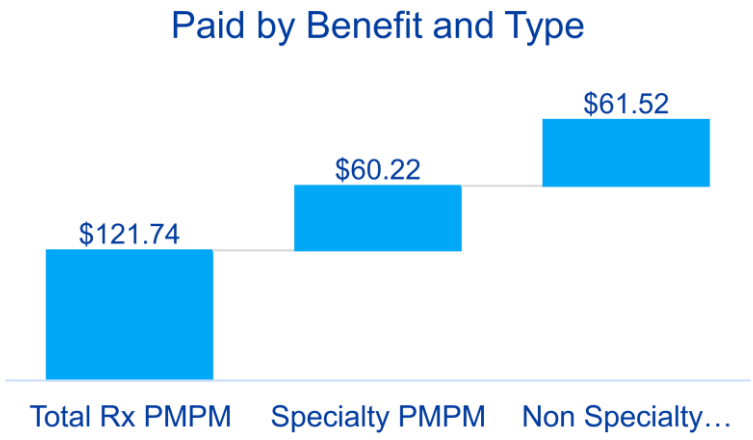
Pharmacy Data

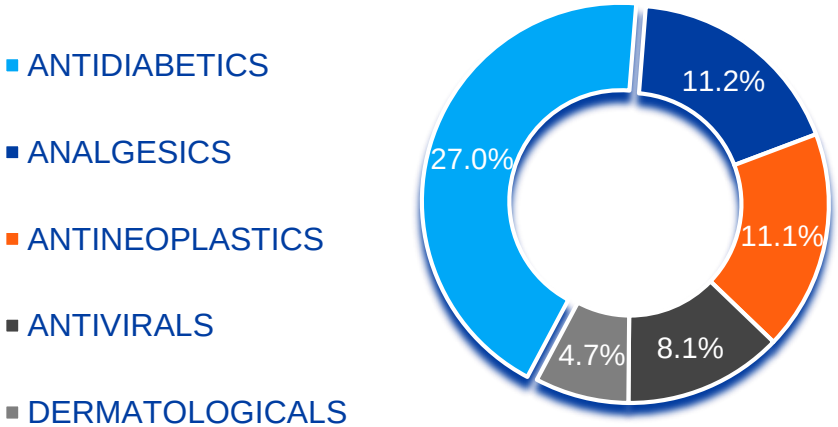
	Prior	Current	Δ	Peer	Δ
Enrolled Members	6,699	6,871	2.6%		
Average Prescriptions PMPY	17.7	17.8	0.8%	11.4	56.3%
Formulary Rate	93.4%	93.6%	0.1%	92.4%	1.3%
Generic Use Rate	87.4%	87.2%	-0.2%	87.2%	0.0%
Generic Substitution Rate	97.3%	97.1%	-0.2%	96.5%	0.6%
Employee Cost Share PMPM	$20.08	$19.62	-2.3%	$13.17	49.0%
Avg Net Paid per Prescription	$81.95	$82.02	0.1%	$86.35	-5.0%
Net Paid PMPM	$120.71	$121.74	0.9%	$82.01	48.5%



Pharmacy PMPM trend is 0.9%

- Average net paid per script increased **0.1%**
- **82.6%** of prescriptions were in Tier 1 and drove only **11.0%** of spend
- Tier 2 utilization increased **14.5%** and spend increased **27.8%**
- Humira continues to increase in spend and utilization

Top 5 Therapuetic Classes by Spend



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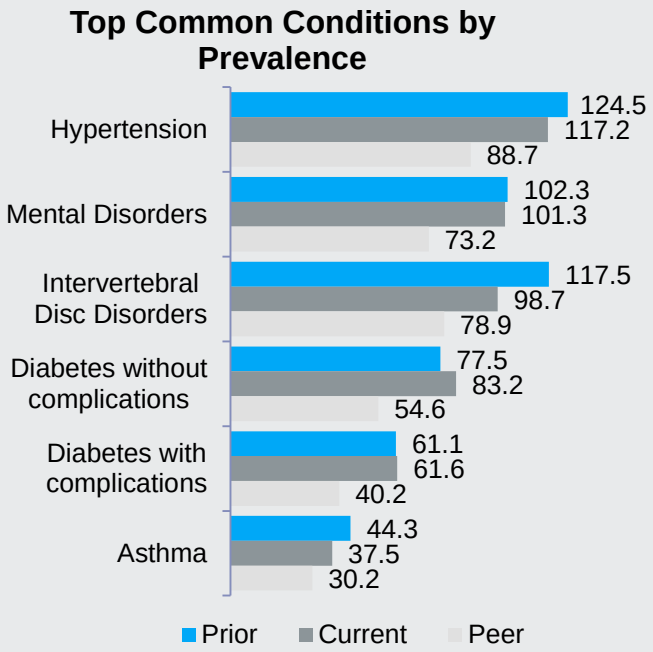
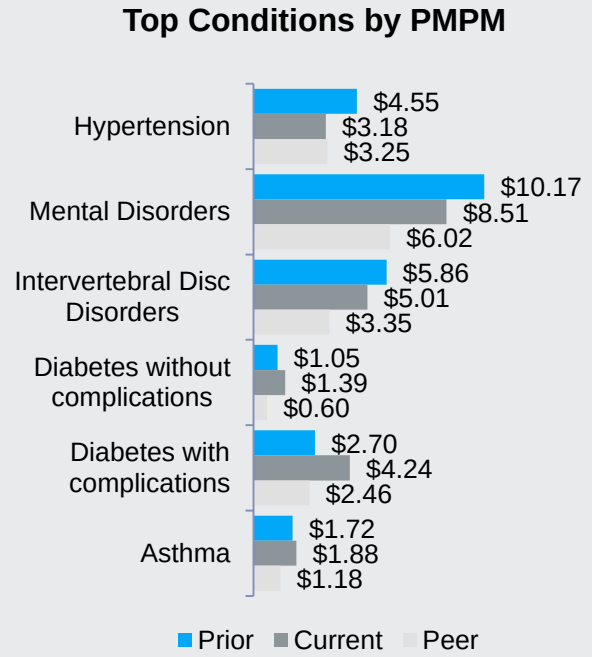
Condition Prevalence

Clinical Drivers

Clinical Conditions and Diagnosis





- Chronic illnesses are driving the top common conditions
- Hypertension, Mental Disorders, Intervertebral Disc Disorders and are the most prevalent clinical conditions within this population
- Prevalence of Diabetes both with and w/out complications increased YOY
- Mental Disorders remained relatively flat year over year, but spend decreased **-16.4%** from prior period

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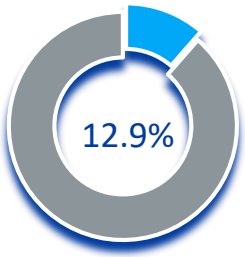
Chronic Condition Cost Drivers

UnitedHealthcare

65% Of Medical spend driven by members with these 4 Chronic Conditions

Asthma

6.9% of Members

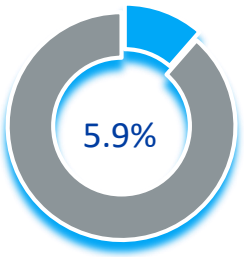


Average paid Per Claimant **$7,704**

Member Engagement **94.2%**

CAD

1.5% of Members

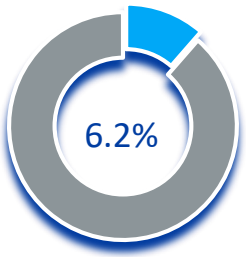


Average paid Per Claimant **$16,213**

Member Engagement **99.0%**

COPD

2.9% of Members

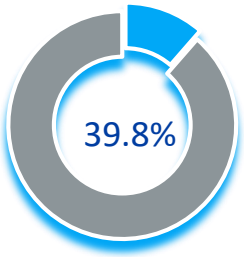


Average paid Per Claimant **$8,928**

Member Engagement **92.8%**

Diabetes

20.4% of Members



Average paid Per Claimant **$8,015**

Member Engagement **93.1**

**Data obtained for this slide is for Eval period Aug-2019 thru Jul-2020*

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Catastrophic Cases

High Cost Claimants

Catastrophic Cases Summary (>$50k)

UnitedHealthcare

8.5 Catastrophic Cases Per 1000

Prior: 7.5 ▲ 14.1%

67 Individuals
.86% of the population

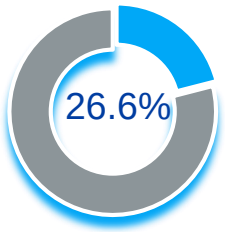
$104,729
Average Paid Per Case

Prior: $112,594 ▼ -7.0%

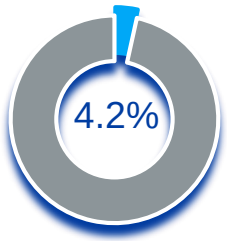
% of Spend as High Cost
20.1%

% Paid Attributed to Catastrophic Cases

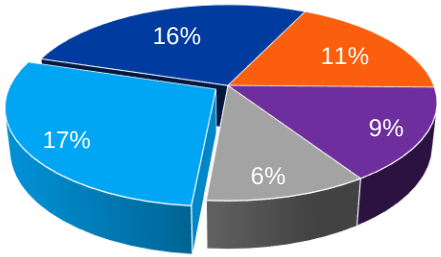
Medical



Pharmacy

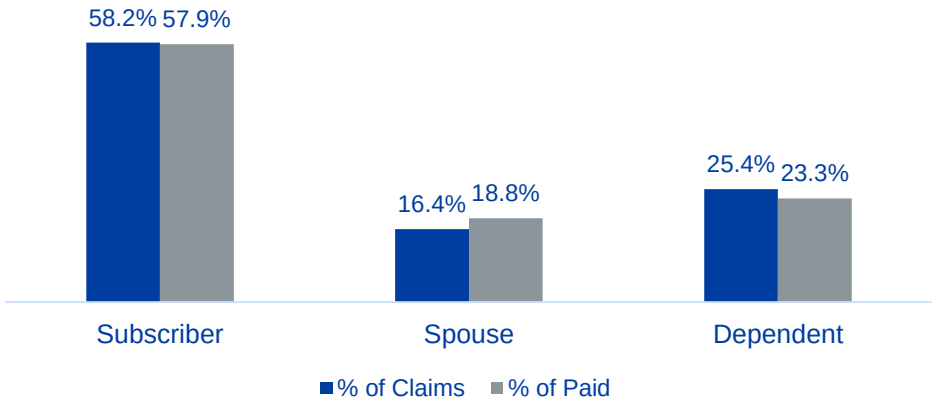


Top 5 AHRQ Chapter Description by Paid



- Neoplasms
- Diseases of the circulatory system
- Complications of pregnancy
- ill-defined conditions and factors influencing health status

Claims and Spend by Relationship



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4.3

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

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 & Performance Report

4.3.6 Hometown Health Providers and Sierra Healthcare Options – PPO Network

4.3.7 HealthPlan of Nevada, Inc. – Southern HMO

4.3.8 Doctor on Demand Engagement Reports through July 2020

4.3.1

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

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

        4.3.1 HealthSCOPE Benefits – Obesity Care Management

HSB DATASCOPE™

Obesity Care Management Report

Nevada Public Employees' Benefits Program

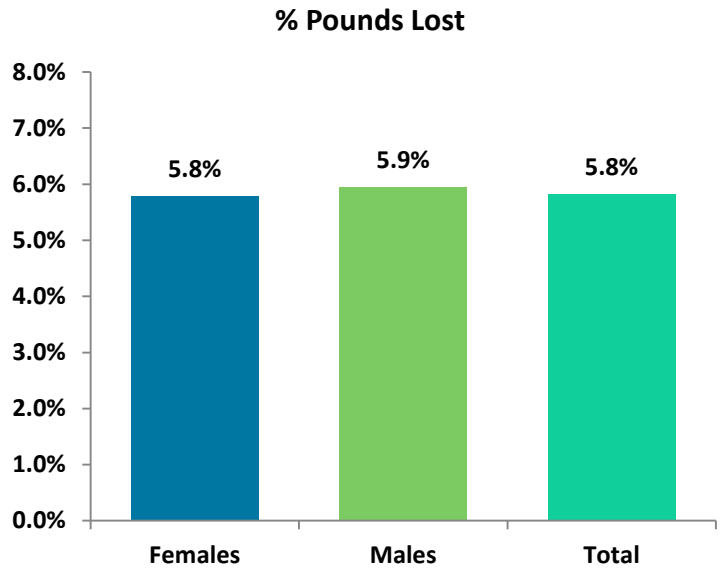
July 2019 – June 2020

HealthSCOPE BENEFITS

Obesity Care Management Overview

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

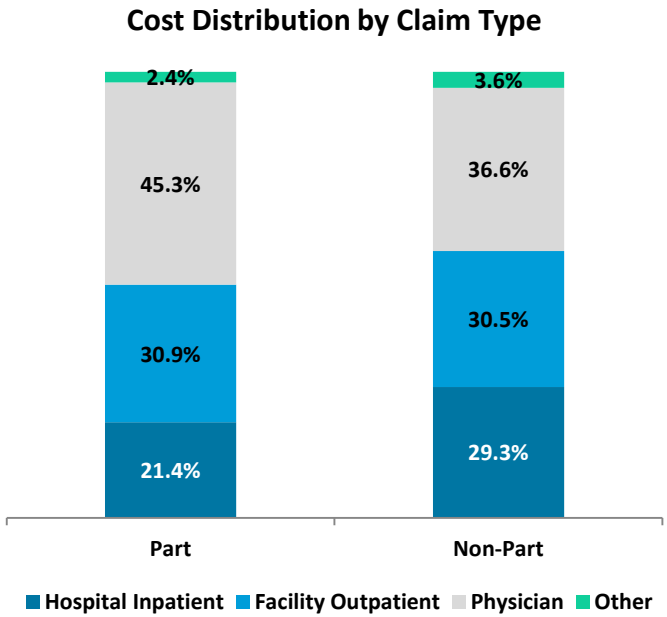
PEBP PY20			
Weight Management Summary	**Females**	**Males**	**Total**
# Mbrs Enrolled in Program	966	255	1,221
Average # Lbs. Lost	10.7	14.6	11.5
Total # Lbs. Lost	10,309.3	3,718.2	14,027.5
% Lbs. Lost	5.8%	5.9%	5.8%
Average Cost/ Member	$4,472	$4,567	$4,492



Obesity Care Management – Financial Summary

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

Summary	Participants	Non-Participants	Variance
Enrollment			
Avg # Employees	1,030	583	76.7%
Avg # Members	1,141	774	47.4%
Member/Employee Ratio	1.1	1.3	-16.5%
Financial Summary			
Gross Cost	$7,069,937	$7,749,221	
Client Paid	$5,485,450	$6,465,385	
Employee Paid	$1,584,487	$1,283,836	
Client Paid-PEPY	$5,324	$11,088	-52.0%
Client Paid-PMPY	$4,809	$8,355	-42.4%
Client Paid-PEPM	$444	$924	-51.9%
Client Paid-PMPM	$401	$696	-42.4%
High Cost Claimants (HCC's) > $100k			
# of HCC's	5	7	
HCC's / 1,000	4.4	9.1	0.0%
Avg HCC Paid	$152,416	$279,389	0.0%
HCC's % of Plan Paid	13.9%	30.2%	0.0%
Cost Distribution - PMPY			
Hospital Inpatient	$1,030	$2,449	-57.9%
Facility Outpatient	$1,484	$2,547	-41.7%
Physician	$2,179	$3,059	-28.8%
Other	$116	$300	-61.3%
Total	$4,809	$8,355	-42.4%



Obesity Care Management – Utilization Summary

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

Summary	Participants	Non-Participants	Variance
Inpatient Facility			
# of Admits	75	69	
# of Bed Days	265	512	
Paid Per Admit	$16,031	$27,785	-42.3%
Paid Per Day	$4,537	$3,744	21.2%
Admits Per 1,000	66	89	-25.8%
Days Per 1,000	232	662	-65.0%
Avg LOS	3.5	7.4	-52.7%
Physician Office			
OV Utilization per Member	9.5	8.4	13.1%
Avg Paid per OV	$78	$67	16.4%
Avg OV Paid per Member	$736	$562	31.0%
DX&L Utilization per Member	15.3	18.1	-15.5%
Avg Paid per DX&L	$51	$60	-15.0%
Avg DX&L Paid per Member	$782	$1,089	-28.2%
Emergency Room			
# of Visits	300	241	
# of Admits	34	28	
Visits Per Member	0.26	0.31	-16.1%
Visits Per 1,000	263	311	-15.4%
Avg Paid per Visit	$2,654	$2,608	1.8%
Admits Per Visit	0.11	0.12	-8.3%
Urgent Care			
# of Visits	567	380	
Visits Per Member	0.50	0.49	2.0%
Visits Per 1,000	497	491	1.2%
Avg Paid per Visit	$62	$114	-45.6%

4.3.2

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

    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

HSB DATASCOPE™

Diabetes Care Management Report

Nevada Public Employees' Benefits Program

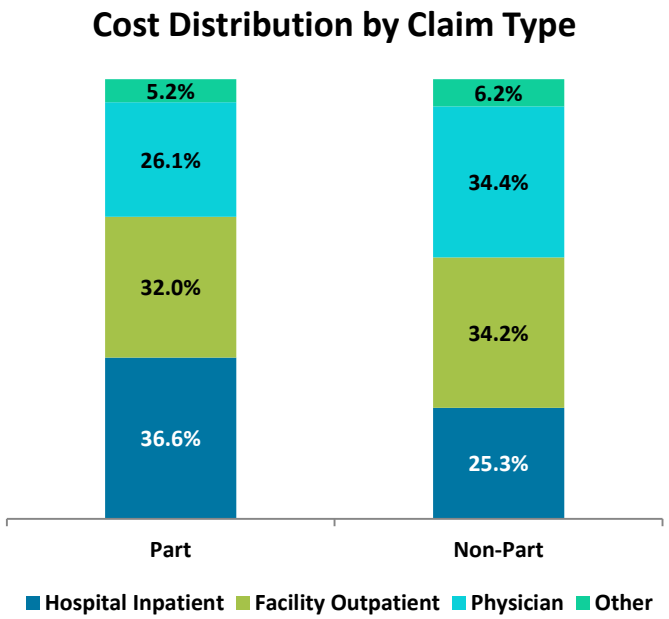
July 2019 – June 2020

HealthSCOPE BENEFITS

Diabetes Care Management – Financial Summary

*Non-Participant is defined as a member who has been diagnosed with diabetes in the past 12 months, but is not enrolled in the program
*Analysis based on active members

Summary	Participants	Non-Participants	Variance
Enrollment			
Avg # Employees	444	1,384	-67.9%
Avg # Members	618	1,752	-64.7%
Member/Employee Ratio	1.4	1.3	9.4%
Financial Summary			
Gross Cost	$5,811,206	$17,710,449	
Client Paid	$4,834,602	$14,830,569	
Employee Paid	$976,604	$2,879,880	
Client Paid-PEPY	$10,879	$10,714	1.5%
Client Paid-PMPY	$7,820	$8,463	-7.6%
Client Paid-PEPM	$907	$893	1.6%
Client Paid-PMPM	$652	$705	-7.5%
High Cost Claimants (HCC's) > $100k			
# of HCC's	9	17	
HCC's / 1,000	14.6	9.7	0.0%
Avg HCC Paid	$208,887	$179,650	0.0%
HCC's % of Plan Paid	38.9%	20.60%	0.0%
Cost Distribution - PMPY			
Hospital Inpatient	$2,866	$2,137	34.1%
Facility Outpatient	$2,505	$2,896	-13.5%
Physician	$2,039	$2,909	-29.9%
Other	$410	$521	-21.3%
Total	$7,820	$8,463	-7.6%



Diabetes Care Management – Utilization Summary

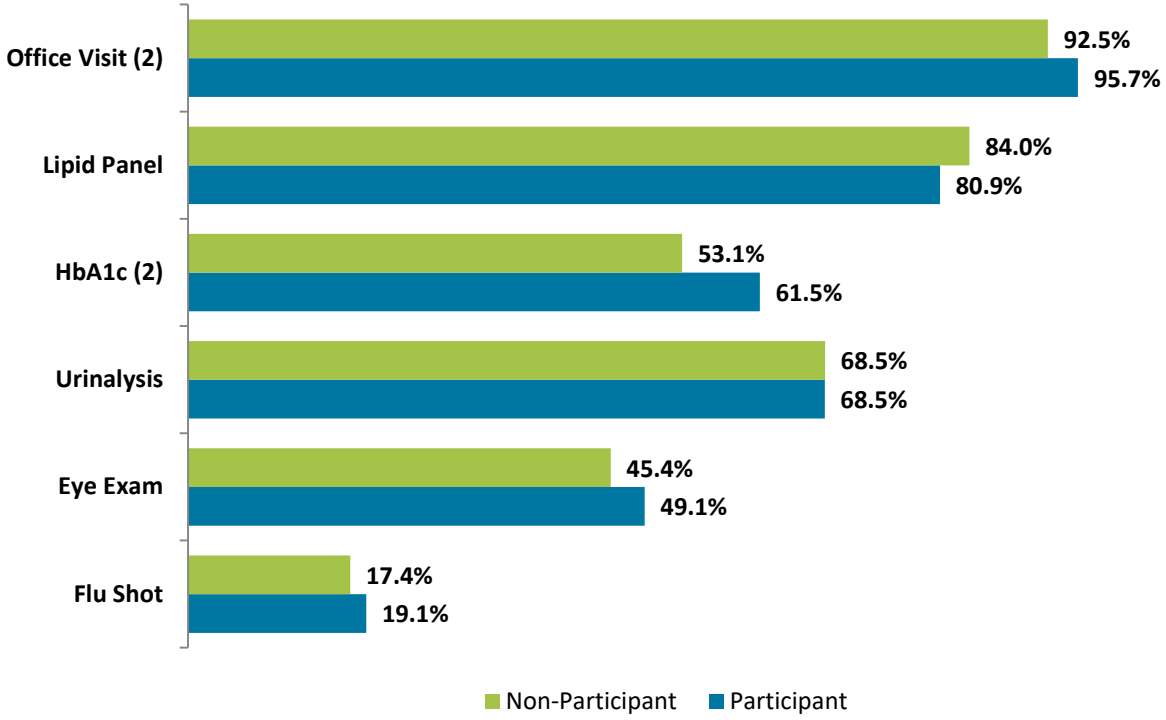
*Non-Participant is defined as a member who has been diagnosed with diabetes in the past 12 months, but is not enrolled in the program
*Analysis based on active members

Summary	Participants	Non-Participants	Variance
Inpatient Facility			
# of Admits	68	220	
# of Bed Days	374	1028	
Paid Per Admit	$26,355	$16,588	58.9%
Paid Per Day	$4,792	$3,550	35.0%
Admits Per 1,000	110	126	-12.7%
Days Per 1,000	605	587	3.1%
Avg LOS	5.5	4.7	17.0%
Physician Office			
OV Utilization per Member	6.9	8.5	-18.8%
Avg Paid per OV	$63	$65	-3.1%
Avg OV Paid per Member	$436	$550	-20.7%
DX&L Utilization per Member	16.5	22.1	-25.3%
Avg Paid per DX&L	$52	$57	-8.8%
Avg DX&L Paid per Member	$859	$1,260	-31.8%
Emergency Room			
# of Visits	160	627	
# of Admits	43	142	
Visits Per Member	0.26	0.36	-27.8%
Visits Per 1,000	259	358	-27.7%
Avg Paid per Visit	$2,049	$2,707	-24.3%
Admits Per Visit	0.27	0.23	17.4%
Urgent Care			
# of Visits	136	608	
Visits Per Member	0.22	0.35	-37.1%
Visits Per 1,000	220	347	-36.6%
Avg Paid per Visit	$140	$124	12.9%

Diabetic Compliance

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

Diabetic Population		
Year	Participant	Non-Participant
Members	444	1,835



4.3.3

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

    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

Public Employees' Benefits Program – State of Nevada

Medical Management Review

July 01, 2019 – June 30, 2020

AmericanHealth
American Health Holding Inc

Table of Contents

Executive Overview

Proprietary

Overview

This presentation contains information for **Public Employees' Benefits Program** and provides an overview of the **Utilization Management, Case Management, and Post-Discharge Counseling**.

All data included is as of **July 31, 2020** and covers the reporting period of **July 01, 2019 – June 30, 2020**; all tables and graphs reflect the reporting period unless expressly noted. When requested, prior period comparison details are provided and indicated on the associated graphs or charts.

Return on Investment

- Summary of medical management savings and ROI
  - Utilization Management savings are achieved through medical necessity reviews of inpatient bed days and outpatient services.
  - Case Management savings are estimated costs that would have been incurred to the plan, had we not intervened.

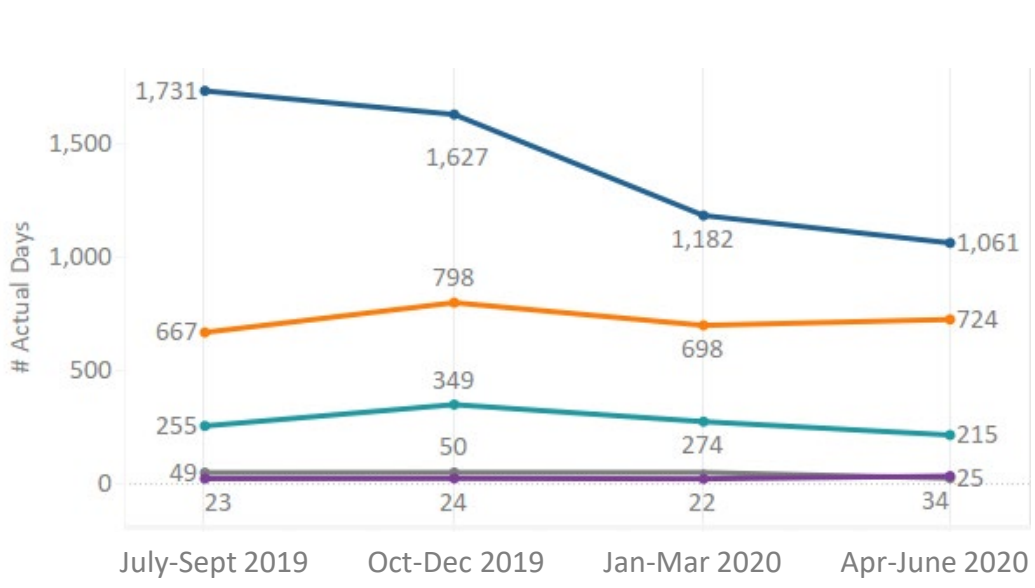
July 1, 2019 - June 30, 2020			
	Fees	**Estimated Savings**	**ROI**
Utilization Management	$741,701	$4,514,894	6.1 to 1
Case Management	$1,184,866	$4,186,698	3.5 to 1
Total	$1,926,567	$8,701,592	4.5 to 1

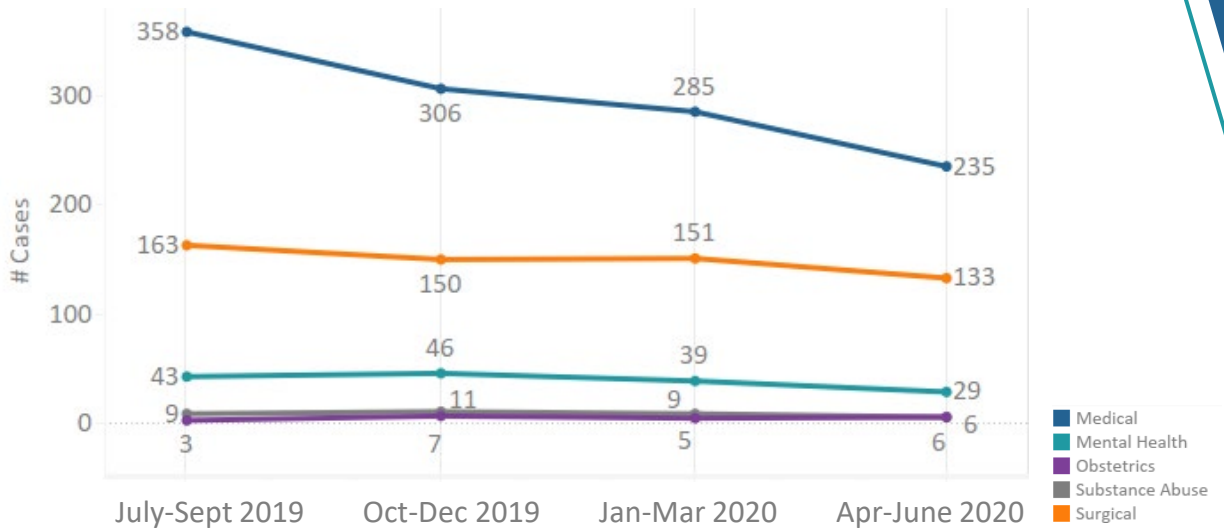
Utilization Management Breakout	
Inpatient Savings	$2,453,644
Outpatient Savings	$2,061,250

Utilization Management

Proprietary

Acute Inpatient Activity Summary



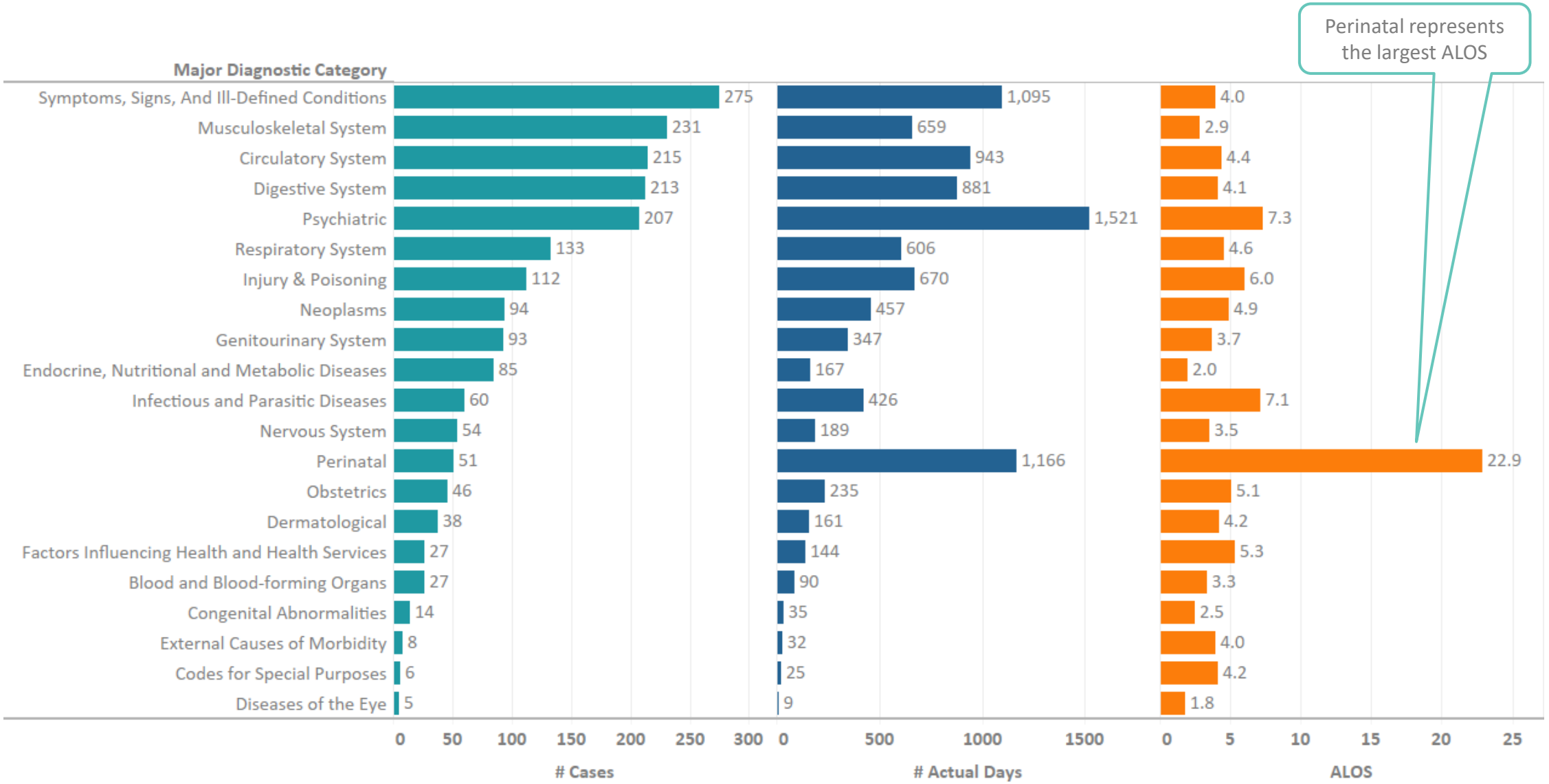


Utilization Review Process

Days Saved: 322
Estimated Savings: $2,342,120

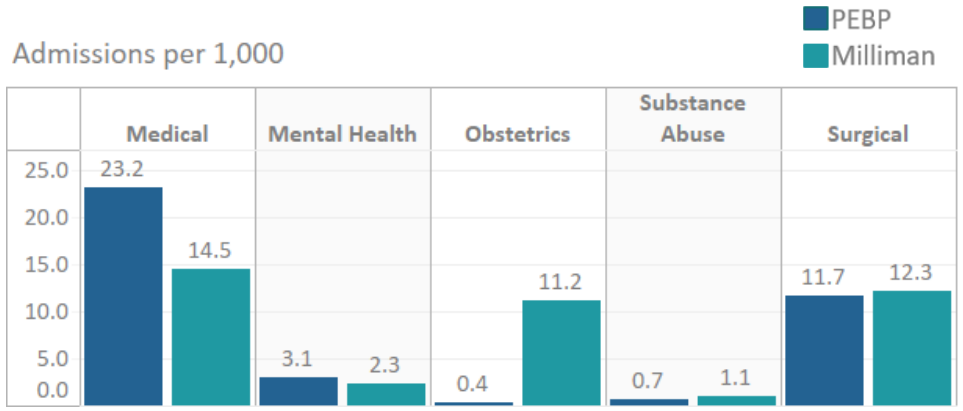
July 1, 2019 - June 30, 2020						
	Cases	Actual Days	Requested Days	Approved Days	Saved Days	Estimated Savings
Medical	1,184	5,601	5,656	5,508	148	$911,433
Surgical	597	2,887	2,924	2,821	103	$1,331,892
Mental Health	157	1,093	1,095	1,046	49	$67,947
Substance Abuse	35	174	175	154	21	$26,072
Obstetrics	21	103	103	102	1	$4,776
Grand Total	**1,994**	**9,858**	**9,953**	**9,631**	**322**	**$2,342,120**

Acute Inpatient – Case and Actual Days by Diagnostic Categories

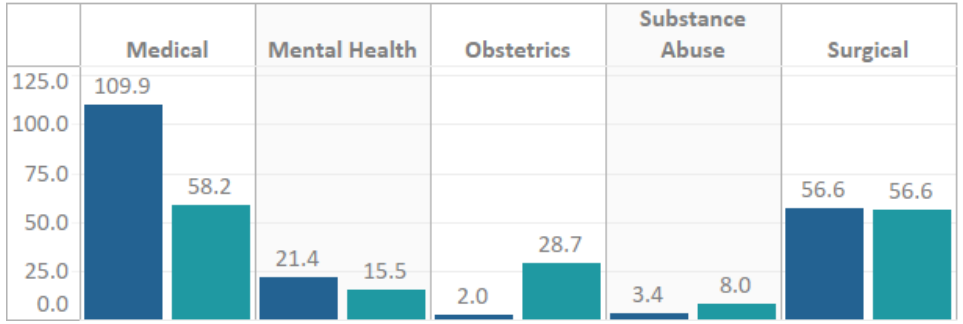


Acute Inpatient Activity – Utilization Benchmarks

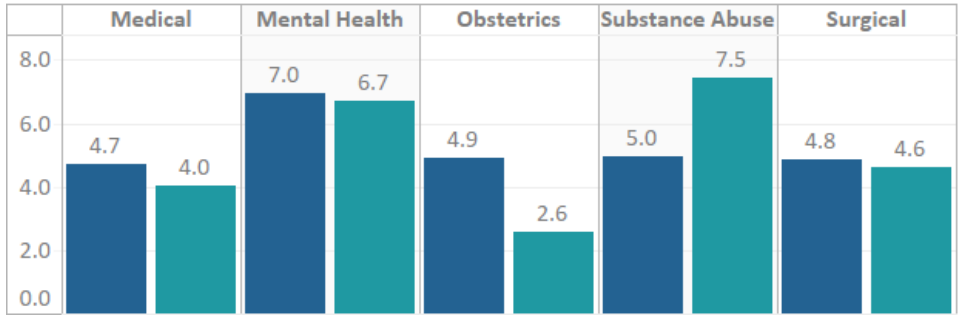
Admissions per 1,000



Days per 1,000



ALOS



Admissions per 1,000

- Medical: Admissions were 60.0% higher than the Milliman Benchmark.
  - **55** members had **3 or more** inpatient admissions
- Mental Health: Admissions were 34.8% higher than Milliman Benchmark.
  - **6** members had **3 or more** inpatient admissions

Days per 1,000

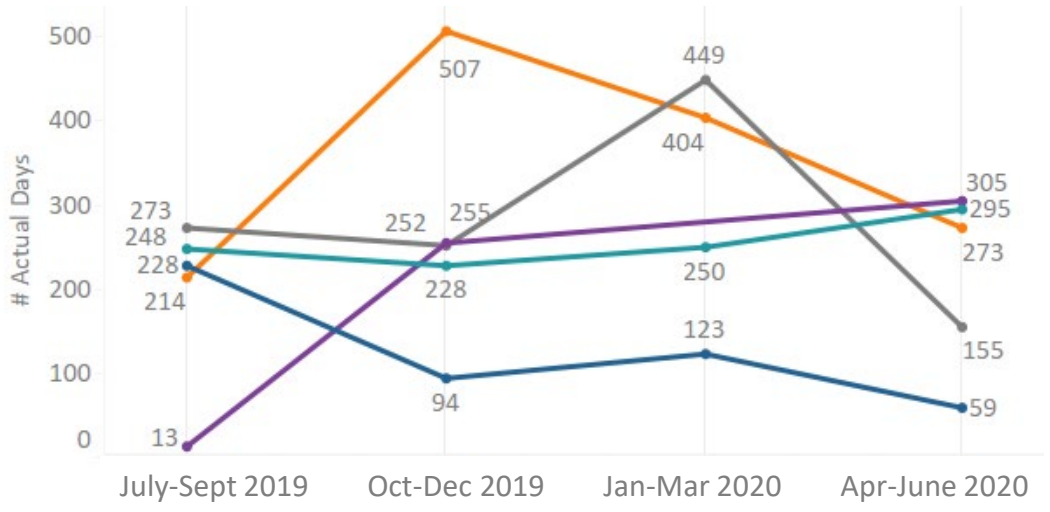
- Medical: Days were 88.8% higher than the Milliman Benchmark.
  - **107** cases utilized **10 or more** days during the report period
- Mental Health: Days were 38.1% higher than Milliman Benchmark.
  - **14** cases utilized **15 or more** days during the report period

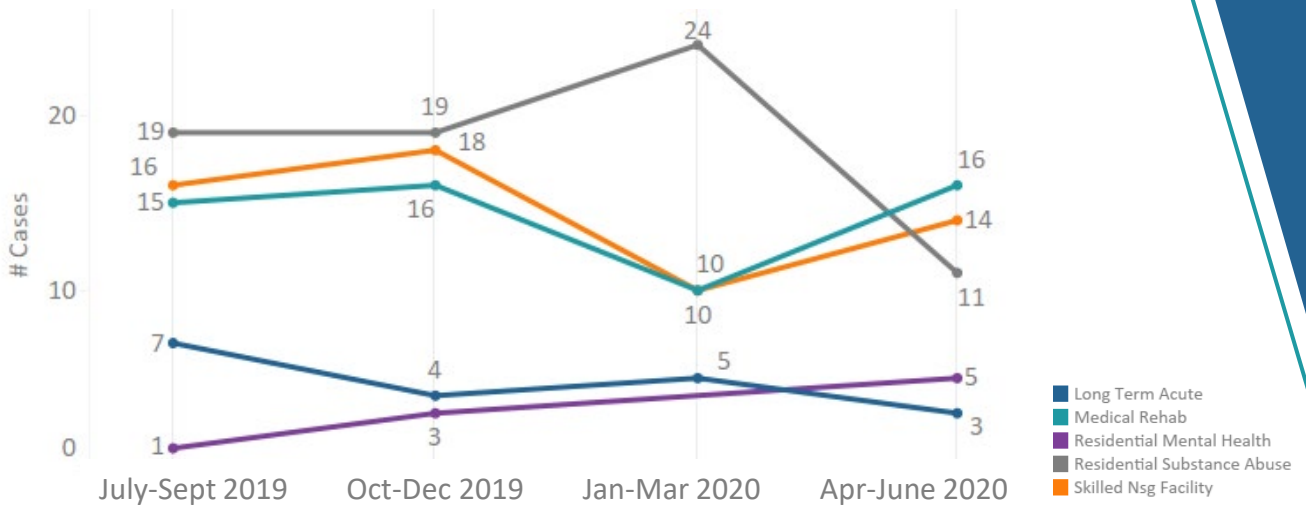
Average Length of Stay

- Medical: ALOS was 0.7 days higher than the Milliman Benchmark.
  - Removal of **10** outlier cases that consumed **46 or more** days each resulted in an ALOS of 4.1
- Mental Health: ALOS was 0.3 days higher than Milliman Benchmark.
  - Removal of **1** outlier case that consumed **56** days resulted in an ALOS of 6.7
- Obstetrics: ALOS was 2.3 days higher than Milliman Benchmark.
  - Removal of **11** outlier cases that consumed **4 or more** days each resulted in an ALOS of 2.6
- Surgical: ALOS was 0.2 days higher than Milliman Benchmark.
  - Removal of **1** outlier case that consumed **186** days resulted in an ALOS of 4.5

Due to federal mandate regulations, not all Obstetrics cases require pre-certification; therefore, Obstetrics ALOS should be interpreted with caution.

