STEVE SISOLAK
Governor

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

LAURA FREED
Board Chair

MEETING NOTICE AND AGENDA

Name of Organization:	Public Employees' Benefits Program Board
Date and Time of Meeting:	March 24, 2022 9:00 a.m.
Place of Meeting:	Pursuant to Assembly Bill 253 (2021), this meeting will be held virtually. Participation will be enabled by the use of remote technology using video- and tele-conference. Instructions for both options are below. This meeting can be viewed live over the Internet on the PEBP YouTube channel at https://youtu.be/2yemh6eNnFA

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://us06web.zoom.us/j/84961191110

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: 849 6119 1110 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. The total time allotted to public comment may be limited to one hour at the discretion of the chairperson. As noted above, members of the public may make public comment by using the call-in number provided above. Persons unable to attend the meeting by telephone and persons whose comments may extend past the three minute time limit may submit their public comment in writing to PEBP Attn: Wendi Lunz 901 S. Stewart St, Suite 1001 Carson City NV 89701, Fax: (775) 684-7028 or wlunz@peb.nv.gov at least two business days prior to the meeting. Persons making public comment need to state and spell their name for the record at the beginning of their testimony.

3. PEBP Board disclosures for applicable Board meeting agenda items. (Michelle Briggs, Chief 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 January 27, 2022 PEBP Board Meeting

   4.2 Receipt of quarterly staff reports for the period ending December 31, 2021:

   4.2.1 Budget Report

   4.2.2 Utilization Report

   4.3 Receipt of quarterly vendor reports for the period ending December 31, 2021:

   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 Insurance

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

   4.3.6 AETNA Signature Administrators – PPO Network

   4.3.7 HealthPlan of Nevada, Inc. – Southern Nevada HMO

   4.3.8 Doctor on Demand

4.4 Acceptance of Claim Technologies Incorporated audit findings for State of Nevada Public Employees' Benefits Program Plans administered by HealthSCOPE Benefits for:

4.4.1 Period October 1, 2020 – December 31, 2020 (FY21.Q2)

4.4.2 Period January 1, 2021 – March 31, 2021 (FY21.Q3)

4.4.3 Period April 1, 2021 – June 30, 2021 (FY21.Q4)

4.4.4 Focus audit for the period February 1, 2020 through September 30, 2021

4.5 Willis Towers Watson (WTW) response to the recommendations from Claim Technologies Incorporated (CTI) to the Audit of the State of Nevada Public Employees' Benefits Program Health Reimbursement Arrangement for the period of July 2020 – June 2021

4.6 Clifton Larson Allen Audited Financial Statements of Public Employees' Benefits Program Self-Insurance Trust Fund for FY21

4.7 AON June 30, 2021 IBNP Report

4.8 Proposed summary revisions to the Plan Year 2023 Master Plan Documents for the Consumer Driven High Deductible Plan, Low Deductible Plan and Exclusive Provider Organization Plan

5. Executive Officer Report (Laura Rich, Executive Officer) (Information/Discussion)
6. COVID-19 Status Update including possible action to eliminate COVID-19 surcharges (Laura Rich, Executive Officer) **(For Possible Action)**
7. Enrollment and Eligibility System Implementation Update including possible action regarding changes to contract and vendor relationships and vendor payments (Nik Proper, Operations Officer) (**For Possible Action**)
8. 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**)

8.1. Contract Overview

8.2. New Contracts

8.2.1. Segal Actuarial Consulting

8.2.2. United Healthcare Life Insurance

8.2.3. Vivo Technologies

8.2.4. LifeWorks, LTD

8.3. Contract Amendments

8.3.1. Healthscope Benefits Third Party Administration

8.3.2. UMR, Inc.

8.4. Contract Solicitations

8.4.1. Eligibility and Enrollment System

8.5. Status of Current Solicitations

9. Presentation on PEBP claims experience and trend (Collen Huber, Aon) (Information/Discussion)

10. Discussion and possible action to include approving Plan Year 23 (July 1, 2022 – June 30, 2023) rates for State and Non-State employees, retirees and their dependents for the Consumer Driven Health Plan (CDHP), Low Deductible (LD) Plan, Exclusive Provider Organization (EPO) Plan, and Health Maintenance Organization (HMO) Plan (Laura Rich, Executive Officer) (**For Possible Action**)

11. Public Comment

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

12. Adjournment

The supporting material to this agenda, also known as the Board Packet, is available, at no charge, on the PEBP website at www.pebp.state.nv.us/meetings-events/board-/meetings (under the Board Meeting date referenced above). Contact Wendi Lunz at PEBP, 901 S Stewart Street, Suite 1001, Carson City NV 89701 (775) 684-7020 or (800) 326-5496
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, at the office of the public body and 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. (Michelle Briggs, Chief 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 January 27, 2022 PEBP Board Meeting

4.2 Receipt of quarterly staff reports for the period ending December 31, 2021:

4.2.1 Budget Report

4.2.2 Utilization Report

4.3 Receipt of quarterly vendor reports for the period ending December 31, 2021:

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 Insurance

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

4.3.6 AETNA Signature Administrators – PPO Network

4.3.7 Health Plan of Nevada, Inc. – Southern Nevada HMO

4.3.8 Doctor on Demand Engagement Report

4.1

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

4.1 Approval of Action Minutes from the January 27, 2022 PEBP Board Meeting.

STATE OF NEVADA
PUBLIC EMPLOYEES' BENEFITS PROGRAM
BOARD MEETING

Video/Telephonic Open Meeting
Carson City

ACTION MINUTES (Subject to Board Approval)
January 27, 2022

MEMBERS PRESENT VIA TELECONFERENCE:	Ms. Laura Freed, Board Chair Ms. Linda Fox, Vice Chair Ms. Michelle Kelley, Member Mr. Tom Verducci, Member Ms. Betsy Aiello, Member Ms. April Caughron, Member Mr. Jim Barnes, Member Ms. Leslie Bittleston, Member Dr. Jennifer McClendon, Member
FOR THE BOARD:	Ms. Michelle Briggs, Chief Deputy Attorney General
FOR STAFF:	Ms. Laura Rich, Executive Officer Mr. Nik Proper, Operations Officer Ms. Cari Eaton, Chief Financial Officer Mr. Tim Lindley, Quality Control Officer Ms. Wendi Lunz, Executive Assistant
OTHER PRESENTERS:	Dylan Garrison – Clifton Larson Allen Chris Garcia – Willis Towers Watson Erinn Keller – Aetna Signature Administrators Scott Muir _ LSI Amy Winters – Benefit Focus

1. Open Meeting; Roll Call

    - Board Chair Freed opened the meeting at 9:02 a.m.

2. Public Comment
    - Kent Ervin – Nevada Faculty Alliance
    - Matthew Parker – State Employee
    - Terri Laird - RPEN
    - Brooke Maylath

3. PEBP Board disclosures for applicable Board meeting agenda items. (Michelle Briggs, Chief 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 Minutes from the December 2, 2021 PEBP Board Meeting.

    4.2 Receipt of quarterly staff reports for the period ending September 30, 2021:

        4.2.1 Budget Report

        4.2.2 Utilization Report

    4.3 Receipt of quarterly vendor reports for the period ending September 30, 2021:

        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

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

        4.3.6 AETNA Signature Administrators – PPO Network

        4.3.7 HealthPlan of Nevada, Inc. – Southern Nevada HMO

        4.3.8 Doctor on Demand

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

4.5 Acceptance of Claim Technologies Incorporated audit findings for Health Reimbursement Arrangement administered by Via Benefits from Willis Towers Watson for the timeframe July 1, 2020 – June 30, 2021.

4.6 Clifton Larson Allen Audited Financial Statements for PEBP for FY21

BOARD ACTION ON ITEM 4
MOTION: Motion to approve everything in Item Four save for 4.2.1, 4.3.5, 4.3.6, 4.5 and 4.6.
BY: Member Leslie Bittleston
SECOND: Member April Caughron
VOTE: Unanimous; the motion carried

BOARD ACTION ON ITEM 4.2.1, 4.3.5, 4.3.6, 4.5 and 4.6
MOTION: Motion to accept 4.2.1, 4.3.5, 4.3.6, 4.5 and 4.6.
BY: Member Betsy Aiello
SECOND: Member Michelle Kelley
VOTE: Unanimous; the motion carried

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

6. Enrollment and Eligibility System Implementation Update (Nik Proper, Operations Officer) (**For Possible Action**)

BOARD ACTION ON ITEM 6
MOTION: Motion to accept the credit from LSI to PEBP in the amount of $87,618.50 as well as require a report back at the next Board meeting on the status of all of this.
BY: Member Leslie Bittleston
SECOND: Vice Chair Linda Fox
VOTE: Unanimous; the motion carried

Agenda Item 7 was heard in the following order - 7.1, 7.3, 7.4, 7.5, 7.2

7. 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**)

7.1 Contract Overview

7.2 New Contracts

7.2.1 Selection of Pharmacy Benefit Manager between: Express Scripts (pursuant to Request for Proposal No. 95PEBP-S1711) and Northwest Drug Consortium (pursuant to NRS 333.475)

7.3 Contract Amendments

7.3.1 Express Scripts – Amendment #6

7.4 Contract Solicitations

7.5 Status of Current Solicitations

BOARD ACTION ON ITEM 7.3.1

MOTION: Motion to authorize PEBP staff to amend the contract between PEBP and Express Scripts, Contract 17715 to add Medicaid Subrogation program, update the fee schedule and increase the contract maximum.
BY: Member Michelle Kelley
SECOND: Member Betsy Aiello
VOTE: Unanimous; the motion carried

11:30 a.m. – 1:00 p.m. MEETING CLOSED PURSUANT TO NRS 333.475 FOR BOARD TO DISCUSS FINANCIAL OFFERS SUBMITTED BY BIDDERS.

BOARD ACTION ON ITEM 7.2.1

MOTION: Motion to approve E Scripts, ESI to provide pharmacy services beginning July 1 of 2022, including their best and final offer and modified performance guarantee.
BY: Member Tom Verducci
SECOND: Member Leslie Bittleston
VOTE: Unanimous; the motion carried

8 Public Comment

- Tony Gutierrez
- Kent Ervin – Nevada Faculty Alliance

9 Adjournment

- Board Chair Freed adjourned the meeting at 1:13 p.m.

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 December 31, 2021:

4.2.1 Budget Report

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LAURA RICH
Executive Officer

LAURA FREED
Board Chair

AGENDA ITEM

[X] Action Item
[ ] Information Only

Date: March 24, 2022

Item Number: IV.II.I

Title: Chief Financial Officer Budget Report

Summary

This report addresses the Operational Budget as of December 31, 2021 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 December 31, 2021, with comparisons to the same period in Fiscal Year 2021. 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 $184.2 million as of December 31, 2021, compared to $202.1 million as of December 31, 2020, or a decrease of 8.9%. Total expenses for the period have increased by $6.2 million or 3.3% for the same period.

The budget status report shows Realized Funding Available (cash) at $148.0 million. This compares to $168.0 million for last year. The table below reflects the actual revenue and expenditures for the period.

Operational Budget 1338

	FISCAL YEAR 2022			FISCAL YEAR 2021		
	Actual as of 12/31/2021	Work Program	Percent	Actual as of 12/31/2020	Fiscal Year 2021 Close	Percent
Beginning Cash	159,011,280	159,011,280	100%	154,541,329	154,541,329	100%
Premium Income	170,513,699	355,412,324	48%	194,503,274	368,807,766	53%
All Other Income	13,705,296	24,887,105	55%	7,632,569	24,098,398	32%
Total Income	184,218,995	380,299,429	48%	202,135,843	392,906,164	51%
Personnel Services	1,108,041	2,822,786	39%	1,089,420	2,413,496	45%
Operating - Other than Personnel	1,137,433	2,635,822	43%	1,158,070	2,340,118	49%
Insurance Program Expenses	192,830,198	383,260,298	50%	186,569,016	383,166,380	49%
All Other Expenses	153,356	331,125	46%	262,068	516,219	51%
Total Expenses	195,229,027	389,050,031	50%	189,078,574	388,436,213	49%
Change in Cash	(11,010,032)	(8,750,602)		13,057,269	4,469,951	
REALIZED FUNDING AVAILABLE	148,001,248	150,260,678	98%	167,598,598	159,011,280	105%
Incurred But Not Reported Liability	(52,286,000)	(52,286,000)		(51,514,000)	(51,514,000)	
Catastrophic Reserve	(34,875,000)	(34,875,000)		(34,835,000)	(34,835,000)	
HRA Reserve	(25,056,050)	(25,056,050)		(30,550,651)	(30,550,651)	
NET REALIZED FUNDING AVAILABLE	35,784,198	38,043,628		50,698,947	42,111,629	

Current Budget Projections

The following table represents projections for FY 2022. The projection reflects total income to be less than budgeted by 4.5% ($520.7 million vs $545.3 million), total expenditures are projected to be less than budgeted by 1.1% ($392.8 million vs $397.1 million); total reserves are projected to be less than budgeted by 13.6% ($128.0 million vs $150.8 million).

State Subsidies are projected to be less than the budgeted amount by $16.1 million (6.0%), Non-State Subsidies are projected to be more than budgeted by $2.7 million (13.8%), and Premium Income is projected to be less than budgeted by $9.0 million (13.1%). This overall decrease in budgeted revenue is due in part to a planned 1-month employee premium holiday in October 2021 and 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:

- 4.19% fewer state actives,
- 1.45% more state non-Medicare retirees,
- 0% no change in non-state actives,
- 18.02% fewer non-state, non-Medicare retirees
- 3.96% more state Medicare retirees, and
- 1.97% fewer non-state Medicare retirees

Budgeted and Projected Income (Budget Account 1338)					
Description	**Budget**	**Actual 12/31/21**	**Projected**	**Difference**	
Carryforward	159,011,280	159,011,280	159,011,280	0	0.0%
State Subsidies	266,543,926	130,742,532	250,458,412	(16,085,514)	-6.0%
Non-State Subsidies	20,042,853	11,613,446	22,813,696	2,770,843	13.8%
Premium	68,825,545	28,157,721	59,792,255	(9,033,290)	-13.1%
COVID Funds	8,557,308	5,069,501	8,557,308	0	-8.5%
Appropriations	6,009,449	0	5,141,274	(868,175)	-4.5%
All Other	16,329,797	8,635,795	14,938,953	(1,390,844)	-8.5%
Total	545,320,158	343,230,275	520,713,177	(24,606,981)	-4.5%
Budgeted and Projected Expenses (Budget Account 1338)					
Description	**Budget**	**Actual 12/31/21**	**Projected**	**Difference**	
Operating	6,289,602	2,398,830	5,479,464	810,138	12.9%
State Insurance Costs	340,421,064	169,958,542	339,836,859	584,205	0.2%
Non-State Insurance Costs	11,507,187	3,929,238	7,970,426	3,536,761	30.7%
Medicare Retiree Insurance Costs	38,883,471	18,942,418	39,559,309	(675,838)	-1.7%
Total Insurance Costs	390,811,722	192,830,198	387,366,594	3,445,128	0.9%
Total Expenses	397,101,324	195,229,028	392,846,058	4,255,266	1.1%
Restricted Reserves	112,217,050	112,217,050	111,805,571	411,479	0.4%
Differential Cash Available	36,001,784	35,784,197	16,194,527	19,807,257	55.0%
Total Reserves	148,218,834	148,001,247	128,000,098	20,218,736	13.6%
Total of Expenses and Reserves	545,320,158	343,230,275	520,713,177	24,606,982	4.5%

Expenses for Fiscal Year 2022 are projected to be $4.3 million (1.1%) less than budgeted when changes to reserves are excluded. Operating expenses are projected to be less than budgeted by $0.8 million (12.9%). Employee and Retiree insurances costs are projected to be less than budgeted by $3.4 million (0.9%) when taken in total (see table above for specific information).

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 December 31, 2021:

        4.2.1 Budget Report

        4.2.2 Utilization Report

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LAURA FREED
Board Chair

AGENDA ITEM

[X] Action Item
[ ] Information Only

Date: March 24, 2022

Item Number: IV.II.II

Title: Self-Funded CDHP, LDPPO, and EPO Plan Utilization Report for the period ending December 31, 2021

This report addresses medical, dental, prescription drug and HSA/HRA utilization for the PY 2022 period ending December 31, 2021. 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 LDPPO 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 D for Q2 Plan Year 2022 utilization data.

Executive Summary

CONSUMER DRIVEN HEALTH PLAN (CDHP)

The Consumer Driven Health Plan (CDHP) experience for Q2 of Plan Year 2022 compared to Q2 of Plan Year 2021 is summarized below.

- Population:
  - 17.6% decrease for primary participants
  - 20.3% decrease for primary participants plus dependents (members)
- Medical Cost:
  - 30.4% increase for primary participants
  - 34.6% increase for primary participants plus dependents (members)
- High-Cost Claims:
  - There were 91 High-Cost Claimants accounting for 34.3% of the total plan paid for Q2 of Plan Year 2022
  - 59.2% increase in High-Cost Claimants per 1,000 members
  - 38.3% increase in average cost of High-Cost Claimant paid
- Top three highest cost clinical classifications include:
  - Pregnancy-related Disorders ($5.3 million) – 24.2% of paid claims
  - Cancer ($3.9 million) – 17.6% of paid claims
  - Cardiac Disorders ($2.4 million) – 11.0% of paid claims
- Emergency Room:
  - ER visits per 1,000 members increased 30.7%
  - Average paid per ER visit decreased 17.8%
- Urgent Care:
  - Urgent Care visits per 1,000 members increased by 20.0%
  - Average paid per Urgent Care visit decreased 7.4% (decrease from $68 to $63)
- Network Utilization:
  - 98.9% of claims are from In-Network providers
  - Q2 of Plan Year 2022 In-Network utilization increased 1.0% over PY 2021
  - Q2 of Plan Year 2022 In-Network discounts decreased 1.5% over PY 2021

- Prescription Drug Utilization:
  - Overall:
    - Total Net Claims decreased 14.1%
    - Total Gross Claims Costs decreased 18.6% ($5.1 million)
    - Average Total Cost per Claim decreased 5.3%
      - From $106.24 to $100.58
  - Member:
    - Total Member Cost decreased 19.6%
    - Average Participant Share per Claim decreased 6.5%
    - Net Member PMPM increased 1.1%
      - From $27.78 to $28.07

- Plan
  - Total Plan Cost decreased 18.3%
  - Average Plan Share per Claim decreased 4.9%
  - Net Plan PMPM increased 2.7%
    - From $80.43 to $82.62
  - Net Plan PMPM factoring rebates decreased 13.3%
    - From $61.14 to $53.03

LOW DEDUCTIBLE PPO PLAN (LDPPO)

The Low Deductible PPO Plan (LDPPO) experience for Q2 of Plan Year 2022 is summarized below.

- Population:
  - 3,871 primary participants
  - 7,987 primary participants plus dependents (members)
- Medical Cost:
  - $502 PEPM for primary participants
  - $243 PMPM for primary participants plus dependents (members)
- High-Cost Claims:
  - There were 18 High-Cost Claimants accounting for 29.1% of the total plan paid for Q2 of Plan Year 2022
  - High-Cost Claimants per 1,000 members was 2.3
  - Average cost of High-Cost Claimant paid was $188,430
- Top three highest cost clinical classifications include:
  - Cancer ($1million) – 28.4% of paid claims
  - Pregnancy-related Disorders ($0.8 million) – 25.1% of paid claims
  - Trauma / Accidents ($0.4 million) – 11.0% of paid claims
- Emergency Room:
  - 112 ER visits per 1,000 members
  - Average paid per ER visit was $2,050
- Urgent Care:
  - 236 Urgent Care visits per 1,000 members
  - Average paid per Urgent Care visit was $120
- Network Utilization:
  - 99.2% of claims are from In-Network providers
  - Q2 of Plan Year 2022 In-Network discounts was 60.5%

- Prescription Drug Utilization:
  - Overall:
    - Total Net Claims through Q2 was 55,750
    - Total Gross Claims Costs was $5.6 million
    - Average Total Cost per Claim was $101.55
  - Member:
    - Total Member Cost through Q2 was $1.0 million
    - Average Participant Share per Claim was $18.66
    - Net Member PMPM was $21.82

- Plan
  - Total Plan Cost through Q2 was $4.6 million
  - Average Plan Share per Claim was $81.89
  - Net Plan PMPM was $95.74

PEBP PREMIER PLAN (EPO)

The PEBP Premier Plan (EPO) experience for Q2 of Plan Year 2022 compared to Q2 of Plan Year 2021 is summarized below.

- Population:
  - 12.4% decrease for primary participants
  - 11.5% decrease for primary participants plus dependents (members)
- Medical Cost:
  - 17.6% increase for primary participants
  - 16.4% increase for primary participants plus dependents (members)
- High-Cost Claims:
  - There were 29 High-Cost Claimants accounting for 30.7% of the total plan paid for Plan Year 2022
  - 13.1% increase in High-Cost Claimants per 1,000 members
  - 39.1% increase in average cost of High-Cost Claimant paid
- Top three highest cost clinical classifications include:
  - Pulmonary Disorders ($1.6 million) – 20.4% of paid claims
  - Infections ($1.1 million) – 14.3% of paid claims
  - Pregnancy-related Disorders ($1.1 million) – 14.1% of paid claims
- Emergency Room:
  - ER visits per 1,000 members increased by 26.3%
  - Average paid per ER visit decreased by 22.7%
- Urgent Care:
  - Urgent Care visits per 1,000 members increased by 33.5%
  - Average paid per Urgent Care visit increased 9.7%
- Network Utilization:
  - 100% of claims are from In-Network providers
  - In-Network utilization increased 0.1%
  - In-Network discounts decreased 0.4%

- Prescription Drug Utilization:
  - Overall:
    - Total Net Claims decreased 9.3%
    - Total Gross Claims Costs decreased 10.2% ($1.1 million)
    - Average Total Cost per Claim decreased 1.1%
      - From $127.32 to $125.95
  - Member:
    - Total Member Cost decreased 11.8%
    - Average Participant Share per Claim decreased 2.8%
    - Net Member PMPM decreased 0.3%
      - From $34.77 to $34.65

- Plan
  - Total Plan Cost decreased 9.9%
  - Average Plan Share per Claim decreased 0.7%
  - Net Plan PMPM increased 1.8%
    - From $175.39 to $178.55
  - Net Plan PMPM factoring rebates decreased 0.9%
    - From $135.74 to $134.51

DENTAL PLAN

The Dental Plan experience for Q2 of Plan Year 2022 is summarized below.

- Dental Cost:
  - Total Dental claims paid increased 3.1% (from $12.7 million for Q2 of PY21 to $13.1 million for Q2 of PY22)
    - Preventative claims account for 43.5% ($5.7 million)
    - Basic claims account for 28.5% ($3.7 million)
    - Major claims account for 21.3% ($2.8 million)
    - Periodontal claims account for 6.7% ($0.9 million)

HEALTH REIMBURSEMENT ARRANGEMENT

The table below provides a list of CDHP HRA account balances as of December 31, 2021.

HRA Account Balances as of December 31, 2021			
$Range	**# Accounts**	**Total Account Balance**	**Average Per Account Balance**
0	990	0	0
$.01 - $500.00	2,444	592,740	243
$500.01 - $1,000	1,765	1,199,694	680
$1,000.01 - $1,500	818	1,013,790	1,239
$1,500.01 - $2,000	537	932,177	1,736
$2,000.01 - $2,500	351	796,281	2,269
$2,500.01 - $3,000	324	888,466	2,742
$3,000.01 - $3,500	271	873,523	3,223
$3,500.01 - $4,000	185	688,460	3,721
$4,000.01 - $4,500	154	653,402	4,243
$4,500.01 - $5,000	114	542,440	4,758
$5,000.01 +	**736**	**6,093,941**	**223,763**
Total	**8,689**	**$ 14,274,913**	**$ 1,643**

CONCLUSION

The information in this report provides plan experience for the Consumer Driven Health Plan (CDHP), Low Deductible PPO Plan (LDPPO) and the PEBP Premier Plan (EPO) through the second quarter of Plan Year 2022. The CDHP total plan paid costs increased 7.4% over the same time for Plan Year 2021. The EPO total plan paid costs increased 17.6% over Q2 of Plan Year 2021. For HMO utilization and cost data please see the report provided in Appendix D.

Appendix A

Index of Tables
HealthSCOPE – CDHP Utilization Review for PEBP
July 1, 2021 – December 31, 2021

HEALTHSCOPE BENEFITS OVERVIEW.....2

MEDICAL

Paid Claims by Age Group ***3***

Financial Summary 4

Paid Claims by Claim Type 8

Cost Distribution – Medical Claims 11

Utilization Summary.....12

Provider Network Summary 14

DENTAL

Claims Analysis 26

Savings Summary 27

PREVENTIVE SERVICES

Quality Metrics 28

PRESCRIPTION DRUG COSTS

Prescription Drug Cost Comparison 31

HSB DATASCOPE™

Nevada Public Employees' Benefits Program
HDHP Plan

July – December 2021

HealthSCOPE BENEFITS

Overview

- Total Medical Spend for 2Q22 was $63,977,931 of which 78.5% was spent in the State Active population. When compared to 2Q21, this reflected an increase of 7.4% in plan spend, with State Actives having an increase of 13.2%.
  - When compared to 2Q20, 2Q22 decreased 7.1%, with State Actives having an increase of 1.1%.
- On a PEPY basis (annualized), 2Q22 reflected an increase of 30.4% when compared to 2Q21. The largest group, State Actives, increased 39.9%.
  - When compared to 2Q20, 2Q22 increased 14.4%, with State Actives increasing by 26.4%.
- 92.6% of the Average Membership had paid Medical claims less than $2,500, with 28.8% of those having no claims paid at all during the reporting period.
- There were 91 high-cost Claimants (HCC's) over $100K, that accounted for 34.3% of the total spend. HCCs accounted for 24.8% of total spend during 2Q21, with 72 members hitting the $100K threshold. The largest diagnosis grouper was Pregnancy-related Disorders accounting for 24.2% of high-cost claimant dollars.
- IP Paid per Admit was $22,345 which is a decrease of 40.9% compared to 2Q21.
- ER Paid per Visit is $1,674, which is a decrease of 17.8% compared to 2Q21.
- 98.9% of all Medical spend dollars were to In Network providers. The average In Network discount was 64.4%, which is a decrease of 2.3% compared to the PY21 average discount of 65.9%.

Paid Claims by Age Group

Paid Claims by Age Group																
	2Q21						2Q22						% Change	
Age Range	Med Net Pay	Med PMPM	Rx Net Pay	Rx PMPM	Net Pay	PMPM	Med Net Pay	Med PMPM	Rx Net Pay	Rx PMPM	Net Pay	PMPM	Net Pay	PMPM
<1	$ 1,971,150	$ 944	$ 11,666	$ 6	$ 1,988,731	$ 952	$ 7,120,001	$ 4,411	$ 7,612	$ 5	$ 7,127,613	$ 4,416	258.4%	364.1%
1	$ 384,894	$ 162	$ 93,095	$ 39	$ 503,081	$ 209	$ 250,066	$ 158	$ 11,012	$ 7	$ 261,078	$ 165	-48.1%	-20.7%
2 - 4	$ 608,391	$ 76	$ 152,536	$ 19	$ 946,369	$ 112	$ 701,803	$ 124	$ 132,741	$ 23	$ 834,544	$ 147	-11.8%	31.8%
5 - 9	$ 952,603	$ 64	$ 209,508	$ 14	$ 1,766,508	$ 108	$ 635,368	$ 57	$ 323,481	$ 29	$ 958,849	$ 86	-45.7%	-20.8%
10 - 14	$ 1,192,118	$ 70	$ 222,874	$ 13	$ 2,079,147	$ 111	$ 1,827,508	$ 143	$ 227,685	$ 18	$ 2,055,193	$ 161	-1.2%	44.4%
15 - 19	$ 1,513,141	$ 85	$ 326,386	$ 18	$ 2,673,515	$ 136	$ 2,051,950	$ 149	$ 376,663	$ 27	$ 2,428,613	$ 176	-9.2%	29.7%
20 - 24	$ 2,402,666	$ 120	$ 638,417	$ 32	$ 3,536,503	$ 170	$ 2,153,582	$ 137	$ 486,543	$ 31	$ 2,640,125	$ 168	-25.3%	-1.4%
25 - 29	$ 3,403,240	$ 215	$ 746,614	$ 47	$ 4,653,845	$ 286	$ 3,212,694	$ 256	$ 428,538	$ 34	$ 3,641,232	$ 291	-21.8%	1.6%
30 - 34	$ 3,025,186	$ 165	$ 1,299,860	$ 71	$ 4,941,780	$ 262	$ 2,637,006	$ 181	$ 838,112	$ 57	$ 3,475,118	$ 238	-29.7%	-8.9%
35 - 39	$ 3,101,725	$ 156	$ 2,172,938	$ 109	$ 5,993,951	$ 292	$ 3,557,728	$ 230	$ 725,240	$ 47	$ 4,282,968	$ 276	-28.5%	-5.3%
40 - 44	$ 3,323,267	$ 178	$ 1,201,565	$ 64	$ 5,219,081	$ 270	$ 3,780,657	$ 249	$ 977,371	$ 64	$ 4,758,028	$ 314	-8.8%	16.1%
45 - 49	$ 4,059,468	$ 212	$ 1,708,128	$ 89	$ 6,542,153	$ 331	$ 3,683,624	$ 251	$ 1,294,732	$ 88	$ 4,978,356	$ 339	-23.9%	2.5%
50 - 54	$ 7,136,700	$ 354	$ 2,570,181	$ 127	$ 10,585,308	$ 512	$ 6,215,761	$ 374	$ 2,003,540	$ 121	$ 8,219,301	$ 495	-22.4%	-3.2%
55 - 59	$ 7,837,772	$ 358	$ 3,096,424	$ 141	$ 11,999,882	$ 534	$ 9,149,918	$ 512	$ 2,855,617	$ 160	$ 12,005,535	$ 671	0.0%	25.8%
60 - 64	$ 12,490,962	$ 511	$ 3,837,310	$ 157	$ 17,645,783	$ 706	$ 10,922,357	$ 521	$ 3,850,185	$ 184	$ 14,772,542	$ 704	-16.3%	-0.2%
65+	$ 6,164,234	$ 434	$ 2,675,079	$ 189	$ 12,169,852	$ 664	$ 6,077,908	$ 472	$ 2,381,490	$ 185	$ 8,459,398	$ 657	-30.5%	-1.0%
Total	**$ 59,567,516**	**$ 234**	**$ 20,962,581**	**$ 82**	**$ 93,245,489**	**$ 347**	**$ 63,977,931**	**$ 315**	**$ 16,920,562**	**$ 83**	**$ 80,898,493**	**$ 398**	**-13.2%**	**14.8%**

Financial Summary (p. 1 of 2)

	Total				State Active				Non-State Active			
Summary	**2Q20**	**2Q21**	**2Q22**	**Variance to Prior Year**	**2Q20**	**2Q21**	**2Q22**	**Variance to Prior Year**	**2Q20**	**2Q21**	**2Q22**	**Variance to Prior Year**
Enrollment												
Avg # Employees	23,652	23,391	19,267	-17.6%	19,761	19,545	15,814	-19.1%	4	4	3	-18.3%
Avg # Members	42,850	42,479	33,844	-20.3%	37,257	36,879	28,790	-21.9%	7	8	8	0.0%
Ratio	1.8	1.8	1.8	-3.3%	1.9	1.9	1.8	-3.7%	1.8	2.2	2.7	22.5%
Financial Summary												
Gross Cost	$94,029,865	$81,146,482	$84,509,450	4.1%	$69,915,428	$61,683,401	$66,234,286	7.4%	$32,755	$4,863	$27,588	467.3%
Client Paid	$68,852,282	$59,567,516	$63,977,931	7.4%	$49,660,887	$44,364,510	$50,221,644	13.2%	$23,556	$2,263	$17,886	690.4%
Employee Paid	$25,177,583	$21,578,966	$20,531,518	-4.9%	$20,254,541	$17,318,891	$16,012,642	-7.5%	$9,198	$2,600	$9,702	273.2%
Client Paid-PEPY	$5,822	$5,093	$6,641	30.4%	$5,026	$4,540	$6,352	39.9%	$11,778	$1,234	$11,924	866.3%
Client Paid-PMPY	$3,214	$2,805	$3,781	34.8%	$2,666	$2,406	$3,489	45.0%	$6,730	$566	$4,471	689.9%
Client Paid-PEPM	$485	$424	$553	30.4%	$419	$378	$529	39.9%	$982	$103	$994	865.0%
Client Paid-PMPM	$268	$234	$315	34.6%	$222	$200	$291	45.5%	$561	$47	$373	693.6%
High Cost Claimants (HCC's) > $100k												
# of HCC's	86	72	91	26.4%	59	50	67	34.0%	0	0	0	0.0%
HCC's / 1,000	2.0	1.7	2.7	59.2%	1.6	1.4	2.3	71.3%	0.0	0.0	0.0	0.0%
Avg HCC Paid	$216,669	$205,168	$240,886	17.4%	$175,311	$178,470	$256,147	43.5%	$0	$0	$0	0.0%
HCC's % of Plan Paid	27.1%	24.8%	34.3%	38.3%	20.8%	20.1%	34.2%	70.1%	0.0%	0.0%	0.0%	0.0%
Cost Distribution by Claim Type (PMPY)												
Facility Inpatient	$1,133	$854	$1,507	76.5%	$846	$685	$1,415	106.6%	$0	$32	$0	0.0%
Facility Outpatient	$981	$923	$1,091	18.2%	$819	$770	$939	21.9%	$2,975	$121	$2,389	1874.4%
Physician	$1,023	$970	$1,106	14.0%	$938	$901	$1,065	18.2%	$3,470	$413	$2,020	389.1%
Other	$76	$58	$77	32.8%	$63	$50	$70	40.0%	$285	$0	$62	0.0%
Total	$3,214	$2,805	$3,781	34.8%	$2,666	$2,406	$3,489	45.0%	$6,730	$566	$4,471	689.9%
	Annualized	Annualized	Annualized		Annualized	Annualized	Annualized		Annualized	Annualized	Annualized	

Financial Summary (p. 2 of 2)

