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

LAURA RICH
Executive Officer

MEETING NOTICE AND AGENDA – Amended 01/21/21

Name of Organization:	Public Employees' Benefits Program Board
Date and Time of Meeting:	January 28, 2021 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/rrpBx1MmXzg

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

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

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

Option #1 **Join the webinar as an attendee** https://zoom.us/j/96275310197 **. This link is only for those who want to make public comment. If you are just listening to the webinar, please use the YouTube Link located in the "Place of Meeting" field above.**

Option #2 **Dial: (669) 900-6833. When prompted to provide your Meeting ID, please enter: 962 7531 0197 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 November 23, 2020 PEBP Board Meeting

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

      4.2.1 Budget Report

      4.2.2 Utilization Report

   4.3 Receipt of quarterly vendor reports for the period ending September 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 September 2020

4.4 Revised Financial Statement for the Self Insurance Trust Fund

4.5 Acceptance of the annual PEBP Appeals and Complaints Summary for submission to the Nevada Division of Insurance.

5. Presentation and possible action on Governor's Recommended Budget and approval of PY22 Plan Benefit Design (Laura Rich, Executive Officer) (**For Possible Action**)

6. Presentation and possible action on the status and approval of new PEBP contracts, contract amendments and solicitations (Cari Eaton, Chief Financial Officer) (**For Possible Action**)

6.1. Contract Overview

6.2. New Contracts

6.2.1. Aetna Signature Administrators - Statewide PPO/EPO Network (pursuant to Request for Proposal No. 95PEBP-S1289)

6.2.2. Health Plan of Nevada – Statewide HMO Plan (pursuant to Request for Proposal No. 95PEBP-S1291)

6.2.3. Diversified Dental – Dental Network (pursuant to Request for Proposal No. 95PEBP-S1299)

6.3. Contract Amendments

6.3.1. Hometown Health - Statewide PPO - increases contract maximum to allow sufficient authority through remainder of contract

6.3.2. The Standard – Life insurance and Long Term Disability – decreases contract to reflect changes in plan benefit design

6.3.3. Aon Consulting – Consulting Services – increases contract authority for consulting services

6.4. Contract Solicitations

6.4.1. Website hosting

6.4.2. Third Party Administrator and associated services

6.4.3. Pharmacy Benefit Manager

6.5. Status of Current Solicitations

7. Discussion and possible action on rate setting and rate development (Stephanie Messier, Aon) (**For Possible Action**)

8. Discussion and possible action on Legislative Counsel Bureau Information Technology Audit Report and Corrective Action Plan (Laura Rich, Executive Officer) (**For Possible Action**)

9. Discussion and possible action on updates to Board policies and procedures to include edits reflecting (1) Board policy decisions and (2) Subcommittee recommendations relating to the Legislative Counsel Bureau contract audit report (Laura Rich, Executive Officer) (**For Possible Action**)

10. Discussion and possible action regarding the withdrawal of funds from the Retirement Benefits Investment Fund (Laura Rich, Executive Officer) (**For Possible Action**)
11. Executive Officer Report (Laura Rich, Executive Officer) (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**)

   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 November 23, 2020 PEBP Board Meeting.

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      4.2.1 Budget Report

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4.5 Acceptance of the annual PEBP Appeals and Complaints Summary for submission to the Nevada Division of Insurance

4.1

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

STATE OF NEVADA
PUBLIC EMPLOYEES' BENEFITS PROGRAM
BOARD MEETING

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

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

MEMBERS PRESENT VIA TELECONFERENCE:	Ms. Laura Freed, Board Chair Ms. Linda Fox, Vice Chair Ms. Michelle Kelley, Member Mr. Tom Verducci, Member Ms. Jennifer Krupp, Member Ms. Betsy Aiello, Member Mr. Tim Lindley, Member Dr. Marsha Urban, Member
MEMBERS EXCUSED:	Mr. Don Bailey, Member Mr. David Smith, 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. Steven Martin, 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 9:10 a.m.

2. Public Comment

   - Jason Wasden – UNLV Administrative Faculty Committee & Classified Staff Counsel
   - Kent Ervin – Nevada Faculty Alliance
   - Donna Healy – UNR Classified Employee
   - Jose Garcia – Classified Employee
   - Marlene Lockard – RPEN
   - Doug Unger – UNLV Employee Benefits Advisory Committee
   - Priscilla Maloney – AFSCME
   - Ian Knight – Active Employee
   - Jerry Beam – Active Employee
   - Maria Schellhase – CSN Professor
   - Raven Sumner – UNLV Active Employee
   - Janell Woodward – Active Employee
   - Margarethe Miller – Retiree
   - Unidentified Speaker – Active Employee
   - DT Allen – Active Employee
   - Cameron Hopkins – Active Employee
   - Kevin Ranft - AFSCME

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

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

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

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

   4.2 Health Claim Auditors, Inc. quarterly audit of HealthSCOPE Benefits for the timeframe July 1, 2020 – September 30, 2020: (1) Report from Health Claim Auditors; (2) HealthSCOPE Benefits response to audit report; and (3) for possible action to accept audit report findings and assess penalties, if applicable, in accordance with the performance guarantees included in the contract pursuant to the recommendation of Health Claim Auditors.

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

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

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

BOARD ACTION ON ITEM 4
MOTION: Motion to approve items 4.1 – 4.5 on the Consent Agenda
BY: Vice Chair Linda Fox
SECOND: Member Jennifer Krupp
VOTE: Unanimous; the motion carried

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

BOARD ACTION ON ITEM 5
MOTION: Motion to authorize the PEBP staff to execute contracts for the December BOE for the enrollment and eligibility system contract with a maximum of $6, 849, 000 for the term of the contract.
BY: Vice Chair Linda Fox
SECOND: Member Michelle Kelley
VOTE: Unanimous; the motion carried

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

BOARD ACTION ON ITEM 6
MOTION: Motion to approve American Health Holding contract amendment addressing temporary ownership of toll-free number.
BY: Vice Chair Linda Fox
SECOND: Member Betsy Aiello
VOTE: Unanimous; the motion carried

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

8. Discussion and possible action regarding potential budget reserve options and proposed plan design changes for Plan Year 2022 (July 1, 2021 – June 30, 2022) including but not limited to the following: (Laura Rich, Executive Officer) **(All Items for Possible Action)**

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

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

    8.3 Possible Implementation of Smart 90 to EPO

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

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

    8.6 Possible Reductions in or Elimination of Basic Life Insurance Benefit

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

    8.8 Possible Elimination of Medicare Part B Subsidy

    8.9 Possible Elimination of Retiree Dependent Subsidies

    8.10 Possible Unbundling of Dental Premium

    8.11 Possible Increases in Premiums to Achieve Necessary Budget Reserve Requirements

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

BOARD ACTION ON ITEM 8

MOTION: Motion to present budget reduction scenario involving plan design changes as reflected in 8.1.A, including the savings measures in 8.2, 8.3, 8.4, 8.5 Option 2, 8.6 Option 2, 8.7 to reduce the long-term disability benefit, but not eliminate it and 8.10 unbundling of the dental premium and to the extent that that does not get the Board to its $36 million subsidy target, make up the reductions in the B participants share of the total premium.

BY: Board Chair Laura Freed

SECOND: Member Tim Lindley

VOTE: 7 Yes, 1 No; the motion carried

9. Public Comment

- Kent Ervin – Nevada Faculty Alliance
- Doug Unger - UNLV Employee Benefits Advisory Committee
- Shaun Franklin Sewell – UNLV Employee Benefits Advisory Committee
- Jose Garcia - Classified Employee
- Kevin Ranft – AFSCME
- Margarethe Miller – Retiree
- Brian - Retiree
- Alejandra Livingston – Active Employee
- Priscilla Maloney – AFSCME
- Clarabell Zecena - AFSCME

10. Adjournment

- Board Chair Freed adjourned the meeting at 4:52 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 September 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 September 30, 2020:

   4.2.1 Budget Report

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LAURA RICH
Executive Officer

AGENDA ITEM

[X] Action Item

[ ] Information Only

Date: January 28, 2021

Item Number: IV.II.I

Title: Chief Financial Officer Budget Report

Summary

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

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

Budget Account 1338 – Operational Budget – Shown below is a summary of the operational budget account status as of September 30, 2020 with comparisons to the same period in Fiscal Year 2020. 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 $77.6 million as of September 30, 2020 compared to $71.1 million as of September 30, 2019 or an increase of 9.2%. Total expenses for the period have decreased by $5.8 million or 5.5% for the same period.

The budget status report shows Realized Funding Available (cash) at $133.3 million. This compares to $116.8 million for last year. After subtracting $51.5 million for reserves for Incurred but not Reported (IBNR) claims, $34.8 million for the Catastrophic Reserve and $30.6 million for the HRA Reserve, the remaining balance is $16.4 million in Differential Cash Available. The table below reflects the actual revenue and expenditures for the period.

Operational Budget 1338

	FISCAL YEAR 2021			FISCAL YEAR 2020		
	Actual as of 9/30/2020	Work Program	Percent	Actual as of 9/30/2019	Fiscal Year 2020 Close	Percent
Beginning Cash	154,541,329	154,541,329	100%	150,276,433	150,276,433	100%
Premium Income	74,097,153	375,455,443	20%	67,953,334	378,746,198	18%
All Other Income	3,466,083	15,615,925	22%	3,099,925	16,661,308	19%
Total Income	77,563,235	391,071,368	20%	71,053,260	395,407,507	18%
Personnel Services	456,897	2,896,914	16%	537,963	2,603,314	21%
Operating - Other than Personnel	437,631	2,383,918	18%	375,244	2,073,172	18%
Insurance Program Expenses	97,772,799	402,016,663	24%	103,516,786	235,979,740	44%
All Other Expenses	115,304	647,864	18%	115,682	618,845	19%
Total Expenses	98,782,631	407,945,359	24%	104,545,675	241,275,071	43%
Change in Cash	(21,219,396)	(16,873,991)		(33,492,416)	154,132,436	
REALIZED FUNDING AVAILABLE	133,321,933	137,667,338	97%	116,784,017	304,408,869	38%
Incurred But Not Reported Liability	(51,514,000)	(51,514,000)		(58,790,000)	(58,790,000)	
Catastrophic Reserve	(34,835,000)	(34,835,000)		(24,201,541)	(24,201,541)	
HRA Reserve	(30,550,651)	(30,550,651)		(36,204,203)	(36,204,203)	
NET REALIZED FUNDING AVAILABLE	16,422,282	20,767,687		(2,411,727)	185,213,125	

Current Budget Projections

The following table represents projections for FY 2021. The projection reflects total income to be less than budgeted by 1.9% ($543.4 million vs $550.9 million), total expenditures are projected to be less than budgeted by 4.1% ($407.3 million vs $424.7 million); total reserves are projected to be more than budgeted by 7.9% ($136.1 million vs $126.1 million).

Budgeted and Projected Income (Budget Account 1338)					
Description	**Budget**	**Actual 9/30/20**	**Projected**	**Difference**	
Carryforward	154,541,329	154,541,329	154,541,329	0	0.0%
State Subsidies	278,042,182	49,760,639	271,105,042	(6,937,140)	-2.5%
Non-State Subsidies	29,075,407	6,097,896	24,241,152	(4,834,255)	-16.6%
Premium	68,337,854	18,238,617	72,526,584	4,188,730	6.1%
All Other	20,863,995	3,466,083	21,000,496	136,501	0.7%
Total	550,860,767	232,104,564	543,414,603	(7,446,164)	-1.4%
Budgeted and Projected Expenses (Budget Account 1338)					
Description	**Budget**	**Actual 9/30/20**	**Projected**	**Difference**	
Operating	5,928,696	1,009,832	5,421,379	507,317	8.6%
State Employee Ins Cost	308,157,770	76,145,633	287,679,221	20,478,549	6.6%
State Retirees Ins Cost	53,659,367	10,328,667	62,414,135	(8,754,768)	-16.3%
Non-State Employees Ins Cost	142,871	22,479	155,574	(12,703)	-8.9%
Non-State Retirees Ins Cost	13,453,450	2,134,208	11,723,573	1,729,877	12.9%
State Medicare Ret Ins Cost	25,382,152	6,170,046	21,818,953	3,563,199	14.0%
Non-State Medicare Ret Ins Cost	17,991,547	2,971,767	18,124,006	(132,459)	-0.7%
Total Insurance Costs	418,787,157	97,772,799	401,915,462	16,871,695	4.0%
Total Expenses	424,715,853	98,782,631	407,336,841	17,379,012	4.1%
Restricted Reserves	116,899,651	116,899,651	112,277,348	4,622,303	4.0%
Differential Cash Available	9,245,263	16,422,282	23,800,414	(14,555,151)	-157.4%
Total Reserves	126,144,914	133,321,933	136,077,762	(9,932,848)	-7.9%
Total of Expenses and Reserves	550,860,767	232,104,564	543,414,603	7,446,164	1.4%

State Subsidies are projected to be less than the budgeted amount by $7.0 million (2.5%), Non-State Subsidies are projected to be less than budgeted by $5.0 million (16.6%), and Premium Income is projected to be more than budgeted by $4.2 million (6.1%). This overall decrease in budgeted revenue is due in part to a reduction in State Subsidies as a result of average enrollment as compared to budgeted enrollment and a change in the mix of plan tiers. The mix of participants is as follows:

- 2.92% fewer state actives,
- 0.51% fewer state non-Medicare retirees,
- 8.33% fewer non-state actives,
- 0.25% more non-state, non-Medicare retirees
- 5.89% fewer state Medicare retirees, and
- 6.66% fewer non-state Medicare retirees

Expenses for Fiscal Year 2021 are projected to be $17.4 million (4.1%) less than budgeted when changes to reserves are excluded. Operating expenses are projected to be less than budgeted by $0.5 million (8.6%). Employee and Retiree insurances costs are projected to be less than budgeted by $17.0 million (4%) 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 July and September during the COVID-19 shutdown.

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 September 30, 2020:

        4.2.1 Budget Report

        4.2.2 Utilization Report

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LAURA RICH
Executive Officer

AGENDA ITEM

☒ Action Item
☐ Information Only

Date: January 28, 2021

Item Number: IV.II.II

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

This report addresses medical, dental, prescription drug and HSA/HRA utilization for the PY 2021 period ending September 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 Q1 Plan Year 2021 utilization data.

Executive Summary

Consumer Driven Health Plan (CDHP)

The Consumer Driven Health Plan (CDHP) experience for Q1 of Plan Year 2021 compared to Q1 of Plan Year 2020 is summarized below.

- Population:
  - 0.7% decrease for primary participants
  - 0.4% decrease for primary participants plus dependents (members)
- Medical Cost:
  - 16.8% decrease for primary participants
  - 17.1% decrease for primary participants plus dependents (members)
- High Cost Claims:
  - There were 26 High Cost Claimants accounting for 17.5% of the total plan paid for Q1 in Plan Year 2021
  - 10.3% decrease in High Cost Claimants per 1,000 members
  - 28.8% decrease in average cost of High Cost Claimant paid
- Top three highest cost clinical classifications include:
  - Diseases of the Digestive System ($1.2 million) – 24.2% of paid claims
  - Diseases of the Circulatory System ($0.6 million) – 13.0% of paid claims
  - Certain Conditions Originating in the Perinatal Period ($0.5 million) – 11.1% of paid claims
- Emergency Room:
  - ER visits per 1,000 members decreased 19.8%
  - Average paid per ER visit increased 5.6%
- Urgent Care:
  - Urgent Care visits per 1,000 members decreased by 26.5%
  - Average paid per Urgent Care visit increased 128.9% (increase from $38 to $87)
- Network Utilization:
  - 95.7% of claims are from In-Network providers
  - Q1 of Plan Year 2021 In-Network utilization decreased 0.2% over PY 2020
  - Q1 of Plan Year 2021 In-Network discounts increased 1.5% over PY 2020
- Preventive Services:
  - Overall Preventive Services Compliance Rates decreased in 8 out of 9 categories from Plan Year 2020 between 0.9% - 3.3%.
- Prescription Drug Utilization:
  - Overall:
    - Total Net Claims increased 1.4%
    - Total Gross Claims Costs increased 17.5% ($2.0 million)
    - Average Total Cost per Claim increased 15.9%
      - From $88.69 to $102.75
  - Member:
    - Total Member Cost decreased 9.0%
    - Average Participant Share per Claim decreased 10.3%

        - Net Member PMPM decreased 8.7%
            - From $33.23 to $30.33
    - Plan
        - Total Plan Cost increased 33.4%
        - Average Plan Share per Claim increased 31.5%
        - Net Plan PMPM increased 33.8%
            - From $55.32 to $74.01
        - Net Plan PMPM factoring rebates increase 44.8%
            - From $37.85 to $54.81

PEBP PREMIER PLAN (EPO)

The PEBP Premier Plan (EPO) experience for Q1 of Plan Year 2021 compared to the Q1 of Plan Year 2020 is summarized below.

- Population:
    - 2.2% decrease for primary participants
    - 1.8% decrease for primary participants plus dependents (members)
- Medical Cost:
    - 5.0% increase for primary participants
    - 4.7% increase for primary participants plus dependents (members)
- High Cost Claims:
    - There were 9 High Cost Claimants accounting for 12.5% of the total plan paid for Q1 in Plan Year 2021
    - 131.1% increase in High Cost Claimants per 1,000 members (increase from 0.5 to 1.0)
    - 5.9% decrease in average cost of High Cost Claimant paid
- Top three highest cost clinical classifications include:
    - Injury, Poisoning and Certain Other Consequences of External Causes ($0.5 million) – 31.9% of paid claims
    - Diseases of the Blood ($0.4 million) – 24.9% of paid claims
    - Certain Conditions Originating in the Perinatal Period ($0.2 million) – 15.2% of paid claims
- Emergency Room:
    - ER visits per 1,000 members decreased by 16.3%
    - Average paid per ER visit decreased by 2.9%
- Urgent Care:
    - Urgent Care visits per 1,000 members decreased by 29.6%
    - Average paid per Urgent Care visit increased 7.8%
- Network Utilization:
    - 97.2% of claims are from In-Network providers
    - In-Network utilization decreased 0.2%
    - In-Network discounts had no change from Plan Year 2020
- Preventive Services:
    - Overall Preventive Services Compliance Rates increased from Plan Year 2020 in 6 out of 9 categories.

- Prescription Drug Utilization:
    - Overall:
        - Total Net Claims increased 1.3%
        - Total Gross Claims Costs increased 4.1% ($0.2 million)
        - Average Total Cost per Claim increased 2.8%
            - From $117.49 to $120.80
    - Member:
        - Total Member Cost increased 5.6%
        - Average Participant Share per Claim increased 4.3%
        - Net Member PMPM increased 7.4%
            - From $31.54 to $33.88
    - Plan
        - Total Plan Cost increased 3.8%
        - Average Plan Share per Claim increased 2.5%
        - Net Plan PMPM increased 5.6%
            - From $157.10 to $165.92
        - Net Plan PMPM factoring rebates increased 1.6%
            - From $125.25 to $127.19

DENTAL PLAN

The Dental Plan experience for Q1 of Plan Year 2021 is summarized below.

- Dental Cost:
    - Total of $6,576,425 paid for Dental claims
        - Preventative claims account for 42.8% ($2.8 million)
        - Basic claims account for 29.5% ($2.0 million)
        - Major claims account for 22.4% ($1.5 million)
        - Periodontal claims account for 5.4% ($0.4 million)

HEALTH REIMBURSEMENT ARRANGEMENT

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

HRA Account Balances as of September 30, 2020			
$Range	**# Accounts**	**Total Account Balance**	**Average Per Account Balance**
0	451	0	0
$.01 - $500.00	1,245	297,800	239
$500.01 - $1,000	2,512	1,868,662	744
$1,000.01 - $1,500	1,302	1,594,898	1,225
$1,500.01 - $2,000	929	1,622,505	1,747
$2,000.01 - $2,500	633	1,431,151	2,261
$2,500.01 - $3,000	412	1,130,798	2,745
$3,000.01 - $3,500	298	960,129	3,222
$3,500.01 - $4,000	200	748,533	3,743
$4,000.01 - $4,500	172	732,425	4,258
$4,500.01 - $5,000	134	635,365	4,742
$5,000.01 +	**891**	**7,079,561**	**223,983**
Total	**9,179**	**$ 18,101,827**	**$ 1,972**

CONCLUSION

The information in this report provides plan experience for the Consumer Driven Health Plan (CDHP) and the PEBP Premier Plan (EPO) for the first quarter of Plan Year 2021. The CDHP total plan paid costs decreased 17.5% over the same time for Plan Year 2020. The EPO total plan paid costs increased 2.8% over the first quarter of Plan Year 2020. 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

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HealthSCOPE – CDHP Utilization Review for PEBP
July 1, 2020 – September 30, 2020

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HSB DATASCOPE™

Nevada Public Employees' Benefits Program
HDHP Plan

July – September 2020

Overview

- Total Medical Spend for 1Q21 was $27,806,203 of which 74.7% was spent in the State Active population. When compared to 1Q20, this quarter reflected a decrease of 17.5% in plan spend, with State Actives having an decrease of 10.9%.
    - When compared to 1Q19, 1Q21 reflected an decrease of 6.4% in plan spend, with State Actives having an decrease of 7.3%.
- On a PEPY basis, 1Q21 reflected an decrease of 16.9% when compared to 1Q20. The largest group, State Actives, decreased 10.4%.
    - When compared to 1Q19, 1Q21 reflected a decrease in PEPY of 6.7%, with State Actives decreasing by 8.3%.
- 96.8% of the Average Membership had paid Medical claims less than $2,500, with 47.7% of those having no claims paid at all during the reporting period.
- There were 26 High Cost Claimants (HCC's) over $100K, that accounted for 17.5% of the total spend. HCC's accounted for 22.6% of total spend during 1Q20, with 29 members hitting the $100K threshold. The largest diagnosis grouper was Diseases of the Digestive System accounting for 24.2% of high cost claimant dollars.
- IP Paid per Admit was $18,866 which is a decrease of 10.2% compared to 1Q20.
- ER Paid per Visit is $2,086, which is a decrease of 8.2% compared to 1Q20.
- 95.7% of all Medical spend dollars were to In Network providers. The average In Network discount was 66.8%, which is slightly higher than PY20 discount of 65.3%.

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

Paid Claims by Age Group								
	1Q20							
Age Range	Med Net Pay	Med PMPM	Rx Net Pay	Rx PMPM	Dental Net Pay	Dental PMPM	Net Pay	PMPM
<1	$ 1,360,538	$ 1,292	$ 622	$ 1	$ 5,877	$ 4	$ 1,367,037	$ 1,297
1	$ 189,340	$ 160	$ 3,961	$ 3	$ 14,375	$ 8	$ 207,676	$ 172
2 - 4	$ 297,539	$ 75	$ 22,370	$ 6	$ 103,144	$ 19	$ 423,053	$ 99
5 - 9	$ 328,967	$ 43	$ 33,912	$ 4	$ 345,805	$ 33	$ 708,683	$ 81
10 - 14	$ 771,802	$ 90	$ 92,458	$ 11	$ 360,310	$ 30	$ 1,224,571	$ 131
15 - 19	$ 894,484	$ 99	$ 182,942	$ 20	$ 478,787	$ 38	$ 1,556,214	$ 157
20 - 24	$ 1,477,619	$ 144	$ 182,174	$ 18	$ 281,628	$ 21	$ 1,941,422	$ 183
25 - 29	$ 1,349,018	$ 162	$ 194,852	$ 23	$ 279,863	$ 27	$ 1,823,733	$ 212
30 - 34	$ 1,699,398	$ 191	$ 411,265	$ 46	$ 317,653	$ 27	$ 2,428,316	$ 265
35 - 39	$ 1,559,929	$ 158	$ 300,269	$ 30	$ 384,477	$ 30	$ 2,244,675	$ 218
40 - 44	$ 1,612,602	$ 181	$ 405,682	$ 46	$ 391,759	$ 33	$ 2,410,043	$ 259
45 - 49	$ 2,215,635	$ 228	$ 827,423	$ 85	$ 467,221	$ 34	$ 3,510,280	$ 347
50 - 54	$ 3,289,986	$ 325	$ 779,967	$ 77	$ 515,468	$ 36	$ 4,585,421	$ 438
55 - 59	$ 3,774,612	$ 337	$ 1,385,110	$ 124	$ 624,390	$ 39	$ 5,784,112	$ 500
60 - 64	$ 9,183,185	$ 721	$ 1,648,179	$ 129	$ 776,883	$ 43	$ 11,608,246	$ 894
65+	$ 3,687,785	$ 543	$ 975,677	$ 144	$ 1,783,816	$ 45	$ 6,447,278	$ 732
Total	**$ 33,692,440**	**$ 263**	**$ 7,446,866**	**$ 58**	**$ 7,131,456**	**$ 35**	**$ 48,270,762**	**$ 355**

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

Paid Claims by Age Group										
	1Q21								% 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	$ 1,080,593	$ 1,003	$ 793	$ 1	$ 4,323	$ 3	$ 1,085,709	$ 1,007	-20.6%	-22.4%
1	$ 197,607	$ 164	$ 35,200	$ 29	$ 14,982	$ 9	$ 247,789	$ 202	19.3%	17.6%
2 - 4	$ 327,957	$ 81	$ 111,736	$ 28	$ 102,409	$ 19	$ 542,102	$ 128	28.1%	29.0%
5 - 9	$ 420,452	$ 56	$ 67,769	$ 9	$ 331,101	$ 32	$ 819,322	$ 97	15.6%	20.9%
10 - 14	$ 543,849	$ 64	$ 101,849	$ 12	$ 359,102	$ 31	$ 1,004,800	$ 106	-17.9%	-19.2%
15 - 19	$ 699,507	$ 78	$ 157,419	$ 18	$ 450,025	$ 36	$ 1,306,952	$ 131	-16.0%	-16.6%
20 - 24	$ 1,215,352	$ 121	$ 294,446	$ 29	$ 281,160	$ 21	$ 1,790,958	$ 171	-7.8%	-6.7%
25 - 29	$ 1,611,528	$ 201	$ 345,132	$ 43	$ 257,375	$ 25	$ 2,214,035	$ 269	21.4%	26.9%
30 - 34	$ 1,317,372	$ 144	$ 525,273	$ 58	$ 328,874	$ 28	$ 2,171,520	$ 230	-10.6%	-13.2%
35 - 39	$ 1,527,645	$ 153	$ 987,609	$ 99	$ 373,973	$ 28	$ 2,889,227	$ 280	28.7%	28.4%
40 - 44	$ 1,418,558	$ 153	$ 522,574	$ 56	$ 343,866	$ 28	$ 2,284,998	$ 236	-5.2%	-8.8%
45 - 49	$ 1,782,677	$ 186	$ 816,086	$ 85	$ 397,638	$ 30	$ 2,996,401	$ 302	-14.6%	-13.1%
50 - 54	$ 3,555,545	$ 353	$ 1,093,621	$ 109	$ 428,987	$ 30	$ 5,078,153	$ 492	10.7%	12.3%
55 - 59	$ 3,253,538	$ 297	$ 1,411,874	$ 129	$ 520,748	$ 34	$ 5,186,160	$ 460	-10.3%	-8.0%
60 - 64	$ 5,890,686	$ 480	$ 1,760,456	$ 143	$ 680,896	$ 40	$ 8,332,038	$ 663	-28.2%	-25.8%
65+	$ 2,963,338	$ 420	$ 1,222,954	$ 173	$ 1,700,965	$ 42	$ 5,887,257	$ 635	-8.7%	-13.2%
Total	**$ 27,806,203**	**$ 218**	**$ 9,454,791**	**$ 74**	**$ 6,576,425**	**$ 32**	**$ 43,837,420**	**$ 324**	**-9.2%**	**-8.9%**

Financial Summary - (p. 1 of 2)

	Total				State Active				Non-State Active			
Summary	**1Q19**	**1Q20**	**1Q21**	**Variance to Prior Year**	**1Q19**	**1Q20**	**1Q21**	**Variance to Prior Year**	**1Q19**	**1Q20**	**1Q21**	**Variance to Prior Year**
Enrollment												
Avg # Employees	23,341	23,581	23,419	-0.7%	19,337	19,669	19,563	-0.5%	4	4	3	-16.8%
Avg # Members	42,546	42,753	42,580	-0.4%	36,862	37,138	36,973	-0.4%	7	7	7	0.0%
Ratio	1.8	1.8	1.8	0.6%	1.9	1.9	1.9	0.0%	1.8	1.8	2.1	20.0%
Financial Summary												
Gross Cost	$40,882,487	$46,374,477	$38,766,628	-16.4%	$31,274,328	$33,530,604	$29,572,105	-11.8%	$3,642	$14,108	$2,580	-81.7%
Client Paid	$29,707,759	$33,692,440	$27,806,203	-17.5%	$22,392,073	$23,296,415	$20,763,800	-10.9%	$2,404	$9,764	$1,404	-85.6%
Employee Paid	$11,174,745	$12,682,036	$10,960,425	-13.6%	$8,882,260	$10,234,189	$8,808,304	-13.9%	$1,238	$4,344	$1,176	-72.9%
Client Paid-PEPY	$5,091	$5,715	$4,749	-16.9%	$4,632	$4,738	$4,246	-10.4%	$2,404	$9,764	$1,684	-82.8%
Client Paid-PMPY	$2,793	$3,152	$2,612	-17.1%	$2,430	$2,509	$2,246	-10.5%	$1,374	$5,579	$802	-85.6%
Client Paid-PEPM	$424	$476	$396	-16.8%	$386	$395	$354	-10.4%	$200	$814	$140	-82.8%
Client Paid-PMPM	$233	$263	$218	-17.1%	$202	$209	$187	-10.5%	$114	$465	$67	-85.6%
High Cost Claimants (HCC's) > $100k												
# of HCC's	33	29	26	-10.3%	22	19	16	-15.8%	0	0	0	0.0%
HCC's / 1,000	0.8	0.7	0.6	-10.3%	0.6	0.5	0.4	-15.7%	0.0	0.0	0.0	0.0%
Avg HCC Paid	$173,519	$262,888	$187,205	-28.8%	$194,896	$177,846	$146,448	-17.7%	$0	$0	$0	0.0%
HCC's % of Plan Paid	19.3%	22.6%	17.5%	-22.6%	19.1%	14.5%	11.3%	-22.1%	0.0%	0.0%	0.0%	0.0%
Cost Distribution by Claim Type (PMPY)												
Facility Inpatient	$972	$1,123	$820	-27.0%	$836	$745	$615	-17.4%	$0	$0	$0	0.0%
Facility Outpatient	$851	$968	$855	-11.7%	$718	$802	$768	-4.2%	$108	$1,746	$146	-91.6%
Physician	$905	$985	$884	-10.3%	$825	$898	$821	-8.6%	$1,162	$3,490	$656	-81.2%
Other	$65	$77	$53	-31.2%	$50	$65	$42	-35.4%	$104	$343	$0	0.0%
Total	$2,793	$3,152	$2,612	-17.1%	$2,430	$2,509	$2,246	-10.5%	$1,374	$5,579	$802	-85.6%
	Annualized	Annualized	Annualized		Annualized	Annualized	Annualized		Annualized	Annualized	Annualized	

Financial Summary - (p. 2 of 2)

	State Retirees				Non-State Retirees				
Summary	**1Q19**	**1Q20**	**1Q21**	**Variance to Prior Year**	**1Q19**	**1Q20**	**1Q21**	**Variance to Prior Year**	**HSB Peer Index**
Enrollment									
Avg # Employees	3,218	3,250	3,295	1.4%	783	658	558	-15.2%	
Avg # Members	4,791	4,852	4,944	1.9%	885	757	656	-13.3%	
Ratio	1.5	1.5	1.5	0.7%	1.1	1.2	1.2	2.6%	1.8
Financial Summary									
Gross Cost	$7,284,198	$11,245,697	$7,154,081	-36.4%	$2,320,318	$1,584,068	$2,037,862	28.6%	
Client Paid	$5,400,934	$9,169,894	$5,339,239	-41.8%	$1,912,348	$1,216,367	$1,701,760	39.9%	
Employee Paid	$1,883,282	$2,075,803	$1,814,842	-12.6%	$407,970	$367,701	$336,102	-8.6%	
Client Paid-PEPY	$6,714	$11,287	$6,482	-42.6%	$9,769	$7,394	$12,206	65.1%	$6,209
Client Paid-PMPY	$4,509	$7,560	$4,320	-42.9%	$8,640	$6,430	$10,377	61.4%	$3,437
Client Paid-PEPM	$560	$941	$540	-42.6%	$814	$616	$1,017	65.1%	$517
Client Paid-PMPM	$376	$630	$360	-42.9%	$720	$536	$865	61.4%	$286
High Cost Claimants (HCC's) > $100k									
# of HCC's	5	9	8	-11.1%	6	2	2	0.0%	
HCC's / 1,000	1.0	1.9	1.6	-12.9%	6.8	2.6	3.1	15.5%	
Avg HCC Paid	$133,600	$446,461	$217,549	-51.3%	$125,530	$113,262	$391,889	246.0%	
HCC's % of Plan Paid	12.4%	43.8%	32.6%	-25.6%	39.4%	18.6%	46.1%	147.8%	
Cost Distribution by Claim Type (PMPY)									
Facility Inpatient	$1,429	$3,722	$1,506	-59.5%	$4,151	$3,007	$7,215	139.9%	$1,057
Facility Outpatient	$1,560	$2,065	$1,442	-30.2%	$2,573	$2,063	$1,365	-33.8%	$1,145
Physician	$1,385	$1,609	$1,255	-22.0%	$1,637	$1,265	$1,604	26.8%	$1,122
Other	$135	$164	$117	-28.7%	$279	$95	$192	102.1%	$113
Total	$4,509	$7,560	$4,320	-42.9%	$8,640	$6,430	$10,377	61.4%	$3,437
	Annualized	Annualized	Annualized		Annualized	Annualized	Annualized		

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

	Total				State Active				Non-State Active			
Summary	PY19	PY20	1Q21	Variance to Prior Year	PY19	PY20	1Q21	Variance to Prior Year	PY19	PY20	1Q21	Variance to Prior Year
Enrollment												
Avg # Employees	23,569	23,673	23,419	-1.1%	19,612	19,809	19,563	-1.2%	4	4	3	-13.1%
Avg # Members	42,776	42,865	42,580	-0.7%	37,138	37,291	36,973	-0.9%	7	7	7	2.5%
Ratio	1.8	1.8	1.8	0.6%	1.9	1.9	1.9	0.5%	1.8	1.8	2.1	18.0%
Financial Summary												
Gross Cost	$172,993,213	$185,251,114	$38,766,628	-79.1%	$129,947,874	$139,774,757	$29,572,105	-78.8%	$105,325	$46,064	$2,580	-94.4%
Client Paid	$133,179,670	$143,667,208	$27,806,203	-80.6%	$97,851,639	$106,095,205	$20,763,800	-80.4%	$96,469	$35,053	$1,404	-96.0%
Employee Paid	$39,813,543	$41,583,906	$10,960,425	-73.6%	$32,096,235	$33,679,553	$8,808,304	-73.8%	$8,857	$11,011	$1,176	-89.3%
Client Paid-PEPY	$5,651	$6,069	$4,749	-21.7%	$4,989	$5,356	$4,246	-20.7%	$24,117	$9,144	$1,684	-81.6%
Client Paid-PMPY	$3,113	$3,352	$2,612	-22.1%	$2,635	$2,845	$2,246	-21.1%	$13,781	$5,130	$802	-84.4%
Client Paid-PEPM	$471	$506	$396	-21.7%	$416	$446	$354	-20.6%	$2,010	$762	$140	-81.6%
Client Paid-PMPM	$259	$279	$218	-21.9%	$220	$237	$187	-21.1%	$1,148	$427	$67	-84.3%
High Cost Claimants (HCC's) > $100k												
# of HCC's	198	206	26		124	151	16		0	0	0	
HCC's / 1,000	4.6	4.8	0.6		3.3	4.1	0.4		0.0	0.0	0.0	
Avg HCC Paid	$219,374	$236,642	$187,205	-20.9%	$218,720	$206,591	$146,448	-29.1%	$0	$0	$0	0.0%
HCC's % of Plan Paid	32.6%	33.9%	17.5%	-48.4%	27.7%	29.4%	11.3%	-61.6%	0.0%	0.0%	0.0%	0.0%
Cost Distribution by Claim Type (PMPY)												
Facility Inpatient	$1,071	$1,139	$820	-28.0%	$847	$883	$615	-30.4%	$3,087	$0	$0	0.0%
Facility Outpatient	$925	$1,040	$855	-17.8%	$782	$880	$768	-12.7%	$6,561	$2,087	$146	-93.0%
Physician	$1,045	$1,093	$884	-19.1%	$948	$1,014	$821	-19.0%	$4,006	$2,777	$656	-76.4%
Other	$72	$80	$53	-33.8%	$58	$68	$42	-38.2%	$129	$266	$0	0.0%
Total	$3,113	$3,352	$2,612	-22.1%	$2,635	$2,845	$2,246	-21.1%	$13,781	$5,130	$802	-84.4%
			Annualized				Annualized				Annualized	

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

	State Retirees				Non-State Retirees				
Summary	**PY19**	**PY20**	**1Q21**	**Variance to Prior Year**	**PY19**	**PY20**	**1Q21**	**Variance to Prior Year**	**HSB Peer Index**
Enrollment									
Avg # Employees	3,224	3,246	3,295	1.5%	729	615	558	-9.3%	
Avg # Members	4,799	4,858	4,944	1.8%	832	710	656	-7.6%	
Ratio	1.5	1.5	1.5	0.0%	1.1	1.2	1.2	1.7%	1.8
Financial Summary									
Gross Cost	$34,175,219	$39,350,569	$7,154,081	-81.8%	$8,764,794	$6,079,723	$2,037,862	-66.5%	
Client Paid	$27,761,940	$32,691,908	$5,339,239	-83.7%	$7,469,622	$4,845,042	$1,701,760	-64.9%	
Employee Paid	$6,413,280	$6,658,661	$1,814,842	-72.7%	$1,295,172	$1,234,681	$336,102	-72.8%	
Client Paid-PEPY	$8,612	$10,070	$6,482	-35.6%	$10,246	$7,882	$12,206	54.9%	$6,209
Client Paid-PMPY	$5,785	$6,730	$4,320	-35.8%	$8,983	$6,821	$10,377	52.1%	$3,437
Client Paid-PEPM	$718	$839	$540	-35.6%	$854	$657	$1,017	54.8%	$517
Client Paid-PMPM	$482	$561	$360	-35.8%	$749	$568	$865	52.3%	$286
High Cost Claimants (HCC's) > $100k									
# of HCC's	58	60	8		16	8	2		
HCC's / 1,000	12.1	12.4	1.6		19.2	11.3	3.1		
Avg HCC Paid	$220,380	$271,721	$217,549	-19.9%	$220,793	$156,233	$391,889	150.8%	
HCC's % of Plan Paid	46.0%	49.9%	32.6%	-34.7%	47.3%	25.8%	46.1%	78.7%	
Cost Distribution by Claim Type (PMPY)									
Facility Inpatient	$2,155	$2,853	$1,506	-47.2%	$4,794	$2,835	$7,215	154.5%	$1,057
Facility Outpatient	$1,787	$2,107	$1,442	-31.6%	$2,295	$2,143	$1,365	-36.3%	$1,145
Physician	$1,677	$1,600	$1,255	-21.6%	$1,732	$1,745	$1,604	-8.1%	$1,122
Other	$166	$170	$117	-31.2%	$163	$98	$192	95.9%	$113
Total	$5,785	$6,730	$4,320	-35.8%	$8,983	$6,821	$10,377	52.1%	$3,437
			Annualized				Annualized		

Paid Claims by Claim Type – State Participants

Net Paid Claims - Total
State Participants

	1Q20				1Q21				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical									
Inpatient	$ 8,170,264	$ 4,244,364	$ 738,230	$ 13,152,858	$ 6,693,576	$ 1,239,353	$ 897,650	$ 8,830,580	-32.9%
Outpatient	$ 15,126,151	$ 3,709,427	$ 477,873	$ 19,313,451	$ 14,070,224	$ 2,789,777	$ 412,459	$ 17,272,460	-10.6%
Total - Medical	$ 23,296,415	$ 7,953,790	$ 1,216,103	$ 32,466,309	$ 20,763,800	$ 4,029,130	$ 1,310,109	$ 26,103,040	-19.6%
Dental	$ 4,899,016	$ 574,934	$ 159,560	$ 5,633,510	$ 4,478,336	$ 517,283	$ 151,183	$ 5,146,801	-8.6%
Dental Exchange	$ -	$ -	$ 840,879	$ 840,879	$ -	$ -	$ 825,777	$ 825,777	-1.8%
Total	**$ 28,195,431**	**$ 8,528,725**	**$ 2,216,543**	**$ 38,940,698**	**$ 25,242,136**	**$ 4,546,413**	**$ 2,287,069**	**$ 32,075,619**	**-17.6%**

Net Paid Claims - Per Participant per Month

	1Q20				1Q21				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical	$ 395	$ 1,006	$ 660	$ 472	$ 354	$ 506	$ 681	$ 381	-19.4%
Dental	$ 60	$ 57	$ 73	$ 60	$ 55	$ 51	$ 66	$ 55	-8.4%
Dental Exchange	$ -	$ -	$ 53	$ 53	$ -	$ -	$ 50	$ 50	-6.0%

Paid Claims by Claim Type – Non-State Participants

Net Paid Claims - Total									
Non-State Participants									
	1Q20				1Q21				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical									
Inpatient	$ 204	$ 238,377	$ 364,193	$ 602,775	$ -	$ 360,962	$ 851,112	$ 1,212,075	101.1%
Outpatient	$ 9,560	$ 477,458	$ 136,338	$ 623,356	$ 1,404	$ 129,208	$ 360,477	$ 491,089	-21.2%
Total - Medical	$ 9,764	$ 715,836	$ 500,532	$ 1,226,131	$ 1,404	$ 490,171	$ 1,211,589	$ 1,703,164	38.9%
Dental	$ 878	$ 85,303	$ 60,299	$ 146,479	$ 1,327	$ 64,084	$ 57,257	$ 122,667	-16.3%
Dental Exchange	$ -	$ -	$ 510,588	$ 510,588	$ -	$ -	$ 481,180	$ 481,180	-5.8%
Total	**$ 10,642**	**$ 801,138**	**$ 1,071,419**	**$ 1,883,199**	**$ 2,730**	**$ 554,254**	**$ 1,750,026**	**$ 2,307,010**	**22.5%**

Net Paid Claims - Per Participant per Month									
	1Q20				1Q21				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical	$ 814	$ 602	$ 638	$ 617	$ 140	$ 558	$ 1,526	$ 1,012	63.9%
Dental	$ 37	$ 43	$ 49	$ 45	$ 60	$ 44	$ 46	$ 45	-0.6%
Dental Exchange	$ -	$ -	$ 47	$ 47	$ -	$ -	$ 45	$ 45	-3.7%

Paid Claims by Claim Type – Total

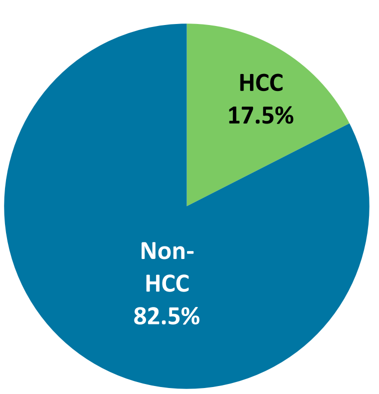
Net Paid Claims - Total									
Total Participants									
	1Q20				1Q21				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical									
Inpatient	$ 8,170,468	$ 4,482,741	$ 1,102,423	$ 13,755,633	$ 6,693,576	$ 1,600,316	$ 1,748,762	$ 10,042,654	-27.0%
Outpatient	$ 15,135,711	$ 4,186,885	$ 614,212	$ 19,936,808	$ 14,071,628	$ 2,918,985	$ 772,936	$ 17,763,549	-10.9%
Total - Medical	$ 23,306,179	$ 8,669,626	$ 1,716,635	$ 33,692,440	$ 20,765,204	$ 4,519,301	$ 2,521,698	$ 27,806,203	-17.5%
Dental	$ 4,899,893	$ 660,237	$ 219,859	$ 5,779,989	$ 4,479,663	$ 581,367	$ 208,439	$ 5,269,468	-8.8%
Dental Exchange	$ -	$ -	$ 1,351,467	$ 1,351,467	$ -	$ -	$ 1,306,957	$ 1,306,957	-3.3%
Total	**$ 28,206,073**	**$ 9,329,863**	**$ 3,287,961**	**$ 40,823,897**	**$ 25,244,866**	**$ 5,100,667**	**$ 4,037,095**	**$ 34,382,629**	**-15.8%**

Net Paid Claims - Per Participant per Month									
	1Q20				1Q21				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	
Medical	$ 395	$ 953	$ 654	$ 476	$ 354	$ 511	$ 928	$ 396	-16.9%
Dental	$ 60	$ 54	$ 64	$ 60	$ 55	$ 50	$ 59	$ 55	-8.1%
Dental Exchange	$ -	$ -	$ 51	$ 51	$ -	$ -	$ 48	$ 48	-5.0%

Cost Distribution – Medical Claims

1Q20							1Q21					
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
26	0.1%	$7,623,742	22.6%	$100,984	0.8%	$100,000.01 Plus	21	0.0%	$4,842,321	17.4%	$99,429	0.9%
44	0.1%	$3,430,142	10.2%	$209,515	1.7%	$50,000.01-$100,000.00	49	0.1%	$3,692,075	13.3%	$245,563	2.2%
119	0.3%	$4,447,896	13.2%	$414,109	3.3%	$25,000.01-$50,000.00	112	0.3%	$4,087,731	14.7%	$487,419	4.4%
342	0.8%	$5,717,455	17.0%	$1,143,449	9.0%	$10,000.01-$25,000.00	312	0.7%	$5,177,782	18.6%	$1,179,525	10.8%
506	1.2%	$3,804,626	11.3%	$1,378,035	10.9%	$5,000.01-$10,000.00	379	0.9%	$2,733,428	9.8%	$1,040,624	9.5%
693	1.6%	$2,608,986	7.7%	$1,309,951	10.3%	$2,500.01-$5,000.00	512	1.2%	$1,925,948	6.9%	$962,815	8.8%
15,154	35.4%	$6,059,593	18.0%	$5,809,430	45.8%	$0.01-$2,500.00	14,301	33.6%	$5,346,918	19.2%	$4,990,138	45.5%
7,327	17.1%	$0	0.0%	$2,316,563	18.3%	$0.00	6,586	15.5%	$0	0.0%	$1,954,911	17.8%
18,543	43.4%	$0	0.0%	$0	0.0%	No Claims	20,309	47.7%	$0	0.0%	$0	0.0%
42,753	100.0%	$33,692,440	100.0%	$12,682,036	100.0%		42,580	100.0%	$27,806,203	100.0%	$10,960,425	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 DIG) Diseases of the Digestive System	4	$1,176,349	24.2%
(CCS CIR) Diseases of the Circulatory System	18	$631,731	13.0%
(CCS PNL) Certain Conditions Originating in the Perinatal Period	2	$541,390	11.1%
(CCS NEO) Neoplasms	8	$514,704	10.6%
(CCS INJ) Injury, Poisoning and Certain Other Consequences of External Causes	13	$466,440	9.6%
(CCS NVS) Diseases of the Nervous System	15	$308,774	6.3%
(CCS MUS) Diseases of the Musculoskeletal System and Connective Tissue	12	$287,561	5.9%
(CCS END) Endocrine, Nutritional and Metabolic Diseases	10	$227,276	4.7%
(CCS MBD) Mental, Behavioral and Neurodevelopmental Disorders	5	$211,634	4.3%
(CCS FAC) Factors Influencing Health Status and Contact with Health Services	19	$177,918	3.7%
(CCS INF) Certain Infectious and Parasitic Diseases	7	$101,182	2.1%
(CCS GEN) Diseases of the Genitourinary System	7	$85,224	1.8%
(CCS SYM) Symptoms, Signs and Abnormal Clinical and Laboratory Findings, Not Elsewhere (	19	$76,199	1.6%
(CCS MAL) Congenital Malformations, Deformations and Chromosomal Abnormalities	3	$35,614	0.7%
(CCS SKN) Diseases of the Skin and Subcutaneous Tissue	6	$15,207	0.3%
(CCS RSP) Diseases of the Respiratory System	7	$6,375	0.1%
(CCS BLD) Diseases of the Blood and Blood Forming Organs and Certain Disorders Involving	6	$3,756	0.1%
All Others	2	$0	0.0%
Overall	----	$4,867,336	100.0%