Non-Acute Inpatient Activity Summary



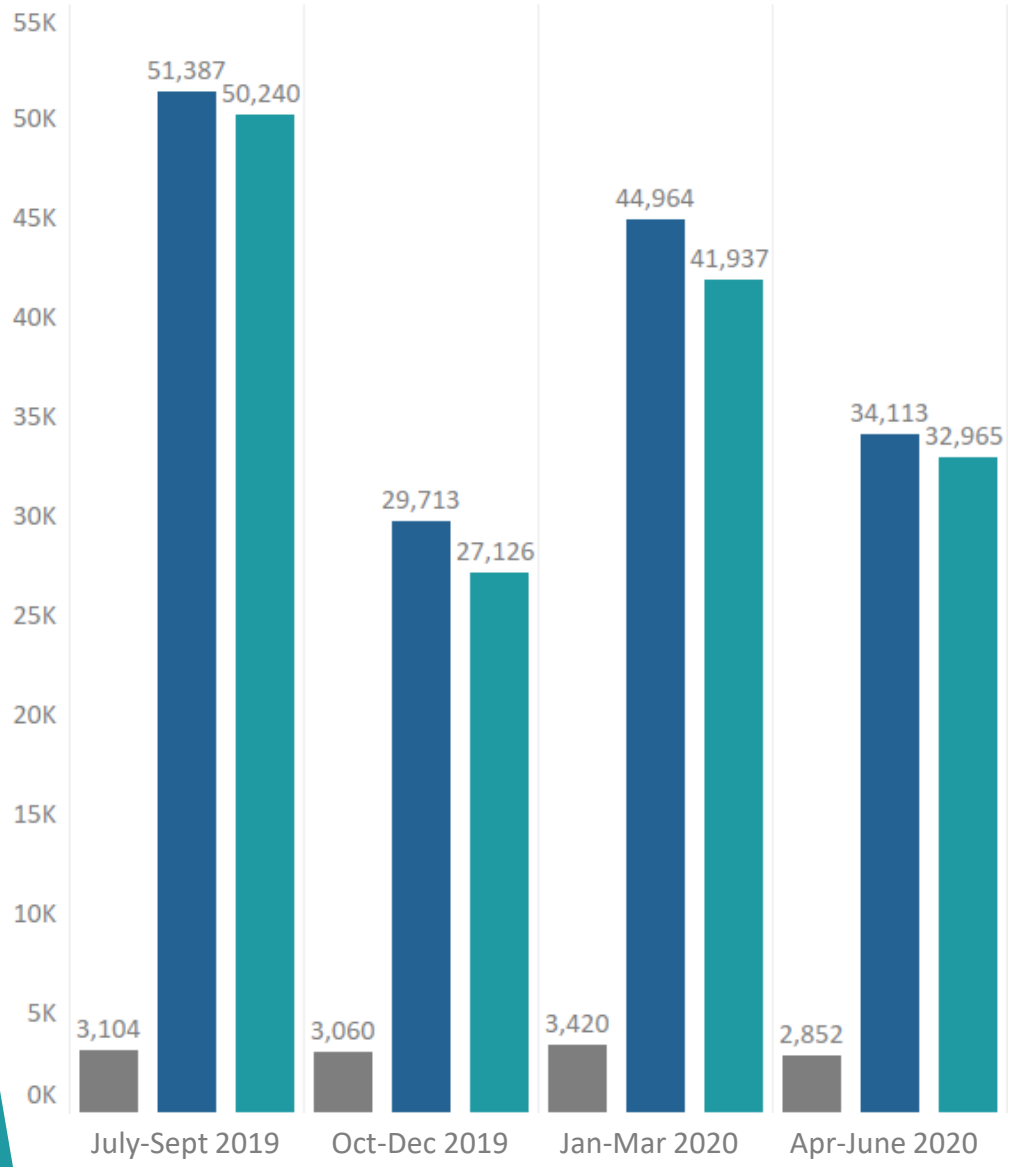


Utilization Review Process

Days Saved: 58
Estimated Savings: $111,524

July 1, 2019 - June 30, 2020						
	Cases	Actual Days	Requested Days	Approved Days	Saved Days	Estimated Savings
Residential Substance Abuse	73	1,129	1,151	1,144	7	$6,321
Skilled Nsg Facility	58	1,398	1,405	1,392	13	$8,851
Medical Rehab	57	1,021	1,027	1,006	21	$59,899
Long Term Acute	19	504	504	496	8	$30,872
Residential Mental Health	9	573	575	566	9	$5,581
Grand Total	**216**	**4,625**	**4,662**	**4,604**	**58**	**$111,524**

Outpatient Activity Summary

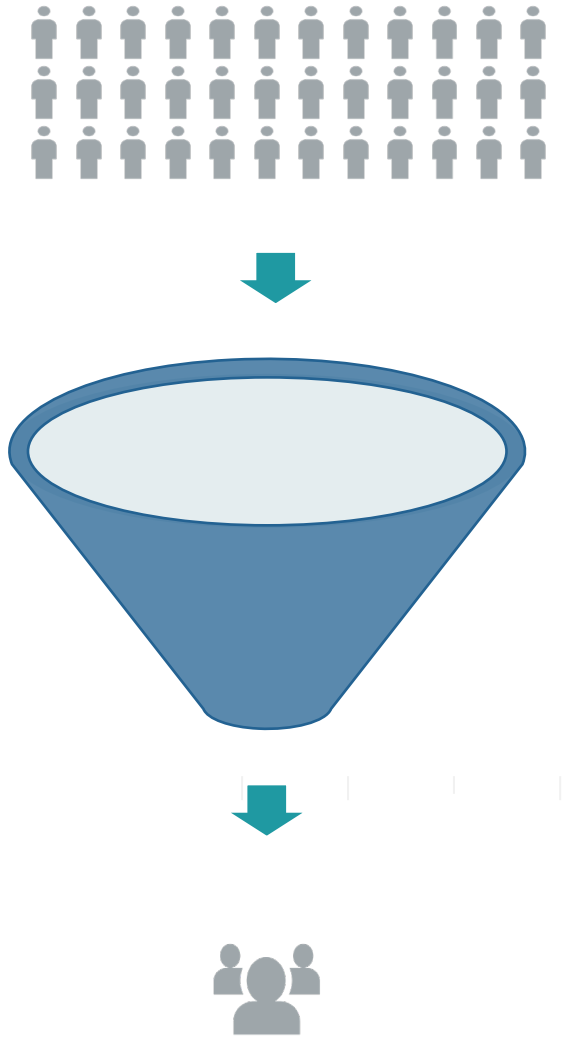


July 1, 2019 - June 30, 2020					
Outpatient Setting	**# Cases**	**# Units Requested**	**# Units Approved**	**# Units Saved**	**Outpatient Savings**
Diagnostic Test	6,034	7,521	7,106	415	$561,791
Med Treatment	2,456	33,793	33,145	648	$1,120,028
Surgery	2,220	4,451	4,357	94	$181,335
DME	993	96,802	90,417	6,385	$160,898
Home Health	143	3,442	3,279	163	$33,048
Home Infusion	110	10,009	9,857	152	$0
MH/SA	96	1,480	1,451	29	$1,359
PT/OT/ST	23	679	663	16	$2,792
Home Enteral Feeding	8	1,501	1,501	0	$0
Hospice Home	3	329	329	0	$0
23 Hour Observation	1	170	163	7	$0
Grand Total	**12,087**	**160,177**	**152,268**	**7,909**	**$2,061,250**

Utilization Review Process

Units Saved: 7,909
Estimated Savings: $2,061,250

Case Management Referrals from Utilization Management



- **2,210** inpatient cases were completed in Utilization Review
- **12,087** outpatient cases were completed in Utilization Review

- **1,291** inpatient cases **(58.4%)** automatically triggered to Case Management
- **2,816** outpatient cases **(23.3%)** automatically triggered to Case Management

- **655** inpatient cases **(50.7%)** were deemed appropriate for Case Management
- **139** outpatient cases **(4.9%)** were deemed appropriate for Case Management

Case Management

Proprietary

Case Management Summary

The following tables illustrate overall case activity and total savings achieved for the report period

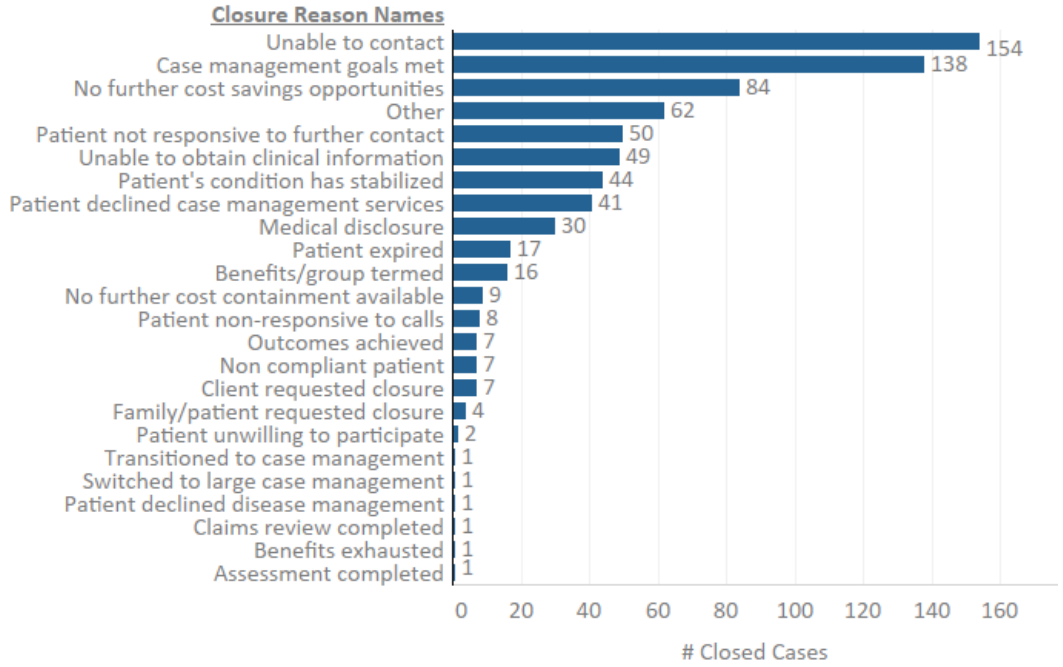
Total Case Management Savings

$4,186,698

Average Savings per Case = $5,502

Based on 761 cases in an open state between 07/01/2019 – 06/30/2020

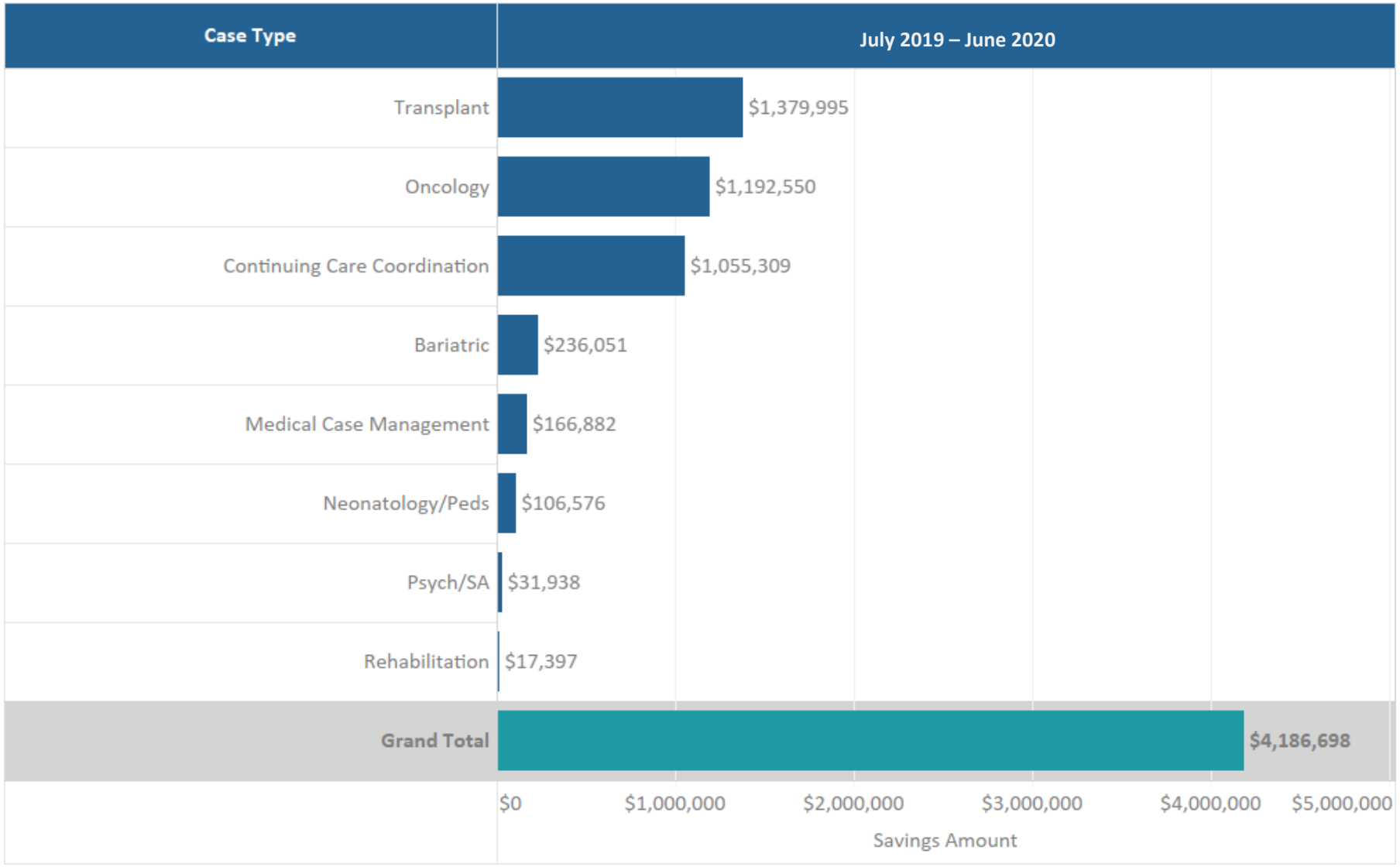
Number of Cases					
Case Activity	July-Sept 2019	Oct-Dec 2019	Jan-Mar 2020	Apr-June 2020	Annual July 2019 - June 2020
Beginning Cases	93	188	169	190	93
Opened Cases	232	136	169	131	668
Closed Cases	137	155	148	128	568
Ending Cases	188	169	190	193	193



Total number of closure reasons may be greater than the number of cases as cases may have more than one closure reason.

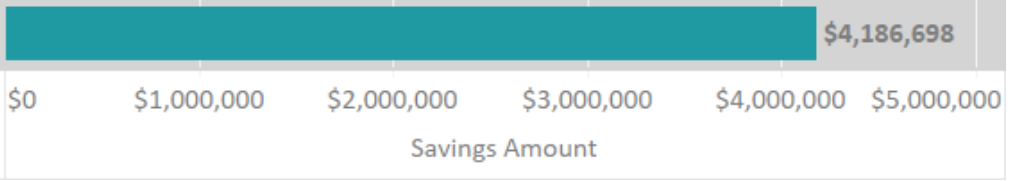
Case Type	July 2019 – June 2020
Continuing Care Coordination	274
Short Term CM	212
Bariatric	108
Oncology	71
Medical Case Management	34
Psych/SA	22
Neonatology/Peds	19
Transplant	11
Maternity Case Management	5
Rehabilitation	3
Research and Review	2
Grand Total	**761**

Case Management – Savings by Case Type



Case Management – Savings by Source

Savings Type	Saving Reason Name	July 2019 – June 2020
Managed	Steerage to Transplant Network	$1,789,640
	Averted Inpatient Admission	$1,293,366
	Averted Medical Complications	$527,140
	Services Not Medically Necessary	$184,301
	Averted Usage of Services	$121,818
	Steerage to Network Providers	$118,261
	Transition to Alternate Level of Care	$90,551
	Referral to Specialist/Medical Consultant	$16,765
	Days Saved via Intervention	$15,408
	Services Reduced via Intervention	$8,190
	Alternative Payer Source Identified	$1,115
Negotiated	Rehab	$20,143
	Grand Total	**$4,186,698**



Post-Discharge Counseling

Proprietary

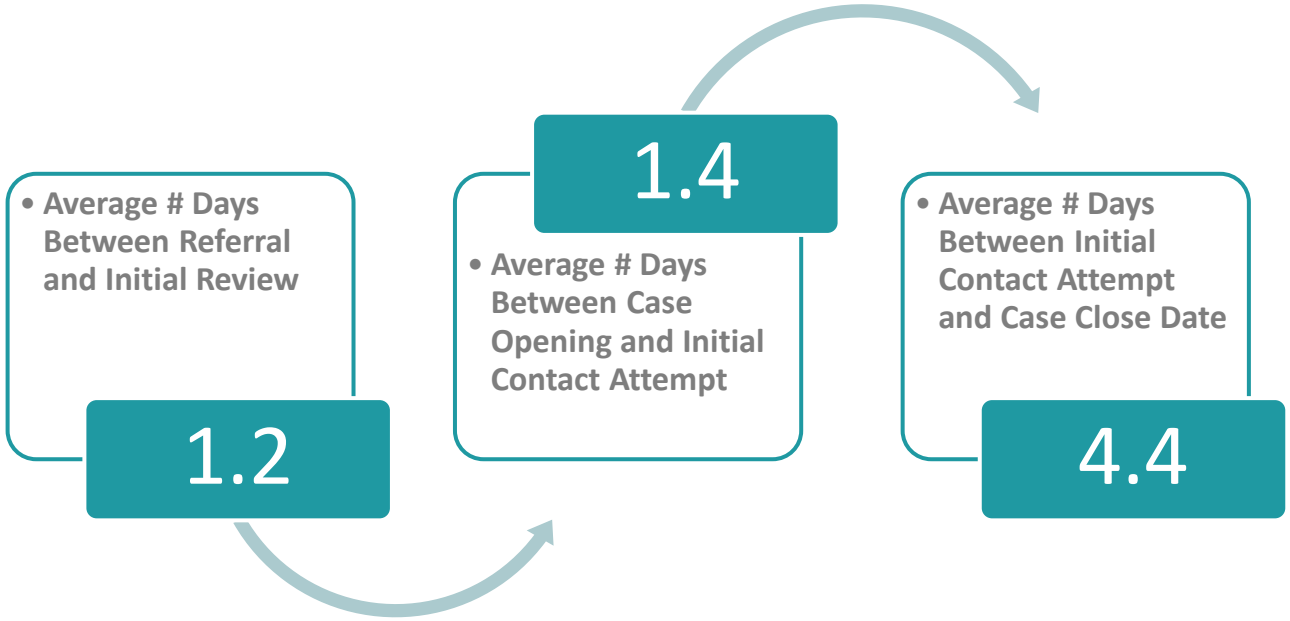
Post-Discharge Counseling – Participation Summary

Program Metric	July 1, 2019 – June 30, 2020
# Cases Identified	1,230
# Participating Cases	264
% of Cases with Successful Outreach	**21.5%**

AHH BOB
AHH BOB Percent of Cases with Successful Outreach
51.5%

Post-Discharge Counseling – Turnaround Time

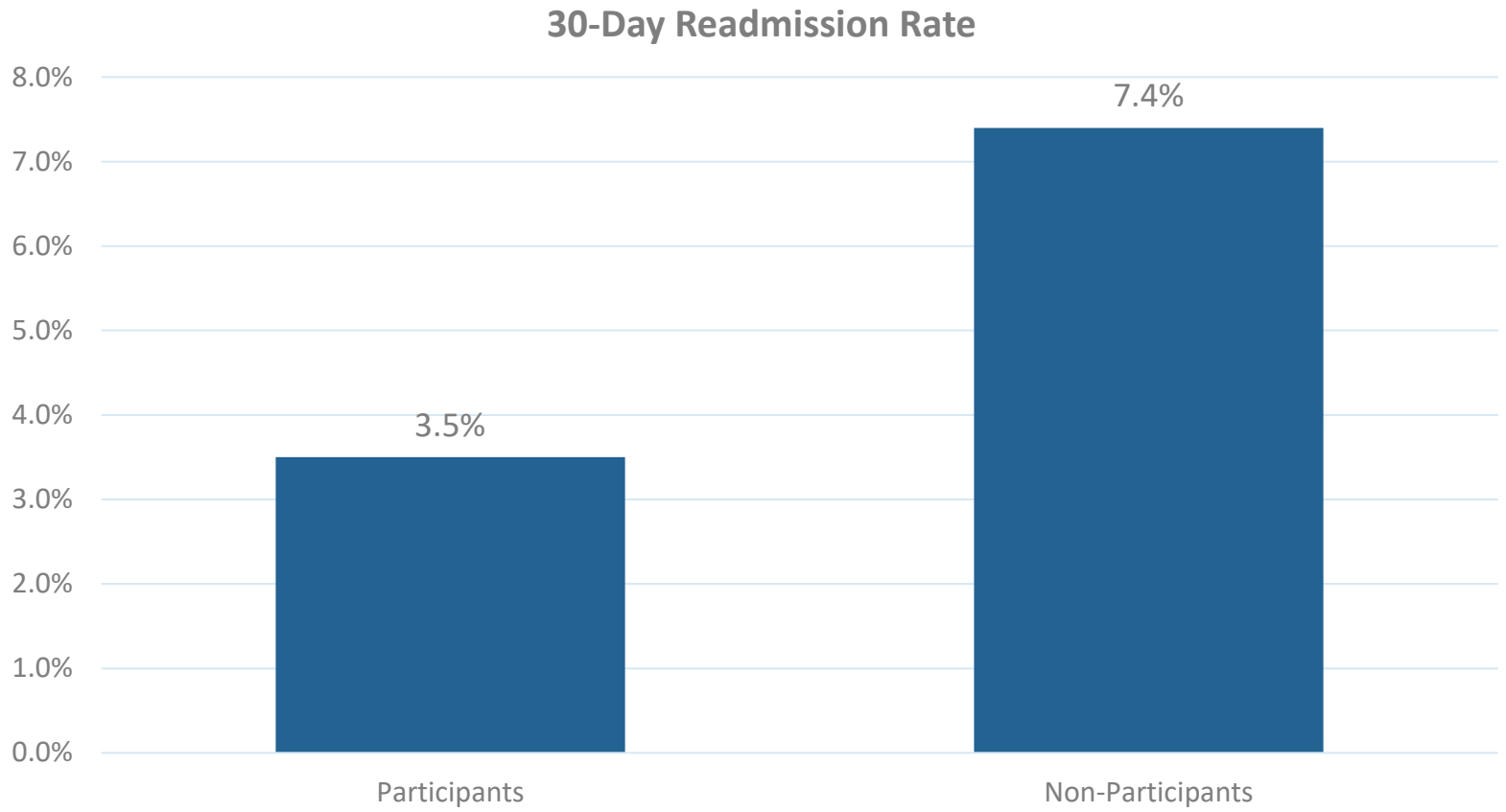
Below is a summary of the average turnaround times for the Post-Discharge Counseling program. Following a referral to the Post-Discharge Counseling program, the CMC will complete an initial review of the case and determine if the case is appropriate for the program. Once the case is reviewed and deemed appropriate, the case will be referred to a case manager who will review the case and subsequently make an initial contact attempt.



*Note that the average number of days between a referral for the Post-Discharge Counseling program and the initial contact attempt was 4.6 days

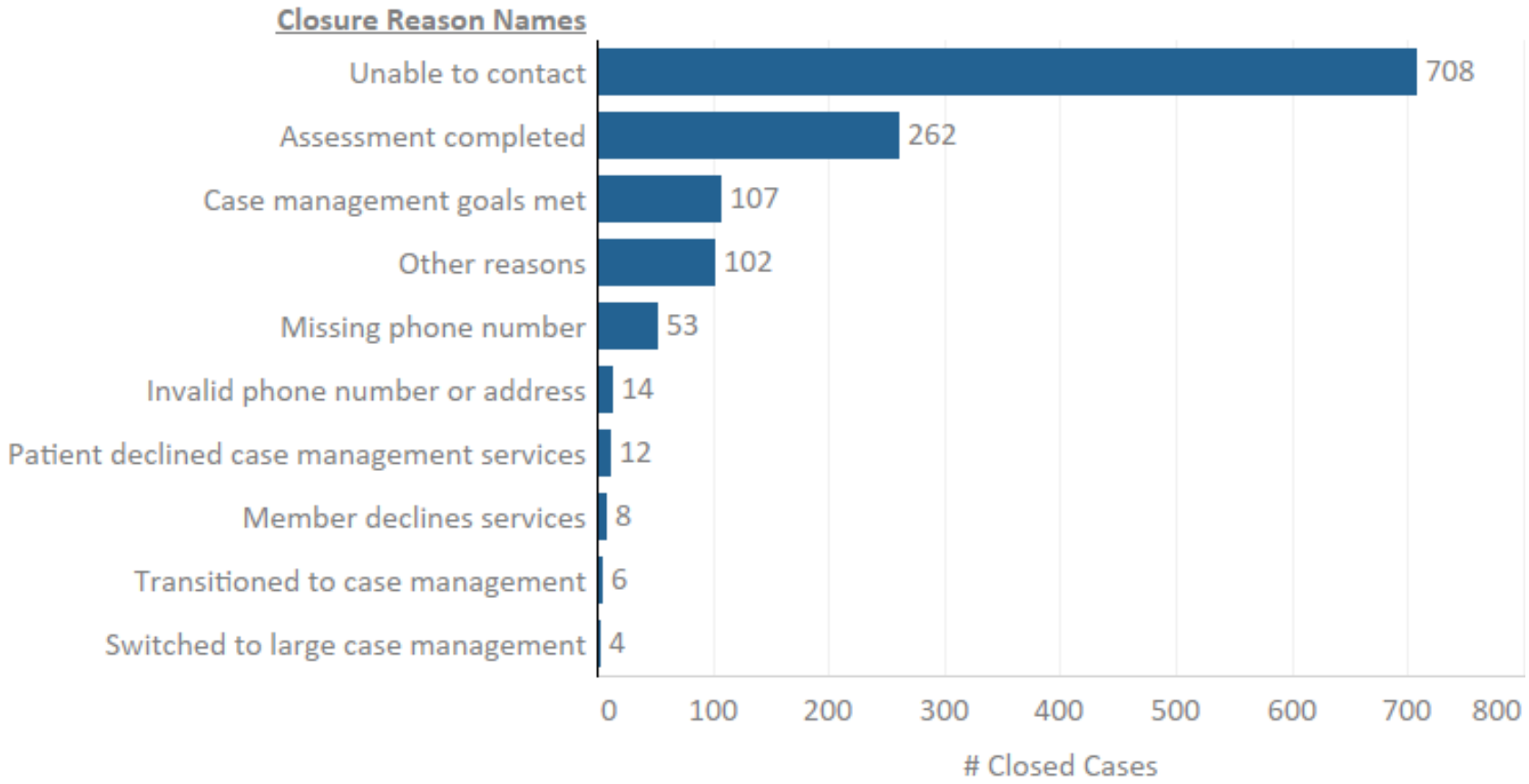
Post-Discharge Counseling – 30-Day Readmission Rate

There were 7 members with 30-day readmissions that participated in the Post-Discharge Counseling program during the report period. The 30-day readmission rates for participants in the program were below the rates for non-participation, illustrating the effectiveness of the Post-Discharge program.



Post-Discharge Counseling – Case Closure Reason

Post-Discharge Counseling cases are closed for a variety of reasons and a case may have more than one closure reason. The following graph presents the number of closed cases by closure reason during the report period.



Observations and Insights

Observations

- Medical attributed to 59.4% of acute inpatient cases and 56.8% of actual days
- Medical and Mental Health were higher than the Milliman benchmark for acute inpatient admissions, days, and ALOS
- Diagnostic Test represented 49.9% of all outpatient cases and accounted for 27.3% of savings
- Continuing Care Coordination made up 36.0% of case management case types

Insights

- Symptoms, Signs, and Ill-Defined Conditions represented 20.4% of acute inpatient Medical cases, which resulted in an average of 3.5 days per case
- Although Perinatal represented only 4.1% of Medical cases, actual days utilized were 17.3% of total medical days with an ALOS of 19.8
- Symptoms, Sign, and Ill-Defined Conditions represented approximately 23.6% of Diagnostic Test outpatient cases, units requested, and units approved
- Neoplasms major diagnostic category represented 107 of the 274 open CM Continuing Care Coordination cases

tary

Performance Measures

Performance Measures

Service Performance Standard	Guarantee	Method of Measurement	Actual	Pass/Fail
I. Quarterly and annual management reports	10 calendar days	Number of days after the end of the quarter that quarterly and annual reports are provided to PEBP and/or PEBP's actuary.	100%	Pass
II. Notification of potential high expense cases. High expense case is defined as a single claim or treatment plan expected to exceed $100,000.00	98%	Designated PEBP staff will be notified within 5 business days of the UM/CM vendors initial notification of the requested service	100%	Pass
III. Pre-certification information shall be provided to PEBP's third party administrator	98%	Precertification requests from healthcare providers shall be completed in accordance with URAC/NCQA standards and turn-around timeframes, or more efficient timeframe as proposed in questions 2.8.11; completed Pre-certifications shall be communicated to PEBP's Third Party Administrator using an approved method e.g. electronically, within 5 business days of UM completing Precertification determination.	100%	Pass
IV. Concurrent hospital review	98%	Concurrent hospital reviews shall be completed in accordance with URAC/NCQA standards; completed reviews shall be communicated to the provider using an approved method e.g. electronically within 2 business days of determination decision.	99.05%	Pass
V. Retrospective hospital review	98%	Retrospective reviews must be completed in accordance with URAC/NCQA standards; completed reviews shall be communicated using an approved method e.g. electronically within 5 business days of determination decision.	100%	Pass
VI. Implementation, initial transition from current UM/CM vendor and future transition to incoming UM/CM vendor during and after the termination of this contract.	98%	Tasks: Percent of tasks complete on time pursuant to the implementation or transition plan in the RFP response or as mutually agreed to by vendor and PEBP. Problem Resolution: Percent of problems document within 2 business days and resolved within 10 business days or later if agreed to by PEBP.	100%	Pass

Performance Measures

Service Performance Standard	Guarantee	Method of Measurement	Actual	Pass/Fail
VII. Customer Satisfaction Survey	90% or greater	Survey 100% of CM post-encounters within 7 days of closing the CM case; vendor may use hard copy surveys mailed via first class mail with return envelope to the member; or, vendor may use an electronic survey method. The survey responses will be reported semi-annually to PEBP no later than 30 calendar days following the end of the 2nd and 4th quarters of each plan year. Report shall include the prior semi-annual report findings for comparison purposes.	94%	Pass
VIII. Hospital Discharge Planning	95%	CM will contact or attempt to contact 95% of patients discharged from any facility within 3 business days of notification of discharge with clinical coaching and discharge planning assistance.	100%	Pass
IX. Large Case Management	95%	CM will identify and initiate case management for chronic disease, high dollar claims, and ER usage.	100%	Pass
X. Utilization Management for medical necessity and Center of Excellence usage	98%	UM review to determine medical necessity in accordance with the MPDs. Services to be performed at a Center of Excellence to be managed through the Case Management process.	100%	Pass
XI. Return On Investment (ROI) Guarantee	2:1 Savings to Fees for UM 3:1 Savings to Fees for CM	UM Pass/Fail CM Pass/Fail	UM ROI 6.1 to 1 CM ROI 3.5 to 1	Pass
XII. Disclosure of subcontractors and unauthorized transfer of PEBP data.	100%	A. All subcontractors who have access to PHI or PII data and physical locations where PEBP PHI or PII data is maintained and/or stored must be identified in this contract. Any changes to those subcontractors or physical locations where PEBP data is stored must be communicated to PEBP at least 60 days prior to implementation of services by the subcontractor. Implementation will not be in effect until PEBP has provided written authorization. B. All PEBP PHI or PII data will be stored, processed and maintained solely on currently designated servers and storage devices identified in this contract. Any changes to those designated systems during the life of this agreement shall be reported to PEBP at least 60 days prior to the changes being implemented. Implementation will not be in effect until PEBP has provided written authorization.	100%	Pass

4.3.4

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

    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

The Standard

Quarterly Report: Basic Life Insurance and Long Term Disability:
Quarter Ending
June 30, 2020

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Basic Life Insurance & Long Term Disability Executive Summary

Most Recent Five Plan Years: July 01, 2015 to June 30, 2020

This is the final report for the 2019-20 plan year, providing updated information for the period beginning July 1, 2015 and ending June 30, 2020.

Basic Life

Basic Life claim incidence and loss ratios decreased slightly in the 2019-20 plan year compared to the prior plan year. Incidence (page 4) was down slightly for actives (1.4 compared to 1.5/1,000) and retirees (13.2 compared to 14.8/1,000). The loss ratios (page 5) for actives and retirees both trended down, with the active loss ratio down slightly at 27% compared to 28% last year and retiree loss ratio more significantly at 254% compared to 315%. The overall loss ratio for Basic Life decreased for this period, 78% compared to 93% last year. The Basic Life plan suffered a small loss of $22,600 for the plan year compared to a negative $651,000 last year, so the experience has improved compared to the prior plan year.

When looking at the retiree liability for the plan year, the incidence has decreased from 276 claims/$1,000 for the prior plan year to 208 claims for this plan year. Although the loss ratio still remains high for the retiree plan overall, both the state and non-state retiree loss ratios decreased this plan year compared to the prior plan year, 260% compared to 308% for state retirees and 240% compared to 330% for non-state retirees (page 6).

Long Term Disability

LTD claim incidence (page 7) is reported on an incurred basis; claims are charged to the plan year in which the disability began. While we do not have complete information, it appears the 2019-20 plan year may result in a decrease in incidence, 19 claims for this plan year versus 25 for the prior plan year based on the most recent claim data.

LTD loss ratios (page 8) are reported on a cash basis, without regard for incurred date. The loss ratio for the 2019-20 plan year (96%) was up over the 2018-19 plan year (42%). Despite the decrease in claim incidence, the claim liability is significantly higher, over double compared to the prior year.

For the 2019-20 plan year, LTD claims and expenses exceeded premiums by $1.4 million, increasing the all year's deficit to $4.8 million.