	State Retirees				Non-State Retirees				
Summary	**2Q20**	**2Q21**	**2Q22**	**Variance to Prior Year**	**2Q20**	**2Q21**	**2Q22**	**Variance to Prior Year**	**HSB Peer Index**
Enrollment									
Avg # Employees	3,245	3,298	3,001	-9.0%	642	546	450	-17.6%	
Avg # Members	4,848	4,950	4,512	-8.8%	739	642	534	-16.9%	
Ratio	1.5	1.5	1.5	0.0%	1.2	1.2	1.2	0.8%	1.6
Financial Summary									
Gross Cost	$20,854,519	$16,039,320	$16,398,069	2.2%	$3,227,164	$3,418,899	$1,849,506	-45.9%	
Client Paid	$16,734,691	$12,420,150	$12,488,707	0.6%	$2,433,148	$2,780,594	$1,249,695	-55.1%	
Employee Paid	$4,119,828	$3,619,170	$3,909,362	8.0%	$794,016	$638,305	$599,811	-6.0%	
Client Paid-PEPY	$10,313	$7,533	$8,323	10.5%	$7,582	$10,195	$5,558	-45.5%	$6,297
Client Paid-PMPY	$6,904	$5,018	$5,536	10.3%	$6,588	$8,662	$4,683	-45.9%	$3,879
Client Paid-PEPM	$859	$628	$694	10.5%	$632	$850	$463	-45.5%	$525
Client Paid-PMPM	$575	$418	$461	10.3%	$549	$722	$390	-46.0%	$323
High Cost Claimants (HCC's) > $100k									
# of HCC's	27	19	26	36.8%	4	4	1	-75.0%	
HCC's / 1,000	5.6	3.8	5.8	50.0%	5.4	6.2	1.9	-70.0%	
Avg HCC Paid	$287,451	$247,107	$173,785	-29.7%	$132,243	$288,394	$240,433	-16.6%	
HCC's % of Plan Paid	46.4%	37.8%	36.2%	-4.2%	21.7%	41.5%	19.2%	-53.7%	
Cost Distribution by Claim Type (PMPY)									
Facility Inpatient	$3,063	$1,615	$2,048	26.8%	$2,962	$4,695	$1,910	-59.3%	$1,149
Facility Outpatient	$2,062	$1,941	$2,025	4.3%	$2,058	$1,840	$1,375	-25.3%	$1,333
Physician	$1,597	$1,358	$1,342	-1.2%	$1,480	$1,990	$1,328	-33.3%	$1,301
Other	$182	$104	$122	17.3%	$88	$138	$70	-49.3%	$96
Total	$6,904	$5,018	$5,536	10.3%	$6,588	$8,662	$4,683	-45.9%	$3,879
	Annualized	Annualized	Annualized		Annualized	Annualized	Annualized		

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

	Total				State Active				Non-State Active			
Summary	**PY20**	**PY21**	**2Q22**	**Variance to Prior Year**	**PY20**	**PY21**	**2Q22**	**Variance to Prior Year**	**PY20**	**PY21**	**2Q22**	**Variance to Prior Year**
Enrollment												
Avg # Employees	23,673	23,322	19,267	-17.4%	19,809	19,529	15,814	-19.0%	4	4	3	-25.0%
Avg # Members	42,865	42,317	33,844	-20.0%	37,291	36,761	28,790	-21.7%	7	9	8	-11.1%
Ratio	1.8	1.8	1.8	-2.8%	1.9	1.9	1.8	-3.2%	1.8	2.3	2.7	18.7%
Financial Summary												
Gross Cost	$185,251,114	$169,798,016	$84,509,450	-50.2%	$139,774,757	$131,033,700	$66,234,286	-49.5%	$46,064	$40,353	$27,588	-31.6%
Client Paid	$143,667,208	$132,093,355	$63,977,931	-51.6%	$106,095,205	$100,467,765	$50,221,644	-50.0%	$35,053	$26,699	$17,886	-33.0%
Employee Paid	$41,583,906	$37,704,661	$20,531,518	-45.5%	$33,679,553	$30,565,935	$16,012,642	-47.6%	$11,011	$13,654	$9,702	-28.9%
Client Paid-PEPY	$6,069	$5,664	$6,641	17.2%	$5,356	$5,144	$6,352	23.5%	$9,144	$6,675	$11,924	78.6%
Client Paid-PMPY	$3,352	$3,122	$3,781	21.1%	$2,845	$2,733	$3,489	27.7%	$5,130	$2,967	$4,471	50.7%
Client Paid-PEPM	$506	$472	$553	17.2%	$446	$429	$529	23.3%	$762	$556	$994	78.8%
Client Paid-PMPM	$279	$260	$315	21.2%	$237	$228	$291	27.6%	$427	$247	$373	51.0%
High Cost Claimants (HCC's) > $100k												
# of HCC's	206	178	91		151	128	67		0	0	0	
HCC's / 1,000	4.8	4.2	2.7		4.1	3.5	2.3		0.0	0.0	0.0	
Avg HCC Paid	$236,642	$246,763	$240,886	-2.4%	$206,591	$237,270	$256,147	8.0%	$0	$0	$0	0.0%
HCC's % of Plan Paid	33.9%	33.3%	34.3%	3.0%	29.4%	30.2%	34.2%	13.2%	0.0%	0.0%	0.0%	0.0%
Cost Distribution by Claim Type (PMPY)												
Facility Inpatient	$1,139	$893	$1,507	68.8%	$883	$750	$1,415	88.7%	$0	$14	$0	0.0%
Facility Outpatient	$1,040	$991	$1,091	10.1%	$880	$822	$939	14.2%	$2,087	$2,152	$2,389	11.0%
Physician	$1,093	$1,174	$1,106	-5.8%	$1,014	$1,105	$1,065	-3.6%	$2,777	$770	$2,020	162.3%
Other	$80	$64	$77	20.3%	$68	$56	$70	25.0%	$266	$30	$62	0.0%
Total	$3,352	$3,122	$3,781	21.1%	$2,845	$2,733	$3,489	27.7%	$5,130	$2,967	$4,471	50.7%
			Annualized				Annualized				Annualized	

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

	State Retirees				Non-State Retirees				
Summary	**PY20**	**PY21**	**2Q22**	**Variance to Prior Year**	**PY20**	**PY21**	**2Q22**	**Variance to Prior Year**	**HSB Peer Index**
Enrollment									
Avg # Employees	3,246	3,268	3,001	-8.2%	615	521	450	-13.6%	
Avg # Members	4,858	4,933	4,512	-8.5%	710	614	534	-13.1%	
Ratio	1.5	1.5	1.5	-0.7%	1.2	1.2	1.2	0.8%	1.6
Financial Summary									
Gross Cost	$39,350,569	$33,024,994	$16,398,069	-50.3%	$6,079,723	$5,698,970	$1,849,506	-67.5%	
Client Paid	$32,691,908	$26,900,984	$12,488,707	-53.6%	$4,845,042	$4,697,908	$1,249,695	-73.4%	
Employee Paid	$6,658,661	$6,124,010	$3,909,362	-36.2%	$1,234,681	$1,001,063	$599,811	-40.1%	
Client Paid-PEPY	$10,070	$8,231	$8,323	1.1%	$7,882	$9,024	$5,558	-38.4%	$6,297
Client Paid-PMPY	$6,730	$5,454	$5,536	1.5%	$6,821	$7,646	$4,683	-38.8%	$3,879
Client Paid-PEPM	$839	$686	$694	1.2%	$657	$752	$463	-38.4%	$525
Client Paid-PMPM	$561	$454	$461	1.5%	$568	$637	$390	-38.8%	$323
High Cost Claimants (HCC's) > $100k									
# of HCC's	60	44	26		8	9	1		
HCC's / 1,000	12.4	8.9	5.8		11.3	14.7	1.9		
Avg HCC Paid	$271,721	$261,318	$173,785	-33.5%	$156,233	$228,360	$240,433	5.3%	
HCC's % of Plan Paid	49.9%	42.7%	36.2%	-15.2%	25.8%	43.7%	19.2%	-56.1%	
Cost Distribution by Claim Type (PMPY)									
Facility Inpatient	$2,853	$1,597	$2,048	28.2%	$2,835	$3,771	$1,910	-49.4%	$1,149
Facility Outpatient	$2,107	$2,154	$2,025	-6.0%	$2,143	$1,733	$1,375	-20.7%	$1,333
Physician	$1,600	$1,586	$1,342	-15.4%	$1,745	$2,022	$1,328	-34.3%	$1,301
Other	$170	$116	$122	5.2%	$98	$120	$70	-41.7%	$96
Total	$6,730	$5,454	$5,536	1.5%	$6,821	$7,646	$4,683	-38.8%	$3,879
			Annualized				Annualized		

Paid Claims by Claim Type – State Participants

Net Paid Claims - Total State Participants	2Q21				2Q22				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical									
Inpatient	$ 14,876,766	$ 2,928,106	$ 1,578,041	$ 19,382,914	$ 22,475,890	$ 4,180,307	$ 901,240	$ 27,557,438	42.2%
Outpatient	$ 29,487,744	$ 6,949,375	$ 964,627	$ 37,401,746	$ 27,745,754	$ 6,579,712	$ 827,448	$ 35,152,914	-6.0%
Total - Medical	**$ 44,364,510**	**$ 9,877,481**	**$ 2,542,669**	**$ 56,784,660**	**$ 50,221,644**	**$ 10,760,019**	**$ 1,728,688**	**$ 62,710,351**	**10.4%**

Net Paid Claims - Per Participant per Month	2Q21				2Q22				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical	$ 378	$ 619	$ 664	$ 414	$ 529	$ 748	$ 478	$ 555	34.1%

Paid Claims by Claim Type – Non-State Participants

Net Paid Claims - Total Non-State Participants	2Q21				2Q22				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical									
Inpatient	$ 126	$ 1,113,031	$ 496,882	$ 1,610,039	$ 435	$ 362,261	$ 192,059	$ 554,756	-65.5%
Outpatient	$ 2,137	$ 888,545	$ 282,135	$ 1,172,817	$ 17,450	$ 414,976	$ 280,399	$ 712,825	-39.2%
Total - Medical	**$ 2,263**	**$ 2,001,576**	**$ 779,017**	**$ 2,782,857**	**$ 17,886**	**$ 777,237**	**$ 472,458**	**$ 1,267,581**	**-54.5%**

Net Paid Claims - Per Participant per Month	2Q21				2Q22				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical	$ 103	$ 1,193	$ 488	$ 845	$ 994	$ 708	$ 295	$ 466	-44.8%

Paid Claims by Claim Type – Total Participants

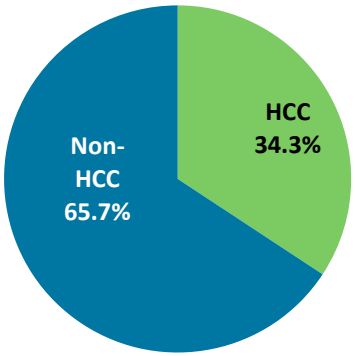
Net Paid Claims - Total Total Participants	2Q21				2Q22				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical									
Inpatient	$ 14,876,892	$ 4,041,137	$ 2,074,924	$ 20,992,953	$ 22,476,325	$ 4,542,569	$ 1,093,299	$ 28,112,193	33.9%
Outpatient	$ 29,489,881	$ 7,837,920	$ 1,246,762	$ 38,574,563	$ 27,763,205	$ 6,994,688	$ 1,107,847	$ 35,865,739	-7.0%
Total - Medical	**$ 44,366,773**	**$ 11,879,057**	**$ 3,321,686**	**$ 59,567,516**	**$ 50,239,530**	**$ 11,537,256**	**$ 2,201,146**	**$ 63,977,931**	**7.4%**

Net Paid Claims - Per Participant per Month	2Q21				2Q22				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	
Medical	$ 378	$ 673	$ 613	$ 424	$ 529	$ 745	$ 422	$ 553	30.4%

Cost Distribution – Medical Claims

2Q21							2Q22					
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
62	0.1%	$14,757,845	24.8%	$438,323	2.0%	$100,000.01 Plus	70	0.2%	$21,564,208	33.7%	$480,929	2.3%
112	0.3%	$8,205,997	13.8%	$629,846	2.9%	$50,000.01-$100,000.00	90	0.3%	$7,900,302	12.3%	$586,424	2.9%
225	0.5%	$8,149,864	13.7%	$1,123,566	5.2%	$25,000.01-$50,000.00	190	0.6%	$8,090,999	12.6%	$1,028,670	5.0%
586	1.4%	$9,619,497	16.1%	$2,567,045	11.9%	$10,000.01-$25,000.00	463	1.4%	$8,456,070	13.2%	$2,141,716	10.4%
748	1.8%	$5,538,987	9.3%	$2,412,521	11.2%	$5,000.01-$10,000.00	669	2.0%	$5,447,633	8.5%	$2,236,215	10.9%
1,017	2.4%	$3,843,670	6.5%	$2,234,603	10.4%	$2,500.01-$5,000.00	1,061	3.1%	$4,182,370	6.5%	$2,505,082	12.2%
21,490	50.6%	$9,451,659	15.9%	$10,046,762	46.6%	$0.01-$2,500.00	16,465	48.7%	$8,336,349	13.0%	$9,337,076	45.5%
5,595	13.2%	$0	0.0%	$2,126,300	9.9%	$0.00	5,099	15.1%	$0	0.0%	$2,215,406	10.8%
12,645	29.8%	$0	0.0%	$0	0.0%	No Claims	9,735	28.8%	$0	0.0%	$0	0.0%
42,479	**100.0%**	**$59,567,516**	**100.0%**	**$21,578,966**	**100.0%**		**33,844**	**100.0%**	**$63,977,931**	**100.0%**	**$20,531,518**	**100.0%**

Distribution of HCC Medical Claims Paid



HCC – High-Cost Claimant over $100K

HCC's by Diagnosis Grouper			
Top 10 Diagnosis Groupers	Patients	Total Paid	% Paid
Pregnancy-related Disorders	4	$5,308,114	24.2%
Cancer	34	$3,858,633	17.6%
Cardiac Disorders	59	$2,421,243	11.0%
Infections	46	$2,204,806	10.1%
Spine-related Disorders	15	$934,205	4.3%
Gastrointestinal Disorders	44	$903,323	4.1%
Renal/Urologic Disorders	33	$812,643	3.7%
Endocrine/Metabolic Disorders	35	$716,978	3.3%
Trauma/Accidents	25	$664,015	3.0%
Mental Health	22	$642,656	2.9%
All Other		$3,454,043	15.8%
Overall	**----**	**$21,920,658**	**100.0%**

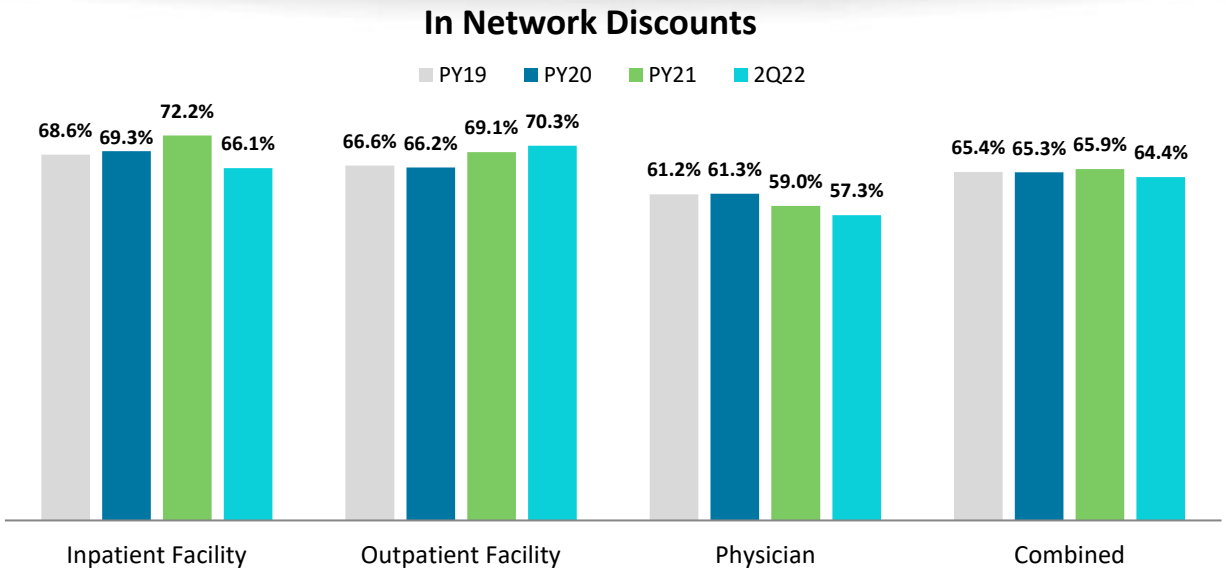
Utilization Summary (p. 1 of 2)

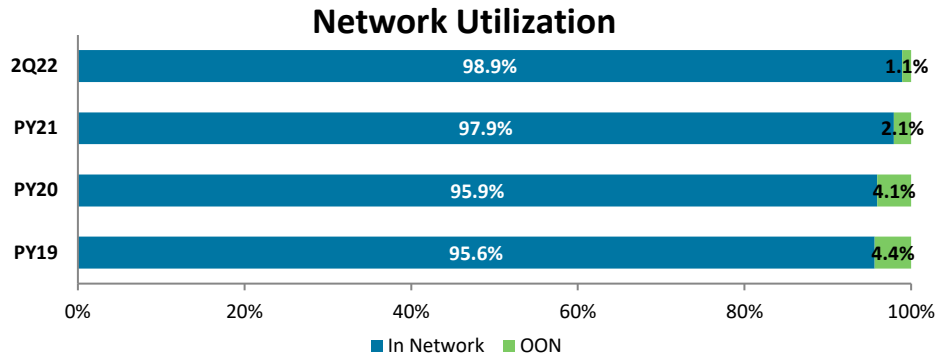
	Total				State Active				Non-State Active			
Summary	**2Q20**	**2Q21**	**2Q22**	**Variance to Prior Year**	**2Q20**	**2Q21**	**2Q22**	**Variance to Prior Year**	**2Q20**	**2Q21**	**2Q22**	**Variance to Prior Year**
Inpatient Summary												
# of Admits	952	831	731		725	676	544		0	0	0	
# of Bed Days	5,667	5,928	4,145		4,289	4,941	3,112		0	0	0	
Paid Per Admit	$26,636	$37,814	$22,345	-40.9%	$26,004	$36,853	$23,356	-36.6%	$0	$0	$0	0.0%
Paid Per Day	$4,475	$5,301	$3,941	-25.7%	$4,396	$5,042	$4,083	-19.0%	$0	$0	$0	0.0%
Admits Per 1,000	44	39	43	10.3%	39	37	38	2.7%	0	0	0	0.0%
Days Per 1,000	263	279	245	-12.2%	228	267	216	-19.1%	0	0	0	0.0%
Avg LOS	6	7.1	5.7	-19.7%	5.9	7.3	5.7	-21.9%	0	0	0	0.0%
# Admits From ER	476	435	416		332	334	283		0	0	0	
Physician Office												
OV Utilization per Member	4.2	3.7	4.1	10.8%	3.9	3.5	3.9	11.4%	14	4.0	3.5	-12.5%
Avg Paid per OV	$69	$69	$77	11.6%	$69	$71	$80	12.7%	$99	$86	$44	-48.8%
Avg OV Paid per Member	$290	$259	$317	22.4%	$270	$250	$308	23.2%	$1,391	$346	$153	-55.8%
DX&L Utilization per Member	8.2	7.7	8.2	6.5%	7.6	7.2	7.7	6.9%	0	0	15.8	0.0%
Avg Paid per DX&L	$51	$53	$54	1.9%	$48	$48	$50	4.2%	$0	$0	$127	0.0%
Avg DX&L Paid per Member	$416	$405	$442	9.1%	$366	$348	$384	10.3%	$0	$0	$2,005	0.0%
Emergency Room												
# of Visits	3,194	2,431	2,522		2,649	2,088	2,104		2	0	3	
Visits Per Member	0.15	0.11	0.15	36.4%	0.14	0.11	0.15	36.4%	0.57	0.00	0.75	0.0%
Visits Per 1,000	148	114	149	30.7%	141	113	146	29.2%	571	0	750	0.0%
Avg Paid per Visit	$2,000	$2,036	$1,674	-17.8%	$1,997	$2,023	$1,684	-16.8%	$1,803	$0	$1,489	0.0%
Urgent Care												
# of Visits	6,354	4,797	4,574		5,738	4,309	4,062		1	0	1	
Visits Per Member	0.29	0.23	0.27	17.4%	0.31	0.23	0.28	21.7%	0.29	0.00	0.25	0.0%
Visits Per 1,000	294	225	270	20.0%	305	233	282	21.0%	286	0	250	0.0%
Avg Paid per Visit	$31	$68	$63	-7.4%	$30	$68	$63	-7.4%	$170	$0	$113	0.0%
	Annualized	Annualized	Annualized		Annualized	Annualized	Annualized		Annualized	Annualized	Annualized	

Utilization Summary (p. 2 of 2)

	State Retirees				Non-State Retirees				
Summary	**2Q20**	**2Q21**	**2Q22**	**Variance to Prior Year**	**2Q20**	**2Q21**	**2Q22**	**Variance to Prior Year**	**HSB Peer Index**
Inpatient Summary									
# of Admits	174	128	171		53	27	16		
# of Bed Days	1,118	815	928		260	172	105		
Paid Per Admit	$31,894	$40,391	$19,613	-51.4%	$18,021	$49,664	$17,131	-65.5%	$16,632
Paid Per Day	$4,964	$6,344	$3,614	-43.0%	$3,674	$7,796	$2,611	-66.5%	$3,217
Admits Per 1,000	72	52	76	46.2%	144	84	60	-28.6%	76
Days Per 1,000	462	332	411	23.8%	707	537	394	-26.6%	391
Avg LOS	6.4	6.4	5.4	-15.6%	4.9	6.4	6.6	3.1%	5.2
# Admits From ER	103	83	125		41	18	8		
Physician Office									
OV Utilization per Member	5.8	4.9	5.2	6.1%	7.6	6.4	7.3	14.1%	5.0
Avg Paid per OV	$72	$62	$75	21.0%	$65	$59	$31	-47.5%	$57
Avg OV Paid per Member	$420	$305	$390	27.9%	$495	$378	$226	-40.2%	$286
DX&L Utilization per Member	11.9	10.5	10.7	1.9%	14.2	12.4	11.6	-6.5%	10.5
Avg Paid per DX&L	$63	$74	$74	0.0%	$53	$66	$53	-19.7%	$50
Avg DX&L Paid per Member	$753	$775	$789	1.8%	$746	$821	$615	-25.1%	$522
Emergency Room									
# of Visits	436	304	358		107	39	57		
Visits Per Member	0.18	0.12	0.16	33.3%	0.29	0.12	0.21	75.0%	0.24
Visits Per 1,000	180	124	159	28.2%	291	122	214	75.4%	235
Avg Paid per Visit	$2,175	$2,012	$1,697	-15.7%	$1,366	$2,898	$1,198	-58.7%	$943
Urgent Care									
# of Visits	522	428	462		93	60	49		
Visits Per Member	0.22	0.17	0.20	17.6%	0.25	0.19	0.18	-5.3%	0.3
Visits Per 1,000	216	174	205	17.8%	253	187	184	-1.6%	300
Avg Paid per Visit	$40	$70	$60	-14.3%	$32	$62	$27	-56.5%	$84
	Annualized	Annualized	Annualized		Annualized	Annualized	Annualized		

Provider Network Summary





Diagnosis Grouper Summary

Diagnosis Grouper	Total Paid	% Paid	Insured	Spouse	Child	Male	Female	Unassigned
Pregnancy-related Disorders	$8,034,521	12.6%	$1,436,999	$464,194	$6,133,327	$5,580,590	$2,238,701	$215,230
Cancer	$6,927,820	10.8%	$5,656,087	$834,300	$437,433	$3,300,266	$3,627,553	$0
Infections	$6,062,619	9.5%	$3,997,012	$1,407,834	$657,773	$3,144,889	$2,917,659	$70
COVID-19, Confirmed	$2,994,280	4.7%	$2,072,245	$788,781	$133,253	$1,537,577	$1,456,702	$0
Health Status/Encounters	$5,065,634	7.9%	$2,928,265	$719,426	$1,417,943	$1,972,216	$3,090,447	$2,971
Cardiac Disorders	$4,945,799	7.7%	$3,808,685	$1,087,172	$49,942	$3,494,760	$1,448,002	$3,037
Gastrointestinal Disorders	$4,577,949	7.2%	$3,342,655	$787,457	$447,837	$2,287,262	$2,290,675	$11
Musculoskeletal Disorders	$4,016,688	6.3%	$2,872,680	$588,542	$555,466	$1,489,390	$2,525,688	$1,611
Mental Health	$2,984,044	4.7%	$1,045,117	$208,364	$1,730,563	$1,275,002	$1,709,042	$0
Spine-related Disorders	$2,926,668	4.6%	$2,146,846	$574,343	$205,479	$756,875	$2,169,792	$0
Trauma/Accidents	$2,743,598	4.3%	$1,621,173	$387,874	$734,551	$1,219,108	$1,524,490	$0
Neurological Disorders	$2,665,826	4.2%	$1,797,322	$465,398	$403,106	$951,432	$1,713,844	$550
Renal/Urologic Disorders	$2,095,358	3.3%	$1,312,698	$585,092	$197,568	$1,347,027	$748,330	$0
Eye/ENT Disorders	$1,633,112	2.6%	$1,199,738	$168,755	$264,619	$712,515	$920,539	$58
Endocrine/Metabolic Disorders	$1,384,649	2.2%	$1,203,395	$142,138	$39,116	$414,700	$969,949	$0
Pulmonary Disorders	$1,281,132	2.0%	$802,875	$161,597	$316,660	$567,686	$713,446	$0
Gynecological/Breast Disorders	$1,090,008	1.7%	$696,654	$236,034	$157,320	$37,403	$1,052,526	$79
Non-malignant Neoplasm	$850,491	1.3%	$611,165	$219,172	$20,153	$292,803	$557,687	$0
Hematological Disorders	$723,312	1.1%	$675,961	$20,254	$27,097	$179,594	$543,718	$0
Congenital/Chromosomal Anomalies	$713,122	1.1%	$96,317	$2,401	$614,404	$428,678	$284,312	$132
Medical/Surgical Complications	$671,756	1.0%	$555,048	$95,245	$21,463	$436,472	$235,284	$0
Dermatological Disorders	$638,506	1.0%	$418,580	$51,094	$168,832	$370,568	$267,938	$0
Miscellaneous	$564,646	0.9%	$293,614	$183,292	$87,740	$286,926	$276,964	$757
Diabetes	$513,400	0.8%	$359,849	$91,752	$61,799	$313,763	$199,637	$0
Vascular Disorders	$384,161	0.6%	$311,307	$68,888	$3,966	$92,731	$291,431	$0
Abnormal Lab/Radiology	$281,774	0.4%	$213,856	$57,998	$9,920	$116,142	$165,325	$307
Medication Related Conditions	$89,188	0.1%	$45,107	$12,247	$31,835	$35,064	$54,124	$0
Cholesterol Disorders	$43,727	0.1%	$35,088	$7,706	$933	$21,563	$22,164	$0
External Hazard Exposure	$24,276	0.0%	$8,317	$10,481	$5,478	$16,140	$8,137	$0
Dental Conditions	$23,751	0.0%	$19,734	$509	$3,508	$5,045	$18,706	$0
Allergic Reaction	$20,396	0.0%	$9,633	$3,617	$7,146	$9,519	$10,877	$0
Total	**$63,977,931**	**100.0%**	**$39,521,778**	**$9,643,176**	**$14,812,978**	**$31,156,129**	**$32,596,990**	**$224,812**

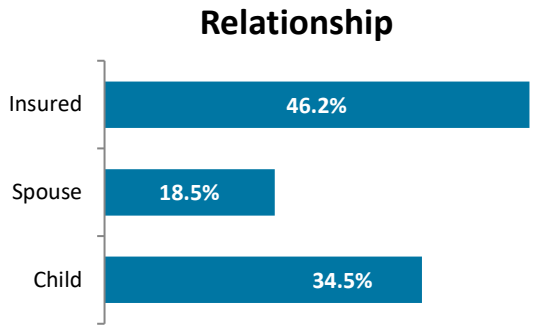
Mental Health Drilldown

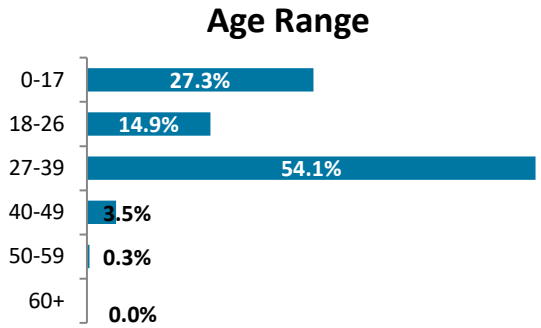
	PY19		PY20		PY21		2Q22	
Grouper	Patients	Total Paid	Patients	Total Paid	Patients	Total Paid	Patients	Total Paid
Depression	1,438	$960,442	1,578	$1,202,510	1,622	$1,042,887	900	$505,007
Developmental Disorders	132	$376,873	155	$796,920	190	$1,169,559	113	$478,159
Alcohol Abuse/Dependence	127	$888,930	134	$689,963	129	$999,750	68	$401,043
Eating Disorders	46	$77,221	49	$159,855	50	$598,404	44	$345,752
Mental Health Conditions, Other	1,243	$504,177	1,341	$786,711	1,278	$792,762	762	$250,625
Substance Abuse/Dependence	115	$1,226,970	131	$1,029,390	138	$370,274	67	$241,135
Mood and Anxiety Disorders	1,646	$366,935	1,860	$484,244	1,957	$609,469	1,063	$225,305
Complications of Substance Abuse	85	$578,454	94	$713,276	74	$456,459	40	$215,217
Bipolar Disorder	343	$314,670	349	$379,745	319	$507,979	183	$167,888
Psychoses	47	$102,096	59	$71,859	52	$115,493	29	$52,057
Schizophrenia	26	$49,918	30	$46,596	26	$136,199	19	$47,077
Attention Deficit Disorder	428	$49,357	460	$60,539	493	$68,592	294	$23,360
Sleep Disorders	529	$48,331	568	$45,329	549	$70,710	268	$20,002
Sexually Related Disorders	53	$27,530	60	$20,133	67	$164,428	40	$4,340
Personality Disorders	18	$13,066	24	$18,327	26	$17,095	13	$3,835
Tobacco Use Disorder	172	$13,424	161	$6,997	124	$8,023	71	$3,242
Total		**$5,598,394**		**$6,512,394**		**$7,128,082**		**$2,984,044**

Diagnosis Grouper – Pregnancy-related Disorders

Diagnosis Sub-Grouper	Patients	Claims	Total Paid	% Paid
Perinatal Disorders	98	294	$2,567,463	32.0%
Prematurity and Low Birth Weight	6	12	$2,562,563	31.9%
Labor and Delivery Related	165	423	$879,753	10.9%
Liveborn Infants	143	241	$864,732	10.8%
Pregnancy Complications	294	966	$830,977	10.3%
Supervision of Pregnancy	368	1,263	$171,192	2.1%
Fetal Distress	8	37	$95,988	1.2%
Multiple Gestation Related	9	56	$32,621	0.4%
Abortion Related	27	66	$18,991	0.2%
Cesarean Delivery	6	6	$5,711	0.1%
Ectopic Pregnancy	3	6	$4,235	0.1%
Birth Injury	1	3	$294	0.0%
Overall	**----**	**----**	**$8,034,521**	**100.0%**

*Patient and claim counts are unique only within the category

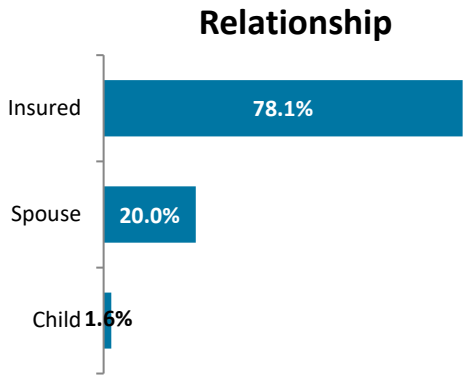


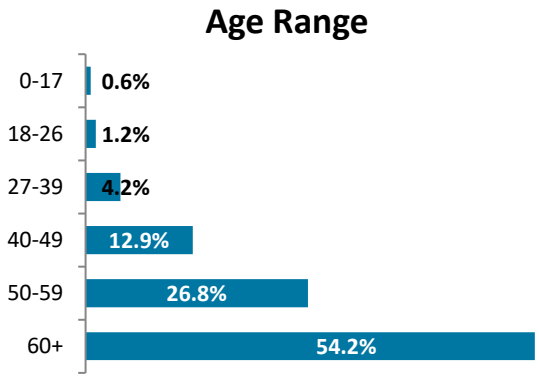


Diagnosis Grouper – Cancer

Diagnosis Sub-Grouper	Patients	Claims	Total Paid	% Paid
Cancer Therapies	95	564	$2,528,932	36.5%
Cancers, Other	306	1,146	$875,924	12.6%
Breast Cancer	193	1,162	$707,873	10.2%
Leukemias	28	320	$467,856	6.8%
Cervical/Uterine Cancer	46	207	$311,297	4.5%
Brain Cancer	12	143	$275,488	4.0%
Prostate Cancer	96	381	$251,526	3.6%
Melanoma	48	161	$228,783	3.3%
Lung Cancer	24	168	$226,799	3.3%
Secondary Cancers	58	239	$216,860	3.1%
Thyroid Cancer	69	231	$170,446	2.5%
Colon Cancer	44	234	$167,274	2.4%
Ovarian Cancer	20	85	$141,403	2.0%
Pancreatic Cancer	10	74	$114,569	1.7%
Lymphomas	40	257	$81,207	1.2%
Myeloma	9	115	$67,317	1.0%
Carcinoma in Situ	69	112	$43,815	0.6%
Kidney Cancer	16	51	$31,293	0.5%
Bladder Cancer	19	109	$19,158	0.3%
Overall	**----**	**----**	**$6,927,820**	**100.0%**