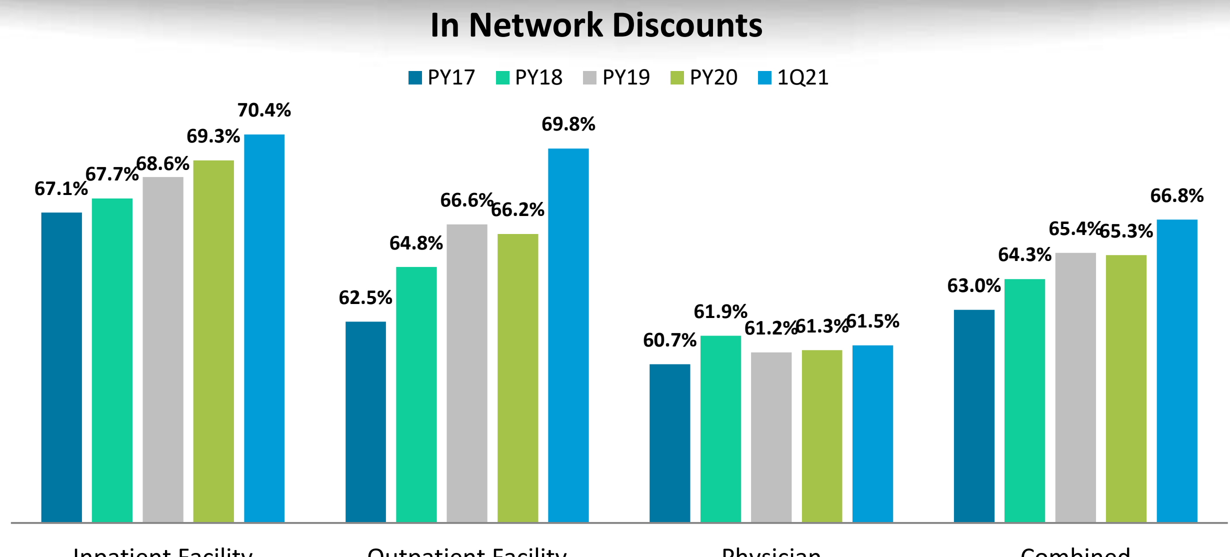
Utilization Summary (p. 1 of 2)

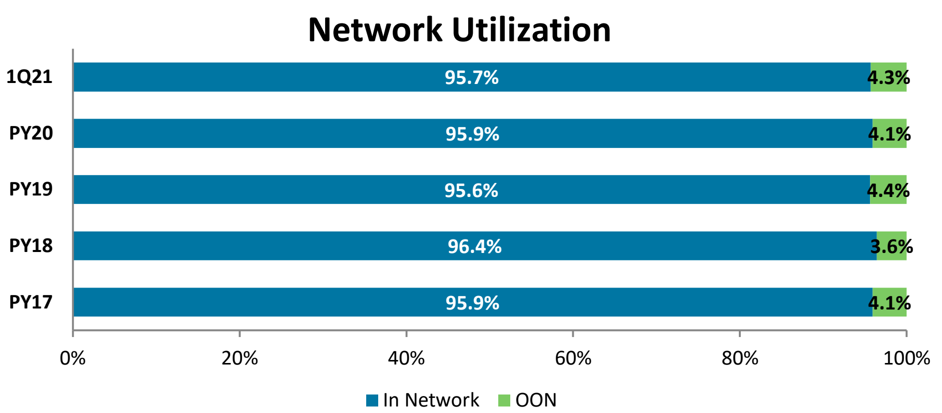
Summary	Total 1Q19	Total 1Q20	Total 1Q21	Total Variance to Prior Year	State Active 1Q19	State Active 1Q20	State Active 1Q21	State Active Variance to Prior Year	Non-State Active 1Q19	Non-State Active 1Q20	Non-State Active 1Q21	Non-State Active Variance to Prior Year
Inpatient Facility												
# of Admits	622	581	478		429	461	383		0	0	0	
# of Bed Days	2,834	2,858	2,247		1,907	2,082	1,778		0	0	0	
Paid Per Admit	$18,870	$20,816	$18,866	-9.4%	$19,227	$15,237	$15,461	1.5%	$0	$0	$0	0.0%
Paid Per Day	$4,141	$4,232	$4,013	-5.2%	$4,325	$3,374	$3,330	-1.3%	$0	$0	$0	0.0%
Admits Per 1,000	49	54	45	-16.7%	47	50	41	-18.0%	0	0	0	0.0%
Days Per 1,000	222	267	211	-21.0%	207	224	192	-14.3%	0	0	0	0.0%
Avg LOS	4.6	4.9	4.7	-4.1%	4.4	4.5	4.6	2.2%	0	0	0	0.0%
Physician Office												
OV Utilization per Member	3.2	3.9	3.2	-17.9%	3.2	3.7	3.1	-16.2%	4	9.7	4.6	-52.6%
Avg Paid per OV	$46	$40	$41	2.5%	$40	$40	$41	2.5%	$58	$70	$65	-7.1%
Avg OV Paid per Member	$147	$156	$132	-15.4%	$126	$146	$126	-13.7%	$231	$675	$299	-55.7%
DX&L Utilization per Member	6.6	8.5	7.4	-12.9%	6.5	7.9	7	-11.4%	0	0	0	0.0%
Avg Paid per DX&L	$65	$54	$61	13.0%	$57	$53	$54	1.9%	$0	$0	$0	0.0%
Avg DX&L Paid per Member	$426	$454	$451	-0.7%	$369	$414	$381	-8.0%	$0	$0	$0	0.0%
Emergency Room												
# of Visits	1,587	1,785	1,425		1,262	1,448	1,208		0	1	0	
# of Admits	262	233	203		193	176	155		0	0	0	
Visits Per Member	0.15	0.17	0.13	-22.2%	0.14	0.16	0.13	-16.6%	0	0.57	0.00	0.0%
Visits Per 1,000	149	167	134	-19.8%	137	156	131	-16.0%	0	571	0	0.0%
Avg Paid per Visit	$1,717	$1,976	$2,086	5.6%	$1,672	$1,994	$2,116	6.1%	$0	$365	$0	0.0%
Admits Per Visit	0.17	0.13	0.14	7.3%	0.15	0.12	0.13	7.0%	0.00	0.00	0.00	0.0%
Urgent Care												
# of Visits	2,125	2,745	2,009		1,912	2,483	1,813		0	1	0	
Visits Per Member	0.20	0.26	0.19	-26.9%	0.21	0.27	0.20	-25.9%	0.00	0.57	0.00	0.0%
Visits Per 1,000	200	257	189	-26.5%	207	267	196	-26.6%	0	571	0	0.0%
Avg Paid per Visit	$27	$38	$87	128.9%	$27	$35	$88	151.4%	$0	$170	$0	0.0%
	Annualized	Annualized	Annualized		Annualized	Annualized	Annualized		Annualized	Annualized	Annualized	

Utilization Summary (p. 2 of 2)

	State Retirees				Non-State Retirees				
Summary	**1Q19**	**1Q20**	**1Q21**	**Variance to Prior Year**	**1Q19**	**1Q20**	**1Q21**	**Variance to Prior Year**	**HSB Peer Index**
Inpatient Facility									
# of Admits	94	96	62		30	24	33		
# of Bed Days	498	629	311		208	147	158		
Paid Per Admit	$18,797	$45,601	$29,980	-34.3%	$32,051	$28,829	$37,514	30.1%	$16,173
Paid Per Day	$3,548	$6,960	$5,977	-14.1%	$4,623	$4,707	$7,835	66.5%	$3,708
Admits Per 1,000	78	79	50	-36.7%	136	127	201	58.3%	61
Days Per 1,000	416	519	252	-51.4%	940	777	963	23.9%	264
Avg LOS	5.3	6.6	5	-24.2%	6.9	6.1	4.8	-21.3%	4.3
Physician Office									
OV Utilization per Member	4.5	5.4	4.3	-20.4%	6	7.2	6.2	-13.9%	3.3
Avg Paid per OV	$39	$40	$40	0.0%	$33	$32	$27	-15.6%	$50
Avg OV Paid per Member	$173	$216	$173	-19.9%	$200	$228	$165	-27.6%	$167
DX&L Utilization per Member	10.1	12	9.9	-17.5%	12.7	14.1	10.8	-23.4%	8.3
Avg Paid per DX&L	$78	$59	$96	62.7%	$75	$54	$59	9.3%	$67
Avg DX&L Paid per Member	$792	$707	$947	33.9%	$950	$763	$635	-16.8%	$554
Emergency Room									
# of Visits	249	264	178		76	72	39		
# of Admits	53	49	38		16	8	10		
Visits Per Member	0.21	0.22	0.14	-35.7%	0.34	0.38	0.24	-36.9%	0.17
Visits Per 1,000	208	218	144	-33.8%	343	381	238	-37.5%	174
Avg Paid per Visit	$1,814	$2,090	$1,761	-15.7%	$2,144	$1,217	$2,637	116.7%	$1,684
Admits Per Visit	0.21	0.19	0.21	10.5%	0.21	0.11	0.26	136.4%	0.14
Urgent Care									
# of Visits	177	228	174		36	33	22		
Visits Per Member	0.15	0.19	0.14	-26.3%	0.16	0.17	0.13	-23.5%	0.24
Visits Per 1,000	148	188	141	-25.0%	163	174	134	-23.0%	242
Avg Paid per Visit	$29	$62	$74	19.4%	$32	$44	$38	-13.6%	$74
	Annualized	Annualized	Annualized		Annualized	Annualized	Annualized		

Provider Network Summary



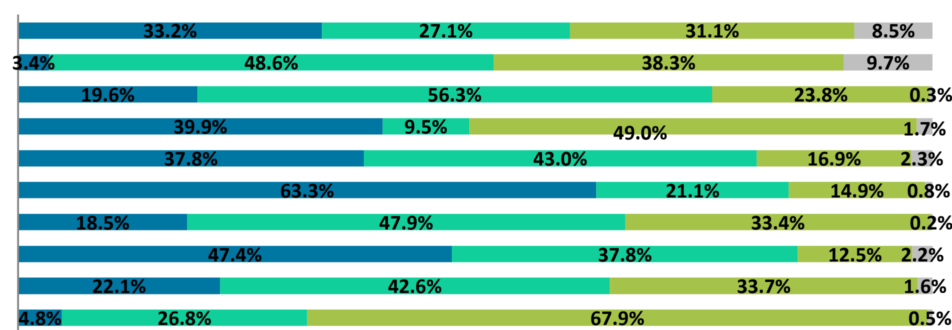


AHRQ* Clinical Classifications Summary

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

AHRQ Clinical Classifications Chapter	Total Paid	% Paid	Insured	Spouse	Child	Male	Female
(CCS FAC) Factors Influencing Health Status and Contact with Health Services	$4,030,199	14.5%	$2,465,313	$658,800	$906,086	$1,331,679	$2,698,520
(CCS MUS) Diseases of the Musculoskeletal System and Connective Tissue	$2,895,470	10.4%	$1,755,132	$819,184	$321,155	$1,103,373	$1,792,098
(CCS CIR) Diseases of the Circulatory System	$2,823,200	10.2%	$2,172,584	$568,380	$82,237	$1,485,325	$1,337,876
(CCS NEO) Neoplasms	$2,688,610	9.7%	$2,269,321	$392,493	$26,797	$1,029,847	$1,658,763
(CCS DIG) Diseases of the Digestive System	$2,527,620	9.1%	$1,368,090	$950,312	$209,218	$1,190,738	$1,336,882
(CCS INJ) Injury, Poisoning and Certain Other Consequences of External Causes	$2,300,167	8.3%	$1,327,110	$536,809	$436,248	$1,254,066	$1,046,101
(CCS MBD) Mental, Behavioral and Neurodevelopmental Disorders	$1,402,642	5.0%	$535,762	$185,801	$681,079	$636,341	$766,301
(CCS GEN) Diseases of the Genitourinary System	$1,351,401	4.9%	$983,119	$268,665	$99,617	$517,137	$834,264
(CCS SYM) Symptoms, Signs and Abnormal Clinical and Laboratory Findings, Not Els	$1,238,928	4.5%	$842,382	$209,319	$187,227	$488,292	$750,636
(CCS NVS) Diseases of the Nervous System	$1,215,250	4.4%	$782,485	$268,441	$164,324	$288,656	$926,595
(CCS PRG) Pregnancy, Childbirth and the Puerperium	$997,429	3.6%	$656,222	$324,612	$16,596	$0	$997,429
(CCS END) Endocrine, Nutritional and Metabolic Diseases	$980,258	3.5%	$631,789	$205,447	$143,021	$492,965	$487,293
(CCS PNL) Certain Conditions Originating in the Perinatal Period	$828,028	3.0%	$1,638	$478	$825,911	$654,681	$173,346
(CCS INF) Certain Infectious and Parasitic Diseases	$754,991	2.7%	$663,005	$67,277	$24,708	$329,540	$425,450
(CCS RSP) Diseases of the Respiratory System	$642,727	2.3%	$428,062	$50,767	$163,898	$297,919	$344,808
(CCS EYE) Diseases of the Eye and Adnexa	$491,769	1.8%	$307,680	$115,079	$69,010	$209,856	$281,913
(CCS MAL) Congenital Malformations, Deformations and Chromosomal Abnormaliti	$217,483	0.8%	$39,638	$1,065	$176,779	$63,228	$154,255
(CCS SKN) Diseases of the Skin and Subcutaneous Tissue	$170,262	0.6%	$96,729	$33,687	$39,846	$103,683	$66,579
(CCS BLD) Diseases of the Blood and Blood Forming Organs and Certain Disorders I	$121,577	0.4%	$97,613	$14,250	$9,714	$39,410	$82,167
(CCS EAR) Diseases of the Ear and Mastoid Process	$119,402	0.4%	$63,000	$11,072	$45,330	$64,220	$55,182
(CCS 18) Residual Codes; Unclassified; All E Codes [259. And 260.]	$8,702	0.0%	$6,207	$95	$2,401	$3,986	$4,716
(CCS EXT) External Causes of Morbidity	$88	0.0%	$88	$0	$0	$0	$88
Total	**$27,806,203**	**100.0%**	**$17,492,970**	**$5,682,032**	**$4,631,202**	**$11,584,941**	**$16,221,263**

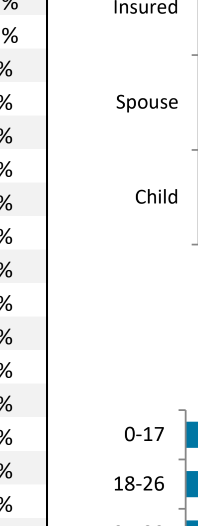
Top 10 Categories by Claim Type



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

Diagnosis Category	Patients	Claims	Total Paid	% Paid
Exposure, Encounters, Screening Or Contact With Infectious Disease	4,787	7,332	$894,484	22.2%
Medical Examination/Evaluation	5,855	8,762	$880,871	21.9%
Encounter For Antineoplastic Therapies	59	249	$704,491	17.5%
Neoplasm-Related Encounters	2,124	3,559	$679,579	16.9%
Other Aftercare Encounter	277	654	$282,556	7.0%
Contraceptive And Procreative Management	485	698	$186,583	4.6%
Personal/Family History Of Disease	327	490	$100,487	2.5%
Implant, Device Or Graft Related Encounter	259	597	$96,889	2.4%
Other Specified Status	692	1,239	$80,787	2.0%
Encounter For Prophylactic Or Other Procedures	36	47	$45,360	1.1%
Organ Transplant Status	26	157	$21,488	0.5%
Encounter For Observation And Examination For Conditions Ruled Out (Excl	746	900	$19,079	0.5%
Acquired Absence Of Limb Or Organ	16	22	$15,806	0.4%
Other Specified Encounters And Counseling	166	261	$14,303	0.4%
Encounter For Administrative Purposes	85	98	$5,398	0.1%
Lifestyle/Life Management Factors	26	34	$686	0.0%
Screening For Neurocognitive Or Neurodevelopmental Condition	11	11	$514	0.0%
Encounter For Prophylactic Measures (Excludes Immunization)	10	20	$329	0.0%
Encounter For Mental Health Conditions	68	70	$304	0.0%
Carrier Status	2	3	$76	0.0%
Socioeconomic/Psychosocial Factors	13	23	$64	0.0%
No Immunization Or Underimmunization	7	9	$63	0.0%
Overall	**----**	**----**	**$4,030,199**	**100.0%**

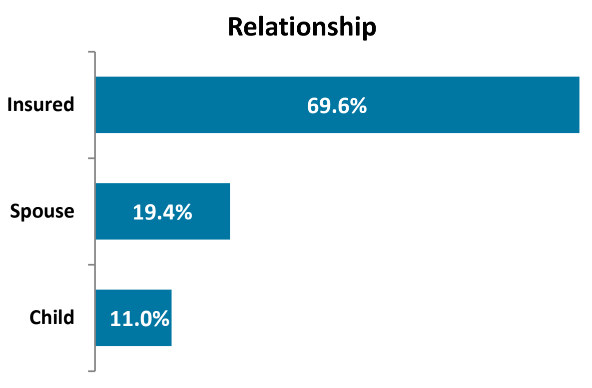
*Patient and claim counts are unique only within the category

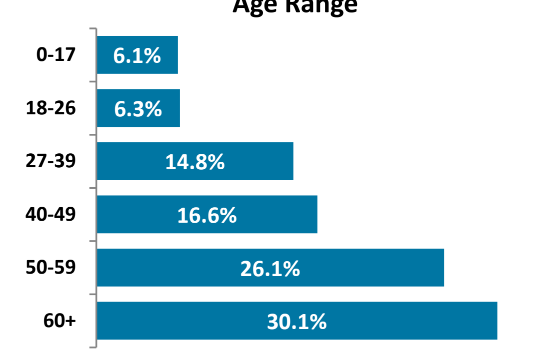


AHRQ Category – Diseases of the Musculoskeletal System & Connective Tissue

Diagnosis Category	Patients	Claims	Total Paid	% Paid
Spondylopathies/Spondyloarthropathy (Including Infective)	1,259	4,486	$763,425	26.4%
Osteoarthritis	463	1,013	$573,496	19.8%
Musculoskeletal Pain, Not Low Back Pain	1,807	5,869	$273,322	9.4%
Tendon And Synovial Disorders	367	977	$247,614	8.6%
Scoliosis And Other Postural Dorsopathic Deformities	37	144	$188,718	6.5%
Osteomyelitis	17	191	$152,870	5.3%
Other Specified Joint Disorders	266	604	$139,475	4.8%
Postprocedural Or Postoperative Musculoskeletal System Complication	33	78	$120,537	4.2%
Acquired Foot Deformities	105	318	$97,042	3.4%
Other Specified Connective Tissue Disease	479	967	$74,840	2.6%
Low Back Pain	545	1,606	$59,371	2.1%
Rheumatoid Arthritis And Related Disease	102	192	$43,604	1.5%
Other Specified Bone Disease And Musculoskeletal Deformities	117	193	$27,343	0.9%
Muscle Disorders	71	259	$26,573	0.9%
Pathological Fracture, Initial Encounter	2	6	$24,317	0.8%
Acquired Deformities (Excluding Foot)	28	59	$16,085	0.6%
Biomechanical Lesions	686	1,861	$13,535	0.5%
Osteoporosis	83	125	$10,907	0.4%
Neurogenic/Neuropathic Arthropathy	3	15	$8,147	0.3%
Traumatic Arthropathy	13	31	$7,524	0.3%
Juvenile Arthritis	5	14	$6,081	0.2%
Pathological Fracture, Subsequent Encounter	1	3	$5,236	0.2%
Systemic Lupus Erythematosus And Connective Tissue Disorders	82	153	$5,110	0.2%
Disorders Of Jaw	24	61	$3,601	0.1%
Gout	83	126	$2,575	0.1%
Stress Fracture, Initial Encounter	14	26	$2,223	0.1%
Aseptic Necrosis And Osteonecrosis	4	13	$1,239	0.0%
Stress Fracture, Subsequent Encounter	6	43	$660	0.0%
Other Bone Disease And Musculoskeletal Deformities [212.]	1	1	$0	0.0%
Infective Arthritis	2	2	$0	0.0%
Crystal Arthropathies (Excluding Gout)	1	2	$0	0.0%
Autoinflammatory Syndromes	2	2	$0	0.0%
Musculoskeletal Abscess	1	1	$0	0.0%
Immune-Mediated/Reactive Arthropathies	1	1	$0	0.0%
	----	----	$2,895,470	100.0%

*Patient and claim counts are unique only within the category





AHRQ Category – Diseases of the Circulatory System

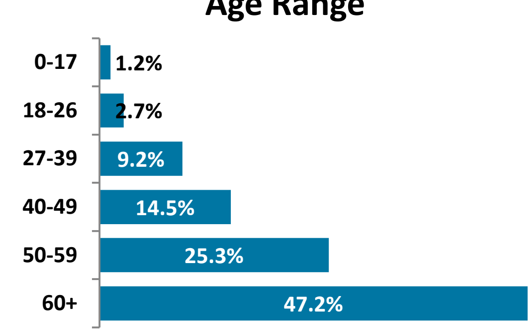
Diagnosis Category	Patients	Claims	Total Paid	% Paid
Coronary Atherosclerosis And Other Heart Disease	240	517	$503,061	17.8%
Cardiac Dysrhythmias	266	636	$470,913	16.7%
Cerebral Infarction	49	213	$446,537	15.8%
Nonspecific Chest Pain	555	1,160	$376,849	13.3%
Heart Failure	80	185	$173,572	6.1%
Sequela Of Hemorrhagic Cerebrovascular Disease	2	14	$140,870	5.0%
Acute Hemorrhagic Cerebrovascular Disease	21	40	$106,647	3.8%
Other And Ill-Defined Cerebrovascular Disease	25	39	$76,268	2.7%
Peripheral And Visceral Vascular Disease	67	133	$62,059	2.2%
Essential Hypertension	1,275	1,941	$61,287	2.2%
Acute Myocardial Infarction	30	91	$59,930	2.1%
Acute Phlebitis; Thrombophlebitis And Thromboembolism	47	114	$55,881	2.0%
Aortic And Peripheral Arterial Embolism Or Thrombosis	4	7	$44,164	1.6%
Aortic; Peripheral; And Visceral Artery Aneurysms	23	47	$32,931	1.2%
Acute Pulmonary Embolism	25	88	$31,852	1.1%
Sequela Of Cerebral Infarction And Other Cerebrovascular Disease	18	70	$28,342	1.0%
Varicose Veins Of Lower Extremity	52	128	$22,264	0.8%
Nonrheumatic And Unspecified Valve Disorders	91	166	$22,149	0.8%
Myocarditis And Cardiomyopathy	38	59	$13,122	0.5%
Hypertension With Complications And Secondary Hypertension	22	30	$11,720	0.4%
Postthrombotic Syndrome And Venous Insufficiency/Hypertension	44	79	$11,202	0.4%
Other And Ill-Defined Heart Disease	33	42	$10,316	0.4%
Other Specified Diseases Of Veins And Lymphatics	31	57	$8,776	0.3%
Cardiac Arrest And Ventricular Fibrillation	5	12	$8,126	0.3%
Occlusion Or Stenosis Of Precerebral Or Cerebral Arteries Without Infarction	37	52	$7,255	0.3%
Hypotension	17	31	$5,487	0.2%
Endocarditis And Endocardial Disease	3	8	$5,214	0.2%
Conduction Disorders	62	95	$5,173	0.2%
Chronic Rheumatic Heart Disease	60	64	$5,165	0.2%
Other Specified And Unspecified Circulatory Disease	26	35	$4,732	0.2%
Pulmonary Heart Disease	22	41	$3,548	0.1%
Gangrene	3	10	$3,430	0.1%
Arterial Dissections	5	7	$2,252	0.1%
Postprocedural Or Postoperative Circulatory System Complication	6	18	$1,806	0.1%
Pericarditis And Pericardial Disease	4	5	$297	0.0%
Chronic Phlebitis; Thrombophlebitis And Thromboembolism	4	6	$0	0.0%
Overall	----	----	$2,823,200	100.0%

*Patient and claim counts are unique only within the category

Relationship

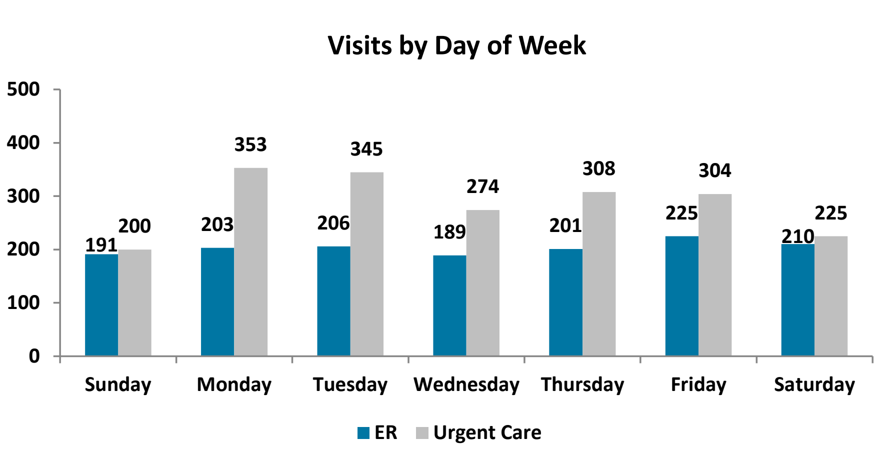
Relationship	%
Insured	76.1%
Spouse	20.8%
Child	3.1%

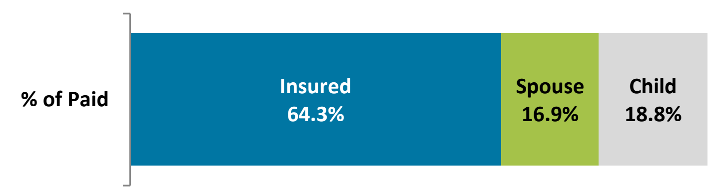
Age Range



Emergency Room / Urgent Care Summary

ER/Urgent Care	1Q20 ER	1Q20 Urgent Care	1Q21 ER	1Q21 Urgent Care	HSB Peer Index ER	HSB Peer Index Urgent Care
Number of Visits	1,785	2,745	1,425	2,009		
Number of Admits	233	----	203	----		
Visits Per Member	0.17	0.26	0.13	0.19	0.17	0.24
Visits/1000 Members	167	257	134	189	174	242
Avg Paid Per Visit	$1,976	$38	$2,086	$87	$1,684	$74
Admits per Visit	0.13	----	0.14	----	0.14	
% of Visits with HSB ER Dx	74.8%	----	76.9%	----		
% of Visits with a Physician OV*	78.2%	74.1%	77.7%	71.8%		
Total Plan Paid	**$3,526,669**	**$103,706**	**$2,972,411**	**$174,002**		
*looks back 12 months from ER visit	Annualized	Annualized	Annualized	Annualized		





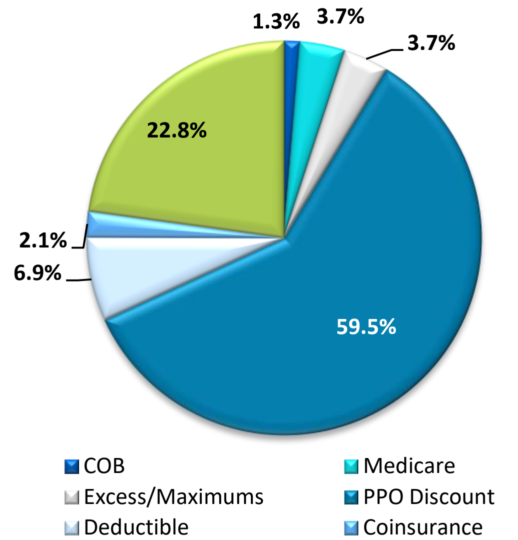
ER / UC Visits by Relationship

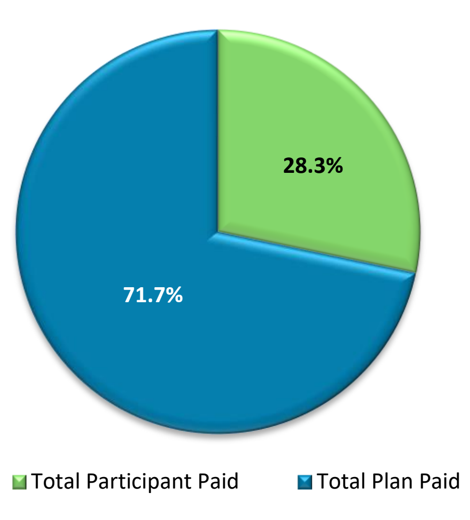
Relationship	ER	Per 1,000	Urgent Care	Per 1,000	Total	Per 1,000
Insured	860	37	1,288	55	2,148	92
Spouse	245	44	243	44	488	88
Child	320	24	478	35	798	59
Total	**1,425**	**33**	**2,009**	**47**	**3,434**	**81**

Savings Summary – Medical Claims

Description	Dollars	PPPM	% of Eligible
Eligible Charges	$121,784,690	$1,733	100.0%
COB	$1,562,767	$22	1.3%
Medicare	$4,526,247	$64	3.7%
Excess/Maximums	$4,486,976	$64	3.7%
PPO Discount	$72,442,071	$1,031	59.5%
Deductible	$8,390,977	$119	6.9%
Coinsurance	$2,569,448	$37	2.1%
Total Participant Paid	**$10,960,425**	**$156**	**9.0%**
Total Plan Paid	**$27,806,203**	**$396**	**22.8%**

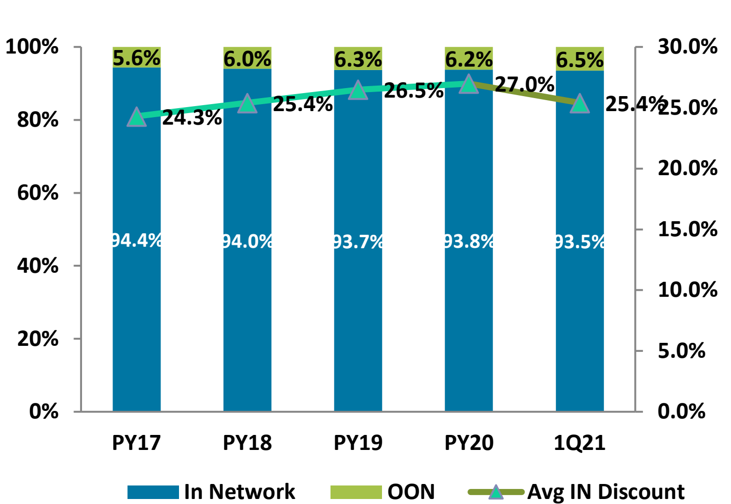
Total Participant Paid - PY20	**$146**
Total Plan Paid - PY20	**$506**



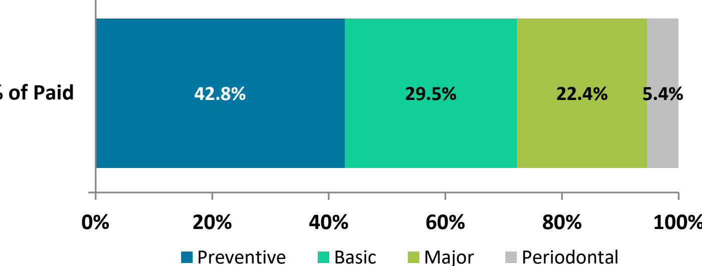


Dental Claims Analysis

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	1,410	2.1%	3,890	11.8%	$1,997,849	30.4%	$1,410,390	40.6%
$750.01-$1,000.00	684	1.0%	1,539	4.7%	$598,151	9.1%	$381,223	11.0%
$500.01-$750.00	1,329	1.9%	2,767	8.4%	$819,009	12.5%	$559,677	16.1%
$250.01-$500.00	2,176	3.2%	4,045	12.3%	$788,579	12.0%	$422,555	12.2%
$0.01-$250.00	17,689	25.9%	19,960	60.6%	$2,372,837	36.1%	$649,571	18.7%
$0.00	738	1.1%	760	2.3%	$0	0.0%	$47,853	1.4%
No Claims	44,371	64.9%	0	0.0%	$0	0.0%	$0	0.0%
Total	**68,397**	**100.0%**	**32,961**	**100.0%**	**$6,576,425**	**100.0%**	**$3,471,268**	**100.0%**



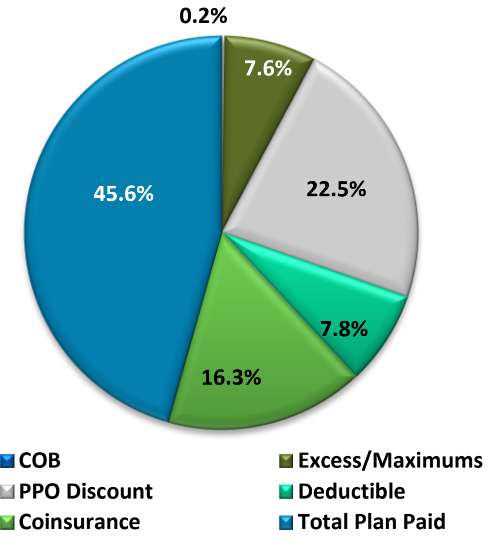
Claim Category	Total Paid	% of Paid
Preventive	$2,812,347	42.8%
Basic	$1,939,811	29.5%
Major	$1,470,528	22.4%
Periodontal	$353,740	5.4%
Total	**$6,576,425**	**100.0%**

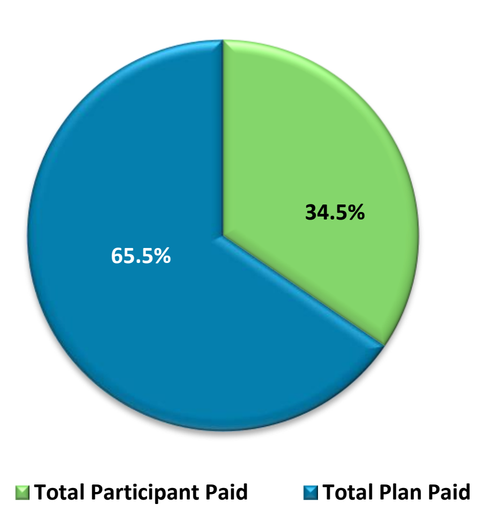


Savings Summary – Dental Claims

Description	Dollars	PPPM	% of Eligible
Eligible Charges	$14,415,268	$117	100.0%
COB	$33,215	$0	0.2%
Excess/Maximums	$1,093,791	$9	7.6%
PPO Discount	$3,240,569	$26	22.5%
Deductible	$1,117,863	$9	7.8%
Coinsurance	$2,353,405	$19	16.3%
Total Participant Paid	**$3,471,268**	**$28**	**24.1%**
Total Plan Paid	**$6,576,425**	**$53**	**45.6%**

Total Participant Paid - PY20	**$22**
Total Plan Paid - PY20	**$46**



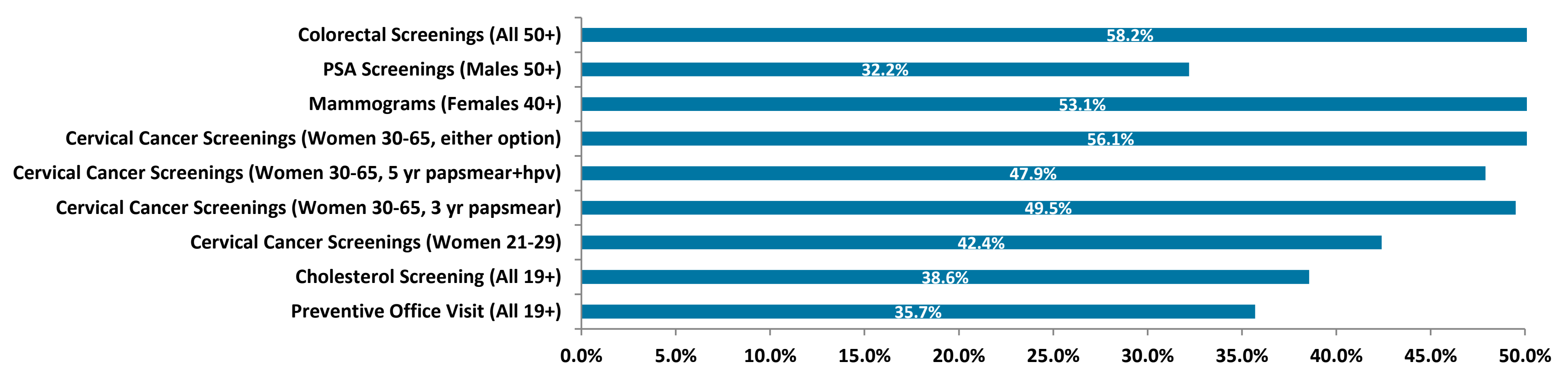


Preventive Services Compliance

*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.

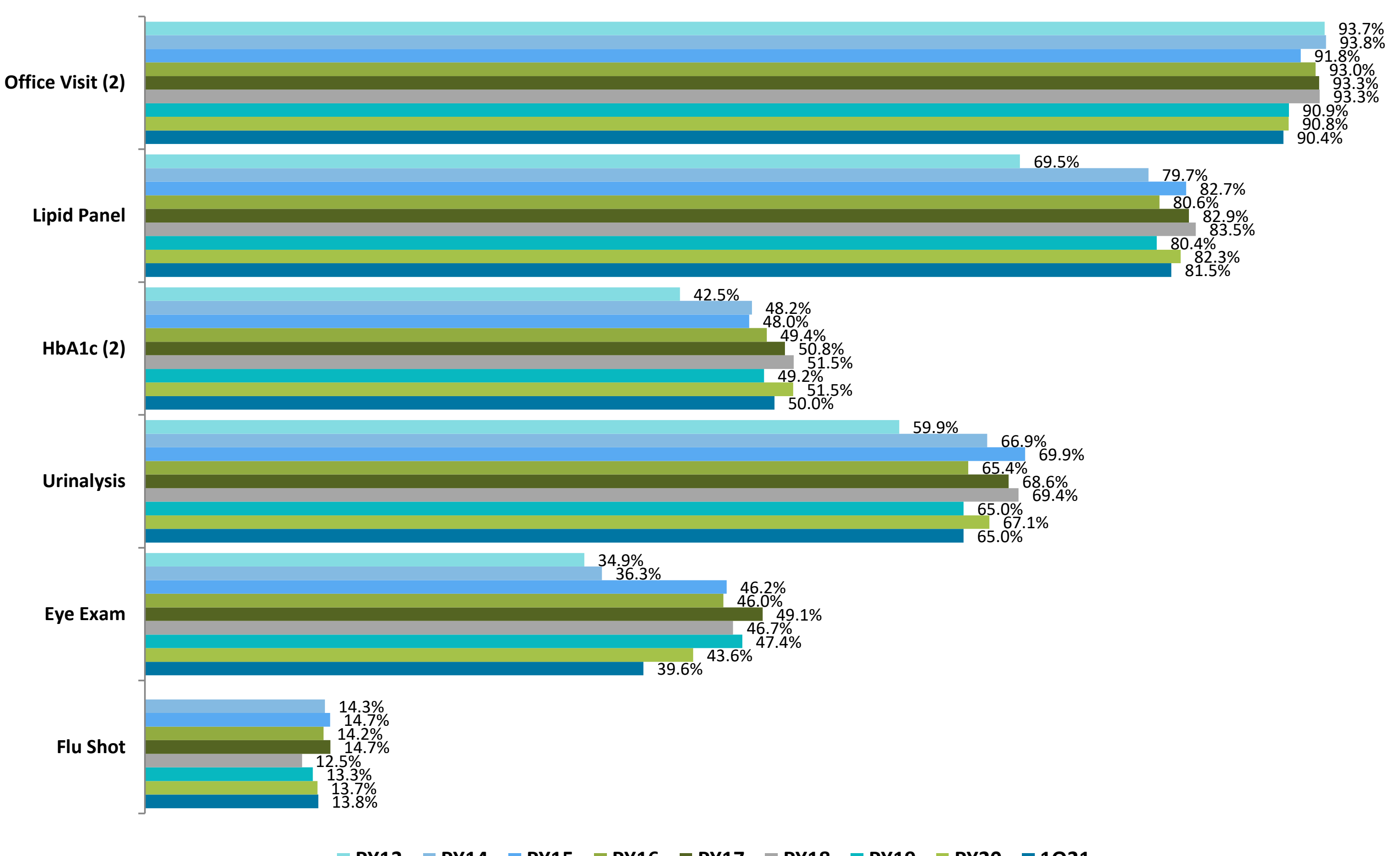
	Female			Male			Total		
Service	**Eligible**	**Compliant**	**% Compliant**	**Eligible**	**Compliant**	**% Compliant**	**Eligible**	**Compliant**	**% Compliant**
Preventive Office Visit (All 19+)	17,330	8,058	46.5%	15,217	3,561	23.4%	32,547	11,619	35.7%
Cholesterol Screening (All 19+)	17,330	7,227	41.7%	15,217	5,326	35.0%	32,547	12,553	38.6%
Cervical Cancer Screenings (Women 21-29)	2,737	1,160	42.4%	----	----	----	2,737	1,160	42.4%
Cervical Cancer Screenings (Women 30-65, 3 yr papsmear)	13,063	6,466	49.5%	----	----	----	13,063	6,466	49.5%
Cervical Cancer Screenings (Women 30-65, 5 yr papsmear+hpv)	13,063	6,257	47.9%	----	----	----	13,063	6,257	47.9%
Cervical Cancer Screenings (Women 30-65, either option)	13,063	7,328	56.1%	----	----	----	13,063	7,328	56.1%
Mammograms (Females 40+)	10,662	5,662	53.1%	----	----	----	10,662	5,662	53.1%
PSA Screenings (Males 50+)	----	----	----	6,394	2,059	32.2%	6,394	2,059	32.2%
Colorectal Screenings (All 50+)	7,345	4,422	60.2%	6,394	3,568	55.8%	13,739	7,990	58.2%



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	PY13	PY14	PY15	PY16	PY17	PY18	PY19	PY20	1Q21
Members	1,643	1,555	1,676	1,693	1,704	1,747	1,838	1,876	1,866

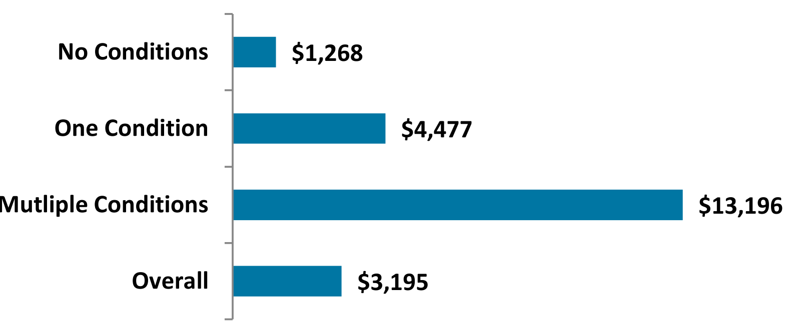


Chronic Conditions Summary

*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	1,194	1,138	28	39	$7,107,482	$5,953	99.0%	1 Office Visit
Cancer	1,326	1,259	31	59	$30,696,112	$23,149	----	----
Chronic Kidney Disease	322	303	8	59	$6,597,867	$20,490	----	----
Chronic Obstructive Pulmonary Disease (COPD)	244	230	6	60	$6,312,251	$25,870	98.4%	1 Office Visit
Congestive Heart Failure (CHF)	149	135	3	62	$10,742,004	$72,094	13.4%	1 Office Visit, 1 Lipid Profile, 1 Wellness Visit
Coronary Artery Disease (CAD)	589	560	14	62	$9,452,275	$16,048	20.9%	1 Office Visit, 1 Lipid Profile, 1 Wellness Visit
Depression	1,541	1,444	36	40	$14,526,795	$9,427	95.8%	1 Office Visit
Diabetes	1,866	1,765	44	56	$16,144,641	$8,652	17.7%	2 Office Visits, 1 Lipid Profile, 2 HbA1c's, 1 Urinalysis, 1 Eye Exam, 1 Flu Shot
Hyperlipidemia	3,188	3,075	74	54	$18,124,875	$5,685	39.0%	1 Office Visit, 1 Lipid Profile, 1 Wellness Visit
Hypertension	3,634	3,463	85	57	$34,213,229	$9,415	26.4%	1 Office Visit, 1 Lipid Profile, 1 Wellness Visit
Obesity	824	786	19	43	$5,623,899	$6,825	----	----

# of Conditions	Avg Members	Average Age	Relationship		
			Insured	Spouse	Child
No Conditions	29,483	31	47.4%	11.9%	40.7%
One Condition	8,783	47	70.4%	16.9%	12.8%
Multiple Conditions	4,595	56	78.3%	19.1%	2.6%
Overall	**42,821**	**36**	**54.7%**	**13.5%**	**31.8%**



Public Employees' Benefits Program - RX Costs
PY 2021 - Quarter Ending September 30, 2020

Express Scripts

Membership Summary	1Q FY2021	1Q FY2020	Difference	% Change
Member Count (Membership)	42,603	42,725	(122)	-0.3%
Utilizing Member Count (Patients)	19,817	20,041	(224)	-1.1%
Percent Utilizing (Utilization)	46.5%	46.9%	(0.00)	-0.8%
Claim Summary			**Claims Summary**	
Net Claims (Total Rx's)	129,787	127,980	1,807	1.4%
Claims per Elig Member per Month (Claims PMPM)	1.02	1.00	0.02	2.0%
Total Claims for Generic (Generic Rx)	111,809	111,447	362.00	0.3%
Total Claims for Brand (Brand Rx)	17,978	16,533	1,445.00	8.7%
Total Claims for Brand w/Gen Equiv (Multisource Brand Claims)	2,045	1,972	73.00	3.7%
Total Non-Specialty Claims	128,257	126,473	1,784.00	1.4%
Total Specialty Claims	1,530	1,507	23.00	1.5%
Generic % of Total Claims (GFR)	**86.1%**	**87.1%**	(0.01)	-1.1%
Generic Effective Rate (GCR)	**98.2%**	**98.3%**	(0.00)	-0.1%
Mail Order Claims	27,258	20,855	6,403.00	30.7%
Mail Penetration Rate*	23.7%	18.4%	0.05	5.3%
Claims Cost Summary			**Claims Cost Summary**	
Total Prescription Cost (Total Gross Cost)	$13,335,728.00	$11,350,523.00	$1,985,205.00	17.5%
Total Generic Gross Cost	$2,099,998.00	$1,892,145.00	$207,853.00	11.0%
Total Brand Gross Cost	$11,235,730.00	$9,458,379.00	$1,777,351.00	18.8%
Total MSB Gross Cost	$445,930.00	$429,641.00	$16,289.00	3.8%
Total Ingredient Cost	$13,225,033.00	$11,258,409.00	$1,966,624.00	17.5%
Total Dispensing Fee	$105,091.00	$87,509.00	$17,582.00	20.1%
Total Other (e.g. tax)	$5,604.00	$5,606.00	($2.00)	0.0%
Avg Total Cost per Claim (Gross Cost/Rx)	**$102.75**	**$88.69**	$14.06	15.9%
Avg Total Cost for Generic (Gross Cost/Generic Rx)	$18.78	$16.98	$1.80	10.6%
Avg Total Cost for Brand (Gross Cost/Brand Rx)	$624.97	$572.09	$52.88	9.2%
Avg Total Cost for MSB (MSB Gross Cost/MSB ARx)	$217.95	$217.87	$0.08	0.0%
Member Cost Summary			**Member Cost Summary**	
Total Member Cost	**$3,876,275.00**	**$4,259,472.00**	($383,197.00)	-9.0%
Total Copay	$2,358,444.00	$1,505,132.00	$853,312.00	56.7%
Total Deductible	$1,517,831.00	$2,754,340.00	($1,236,509.00)	-44.9%
Avg Copay per Claim (Copay/Rx)	$18.17	$11.76	$6.41	54.5%
Avg Participant Share per Claim (Copay+Deductible/RX)	**$29.87**	**$33.28**	**($3.42)**	**-10.3%**
Avg Copay for Generic (Copay/Generic Rx)	$10.79	$11.08	($0.29)	-2.6%
Avg Copay for Brand (Copay/Brand Rx)	$148.49	$182.97	($34.48)	-18.8%
Avg Copay for Brand w/ Generic Equiv (Copay/Multisource Rx)	$80.90	$90.76	($9.86)	-10.9%
Net PMPM (Participant Cost PMPM)	**$30.33**	**$33.23**	($2.90)	-8.7%
Copay % of Total Prescription Cost (Member Cost Share %)	29.1%	37.5%	-8.5%	-22.5%
Plan Cost Summary			**Plan Cost Summary**	
Total Plan Cost (Plan Cost)	**$9,459,453.00**	**$7,091,051.00**	**$2,368,402.00**	**33.4%**
Total Non-Specialty Cost (Non-Specialty Plan Cost)	$3,145,193.00	$2,673,598.00	$471,595.00	17.6%
Total Specialty Drug Cost (Specialty Plan Cost)	$6,314,260.00	$4,417,453.00	$1,896,807.00	42.9%
Avg Plan Cost per Claim (Plan Cost/Rx)	**$72.88**	**$55.41**	$17.48	31.5%
Avg Plan Cost for Generic (Plan Cost/Generic Rx)	$7.99	$5.90	$2.09	35.4%
Avg Plan Cost for Brand (Plan Cost/Brand Rx)	$476.48	$389.12	$87.36	22.5%
Avg Plan Cost for MSB (MSB Plan Cost/MSB ARx)	$137.05	$127.12	$9.93	7.8%
Net PMPM (Plan Cost PMPM)	**$74.01**	**$55.32**	**$18.69**	**33.8%**
PMPM for Specialty Only (Specialty PMPM)	$49.40	$34.46	$14.94	43.4%
PMPM without Specialty (Non-Specialty PMPM)	$24.61	$20.86	$3.75	18.0%
Rebates (Q1 FY2021 actual)	$2,454,526.22	$2,240,109.74	$214,416.48	9.6%
Net PMPM (Plan Cost PMPM factoring Rebates)	**$54.81**	**$37.85**	**$16.96**	**44.8%**
PMPM for Specialty Only (Specialty PMPM)	$43.50	$28.56	$14.94	52.3%
PMPM without Specialty (Non-Specialty PMPM)	$12.06	$8.94	$3.12	34.9%

Appendix B

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HealthSCOPE – EPO Utilization Review for PEBP
July 1, 2020 – September 30, 2020

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HSB DATASCOPE™

Nevada Public Employees' Benefits Program
EPO Plan

July – September 2020

Overview

- Total Medical Spend for 1Q21 was $11,648,774 with an annualized plan cost per employee per year of $9,845. This is an increase of 5.1% when compared to 1Q20.
  - IP Cost per Admit is $15,532 which is 44.0% higher than 1Q20.
  - ER Cost per Visit is $2,483 which is 2.9% lower than 1Q20.
- Employees shared in 5.6% of the medical cost.
- Inpatient facility costs were 18.0% of the plan spend.
- 92.6% of the Average Membership had paid Medical claims less than $2,500, with 35.0% of those having no claims paid at all during the reporting period.
- 9 members exceeded the $100k high cost threshold during the reporting period, which accounted for 12.5% of the plan spend. The highest diagnosis category was Injuries, accounting for 31.9% of the high cost claimant dollars.
- Total spending with in-network providers was 97.2%. The overall in-network discount was 57.3%.