Basic Life Insurance Claims by Plan Year and Participant Type

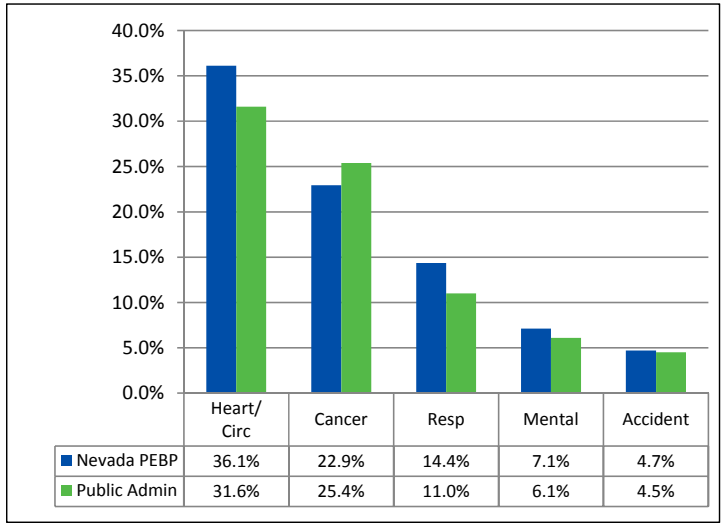
Most Recent Five Plan Years: July 01, 2015 to June 30, 2020

	From Jul-15 Through Jun-16		From Jul-16 Through Jun-17		From Jul-17 Through Jun-18		From Jul-18 Through Jun-19		From Jul-19 Through Jun-20	
Participant Type	**Count**	**Inc./ 1000**	**Count**	**Inc./ 1000**	**Count**	**Inc./ 1000**	**Count**	**Inc./ 1000**	**Count**	**Inc./ 1000**
Actives	41	1.7	51	2.0	41	1.6	47	1.8	38	1.4
Retirees	274	18.6	325	21.8	295	19.5	276	17.6	208	13.2
Totals	**315**	**8.5**	**376**	**9.6**	**336**	**8.4**	**323**	**7.9**	**246**	**5.7**

Basic Life Insurance Claims by Diagnostic Category

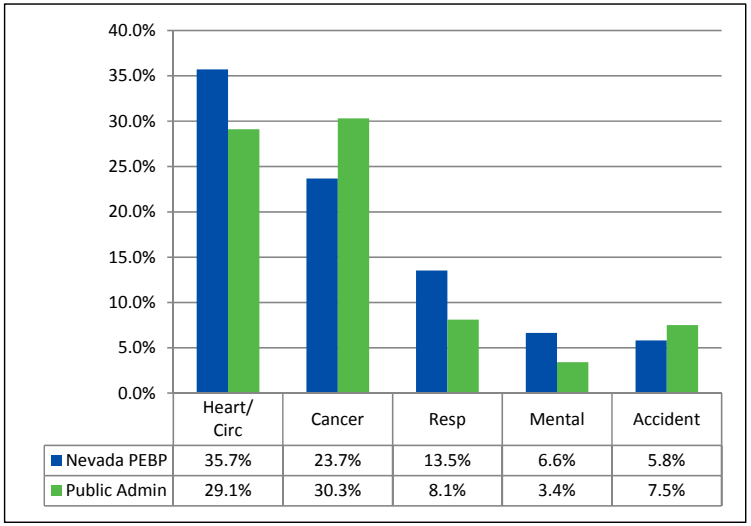
Public Admin benchmark is from SIC book of business for most recent 5 calendar years

Top Five Diagnostic Categories by Incidence



	Heart/ Circ	Cancer	Resp	Mental	Accident
Nevada PEBP	36.1%	22.9%	14.4%	7.1%	4.7%
Public Admin	31.6%	25.4%	11.0%	6.1%	4.5%

Top Five Diagnostic Categories by Liability

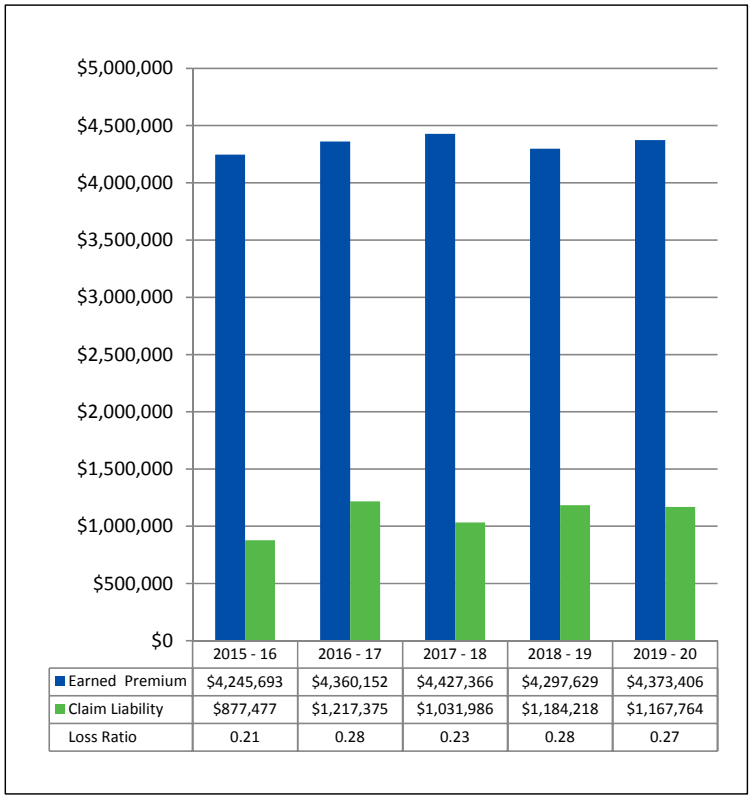


	Heart/ Circ	Cancer	Resp	Mental	Accident
Nevada PEBP	35.7%	23.7%	13.5%	6.6%	5.8%
Public Admin	29.1%	30.3%	8.1%	3.4%	7.5%

Basic Life Insurance Earned Premiums & Liability by Participant Type

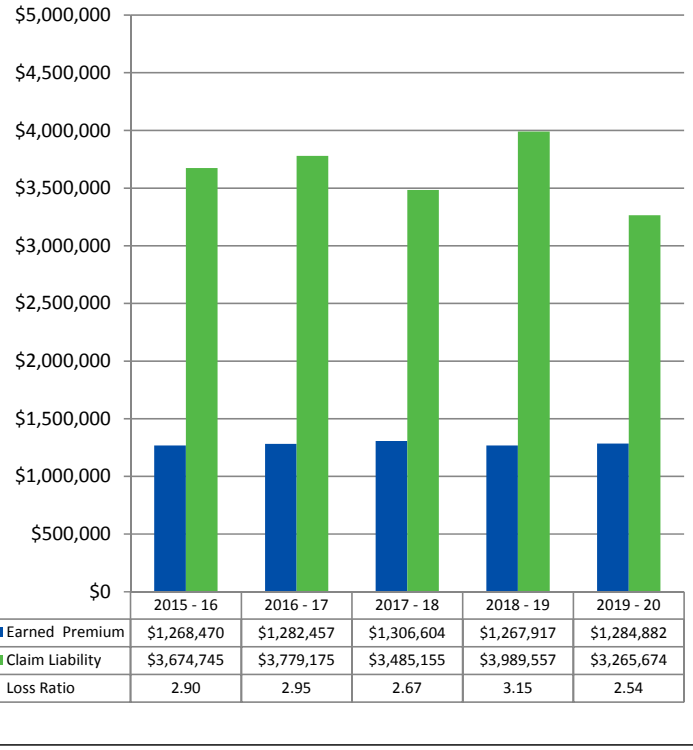
Most Recent Five Plan Years: July 01, 2015 to June 30, 2020

Active Participants



	2015 - 16	2016 - 17	2017 - 18	2018 - 19	2019 - 20
Earned Premium	$4,245,693	$4,360,152	$4,427,366	$4,297,629	$4,373,406
Claim Liability	$877,477	$1,217,375	$1,031,986	$1,184,218	$1,167,764
Loss Ratio	0.21	0.28	0.23	0.28	0.27

Retired Participants

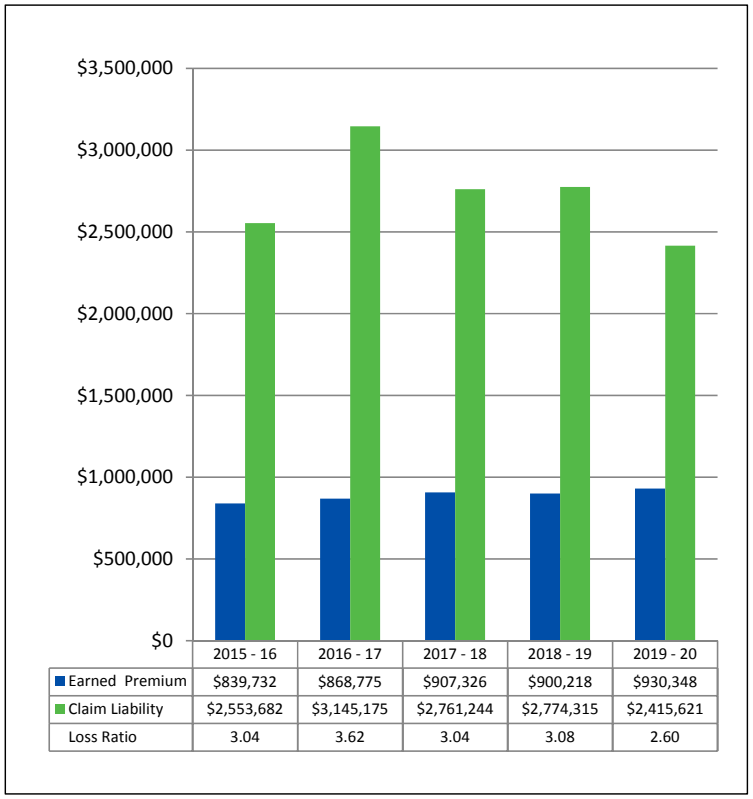


	2015 - 16	2016 - 17	2017 - 18	2018 - 19	2019 - 20
Earned Premium	$1,268,470	$1,282,457	$1,306,604	$1,267,917	$1,284,882
Claim Liability	$3,674,745	$3,779,175	$3,485,155	$3,989,557	$3,265,674
Loss Ratio	2.90	2.95	2.67	3.15	2.54

Basic Life Retiree Insurance Earned Premiums & Liability by Participant Type

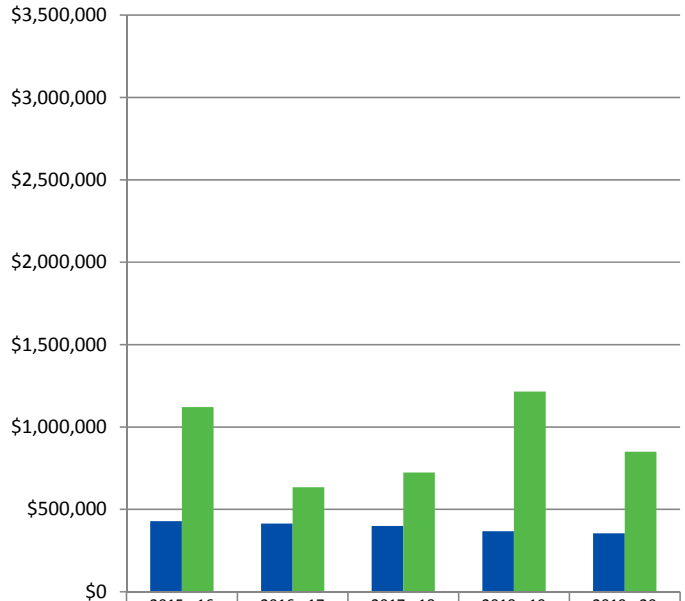
Most Recent Five Plan Years: July 01, 2015 to June 30, 2020

State Retired Participants



	2015 - 16	2016 - 17	2017 - 18	2018 - 19	2019 - 20
Earned Premium	$839,732	$868,775	$907,326	$900,218	$930,348
Claim Liability	$2,553,682	$3,145,175	$2,761,244	$2,774,315	$2,415,621
Loss Ratio	3.04	3.62	3.04	3.08	2.60

Non-State Retired Participants



	2015 - 16	2016 - 17	2017 - 18	2018 - 19	2019 - 20
Earned Premium	$428,738	$413,682	$399,278	$367,699	$354,534
Claim Liability	$1,121,063	$634,000	$723,911	$1,215,242	$850,053
Loss Ratio	2.61	1.53	1.81	3.30	2.40

Long Term Disability Claims by Plan Year

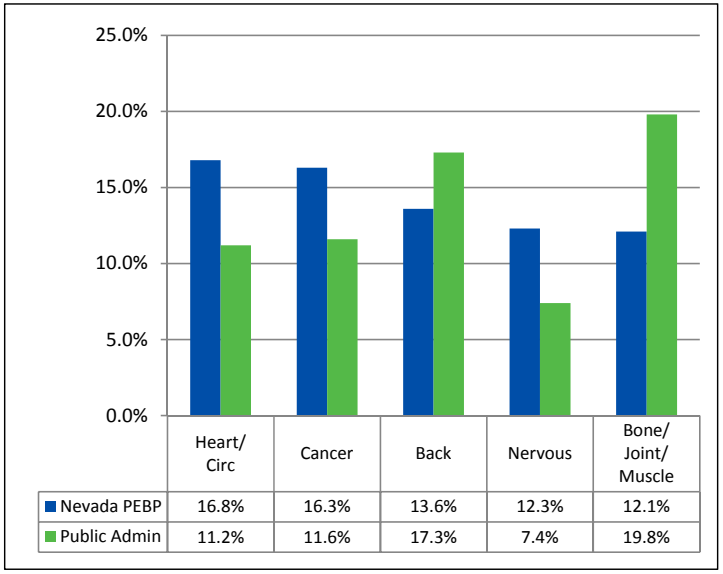
Most Recent Five Plan Years: July 01, 2015 to June 30, 2020

	From Jul-15 Through Jun-16		From Jul-16 Through Jun-17		From Jul-17 Through Jun-18		From Jul-18 Through Jun-19		From Jul-19 Through Jun-20	
	Count	Inc./ 1000	Count	Inc./ 1000	Count	Inc./ 1000	Count	Inc./ 1000	Count	Inc./ 1000
LTD Claims	29	1.2	36	1.4	29	1.1	25	1.0	19	0.7

Long Term Disability Claims by Diagnostic Category

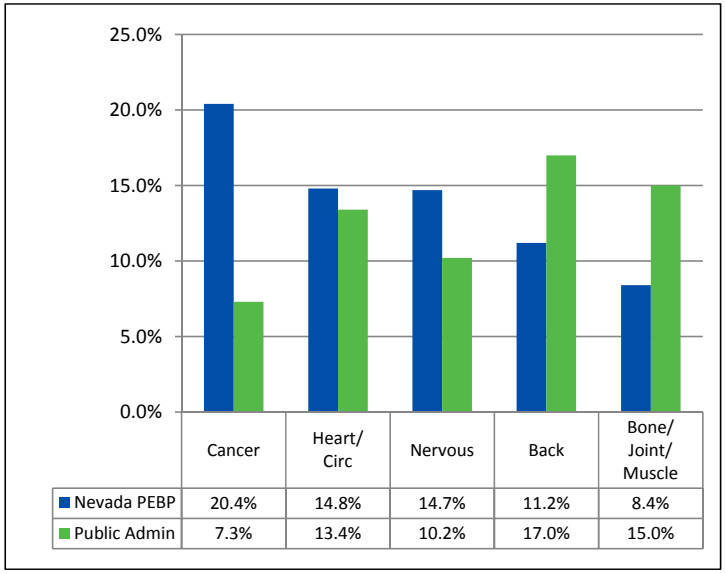
Public Admin benchmark is from SIC book of business for most recent 5 calendar years

Top Five Diagnostic Categories by Incidence



	Heart/ Circ	Cancer	Back	Nervous	Bone/ Joint/ Muscle
Nevada PEBP	16.8%	16.3%	13.6%	12.3%	12.1%
Public Admin	11.2%	11.6%	17.3%	7.4%	19.8%

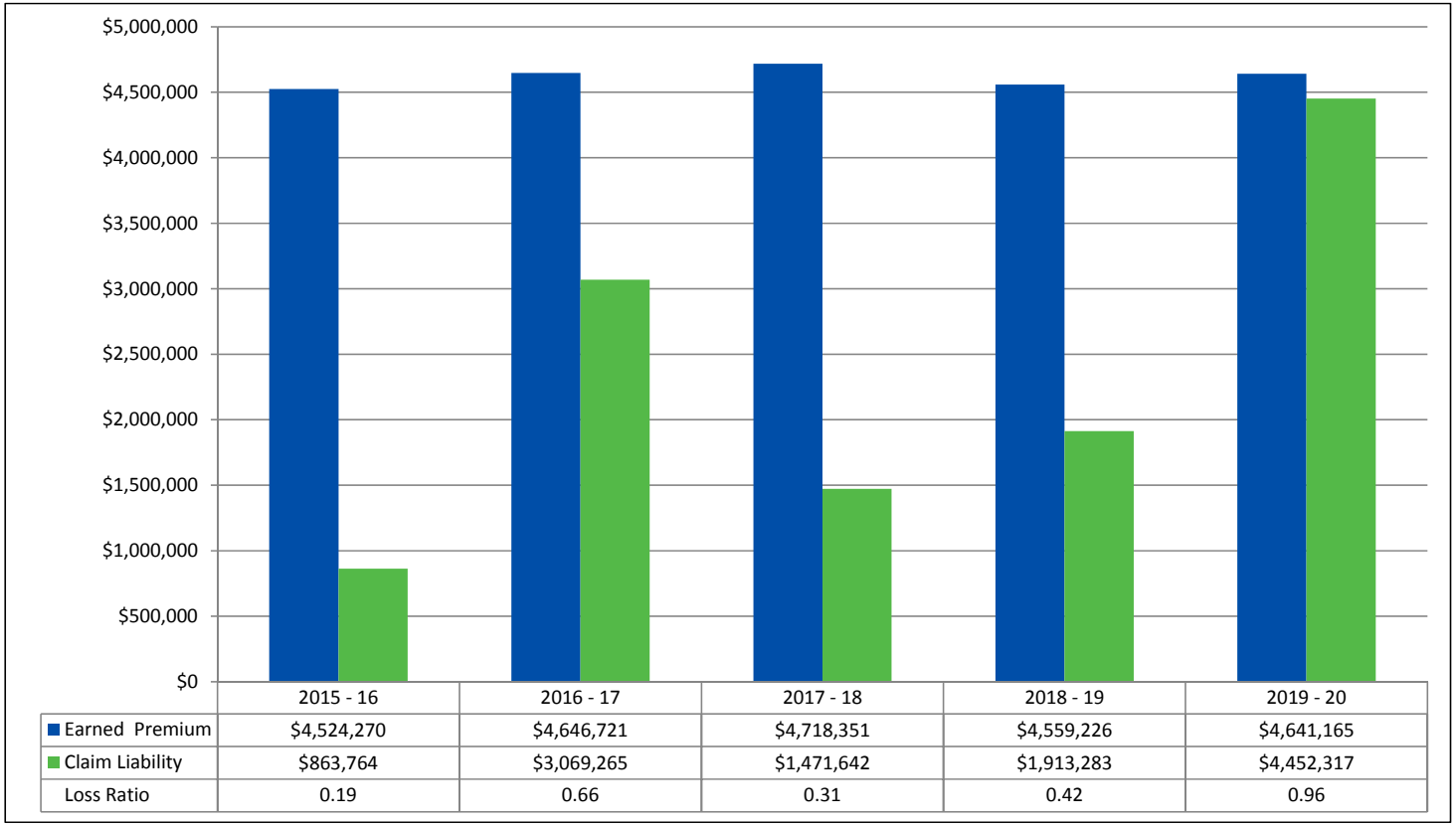
Top Five Diagnostic Categories by Liability



	Cancer	Heart/ Circ	Nervous	Back	Bone/ Joint/ Muscle
Nevada PEBP	20.4%	14.8%	14.7%	11.2%	8.4%
Public Admin	7.3%	13.4%	10.2%	17.0%	15.0%

Long Term Disability Earned Premiums & Liability

Most Recent Five Plan Years: July 01, 2015 to June 30, 2020



	2015 - 16	2016 - 17	2017 - 18	2018 - 19	2019 - 20
Earned Premium	$4,524,270	$4,646,721	$4,718,351	$4,559,226	$4,641,165
Claim Liability	$863,764	$3,069,265	$1,471,642	$1,913,283	$4,452,317
Loss Ratio	0.19	0.66	0.31	0.42	0.96

Claim Appeals

Quarterly Update for Plan Year to Date July 01, 2019 to June 30, 2020

	In Process	Decision Upheld	Decision Overturned	Total
Claim Appeals				
Life Insurance Claims	0	0	0	0
Long-Term Disability Claims	0	2	1	3
Short-Term Disability Claims	0	0	0	0
Total Appeals	**0**	**2**	**1**	**3**

4.3.5

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

    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 & Performance Report

Nevada Public Employees Benefit Program

Quarterly Update – 4th Quarter Plan Year 2020

Willis Towers Watson's Individual Marketplace

August 4, 2020

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The Public Employees Benefit Program Executive Dashboard

Quarterly Update – 4th Quarter Plan Year 2020

Executive Summary

Plan Enrollment:

- At the end of Q4 2020, PEBP's total enrollment into Medicare policies through Willis Towers Watson's Individual Marketplace decreased to 12,381. Since inception, 105 carriers have been selected by PEBP's retirees with current enrollment in 1,393 different plans.
- Medicare Supplement (MS) plan selection increased to 83% of the total population with the majority of participants selecting AARP and Anthem BCBS of Nevada as their insurer; each carrier holds plans for 6,308 and 2,177 enrollees respectively. The average monthly premium cost for MS plans remained consistent at $147.
- The percentage of Medicare Advantage (MA or MAPD) plans selected decreased to 17%. Top MA carriers include Hometown Health Plan with 993 individual plan selections and Humana with 201 individual plan selections. The average monthly premium cost to PEBP participants is $21.

Customer Satisfaction:

- In Q4 2020, PEBP participant satisfaction with Enrollment Calls had an average satisfaction score result of 4.8 out of 5.0 based on 58 surveys returned. This is the highest customer satisfaction score we have seen all year!
- For Q4 2020, the average satisfaction score for Service Calls was 4.4 out of 5.0 based on 764 surveys returned.
- The combined average satisfaction score for Enrollment Calls and Service Calls was 4.4 out of 5.0 for Q4 2020.

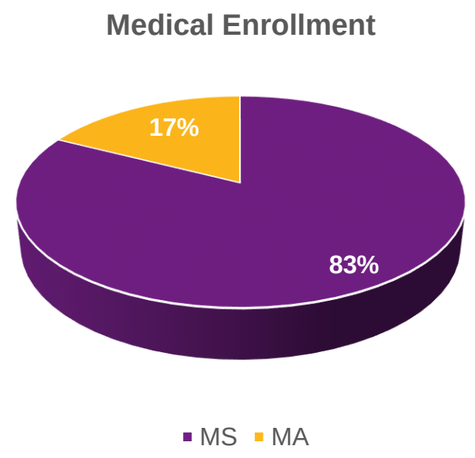
Health Reimbursement Arrangement:

- At the end of Q4 2020 there were 12,583 Health Reimbursement Arrangement (HRA) accounts for PEBP participants.
- There were 76,806 claims submitted against the HRA for reimbursement in Q4, with 95% being submitted via Auto-Reimbursement, meaning that participants did not have to manually submit 73,043 claims for Premium Reimbursement.
- The total reimbursement amount processed for Q4 was $7,933,180

Summary of Retiree Decisions and Costs

Retiree Plan Selection Through 06/30/2020		Previous Qtr
Total enrolled through individual marketplace	12,381	12,749
Number of carriers**	105	103
Number of plans**	1,393	1,381

Plan Type Selection Through 06/30/2020		Previous Qtr
Medicare Advantage (MA, MAPD)	2,166	2,585
Medicare Supplement (MS)	10,215	10,167



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

Plan Type	Number Enrolled	Average Premium
Medicare Supplement	10,215	$147
Medicare Advantage (MA,MAPD)	2,166	$0 / $21
Part D drug coverage	7,314	$25
Dental coverage	1,070	$36
Vision coverage	1,993	$12

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

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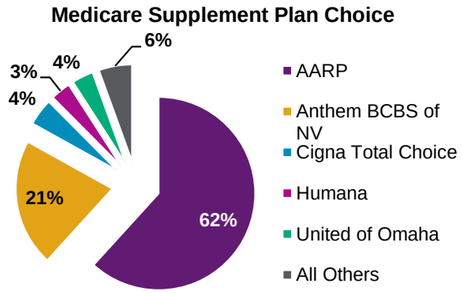
The Public Employees Benefit Program Executive Dashboard

Quarterly Update – 4th Quarter Plan Year 2020

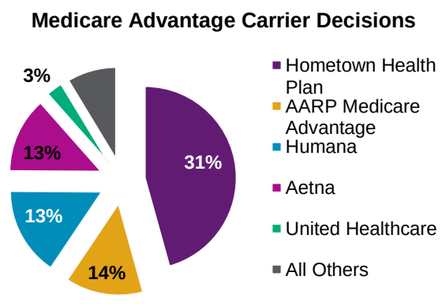
Summary of Retiree Carrier Choice

Top Medicare Supplement Plans	Total
AARP	6,308
Anthem BCBS of NV	2,177
Cigna Total Choice	458
Humana	341
United of Omaha	365



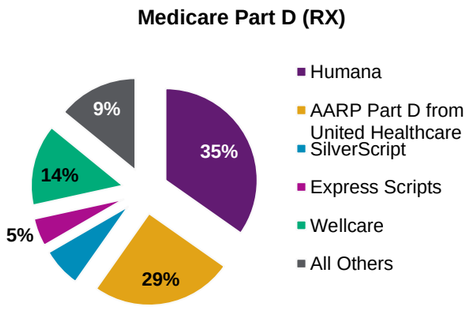
Cost Data For MS Plans	Cost
Minimum	$22
Average	$147
Median	$142
Maximum	$459

Top Medicare Advantage Plans	Total
AARP Medicare Advantage	345
Aetna	367
Hometown Health Plan	993
Humana	201
Anthem BCBS	49



Cost Data For MA Plans	Cost
Minimum	$0
Average	$21
Median	$0
Maximum	$188

Top Medicare Part D (RX)	Total
AARP Medicare Advantage	1,928
Express Scripts Medicare	440
Humana	2,723
SilverScript	571
WellCare	1,301



Cost Data For Part D (RX)	Cost
Minimum	$10
Average	$25
Median	$19
Maximum	$130

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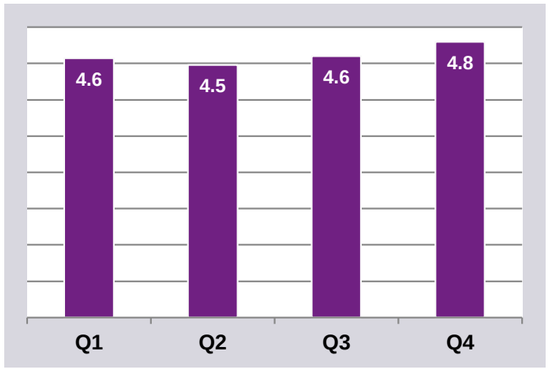
Quarterly Update – 4th Quarter Plan Year 2020

Customer Service – Voice of the Customer (VoC)

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

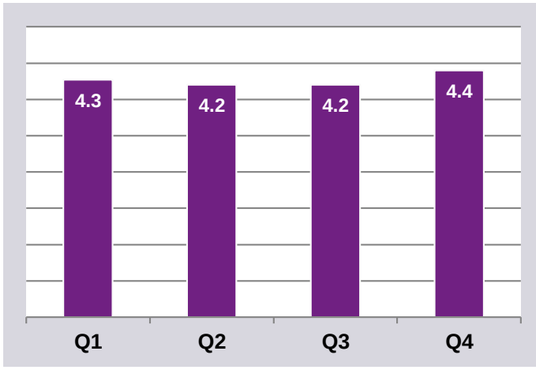
Q4 Enrollment Satisfaction

CSAT score	Count	%
5	47	81%
4	9	16%
3	2	3%
2	0	0%
1	0	0%
	58	**100%**



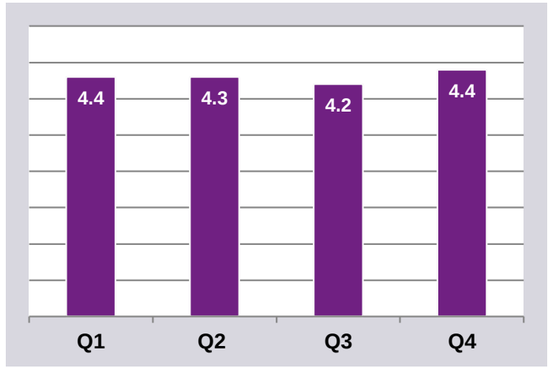
Q4 Service Satisfaction

CSAT score	Count	%
5	517	68%
4	130	17%
3	50	7%
2	35	5%
1	32	4%
	764	**100%**



Q4 Enrollment & Service Combined

CSAT score	Count	%
5	564	69%
4	139	17%
3	52	6%
2	35	4%
1	32	4%
	822	**100%**



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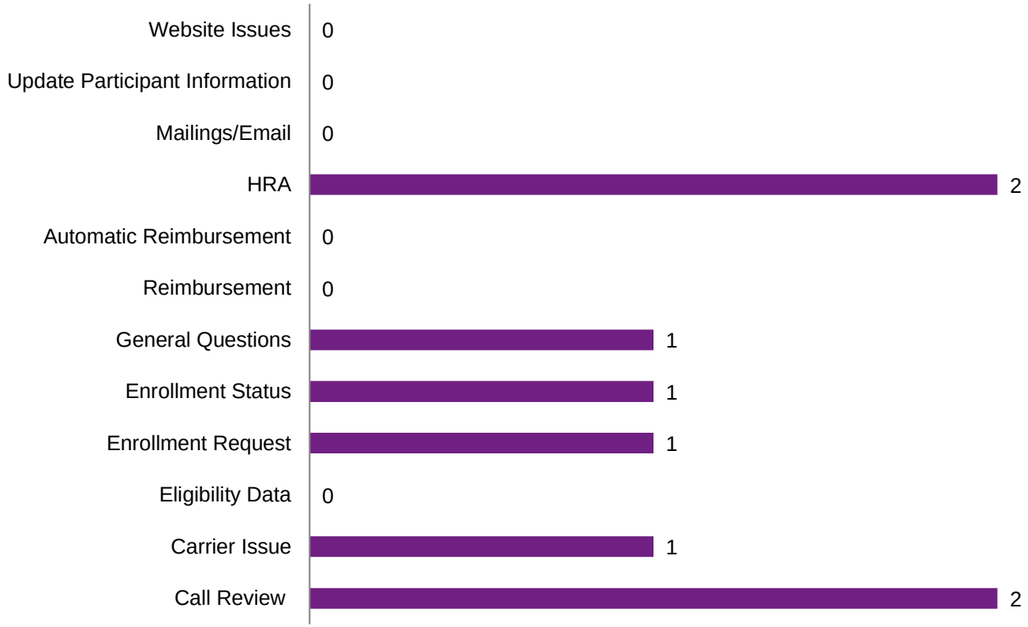
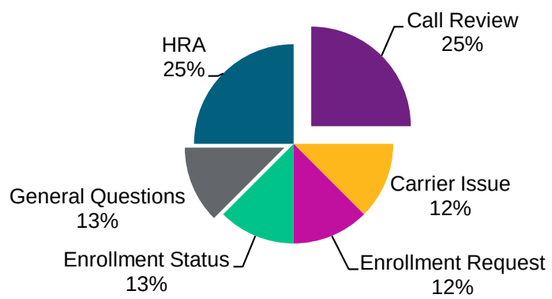
The Public Employees Benefit Program Executive Dashboard

Quarterly Update – 4th Quarter Plan Year 2020

Customer Service – Issues Log Resolution

Each quarter a certain number of participant inquiries are received by both PEBP and Willis Towers Watson that require escalation to Individual Marketplace Issues Log. Items on the Issues Log are carefully evaluated and continuously monitored by seasoned Willis Towers Watson staff until resolution is reached. The total number of inquiries reviewed during Q4-PY20 is 9 and are associated with the following categories:





Health Reimbursement Account (HRA)

Claim Activity for the Qtr.	Total
HRA accounts	12,583
Number of payments	53,089
Accounts with no balance	7,462
Claims paid amount	$7,933,180.30

Claims By Source	Total
A/R file	73,043
Mail	2,271
Web	1,492
Mobile App	0

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The Public Employees Benefit Program Executive Dashboard

Quarterly Update – 4th Quarter Plan Year 2020

Performance Guarantees*

Category	Commitment	Outcome	PG MET
Claims Turnaround Time	≤ 2 days	0.48 Days	Yes
Claim Financial Accuracy	≥ 98%	98.04%	Yes
Claim Processing Payment Precision	≥ 98%	Results not Reported on Benefits Accounts	Yes
Reports	≤ 15 business days	Met	Yes
HRA Web Services	≥ 99%	99.86%	Yes
Benefits Administration Customer Service Avg. Speed to Answer	≤ 2 min. in Q1 ≤ 90 sec in Q2 and Q3 ≤ 5 minutes in Q4 Note - Quarters listed are based on calendar year.	20 Seconds	Yes
Benefits Administration Customer Service Abandonment Rate	≤ 5%	0.53%	Yes
Customer Satisfaction	≥ 80%	91.85%	Yes
Disclosure of Subcontractors	100%	100%	Yes
Unauthorized Transfer of PEBP Data	100%	100%	Yes

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

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The Public Employees Benefit Program Executive Dashboard

Quarterly Update – 4th Quarter Plan Year 2020

Operations Report

Fall Retiree Meetings

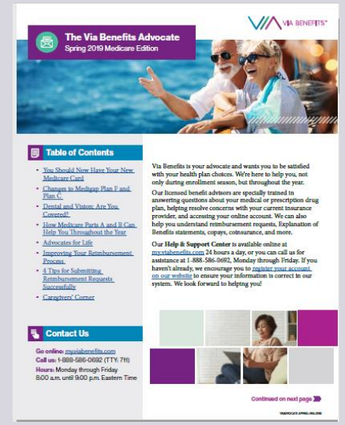
Normally we will hold 3 days of retiree meetings in the Fall (October) focusing participants ageing into Medicare as well as those already enrolled but may need help with their HRA. The meetings typically would occur in Las Vegas, Reno, and Carson City with 2 presentations per day. Due to COVID-19, we are not able to have the live meetings but are working on creating virtual presentations with a live Question and Answer Session. The goal is to hold these virtual meetings in October as well, but the timing is TBD.

Communications:

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

- Fall Newsletter
  - This communication is sent to participants via mail or email and is typically sent starting in September. The intent of this communication is to educate participants on different areas like Medicare (in particular the upcoming Open Enrollment season), HRA, Direct Deposit, and Auto-Reimbursement functionality.

- Fall Balance Reminder
  - This communication is mailed to participants who have not had any payment activity in their HRA in the prior 90 days. It is designed to remind them of their HRA balance so they can take action and submit new claims for reimbursement from their account. The reminder is generally mailed starting in September.


The Via Benefits Advocate
Spring 2019 Medicare Edition

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

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Call us: 1-888-586-0692 (TTY: 711)
Hours: Monday through Friday 8:00 a.m. until 9:00 p.m. Eastern Time

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

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

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

Continued on next page

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The Public Employees Benefit Program Executive Dashboard

Quarterly Update – 4th Quarter Plan Year 2020

Nevada PEBP Historical Call Statistics

The below charts reflect the historical call statistics for Nevada PEBP for 2020.

Month	Average Wait Time	Total Calls	Abandoned Calls	Average Handle Time	Outreach Attempts
January	4m 36s	2,958	244	23m 48s	394
February	1m 11s	2,100	60	22m 19s	178
March	49s	1,988	29	21m 38s	300
April	22s	2,866	18	18m 02s	262
May	14s	1,766	6	22m 17s	196
June	22s	1,775	11	20m 15s	313
July	37s	2,521	25	17m 06s	428
August					
September					
October					
November					
December					

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The Public Employees Benefit Program Executive Dashboard

Quarterly Update – 4th Quarter Plan Year 2020

Nevada PEBP Historical Call Statistics

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

Month	Average Wait Time	Total Calls	Abandoned Calls	Average Handle Time	Outreach Attempts
January	1m 10s	2,623	89	22m 17s	356
February	24s	1,732	11	22m 23s	160
March	14s	1,584	5	23m 24s	228
April	14s	1,602	6	24m 00s	230
May	15s	1,780	3	24m 41s	192
June	15s	1,475	4	26m 58s	201
July	15s	2,070	3	25m 38s	227
August	15s	1,706	6	25m 31s	246
September	15s	1,494	7	26m 17s	193
October	1m 07s	2,958	72	31m 16s	409
November	6m 52s	4,050	605	35m 05s	450
December	12m 21s	4,251	668	27m 10s	459

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The Public Employees Benefit Program Executive Dashboard

Quarterly Update – 4th Quarter Plan Year 2020

Nevada PEBP Historical Call Statistics

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

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

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4.3.6

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

    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 & Performance Report

        4.3.6 Hometown Health Providers and Sierra Healthcare Options – PPO Network

Hometown Health Providers & Sierra Healthcare Options

Q4 PlanYear2020

April 1st, 2020 – June 30, 2020

Hometown Health

SIERRA HEALTH-CARE OPTIONS, INC.

Nevada PUBLIC EMPLOYEES' BENEFITS PROGRAM

PEBP

Health Matters.

Sept 24, 2020

Service Performance Standard(Metric)	Guarantee Measurement	Actual	Pass/Fail
I. EDI claims repricing	**95%**- Turnaround time frame for repricing of medical claims within 3 business days of receipt from PEBP's TPA	96%	Pass
	97%- Accuracy of claims repriced by the PPO Network must be accurate and must not cause a claim adjustment by PEBP'sTPA	98.4%	Pass
II. A.Hometown Health Provider DataChanges*	**100%**- Data changes must be provided to PEBP'sTPA within 30 calendar days following the effective date of the change	100%	Pass
	100%- Provider fee schedule revisions must be provided to PEBP'sTPA within 30 calendar days following the effective date of the change	100%	Pass
II. B.Sierra Healthcare Options(SHO) Provider DataChanges*	**100%**- Data changes must be provided to PEBP'sTPA within 30 calendar days following the effective date of the change	100%	Pass
	100%- Provider fee schedule revisions must be provided to PEBP'sTPA within 30 calendar following the effective date of the change	100%	Pass
	(100% of the ACT'sare rounted to the State of Nevada within 30 days of notification of the add, change or term. Please note: the effective date of add, change or term can be greater than 30 days based on the date SHO receives the notifaction or signed document from the provider)		
III. Data Reporting	A. Standard reports must be delivered within 10days of end of reporting period or event as determined by PEBP. B. Special reports requested by PEBP and/or PEBP's Consultant/Actuary must be delivered within 10 days of agreed response date. .	100% 100%	Pass Pass
IV. Subcontractor disclosure	**100%**- of all subcontractors utilized by vendor are disclosed prior to any work being done on behalf of PEBP. Business Associate Agreements completed by all subcontractors.	100%	Pass
V. Website	**100%**- Network website must be updated within 30 calendar days as provider information changes take effect	100%	Pass

4.3.7

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

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

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        4.3.6 Hometown Health Providers and Sierra Healthcare Options – PPO Network

        4.3.7 HealthPlan of Nevada, Inc. – Southern Nevada HMO

Health Plan of Nevada

Annual
Update for
July 1, 2019 – June 30, 2020

HEALTH PLAN OF NEVADA
A UnitedHealthcare Company

Nevada PUBLIC EMPLOYEES' BENEFITS PROGRAM
PEBP
Health Matters.

August 13th, 2020

Health Plan of Nevada HMO

Performance Standards and Guarantees- Self Reported

Annual Report for July 2019 – June 2020

Service Performance Standard (Metric)	Guarantee Measurement	Actual	Pass/Fail
I. Claims Processing	**97%** - Claims Financial Accuracy	100.00%	Pass
	95% - Claims Procedural Accuracy	100.00%	Pass
	95% in 30 working days - Clean claims turnaround for unaffiliated providers	99.60%	Pass
II. Participant Correspondence	ID Card Turnaround- Mailed within 10 working days of date of eligibility input	4.70 days	Pass
	Membership materials (electronic)- Available within 10 working days of date of eligibility input	8.02 days	Pass
III. Customer Service- Telephone	Speed to queue and answer by live voice- Within 60 seconds	53.75 sec	Pass
	5% or less - Telephone abandonment rate	4.75%	Pass
IV. Other Customer Service	**98%** - Resolved resolution within 30 days of receipt of written correspondence (i.e. complaint or appeal)	100.00%	Pass
	Notification to member regarding PCP disenrollment - within 30 working days	100%	Pass
	Primary Care Physician /Member Ratio - 1 to 2450	1 to 309.5	Pass

4.3.8

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

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

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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 Reports through July 2020

NVPEB

HealthSCOPE Benefits

2020-07 Engagement Report

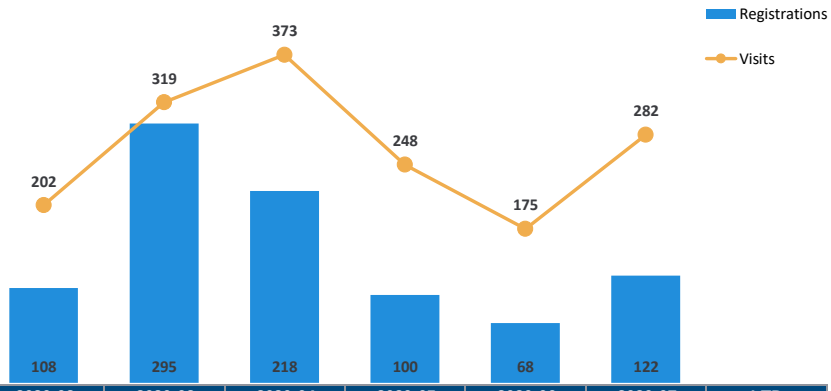
Note: Only Doctor On Demand visits with an associated claim submission to the Payer are included in the Engagement Report -- any free, discounted, uncovered, or other non-claim visits are not included. This is true of all metrics, trends, and aggregations.