*Patient and claim counts are unique only within the category

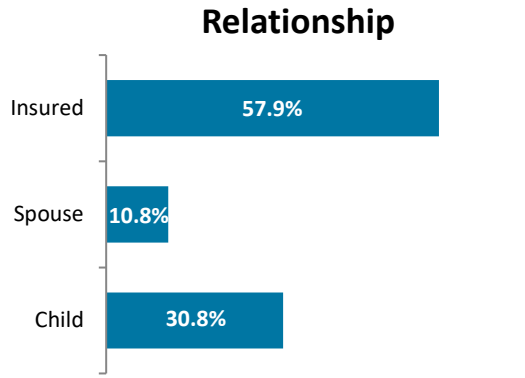


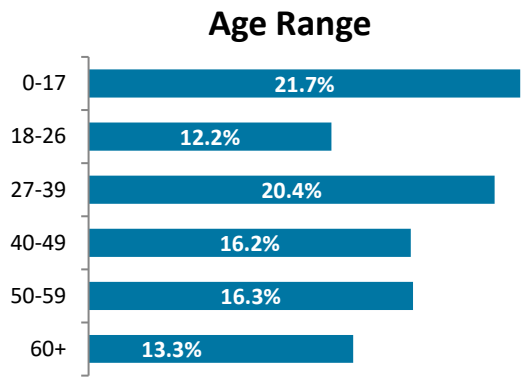


Diagnosis Grouper – Infections

Diagnosis Sub-Grouper	Patients	Claims	Total Paid	% Paid
Infectious Diseases	5,655	11,646	$3,956,687	65.3%
Septicemia	101	236	$1,941,807	32.0%
Osteomyelitis	15	312	$153,385	2.5%
HIV	35	92	$9,349	0.2%
Influenza	16	18	$733	0.0%
Hepatitis B	13	33	$652	0.0%
Hepatitis C	4	4	$7	0.0%
Tuberculosis	2	2	$0	0.0%
Clostridium Difficile	2	2	$0	0.0%
Overall	----	----	**$6,062,619**	**100.0%**

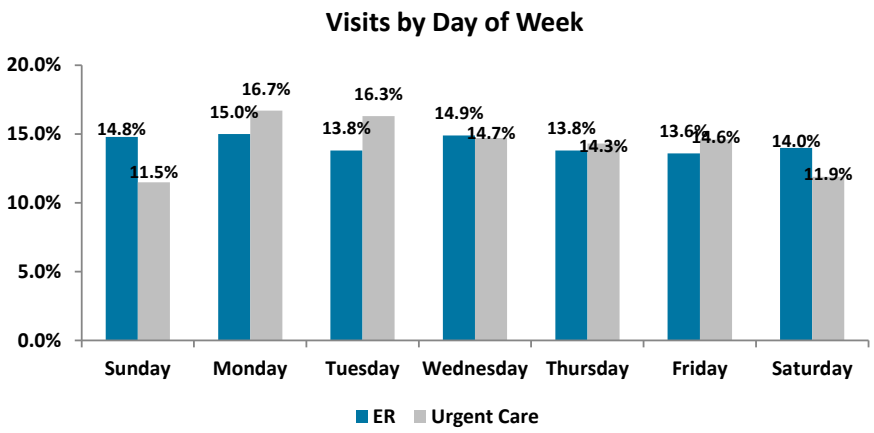
*Patient and claim counts are unique only within the category

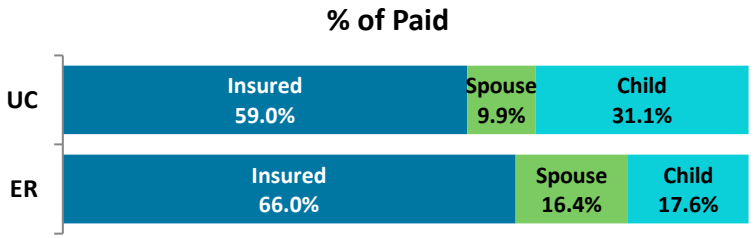




Emergency Room / Urgent Care Summary

	2Q21		2Q22		HSB Peer Index	
ER/Urgent Care	ER	Urgent Care	ER	Urgent Care	ER	Urgent Care
Number of Visits	2,431	4,797	2,522	4,574		
Visits Per Member	0.11	0.23	0.15	0.27	0.17	0.24
Visits/1000 Members	114	225	149	270	174	242
Avg Paid Per Visit	$2,036	$68	$1,674	$63	$1,684	$74
% with OV*	83.1%	78.9%	85.0%	81.1%		
% Avoidable	11.0%	24.0%	11.3%	29.1%		
Total Member Paid	**$2,770,223**	**$515,483**	**$2,609,908**	**$510,720**		
Total Plan Paid	**$4,949,028**	**$325,345**	**$4,222,925**	**$286,230**		
*looks back 12 months	Annualized	Annualized	Annualized	Annualized		



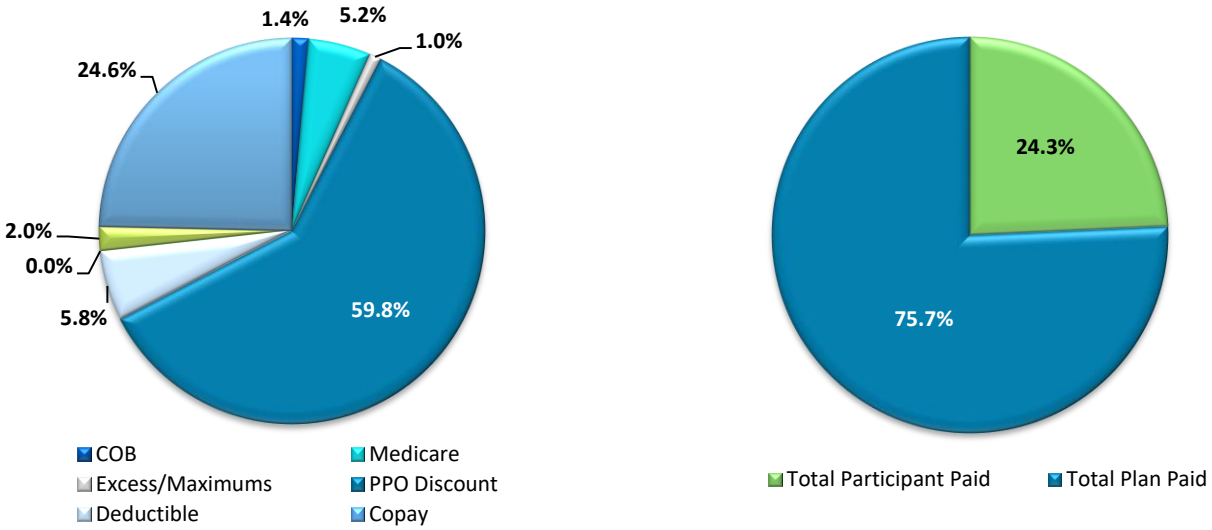


ER / UC Visits by Relationship						
Relationship	ER	Per 1,000	Urgent Care	Per 1,000	Total	Per 1,000
Insured	1,515	79	2,711	4,380	4,226	219
Spouse	364	86	464	863	828	196
Child	643	62	1,399	1,655	2,042	197
Total	**2,522**	**75**	**4,574**	**135**	**7,096**	**210**

Savings Summary – Medical Claims

Description	Dollars	PPPM	% of Eligible
Eligible Charges	$258,868,990	$2,239	100.0%
COB	$3,571,115	$31	1.4%
Medicare	$13,531,952	$117	5.2%
Excess/Maximums	$2,616,156	$23	1.0%
PPO Discount	$155,343,332	$1,344	60.0%
Deductible	$15,176,524	$131	5.9%
Copay	$75,962	$1	0.0%
Coinsurance	$5,279,033	$46	2.0%
Total Participant Paid	**$20,531,518**	**$178**	**7.9%**
Total Plan Paid	**$63,977,931**	**$553**	**24.7%**

Total Participant Paid - PY21	**$135**
Total Plan Paid - PY21	**$472**



Paid Claims by Age Range – Dental

Dental Paid Claims by Age Group									
	2Q20		2Q21		2Q22		% Change	
Age Range	Dental Plan Paid	Dental PMPM	Dental Plan Paid	Dental PMPM	Dental Plan Paid	Dental PMPM	Dental Plan Paid	Dental PMPM
<1	$ 9,126	$ 3	$ 5,915	$ 2	$ 4,637	$ 2	-21.6%	-14.0%
1	$ 25,737	$ 8	$ 25,092	$ 7	$ 26,996	$ 9	7.6%	17.0%
2 - 4	$ 205,909	$ 19	$ 185,442	$ 17	$ 208,939	$ 20	12.7%	19.3%
5 - 9	$ 661,689	$ 31	$ 604,397	$ 30	$ 647,643	$ 33	7.2%	12.3%
10 - 14	$ 641,514	$ 27	$ 664,155	$ 28	$ 666,817	$ 29	0.4%	2.7%
15 - 19	$ 776,827	$ 31	$ 833,988	$ 33	$ 789,260	$ 32	-5.4%	-3.9%
20 - 24	$ 524,971	$ 19	$ 495,420	$ 18	$ 478,271	$ 18	-3.5%	-0.8%
25 - 29	$ 528,795	$ 25	$ 503,991	$ 24	$ 455,130	$ 24	-9.7%	-2.7%
30 - 34	$ 612,847	$ 26	$ 616,734	$ 26	$ 593,620	$ 26	-3.7%	1.0%
35 - 39	$ 742,642	$ 29	$ 719,288	$ 27	$ 754,787	$ 30	4.9%	8.7%
40 - 44	$ 725,414	$ 30	$ 694,249	$ 28	$ 726,045	$ 29	4.6%	4.2%
45 - 49	$ 886,480	$ 32	$ 774,557	$ 29	$ 755,359	$ 30	-2.5%	3.2%
50 - 54	$ 972,069	$ 34	$ 878,427	$ 30	$ 966,569	$ 34	10.0%	10.7%
55 - 59	$ 1,178,205	$ 37	$ 1,065,686	$ 35	$ 1,095,005	$ 37	2.8%	5.4%
60 - 64	$ 1,435,524	$ 40	$ 1,317,511	$ 38	$ 1,382,146	$ 42	4.9%	8.2%
65+	$ 3,421,967	$ 43	$ 3,330,539	$ 41	$ 3,552,447	$ 44	6.7%	6.5%
Total	**$13,349,718**	**$ 32**	**$ 12,715,391**	**$ 31**	**$ 13,103,671**	**$ 33**	**3.1%**	**5.7%**

Dental Paid Claims – State Participants

Dental Paid Claims - Total State Participants	2Q21				2Q22				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Dental	$ 8,645,923	$ 1,017,552	$ 274,399	$ 9,937,874	$ 8,718,106	$ 1,122,018	$ 274,488	$ 10,114,612	1.8%
Dental Exchange	$ -	$ -	$ 1,615,026	$ 1,615,026	$ -	$ -	$ 1,799,747	$ 1,799,747	11.4%
Total	**$ 8,645,923**	**$ 1,017,552**	**$ 1,889,424**	**$ 11,552,899**	**$ 8,718,106**	**$ 1,122,018**	**$ 2,074,235**	**$ 11,914,359**	**13.2%**

Dental Paid Claims - Per Participant per Month	2Q21				2Q22				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Dental	$ 53	$ 50	$ 60	$ 53	$ 56	$ 54	$ 61	$ 56	4.5%
Dental Exchange	$ -	$ -	$ 49	$ 49	$ -	$ -	$ 53	$ 53	8.4%

Dental Paid Claims – Non-State Participants

Dental Paid Claims - Total Non-State Participants	2Q21				2Q22				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Dental	$ 2,188	$ 117,318	$ 112,403	$ 231,909	$ 3,507	$ 87,788	$ 121,784	$ 213,079	-8.1%
Dental Exchange	$ -	$ -	$ 930,582	$ 930,582	$ -	$ -	$ 976,233	$ 976,233	4.9%
Total	**$ 2,188**	**$ 117,318**	**$ 1,042,985**	**$ 1,162,491**	**$ 3,507**	**$ 87,788**	**$ 1,098,017**	**$ 1,189,312**	**2.3%**

Dental Paid Claims - Per Participant per Month	2Q21				2Q22				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Dental	$ 48	$ 42	$ 45	$ 43	$ 83	$ 47	$ 47	$ 47	9.1%
Dental Exchange	$ -	$ -	$ 44	$ 44	$ -	$ -	$ 47	$ 47	7.2%

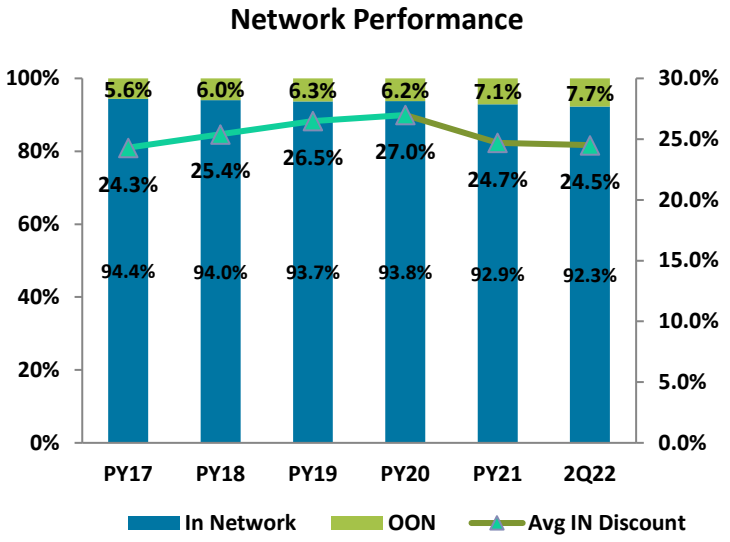
Dental Paid Claims – Total Participants

Dental Paid Claims - Total Total Participants	2Q21				2Q22				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Dental	$ 8,648,111	$ 1,134,870	$ 386,802	$ 10,169,783	$ 8,721,613	$ 1,209,806	$ 396,272	$ 10,327,691	1.6%
Dental Exchange	$ -	$ -	$ 2,545,608	$ 2,545,608	$ -	$ -	$ 2,775,980	$ 2,775,980	9.0%
Total	**$ 8,648,111**	**$ 1,134,870**	**$ 2,932,410**	**$ 12,715,391**	**$ 8,721,613**	**$ 1,209,806**	**$ 3,172,252**	**$ 13,103,671**	**3.1%**

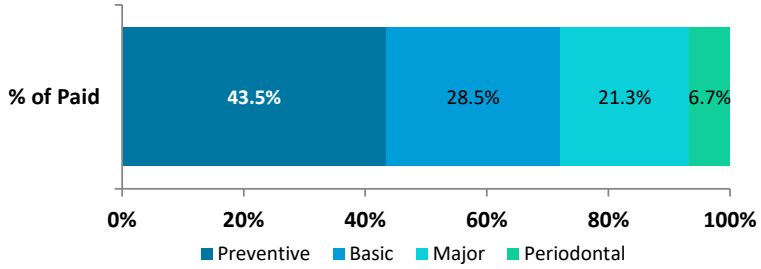
Dental Paid Claims - Per Participant per Month	2Q21				2Q22				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	
Dental	$ 53	$ 49	$ 55	$ 53	$ 56	$ 53	$ 56	$ 55	4.6%
Dental Exchange	$ -	$ -	$ 47	$ 47	$ -	$ -	$ 51	$ 51	8.1%

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	3,186	4.8%	11,422	17.0%	$4,699,312	35.9%	$3,273,137	50.0%
$750.01-$1,000.00	1,389	2.1%	4,210	6.3%	$1,227,275	9.4%	$725,091	11.1%
$500.01-$750.00	2,298	3.4%	5,935	8.8%	$1,442,275	11.0%	$842,036	12.9%
$250.01-$500.00	6,443	9.7%	14,301	21.3%	$2,223,055	17.0%	$730,585	11.2%
$0.01-$250.00	23,372	35.0%	30,637	45.6%	$3,511,754	26.8%	$929,009	14.2%
$0.00	602	0.9%	655	1.0%	$0	0.0%	$46,939	0.7%
No Claims	29,438	44.1%	0	0.0%	$0	0.0%	$0	0.0%
Total	**66,728**	**100.0%**	**67,160**	**100.0%**	**$13,103,671**	**100.0%**	**$6,546,796**	**100.0%**



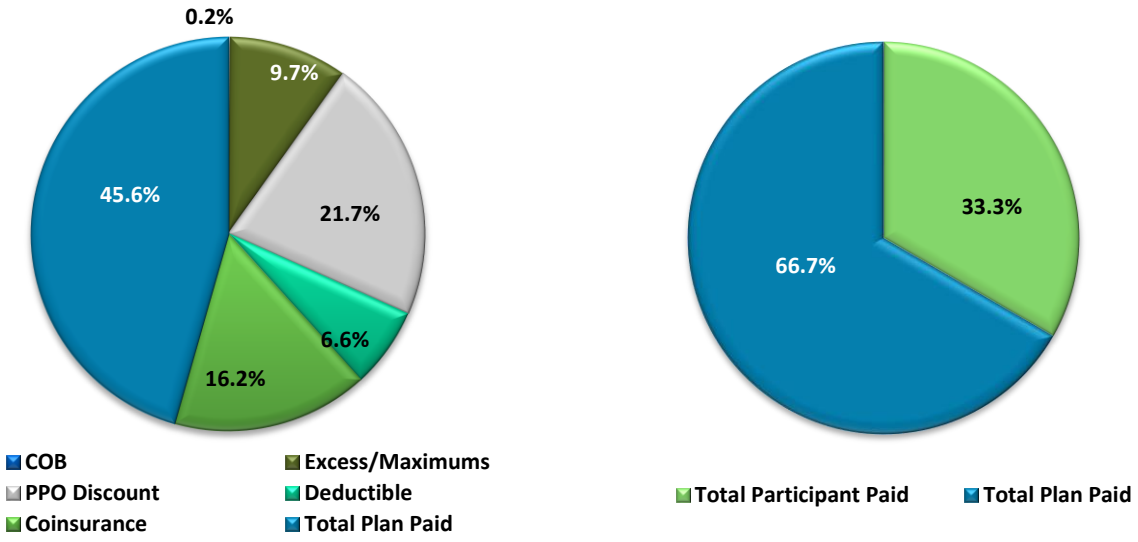
Claim Category	Total Paid	% of Paid
Preventive	$5,700,081	43.5%
Basic	$3,737,165	28.5%
Major	$2,793,652	21.3%
Periodontal	$872,773	6.7%
Total	**$13,103,671**	**100.0%**



Savings Summary – Dental Claims

Description	Dollars	PPPM	% of Eligible
Eligible Charges	$28,663,547	$119	100.0%
COB	$51,378	$0	0.2%
Excess/Maximums	$2,797,138	$12	9.8%
PPO Discount	$6,243,024	$26	21.8%
Deductible	$1,903,142	$8	6.6%
Coinsurance	$4,643,654	$19	16.2%
Total Participant Paid	**$6,546,796**	**$27**	**22.8%**
Total Plan Paid	**$13,103,671**	**$54**	**45.7%**

Total Participant Paid - PY21	**$23**
Total Plan Paid - PY21	**$51**



Quality Metrics

Condition	Metric	#Members in Group	#Meeting Metric	#Not Meeting Metric	% Meeting Metric
Asthma	Asthma and a routine provider visit in the last 12 months	1,144	1,100	44	96.2%
	<2 asthma related ER Visits in the last 6 months	1,144	1,143	1	99.9%
	No asthma related admit in last 12 months	1,144	1,143	1	99.9%
Chronic Obstructive Pulmonary Disease	No exacerbations in last 12 months	231	224	7	97.0%
	Members with COPD who had an annual spirometry test	231	33	198	14.3%
Congestive Heart Failure	No re-admit to hosp with Heart Failure diag w/in 30 days of HF inpatient stay discharge	12	11	1	91.7%
	No ER Visit for Heart Failure in last 90 days	212	207	5	97.6%
	Follow-up OV within 4 weeks of discharge from HF admission	12	10	2	83.3%
Diabetes	Annual office visit	1,683	1,601	82	95.1%
	Annual dilated eye exam	1,683	691	992	41.1%
	Annual foot exam	1,683	685	998	40.7%
	Annual HbA1c test done	1,683	1,354	329	80.5%
	Diabetes Annual lipid profile	1,683	1,276	407	75.8%
	Annual microalbumin urine screen	1,683	1,144	539	68.0%
Hyperlipidemia	Hyperlipidemia Annual lipid profile	4,181	3,345	836	80.0%
Hypertension	Annual lipid profile	4,658	3,127	1,531	67.1%
	Annual serum creatinine test	4,572	3,624	948	79.3%
Wellness	Well Child Visit - 15 months	242	228	14	94.2%
	Routine office visit in last 6 months	33,230	19,649	13,581	59.1%
	Age 45 to 75 years with colorectal cancer screening	13,118	2,938	10,180	22.4%
	Women age 25-65 with recommended cervical cancer screening	10,480	7,284	3,196	69.5%
	Males age greater than 49 with PSA test in last 24 months	5,087	2,368	2,719	46.6%
	Routine exam in last 24 months	33,230	27,718	5,512	83.4%
	Women age 40 to 75 with a screening mammogram last 24 months	8,433	4,749	3,684	56.3%

All member counts represent members active at the end of the report period.
Quality Metrics are always calculated on an incurred basis.

Chronic Conditions Prevalence

A member is identified as having a chronic condition if any one of the following three conditions is met within a 24 month service date period:

- **Two outpatient claims for the Dx on separate days of service**
- **One ER Visit with the Dx as primary**
- **One IP admission with the Dx as the admitting**

*For Diabetes only, one or more Rx claims can also be used to identify the condition.

Chronic Condition	# With Condition	% of Members	Members per 1000	PMPY
Affective Psychosis	202	0.61%	5.97	$13,788
Asthma	1,290	3.88%	38.12	$12,633
Atrial Fibrillation	322	0.97%	9.51	$31,021
Blood Disorders	1,692	5.09%	50.00	$26,213
CAD	658	1.98%	19.44	$21,344
COPD	230	0.69%	6.80	$24,171
Cancer	1,190	3.58%	35.16	$23,116
Chronic Pain	628	1.89%	18.56	$20,125
Congestive Heart Failure	211	0.63%	6.23	$45,850
Demyelinating Diseases	76	0.23%	2.25	$50,857
Depression	1,883	5.66%	55.64	$12,712
Diabetes	1,843	5.54%	54.46	$15,509
ESRD	45	0.14%	1.33	$96,359
Eating Disorders	105	0.32%	3.10	$35,043
HIV/AIDS	37	0.11%	1.09	$51,278
Hyperlipidemia	4,413	13.27%	130.39	$9,010
Hypertension	4,686	14.09%	138.46	$12,012
Immune Disorders	87	0.26%	2.57	$72,947
Inflammatory Bowel Disease	105	0.32%	3.10	$36,106
Liver Diseases	589	1.77%	17.40	$19,801
Morbid Obesity	788	2.37%	23.28	$16,098
Osteoarthritis	1,116	3.36%	32.98	$14,579
Peripheral Vascular Disease	171	0.51%	5.05	$18,987
Rheumatoid Arthritis	145	0.44%	4.28	$31,098

Data Includes Medical and Pharmacy
Based on 24 months incurred dates

Methodology

- Average member counts were weighted by the number of months each member had on the plan.
- Claims were pulled based upon the date paid.
- Claims were categorized based upon four groups:
  - Inpatient Facility
  - Outpatient Facility
  - Physician
  - Other (Other includes any medical reimbursements or durable medical equipment.)
- Inpatient analysis was done by identifying facility claims where a room and board charge was submitted and paid. Claims were then rolled up for the entire admission and categorized by the diagnosis code that held the highest paid amount. (Hospice and skilled nursing facility claims were excluded)
- Outpatient claims were flagged by an in-or-outpatient indicator being present on the claim that identified it as taking place at an outpatient facility.
- Physician claims were identified when the vendor type indicator was flagged as a professional charge.
  - These claims were in some cases segregated further to differentiate primary care physicians and specialists.
  - Office visits were identified by the presence of evaluation and management or consultation codes.
- Emergency room and urgent care episodes should be considered subcategories of physician and outpatient facility.
  - Emergency Room visits are identified by facility claims with a revenue code of 450-455, 457-459.
  - Urgent Care visits are identified by facility claims with a revenue code of 456 or physician claims with a place of service of “Urgent Care”.
  - Outpatient claims (including facility and physician) are then rolled up for the day of service and summarized as an ER/UC visit.
  - If a member has an emergency room visit on the same day as an urgent care visit, all claims are grouped into one episode and counted as an emergency room visit.
  - If a member was admitted into the hospital through the ER, the member will not show an ER visit. ER claims are bundled with the inpatient stay.

Public Employees' Benefits Program - RX Costs
PY 2022 - Quarter Ending December 31, 2021

Express Scripts

Membership Summary	2Q FY2022 CDHP	2Q FY2021 CDHP	Difference	% Change
			Membership Summary	
Member Count (Membership)	33,790	42,487	(8,697)	-20.5%
Utilizing Member Count (Patients)	22,695	24,706	(2,011)	-8.1%
Percent Utilizing (Utilization)	67.2%	58.1%	0.09	15.5%
Claim Summary			**Claims Summary**	
Net Claims (Total Rx's)	223,104	259,638	(36,534)	-14.1%
Claims per Elig Member per Month (Claims PMPM)	1.10	1.02	0.08	7.8%
Total Claims for Generic (Generic Rx)	185,889	222,076	(36,187.00)	-16.3%
Total Claims for Brand (Brand Rx)	37,215	37,562	(347.00)	-0.9%
Total Claims for Brand w/Gen Equiv (Multisource Brand Claims)	1,628	4,035	(2,407.00)	-59.7%
Total Non-Specialty Claims	220,414	256,453	(36,039.00)	-14.1%
Total Specialty Claims	2,690	3,185	(495.00)	-15.5%
Generic % of Total Claims (GFR)	**83.3%**	**85.5%**	(0.02)	-2.6%
Generic Effective Rate (GCR)	**99.1%**	**98.2%**	0.01	0.9%
Mail Order Claims	52,584	56,417	(3,833.00)	-6.8%
Mail Penetration Rate*	28.0%	24.6%	0.03	3.4%
Claims Cost Summary			**Claims Cost Summary**	
Total Prescription Cost (Total Gross Cost)	$22,440,808	$27,583,540	($5,142,732.00)	-18.6%
Total Generic Gross Cost	$3,118,301	$4,349,401	($1,231,100.00)	-28.3%
Total Brand Gross Cost	$19,322,507	$23,234,139	($3,911,632.00)	-16.8%
Total MSB Gross Cost	$588,035	$1,008,526	($420,491.00)	-41.7%
Total Ingredient Cost	$21,833,666	$27,344,946	($5,511,280.00)	-20.2%
Total Dispensing Fee	$597,861	$226,806	$371,055.00	163.6%
Total Other (e.g. tax)	$9,282	$11,787	($2,505.00)	-21.3%
Avg Total Cost per Claim (Gross Cost/Rx)	**$100.58**	**$106.24**	($5.65)	-5.3%
Avg Total Cost for Generic (Gross Cost/Generic Rx)	$16.78	$19.59	($2.81)	-14.3%
Avg Total Cost for Brand (Gross Cost/Brand Rx)	$519.21	$618.55	($99.34)	-16.1%
Avg Total Cost for MSB (MSB Gross Cost/MSB ARx)	$361.20	$249.94	$111.26	44.5%
Member Cost Summary			**Member Cost Summary**	
Total Member Cost	**$5,690,935**	**$7,080,906**	($1,389,971.00)	-19.6%
Total Copay	$3,950,771	$4,731,862	($781,091.00)	-16.5%
Total Deductible	$1,740,163	$2,349,044	($608,881.00)	-25.9%
Avg Copay per Claim (Copay/Rx)	$17.71	$18.22	($0.52)	-2.8%
Avg Participant Share per Claim (Copay+Deductible/RX)	**$25.51**	**$27.27**	**($1.76)**	**-6.5%**
Avg Copay for Generic (Copay/Generic Rx)	$9.17	$9.98	($0.81)	-8.1%
Avg Copay for Brand (Copay/Brand Rx)	$107.10	$129.52	($22.42)	-17.3%
Avg Copay for Brand w/ Generic Equiv (Copay/Multisource Rx)	$95.58	$74.95	$20.63	27.5%
Net PMPM (Participant Cost PMPM)	**$28.07**	**$27.78**	$0.29	1.1%
Copay % of Total Prescription Cost (Member Cost Share %)	25.4%	25.7%	-0.3%	-1.2%
Plan Cost Summary			**Plan Cost Summary**	
Total Plan Cost (Plan Cost)	**$16,749,874**	**$20,502,634**	**($3,752,760.00)**	**-18.3%**
Total Non-Specialty Cost (Non-Specialty Plan Cost)	$5,951,805	$6,948,383	($996,578.00)	-14.3%
Total Specialty Drug Cost (Specialty Plan Cost)	$10,798,069	$13,554,251	($2,756,182.00)	-20.3%
Avg Plan Cost per Claim (Plan Cost/Rx)	**$75.08**	**$78.97**	($3.89)	-4.9%
Avg Plan Cost for Generic (Plan Cost/Generic Rx)	$7.60	$9.61	($2.01)	-20.9%
Avg Plan Cost for Brand (Plan Cost/Brand Rx)	$412.11	$489.04	($76.93)	-15.7%
Avg Plan Cost for MSB (MSB Plan Cost/MSB ARx)	$265.62	$175.00	$90.62	51.8%
Net PMPM (Plan Cost PMPM)	**$82.62**	**$80.43**	**$2.19**	**2.7%**
PMPM for Specialty Only (Specialty PMPM)	$53.26	$53.17	$0.09	0.2%
PMPM without Specialty (Non-Specialty PMPM)	$29.36	$27.26	$4.02	17.3%
Specialty % of Plan Cost	64.5%	66.10%	($0.02)	-2.4%
Rebates Received (Q1-Q2 FY2022 actual)	$5,997,859	$4,915,767	$1,082,091.27	22.0%
Net PMPM (Plan Cost PMPM factoring Rebates)	**$53.03**	**$61.14**	**($8.11)**	**-13.3%**
PMPM for Specialty Only (Specialty PMPM)	$43.58	$45.80	($2.22)	-4.8%
PMPM without Specialty (Non-Specialty PMPM)	$17.45	$13.78	$3.67	26.6%

Appendix B

Index of Tables
HealthSCOPE – LDPPO Utilization Review for PEBP
July 1, 2021 – December 31, 2021

HEALTHSCOPE BENEFITS OVERVIEW.....2

MEDICAL

Paid Claims by Age Group ***3***

Financial Summary 4

Paid Claims by Claim Type 5

Cost Distribution – Medical Claims 8

Utilization Summary.....9

Provider Network Summary 10

PREVENTIVE SERVICES

Quality Metrics 18

PRESCRIPTION DRUG COSTS

Prescription Drug Cost Comparison 21

HSB DATASCOPE™

Nevada Public Employees' Benefits Program
Low Deductible Plan

July – December 2021

HealthSCOPE BENEFITS

Overview

- Total Medical Spend for 2Q22 was $11,668,043 with an annualized plan cost per employee per year (PEPY) of $6,028.
  - IP Cost per Admit is $25,768.
  - ER Cost per Visit is $2,050.
- Employees shared in 18.5% of the medical cost.
- Inpatient facility costs were 28.9% of the plan spend.
- 92.5% of the Average Membership had paid Medical claims less than $2,500, with 29.3% of those having no claims paid at all during the reporting period.
- 18 members exceeded the $100k high-cost threshold during the reporting period, which accounted for 29.1% of the plan spend. The highest diagnosis category was Cancer, accounting for 28.4% of the high-cost claimant dollars.
- Total spending with in-network providers was 99.2%. The average In Network discount was 60.5%.