Paid Claims by Age Group

Paid Claims by Age Group														
	1Q20						1Q21						% 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	$ 334,085	$ 986	$ 771	$ 2	$ 334,856	$ 988	$ 380,703	$ 1,295	$ 1,866	$ 6	$ 382,569	$ 1,301	14.2%	31.7%
1	$ 111,058	$ 416	$ 2,876	$ 11	$ 113,934	$ 427	$ 48,674	$ 156	$ 520	$ 2	$ 49,194	$ 158	-56.8%	-63.1%
2 - 4	$ 149,174	$ 171	$ 3,522	$ 4	$ 152,696	$ 175	$ 99,228	$ 119	$ 3,385	$ 4	$ 102,613	$ 123	-32.8%	-29.7%
5 - 9	$ 185,832	$ 116	$ 28,802	$ 18	$ 214,634	$ 134	$ 116,007	$ 76	$ 15,746	$ 10	$ 131,753	$ 86	-38.6%	-35.6%
10 - 14	$ 411,700	$ 208	$ 59,872	$ 30	$ 471,572	$ 238	$ 234,320	$ 126	$ 50,397	$ 27	$ 284,717	$ 154	-39.6%	-35.4%
15 - 19	$ 653,403	$ 303	$ 114,109	$ 53	$ 767,512	$ 355	$ 467,329	$ 216	$ 92,183	$ 43	$ 559,512	$ 259	-27.1%	-27.2%
20 - 24	$ 341,599	$ 189	$ 101,897	$ 56	$ 443,496	$ 245	$ 453,790	$ 228	$ 220,279	$ 111	$ 674,069	$ 339	52.0%	38.7%
25 - 29	$ 319,942	$ 284	$ 105,617	$ 94	$ 425,559	$ 378	$ 313,772	$ 289	$ 213,693	$ 197	$ 527,465	$ 486	23.9%	28.4%
30 - 34	$ 658,917	$ 439	$ 80,714	$ 54	$ 739,631	$ 493	$ 869,527	$ 610	$ 172,291	$ 121	$ 1,041,818	$ 731	40.9%	48.3%
35 - 39	$ 791,051	$ 468	$ 201,138	$ 119	$ 992,189	$ 586	$ 907,005	$ 518	$ 208,290	$ 119	$ 1,115,295	$ 637	12.4%	8.6%
40 - 44	$ 726,250	$ 429	$ 293,424	$ 173	$ 1,019,674	$ 603	$ 620,333	$ 364	$ 355,370	$ 209	$ 975,703	$ 573	-4.3%	-5.0%
45 - 49	$ 1,040,419	$ 480	$ 377,040	$ 174	$ 1,417,459	$ 654	$ 1,068,035	$ 531	$ 299,271	$ 149	$ 1,367,306	$ 679	-3.5%	3.9%
50 - 54	$ 1,214,518	$ 516	$ 540,982	$ 230	$ 1,755,500	$ 745	$ 1,254,437	$ 509	$ 634,820	$ 257	$ 1,889,257	$ 766	7.6%	2.8%
55 - 59	$ 1,785,524	$ 660	$ 830,357	$ 307	$ 2,615,881	$ 967	$ 1,434,014	$ 559	$ 704,947	$ 275	$ 2,138,961	$ 834	-18.2%	-13.7%
60 - 64	$ 1,906,638	$ 634	$ 855,541	$ 285	$ 2,762,179	$ 919	$ 2,519,978	$ 888	$ 1,009,228	$ 356	$ 3,529,206	$ 1,244	27.8%	35.3%
65+	$ 696,152	$ 574	$ 372,134	$ 307	$ 1,068,286	$ 881	$ 861,625	$ 711	$ 459,937	$ 379	$ 1,321,562	$ 1,090	23.7%	23.7%
Total	**$ 11,326,261**	**$ 427**	**$ 3,968,796**	**$ 150**	**$15,295,058**	**$ 577**	**$ 11,648,774**	**$ 447**	**$ 4,442,222**	**$ 171**	**$ 16,090,999**	**$ 618**	**5.2%**	**7.1%**

Financial Summary (p. 1 of 2)

	Total				State Active				Non-State Active			
Summary	PY19	1Q20	1Q21	Variance to Prior Year	PY19	1Q20	1Q21	Variance to Prior Year	PY19	1Q20	1Q21	Variance to Prior Year
Enrollment												
Avg # Employees	4,653	4,837	4,733	-2.2%	3,878	4,078	4,016	-1.5%	4	4	4	0.0%
Avg # Members	8,488	8,832	8,678	-1.8%	7,445	7,812	7,712	-1.3%	5	5	5	0.0%
Ratio	1.8	1.8	1.8	0.0%	1.9	1.9	1.9	0.0%	1.3	1.3	1.3	0.0%
Financial Summary												
Gross Cost	$45,094,672	$12,759,081	$12,336,809	-3.3%	$35,711,039	$10,932,583	$10,508,606	-3.9%	$45,961	$5,288	$3,952	-25.3%
Client Paid	$40,764,731	$11,326,261	$11,648,774	2.8%	$32,097,283	$9,689,772	$9,926,728	2.4%	$40,931	$4,713	$3,222	-31.6%
Employee Paid	$4,329,941	$1,432,820	$688,035	-52.0%	$3,613,757	$1,242,811	$581,878	-53.2%	$5,030	$574	$730	27.2%
Client Paid-PEPY	$8,745	$9,366	$9,845	5.1%	$8,277	$9,504	$9,886	4.0%	$10,233	$4,713	$3,222	-31.6%
Client Paid-PMPY	$4,794	$5,129	$5,370	4.7%	$4,311	$4,961	$5,149	3.8%	$8,186	$3,771	$2,578	-31.6%
Client Paid-PEPM	$729	$781	$820	5.0%	$690	$792	$824	4.0%	$853	$393	$269	-31.6%
Client Paid-PMPM	$400	$427	$447	4.7%	$359	$413	$429	3.9%	$682	$314	$215	-31.5%
High Cost Claimants (HCC's) > $100k												
# of HCC's	39	4	9	125.0%	27	4	9	125.0%	0	0	0	0.0%
HCC's / 1,000	4.6	0.5	1.0	131.1%	3.6	0.5	1.2	129.4%	0.0	0.0	0.0	0.0%
Avg HCC Paid	$274,612	$152,390	$161,344	5.9%	$246,453	$152,390	$154,128	1.1%	$0	$0	$0	0.0%
HCC's % of Plan Paid	26.3%	5.4%	12.5%	132.3%	20.7%	6.3%	14.0%	122.6%	0.0%	0.0%	0.0%	0.0%
Cost Distribution by Claim Type (PMPY)												
Facility Inpatient	$1,218	$849	$964	13.5%	$944	$782	$964	23.3%	$3,360	$0	$0	0.0%
Facility Outpatient	$1,506	$1,660	$1,755	5.7%	$1,395	$1,617	$1,662	2.8%	$1,369	$1,374	$223	-83.8%
Physician	$1,923	$2,454	$2,445	-0.4%	$1,844	$2,412	$2,374	-1.6%	$3,030	$2,349	$2,152	-8.4%
Other	$148	$167	$205	22.8%	$127	$151	$149	-1.3%	$427	$48	$203	322.9%
Total	$4,794	$5,129	$5,370	4.7%	$4,311	$4,961	$5,149	3.8%	$8,186	$3,771	$2,578	-31.6%
		Annualized	Annualized			Annualized	Annualized			Annualized	Annualized	

Financial Summary (p. 2 of 2)

Summary	State Retirees PY19	State Retirees 1Q20	State Retirees 1Q21	State Retirees Variance to Prior Year	Non-State Retirees PY19	Non-State Retirees 1Q20	Non-State Retirees 1Q21	Non-State Retirees Variance to Prior Year	HSB Peer Index
Enrollment									
Avg # Employees	599	596	582	-2.3%	181	159	131	-17.6%	
Avg # Members	826	815	793	-2.7%	227	201	168	-16.4%	
Ratio	1.4	1.4	1.4	-0.7%	1.3	1.3	1.3	1.6%	1.8
Financial Summary									
Gross Cost	$7,418,807	$1,599,330	$1,645,732	2.9%	$1,918,864	$221,881	$178,519	-19.5%	
Client Paid	$6,863,148	$1,437,635	$1,559,274	8.5%	$1,763,370	$194,141	$159,551	-17.8%	
Employee Paid	$555,659	$161,695	$86,459	-46.5%	$155,495	$27,740	$18,968	-31.6%	
Client Paid-PEPY	$11,461	$9,649	$10,717	11.1%	$9,769	$4,894	$4,884	-0.2%	$6,209
Client Paid-PMPY	$8,313	$7,059	$7,865	11.4%	$7,777	$3,870	$3,806	-1.7%	$3,437
Client Paid-PEPM	$955	$804	$893	11.1%	$814	$408	$407	-0.2%	$517
Client Paid-PMPM	$693	$588	$655	11.4%	$648	$322	$317	-1.6%	$286
High Cost Claimants (HCC's) > $100k									
# of HCC's	9	0	1	0.0%	3	0	0	0.0%	
HCC's / 1,000	10.9	0.0	1.3	0.0%	13.2	0.0	0.0	0.0%	
Avg HCC Paid	$339,256	$0	$64,942	0.0%	$334,114	$0	$0	0.0%	
HCC's % of Plan Paid	44.5%	0.0%	4.2%	0.0%	56.8%	0.0%	0.0%	0.0%	
Cost Distribution by Claim Type (PMPY)									
Facility Inpatient	$3,028	$1,491	$1,023	-31.4%	$3,554	$904	$755	-16.5%	$1,057
Facility Outpatient	$2,243	$2,232	$2,850	27.7%	$2,477	$1,024	$888	-13.3%	$1,145
Physician	$2,713	$3,007	$3,328	10.7%	$1,587	$1,846	$1,559	-15.5%	$1,122
Other	$328	$330	$665	101.5%	$158	$97	$605	523.7%	$113
Total	$8,313	$7,059	$7,865	11.4%	$7,777	$3,870	$3,806	-1.7%	$3,437
		Annualized	Annualized			Annualized	Annualized		

Financial Summary – Prior Year Comparison (p. 1 of 2)

	Total				State Active				Non-State Active			
Summary	PY19	PY20	1Q21	Variance to Prior Year	PY19	PY20	1Q21	Variance to Prior Year	PY19	PY20	1Q21	Variance to Prior Year
Enrollment												
Avg # Employees	4,653	4,794	4,733	-1.3%	3,878	4,054	4,016	-0.9%	4	4	4	0.0%
Avg # Members	8,488	8,768	8,678	-1.0%	7,445	7,768	7,712	-0.7%	5	5	5	0.0%
Ratio	1.8	1.8	1.8	0.0%	1.9	1.9	1.9	0.0%	1.3	1.3	1.3	0.0%
Financial Summary												
Gross Cost	$45,094,672	$55,523,229	$12,336,809	-77.8%	$35,711,039	$45,961,999	$10,508,606	-77.1%	$45,961	$70,916	$3,952	-94.4%
Client Paid	$40,764,731	$50,293,887	$11,648,774	-76.8%	$32,097,283	$41,579,805	$9,926,728	-76.1%	$40,931	$65,329	$3,222	-95.1%
Employee Paid	$4,329,941	$5,229,342	$688,035	-86.8%	$3,613,757	$4,382,194	$581,878	-86.7%	$5,030	$5,587	$730	-86.9%
Client Paid-PEPY	$8,745	$10,492	$9,845	-6.2%	$8,277	$10,256	$9,886	-3.6%	$10,233	$16,332	$3,222	-80.3%
Client Paid-PMPY	$4,794	$5,736	$5,370	-6.4%	$4,311	$5,352	$5,149	-3.8%	$8,186	$13,066	$2,578	-80.3%
Client Paid-PEPM	$729	$874	$820	-6.2%	$690	$855	$824	-3.6%	$853	$1,361	$269	-80.2%
Client Paid-PMPM	$400	$478	$447	-6.5%	$359	$446	$429	-3.8%	$682	$1,089	$215	-80.3%
High Cost Claimants (HCC's) > $100k												
# of HCC's	39	51	9	-82.4%	27	40	9	-77.5%	0	0	0	0.0%
HCC's / 1,000	4.6	5.8	1.0	-82.1%	3.6	5.2	1.2	-77.3%	0.0	0.0	0.0	0.0%
Avg HCC Paid	$274,612	$202,775	$161,344	-20.4%	$246,453	$179,535	$154,128	-14.2%	$0	$0	$0	0.0%
HCC's % of Plan Paid	26.3%	20.6%	12.5%	-39.3%	20.7%	17.3%	14.0%	-19.1%	0.0%	0.0%	0.0%	0.0%
Cost Distribution by Claim Type (PMPY)												
Facility Inpatient	$1,218	$1,169	$964	-17.5%	$944	$1,036	$964	-6.9%	$3,360	$2,928	$0	-100.0%
Facility Outpatient	$1,506	$1,832	$1,755	-4.2%	$1,395	$1,693	$1,662	-1.8%	$1,369	$4,817	$223	-95.4%
Physician	$1,923	$2,541	$2,445	-3.8%	$1,844	$2,461	$2,374	-3.5%	$3,030	$5,153	$2,152	-58.2%
Other	$148	$194	$205	5.7%	$127	$163	$149	-8.6%	$427	$168	$203	20.8%
Total	$4,794	$5,736	$5,370	-6.4%	$4,311	$5,352	$5,149	-3.8%	$8,186	$13,066	$2,578	-80.3%
			Annualized				Annualized				Annualized	

Financial Summary – Prior Year Comparison (p. 2 of 2)

	State Retirees				Non-State Retirees				
Summary	**PY19**	**PY20**	**1Q21**	**Variance to Prior Year**	**PY19**	**PY20**	**1Q21**	**Variance to Prior Year**	**HSB Peer Index**
Enrollment									
Avg # Employees	599	588	582	-1.0%	181	148	131	-11.5%	
Avg # Members	826	807	793	-1.7%	227	188	168	-10.6%	
Ratio	1.4	1.4	1.4	-0.7%	1.3	1.3	1.3	0.8%	1.8
Financial Summary									
Gross Cost	$7,418,807	$8,514,643	$1,645,732	-80.7%	$1,918,864	$975,672	$178,519	-81.7%	
Client Paid	$6,863,148	$7,803,114	$1,559,274	-80.0%	$1,763,370	$845,639	$159,551	-81.1%	
Employee Paid	$555,659	$711,529	$86,459	-87.8%	$155,495	$130,033	$18,968	-85.4%	
Client Paid-PEPY	$11,461	$13,272	$10,717	-19.3%	$9,769	$5,730	$4,884	-14.8%	$6,209
Client Paid-PMPY	$8,313	$9,674	$7,865	-18.7%	$7,777	$4,508	$3,806	-15.6%	$3,437
Client Paid-PEPM	$955	$1,106	$893	-19.3%	$814	$477	$407	-14.7%	$517
Client Paid-PMPM	$693	$806	$655	-18.7%	$648	$376	$317	-15.7%	$286
High Cost Claimants (HCC's) > $100k									
# of HCC's	9	18	1	-94.4%	3	0	0	0.0%	
HCC's / 1,000	10.9	22.3	1.3	-94.4%	13.2	0.0	0.0	0.0%	
Avg HCC Paid	$339,256	$175,561	$64,942	-63.0%	$334,114	$0	$0	0.0%	
HCC's % of Plan Paid	44.5%	40.5%	4.2%	-89.7%	56.8%	0.0%	0.0%	0.0%	
Cost Distribution by Claim Type (PMPY)									
Facility Inpatient	$3,028	$2,529	$1,023	-59.5%	$3,554	$787	$755	-4.1%	$1,057
Facility Outpatient	$2,243	$3,276	$2,850	-13.0%	$2,477	$1,314	$888	-32.4%	$1,145
Physician	$2,713	$3,385	$3,328	-1.7%	$1,587	$2,165	$1,559	-28.0%	$1,122
Other	$328	$484	$665	37.4%	$158	$242	$605	150.0%	$113
Total	$8,313	$9,674	$7,865	-18.7%	$7,777	$4,508	$3,806	-15.6%	$3,437
			Annualized				Annualized		

Paid Claims by Claim Type – State Participants

Net Paid Claims - Total									
State Participants									
	1Q20				1Q21				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical									
Inpatient	$ 2,165,416	$ 286,395	$ 89,421	$ 2,541,233	$ 2,386,759	$ 235,184	$ 17,071	$ 2,639,014	3.8%
Outpatient	$ 7,524,356	$ 837,775	$ 224,044	$ 8,586,174	$ 7,539,969	$ 1,182,817	$ 124,201	$ 8,846,987	3.0%
Total - Medical	**$ 9,689,772**	**$ 1,124,170**	**$ 313,465**	**$ 11,127,407**	**$ 9,926,728**	**$ 1,418,001**	**$ 141,272**	**$ 11,486,001**	**3.2%**

Net Paid Claims - Per Participant per Month									
	1Q20				1Q21				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical	$ 792	$ 741	$ 1,161	$ 794	$ 824	$ 946	$ 572	$ 833	4.9%

Paid Claims by Claim Type – Non-State Participants

Net Paid Claims - Total									
Non-State Participants									
	1Q20				1Q21				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical									
Inpatient	$ 1,262	$ 36,045	$ 24,565	$ 61,872	$ -	$ 34,043	$ 360	$ 34,403	-44.4%
Outpatient	$ 3,452	$ 112,177	$ 21,354	$ 136,982	$ 3,222	$ 19,348	$ 105,799	$ 128,370	-6.3%
Total - Medical	**$ 4,713**	**$ 148,222**	**$ 45,919**	**$ 198,854**	**$ 3,222**	**$ 53,392**	**$ 106,159**	**$ 162,773**	**-18.1%**

Net Paid Claims - Per Participant per Month									
	1Q20				1Q21				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical	$ 393	$ 472	$ 283	$ 407	$ 269	$ 235	$ 643	$ 403	-1.1%

Paid Claims by Claim Type – Total

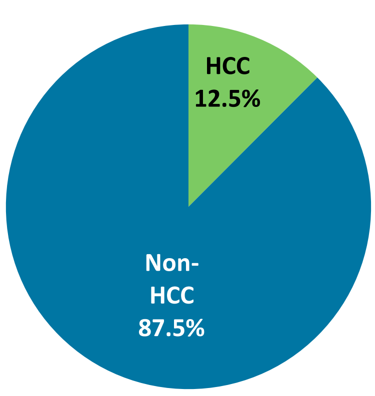
Net Paid Claims - Total									
Total Participants									
	1Q20				1Q21				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical									
Inpatient	$ 2,166,678	$ 322,440	$ 113,987	$ 2,603,105	$ 2,386,759	$ 269,227	$ 17,431	$ 2,673,418	2.7%
Outpatient	$ 7,527,807	$ 949,951	$ 245,397	$ 8,723,156	$ 7,543,191	$ 1,202,166	$ 230,000	$ 8,975,357	2.9%
Total - Medical	**$ 9,694,485**	**$ 1,272,392**	**$ 359,384**	**$ 11,326,261**	**$ 9,929,950**	**$ 1,471,393**	**$ 247,431**	**$ 11,648,774**	**2.8%**

Net Paid Claims - Per Participant per Month									
	1Q20				1Q21				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical	$ 792	$ 695	$ 832	$ 781	$ 823	$ 852	$ 601	$ 820	5.1%

Cost Distribution – Medical Claims

1Q20							1Q21					
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
4	0.0%	$609,558	5.4%	$3,746	0.3%	$100,000.01 Plus	7	0.1%	$1,452,092	12.5%	($58,624)	-8.5%
15	0.2%	$1,050,048	9.3%	$23,167	1.6%	$50,000.01-$100,000.00	20	0.2%	$1,445,687	12.4%	$33,320	4.8%
35	0.4%	$1,293,627	11.4%	$9,228	0.6%	$25,000.01-$50,000.00	48	0.5%	$1,816,271	15.6%	$12,678	1.8%
168	1.9%	$2,719,659	24.0%	$196,014	13.7%	$10,000.01-$25,000.00	129	1.5%	$2,114,530	18.2%	$53,096	7.7%
196	2.2%	$1,432,524	12.6%	$191,401	13.4%	$5,000.01-$10,000.00	151	1.7%	$1,101,531	9.5%	$62,774	9.1%
339	3.8%	$1,211,128	10.7%	$242,132	16.9%	$2,500.01-$5,000.00	288	3.3%	$1,014,139	8.7%	$102,800	14.9%
5,336	60.4%	$3,009,717	26.6%	$758,630	53.3%	$0.01-$2,500.00	4,935	56.9%	$2,704,524	23.2%	$477,766	69.4%
49	0.6%	$0	0.0%	$8,503	0.6%	$0.00	62	0.7%	$0	0.0%	$4,226	0.6%
2,691	30.5%	$0	0.0%	$0	0.0%	No Claims	3,039	35.0%	$0	0.0%	$0	0.0%
8,832	**100.0%**	**$11,326,261**	**100.0%**	**$1,432,820**	**100.0%**		**8,678**	**100.0%**	**$11,648,774**	**100.0%**	**$688,035**	**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 INJ) Injury, Poisoning and Certain Other Consequences of External Causes	3	$463,342	31.9%
(CCS BLD) Diseases of the Blood and Blood Forming Organs and Certain Disorders Involving	2	$361,994	24.9%
(CCS PNL) Certain Conditions Originating in the Perinatal Period	2	$220,910	15.2%
(CCS NEO) Neoplasms	2	$158,036	10.9%
(CCS END) Endocrine, Nutritional and Metabolic Diseases	1	$157,554	10.9%
(CCS FAC) Factors Influencing Health Status and Contact with Health Services	8	$77,092	5.3%
(CCS NVS) Diseases of the Nervous System	3	$6,959	0.5%
(CCS CIR) Diseases of the Circulatory System	2	$2,713	0.2%
(CCS SYM) Symptoms, Signs and Abnormal Clinical and Laboratory Findings, Not Elsewhere (	4	$1,370	0.1%
(CCS DIG) Diseases of the Digestive System	3	$1,055	0.1%
(CCS MUS) Diseases of the Musculoskeletal System and Connective Tissue	4	$536	0.0%
(CCS MBD) Mental, Behavioral and Neurodevelopmental Disorders	1	$531	0.0%
Overall	**----**	**$1,452,092**	**100.0%**

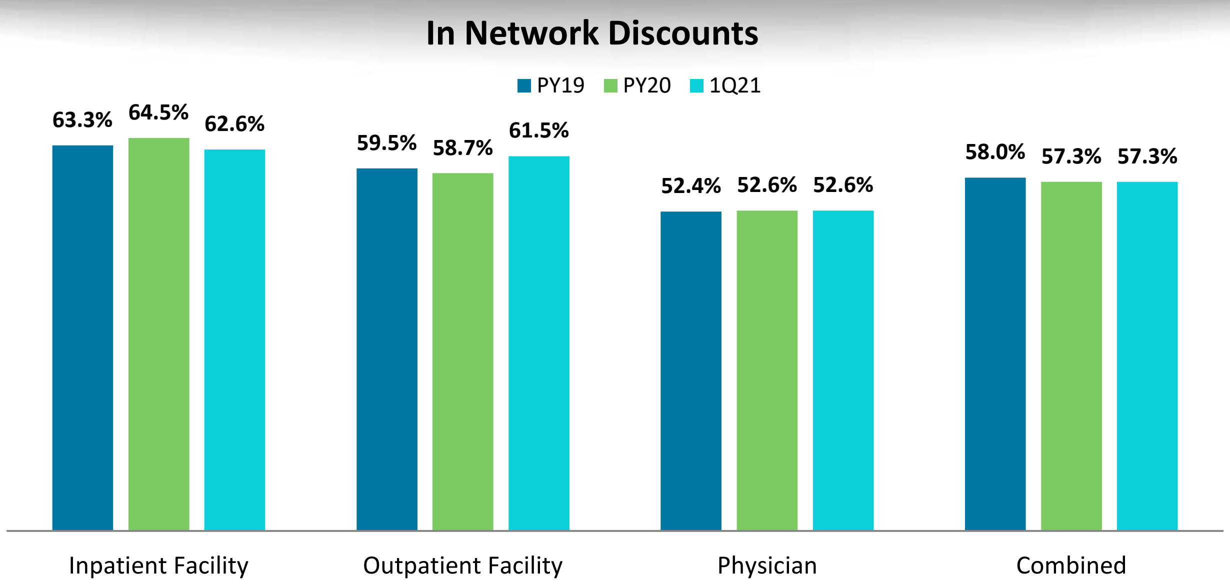
Utilization Summary (p. 1 of 2)

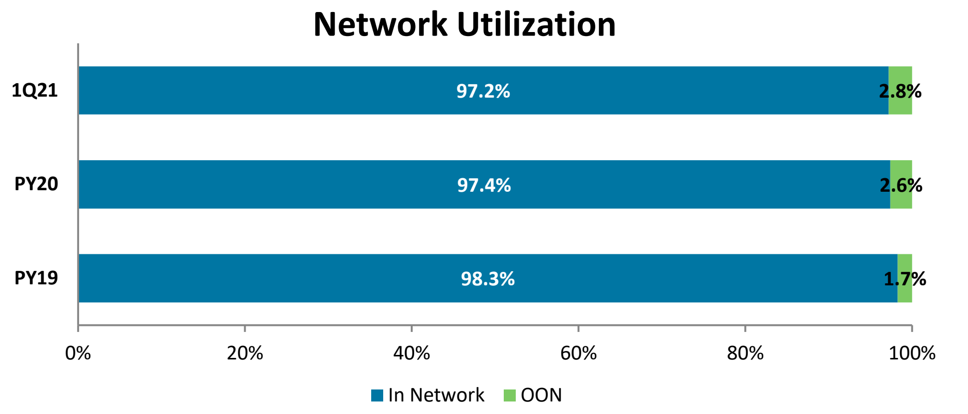
	Total				State Active				Non-State Active			
Summary	PY19	1Q20	1Q21	Variance to Prior Year	PY19	1Q20	1Q21	Variance to Prior Year	PY19	1Q20	1Q21	Variance to Prior Year
Inpatient Facility												
# of Admits	507	179	145	-19.0%	441	150	130	-13.3%	1	0	0	0.0%
# of Bed Days	2,491	896	808	-9.8%	2,026	760	584	-23.2%	2	0	0	0.0%
Paid Per Admit	$20,394	$10,789	$15,532	44.0%	$15,930	$10,583	$15,042	42.1%	$16,801	$0	$0	0.0%
Paid Per Day	$4,151	$2,155	$2,787	29.3%	$3,468	$2,089	$3,348	60.3%	$8,401	$0	$0	0.0%
Admits Per 1,000	60	81	67	-17.3%	59	77	67	-13.0%	200	0	0	0.0%
Days Per 1,000	293	406	372	-8.4%	272	389	303	-22.1%	400	0	0	0.0%
Avg LOS	4.9	5	5.6	12.0%	4.6	5.1	4.5	-11.8%	2.0	0.0	0.0	0.0%
Physician Office												
OV Utilization per Member	4.4	5.3	4.6	-13.2%	4.2	5.1	4.4	-13.7%	5.6	5.6	4.6	-17.9%
Avg Paid per OV	$94	$100	$101	1.0%	$95	$102	$103	1.0%	$105	$84	$65	-22.6%
Avg OV Paid per Member	$410	$532	$463	-13.0%	$402	$521	$448	-14.0%	$587	$470	$299	-36.4%
DX&L Utilization per Member	8.9	11.2	9.9	-11.6%	8.4	10.5	9.5	-9.5%	14	18.4	0	-100.0%
Avg Paid per DX&L	$78	$71	$82	15.5%	$75	$73	$82	12.3%	$106	$101	$0	-100.0%
Avg DX&L Paid per Member	$690	$791	$810	2.4%	$629	$764	$773	1.2%	$1,491	$1,865	$0	-100.0%
Emergency Room												
# of Visits	1,453	483	398	-17.6%	1,261	405	356	-12.1%	0	0	0	0.0%
# of Admits	192	68	46	-32.4%	154	48	38	-20.8%	0	0	0	0.0%
Visits Per Member	0.17	0.22	0.18	-17.7%	0.17	0.21	0.18	-13.2%	0.00	0.00	0.00	0.0%
Visits Per 1,000	171	219	183	-16.3%	169	207	185	-10.8%	0	0	0	0.0%
Avg Paid per Visit	$2,608	$2,557	$2,483	-2.9%	$2,546	$2,609	$2,434	-6.7%	$0	$0	$0	0.0%
Admits Per Visit	0.13	0.14	0.12	-14.8%	0.12	0.12	0.11	-7.2%	0.00	0.00	0.00	0.0%
Urgent Care												
# of Visits	2,450	693	480	-30.7%	2,232	632	419	-33.7%	0	0	0	0.0%
Visits Per Member	0.29	0.31	0.22	-29.9%	0.30	0.32	0.22	-32.0%	0.00	0.00	0.00	0.0%
Visits Per 1,000	288	314	221	-29.6%	300	324	217	-32.9%	0	0	0	0.0%
Avg Paid per Visit	$140	$154	$166	7.8%	$140	$154	$165	7.1%	$0	$0	$0	0.0%
		Annualized	Annualized			Annualized	Annualized			Annualized	Annualized	

Utilization Summary (p. 2 of 2)

	State Retirees				Non-State Retirees				
Summary	**PY19**	**1Q20**	**1Q21**	**Variance to Prior Year**	**PY19**	**1Q20**	**1Q21**	**Variance to Prior Year**	**HSB Peer Index**
Inpatient Facility									
# of Admits	52	25	12	-52.0%	13	4	3	-25.0%	
# of Bed Days	361	127	120	-5.5%	102	9	104	1055.6%	
Paid Per Admit	$47,923	$11,966	$17,237	44.0%	$61,977	$11,129	$29,957	169.2%	$16,173
Paid Per Day	$6,903	$2,355	$1,724	-26.8%	$7,899	$4,946	$864	-82.5%	$3,708
Admits Per 1,000	63	123	61	-50.4%	57	80	72	-10.0%	61
Days Per 1,000	437	624	605	-3.0%	450	179	2,481	1286.0%	264
Avg LOS	6.9	5.1	10	96.1%	7.8	2.3	34.7	1408.7%	4.3
Physician Office									
OV Utilization per Member	5.6	7.2	6.6	-8.3%	5.0	6.7	5.9	-11.9%	3.3
Avg Paid per OV	$85	$88	$92	4.5%	$86	$78	$77	-1.3%	$50
Avg OV Paid per Member	$473	$636	$609	-4.2%	$431	$520	$458	-11.9%	$167
DX&L Utilization per Member	12.1	15.8	13.9	-12.0%	12.2	16.2	11.8	-27.2%	8.3
Avg Paid per DX&L	$88	$64	$84	31.3%	$104	$56	$67	19.6%	$67
Avg DX&L Paid per Member	$1,069	$1,016	$1,171	15.3%	$1,274	$905	$797	-11.9%	$554
Emergency Room									
# of Visits	158	68	40	-41.2%	94	10	2	-80.0%	
# of Admits	30	18	7	-61.1%	8	2	1	-50.0%	
Visits Per Member	0.19	0.33	0.20	-40.1%	0.41	0.20	0.05	-74.9%	0.17
Visits Per 1,000	191	334	202	-39.5%	415	199	48	-75.9%	174
Avg Paid per Visit	$2,991	$2,381	$2,841	19.3%	$1,195	$1,627	$4,015	146.8%	$1,684
Admits Per Visit	0.19	0.26	0.18	-30.8%	0.09	0.20	0.50	150.0%	0.14
Urgent Care									
# of Visits	158	46	49	6.5%	60	15	12	-20.0%	
Visits Per Member	0.19	0.23	0.25	10.7%	0.26	0.30	0.29	-3.0%	0.24
Visits Per 1,000	191	226	247	9.4%	265	299	286	-4.3%	242
Avg Paid per Visit	$154	$180	$184	2.2%	$96	$76	$144	89.5%	$74
		Annualized	Annualized			Annualized	Annualized		

Provider Network Summary

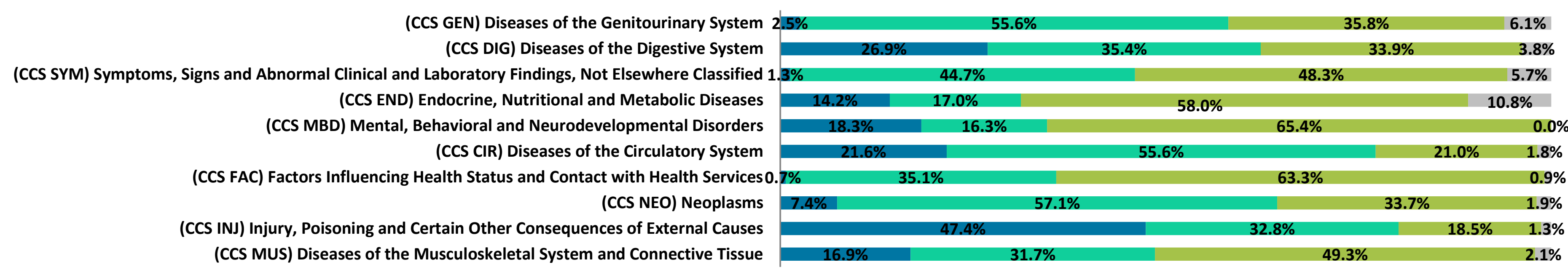




AHRQ* Clinical Classifications Summary

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

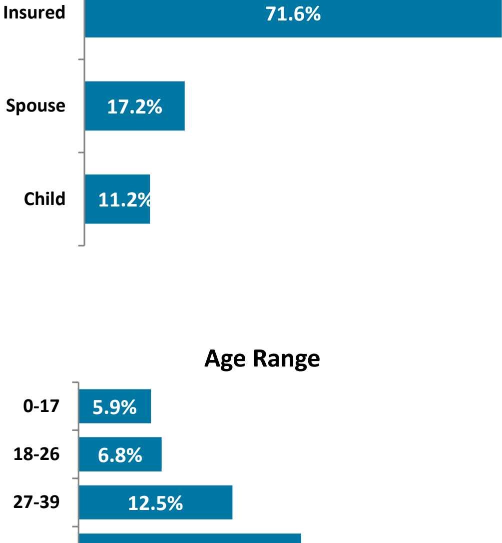
AHRQ Clinical Classifications Chapter	Total Paid	% Paid	Insured	Spouse	Child	Male	Female
(CCS MUS) Diseases of the Musculoskeletal System and Connective Tissue	$1,569,015	13.5%	$1,044,910	$401,155	$122,950	$624,969	$944,046
(CCS INJ) Injury, Poisoning and Certain Other Consequences of External Causes	$1,149,747	9.9%	$790,965	$208,528	$150,254	$442,213	$707,534
(CCS NEO) Neoplasms	$1,144,822	9.8%	$856,804	$278,908	$9,109	$360,249	$784,573
(CCS FAC) Factors Influencing Health Status and Contact with Health Services	$1,012,922	8.7%	$628,743	$87,371	$296,807	$382,601	$630,321
(CCS CIR) Diseases of the Circulatory System	$882,759	7.6%	$661,764	$204,318	$16,678	$454,780	$427,980
(CCS MBD) Mental, Behavioral and Neurodevelopmental Disorders	$856,503	7.4%	$457,742	$114,158	$284,603	$206,420	$650,083
(CCS END) Endocrine, Nutritional and Metabolic Diseases	$709,434	6.1%	$559,383	$103,553	$46,498	$205,330	$504,104
(CCS SYM) Symptoms, Signs and Abnormal Clinical and Laboratory Findings, Not Els	$643,974	5.5%	$409,172	$91,849	$142,952	$243,653	$400,321
(CCS DIG) Diseases of the Digestive System	$569,490	4.9%	$420,650	$112,036	$36,804	$292,513	$276,977
(CCS GEN) Diseases of the Genitourinary System	$463,837	4.0%	$322,815	$68,401	$72,622	$175,713	$288,124
(CCS NVS) Diseases of the Nervous System	$435,135	3.7%	$325,864	$62,641	$46,629	$204,003	$231,132
(CCS BLD) Diseases of the Blood and Blood Forming Organs and Certain Disorders I	$409,147	3.5%	$225,249	$182,880	$1,017	$197,322	$211,825
(CCS PRG) Pregnancy, Childbirth and the Puerperium	$392,204	3.4%	$300,456	$68,643	$23,105	$0	$392,204
(CCS RSP) Diseases of the Respiratory System	$357,906	3.1%	$194,227	$37,232	$126,447	$137,264	$220,642
(CCS PNL) Certain Conditions Originating in the Perinatal Period	$294,226	2.5%	$2,490	$0	$291,737	$29,600	$264,627
(CCS EYE) Diseases of the Eye and Adnexa	$260,003	2.2%	$187,226	$39,253	$33,524	$101,054	$158,949
(CCS INF) Certain Infectious and Parasitic Diseases	$195,341	1.7%	$109,389	$41,550	$44,402	$125,446	$69,895
(CCS SKN) Diseases of the Skin and Subcutaneous Tissue	$171,709	1.5%	$102,216	$38,993	$30,500	$73,292	$98,417
(CCS EAR) Diseases of the Ear and Mastoid Process	$73,724	0.6%	$51,364	$6,739	$15,621	$26,361	$47,363
(CCS MAL) Congenital Malformations, Deformations and Chromosomal Abnormaliti	$55,758	0.5%	$6,107	$6,101	$43,550	$29,946	$25,812
(CCS 18) Residual Codes; Unclassified; All E Codes [259. And 260.]	$996	0.0%	$796	$100	$100	$100	$896
(CCS EXT) External Causes of Morbidity	$122	0.0%	$0	$122	$0	$122	$0
Total	**$11,648,774**	**100.0%**	**$7,600,066**	**$2,141,470**	**$1,776,638**	**$4,256,421**	**$7,261,754**



AHRQ Category – Diseases of the Musculoskeletal System & Connective Tissue

Diagnosis Category	Patients	Claims	Total Paid	% Paid
Spondylopathies/Spondyloarthropathy (Including Infective)	458	1,478	$511,948	32.6%
Osteoarthritis	175	348	$213,620	13.6%
Musculoskeletal Pain, Not Low Back Pain	630	1,742	$178,047	11.3%
Scoliosis And Other Postural Dorsopathic Deformities	14	38	$102,855	6.6%
Acquired Foot Deformities	33	83	$86,189	5.5%
Infective Arthritis	3	35	$84,310	5.4%
Tendon And Synovial Disorders	104	266	$73,768	4.7%
Other Specified Joint Disorders	64	146	$63,830	4.1%
Other Specified Connective Tissue Disease	173	381	$63,332	4.0%
Osteomyelitis	5	19	$47,664	3.0%
Low Back Pain	184	665	$44,520	2.8%
Muscle Disorders	16	31	$19,741	1.3%
Biomechanical Lesions	169	467	$11,786	0.8%
Osteoporosis	20	31	$11,075	0.7%
Postprocedural Or Postoperative Musculoskeletal System Complication	21	86	$10,610	0.7%
Systemic Lupus Erythematosus And Connective Tissue Disorders	32	79	$10,283	0.7%
Other Specified Bone Disease And Musculoskeletal Deformities	36	50	$10,255	0.7%
Rheumatoid Arthritis And Related Disease	36	67	$8,448	0.5%
Disorders Of Jaw	10	23	$7,156	0.5%
Acquired Deformities (Excluding Foot)	7	15	$4,348	0.3%
Gout	17	23	$2,074	0.1%
Neurogenic/Neuropathic Arthropathy	2	17	$1,946	0.1%
Pathological Fracture, Initial Encounter	1	1	$538	0.0%
Pathological, Stress And Atypical Fractures, Sequela	1	2	$349	0.0%
Stress Fracture, Initial Encounter	3	4	$244	0.0%
Stress Fracture, Subsequent Encounter	1	1	$62	0.0%
Traumatic Arthropathy	1	1	$19	0.0%
	----	----	$1,569,015	100.0%

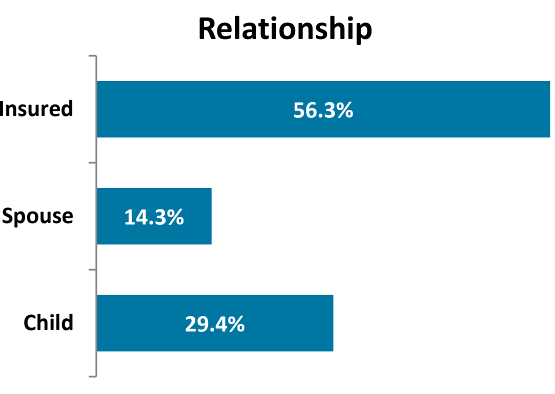
*Patient and claim counts are unique only within the category

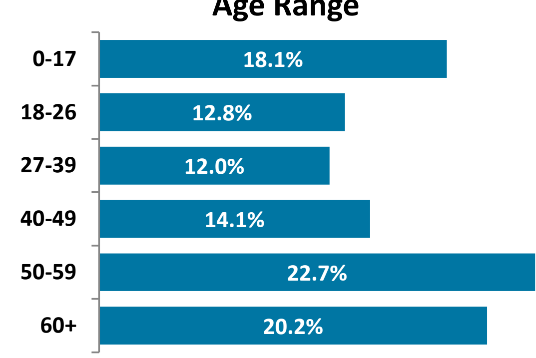


AHRQ Category – Injury, Poisoning, & Certain other Consequences of External Causes

Diagnosis Category	Patients	Claims	Total Paid	% Paid
Fracture Of The Lower Limb (Except Hip), Initial Encounter	35	186	$442,078	38.5%
Sprains And Strains, Initial Encounter	104	222	$115,709	10.1%
Traumatic Brain Injury (Tbi); Concussion, Initial Encounter	13	41	$112,021	9.7%
Fracture Of The Upper Limb, Initial Encounter	41	145	$94,113	8.2%
Traumatic Brain Injury (Tbi); Concussion, Subsequent Encounter	2	16	$47,527	4.1%
Fracture Of Lower Limb (Except Hip), Subsequent Encounter	19	59	$46,259	4.0%
Injury To Nerves, Muscles And Tendons, Initial Encounter	32	97	$40,288	3.5%
Open Wounds To Limbs, Initial Encounter	52	106	$38,109	3.3%
Superficial Injury; Contusion, Initial Encounter	66	98	$24,247	2.1%
Other Unspecified Injury	75	124	$21,242	1.8%
Internal Organ Injury, Initial Encounter	4	9	$19,123	1.7%
Dislocations, Initial Encounter	14	52	$18,149	1.6%
Fracture Of The Upper Limb, Subsequent Encounter	19	55	$17,786	1.5%
Complication Of Other Surgical Or Medical Care, Injury, Initial Encount	13	42	$16,823	1.5%
Fracture Of The Spine And Back, Initial Encounter	6	11	$15,380	1.3%
Complication Of Internal Orthopedic Device Or Implant, Initial Encount	13	24	$13,891	1.2%
Open Wounds Of Head And Neck, Initial Encounter	19	43	$10,496	0.9%
Effect Of Foreign Body Entering Opening, Initial Encounter	17	27	$9,355	0.8%
Sprains And Strains, Subsequent Encounter	24	98	$9,037	0.8%
Complication Of Genitourinary Device, Implant Or Graft, Initial Encoun	2	4	$7,415	0.6%
Allergic Reactions	16	23	$5,456	0.5%
Complication Of Cardiovascular Device, Implant Or Graft, Initial Encou	2	5	$3,488	0.3%
Poisoning By Drugs, Initial Encounter	3	5	$3,227	0.3%
Complication Of Other Surgical Or Medical Care, Injury, Subsequent En	2	7	$2,801	0.2%
Fracture Of The Neck Of The Femur (Hip), Subsequent Encounter	2	2	$2,456	0.2%
All Other	----	148	$13,270	1.2%
	----	----	$1,149,747	100.0%

*Patient and claim counts are unique only within the category

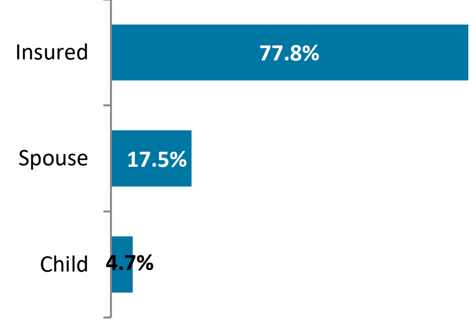


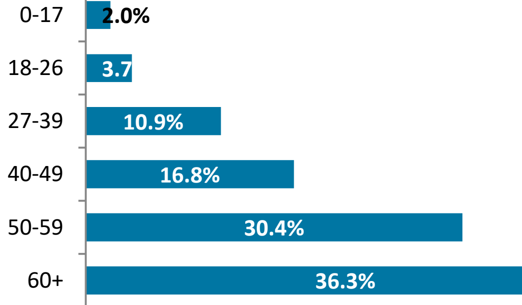


AHRQ Category – Neoplasms

Diagnosis Category	Patients	Claims	Total Paid	% Paid
Breast Cancer - All Other Types	31	204	$345,104	30.1%
Benign Neoplasms	200	284	$151,981	13.3%
Secondary Malignancies	6	12	$108,194	9.5%
Nervous System Cancers - Brain	2	28	$103,432	9.0%
Respiratory Cancers	3	28	$76,779	6.7%
Skin Cancers - All Other Types	13	23	$75,604	6.6%
Male Reproductive System Cancers - Prostate	16	77	$52,823	4.6%
Multiple Myeloma	3	27	$42,016	3.7%
Head And Neck Cancers - Lip And Oral Cavity	1	5	$33,397	2.9%
Neoplasms Of Unspecified Nature Or Uncertain Behavior	168	221	$27,356	2.4%
Myelodysplastic Syndrome (Mds)	2	30	$20,791	1.8%
Leukemia - Acute Myeloid Leukemia (Aml)	1	16	$20,084	1.8%
Skin Cancers - Basal Cell Carcinoma	30	47	$16,098	1.4%
Female Reproductive System Cancers - Cervix	4	11	$14,658	1.3%
Female Reproductive System Cancers - Vulva	1	3	$7,803	0.7%
Leukemia - All Other Types	2	3	$7,793	0.7%
Leukemia - Chronic Lymphocytic Leukemia (Cll)	4	15	$6,075	0.5%
Gastrointestinal Cancers - Colorectal	5	35	$5,794	0.5%
Head And Neck Cancers - Throat	1	11	$4,353	0.4%
Gastrointestinal Cancers - Bile Duct	1	16	$3,986	0.3%
Skin Cancers - Melanoma	6	28	$3,815	0.3%
Endocrine System Cancers - Thyroid	8	22	$3,344	0.3%
Gastrointestinal Cancers - Peritoneum	1	7	$3,000	0.3%
Non-Hodgkin Lymphoma	3	11	$2,750	0.2%
Skin Cancers - Squamous Cell Carcinoma	5	6	$2,484	0.2%
Female Reproductive System Cancers - Endometrium	1	2	$1,294	0.1%
Breast Cancer - Ductal Carcinoma In Situ (Dcis)	5	7	$1,283	0.1%
Hodgkin Lymphoma	2	7	$1,010	0.1%
Male Reproductive System Cancers - Testis	1	4	$814	0.1%
Sarcoma	3	4	$553	0.0%
Gastrointestinal Cancers - Small Intestine	1	1	$288	0.0%
Gastrointestinal Cancers - Liver	1	1	$53	0.0%
Malignant Neoplasm, Unspecified	1	1	$17	0.0%
Female Reproductive System Cancers - Ovary	1	2	$0	0.0%
Gastrointestinal Cancers - All Other Types	1	2	$0	0.0%
Overall	----	----	$1,144,822	100.0%

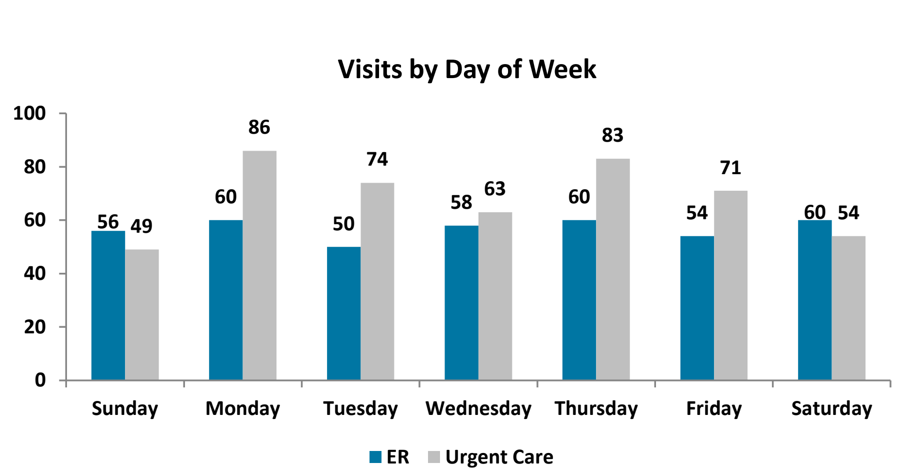
*Patient and claim counts are unique only within the category

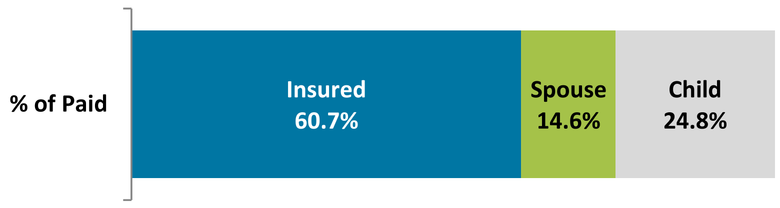




Emergency Room / Urgent Care Summary

ER/Urgent Care	1Q20 ER	1Q20 Urgent Care	1Q21 ER	1Q21 Urgent Care	HSB Peer Index ER	HSB Peer Index Urgent Care
Number of Visits	483	693	398	480		
Number of Admits	68	----	46	----		
Visits Per Member	0.22	0.31	0.18	0.22	0.17	0.24
Visits/1000 Members	219	314	183	221	174	242
Avg Paid Per Visit	$2,557	$154	$2,483	$166	$1,684	$74
Admits per Visit	0.14	----	0.12	----	0.14	
% of Visits with HSB ER Dx	78.9%	----	80.4%	----		
% of Visits with a Physician OV*	81.7%	81.3%	87.1%	85.1%		
Total Plan Paid	**$1,234,911**	**$106,952**	**$988,119**	**$79,722**		
*looks back 12 months from ER visit	Annualized	Annualized	Annualized	Annualized		





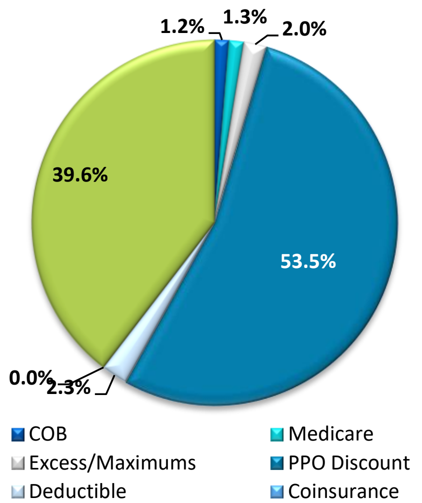
ER / UC Visits by Relationship

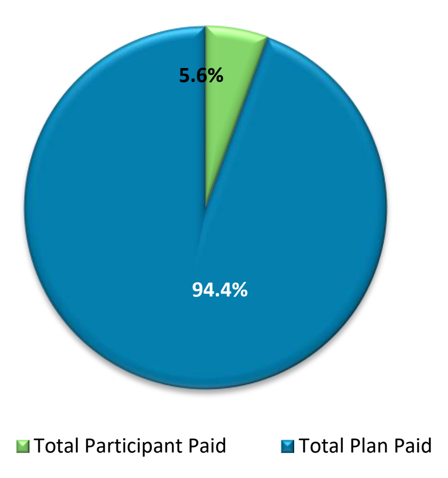
Relationship	ER	Per 1,000	Urgent Care	Per 1,000	Total	Per 1,000
Insured	219	46	275	58	494	104
Spouse	65	69	62	66	127	135
Child	114	38	143	48	257	85
Total	**398**	**46**	**480**	**55**	**878**	**101**

Savings Summary – Medical Claims

Description	Dollars	PPPM	% of Eligible
Eligible Charges	$29,430,969	$2,073	100.0%
COB	$361,718	$25	1.2%
Medicare	$387,756	$27	1.3%
Excess/Maximums	$597,545	$42	2.0%
PPO Discount	$15,747,140	$1,109	53.5%
Deductible	$688,035	$48	2.3%
Coinsurance	$0	$0	0.0%
Total Participant Paid	**$688,035**	**$48**	**2.3%**
Total Plan Paid	**$11,648,774**	**$820**	**39.6%**

Total Participant Paid - PY20	**$91**
Total Plan Paid - PY20	**$874**

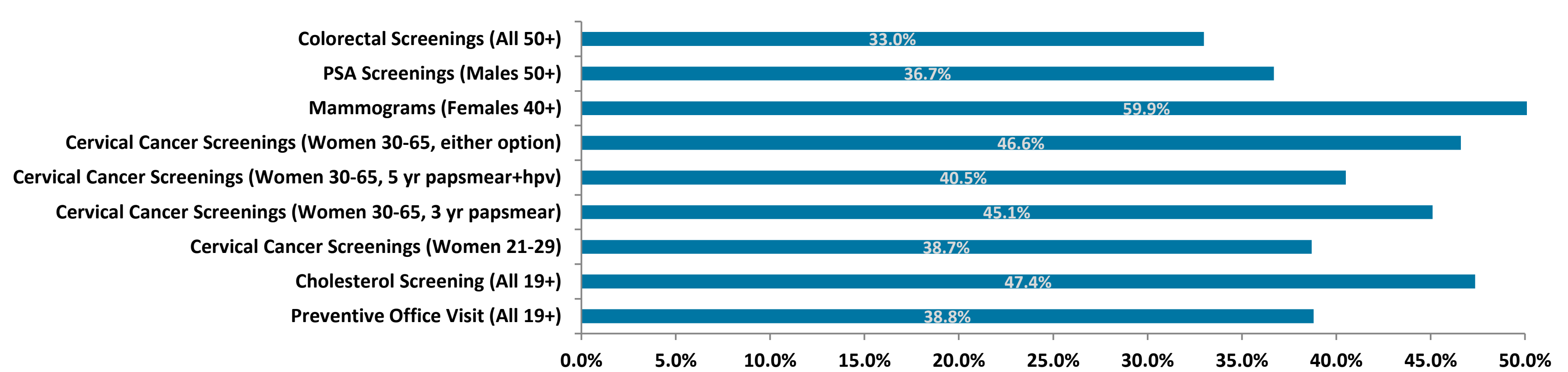




Preventive Services Compliance

*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.