Year To Date Activity

Registration Summary	YTD
# Registered	1,030

Visit Summary	YTD
# Unique Visitors	1,164
# Visits	1,820

Monthly Activity



Registration Summary	Prior	2020-02	2020-03	2020-04	2020-05	2020-06	2020-07	LTD
# Registered	7,620	108	295	218	100	68	122	8,531

Note: Registration month is captured per the date of Doctor On Demand registration, not the date when the member entered health insurance to his/her profile.

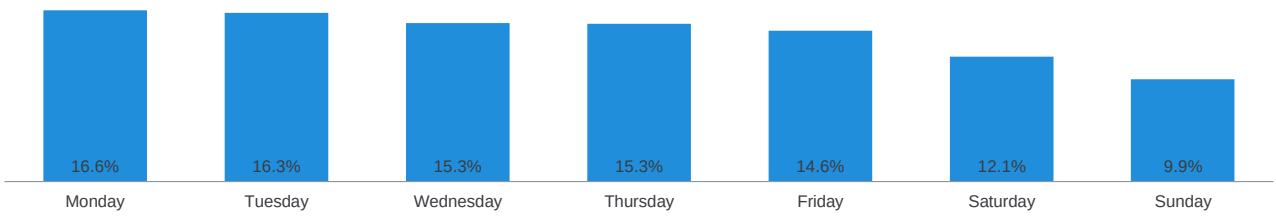
Visit Summary		Prior	2020-02	2020-03	2020-04	2020-05	2020-06	2020-07	LTD
# Unique Visitors		2,478	183	284	307	212	152	236	3,142
# Visits		4,960	202	319	373	248	175	282	6,559
Visit Frequency	% 1 Visit	60.5%	90.2%	89.4%	86.3%	86.3%	87.5%	85.2%	59.4%
	% 2 Visits	20.1%	9.3%	9.2%	9.8%	10.4%	10.5%	11.4%	19.0%
	% 3 Visits Or More	19.5%	0.5%	1.4%	3.9%	3.3%	2.0%	3.4%	21.6%

Note: Because a visitor can be unique in multiple months, but only once over history, Prior + Monthly "# Unique Visitors" will not sum to the Total.

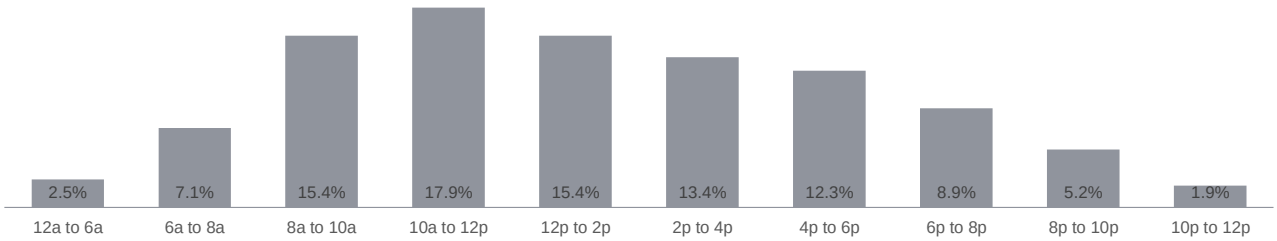
Visit Type Summary		Prior	2020-02	2020-03	2020-04	2020-05	2020-06	2020-07	LTD
Medical		4,128	177	272	320	204	124	236	5,461
Mental Health	Therapy	500	11	20	24	25	17	24	621
	Psychiatry	332	14	27	29	19	34	22	477

Six Month Trends: Visit Time And Demographics

Day Of Week



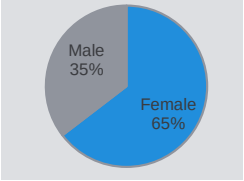
Hour Of Day



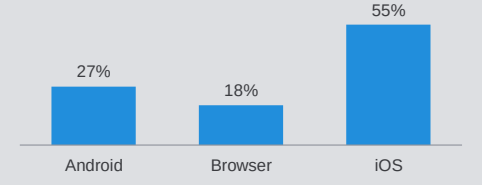
Patient Age

0 to 17 (Custodial)	8%
18 to 29	22%
30 to 49	49%
50 and over	21%

Patient Gender



Visitor App Type



NVPEB

HealthSCOPE Benefits

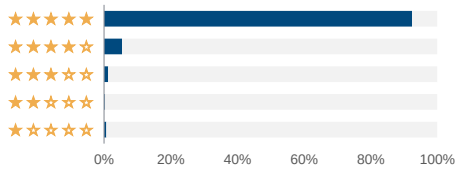
2020-07 Engagement Report

Historical Visit Experience

5,045 Visit Ratings (1-5 Stars):

Average: **4.9**

Stars:



Avg Connection Time (On Demand Visits Only): **9.1 Minutes**

Historical Post Visit Survey Results

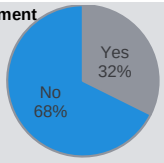
Without Doctor On Demand, where would you have gone to get this issue treated?

Note: Survey presented only when no other post visit action was required

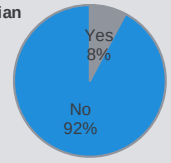
Response	# Responses	% Responses
Emergency Room	68	3%
Urgent Care	1,245	53%
Doctor's Office	655	28%
Stayed Home	277	12%
Other	93	4%

Six Month Trends: Visit Initiation

Initiated By Appointment (Medical Visits Only)

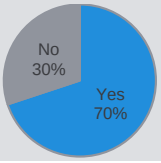


Initiated By Custodian

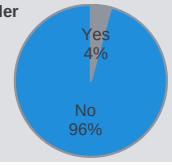


Six Month Trends: Visit Result

Resulted In Rx



Resulted In Lab Order



Historical Top 15 Symptoms

Symptom	# Symptoms	% of All Sym
Chest: Cough	1,642	6.3%
Head / Neck: Headache	1,614	6.2%
General Symptoms: Fatigue / weakness	1,587	6.1%
Head / Neck: Sore throat	1,530	5.8%
General Symptoms: Difficulty sleeping	1,283	4.9%
Head / Neck: Nasal discharge	1,254	4.8%
Head / Neck: Congestion/sinus problem	1,002	3.8%
General Symptoms: Fever	929	3.5%
Head / Neck: Congestion / sinus problem	918	3.5%
General Symptoms: Loss of appetite	748	2.9%
Genitourinary: Discomfort / burning with urination	635	2.4%
Genitourinary: Frequent urination	625	2.4%
Gastrointestinal: Sore throat	562	2.1%
Chest: Shortness of breath	478	1.8%
Head / Neck: Difficulty / pain swallowing	456	1.7%

Historical Top 15 ICD10 Codes

ICD10 Code And Description	# ICD10s	% of All ICD10
N39.0 - Urinary tract infection, site not specified	605	7.2%
J06.9 - Acute upper respiratory infection, unspecified	495	5.9%
J01.90 - Acute sinusitis, unspecified	463	5.5%
J02.9 - Acute pharyngitis, unspecified	259	3.1%
J20.9 - Acute bronchitis, unspecified	219	2.6%
F41.1 - Generalized anxiety disorder	204	2.4%
R05 - Cough	191	2.3%
Z76.0 - Encounter for issue of repeat prescription	162	1.9%
F43.23 - Adjustment disorder with mixed anxiety and depressed n	147	1.8%
Z63.0 - Problems in relationship with spouse or partner	147	1.8%
J01.80 - Other acute sinusitis	128	1.5%
F41.9 - Anxiety disorder, unspecified	120	1.4%
J01.00 - Acute maxillary sinusitis, unspecified	116	1.4%
J11.1 - Influenza due to unidentified influenza virus with other resp	113	1.3%
F33.1 - Major depressive disorder, recurrent, moderate	98	1.2%

Historical Top 15 Rx

Rx	# Visits	% of All Rx
benzonatate	529	7.6%
amoxicillin-clavulanate	497	7.1%
predniSONE	481	6.9%
albuterol	431	6.2%
nitrofurantoin	428	6.2%
fluticasone nasal	209	3.0%
methylPREDNISolone	193	2.8%
azithromycin	184	2.6%
amoxicillin	180	2.6%
sulfamethoxazole-trimethoprim	178	2.6%
fluconazole	172	2.5%
oseltamivir	162	2.3%
ipratropium nasal	154	2.2%
doxycycline	142	2.0%
sertraline	123	1.8%

Historical Top 15 Lab Orders

Lab Name	# Lab Orders	% of All Orders
TSH with Reflex to Free T4	55	10.8%
Urinalysis, Complete with Reflex	47	9.3%
Comprehensive Metabolic Panel	40	7.9%
Urine Culture, Routine	34	6.7%
CBC+diff	32	6.3%
Lipid Panel	30	5.9%
Hemoglobin A1c	26	5.1%
Vitamin D	23	4.5%
Urinalysis, Complete	19	3.7%
B12/Folate	18	3.6%
Chlamydia/GC, Urine	18	3.6%
Basic Metabolic Panel	12	2.4%
SARS-CoV-2 IgG	10	2.0%
RPR w/ Reflex	8	1.6%
Glucose, Serum	7	1.4%

4.4

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

4.4 Acceptance of Health Claim Auditors, Inc. quarterly audit of HealthSCOPE Benefits for the timeframe April 1, 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.

Claims and System Audit Report

for

Nevada PUBLIC EMPLOYEES' BENEFITS PROGRAM

PEBP

Health Matters.

Audit Period: PEBP Plan Year 2020, Quarter Four
April, May and June 2020

Audited Vendor:

HealthSCOPE BENEFITS

Healthy People
Healthy Business
Healthy Futures

Submitted By:
Health Claim Auditors, Inc.
August 2020

TABLE OF CONTENTS

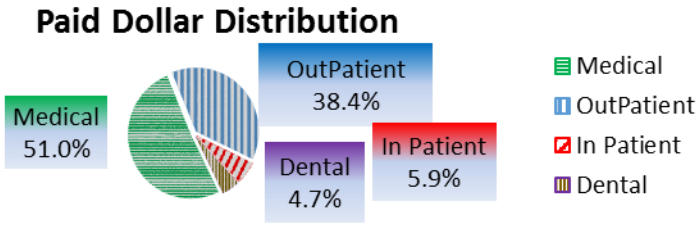
The following categories are reviewed each quarterly audit, however, because of their constant properties, the detail of each category will only be displayed within the first quarter audit of the PEBP fiscal year unless a change or defect is detected:

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

EXECUTIVE SUMMARY

Audited Random Selection Data

Total number of claims: 500
Total Charge Value of random selection: $1,147,834.68
Total Paid Value of random selection: $ 272,389.23



Performance Guaranteed Metric Results

Metric	Guarantee Measurement	Actual	Pass/Fail
Payment Accuracy	≥ 98% of claims audited are to be paid accurately	98.6%	Pass
Financial Accuracy	≥ 99% of the dollars paid for the audited claims is to be paid accurately	99.8%	Pass
Claim Processing Turnaround Time	- 99% of all claims are to be processed within 30 days.	99.8%	Pass
Customer Service	-Telephone Response Time: ≤ 30 seconds. -Telephone Abandonment Rate: ≤ 2%. -First Call Resolution: ≥ 95%	5 sec. 0.11% 97.45%	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 14.

Incorrect rate due to network re-pricing;
Supporting reference nos. 120, 160, 165, 217, 278, 417, 428, 443, 450 and 508

Incorrect copay applied;
Supporting reference nos. **070** and 417

Claim/charge denied in error;
Supporting reference nos. 167 and **415**

Incorrect allowable applied;
Supporting reference nos. **277** and **291**

Discount not applied;
Supporting reference no. **034**

Copay applied in error;
Supporting reference no. **046**

DOS not verified on corrected claim before making adjustment;
Supporting reference no. **273**

CLAIM PROCEDURES/SYSTEM CAPABILITIES/SUPPORT DATA

Introduction

In July 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 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 03 August 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 June 2020 and were processed by HealthSCOPE from 01 April 2020 through 30 June 2020 (PEBP's Fourth Quarter Plan Year 2020). 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	$ 445,364.06	$ 139,066.42	51.0%	379
Outpt. Hospital	$ 626,946.72	$ 104,414.56	38.4%	58
Inpt. Hospital	$ 38,837.25	$ 16,130.02	5.9%	1
Dental	$ 36,686.65	$ 12,778.23	4.7%	62
TOTAL	**$1,147,834.68**	**$ 272,389.23**	**100%**	**500**

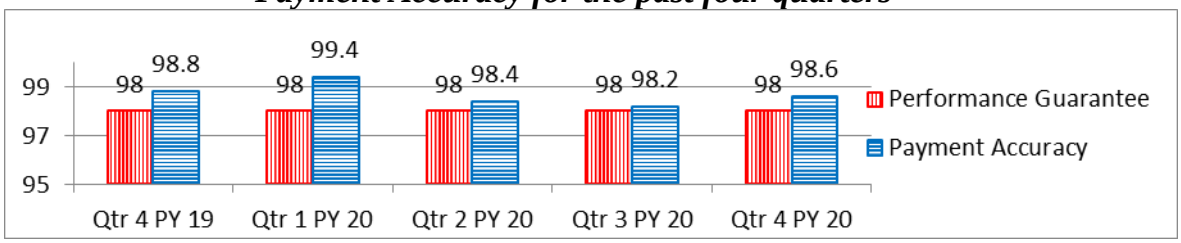
Payment Accuracy

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 98.6%.

Number of claims:	500
Number of claims paid incorrectly:	7
Percentage of claims paid incorrectly:	1.4%
Number of claims paid correctly:	493
Percentage of claims paid correctly:	98.6%

Payment Accuracy for the past four quarters



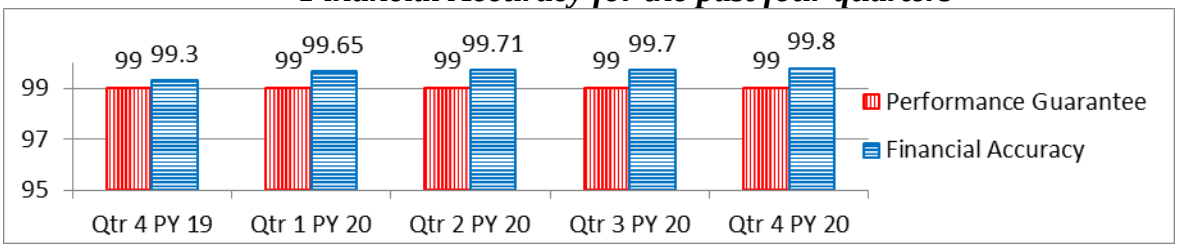
Financial Accuracy

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 99.8%. This audit reflected forty-six and two tenths percent (46.2%) of the audited errors within the valid random selection were overpayments.

Paid dollars audited	$ 272,389.23
Amount of paid dollars remitted incorrectly	$ 298.41
Percentage of Dollars paid incorrectly	0.2%
Paid Dollars of claims paid correctly	$ 272,090.82
Percentage of Dollars Paid correctly	99.8%

Financial Accuracy for the past four quarters



Historical Statistical Data of Performance Guarantees

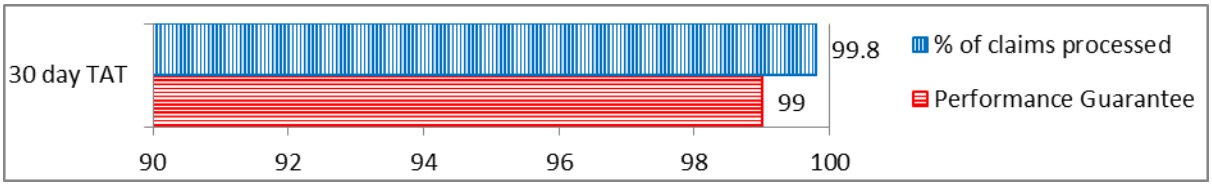
The following reflects the historical statistical data since the origin of PEBP medical claims administration by HealthSCOPE. The entries designated in **bold red type** are measurable categories with underperformance of the Service Performance Guarantees.

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%**

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 99.8% 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 3.7 days.

Turnaround Time Measurements



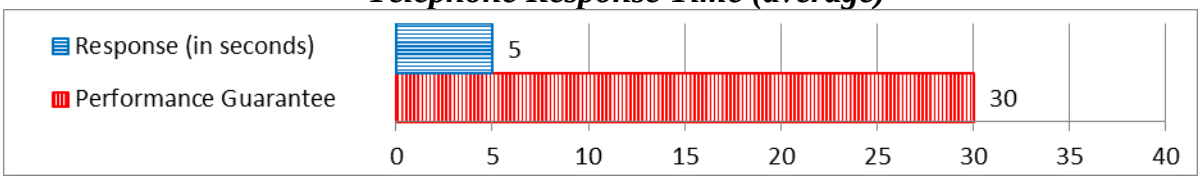
The turnaround time, measured only from the random selected claims, for Medical claims 6.9 calendar days, Out Patient Hospital claims was 7.7 calendar days, In Patient Hospital claims was 4.0 calendar days and Dental claims was 1.5 calendar days.

During the audit period of 01 April 2020 – 30 June 2020, HealthSCOPE had received 1,033 PEBP e-mail inquiries for information via the internet. The average turnaround time for these inquiries was calculated at approximately 7.5 hours.

Customer Service Satisfaction

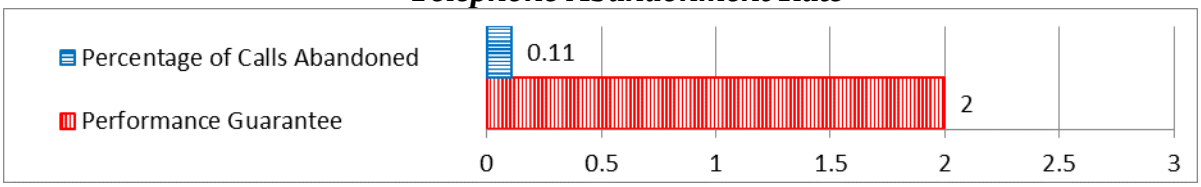
Per the Service Performance Standards and Financial Guarantees Agreement, the telephone response time reflects all calls must be answered within thirty (30) seconds or a penalty of one percent (1%) of Quarterly Administration fees for each second in non-compliance is to be applied. HCA has reviewed the appropriate report for the PEBP fourth fiscal quarter Plan Year 2020, which revealed the average incoming answer speed to be 5 seconds (0:05.0). The telephone response time was 3 seconds for April 2020, 4 seconds for May 2020 and 7 seconds for June 2020.

Telephone Response Time (average)



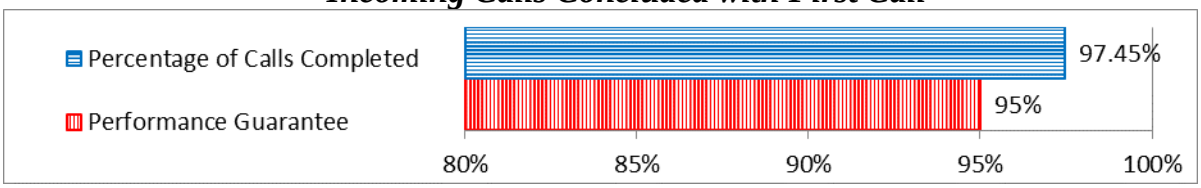
Per the Service Performance Standards and Financial Guarantees Agreement, the abandonment rate must be under two percent (2%) of total calls or a penalty of one percent (1%) of Quarterly Administration fees for each percentage point or fraction thereof in non-compliance is to be applied. HCA has reviewed the appropriate report for the PEBP fourth fiscal quarter Plan Year 2020, which revealed the abandoned calls ratio to be 0.11%. The telephone abandonment rate was 0% for April 2020, 0.07% for May 2020 and 0.22% for June 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 fourth fiscal quarter Plan Year 2020, which revealed that HealthSCOPE documented 97.45% of incoming calls were brought to completion on the first call.

Incoming Calls Concluded with First Call



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

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

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

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

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

HealthSCOPE's telephone conversations are documented for future reference.

HealthSCOPE does have an audit process for Customer Service Representatives.

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

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

Soft Denied Claims

The audit identifies the volume of claims adjudicated and placed in a "soft denied" status. HCA recognizes and respects the need to place certain claims in a soft denied status such as claims that require additional information or special calculation of payment. It is important to include this data within this report to disclose the outstanding unpaid claims that could create an artificial debit/savings during the time that these claims were adjudicated. Note: The measurement of this data was provided as a "snapshot" report. The report reflected the "soft edit" amounts as they were reported on the specific day that the report was recorded. The report for the current claims placed in a "soft denied" status reflect a total of 3,909 claims representing $ 17,472,693.36.

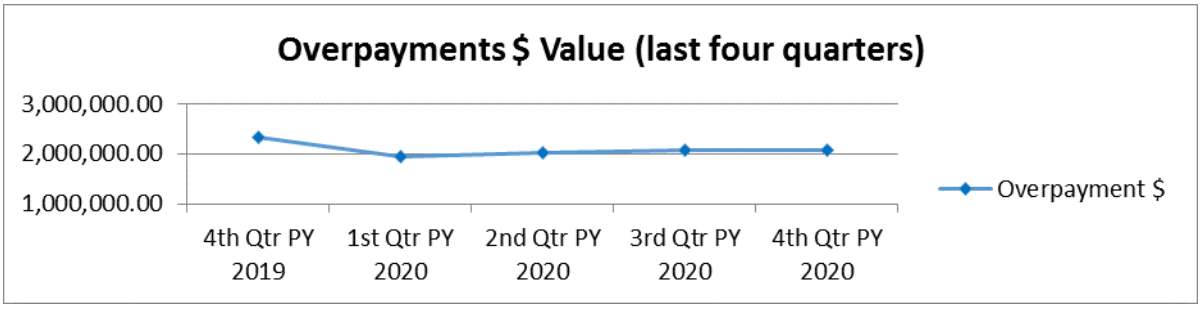
Audit Period	Total Number of Claims	Charge Amount Value of Soft Edits
1st Qtr PY 2012	2,607	$ 7,544,177.55
2nd Qtr PY 2012	4,068	$10,697,954.53
3rd Qtr PY 2012	1,536	$ 6,472,249.56
4th Qtr PY 2012	559	$ 2,205,318.16
1st Qtr PY 2013	1,053	$ 3,413,738.12
2nd Qtr PY 2013	1,107	$ 5,019,961.70
3rd Qtr PY 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**

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 $2,059,471.76 (a decrease of $16,991.77). 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	$ 101,877.77
- Fiscal Year 2013	$ 140,505.35
- Fiscal Year 2014	$ 60,215.17
- Fiscal Year 2015	$ 131,758.66
- Fiscal Year 2016	$ 182,092.61
- Fiscal Year 2017	$ 99,535.36
- Fiscal Year 2018	$ 328,171.58
- Fiscal Year 2019	$ 141,160.13
- Fiscal Year 2020 (to date)	$ 874,155.13
TOTAL	$2,059,471.76



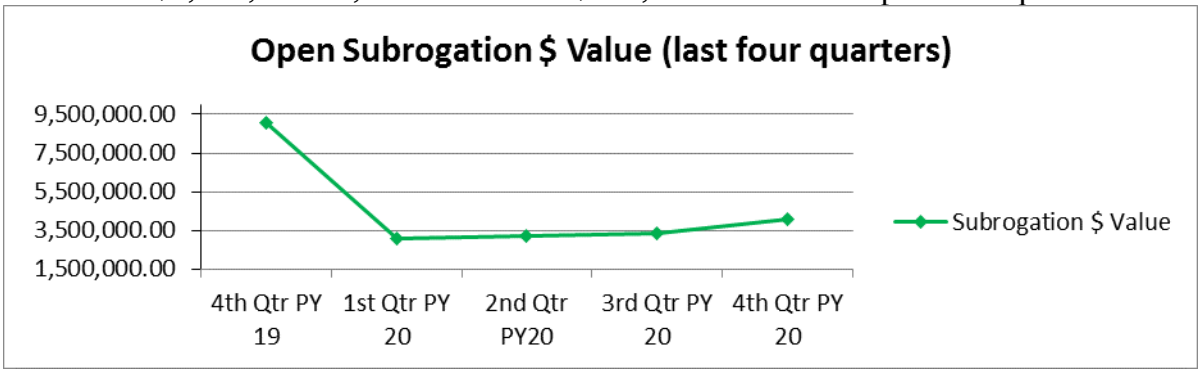
Of the 1,098 most current (Plan Year 2020) identified outstanding overpayments (HSB only), 52% were found to be caused by external sources that are not a cause of the HealthSCOPE adjudication processes. Breakout of the HealthSCOPE's most current overpayments (by claim count) are listed by reason as follows:

15.66%	Incorrect Benefit Applied
15.48%	No COB on file
15.29%	Incorrect Rate Applied
14.75%	Provider caused, rebilled, charges billed in error, corrected EOB
13.93%	Corrected HTH Network Pricing
3.92%	Retro termination
3.55%	Duplicate
3.46%	SHO Pricing Correction
3.10%	COB incorrectly calculated or not applied
1.55%	Previous Information Received
1.09%	Processed under the incorrect provider
0.91%	Paid NON PPO as PPO
0.91%	Service not covered
0.82%	Adjusted after Medical Review
0.64%	Processed under incorrect patient
0.64%	Pharmacy Deductible Error
0.55%	Category error
0.46%	Benefit Clarification
0.46%	Subrogation error
0.46%	Same Day Void
0.36%	Entry Error
0.36%	Pre-Certification Error
0.27%	Paid PPO provider as NON PPO
0.27%	Incorrect Assignment Applied
0.18%	Aetna network Pricing
0.18%	Paid over Maximum
0.18%	System Error
0.18%	Undefined Code
0.09%	Workers Compensation Claim
0.09%	Stop Payment
0.09%	Eligibility Error

Subrogation

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

This report reflects open subrogation claims representing a current potential recovery amount of $4,049,321.26; an increase of $689,247.78 from the previous quarter.



Reports received from HealthSCOPE reflect that subrogation recoveries for the audited period was $188,509.24. After contingency fees were paid, PEBP received $139,561.92.

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 forty-seven (47) active members and thirty-one (31) dependents for a total of 78 active participants, who have obtained this level of plan payment participation representing an accrued dollar paid amount of $102,000,273.27.

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; **CHANGED**,1 individual added for a total of 2 individuals;
- Claims Analysts, 15 individuals;
- Eligibility Director;
- Eligibility Specialists; 2 individuals;
- Customer Service Vice President;
- Customer Service Director;
- Customer Service Representatives, total of 18 individuals;
- Scanning Services Manager;
- Recoveries Manager;
- Recoveries Specialists, 2 individuals;
- Vice President Data Services;
- Senior Data Analyst;
- Chief Information Officer;
- Data Architect
- Computer Domain Hosting (CDH) Services Manager;
- Sr. Vice President-Legal and Compliance;
- COBRA Service Manager;
- Customer Care Supervisor;
- Customer Care Representatives, 3 individuals.

HealthSCOPE POLICY/PROCEDURES/SYSTEM CAPABILITIES

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

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

HCA CLAIM AUDIT PROCEDURES

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

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

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

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

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

AUDIT RESULTS

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

Ref. No. 034 Medical HSB claim no.

Overpayment - $37.95

99396 chg/allow/pd 253.00

Repricing of 215.05 shown. Appears claim overpaid 37.95.

HSB response: Yes, claim is overpaid by $37.95.

Ref. No. 046 Outpatient Hospital HSB claim no.

Overpayment - $12.43

Rev 300 (36415) allow 1.13 copay 1.13 paid 0.00

305 (85025) 11.30 11.30 0.00

920 (93971) 303.60 75.00 228.60

Since lines 1 & 2 are for lab services shouldn't no copay have been applied?

HSB response: Yes, a $75.00 copay should apply for OP diagnostics, not $87.43.

Ref. No. 070 Medical HSB claim no.

Underpayment - $20.00

90837 allow 163.77 copay 40.00 paid 123.77

Claim paid under category GR & taking $40 copay. DX F411, F641

Shouldn't this have paid as MN taking $20 copay?

(Note all claims in history this provider paid under category GR)

HSB response: Yes, claim should take a $20 copay.

Ref. No. 120 Medical HSB claim no.

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

Claim originally paid 2/13/20 under xxxxxx as:

97803 allow/paid 33.36

Audited is adjustment done 4/17/20 to pay additional 116.64

97803 chg/allow/pd 150.00

Appears HTH sent corrected pricing?

HSB response: Yes, HTH did send corrected pricing.

Ref. No. 160 Medical HSB claim no.

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

Claim xxxxxx paid 3/18/20 – COB info needed

Audited paid 4/24/20 as: 00170-AA-P1 allow/paid 567.84

Claim xxxxxx paid 5/19/20 corrected pricing:

Allow 590.52, paid additional 22.68

Appears HTH corrected pricing?

HSB response: Yes, HTH did send corrected pricing.

Ref. No. 165 Medical HSB claim no.

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

Claim originally paid 2/26/20 under xxxxxx as:

Allow/paid 444.00

Audited claim paid 4/27/20 as:

Allow 684.66, additional 240.66 paid

Appears HTH corrected pricing?

HSB response: Yes, HTH did send corrected pricing.

Ref. No. 167 Medical HSB claim no.

NOT charged in statistical calculation. Note to client for information only.
COB w/Medicare
Claim originally processed 4/16/20 under xxxxxx – denied requesting OI info – Medicare info came in with claim
Audited is now paying on 4/29/20 COB's with Medicare
Shouldn't we have paid the claim when originally received versus denying?
HSB response: Yes, original claim xxxxxx should have been paid with Medicare information received on claim.

Ref. No. 217 Medical HSB claim no.

NOT charged in statistical calculation. Note to client for information only.
Claim originally paid 2/17/20 under xxxxxx as:
01214 allow 1054.56 paid 843.65
Audited paid 5/4/20 is adjustment to now allow 1096.68, paying an additional 33.69
Appears HTH provided corrected pricing?
HSB response: Yes, HTH submitted corrected pricing for 01214.

Ref. No. 273 Medical HSB claim no.

Over/Underpayment - $0.00

DOS	5/6	99233	chg 165	allow 0.00	paid 0.00
	5/6	99233	165	50.11	40.09
	5/7	99233	165	50.11	40.09

Claim xxxxxx paid 6/15/20 is adjustment per trns msg provider corrected DOS. Paid now as:

DOS	3/8	99233	allow 50.11	pd 40.09
	5/6	99233	50.11	40.09
	5/6	99233	50.11	50.11

Does not appear per history review that member was inpatient in March 2020. Hospital bill in history for DOS 5/4-5/6/20.
Shouldn't DOS have been confirmed with provider before adjusting?
HSB response: Original claim xxxxxx paid on 5/16/20 paid correctly at the time of receipt. Yes, charges on corrected claim should have been verified prior to making adjustment under claim xxxxxx.

Ref. No. 277 Outpatient Hospital HSB claim no.

Underpayment - $53.39

Provider – Flamingo Surgery Center

Claim paid as: 29848 case rate = 1129.00

25115 742.52 at 50% = 371.26

1500.26 x 80% = 1200.21 paid

Shouldn't allowable have been: 29848 case rate = 1129.00

Grp 4 25115 = 925 x 50% = 462.50

1591.50 x 80% = 1273.20

HSB response: 29848 case rate = $1129.00

25115 grp 3 (876 x 50%) = $438.00

Total allow $1567.00 x 80% = $1253.60

Underpaid $53.39

HCA note: Per CMS, CPT 25115 = ASC grouper 4 but XXXX contract does display CPT 25115 as grouper 4 for this plan.

Ref. No. 278 Medical HSB claim no.

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

Originally claim paid 3/17/20 under xxxxxx as:

01996 allow/paid 243.36

Audited paid 5/14/20 is adjustment to now pay as:

Allow 253.08 – additional 9.72 paid

HSB response: Yes, HTH submitted corrected pricing for 01996.

Ref. No. 291 Outpatient Hospital HSB claim no.

Overpayment - $96.72

Provider – Henderson Surgery Center

Per suspense memo 43239 allow = 435.32

Why was claim paid with allow of 556.23?

HSB response: Agree. Allowable should be $435.32.

Ref. No. 320 Outpatient Hospital HSB claim no.

Provider – Sunrise

Claim paid as CPT 37243 case rate = 3684.00

Rev 278 (w/C2616) = 19984.00

23,668.00

Appears rates used are HCA Children's Trauma Rates

** Additional Question – Contracts under Mountain View and Southern Hills show standard HCA contract rates which are different then the rates shown for the contract listed in Nevada Auditors file for Sunrise.

Sunrise does have a children's hospital and rates by contract are usually higher than for adults.

Attached pg. 20 & 23 from contract sent with response clearly states "HCA Children's Trauma Rate Attachment".

Should the rates at Sunrise for adults be the same as the rates shown on contracts for Mountain View & Southern Hills?

HSB response: I have confirmed that this Sunrise Agreement is not just a Children's Trauma Agreement. It is the Sunrise Agreement but is sometimes known as a Children's Hospital as well.

Ref. No. 415 Outpatient Hospital HSB claim no.

Underpayment - $78.12

Provider – Carson Tahoe

Paid as: allow 7629.84 n/c 186.00

Rev 278 1548.00 x 42% = 650.16

636 568.20 x 42% = 238.64

13757.20 x 49% = 6741.04

7629.84

1) Why were Rev 636 charges 66.70 & 119.30 not covered?

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

2) Surgeon & facility (audited claim) claims paid. Claim xxxxxx same DOS for anesthesia was denied 6/3/20. Shouldn't this claim have been paid?

HSB response: 1) REV 636 for $66.70 & $119.30 should have been paid.

2) Claim xxxxxx for anesthesia should have been paid.

Ref. No. 417 Outpatient Hospital HSB claim no.

NOT charged in statistical calculation. Note to client for information only.
Provider – Renown
Claim paid on 6/12/20 as: allow 1792.41 – copay 286.13 = 1506.28
Claim adjusted on 7/17/20 under xxxxxx to now pay as:
Allow 933.36 – copay 250.00 = 683.36
1) Appears HTH pricing incorrect on audited claim?
2) Why was copay of 286.13 originally applied?
HSB response: 1) HTH repriced the claim. 2) Examiner applied the allowable for REV 255 to copay incorrectly.

Ref. No. 428 Outpatient Hospital HSB claim no.

NOT charged in statistical calculation. Note to client for information only.
Provider – Renown
Audited is original claim paid 6/13/20 as:
Rev 761 1048 x 32% = 335.36 x 80% = 268.29
Claim adjusted on 7/21/20 under xxxxxx as:
1048.00 x 28% = 293.44
Appears HTH corrected pricing?
HSB response: Yes, HTH repriced the claim.

Ref. No. 443 Outpatient Hospital HSB claim no.

NOT charged in statistical calculation. Note to client for information only.
Provider – Renown
Rev 343 chg 828.00 allow 389.16 paid 311.33
404 7216.00 4257.44 3405.95
3717.28 paid 6/16/20
Claim adjusted under xxxxxx on 7/20/20 as:
Rev 343 allow 389.16 paid 311.33
404 2020.48 1616.38
1927.71
Appears that HTH corrected pricing?
HSB response: Yes, HTH repriced the claim

Ref. No. 450 Medical HSB claim no.

NOT charged in statistical calculation. Note to client for information only.
Claim xxxxxx paid 6/23/20 from Renown as:
chg 33983.75 allow 13743.44 coins 1714.71 paid 12028.73
Claim adjusted 7/22/20 under xxxxxx as:
allow 12931.00 coins 1714.71 paid 11,216.29
HSB response: HTH repriced claim.

Ref. No. 508 Inpatient Hospital HSB claim no.

NOT charged in statistical calculation. Note to client for information only.
Provider – Carson Tahoe (DRG 462)
Original claim paid on 3/31/20 under xxxxxx not paying for implants –
Allow 11,304.96 copay 500 paid 10804.96
Audited is to now pay implants on 5/5/20 as:
R278 $27154.00 x 42% = 11,404.68
Please explain how total allow of 22,709.64 was calculated
HCA calculates allow as:
R110 2 days x 2694.22 = 5388.44
278 27154.00 x 42% = 11404.68
16793.12
HSB response: HTH Recon xxxxx. Per attached from HTH, pricing incorrect and will be returned.
HCA Note: Per attached from HTH: "We are in receipt of your request for review of the linked claim. This review has determined the claim was re-priced incorrectly. Hometown Health contract calculation is as follows: Inpatient Medical per diem 2826.24 x 2 = 5652.48, Surgical add-on 2826.24 this should only be one surgery add on line, 278 27154.00 x 42% = 11404.68."

27 Corporate Hill
Little Rock, AR 72205

August 25, 2020

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

Subject: Audit Results April 1, 2020 – June 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 fourth quarter of Plan Year 2020. The audit included 500 claims with paid amounts totaling $272,389.23.

HealthSCOPE Benefits is exceptionally 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 $1.7M through non-network negotiations, subrogation and claims edit savings in the fourth quarter of PY2020.

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

4.5

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

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

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

AGENDA ITEM

[X] Action Item
[ ] Information Only

Date: September 24, 2020

Item Number: IV.V

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.

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.

4.6

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

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.

AON
Empower Results®

June 30, 2020

Ms. Cari Eaton
Chief Financial Officer
State of Nevada
Public Employees' Benefits Program
901 S. Stewart Street, Suite 1001
Carson City, NV 89701

Re: GAS 75 Employer Allocations for Fiscal Year Ending June 30, 2020

Dear Ms. Eaton,

Attached are the fiscal 2020 GAS 75 employer allocations for the State of Nevada Postretirement Health and Life Insurance Plan. The employer allocations are based on the results of the fiscal 2020 GAS 75 valuation provided on June 15, 2020, and the fiscal 2019 employer contributions provided by the State. Fiscal 2019 employer contributions are used for allocation purposes as this is the "measurement period" for the fiscal 2020 GAS 75 valuation.

Please see the fiscal 2020 GAS 75 actuarial valuation report for a summary of the census data, plan provisions and actuarial assumptions used in our calculations.

Please let us know if you have any questions or need further assistance.

Sincerely,

Scott E. Syverson, EA, MAAA
Aon

SES:dlm
Enclosures
cc: Mr. Neal A. Holthus, Aon
Mr. Ronald J. Kalvoda, Aon

State of Nevada
Schedule of Employer Allocations
For the Fiscal Year Ending June 30, 2020

Employer I.D.	Employer		Contribution Amount	Allocation Percentage
101	Board of Medical Examiners	$	57,914	0.1415%
102	Nevada State Board of Nursing		42,302	0.1033%
103	Board of Pharmacy		39,504	0.0965%
104	Board of Chiropractors		2,629	0.0064%
105	Board of Dental Examiners		9,949	0.0243%
106	Legislative Counsel Bureau		499,632	1.2203%
108	Board of Osteopathic Medicine		4,999	0.0122%
109	Board of Massage Therapist		8,730	0.0213%
111	Funeral and Cemetery Board		3,746	0.0091%
113	Public Employee Retirement System		107,891	0.2635%
116	Central Payroll		21,130,765	51.6109%
118	NDOT		2,241,883	5.4757%
128	Board of Accountancy		5,212	0.0127%
129	Board of Cosmetology		26,155	0.0639%
134	Board of Professional Engineers		9,110	0.0223%
139/140	UNLV/UNR		16,724,699	40.8493%
141	Board of Architecture		6,605	0.0161%
146	Board of Examiners for Social Workers		5,079	0.0124%
147	Liquified Petroleum Gas Board		3,790	0.0093%
148	Board of Optometry		2,920	0.0071%
149	Board of Veterinary Examiners		6,516	0.0159%
150	Board of Examiners - Alcohol, Drugs & Gambling		2,401	0.0059%
Total		$	40,942,430	100.0000%

Numbers may not add due to rounding.