Paid Claims by Age Group

Paid Claims by Age Group										
2Q22										
Age Range	Med Net Pay		Med PMPM		Rx Net Pay		Rx PMPM		Net Pay		PMPM	
<1	$	1,506,721	$	3,304	$	1,162	$	3	$	1,507,883	$	3,307
1	$	82,847	$	138	$	3,147	$	5	$	85,994	$	143
2 - 4	$	186,165	$	97	$	29,541	$	15	$	215,706	$	113
5 - 9	$	149,107	$	46	$	25,034	$	8	$	174,141	$	54
10 - 14	$	387,840	$	99	$	94,677	$	24	$	482,517	$	123
15 - 19	$	481,272	$	124	$	161,893	$	42	$	643,165	$	165
20 - 24	$	516,034	$	133	$	123,208	$	32	$	639,242	$	165
25 - 29	$	487,353	$	178	$	179,306	$	66	$	666,659	$	244
30 - 34	$	710,072	$	204	$	265,308	$	76	$	975,380	$	281
35 - 39	$	845,484	$	205	$	287,229	$	70	$	1,132,713	$	274
40 - 44	$	1,078,844	$	267	$	397,669	$	98	$	1,476,513	$	366
45 - 49	$	1,016,977	$	281	$	342,472	$	95	$	1,359,449	$	376
50 - 54	$	800,422	$	203	$	525,752	$	134	$	1,326,174	$	337
55 - 59	$	1,528,813	$	407	$	501,892	$	134	$	2,030,705	$	541
60 - 64	$	1,531,769	$	491	$	935,255	$	300	$	2,467,024	$	791
65+	$	358,322	$	296	$	257,107	$	212	$	615,429	$	508
Total	**$**	**11,668,043**	**$**	**243**	**$**	**4,130,650**	**$**	**86**	**$**	**15,798,693**	**$**	**330**

Financial Summary

	Total	State Active	Non-State Active	State Retirees	Non-State Retirees	
Summary	**2Q22**	**2Q22**	**2Q22**	**2Q22**	**2Q22**	**HSB Peer Index**
Enrollment						
Avg # Employees	3,871	3,502	1	349	20	
Avg # Members	7,987	7,370	2	585	30	
Ratio	2.1	2.1	2.0	1.7	1.5	1.8
Financial Summary						
Gross Cost	$14,311,936	$12,348,595	$14,519	$1,807,322	$141,500	
Client Paid	$11,668,043	$10,033,067	$11,738	$1,508,078	$115,160	
Employee Paid	$2,643,893	$2,315,528	$2,780	$299,244	$26,340	
Client Paid-PEPY	$6,028	$5,731	$23,477	$8,642	$11,421	$6,209
Client Paid-PMPY	$2,922	$2,723	$11,738	$5,154	$7,635	$3,437
Client Paid-PEPM	$502	$478	$1,956	$720	$952	$517
Client Paid-PMPM	$243	$227	$978	$430	$636	$286
High Cost Claimants (HCC's) > $100k						
# of HCC's	18	14	0	5	0	
HCC's / 1,000	2.3	1.9	0.0	8.5	0.0	
Avg HCC Paid	$188,430	$205,225	$0	$103,716	$0	
HCC's % of Plan Paid	29.1%	28.6%	0.0%	34.4%	0.0%	
Cost Distribution by Claim Type (PMPY)						
Facility Inpatient	$843	$833	$0	$1,000	$98	$1,057
Facility Outpatient	$703	$614	$5,328	$1,585	$4,904	$1,145
Physician	$1,337	$1,237	$6,410	$2,514	$2,611	$1,122
Other	$39	$38	$0	$56	$22	$113
Total	$2,922	$2,723	$11,738	$5,154	$7,635	$3,437
	Annualized	Annualized	Annualized	Annualized	Annualized	

Paid Claims by Claim Type – State Participants

Net Paid Claims - Total State Participants	2Q22			
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total
Medical				
Inpatient	$ 3,705,405	$ 325,449	$ 1,816	$ 4,032,670
Outpatient	$ 6,327,663	$ 1,161,380	$ 19,432	$ 7,508,475
Total - Medical	**$ 10,033,067**	**$ 1,486,829**	**$ 21,248**	**$ 11,541,145**

Net Paid Claims - Per Participant per Month	2Q22			
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total
Medical	$ 477	$ 758	$ 154	$ 499

Paid Claims by Claim Type – Non-State Participants

Net Paid Claims - Total Non-State Participants	2Q22			
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total
Medical				
Inpatient	$ -	$ -	$ 3,018	$ 3,018
Outpatient	$ 11,738	$ 81,952	$ 30,190	$ 123,880
Total - Medical	**$ 11,738**	**$ 81,952**	**$ 33,208**	**$ 126,898**

Net Paid Claims - Per Participant per Month	2Q22			
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total
Medical	$ 1,956	$ 1,242	$ 553	$ 961

Paid Claims by Claim Type – Total Participants

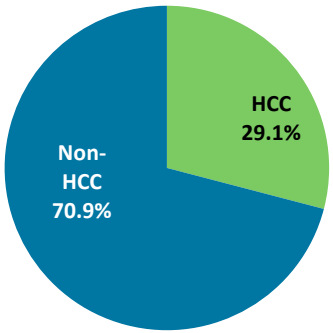
Net Paid Claims - Total Total Participants	2Q22			
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total
Medical				
Inpatient	$ 3,705,405	$ 325,449	$ 4,834	$ 4,035,688
Outpatient	$ 6,339,401	$ 1,243,332	$ 49,622	$ 7,632,355
Total - Medical	**$ 10,044,806**	**$ 1,568,781**	**$ 54,456**	**$ 11,668,043**

Net Paid Claims - Per Participant per Month	2Q22			
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total
Medical	$ 478	$ 774	$ 275	$ 502

Cost Distribution – Medical Claims

	2Q22					
Paid Claims Category	Avg # of Members	% of Members	Total Paid	% of Paid	EE Paid	% EE Paid
$100,000.01 Plus	13	0.2%	$3,260,203	27.9%	$66,703	2.5%
$50,000.01-$100,000.00	15	0.2%	$1,038,883	8.9%	$70,477	2.7%
$25,000.01-$50,000.00	33	0.4%	$1,165,817	10.0%	$122,234	4.6%
$10,000.01-$25,000.00	93	1.2%	$1,444,339	12.4%	$296,197	11.2%
$5,000.01-$10,000.00	162	2.0%	$1,148,013	9.8%	$303,347	11.5%
$2,500.01-$5,000.00	280	3.5%	$1,031,716	8.8%	$365,951	13.8%
$0.01-$2,500.00	4,905	61.4%	$2,579,071	22.1%	$1,399,211	52.9%
$0.00	148	1.8%	$0	0.0%	$19,773	0.7%
No Claims	2,338	29.3%	$0	0.0%	$0	0.0%
	7,987	**100.0%**	**$11,668,043**	**100.0%**	**$2,643,893**	**100.0%**

Distribution of HCC Medical Claims Paid



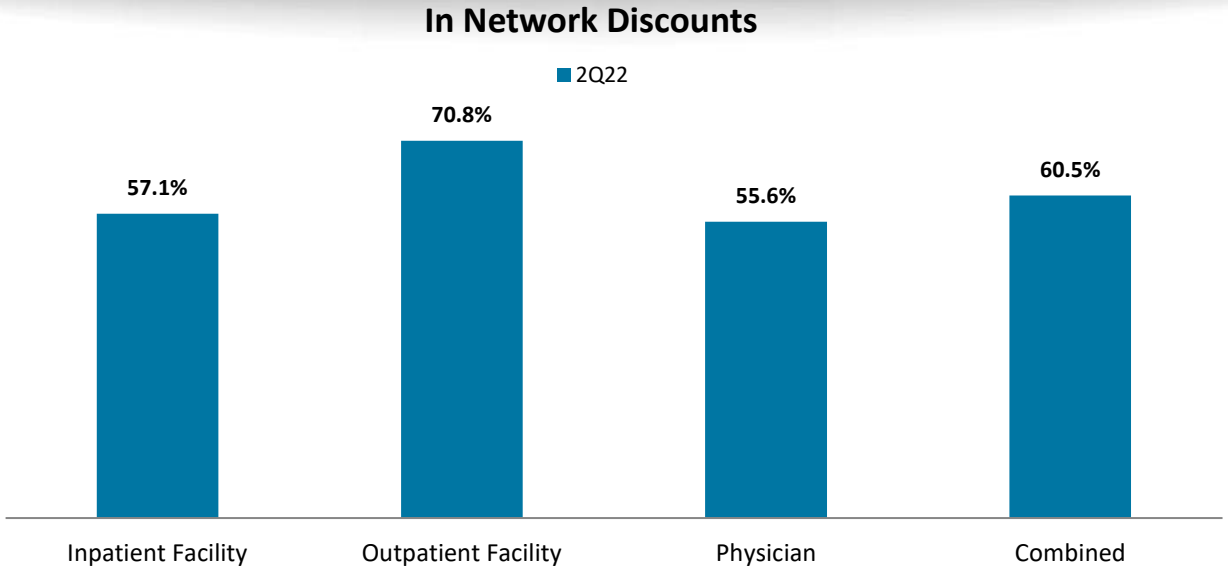
HCC – High-Cost Claimant over $100K

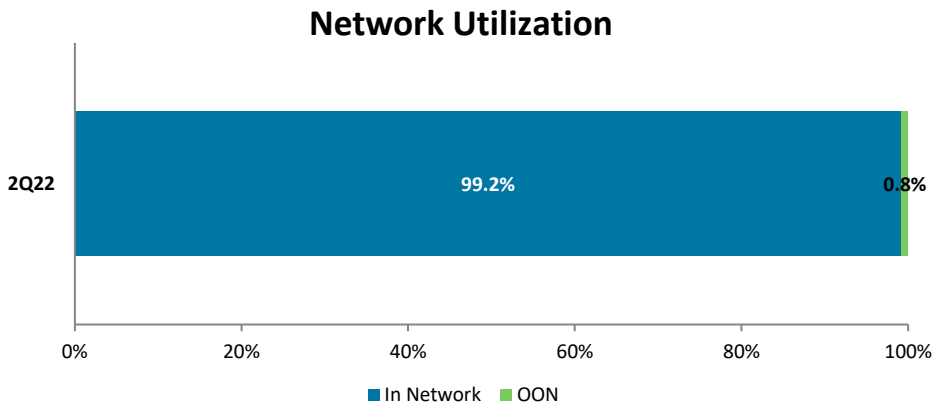
HCC's by Diagnosis Grouper			
Top 10 Diagnosis Groupers	Patients	Total Paid	% Paid
Cancer	7	$964,732	28.4%
Pregnancy-related Disorders	2	$849,936	25.1%
Trauma/Accidents	3	$372,518	11.0%
Cardiac Disorders	8	$266,191	7.8%
Pulmonary Disorders	8	$252,804	7.5%
Mental Health	4	$186,519	5.5%
Spine-related Disorders	5	$140,851	4.2%
Renal/Urologic Disorders	7	$135,501	4.0%
Congenital/Chromosomal Anomalies	3	$65,376	1.9%
Medical/Surgical Complications	2	$42,908	1.3%
All Other		$114,402	3.4%
Overall	**----**	**$3,391,738**	**100.0%**

Utilization Summary

	Total	State Active	Non-State Active	State Retirees	Non-State Retirees	
Summary	**2Q22**	**2Q22**	**2Q22**	**2Q22**	**2Q22**	**HSB Peer Index**
Inpatient Facility						
# of Admits	137	118	0	15	4	
# of Bed Days	679	610	0	57	12	
Paid Per Admit	$25,768	$26,250	$0	$28,113	$2,745	$16,173
Paid Per Day	$5,199	$5,078	$0	$7,398	$915	$3,708
Admits Per 1,000	34	32	0	51	265	61
Days Per 1,000	170	166	0	195	796	264
Avg LOS	5	5.2	0	3.8	3.0	4.3
# Admits From ER	69	57	0	10	2.0	
Physician Office						
OV Utilization per Member	4.2	4.1	10.0	5.7	5.6	3.3
Avg Paid per OV	$134	$125	$230	$213	$117	$50
Avg OV Paid per Member	$560	$506	$2,304	$1,217	$659	$167
DX&L Utilization per Member	7.2	6.8	32	11.7	13.6	8.3
Avg Paid per DX&L	$46	$43	$56	$66	$88	$67
Avg DX&L Paid per Member	$331	$291	$1,786	$780	$1,200	$554
Emergency Room						
# of Visits	449	416	0	32	1	
Visits Per Member	0.11	0.11	0	0.11	0.07	0.17
Visits Per 1,000	112	113	0	109	66	174
Avg Paid per Visit	$2,050	$2,019	$0	$2,452	$1,827	$1,684
Urgent Care						
# of Visits	943	871	0	71	1	
Visits Per Member	0.24	0.24	0.00	0.24	0.07	0.24
Visits Per 1,000	236	236	0	243	66	242
Avg Paid per Visit	$120	$118	$0	$147	$65	$74
	Annualized	Annualized	Annualized	Annualized	Annualized	

Provider Network Summary





Diagnosis Grouper Summary

Diagnosis Grouper	Total Paid	% Paid	Insured	Spouse	Child	Male	Female	Unassigned
Pregnancy-related Disorders	$1,622,128	13.9%	$417,389	$138,734	$1,066,005	$989,663	$630,172	$2,293
Cancer	$1,575,140	13.5%	$803,446	$688,957	$82,737	$736,094	$839,047	$0
Health Status/Encounters	$1,041,678	8.9%	$526,364	$124,063	$391,251	$342,319	$698,967	$393
Cardiac Disorders	$733,397	6.3%	$459,358	$240,329	$33,710	$505,996	$227,401	$0
Gastrointestinal Disorders	$717,443	6.1%	$468,970	$181,673	$66,799	$214,995	$502,447	$0
Musculoskeletal Disorders	$696,136	6.0%	$385,533	$224,175	$86,429	$293,750	$402,386	$0
Mental Health	$694,361	6.0%	$188,563	$47,432	$458,366	$239,218	$455,143	$0
Trauma/Accidents	$661,873	5.7%	$426,090	$68,104	$167,678	$132,321	$529,552	$0
Infections	$570,685	4.9%	$382,603	$94,924	$93,158	$209,965	$360,720	$0
COVID-19, Confirmed	$320,726	2.7%	$235,892	$70,404	$14,430	$126,756	$193,970	$0
Pulmonary Disorders	$520,933	4.5%	$187,692	$48,514	$284,726	$299,705	$221,228	$0
Eye/ENT Disorders	$512,700	4.4%	$268,084	$77,921	$166,695	$226,935	$285,681	$83
Spine-related Disorders	$423,136	3.6%	$192,299	$80,917	$149,920	$107,676	$315,460	$0
Renal/Urologic Disorders	$355,852	3.0%	$264,386	$48,335	$43,132	$295,317	$60,536	$0
Neurological Disorders	$355,357	3.0%	$207,376	$102,827	$45,155	$98,966	$256,391	$0
Gynecological/Breast Disorders	$286,055	2.5%	$188,907	$48,737	$48,411	$6,972	$279,083	$0
Endocrine/Metabolic Disorders	$180,400	1.5%	$140,363	$31,336	$8,701	$83,820	$96,580	$0
Miscellaneous	$130,409	1.1%	$46,676	$10,643	$73,090	$67,349	$63,060	$0
Non-malignant Neoplasm	$103,973	0.9%	$75,060	$14,077	$14,837	$47,071	$56,903	$0
Dermatological Disorders	$87,258	0.7%	$53,608	$13,179	$20,471	$27,497	$59,761	$0
Congenital/Chromosomal Anomalies	$86,205	0.7%	$5,285	$8,577	$72,343	$75,225	$10,981	$0
Abnormal Lab/Radiology	$73,765	0.6%	$53,063	$18,285	$2,417	$30,760	$43,005	$0
Diabetes	$67,064	0.6%	$38,282	$12,476	$16,306	$23,308	$43,756	$0
Medical/Surgical Complications	$47,739	0.4%	$3,835	$2,282	$41,622	$2,470	$45,269	$0
Hematological Disorders	$42,126	0.4%	$29,628	$6,601	$5,897	$6,135	$35,990	$0
Vascular Disorders	$27,268	0.2%	$13,350	$7,165	$6,753	$10,942	$16,325	$0
Cholesterol Disorders	$25,246	0.2%	$18,638	$5,751	$858	$11,742	$13,504	$0
Allergic Reaction	$11,050	0.1%	$8,469	$0	$2,581	$463	$10,587	$0
Medication Related Conditions	$7,506	0.1%	$3,531	$650	$3,326	$1,794	$5,713	$0
Dental Conditions	$6,238	0.1%	$146	$1,503	$4,589	$1,923	$4,315	$0
External Hazard Exposure	$4,922	0.0%	$254	$0	$4,667	$3,967	$955	$0
Total	**$11,668,043**	**100.0%**	**$5,857,247**	**$2,348,166**	**$3,462,631**	**$5,094,358**	**$6,570,917**	**$2,768**

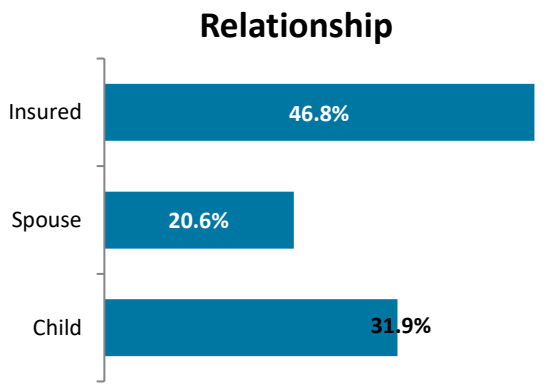
Mental Health Drilldown

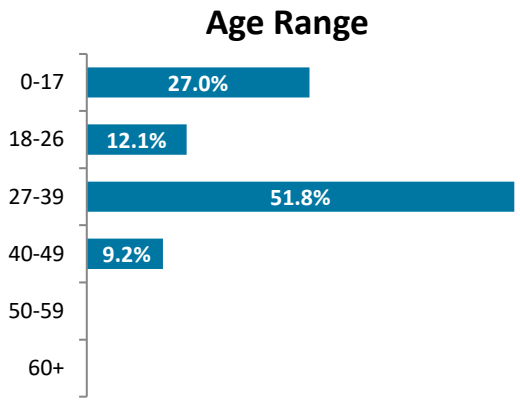
Grouper	2Q22 Patients	2Q22 Total Paid
Depression	252	$222,336
Mental Health Conditions, Other	218	$145,599
Developmental Disorders	32	$90,157
Mood and Anxiety Disorders	305	$86,193
Bipolar Disorder	66	$38,594
Eating Disorders	10	$34,063
Attention Deficit Disorder	111	$28,731
Substance Abuse/Dependence	17	$20,101
Psychoses	3	$7,082
Sleep Disorders	54	$6,577
Personality Disorders	8	$5,225
Tobacco Use Disorder	10	$3,993
Sexually Related Disorders	13	$3,081
Complications of Substance Abuse	3	$1,000
Schizophrenia	1	$953
Alcohol Abuse/Dependence	6	$677
Total		**$694,361**

Diagnosis Grouper – Pregnancy-related Disorders

Diagnosis Sub-Grouper	Patients	Claims	Total Paid	% Paid
Perinatal Disorders	20	46	$885,561	54.6%
Labor and Delivery Related	40	146	$278,346	17.2%
Pregnancy Complications	64	239	$238,557	14.7%
Liveborn Infants	32	49	$149,668	9.2%
Supervision of Pregnancy	85	349	$36,737	2.3%
Multiple Gestation Related	2	22	$19,838	1.2%
Abortion Related	7	14	$8,007	0.5%
Ectopic Pregnancy	1	8	$5,244	0.3%
Prematurity and Low Birth Weight	1	1	$157	0.0%
Cesarean Delivery	1	1	$12	0.0%
Overall	**----**	**----**	**$1,622,128**	**100.0%**

*Patient and claim counts are unique only within the category

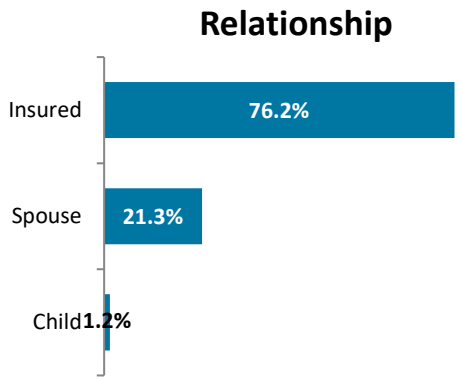


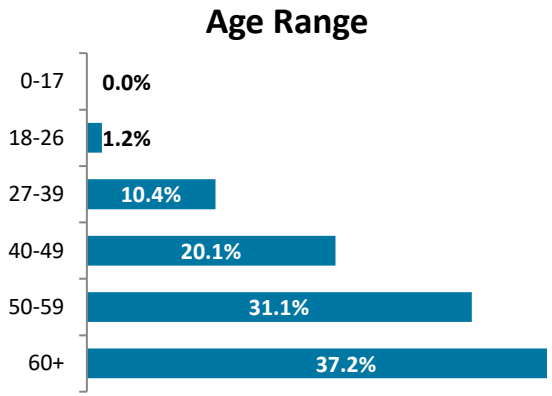


Diagnosis Grouper – Cancer

Diagnosis Sub-Grouper	Patients	Claims	Total Paid	% Paid
Cancer Therapies	17	129	$618,848	58.8%
Brain Cancer	1	57	$298,046	28.3%
Melanoma	11	59	$268,416	25.5%
Cancers, Other	46	207	$164,789	15.7%
Breast Cancer	34	268	$55,336	5.3%
Thyroid Cancer	12	34	$30,421	2.9%
Colon Cancer	4	81	$24,267	2.3%
Secondary Cancers	12	44	$24,254	2.3%
Prostate Cancer	12	66	$23,193	2.2%
Carcinoma in Situ	18	73	$20,283	1.9%
Kidney Cancer	2	7	$12,284	1.2%
Bladder Cancer	3	43	$10,488	1.0%
Lung Cancer	6	42	$10,331	1.0%
Cervical/Uterine Cancer	8	19	$6,734	0.6%
Lymphomas	11	34	$4,382	0.4%
Leukemias	10	28	$3,069	0.3%
Overall	**----**	**----**	**$1,575,140**	**100.0%**

*Patient and claim counts are unique only within the category

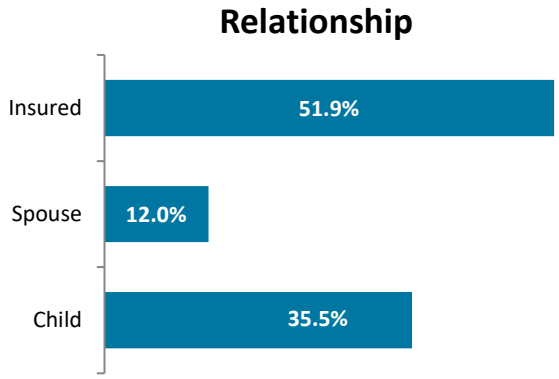


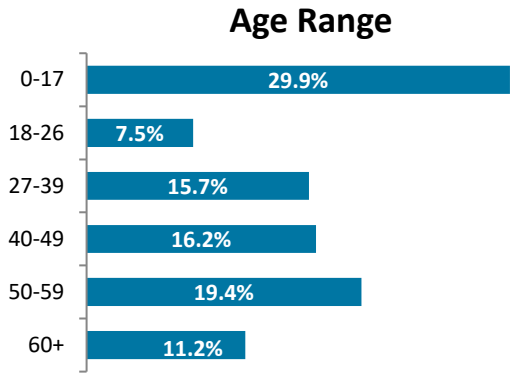


Diagnosis Grouper – Health Status/Encounters

Diagnosis Category	Patients	Claims	Total Paid	% Paid
Screenings	1,022	1,770	$280,371	26.9%
Prophylactic Measures	1,206	1,491	$275,385	26.4%
Exams	1,488	2,487	$259,313	24.9%
Encounters - Infants/Children	705	901	$145,556	14.0%
Personal History of Condition	91	128	$20,494	2.0%
Prosthetics/Devices/Implants	55	127	$17,134	1.6%
Aftercare	51	74	$13,818	1.3%
History of Condition	32	40	$7,388	0.7%
Family History of Condition	26	39	$5,988	0.6%
Counseling	53	78	$4,634	0.4%
Follow-Up Encounters	5	11	$3,200	0.3%
Donors	1	3	$3,096	0.3%
Lifestyle/Situational Issues	48	56	$2,537	0.2%
Encounter - Procedure	9	10	$1,540	0.1%
Health Status, Other	13	16	$655	0.1%
Replacements	12	19	$523	0.1%
Miscellaneous Examinations	6	7	$24	0.0%
Encounter - Transplant Related	2	2	$23	0.0%
Overall	**----**	**----**	**$1,041,678**	**100.0%**

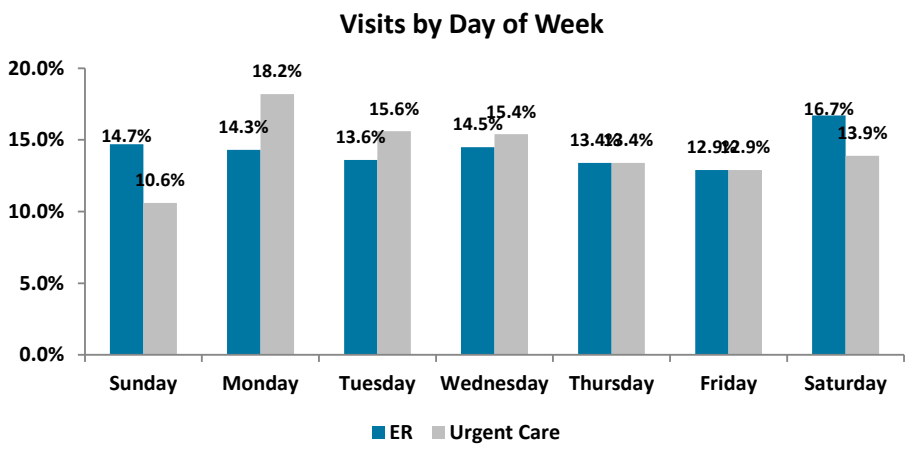
*Patient and claim counts are unique only within the category

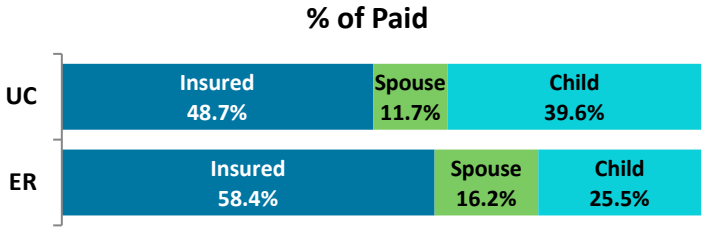




Emergency Room / Urgent Care Summary

	2Q22		HSB Peer Index	
ER/Urgent Care	**ER**	**Urgent Care**	**ER**	**Urgent Care**
Number of Visits	449	943		
Visits Per Member	0.11	0.24	0.17	0.24
Visits/1000 Members	112	236	174	242
Avg Paid Per Visit	$2,050	$120	$1,684	$74
% with OV*	79.5%	80.0%		
% Avoidable	10.5%	31.5%		
Total Member Paid	**$248,644**	**$61,384**		
Total Plan Paid	**$920,264**	**$113,237**		
*looks back 12 months from ER visit	Annualized	Annualized		

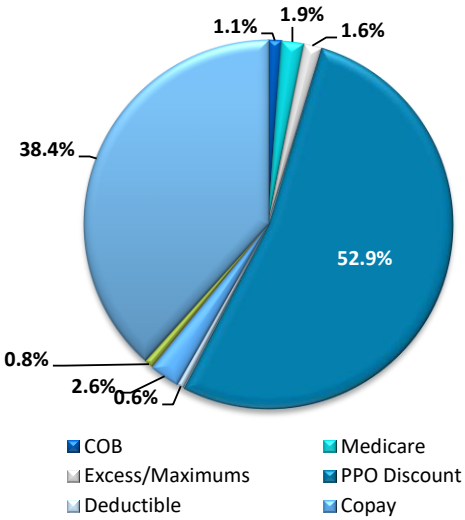


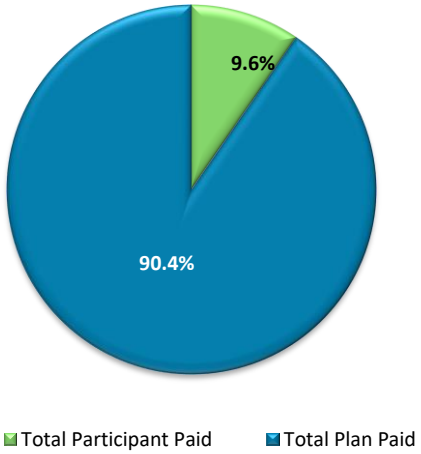


ER / UC Visits by Relationship						
Relationship	**ER**	**Per 1,000**	**Urgent Care**	**Per 1,000**	**Total**	**Per 1,000**
Insured	231	60	459	119	1,056	273
Spouse	57	50	114	101	202	178
Child	161	54	370	124	513	172
Total	**449**	**56**	**943**	**118**	**1,771**	**222**

Savings Summary – Medical Claims

Description	Dollars	PPPM	% of Eligible
Eligible Charges	$37,818,535	$1,531	100.0%
COB	$164,808	$7	0.4%
Medicare	$538,767	$22	1.4%
Excess/Maximums	$592,458	$24	1.6%
PPO Discount	$22,225,159	$900	58.8%
Deductible	$923,690	$37	2.4%
Copay	$1,103,384	$45	2.9%
Coinsurance	$616,819	$25	1.6%
Total Participant Paid	**$2,643,893**	**$107**	**7.0%**
Total Plan Paid	**$11,668,043**	**$502**	**30.9%**





Quality Metrics

Condition	Metric	#Members in Group	#Meeting Metric	#Not Meeting Metric	% Meeting Metric
Asthma	Asthma and a routine provider visit in the last 12 months	313	308	5	98.4%
	<2 asthma related ER Visits in the last 6 months	313	313	0	100.0%
	No asthma related admit in last 12 months	313	311	2	99.4%
Chronic Obstructive Pulmonary Disease	No exacerbations in last 12 months	27	25	2	92.6%
	Members with COPD who had an annual spirometry test	27	1	26	3.7%
Congestive Heart Failure	No re-admit to hosp with Heart Failure diag w/in 30 days of HF inpatient stay discharge	2	2	0	100.0%
	No ER Visit for Heart Failure in last 90 days	35	33	2	94.3%
	Follow-up OV within 4 weeks of discharge from HF admission	2	1	1	50.0%
Diabetes	Annual office visit	356	344	12	96.6%
	Annual dilated eye exam	356	155	201	43.5%
	Annual foot exam	356	163	193	45.8%
	Annual HbA1c test done	356	304	52	85.4%
	Diabetes Annual lipid profile	356	277	79	77.8%
	Annual microalbumin urine screen	356	253	103	71.1%
Hyperlipidemia	Hyperlipidemia Annual lipid profile	914	767	147	83.9%
Hypertension	Annual lipid profile	850	629	221	74.0%
	Annual serum creatinine test	777	673	104	86.6%
Wellness	Well Child Visit - 15 months	83	68	15	81.9%
	Routine office visit in last 6 months	8,551	5,301	3,250	62.0%
	Age 45 to 75 years with colorectal cancer screening	2,751	629	2,122	22.9%
	Women age 25-65 with recommended cervical cancer screening	2,879	1,787	1,092	62.1%
	Males age greater than 49 with PSA test in last 24 months	885	385	500	43.5%
	Routine exam in last 24 months	8,551	6,690	1,861	78.2%
	Women age 40 to 75 with a screening mammogram last 24 months	2,020	1,135	885	56.2%

All member counts represent members active at the end of the report period.
Quality Metrics are always calculated on an incurred basis.

Chronic Conditions Prevalence

A member is identified as having a chronic condition if any one of the following three conditions is met within a 24 month service date period:

- **Two outpatient claims for the Dx on separate days of service**
- **One ER Visit with the Dx as primary**
- **One IP admission with the Dx as the admitting**

*For Diabetes only, one or more Rx claims can also be used to identify the condition.

Chronic Condition	# With Condition	% of Members	Members per 1000	PMPY
Affective Psychosis	69	0.81%	8.64	$12,283
Asthma	340	3.97%	42.57	$9,335
Atrial Fibrillation	56	0.65%	7.01	$13,928
Blood Disorders	408	4.77%	51.08	$17,443
CAD	90	1.05%	11.27	$23,408
COPD	26	0.30%	3.26	$18,291
Cancer	247	2.89%	30.93	$21,896
Chronic Pain	133	1.55%	16.65	$16,804
Congestive Heart Failure	35	0.41%	4.38	$42,293
Demyelinating Diseases	20	0.23%	2.50	$40,429
Depression	580	6.78%	72.62	$7,602
Diabetes	377	4.41%	47.20	$13,210
ESRD	4	0.05%	0.50	$126,197
Eating Disorders	35	0.41%	4.38	$5,753
HIV/AIDS	4	0.05%	0.50	$24,163
Hyperlipidemia	934	10.92%	116.94	$9,109
Hypertension	856	10.01%	107.17	$11,118
Immune Disorders	31	0.36%	3.88	$25,187
Inflammatory Bowel Disease	37	0.43%	4.63	$16,232
Liver Diseases	117	1.37%	14.65	$14,688
Morbid Obesity	221	2.58%	27.67	$8,419
Osteoarthritis	189	2.21%	23.66	$18,204
Peripheral Vascular Disease	31	0.36%	3.88	$4,966
Rheumatoid Arthritis	38	0.44%	4.76	$24,605

Data Includes Medical and Pharmacy
Based on 24 months incurred dates

Methodology

- Average member counts were weighted by the number of months each member had on the plan.
- Claims were pulled based upon the date paid.
- Claims were categorized based upon four groups:
  - Inpatient Facility
  - Outpatient Facility
  - Physician
  - Other (Other includes any medical reimbursements or durable medical equipment.)
- Inpatient analysis was done by identifying facility claims where a room and board charge was submitted and paid. Claims were then rolled up for the entire admission and categorized by the diagnosis code that held the highest paid amount. (Hospice and skilled nursing facility claims were excluded)
- Outpatient claims were flagged by an in-or-outpatient indicator being present on the claim that identified it as taking place at an outpatient facility.
- Physician claims were identified when the vendor type indicator was flagged as a professional charge.
  - These claims were in some cases segregated further to differentiate primary care physicians and specialists.
  - Office visits were identified by the presence of evaluation and management or consultation codes.
- Emergency room and urgent care episodes should be considered subcategories of physician and outpatient facility.
  - Emergency Room visits are identified by facility claims with a revenue code of 450-455, 457-459.
  - Urgent Care visits are identified by facility claims with a revenue code of 456 or physician claims with a place of service of “Urgent Care”.
  - Outpatient claims (including facility and physician) are then rolled up for the day of service and summarized as an ER/UC visit.
  - If a member has an emergency room visit on the same day as an urgent care visit, all claims are grouped into one episode and counted as an emergency room visit.
  - If a member was admitted into the hospital through the ER, the member will not show an ER visit. ER claims are bundled with the inpatient stay.

Public Employees' Benefits Program - RX Costs
PY 2022 - Quarter Ending December 31, 2021

Express Scripts

Membership Summary	2Q FY2022 LDPPO		Difference	% Change
			Membership Summary	
Member Count (Membership)	7,947		7,947	#DIV/0!
Utilizing Member Count (Patients)	5,751		5,751	#DIV/0!
Percent Utilizing (Utilization)	72.4%	#DIV/0!	#DIV/0!	#DIV/0!

Claim Summary			Claims Summary	
Net Claims (Total Rx's)	55,750		55,750	#DIV/0!
Claims per Elig Member per Month (Claims PMPM)	1.17		1.17	#DIV/0!
Total Claims for Generic (Generic Rx)	45,394		45,394.00	#DIV/0!
Total Claims for Brand (Brand Rx)	10,356		10,356.00	#DIV/0!
Total Claims for Brand w/Gen Equiv (Multisource Brand Claims)	472		472.00	#DIV/0!
Total Non-Specialty Claims	55,099		55,099.00	#DIV/0!
Total Specialty Claims	651		651.00	#DIV/0!
Generic % of Total Claims (GFR)	**81.4%**	**#DIV/0!**	#DIV/0!	#DIV/0!
Generic Effective Rate (GCR)	**99.0%**	**#DIV/0!**	#DIV/0!	#DIV/0!
Mail Order Claims	14,370		14,370.00	#DIV/0!
Mail Penetration Rate*	30.8%		0.31	30.8%

Claims Cost Summary			Claims Cost Summary	
Total Prescription Cost (Total Gross Cost)	$5,605,481		$5,605,481.00	#DIV/0!
Total Generic Gross Cost	$1,066,834		$1,066,834.00	#DIV/0!
Total Brand Gross Cost	$4,538,647		$4,538,647.00	#DIV/0!
Total MSB Gross Cost	$153,809		$153,809.00	#DIV/0!
Total Ingredient Cost	$5,468,610		$5,468,610.00	#DIV/0!
Total Dispensing Fee	$143,045		$143,045.00	#DIV/0!
Total Other (e.g. tax)	$3,826		$3,826.00	#DIV/0!
Avg Total Cost per Claim (Gross Cost/Rx)	**$100.55**	**#DIV/0!**	#DIV/0!	#DIV/0!
Avg Total Cost for Generic (Gross Cost/Generic Rx)	$23.50		$23.50	#DIV/0!
Avg Total Cost for Brand (Gross Cost/Brand Rx)	$438.26		$438.26	#DIV/0!
Avg Total Cost for MSB (MSB Gross Cost/MSB ARx)	$325.87		$325.87	#DIV/0!