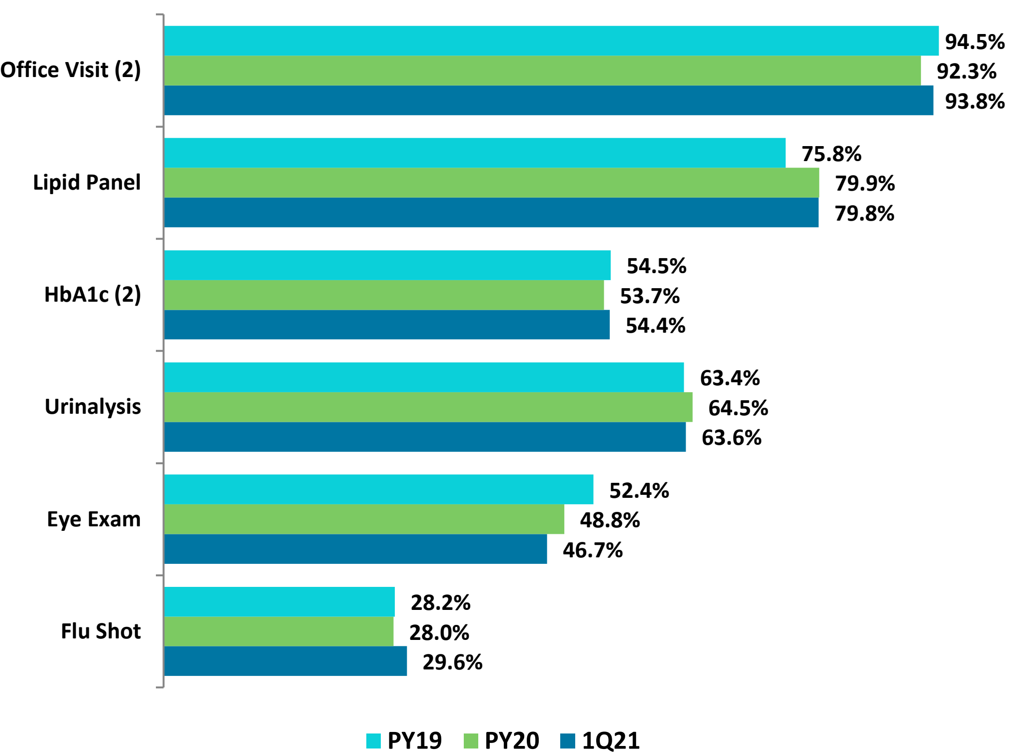
	Female			Male			Total		
Service	Eligible	Compliant	% Compliant	Eligible	Compliant	% Compliant	Eligible	Compliant	% Compliant
Preventive Office Visit (All 19+)	3,692	1,765	47.8%	2,766	741	26.8%	6,458	2,506	38.8%
Cholesterol Screening (All 19+)	3,692	1,816	49.2%	2,766	1,242	44.9%	6,458	3,058	47.4%
Cervical Cancer Screenings (Women 21-29)	460	178	38.7%	----	----	----	460	178	38.7%
Cervical Cancer Screenings (Women 30-65, 3 yr papsmear)	2,915	1,315	45.1%	----	----	----	2,915	1,315	45.1%
Cervical Cancer Screenings (Women 30-65, 5 yr papsmear+hpv)	2,915	1,181	40.5%	----	----	----	2,915	1,181	40.5%
Cervical Cancer Screenings (Women 30-65, either option)	2,915	1,358	46.6%	----	----	----	2,915	1,358	46.6%
Mammograms (Females 40+)	2,451	1,468	59.9%	----	----	----	2,451	1,468	59.9%
PSA Screenings (Males 50+)	----	----	----	1,352	496	36.7%	1,352	496	36.7%
Colorectal Screenings (All 50+)	1,742	615	35.3%	1,352	406	30.0%	3,094	1,021	33.0%



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	1Q21
Members	525	569	550

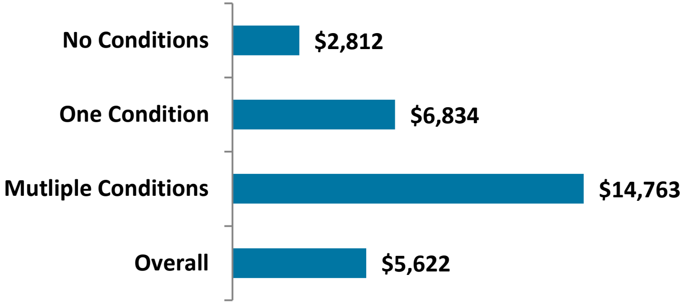


Chronic Conditions Summary

*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	398	382	46	38	$3,911,266	$9,827	99.7%	1 Office Visit
Cancer	283	267	32	57	$6,264,137	$22,135	----	----
Chronic Kidney Disease	70	66	8	58	$1,621,576	$23,165	----	----
Chronic Obstructive Pulmonary Disease (COPD)	86	81	10	60	$2,056,783	$23,916	98.8%	1 Office Visit
Congestive Heart Failure (CHF)	41	39	5	62	$1,645,684	$40,139	14.6%	1 Office Visit, 1 Lipid Profile, 1 Wellness Visit
Coronary Artery Disease (CAD)	135	129	15	61	$3,111,140	$23,045	22.2%	1 Office Visit, 1 Lipid Profile, 1 Wellness Visit
Depression	623	586	71	40	$5,976,059	$9,592	97.9%	1 Office Visit
Diabetes	550	517	63	55	$5,733,050	$10,424	21.5%	2 Office Visits, 1 Lipid Profile, 2 HbA1c's, 1 Urinalysis, 1 Eye Exam, 1 Flu Shot
Hyperlipidemia	675	646	77	55	$5,831,413	$8,639	34.2%	1 Office Visit, 1 Lipid Profile, 1 Wellness Visit
Hypertension	823	780	94	56	$10,074,873	$12,242	26.2%	1 Office Visit, 1 Lipid Profile, 1 Wellness Visit
Obesity	255	247	29	46	$2,550,911	$10,004	----	----

# of Conditions	Avg Members	Average Age	Relationship		
			Insured	Spouse	Child
No Conditions	5,224	30	41.7%	9.6%	48.7%
One Condition	2,198	46	69.5%	14.9%	15.6%
Multiple Conditions	1,315	54	80.2%	15.6%	4.2%
Overall	**8,737**	**37**	**53.6%**	**11.7%**	**34.7%**



Public Employees' Benefits Program - RX Costs
PY 2021 - Quarter Ending September 30, 2020
Express Scripts

	1Q FY2021 EPO	1Q FY2020 EPO	Difference	% Change
Membership Summary			**Membership Summary**	
Member Count (Membership)	8,681	8,832	(151)	-1.7%
Utilizing Member Count (Patients)	5,101	5,300	(199)	-3.8%
Percent Utilizing (Utilization)	58.8%	60.0%	(0)	-2.1%
Claim Summary			**Claims Summary**	
Net Claims (Total Rx's)	43,075	42,543	532	1.3%
Claims per Elig Member per Month (Claims PMPM)	1.65	1.61	0.04	2.5%
Total Claims for Generic (Generic Rx)	36,856	36,933	(77.00)	-0.2%
Total Claims for Brand (Brand Rx)	6,219	5,610	609.00	10.9%
Total Claims for Brand w/Gen Equiv (Multisource Brand Claims)	678	695	(17.00)	-2.4%
Total Non-Specialty Claims	42,531	41,927	604.00	1.4%
Total Specialty Claims	544	616	(72.00)	-11.7%
Generic % of Total Claims (GFR)	**85.6%**	**86.8%**	(0.01)	-1.4%
Generic Effective Rate (GCR)	**98.2%**	**98.2%**	0.00	0.0%
Mail Order Claims	4,756	4,223	533.00	12.6%
Mail Penetration Rate*	12.1%	10.9%	0.01	1.2%
Claims Cost Summary			**Claims Cost Summary**	
Total Prescription Cost (Total Gross Cost)	$5,203,572.00	$4,998,282.00	$205,290.00	4.1%
Total Generic Gross Cost	$862,143.00	$944,022.00	($81,879.00)	-8.7%
Total Brand Gross Cost	$4,341,429.00	$4,054,260.00	$287,169.00	7.1%
Total MSB Gross Cost	$166,383.00	$134,820.00	$31,563.00	23.4%
Total Ingredient Cost	$5,179,467.00	$4,978,306.00	$201,161.00	4.0%
Total Dispensing Fee	$22,845.00	$19,352.00	$3,493.00	18.0%
Total Other (e.g. tax)	$1,260.00	$624.00	$636.00	101.9%
Avg Total Cost per Claim (Gross Cost/Rx)	**$120.80**	**$117.49**	$3.31	2.8%
Avg Total Cost for Generic (Gross Cost/Generic Rx)	$23.39	$25.56	($2.17)	-8.5%
Avg Total Cost for Brand (Gross Cost/Brand Rx)	$698.09	$722.68	($24.59)	-3.4%
Avg Total Cost for MSB (MSB Gross Cost/MSB ARx)	$245.40	$193.99	$51.41	26.5%
Member Cost Summary			**Member Cost Summary**	
Total Member Cost	**$882,413.00**	**$835,798.00**	$46,615.00	5.6%
Total Copay	$882,413.00	$835,798.00	$46,615.00	5.6%
Total Deductible	$0.00	$0.00	$0.00	0.0%
Avg Copay per Claim (Copay/Rx)	$20.49	$19.65	$0.84	4.3%
Avg Participant Share per Claim (Copay+Deductible/RX)	**$20.49**	**$19.65**	**$0.84**	**4.3%**
Avg Copay for Generic (Copay/Generic Rx)	$7.51	$7.63	($0.12)	-1.6%
Avg Copay for Brand (Copay/Brand Rx)	$97.40	$98.78	($1.38)	-1.4%
Avg Copay for Brand w/ Generic Equiv (Copay/Multisource Rx)	$32.78	$27.59	$5.19	18.8%
Net PMPM (Participant Cost PMPM)	**$33.88**	**$31.54**	$2.34	7.4%
Copay % of Total Prescription Cost (Member Cost Share %)	17.0%	16.7%	0.2%	1.4%
Plan Cost Summary			**Plan Cost Summary**	
Total Plan Cost (Plan Cost)	**$4,321,159.00**	**$4,162,485.00**	**$158,674.00**	**3.8%**
Total Non-Specialty Cost (Non-Specialty Plan Cost)	$2,221,555.00	$1,949,093.00	$272,462.00	14.0%
Total Specialty Drug Cost (Specialty Plan Cost)	$2,099,604.00	$2,213,392.00	($113,788.00)	-5.1%
Avg Plan Cost per Claim (Plan Cost/Rx)	**$100.32**	**$97.84**	$2.48	2.5%
Avg Plan Cost for Generic (Plan Cost/Generic Rx)	$15.89	$17.93	($2.04)	-11.4%
Avg Plan Cost for Brand (Plan Cost/Brand Rx)	$600.69	$623.91	($23.22)	-3.7%
Avg Plan Cost for MSB (MSB Plan Cost/MSB ARx)	$212.63	$166.39	$46.24	27.8%
Net PMPM (Plan Cost PMPM)	**$165.92**	**$157.10**	**$8.83**	**5.6%**
PMPM for Specialty Only (Specialty PMPM)	$80.62	$83.54	($2.92)	-3.5%
PMPM without Specialty (Non-Specialty PMPM)	$85.30	$73.56	$11.74	16.0%
Rebates (Q1 FY2021 actual)	$1,008,649.28	$843,970.26	**$164,679.02**	**19.5%**
Net PMPM (Plan Cost PMPM factoring Rebates)	**$127.19**	**$125.25**	**$1.95**	**1.6%**
PMPM for Specialty Only (Specialty PMPM)	$70.48	$54.70	$15.78	28.8%
PMPM without Specialty (Non-Specialty PMPM)	$60.45	$54.33	$6.12	11.3%

Appendix C

Index of Tables

Health Plan of Nevada –Utilization Review for PEBP
July 1, 2020 – September 30, 2020

KEY PERFORMANCE INDICATORS

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Utilization Highlights 5

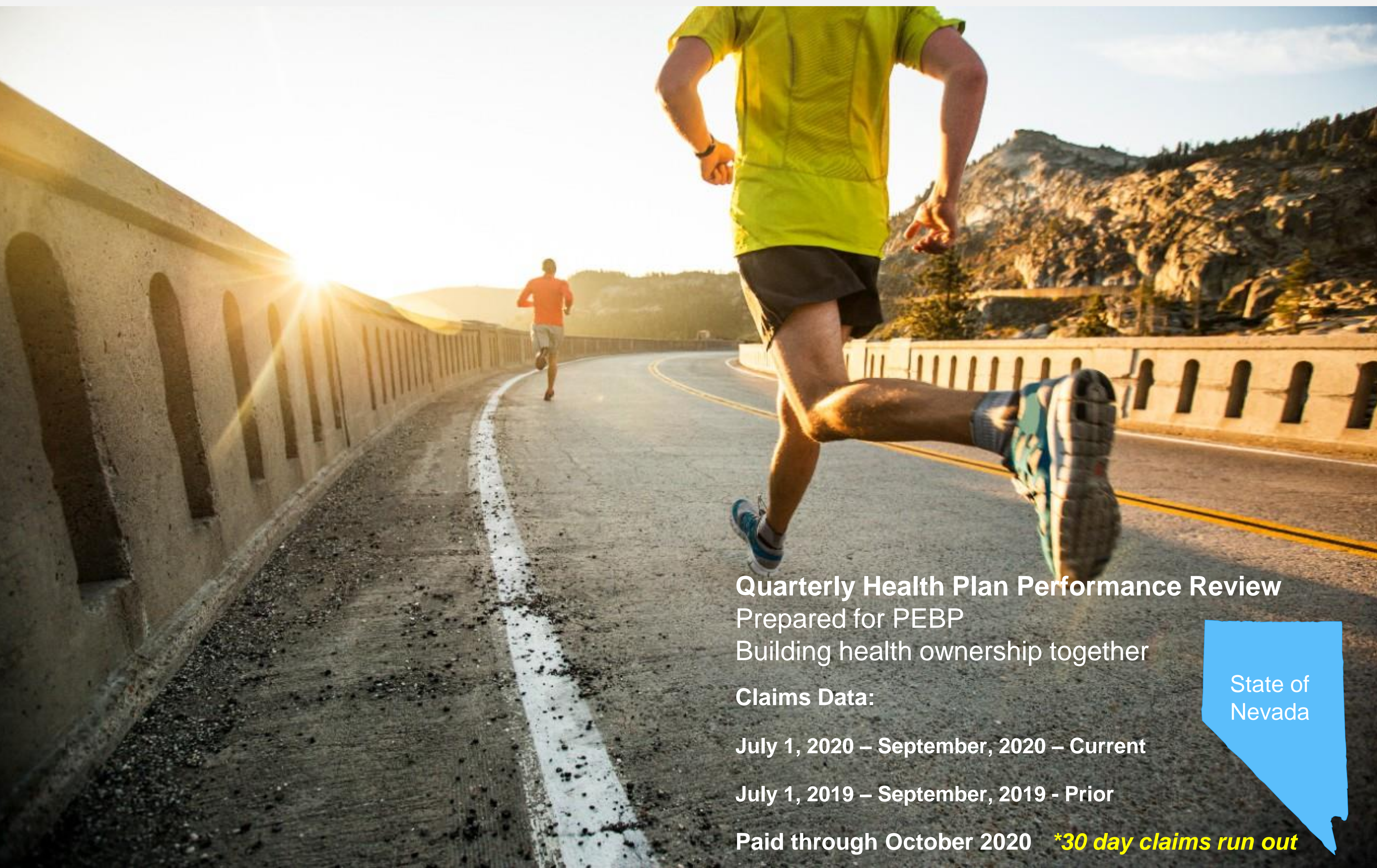
Clinical Drivers 8

High Cost Claimants 11

PRESCRIPTION DRUG COSTS

Prescription Drug Cost 7

Power Of Partnership.



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
- ✓ NV Orthopedic and Spine Center's Fast Track Clinic for patients with acute injuries

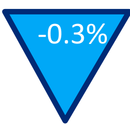
Key Performance Indicators
Includes Demographics And Financials

Demographic and Financial Overview

Demographics

Membership	Age	Famiy size	Dependents <18	HHS Risk
Members: 6,823 Employees: 3,936	37.3	1.74	22.40%	1.51
Prior: 6,844 3,947	Prior : 37.4 Norm: 35.2	Prior : 1.73 Norm: 1.82	Prior: 22.7 Norm: 21.7	Prior: 1.45 Norm: 1.33
▼ -0.3%	▼ -0.4%	▲ 0.1%	▲ 0.1%	▲ 4.2%

Medical and Rx Spend



2.5%

Medical PMPM
$319.15

Prior $311.36
Norm: $282.84

Utilization

Inpatient: ▼-26.3%
Outpatient: ▼-24.7%
Professional: ▼-11.8%

Spend

Inpatient: ▲10.0%
Outpatient: ▼-11.9%
Professional: ▲ 6.1%

▲ 1.9%

Overall PMPM
$447.49

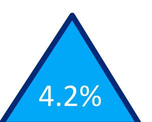
Prior: $438.96
Norm: $370.34

-3.9%
Specialty Rx
$63.11

Prior: $65.66
Norm: $43.25

.02%
Avg. Scripts PMPY
17.4

Prior: 17.4
Norm: 11.1



0.6%

Rx PMPM
$128.34

Specialty Rx accounts for 49.2% of Rx Spend

Prior: $127.60
Norm: $87.50

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Medical and Rx Plan Experience

What Happened

Highlights of Utilization

Utilization Metric	Prior	Current	Δ
Physician Office Vists			
Per Member Per Year	1.8	1.5	-17.8%
Specialist Office Vists			
Per Member Per Year	3.4	2.9	-13.5%
Emergency Room			
ER Visits	205	136	-33.6%
ER Visits per K	30.0	19.9	-33.5%
Urgent Care			
UC Visits	987	825	-16.5%
UC Visits per K	144.2	120.7	-16.3%
OutPatient Surgery			
Facility	8.9	7.3	-17.9%
ASC	36.1	20.2	-44.0%
Inpatient Utilization			
Admissions Per K	18.3	13.5	-26.3%
Bed Days Per K	307.1	224.6	-26.9%
Average Length of Stay	16.8	16.7	-0.8%
On Demand			
Now Clinic Visits	78	351	350.0%
TAN Calls	115	168	46.1%

*Not representative of all Utilization

Highlights

- PCP and Specialist visits both increased from the prior period on a PMPY basis
- ER utilization decreased **-33.5%**,
  - Average Net Paid / Visit increased 27% with more emergent ER admits
- Urgent Care Utilization increased **-16.3%**
- Outpatient surgeries decreased at both facility and ASC settings
- Admits Per K decreased -**26.3%** from prior period, but average length of stay remained flat
- 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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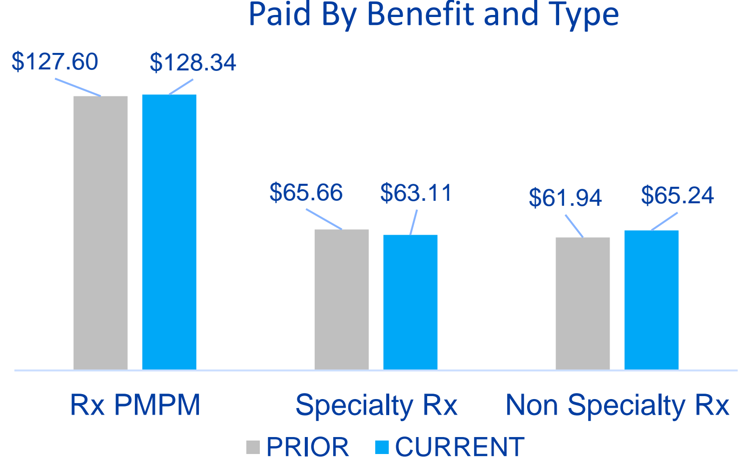
Pharmacy Data

	Prior	Current	Δ	Peer	Δ
Enrolled Members	6,844	6,832	-0.2%		
Average Prescriptions PMPY	17.4	17.4	0.2%	11.1	57.3%
Formulary Rate	92.8%	91.9%	-0.9%	91.3%	0.6%
Generic Use Rate	86.9%	85.6%	-1.6%	85.6%	-0.1%
Generic Substitution Rate	97.3%	97.2%	-0.1%	96.6%	0.6%
Employee Cost Share PMPM	$19.21	$22.39	16.5%	$11.42	96.1%
Avg Net Paid per Prescription	$88.03	$88.33	0.3%	$94.75	-6.8%
Net Paid PMPM	$127.60	$128.34	0.6%	$87.50	46.7%

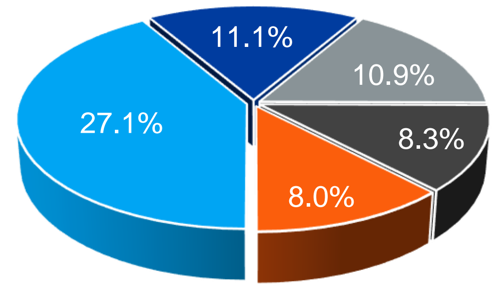


Pharmacy PMPM trend is 0.6%

- Average net paid per script increased **0.3%**
- **80.4%** of prescriptions were in Tier 1 and drove only **10.5%** of spend
- Tier 2 utilization increased **16.9%** and spend increased **12.5%**
- Antivirals increased 25.6% in spend on a PMPM basis. Biktarvy (HIV) Rx saw an increase >100% in both spend and utilization

Top 5 Therapuetic Classes by Spend

- ANTINEOPLASTICS
- ANALGESICS
- DERMATOLOGICALS
- ANTIVIRALS



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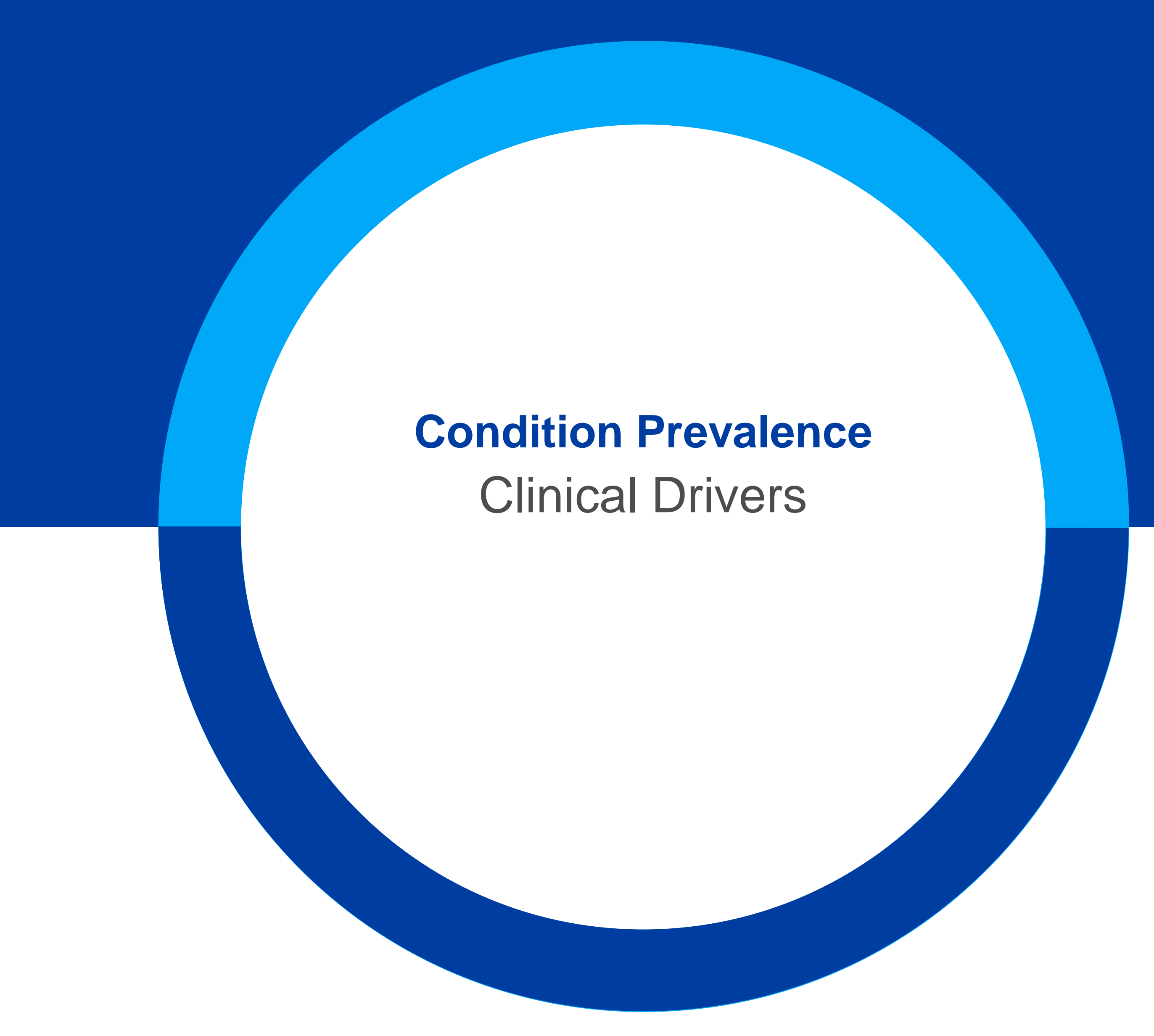
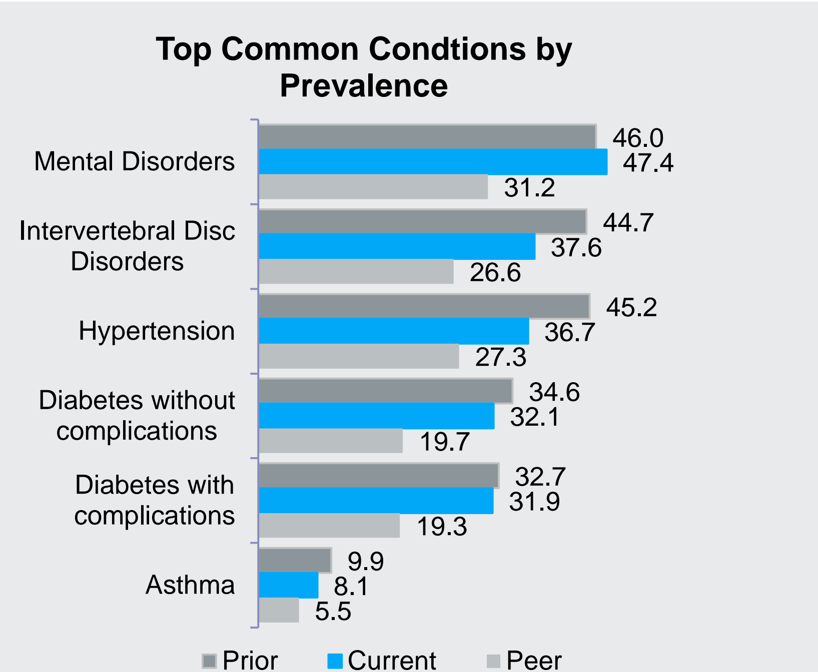
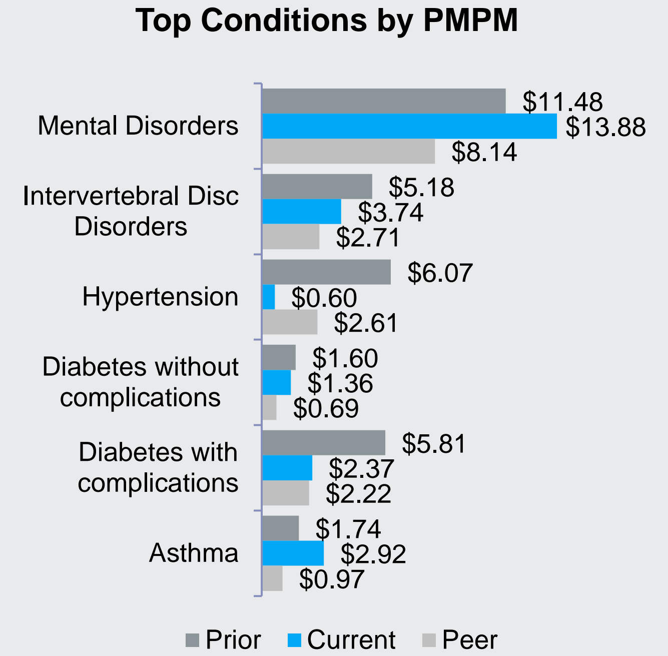

Condition Prevalence
Clinical Drivers

Clinical Conditions and Diagnosis





- Chronic illnesses are driving the top common conditions
- Mental Disorders, Intervertebral Disc Disorders and Hypertension are the most prevalent clinical conditions within this population
- Prevalence of Diabetes both with and w/out complications decreased from the prior quarterly period, but is up overall annually.
- Mental Disorders increased 20.9% in spend due to 3 complex Mental Health Acute stays

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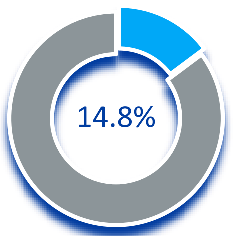
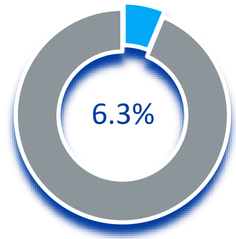
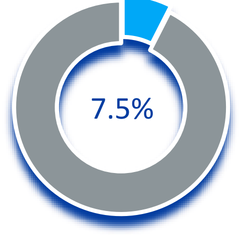
Chronic Condition Cost Drivers

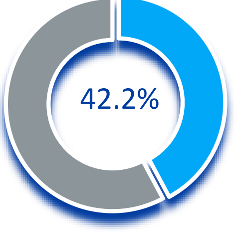
70% Of Medical spend driven by members with these 4 Chronic Conditions

Asthma	CAD	COPD	Diabetes
6.9% of Members	1.7% of Members	2.7% of Members	21.3% of Members

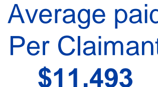








Asthma	CAD	COPD	Diabetes
Average paid Per Claimant **$8,893**	Average paid Per Claimant **$15,100**	Average paid Per Claimant **$11,493**	Average paid Per Claimant **$8,218**
Member Engagement **94.0%**	Member Engagement **98.3%**	Member Engagement **92.9%**	Member Engagement **93.6%**



**Data obtained for this slide is for Eval period Nov-2019 thru Oct-2020*

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Catastrophic Cases
High Cost Claimants

Catastrophic Cases Summary (>$50k)

2.54 Catastrophic Cases Per 1000

Prior: ▲ 1.54%

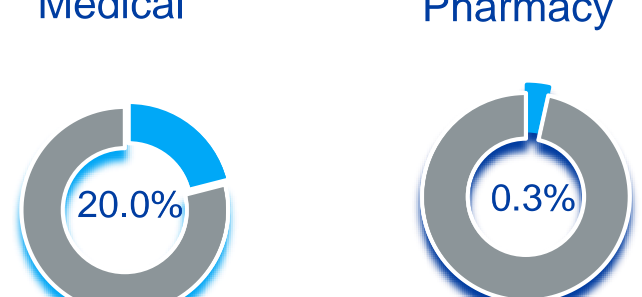
16 Individuals
.23% of the population

$82,203
Average Paid Per Case

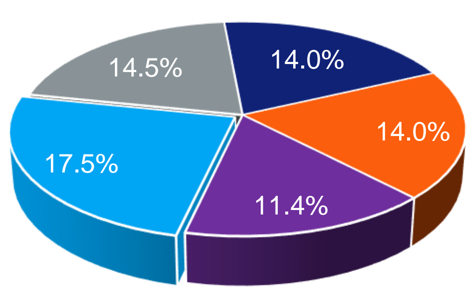
Prior: $81,717 ▲ 0.6%

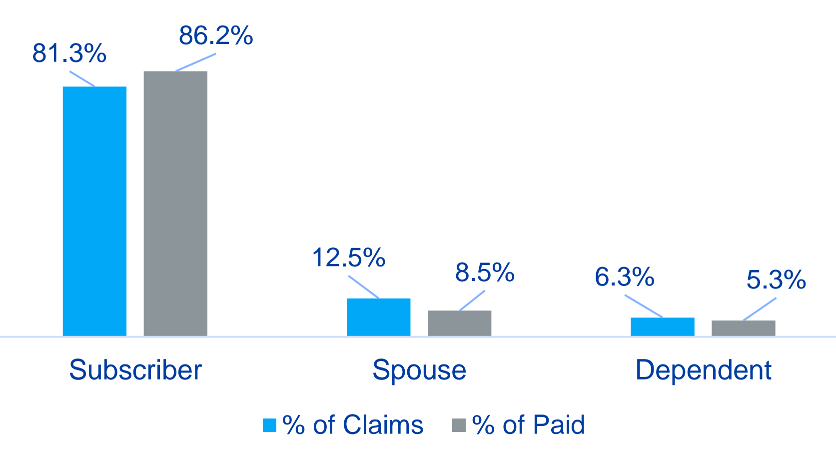
% of Spend as High Cost
14.3%

% Paid Attributed to Catastrophic Cases



- Injury and poisoning
- Infectious diseases
- Circulatory system
- Neoplasms
- Genitourinary system





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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 September 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 September 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 September 30, 2020:

        4.3.1 HealthSCOPE Benefits – Obesity Care Management

HSB DATASCOPE™

Obesity Care Management Report

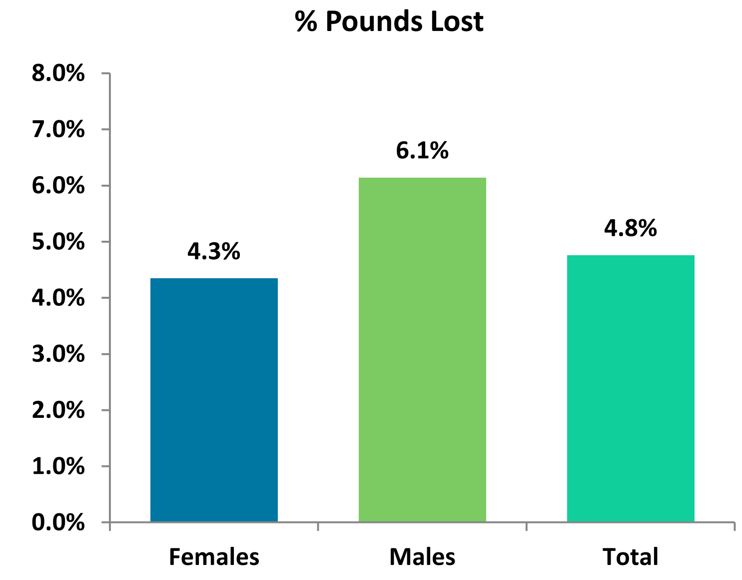
Nevada Public Employees' Benefits Program

July – September 2020

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

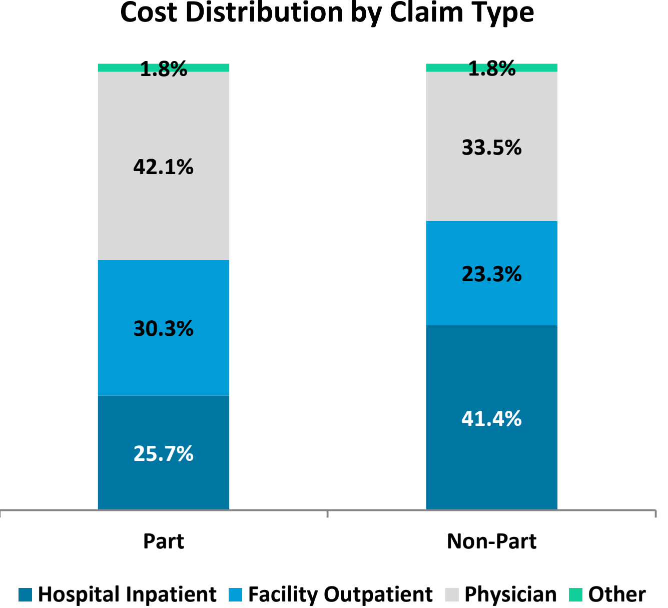
PEBP 1Q21			
Weight Management Summary	**Females**	**Males**	**Total**
# Mbrs Enrolled in Program	896	232	1,128
Average # Lbs. Lost	9.3	15.1	10.5
Total # Lbs. Lost	8,325.3	3,510.5	11,835.8
% Lbs. Lost	4.3%	6.1%	4.8%
Average Cost/ Member	$4,892	$4,724	$4,858



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	989	538	84.0%
Avg # Members	1,105	715	54.4%
Member/Employee Ratio	1.1	1.3	-15.8%
Financial Summary			
Gross Cost	$1,795,168	$1,847,321	
Client Paid	$1,325,704	$1,539,491	
Employee Paid	$469,464	$307,831	
Client Paid-PEPY	$5,360	$11,453	-53.2%
Client Paid-PMPY	$4,800	$8,609	-44.2%
Client Paid-PEPM	$447	$954	-53.1%
Client Paid-PMPM	$400	$717	-44.2%
High Cost Claimants (HCC's) > $100k			
# of HCC's	1	1	
HCC's / 1,000	0.9	1.4	0.0%
Avg HCC Paid	$128,926	$309,125	0.0%
HCC's % of Plan Paid	9.7%	20.1%	0.0%
Cost Distribution - PMPY			
Hospital Inpatient	$1,233	$3,568	-65.4%
Facility Outpatient	$1,456	$2,005	-27.4%
Physician	$2,023	$2,882	-29.8%
Other	$88	$154	-42.9%
Total	$4,800	$8,609	-44.2%
	Annualized	Annualized	



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	24	18	
# of Bed Days	131	164	
Paid Per Admit	$14,789	$35,440	-58.3%
Paid Per Day	$2,709	$3,890	-30.4%
Admits Per 1,000	87	101	-13.9%
Days Per 1,000	474	917	-48.3%
Avg LOS	5.5	9.1	-39.6%
Physician Office			
OV Utilization per Member	9.3	7.5	24.0%
Avg Paid per OV	$75	$57	31.6%
Avg OV Paid per Member	$700	$431	62.4%
DX&L Utilization per Member	15.5	19.0	-18.4%
Avg Paid per DX&L	$51	$50	2.0%
Avg DX&L Paid per Member	$791	$948	-16.6%
Emergency Room			
# of Visits	66	42	
# of Admits	12	6	
Visits Per Member	0.24	0.23	4.3%
Visits Per 1,000	239	235	1.7%
Avg Paid per Visit	$1,938	$3,020	-35.8%
Admits Per Visit	0.18	0.14	28.6%
Urgent Care			
# of Visits	107	66	
Visits Per Member	0.39	0.37	5.4%
Visits Per 1,000	387	369	4.9%
Avg Paid per Visit	$101	$91	11.0%
	Annualized	Annualized	

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 September 30, 2020:

      4.3.1 HealthSCOPE Benefits – Obesity Care Management

      4.3.2 HealthSCOPE Benefits – Diabetes Care Management

HSB DATASCOPE™

Diabetes Care Management Report

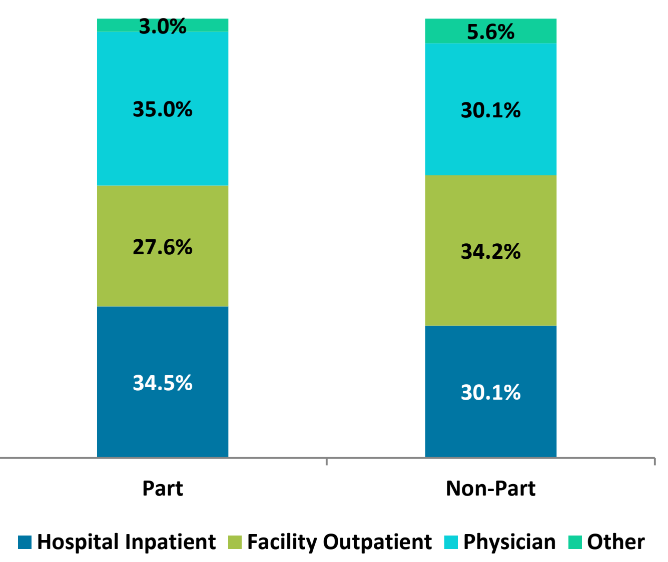
Nevada Public Employees' Benefits Program

July – September 2020

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	409	1,379	-70.3%
Avg # Members	586	1,752	-66.6%
Member/Employee Ratio	1.4	1.3	12.6%
Financial Summary			
Gross Cost	$1,350,441	$4,422,538	
Client Paid	$1,074,542	$3,613,548	
Employee Paid	$275,899	$808,990	
Client Paid-PEPY	$10,500	$10,484	0.2%
Client Paid-PMPY	$7,335	$8,249	-11.1%
Client Paid-PEPM	$875	$874	0.1%
Client Paid-PMPM	$611	$687	-11.1%
High Cost Claimants (HCC's) > $100k			
# of HCC's	2	6	
HCC's / 1,000	3.4	3.4	0.0%
Avg HCC Paid	$189,553	$129,990	0.0%
HCC's % of Plan Paid	35.3%	21.60%	0.0%
Cost Distribution - PMPY			
Hospital Inpatient	$2,528	$2,486	1.7%
Facility Outpatient	$2,021	$2,819	-28.3%
Physician	$2,568	$2,479	3.6%
Other	$217	$465	-53.3%
Total	$7,335	$8,249	-11.1%
	Annualized	Annualized	