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State of Nevada
Schedule of Deferred Inflows / Outflows by Employer
For the Fiscal Year Ending June 30, 2020

		Deferred Outflow of Resources				Deferred Inflow of Resources			
Employer I.D.	Net OPEB Liability	Liability Experience	Assumption Changes	Asset Experience	Total	Liability Experience	Assumption Changes	Asset Experience	Total
101	$ 1,971,236	$ -	$ 42,474	$ -	$ 42,474	$ 35,219	$ 84,202	$ 335	$ 119,755
102	1,439,874	-	31,025	-	31,025	25,725	61,504	244	87,474
103	1,344,606	-	28,972	-	28,972	24,023	57,435	228	81,686
104	89,490	-	1,928	-	1,928	1,599	3,823	15	5,437
105	338,628	-	7,296	-	7,296	6,050	14,465	57	20,572
106	17,006,258	-	366,436	-	366,436	303,841	726,424	2,886	1,033,151
108	170,154	-	3,666	-	3,666	3,040	7,268	29	10,337
109	297,145	-	6,403	-	6,403	5,309	12,693	50	18,052
111	127,511	-	2,747	-	2,747	2,278	5,447	22	7,746
113	3,672,356	-	79,129	-	79,129	65,612	156,865	623	223,100
116	719,240,441	-	15,497,572	-	15,497,572	12,850,242	30,722,432	122,060	43,694,734
118	76,308,308	-	1,644,226	-	1,644,226	1,363,355	3,259,518	12,950	4,635,823
128	177,416	-	3,823	-	3,823	3,170	7,578	30	10,778
129	890,260	-	19,183	-	19,183	15,906	38,028	151	54,084
134	310,073	-	6,681	-	6,681	5,540	13,245	53	18,837
139/140	569,268,536	-	12,266,107	-	12,266,107	10,170,783	24,316,366	96,609	34,583,758
141	224,801	-	4,844	-	4,844	4,016	9,602	38	13,657
146	172,871	-	3,725	-	3,725	3,089	7,384	29	10,502
147	129,002	-	2,780	-	2,780	2,305	5,510	22	7,837
148	99,406	-	2,142	-	2,142	1,776	4,246	17	6,039
149	221,804	-	4,779	-	4,779	3,963	9,474	38	13,475
150	81,724	-	1,761	-	1,761	1,460	3,491	14	4,965
Total	$ 1,393,581,900	$ -	$ 30,027,700	$ -	$ 30,027,700	$ 24,898,300	$ 59,527,000	$ 236,500	$ 84,661,800

Numbers may not add due to rounding.

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State of Nevada
Schedule of GASB 75 Expense by Employer
For the Fiscal Year Ending June 30, 2020

	GASB 75 Expense									
							Amortization of Unrecognized (Gain)/Loss			
Employer I.D.	Service Cost	Interest Cost	Expected Inv. Return	Contributions from NECE	Administrative Expenses	Plan Changes	Liability Experience	Assumption Changes	Asset Experience	Total
101	$ 72,633	$ 74,245	$ (46)	$ -	$ -	$ -	$ (9,317)	$ (29,941)	$ (109)	$ 107,465
102	53,055	54,232	(33)	-	-	-	(6,806)	(21,870)	(80)	78,497
103	49,544	50,644	(31)	-	-	-	(6,355)	(20,423)	(75)	73,303
104	3,297	3,371	(2)	-	-	-	(423)	(1,359)	(5)	4,879
105	12,477	12,754	(8)	-	-	-	(1,601)	(5,143)	(19)	18,461
106	626,623	640,528	(393)	-	-	-	(80,382)	(258,310)	(945)	927,122
108	6,270	6,409	(4)	-	-	-	(804)	(2,584)	(9)	9,276
109	10,949	11,192	(7)	-	-	-	(1,404)	(4,513)	(17)	16,199
111	4,698	4,803	(3)	-	-	-	(603)	(1,937)	(7)	6,951
113	135,314	138,316	(85)	-	-	-	(17,358)	(55,780)	(204)	200,204
116	26,501,588	27,089,643	(16,619)	-	-	-	(3,399,560)	(10,924,638)	(39,947)	39,210,468
118	2,811,704	2,874,094	(1,763)	-	-	-	(360,679)	(1,159,057)	(4,238)	4,160,061
128	6,537	6,682	(4)	-	-	-	(839)	(2,695)	(10)	9,672
129	32,803	33,531	(21)	-	-	-	(4,208)	(13,522)	(49)	48,534
134	11,425	11,679	(7)	-	-	-	(1,466)	(4,710)	(17)	16,904
139/140	20,975,628	21,441,065	(13,153)	-	-	-	(2,690,703)	(8,646,695)	(31,617)	31,034,525
141	8,283	8,467	(5)	-	-	-	(1,063)	(3,415)	(12)	12,255
146	6,370	6,511	(4)	-	-	-	(817)	(2,626)	(10)	9,424
147	4,753	4,859	(3)	-	-	-	(610)	(1,959)	(7)	7,033
148	3,663	3,744	(2)	-	-	-	(470)	(1,510)	(6)	5,419
149	8,173	8,354	(5)	-	-	-	(1,048)	(3,369)	(12)	12,092
150	3,011	3,078	(2)	-	-	-	(386)	(1,241)	(5)	4,455
Total	$ 51,348,800	$ 52,488,200	$ (32,200)	$ -	$ -	$ -	$ (6,586,900)	$ (21,167,300)	$ (77,400)	$ 75,973,200

Numbers may not add due to rounding.

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State of Nevada
Schedule of Total OPEB Liability by Employer
For the Fiscal Year Ending June 30, 2020

	Total OPEB Liability (TOL)									
Employer I.D.	Service Cost	Interest Cost	Benefit Changes	Liability Experience	Assumption Changes	Benefit Payments	Changes in Proportion	Net Changes	TOL (Beginning)	TOL (Ending)
101	$ 72,633	$ 74,245	$ -	$ (44,536)	$ 53,711	$ (60,102)	$ (2,269)	$ 93,682	$ 1,877,881	$ 1,971,564
102	53,055	54,232	-	(32,531)	39,233	(43,901)	115,098	185,185	1,254,928	1,440,113
103	49,544	50,644	-	(30,379)	36,637	(40,997)	(46,049)	19,400	1,325,429	1,344,829
104	3,297	3,371	-	(2,022)	2,438	(2,729)	(1,276)	3,080	86,425	89,505
105	12,477	12,754	-	(7,651)	9,227	(10,325)	(18,524)	(2,041)	340,726	338,685
106	626,623	640,528	-	(384,222)	463,377	(518,515)	(150,922)	676,869	16,332,213	17,009,082
108	6,270	6,409	-	(3,844)	4,636	(5,188)	(33,217)	(24,935)	195,116	170,182
109	10,949	11,192	-	(6,713)	8,096	(9,060)	9,332	23,796	273,399	297,195
111	4,698	4,803	-	(2,881)	3,474	(3,888)	100,688	106,894	20,638	127,532
113	135,314	138,316	-	(82,970)	100,062	(111,969)	310,912	489,667	3,183,299	3,672,966
116	26,501,588	27,089,643	-	(16,249,801)	19,597,441	(21,929,377)	(20,300,514)	14,708,980	704,650,889	719,359,868
118	2,811,704	2,874,094	-	(1,724,034)	2,079,204	(2,326,612)	(2,676,884)	1,037,472	75,283,506	76,320,978
128	6,537	6,682	-	(4,008)	4,834	(5,409)	(3,776)	4,860	172,586	177,445
129	32,803	33,531	-	(20,114)	24,257	(27,144)	(20,593)	22,741	867,667	890,408
134	11,425	11,679	-	(7,005)	8,449	(9,454)	43,222	58,315	251,809	310,124
139/140	20,975,628	21,441,065	-	(12,861,486)	15,511,094	(17,356,788)	22,774,797	50,484,311	518,878,750	569,363,061
141	8,283	8,467	-	(5,079)	6,125	(6,854)	(62,082)	(51,139)	275,978	224,839
146	6,370	6,511	-	(3,906)	4,710	(5,271)	(3,378)	5,036	167,864	172,900
147	4,753	4,859	-	(2,915)	3,515	(3,933)	(48,502)	(42,223)	171,247	129,024
148	3,663	3,744	-	(2,246)	2,709	(3,031)	(54,973)	(50,135)	149,558	99,423
149	8,173	8,354	-	(5,011)	6,044	(6,763)	76,985	87,782	134,059	221,840
150	3,011	3,078	-	(1,846)	2,227	(2,492)	(8,076)	(4,098)	85,836	81,738
Total	$ 51,348,800	$ 52,488,200	$ -	$ (31,485,200)	$ 37,971,500	$ (42,489,800)	$ -	$ 67,833,500	$ 1,325,979,800	$ 1,393,813,300

Numbers may not add due to rounding.

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State of Nevada
Schedule of Plan Fiduciary Net Position by Employer
For the Fiscal Year Ending June 30, 2020

	Plan Fiduciary Net Position (PFNP)							
Employer I.D.	Employer Contributions	Investment Experience	Benefit Payments	Administrative Expenses	Changes in Proportion	Net Changes	PFNP (Beginning)	PFNP (Ending)
101	$ 57,913	$ 257	$ (60,102)	$ -	$ (3)	$ (1,935)	$ 2,262	$ 327
102	42,302	188	(43,901)	-	139	(1,273)	1,512	239
103	39,504	175	(40,997)	-	(55)	(1,373)	1,597	223
104	2,629	12	(2,729)	-	(2)	(89)	104	15
105	9,949	44	(10,325)	-	(22)	(354)	410	56
106	499,631	2,215	(518,515)	-	(182)	(16,850)	19,674	2,824
108	4,999	22	(5,188)	-	(40)	(207)	235	28
109	8,730	39	(9,060)	-	11	(280)	329	49
111	3,746	17	(3,888)	-	121	(4)	25	21
113	107,891	478	(111,969)	-	375	(3,225)	3,835	610
116	21,130,749	93,674	(21,929,377)	-	(24,454)	(729,408)	848,836	119,428
118	2,241,881	9,938	(2,326,612)	-	(3,225)	(78,017)	90,688	12,671
128	5,212	23	(5,409)	-	(5)	(178)	208	29
129	26,155	116	(27,144)	-	(25)	(897)	1,045	148
134	9,110	40	(9,454)	-	52	(252)	303	51
139/140	16,724,686	74,141	(17,356,788)	-	27,435	(530,526)	625,051	94,525
141	6,604	29	(6,854)	-	(75)	(295)	332	37
146	5,079	23	(5,271)	-	(4)	(174)	202	29
147	3,790	17	(3,933)	-	(58)	(185)	206	21
148	2,920	13	(3,031)	-	(66)	(164)	180	17
149	6,516	29	(6,763)	-	93	(125)	161	37
150	2,401	11	(2,492)	-	(10)	(90)	103	14
Total	$ 40,942,400	$ 181,500	$ (42,489,800)	$ -	$ -	$ (1,365,900)	$ 1,597,300	$ 231,400

Numbers may not add due to rounding.

AON
Empower Results®

State of Nevada
Schedule of Discount Rate Sensitivity by Employer
For the Fiscal Year Ending June 30, 2020

	1% Decrease (2.51%)			Current Discount Rate (3.51%)			1% Increase (4.51%)		
Employer I.D.	Total OPEB Liability	Plan Fiduciary Net Position	Net OPEB Liability	Total OPEB Liability	Plan Fiduciary Net Position	Net OPEB Liability	Total OPEB Liability	Plan Fiduciary Net Position	Net OPEB Liability
101	$ 2,173,773	$ 327	$ 2,173,446	$ 1,971,564	$ 327	$ 1,971,236	$ 1,796,125	$ 327	$ 1,795,798
102	1,587,816	239	1,587,577	1,440,113	239	1,439,874	1,311,966	239	1,311,727
103	1,482,759	223	1,482,536	1,344,829	223	1,344,606	1,225,161	223	1,224,937
104	98,685	15	98,670	89,505	15	89,490	81,540	15	81,525
105	373,421	56	373,365	338,685	56	338,628	308,547	56	308,491
106	18,753,583	2,824	18,750,759	17,009,082	2,824	17,006,258	15,495,538	2,824	15,492,714
108	187,636	28	187,608	170,182	28	170,154	155,038	28	155,010
109	327,676	49	327,627	297,195	49	297,145	270,749	49	270,700
111	140,612	21	140,591	127,532	21	127,511	116,183	21	116,162
113	4,049,676	610	4,049,066	3,672,966	610	3,672,356	3,346,129	610	3,345,519
116	793,139,537	119,428	793,020,109	719,359,868	119,428	719,240,441	655,348,031	119,428	655,228,604
118	84,148,683	12,671	84,136,012	76,320,978	12,671	76,308,308	69,529,599	12,671	69,516,928
128	195,645	29	195,615	177,445	29	177,416	161,655	29	161,626
129	981,730	148	981,583	890,408	148	890,260	811,175	148	811,027
134	341,931	51	341,880	310,124	51	310,073	282,528	51	282,476
139/140	627,758,615	94,525	627,664,089	569,363,061	94,525	569,268,536	518,698,606	94,525	518,604,081
141	247,899	37	247,861	224,839	37	224,801	204,831	37	204,794
146	190,633	29	190,604	172,900	29	172,871	157,514	29	157,486
147	142,257	21	142,235	129,024	21	129,002	117,542	21	117,521
148	109,620	17	109,604	99,423	17	99,406	90,576	17	90,559
149	244,593	37	244,556	221,840	37	221,804	202,100	37	202,063
150	90,121	14	90,108	81,738	14	81,724	74,464	14	74,451
Total	$ 1,536,766,900	$ 231,400	$ 1,536,535,500	$ 1,393,813,300	$ 231,400	$ 1,393,581,900	$ 1,269,785,600	$ 231,400	$ 1,269,554,200

Numbers may not add due to rounding.

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State of Nevada
Schedule of Trend Rate Sensitivity by Employer
For the Fiscal Year Ending June 30, 2020

	1% Decrease			Current Trend Rates			1% Increase		
Employer I.D.	Total OPEB Liability	Plan Fiduciary Net Position	Net OPEB Liability	Total OPEB Liability	Plan Fiduciary Net Position	Net OPEB Liability	Total OPEB Liability	Plan Fiduciary Net Position	Net OPEB Liability
101	$ 1,829,210	$ 327	$ 1,828,882	$ 1,971,564	$ 327	$ 1,971,236	$ 2,140,664	$ 327	$ 2,140,336
102	1,336,132	239	1,335,893	1,440,113	239	1,439,874	1,563,631	239	1,563,392
103	1,247,728	223	1,247,505	1,344,829	223	1,344,606	1,460,175	223	1,459,952
104	83,042	15	83,027	89,505	15	89,490	97,182	15	97,167
105	314,230	56	314,174	338,685	56	338,628	367,734	56	367,677
106	15,780,965	2,824	15,778,141	17,009,082	2,824	17,006,258	18,467,943	2,824	18,465,119
108	157,894	28	157,866	170,182	28	170,154	184,778	28	184,750
109	275,736	49	275,687	297,195	49	297,145	322,685	49	322,636
111	118,324	21	118,302	127,532	21	127,511	138,470	21	138,449
113	3,407,764	610	3,407,154	3,672,966	610	3,672,356	3,987,994	610	3,987,384
116	667,419,516	119,428	667,300,088	719,359,868	119,428	719,240,441	781,059,020	119,428	780,939,593
118	70,810,331	12,671	70,797,660	76,320,978	12,671	76,308,308	82,866,992	12,671	82,854,321
128	164,633	29	164,604	177,445	29	177,416	192,665	29	192,635
129	826,117	148	825,969	890,408	148	890,260	966,777	148	966,630
134	287,732	51	287,681	310,124	51	310,073	336,723	51	336,672
139/140	528,253,014	94,525	528,158,489	569,363,061	94,525	569,268,536	618,197,058	94,525	618,102,533
141	208,604	37	208,567	224,839	37	224,801	244,123	37	244,086
146	160,416	29	160,387	172,900	29	172,871	187,729	29	187,701
147	119,708	21	119,686	129,024	21	129,002	140,090	21	140,068
148	92,244	17	92,228	99,423	17	99,406	107,950	17	107,934
149	205,823	37	205,786	221,840	37	221,804	240,868	37	240,831
150	75,836	14	75,823	81,738	14	81,724	88,748	14	88,735
Total	$ 1,293,175,000	$ 231,400	$ 1,292,943,600	$ 1,393,813,300	$ 231,400	$ 1,393,581,900	$ 1,513,360,000	$ 231,400	$ 1,513,128,600

Numbers may not add due to rounding.

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State of Nevada
Schedule of Deferred Inflows / Outflows Recognition by Employer
For the Fiscal Year Ending June 30, 2020

	Amounts to be Recognized in Deferred Inflows/Outflows				
Employer I.D.	Year-End 6/30/2021	Year-End 6/30/2022	Year-End 6/30/2023	Year-End 6/30/2024	Year-End 6/30/2025
101	$ (39,368)	$ (32,708)	$ (6,660)	$ 1,456	$ -
102	(28,756)	(23,891)	(4,865)	1,063	-
103	(26,853)	(22,310)	(4,543)	993	-
104	(1,787)	(1,485)	(302)	66	-
105	(6,763)	(5,619)	(1,144)	250	-
106	(339,637)	(282,177)	(57,458)	12,557	-
108	(3,398)	(2,823)	(575)	126	-
109	(5,934)	(4,930)	(1,004)	219	-
111	(2,547)	(2,116)	(431)	94	-
113	(73,342)	(60,934)	(12,408)	2,712	-
116	(14,364,145)	(11,934,045)	(2,430,049)	531,076	-
118	(1,523,974)	(1,266,151)	(257,818)	56,345	-
128	(3,543)	(2,944)	(599)	131	-
129	(17,780)	(14,772)	(3,008)	657	-
134	(6,193)	(5,145)	(1,048)	229	-
139/140	(11,369,015)	(9,445,626)	(1,923,349)	420,339	-
141	(4,490)	(3,730)	(760)	166	-
146	(3,452)	(2,868)	(584)	128	-
147	(2,576)	(2,140)	(436)	95	-
148	(1,985)	(1,649)	(336)	73	-
149	(4,430)	(3,680)	(749)	164	-
150	(1,632)	(1,356)	(276)	60	-
Total	$ (27,831,600)	$ (23,123,100)	$ (4,708,400)	$ 1,029,000	$ -

Numbers may not add due to rounding.

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Actuarial Report

State of Nevada Postretirement Health and Life Insurance Plan

GASB 75 Accounting Valuation for the Fiscal Year Ending June 30, 2020

Based on a June 30, 2019 Measurement Date

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Contents

Introduction

This report documents the results of the actuarial valuation for the fiscal year ending June 30, 2020 of the Postretirement Health and Life Insurance Plan for the State of Nevada (the "State"). These results are based on a measurement date of June 30, 2019. The information provided in this report is intended strictly for documenting financial accounting disclosure and reporting requirements.

Determinations for purposes other than financial accounting disclosure and reporting requirements may be significantly different from the results in this report. Thus, the use of this report for purposes other than those expressed here may not be appropriate.

This valuation has been conducted in accordance with generally accepted actuarial principles and practices, including the applicable Actuarial Standards of Practice as issued by the Actuarial Standards Board. In addition, the valuation results are based on our understanding of the financial accounting and reporting requirements under U.S. Generally Accepted Accounting Principles as set forth in Governmental Accounting Standards Board Statement 75 (GASB 75) including any guidance or interpretations provided by the State and/or its audit partners prior to the issuance of this report. The information in this report is not intended to supersede or supplant the advice and interpretations of the State's auditors. Additional disclosures may be required under GASB 74.

Future actuarial measurements may differ significantly from the current measurements presented in this report due (but not limited to) to such factors as the following:

- Plan experience differing from that anticipated by the economic or demographic assumptions;
- Changes in actuarial methods or in economic or demographic assumptions;
- Increases or decreases expected as part of the natural operation of the methodology used for these measurements (such as the end of an amortization period); and
- Changes in plan provisions or applicable law.

Due to the limited scope of our assignment, we did not perform an analysis of the potential range of such future measurements.

Funded status measurements shown in this report are determined based on various measures of plan assets and liabilities. For financial accounting disclosure and reporting purposes, funded status is determined using plan assets measured at market value. Plan liabilities are measured based on the interest rates and other assumptions summarized in the Actuarial Assumptions and Methods section of this report. These funded status measurements may not be appropriate for assessing the sufficiency of plan assets to cover the estimated cost of settling the plan's benefit obligations, and funded status measurements for financial accounting disclosure and reporting purposes may not be appropriate for assessing the need for or the amount of future contributions.

In conducting the valuation, we have relied on personnel, plan design, and asset information supplied by the State. While we cannot verify the accuracy of all the information, the supplied information was reviewed for consistency and reasonableness. As a result of this review, we have no reason to doubt the substantial accuracy or completeness of the information and believe that it has produced appropriate results.

The actuarial assumptions and methods used in this valuation are described in the Actuarial Assumptions and Methods section of this report. The State selected the economic and demographic assumptions and prescribed them for use for purposes of compliance with GASB 75. In general, demographic assumptions are based on the June 30, 2016 actuarial experience study for the Public Employees' Retirement System for the State of Nevada and have not been assessed for reasonability since this would require significant additional work outside the scope of the valuation. With respect to the economic assumptions, it is our belief that the assumptions represent reasonable expectations of anticipated plan experience.

The undersigned are familiar with the near-term and long-term aspects of postemployment benefits and collectively meet the Qualification Standards of the American Academy of Actuaries necessary to render the actuarial opinions contained herein. The information provided in this report is dependent upon various factors as documented throughout this report, which may be subject to change. Each section of this report is considered to be an integral part of the actuarial opinions.

To our knowledge, no colleague of Aon providing services to the State has any material direct or indirect financial interest in the State. Thus, we believe there is no relationship existing that might affect our capacity to prepare and certify this actuarial report for the State.

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August 2020

Summary

This report documents the results of the actuarial valuation for the State of Nevada Postretirement Health and Life Insurance Plan for the fiscal year ending June 30, 2020. The valuation results are based on the financial accounting and reporting requirements under GASB 75 and a June 30, 2019 measurement date.

This valuation includes retiree medical, prescription drug, dental and life insurance benefits. The valuation results reflect the plan provisions in effect as of January 1, 2018. It's our understanding there have been no significant plan changes between January 1, 2018 and the June 30, 2019 measurement date. In addition, the valuation is based census data provided by the State as of January 1, 2018. Active employees hired after December 31, 2011 are not eligible for benefits and have been excluded from the valuation.

A nominal amount of assets, associated with the HRA benefit, have been accumulated in a trust by the State for purposes of paying future benefits. The amount of assets in the trust are less than the expected benefit payments in the first year. In addition, it is our understanding that the State intends to fund future benefits on a pay-as-you-go basis. Therefore, the discount rate used in the valuation is based on the Bond Buyer General Obligation 20-Bond Municipal Bond Index for all years, consistent with the requirements of GASB 75.

Plan Changes

There have been no plan changes since the prior valuation.

Assumption Changes

The valuation reflects the following assumption changes from the June 30, 2018 measurement date to the June 30, 2019 measurement date:

- Discount rate changed from 3.87% to 3.51%
- The following assumptions were updated based on the June 30, 2016 actuarial experience study for Nevada PERS:
  - Retirement rates
  - Withdrawal rates
  - Disability rates
  - Mortality rates

Method Changes

There have been no method changes since the prior valuation.

Valuing Postretirement Medical Benefits

In reviewing these valuation results, it should be noted that determining the value of future health care benefits is especially difficult because assumptions must be made about future events that are difficult to predict. Future increases in health care costs are affected by many factors, including:

- Heath care inflation
- Changes in utilization patterns
- Technological advances
- Cost shifting (i.e., increase in private plans' costs in non-managed programs due to uninsured claims, changes in the Medicare payment structure, and increased emphasis on managed care programs)
- Cost leveraging (i.e., erosion of fixed deductibles and out of pocket maximums)
- Changes to government medical programs, such as Medicare

Changes, even small changes, in assumptions or actual experience can lead to significant changes in results. Due to the limited scope of our assignment, we did not perform an analysis of the potential range of such future measurements.

Estimating Current Health Care Costs

In addition to estimating future increases in health care claims costs, it is necessary to develop a starting claims cost on a per covered individual basis. For a discussion of the process used to develop claims and details on the health care trend and other assumptions used in this valuation, see the Health Care Claims Development and Actuarial Assumptions and Method sections of this report.

Accounting Requirements

Net OPEB Liability

The following table illustrates the Net OPEB Liability under GASB 75.

	Fiscal Year Ending 6/30/2019	Fiscal Year Ending 6/30/2020
▪ Total OPEB Liability		
– Retired Participants and Beneficiaries Receiving Payment	$ 712,368,500	$ 703,651,800
– Active Participants	613,611,300	690,161,500
– Total	$ 1,325,979,800	$ 1,393,813,300
▪ Plan Fiduciary Net Position	$ 1,597,300	$ 231,400
▪ Net OPEB Liability	$ 1,324,382,500	$ 1,393,581,900
▪ Plan Fiduciary Net Position as a Percentage of the Total OPEB Liability	0%	0%
▪ Deferred Outflow of Resources for Contributions Made After Measurement Date	$ 40,942,400	$ TBD

OPEB Expense

The following table illustrates the OPEB expense under GASB 75.

	Fiscal Year Ending 6/30/2020
▪ Service Cost	$ 51,348,800
▪ Interest Cost	52,488,200
▪ Expected Investment Return	(32,200)
▪ Contributions from Non-Employer Contributing Entities	0
▪ Administrative Expense	0
▪ Plan Changes	0
▪ Amortization of Unrecognized	
– Liability (Gain)/Loss	(6,586,900)
– Assumption Changes	(21,167,300)
– Asset (Gain)/Loss	(77,400)
▪ Total Expense	$ 75,973,200

Development of OPEB Expense

Shown below are details regarding the calculation of Service Cost, Interest Cost, and Expected Investment Return components of the OPEB Expense.

	Fiscal Year Ending 6/30/2020
Development of Service Cost:	
▪ Normal Cost at Measurement Date	$ 51,348,800
Development of Interest Cost:	
▪ Total OPEB Liability at Measurement Date	$ 1,325,979,800
▪ Normal Cost at Measurement Date	51,348,800
▪ Benefit Payments, net of Employee Contributions	(42,489,800)
▪ Discount Rate	3.87%
▪ Interest Cost	$ 52,488,200
Development of Expected Investment Return:	
▪ Plan Fiduciary Net Position at Measurement Date	$ 1,597,300
▪ Employer Contributions	40,942,400
▪ Benefit Payments, net of Employee Contributions	(42,489,800)
▪ Administrative Expenses	0
▪ Expected Return on Assets	3.87%
▪ Expected Investment Return	$ 32,200

Reconciliation of Net OPEB Liability

Shown below are details regarding the Total OPEB Liability, Plan Fiduciary Net Position, and Net OPEB Liability for the period from June 30, 2019 to June 30, 2020.

	Fiscal Year Ending 6/30/2020		
	Total OPEB Liability	**Plan Fiduciary Net Position**	**Net OPEB Liability**
Balance Recognized at 6/30/2019 (Based on 6/30/2018 Measurement Date)	$ 1,325,979,800	$ 1,597,300	$ 1,324,382,500
Changes Recognized for the Fiscal Year:			
▪ Service Cost	51,348,800	N/A	51,348,800
▪ Interest on Total OPEB Liability	52,488,200	N/A	52,488,200
▪ Changes of Benefit Terms	0	N/A	0
▪ Differences Between Expected and Actual Experience	(31,485,200)	N/A	(31,485,200)
▪ Assumption Changes	37,971,500	N/A	37,971,500
▪ Benefit Payments, net of Employee Contributions	(42,489,800)	(42,489,800)	0
▪ Employer Contributions	N/A	40,942,400	(40,942,400)
▪ Net Investment Income	N/A	181,500	(181,500)
▪ Administrative Expense	N/A	0	0
Net Changes	67,833,500	(1,365,900)	69,199,400
Balance Recognized at 6/30/2020 (Based on 6/30/2019 Measurement Date)	$ 1,393,813,300	$ 231,400	$ 1,393,581,900

Sensitivity

The following table illustrates the impact of discount rate sensitivity on the Net OPEB Liability for the fiscal year ending June 30, 2020:

	1% Decrease (2.51%)	**Discount Rate (3.51%)**	**1% Increase (4.51%)**
Total OPEB Liability	$ 1,536,766,900	$ 1,393,813,300	$ 1,269,785,600
Plan Fiduciary Net Position	231,400	231,400	231,400
Net OPEB Liability	$ 1,536,535,500	$ 1,393,581,900	$ 1,269,544,200

The following table illustrates the impact of health care trend rate sensitivity on the Net OPEB Liability for the fiscal year ending June 30, 2020:

	1% Decrease	**Trend Rates**	**1% Increase**
Total OPEB Liability	$ 1,293,175,000	$ 1,393,813,300	$ 1,513,360,000
Plan Fiduciary Net Position	231,400	231,400	231,400
Net OPEB Liability	$ 1,292,943,600	$ 1,393,851,900	$ 1,513,128,600

Liability (Gain)/Loss

The following table illustrates the liability gain/loss under GASB 75.

	Fiscal Year Ending 6/30/2020
▪ OPEB Liability at Beginning of Measurement Period	$ 1,325,979,800
▪ Service Cost	51,348,800
▪ Interest on the Total OPEB Liability	52,488,200
▪ Changes of Benefit Terms	0
▪ Assumption Changes	37,971,500
▪ Benefit Payments, net of Employee Contributions	(42,489,800)
▪ Expected OPEB Liability at End of Measurement Period	$ 1,425,298,500
▪ Actual OPEB Liability at End of Measurement Period	1,393,813,300
▪ OPEB Liability (Gain)/Loss	$ (31,485,200)
▪ Average Future Working Life Expectancy	4.78
▪ OPEB Liability (Gain)/Loss Amortization	$ (6,586,900)
▪ Assumption Changes	$ 37,971,500
▪ Average Future Working Life Expectancy	4.78
▪ Assumption Changes Amortization	$ 7,943,800

Asset (Gain)/Loss

The following table illustrates the asset gain loss under GASB 75.

	Fiscal Year Ending 6/30/2020
▪ OPEB Asset at Beginning of Measurement Period	$ 1,597,300
▪ Employer Contributions	40,942,400
▪ Expected Investment Income	32,200
▪ Benefit Payments, net of Employee Contributions	(42,489,800)
▪ Administrative Expense	0
▪ Expected OPEB Asset at End of Measurement Period	$ 82,100
▪ Actual OPEB Asset at End of Measurement Period	231,400
▪ OPEB Asset (Gain)/Loss	$ (149,300)
▪ Amortization Factor	5.00
▪ OPEB Asset (Gain)/Loss Amortization	$ (29,900)

Deferred Outflows/Inflows

The following table illustrates the Deferred Inflows and Outflows at the end of the fiscal year under GASB 75.

		Deferred Outflows		Deferred Inflows
Difference Between Actual and Expected Experience				
▪ Measurement Date June 30, 2017	$	0	$	0
▪ Measurement Date June 30, 2018	$	0	$	0
▪ Measurement Date June 30, 2019	$	0	$	24,898,300
Assumption Changes				
▪ Measurement Date June 30, 2017	$	0	$	38,094,700
▪ Measurement Date June 30, 2018	$	0	$	21,432,300
▪ Measurement Date June 30, 2019	$	30,027,700	$	0
Net Difference Between Expected and Actual Earnings on OPEB Plan Investments				
▪ Measurement Date June 30, 2017	$	0	$	51,000
▪ Measurement Date June 30, 2018	$	0	$	66,100
▪ Measurement Date June 30, 2019	$	0	$	119,400
Contribution Made in Fiscal Year Ending June 30, 2020		TBD		N/A
Total	$	30,027,700	$	84,661,800

Amortization of Deferred Inflows/Outflows

The table below lists the amortization bases included in the deferred inflows/outflows as of June 30, 2020.

Date Established	Type of Base	Period		Balance		Annual Payment
		Original	Remaining	Original	Remaining	
July 1, 2017	Liability (Gain)/Loss	4.78	1.78	$ 0	$ 0	$ 0
July 1, 2017	Assumption Changes	4.78	1.78	$ (102,299,500)	$ (38,094,700)	$ (21,401,600)
July 1, 2017	Asset (Gain)/Loss	5.00	2.00	$ (127,200)	$ (51,000)	$ (25,400)
July 1, 2018	Liability (Gain)/Loss	4.78	2.78	$ 0	$ 0	$ 0
July 1, 2018	Assumption Changes	4.78	2.78	$ (36,851,300)	$ (21,432,300)	$ (7,709,500)
July 1, 2018	Asset (Gain)/Loss	5.00	3.00	$ (110,300)	$ (66,100)	$ (22,100)
July 1, 2019	Liability (Gain)/Loss	4.78	3.78	$ (31,485,200)	$ (24,898,300)	$ (6,586,900)
July 1, 2019	Assumption Changes	4.78	3.78	$ 37,971,500	$ 30,027,700	$ 7,943,800
July 1, 2019	Asset (Gain)/Loss	5.00	4.00	$ (149,300)	$ (119,400)	$ (29,900)
	Total Charges				$ (54,634,100)	$ (27,831,600)

Amounts Recognized in the deferred outflows of resources and deferred inflows of resources related to OPEB will be recognized in the OPEB expense as follows:

Year-End 6/30	
2021	$ (27,831,600)
2022	$ (23,132,100)
2023	$ (4,708,400)
2024	$ 1,029,000
2025	$ 0

Supplemental Information

Changes in the Net OPEB Liability and Related Ratios

The follow exhibit is a 3-year history of change in Net OPEB Liability.

	Fiscal Year Ending June 30		
	2018	**2019**	**2020**
Total OPEB Liability			
▪ Service Cost	$ 59,309,600	$ 51,881,500	$ 51,348,800
▪ Interest Cost	39,468,600	47,795,300	52,488,200
▪ Changes of Benefit Terms	0	0	0
▪ Differences Between Expected and Actual Experiences	0	0	(31,485,200)
▪ Changes of Assumptions	(102,299,500)	(36,851,300)	37,971,500
▪ Benefit Payments, net of Employee Contributions	(38,069,200)	(39,710,200)	(42,489,800)
▪ Net Change in Total OPEB Liability	$ (41,590,500)	$ 23,115,300	$ 67,833,500
▪ Total OPEB Liability (Beginning)	$ 1,344,455,000	$ 1,302,864,500	$ 1,325,979,800
▪ Total OPEB Liability (Ending)	$ 1,302,864,500	$ 1,325,979,800	$ 1,393,813,300
Plan Fiduciary Net Position			
▪ Employer Contributions	$ 38,048,600	$ 39,668,900	$ 40,942,400
▪ Net Investment Income	164,800	162,400	181,500
▪ Benefit Payments, net of Employee Contributions	(38,069,200)	(39,710,200)	(42,489,800)
▪ Administrative Expense	0	0	0
▪ Net Change in Plan Fiduciary Net Position	$ 144,300	$ 121,100	$ (1,365,900)
▪ Plan Fiduciary Net Position (Beginning)	$ 1,331,900	$ 1,476,200	$ 1,597,300
▪ Plan Fiduciary Net Position (Ending)	$ 1,476,200	$ 1,597,300	$ 231,400
▪ Net OPEB Liability (Ending)	$ 1,301,388,300	$ 1,324,382,500	$ 1,393,581,900
▪ Net Position as a % of OPEB Liability	0%	0%	0%
▪ Covered Payroll	$ 1,663,856,400	$ 1,890,946,300	$ 1,991,456,200
▪ Net OPEB Liability as a % of Payroll[1]	78%	70%	70%

[1] Covered Payroll provided by Nevada Public Employees' Benefits Program

Contribution Schedule

The follow exhibit is a 3-year history of Contributions.

	Fiscal Year Ending June 30		
	2018	**2019**	**2020**
Actuarially Determined Contribution	N/A	N/A	N/A
Contributions Made in Relation to the Actuarially Determined Contribution	N/A	N/A	N/A
Contribution Deficiency (Excess)	N/A	N/A	N/A
Covered Payroll[1]	$ 1,663,856,400	$ 1,890,946,300	$ 1,991,456,200
Contributions as a % of Payroll	N/A	N/A	N/A

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 Rates	Varies by age and service
Mortality Rates	Headcount-weighted RP-2014 table projected to 2020 with Scale MP-2016 (See Actuarial Assumptions and Methods section for additional details)

[1] Covered Payroll provided by Nevada Public Employees' Benefits Program

Personnel Information

This actuarial valuation was based on personnel data supplied by the State as of January 1, 2018.

	January 1, 2018
Health Care Participants	
Active Participants[1]	
Number	13,190
Average Age	51.51
Average Service	14.41
Inactive Participants[2]	
State Retirees and Surviving Spouses Under Age 65	3,355
Average Age	59.36
State Retirees and Surviving Spouses Age 65 and Older	7,129
Average Age	73.69
Terminated Vested	2,272
Average Age	53.38
State Covered Spouses	2,067
Average Age	63.57
Total Participants	
Number	28,013
Life Insurance Participants	
Active Participants[1]	
Number	13,190
Average Age	51.51
Average Service	14.41
State Inactive Participants	
Number	12,375
Average Age	62.67
Non-State Inactive Participants	
Number	7,354
Average Age	68.15

[1] Active counts reflect those hired prior to January 1, 2012.
[2] Inactive counts include terminated vested participants.

Active Participants By Age and Service

The following table summarizes the distribution of the future retiree population by age and service as of January 1, 2018:

HTH ACTIVES
(AS OF JANUARY 1, 2018)

	COMPLETED YEARS OF SERVICE										
Age	Under 1	1 to 4	5-10	10-14	15-19	20-24	25-29	30-34	35-39	40+	Total
Under 25	0	0	0	0	0	0	0	0	0	0	0
25-29	0	0	8	2	0	0	0	0	0	0	10
30-34	0	0	53	27	2	0	0	0	0	0	82
35-39	0	0	63	80	14	2	0	0	0	0	159
40-44	0	0	68	88	64	12	0	0	0	0	232
45-49	0	0	74	140	93	58	14	0	0	0	379
50-54	0	0	111	107	82	72	22	5	0	0	399
55-59	0	0	82	137	91	59	32	0	1	0	402
60-64	0	0	72	103	65	34	15	6	2	0	297
65-69	0	0	27	28	20	14	12	2	1	0	104
70+	0	0	3	12	12	5	4	1	0	0	37
Total	0	0	561	724	443	256	99	14	4	0	2,101

HPN ACTIVES
(AS OF JANUARY 1, 2018)

	COMPLETED YEARS OF SERVICE										
Age	Under 1	1 to 4	5-10	10-14	15-19	20-24	25-29	30-34	35-39	40+	Total
Under 25	0	0	0	0	0	0	0	0	0	0	0
25-29	0	0	12	1	0	0	0	0	0	0	13
30-34	0	0	56	28	1	0	0	0	0	0	85
35-39	0	0	63	75	15	0	0	0	0	0	153
40-44	0	0	67	108	43	18	1	0	0	0	237
45-49	0	0	86	118	80	39	6	0	0	0	329
50-54	0	0	64	120	78	42	25	1	0	0	330
55-59	0	0	52	100	70	47	22	3	0	0	294
60-64	0	0	45	83	59	36	19	1	0	0	243
65-69	0	0	21	32	26	7	12	2	2	0	102
70+	0	0	7	9	9	10	6	2	2	1	46
Total	0	0	473	674	381	199	91	9	4	1	1,832

CDHP ACTIVES
(AS OF JANUARY 1, 2018)

	COMPLETED YEARS OF SERVICE										
Age	Under 1	1 to 4	5-10	10-14	15-19	20-24	25-29	30-34	35-39	40+	Total
Under 25	0	0	0	0	0	0	0	0	0	0	0
25-29	0	0	83	4	0	0	0	0	0	0	87
30-34	0	0	299	161	4	0	0	0	0	0	464
35-39	0	0	375	437	65	2	0	0	0	0	879
40-44	0	0	371	510	257	57	2	0	0	0	1,197
45-49	0	0	368	512	371	198	35	3	0	0	1,487
50-54	0	0	382	522	374	209	98	19	0	0	1,604
55-59	0	0	309	498	314	227	109	41	3	0	1,501
60-64	0	0	200	365	266	165	98	49	6	1	1,150
65-69	0	0	110	176	106	82	76	38	18	6	612
70+	0	0	26	68	58	37	29	23	16	19	276
Total	0	0	2,523	3,253	1,815	977	447	173	43	26	9,257

Plan Provisions

Eligibility

For a retiree to participate in the PEBP program, the participant must be receiving a PERS, LRS, JRS, or RPA benefit. PERS eligibility requirements vary by employee group and benefit type. Actives hired after December 31, 2011 are not eligible for any subsidy from PEBP. In addition, actives hired after December 31, 2009 and who retire with less than 15 years of continuous service (except a disability retirement) are not eligible for a subsidy from PEBP.