Member Cost Summary			Member Cost Summary	
Total Member Cost	**$1,040,252**		$1,040,252.00	#DIV/0!
Total Copay	$1,020,233	$0.00	$1,020,233.00	#DIV/0!
Total Deductible	$20,018	$0.00	$20,018.00	0.0%
Avg Copay per Claim (Copay/Rx)	$18.30	#DIV/0!	#DIV/0!	#DIV/0!
Avg Participant Share per Claim (Copay+Deductible/RX)	**$18.66**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**
Avg Copay for Generic (Copay/Generic Rx)	$7.52		$7.52	#DIV/0!
Avg Copay for Brand (Copay/Brand Rx)	$67.50		$67.50	#DIV/0!
Avg Copay for Brand w/ Generic Equiv (Copay/Multisource Rx)	$43.17		$43.17	#DIV/0!
Net PMPM (Participant Cost PMPM)	**$21.82**	**#DIV/0!**	#DIV/0!	#DIV/0!
Copay % of Total Prescription Cost (Member Cost Share %)	18.6%	#DIV/0!	#DIV/0!	#DIV/0!

Plan Cost Summary			Plan Cost Summary	
Total Plan Cost (Plan Cost)	**$4,565,229**		**$4,565,229.00**	**#DIV/0!**
Total Non-Specialty Cost (Non-Specialty Plan Cost)	$2,615,647		$2,615,647.00	#DIV/0!
Total Specialty Drug Cost (Specialty Plan Cost)	$1,949,582		$1,949,582.00	#DIV/0!
Avg Plan Cost per Claim (Plan Cost/Rx)	**$81.89**	**#DIV/0!**	#DIV/0!	#DIV/0!
Avg Plan Cost for Generic (Plan Cost/Generic Rx)	$15.98		$15.98	#DIV/0!
Avg Plan Cost for Brand (Plan Cost/Brand Rx)	$370.76		$370.76	#DIV/0!
Avg Plan Cost for MSB (MSB Plan Cost/MSB ARx)	$282.70		$282.70	#DIV/0!
Net PMPM (Plan Cost PMPM)	**$95.74**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**
PMPM for Specialty Only (Specialty PMPM)	$40.89		$40.89	#DIV/0!
PMPM without Specialty (Non-Specialty PMPM)	$54.86		$54.86	#DIV/0!
Rebates Received (Q1-Q2 FY2022 actual)	$0.00		**$0.00**	**#DIV/0!**
Net PMPM (Plan Cost PMPM factoring Rebates)	**$95.74**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**
PMPM for Specialty Only (Specialty PMPM)			$0.00	#DIV/0!
PMPM without Specialty (Non-Specialty PMPM)			$0.00	#DIV/0!

Appendix C

Index of Tables
HealthSCOPE – EPO Utilization Review for PEBP
July 1, 2021 – December 31, 2021

HEALTHSCOPE BENEFITS OVERVIEW.....2

MEDICAL

Paid Claims by Age Group ***3***

Financial Summary 4

Paid Claims by Claim Type 8

Cost Distribution – Medical Claims 11

Utilization Summary.....12

Provider Network Summary 14

PREVENTIVE SERVICES

Quality Metrics 22

PRESCRIPTION DRUG COSTS

Prescription Drug Cost Comparison 25

HSB DATASCOPE™

Nevada Public Employees' Benefits Program
EPO Plan

July – December 2021

HealthSCOPE BENEFITS

Overview

- Total Medical Spend for 2Q22 was $25,760,997 with an annualized plan cost per employee per year (PEPY) of $12,519. This is an increase of 17.6% when compared to 2Q21.
  - IP Cost per Admit is $26,751 which is 30.1% lower than 2Q21.
  - ER Cost per Visit is $1,863 which is 22.7% lower than 2Q21.
- Employees shared in 9.2% of the medical cost.
- Inpatient facility costs were 32.7% of the plan spend.
- 83.7% of the Average Membership had paid Medical claims less than $2,500, with 17.0% of those having no claims paid at all during the reporting period.
- 29 members exceeded the $100k high-cost threshold during the reporting period, which accounted for 30.7% of the plan spend. The highest diagnosis category was Pulmonary Disorders, accounting for 20.4% of the high-cost claimant dollars.
- Total spending with in-network providers was 100.0%. The average In Network discount was 53.8%, which is .7% lower than the PY21 average discount of 54.2%.

Paid Claims by Age Group

Paid Claims by Age Group																
	2Q21						2Q22						% 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	$ 755,466	$1,298	$ 8,243	$14	$ 763,709	$1,312	$ 1,462,286	$ 3,385	$ 1,648	$ 4	$ 1,463,934	$ 3,389	91.7%	158.2%
1	$ 92,724	$147	$ 1,175	$2	$ 93,899	$149	$ 163,867	$ 355	$ 1,310	$ 3	$ 165,177	$ 358	75.9%	139.9%
2 - 4	$ 166,045	$100	$ 6,299	$4	$ 172,344	$103	$ 245,946	$ 158	$ 10,851	$ 7	$ 256,797	$ 165	49.0%	59.3%
5 - 9	$ 255,835	$84	$ 40,755	$13	$ 296,590	$97	$ 193,767	$ 76	$ 26,297	$ 10	$ 220,064	$ 87	-25.8%	-11.1%
10 - 14	$ 501,931	$136	$ 107,041	$29	$ 608,972	$164	$ 911,496	$ 274	$ 109,038	$ 33	$ 1,020,534	$ 307	67.6%	86.6%
15 - 19	$ 1,153,196	$268	$ 216,715	$50	$ 1,369,911	$319	$ 932,349	$ 233	$ 183,100	$ 46	$ 1,115,449	$ 278	-18.6%	-12.7%
20 - 24	$ 997,822	$252	$ 347,621	$88	$ 1,345,443	$339	$ 665,253	$ 184	$ 196,682	$ 54	$ 861,935	$ 238	-35.9%	-29.8%
25 - 29	$ 625,083	$293	$ 555,437	$261	$ 1,180,520	$554	$ 702,374	$ 429	$ 418,445	$ 255	$ 1,120,819	$ 684	-5.1%	23.5%
30 - 34	$ 1,922,273	$683	$ 393,850	$140	$ 2,316,123	$823	$ 1,132,185	$ 506	$ 235,062	$ 105	$ 1,367,247	$ 611	-41.0%	-25.8%
35 - 39	$ 1,967,049	$561	$ 427,343	$122	$ 2,394,392	$683	$ 1,756,493	$ 577	$ 349,314	$ 115	$ 2,105,807	$ 692	-12.1%	1.3%
40 - 44	$ 1,426,392	$417	$ 719,424	$210	$ 2,145,816	$627	$ 1,666,398	$ 532	$ 930,776	$ 297	$ 2,597,174	$ 829	21.0%	32.2%
45 - 49	$ 2,274,793	$574	$ 580,217	$147	$ 2,855,010	$721	$ 1,542,954	$ 442	$ 560,628	$ 161	$ 2,103,582	$ 602	-26.3%	-16.4%
50 - 54	$ 2,521,730	$513	$ 1,264,072	$257	$ 3,785,802	$770	$ 4,350,072	$ 1,010	$ 1,167,128	$ 271	$ 5,517,200	$ 1,281	45.7%	66.2%
55 - 59	$ 3,260,075	$641	$ 1,331,853	$262	$ 4,591,928	$904	$ 3,748,967	$ 840	$ 1,118,247	$ 251	$ 4,867,214	$ 1,090	6.0%	20.7%
60 - 64	$ 5,351,303	$952	$ 2,063,246	$367	$ 7,414,549	$1,319	$ 3,832,194	$ 727	$ 1,959,239	$ 371	$ 5,791,433	$ 1,098	-21.9%	-16.7%
65+	$ 1,721,176	$708	$ 921,919	$379	$ 2,643,095	$1,088	$ 2,454,396	$ 1,065	$ 959,549	$ 416	$ 3,413,945	$ 1,482	29.2%	36.2%
Total	**$24,992,892**	**$483**	**$8,985,212**	**$174**	**$33,978,105**	**$656**	**$ 25,760,997**	**$ 562**	**$ 8,227,314**	**$ 180**	**$ 33,988,311**	**$ 742**	**0.0%**	**13.0%**

Financial Summary (p. 1 of 2)

	Total				State Active				Non-State Active			
Summary	**2Q20**	**2Q21**	**2Q22**	**Variance to Prior Year**	**2Q20**	**2Q21**	**2Q22**	**Variance to Prior Year**	**2Q20**	**2Q21**	**2Q22**	**Variance to Prior Year**
Enrollment												
Avg # Employees	4,823	4,696	4,116	-12.4%	4,074	3,986	3,454	-13.4%	4	4	3	-20.8%
Avg # Members	8,819	8,627	7,637	-11.5%	7,808	7,666	6,721	-12.3%	5	5	3	-32.1%
Ratio	1.8	1.8	1.9	1.1%	1.9	1.9	2.0	1.6%	1.3	1.2	1.0	-14.5%
Financial Summary												
Gross Cost	$26,998,382	$26,605,674	$28,491,239	7.1%	$23,079,745	$22,398,978	$24,404,728	9.0%	$38,573	$27,972	$3,252	-88.4%
Client Paid	$24,249,744	$24,992,892	$25,760,997	3.1%	$20,843,376	$21,045,129	$22,152,079	5.3%	$35,593	$26,079	$2,391	-90.8%
Employee Paid	$2,748,639	$1,612,781	$2,730,242	69.3%	$2,236,369	$1,353,850	$2,252,648	66.4%	$2,979	$1,893	$861	-54.5%
Client Paid-PEPY	$10,055	$10,644	$12,519	17.6%	$10,233	$10,560	$12,829	21.5%	$17,797	$13,039	$1,510	-88.4%
Client Paid-PMPY	$5,499	$5,794	$6,747	16.4%	$5,339	$5,491	$6,592	20.1%	$14,237	$11,177	$1,510	-86.5%
Client Paid-PEPM	$838	$887	$1,043	17.6%	$853	$880	$1,069	21.5%	$1,483	$1,087	$126	-88.4%
Client Paid-PMPM	$458	$483	$562	16.4%	$445	$458	$549	19.9%	$1,186	$931	$126	-86.5%
High Cost Claimants (HCC's) > $100k												
# of HCC's	15	29	29	0.0%	14	23	25	8.7%	0	0	0	0.0%
HCC's / 1,000	1.7	3.4	3.8	13.1%	1.8	3.0	3.7	24.0%	0.0	0.0	0.0	0.0%
Avg HCC Paid	$183,130	$195,921	$272,456	39.1%	$189,023	$201,553	$297,002	47.4%	$0	$0	$0	0.0%
HCC's % of Plan Paid	11.3%	22.7%	30.7%	35.2%	12.7%	22.0%	33.5%	52.3%	0.0%	0.0%	0.0%	0.0%
Cost Distribution by Claim Type (PMPY)												
Facility Inpatient	$1,060	$1,106	$2,203	99.2%	$1,025	$1,108	$2,198	98.4%	$5,856	$0	$0	0.0%
Facility Outpatient	$1,727	$1,929	$1,806	-6.4%	$1,674	$1,778	$1,764	-0.8%	$1,978	$6,326	$0	-100.0%
Physician	$2,534	$2,556	$2,582	1.0%	$2,480	$2,442	$2,489	1.9%	$6,126	$4,050	$1,401	-65.4%
Other	$178	$203	$156	-23.2%	$161	$163	$141	-13.5%	$277	$801	$108	-86.5%
Total	$5,499	$5,794	$6,747	16.4%	$5,339	$5,491	$6,592	20.1%	$14,237	$11,177	$1,510	-86.5%
	Annualized	Annualized	Annualized		Annualized	Annualized	Annualized		Annualized	Annualized	Annualized	

Financial Summary (p. 2 of 2)

	State Retirees				Non-State Retirees				
Summary	**2Q20**	**2Q21**	**2Q22**	**Variance to Prior Year**	**2Q20**	**2Q21**	**2Q22**	**Variance to Prior Year**	**HSB Peer Index**
Enrollment									
Avg # Employees	592	578	567	-1.8%	154	129	92	-28.6%	
Avg # Members	811	791	791	0.0%	195	165	122	-26.3%	
Ratio	1.4	1.4	1.4	2.2%	1.3	1.3	1.3	3.9%	1.6
Financial Summary									
Gross Cost	$3,433,058	$3,710,234	$3,491,677	-5.9%	$447,006	$468,489	$591,582	26.3%	
Client Paid	$2,999,537	$3,499,564	$3,095,882	-11.5%	$371,237	$422,121	$510,645	21.0%	
Employee Paid	$433,521	$210,670	$395,795	87.9%	$75,769	$46,368	$80,937	74.6%	
Client Paid-PEPY	$10,142	$12,113	$10,917	-9.9%	$4,816	$6,561	$11,121	69.5%	$6,297
Client Paid-PMPY	$7,397	$8,848	$7,824	-11.6%	$3,808	$5,106	$8,383	64.2%	$3,879
Client Paid-PEPM	$845	$1,009	$910	-9.8%	$401	$547	$927	69.5%	$525
Client Paid-PMPM	$616	$737	$652	-11.5%	$317	$426	$699	64.1%	$323
High Cost Claimants (HCC's) > $100k									
# of HCC's	1	7	4	0.0%	0	1	1	0.0%	
HCC's / 1,000	1.2	8.9	5.1	0.0%	0.0	6.1	8.2	0.0%	
Avg HCC Paid	$100,633	$131,142	$67,101	0.0%	$0	$127,984	$207,778	0.0%	
HCC's % of Plan Paid	3.4%	26.2%	8.7%	0.0%	0.0%	30.3%	40.7%	0.0%	
Cost Distribution by Claim Type (PMPY)									
Facility Inpatient	$1,510	$1,151	$1,897	64.8%	$465	$831	$4,519	443.8%	$1,149
Facility Outpatient	$2,401	$3,520	$2,250	-36.1%	$1,064	$1,198	$1,254	4.7%	$1,333
Physician	$3,160	$3,637	$3,410	-6.2%	$2,028	$2,633	$2,353	-10.6%	$1,301
Other	$326	$540	$268	-50.4%	$250	$444	$257	-42.1%	$96
Total	$7,397	$8,848	$7,824	-11.6%	$3,808	$5,106	$8,383	64.2%	$3,879
	Annualized	Annualized	Annualized		Annualized	Annualized	Annualized		

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

	Total				State Active				Non-State Active			
Summary	**PY20**	**PY21**	**2Q22**	**Variance to Prior Year**	**PY20**	**PY21**	**2Q22**	**Variance to Prior Year**	**PY20**	**PY21**	**2Q22**	**Variance to Prior Year**
Enrollment												
Avg # Employees	4,794	4,650	4,116	-11.5%	4,054	3,949	3,454	-12.5%	4	4	3	-20.8%
Avg # Members	8,768	8,553	7,637	-10.7%	7,768	7,602	6,721	-11.6%	5	4	3	-26.8%
Ratio	1.8	1.8	1.9	1.1%	1.9	1.9	2.0	1.0%	1.3	1.1	1.0	-7.4%
Financial Summary												
Gross Cost	$55,523,229	$56,804,046	$28,491,239	-49.8%	$45,961,999	$44,805,657	$24,404,728	-45.5%	$70,916	$44,403	$3,252	-92.7%
Client Paid	$50,293,887	$53,113,944	$25,760,997	-51.5%	$41,579,805	$41,757,107	$22,152,079	-47.0%	$65,329	$41,594	$2,391	-94.3%
Employee Paid	$5,229,342	$3,690,102	$2,730,242	-26.0%	$4,382,194	$3,048,550	$2,252,648	-26.1%	$5,587	$2,808	$861	-69.3%
Client Paid-PEPY	$10,492	$11,422	$12,519	9.6%	$10,256	$10,575	$12,829	21.3%	$16,332	$10,399	$1,510	-85.5%
Client Paid-PMPY	$5,736	$6,210	$6,747	8.6%	$5,352	$5,493	$6,592	20.0%	$13,066	$9,599	$1,510	-84.3%
Client Paid-PEPM	$874	$952	$1,043	9.6%	$855	$881	$1,069	21.3%	$1,361	$867	$126	-85.5%
Client Paid-PMPM	$478	$518	$562	8.5%	$446	$458	$549	19.9%	$1,089	$800	$126	-84.3%
High Cost Claimants (HCC's) > $100k												
# of HCC's	51	61	29	-52.5%	40	49	25	-49.0%	0	0	0	0.0%
HCC's / 1,000	5.8	7.1	3.8	-46.7%	5.2	6.5	3.7	-42.3%	0.0	0.0	0.0	0.0%
Avg HCC Paid	$202,775	$257,989	$272,456	5.6%	$179,535	$212,968	$297,002	39.5%	$0	$0	$0	0.0%
HCC's % of Plan Paid	20.6%	29.6%	30.7%	3.7%	17.3%	25.0%	33.5%	34.0%	0.0%	0.0%	0.0%	0.0%
Cost Distribution by Claim Type (PMPY)												
Facility Inpatient	$1,169	$1,457	$2,203	51.2%	$1,036	$1,091	$2,198	101.5%	$2,928	$0	$0	0.0%
Facility Outpatient	$1,832	$1,951	$1,806	-7.4%	$1,693	$1,779	$1,764	-0.8%	$4,817	$4,611	$0	-100.0%
Physician	$2,541	$2,608	$2,582	-1.0%	$2,461	$2,464	$2,489	1.0%	$5,153	$4,469	$1,401	-68.7%
Other	$194	$194	$156	-19.6%	$163	$159	$141	-11.3%	$168	$518	$108	-79.2%
Total	$5,736	$6,210	$6,747	8.6%	$5,352	$5,493	$6,592	20.0%	$13,066	$9,599	$1,510	-84.3%
			Annualized				Annualized				Annualized	

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

	State Retirees				Non-State Retirees				
Summary	**PY20**	**PY21**	**2Q22**	**Variance to Prior Year**	**PY20**	**PY21**	**2Q22**	**Variance to Prior Year**	**HSB Peer Index**
Enrollment									
Avg # Employees	588	576	567	-1.4%	148	122	92	-24.9%	
Avg # Members	807	789	791	0.3%	188	158	122	-22.8%	
Ratio	1.4	1.4	1.4	2.2%	1.3	1.3	1.3	3.1%	1.6
Financial Summary									
Gross Cost	$8,514,643	$7,966,596	$3,491,677	-56.2%	$975,672	$3,987,390	$591,582	-85.2%	
Client Paid	$7,803,114	$7,426,217	$3,095,882	-58.3%	$845,639	$3,889,026	$510,645	-86.9%	
Employee Paid	$711,529	$540,380	$395,795	-26.8%	$130,033	$98,364	$80,937	-17.7%	
Client Paid-PEPY	$13,272	$12,904	$10,917	-15.4%	$5,730	$31,812	$11,121	-65.0%	$6,297
Client Paid-PMPY	$9,674	$9,413	$7,824	-16.9%	$4,508	$24,653	$8,383	-66.0%	$3,879
Client Paid-PEPM	$1,106	$1,075	$910	-15.3%	$477	$2,651	$927	-65.0%	$525
Client Paid-PMPM	$806	$784	$652	-16.8%	$376	$2,054	$699	-66.0%	$323
High Cost Claimants (HCC's) > $100k									
# of HCC's	18	18	4	-77.8%	0	2	1	0.0%	
HCC's / 1,000	22.3	22.8	5.1	-77.9%	0.0	12.7	8.2	0.0%	
Avg HCC Paid	$175,561	$113,454	$67,101	-40.9%	$0	$1,629,851	$207,778	0.0%	
HCC's % of Plan Paid	40.5%	27.5%	8.7%	-68.5%	0.0%	83.8%	40.7%	0.0%	
Cost Distribution by Claim Type (PMPY)									
Facility Inpatient	$2,529	$1,454	$1,897	30.5%	$787	$19,176	$4,519	-76.4%	$1,149
Facility Outpatient	$3,276	$3,575	$2,250	-37.1%	$1,314	$2,010	$1,254	-37.6%	$1,333
Physician	$3,385	$3,897	$3,410	-12.5%	$2,165	$3,054	$2,353	-23.0%	$1,301
Other	$484	$487	$268	-45.0%	$242	$413	$257	-37.8%	$96
Total	$9,674	$9,413	$7,824	-16.9%	$4,508	$24,653	$8,383	-66.0%	$3,879
			Annualized				Annualized		

Paid Claims by Claim Type – State Participants

Net Paid Claims - Total State Participants	2Q21				2Q22				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical									
Inpatient	$ 5,240,874	$ 551,033	$ 44,289	$ 5,836,196	$ 8,463,729	$ 725,318	$ 172,559	$ 9,361,605	60.4%
Outpatient	$ 15,804,254	$ 2,616,412	$ 287,830	$ 18,708,497	$ 13,688,350	$ 2,027,950	$ 170,056	$ 15,886,356	-15.1%
Total - Medical	**$ 21,045,129**	**$ 3,167,445**	**$ 332,119**	**$ 24,544,693**	**$ 22,152,079**	**$ 2,753,267**	**$ 342,615**	**$ 25,247,961**	**2.9%**

Net Paid Claims - Per Participant per Month	2Q21				2Q22				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical	$ 880	$ 1,061	$ 688	$ 896	$ 1,069	$ 931	$ 772	$ 1,047	16.7%

Paid Claims by Claim Type – Non-State Participants

Net Paid Claims - Total Non-State Participants	2Q21				2Q22				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical									
Inpatient	$ 1,391	$ 79,523	$ 37,565	$ 118,479	$ -	$ 237,790	$ 48,643	$ 286,433	141.8%
Outpatient	$ 24,688	$ 242,668	$ 62,364	$ 329,720	$ 2,391	$ 123,475	$ 100,738	$ 226,603	-31.3%
Total - Medical	**$ 26,079**	**$ 322,191**	**$ 99,929**	**$ 448,200**	**$ 2,391**	**$ 361,265**	**$ 149,380**	**$ 513,036**	**14.5%**

Net Paid Claims - Per Participant per Month	2Q21				2Q22				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical	$ 1,087	$ 731	$ 302	$ 563	$ 133	$ 1,505	$ 479	$ 900	59.9%

Paid Claims by Claim Type – Total

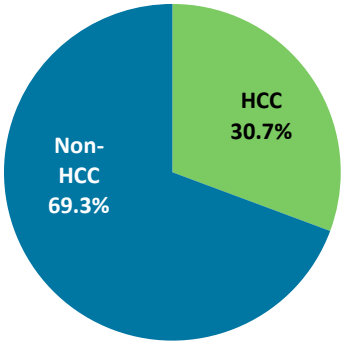
Net Paid Claims - Total Total Participants	2Q21				2Q22				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical									
Inpatient	$ 5,242,265	$ 630,556	$ 81,854	$ 5,954,675	$ 8,463,729	$ 963,108	$ 221,201	$ 9,648,038	62.0%
Outpatient	$ 15,828,943	$ 2,859,080	$ 350,194	$ 19,038,217	$ 13,690,741	$ 2,151,425	$ 270,793	$ 16,112,959	-15.4%
Total - Medical	**$ 21,071,207**	**$ 3,489,636**	**$ 432,049**	**$ 24,992,892**	**$ 22,154,470**	**$ 3,114,532**	**$ 491,995**	**$ 25,760,997**	**3.1%**

Net Paid Claims - Per Participant per Month	2Q21				2Q22				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical	$ 880	$ 1,019	$ 531	$ 887	$ 1,068	$ 974	$ 651	$ 1,043	17.6%

Cost Distribution – Medical Claims

2Q21							2Q22					
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
25	0.3%	$5,681,700	22.7%	($31,257)	-1.9%	$100,000.01 Plus	22	0.3%	$7,848,499	30.5%	$71,255	2.6%
35	0.4%	$2,531,061	10.1%	$42,015	2.6%	$50,000.01-$100,000.00	32	0.4%	$2,453,690	9.5%	$115,674	4.2%
97	1.1%	$3,584,636	14.3%	$118,462	7.3%	$25,000.01-$50,000.00	86	1.1%	$3,161,157	12.3%	$180,203	6.6%
279	3.2%	$4,527,857	18.1%	$228,903	14.2%	$10,000.01-$25,000.00	235	3.1%	$4,084,447	15.9%	$396,867	14.5%
328	3.8%	$2,396,592	9.6%	$238,130	14.8%	$5,000.01-$10,000.00	304	4.0%	$2,312,183	9.0%	$386,747	14.2%
638	7.4%	$2,297,228	9.2%	$320,714	19.9%	$2,500.01-$5,000.00	569	7.5%	$2,091,693	8.1%	$474,616	17.4%
5,632	65.3%	$3,973,818	15.9%	$691,783	43.0%	$0.01-$2,500.00	5,038	66.0%	$3,809,327	14.8%	$1,099,137	40.3%
26	0.3%	$0	0.0%	$4,032	0.2%	$0.00	57	0.7%	$0	0.0%	$5,743	0.2%
1,567	18.2%	$0	0.0%	$0	0.0%	No Claims	1,295	17.0%	$0	0.0%	$0	0.0%
8,627	**100.0%**	**$24,992,892**	**100.0%**	**$1,612,781**	**100.0%**		**7,637**	**100.0%**	**$25,760,997**	**100.0%**	**$2,730,242**	**100.0%**

Distribution of HCC Medical Claims Paid



HCC – High-Cost Claimant over $100K

HCC's by Diagnosis Grouper			
Top 10 Diagnosis Groupers	**Patients**	**Total Paid**	**% Paid**
Pulmonary Disorders	19	$1,608,326	20.4%
Infections	12	$1,130,239	14.3%
Pregnancy-related Disorders	3	$1,111,026	14.1%
Endocrine/Metabolic Disorders	11	$1,048,759	13.3%
Cancer	9	$955,604	12.1%
Congenital/Chromosomal Anomalies	4	$656,038	8.3%
Hematological Disorders	5	$340,491	4.3%
Medical/Surgical Complications	5	$302,247	3.8%
Renal/Urologic Disorders	4	$188,577	2.4%
Cardiac Disorders	12	$141,191	1.8%
All Other		$418,735	5.3%
Overall	**----**	**$7,901,232**	**100.0%**

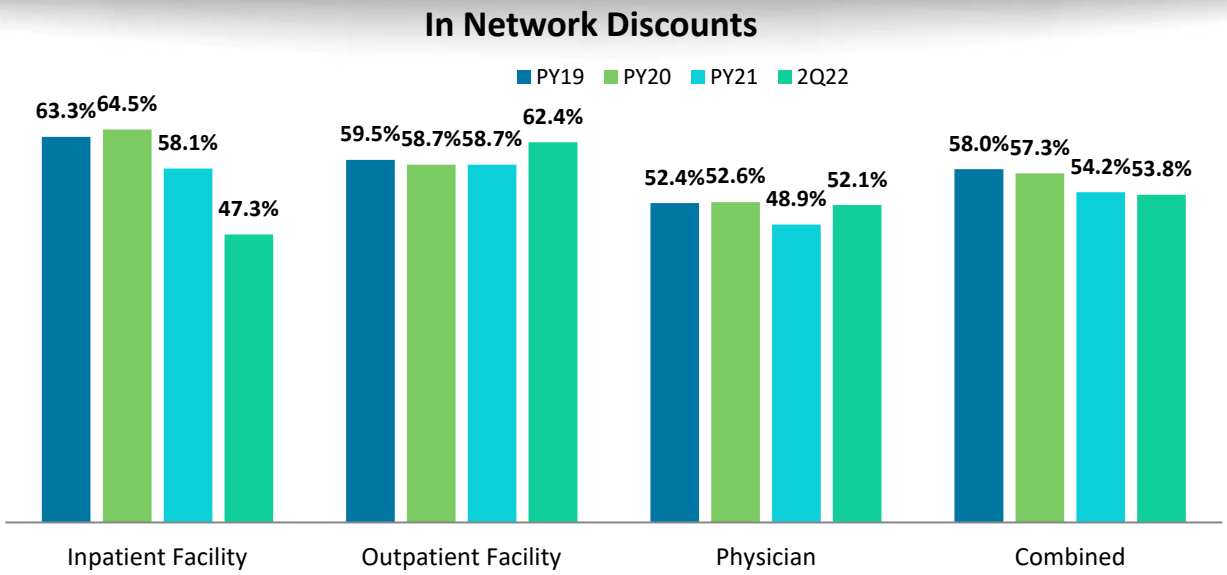
Utilization Summary (p. 1 of 2)

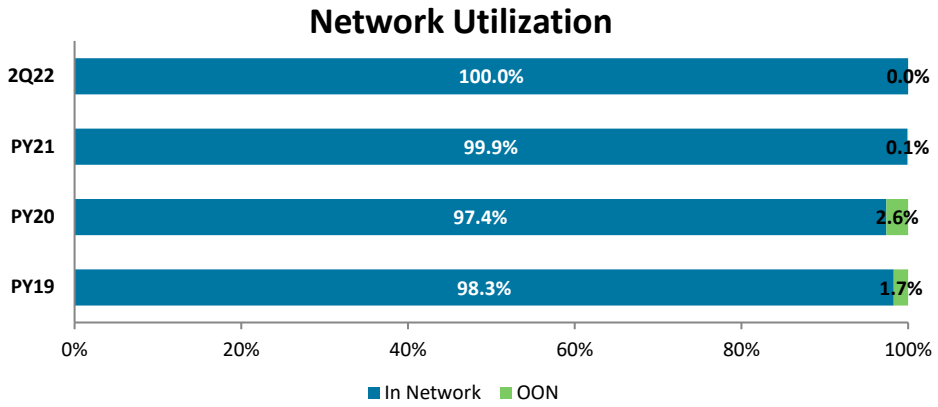
	Total				State Active				Non-State Active			
Summary	**2Q20**	**2Q21**	**2Q22**	**Variance to Prior Year**	**2Q20**	**2Q21**	**2Q22**	**Variance to Prior Year**	**2Q20**	**2Q21**	**2Q22**	**Variance to Prior Year**
Inpatient Summary												
# of Admits	278	243	226		237	206	193		1	0	0	
# of Bed Days	1,364	1,662	1,188		1,158	1,151	994		2	0	0	
Paid Per Admit	$22,894	$38,287	$26,751	-30.1%	$23,107	$25,029	$27,878	11.4%	$22,498	$0	$0	0.0%
Paid Per Day	$4,666	$5,598	$5,089	-9.1%	$4,729	$4,480	$5,413	20.8%	$11,249	$0	$0	0.0%
Admits Per 1,000	63	56	59	5.4%	61	54	57	5.6%	400	0	0	0.0%
Days Per 1,000	309	385	311	-19.2%	296	300	296	-1.3%	800	0	0	0.0%
Avg LOS	4.9	6.8	5.3	-22.1%	4.9	5.6	5.2	-7.1%	2.0	0.0	0.0	0.0%
# Admits From ER	129	109	123		100	85	98		0	0	0	
Physician Office												
OV Utilization per Member	6.1	6	6.0	0.0%	5.9	5.8	5.8	0.0%	8.4	6.0	7.6	26.7%
Avg Paid per OV	$147	$149	$156	4.7%	$151	$151	$156	3.3%	$133	$99	$151	52.5%
Avg OV Paid per Member	$899	$892	$931	4.4%	$896	$867	$904	4.3%	$1,120	$594	$1,142	92.3%
DX&L Utilization per Member	11	10.2	10.4	2.0%	10.4	9.7	9.9	2.1%	20	12.4	0	-100.0%
Avg Paid per DX&L	$66	$70	$65	-7.1%	$67	$68	$67	-1.5%	$107	$67	$0	-100.0%
Avg DX&L Paid per Member	$723	$708	$680	-4.0%	$697	$659	$664	0.8%	$2,141	$833	$0	-100.0%
Emergency Room												
# of Visits	907	655	732		804	585	622		1	2	0	
Visits Per Member	0.21	0.15	0.19	26.7%	0.21	0.15	0.19	26.7%	0.40	0.86	0.00	0.0%
Visits Per 1,000	205	152	192	26.3%	205	152	185	21.7%	400	857	0	0.0%
Avg Paid per Visit	$2,548	$2,409	$1,863	-22.7%	$2,593	$2,399	$1,846	-23.1%	$3,495	$10,325	$0	0.0%
Urgent Care												
# of Visits	1,697	1,213	1,431		1,564	1,102	1,292		0	0	0	
Visits Per Member	0.38	0.28	0.37	32.1%	0.40	0.29	0.38	31.0%	0.00	0.00	0.00	0.0%
Visits Per 1,000	384	281	375	33.5%	399	287	384	33.8%	0	0	0	0.0%
Avg Paid per Visit	$144	$145	$159	9.7%	$145	$147	$161	9.5%	$0	$0	$0	0.0%
	Annualized	Annualized	Annualized		Annualized	Annualized	Annualized		Annualized	Annualized	Annualized	

Utilization Summary (p. 2 of 2)

	State Retirees				Non-State Retirees				
Summary	**2Q20**	**2Q21**	**2Q22**	**Variance to Prior Year**	**2Q20**	**2Q21**	**2Q22**	**Variance to Prior Year**	**HSB Peer Index**
Inpatient Summary									
# of Admits	37	33	25		3	4	8		
# of Bed Days	188	361	137		16	150	57		
Paid Per Admit	$22,322	$28,441	$21,240	-25.3%	$13,268	$802,313	$16,772	-97.9%	$16,632
Paid Per Day	$4,393	$2,600	$3,876	49.1%	$2,488	$21,395	$2,354	-89.0%	$3,217
Admits Per 1,000	92	84	63	-25.0%	31	49	131	167.3%	76
Days Per 1,000	468	923	346	-62.5%	164	1,829	936	-48.8%	391
Avg LOS	5.1	10.9	5.5	-49.5%	5.3	37.5	7.1	-81.1%	5.2
# Admits From ER	28	22	19		1	2	6		
Physician Office									
OV Utilization per Member	8.0	7.8	7.1	-9.0%	7.0	6.9	7.8	13.0%	5.0
Avg Paid per OV	$120	$146	$165	13.0%	$112	$123	$113	-8.1%	$57
Avg OV Paid per Member	$954	$1,140	$1,171	2.7%	$786	$853	$888	4.1%	$286
DX&L Utilization per Member	15.8	14.8	14.2	-4.1%	14.4	11.5	13.9	20.9%	10.5
Avg Paid per DX&L	$59	$80	$57	-28.8%	$58	$61	$49	-19.7%	$50
Avg DX&L Paid per Member	$935	$1,191	$810	-32.0%	$840	$695	$686	-1.3%	$522
Emergency Room									
# of Visits	92	58	91		10	10	19		
Visits Per Member	0.23	0.15	0.23	53.3%	0.10	0.12	0.31	158.3%	0.24
Visits Per 1,000	229	148	230	55.4%	103	122	312	155.7%	235
Avg Paid per Visit	$2,277	$2,270	$2,172	-4.3%	$1,291	$2,239	$934	-58.3%	$943
Urgent Care									
# of Visits	95	92	118		38	19	21		
Visits Per Member	0.24	0.24	0.30	25.0%	0.39	0.23	0.34	47.8%	0.3
Visits Per 1,000	237	235	298	26.8%	390	232	345	48.7%	300
Avg Paid per Visit	$152	$133	$152	14.3%	$93	$128	$69	-46.1%	$84
	Annualized	Annualized	Annualized		Annualized	Annualized	Annualized		