Diabetes Care Management – Utilization Summary

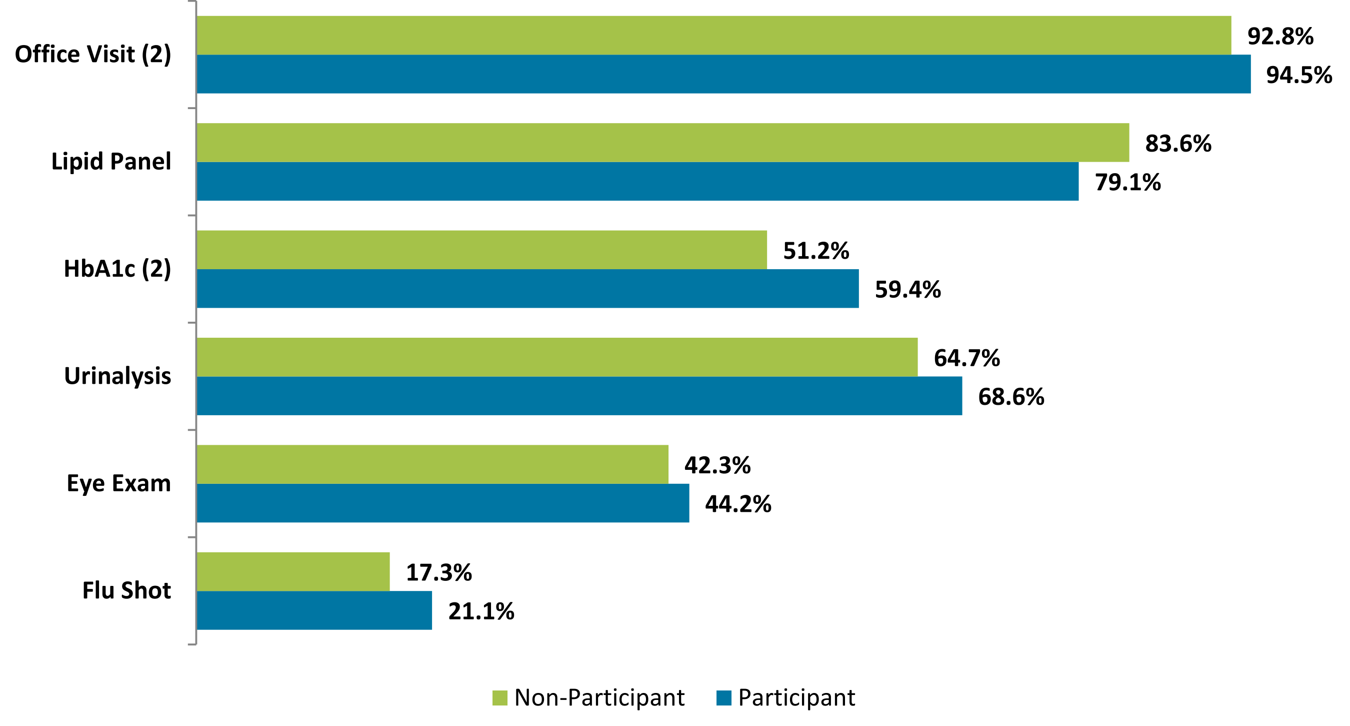
*Non-Participant is defined as a member who has been diagnosed with diabetes in the past 12 months, but is not enrolled in the program
*Analysis based on active members

Summary	Participants	Non-Participants	Variance
Inpatient Facility			
# of Admits	9	61	
# of Bed Days	58	248	
Paid Per Admit	$39,548	$16,128	145.2%
Paid Per Day	$6,137	$3,967	54.7%
Admits Per 1,000	61	139	-56.1%
Days Per 1,000	396	566	-30.0%
Avg LOS	6.4	4.1	56.1%
Physician Office			
OV Utilization per Member	6.3	8.1	-22.2%
Avg Paid per OV	$55	$55	0.0%
Avg OV Paid per Member	$348	$443	-21.4%
DX&L Utilization per Member	16.2	21.3	-23.9%
Avg Paid per DX&L	$49	$63	-22.2%
Avg DX&L Paid per Member	$793	$1,333	-40.5%
Emergency Room			
# of Visits	20	127	
# of Admits	4	38	
Visits Per Member	0.14	0.29	-51.7%
Visits Per 1,000	137	290	-52.8%
Avg Paid per Visit	$1,711	$2,161	-20.8%
Admits Per Visit	0.20	0.30	-33.3%
Urgent Care			
# of Visits	25	131	
Visits Per Member	0.17	0.3	-43.3%
Visits Per 1,000	171	299	-42.8%
Avg Paid per Visit	$99	$110	-10.0%
	Annualized	Annualized	

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	421	1,857



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 September 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 Benefit Program – State of Nevada

Medical Management Review

Q1 2021

July 1, 2020 – September 30, 2020

Table of Contents

Executive Overview

- Return on Investment

Medical Management Summary

- Utilization Management
- Case Management
- Post-Discharge Counseling

Executive Overview

Overview

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

All data included is as of **October 31, 2020** and covers the reporting period of **July 01, 2020 – September 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 – Year Over Year Comparison

- 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

April 1, 2020 - June 30, 2020			
	Fees	Estimated Savings	ROI
Utilization Management	$198,736	$1,020,153	5.1 to 1
Case Management	$297,255	$1,343,926	4.5 to 1
Total	$495,991	$2,364,079	4.8 to 1

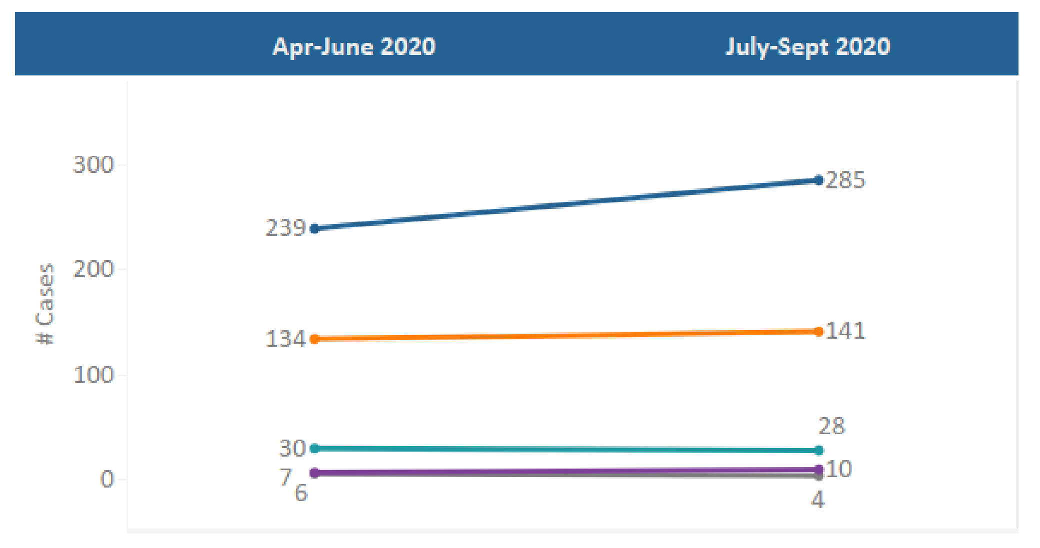
Utilization Management Breakout	
Inpatient Savings	$593,782
Outpatient Savings	$426,371

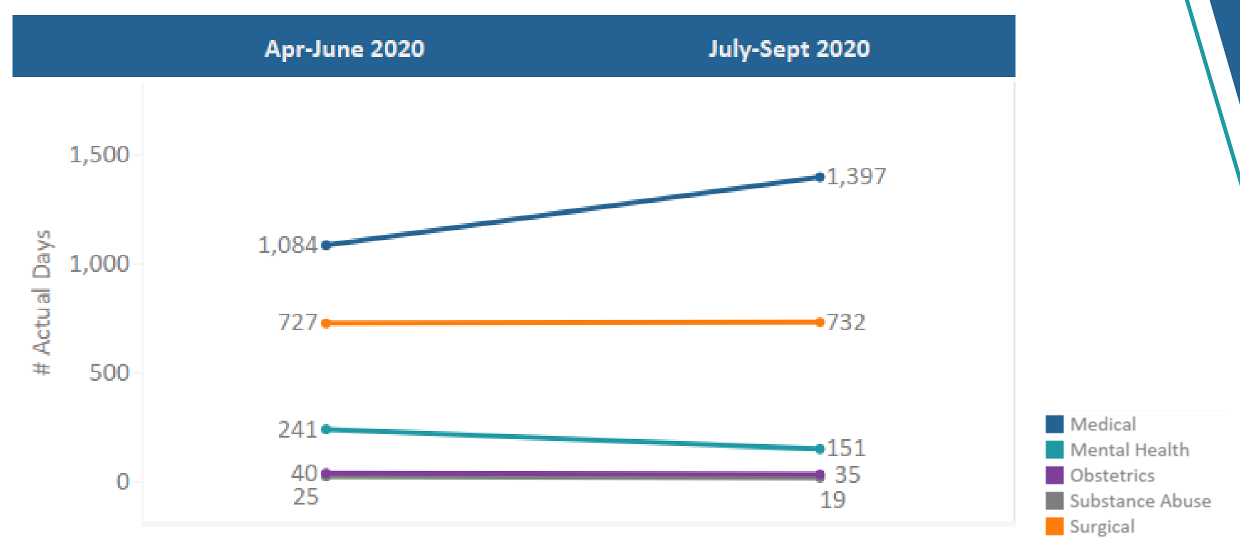
July 1, 2020 - September 30, 2020			
	Fees	Estimated Savings	ROI
Utilization Management	$196,284	$1,442,760	7.4 to 1
Case Management	$293,587	$860,907	2.9 to 1
Total	$489,871	$2,303,667	4.7 to 1

Utilization Management Breakout	
Inpatient Savings	$834,445
Outpatient Savings	$608,315

Utilization Management

Acute Inpatient Activity Summary



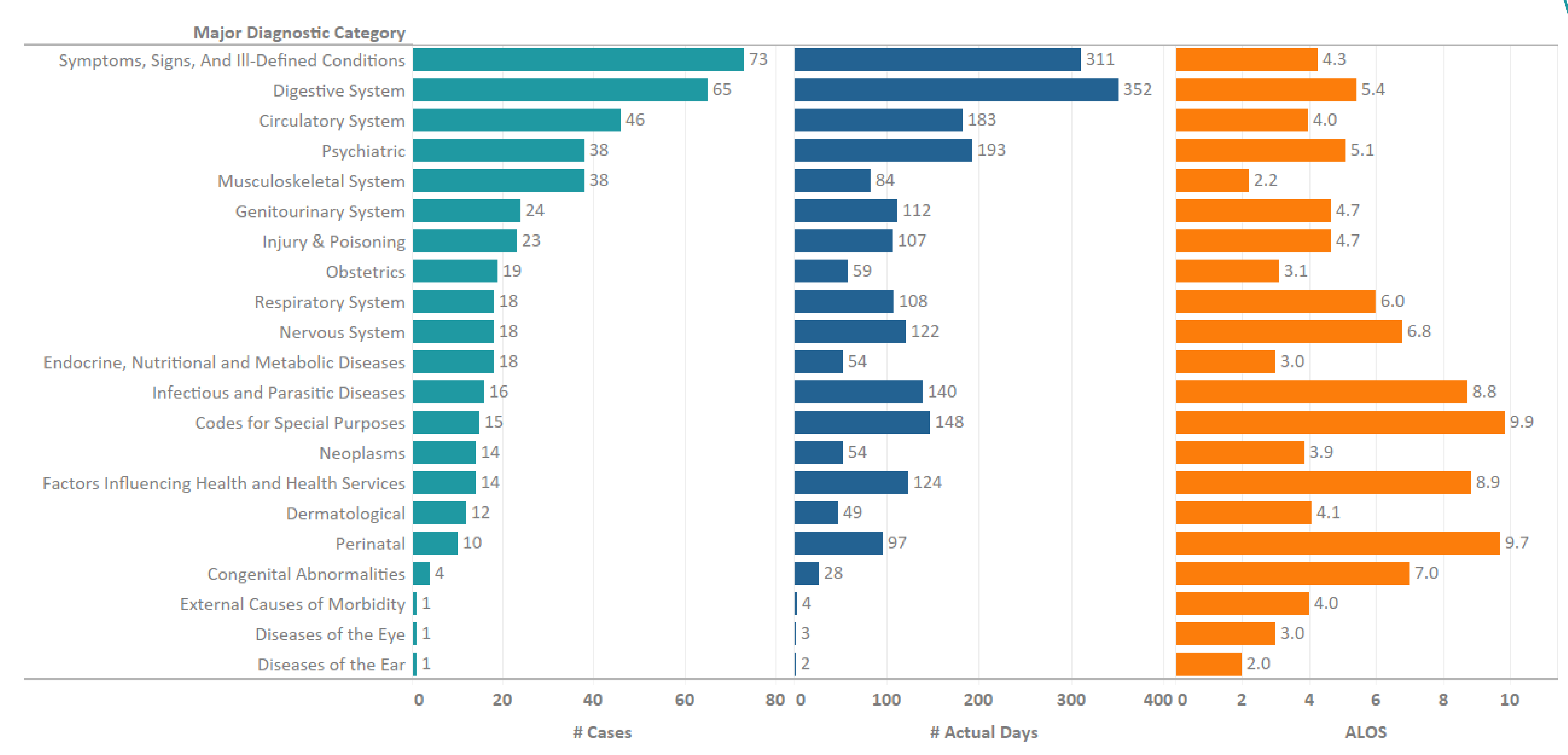


Utilization Review Process

Days Saved: 89
Estimated Savings: $777,447

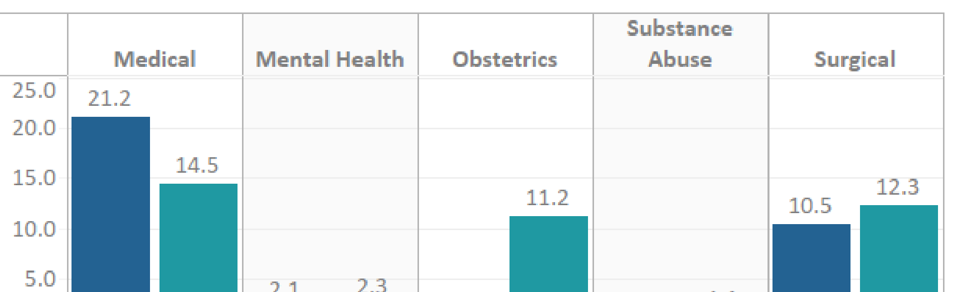
July 1, 2020 - September 30, 2020						
	Cases	Actual Days	Requested Days	Approved Days	Saved Days	Estimated Savings
Medical	285	1,397	1,412	1,362	50	$307,917
Surgical	141	732	740	704	36	$465,516
Mental Health	28	151	151	149	2	$2,773
Substance Abuse	4	19	19	18	1	$1,242
Obstetrics	10	35	35	35	0	$0
Grand Total	**468**	**2,334**	**2,357**	**2,268**	**89**	**$777,447**

Acute Inpatient – Case and Actual Days by Diagnostic Categories



Acute Inpatient Activity – Utilization Benchmarks

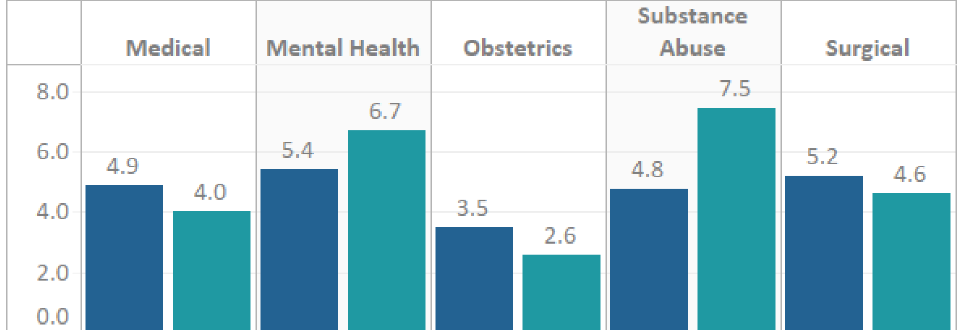
Admissions per 1,000



Days per 1,000

Medical
Mental Health
Obstetrics
Substance Abuse
Surgical
125.0
100.0
75.0
50.0
25.0
0.0
103.7
58.2
11.2
15.5
2.6
28.7
1.4
8.0
54.4
56.6

ALOS



Admissions per 1,000

- Medical: Admissions were 46.2% higher than the Milliman Benchmark.
  - **24** members had **2 or more** inpatient admissions

Days per 1,000

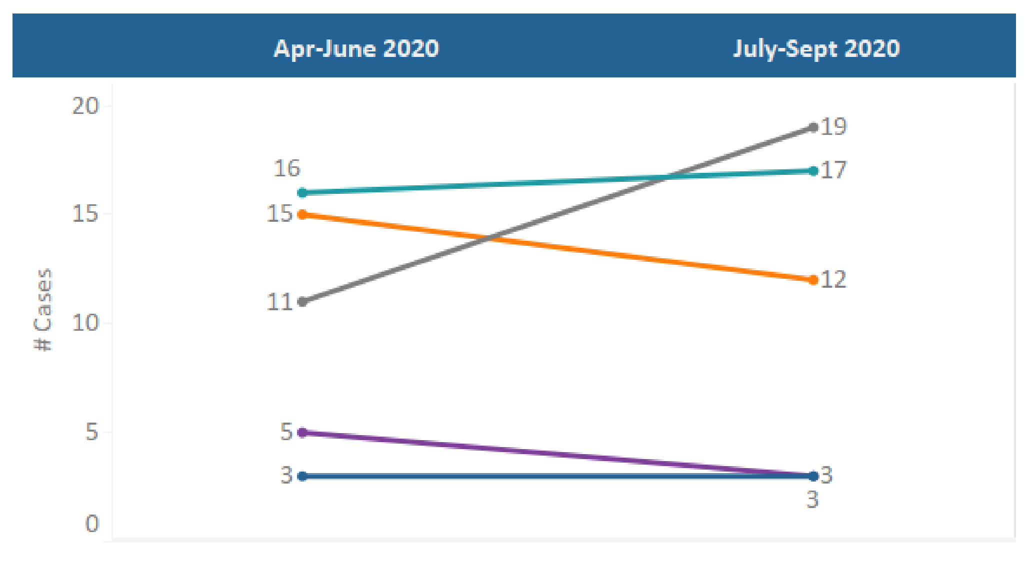
- Medical: Days were 78.2% higher than the Milliman Benchmark.
  - **33** cases utilized **10 or more** days during the report period

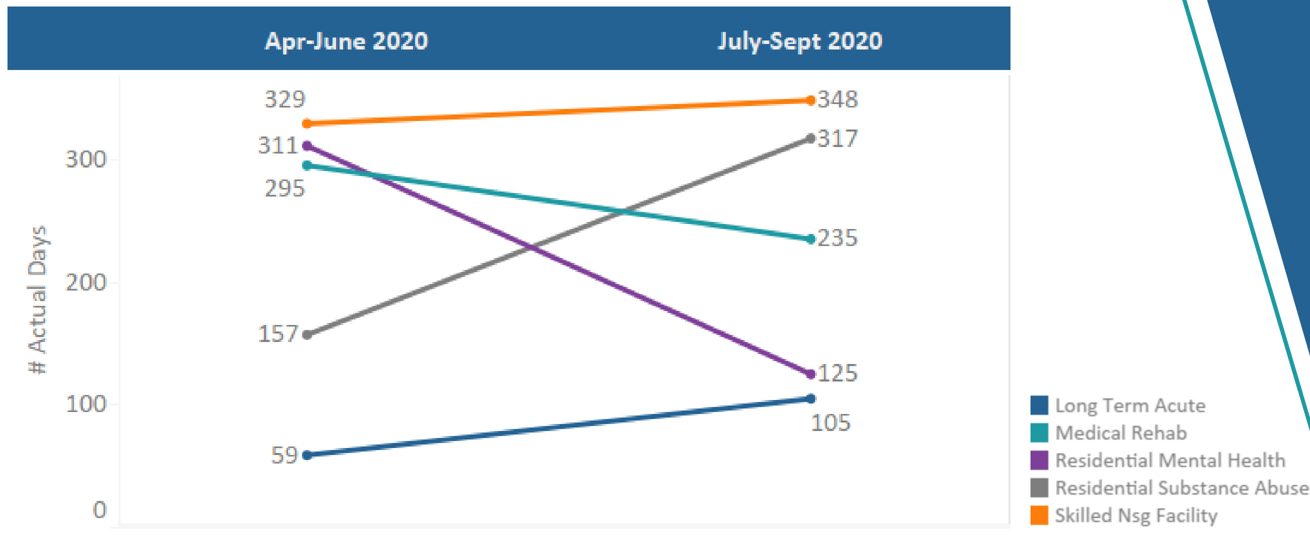
Average Length of Stay

- Medical: ALOS was 0.9 days higher than the Milliman Benchmark.
  - Removal of **10** outlier cases that consumed **23 or more** days each resulted in an ALOS of 3.9
- Obstetrics: ALOS was 0.9 days higher than Milliman Benchmark.
  - Removal of **5** outlier cases that consumed **4 or more** days each resulted in an ALOS of 2.4
- Surgical: ALOS was 0.6 days higher than Milliman Benchmark.
  - Removal of **2** outlier cases that consumed **49 or more** days resulted in an ALOS of 4.4

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



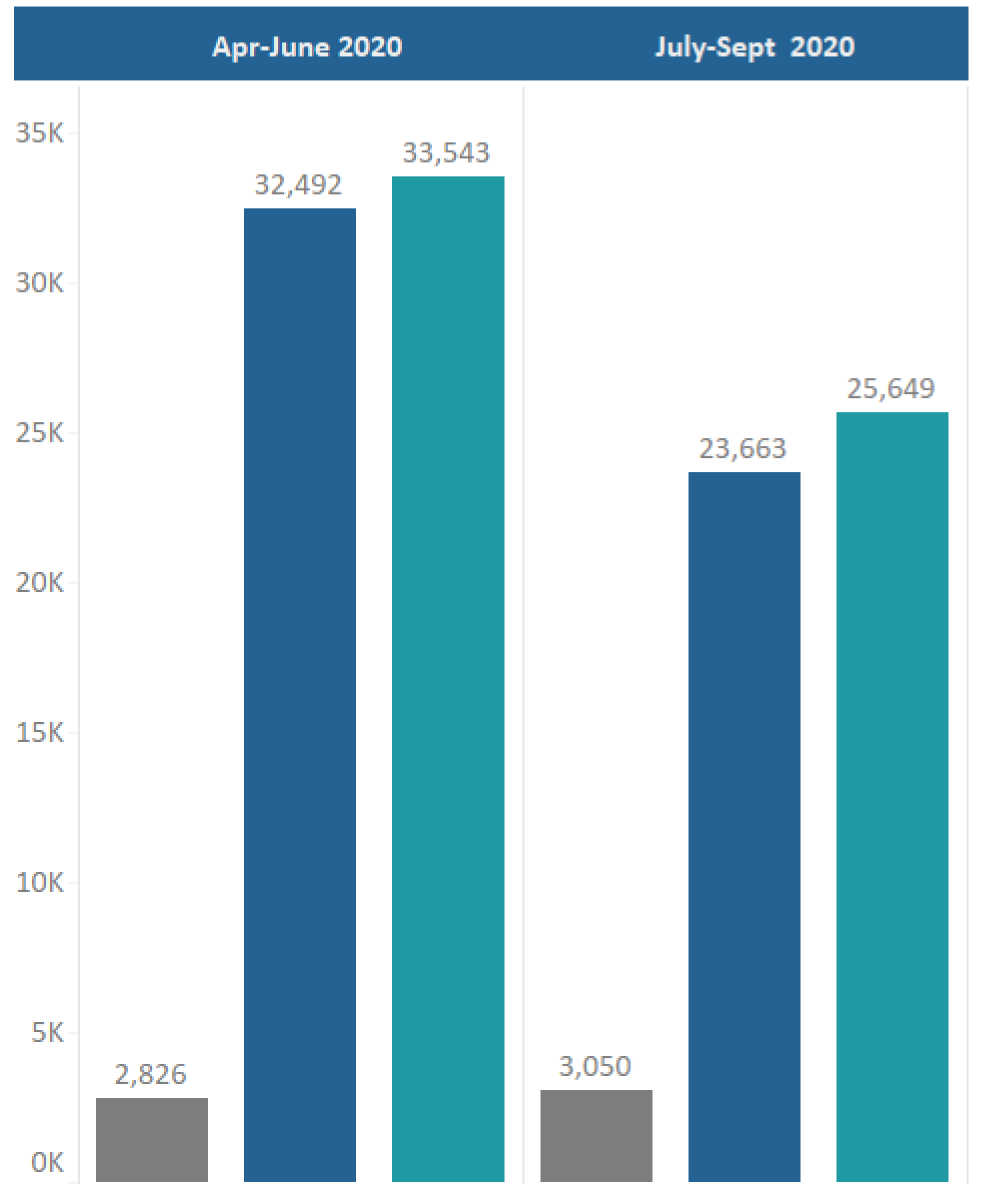


Utilization Review Process

Days Saved: 35
Estimated Savings: $56,998

July 1, 2020 - September 30, 2020						
	Cases	Actual Days	Requested Days	Approved Days	Saved Days	Estimated Savings
Residential Substance Abuse	19	317	317	316	1	$903
Skilled Nsg Facility	12	348	355	332	23	$15,659
Medical Rehab	17	235	244	242	2	$5,705
Long Term Acute	3	105	105	96	9	$34,731
Residential Mental Health	3	125	128	128	0	$0
Grand Total	**54**	**1,130**	**1,149**	**1,114**	**35**	**$56,998**

Outpatient Activity Summary

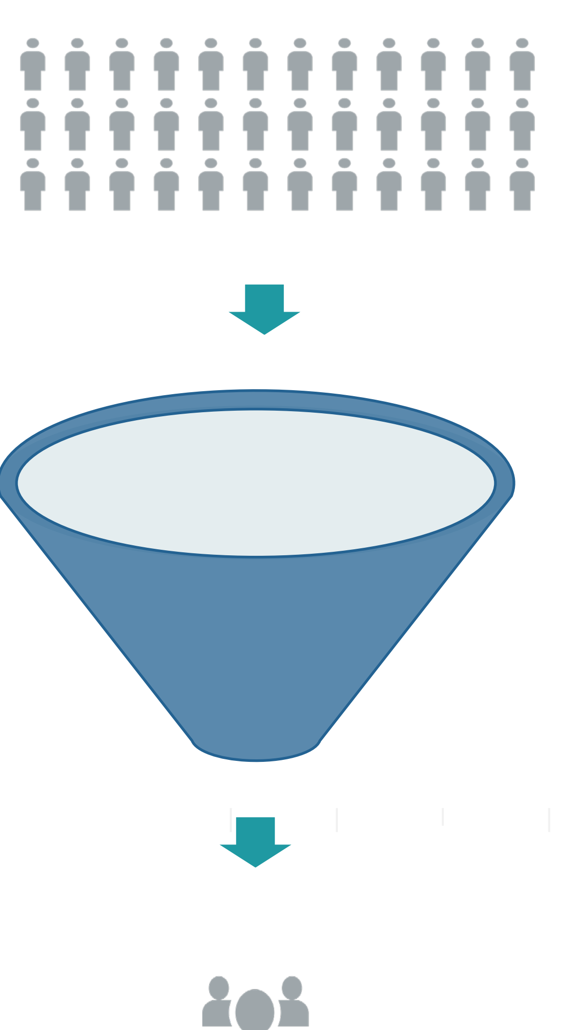


July 1, 2020 - September 30, 2020					
Outpatient Setting	# Cases	# Units Requested	# Units Approved	# Units Saved	Outpatient Savings
Diagnostic Test	1,622	2,132	1,931	201	$195,907
Surgery	617	1,099	1,086	13	$19,533
Med Treatment	492	7,249	7,019	230	$333,147
DME	199	10,910	9,793	1,117	$32,740
Home Health	66	1,185	1,094	91	$16,038
MH/SA	24	333	333	0	$0
Home Infusion	22	2,275	1,972	303	$0
PT/OT/ST	4	135	135	0	$0
Home Enteral Feeding	3	238	238	0	$0
Hospice Home	1	93	62	31	$10,951
Grand Total	**3,050**	**25,649**	**23,663**	**1,986**	**$608,315**

Utilization Review Process

Units Saved: 1,986
Estimated Savings: $608,315

Case Management Referrals from Utilization Management



- **522** inpatient cases were completed in Utilization Review
- **3,050** outpatient cases were completed in Utilization Review

---

- **307** inpatient cases **(58.8%)** automatically triggered to Case Management
- **715** outpatient cases **(23.4%)** automatically triggered to Case Management

---

- **194** inpatient cases **(63.2%)** were deemed appropriate for Case Management
- **31** outpatient cases **(4.3%)** were deemed appropriate for Case Management

Case Management

Case Management Summary

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

Total Case Management Savings

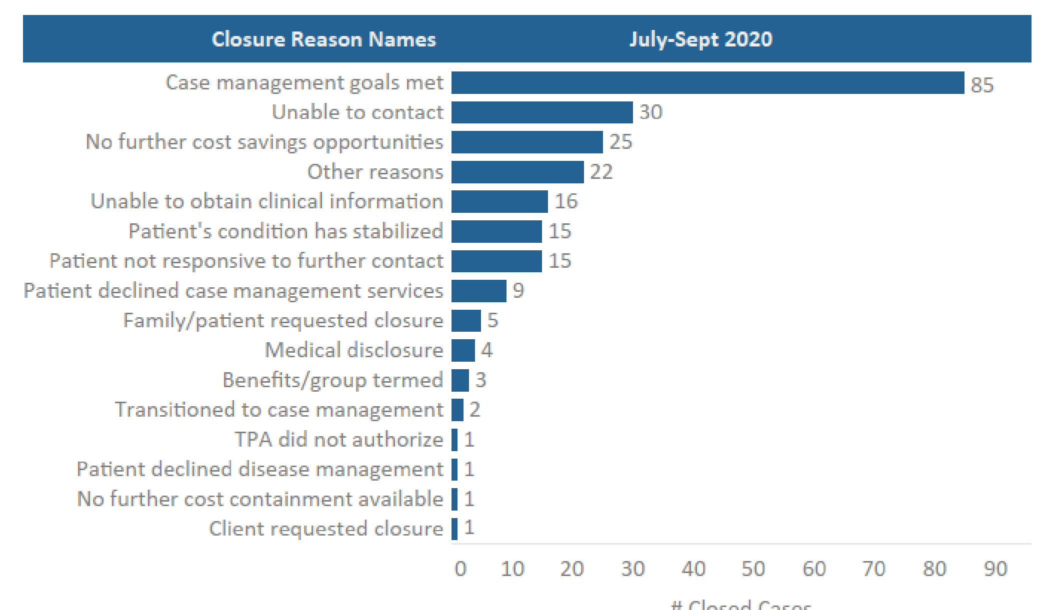
$860,907

Average Savings per Case = $2,225

Based on 387 cases in an open state between 07/01/2020 – 09/30/2020

Number of Cases

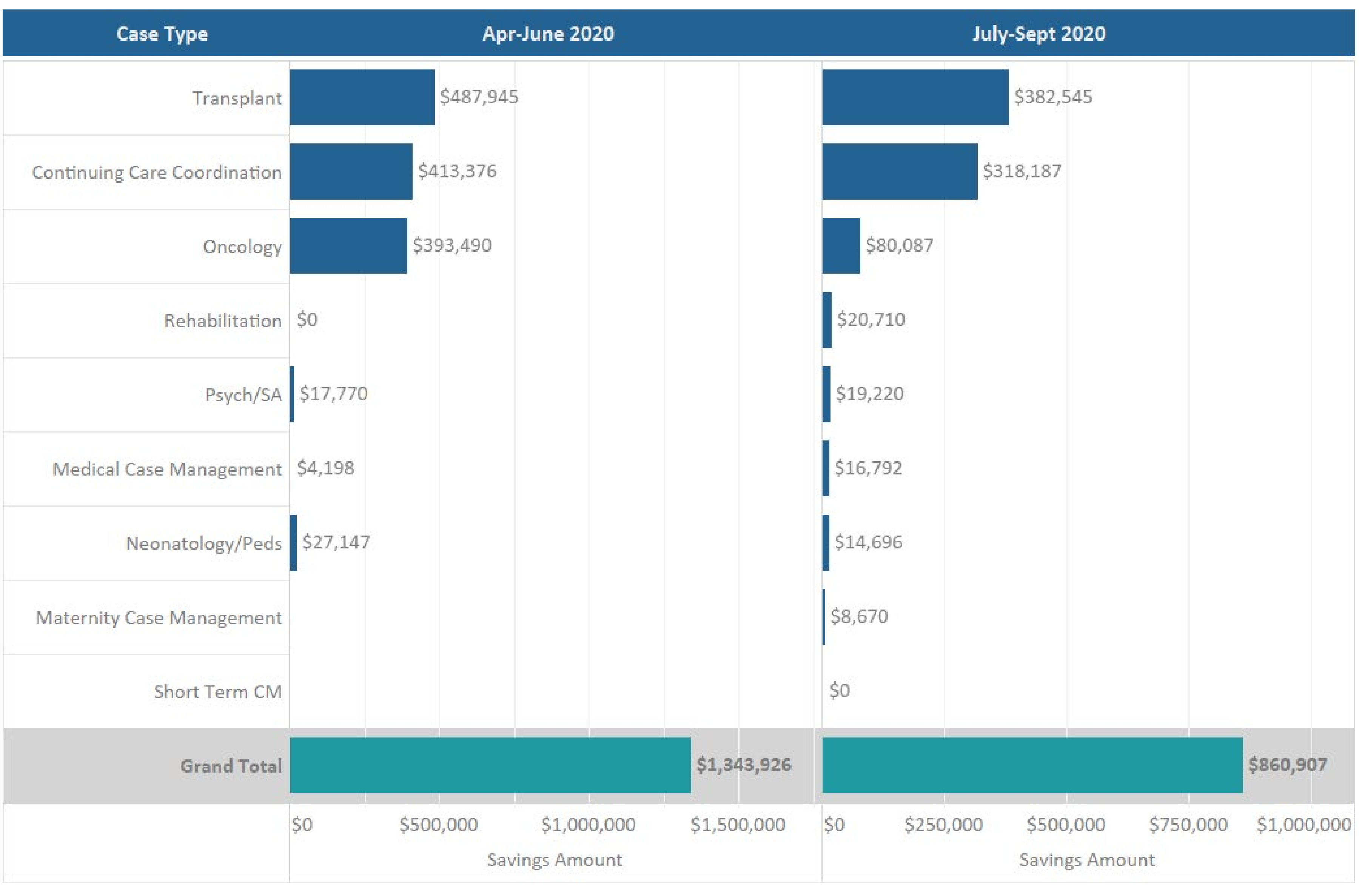
Case Activity	Apr-June 2020	July-Sept 2020
# Beginning Cases	193	200
# Opened Cases	135	187
# Closed Cases	128	213
# Ending Cases	200	174



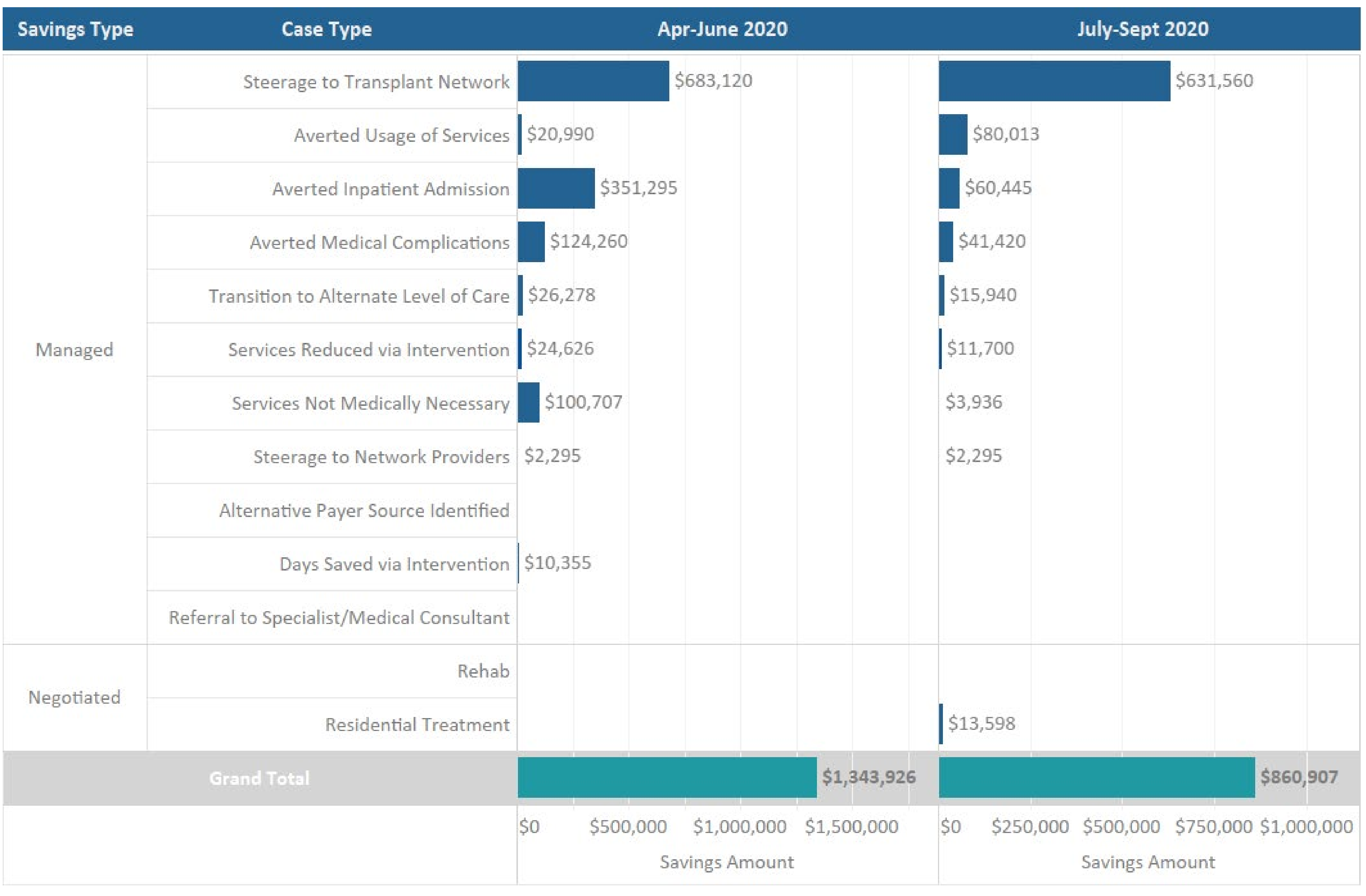
Total number of closure reasons may be greater than the number of cases as cases may have more than one closure reason.

Case Type	July-Sept 2020
Continuing Care Coordination	114
Short Term CM	95
Bariatric	51
Oncology	43
Psych/SA	19
Medical Case Management	18
Neonatology/Peds	16
Advocacy	14
Transplant	11
Rehabilitation	4
Maternity Case Management	1
Air Evacuation	1
Research and Review	0
Grand Total	**387**

Case Management – Savings by Case Type



Case Management – Savings by Source



Post-Discharge Counseling

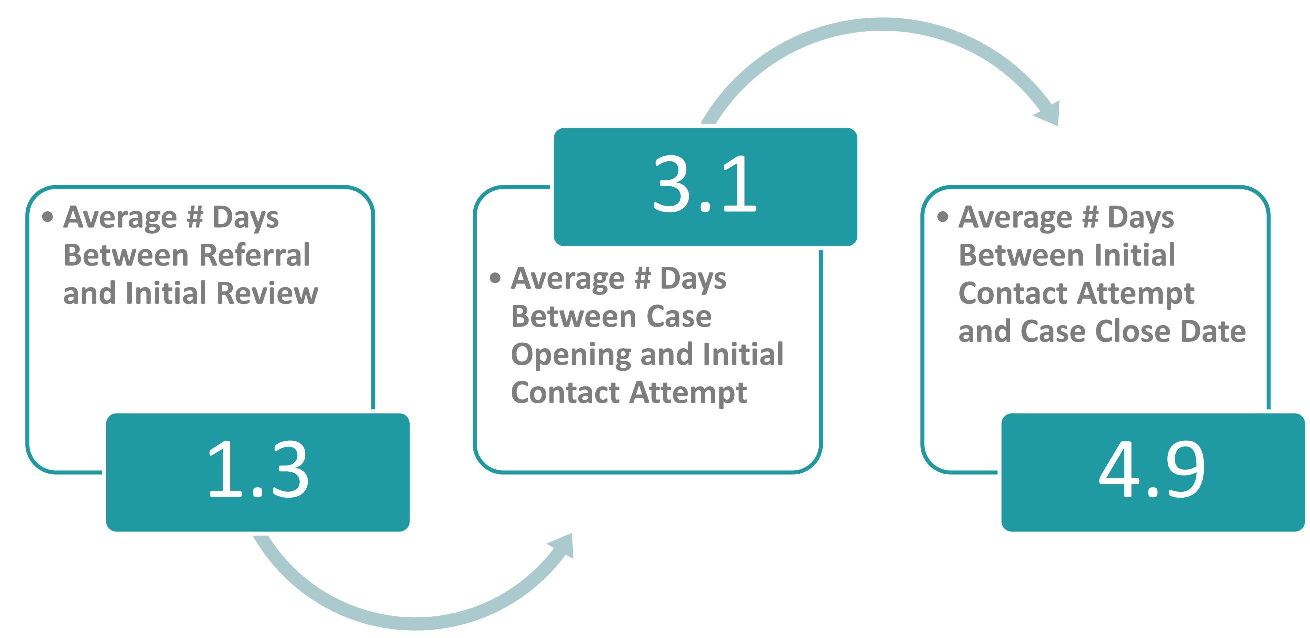
Post-Discharge Counseling – Participation Summary

Program Metric	July 1, 2020 – September 30, 2020
# Cases Identified	272
# Participating Cases	92
% of Cases with Successful Outreach	**33.8%**

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

Post-Discharge Counseling – Turnaround Time

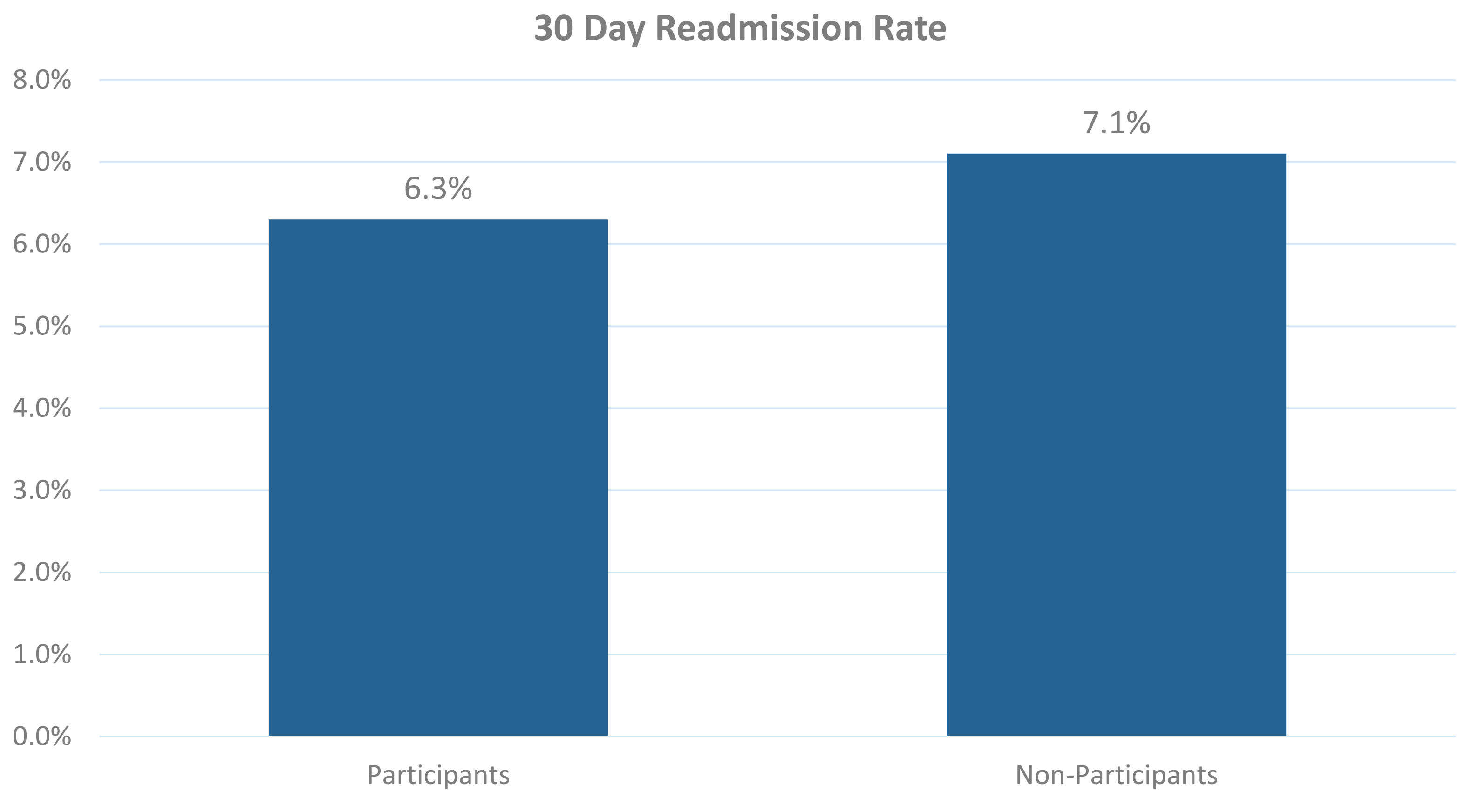
Below is a summary of the average turnaround times for the Post-Discharge Counseling program. Following a referral to the Post-Discharge Counseling program, the CMC will complete an initial review of the case and determine if the case is appropriate for the program. Once the case is reviewed and deemed 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 7.0 days

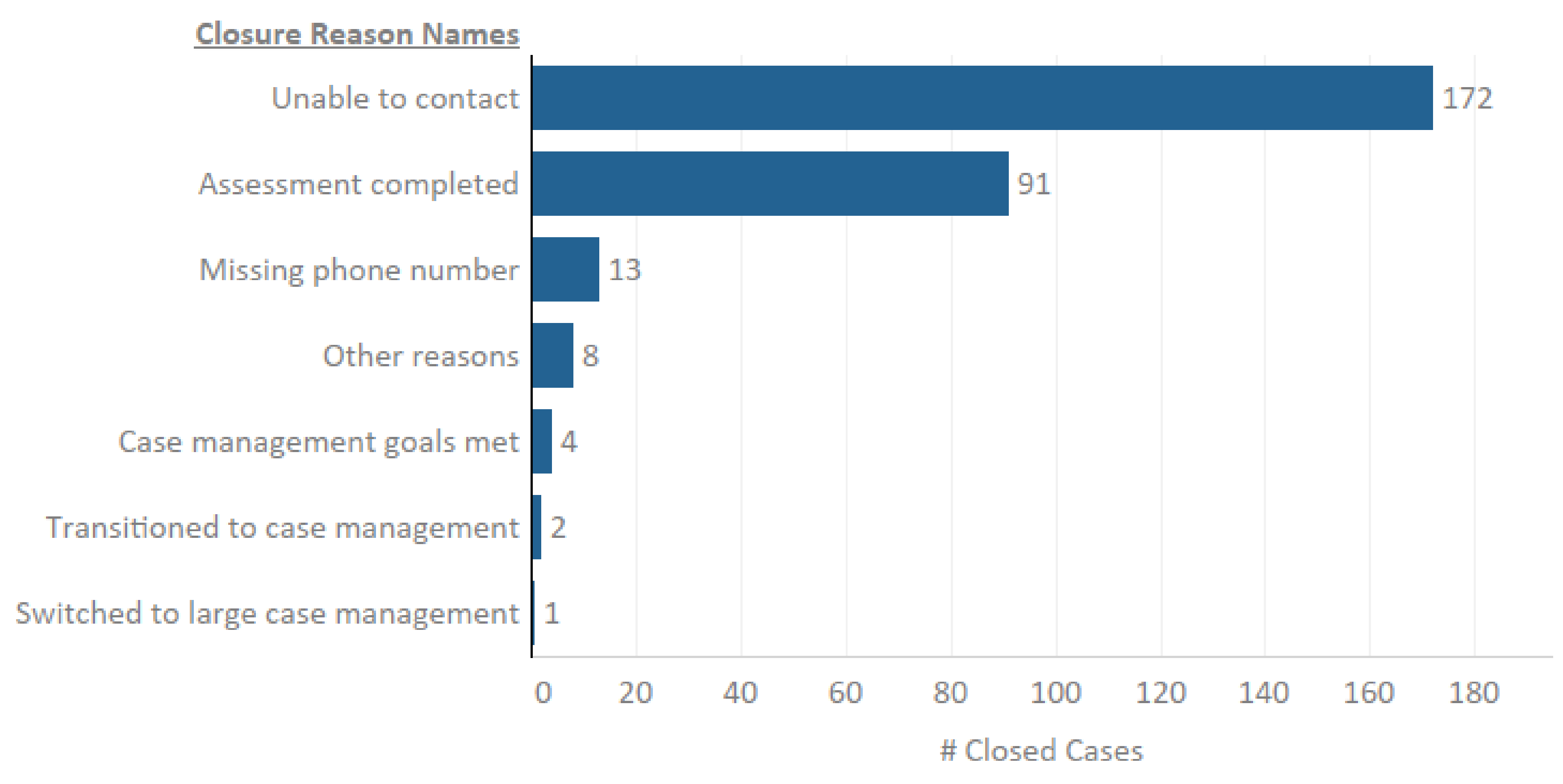
Post-Discharge Counseling – 30-Day Readmission Rate

There were 3 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 60.9% of acute inpatient cases and 59.9% of actual days
- Medical was higher than the Milliman benchmark for acute inpatient admissions, days, and ALOS
- Diagnostic Test represented 53.2% of all outpatient cases and accounted for 32.2% of savings
- Continuing Care Coordination made up 29.5% of case management case types

Insights

- Symptoms, Signs, and Ill-Defined Conditions represented approximately 20.5% of acute inpatient Medical cases and actual days
- Although Factors Influencing Health and Health Services represented only 6.4% of Medical actual days, it attributed to the largest Medical ALOS of 12.7
- Symptoms, Sign, and Ill-Defined Conditions represented approximately 24.7% of Diagnostic Test outpatient cases, units requested, and units approved
- Psychiatric and Neoplasms major diagnostic categories accounted for 63.2% of open CM Continuing Care Coordination cases

tary

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 September 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
September 30, 2020

Board Meeting Date: November 23, 2020

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Basic Life Insurance & Long Term Disability Executive Summary

Most Recent Five Plan Years: July 01, 2016 to September 30, 2020

This is the initial report for the 2020-21 plan year, providing information for the most recent 5-year plan period, beginning July 1, 2016 and ending September 30, 2020.