Normal Retirement—Regular Employees

- Minimum age of 65 with 5+ years of service
- Minimum age of 60 with 10+ years of service
- Minimum 30 years of service, regardless of age

Normal Retirement—Police & Fire Employees

- Minimum age of 65 with 5+ years of service
- Minimum age of 55 with 10+ years of service
- Minimum age of 50 and 20+ years of service
- Minimum 25 years of service, regardless of age

Disability Benefit

- Minimum 5 years of service, regardless of age

Reduced Benefit

- Minimum 5 years of service, regardless of age

For this valuation, Regular Employees were considered eligible for retirement at a minimum age of 50 with 5 years of service and Police & Fire Employees were considered eligible for retirement at a minimum age of 45 with 5 years of service.

Surviving spouses are not eligible to receive post-Medicare benefits.

Medical and Rx Benefits

- Pre-Medicare Retires

For retirees with younger spouses, retirees and spouses will move to the Exchange once the spouse becomes Medicare eligible (age 65). For retirees with older spouse, retirees and spouses will both move to the Exchange when the retiree becomes Medicare eligible.

- Medicare Retirees

Certain retirees over age 65 are not eligible for Medicare Part A as indicated on the data. For these participants, we have assumed they will not become eligible for Medicare Part A at any time in the future. Current active employees are assumed to be eligible for Medicare Part A. Medicare eligible retirees will go to the Exchange.

Medical and Rx Benefits ▪ Terminated Vesteds	If service is less than 10 years, Terminated Vested (TVs) participants are assumed to retire at age 65 and go directly to the Exchange. If service is ten years or more, TVs are assumed to retire at age 60 and move to the Exchange in the same manner as actives outlines above.
▪ Current Actives	Actives enrolled in the CDHP are assumed to participate in this plan upon retirement. It is assumed 5% of pre-Medicare actives enrolled in the HPN Plan will participate in the CDHP upon retirement. Likewise, it is assumed 20% of pre-Medicare actives enrolled in the HTH Plan will participate in the CDHP upon retirement. The balance of the HMO populations will remain in the HMO plan as early retirees. These assumptions were based upon actual PEBP census. For all plans, when actives retire and then reach age 65, it is assumed they become Medicare eligible. Once both the participant and spouse become Medicare eligible, it is assumed they will both participate in the Exchange.
Dental Benefits	Pre-Medicare retirees will participate in PEBP's Dental Plan. Those enrolled in the EHPD plan will assume to enroll in PEBP's dental plan. For those future Exchange retirees, we assume 55% will participate in PEBP's Dental program.
Life Insurance Benefits	If you participate in a PEBP medical plan, your benefits include $12,500 life insurance. Zero retiree contributions have been assumed for the life insurance. The life insurance retiree contribution for non-Medicare retirees is included in the medical premium. For Medicare retirees, the premium is paid by PEBP.
HRA Benefit	The following monthly amount will be credited on behalf of Medicare Eligible Retirees, effective July 1, 2016: ▪ For those who retired prior to January 1, 1994, the dollar amount is equal to $180 (previously was $165). ▪ For those who retired on or after January 1, 1994, the dollar amount is equal to the base amount ($12) multiplied by the years of service credit up to a maximum of 20 years of service. Prior to this plan year, the base amount was $11. ▪ A one-time contribution $2 per year of service per month for plan year 2016 and 2017.

Retiree Medical Contributions (Effective 7/1/2017-6/30/2018)

- State Non-Medicare Retirees and Survivors

	CDHP	HMO
Retiree	$ 209.08	$ 397.99
Retiree + Spouse	$ 477.86	$ 942.40
Surviving Spouse	$ 581.78	$ 802.75

- Non-State Non-Medicare Retirees and Survivors

	CDHP	HMO
Retiree	$ 391.67	$ 439.31
Retiree + Spouse	$ 953.23	$ 1,038.00
Surviving Spouse	$ 1,100.86	$ 868.57

- Voluntary Dental Rates for Medicare Exchange Retirees

	State	Non-State
Retiree	$ 38.89	$ 38.21
Retiree + Spouse	$ 77.78	$ 76.42
Surviving Spouse	$ 38.89	$ 38.21

Subsidy for Retires Enrolled in CDHP or HMO Plans

Years of Service	7/1/2016	7/1/2017
5	$ 322.72	$ 333.77
6	$ 290.45	$ 300.39
7	$ 258.18	$ 267.02
8	$ 225.91	$ 233.64
9	$ 193.63	$ 200.26
10	$ 161.36	$ 166.89
11	$ 129.09	$ 133.51
12	$ 96.82	$ 100.13
13	$ 64.54	$ 66.75
14	$ 32.27	$ 33.38
15	$ 0.00	$ 0.00
16	$ (32.27)	$ (33.38)
17	$ (64.54)	$ (66.75)
18	$ (96.82)	$ (100.13)
19	$ (129.09)	$ (133.51)
20	$ (161.36)	$ (166.89)

Part B Premium	The State of Nevada pays the Part B premium for eligible participants in the CDHP and HMO Plans. If not specifically indicated on the data, it is assumed any retiree over age 65 and participating in these plans will receive the Part B premium and the State pays the premium. For retirees indicated on the data file as eligible for Part B, it is assumed they will receive the Part B premium subsidy. The Part B premium subsidy in effect for 2018 calendar year is $134 per month.
Administrative Fees (Per Employee Basis)	Effective as of January 1, 2018 ▪ CDHP: $610.92 ▪ HMO: $269.04
HRA Account Reversions	▪ Pre-65 CDHP: 5.0% ▪ Medicare HRA: 0.5%

Health Care Claims Development

On March 23, 2010, the "Patient Protection and Affordable Care Act" was signed into law, followed by the passage of the "Health Care and Education Affordability Reconciliation Act of 2010" on March 30, 2010 ("Acts"). The health care reforms contained in these Acts have wide-spread impact on health care programs, including those covering retirees. This valuation reflects Aon's interpretation of the Acts based on information currently available. Future regulations on each aspect of the Acts may be different than Aon's initial interpretations.

Key issues in Health Care Reform that have an effect on the valuation include:

- Excise tax on high-cost health plans
- Group market reforms
- Early Retiree Reimbursement Program
- Taxation of Retiree Drug Subsidy for post-65 coverage

The valuation issues related to each of these topics are discussed below.

Excise Tax on High-Cost Health Plans

The excise tax on high cost plans becomes effective in 2022. However, the expected additional cost needs to be reflected in current valuations. Key features of the law include:

- Imposes a non-deductible excise tax of 40% on plans with an aggregate value of health insurance coverage exceeding specified dollar thresholds beginning in 2022
  - Aggregate value includes medical, pharmacy, and employer HSA/HRA contributions (excludes standalone dental and vision plans)
- 2018 thresholds for high-risk professions are:
  - $11,850 for single coverage and $30,950 for family coverage for age 55 to 64 retirees
  - $10,200 for single coverage and $27,500 for family coverage for Medicare retirees
- Thresholds will be increased if the increase in the cost of the Federal Employees Health Benefit Plan (FEHBP) increases by more than 55% from 2010 to 2018
  - Thresholds indexed at general inflation (CPI-U) plus 1 % from 2018 to 2019, and to CPI-U only thereafter
- Excise tax applies only to portion of cost that exceeds threshold amount
- The law provides for blending of pre-65 and post-65 retirees

The pre-65 and the post-65 retirees were blended together to determine the overall value of the benefit relative to the excise tax threshold. The values of the benefits were assumed to increase with the valuation trend and the excise tax thresholds were assumed to increase by 2.5% per year.

For purposes of determining the impact of excise tax on the State's Plan, the impact associated with the Medicare Exchange was determined separately from all other plans at the request of the State. As a result, the excise tax has no impact on the Medicare Exchange. The excise tax is anticipated to impact the non-Medicare Exchange plans in 2022. The estimated impact of the excise tax on the Total OPEB Liability is an increase of approximately 3.8%.

Health Care Claims Development

Group Market Reforms

- Requirement to Cover Children to Age 26
  - The Acts requires that a group health plan that provides dependent coverage of children shall continue to make such coverage available for an adult child until the child turns 26 years of age. Current and future dependent children are valued implicitly in the valuation. Per capita claims costs were developed using claims information for all covered lives and adult headcounts. As such, the impact of child coverage is built into the per capita claims for retirees and spouses.
- Elimination of Benefit Limitations
  - The Acts include a number of other provisions that may increase the cost of retiree health care including the elimination of lifetime maximum benefits and "restrictive" annual benefit limitations. We have made no adjustment for these additional benefits because there are no material limits in the plans.

Medicare Part D reimbursements and the Early Retiree Reinsurance program do not fall under GASB 75.

Claims Cost Development

The first step in determining the liabilities under a postretirement welfare plan is to calculate the expected average claims cost per participant in the coming year. The preliminary per capita costs were developed as follows:

- For the CDHP plan, the per capita costs were based on the claims and enrollment for the time period January 1, 2015 – December 31, 2017, separately for state versus non-state. The experience was adjusted for demographics, historical plan design changes, rebates, and trended to the valuation period.
- For the HMO plans, the per capita rates were based on the July 2017 – June 2018 retiree premium rates provided for state versus non-state and adjusted for trend and demographics.
- For the dental plan, the per capita costs were based on the claims and enrollment for the time period January 1, 2015 – December 31, 2017. The experience was trended to the valuation period. No aging was assumed.
- The final per capita costs for all the plans were based on a blend of the preliminary claim costs and the prior valuation's claim costs trended forward to the valuation period.

A sample of the resulting age related annual claims rates, including administrative expenses are shown below:

Health Care Claims Development

Health Care Claims as of January 1, 2018—CDHP Medical

	CDHP Medical			
	State		Non-State	
Age	Non-Medicare	Medicare	Non-Medicare	Medicare
30	$3,016	$3,016	$3,479	$3,479
31	$3,106	$3,106	$3,583	$3,583
32	$3,199	$3,199	$3,691	$3,691
33	$3,295	$3,295	$3,802	$3,802
34	$3,394	$3,394	$3,916	$3,916
35	$3,496	$3,496	$4,033	$4,033
36	$3,601	$3,601	$4,154	$4,154
37	$3,709	$3,709	$4,279	$4,279
38	$3,820	$3,820	$4,407	$4,407
39	$3,935	$3,935	$4,539	$4,539
40	$4,053	$4,053	$4,675	$4,675
41	$4,175	$4,175	$4,815	$4,815
42	$4,300	$4,300	$4,959	$4,959
43	$4,429	$4,429	$5,108	$5,108
44	$4,562	$4,562	$5,261	$5,261
45	$4,699	$4,699	$5,419	$5,419
46	$4,873	$4,873	$5,619	$5,619
47	$5,053	$5,053	$5,827	$5,827
48	$5,240	$5,240	$6,043	$6,043
49	$5,434	$5,434	$6,267	$6,267
50	$5,635	$5,635	$6,499	$6,499
51	$5,872	$5,872	$6,772	$6,772
52	$6,119	$6,119	$7,056	$7,056
53	$6,376	$6,376	$7,352	$7,352
54	$6,644	$6,644	$7,661	$7,661
55	$6,923	$6,923	$7,983	$7,983
56	$7,228	$7,228	$8,334	$8,334
57	$7,546	$7,546	$8,701	$8,701
58	$7,878	$7,878	$9,084	$9,084
59	$8,225	$8,225	$9,484	$9,484
60	$8,587	$8,587	$9,901	$9,901
61	$8,905	$8,905	$10,267	$10,267
62	$9,234	$9,234	$10,647	$10,647
63	$9,576	$9,576	$11,041	$11,041
64	$9,930	$9,930	$11,450	$11,450
65	$10,297	$3,604	$11,874	$4,156
66	$10,575	$3,701	$12,195	$4,268
67	$10,861	$3,801	$12,524	$4,383
68	$11,154	$3,904	$12,862	$4,502
69	$11,455	$4,009	$13,209	$4,623
70	$11,764	$4,117	$13,566	$4,748
71	$11,976	$4,192	$13,810	$4,834
72	$12,192	$4,267	$14,059	$4,921
73	$12,411	$4,344	$14,312	$5,009
74	$12,634	$4,422	$14,570	$5,100
75	$12,861	$4,501	$14,832	$5,191

Health Care Claims Development

Health Care Claims as of January 1, 2018—CDHP Rx

	CDHP Rx			
	State		Non-State	
Age	Non-Medicare	Medicare	Non-Medicare	Medicare
30	$652	$652	$599	$599
31	$683	$683	$628	$628
32	$716	$716	$658	$658
33	$750	$750	$690	$690
34	$786	$786	$723	$723
35	$824	$824	$758	$758
36	$864	$864	$794	$794
37	$905	$905	$832	$832
38	$948	$948	$872	$872
39	$993	$993	$914	$914
40	$1,041	$1,041	$958	$958
41	$1,091	$1,091	$1,004	$1,004
42	$1,143	$1,143	$1,052	$1,052
43	$1,198	$1,198	$1,103	$1,103
44	$1,255	$1,255	$1,156	$1,156
45	$1,315	$1,315	$1,211	$1,211
46	$1,377	$1,377	$1,268	$1,268
47	$1,442	$1,442	$1,328	$1,328
48	$1,510	$1,510	$1,390	$1,390
49	$1,581	$1,581	$1,455	$1,455
50	$1,655	$1,655	$1,523	$1,523
51	$1,733	$1,733	$1,595	$1,595
52	$1,814	$1,814	$1,670	$1,670
53	$1,899	$1,899	$1,748	$1,748
54	$1,988	$1,988	$1,830	$1,830
55	$2,081	$2,081	$1,916	$1,916
56	$2,177	$2,177	$2,004	$2,004
57	$2,277	$2,277	$2,096	$2,096
58	$2,382	$2,382	$2,192	$2,192
59	$2,492	$2,492	$2,293	$2,293
60	$2,607	$2,607	$2,399	$2,399
61	$2,727	$2,727	$2,509	$2,509
62	$2,853	$2,853	$2,624	$2,624
63	$2,984	$2,984	$2,745	$2,745
64	$3,121	$3,121	$2,871	$2,871
65	$3,265	$3,265	$3,003	$3,003
66	$3,389	$3,389	$3,117	$3,117
67	$3,518	$3,518	$3,235	$3,235
68	$3,652	$3,652	$3,358	$3,358
69	$3,791	$3,791	$3,486	$3,486
70	$3,935	$3,935	$3,618	$3,618
71	$4,033	$4,033	$3,708	$3,708
72	$4,134	$4,134	$3,801	$3,801
73	$4,237	$4,237	$3,896	$3,896
74	$4,343	$4,343	$3,993	$3,993
75	$4,452	$4,452	$4,093	$4,093

Health Care Claims Development

Health Care Claims as of January 1, 2018—HMO

	HMO			
	State		Non-State	
Age	Non-Medicare	Medicare	Non-Medicare	Medicare
30	$3,723	$3,723	$3,727	$3,727
31	$3,835	$3,835	$3,839	$3,839
32	$3,950	$3,950	$3,954	$3,954
33	$4,069	$4,069	$4,073	$4,073
34	$4,191	$4,191	$4,195	$4,195
35	$4,317	$4,317	$4,321	$4,321
36	$4,446	$4,446	$4,451	$4,451
37	$4,579	$4,579	$4,585	$4,585
38	$4,716	$4,716	$4,723	$4,723
39	$4,857	$4,857	$4,865	$4,865
40	$5,003	$5,003	$5,011	$5,011
41	$5,153	$5,153	$5,161	$5,161
42	$5,308	$5,308	$5,316	$5,316
43	$5,467	$5,467	$5,475	$5,475
44	$5,631	$5,631	$5,639	$5,639
45	$5,800	$5,800	$5,808	$5,808
46	$6,015	$6,015	$6,023	$6,023
47	$6,238	$6,238	$6,246	$6,246
48	$6,469	$6,469	$6,477	$6,477
49	$6,708	$6,708	$6,717	$6,717
50	$6,956	$6,956	$6,966	$6,966
51	$7,248	$7,248	$7,259	$7,259
52	$7,552	$7,552	$7,564	$7,564
53	$7,869	$7,869	$7,882	$7,882
54	$8,200	$8,200	$8,213	$8,213
55	$8,544	$8,544	$8,558	$8,558
56	$8,920	$8,920	$8,935	$8,935
57	$9,313	$9,313	$9,328	$9,328
58	$9,723	$9,723	$9,738	$9,738
59	$10,151	$10,151	$10,166	$10,166
60	$10,598	$10,598	$10,613	$10,613
61	$10,990	$10,990	$11,006	$11,006
62	$11,397	$11,397	$11,413	$11,413
63	$11,819	$11,819	$11,835	$11,835
64	$12,256	$12,256	$12,273	$12,273
65	$12,709	$4,448	$12,727	$4,454
66	$13,052	$4,568	$13,071	$4,575
67	$13,404	$4,691	$13,424	$4,698
68	$13,766	$4,818	$13,786	$4,825
69	$14,138	$4,948	$14,158	$4,955
70	$14,520	$5,082	$14,540	$5,089
71	$14,781	$5,173	$14,802	$5,181
72	$15,047	$5,266	$15,068	$5,274
73	$15,318	$5,361	$15,339	$5,369
74	$15,594	$5,458	$15,615	$5,465
75	$15,875	$5,556	$15,896	$5,564

Health Care Claims Development

Dental Claims as of January 1, 2018

	Gross Claims	
Pre-65	$	533
Post-65	$	533

Age Grading Factors

Age	Medical	Rx
Under 44	3.0%	4.8%
45–49	3.7%	4.7%
50–54	4.2%	4.7%
55–59	4.4%	4.6%
60–64	3.7%	4.6%
65–69	2.7%	3.8%
70–74	1.8%	2.5%
75–79	2.2%	0.8%
80–84	2.8%	0.2%
85–89	1.4%	0.1%
90 and Over	0.0%	0.0%

Actuarial Assumptions and Methods

The actuarial assumptions and methods used in the June 30, 2020 valuation are stated below.

Valuation Date	January 1, 2018
Census Date	January 1, 2018
Measurement Date	June 30, 2019
Actuarial Method	Entry Age Normal Level % of Pay
Inflation (CPI)	2.50%
Discount Rate	Based on Bond Buyer General Obligation 20-Bond Municipal Bond Index: ▪ Measurement Date June 30, 2018: 3.87% ▪ Measurement Date June 30, 2019: 3.51%

Health Care Trend Rates

- Medical, Rx and Administrative Fees

Year	Trend
2018	7.50%
2019	7.00%
2020	6.50%
2021	6.00%
2022	5.50%
2023	5.25%
2024	5.00%
2025	4.75%
2026+	4.50%

- Dental 4.00%
- HRA Accounts 0.00%
- Part B Premiums 4.50%

Life Insurance Administrative Load 10.00%

Actuarial Assumptions and Methods

Health Benefits Participation	90% of current eligible actives and 60% of current terminated vested employees will elect retiree plan coverage. Additionally, 60% of future retirees who have declined coverage are assumed to elect to participate in the plan upon retirement. 60% of actives decremented to withdrawal from the plan with at least five years of service will elect retiree medical and dental coverage.
Life Insurance Participation	All active employees and current retirees that elected healthcare coverage. Reinstated retirees and survivors are not eligible to receive the life insurance benefit.
Plan Election Percentage	Future retiree election percentage is based on the current retiree plan enrollment distribution.
Demographic Assumptions	Census data was provided by the State and adjustments were made for missing data, which have an insignificant effect on the liability. The census provided did not include gender for every terminated vested participant, so it was assumed that the percentage of males among the terminated vested population is consistent with the percentage of males among the retiree population. All actives are assumed to accumulate State service only. A factor has been applied to total service for State and Non-State retirees which represents the percentage of a retiree's total service that is attributable to service with the State: ▪ State: 94% ▪ Non-State Retiree: 13%
Spouse Age Difference & Marriage Percentage	Male participants are assumed to be four years older than spouses; female participants are assumed to be two years younger than spouses. 30% of active males and 15% of active females will elect retiree spouse coverage.

Actuarial Assumptions and Methods

Healthy Mortality

- Pre-Retirement: Headcount-weighted RP-2014 Employee table projected to 2020 with Scale MP-2016.
- Post-Retirement: Headcount-weighted RP-2014 Healthy Annuitant table projected to 2020 with Scale MP-2016, set forward one year for spouses and beneficiaries.

Disabled Mortality

Headcount-weighted RP-2014 Disabled Retiree table, set forward four years.

Retirement Rates

See Table A.

Withdrawal Rates

See Table B.

Disability Rates

See Table C.

Salary Scale

- Inflation: 2.75%
- Productivity Pay Increases: 0.50%
- Promotional and Merit Salary Increase

Years of Service	Regular	Police & Fire
Under 1	5.90%	10.65%
1	4.80%	7.15%
2	4.00%	5.20%
3	3.60%	4.60%
4	3.30%	4.30%
5	3.00%	4.15%
6	2.80%	3.90%
7	2.70%	3.50%
8	2.50%	3.15%
9	2.35%	2.90%
10	2.15%	2.50%
11	1.75%	1.90%
12	1.50%	1.50%
13	1.25%	1.30%
14	1.10%	1.30%
15+	1.00%	1.30%

Actuarial Assumptions and Methods

Table A—Retirement Rates

	Regular				
	Years of Service (%)				
Age	**5-9**	**10-19**	**20-24**	**25-29**	**30+**
45-49	0.00	0.00	0.75	6.50	16.00
50-54	0.50	1.50	1.50	8.50	18.00
55-59	1.50	3.50	5.00	12.00	20.00
60-61	6.50	11.00	17.00	22.00	22.00
62-64	9.00	13.00	17.00	22.00	22.00
65-69	20.00	20.00	22.00	25.00	25.00
70-74	30.00	30.00	40.00	40.00	40.00
75+	100.00	100.00	100.00	100.00	100.00

	Police/Fire				
	Years of Service (%)				
Age	**5-9**	**10-19**	**20-24**	**25-29**	**30+**
Under 40	0.00	0.00	0.00	0.00	0.00
40-44	0.00	0.50	3.50	0.00	0.00
45-49	0.00	1.00	6.50	18.00	18.00
50-54	1.50	4.50	13.00	20.00	24.00
55-59	3.50	10.00	20.00	25.00	28.00
60-64	9.00	18.00	25.00	35.00	35.00
65-69	50.00	50.00	60.00	60.00	60.00
70+	100.00	100.00	100.00	100.00	100.00

Actuarial Assumptions and Methods

Table B—Withdrawal Rates

Years of Service	% Regular	% Police/Fire
0-1	16.00	15.00
1-2	12.50	8.00
2-3	10.25	7.50
3-4	8.00	6.00
4-5	7.50	5.00
5-6	6.00	3.75
6-7	5.25	3.50
7-8	4.25	2.50
8-9	4.00	2.25
9-10	3.75	1.90
10-11	3.25	1.50
11-12	3.00	1.30
12-13	2.75	1.00
13-14	2.50	0.90
14-15	2.25	0.80
15-16	2.00	0.70
16-17	2.00	0.60
17-18	1.75	0.50
18-19	1.75	0.50
19-20	1.75	0.50
20+	1.75	0.45

Actuarial Assumptions and Methods

Table C—Disability Rates

Age	% Regular	% Police/Fire
20-24	0.01	0.00
25-29	0.03	0.06
30-34	0.06	0.12
35-39	0.10	0.30
40-44	0.21	0.45
45-49	0.35	0.65
50-54	0.60	0.80
55-59	0.75	0.65
60-64	0.40	0.50
65+	0.00	0.00

5.

5. Presentation on Ethics in Government (Yvonne Nevarez-Goodson, Executive Director, Nevada Commission on Ethics) (Information/Discussion)

Ethics in Government Law: NRS 281A Public Officers and Employees

Presented by:

Yvonne M. Nevarez-Goodson, Esq.
Executive Director

Nevada Commission on Ethics

Let’s Get Ethical:

https://www.youtube.com/watch?v=9sgJ1VRNuDE

What is the Nevada Commission on Ethics?

- The Commission
- The Ethics Commission consists of 8 members appointed to serve 4-year terms
  - 4 members appointed by the Governor
  - 4 members appointed by the Legislative Commission.

Interpret and enforce the Ethics In Government Law – NRS 281A

"Conflicts of Interest" for Public Officers and Public Employees

Nevada Commission on Ethics

OUR MISSION

To enhance the public's faith and confidence in government and uphold the public trust by **ensuring that public officers and public employees commit themselves to avoiding conflicts** between their private interests and their public duties.

TOP U.S. Scandal:

- https://youtu.be/WrTf6CaTTc0

Commission Jurisdiction (2 years)

- Public Officers
- Public Employees
- State Legislators
  - Exceptions
- Former Public Officers and Employees

- Exceptions:
  - Judicial Officers
  - Advisory Board Members

Nevada Commission on Ethics

- 3 Primary Functions:
  - Advisory Opinions (Confidential)
  - Ethics Complaints (Investigation Confidential)
  - Outreach/Education
    - AB 70
    - Exempts Ethics Training from OML
- Acknowledgment of Statutory Ethical Standards Form
  - Appointed: 30 days of appointment/reappointment; January 15 each even-numbered year for appointed officer who doesn't have definite term.
  - Elected: January 15 after General election; 30 days after special election

Private Interests:

- "Pecuniary" (NRS 281A.139)
- "Commitments in a Private Capacity" (NRS 281A.065)
  - Family/Relatives – 3rd Degree of Consanguinity/Affinity
  - Employers
  - Business Relationships
  - Household Members
  - Substantially Similar Relationships
    - Fiduciary Positions – Nonprofit Boards of Directors

PROHIBITED CONDUCT

GIFTS…

(Improper Influence)

NRS 281A.400(1)

Scandal - Blagovevich:

- https://youtu.be/NnBN9DyOgrs

PROHIBITED CONDUCT

- IMPROPER USE OF POSITION
  - Unwarranted Benefits

NRS 281A.400(2)

Scandal – Bridgegate:

- https://youtu.be/Pk8pa85awQI

PROHIBITED CONDUCT

- IMPROPER USE OF POSITION

Improper Contracts/Employment

(Negotiating/Entering)

New Limitations –

SB 129 (2019)

- Contracts with agency

NRS 281A.400(3,10); 281A.430

PROHIBITED CONDUCT

- IMPROPER USE OF POSITION

  Additional Compensation – Private Source

NRS 281A.400(4)

PROHIBITED CONDUCT

- IMPROPER USE OF POSITION

Using/Suppressing Non-public Government Information

NRS 281A.400(5,6)

PROHIBITED CONDUCT

- MISUSE GOVERNMENT RESOURCES

Limited Use Exceptions

NRS 281A.400(7)

Scandal - Stolen Time:

https://youtu.be/xjyC5pv-hGc

Scandal: IRS Spending/Gifts

- https://youtu.be/0QqPwoU7ic4

PROHIBITED CONDUCT

- IMPROPER USE OF POSITION

Influencing Subordinate – Personal Purpose

NRS 281A.400(9)

PROHIBITED CONDUCT

Honoraria for performing your public duty.

Causing a governmental entity to make an expenditure to support or oppose a ballot question or candidate (during period between candidate filing and election).

NRS 281A.510 and 281A.520

“Cooling-Off” Prohibitions

- One-year cooling off period to seek or accept employment or certain private representations after leaving public service (certain exceptions)
- NRS 281A.550(3) – Prohibits Executive Branch officers/employees of State Government from employment by regulated business/industry
- NRS 281A.550(5) – Prohibits certain public officer/employee from employment with vendors of agency. (State/Local)
- NRS 281A.410 – Prohibits any public officer/employee from representing or counseling private persons/entities on issues that were before the agency.
- Relief may be granted from the strict application of NRS 281A.550(3) and (5). (NRS 281A.550(6))

NRS 281A.410 and 281A.550(3)(5)(6)

Disclosure and Abstention for Public Officers and Employees

Walking the Disclosure & Abstention tightrope

Disclosures

- **Disclosure** is mandatory for <u>any interest</u> created by:
  - ✓ A gift or loan
  - ✓ A substantial* pecuniary interest
  - ✓ A “commitment in a private capacity”
  - ✓ Representation of private client

- **Disclosure** must be made at the time the matter is considered.
- **Sufficient** to Inform Public – Nature and Scope

NRS 281A.420(1)

Disclosure – Public Employees

- **To supervisory head of organization**
- **Sufficient to inform public**

Voting & Abstention

Abstention is ***required only*** in clear cases where the independence of judgment of a reasonable person in the public officer's situation would be materially affected.

This determination should be made by the public officer and explained on the record.

NRS 281A.420(4)

Voting & Abstention

- Voting is presumed permissible **if** the resulting benefit/detriment to the public officer (or committed person) is no greater than the benefit/detriment to anyone else affected by the matter.

NRS 281A.420(4)

SAFE HARBOR PROVISIONS

No willful violation **IF**:

(a) The public officer or employee relied in good faith upon the advice of the legal counsel retained by his or her the public body, agency or employer:

and

(b) The legal advice was:

- Provided before conduct; and
- Not contrary to prior published opinions on Commission website.

Immunity:

- https://youtu.be/V1Xk_w9PHyE

What Ethics Law is NOT:

- Campaign Finance
- Rude Behavior
- Laziness
- Poor Policy Decisions
- Sexual Harassment
- Discrimination

Office Complainers:

https://youtu.be/2xbjNwgdidk

Commission Opinions & Other Resources

- Resources and Opinions of the Nevada Commission on Ethics are indexed on the NCOE website:

www.ethics.nv.gov

Nevada Commission on Ethics

Nevada Commission on Ethics
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775- 687-5469 (Office)
775-687-1279 (Fax)

Yvonne M. Nevarez-Goodson
Executive Director
Direct Line: 775-687-4312

Website: www.ethics.nv.gov
ynevarez@ethics.nv.gov

6.

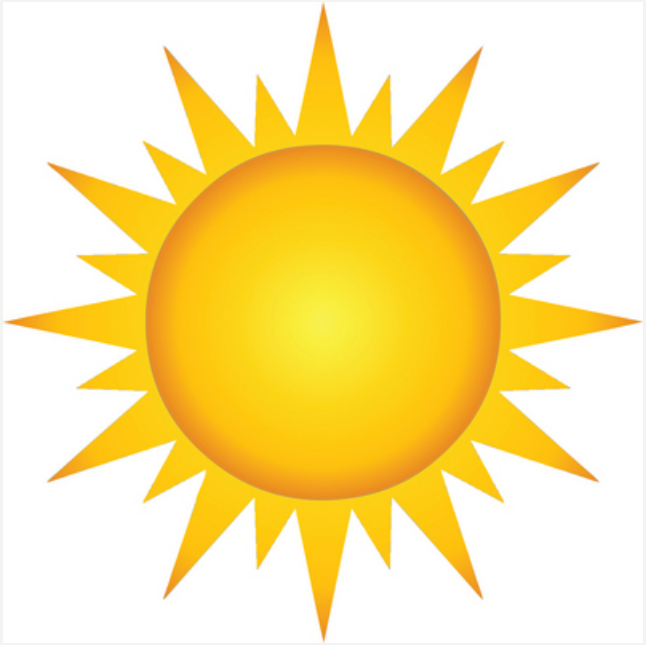
6. Presentation on the Open Meeting Law (Brandee Mooneyhan, Deputy Attorney General, Nevada Attorney General's Office)
(Information/Discussion)

OPEN MEETING LAW TRAINING

PUBLIC EMPLOYEES' BENEFITS PROGRAM BOARD

SEPTEMBER 24, 2020

Deputy Attorney General
Brandee Mooneyhan



- Every state, the District of Columbia, and the federal government have all adopted open meeting (AKA “sunshine”) laws

- Designed to ensure that the people’s business is done in a transparent way

Resources

Nevada adopted open meeting law provisions in 1960

- NRS Chapter 241
- Nevada Supreme Court opinions
- Attorney General website:
  - Attorney General Opinions
  - Open Meeting Law Manual
  - OML training materials

LEGISLATIVE INTENT

"In enacting this chapter, the Legislature finds and declares that all public bodies exist to aid in the conduct of the people's business. It is the intent of the law that their actions be taken openly and that their deliberations be conducted openly."

NRS 241.010(1)

Exceptions exist—but they are NARROW

- "The exceptions provided in this chapter, and electronic communication, must not be used to circumvent the spirit or letter of this chapter to deliberate or act, outside of an open and public meeting, upon a matter over which the public body has supervision, control, jurisdiction or advisory powers." NRS 241.016(4).

- The spirit and policy behind the OML favors open meetings and any exceptions thereto should be strictly construed.
McKay v. Board of Supervisors, 102 Nev. 644, 730 P.2d 438 (1986).

Applicability

- Meetings of public bodies. NRS 241.016(1).

- A “public body” is “Any administrative, advisory, executive or legislative body of the State or a local government consisting of at least two persons which expends or disburses or is supported in whole or in part by tax revenue . . . .” NRS 241.015(4).

- Includes subcommittees created by public bodies. NRS 241.015(4).

PEBP Board is a public body – all meetings are subject to OML

PENALTIES AND REMEDIES

- Actions taken in violation of law are void. NRS 241.036.
- Attorney General has statutory enforcement powers and authority to investigate and prosecute violations. NRS 241.037; NRS 241.039; NRS 241.040.
- When a violation of the OML occurs or is alleged, the OAG recommends that the public body make every effort to promptly correct the apparent violation. NRS 241.0365.
- Although it may not completely eliminate a violation, corrective action can mitigate the severity of the violation and further ensure that the business of government is accomplished in the open.
- Corrective action is prospective only. NRS 241.0365(4).

NRS 241.040:

- Members who attend a meeting where any violation of OML occurs, have knowledge of the violation, and participate in the violation, are guilty of a MISDEMEANOR
    - Also subject to administrative fines:
        - First offense: $500
        - Second offense: $1,000
        - Third or subsequent offense: $2,500
- Wrongful exclusion of any person is a MISDEMEANOR
- Legal advice: No criminal penalty or administrative fine may be imposed upon a member if violation is a result of legal advice provided by an attorney employed or retained by the public body.

"Meeting"

- NRS 241.015:
  - **Quorum** of members of a public body gathering together with:
  - **Deliberation** toward a decision; and/or
  - **Action**: making a decision, commitment or promise over a matter within the public body's supervision, jurisdiction, control or advisory power.

- A quorum is a simple majority of the total body (NRS 241.015(5));
- "'Deliberate' means to examine, weigh and reflect upon the reasons for or against the action. The term includes, without limitation, collective discussion and the collective acquisition or exchange of facts preliminary to the ultimate decision." (NRS 241.015(2));
- Action requires majority vote of members present (NRS 241.015(1)).

Exceptions:

- A gathering of a quorum at a social function is not a meeting as long as there is no deliberation or action.
- An attorney-client conference on potential and existing litigation is not a meeting as long as there is no action.

Constructive quorums/meetings

- Serial communications or “walking quorums” can constitute a constructive meeting
- A constructive quorum can exist with less than a quorum speaking together at any given time if opinions are relayed between members
- Email pitfalls – “Reply all” email chains can constitute a meeting
- Example of a constructive quorum: Two members of a five-member public body discuss how they intend to vote on an issue and why. One of those members then has that same discussion with a third member, including how both the first two members intend to vote and why. A quorum (three members) has deliberated on an issue outside of a meeting.

Subcommittees/Advisory Committees

- 2019 Legislature set forth a better definition of "subcommittee or working group" as having a majority that are members or staff or that is authorized to make a recommendation to or take action on behalf of the public body. *See* NRS 241.015(4)(d).
- Subcommittee meetings governed by the open meeting law
- Board assignment of a matter to an individual is not creating a subcommittee
  - Individual given assignment may not engage a quorum of the Board

Texting

- Scenario: During public meeting, a number less than a quorum of board members text each other and board staff on subjects under discussion

- "... **electronic communication**... must not be used to circumvent the spirit or letter of this chapter to deliberate or act, outside of an open and public meeting, upon a matter over which the public body has supervision, control, jurisdiction or advisory powers." NRS 241.016(4).

- Recommendation: Refrain from texting each other about Board business

Closed meetings

- Closure pursuant to NRS 241.030
  - Except as otherwise provided in this section and NRS 241.031 and 241.033, a public body may hold a closed meeting to . . .Consider the character, alleged misconduct, professional competence, or physical or mental health of a person.

PEBP-specific statute

NRS 287.0415(4):

The Board may meet in closed session:

(a) To discuss matters relating to personnel;

(b) With investment counsel to plan future investments or establish investment objectives and policies;

(c) With legal counsel to receive advice upon claims or suits by or against the Program;

(d) To prepare a request for a proposal or other solicitation for bids to be released by the Board for competitive bidding; or

(e) As otherwise provided pursuant to chapter 241 of NRS.

Must publish and follow clear and complete agendas . . .

NRS 241.020(3):

Except in an emergency, written notice of all meetings must be given at least 3 working days before the meeting. The notice must include:

(a) The time, place and location of the meeting.

(b) A list of the locations where the notice has been posted.

(c) The name and contact information for the person designated by the public body from whom a member of the public may request the supporting material for the meeting described in subsection 7 and a list of the locations where the supporting material is available to the public.

(d) An agenda consisting of:

(1) A clear and complete statement of the topics scheduled to be considered during the meeting.

(2) A list describing the items on which action may be taken and clearly denoting that action may be taken on those items by placing the term "for possible action" next to the appropriate item or, if the item is placed on the agenda pursuant to NRS 241. 0365, by placing the term "for possible corrective action" next to the appropriate item.

(3) Periods devoted to comments by the general public, if any, and discussion of those comments. Comments by the general public must be taken:

(I) At the beginning of the meeting before any items on which action may be taken are heard by the public body and again before the adjournment of the meeting; or

(II) After each item on the agenda on which action may be taken is discussed by the public body, but before the public body takes action on the item.

Must publish and follow clear and complete agendas . . .

- What is clear and complete?

> "Nevada's Open Meeting Law seeks to give the public clear notice of the topics to be discussed at public meetings so that the public can attend a meeting when an issue of interest will be discussed."

Sandoval v. Board of Regents of University, 119 Nev. 148, 155 (2003)

Must publish and follow clear and complete agendas . . .

Further guidance from *Sandoval*:

- Do not "exceed the scope of a clearly and completely stated agenda topic."
  - *Sandoval* involved an information item:
    - Review UCCSN, state and federal statutes, regulations, case law, and policies that govern the release of materials, documents, and reports to the public.
  - After presentation of the information item, the Board of Regents went beyond the foregoing information item:
    - [A] Regent . . . proceeded to discuss a controversial report, prepared by the Nevada Division of Investigation (NDI), regarding a dormitory raid that occurred on the University of Nevada, Las Vegas (UNLV) campus. [The regent] discussed details of the dormitory raid, criticized the UNLV police department's actions, and recommended that the UNLV police department be disarmed. [Another regent] then commented on the danger of drugs on the UNLV campus.

IS ACTION ITEM CORRECTLY DISCLOSED?