Provider Network Summary





Diagnosis Grouper Summary

Diagnosis Grouper	Total Paid	% Paid	Insured	Spouse	Child	Male	Female	Unassigned
Pulmonary Disorders	$2,243,805	8.7%	$2,020,376	$68,219	$155,210	$1,875,978	$367,827	$0
Infections	$2,167,262	8.4%	$1,784,399	$182,401	$200,463	$808,740	$1,358,523	$0
COVID-19, Confirmed	$1,465,922	5.7%	$1,327,772	$76,577	$61,573	$473,937	$991,985	$0
Pregnancy-related Disorders	$2,072,970	8.0%	$636,523	$140,429	$1,296,018	$492,353	$1,574,861	$5,756
Cancer	$1,710,236	6.6%	$1,028,330	$657,776	$24,130	$1,056,824	$653,412	$0
Health Status/Encounters	$1,697,717	6.6%	$974,804	$190,389	$532,524	$600,829	$1,096,206	$682
Endocrine/Metabolic Disorders	$1,658,258	6.4%	$1,505,633	$110,972	$41,652	$538,284	$1,119,973	$0
Musculoskeletal Disorders	$1,593,615	6.2%	$1,119,144	$241,040	$233,431	$674,903	$918,712	$0
Gastrointestinal Disorders	$1,559,415	6.1%	$1,172,713	$263,887	$122,814	$579,402	$979,969	$43
Cardiac Disorders	$1,347,057	5.2%	$1,117,965	$200,457	$28,636	$606,262	$740,730	$65
Mental Health	$1,129,573	4.4%	$628,416	$90,535	$410,623	$390,892	$738,682	$0
Neurological Disorders	$1,060,415	4.1%	$740,355	$117,407	$202,653	$264,908	$795,093	$414
Renal/Urologic Disorders	$990,686	3.8%	$782,982	$120,172	$87,532	$535,136	$455,488	$61
Spine-related Disorders	$974,194	3.8%	$717,614	$228,362	$28,219	$409,769	$564,426	$0
Eye/ENT Disorders	$920,890	3.6%	$541,832	$96,673	$282,385	$407,585	$513,305	$0
Congenital/Chromosomal Anomalies	$773,161	3.0%	$291,863	$1,206	$480,092	$50,254	$722,907	$0
Trauma/Accidents	$623,207	2.4%	$376,604	$85,061	$161,542	$316,986	$306,221	$0
Gynecological/Breast Disorders	$604,113	2.3%	$481,156	$48,031	$74,925	$10,928	$593,185	$0
Medical/Surgical Complications	$525,944	2.0%	$388,888	$49,089	$87,967	$203,203	$322,741	$0
Hematological Disorders	$423,816	1.6%	$401,206	$19,626	$2,984	$361,326	$62,490	$0
Non-malignant Neoplasm	$302,144	1.2%	$237,946	$46,182	$18,015	$66,134	$236,009	$0
Diabetes	$301,318	1.2%	$220,456	$50,988	$29,874	$177,423	$123,894	$0
Miscellaneous	$265,554	1.0%	$198,447	$28,018	$39,089	$120,104	$145,450	$0
Dermatological Disorders	$255,559	1.0%	$166,011	$36,935	$52,613	$98,546	$157,013	$0
Vascular Disorders	$190,519	0.7%	$185,406	$4,936	$177	$127,469	$63,050	$0
Abnormal Lab/Radiology	$127,330	0.5%	$102,994	$17,113	$7,224	$44,908	$82,422	$0
Medication Related Conditions	$90,863	0.4%	$49,958	$31,208	$9,697	$31,458	$59,405	$0
Cholesterol Disorders	$75,882	0.3%	$69,221	$5,734	$928	$19,477	$56,405	$0
Dental Conditions	$50,777	0.2%	$37,617	$4,160	$9,000	$5,602	$45,175	$0
External Hazard Exposure	$14,836	0.1%	$5,203	$253	$9,379	$11,315	$3,521	$0
Allergic Reaction	$9,882	0.0%	$2,580	$530	$6,772	$5,502	$4,380	$0
Total	**$25,760,997**	**100.0%**	**$17,986,641**	**$3,137,789**	**$4,636,567**	**$10,892,502**	**$14,861,474**	**$7,021**

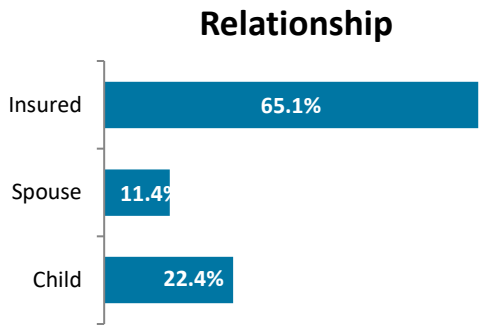
Mental Health Drilldown

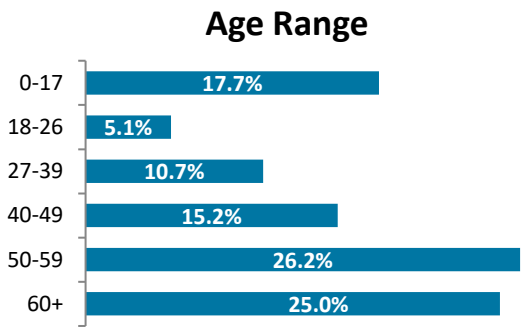
	PY19		PY20		PY21		2Q22	
Grouper	Patients	Total Paid	Patients	Total Paid	Patients	Total Paid	Patients	Total Paid
Depression	532	$751,739	632	$1,048,452	655	$861,117	391	$303,145
Mental Health Conditions, Other	464	$493,299	595	$616,280	662	$938,742	386	$226,060
Mood and Anxiety Disorders	551	$333,099	694	$531,718	716	$636,220	461	$209,686
Sexually Related Disorders	11	$3,408	20	$167,866	26	$81,490	16	$80,095
Complications of Substance Abuse	26	$319,764	34	$325,820	30	$138,433	22	$67,279
Bipolar Disorder	121	$202,469	151	$279,948	135	$252,449	80	$63,563
Attention Deficit Disorder	153	$58,480	187	$95,843	190	$94,546	133	$40,060
Eating Disorders	14	$268,532	17	$111,963	25	$376,295	20	$37,212
Developmental Disorders	53	$61,872	64	$149,263	64	$155,167	47	$33,273
Alcohol Abuse/Dependence	33	$24,550	43	$162,989	39	$168,417	27	$25,179
Sleep Disorders	165	$29,028	186	$36,835	187	$38,393	90	$17,877
Personality Disorders	9	$10,876	10	$10,468	15	$18,725	15	$11,772
Substance Abuse/Dependence	40	$20,086	48	$107,498	54	$44,537	26	$6,350
Psychoses	7	$3,308	14	$18,805	8	$54,549	3	$3,822
Tobacco Use Disorder	49	$5,087	54	$5,349	42	$4,779	20	$2,629
Schizophrenia	9	$10,155	11	$16,662	10	$10,630	6	$1,571
Total		**$2,595,750**		**$3,685,761**		**$3,874,490**		**$1,129,573**

Diagnosis Grouper – Pulmonary Disorders

Diagnosis Sub-Grouper	Patients	Claims	Total Paid	% Paid
Respiratory Failure	38	190	$1,690,349	75.3%
Sleep Apnea	410	1,603	$134,756	6.0%
Respiratory Symptoms	494	846	$114,524	5.1%
Lung Conditions, Other	97	167	$92,765	4.1%
Asthma	212	336	$67,156	3.0%
Bronchitis	74	98	$61,705	2.8%
Pneumonia	49	93	$54,342	2.4%
COPD	51	147	$26,305	1.2%
Aspiration Related	6	10	$1,904	0.1%
Cystic Fibrosis	0	0	$0	0.0%
Overall	**----**	**----**	**$2,243,805**	**100.0%**

*Patient and claim counts are unique only within the category

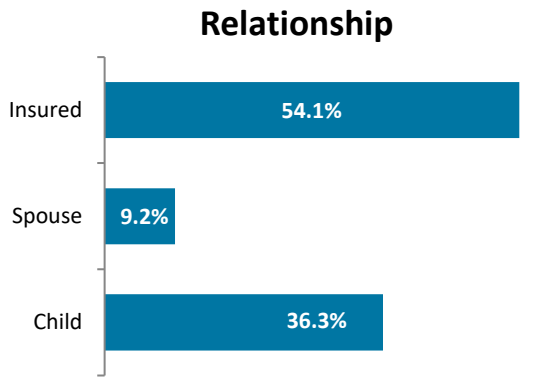


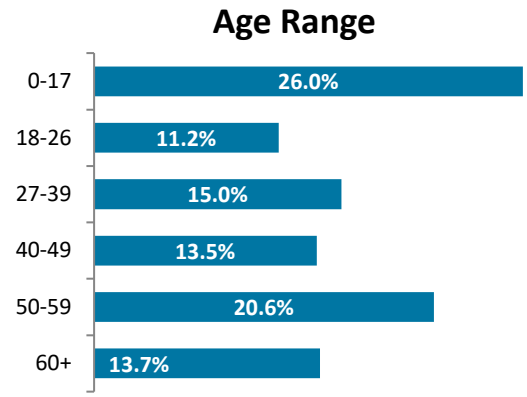


Diagnosis Grouper – Infections

Diagnosis Sub-Grouper	Patients	Claims	Total Paid	% Paid
Infectious Diseases	1,509	3,067	$1,756,959	81.1%
Septicemia	29	72	$398,403	18.4%
Osteomyelitis	4	16	$6,196	0.3%
Central Nervous System Infection	1	4	$3,907	0.2%
HIV	7	16	$1,313	0.1%
Influenza	3	3	$180	0.0%
Clostridium Difficile	1	1	$115	0.0%
Hepatitis C	2	2	$104	0.0%
Hepatitis B	3	3	$74	0.0%
Tuberculosis	2	2	$11	0.0%
Overall	**----**	**----**	**$2,167,262**	**100.0%**

*Patient and claim counts are unique only within the category

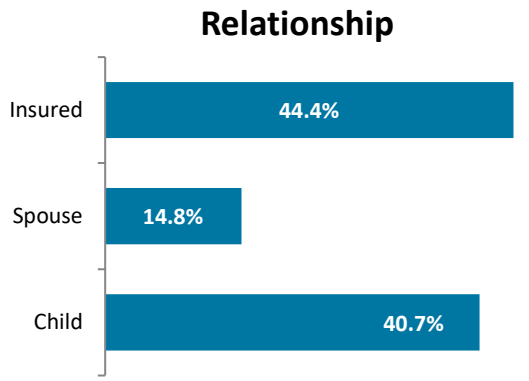


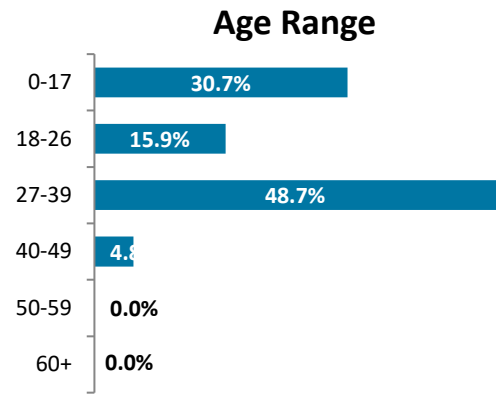


Diagnosis Grouper – Pregnancy-related Disorders

Diagnosis Sub-Grouper	Patients	Claims	Total Paid	% Paid
Liveborn Infants	53	94	$1,015,809	49.0%
Labor and Delivery Related	58	168	$484,431	23.4%
Pregnancy Complications	82	298	$220,488	10.6%
Fetal Distress	3	71	$193,770	9.3%
Supervision of Pregnancy	99	330	$76,703	3.7%
Perinatal Disorders	32	63	$34,855	1.7%
Abortion Related	7	19	$22,401	1.1%
Multiple Gestation Related	3	25	$16,745	0.8%
Prematurity and Low Birth Weight	5	9	$3,988	0.2%
Cesarean Delivery	3	4	$3,710	0.2%
Ectopic Pregnancy	1	1	$70	0.0%
Overall	**----**	**----**	**$2,072,970**	**100.0%**

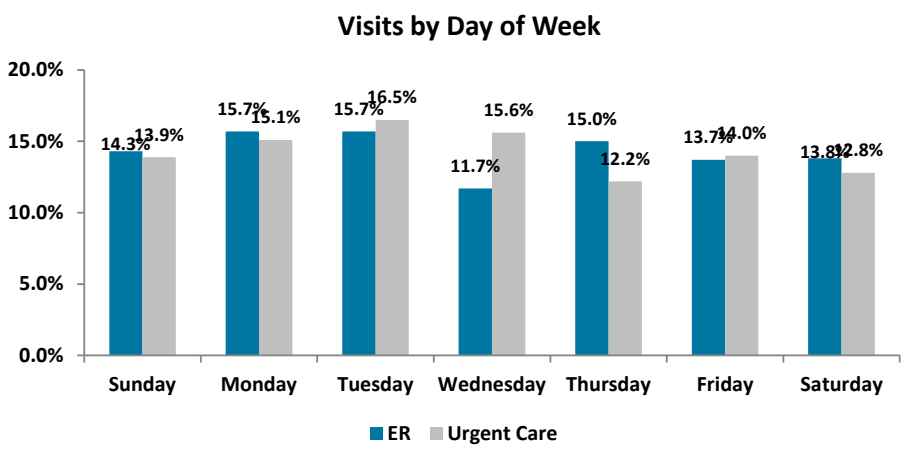
*Patient and claim counts are unique only within the category

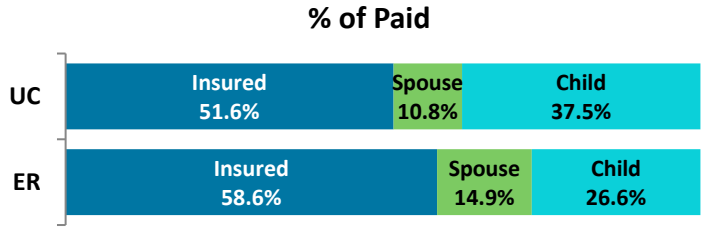




Emergency Room / Urgent Care Summary

	2Q21		2Q22		HSB Peer Index	
ER/Urgent Care	ER	Urgent Care	ER	Urgent Care	ER	Urgent Care
Number of Visits	655	1,213	732	1,431		
Visits Per Member	0.15	0.28	0.19	0.37	0.17	0.24
Visits/1000 Members	152	281	192	375	174	242
Avg Paid Per Visit	$2,409	$145	$1,863	$159	$1,684	$74
% with OV*	91.9%	87.8%	91.5%	89.7%		
% Avoidable	9.3%	29.6%	11.1%	34.8%		
Total Member Paid	**$260,101**	**$48,482**	**$374,405**	**$60,667**		
Total Plan Paid	**$1,578,049**	**$176,321**	**$1,363,560**	**$227,062**		
*looks back 12 months from ER visit	Annualized	Annualized	Annualized	Annualized		



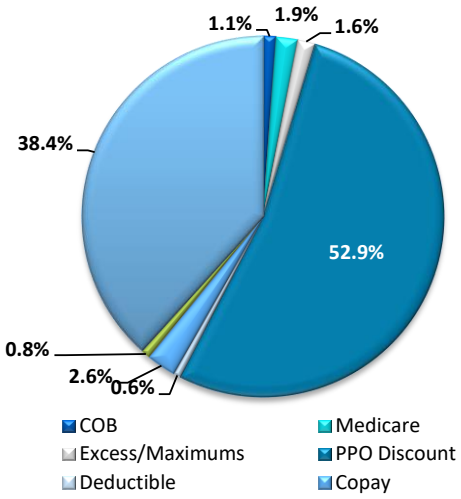


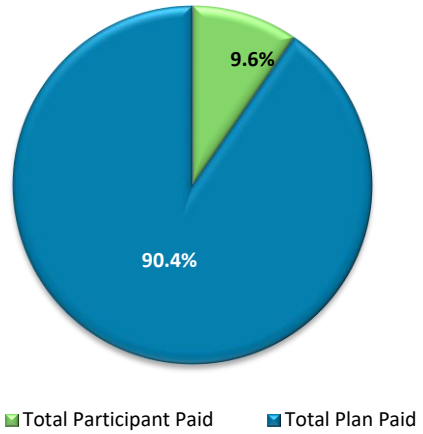
ER / UC Visits by Relationship						
Relationship	ER	Per 1,000	Urgent Care	Per 1,000	Total	Per 1,000
Insured	392	95	747	181	1,056	257
Spouse	96	116	151	182	202	243
Child	244	91	533	198	513	191
Total	**732**	**96**	**1,431**	**187**	**1,771**	**232**

Savings Summary – Medical Claims

Description	Dollars	PPPM	% of Eligible
Eligible Charges	$67,112,802	$2,718	100.0%
COB	$752,644	$30	1.1%
Medicare	$1,296,437	$53	1.9%
Excess/Maximums	$1,070,826	$43	1.6%
PPO Discount	$35,561,673	$1,440	53.0%
Deductible	$420,016	$17	0.6%
Copay	$1,767,682	$72	2.6%
Coinsurance	$542,543	$22	0.8%
Total Participant Paid	**$2,730,241**	**$111**	**4.1%**
Total Plan Paid	**$25,760,997**	**$1,043**	**38.4%**

Total Participant Paid - PY21	**$66**
Total Plan Paid - PY21	**$952**





Quality Metrics

Condition	Metric	#Members in Group	#Meeting Metric	#Not Meeting Metric	% Meeting Metric
Asthma	Asthma and a routine provider visit in the last 12 months	488	482	6	98.8%
	<2 asthma related ER Visits in the last 6 months	488	488	0	100.0%
	No asthma related admit in last 12 months	488	488	0	100.0%
Chronic Obstructive Pulmonary Disease	No exacerbations in last 12 months	90	85	5	94.4%
	Members with COPD who had an annual spirometry test	90	14	76	15.6%
Congestive Heart Failure	No re-admit to hosp with Heart Failure diag w/in 30 days of HF inpatient stay discharge	4	4	0	100.0%
	No ER Visit for Heart Failure in last 90 days	68	65	3	95.6%
	Follow-up OV within 4 weeks of discharge from HF admission	4	3	1	75.0%
Diabetes	Annual office visit	565	559	6	98.9%
	Annual dilated eye exam	565	270	295	47.8%
	Annual foot exam	565	228	337	40.4%
	Annual HbA1c test done	565	483	82	85.5%
	Diabetes Annual lipid profile	565	441	124	78.1%
	Annual microalbumin urine screen	565	399	166	70.6%
Hyperlipidemia	Hyperlipidemia Annual lipid profile	1,243	982	261	79.0%
Hypertension	Annual lipid profile	1,294	889	405	68.7%
	Annual serum creatinine test	1,263	1,041	222	82.4%
Wellness	Well Child Visit - 15 months	64	62	2	96.9%
	Routine office visit in last 6 months	7,516	5,503	2,013	73.2%
	Age 45 to 75 years with colorectal cancer screening	3,189	760	2,429	23.8%
	Women age 25-65 with recommended cervical cancer screening	2,441	1,805	636	73.9%
	Males age greater than 49 with PSA test in last 24 months	1,136	583	553	51.3%
	Routine exam in last 24 months	7,516	6,905	611	91.9%
	Women age 40 to 75 with a screening mammogram last 24 months	2,139	1,337	802	62.5%

All member counts represent members active at the end of the report period.
Quality Metrics are always calculated on an incurred basis.

Chronic Conditions Prevalence

A member is identified as having a chronic condition if any one of the following three conditions is met within a 24 month service date period:

- **Two outpatient claims for the Dx on separate days of service**
- **One ER Visit with the Dx as primary**
- **One IP admission with the Dx as the admitting**

*For Diabetes only, one or more Rx claims can also be used to identify the condition.

Chronic Condition	# With Condition	% of Members	Members per 1000	PMPY
Affective Psychosis	118	1.57%	15.45	$14,474
Asthma	537	7.14%	70.32	$14,329
Atrial Fibrillation	83	1.10%	10.87	$28,608
Blood Disorders	465	6.19%	60.89	$36,895
CAD	161	2.14%	21.08	$24,058
COPD	90	1.20%	11.78	$46,306
Cancer	320	4.26%	41.90	$23,288
Chronic Pain	377	5.01%	49.37	$22,601
Congestive Heart Failure	68	0.90%	8.90	$34,359
Demyelinating Diseases	26	0.35%	3.40	$37,559
Depression	851	11.32%	111.43	$13,145
Diabetes	600	7.98%	78.57	$26,094
ESRD	9	0.12%	1.18	$102,360
Eating Disorders	34	0.45%	4.45	$17,675
HIV/AIDS	11	0.15%	1.44	$28,987
Hyperlipidemia	1,282	17.05%	167.87	$17,899
Hypertension	1,300	17.29%	170.23	$16,253
Immune Disorders	32	0.43%	4.19	$29,905
Inflammatory Bowel Disease	51	0.68%	6.68	$39,607
Liver Diseases	175	2.33%	22.92	$35,479
Morbid Obesity	323	4.30%	42.30	$22,388
Osteoarthritis	420	5.59%	55.00	$18,998
Peripheral Vascular Disease	44	0.59%	5.76	$31,004
Rheumatoid Arthritis	74	0.98%	9.69	$39,083

Data Includes Medical and Pharmacy
Based on 24 months incurred dates

Methodology

- Average member counts were weighted by the number of months each member had on the plan.
- Claims were pulled based upon the date paid.
- Claims were categorized based upon four groups:
  - Inpatient Facility
  - Outpatient Facility
  - Physician
  - Other (Other includes any medical reimbursements or durable medical equipment.)
- Inpatient analysis was done by identifying facility claims where a room and board charge was submitted and paid. Claims were then rolled up for the entire admission and categorized by the diagnosis code that held the highest paid amount. (Hospice and skilled nursing facility claims were excluded)
- Outpatient claims were flagged by an in-or-outpatient indicator being present on the claim that identified it as taking place at an outpatient facility.
- Physician claims were identified when the vendor type indicator was flagged as a professional charge.
  - These claims were in some cases segregated further to differentiate primary care physicians and specialists.
  - Office visits were identified by the presence of evaluation and management or consultation codes.
- Emergency room and urgent care episodes should be considered subcategories of physician and outpatient facility.
  - Emergency Room visits are identified by facility claims with a revenue code of 450-455, 457-459.
  - Urgent Care visits are identified by facility claims with a revenue code of 456 or physician claims with a place of service of “Urgent Care”.
  - Outpatient claims (including facility and physician) are then rolled up for the day of service and summarized as an ER/UC visit.
  - If a member has an emergency room visit on the same day as an urgent care visit, all claims are grouped into one episode and counted as an emergency room visit.
  - If a member was admitted into the hospital through the ER, the member will not show an ER visit. ER claims are bundled with the inpatient stay.

Public Employees' Benefits Program - RX Costs
PY 2022 - Quarter Ending December 31, 2021

Express Scripts

Membership Summary	2Q FY2022 EPO	2Q FY2021 EPO	Difference	% Change
			Membership Summary	
Member Count (Membership)	7,635	8,629	(994)	-11.5%
Utilizing Member Count (Patients)	5,874	6,095	(221)	-3.6%
Percent Utilizing (Utilization)	76.9%	70.6%	0	8.9%

Claim Summary			Claims Summary	
Net Claims (Total Rx's)	77,547	85,456	(7,909)	-9.3%
Claims per Elig Member per Month (Claims PMPM)	1.69	1.65	0.04	2.4%
Total Claims for Generic (Generic Rx)	64,962	72,772	(7,810.00)	-10.7%
Total Claims for Brand (Brand Rx)	12,585	12,684	(99.00)	-0.8%
Total Claims for Brand w/Gen Equiv (Multisource Brand Claims)	650	1,355	(705.00)	-52.0%
Total Non-Specialty Claims	76,445	84,327	(7,882.00)	-9.3%
Total Specialty Claims	1,102	1,129	(27.00)	-2.4%
Generic % of Total Claims (GFR)	**83.8%**	**85.2%**	(0.01)	-1.6%
Generic Effective Rate (GCR)	**99.0%**	**98.2%**	0.01	0.8%
Mail Order Claims	15,494	9,729	5,765.00	59.3%
Mail Penetration Rate*	22.7%	12.5%	0.10	10.2%

Claims Cost Summary			Claims Cost Summary	
Total Prescription Cost (Total Gross Cost)	$9,767,101	$10,880,580	($1,113,479.00)	-10.2%
Total Generic Gross Cost	$1,440,839	$1,693,171	($252,332.00)	-14.9%
Total Brand Gross Cost	$8,326,263	$9,187,409	($861,146.00)	-9.4%
Total MSB Gross Cost	$147,078	$330,602	($183,524.00)	-55.5%
Total Ingredient Cost	$9,635,588	$10,828,565	($1,192,977.00)	-11.0%
Total Dispensing Fee	$128,074	$49,348	$78,726.00	159.5%
Total Other (e.g. tax)	$3,439	$2,668	$771.00	28.9%
Avg Total Cost per Claim (Gross Cost/Rx)	**$125.95**	**$127.32**	($1.37)	-1.1%
Avg Total Cost for Generic (Gross Cost/Generic Rx)	$22.18	$23.27	($1.09)	-4.7%
Avg Total Cost for Brand (Gross Cost/Brand Rx)	$661.60	$724.33	($62.73)	-8.7%
Avg Total Cost for MSB (MSB Gross Cost/MSB ARx)	$226.27	$243.99	($17.72)	-7.3%

Member Cost Summary			Member Cost Summary	
Total Member Cost	**$1,587,511**	**$1,800,157**	($212,646.00)	-11.8%
Total Copay	$1,577,721	$1,800,157	($222,436.00)	-12.4%
Total Deductible	$9,790	$0	$9,790.00	0.0%
Avg Copay per Claim (Copay/Rx)	$20.35	$21.07	($0.72)	-3.4%
Avg Participant Share per Claim (Copay+Deductible/RX)	**$20.47**	**$21.07**	**($0.59)**	**-2.8%**
Avg Copay for Generic (Copay/Generic Rx)	$7.65	$7.49	$0.16	2.1%
Avg Copay for Brand (Copay/Brand Rx)	$86.63	$98.96	($12.33)	-12.5%
Avg Copay for Brand w/ Generic Equiv (Copay/Multisource Rx)	$32.34	$31.69	$0.65	2.1%
Net PMPM (Participant Cost PMPM)	**$34.65**	**$34.77**	($0.12)	-0.3%
Copay % of Total Prescription Cost (Member Cost Share %)	16.3%	16.5%	-0.3%	-1.8%

Plan Cost Summary			Plan Cost Summary	
Total Plan Cost (Plan Cost)	**$8,179,590**	**$9,080,423**	**($900,833.00)**	**-9.9%**
Total Non-Specialty Cost (Non-Specialty Plan Cost)	$4,093,854	$4,428,604	($334,750.00)	-7.6%
Total Specialty Drug Cost (Specialty Plan Cost)	$4,085,736	$4,651,818	($566,082.00)	-12.2%
Avg Plan Cost per Claim (Plan Cost/Rx)	**$105.48**	**$106.26**	($0.78)	-0.7%
Avg Plan Cost for Generic (Plan Cost/Generic Rx)	$14.53	$15.78	($1.25)	-7.9%
Avg Plan Cost for Brand (Plan Cost/Brand Rx)	$574.97	$625.37	($50.40)	-8.1%
Avg Plan Cost for MSB (MSB Plan Cost/MSB ARx)	$193.94	$212.29	($18.35)	-8.6%
Net PMPM (Plan Cost PMPM)	**$178.55**	**$175.39**	**$3.17**	**1.8%**
PMPM for Specialty Only (Specialty PMPM)	$89.19	$89.85	($0.66)	-0.7%
PMPM without Specialty (Non-Specialty PMPM)	$89.37	$85.54	$3.83	4.5%
Rebates Received (Q1-Q2 FY2022 actual)	$2,017,849.94	$2,052,634.70	**($34,784.76)**	**-1.7%**
Net PMPM (Plan Cost PMPM factoring Rebates)	**$134.51**	**$135.74**	**($1.23)**	**-0.9%**
PMPM for Specialty Only (Specialty PMPM)	$72.31	$76.03	($3.72)	-4.9%
PMPM without Specialty (Non-Specialty PMPM)	$62.13	$58.74	$3.39	5.8%

Appendix D

Index of Tables
Health Plan of Nevada –Utilization Review for PEBP
July 1, 2021 – September 30, 2021

KEY PERFORMANCE INDICATORS

Demographic Overview 3

Utilization Highlights 6

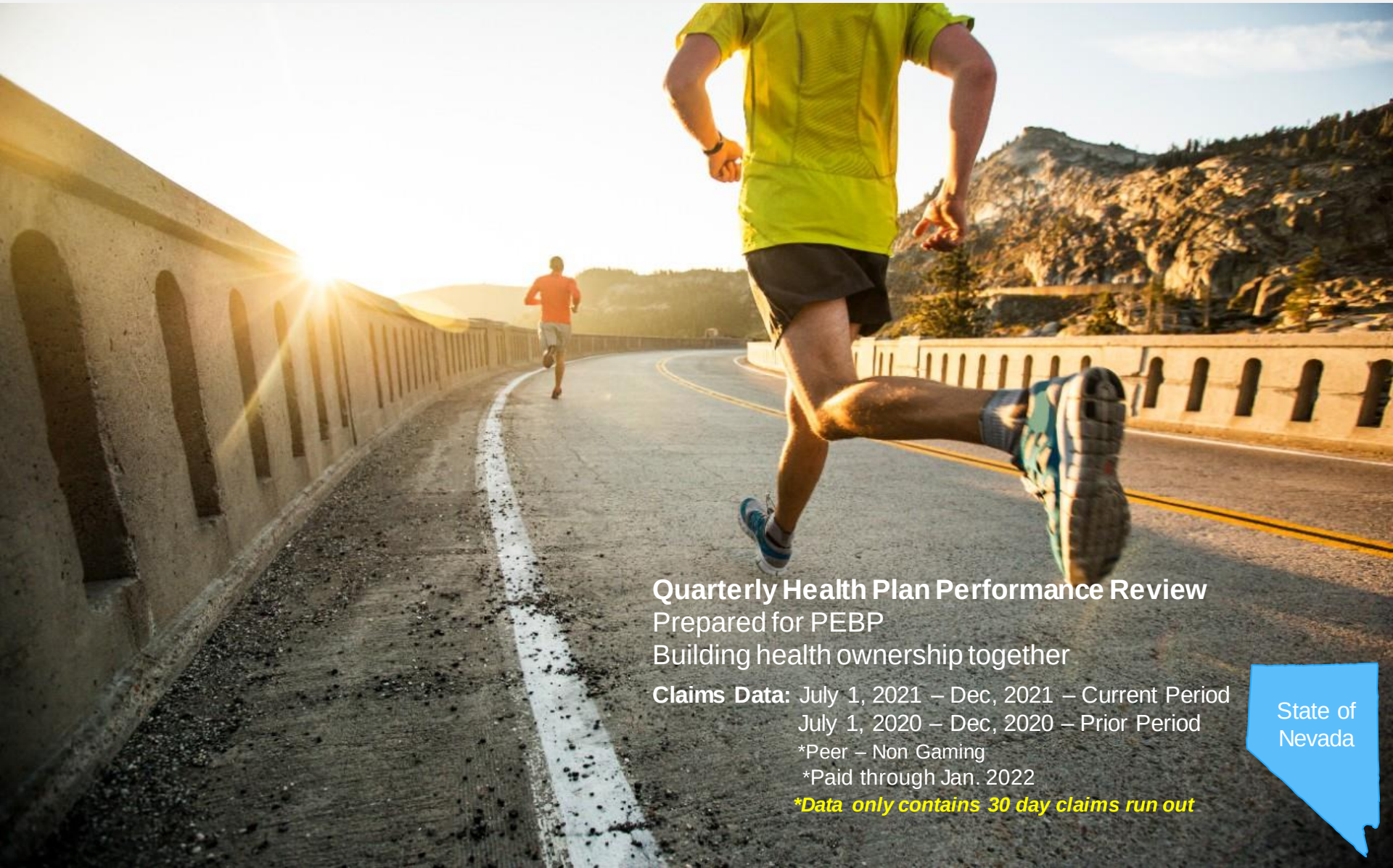
Clinical Drivers 8

High Cost Claimants 11

PRESCRIPTION DRUG COSTS

Prescription Drug Cost 7

Power Of Partnership.