Basic Life

Because this is the first report for the plan year, there's not much to report on an incidence basis for Basic Life. Incidence (page 4) is reported on an incurred rather than paid basis. There were 5 employee claims incurred during the first quarter, along with 31 retiree claims. For the recently completed 2019-20 plan year, the overall Basic Life incidence was down, 5.7 claims per 1,000 insureds compared to the most recent five-year average of 8.0. Incidence for both employees and retirees contributed to those results with active employees at 1.4 claims and retirees at 13.2 claims per 1,000, compared to five-year averages of 1.7 and 18.14, respectively.

The Basic Life loss ratio for active employees (page 5) for the most recent quarter was 24%. For the 2019-20 plan year, the loss ratio for active employees was 27%, a slight decrease from the prior year which was 28%. Retirees resulted in a 377% loss ratio for the most recent quarter, compared to a 254% loss ratio for the 2019-20 plan year. Overall, the most recent quarter's combined Basic Life loss ratio was 105%, compared to most recent 2019-20 plan year loss ratio of 78%.

Long Term Disability

With only one quarter of information, there is little credibility to LTD claim experience for the current plan year. We approved 1 new claim incurred during the quarter. Low claim incidence is common in the first quarter results when you look at the same periods in prior years. LTD claim incidence (page 7) for the 2019-20 plan year resulted in 21 new claims during the entire plan year, an incidence of 0.8 claims per 100, below the five-year average of 1.08.

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 resulted in 96%. This trended higher than the 42% loss ratio in the 2018-2019 plan year. The first quarter loss ratio is 0% for the 2020-21 plan year. This is primarily due to a significant decrease in active claim reserves offsetting the total claim cost for this period.

Basic Life Insurance Claims by Plan Year and Participant Type

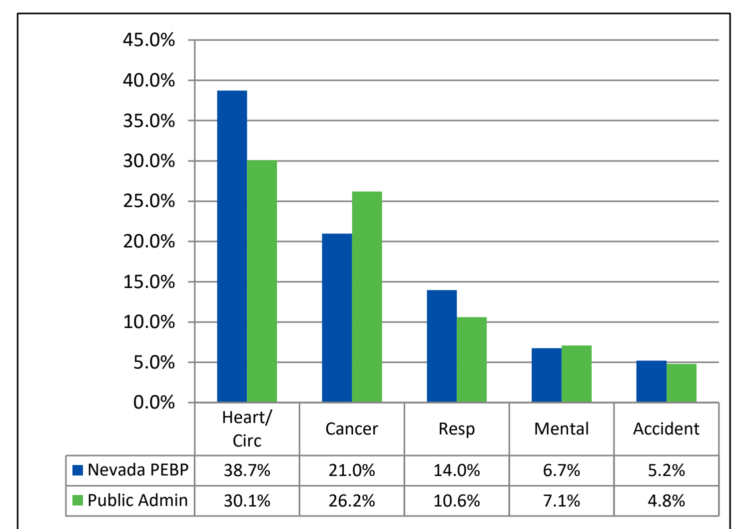
Most Recent Five Plan Years: July 01, 2016 to September 30, 2020

	From Jul-16 Through Jun-17		From Jul-17 Through Jun-18		From Jul-18 Through Jun-19		From Jul-19 Through Jun-20		From Jul-20 Through Jun-21	
Participant Type	**Count**	**Inc./ 1000**	**Count**	**Inc./ 1000**	**Count**	**Inc./ 1000**	**Count**	**Inc./ 1000**	**Count**	**Inc./ 1000**
Actives	51	2.0	41	1.6	47	1.8	46	1.7	5	0.2
Retirees	325	21.8	295	19.5	278	17.7	272	17.2	31	1.9
Totals	**376**	**9.6**	**336**	**8.4**	**325**	**7.9**	**318**	**7.4**	**36**	**0.8**

Basic Life Insurance Claims by Diagnostic Category

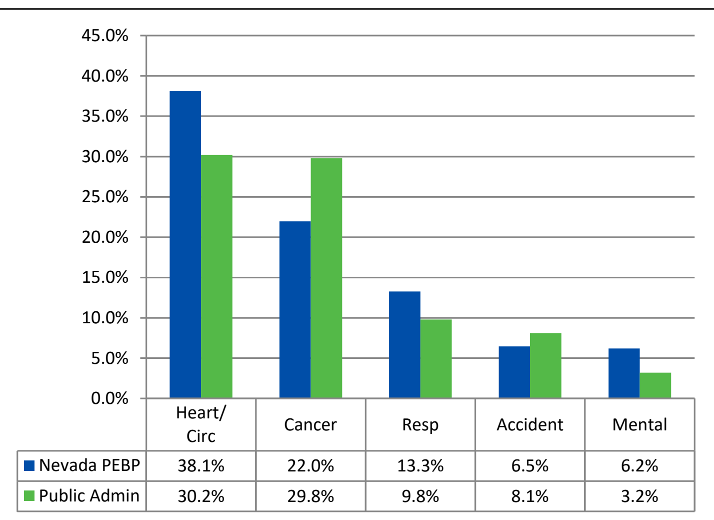
Public Admin benchmark is from SIC book of business for most recent 5 calendar years

Top Five Diagnostic Categories by Incidence



	Heart/ Circ	Cancer	Resp	Mental	Accident
Nevada PEBP	38.7%	21.0%	14.0%	6.7%	5.2%
Public Admin	30.1%	26.2%	10.6%	7.1%	4.8%

Top Five Diagnostic Categories by Liability

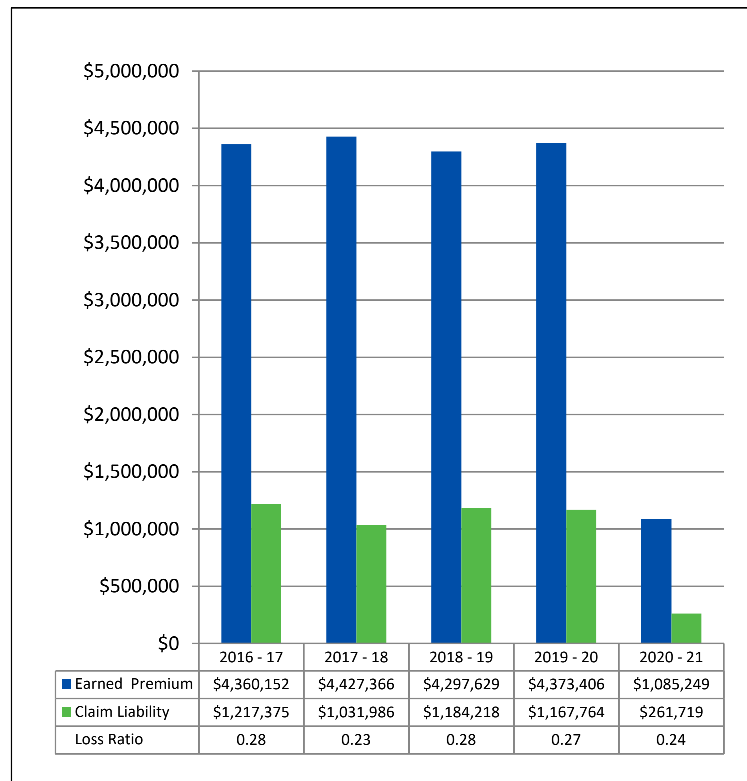


	Heart/ Circ	Cancer	Resp	Accident	Mental
Nevada PEBP	38.1%	22.0%	13.3%	6.5%	6.2%
Public Admin	30.2%	29.8%	9.8%	8.1%	3.2%

Basic Life Insurance Earned Premiums & Liability by Participant Type

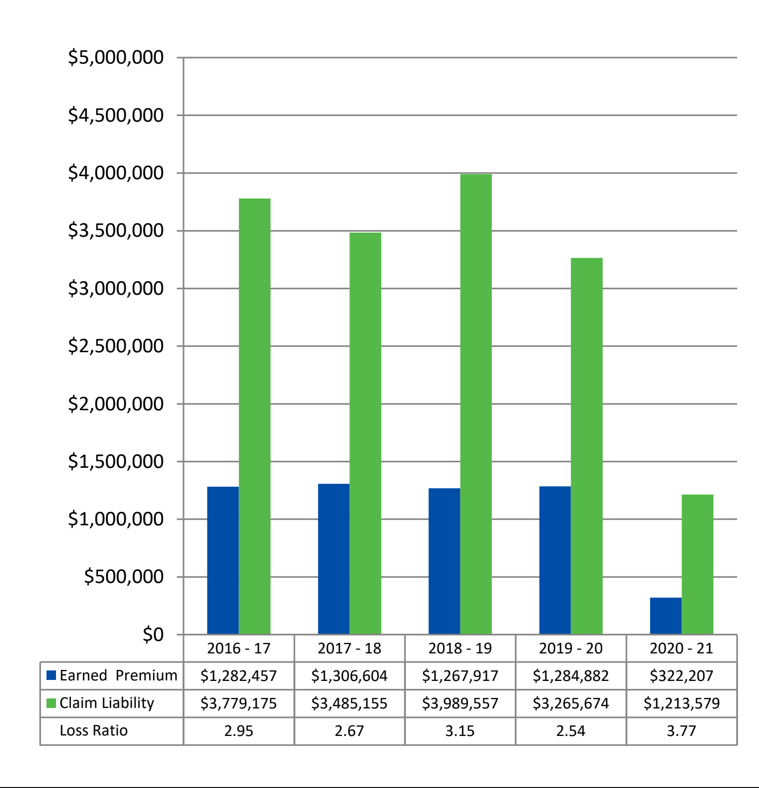
Most Recent Five Plan Years: July 01, 2016 to September 30, 2020

Active Participants



	2016 - 17	2017 - 18	2018 - 19	2019 - 20	2020 - 21
Earned Premium	$4,360,152	$4,427,366	$4,297,629	$4,373,406	$1,085,249
Claim Liability	$1,217,375	$1,031,986	$1,184,218	$1,167,764	$261,719
Loss Ratio	0.28	0.23	0.28	0.27	0.24

Retired Participants

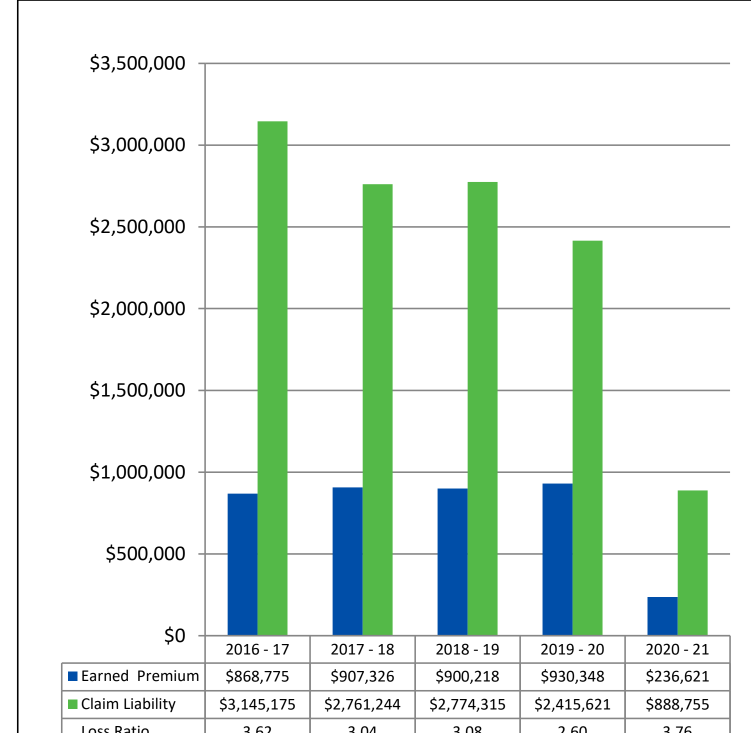


	2016 - 17	2017 - 18	2018 - 19	2019 - 20	2020 - 21
Earned Premium	$1,282,457	$1,306,604	$1,267,917	$1,284,882	$322,207
Claim Liability	$3,779,175	$3,485,155	$3,989,557	$3,265,674	$1,213,579
Loss Ratio	2.95	2.67	3.15	2.54	3.77

Basic Life Retiree Insurance Earned Premiums & Liability by Participant Type

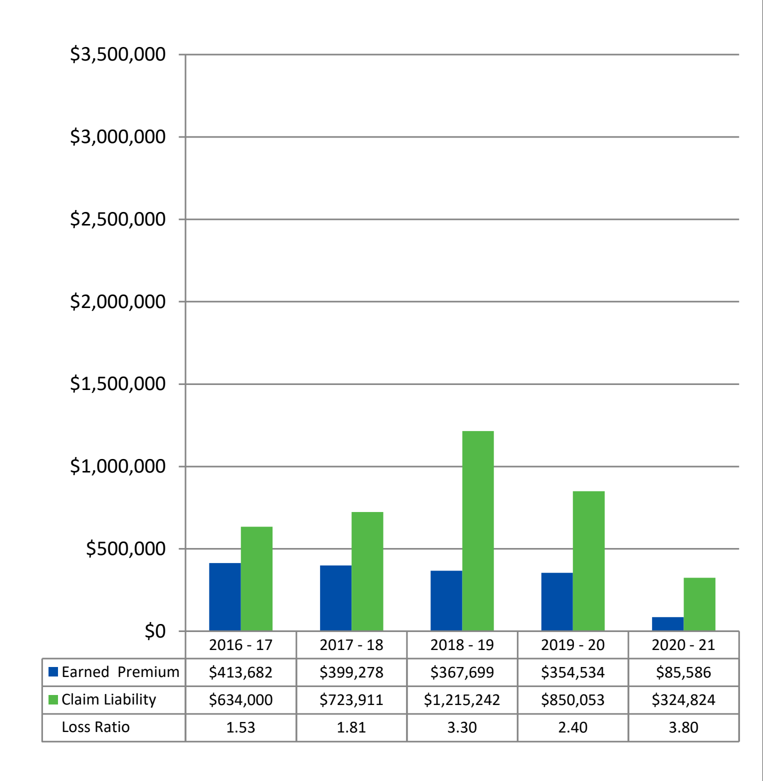
Most Recent Five Plan Years: July 01, 2016 to September 30, 2020

State Retired Participants



	2016 - 17	2017 - 18	2018 - 19	2019 - 20	2020 - 21
Earned Premium	$868,775	$907,326	$900,218	$930,348	$236,621
Claim Liability	$3,145,175	$2,761,244	$2,774,315	$2,415,621	$888,755
Loss Ratio	3.62	3.04	3.08	2.60	3.76

Non-State Retired Participants



	2016 - 17	2017 - 18	2018 - 19	2019 - 20	2020 - 21
Earned Premium	$413,682	$399,278	$367,699	$354,534	$85,586
Claim Liability	$634,000	$723,911	$1,215,242	$850,053	$324,824
Loss Ratio	1.53	1.81	3.30	2.40	3.80

Long Term Disability Claims by Plan Year

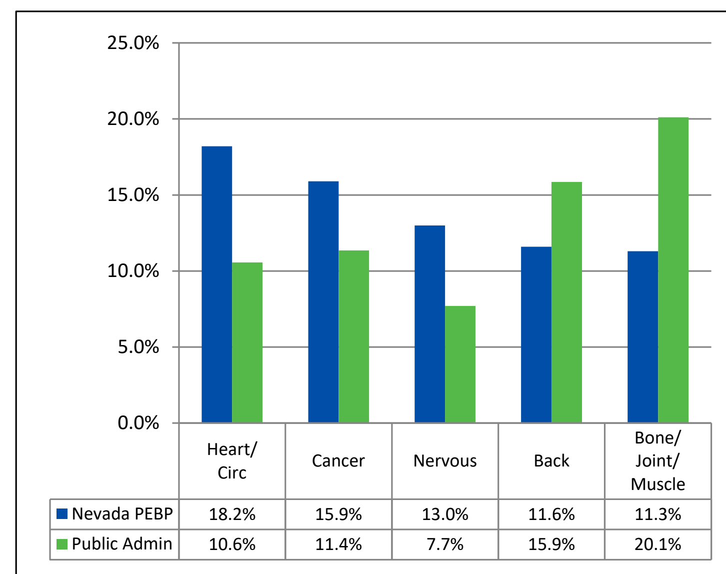
Most Recent Five Plan Years: July 01, 2016 to September 30, 2020

	From Jul-16 Through Jun-17		From Jul-17 Through Jun-18		From Jul-18 Through Jun-19		From Jul-19 Through Jun-20		From Jul-20 Through Jun-21	
	Count	Inc./ 1000	Count	Inc./ 1000	Count	Inc./ 1000	Count	Inc./ 1000	Count	Inc./ 1000
LTD Claims	36	1.4	29	1.1	25	1.0	21	0.8	1	0.0

Long Term Disability Claims by Diagnostic Category

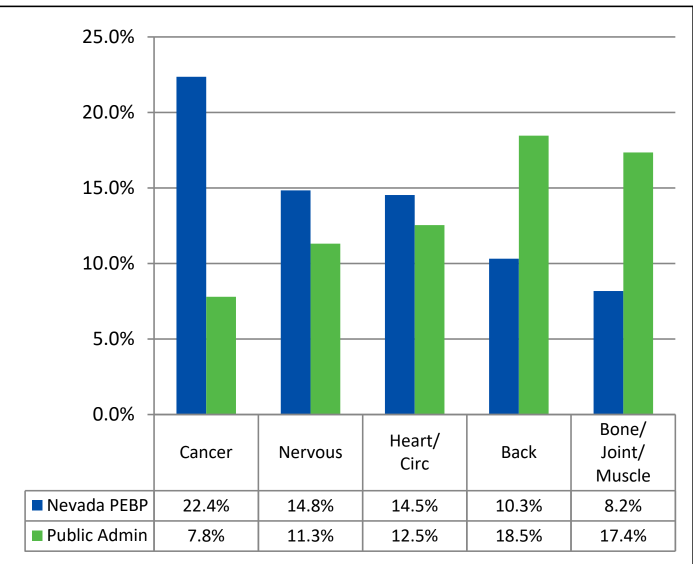
Public Admin benchmark is from SIC book of business for most recent 5 calendar years

Top Five Diagnostic Categories by Incidence



	Heart/ Circ	Cancer	Nervous	Back	Bone/ Joint/ Muscle
Nevada PEBP	18.2%	15.9%	13.0%	11.6%	11.3%
Public Admin	10.6%	11.4%	7.7%	15.9%	20.1%

Top Five Diagnostic Categories by Liability



	Cancer	Nervous	Heart/ Circ	Back	Bone/ Joint/ Muscle
Nevada PEBP	22.4%	14.8%	14.5%	10.3%	8.2%
Public Admin	7.8%	11.3%	12.5%	18.5%	17.4%

Long Term Disability Earned Premiums & Liability

Most Recent Five Plan Years: July 01, 2016 to September 30, 2020

	2016 - 17	2017 - 18	2018 - 19	2019 - 20	2020 - 21
Earned Premium	$4,646,721	$4,718,351	$4,559,226	$4,641,165	$1,151,694
Claim Liability	$3,069,265	$1,471,642	$1,913,283	$4,452,317	-$68,431
Loss Ratio	0.66	0.31	0.42	0.96	-0.06

Claim Appeals

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

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

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 September 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

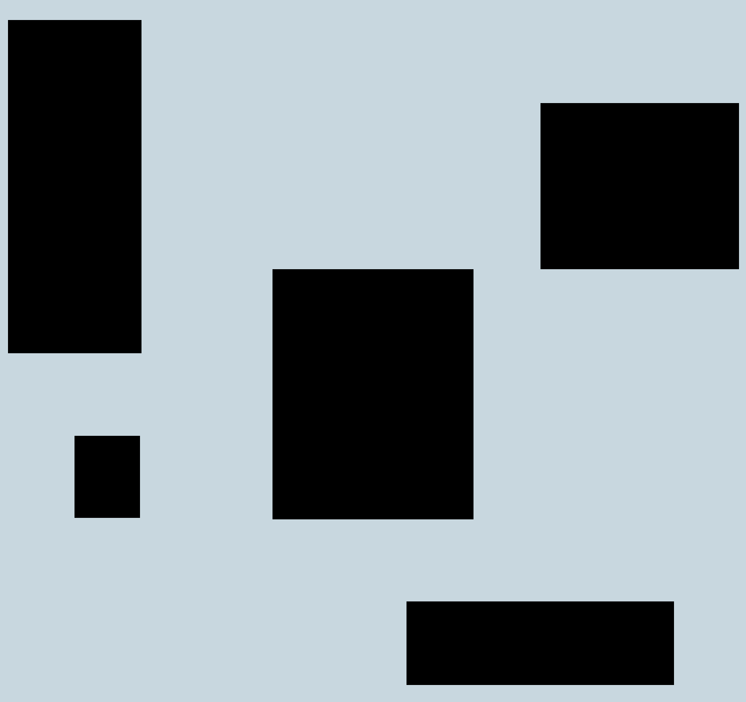
        4.3.5 Willis Towers Watson's Individual Marketplace Enrollment & Performance Report

Nevada Public Employees Benefit Program

Quarterly Update – 1st Quarter Plan Year 2021

Willis Towers Watson's Individual Marketplace

October 29, 2020



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Willis Towers Watson

The Public Employees Benefit Program Executive Dashboard

Quarterly Update – 1st Quarter Plan Year 2021

Executive Summary

Plan Enrollment:

- At the end of Q1 2021, PEBP's total enrollment into Medicare policies through Willis Towers Watson's Individual Marketplace decreased to 12,200. Since inception, 106 carriers have been selected by PEBP's retirees with current enrollment in 1,414 different plans.
- Medicare Supplement (MS) plan selection increased to 84% of the total population with the majority of participants selecting AARP and Anthem BCBS of Nevada as their insurer; each carrier holds plans for 6,369 and 2,207 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 16%. Top MA carriers include Hometown Health Plan with 991 individual plan selections and Aetna with 391 individual plan selections. The average monthly premium cost to PEBP participants is $21.

Customer Satisfaction:

- In Q1 2021, PEBP participant satisfaction with Enrollment Calls had an average satisfaction score result of 4.8 out of 5.0 based on 53 surveys returned.
- For Q1 2021, the average satisfaction score for Service Calls was 4.4 out of 5.0 based on 627 surveys returned.
- The combined average satisfaction score for Enrollment Calls and Service Calls was 4.5 out of 5.0 for Q1 2021.

Health Reimbursement Arrangement:

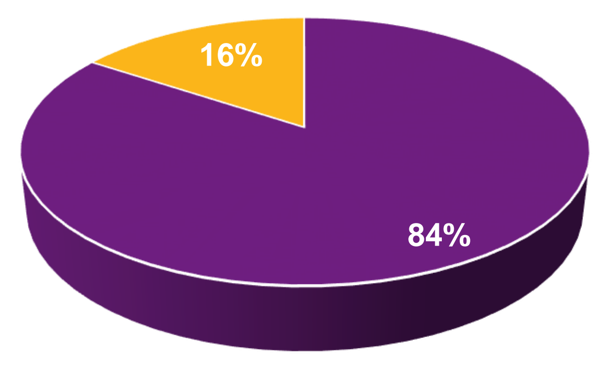
- At the end of Q1 2021 there were 12,990 Health Reimbursement Arrangement (HRA) accounts for PEBP participants.
- There were 92,738 claims processed in Q1, with 81% being submitted via Auto-Reimbursement, meaning that participants did not have to manually submit 74,842 claims for Premium Reimbursement.
- The total reimbursement amount processed for Q1 was $7,983,976

Summary of Retiree Decisions and Costs

Retiree Plan Selection Through 09/30/2020		Previous Qtr.
Total enrolled through individual marketplace	12,200	12,381
Number of carriers**	106	105
Number of plans**	1,414	1,393

Plan Type Selection Through 09/30/2020		Previous Qtr.
Medicare Advantage (MA, MAPD)	1,915	2,166
Medicare Supplement (MS)	10,285	10,215

Medical Enrollment



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

Plan Type	Number Enrolled	Average Premium
Medicare Supplement	10,285	$147
Medicare Advantage (MA,MAPD)	1,915	$0 / $21
Part D drug coverage	7,403	$24
Dental coverage	1,072	$36
Vision coverage	2,012	$12

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

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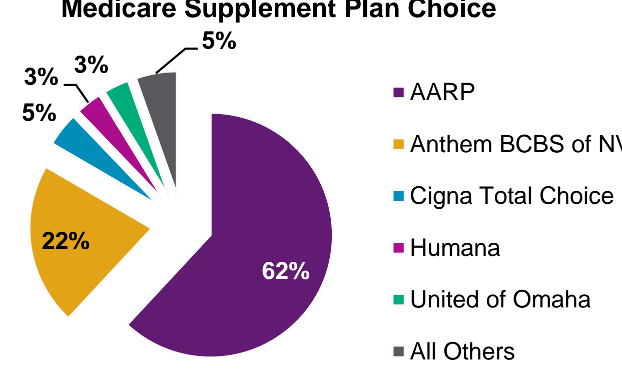
Quarterly Update – 1st Quarter Plan Year 2021

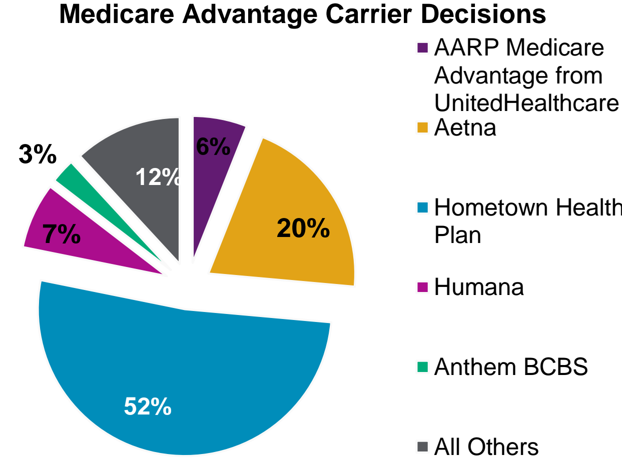
Summary of Retiree Carrier Choice

Top Medicare Supplement Plans	Total
AARP	6,369
Anthem BCBS of NV	2,207
Cigna Total Choice	458
Humana	349
United of Omaha	345



Cost Data For MS Plans	Cost
Minimum	$22
Average	$147
Median	$141
Maximum	$459

Top Medicare Advantage Plans	Total
AARP Medicare Advantage	155
Aetna	391
Hometown Health Plan	991
Humana	139
Anthem BCBS	52



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

Top Medicare Part D (RX)	Total
AARP Part D from UnitedHealthcare	1,922
Aetna Medicare Rx (SilverScript)	557
Express Scripts Medicare	453
Humana	2,747
WellCare	1,373

Medicare Part D (RX)

26%
6%
37%
7%
19%
5%

- AARP Part D from UnitedHealthcare
- Express Scripts Medicare
- Humana
- Aetna SilverScript
- WellCare
- All Others

Cost Data For Part D (RX)	Cost
Minimum	$10
Average	$24
Median	$18
Maximum	$130

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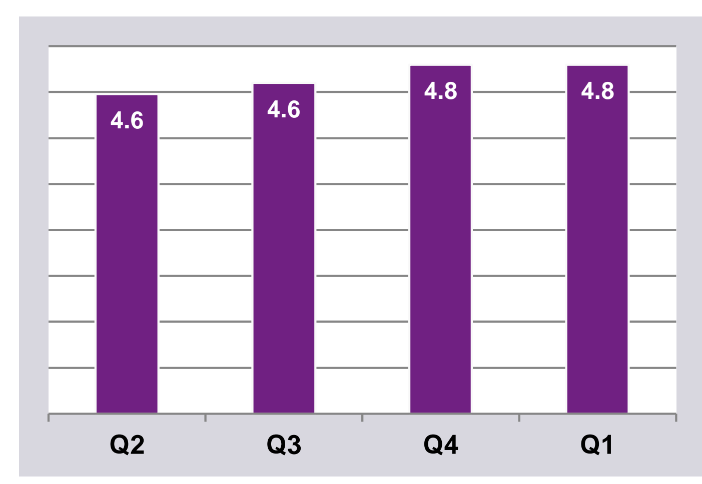
Quarterly Update – 1st Quarter Plan Year 2021

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

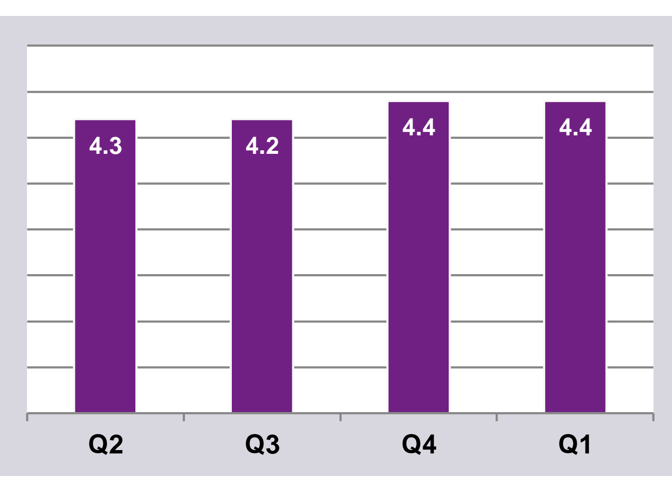
Q1 Enrollment Satisfaction

CSAT score	Count	%
5	44	83%
4	5	9%
3	4	8%
2	0	0%
1	0	0%
	53	100%



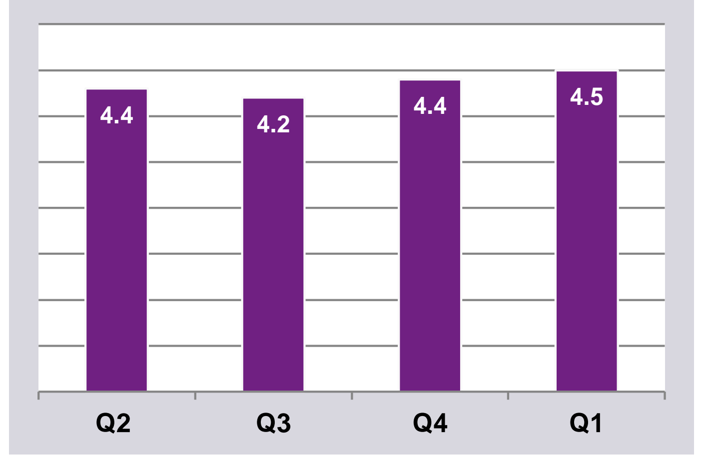
Q1 Service Satisfaction

CSAT score	Count	%
5	440	70%
4	95	15%
3	47	7%
2	15	2%
1	30	5%
	627	100%



Q1 Enrollment & Service Combined

CSAT score	Count	%
5	484	71%
4	100	15%
3	51	8%
2	15	2%
1	30	4%
	680	100%



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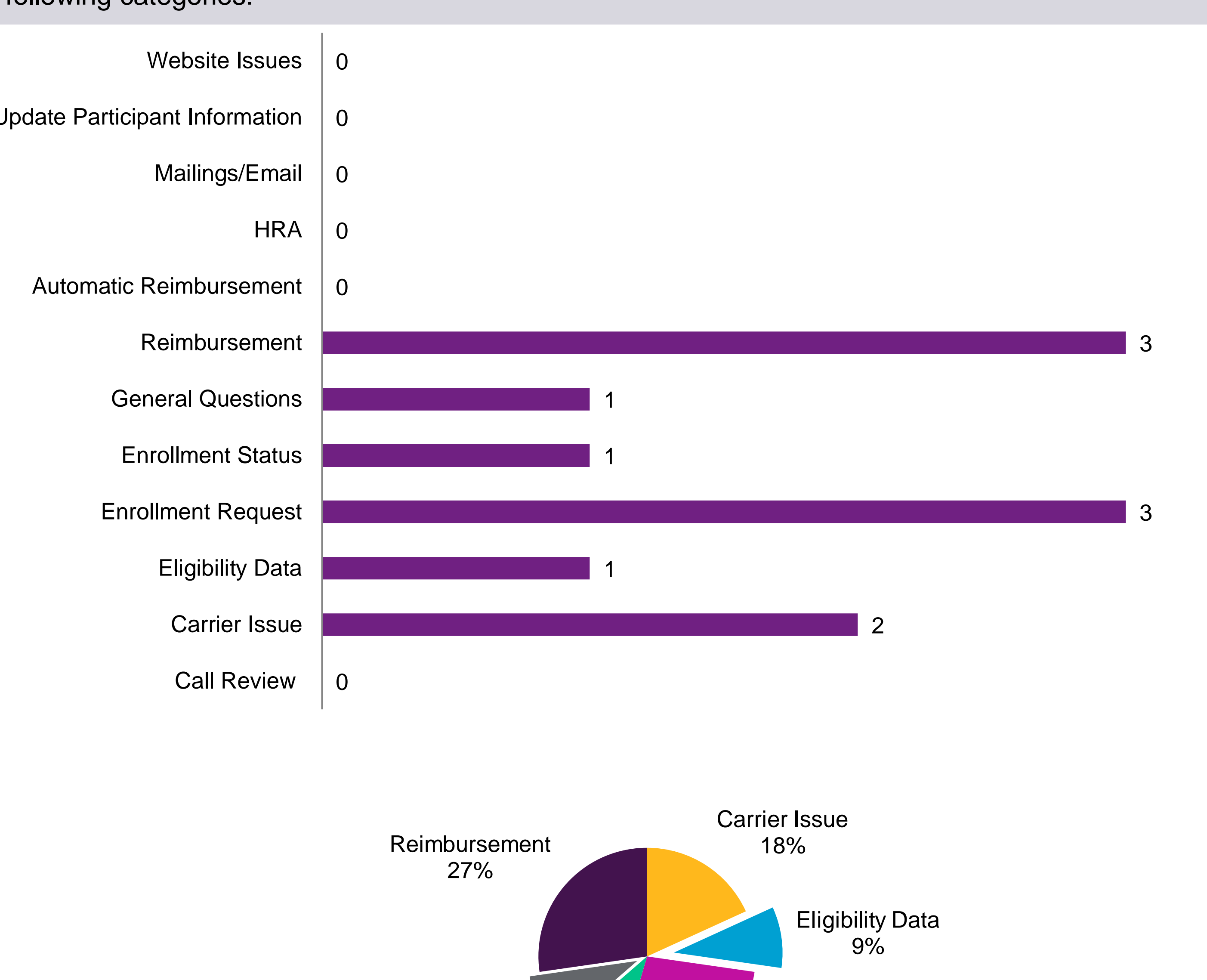
The Public Employees Benefit Program Executive Dashboard

Quarterly Update – 1st Quarter Plan Year 2021

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 Q1-PY21 is 11 and are associated with the following categories:



Health Reimbursement Account (HRA)

Claim Activity for the Qtr.	Total
HRA accounts	12,990
Number of payments	54,481
Accounts with no balance	7,085
Claims paid amount	$7,983,976.54

Claims By Source	Total 92,738
A/R file	74,842
Mail	9,922
Web	7,585
Mobile App	389

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The Public Employees Benefit Program Executive Dashboard

Quarterly Update – 1st Quarter Plan Year 2021

Performance Guarantees*

Category	Commitment	Outcome	PG MET
Claims Turnaround Time	≤ 2 days	0.21 Days	Yes
Claim Financial Accuracy	≥ 98%	99.56%	Yes
Claim Processing Payment Precision	≥ 98%	Results not Reported on Benefits Accounts	Yes
Reports	≤ 15 business days	Met	Yes
HRA Web Services	≥ 99%	99.88%	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.	37 Seconds	Yes
Benefits Administration Customer Service Abandonment Rate	≤ 5%	1.20%	Yes
Customer Satisfaction	≥ 80%	93%	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 – 1st Quarter Plan Year 2021

Operations Report

Fall Retiree Meetings

Normally, Willis Towers Watson and Nevada PEBP hold three days of retiree meetings in the Fall (October) focusing on participants ageing into Medicare as well as those already enrolled but who may need help with their HRA. The meetings typically would occur in Las Vegas, Reno, and Carson City with 2 presentations per day. However, due to COVID-19, we were not able to have the live meetings. Instead, we held two days of virtual meetings with two meetings per day. The virtual meetings were held on October 19th and 20th and were well attended. Recordings of two of the meetings have been made available on the Via Benefits Website for participants to review.

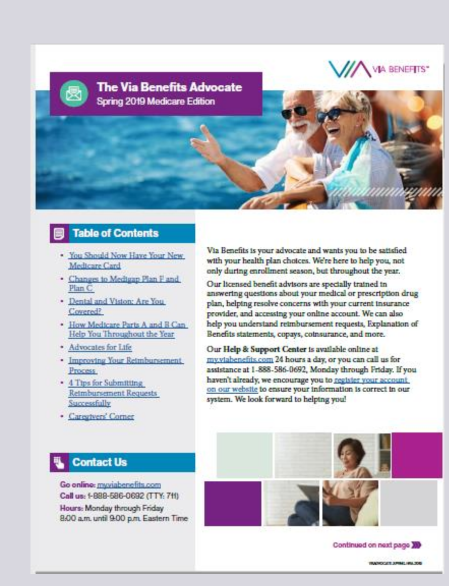
Meeting Date/Time	Meeting Type	Number of Attendees
October 19 - 9:30 am PT	Pre-Medicare/Ageing into Medicare	229
October 19 – 12:00 pm PT	HRA/Medicare Open Enrollment	78
October 20 - 12:00 pm PT	Pre-Medicare/Ageing into Medicare	188
October 20 - 2:00 pm PT	HRA/Medicare Open Enrollment	63

Communications:

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

- Spring Newsletter
  - This communication is sent to participants via mail or email and is typically sent starting in the February/March. The intent of this communication is to educate participants on different areas like Medicare, HRA, Direct Deposit, and Auto-Reimbursement functionality.

- Spring 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 March.



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The Public Employees Benefit Program Executive Dashboard

Quarterly Update – 1st Quarter Plan Year 2021

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	27s	1,974	11	22m 22s	278
September	54s	1,883	41	22m 46s	204
October					
November					
December					

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The Public Employees Benefit Program Executive Dashboard

Quarterly Update – 1st Quarter Plan Year 2021

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 – 1st Quarter Plan Year 2021

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 September 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

Q1 PlanYear2021

July 1, 2020 – September 30, 2020

Jan 28, 2021

Service Performance	Guarantee Measurement	Actual	Pass/Fail Standard(Metric)
I. EDI claims repricing	**95%**-Turnaround time frame for repricing of medical claims within 3 business days of receipt from PEBP's TPA **97%**-Accuracy of claims repriced by the PPONetwork must be accurate and must not cause a claim adjustment by PEBP'sTPA	93% 99%	Fail 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%**- Provider fee schedule revisions must be provided to PEBP'sTPA within 30 calendar days following the effective date of the change	100% 100%	Pass 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%**- Provider fee schedule revisions must be provided to PEBP'sTPA within 30 calendar following the effective date of the change (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)	100% 100%	Pass Pass
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 September 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 Nevada HMO

Health Plan of Nevada

Quarterly Update for July-September 2020

November 13th, 2020

Health Plan of Nevada HMO

Performance Standards and Guarantees- Self Reported

Quarterly Report for July – September 2020

Service Performance Standard (Metric)	Guarantee Measurement	Actual	Pass/Fail
I. Claims Processing	**97%** - Claims Financial Accuracy	100%	Pass
	95% - Claims Procedural Accuracy	100%	Pass
	95% in 30 working days - Clean claims turnaround for unaffiliated providers	100%	Pass
II. Participant Correspondence	ID Card Turnaround- Mailed within 10 working days of date of eligibility input	2.49 days	Pass
	Membership materials (electronic)- Available within 10 working days of date of eligibility input	6.58 days	Pass
III. Customer Service- Telephone	Speed to queue and answer by live voice- Within 60 seconds	31 sec	Pass
	5% or less - Telephone abandonment rate	3%	Pass
IV. Other Customer Service	**98% -** Resolved resolution within 30 days of receipt of written correspondence (i.e. complaint or appeal)	100%	Pass
	Notification to member regarding PCP disenrollment - within 30 working days	100%	Pass
	Primary Care Physician /Member Ratio - 1 to 2450	1 to 293	Pass

November 13th, 2020

HEALTH PLAN OF NEVADA
A UnitedHealthcare Company

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 September 30, 2020:

      4.3.1 HealthSCOPE Benefits – Obesity Care Management

      4.3.2 HealthSCOPE Benefits – Diabetes Care Management

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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 September 2020

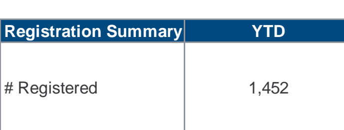
NVPEB

HealthSCOPE Benefits

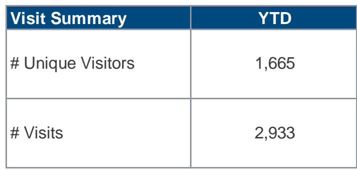
2020-12 Engagement Report

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

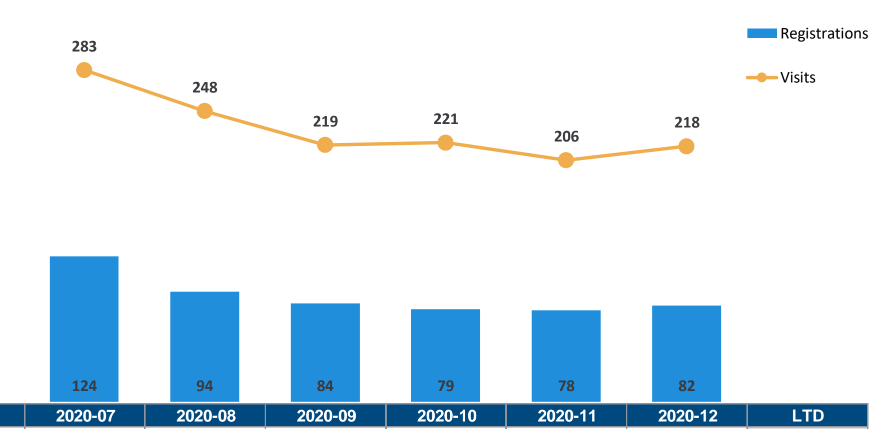


Registration Summary	YTD
# Registered	1,452



Visit Summary	YTD
# Unique Visitors	1,665
# Visits	2,933

Monthly Activity



Registration Summary	Prior	2020-07	2020-08	2020-09	2020-10	2020-11	2020-12	LTD
# Registered	8,427	124	94	84	79	78	82	8,968

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.

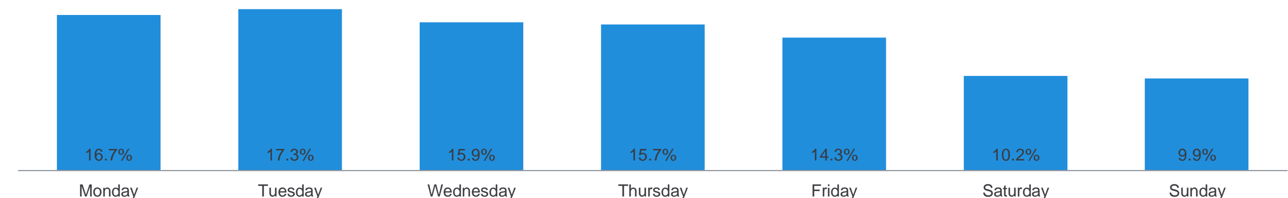
Visit Summary		Prior	2020-07	2020-08	2020-09	2020-10	2020-11	2020-12	LTD
# Unique Visitors		3,042	236	201	185	183	182	190	3,521
# Visits		6,277	283	248	219	221	206	218	7,672
Visit Frequency	% 1 Visit	59.7%	84.7%	84.6%	84.3%	85.2%	89.0%	88.9%	58.1%
	% 2 Visits	19.4%	11.9%	10.9%	13.5%	10.9%	8.8%	7.9%	18.4%
	% 3 Visits Or More	20.9%	3.4%	4.5%	2.2%	3.8%	2.2%	3.2%	23.5%

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.

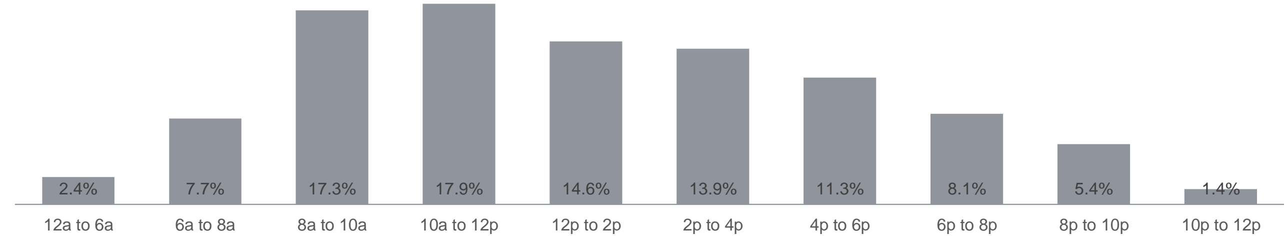
Visit Type Summary		Prior	2020-07	2020-08	2020-09	2020-10	2020-11	2020-12	LTD
Medical		5,225	236	207	176	166	171	183	6,364
Mental Health	Therapy	597	24	21	17	27	16	10	712
	Psychiatry	455	23	20	26	28	19	25	596

Six Month Trends: Visit Time And Demographics

Day Of Week

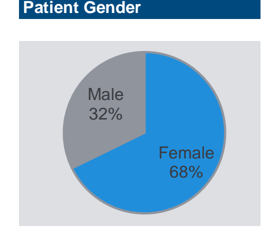


Hour Of Day

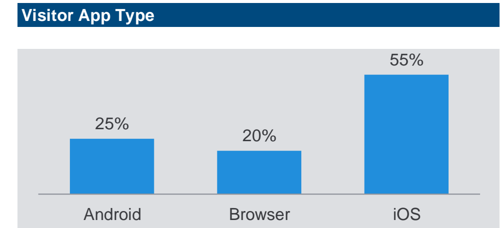


Patient Age	
0 to 17 (Custodial)	6%
18 to 29	24%
30 to 49	48%
50 and over	23%

Patient Gender



Visitor App Type



NVPEB

HealthSCOPE Benefits

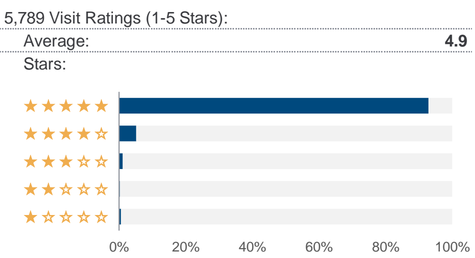
2020-12 Engagement Report

Historical Visit Experience

5,789 Visit Ratings (1-5 Stars):

Average: **4.9**

Stars:



Avg Connection Time (On Demand Visits Only) **8.7 Minutes**

Historical Top 15 Symptoms

Symptom	# Symptoms	% of All Sym
Head / Neck: Headache	1,826	6.1%
General Symptoms: Fatigue / weakness	1,794	6.0%
Chest: Cough	1,779	6.0%
Head / Neck: Sore throat	1,654	5.6%
General Symptoms: Difficulty sleeping	1,458	4.9%
Head / Neck: Nasal discharge	1,351	4.5%
Head / Neck: Congestion / sinus problem	1,124	3.8%
General Symptoms: Fever	1,006	3.4%
Head / Neck: Congestion/sinus problem	1,002	3.4%
General Symptoms: Loss of appetite	845	2.8%
Genitourinary: Discomfort / burning with urination	757	2.5%
Genitourinary: Frequent urination	747	2.5%
Gastrointestinal: Sore throat	562	1.9%
Chest: Shortness of breath	536	1.8%
Head / Neck: Difficulty / pain swallowing	508	1.7%

Historical Post Visit Survey Results

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

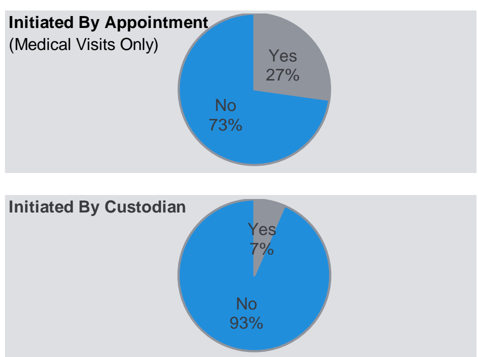
Note: Survey presented only when no other post visit action was required

Response	# Responses	% Responses
Emergency Room	78	3%
Urgent Care	1,444	52%
Doctor's Office	796	29%
Stayed Home	351	13%
Other	114	4%

Historical Top 15 ICD10 Codes

ICD10 Code And Description	# ICD10s	% of All ICD10
N39.0 - Urinary tract infection, site not specified	701	7.1%
J06.9 - Acute upper respiratory infection, unspecified	519	5.2%
J01.90 - Acute sinusitis, unspecified	514	5.2%
J02.9 - Acute pharyngitis, unspecified	297	3.0%
F41.1 - Generalized anxiety disorder	277	2.8%
R05 - Cough	261	2.6%
J20.9 - Acute bronchitis, unspecified	221	2.2%
Z76.0 - Encounter for issue of repeat prescription	200	2.0%
F43.23 - Adjustment disorder with mixed anxiety and depressed m	177	1.8%
F41.9 - Anxiety disorder, unspecified	152	1.5%
J01.80 - Other acute sinusitis	148	1.5%
Z63.0 - Problems in relationship with spouse or partner	147	1.5%
F33.1 - Major depressive disorder, recurrent, moderate	127	1.3%
J01.00 - Acute maxillary sinusitis, unspecified	117	1.2%
J11.1 - Influenza due to unidentified influenza virus with other resp	113	1.1%

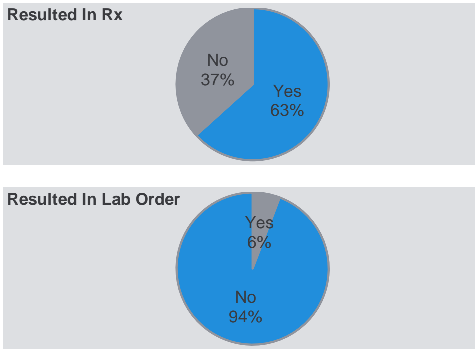
Six Month Trends: Visit Initiation



Historical Top 15 Rx

Rx	# Visits	% of All Rx
benzonatate	557	7.0%
amoxicillin-clavulanate	553	6.9%
predniSONE	520	6.5%
nitrofurantoin	506	6.3%
albuterol	484	6.0%
fluticasone nasal	237	3.0%
sulfamethoxazole-trimethoprim	211	2.6%
amoxicillin	207	2.6%
methylPREDNISolone	207	2.6%
azithromycin	205	2.6%
fluconazole	204	2.5%
ipratropium nasal	169	2.1%
oseltamivir	167	2.1%
doxycycline	165	2.1%
sertraline	146	1.8%

Six Month Trends: Visit Result



Historical Top 15 Lab Orders

Lab Name	# Lab Orders	% of All Orders
TSH with Reflex to Free T4	79	10.8%
Urinalysis, Complete with Reflex	65	8.9%
Comprehensive Metabolic Panel	64	8.8%
CBC+diff	54	7.4%
Lipid Panel	44	6.0%
Urine Culture, Routine	42	5.8%
Hemoglobin A1c	36	4.9%
Vitamin D	31	4.2%
Chlamydia/GC, Urine	29	4.0%
B12/Folate	25	3.4%
Urinalysis, Complete	24	3.3%
Basic Metabolic Panel	17	2.3%
RPR w/ Reflex	13	1.8%
SARS-CoV-2 IgG	12	1.6%
T. Vaginalis, Urine MALE	12	1.6%

4.4

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

   4.4 Revised Financial Statement for the Self Insurance Trust Fund

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

JUNE 30, 2020 AND 2019

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

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Casey Neilon
Accountants and Advisors

INDEPENDENT AUDITOR'S REPORT

To the Board of the
Public Employees' Benefits Program

Report on the Financial Statements

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

Management's Responsibility for the Financial Statements

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

Auditor's Responsibility

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

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

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

Opinion

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

Emphasis of a Matter

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

Other Matters

Required Supplementary Information

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

Other Reporting Required by Government Auditing Standards

In accordance with *Government Auditing Standards,* we have also issued our report dated January 7, 2021 on our consideration of the Self Insurance Trust Fund, Public Employees' Benefits Program of the State of Nevada's internal control over financial reporting and on our tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements and other matters. The purpose of that report is to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing, and not to provide an opinion on the effectiveness of the Self Insurance Trust Fund, Public Employees' Benefit Program of the State of Nevada internal control over financial reporting or on compliance. That report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering the Self Insurance Trust Fund, Public Employees' Benefits Program of the State of Nevada's internal control over financial reporting and compliance.