The agenda should have a higher degree of specificity when addressing a subject of special or significant interest to the public. Sandoval at pp. 154-5

- Reno City Counsel Agenda, November 14, 2012:
- "Discussion, direction to staff and possible approval of Limited Guaranty pertaining to Settlement and Restructuring Agreement."

"CLEAR AND COMPLETE" WHEN AGENCY WANTS TO DISCUSS BILL DRAFTS

- The Nevada Supreme Court has held that when a public body was reviewing legislation during session for possible recommendations, it did not violate the clear and complete requirement although the specific legislation was not listed on the noticing agenda, as the agenda referred to a website where list of legislation could be found prior to the hearing date, which the Court found to be "reasonable notice."

Schmidt v. Washoe County, 123 Nev. 128, 138 (2007)

CLEAR AND COMPLETE AGENDA: ADMINISTRATIVE ACTION REGARDING A PERSON

- Agenda must include name of person **regarding** whom action may be taken. NRS 241.020(5). For example: appointees, contract awards.

- If a person is to be named in a motion, that person's name should be on the agenda

"FOR POSSIBLE ACTION"

- Agenda must contain: A list describing the items on which action may be taken and clearly denoting what action may be taken on those items by placing the term "for possible action" next to the appropriate item.

- The Board cannot take action on item not designated as an action item.

Boards may be required to give individual notice in certain circumstances

- NRS 241.033: Except for employment applicants, "a public body shall not hold a meeting to consider the character, alleged misconduct, professional competence, or physical or mental health of any person or to consider an appeal by a person of the results of an examination conducted by or on behalf of the public body unless it has (a) Given written notice to that person of the time and place of the meeting; and (b) Received proof of service of the notice . . ."

Boards may be required to give individual notice in certain circumstances

- In other words, public bodies should avoid discussions of character, alleged misconduct, professional competence, or physical or mental health of specifically identifiable persons unless (1) that subject is within the scope of the clear and complete agenda item and (2) the person has been given individual notice.
- Notice required: 5 working days personal delivery or 21 working days by certified mail
- New in 2019 Legislature: clarification that meeting held to recognize or award positive achievements of a person is not subject to the notice requirements of NRS 241.033.

OTHER INDIVIDUAL NOTICE REQUIREMENT

- Same notice required before holding meeting to consider administrative action against a person
- "Administrative action against a person"
  - "Person" includes corporate entities
- Per Open Meeting Law Manual: Administrative Action against a person "does not occur unless the matter being acted on is uniquely personal to the individual or entity. 'Administrative action against a person' does not occur when the legal basis of the action is consideration of the inanimate characteristics of a facility or property and no consideration of the characteristics or qualifications of the individual or entity (the person) that has sought the governmental approval."

Make Meeting Materials Available

NRS 241.020

7. Upon any request, a public body shall provide, at no charge, at least one copy of:

(a) An agenda for a public meeting;

(b) A proposed ordinance or regulation which will be discussed at the public meeting; and

(c) Subject to the provisions of subsection 8 or 9, as applicable, any other supporting material provided to the members of the public body for an item on the agenda, except materials:

(1) Submitted to the public body pursuant to a nondisclosure or confidentiality agreement which relates to proprietary information;

(2) Pertaining to the closed portion of such a meeting of the public body; or

(3) Declared confidential by law, unless otherwise agreed to by each person whose interest is being protected under the order of confidentiality.

The public body shall make at least one copy of the documents described in paragraphs (a), (b) and (c) available to the public at the meeting to which the documents pertain. As used in this subsection, "proprietary information" has the meaning ascribed to it in NRS 332.025.

Make Meeting Materials Available

NRS 241.020 (cont'd)

8. Unless it must be made available at an earlier time pursuant to NRS 288.153, a copy of supporting material required to be provided upon request pursuant to paragraph (c) of subsection 7 must be:

(a) If the supporting material is provided to the members of the public body before the meeting, made available to the requester at the time the material is provided to the members of the public body; or

(b) If the supporting material is provided to the members of the public body at the meeting, made available at the meeting to the requester at the same time the material is provided to the members of the public body.

If the requester has agreed to receive the information and material set forth in subsection 7 by electronic mail, the public body shall, if feasible, provide the information and material by electronic mail.

- OMLO 98-01 "Made available" does not equal "mailed." In other words, a requester who wants a paper copy of supporting materials before the meeting may be required to come to the agency to get it.

RECORDING MEETING—MINUTES

- NRS 241.035 requires that written minutes be kept of:

  (a) The date, time and place of the meeting.

  (b) Those members of the public body who were present and those who were absent.

  (c) The substance of all matters proposed, discussed or decided and, at the request of any member, a record of each member's vote on any matter decided by vote.

  (d) The substance of remarks made by any member of the general public who addresses the public body if the member of the general public requests that the minutes reflect those remarks or, if the member of the general public has prepared written remarks, a copy of the prepared remarks if the member of the general public submits a copy for inclusion.

  (e) Any other information which any member of the public body requests to be included or reflected in the minutes.

PUBLIC COMMENT

- Must be on agenda at least (1) once before first action item and again before end of meeting OR (2) on all action items (before action taken) if additional opportunity is given to provide comment on other items, as well
- The Board may not take action based on public comment except as it relates to an action agenda item
- Court may discuss public comment it receives
- The Board may not discriminate based on viewpoint
- Comment may be limited to areas relevant to Board jurisdiction
- Repetition and caustic personal attacks may be limited
- Any time limit or other permissible restriction on public comment should be spelled out on agenda

Recent changes (2019 Legislature)

- Ability to delegate litigation decisions to chair or executive officer: NRS 241.0357

- Language regarding use of teleconferencing or videoconferencing technology for a meeting: NRS 241.023

- Ability of a public body to receive certain training outside of a public meeting, so long as there is no deliberation or action on any matter within the public body's jurisdiction and control: NRS 241.015(3)(b)(3)

Recent changes cont'd

- Public officers and employees responsible for a public meeting must "make reasonable efforts to ensure the facilities for the meeting are large enough to accommodate the anticipated number of attendees.

  - If reasonable efforts are taken, no violation if a person is not allowed to attend the meeting because the facility has reached maximum capacity.

  - Public body not required to incur costs to secure a facility outside the control or jurisdiction of the public body or to upgrade, improve or otherwise modify an existing facility to accommodate the anticipated number of attendees.

NRS 241.020(2).

COVID-19

Some OML provisions temporarily affected by Governor's Emergency Directives related novel coronavirus:

- Requirement for physical location where members of public are permitted to attend and participate (NRS 241.023(1)(b)) suspended
  - If meeting held by teleconference or video conference only, agenda should explain how public may provide public comment
- Requirement for agenda to be posted at physical locations (NRS 241.020(4)(a)) suspended
  - Agendas must still be posted to Nevada's notice website and public body's website; must still provide copy to those who request them by U.S. mail or email
- Requirement that physical locations be available for the public to receive supporting material for public meetings (NRS 241.020(3)(c)) suspended.
  - Must provide on agenda the name and contact information for person from whom supporting material may be requested electronically; must also post to public body's website
- Must ensure that any party entitled to or required to appear is able to do so through remote means and fully able to participate in the agenda items that pertain to them.

QUESTIONS?

7.

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

STEVE SISOLAK
Governor

LAURA FREED
Board Chair

STATE OF NEVADA
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Expires 04/01/2021

LAURA RICH
Executive Officer

AGENDA ITEM

☐ Action Item
☒ Information Only

Date: September 24, 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 continues to monitor COVID-19 claims costs very closely. As of September 15th, the plan has paid approximately $1.5M in COVID-19 related testing, office visits and treatments. Over the course of the last month, the week over week increase in costs has been growing and as we get into the fall and winter months, the likelihood of that trend continuing is higher. Obviously, this is a very significant concern to the program and the PEBP budget, as these costs can have a substantial impact on overall claims costs and ultimately, member rates. Although PEBP has received approximately $410,000 in CARES Act funds to offset some of these costs, any future funding is not guaranteed. Actual expenses of COVID-19 claims have been and will continue to be reported to the Governor's Finance Office (GFO) on a weekly basis through the end of October. At that point, GFO has requested that all agencies provide estimates for November and December expenses in order to determine reimbursement amounts available for each agency.

SOLICITATIONS UPDATE

Enrollment and Eligibility System RFP
A Notice of Intent was issued on 9/15/20 and negotiations are already underway. PEBP expects to bring this contract to the November Board meeting for approval.

Medical Network RFP
This RFP was released on 8/24/20 with proposals due on 10/08/20. PEBP expects to bring this contract to the January Board meeting for approval.

Health Maintenance Organization (HMO) RFP
This RFP was released on 9/4/20 with proposals due on 10/13/20. PEBP expects to bring this contract to the November Board meeting for approval.

Dental Network RFP
This RFP was released on 9/11/20 with proposals due on 10/15/20. PEBP expects to bring this contract to the November Board meeting for approval.

Financial Auditor RFP
The current contract does not expire until 12/30/21, so PEBP does not expect to release this RFP until early 2021.

OPERATIONAL UPDATE

PEBP is currently staffed at 26/34 employees. This is concerning given the major plan changes slated for PY22 and potential vendor changes that may result from the various solicitations. The plan changes require major updates to plan documents, website materials, and will undoubtedly result in a high volume of incoming calls and emails from members. Any vendor changes will require an increase of staff time for any necessary implementations and will also result in an enormous communications effort to ensure members are aware of any changes that may affect their healthcare decisions. In addition to all these activities, the upcoming legislative session will also require additional staff time. Anticipating this increase in workload, PEBP has submitted several Justifications to Fill (JTF) to the Governor's Finance Office.

CONCLUSION

The PEBP team will have a lot to juggle in the coming months, but staff are prepared and determined.

8.

8. Discussion and Possible Action on Proposed changes to Healthcare Blue Book rewards payments (Laura Rich, Executive 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: September 24, 2020

Item Number: VIII

Title: Proposed Changes to Healthcare Blue Book Rewards Payments

SUMMARY

This report provides information on the Healthcare Blue Book rewards program and proposed changes to financial incentives.

BACKGROUND

On November 30, 2017, the Board approved Plan Year 2019 cost savings activities to include the implementation of Healthcare Bluebook, a transparency tool that incentivizes members to shop for high quality, low cost providers in their region. By displaying the variations in price and quality for specific procedures, Healthcare Bluebook helps members become better consumers and in some cases receive a cash incentive if they choose to seek care at the identified facilities.

In March 2018, the Board approved the rewards option that separated rewards by region, and in turn capitalized on each market condition throughout the state. In this scenario, specific medical procedures that experienced lowest utilization of low cost providers were chosen for each region, and members who used those low cost, high quality providers (labeled as "green providers") for those specific services were automatically provided a monetary reward.

Since PEBP now has two years of HCBB data showing excellent member utilization rates, it is an opportune time to reevaluate the rewards methodology. Currently, PEBP is incentivizing all utilization of green providers for specific services regardless of whether or not a member uses HCBB to search for the procedure. PEBP is proposing transitioning to a model where members must actively use HCBB to search for a procedure and subsequently use the green provider to receive the associated financial reward. Additionally, PEBP is recommending expanding the list of qualifying procedures and in some cases, increasing the dollar amounts, in order to further incentivize positive shopping behavior and ultimately drive more members to lower cost, high quality providers.

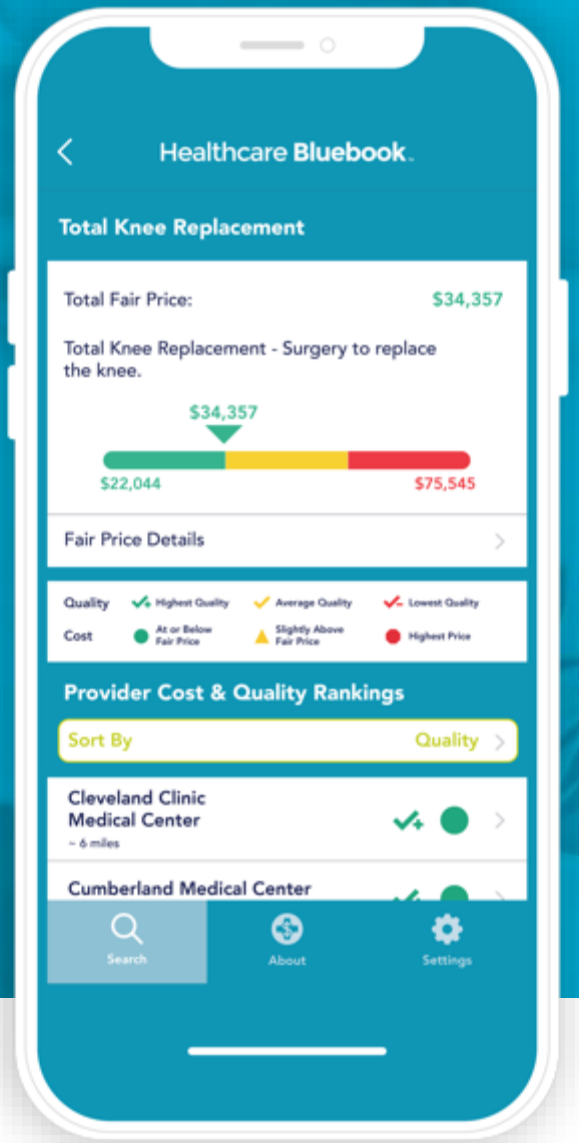
Although the amount of qualifying procedures and reward dollars will increase under this proposal, it is expected to at best, incur additional savings to the program or in a worst case scenario, be cost neutral.

REPORT

See Attachment A.

RECOMMENDATION:

PEBP recommends the Board to approve the method rewards payments for HCBB are issued so that rewards amounts are awarded only when members search for a qualifying procedure and subsequently choose a green provider to perform the procedure.



Healthcare Bluebook

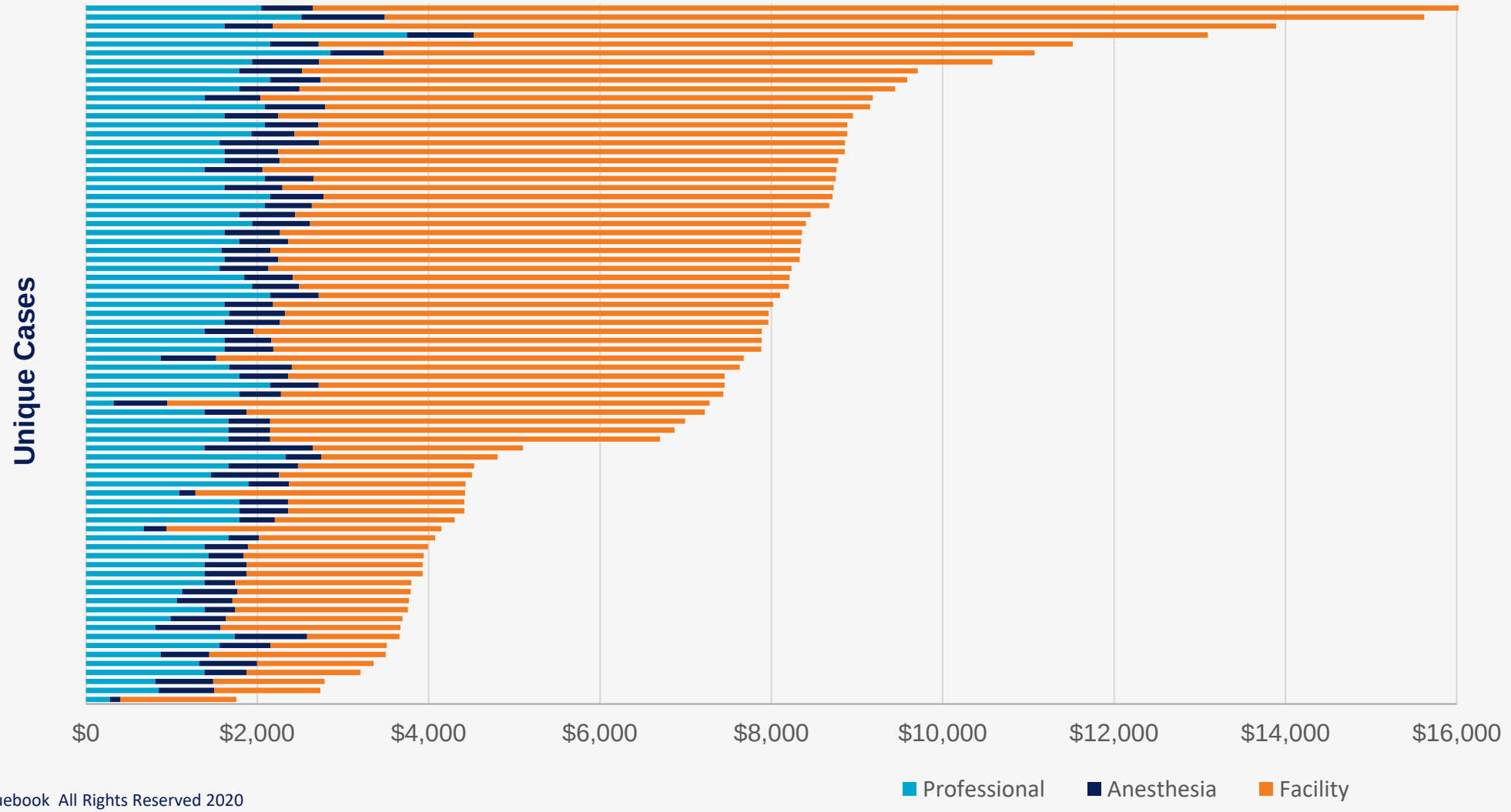
Healthcare Bluebook Rewards

September 24, 2020

Healthcare Bluebook

Knee Arthroscopy

Market | Reno



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Healthcare Bluebook.

Hospitals may do everything, but they are not great at everything...

MOUNTAIN VIEW HOSPITAL

A Sunrise Health System Hospital

- Joint Replacement — ***95th percentile***
- Neurosurgery — ***55th percentile***
- Spinal Fusion — ***6th percentile***

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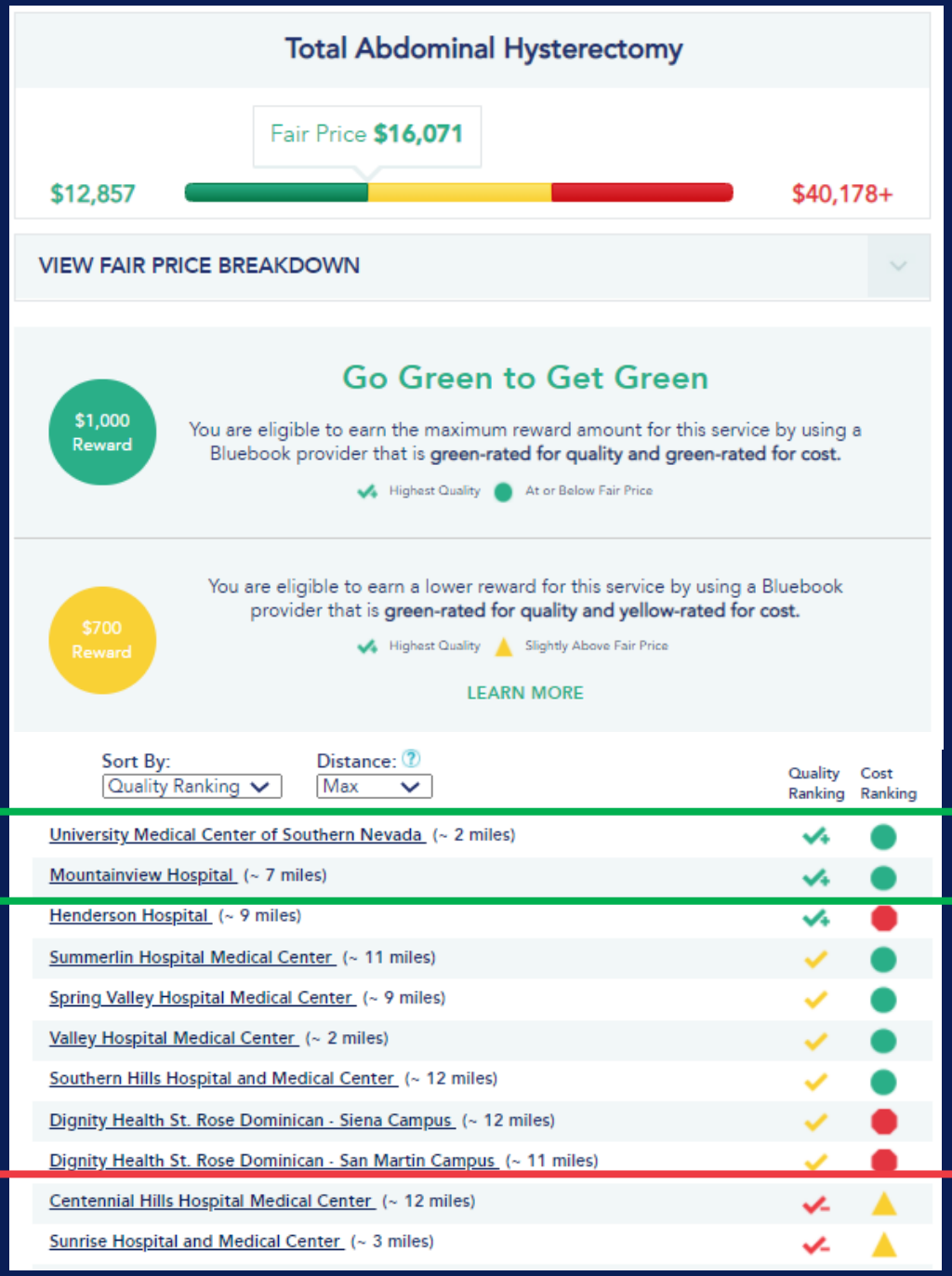
Healthcare Bluebook.

Aligning Quality + Cost

Centers of Excellence

Centers of Dysfunction



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Healthcare Bluebook

Year 1 Outcomes

Summary

$1,620,416 TOTAL SAVINGS

3.3:1 ROI*

23.1% UTILIZATION

**savings and ROI validated by Health Claim Auditors, Inc. in February 2020*

Healthcare Bluebook.

Engagement Rewards

Healthcare Bluebook.

Current: All Green Rewards

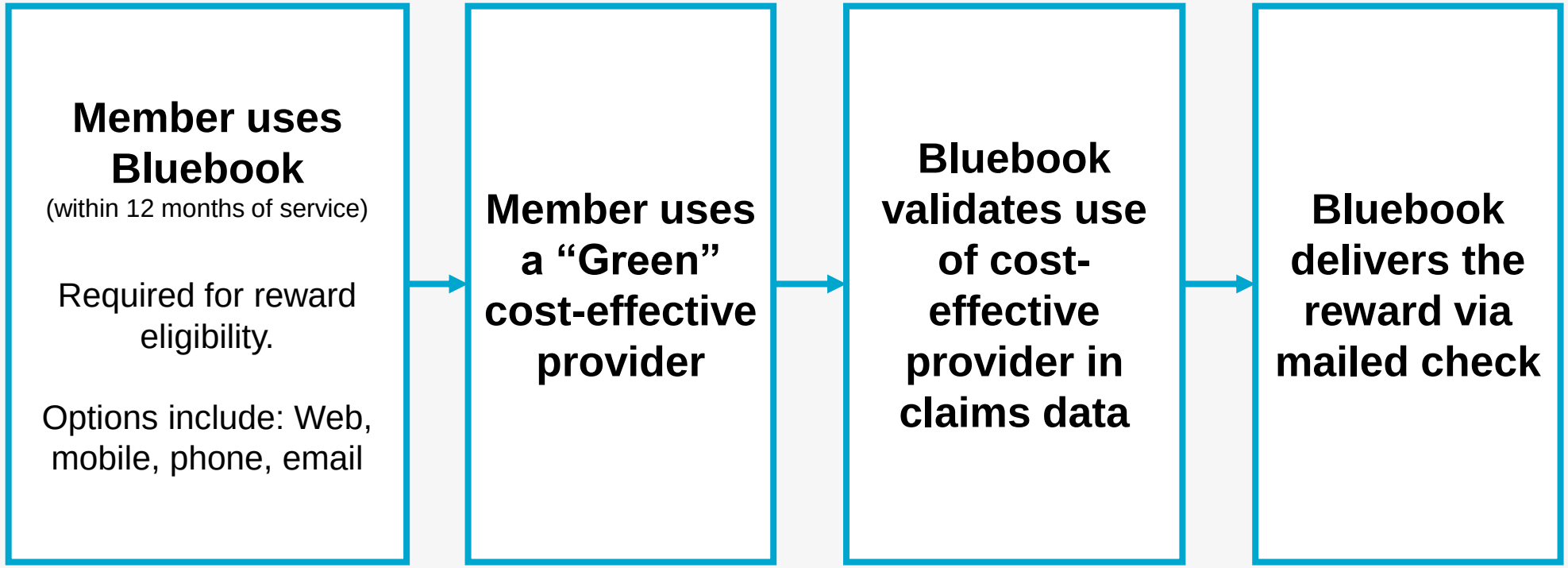
- Rewards all members that choose green providers
- 200 rewardable procedures
- Maximum rewards = $125
- Annual reporting

Proposed: Engagement Rewards

- Attribution: requires members to shop and then choose a green provider
- 420+ rewardable procedures
- Inpatient and Outpatient Procedures
- Max rewards up to $1,000
- Quarterly reporting
- Higher engagement (requires use of Bluebook digital engagement)

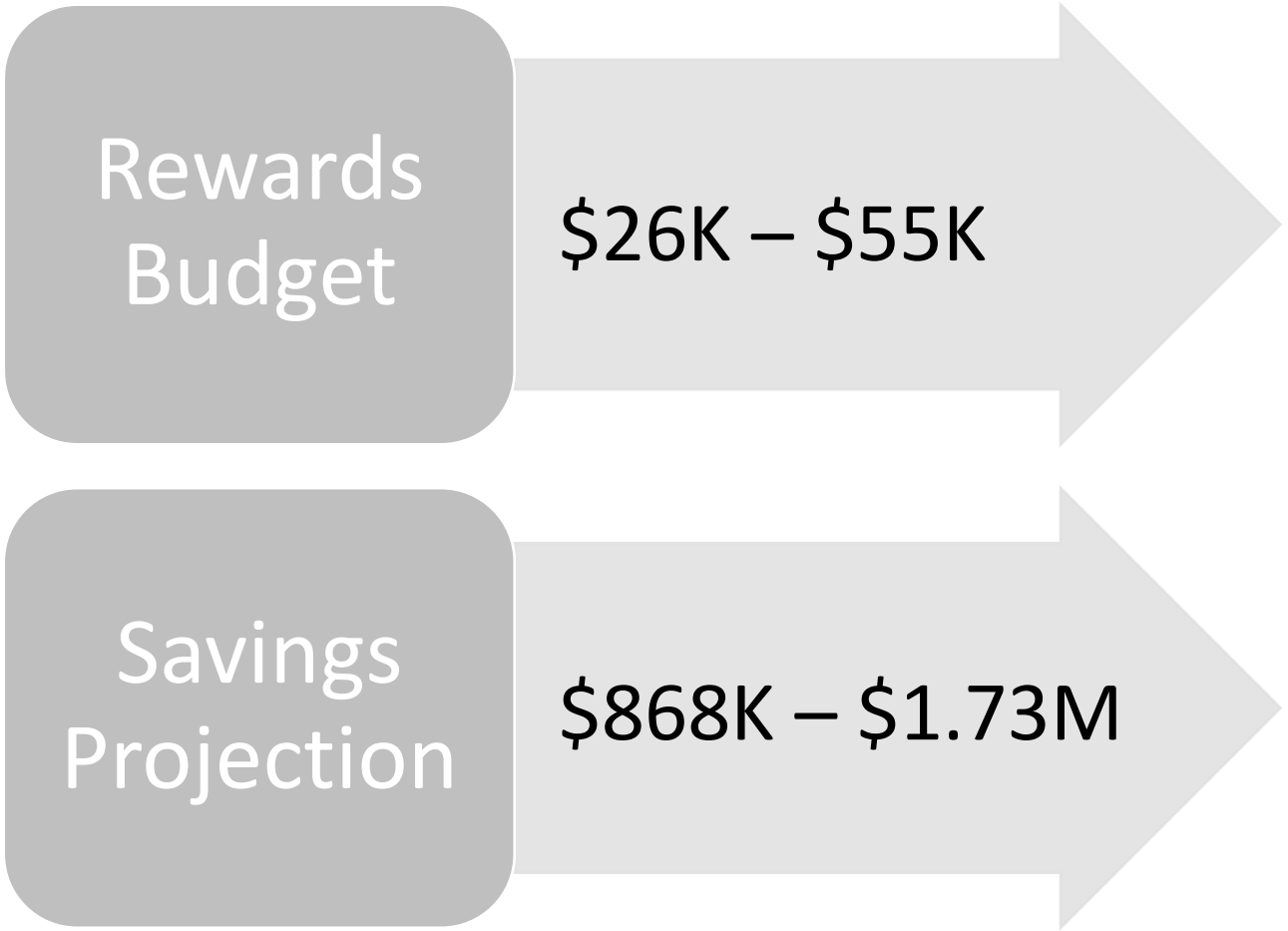
Healthcare Bluebook

Reward Process



Healthcare Bluebook.

Budget & Savings



Note. Projection represents savings for rewards categories alone. We estimate there are additional savings in other categories not yet being tracked.

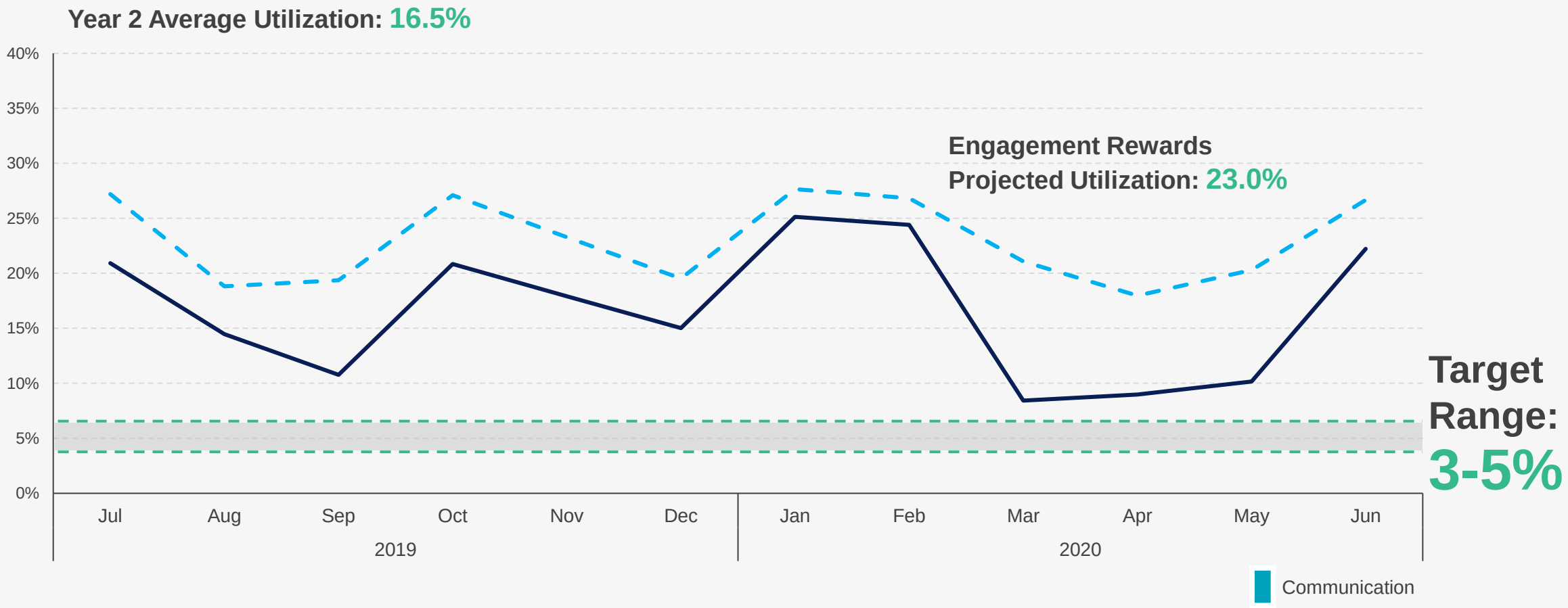
Healthcare Bluebook

Case Study

- Single-state employer, over 100,000 employees
- Year 1 with Healthcare Bluebook
- Utilizing digital engagement best practices
- 15% average monthly utilization
- ROI > 2.5:1
- Total Savings: >$3.6 million

Healthcare Bluebook

Monthly Website Utilization



Healthcare Bluebook

Las Vegas Outpatient Engagement Rewards List

Procedure	Reward Amount
Bone Density Scan	$0
Breast Biopsy	$100
Carpal Tunnel Surgery	$100
Cataract Surgery	$0
Cholecystectomy	$100
Colonoscopy	$25
Complex Ear Drum Repair	$100
CTs	$0
Diagnostic Mammogram	$0
Ear Tube Placement	$100
Heart Perfusion Imaging	$0
Hysteroscopy	$100
Lithotripsy	$100
MRIs	$25
Nasal Surgery	$100
Non-Obstetric Ultrasound	$0
Obstetric Ultrasound	$0
OP Elbow Surgery	$150
OP Hip Surgery	$150
OP Knee Surgery	$150
OP Shoulder Surgery	$150
Removal of Adenoids	$100
Repair Finger Tendon	$100
Screening Mammogram	$0
Sleep Study	$0
Tonsillectomy	$100
Transesophageal Echocardiogram	$50
Transthoracic Echocardiogram	$0
Upper GI Endoscopy	$50
X-Ray	$0

Healthcare Bluebook

Reno Outpatient Engagement Rewards List

Procedure	Reward Amount
Bone Density Scan	$0
Breast Biopsy	$100
Carpal Tunnel Surgery	$100
Cataract Surgery	$100
Cholecystectomy	$100
Colonoscopy	$0
Complex Ear Drum Repair	$100
CTs	$25
Diagnostic Mammogram	$0
Ear Tube Placement	$100
Heart Perfusion Imaging	$50
Hysteroscopy	$100
Lithotripsy	$100
MRIs	$25
Nasal Surgery	$100
Non-Obstetric Ultrasound	$0
Obstetric Ultrasound	$0
OP Elbow Surgery	$150
OP Hip Surgery	$150
OP Knee Surgery	$150
OP Shoulder Surgery	$150
Removal of Adenoids	$100
Repair Finger Tendon	$100
Screening Mammogram	$0
Sleep Study	$0
Tonsillectomy	$100
Transesophageal Echocardiogram	$50
Transthoracic Echocardiogram	$25
Upper GI Endoscopy	$50
X-Ray	$0

Healthcare Bluebook

Elko Outpatient Engagement Rewards List

Procedure	Reward Amount
Bone Density Scan	$0
Breast Biopsy	$100
Carpal Tunnel Surgery	$100
Cataract Surgery	$100
Cholecystectomy	$100
Colonoscopy	$75
Complex Ear Drum Repair	$100
CTs	$50
Diagnostic Mammogram	$0
Ear Tube Placement	$100
Heart Perfusion Imaging	$50
Hysteroscopy	$100
Lithotripsy	$100
MRIs	$50
Nasal Surgery	$100
Non-Obstetric Ultrasound	$0
Obstetric Ultrasound	$0
OP Elbow Surgery	$150
OP Hip Surgery	$150
OP Knee Surgery	$150
OP Shoulder Surgery	$150
Removal of Adenoids	$100
Repair Finger Tendon	$100
Screening Mammogram	$0
Sleep Study	$75
Tonsillectomy	$100
Transesophageal Echocardiogram	$50
Transthoracic Echocardiogram	$50
Upper GI Endoscopy	$75
X-Ray	$0

Healthcare Bluebook

Inpatient Engagement Rewards List (COE)

Procedure	Green Quality Green Price	Green Quality Yellow Price
Benign Breast Tumor Removal	$350	$250
Hysterectomy	$350	$250
Spinal Fusion	$1,000	$750

9.

9. Discussion and Possible Action regarding Legislative Commission's Audit Subcommittee Audit Findings and Corrective Action Plan (Laura Rich, Executive 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: September 24, 2020

Item Number: IX

Title: Legislative Counsel Bureau (LCB) Audit Findings and Proposed Corrective Action Plan

SUMMARY

This report summarizes the Legislative Counsel Bureau (LCB) audit findings and proposed Corrective Action Plan.

BACKGROUND

In March 2019, PEBP was notified by the Legislative Counsel Bureau (LCB) Audit Division that it would be performing a contract and operational audit of the agency. Throughout 2019, PEBP staff worked diligently to assist the auditors and collect all requested data and information required to perform this function. In May 2020, PEBP was provided an initial draft of the final findings by the LCB Audit Division and was required to submit a written response to the findings indicating acceptance or disagreement. The report includes a total of five findings: three regarding procurement practices, one concerning acceptance of gifts and one regarding improper expenditures. Each finding also includes recommendations offered by the auditors for staff and the Board. PEBP accepted all five findings and provided an initial plan on how the agency intended to rectify the deficiencies identified in the report. The findings and associated responses (Attachment A) were presented to and accepted by the Legislative Commission's Audit Subcommittee on September 3, 2020. PEBP is required to provide an initial 60-day corrective action plan followed by a subsequent six-month status report due at a later date.

REPORT

Based on the recommendations provided, PEBP has developed the proposed Corrective Action Plan:

Recommendation 1:
The PEBP Board should develop policies and procedures to ensure:

- *Competitive procurement of contracted services once the original term of the contract ends, in compliance with state policies*
- *Contracts and contract amendments have supporting documentation, including proper approvals by the Board and State Purchasing Division; and*
- *Changes to a contract's original scope of work are competitively bid*

Response: PEBP accepts this recommendation.

Proposed Corrective Action:
The PEBP Board shall form a subcommittee with the purpose of editing existing and/or developing new policies and procedures to address PEBP procurement practices.

Recommendation 2:
Comply with state law and agency policy concerning gifts and include periodic training and documented attestations of Board member and employee acceptance of policies.

Response: PEBP accepts this recommendation.

Proposed Corrective Action:
PEBP will coordinate with the Department of Human Resource Management to ensure PEBP policies and Procedures are updated to reflect state gifting policies and ensure all employees sign updated attestations. Additionally, PEBP will continue to request ethics training be provided to staff and Board members on an annual basis.

Recommendation 3:
Establish formal policies and procedures regarding the Request for Information process and compliance with State Purchasing guidelines.

Response: PEBP accepts this recommendation.

Proposed Corrective Action:
PEBP staff will edit existing and/or develop new policies and procedures addressing procurement practices that align with State Purchasing guidelines.

Recommendation 4:
Develop policies and procedures that require accurate information be provided to the Board and other governing bodies when seeking to amend contracts and supporting documentation to be provided.

Response: PEBP accepts this recommendation.

Proposed Corrective Action:

1. The PEBP Board shall form a subcommittee with the purpose of creating criteria and/or guidelines to be met by staff before any contract amendments are brought to the Board for consideration.

2. Once Subcommittee recommendations have been approved by the Board, PEBP staff will update its policies and procedures accordingly.

Recommendation 5:
Develop policies and procedures, in consultation with PEBP's Board, to ensure the use of funds and resources directly relate to the purpose of the agency and the statutory intent for the use of those resources.

Response: PEBP accepts this recommendation.

Proposed Corrective Action:

1. The PEBP Board shall form a subcommittee with the purpose of creating criteria and/or guidelines to address NRS 287.0434(1) regarding authorized expenditures to be met by staff before any proposed expenditures are brought to the Board for consideration.
2. Once Subcommittee recommendations have been approved by the Board, PEBP staff will update its policies and procedures accordingly.