Quarterly Health Plan Performance Review
Prepared for PEBP
Building health ownership together

Claims Data: July 1, 2021 – Dec, 2021 – Current Period
July 1, 2020 – Dec, 2020 – Prior Period
*Peer – Non Gaming
*Paid through Jan. 2022
Data only contains 30 day claims run out

State of Nevada

Key Performance Indicators

Includes Demographics And Financials

39 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
- ✓ 2 ambulatory surgery centers
- ✓ 55,000 sq ft state-of-the-art cancer center
- ✓ Saturday appointments with primary care

Enhancements Made for Your Members

- ✓ Provided COVID-19 testing and vaccinations at multiple locations throughout the Las Vegas area, including drive through locations.
- ✓ Introduced the **Tummy2Toddler pregnancy support app** helping mothers stay healthy during every step of pregnancy and early childhood.
- ✓ NowClinic and Walgreens now offering same-day medication delivery
- ✓ Added HCA hospitals and 17 Care Now Urgent Cares to the network
- ✓ Real Appeal weight loss program
- ✓ Dispatch Health to provide at home urgent visits

Demographic and Financial Overview

UnitedHealthcare

Demographics

Membership	Age	Famiy size	Dependents <18	HHS Risk
Members: 6,731 Employees: 3,815 Prior: 6,815 3,918 -1.2%	37.1 Prior : 37.2 Norm: 35.4 -0.3%	1.76 Prior : 1.74 Norm: 1.8 1.4 %	22.9% Prior: 22.5 Norm: 22.7 2.1%	1.47 Prior: 1.49 Norm: 1.24 4.4%

Medical and Rx Spend

10.4%

Medical PMPM
$389.36

Prior $352.70
Norm: $319.55

Utilization

Inpatient: ▲ 1.2%
Outpatient: ▼ -18.0%
Professional: ▲ 1.5%

Spend

Inpatient: ▼ -3.3%
Outpatient: ▲ 7.6%
Professional: ▲ 24.1%

10.5%

Overall PMPM
$535.38

Prior: $484.59
Norm: $421.23

11.6%
Specialty Rx
$61.88

Prior: $55.44
Norm: $53.28

-0.2%
Avg. Scripts PMPY
17.3

Prior: 17.3
Norm: 11.6

10.7%

Rx PMPM
$146.02

*Specialty Rx accounts for **42.4%** of Rx Spend*

Prior: $131.89
Norm: $101.68

Medical and Rx Plan Experience

What Happened

Highlights of Utilization

UnitedHealthcare

Key Metrics			
Utilization Metric	Prior	Current	Δ
Physician Office Vists PMPY	2.5	2.4	-4.8%
Specialist Office Vists PMPY	4.6	4.9	5.9%
ER Visits per K	100.5	103.5	3.0%
UC Visits per K	546.3	833.6	52.6%
On Demand	503.5	585.5	16.3%
OutPatient Surgery			
ASC	120.0	113.2	-5.7%
Facility	42.6	30.0	-29.5%
Inpatient Utilization			
Admissions Per K	60.0	60.8	1.2%
Bed Days Per K	350.7	378.8	8.0%
Average Length of Stay	5.8	6.2	6.7%

**Not representative of all Utilization*

Highlights

- PCP Visits decreased in the current period, down -4.8%
- Specialist Office visits increased 5.9%
- ER utilization increased 3.0%,
  - Average paid per visit decreased -21.4%, due to less emergent cases
- Urgent Care Utilization increased 52.6%
- Outpatient surgeries had decreases at both ASC and OP Facility settings
  - Procedures in ASC settings are more than double than those at OP setting
- IP Admits remained relatively flat from prior period
- Overall IP spend had a slight decreased of -3.3%

- Average length of stay went from an average of 5.8 to 6.2 days per stay Average length of stay increased 6.7%

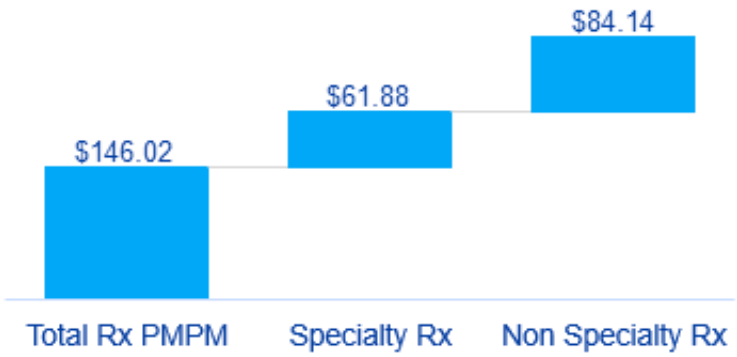
- 7 less maternity stays in the current period, a decrease of -39.5%

- NICU visits had a significant decrease of -43.6% in the current period. NICU avg. length of stay decreased by 64.0%

Pharmacy Data

	Prior	Current	Δ	Peer	Δ
Enrolled Members	6,815	6,731	-1.2%		
Average Prescriptions PMPY	17.3	17.3	-0.2%	11.6	49.5%
Formulary Rate	91.7%	87.7%	-4.4%	85.6%	2.4%
Generic Use Rate	85.4%	81.8%	-4.3%	81.0%	0.9%
Generic Substitution Rate	97.2%	98.2%	1.0%	97.9%	0.3%
Employee Cost Share PMPM	$21.70	$25.44	17.3%	$14.08	80.7%
Avg Net Paid per Prescription	$91.44	$101.46	11.0%	$105.64	-3.9%
Net Paid PMPM	$131.89	$146.02	10.7%	$101.68	43.6%

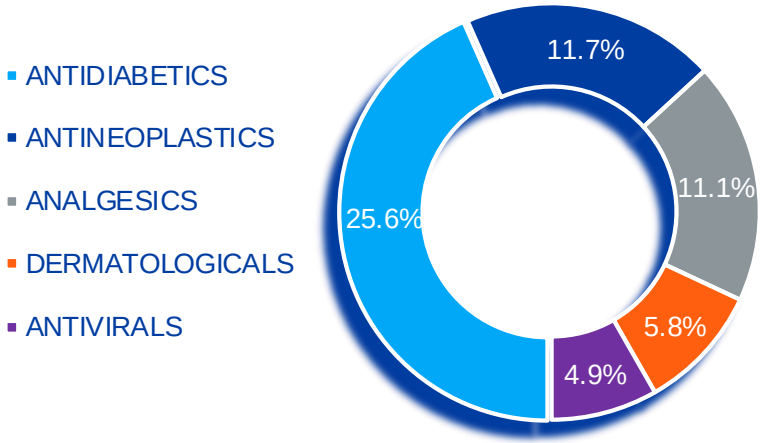
Paid By Benefit and Type



Pharmacy Spend is up 10.7% ($14.13 PMPM)

- Average net paid per script increased 11.0% (up $10.02 PMPM from prior period)
- Consistent with market trends; diabetic compliance is on the rise Antidiabetic Rx Spend increased 4.9%
- Specialty Rx Spend increased 11.6%
  Specialty Rx Drivers:
  *Humira (Analgesics, spend up 4.5%)
  *Stelara (Dermatologic, spend up 199.3%)
  *Aubagio(Psychotherapeutic, spend up 11.8%)
- Avg. Prescriptions PMPY decreased -0.2%

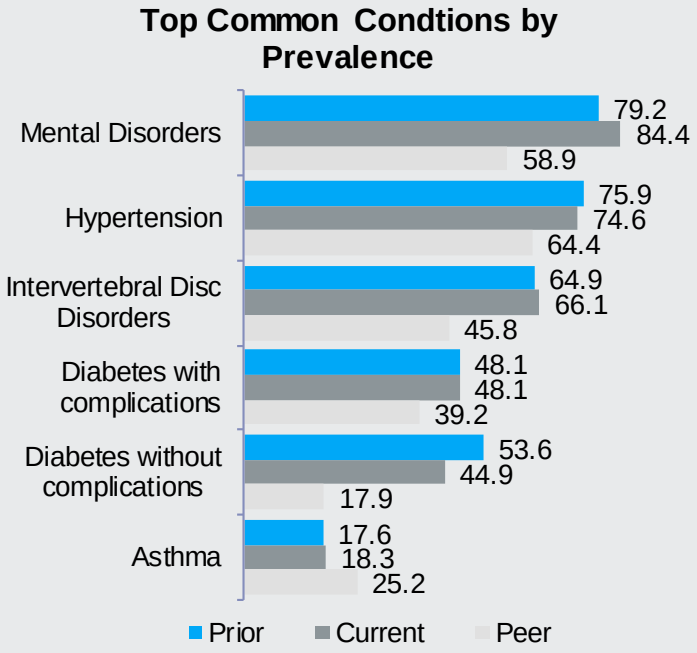
Top 5 Therapeutic Classes by Spend

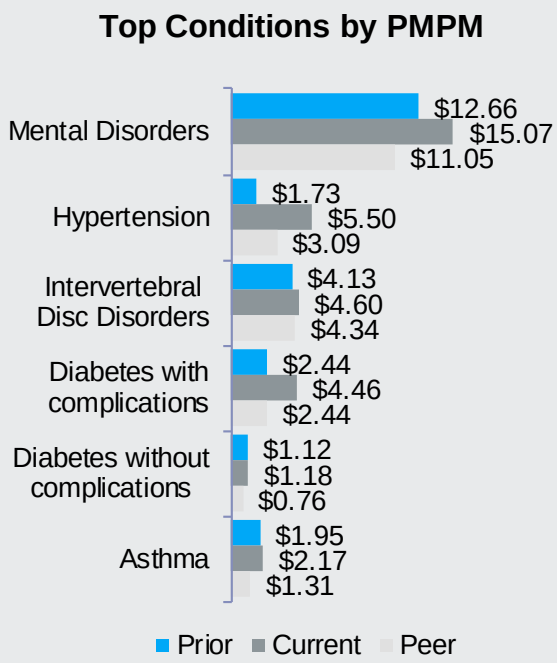


Condition Prevalence

Clinical Drivers

Clinical Conditions and Diagnosis





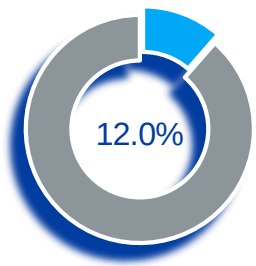
- Chronic illnesses continue to drive the top common conditions
- Mental Disorders, Hypertension and Intervertebral Disc Disorders are the most prevalent clinical conditions within this population for this period
- Mental Disorder prevalence increased 6.5% and had an increased in overall spend increased 19.0% (up,$2.41PMPM) from prior period
  - Spend for Alcohol related disorders increased 80.6%, up $0.91 PMPM from prior period
  - Autism spend increased 44.4% (ABA therapy) up $2.82 PMPM from prior period

Chronic Condition Cost Drivers

85.9% Of Medical spend driven by members with these 4 Chronic Conditions. Average Engagement 97%

Asthma

6.5% of Members

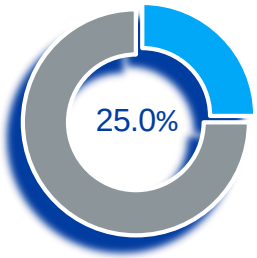


Average paid Per Claimant **$9,041.34**

Member Engagement **95.3%**

Cardio Hypertension

13.1% of Members

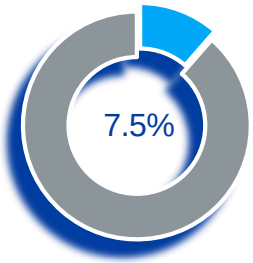


Average paid Per Claimant **$9,342**

Member Engagement **96.6%**

CAD

1.8% of Members

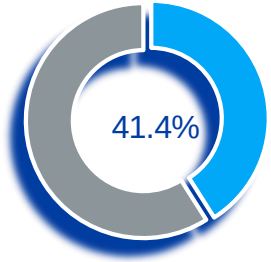


Average paid Per Claimant **$20,802**

Member Engagement **100.0%**

Diabetes

21.8% of Members



Average paid Per Claimant **$9,293**

Member Engagement **94.6%**

**Data obtained for this slide is for Eval period Nov-2020 thru Oct-2021*

Catastrophic Cases

High Cost Claimants

Catastrophic Cases Summary (>$50k)

UnitedHealthcare

6.23 Catastrophic Cases Per 1000

Prior: 4.04 ▲ 54.3%

45 Individuals (29 Prior Period)
0.62% of the population

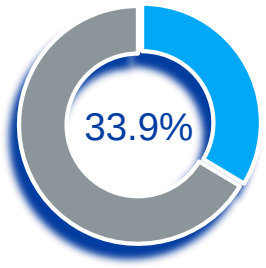
$124,005
Average Paid Per Case

Prior: $141,530 ▼ **12.4%**

% of Total Med/Rx Spend as High Cost: **25.8%**

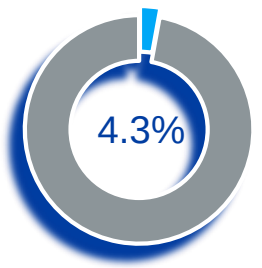
% Paid Attributed to Catastrophic Cases

Medical



HCC Spend ■ Non HCC

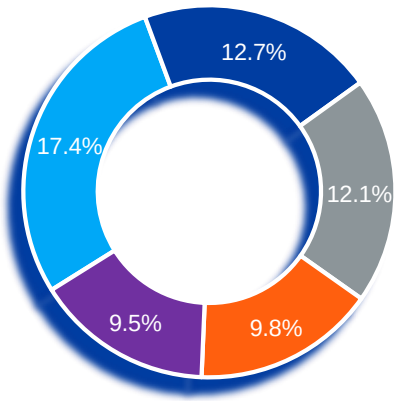
Pharmacy



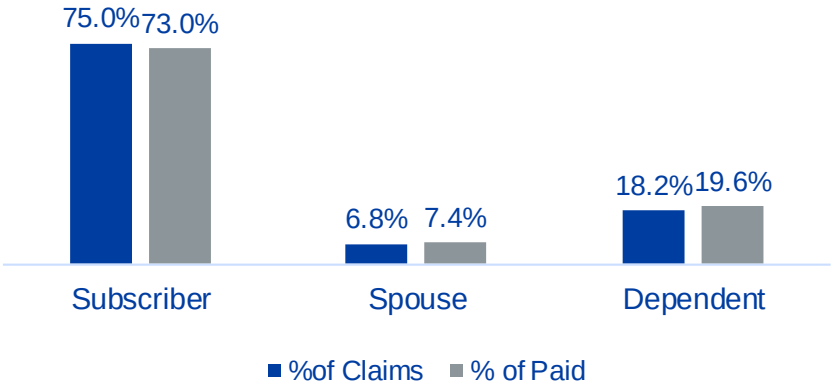
HCC Spend ■ Non HCC

Top 5 AHRQ Chapter Description by Paid

- Endocrine; Metabolic diseases
- Infectious and parasitic diseases
- Diseases of the respiratory system
- Diseases of the circulatory system
- Neoplasms



Claims and Spend by Relationship



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 December 31, 2021:

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 Insurance

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

4.3.6 AETNA Signature Administrators – PPO Network

4.3.7 HealthPlan of Nevada, Inc. – Southern HMO

4.3.8 Doctor on Demand Engagement Report

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 December 31, 2021:

        4.3.1 HealthSCOPE Benefits – Obesity Care Management

HSB DATASCOPE™

Obesity Care Management Report

Nevada Public Employees' Benefits Program

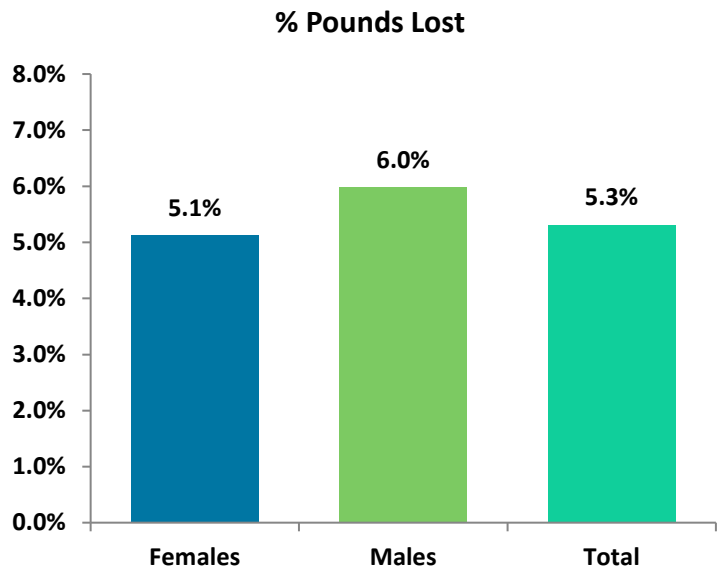
July – December 2021

HealthSCOPE BENEFITS

Obesity Care Management Overview

*Non-participant is defined as a member with morbid obesity chronic condition flag, but is not enrolled in the Obesity Care Management Program

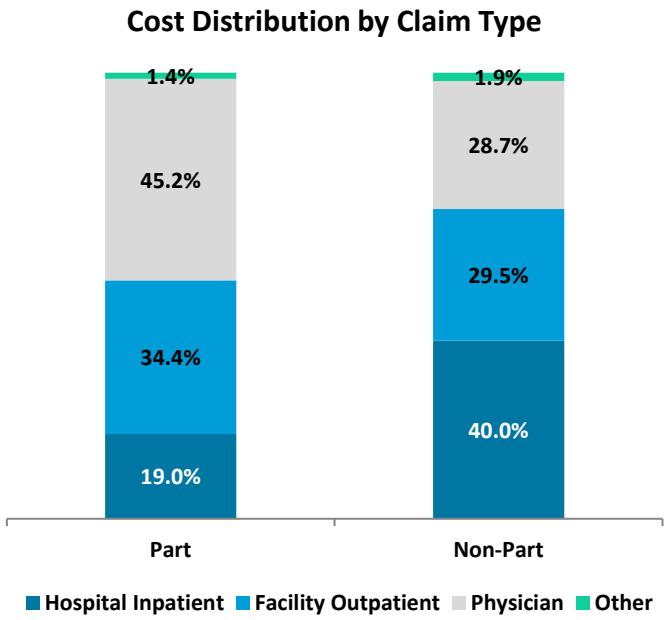
PEBP 2Q22			
Weight Management Summary	**Females**	**Males**	**Total**
# Mbrs Enrolled in Program	869	219	1,088
Average # Lbs. Lost	10.7	14.5	11.4
Total # Lbs. Lost	9,263.0	3,172.3	12,435.3
% Lbs. Lost	5.1%	6.0%	5.3%
Average Cost/ Member	$4,570	$6,038	$4,866



Obesity Care Management – Financial Summary

*Non-participant is defined as a member with morbid obesity chronic condition flag, but is not enrolled in the Obesity Care Management Program

Summary	Participants	Non-Participants	Variance
Enrollment			
Avg # Employees	947	810	17.0%
Avg # Members	1,052	1,035	1.6%
Member/Employee Ratio	1.1	1.3	-13.3%
Financial Summary			
Gross Cost	$3,264,199	$9,322,891	
Client Paid	$2,458,329	$8,045,431	
Employee Paid	$805,871	$1,277,460	
Client Paid-PEPY	$5,191	$19,878	-73.9%
Client Paid-PMPY	$4,673	$15,544	-69.9%
Client Paid-PEPM	$433	$1,656	-73.9%
Client Paid-PMPM	$389	$1,295	-70.0%
High Cost Claimants (HCC's) > $100k			
# of HCC's	2	12	
HCC's / 1,000	1.9	11.6	0.0%
Avg HCC Paid	$238,353	$196,778	0.0%
HCC's % of Plan Paid	19.4%	29.4%	0.0%
Cost Distribution - PMPY			
Hospital Inpatient	$887	$6,211	-85.7%
Facility Outpatient	$1,609	$4,579	-64.9%
Physician	$2,113	$4,455	-52.6%
Other	$64	$298	-78.5%
Total	$4,673	$15,544	-69.9%
	Annualized	Annualized	



Obesity Care Management – Utilization Summary

*Non-participant is defined as a member with morbid obesity chronic condition flag, but is not enrolled in the Obesity Care Management Program

Summary	Participants	Non-Participants	Variance
Inpatient Facility			
# of Admits	26	105	
# of Bed Days	83	525	
Paid Per Admit	$18,479	$28,584	-35.4%
Paid Per Day	$5,789	$5,717	1.3%
Admits Per 1,000	49	203	-75.9%
Days Per 1,000	158	1014	-84.4%
Avg LOS	3.2	5	-36.0%
# of Admits From ER	12	70	-82.9%
Physician Office			
OV Utilization per Member	9.9	9.5	4.2%
Avg Paid per OV	$111	$113	-1.8%
Avg OV Paid per Member	$1,096	$1,074	2.0%
DX&L Utilization per Member	16.0	22.4	-28.6%
Avg Paid per DX&L	$36	$79	-54.4%
Avg DX&L Paid per Member	$582	$1,758	-66.9%
Emergency Room			
# of Visits	110	188	
Visits Per Member	0.21	0.36	-41.7%
Visits Per 1,000	209	363	-42.4%
Avg Paid per Visit	$2,125	$2,015	5.5%
Urgent Care			
# of Visits	236	285	
Visits Per Member	0.45	0.55	-18.2%
Visits Per 1,000	449	551	-18.5%
Avg Paid per Visit	$84	$114	-26.3%
	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 December 31, 2021:

        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

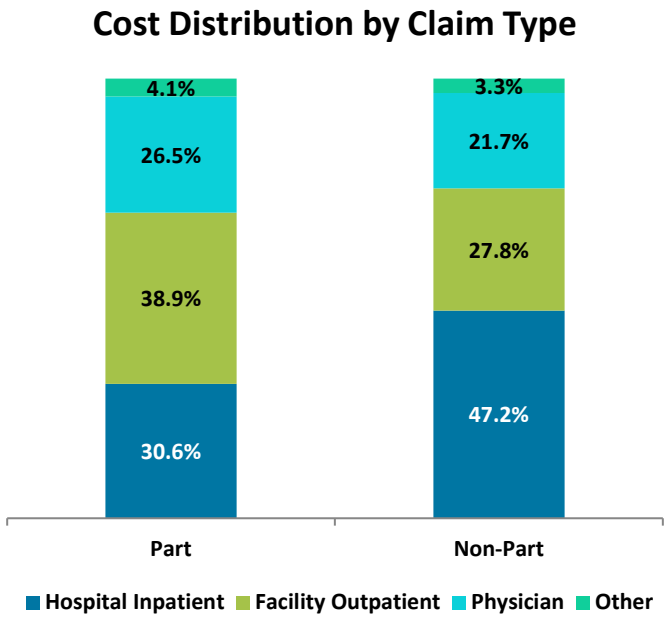
July – December 2021

HealthSCOPE BENEFITS

Diabetes Care Management – Financial Summary

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

Summary	Participants	Non-Participants	Variance
Enrollment			
Avg # Employees	323	1,921	-83.2%
Avg # Members	445	2,430	-81.7%
Member/Employee Ratio	1.4	1.3	9.5%
Financial Summary			
Gross Cost	$2,314,631	$17,904,014	
Client Paid	$1,798,797	$15,236,910	
Employee Paid	$515,834	$2,667,104	
Client Paid-PEPY	$11,127	$15,865	-29.9%
Client Paid-PMPY	$8,078	$12,542	-35.6%
Client Paid-PEPM	$927	$1,322	-29.9%
Client Paid-PMPM	$673	$1,045	-35.6%
High Cost Claimants (HCC's) > $100k			
# of HCC's	5	24	
HCC's / 1,000	11.2	9.9	0.0%
Avg HCC Paid	$176,737	$282,709	0.0%
HCC's % of Plan Paid	49.1%	44.5%	0.0%
Cost Distribution - PMPY			
Hospital Inpatient	$2,470	$5,926	-58.3%
Facility Outpatient	$3,142	$3,483	-9.8%
Physician	$2,138	$2,722	-21.5%
Other	$329	$411	-20.0%
Total	$8,078	$12,542	-35.6%
	Annualized	Annualized	



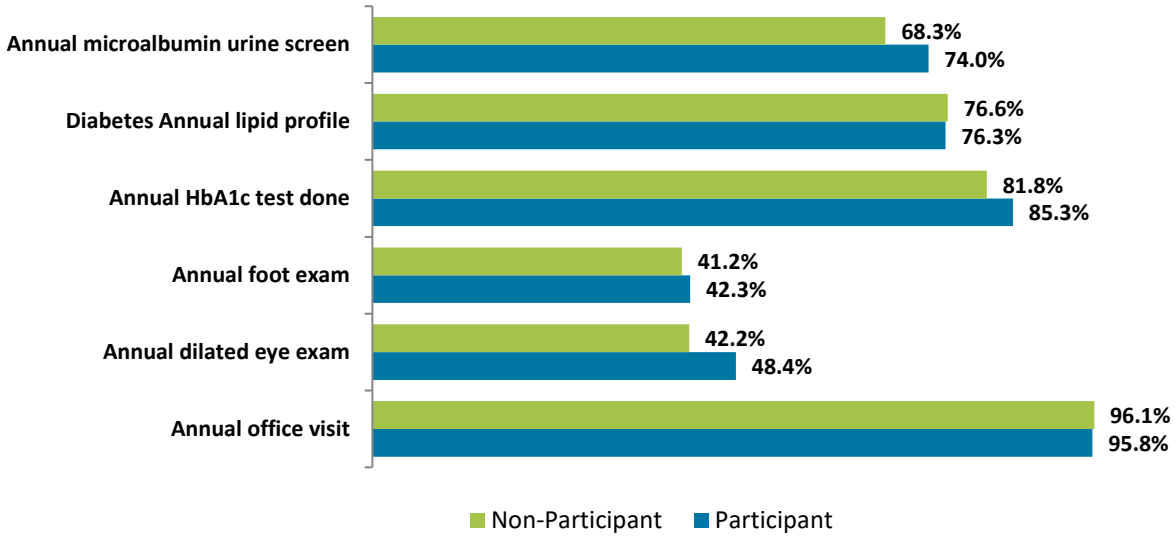
Diabetes Care Management – Utilization Summary

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

Summary	Participants	Non-Participants	Variance
Inpatient Facility			
# of Admits	17	173	
# of Bed Days	67	1,001	
Paid Per Admit	$22,490	$25,733	-12.6%
Paid Per Day	$5,706	$4,447	28.3%
Admits Per 1,000	76	142	-46.5%
Days Per 1,000	301	824	-63.5%
Avg LOS	3.9	5.8	-32.8%
# of Admits From ER	12	128	-90.6%
Physician Office			
OV Utilization per Member	7.7	8.4	-8.3%
Avg Paid per OV	$76	$91	-16.5%
Avg OV Paid per Member	$585	$768	-23.8%
DX&L Utilization per Member	16.9	21.5	-21.4%
Avg Paid per DX&L	$49	$65	-24.6%
Avg DX&L Paid per Member	$834	$1,391	-40.0%
Emergency Room			
# of Visits	36	334	
Visits Per Member	0.16	0.27	-40.7%
Visits Per 1,000	162	275	-41.1%
Avg Paid per Visit	$1,668	$2,441	-31.7%
Urgent Care			
# of Visits	62	449	
Visits Per Member	0.28	0.37	-24.3%
Visits Per 1,000	278	370	-24.9%
Avg Paid per Visit	$44	$107	-58.9%
	Annualized	Annualized	

Quality Metrics

		Participant				Non-Participant			
Condition	Metric	#Members in Group	#Meeting Metric	#Not Meeting Metric	% Meeting Metric	#Members in Group	#Meeting Metric	#Not Meeting Metric	% Meeting Metric
Diabetes	Annual office visit	312	299	13	95.8%	2,289	2,199	90	96.1%
	Annual dilated eye exam	312	151	161	48.4%	2,289	965	1,324	42.2%
	Annual foot exam	312	132	180	42.3%	2,289	943	1,346	41.2%
	Annual HbA1c test done	312	266	46	85.3%	2,289	1,872	417	81.8%
	Diabetes Annual lipid profile	312	238	74	76.3%	2,289	1,753	536	76.6%
	Annual microalbumin urine screen	312	231	81	74.0%	2,289	1,563	726	68.3%



All member counts represent members active at the end of the report period.
Quality Metrics are always calculated on an incurred basis.

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 December 31, 2021:

        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

October 1, 2021 – December 31, 2021

AmericanHealth
American Health Holding Inc

Table of Contents

Executive Overview

- Return on Investment

Medical Management Summary

- Utilization Management
- Case Management
- Post-Discharge Counseling

Executive Overview

AmericanHealth
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Overview

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

All data included is as of **January 31, 2021** and covers the reporting period of **October 1, 2021 – December 31, 2021**; 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 – 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

July 1, 2021 - September 30, 2021			
	Fees	Estimated Savings	ROI
Utilization Management	$188,253	$2,793,444	14.8 to 1
Case Management	$281,575	$1,926,684	6.8 to 1
Total	$469,828	$4,720,128	10.0 to 1

Utilization Management Breakout	
Inpatient Savings	$1,410,226
Outpatient Savings	$1,383,218

October 1, 2021 - December 31, 2021			
	Fees	Estimated Savings	ROI
Utilization Management	$187,628	$3,229,261	17.2 to 1
Case Management	$282,531	$2,356,421	8.3 to 1
Total	$470,159	$5,585,682	11.9 to 1

Utilization Management Breakout	
Inpatient Savings	$2,282,313
Outpatient Savings	$946,948

Utilization Management

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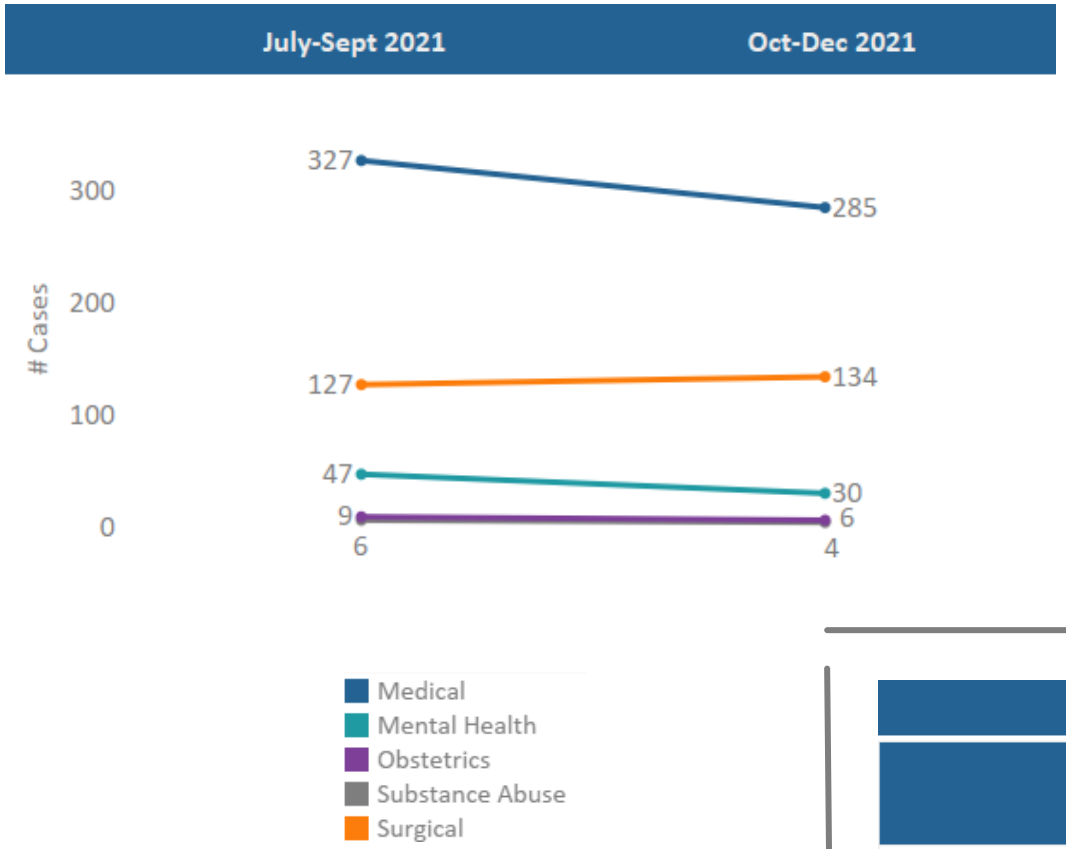
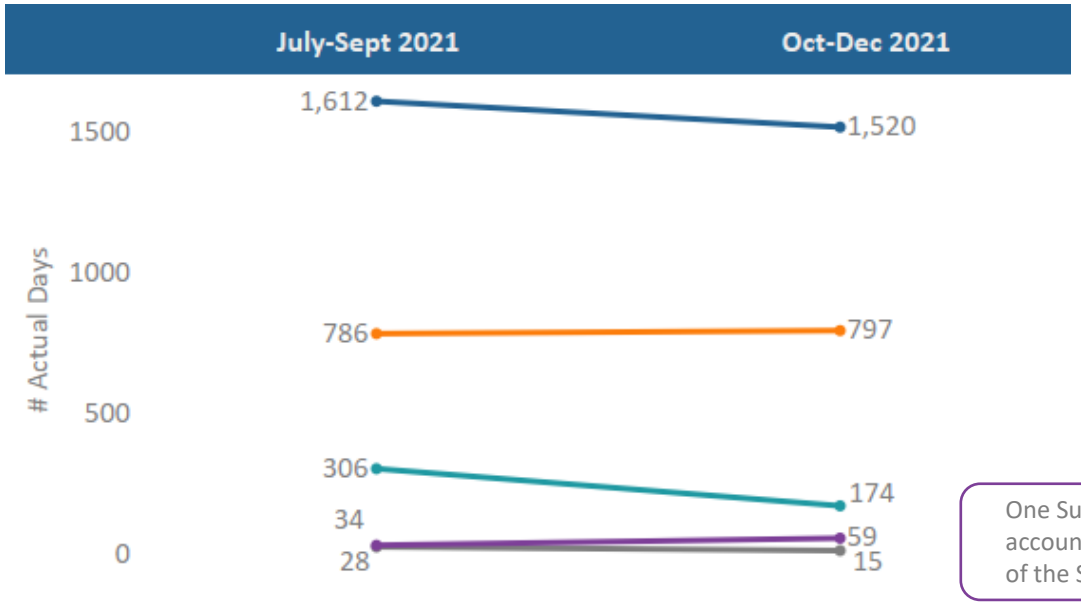
Acute Inpatient Activity Summary