Casey Neilon

Casey Neilon, Inc.
Carson City, Nevada
January 7, 2021

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

	2020	2019
ASSETS		
Current assets:		
Cash and cash equivalents	$ 159,637,188	$ 155,908,618
Prepaid insurance	3,202	3,611
Receivables:		
Accounts receivable, net	6,055,621	6,106,065
Intergovernmental receivable	8,911,233	2,419,215
Due from other funds	1,441,984	1,658,242
Due from fiduciary funds	11,699,729	3,572,579
Due from component units, net	4,567	19,210
Total Current Assets	187,753,524	169,687,540
Capital assets:		
Property and equipment	461,025	466,100
Less: Accumulated depreciation	(435,940)	(411,151)
Total Capital Assets (net of accumulated depreciation)	25,085	54,949
Total Assets	187,778,609	169,742,489
Deferred outflows of resources:		
Pension related amounts	663,273	641,824
OPEB related amounts	69,742	44,268
Total Deferred Outflows of Resources	733,015	686,092
LIABILITIES		
Current liabilities:		
Bank overdraft	3,428,332	3,829,541
Accounts payable	1,409,272	4,274,803
Accrued payroll and related liabilities	98,393	87,285
Due to other funds	20,435	25,334
Unearned revenue	3,489,755	3,662,898
Compensated absences	156,804	163,215
Reserve for losses	89,702,313	94,881,428
Total Current Liabilities	98,305,304	106,924,504
Noncurrent liabilities:		
Compensated absences	38,259	54,490
Net pension obligation	3,833,649	3,547,239
Net OPEB liability	1,301,204	1,417,507
Total Noncurrent Liabilities	5,173,112	5,019,236
Total Liabilities	103,478,416	111,943,740
Deferred inflows of resources:		
Pension related amounts	362,280	257,269
OPEB related amounts	79,050	95,047
Total Deferred Inflows of Resources	441,330	352,316
NET POSITION		
Invested in capital assets	25,085	54,949
Restricted expendable - losses	84,566,793	58,077,576
Total Net Position	$ 84,591,878	$ 58,132,525

See accompanying notes.

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

	2020	2019
OPERATING REVENUES:		
Insurance premiums	391,121,895	$ 357,432,206
Other	5,520	1,902
Total Operating Revenues	391,127,415	357,434,108
OPERATING EXPENSES:		
Salaries and benefits	2,793,277	2,910,928
Operating	2,356,630	3,398,726
Claims expense	303,888,916	314,546,591
Depreciation	40,542	42,013
Insurance premiums and contractual obligations	59,748,805	59,318,572
Total Operating Expenses	368,828,170	380,216,830
Operating Income (Loss)	22,299,245	(22,782,722)
NONOPERATING REVENUES (EXPENSES):		
Investment income	1,407,557	1,694,774
Interest income	2,343,660	3,031,971
Total Nonoperating Revenues	3,751,217	4,726,745
Income Before Transfers	26,050,462	(18,055,977)
Transfers:		
Transfers in	408,891	-
Total Transfers	408,891	-
CHANGE IN NET POSITION	26,459,353	(18,055,977)
NET POSITION		
Beginning of year	58,132,525	76,188,502
End of year	$ 84,591,878	$ 58,132,525

See accompanying notes.

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

	2020	2019
CASH FLOWS FROM OPERATING ACTIVITIES:		
Receipts from customers and users	$ 73,055,552	$ 29,482,963
Receipts for interfund services provided	296,430,133	322,062,620
Receipts from component units	13,822,120	13,588,561
Payments to suppliers, other governments and beneficiaries	(380,396,574)	(349,437,609)
Payments to employees	(2,592,613)	(2,718,441)
Payments for interfund services used	(865,561)	(1,298,678)
Net Cash Provided/(Used) by Operating Activities	(546,943)	11,679,416
CASH FLOWS FROM NON-CAPITAL AND RELATED FINANCING ACTIVITIES:		
Transfers in from other funds	408,891	-
Change in due from other funds	(408,891)	-
Net Cash Used by Non-Capital and Financing Activities	-	-
CASH FLOWS FROM CAPITAL AND RELATED FINANCING ACTIVITIES:		
Purchase of capital assets	(10,678)	-
Net Cash Used by Capital and Financing Activities	(10,678)	-
CASH FLOWS FROM INVESTING ACTIVITIES		
Interest on investments	4,286,191	4,199,606
Net Cash Provided by Investing Activities	4,286,191	4,199,606
Net Increase in Cash and Cash Equivalents	3,728,570	15,879,022
Cash and cash equivalents, July 1	155,908,618	140,029,596
Cash and cash equivalents, June 30	$ 159,637,188	$ 155,908,618
RECONCILIATION OF OPERATING INCOME (LOSS) TO NET CASH USED BY OPERATING ACTIVITIES:		
Operating income	$ 22,299,245	$ (22,782,722)
Adjustments to reconcile operating income to net cash used by operating activities:		
Depreciation	40,542	42,013
Allowance for doubtful accounts	3,595	(3,592)
Changes in assets and liabilities:		
(Increase) decrease in receivables	(14,467,501)	3,464,863
(Increase) decrease in prepaid expenses	409	(3,611)
(Increase) decrease in deferred outflows	(46,923)	(74,158)
Increase (decrease) in payables and accruals	(8,462,288)	27,146,263
Increase (decrease) in unearned revenue	(173,143)	3,613,982
Increase (decrease) in net pension obligation	286,410	185,322
Increase (decrease) in net OPEB liability	(116,303)	77,760
Increase (decrease) in deferred inflows	89,014	13,296
Total Adjustments	(22,846,188)	34,462,138
Net Cash Provided by Operating Activities	$ (546,943)	$ 11,679,416

See accompanying notes.

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

NOTE 1 - Summary of Significant Accounting Policies:

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

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

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

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

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

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

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

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

Fund Accounting:

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

Basis of Accounting:

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

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

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

Cash Equivalents:

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

Receivables:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

NOTE 3 - Cash and Deposits as of June 30:

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

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

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

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

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

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

NOTE 4 - Pension Plan:

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

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

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

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

NOTE 4 - Pension Plan (continued):

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

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

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

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

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

NOTE 4 - Pension Plan (continued):

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

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

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

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

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

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

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

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

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

NOTE 5 – Other Post Employment Retirement Benefits:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

NOTE 6 - Commitments:

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

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

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

NOTE 7 - Risk Management:

Estimated Claims Liabilities:

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

Unpaid Claims Liabilities:

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

Unpaid Claims Liabilities:

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

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

NOTE 8 – Contingencies:

Contingent Liabilities

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

NOTE 9 – Subsequent Events:

Management has evaluated the activities and transactions subsequent to June 30, 2020 to determine the need for any adjustments to and disclosure within the financial statements for the year ended June 30, 2020. Management has evaluated subsequent events through January 7, 2021, the date which the financial statements were available to be issued.

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

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

SCHEDULE OF CHANGES IN NET PENSION LIABILITY

(Last Ten Fiscal Years*)

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

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

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

SCHEDULE OF CONTRIBUTIONS

(Last Ten Fiscal Years*)

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

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

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

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

(Last Ten Fiscal Years*)

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

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

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

SCHEDULE OF THE FUND CONTRIBUTIONS

(Last Ten Fiscal Years*)

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

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

Casey Neilon
Accountants and Advisors

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

To the Board of the
Public Employees' Benefits Program

We have audited, in accordance with the auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards* issued by the Comptroller General of the United States, the basic financial statements of the Self Insurance Trust Fund, Public Employees' Benefits Program of the State of Nevada, as of and for the year ended June 30, 2020, and the related notes to the financial statements, which comprise the Self Insurance Trust Fund, Public Employees' Benefits Programs basic financial statements, and have issued our report thereon dated January 7, 2021.

Internal Control over Financial Reporting

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

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

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

Compliance and Other Matters

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

Purpose of this Report

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

Casey Neilon

Carson City, Nevada
January 7, 2021

4.5

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

   4.4 Revised Financial Statement for the Self Insurance Trust Fund

   4.5 Acceptance of the annual PEBP Appeals and Complaints Summary for submission to the Nevada Division of Insurance

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

STEVE SISOLAK
Governor

LAURA FREED
Board Chair

LAURA RICH
Executive Officer

January 28, 2020

Richard Whitley, MS, Director
Office of Consumer Health Assistance
555 E. Washington Avenue, Suite 4800
Las Vegas, NV 89101

Re: Public Employees' Benefits Program (PEBP) Appeals and Complaints Summary Report calendar year 2020

Dear Mr. Whitley:

In accordance with NRS 695G.310, PEBP presents to the Office of Consumer Health Assistance its annual Appeals and Complaints Summary Report for calendar year 2020. As required by code, the name of the employee(s) responsible for appeals and descriptions of notification procedures and explanation of rights are listed below, followed by a narrative summary of the attached appeals and complaints log. A graph showing the number of appeals and complaints received in calendar years 2013 through 2020 has been included for historical comparison.

NAC 287.750(1)(a), name and title of the employee responsible for the system for resolving complaints:

Nancy Spinelli, Quality Control Officer, PEBP
Laura Landry, Quality Control Analyst, PEBP

NAC 287.750(1)(b), NRS 695G.200, a description of the procedure used to notify an insured of the decision regarding his complaint:

PEBP is contracted with HealthSCOPE Benefits (HSB) located in Little Rock, Arkansas, to provide third-party administration services for the Consumer Driven Health Plan (CDHP) and the Exclusive Provider Organization (EPO). As PEBP's claims administrator, HSB receives claims from physicians, dentists, laboratories, and other providers. HSB reviews the claims and processes them in accordance with provisions located in the applicable plan year PEBP Master Plan Document. Included at the bottom of every explanation of benefits (EOB) notice sent by HSB to participants is a statement that reads:

"If you have any questions about this explanation of benefits, please call Customer Service at the toll-free number on your ID card or send a written request to Attn: Claim Inquiry, PO Box 2860, Little Rock, AR 72203. If you are not satisfied with this decision, either you or your authorized representative can start the appeal process by sending a written request to Attn: Claim Appeals, PO Box 2860, Little Rock, AR 77203 within 180 days of receipt of this explanation of benefits (unless a longer term is permitted by your plan). Please note that if you choose to designate an authorized representative, you must make this designation to us in writing.

Please follow the steps below to make sure that your appeal is processed in a timely manner.

- Send a copy of this explanation of benefits along with any relevant additional information (e.g., benefit documents, medical records) that helps to determine if your claim is covered under the plan. Contact Customer Service if you need help or have further questions.
- Include: 1) Your name, 2) Account number from the front of this form, 3) ID number from the front of this form, 4) Name of the patient and relationship, and 5) "Attention: Claim Appeals Unit" on all supporting documents.
- Contact Customer Service at the number on the front of this form to request access to and copies of all documents, records, and other information about your claim, free of charge. You have the right to billing and diagnosis codes as well.
- If your situation is urgent, you may request an expedited appeal which will generally be conducted within 72 hours. If you believe that your situation is urgent, follow the instructions above for filing an internal appeal and call 1-888-763-8232 to request a simultaneous external review if permitted by your plan.

This is the first step available to every participant in the three-level claims appeal process afforded by the PEBP CDHP or EPO plan. All participants have the right to file a Level 1 appeal for adverse benefit determinations. The written request for appeal is to be mailed to the HealthSCOPE Benefits address listed on the EOB. HealthSCOPE's decision on the Level 1 appeal is mailed to the PEBP participant in writing. If HealthSCOPE approves the appeal, they reprocess the related claim(s). If HealthSCOPE Benefits denies the Level 1 appeal, the denial letter to the participant includes instructions on how to proceed to a Level 2 appeal, if the participant deems necessary. Level 2 appeals are adjudicated by PEBP, and decisions on approval or denial are sent to participants in writing. If the Level 2 appeal is denied, the denial letter to the participant will include instructions on how to proceed to an External Review. External Reviews are managed by the Nevada Office of Consumer Health Assistance (OCHA).

The claim appeal process that PEBP describes in its Master Plan Document is in compliance with the requirements established by the Patient Protection and Affordable Care Act of 2010 (PPACA) and the Nevada Insurance Statutes in NRS 695G. Forms for completing the various levels of review are available by logging in to the E-PEBP Portal at www.pebp.state.nv.us or by calling the PEBP office.

Summary Narrative

The PEBP Quality Control Appeals and Complaints Summary Report lists 10 external reviews, 16 appeals and 72 complaints received in calendar year 2020, categorized by vendor or program, then by type. This compares to 5 external reviews, 20 appeals and 106 complaints received in 2019.

The 2020 Appeals and Complaints have slightly decreased, although PEBP experienced an increase in external reviews compared to 2019. This increase can be attributed to reviews of medical necessity and experimental and investigatory medical procedures / equipment. Towers Watson's VIA Benefits experienced a minor decrease in complaints with 16 in 2020 compared to 20 in 2019. Express Script's (ESI) experienced a significant decrease in complaints with 18 in 2020 compared to 44 in 2019. This decrease is due in part to increased communication from Express Scripts to members, improvements to the online member experience and efficiency of the Express Scripts Client Service Center. Corestream, who has been administering the voluntary benefits for PEBP members beginning in July of 2019 has been effective in assisting PEBP participants and only incurred 3 formal complaints for their first full calendar year. The percentage of complaints for PEBP, Healthscope Benefits, the statewide PPO network, Health Plan of Nevada, and Standard Insurance experienced slight to no changes in 2020.

Sincerely,

Laura Landry
Quality Control Analyst
Public Employees' Benefits Program
775-684-7000
llandry@peb.nv.gov

STEVE SISOLAK
Governor

LAURA FREED
Board Chair

STATE OF NEVADA
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www.pebp.state.nv.us

LAURA RICH
Executive Officer

January 28, 2021

Barbara Richardson, Insurance Commissioner
Nevada Division of Insurance
1818 E. College Parkway, Suite 103
Carson City, NV 89706

Re: Public Employees' Benefits Program (PEBP) Appeals and Complaints Summary Report calendar year 2020.

Dear Commissioner Richardson:

In accordance with NAC 287.750, PEBP presents to the Nevada Division of Insurance its annual Appeals and Complaints Summary Report for calendar year 2020. As required by code, the name of the employee(s) responsible for appeals and descriptions of notification procedures and explanation of rights are listed below, followed by a narrative summary of the attached appeals and complaints log. A graph showing the number of appeals and complaints received in calendar years 2013 through 2020 has been included for historical comparison.

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Nancy Spinelli, Quality Control Officer, PEBP
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Sincerely,

Laura Landry
Quality Control Analyst
Public Employees' Benefits Program
775-684-7000
llandry@peb.nv.gov

2nd Level Appeals - Medical/Dental

	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	YTD Total	% of Total
EPO-Medical Claim Denial	1			1				1					3	18.8%
CDHP-Medical Claim Denial	1	1	1		2	1	1			2			9	56.3%
Dental Claim Denial													0	0.0%
VIA HRA Appeals					1		1	1		1			4	25.0%
Total	2	1	1	1	3	1	2	2	0	3	0	0	16	16.3%

External Review Appeals

	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	YTD Total	% of Total
CDHP Overturned		1	1		1								3	30.0%
CDHP Upheld	1			1			1					1	4	40.0%
EPO Overturned				1			1						2	20.0%
EPO Upheld													0	0.0%
Dental Overturned													0	0.0%
Dental Upheld													0	0.0%
AHH Overturned													0	0.0%
AHH Upheld												1	1	10.0%
Total	1	1	1	2	1	0	2	0	0	0	0	2	10	10.2%

Complaints- HealthSCOPE Benefits

	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	YTD Total	% of Total
HSB-CDHP Customer Service													0	0.0%
HSB-EPO Customer Service			1								1		2	20.0%
HSB-CDHP Medical Claim Denial		1			1					1			3	30.0%
HSB-EPO Medical Claim Denial		2	1								1		4	40.0%
HSB-CDHP Plan Design													0	0.0%
HSB-EPO Plan Design													0	0.0%
HSB-Provider Access Network													0	0.0%
HSB-Dental Claim Denial													0	0.0%
HSB-Dental Customer Service													0	0.0%
HSB-CDHP HSA/HRA/FSA									1				1	10.0%
Total	0	3	2	0	1	0	0	0	1	1	2	0	10	10.2%

Complaints - Healthcare Bluebook

	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	YTD Total	% of Total
HCBB				1									1	100.0%
Total	0	0	0	1	0	0	0	0	0	0	0	0	1	1.0%

Complaints - Hometown Health UM/CM

	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	YTD Total	% of Total
HTH-Customer Service													0	0.0%
HTH-UM/Pre-Cert													0	0.0%
Total	0	0	0	0	0	0	0	0	0	0	0	0	0	0.0%

Complaints - Health Plan of Nevada HMO

	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	YTD Total	% of Total
HPN-Customer Service													0	0.0%
HPN-Plan Design													0	0.0%
HPN-Prescriptions													0	0.0%
HPN-Network Providers													0	0.0%

Total	0	0	0	0	0	0	0	0	0	0	0	0	0	0.0%

Complaints - Diversified Dental

	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	YTD Total	% of Total
DD-Customer Service													0	0.0%
DD-Network Providers								1			1		2	100.0%
DD-Plan Design													0	0.0%
Total	0	0	0	0	0	0	0	1	0	0	1	0	2	2.0%

Complaints - Express Scripts

	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	YTD Total	% of Total
ESI-Plan Design							1		1		1	1	4	22.2%
ESI-Customer Service		1	2						1			1	5	27.8%
ESI-CDHP RX Prior Auth	1					1					1		3	16.7%
ESI-EPO RX Prior Auth		1											1	5.6%
ESI-CDHP RX Price		1		1								1	3	16.7%
ESI-EPO RX Price		1		1									2	11.1%
Total	1	4	2	2	0	1	1	0	2	0	2	3	18	18.4%

Complaints - Aetna Network

	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	YTD Total	% of Total
Aetna-Customer Service													0	0.0%
Total													0	0.0%

Complaints - PEBP

	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	YTD Total	% of Total
PEBP-Customer Service						2	1		1			1	5	35.7%
PEBP-Plan Design			1			1	1		2				5	35.7%
PEBP-Eligibility		1	1	1					1				4	28.6%
Total	0	1	2	1	0	3	2	0	4	0	0	1	14	14.3%

Complaints - SHO/HTH EPO/PPO Network

	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	YTD Total	% of Total
HTH-Network Providers			2		1		2						5	83.3%
SHO -Network Providers				1									1	16.7%
Total	0	0	2	1	1	0	2	0	0	0	0	0	6	6.1%

Complaints - Standard Insurance

	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	YTD Total	% of Total
STD-Customer Service													0	0.0%
STD- Plan Design													0	0.0%
Total	0	0	0	0	0	0	0	0	0	0	0	0	0	0.0%

Complaints - TW/VIA Benefits

	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	YTD Total	% of Total
VIA-Carrier Issues													0	0.0%
VIA-Customer Service		1								1			2	12.5%

	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	YTD Total	% of Total
VIA-Disenroll/Over-pmt		1		3			1		1	1			7	43.8%
VIA-Enrollment													0	0.0%
VIA-HRA Funding	1	2		1		1				1	1		7	43.8%
Total	1	4	0	4	0	1	1	0	1	3	1	0	16	16.3%

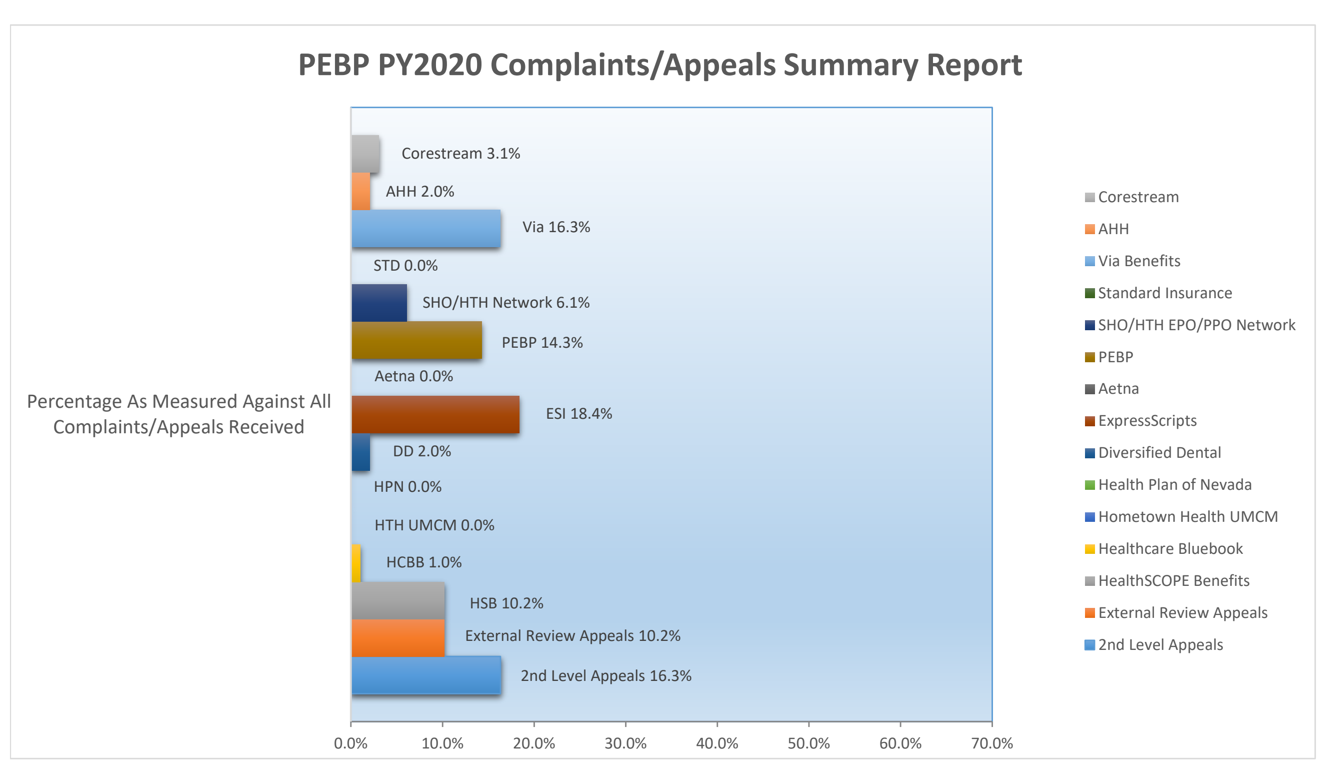
Complaints - American Health Holding UM/CM

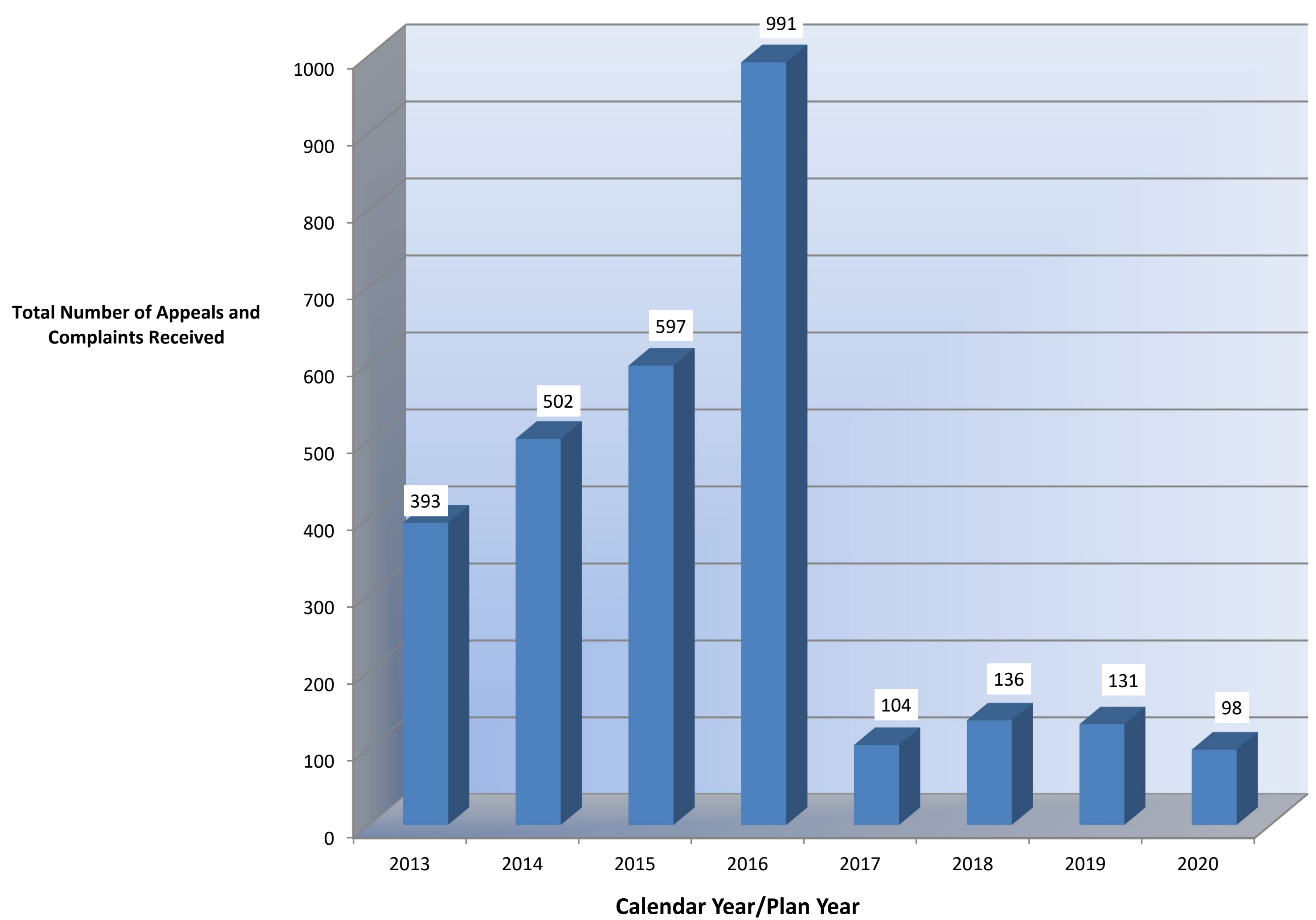
	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	YTD Total	% of Total
AHH-Customer Service												1	1	50.0%
AHH-UM/Pre-Cert	1												1	50.0%
Total	1	0	0	0	0	0	0	0	0	0	0	1	2	2.0%

Complaints - Corestream

	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	YTD Total	% of Total
Corestream-Customer Service					2								2	66.7%
Corestream-Portal Administration													0	0.0%
Corestream-Voluntary Products								1					1	33.3%
Total	0	0	0	0	2	0	0	1	0	0	0	0	3	3.1%

	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	YTD Total
Appeals & Complaints Totals	6	14	10	12	6	6	10	3	8	7	6	7	98




PEBP Complaints and Appeals History Comparison
2013 - 2020
Total Number of Appeals and Complaints Received
0
100
200
300
400
500
600
700
800
900
1000
393
502
597
991
104
136
131
98
2013
2014
2015
2016
2017
2018
2019
2020
Calendar Year/Plan Year

5.

5. Presentation and possible action on Governor's Recommended Budget and approval of PY22 Plan Benefit Design (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: January 28, 2021

Item Number: V

Title: Governor's Recommended Budget for the 2022/2023 biennium

SUMMARY

This report addresses the Governor's Recommended Budget for the 2022/2023 biennium.

BACKGROUND

On November 23, 2020, the PEBP Board met and approved PY22 plan design based on the 12% budget reserve requirements issued by the Governor's Finance Office (GFO) on November 3, 2020. In addition to various plan design changes, the Board approved the following options:

- Implement OON billed charges negotiated by using 140% Medicare model rather than Fair Health Standards
- Implement Smart 90 on EPO and Low Deductible (LD) plans
- Implement Advantage Network to CDHP, EPO and LD plan
- Reduce Medicare HRA contribution from $13 to $11 per year of service
- Reduce basic life insurance benefit from $25k/$12,500 to $10k/$5k
- Reduce Long Term Disability Benefit to 50% benefit
- Unbundling of dental premium

These options were projected to produce the $36M in savings required by PEBP.

REPORT

The Governor's Recommended Budget for Fiscal Years 2022 and 2023 was released on January 18, 2021 and delivered by Governor Sisolak in a State of the State address the following day. In addition to the elimination of furloughs, the Governor's recommended budget was successful in minimizing the impact to state employees through the preservation of medical benefits and stable

premiums. Included in the budget highlight of the Governor's Executive budget is the following statement:

"The Governor's budget prioritizes the health and well-being of state employees, retirees and their families who will continue to have access to an excellent medical benefit package through PEBP. It is more crucial than ever for state employees to have access to options that fit their unique health care needs. PEBP will expand the coverage options offered through the program in the upcoming biennium to include a new low deductible copay-based option. In addition to increased choice, premiums are expected to remain stable for the upcoming plan year."

The Governor's Recommended Budget includes significantly lower cuts than the program had anticipated. Additional funding for the program focuses on prioritizing access to care by preserving medical benefits and avoiding any significant premium increases.

The table below provides a comparison between what is offered today, what was approved by the Board and submitted as part of the 12% budget reserves requirement, and the proposed plan design based on the Governor's Recommended Budget.

	CDHP			New Low Ded PPO w/ copay			EPO/HMO		
	Current	12%	Gov Rec	Current	12%	Gov Rec	Current	12%	Gov Rec
Deductible (Individual w/in Family)	$1,500/$3,000 ($2,800)	$2,000/$4,000 ($2,850)	$1,750/$3,500 ($2,800)		$1000/$2,000 ($1000)	$500/$1,000 ($500)	$0	$500/$1,000 ($500)	$150/$300 ($150)
OOP Max (Individual w/in Family)	$3,900/$7,800 ($6,850)	$6,000/$12,000 ($6,000)	$5,000/$10,000 ($6,850)		$6,000/$12,000 ($6,000)	$5,000/$10,000 ($5,000)	$7,150/$14,300 ($7,150)	$6,000/$12,000 ($6,000)	$5,000/$10,000 ($5,000)
Coinsurance	20%	20%	20%		20%	20%	N/A	20%	20%
Primary Care Visit	20% after ded.	20% after ded.	20% after ded.		$30	$30	$20	$25	$25
Specialist Visit	20% after ded.	20% after ded.	20% after ded.		$50	$50	$40	$40	$40
ER visit	20% after ded.	20% after ded.	20% after ded.		$750	$750	$500	$750 after ded.	$750
UC Visit	20% after ded.	20% after ded.	20% after ded.		$80	$80	$30	$50	$50
Inpatient Hospital	20% after ded.	20% after ded.	20% after ded.		20% after ded.	20% after ded.	$500	$750 after ded.	$750
Outpatient Surgery	20% after ded.	20% after ded.	20% after ded.		$500	$500	$350	$350	$350
Rx Generic	20% after ded.	20% after ded.	20% after ded.		$10	$10	$10	$10	$10
Rx Formulary	20% after ded.	20% after ded.	20% after ded.		$40	$40	$40	$40	$40
Rx Non-formulary	20% after ded.	20% after ded.	20% after ded.		$75	$75	$75	$75	$75
Rx Specialty	20% after ded.	20% after ded.	20% after ded.		30% after ded.	30% after ded.	20%	30% after ded.	30% after ded.
All other services	20% after ded.	20% after ded.	20% after ded.		20% after ded.	20% after ded.	Varies	20% after ded.	20% after ded.
HSA employer contribution	$700 + $200/dep	$300	$600		N/A	N/A	N/A	N/A	N/A
Approximate EE only Rate	**$43.94**	**$66.27**	**$46.72**		**$105.91**	**$66.19**	**$171.05**	**$171.48**	**$139.63**
Approximate E+S Rate	**$227.16**	**$282.29**	**$258.22**		**$361.56**	**$297.16**	**$517.57**	**$492.69**	**$444.05**
Approximate E+C Rate	**$117.80**	**$160.27**	**$146.63**		**$214.77**	**$173.40**	**$343.23**	**$304.92**	**$274.39**
Approximate E+F Rate	**$301.01**	**$335.21**	**$304.73**		**$429.35**	**$350.97**	**$689.74**	**$585.06**	**$525.41**

***Rates are being shown for illustrative purposes only. Rates will not be finalized until March when actuaries have sufficient experience and utilization to model from.**

	Current	12%	Gov Rec
Basic Life Insurance	$25k/$12,500	$10k/$5k	$15k/$7,500
Long Term Disability	60% benefit	50% benefit	Eliminated
Medicare HRA Contribution	$13 per YOS	$11 per YOS	$11 per YOS

All plans proposed in Gov Rec have improved designs in comparison to what was approved by the Board in November. On the CDHP, deductibles have decreased and HSA contributions are higher. With a $500/$1000 deductible, the new low deductible copay-based plan can now accurately be described as a low deductible plan. While a newly implemented deductible on the EPO/HMO plan was not able to be entirely eliminated, it is now dramatically reduced. In addition, OOP maximums were reduced on all plans.

Rates overall, are projected to remain stable. All tiers on the CDHP are expected to experience small, but reasonable premium increases. The EPO and HMO will likely experience a decrease

in rates as a result of the policy decision approved by the Board in July 2020 that applies equal subsidies regardless of plan.

In addition to the above, Gov Rec assumes a 2% reduction in enrollment, the inclusion of the OON billed charges policy change, the addition of the narrow pharmacy network options, and the reduction of the Medicare HRA contribution from $13 to $11 as part of the overall reduction in program costs. The basic life insurance benefit is improved slightly, from the $10k/$5 levels approved by the Board in November, to $15k/$7,500. One significant change is the elimination of the unbundling of dental, which added to the cost of premiums significantly. Unfortunately, the Long-Term Disability Benefit is entirely eliminated but PEBP expects to be able to offer this as a voluntary product in the near future.

In general, PEBP fared very well through this undoubtedly tough budget building process. The program is able to offer its' members more choice and access without having to significantly raise premiums, which aligns with PEBP's mission of providing employees, retirees and their families with access to high quality benefits at affordable prices. PEBP is appreciative of the support that the Governor and his staff have provided and grateful that such a high priority was placed on employee medical benefits.

The full details of the Governor's Executive Budget – 2021-2023 Budget Highlights can be found here:
https://ewscripps.brightspotcdn.com/52/3f/e88ec9d54d68a2c5ce09533c1465/2021-2023-governor-executive-budget-highlights.pdf

RECOMMENDATION:

PEBP recommends the Board approve the following plan changes for PY22 based on the proposals included in the Governor's Recommended Budget:

1. Plan design as illustrated in the table on pg. 2
2. Reduction of basic life insurance from $25k/$12,500 to $15k/$7,500 (active/retiree)
3. Elimination of the Long-Term Disability Benefit

6.

6. Presentation and possible action on the status and approval of new PEBP contracts, contract amendments and solicitations (Cari Eaton, Chief Financial Officer) (**For Possible Action**)

   6.1 Contract Overview

   6.2 New Contracts

      6.2.1 Aetna Signature Administrators – Statewide PPO/EPO Network (pursuant to Request for Proposal No. 95PEBP-S1289)

      6.2.2 Health Plan of Nevada – Statewide HMO Plan (pursuant to Request for Proposal No. 95PEBP-S1291)

      6.2.3 Diversified Dental – Dental Network (pursuant to Request for Proposal No. 95PEBP-S1299)

   6.3 Contract Amendments

      6.3.1 Hometown Health – Statewide PPO – increases contract maximum to allow sufficient authority through remainder of contract

      6.3.2 The Standard – Life insurance and Long Term Disability decreases contract to reflect changes in plan benefit design

6.3.3 Aon Consulting – Consulting Services – increases contract authority for consulting services

6.4 Contract Solicitations

6.4.1 Website hosting

6.4.2 Third Party Administrator and associated services

6.4.3 Pharmacy Benefit Manager

6.5 Status of Current Solicitations

CORE
Expires 04/01/2021

STEVE SISOLAK
Governor

LAURA FREED
Board Chair

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LAURA RICH
Executive Officer

AGENDA ITEM

[X] Action Item

[ ] Information Only

Date: January 28, 2021

Item Number: VI

Title: Contract Status Report

Summary

This report addresses the status of PEBP contracts to include:

1. Contract Overview
2. New Contracts for approval
3. Contract Amendments for approval
4. Contract Solicitations for approval
5. Status of Current Solicitations

6.1 Contracts Overview

Below is a listing of the active PEBP contracts as of December 31, 2020.

PEBP Active Contracts Summary							
Vendor	**Service**	**Contract #**	**Effective Date**	**Termination Date**	**Contract Max**	**Current Expenditures**	**Amount Remaining**
HealthScope Benefits	TPA	11825	2/8/2011	6/30/2022	$ 62,600,000	$ 54,275,958	$ 8,324,042
Health Claim Auditors Inc.	Health Plan Auditor	12614	10/11/2011	9/30/2022	$ 2,827,910	$ 1,535,497	$ 1,292,413
HealthScope Benefits	National PPO	13330	7/1/2012	6/30/2022	$ 15,455,000	$ 10,228,493	$ 5,226,507
The Standard	Group Basic Life Insurance	14276	7/1/2013	6/30/2022	$ 95,000,000	$ 71,251,544	$ 23,748,456
HealthScope Benefits	Voluntary Flexible Spending Account	14465	7/1/2013	6/30/2022	$ 125,000	$ -	$ 125,000
Diversified Dental Services Inc.	Dental Contract	14563	7/9/2013	6/30/2021	$ 3,081,984	$ 2,368,227	$ 713,757
HealthScope Benefits	Dental Claims	14574	7/9/2013	6/30/2022	$ 6,100,000	$ 4,722,572	$ 1,377,428
Hometown Health Providers	In-state PPO Network	15510	7/1/2014	6/30/2021	$ 8,033,380	$ 7,825,904	$ 207,476
Standard Insurance Company	Voluntary Life Insurance	15503	7/1/2014	6/30/2023	$ 22,500,000	$ -	$ 22,500,000
Morneau Shepell LTD	Benefits Management System	15941	1/1/2015	12/31/2023	$ 8,623,789	$ 5,611,679	$ 3,012,110
Extend Health, Inc	Medicare Exchange	16468	7/1/2015	6/30/2025	$ 1,546,000	$ 1,233,742	$ 312,258
KPS3	Website Redesign	17226	11/1/2015	6/30/2021	$ 80,775	$ 68,952	$ 11,823
Casey,Neilon & Associates	Financial Auditor	17424	3/8/2016	12/31/2021	$ 236,500	$ 225,052	$ 11,448
Express Scripts, Inc.	Pharmacy Benefit Manager	17551	4/12/2016	6/30/2022	$226,500,000	$203,537,901	$ 22,962,099
AON Consulting	Consulting Services	17596	7/1/2016	6/30/2022	$ 3,376,585	$ 2,425,496	$ 951,089
Health Plan of Nevada Inc	Southern Nevada HMO	18362	7/1/2017	6/30/2021	$231,000,000	$130,538,861	$100,461,139
American Health Holdings	PPO Utilization Management Case Management	21376	7/1/2019	6/30/2023	$ 8,000,000	$ 2,903,943	$ 5,096,057
Labyrinth Solutions, Inc.	Benefits Management System	23678	12/8/2020	6/30/2027	$ 6,849,000	$ -	$ 6,849,000

Recommendation

No action necessary

6.2 New Contracts

The PEBP Board approved the solicitation for an in-state PPO Network, an HMO provider, and a statewide Dental Network on May 28, 2020. Request for Proposals were released, and PEBP staff has successfully negotiated contracts for these services.

6.2.1 Aetna Signature Administrators

On August 21, 2020, the Public Employees' Benefits Program released Request for Proposal (RFP) 95PEBP-S1289 for In-State Medical Preferred Provider (PPO) Network Services. The following were some items important to PEBP in the consideration of the award of this contract:

- Provide PEBP with a statewide medical network for PEBP's self-funded plans to fulfill the State of Nevada needs.
- Provide proposals meeting PEBP's objectives of providing self-funded plan participants access to a full complement of reputable, qualified medical professionals to include, but not limited to, board-certified specialists and primary care physicians, laboratories, behavioral health providers, urgent care facilities and hospitals while containing costs for the plan through aggressive contract pricing and minimizing the disruption of existing patient-participant relationships.

Vendor responses were scored based on the following criteria.

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

On October 8, 2020, PEBP received five (5) proposals in response to RFP 95PEBP-S1289. The evaluation period began on October 8, 2020 and ended on November 3, 2020. The six-member evaluation committee included three PEBP Board members and other subject matter experts. Aetna Signature Administrators received the highest score by the evaluation committee and PEBP has successfully negotiated a contract. Some of the reasons given by the individual evaluators for their scores were:

- Large statewide network
- Most providers accepting new patients
- Comprehensive credentialing of providers
- Lowest administrative fees, highest network savings

This contract not only expands the network to include St. Mary's and Banner Memorial Hospitals, but it is anticipated to save approximately $4M. Although there will be disruption in the South for members using Southwest Medical Associate providers, members will have the option to retain these providers on the HMO. Should this contract be ratified, PEBP (in coordination with Aetna and HealthSCOPE), will be focused on communicating the changes to members and the provider community to ensure a smooth transition on July 1, 2021.

The effective date of the contract is anticipated to be February 9, 2021 (upon BOE approval) through June 30, 2026. The services are expected to begin on July 1, 2021. The contract maximum is $7,127,250.

Recommendation

Ratify and approve the evaluation committee's recommendation to contract with Aetna Signature Administrators for In-State Medical Preferred Provider (PPO) Network Services beginning July 1, 2021.

6.2.2 Health Plan of Nevada

On September 4, 2020, the Public Employees' Benefits Program released Request for Proposal (RFP) 95PEBP-S1291 for Health Maintenance Organization (HMO) services. The following were some items important to PEBP in the consideration of the award of this contract:

- Provide a fully insured Health Maintenance Organization (HMO) services for State of Nevada and Non-State employees, retirees, and their dependents in Southern Nevada, including Clark, Nye and Esmeralda counties.

- Providing the highest quality health benefits with an emphasis on customer service, preventive and wellness benefits, utilization management, and promoting informed health care utilization while preserving individual choices and options.
- A vendor who will work in partnership with PEBP, provide exemplary services, and make the desires and goals of this agency a priority.
- Access to a comprehensive choice of providers within the covered service area (Clark, Nye and Esmeralda counties) as well as outside of Nevada for emergency and specialized care.
- Include a full complement of reputable, qualified professionals, a variety of specialists, and include centers of excellence.
- Include, but not be limited to, the following services and plan provisions:
  Customer service;
  Utilization review;
  Concurrent review;
  Disease management;
  Large case management;
  Wellness and preventive services benefits;
  Vision benefits; and Mandated health benefits.
- One seamless plan design between the southern HMO and the Northern EPO plans.
- The ability for PEBP to negotiate plan design depending on market conditions and board direction.

Vendor responses were scored based on the following criteria.

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

On October 13, 2020, PEBP received two (2) proposals in response to RFP 95PEBP-S1291. The evaluation period began on October 14, 2020 and ended on October 27, 2020. Health Plan of Nevada received the highest score by the six-member evaluation committee that included PEBP Board members and other subject matter experts. In addition, Aon provided the committee with analysis on cost and provider disruption. Some of the reasons given by the individual evaluators for their scores were:

- Largest Southern Nevada network
- Most providers accepting new patients
- Minimal provider disruption
- Call center with PEBP dedicated toll-free number
- Excellent online provider directory
- Overall cost and rate renewal guarantee

Since Health Plan of Nevada is PEBP's existing HMO vendor, there will be little to no impact to the program or to members.

The effective date of the contract is anticipated to be February 9, 2021 (upon BOE approval) through June 30, 2025. The services are expected to begin on July 1, 2021. The contract maximum is $192,093,848.

Recommendation

Ratify and approve the evaluation committee's recommendation to contract with Health Plan of Nevada for Health Maintenance Organization (HMO) services beginning July 1, 2021.

6.2.3 Diversified Dental

On September 11, 2020, the Public Employees' Benefits Program released Request for Proposal (RFP) 95PEBP-S1299 for Dental Network Services. The following were some items important to PEBP in the consideration of the award of this contract:

- Provide a comprehensive dental provider network both inside and outside of Nevada to PEBP participants at the lowest cost and support the self-insured dental PPO plan
- Offer and maintain a website that will provide information such as a provider directory, provider nomination and other oral health and wellness information as it pertains to participants and the program.

Vendor responses were scored based on the following criteria.

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

On October 15, 2020, PEBP received seven (7) proposals in response to RFP 95PEBP-S1299. The evaluation period began on October 16, 2020 and ended on November 10, 2020. Diversified Dental received the highest score by the six-member evaluation committee, made up of PEBP Board members and subject matter experts. In addition, Aon provided the committee with analysis on cost and provider disruption. Some of the reasons given by the individual evaluators for their scores were:

- Large Network, least provider disruption
- Most providers accepting new patients
- Nevada based company

Since Diversified Dental is PEBP's existing Dental Network, there will be little to no impact to the program or to members.

The effective date of the contract is anticipated to be February 9, 2021 (upon BOE approval) through June 30, 2026. The services are expected to begin on July 1, 2021. The contract maximum is $1,601,613.