Recommendation: PEBP recommends the Board approve the proposed corrective action plan, including any additional edits based on Board member input.

Audit Highlights

Highlights of performance audit report on the Public Employees' Benefits Program, Contract Management issued on September 3, 2020.

Legislative Auditor report # LA20-15.

Background

The Public Employees' Benefits Program (PEBP) is a state agency that is legislatively mandated to provide group health, life, and accident insurance for state and other eligible public employees and retirees. PEBP's mission is to provide employees, retirees, and their families with access to high quality benefits at affordable prices.

PEBP currently administers various benefits and is responsible for designing and managing a quality health care program for approximately 44,000 primary participants and 27,000 covered dependents, totaling over 70,000 individuals.

PEBP enters into contracts with vendors to provide services to its participants. In fiscal year 2019, PEBP paid over $114 million to 19 vendors under contract with the agency. Vendor payments included things like actuarial services and medical, dental, and pharmaceutical administrator services.

A 10-member board oversees PEBP's operations. Nine board members are appointed by the Governor, and the 10th member is the Director of the Department of Administration or a designee approved by the Governor. The Board appoints an Executive Officer to direct the day-to-day operations.

Purpose of Audit

The purpose of the audit was to determine if PEBP has adequate controls to ensure vendor selection and payments complied with state laws, policies, and contract terms; and expenses related to contracts, awards, and accreditations were appropriate. Our audit included a review of contract procurement and payment practices, and award and accreditation expenditures for fiscal year 2019, and prior years for some activities.

Audit Recommendations

This audit report contains four recommendations to improve PEBP's contracting practices and one recommendation to ensure the proper use of PEBP's resources.

PEBP accepted the five recommendations.

Recommendation Status

PEBP's 60-day plan for corrective action is due on December 3, 2020. In addition, the 6-month report on the status of audit recommendations is due on June 3, 2021.

Contract Management

Public Employees' Benefits Program

Summary

The Public Employees' Benefits Program's (PEBP) contracting practices changed over the past several years, focusing more on amending and extending contracts through private negotiations instead of competitive procurements. While contract amendments may be appropriate in some circumstances, for the most part, amendments should be infrequent and not utilized as a default to extend contracts and procure services worth hundreds of millions of dollars. State law creates the PEBP board giving it responsibility for ensuring contracting practices comply with laws and policies, and to help ensure the proper use of agency resources. However, PEBP's contracting practices did not always follow state laws and policies as some amendments significantly modified contracts' scopes of work and contracts were extended without proper approvals. Furthermore, some wasteful spending of agency resources occurred. Without proper contracting practices and agency oversight, there is increased risk the best interests of the State and PEBP participants will not be realized, and agency resources will not be used appropriately.

Key Findings

Between fiscal years 2015 and 2019, PEBP authorized nearly $96 million in contract services that were not competitively bid through a Request for Proposal (RFP) process, as PEBP began to focus more on extending contracts. For 14 of 19 active service contracts in fiscal year 2019, PEBP amended these contracts to extend them beyond the original contract term, with some extended more than once. As a result, the average contract term increased from almost 5.5 years to over 8.5 years, with two contracts having 11-year terms. Under PEBP's management of the past 5 years, 23 contract extensions were performed and only 12 RFPs. State policy indicates contracts should be competitively solicited at least every 4 years. While PEBP claims a longer contract term is more desirable for some contracts, amending and extending contracts indefinitely does not help ensure the State and PEBP participants receive the best value. (page 6)

Private negotiations became a standard practice as PEBP's management extended vendor contracts for multiple years. Some negotiations took place through direct contact with vendors or by emails. For one contract, negotiations included two vendor paid trips, at the request of PEBP management, in which PEBP employees received transportation, lodging, and meals worth more than $7,000. Following the second trip, a significant scope modification occurred and the contract was extended 2 years. The amendments and contract extension occurred despite PEBP management and staff dissatisfaction with the vendor's performance. Not only does accepting gifts violate state ethics laws and policies, but it increases the risk of fraud and that contracting decisions will not be in the best interests of the State or PEBP's participants. (page 10)

PEBP management claimed that competitive bidding for contracts was unnecessary as they performed regular market checks to determine the value of the services their current vendors were providing. However, market checks were only performed multiple years for one vendor, and showed PEBP was paying more than other plans of similar size. In addition, cost savings was used to justify several contract extensions, after vendors agreed to lower pricing in exchange for added years to their contract terms. Market checks and cost savings should not be used to supplant bidding processes since additional value and savings may be received through competition. (page 12)

PEBP's board did not provide adequate oversight of contracting practices as it approved significant modifications to contracts' scopes of work and changes to PEBP's policies and procedures that placed less emphasis on competitive procurement. In addition, 6 of 18 contract extensions took place without State Purchasing's approval or being discussed at a PEBP Board meeting; thereby, circumventing state policy and law. (page 14)

During our testing, we observed some agency expenditures were unnecessary and not an efficient use of agency resources. For instance, PEBP allocated over 620 hours and nearly $51,000 to obtain business awards and an accreditation. It is the responsibility of PEBP's Board and management to ensure funds are spent appropriately. (page 21)

10.

10. Discussion and Possible Action on Solicitation for PEBP Auditor (Laura Rich, Executive 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: September 24, 2020

Item Number: X

Title: Contract Solicitation Report for Auditor Services

SUMMARY

This report requests the Board authorize staff to solicit proposals for Health Plan Auditor services for PEBP's Self-Insured Program.

REPORT

FINANCIAL AUDITOR

PEBP contracted with Health Claim Auditors for Health Plan Auditing Services which began October 11, 2011 resulting from RFP # 1922. The original 6-year contract was extended for an additional 5 years with a termination date of September 30, 2022. Staff has been notified that the owners of Health Claim Auditors have made the decision to retire and will be terminating their contract early.

PEBP will need to solicit for a new Health Plan Auditing Service in order to continue to meet our contract auditing requirements and ensure current vendors are fulfilling contractually agreed upon performance guarantees.

A draft overview and scope of work for this RFP is available in Attachment A for Board review and input.

RECOMMENDATION

PEBP recommends the Board authorize staff to proceed with a Request for Proposal for a Health Claim Auditing Company.

Attachment A – Health Claim Auditor

OVERVIEW OF PROJECT

The State of Nevada, Purchasing Division, on behalf of the Public Employees' Benefits Program (PEBP), headquartered in Carson City, Nevada, is soliciting proposals from Health Claim Auditor entities for the claims and contracts audit of PEBP's contracted vendors.

Audits are essential to assure that services provided by PEBP and PEBP's contracted vendors are in compliance with contract requirements and performance guarantees. The selected vendor will provide audit services of PEBP's Third Party Administrator (TPA) that will include audits of the Health Savings Accounts (HSA) and Health Reimbursement Accounts (HRA) managed by PEBP's TPA, Pharmacy Benefits Manager (PBM), PEBP's Preferred Provider Networks and Utilization Management Company. PEBP is also seeking an audit of its internal practices in the management of its Eligibility and Enrollment processes, to include accounting, security, policies and procedures and contract compliance.

The effective date of the contract resulting from this RFP will most likely be March 1, 2021; however, PEBP reserves the right to initiate service at an earlier date dependent upon proposal responses. The length of the contract will be four (4) years. The contract termination date, pursuant to this RFP, will be February 28, 2025. PEBP reserves the right to renegotiate price terms as market conditions warrant.

SCOPE OF WORK

Audits are essential to assure that services provided by PEBP and PEBP's contracted vendors are in compliance with contract requirements and performance guarantees. The selected vendor will provide audit services of PEBP's Third Party Administrator (TPA) that will include audits of the Health Savings Accounts (HSA) and Health Reimbursement Accounts (HRA) managed by PEBP's TPA, Pharmacy Benefits Manager (PBM), PEBP's Preferred Provider Networks and Utilization Management Company. PEBP is also seeking an audit of its internal practices in the management of its Eligibility and Enrollment processes, to include accounting, security, policies and procedures and contract compliance.

The purpose of this RFP is to secure the services of a Health Plan Auditor who can provide *all* the listed audits. Any proposals submitted without confirmation that all the listed services can be provided will be considered incomplete and will not be considered for award.

Current Contracted Health Plan Auditor

PEBP currently utilizes the services of Health Claim Auditors, Inc. based in Henderson, Nevada.

Current Contracted Vendors

PEBP contracts with the following vendors, whose physical location of each office to be audited is provided:

- HealthSCOPE – Third Party Claims Administrator (PPO & EPO Plans), HSA, HRA Administration, National PPO Network, Flexible Spending Account (Little Rock, AR)
- Express Scripts – Pharmacy Benefits Manager (PPO Plan) (St. Louis, MO)
- American Health Holdings – Utilization Management Review, Large Case Management (New Albany, OH)
- Sierra Healthcare Options and Hometown Health Providers – Nevada Statewide Medical PPO Network (PPO Plan) (Las Vegas, NV and Reno, NV)
- Diversified Dental Services – Dental PPO Network (PPO and HMO) (Reno, NV)
- Health Claim Auditors – Health Plan Auditor services (Excludes HMO vendors)
- AON Consultants – Actuary services (No audit required)
- Health Plan of Nevada (HPN) – Southern Nevada HMO (Las Vegas, NV)
- Morneau Shepell Ltd. – Eligibility and Enrollment (Pittsburgh, PA and Toronto, Canada)
- Extend Health, Inc. – Medicare Coordinator/Exchange (Salt Lake City)
- The Standard – Group Basic Life Insurance (Portland, OR)

PEBP's Health Plan Auditor is required to attend all PEBP Board meetings where audit findings are presented, typically once per quarter. Additionally, auditor is occasionally required to meet in person with PEBP staff, typically bi-monthly. Please confirm your willingness to accept these requirements.

The costs associated with attendance at all required PEBP Board meetings and meetings with PEBP staff should be included in your cost proposal. Any costs not disclosed in the cost proposal may not be payable by PEBP.

Audits

- Third Party Administrator (TPA) - Claims system procedural audit which shall include but not be limited to the following. The final quarterly audit results will be used to measure the Third Party Administrators Performance Guarantees for Financial Accuracy, Payment Accuracy, Claim Processing Turnaround Time, Customer Service Telephone Response Time and Telephone Abandonment Rate.

    a) Edits being utilized in the system to flag claims for medical review.
    b) Membership updating and procedure for eligibility requirements.
    c) Coordination of Benefits in areas of both research and processing.
    d) Proper usual, customary and reasonable application.
    e) Procedure utilized for subrogation identification, investigation and recovery.
    f) Turnaround time for clean claims, pending claims and claims under review.

g) Ability to identify duplicate claim submission.
h) Procedure for identification of potential fraudulent claim submission.
i) Medical necessity of specific professional services.
j) Quality assurance programs and claim production adequacy.
k) Processing of claims secondary to other insurance including Medicare.
l) Identify unbundling and code creeping in billing submissions.
m) Analysis of cost containment software being utilized such as patterns of care and outpatient hospital surgical indexing.
n) Systematic editing for necessary benefit and cost containment analysis, to include but not be limited to coordination of benefits, student status, rental vs. purchase price of durable medical equipment, provider discounting, prompt pay discounting and coding discrepancies.
o) Analysis of hospital audit programs being utilized.
p) Analysis of customer service operations including telephone response time and telephone abandonment rate.
q) Communication between utilization management company and TPA.
r) HIPAA compliance.
s) Quality assurance of electronic data interface(s) to include but not limited to EDI between TPA and PBM for deductible and coinsurance/out-of-pocket accumulators.

- Third Party Administrator (TPA) - The random selection of claims will be a statistically valid sampling of individual medical, dental and vision claims and will be audited for payment accuracy at a minimum, in the following areas. The final quarterly audit results will be used to measure the Third Party Administrators Performance Guarantees for Financial Accuracy and Payment Accuracy.

a) Coordination of Benefits.
b) Subrogation and workers compensation duplication.
c) Accuracy of CPT, HCPCS, ADA and ICD-9 and ICD-10 codes.
d) Administration of benefits including deductible, coinsurance, co-payments, benefit maximums, frequency maximums, usual and customary, PPO discounts and other special requirements as described in PEBP's Plan Document.
e) Provider location and amount paid.
f) Review by medical department when necessary
g) Benefit eligibility.
h) Comparison of amount paid to amount invoiced on claims.
i) Turn-around time of claims.
j) Accuracy and appropriateness of in and out of network claims payment
k) Quality assurance of electronic data interface(s) to include but not limited to EDI between TPA and PBM for deductible and coinsurance/out-of-pocket accumulators.

- HSA/HRA Administrators – HSA/HRA claims system procedural audits for the HSA/HRA Administrator for PPO participants *and* the HRA administrator for Medicare Exchange retirees. The HSA/HRA Administrator for PPO participants is currently PEBP's Third Party Administrator. Therefore costs associated with the audit of the HSA/HRA Administrator for PPO participants shall be included in the cost of the Third Party Administrator. Costs associated with the audit for HRA administrator for Medicare Exchange retirees shall be included in that section. The audits will include a random selection of claims and may include various focus audits. The random selection of claims will be a statistically valid sampling of reimbursement claims. The final report on the audit of the random selection of claims will be used to measure the HSA/HRA Administrator's performance. Audit will include a review of:

    a) Turnaround time for clean claims, pending claims and claims under review
    b) Ability to identify duplicate claim submission
    c) Procedure for identification of potential fraudulent claim submission
    d) Analysis of customer service operations including telephone response time and telephone abandonment rate
    e) HIPAA compliance
    f) Quality assurance of electronic data interface(s)
    g) Benefit eligibility
    h) Comparison of amount paid to amount invoiced on claims

- Pharmacy Benefit Manager – The random selection of prescription claims will be a statistically valid sampling of individual retail and mail order pharmacy claims and will be audited for accuracy in the following areas. The annual audit results will be used to measure the PBM's Performance Guarantees for Financial Accuracy, Payment Accuracy, Claim Processing Turnaround Time, Customer Service Telephone Response Time and Telephone Abandonment Rate.

    a) Dispensing fee review.
    b) Deductible and coinsurance properly processed.
    c) Pharmacy discount review.
    d) Exclusions properly processed.
    e) Quantity limitations properly processed.
    f) Pharmacy claims greater than $500 review.
    g) Pharmacy formulary/non formulary review.
    h) Proper dispensing fee applied for retail brand and generic, mail order brand and mail order generic.
    i) Investigational drug review.
    j) Over the counter drug review.
    k) Injectable drugs properly processed.
    l) Proper rebate administration.

- Utilization Management Company will be audited for accuracy and compliance in the following areas. The annual audit results will be used to measure the Utilization

Management Company's Performance Guarantees for timely delivery of quarterly and annual management reports, timely delivery of potential high dollar claim information to PEBP, timely delivery of precertification notices and concurrent review notifications to PEBP's TPA, customer service telephone response time and telephone abandonment rate.

a) Cases requiring case management properly identified.
b) Pre-certification process.
c) Reporting capabilities.
d) Retrospective review properly managed.
e) Telephone response time to providers and plan participants.
f) Timeliness of documents to providers and plan participants.
g) Quality assurance of electronic data interface(s).
h) Concurrent review process.
i) Provide recommendations for improvement in the areas listed above.

- PEBP contracts with Morneau Shepell Ltd. to lease their eligibility and enrollment system. PEBP is the system of record regarding participant eligibility; this means that PEBP has the responsibility for eligibility final determination, maintenance of eligibility records and reporting of eligibility for its participants and their dependents. Enrollment and Eligibility System will be audited for accuracy and compliance in the following areas:

  a) General system requirements as defined in contract.
  b) System reporting requirements.
  c) Response time to correct issues.
  d) Change management protocols.
  e) Quality assurance of electronic data interface(s).
  f) Review each data entry screen to determine if edits and controls exist to ensure accurate entry of information.
  g) Statistical review of eligibility records in system for participant coverage accuracy.
  h) Identify if benefit calculations are determined properly and in accordance with Nevada state regulations, PEBP eligibility parameters and PEBP accounting policies and procedures.
  i) Identify if data entry screen functions are completed in accordance with system design and user requirements.
  j) Determine if individual records reflect appropriate and timely changes following key eligibility status changes such as active to retired.
  k) Evaluate system function and assist PEBP in determining what processes should be automated versus manual.
  l) Review and evaluate database structure and submit possible recommendations for improvement.
  m) Review system reports and other communication materials for content and accuracy.
  n) Review PEBP operational procedures that are not supported in the Eligibility and Enrollment System.

- Preferred Provider Networks will be audited for accuracy and compliance in the following areas. The audit results will be used to assure PEBP that the contractual requirements between the Preferred Provider Networks and PEBP are satisfied. The audit results will be used to measure the Preferred Provider Network's Performance Guarantees for Claim Repricing Accuracy and Turnaround Time, and Timeliness of Provider Information Updates.

    a) Review the accuracy of information (EDI claims repricing or shared provider data) between Networks and PEBP's TPA.
    b) Review provider credentialing process and ongoing maintenance.
    c) Review provider contract arrangements to assure effective provider discounts.
    d) Review provider contract for provisions regarding patient balance billing.
    e) Review networks communication process with participating providers (newsletters, one on one meetings, etc.).
    f) Review provider contract arrangements for disclosure of any hold back, rebate monies or undisclosed profit from providers.
    g) Review provider contract arrangements and provide recommendations for improvement.

- Annual audit of PEBP's self-administered enrollment and eligibility processes. The audit will include the interview, observation and review of PEBP personnel, policies and procedures within the PEBP eligibility processes. This audit will include collecting information, reviewing policies and procedures and conducting inspection(s) to ensure that PEBP is doing an effective job of controlling and providing eligibility information to its vendors in an accurate and timely fashion. PEBP's office is located in Carson City, NV. The objective of the audit is to review the following areas within the eligibility data process:

    a) Obtaining Eligibility Information
        - Procedures;
        - Accuracy;
        - Security;
        - Appropriate notifications, disclosures, etc. to participants;
        - Turnaround timelines; and
        - Request of information pertaining to possible COBRA, Coordination of Benefits, Medicare, alternate insurance coverages, etc.

    b) Security and Potential Fraud exposure(s)
        - Personnel accesses;
        - Internal audit procedures;
        - Data tracking capacities;
        - Audit of PEBP personnel files;
        - Building and work station(s) accessibility;

- Use of external terminal(s);
- Privacy Officer interview; and
- Security Officer interview;

c) Agreement Documentation
- HIPAA;
- Confidentiality; and
- Business Agreement.

d) Quality Control
- Document Processing Unit policy/procedures;
- Eligibility Processing Unit policy/procedures;
- Maintenance of PEBP vendor accuracy/ Contractual Compliance;
- Transfer of Data in Accordance with PEBP Contract Language; and
- Destruction/Elimination or Proper Storage of Data Following Contract Termination.

e) Accounting
1) Accuracy of Premium Billing;
2) COBRA Administration; and
3) Accurate and Timely Termination for Non-Payment

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b) Security and Potential Fraud exposure(s)
- Personnel accesses;
- Internal audit procedures;
- Data tracking capacities;

- Audit of PEBP personnel files;
- Building and work station(s) accessibility;
- Use of external terminal(s);
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- HIPAA;
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d) Quality Control
- Document Processing Unit policy/procedures;
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- Maintenance of PEBP vendor accuracy/ Contractual Compliance
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- Destruction/Elimination or Proper Storage of Data Following Contract Termination

e) Accounting
- Accuracy of Premium Billing
- COBRA Administration
- Accurate and Timely Termination for Non-Payment

- System Capability Audits – Should PEBP go out to bid for the services above, PEBP may require the Health Plan Auditor to provide system capability audits of up to three finalist vendors for each contract. System capability audits should include review of the finalist vendors' ability to perform services at a level that meets or exceeds best practices, industry standards and the finalist vendors' ability to provide information necessary to perform and pass the audits above. Audits will be conducted after the RFP committee for each RFP selects the finalist vendors. The Health Plan Auditor will have approximately two to three weeks to complete the audit and provide the final report to the RFP committee. Audits will not be required of incumbent vendors.

Qualifications and experience of health plan auditors

Auditors will have extensive background in the areas of medical, dental, vision and pharmacy claims, operating systems and claim adjudication, current updates and inside knowledge of the procedures utilized in billing practices by hospitals and physicians, as well as system enhancements to combat medical inflation. Auditor will also have knowledge of eligibility and billing systems, PPO network operations, Utilization Management, HSA/HRA Administration and Case Management operations. Auditors must have previous experience in both systems and claims auditing practices. Auditors will have systems knowledge, claims adjudication knowledge, cost containment program knowledge and financial auditing experience.

For the purposes of providing statistically random audit reports, please explain your selection criteria process for the following:

a) Third Party Claims Administrator;
b) Pharmacy Benefit Manager;
c) Utilization Management;
d) Enrollment and Eligibility System; and
e) Preferred Provider Network.

Please explain your ability to perform system test audits. Should PEBP go out to bid for a new Third Party Claims Administrator or new Enrollment and Eligibility System vendor, the Health Plan Auditor will be required to perform a system capability audit of potential vendors in each category and report the outcome to the PEBP Board. If the incumbent is included as a potential, the Health Plan Auditor would not be required to perform a system capability audit of the incumbent's system.

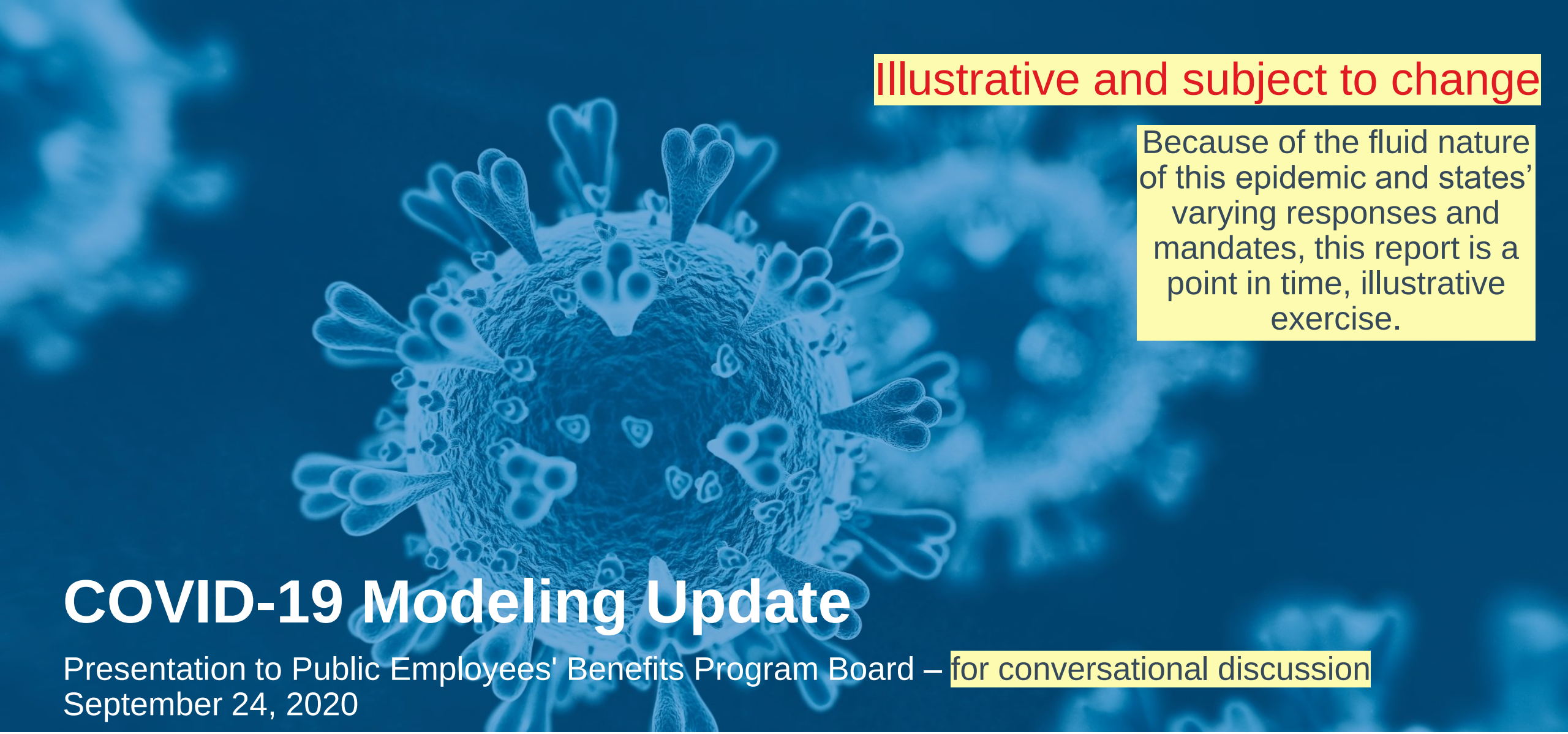
Please provide copies of sample audit reports.

PROPOSED TIMELINE

TASK	DATE/TIME
Release Date	October 2020
Submission Deadline	November 2020
Evaluation Period	November 2020
Contract Negotiations	December 2020
PEBP Board Ratification of Contract	January 2021
Anticipated BOE Approval	February 2021
Contract Start Date (contingent upon BOE approval)	March 2021

11.

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



Illustrative and subject to change

Because of the fluid nature of this epidemic and states' varying responses and mandates, this report is a point in time, illustrative exercise.

COVID-19 Modeling Update

Presentation to Public Employees' Benefits Program Board – for conversational discussion
September 24, 2020

Proprietary for use in discussions with PEBP Board and Staff

AON
Empower Results®

COVID-19 Overall Updates

Statistics

Approaching 7M confirmed cases in the US

Over 200k Fatalities; Over 1k per day

- 80% ages 65+ (as of early Aug)
- 15% ages 50-64 (as of early Aug)

Significant Socioeconomic Disparities in Infection Rates

- 32% of Cases Hispanic
- 20% of Cases African American

Actual cases likely 5-10x+ higher than serology data

700-900k Viral tests per day, still facing logistical challenges

Good News

Fatality Rate: 0.5-1.0%

- <0.2% Ages 0-50
- ~0.5% 50-60
- ~1.5-2.0% 60-75
- >5% over 75

No reinfections *yet*

Risk Awareness / Masking

Rapid Vaccine Progress

- Multiple Vaccines in Phase III trials
- Expected Prelim Approvals toward end of 2020/early 2021

Progress on Therapeutics/Reduction in Mortality

Ongoing Concerns

Ongoing spread and secondary surges

Impact of Fall/Winter season and School Re-openings

Long-term complications emerging

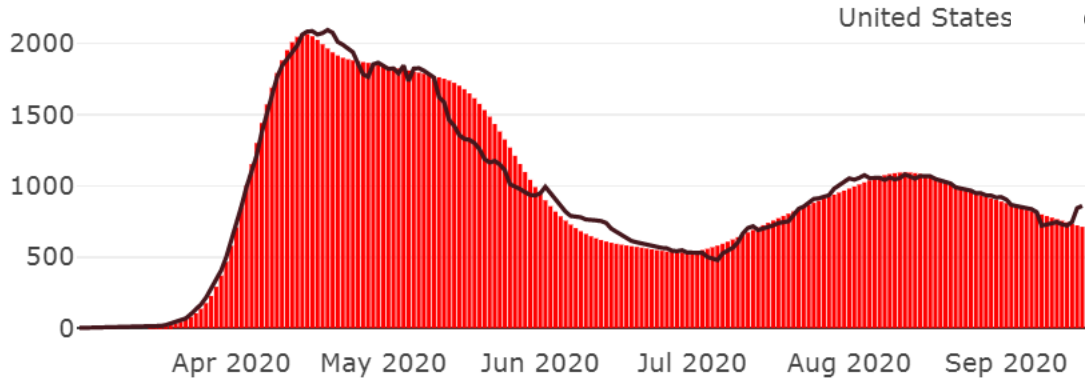
Immunization Timing and Logistics

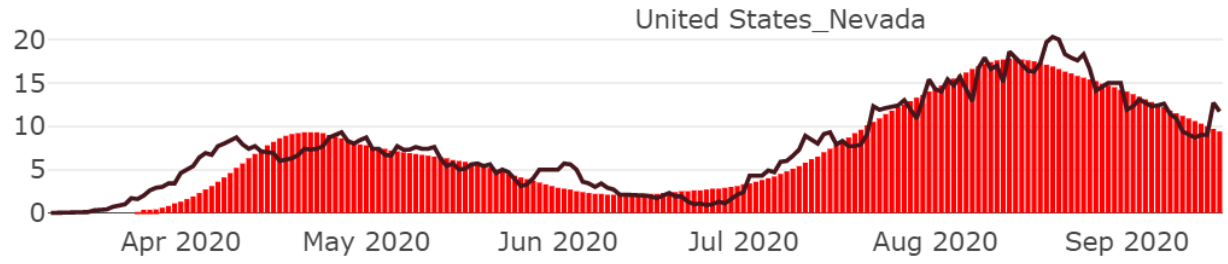
Provider Economic Impact

Ongoing data challenges in US

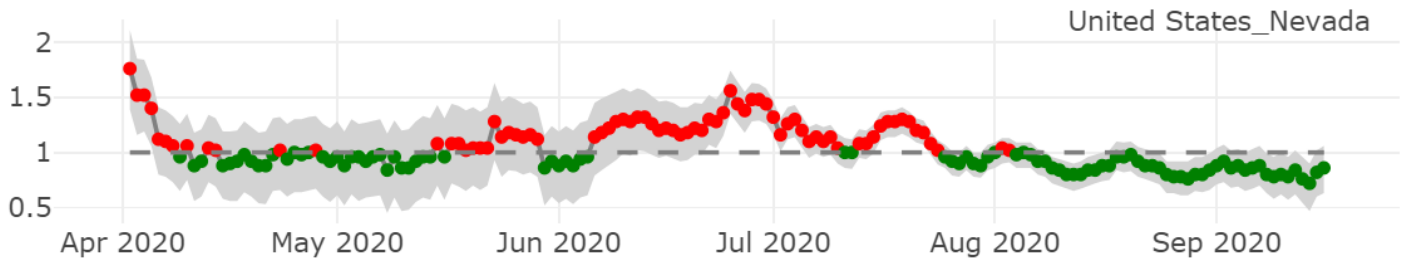
COVID-19: Shape of the Pandemic

The black line represents 7 day moving average of actual deaths reported, the red bars reflect the fatalities fitted by the Aon Employee Impact Model





The chart below shows the live transmission rates R_t



Empower Results®

Impact of COVID-19 on Medical Costs Nationally

Medical Claims increased in July but remain below expected levels

	2H Mar	Apr	May	Jun
IP Admits	-25%	-30%	-15%	-10%
IP Surgery	-40%	-50%	-15%	-5%
OP Surgery	-55%	-75%	-30%	-10%
ER Visits	-30%	-50%	-35%	-20%
Office Visits	-45%	-55%	-30%	-10%

Average net hospital utilization statistics from Tenet and HCA earnings and investor calls
Strata Decision hospital reporting and Commonwealth Fund office visits reporting
Aon client experience

PEBP's Experience: Actual Incurred Claims over Expected

- PEBPs Pharmacy and Dental Actual to Expected Claim Payments have been similar by month to Aon's book of business experience
- The Medical side didn't see as large of a claim drop in April and May as the rest of the benchmark

	PEBP Incurred Claims Actual / Expected			Aon Book of Business Actual / Expected		
Incurred Month Paid through July	Medical	Rx	Dental	Medical	Rx	Dental
March	95%	114%	66%	84%	110%	75%
April	73%	107%	18%	60%	98%	20%
May	96%	95%	62%	76%	92%	80%
June	116%	106%	97%	98%	100%	105%
July	103%	97%	106%			

- July (and to some extent June) is still very immature, the completion factors being applied may not prove to be in line with actual runout experience seen in the days of COVID

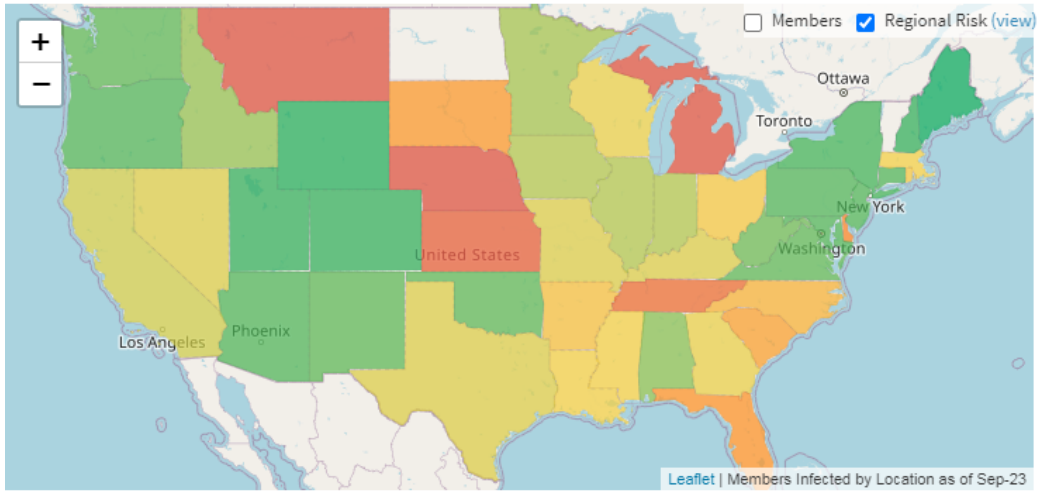
Empower Results®

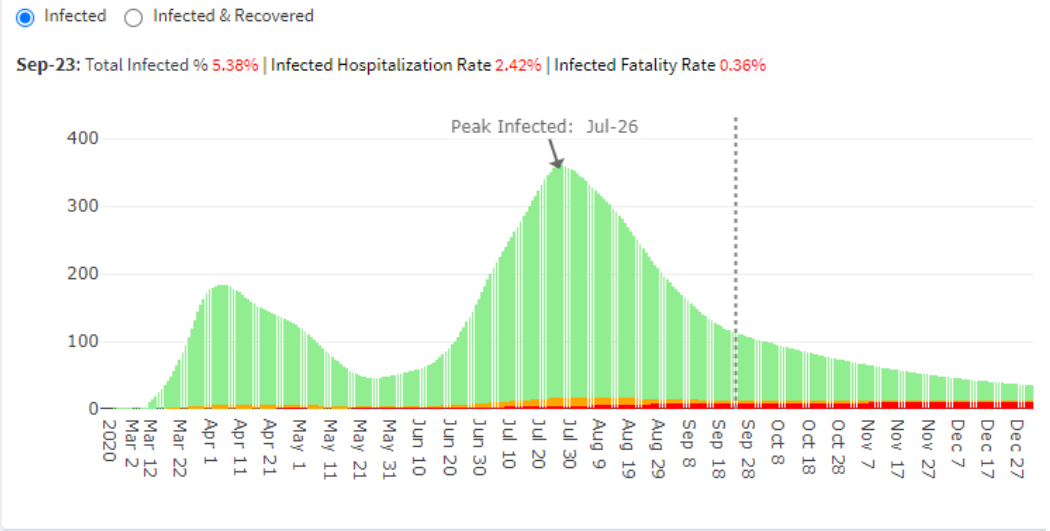
Self-Funded Impact as of September 23rd

Claim costs peak in Q1 of PY21, as COVID-19 cases peaked on July 26th

Includes enrollees in HealthScope CDHP and EPO

Illustrative – to aid in discussion





	SUSCEPTIBLE	MILD (80% undetected/20% detecte	HOSPITALIZED + CRITICAL	DEATHS	TOTAL
MEMBER COUNT :	44,854	100 INFECTED 2,379 RECOVERED	4 INFECTED 58 RECOVERED	9	47,404
MEDICAL CLAIMS COST : *(excludes non-enrolled)*	$637K ($50-$150 per testing)	$744K ($0-$1,500 per case)	$2.7M ($20,000-$80,000 per case)	The medical claims cost and work days lost for cases resulting in deaths is included with the HOSPITALIZED + CRITICAL cases.	$4.1M ($86 per enrolled member)
WORK DAYS LOST :	2,719	6,925	1,437		11,082

Disclaimer: The data contained in the COVID-19 Employee Impact Model generates future forecasts derived from historical information. The site relies on publicly-available data from multiple sources, which are updated frequently, and which may not always agree with each other. The use of sources does not constitute or imply endorsement of the organizations or sources that provided the data. The model results are highly dependent upon a number of factors outside of Aon's control. As such, Aon disclaims any and all representations and warranties with respect to the site, including accuracy and fitness for use.

This model results have been provided as an informational and educational resource for Aon clients and business partners. It is intended to provide general guidance on potential exposures, and is not intended to provide medical advice or address medical concerns or specific risk circumstances. Due to the dynamic nature of infectious diseases, Aon cannot be held liable for the guidance provided. We strongly encourage Aon clients to seek additional safety, medical, and epidemiologic information from credible sources such as the Centers for Disease Control and Prevention (CDC) and World Health Organization (WHO). The analysis does not reflect any change in the patterns of care for non-COVID-19 related morbidity or treatment, including elective and non-emergent procedures, and reliance on this site for any medical guidance is strictly prohibited. Furthermore, we are currently making no representations of the impact from COVID-19 on other workforce impacts and coverage such as productivity, sick time, disability, Workers Compensation or life insurance. As regards insurance coverage questions, whether coverage applies or a policy will respond to any risk or circumstance is subject to the specific terms and conditions of the insurance policies and contracts at issue and underwriter determinations.

COVID-19: Self-Funded Medical Impact as of 12/31/20

Net impact of COVID-19 is most likely savings, but depends on the level of COVID-19 claims transmission and the level of claims suppression within PEBP's population

Illustrative – to aid in discussion

	Claims "Saved"/ Suppressed	COVID $s Transmission R_t = 0.98	Total Cost Impact
Low	($3.4M)	$4.7M	$1.3M
Medium	($6.4M)	$4.7M	($1.6M)
High	($12.1M)	$4.7M	($7.4M)

- Estimates of COVID-19 transmission rates and ongoing claims suppression are associated with large uncertainty
- Claims suppression assumes:
  - Low: Total claims costs return to normal and bounce back above normal over the remaining months
  - Medium: Total claims costs return to normal and remain slightly elevated for the remaining months
  - High: Total claims costs remain slightly suppressed for remainder of the year
- Costs based on August 31, 2020 reprojections

COVID-19: Self-Funded Medical Impact --- **Medium Scenario**

Under this scenario, net impact is estimated to save PEBP $1.6M in calendar year 2020

Because PEBPs financial year ends in the middle of 2020, the majority of the savings ($4.1M) was “booked” in PY20, not in PY21

Illustrative – for discussion

	PY20 and PY21 (in Millions)				Total
	Q3 PY20	Q4 PY20	Q1 PY21	Q2 PY21	
COVID-19 Claims	$0.4	$1.2	$2.6	$0.5	$4.7
Claims Suppression	($1.3)	($4.3)	($1.3)	$0.6	($6.4)
Net Impact	($0.9)	($3.2)	$1.3	$1.2	**($1.6)**

Dental has added an additional $2.5M of surplus thus far in CY20

- COVID-19 estimated increase in claims of $4.7M or 1.9% in CY2020
- Suppression of non-COVID-19 claims estimated to save 2.6% in CY2020

COVID-19 claims estimate based on PEBP’s demographics and geographic distribution
Claims suppression assumptions based on feedback from national carriers as well as national data through June
Actual results may vary

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- **Disclaimer:**

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- **What remains unknown/volatile:**
  - Length of reductions due to suspension of non-critical medical services, timing of returns and their size
  - Health care system revenue pressures
  - Impact of Federal assistance
  - Potential for new drugs or vaccinations to be developed
  - Timing and corresponding impact of second wave of infections, willingness of public to maintain mask or “safer-at-home” mandates etc.

12.

12. Public Comment

13.

13. Adjournment