Recommendation

Ratify and accept the evaluation committee's recommendation to contract with Diversified Dental for Dental Network Services beginning July 1, 2021.

6.3 Contract Amendments

The following active PEBP contracts require amendments:

6.3.1 HOMETOWN HEALTH

PEBP contracted with Hometown Health for In-State Preferred Provider Organization (PPO) Network Services which began July 1, 2014 resulting from RFP 3100.

This contract amendment is required to add additional contract authority in the amount of $526,710 to fulfill our contractual obligations for the remainder of the contract term through June 30, 2021. This contract has been amended and extended and has never increased authority from the original negotiated contract that began on July 1, 2014. When the contract was amended to add the EPO plan for PY19 through PY21, authority was not added to the contract for the increased population as it appeared there would be sufficient authority at the time.

Recommendation

PEBP recommends the Board authorize staff to complete a contract amendment between PEBP and Hometown Health for In-State PPO Network services in contract #15510 to increase the contract authority in the amount of $526,710.

6.3.2 THE STANDARD

PEBP contracted with The Standard for Basic Group Life Insurance and Long-Term Disability Services which began July 1, 2013 resulting from RFP 3020.

This contract amendment is required to amend the fee schedule to align with the plan design changes included in the Governor's recommended budget. The amendment will include a reduction to the maximum contract authority in the approximate amount of $16 million.

- Reduce basic life insurance coverage to $15,000 (active) and $7500 (retiree)
- Elimination of Long-Term Disability

Recommendation

PEBP recommends the Board authorize staff to complete a contract amendment between PEBP and The Standard for Basic Group Life Insurance and Long-Term Disability Services in contract #14276 to update the fee schedule and reduce the contract authority in the approximate amount of $16 million.

6.3.3 AON CONSULTING

As PEBP is finalizing the first round of RFP's, staff is already preparing for the next round. PEBP expects to release many solicitations this upcoming summer, including two major solicitations: the Third-Party Administrator (TPA) RFP and the Pharmacy Benefit Manager (PBM) RFP. Both solicitations will require outside expertise, both in the development phase as well as analysis once the proposals are submitted by vendors. Due to an unanticipated amount of utilization in consulting services related to COVID-19 costs, budgeting activities and solicitations, PEBP does not expect to have sufficient contract authority to be able to enlist the services necessary of Aon in these major contract renewals, therefore PEBP is requesting an additional $225,000 in maximum contract authority. This additional authority may require PEBP to submit a work program and the approval of this contract from the Board of Examiners will likely be contingent on the approval of the work program from the Interim Finance Committee.

Recommendation

PEBP recommends the Board authorize staff to complete a contract amendment between PEBP and AON Consulting for Actuarial and Consulting services in contract #17596 to increase the contract authority in the amount of $225,000.

6.4 Contract Solicitations

Below are the services that are pending solicitations for a new contract.

6.4.1 WEBSITE HOSTING

In 2015, PEBP contracted with KPS3 for website development and hosting using an existing DCNR contract joinder. The current contract is due to expire on June 30, 2021 and PEBP will need to solicit for on-going website hosting and maintenance. Since this contract will be relatively low cost, this solicitation can be accomplished with an informal solicitation. PEBP is currently budgeted for $1,660 each year for these services.

Recommendation

PEBP recommends the Board authorize staff to complete an informal solicitation for web hosting and maintenance services.

6.4.2 Third-Party Administrator (TPA) and associated services

PEBP's current contract for TPA services with HealthSCOPE Benefits (HSB) began in 2011. Since then, the contract has been amended six times, extended twice to add a total of 6 years to the original contract, and is due to expire on June 30, 2022. Currently included in the TPA contract are various services offered through HealthSCOPE that have been implemented by PEBP, such as Doctor on Demand, Health Care Blue Book, 2nd MD, and subrogation services. Many of these services are not standard offerings through a TPA and will likely need to be resolicited separately. Conversely, there are other services PEBP contracts separately for that are typically industry standard in a TPA agreement and will likely result in reduced costs to the program if included as part of the TPA solicitation.

Nonetheless, most of these services expire on June 30, 2022 and PEBP will need to develop multiple solicitations to ensure the continuation of these services. The chart below provides details and staff recommendations on contracted services associated with the TPA solicitation:

Service	Vendor	Expires	Recommendation
TPA medical	HSB TPA contract	6/2022	Include in TPA solicitation
TPA dental	HSB	6/2022	Include in TPA solicitation
National network	Aetna through HSB TPA contract	6/2022	Include in TPA solicitation
Statewide network	Aetna	6/2026	Include in TPA solicitation as an option
Telemedicine Provider	Doctor on Demand through HSB TPA contract	6/2022	Separate solicitation, contract with TPA
Shopping comparison tool	Health Care Blue Book through HSB TPA contract	6/2022	Separate solicitation, contract with TPA
Subrogation	Luper Neidenthal & Logan through HSB TPA contract	6/2022	Include in TPA solicitation OR separate solicitation, contract with TPA
Second opinion services	2nd MD through HSB TPA contract	6/2022	Separate solicitation, contract with TPA
FSA Administration	HSB	6/2022	Offer as voluntary benefit

HSA/HRA Administration	HSB through HSB TPA contract	6/2022	Separate solicitation

Recommendation
PEBP recommends the Board authorize staff to complete multiple solicitations (RFP's) using the recommendations provided in the chart above.

6.4.3 Pharmacy Benefit Manager (PBM)

PEBP's current contract for PBM services with Express Scripts (ESI) began in 2016. Since then, the contract has been amended four times generally because of market checks that have resulted in lower negotiated fees. The original 4-year contract has been previously awarded a one-year extension and is now due to expire on June 30, 2022.

Recommendation
PEBP recommends the Board authorize staff to complete a Request for Proposal for the Pharmacy Benefit Manager.

6.5 Status of Current Solicitations

The chart below provides information on the status of PEBP's in-progress solicitations:

Service	RFP release date	Anticipated/Actual NOI	Anticipated Board Approval
Health Plan Auditor	11/24/2020	1/12/2021	3/25/2021
Financial Auditor	1/08/2021	3/09/2021	5/27/2021

Recommendation

No action necessary

7.

7. Discussion and possible action on rate setting and rate development (Stephanie Messier, Aon) (**For Possible Action**)

Rate Setting Review and PEBP Board Considerations

January 28th, 2021 PEBP Board Meeting

Prepared by Aon
Health Solutions

Before we begin…

WARNING

The numbers contained in this report are included solely to help explain numerical concepts, they are not indicative of future rates that will be presented at the March board meeting, and should not be construed as such

Figures included herein are to facilitate Board discussions and illustrate the Rate Setting process as well as Dependent Subsidy strategies

Today's Agenda

Rate Setting Review

- Base Rate Underwriting
- Enrollment Weighting
- Admin Fees and HSA/HRA Load
- Tiering
- Addition of Life/LTD Costs

PEBP Board Considerations

- Dependent Funding Strategy
- Premiums in Year 2 of Biennium

= Places where enrollment weighting matters

Rate Setting Tutorial

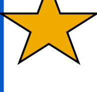
Base Rate Underwriting Refresher

Step 1
- Aon gathers claims data (Medical/Pharmacy/Dental) for the prior 24 months from PEBP vendors

Step 2
- Claims are completed based on prior seasonality and claims lag triangle payment patterns, and trended forward to PY22

Step 3
- Any upcoming Medical, Pharmacy or Dental Plan Design Changes, Market Checks, or Savings Initiatives are applied

Step 4
- Enrollment expectations by tier and plan are applied along with Utilization Assumptions and Actuarial Values



Step 5
- Base Rates PPPMs are then established for the three plan offerings (CDHP, Copay, and EPO) separated by Medical, Pharmacy, and Dental expected Claims

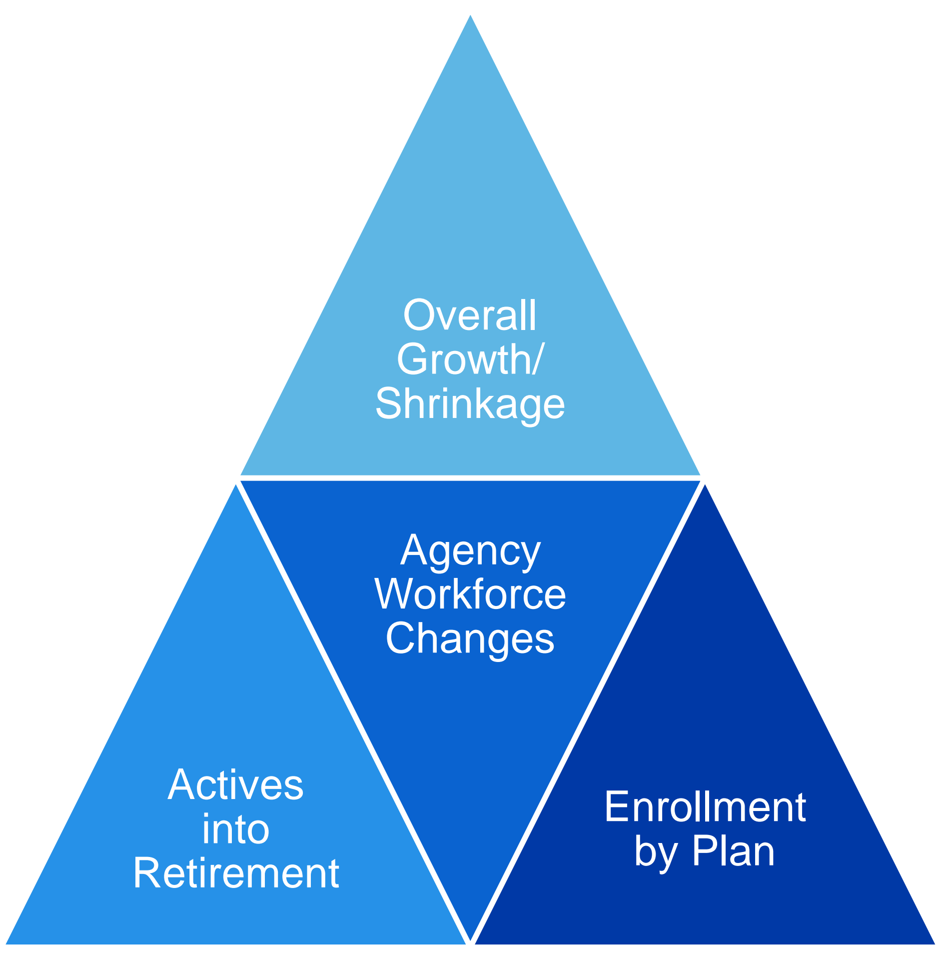
Per PEBP Board direction, we are asked to set rates/trend aggressively – a 50% chance they will be sufficient to cover expected claims costs and a 50% chance they will be short

PPPM = Per Participant Per Month

EPO Base Claims are blended with Fully Insured HMO Rates provided annually by HPN

Enrollment Weighting

PEBP enrollment assumptions are made as to how the populations (both actives and retirees) will shift in the projection year, these assumptions include:



Administrative Fees and HSA/HRA Expense Loads

Administrative Fees PPPMs – made up of PEBP Operating costs and Contract Obligations:

PEBP Costs = $27.27

Medical Fees:

CDHP = $35.27

Copay = $32.77

EPO = $30.26

Pharmacy Fees:

CDHP = $2.88

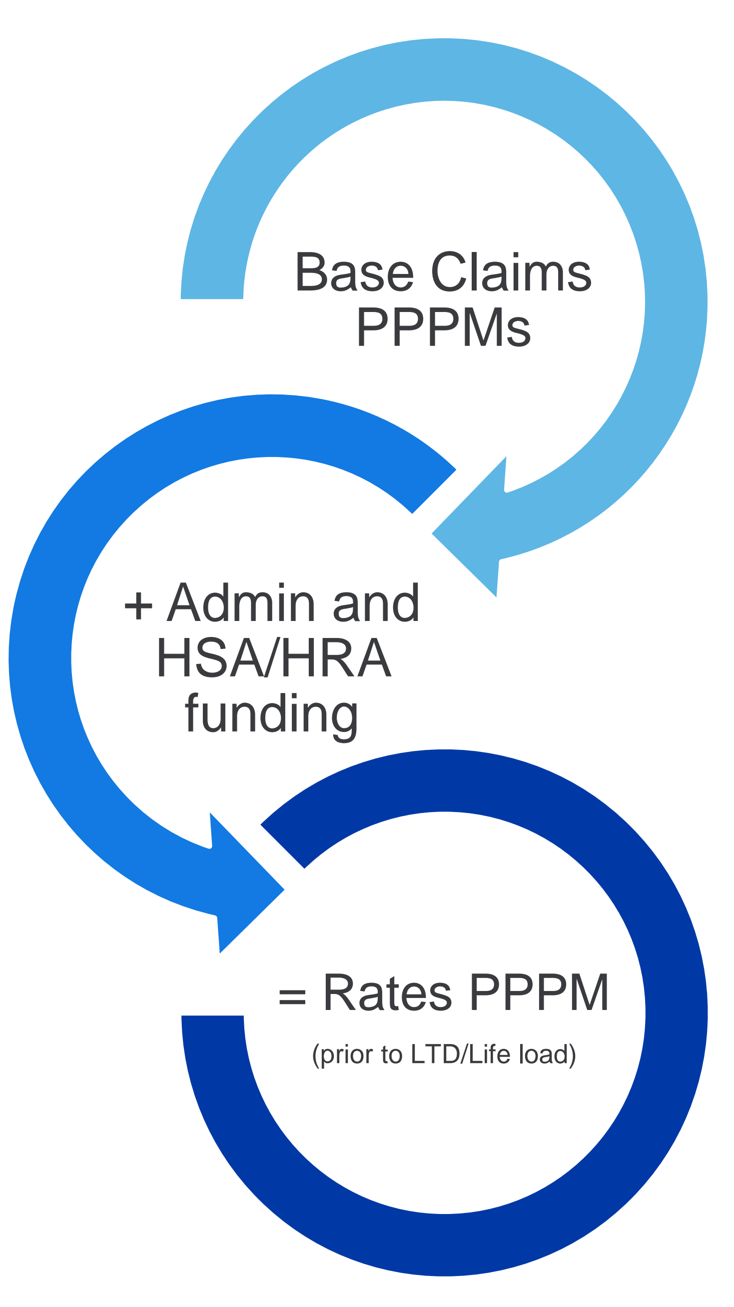
Copay = $2.88

EPO = $3.04

Dental Fees = $1.99

HSA/HRA Funding = $50.00

for Participants not on the Exchange



Life/LTD Costs are added after tiering to avoid overcharging those participants with spouses and children on the plan, as life and LTD benefits apply to the primary participant only.

Tiering: X, 2X, X + Y, 2X + Y

The Base Claims and Admin Fee PPPMs are weighted by projected enrollment by tier

PEBP's requested dependent factors are then applied to create rates by tier

	Participant = X	X
	Participant + Spouse = 2X	2X
	Participant + Child = X + Y	X+Y
	Participant + Family = 2X + Y	2X+Y

Where X is the average cost of an adult and Y is the average cost of a child unit

Addition of Life and LTD Insurance

PPPM Life and LTD Costs are then added to each tier of the three plans to arrive at Final Overall Rates

Active

Life
$8.42

LTD
$14.30

Retiree

Life
$4.21

Exchange

(applied to all non-Exchange participants)

Life
$1.76

Life and LTD Benefits apply to the primary participant of the plan only

Board Considerations

Dependent Funding Strategy for Premiums

Once overall rates are set, PEBPs contribution strategy is applied:

Flat Dollar Contribution – consistent by plan

Varies by participant vs dependent (0.85 factor for dependents)

For example, if the State is providing $585 per active participant, and the current average cost of a child unit (Y) is 0.375, then:

Tier	Example X = $585	State Contribution
Single Active	$585 * 1	$585.00
EE + Spouse	$585 * 2 * 0.85	$994.50
EE + Child(ren)	$585 * (1+Y) * 0.85	$683.72
EE + Family	$585 * (2+Y) * 0.85	$1,180.97

Dependent Funding Strategy for Premiums continued

Last year, the Board made varying adjustments by tier that moved away from the established dependent percentage which had been consistent by tier

1. This puts the Child tier at a disadvantage as we move forward into PY22 and apply the previously established methodology

2. One way to account for this would be to apply an adjustment factor to the Child tier

Tier	PY21 Premiums CDHP / EPO $	$	SAMPLE Increase in PY22 if use PY20 and prior method CDHP / EPO $ / %	$ / %	SAMPLE Increase in PY22 w/ 1.05 adjustment on CH tier CDHP / EPO $ / %	$ / %
Single Active	43.94	171.05	+$16 37%	($18) -11%	+$17 40%	($17) -10%
EE + Spouse	227.16	517.57	+$68 30%	($36) - 7%	+$46 20%	($58) -11%
EE + Child(ren)	117.80	343.23	+$85 72%	($12) - 4%	+$44 37%	($54) -16%
EE + Family	301.01	689.74	+$50 17%	($118) -17%	+$19 6%	($149) -22%

Dependent Funding Strategy for Premiums continued part 3

Another item to consider about the current methodology is that applying a percentage to 3 tiers, produces uneven increases in Premiums in the second year of the biennium, with larger increases given to the Single tier

Assuming a 5% trend from PY22 to PY23: below are the **SAMPLE** impacts to Employee premiums

Actives	**CDHP**			**Copay**			**PEBP EPO & HPN HMO**		
Tier	PY22	PY23	Change ($ / %)	PY22	PY23	Change ($ / %)	PY22	PY23	Change ($ / %)
Single	$60	$92	$32 54%	$79	$112	$33 42%	$153	$190	$37 24%
+ SP	$296	$360	$65 22%	$334	$400	$66 20%	$482	$555	$74 15%
+ CH	$203	$248	$44 22%	$229	$275	$46 20%	$331	$382	$51 15%
Family	$351	$428	$77 22%	$396	$475	$79 20%	$572	$659	$88 15%

Premiums above assume that State Funding remains constant from Year 1 to Year 2 of the biennium

PEBP Board Considerations

Considerations for the Board:

Depending Funding Strategy

- Does the Board want to revert to the prior dependent percentages used in PY20?
- Does the Board wish to make an adjustment to the child tier for this next biennium?
- Or does the Board wish to make a change to a different methodology for dependents?

Biennium Year 2 Funding

- Keep the State Funding amount constant for Plan Years 1 and 2
- Lower State Funding in Year 1 to provide more funding to offset trend in Year 2

  This drives a slightly larger increase in Year 1 but also a more reasonable participant change in Year 2

WARNING

The numbers contained in this report are included solely to help explain numerical concepts, they are not indicative of future rates that will be presented at the March board meeting, and should not be construed as such

Figures included herein are to facilitate Board discussions and illustrate the Rate Setting process as well as Dependent Subsidy strategies

8.

8. Discussion and Possible Action on Legislative Counsel Bureau Information Technology Audit report and Corrective Action Plan (Laura Rich, Executive Officer) (**For Possible Action**)

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

LAURA RICH
Executive Officer

AGENDA ITEM

[X] Action Item

[ ] Information Only

Date: January 28, 2021

Item Number: VIII

Title: Legislative Counsel Bureau IT Audit – Corrective Action Plan

SUMMARY

In January 2019, PEBP was notified by the Legislative Counsel Bureau (LCB) Audit Division that it would be performing an Information Technology and Security audit of the agency.

On January 9, 2020, the LCB provided the agency with an initial draft of the final findings to which PEBP was required to submit a written response indicating acceptance or disagreement. A corrective action plan was developed, approved by the Board and implemented since that time.

In October 2020, PEBP was notified of an addendum to the original audit that included four additional items to be addressed. These four new items were not included on the original LCB audit report due to security risks that could result from making these findings public prior to the appropriate security measures being implemented. These concerns have since been addressed.

On January 14, 2021 PEBP accepted these additional findings during the Legislative Commission Audit Subcommittee meeting. As a result, PEBP must provide an initial 60-day corrective action plan followed by a subsequent six-month status report. PEBP has developed the proposed corrective action plan to future-proof the concerns identified in the audit.

REPORT

See Attachment A

Attachment A

Recommendation 15: Develop and maintain an agency-wide server asset lifecycle plan.

Response:
PEBP accepts this recommendation.
PEBP is eliminating all agency-owned servers and will instead utilize third-party (EITS) servers and services to support its various programs.

Corrective Action:
PEBP will create a new policy and procedure that reflects its ongoing efforts to monitor and manage these hosted systems utilizing existing EITS policies, standards and procedures. Specifically, policy will require that the agency Chief Information Officer review annually with EITS all servers to ensure appropriate lifecycle planning (and any required remediation) is performed annually.

Recommendation 16: Develop policies and procedures to routinely verify servers and receiving operating system and database software critical updates and ensure they are successfully installed.

Response:
PEBP accepts this recommendation.
PEBP is eliminating all agency-owned servers and will instead utilize third-party (EITS) servers and services to support its various programs.

Corrective Action:
PEBP will create a new policy and procedure that reflects its ongoing efforts to monitor and manage these hosted systems utilizing existing EITS policies, standards and procedures. Specifically, policy will require that the agency Information Security Officer and Chief Information Officer review annually with EITS all servers, desktops, databases and other systems to ensure appropriate patching (and any required remediation) is performed at least annually.

Recommendation 17: Develop policies and procedures to ensure vulnerability scanning of servers is conducted at least annually to assist in identifying areas of risk.

Response:
PEBP accepts this recommendation.
PEBP is eliminating all agency-owned servers and will instead utilize third-party (EITS) servers and services to support its various programs.

Corrective Action:
PEBP will create a new policy and procedure that reflects its ongoing efforts to monitor and manage these hosted systems utilizing existing EITS policies, standards and procedures. Specifically, policy will require that the agency Information Security Officer and Chief Information Officer review annually with EITS all servers to ensure appropriate scanning (and any required remediation) is performed annually.

Recommendation 18: Ensure existing server inventory and password management software is maintained.

Response:
PEBP accepts this recommendation.
PEBP will utilize an existing system that maintains this critical and confidential information.

Corrective Action:
PEBP has an existing system (KeePass) that will be utilized and routinely monitored to ensure integrity and accuracy of this critical and confidential data, and this procedure will be updated into policy to be reviewed at least annually.

9.

9. Discussion and Possible Action on updates to Board policies and procedures to include edits reflecting (1) Board policy decisions and (2) Subcommittee recommendatins relating to the Legislative Counsel Bureau contract audit report (Laura Rich, Executive Officer) (**For Possible Action**)

STEVE SISOLAK
Governor

LAURA FREED
Board Chair

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LAURA RICH
Executive Officer

PUBLIC EMPLOYEES' BENEFITS PROGRAM

BOARD AND AGENCY

Duties, Policies and Procedures

~~September 2019~~January 2021

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I. INTRODUCTION

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

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

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

GUIDING PRINCIPLES OF HEALTH CARE BENEFITS ADMINISTRATION

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

II. GOVERNANCE

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

Board members are entrusted with the responsibility of exercising their duties in a manner that ensures the efficient and effective administration of the Program in compliance with all applicable Federal and State laws and regulations, including those relating to ethics (NRS Chapter 281A), contracting (NRS Chapter 333) and the Nevada Open Meeting Law (NRS Chapter 241).

FRAMEWORK:

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

A. BOARD RESPONSIBILITIES

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

1. Be responsible for adopting the Mission Statement, Values, Goals and Objectives (i.e., the Strategic Plan) of the Program.
2. Provide health care, life insurance, and other voluntary ~~insurance~~ benefits in a responsible manner balancing the needs of the State, Plan participants and the taxpaying community. Benefit changes may be considered by the Board based upon recommendations from individual Board members, the Agency or from the public.
3. Adopt sound actuarial and accounting standards and appropriate internal controls.
4. Review and revise Duties, Policies and Procedures regarding matters that are not specifically enumerated in statute or regulation as needed.
5. Take a position on any proposed legislative matters affecting the Program and direct Agency employees to make that position known to the Legislature. During the legislative session, the Board authorizes the Executive Officer to take a position of "neutral" on any new bill affecting the Program by default. This allows for rapid response to legislative committee meetings scheduled prior to a Board vote. The Board can revise the default position at the next Board meeting.
6. Prior to the commencement of each biennial legislative session, review and approve the framework for the biennial budget to be submitted to the Governor's office.
~~6.~~7. Be responsible for PEBP's contracting activities in accordance with NRS 287.043(3), NRS 287.0434, NRS 287.04345 and NRS 333.300(4).
~~7.~~8. Employ and appoint an Executive Officer, subject to the approval of the Governor, to oversee the day-to-day operations of the Program in accordance with NRS 287.0424.
~~8.~~9. Delegate to the Executive Officer the authority to manage the Program within the parameters defined by the Board.
~~9.~~10. Evaluate the Executive Officer as needed in a public forum adhering to all applicable open meeting law requirements.
~~10.~~11. The Director of the Department of Administration appoints the Quality Control Officer for the Program. The Director shall define the duties of the Quality Control Officer with the concurrence of the Board. The Quality Control Officer serves at the pleasure of the Director.

B. BOARD MEMBER CONDUCT

Individual Board members shall:

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

C. BOARD MEETINGS

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

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

D. EXECUTIVE OFFICER AND AGENCY ADMINISTRATION

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

1. The Board authorizes the Executive Officer or his/her designee to provide official press releases and to answer questions from the press and other news media.
2. The Board authorizes the Executive Officer or his/her designee to carry out administrative functions of the Agency, including but not limited to:
    a. Financial management of contribution/rate billing, accounts receivable, accounts payable and budgetary compliance.
    b. Management of Agency personnel, day-to-day operations and vendor performance matters.
    c. Interpretation of NRS and NAC in performing functions of the Agency.
    d. Approval of subrogation settlements and other financial settlements relating to claims processing.
    e. Representation of the Agency to other pertinent governmental bodies.
3. Consistent with Board policies and directions, the Agency shall work with the Governor's Finance Office (GFO) and the Legislative~~ure~~ Counsel Bureau (LCB) to ensure that the Program is funded on an actuarially sound basis. The Agency shall 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.
4. Ensure~~ing~~ the Agency notifies participants of health care benefit changes as approved by the Board.
5. As soon as practical, but within 120 days of the appointment of a new Board member, the Executive Officer shall provide the new Board member with a comprehensive orientation and overview of the Program which the new member shall acknowledge receipt by signing and dating the "Acknowledgment Form for Board Members". The orientation will include, at a minimum, the following:
    a. The history and overview of PEBP and the benefits administered by the Program including any special terminology generally used by the Program.
    b. The Board governance, including the Strategic Plan and these Duties, Policies and Procedures.

c. A review of recent Board actions and precedents and current issues being considered by the Board.
d. An overview of the funding and rate setting process.
e. The continuing education opportunities for the member pending available funding.

6. The Executive Officer will also ensure these Duties, Policies and Procedures are provided to all employees upon approval of any changes by the Board and to new employees within 10 working days of their hire with the Agency. Employees will acknowledge receipt and understanding by signing the "Acknowledgment Form for Employees."
7. The Executive Officer may obtain continuing education credits pertaining to the administration of group benefits for public employees as funding is available.
8. The Executive Officer will provide Agency employees with relevant education and training and will allow employees to attend training classes relating to the administration of health care benefits or to the employee's individual work assignments. The Executive Officer is responsible for setting the eligibility requirements for an employee to attend a training or other educational event and the appropriate reimbursement of cost and/or release time to be provided for the training within the budgetary limits established for the purpose of employee training.
9. The Executive Officer is responsible for interacting with the Executive and Legislative branches of government and shall work diligently and cooperate fully with both to provide any information desired in relation to the operations, functions, or status of the Program.
10. Responses to correspondence addressed to the Chair may be prepared by Executive Staff. Responses to correspondence addressed to the Board may be prepared and signed by Executive Staff on behalf of the Board.

E. ETHICS

The Board and agency employees must:

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

Each Board Member and each member of the Executive Staff will read the most current Ethics Manual and sign an acknowledgement of their understanding of the ethics requirements upon appointment or hire and receive annual Ethics Training provided by the staff of the Commission on

Ethics every subsequent year. _The most current Ethics Manual may be found at:
http://ethics.nv.gov/uploadedFiles/ethicsnvgov/content/Resources/EthicsManual2014.pdf

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

1. Disclose information regarding business developments of a confidential nature received in the course of their duties except in the authorized performance of those duties.
2. Attempt to take advantage of confidential information received in the course of their duties for themselves or any third party.
3. Accept meals, travel, lodging or any other gift from any contractor or vendor ~~bidding on an open Program RFP.~~in accordance to NRS 281A

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

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

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

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

F. SEXUAL HARASSMENT

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

G. HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

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

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

H. TRAVEL POLICY

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

III. CONTRACTS

A. PURPOSE, AUTHORITY, AND POLICY

1. The purpose of this policy is to establish procedures for new contracts and contract extensions which will be in accordance with the State Purchasing Act.

   The Nevada Revised Statute:
   http://www.leg.state.nv.us/NRS/NRS- 333.html#NRS333Sec311
   The Nevada Administrative Code:
   http://www.leg.state.nv.us/NAC/NAC-333.html
   and The State Administrative Manual:
   http://budget.nv.gov/uploadedFiles/budgetnvgov/content/Govern an ce/SAM.pdf

2. There shall be a standing item on the Board meeting agenda to review the status of current contracts and active RFP's~~ and contract negotiations~~.

   ~~The Nevada Revised Statute:~~
   ~~http://www.leg.state.nv.us/NRS/NRS- 333.html#NRS333Sec311~~
   ~~The Nevada Administrative Code:~~
   ~~http://www.leg.state.nv.us/NAC/NAC-333.html~~
   ~~and The State Administrative Manual:~~
   ~~http://budget.nv.gov/uploadedFiles/budgetnvgov/content/Govern an ce/SAM.pdf~~

B. PROCUREMENT PROCESS

1. The Program is subject to the provisions of chapter 333 of NRS.
2. The Board shall act as the chief of the using agency for the purposes of NRS 333.335.
   a. The Board delegates the role as chief of the using agency to the Executive Officer for routine administrative contracts ~~over~~under $100,000 (NRS 333.162), e.g., auditors, leases, PEBP web site management, etc.~~.~~

   ~~a.~~ The Executive Officer shall solicit the participation of Board members to participate in the development of a solicitation as well as serve on the committee as an evaluator.
   b.

   For all other contracts including any that involve the procurement of services to PEBP members or actuarial services, the Board delegates ministerial and administrative duties as chief of the using agency to the Executive Officer.~~for~~
   ~~T~~

   c. The Executive Officer shall ensure that accurate and detailed information and supporting documentation, within the bounds of statute and regulation, is provided to the Board and other governing bodies when seeking to bid new contracts and amend existing contracts.
   d. The Board retains the power and duty as chief of the using agency to appoint members of the Board to evaluation committees pursuant to NRS 333.335.
   e. The duty of negotiating and administering the contracts is delegated to the Executive Officer.

~~b.~~

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

closed meeting.

a. The Executive Officer will provide an appropriate check list to assist the Board in their review of the RFP.

5. The Board shall take the following actions only in an open meeting:
   a. Award the contract pursuant to NRS 333.335;
   b. Cancel the request for proposals; or
   c. Modify and reissue the request for proposals.
   ~~c.~~d. The Board shall review sufficient documentation to ensure justification for the recommended action(s) and validation of recommendations by PEBP management.
6. Service performance standards and Financial Guarantees and/or Penalties will be included in all contracts. Specific -standards, guarantees and penalties will depend upon the type of service(s) provided by vendor.
7. Contracts which are subject to an audit pursuant to the scope of work: the contracted auditor will conduct the audit in accordance with the schedule in the scope of work and provide the results to the Board at the next meeting after the conclusion of the audit and response from the vendor have been rendered.
8. The Board shall oversee significant scope modifications and ensure a competitive bid process is followed for (but not limited to):
   a. Changes in the scope of the competition or vendor status;
   b. Changes that were not within the contemplation of the parties when the original contract was entered;
   c. Changes that materially alter the contract;
   d. Changes in the quantity of major items or portions of work; or
   e. Historically procured services under a separate contract.

~~7.~~

C. Amendments

1. The Board shall review and discuss all contract extensions and ensure extensions receive all required approvals, i.e., solicitation waivers, appropriate justification, and documentation.
2. ~~8.~~ The Executive Officer shall provide appropriate check lists to the Board in order to assist the Board in their evaluation of the amendment.

IV. PREMIUMS AND CONTRIBUTIONS – RATE SETTING PROCESS

A. INTRODUCTION

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

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

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

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

~~A.~~B. RESERVE POLICY

PEBP will maintain fully~~-~~ funded IBNR and Catastrophic Reserves as determined by plan actuaries using the confidence intervals and margins described herein and a fully~~-~~ funded HRA Reserve based on 80% of the total balance remaining in all HRA accounts. Should the Catastrophic Reserve become underfunded or be forecast to be underfunded, the Executive Officer shall notify the Board at the next Board meeting.

The IBNR Reserves will be funded at a 95% confidence level to pay all known incurred claims. The Catastrophic Reserves will be funded at a ~~95% confidence level~~level of 50 days on hand to meet unknown expenses which do not include IBNR. Both IBNR and Catastrophic Reserve levels will be recommended by PEBP's actuaries. The HRA Reserve will be funded to cover ~~100~~80% of available balances.

Any cash-on-hand in addition to required reserves (IBNR, Catastrophic, and HRA) when the Program closes ~~the~~ a fiscal ~~year each year~~ will be identified as "Excess Reserves." Per section 26 of Senate Bill 553 (2019) (the Authorizations Act), "the Public Employees' Benefits Program, including, without limitation, the Board of the Public Employees' Benefits Program, shall not expend or otherwise obligate reserves, either realized or projected, in excess of the amounts authorized in section 1 of this act for purposes of changing the health

benefits available to state and nonstate active employees, retirees and covered dependents over the 2019-2021 biennium without approval of the Interim Finance Committee upon the recommendation of the Governor."

~~B.~~C. DEFINITIONS

As used herein the following terms mean:

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

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

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

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

5. **Premium** – The cost paid for fully-insured benefits (e.g., health maintenance organization membership, life insurance, etc.) as determined by insurance companies contracted with by PEBP. Premiums are passed ~~-~~through PEBP to the participants and employers.

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

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

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

~~C.~~D. OVERVIEW OF THE BIENNIAL PROCESSES[1]

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

2. **Plan Design** – The Board will identify the priorities for plan design (i.e., options for changes in the plan design). These priorities may include scope of benefits offered by the plan and/or cost sharing methodologies between the Program and its participants. To the extent possible, cost estimates are presented at the same time as the plan design option for inclusion in the discussion. The Board can

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

take into consideration all information provided by Program staff and consultants during the year, along with any other sources available to individual Board members.

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

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

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

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

5. **Preparing the Biennial Budget Request** – Departments are required to submit their biennial budget requests no later than September 1st of each even numbered year. Using the strategic plan and the approved allocation methodologies found in Appendix A as a basis, staff preparation of the biennial budget request begins in the

5. spring of each even numbered year. A framework for the budget request will be presented to the Board in late spring or early summer, with final approval required at the July or August Board meeting. Budgetary BDRs will be approved by the Board prior to submission on September 1st.

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

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

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

~~d.~~e. Differential cash will be reported in September to provide the most sound and consistent figures.

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

Appendix A - Plan Year Rating Methodology

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

Plan Design

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

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

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

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

Cost Projections

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

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

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

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

- Participant Tiers of Coverage: Four

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

Rate Development

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

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

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

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

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

- Reserves
  - √ Catastrophic Reserves will be established at a level necessary to ensure plan solvency over the long term ~~at a 95% confidence interval~~to a set 50 days on hand.
  - √ IBNR Reserves will be established at a level to achieve a 95% probability that all incurred claims can be paid.

Participant contributions for HMO/EPO rates are blended between the northern EPO and southern HMO after all ~~of~~ the above adjustments are applied. The blended HMO/EPO rate is based on the average cost of coverage by tier and projected enrollment.

<u>Subsidy Allocation and Participant Contribution</u>

- Base subsidy allocation
  - √ The employer subsidy percentages will be recommended by the Board to the Governor during the Agency Request phase of the Biennial Budget. The Legislature, through the Senate Finance Committee and Assembly Ways and Means Committee, will approve the final employer contribution percentages for each biennium when approving PEBP's biennial budget.
  - √ Non-State Active Employee: Determined by employer
  - √ Non-State Retiree: Determined by State Retiree amount (NRS 287.023(4)(b)) as set in session law and is based only upon years of service, regardless of plan selection or participant tier.
  - √ A single contribution strategy (flat dollar amount) will be applied equally across PEBP plans CHDP, EPO, LD, and HMO).

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

not receive a YOS or base subsidy.

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

Underwriting

- PEBP will underwrite all self-funded plans into one risk pool while continuing to maintain the required state and non-state risk pools.
- PEBP will use the following underwriting guidelines to factor Administrative load into rates:
  - Use a per participant per month factor for claims
  - Add administrative fees on a per participant per month basis
  - Use one tier for all plans, products, state, and non-state
  - Maintain this factor static for the two-year budget cycle (at a minimum)

RFP PROCESS CHECKLIST

Name of RFP: ______________________

Solicitation Type: RFP

RFP # ____________

Start Date ____________ End Date ____________

Contract Amount: ____________

Purchasing Level, BOE Required

Yes N/A	Date Completed	Action
		Present request for solicitication to Board prior to contact expiration
		Request Board members to assist in RFP development and evaluation team
		RFP Development Form with all information pertaining to RFP
		Dept/Agency Information
		Budget
		Contract Terms & Amount, Signers
		Project Overview
		SOW/Specific Terms & Conditions/General Requirements-Penalties
		IT Information/TIN
		Evaluation Committee and Criteria
		Other (financials, references, resumes, Agency attachments, cost schedule, vendor presentations, BAA)
		RFP Development Form submitted to Purchasing
		RFP Release
		Proposal Opening
		Evaluation Period
		Evaluation Committee Meeting
		Vendor Presentations
		Letter of Intent
		Vendor Negotiations
		Present request for new contract to Board for approval
		Prepare Contract (Purchasing)
		Contract
		RFP/Amendments
		Insurance Requirements
		Contractor Proposal
		Other
		CETS Entry - Scan Attachments (if applicable)
		CETS Summary to Purchasing
		SOS Business License
		DAWN vendor detail
		Federal Debarred Vendor Listing
		Insurance (pertinent coverages/additional insured/waiver of subrogation)
		Receive Contract from Purchasing
		Route packet to Fiscal for CETS approval
		Route packet back to Purchasing
		Notice of Award (public post)
		Scheduled BOE Date
		BOE Agenda #
		Receive approved contract from Purchasing
		Scan executed CETS/contract to Shared Location
		Enter in Contract Payment Log - Link to Contract Summary Log
		Make contract binders

INFORMAL SOLICITATION PROCESS CHECKLIST

Name of Solicitation: ______________________

Solicitation Type: ____________

RFP # ____________

Start Date ____________ End Date ____________

Contract Amount: ____________

Purchasing Level, BOE Required

Yes N/A	Date Completed	Action
		Present request for solitication to Board prior to contact expiration
		Solicitation Waiver Request to Purchasing
		Sole Source Request to Purchasing
		Informal Solicitation
		Complete Solicitation Form
		Contract Terms & Amount, Signers
		Project Overview
		SOW/Specific Terms & Conditions/General Requirements-Penalties
		IT Information/TIN
		Other (financials, references, resumes, Agency attachments, cost schedule, vendor presentations, BAA)
		Request Vendor Information from Purchasing
		Review Proposals (Quotes) once received
		Vendor Negotiations
		Present request for new contract to Board for approval
		Prepare Contract (Purchasing)
		Contract
		RFP/Amendments
		Insurance Requirements
		Contractor Proposal
		Other
		CETS Entry - Scan Attachments (if applicable)
		CETS Summary to Purchasing
		SOS Business License
		DAWN vendor detail
		Federal Debarred Vendor Listing
		Insurance (pertinent coverages/additional insured/waiver of subrogation)
		Receive Contract from Purchasing
		Route packet to Fiscal for CETS approval
		Route packet back to Purchasing
		Notice of Award (public post)
		Scheduled BOE Date
		BOE Agenda #
		Receive approved contract from Purchasing
		Scan executed CETS/contract to Shared Location
		Enter in Contract Payment Log - Link to Contract Summary Log
		Make contract binders

CONTRACT PROCESS CHECKLIST

Vendor: ______________________

Contract Type: Standard/Interlocal
CETS # ________
Amendment # ________
Start Date ________
End Date ________
Contract Amount ________
Amendment Amount ________

BOE	$50,000+	Yes / No
Clerk	$2,000-$49,999	Yes / No
Agency	$0-$1,999	Yes / No

Completed or N/A	Action
	Enter pending contract/amendment entry into Contract Log
	Board Approval
	Bid Solicitation (informal/formal/RFP)
	Sole Source Waiver
	Purchasing Extension Request
	Retroactive Memo Request
	TIN Request
	Budget Cost Proposal
	Payment Balance Log (for amendments)
	GFO $0 Justification Letter (amendment to extend) / BOE Justification Letter (original non BOE contract now BOE)
	SOS Business License
	DAWN vendor detail
	Federal Debarred Vendor Listing or OIG
	Insurance (pertinent coverages and additional insured)
	Prepare Contract (complete contract and attachments single sided)
	Prepare Attachments:
	SOW
	Cost Breakdown
	Insurance Reqt's
	BAA
	RFP or Bid
	Contractor Proposal
	Exhibits (amendments)
	CETS Entry - Scan Attachments if pertinent (see line items 16-23)
	Route via email to Vendor (1) copy
	Route packet via email to DAG (1) copy
	Route packet via email to Fiscal for CETS approval
	Contract Manager CETS approval
	Route physical packet to GFO (3) copies (keep final copies for PEBP)
	Scheduled BOE Date
	BOE Agenda #
	Receive approved contract from GFO
	Route via email approved contract to vendor
	Scan executed CETS/contract to Shared Location
	Notify staff
	Create or amend Contract Payment Log - Link to Contract Summary
	Make or update contract binder

10.

10. Discussion and Possible Action regarding the withdrawal of funds from the Retirement Benefits Investment Fund (Laura Rich, Executive Officer) **(For Possible Action)**

STEVE SISOLAK
Governor

LAURA FREED
Board Chair

1.1.1

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urac ACCREDITED
CORE
Expires 04/01/2021

LAURA RICH
Executive Officer

AGENDA ITEM

[X] Action Item
[ ] Information Only

Date: January 28, 2021

Item Number: X

Title: Retirement Benefits Investment Fund

SUMMARY

This report addresses the possible opportunity for PEBP to withdraw funds from the Retirement Board Investment Fund

BACKGROUND

Senate Bill 457 of the 2007 Legislative Session created the Retirement Benefits Investment Fund (RBIF) and set the Board of Trustees as the members of the PERS Board. The fund is a voluntary investment opportunity for the state and local governments to have assets in their OPEB trusts managed in like fashion to the Public Employees' Retirement Fund.

NRS 355.220 authorizes RBIF to invest the money for trust funds established by government agencies for authorized purposes. It is the responsibility of each participating government agency to contribute, withdraw and use the funds for authorized purposes. The funds in the RBIF may be transferred to the State Retirees' Health and Welfare Fund created by NRS 287.0436 for the purposes specified in NRS 287.0436.

The only instance when PEBP has used these funds was during the 2010 special session. Section 79 of AB 3 directed the State Controller to transfer the sum of $24.7M to the fund created by NRS 287.0436. By the time the withdrawal occurred, the market value of the fund had increased which resulted in remaining funds. Although no additional contributions have been made by PEBP, these funds have since been gaining interest and the market value of the fund has grown to approximately $2.1M.

REPORT

NRS 287.0436 establishes the State Retirees' Health and Welfare Benefits Fund as an irrevocable trust fund. The purpose of the fund is to account for the financial assets designated to offset the portion of the current and future costs of health and welfare benefits paid pursuant to subsection 2 of NRS 287.046. The Board has the exclusive control of the fund; however, the funds must be used to offset the costs of the health and welfare benefits for current and future state retirees.

PEBP is projecting a shortfall in the Retiree (REGI) budget account of approximately $12M at the end of FY21 and anticipates the shortfall to grow due to factors such as a decrease in payroll as many positions remain vacant. A withdrawal of the available remaining funds from the RBIF would provide some relief to this account and be an appropriate use of funds as specified in NRS 287.0436. To accomplish this, PEBP, on behalf of the Board, must submit a letter to the Retirement Investment Fund Board requesting the transfer.

RECOMMENDATION:
Approve the transfer of all available funds in the Retirement Benefits Investment Fund to the State Retirees' Health and Welfare Fund.

11.

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

STEVE SISOLAK
Governor

LAURA FREED
Board Chair

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LAURA RICH
Executive Officer

AGENDA ITEM

☐ Action Item

☒ Information Only

Date: January 28, 2021

Item Number: XI

Title: Executive Officer Report

SUMMARY

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

REPORT

INTERIM RETIREMENT AND BENEFITS COMMITTEE

On December 16, 2020 PEBP attended and presented at the annual Interim Retirement and Benefits Committee meeting (IRBC). Statutorily, PEBP is required to present information on the program for the previous plan year. However, this year PEBP coordinated with LCB staff to and the decision was made to take on a different approach. PEBP provided the committee with the required reports, but the presentation to the committee members focused instead on PEBP Board decisions made throughout 2020 and the upcoming Plan Year 2022 Board approved plan benefit design. PEBP presented the Board approved plan design and benefit changes based on the 12% budget proposals submitted to the Governor's Finance Office as well as a summary of previous policy and budgetary decisions made earlier this year to address FY21 budget reserve requirements.

Several IRBC members are also members of the money committees which will be hearing and approving the PEBP budget during the upcoming legislative session, so the information provided at IRBC serves as critical education and insight for both legislators and PEBP.

LEGISLATIVE SESSION

Nevada's 81st Legislative session will begin on February 1, 2021. As of date, PEBP is tracking 101 Bill Draft Requests (BDR) that may impact the Public Employees' Benefits Program. As

more information becomes available on these bills, that number will likely be reduced significantly.

Beginning in February, PEBP will be scheduling monthly Board meetings to provide the Board a summary of the bills that are expected to impact the program, including a description of the potential impact, bill status and fiscal note. Although state agencies typically take a neutral stance when providing legislative testimony on bills, it is important that the Board be able to weigh in and provide direction to ensure that the testimony being provided aligns with the consensus of the Board.

SCR-10 UPDATE

In November, the PEBP Board was provided information on SCR-10, a Senate Concurrent Resolution directing the Legislative Commission to conduct a feasibility study for a public option to improve the stability of Nevada's health insurance market, decrease the number of insured Nevadans and increase access to affordable health insurance coverage. On Tuesday, January 19, 2020 Manatt Health presented a report to the Legislative Commission. The report outlines two potential public options models; one achieved through the Public Employees' Benefits Program, and the other through the Silver State Health Insurance Exchange.

The PEBP option, as described in the report, would allow Nevadan's to purchase health coverage through PEBP and would be eligible to enroll in identical plans as those offered to state employees and retirees. Because of the affordability of PEBP plans and the ability to leverage existing contracts and infrastructure, it is projected that this option would likely offer more affordable premiums than a comparable gold-level plan offered on the market today. In general, the PEBP option would save those seeking coverage approximately 9% overall, with a greater savings in rural areas where health insurance premiums are typically much more expensive. Manatt estimates that this option will attract approximately 6,500 enrollees.

Although on the surface this option appears to be a win-win for Nevadan's and PEBP, there are several factors that could potentially have a negative impact on the program:

- Risk pools – It is determined that the introduction of a new stand-alone risk pool is not viable, so the Manatt recommendation includes blending the new risk pool with the existing state active and retiree populations.
  - This option will likely be most attractive to those in the rural communities where the cost of healthcare is costly. Introducing a higher concentration of claims in the rural counties will likely drive overall claims costs up and will result in higher premiums, which will have to be absorbed by all PEBP members.
  - It is unknown what the demographics of this risk pool will be. If the new population is older or less healthy than the current state risk pool, it will likely have a negative impact on rates.
- Costs – The report estimates that the cost of the PEBP option is estimated to be approximately \$7-\$9.5M, mainly to fund required reserves. There are additional costs not factored in that PEBP expects may need to be considered, including necessary

eligibility and enrollment system upgrades to administer the new group and premium age banding criteria, staffing increases and IT implementations to ensure this option can be displayed on the individual marketplace as an option to consumers.

The second option provides a path for a state sponsored Qualified Health Plan Model offered through the Silver State Health Insurance Exchange. This model is shown to be feasible if the state is able to implement significant cost containment mechanisms, such as setting provider reimbursement caps, which is likely to be a significant and highly political undertaking. In this model, the enrollment estimate of previously uninsured individuals is 1,500 - 4,900 new enrollees. Like the PEBP option, this option also comes with fiscal implications as well as required federal and state regulatory changes.

The full report on this study can be located here:
https://www.leg.state.nv.us/App/InterimCommittee/REL/Interim2019/Meeting/21146

CONCLUSION

PEBP is preparing for a busy and extremely unique legislative session. In addition, internal preparations for major plan changes have started, including staff training, master plan document updates and mass communications that will be required to ensure members are aware of the changes occurring within the program. Although the next six months will be taxing on staff, the PEBP team is up for the challenge and is confident in our ability to succeed.

12.

12. Public Comment

13.

13. Adjournment