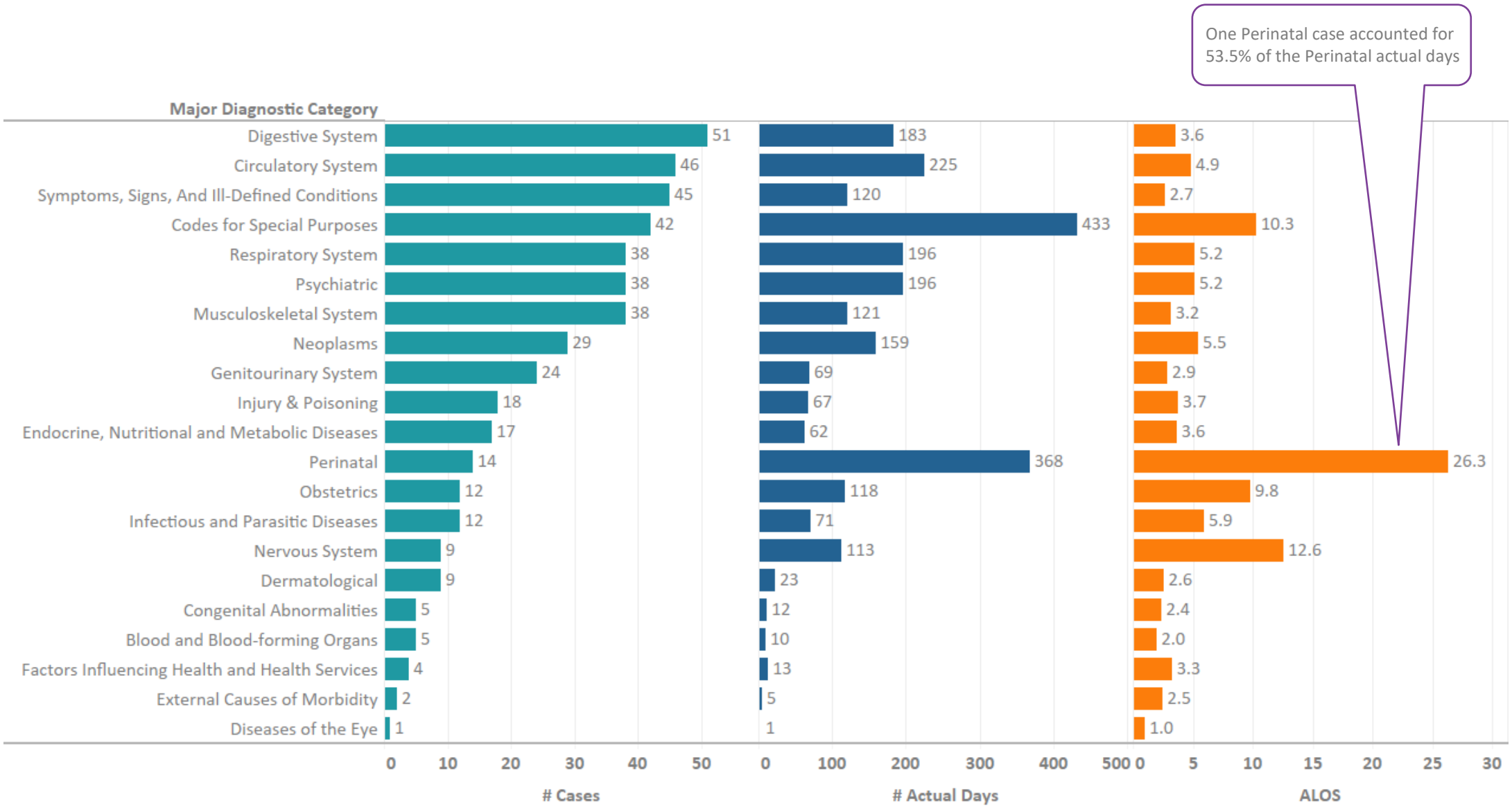
One Surgical case accounted for 49.1% of the Surgical savings

Utilization Review Process

Days Saved: 218
Estimated Savings: $2,237,729

October 1, 2021 - December 31, 2021						
	Cases	Actual Days	Requested Days	Approved Days	Saved Days	Estimated Savings
Medical	285	1,520	1,535	1,433	102	$672,588
Surgical	134	797	803	695	108	$1,548,396
Mental Health	30	174	176	169	7	$11,095
Obstetrics	6	59	59	58	1	$5,650
Substance Abuse	4	15	15	15	0	$0
Grand Total	**459**	**2,565**	**2,588**	**2,370**	**218**	**$2,237,729**

Acute Inpatient – Case and Actual Days by Diagnostic Categories



Acute Inpatient Activity – Utilization Benchmarks

Admissions per 1,000

- During the report period, medical and mental health acute inpatient admissions were above the Milliman benchmarks
  - **30** medical members had **2 or more** inpatient admissions

Days per 1,000

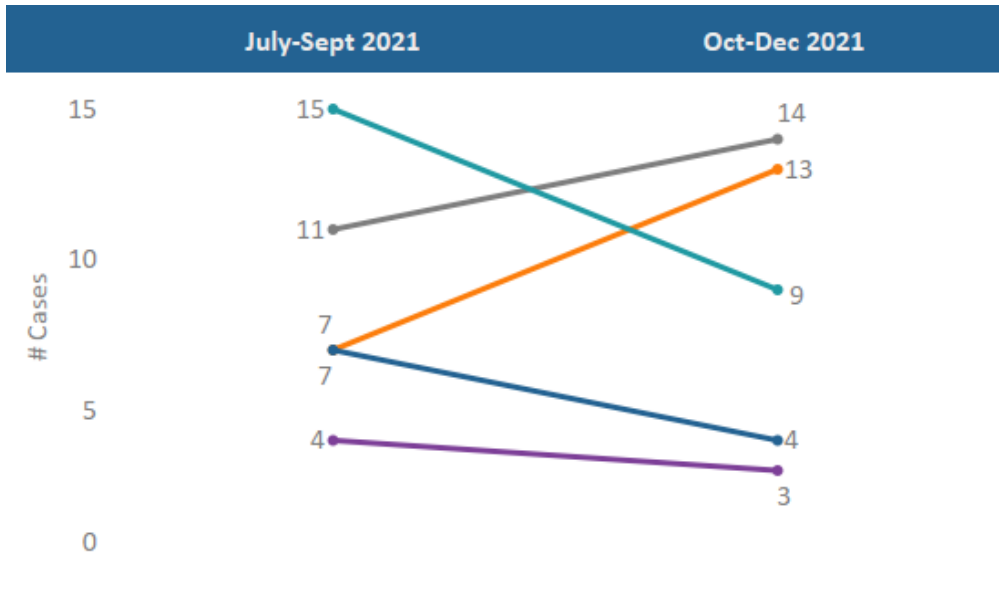
- During the report period, medical and mental health acute inpatient days per 1,000 were above the Milliman benchmarks
  - **38** medical cases utilized **10 or more** days during the report period
  - **1** surgical case utilized **197** days during the report period

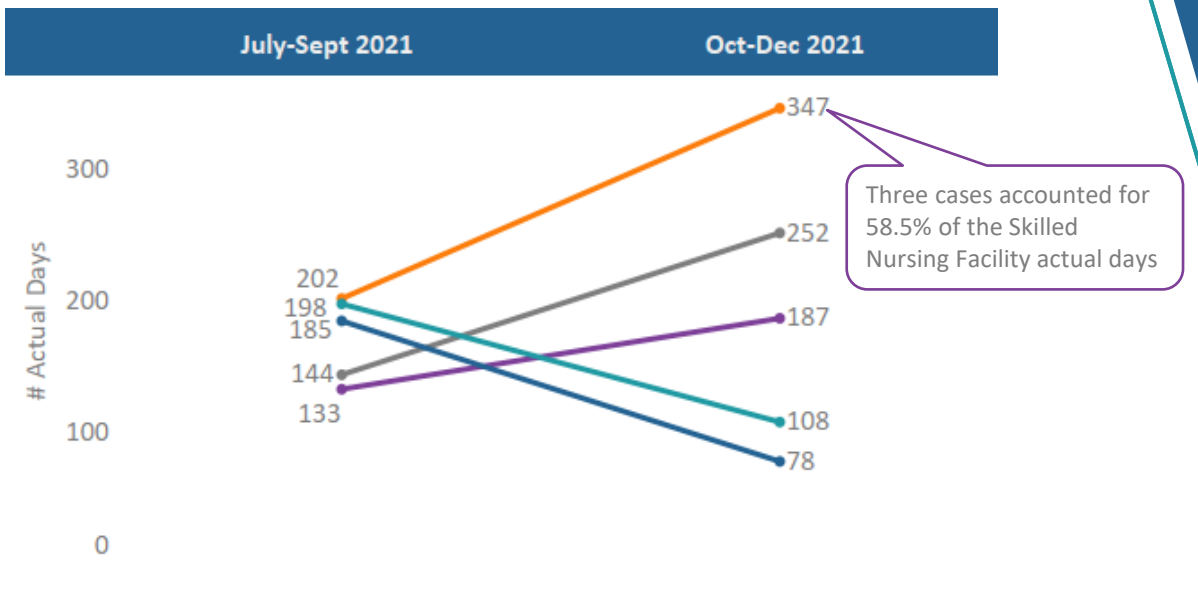
Average Length of Stay

- During the report period, medical, obstetrics, and surgical ALOS were above the Milliman benchmark
  - **95 of the 285** medical cases were above the benchmark during the report period
  - **All 6** obstetrics cases were above the benchmark during the report period
  - **36 of the 134** surgical cases were above the benchmark during the report period

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





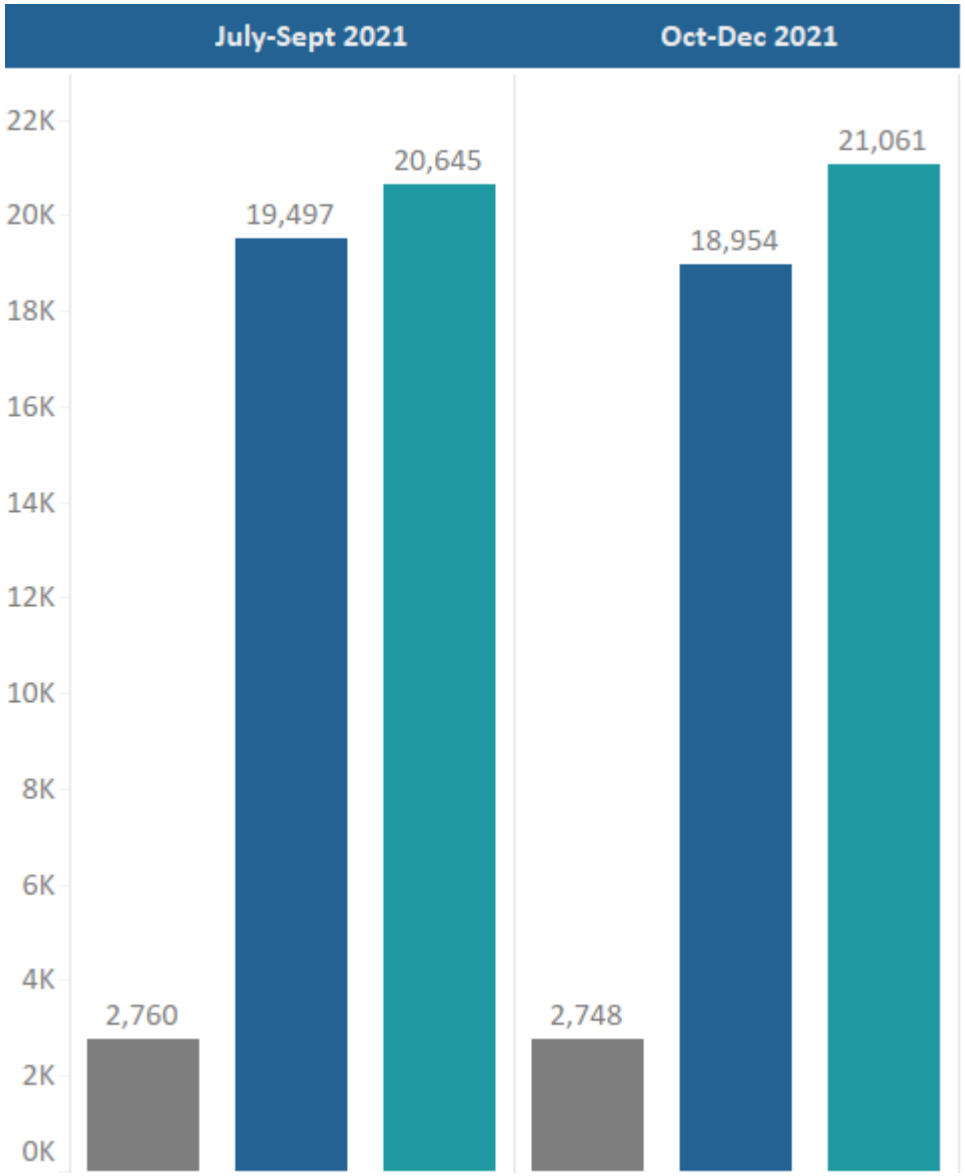
Long Term Acute
Medical Rehab
Residential Mental Health
Residential Substance Abuse
Skilled Nsg Facility

Utilization Review Process

Days Saved: 25
Estimated Savings: $44,584

October 1, 2021 - December 31, 2021						
	Cases	Actual Days	Requested Days	Approved Days	Saved Days	Estimated Savings
Residential Substance Abuse	14	252	255	252	3	$3,024
Skilled Nsg Facility	13	347	347	338	9	$6,003
Medical Rehab	9	108	113	103	10	$26,780
Long Term Acute	4	78	79	77	2	$8,044
Residential Mental Health	3	187	187	186	1	$733
Grand Total	**43**	**972**	**981**	**956**	**25**	**$44,584**

Outpatient Activity Summary



October 1, 2021 - December 31, 2021					
Outpatient Setting	# Cases	# Units Requested	# Units Approved	# Units Saved	Outpatient Savings
Diagnostic Test	1,651	2,098	1,861	237	$337,583
Surgery	593	986	966	20	$33,095
Med Treatment	214	5,803	5,411	392	$517,633
DME	172	8,754	7,412	1,342	$17,980
Home Health	55	567	508	59	$11,053
MH/SA	34	561	508	53	$29,603
Home Infusion	20	605	601	4	$0
PT/OT/ST	4	100	100	0	$0
Home Private Duty	2	1,400	1,400	0	$0
Hospice Home	1	90	90	0	$0
Home Enteral Feeding	1	95	95	0	$0
23 Hour Observation	1	2	2	0	$0
Grand Total	**2,748**	**21,061**	**18,954**	**2,107**	**$946,948**

2 cases accounted for 39.1% of the Med Treatment savings

Utilization Review Process

Units Saved: 2,107
Estimated Savings: $946,948

Case Management Referrals from Utilization Management

A critical function of Utilization Management is to identify members who are in need of more extensive Case Management services. One procedure that fulfills this function is the trigger of Utilization Management cases that meet specific requirements to Case Management.

Inpatient Referrals					
	# Cases	# Cases Referred to CM	% Cases Referred to CM	# Referrals Accepted in CM	% Referrals Accepted in CM
Oct-Dec 2021	502	315	62.7%	222	70.5%

Outpatient Referrals					
	# Cases	# Cases Referred to CM	% Cases Referred to CM	# Referrals Accepted in CM	% Referrals Accepted in CM
Oct-Dec 2021	2,748	621	22.6%	22	3.5%

Case Management

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Case Management Summary

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

Total Case Management Savings

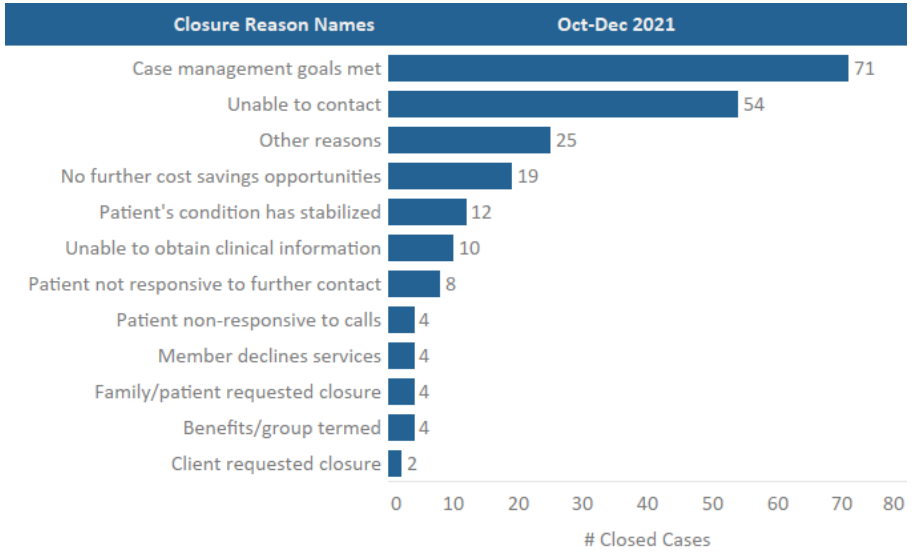
$2,356,421

Average Savings per Case = $6,619

Based on 356 cases in an open state between 10/1/2021 – 12/31/2021

Number of Cases

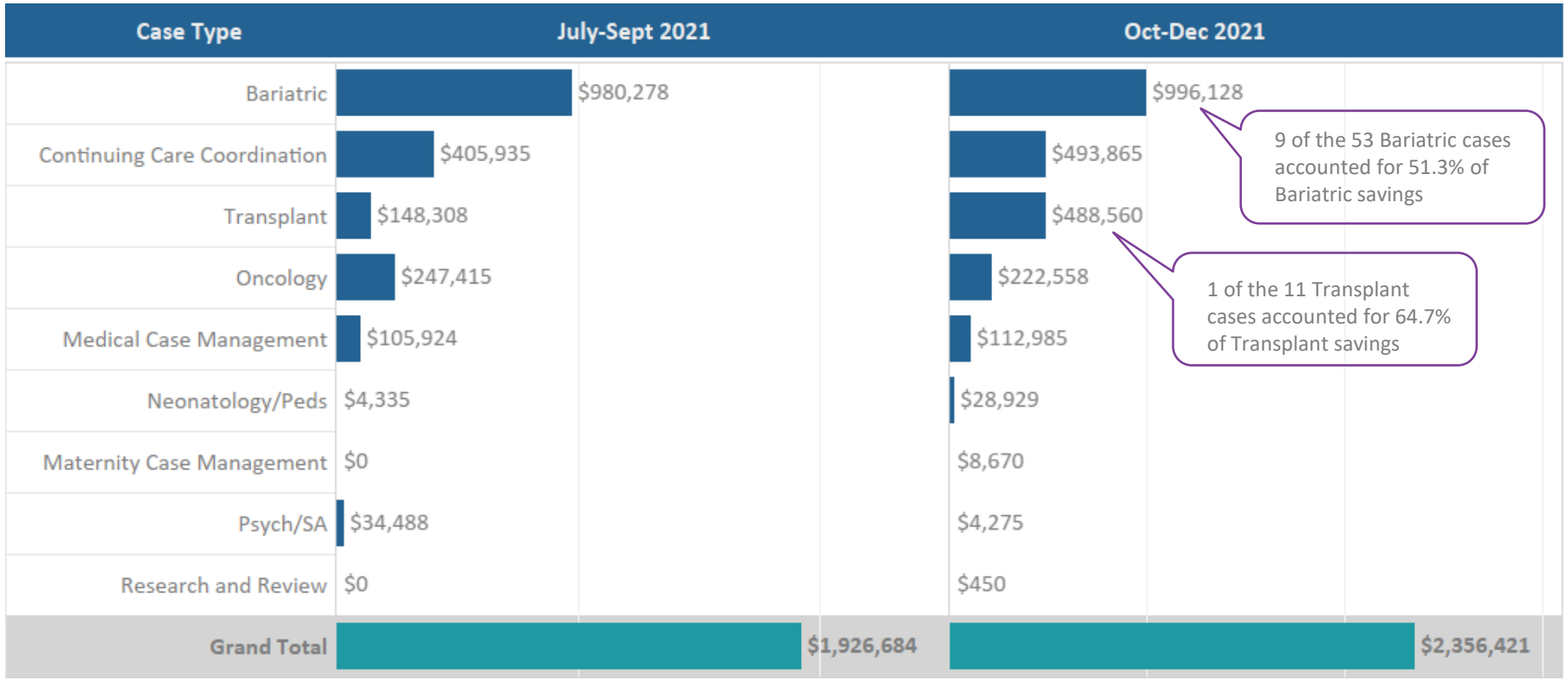
Case Activity	July-Sept 2021	Oct-Dec 2021
# Beginning Cases	193	189
# Opened Cases	247	167
# Closed Cases	251	181
# Ending Cases	189	175



Case Type	Oct-Dec 2021
Continuing Care Coordination	88
Short Term CM	57
Oncology	53
Bariatric	53
Advocacy	49
Medical Case Management	17
Psych/SA	12
Transplant	11
Neonatology/Peds	10
Research and Review	3
Maternity Case Management	2
Rehabilitation	1
Grand Total	**356**

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

Case Management – Savings by Case Type



Case Management – Savings by Source

Savings Type	Case Type	July-Sept 2021	Oct-Dec 2021
Managed	Averted Inpatient Admission	$986,266	$1,036,979
	Steerage to Transplant Network	$123,400	$642,600
	Services Not Medically Necessary	$194,284	$366,674
	Averted Medical Complications	$113,445	$216,056
	Averted Usage of Services	$131,593	$79,340
	Steerage to Network Providers	$355,824	$14,771
	Days Saved via Intervention	$1,162	$0
	Recommended Benefit Exceptions	$20,710	$0
Grand Total		$1,926,684	$2,356,421

Post-Discharge Counseling

AmericanHealth
American Health Holding Inc

Post-Discharge Counseling Summary

The diagram below illustrates the total number of candidates for readmission within the reporting period identified for Post-Discharge Counseling, regardless of whether the member participated in a counseling call and whether the member experienced readmission within 30 days after discharge.

375*
Candidates

Members with Potential for readmission during the report period

*Due to a 30-day requirement to identify a readmission, the referral and call participant populations may differ from the readmission candidate population.

13
Participants

Members with potential for readmission during the report period participated in a program call

0
Participants

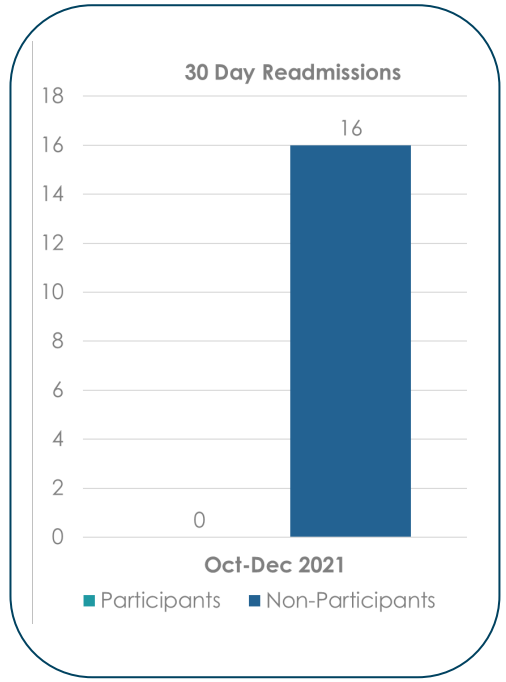
# of participating members with readmissions

362
Non-Participants

Members with potential for readmission during the report period did not participate in a program call

16
Non-Participants

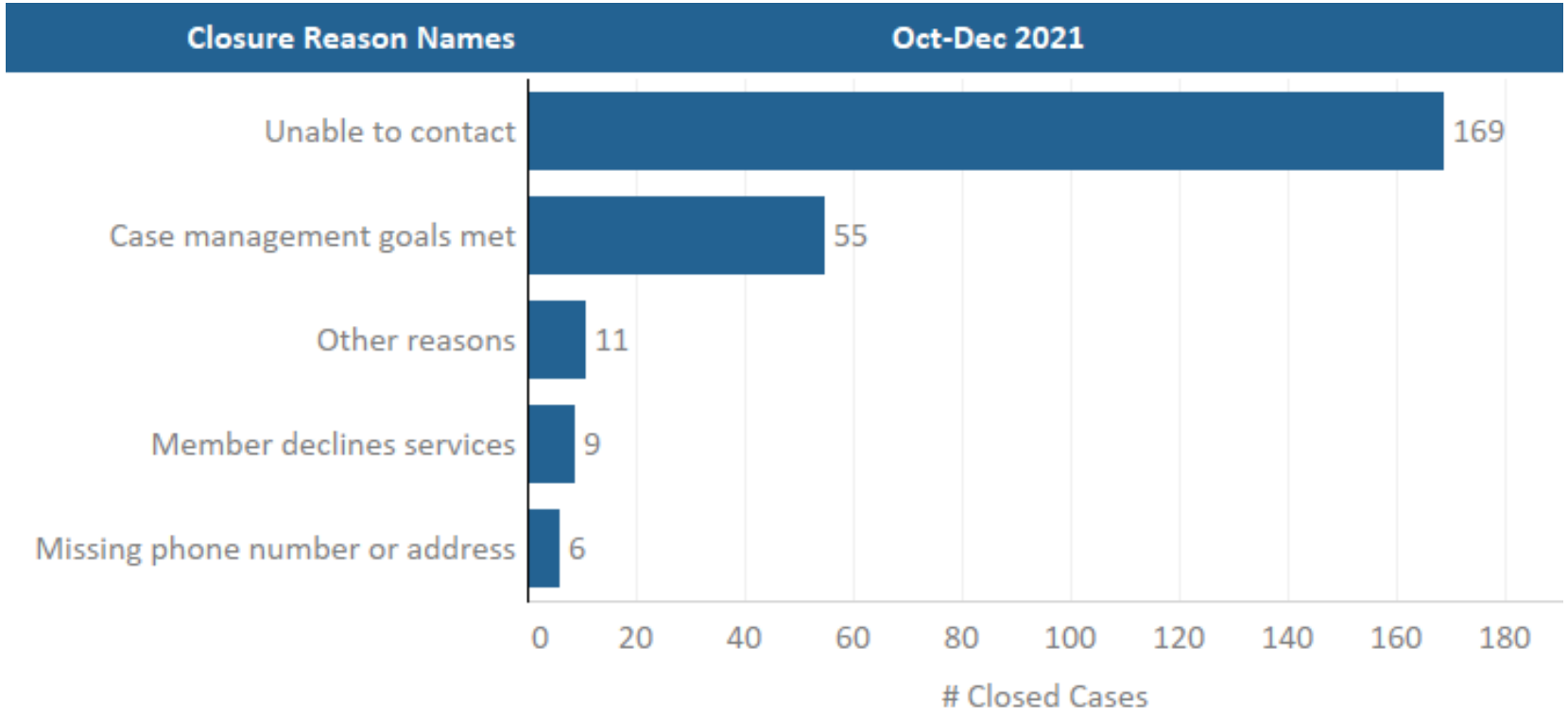
# of non-participating members with readmissions



Due to the small number of participants, any conclusions regarding outcomes must be interpreted with caution.

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.



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 December 31, 2021:

        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 Insurance

The Standard

Quarterly Report: Basic Life Insurance
Quarter Ending
December 31, 2021

Report Table of Contents

Basic Life Insurance & Long Term Disability Executive Summary	Page 3
Basic Life Insurance Claims by Plan Year and Participant Type	Page 4
Basic Life Insurance Claims by Diagnostic Category	Page 4
Basic Life Insurance Earned Premiums & Liability by Participant Type	Page 5
Basic Life Retiree Insurance Earned Premiums & Liability by Participant Type	Page 6
Claim Appeals	Page 7

Basic Life Insurance Executive Summary

This is the second quarter report for the 2021-22 plan year, providing information for the period beginning July 1, 2017 and ending December 31, 2021.

Basic Life

At the half-way point of the current plan year, Basic Life incidence (page 4) is down year-over-year for active members and for retirees. At this time last year, the overall incidence rate was 2.5 claims/1,000 lives; this year, it has decreased to 1.0. We are receiving a large amount of life claims currently and anticipate a significant increase in life claims for the third quarter reporting.

From a loss ratio perspective (page 5), the loss ratio for active members is down slightly from 25% last year to 20% this year. For retirees, the loss ratio is down, from 286% compared to 324% last year. Historically, the highest claim activity for PEBP is in the 3rd quarter of the plan year, so we will see how the life claims we are receiving currently will affect next quarter's results.

PEBP's life claims are very consistent year-over-year from a diagnosis standpoint (page 4) when compared to the rest of The Standard's public sector block. Incidence and liability remain higher than our block for Circulatory and Respiratory claims and lower for Cancer.

Basic Life Insurance Claims by Plan Year and Participant Type

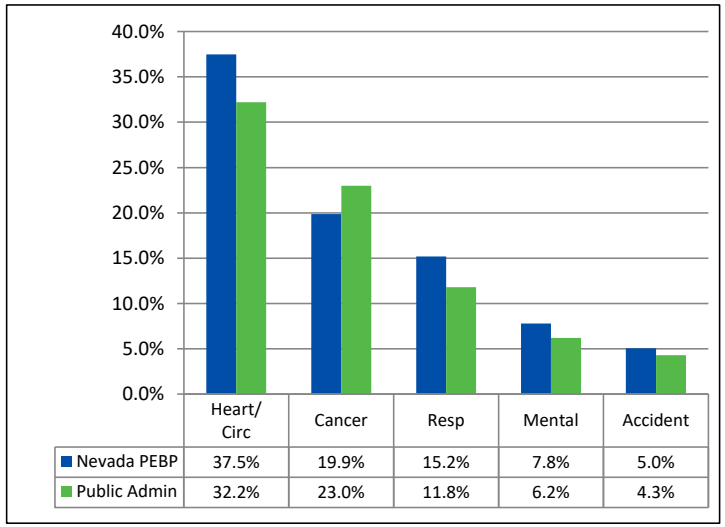
Most Recent Five Plan Years: July 01, 2017 to December 31, 2021

	From Jul-17 Through Jun-18		From Jul-18 Through Jun-19		From Jul-19 Through Jun-20		From Jul-20 Through Jun-21		From Jul-21 Through Jun-22	
Participant Type	**Count**	**Inc./ 1000**	**Count**	**Inc./ 1000**	**Count**	**Inc./ 1000**	**Count**	**Inc./ 1000**	**Count**	**Inc./ 1000**
Actives	41	1.6	47	1.8	47	1.7	66	2.5	17	0.7
Retirees	295	19.5	279	17.8	298	18.9	341	21.4	25	1.5
Totals	**336**	**8.6**	**326**	**8.1**	**345**	**8.4**	**407**	**9.5**	**42**	**1.0**

Basic Life Insurance Claims by Diagnostic Category

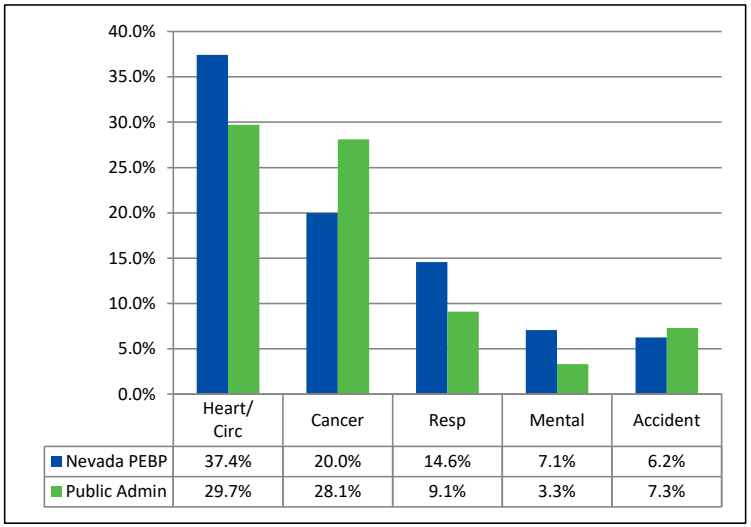
Public Admin benchmark is from SIC book of business for most recent 5 calendar years

Top Five Diagnostic Categories by Incidence



	Heart/ Circ	Cancer	Resp	Mental	Accident
Nevada PEBP	37.5%	19.9%	15.2%	7.8%	5.0%
Public Admin	32.2%	23.0%	11.8%	6.2%	4.3%

Top Five Diagnostic Categories by Liability

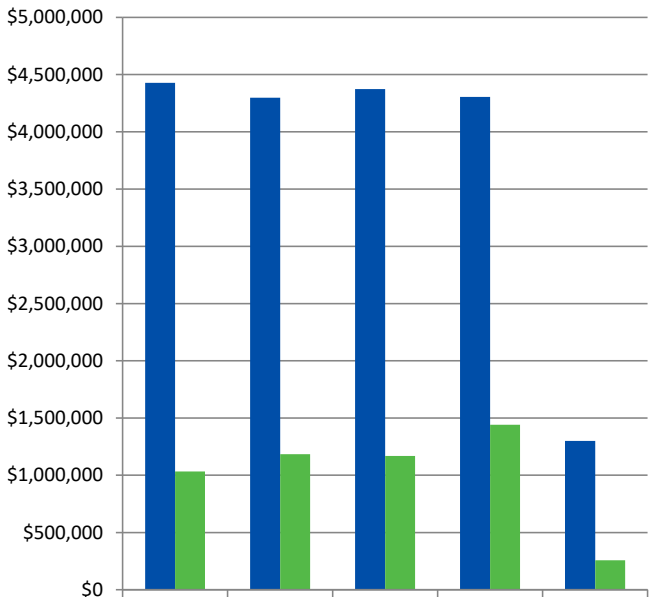


	Heart/ Circ	Cancer	Resp	Mental	Accident
Nevada PEBP	37.4%	20.0%	14.6%	7.1%	6.2%
Public Admin	29.7%	28.1%	9.1%	3.3%	7.3%

Basic Life Insurance Earned Premiums & Liability by Participant Type

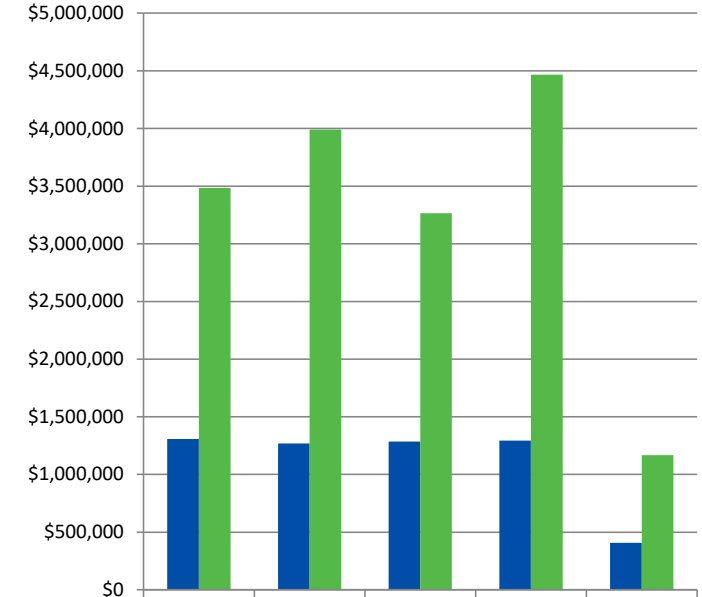
Most Recent Five Plan Years: July 01, 2017 to December 31, 2021

Active Participants



	2017 - 18	2018 - 19	2019 - 20	2020 - 21	2021 - 22
Earned Premium	$4,427,366	$4,297,629	$4,373,406	$4,304,373	$1,299,942
Claim Liability	$1,031,986	$1,184,218	$1,167,764	$1,440,302	$258,485
Loss Ratio	0.23	0.28	0.27	0.33	0.20

Retired Participants

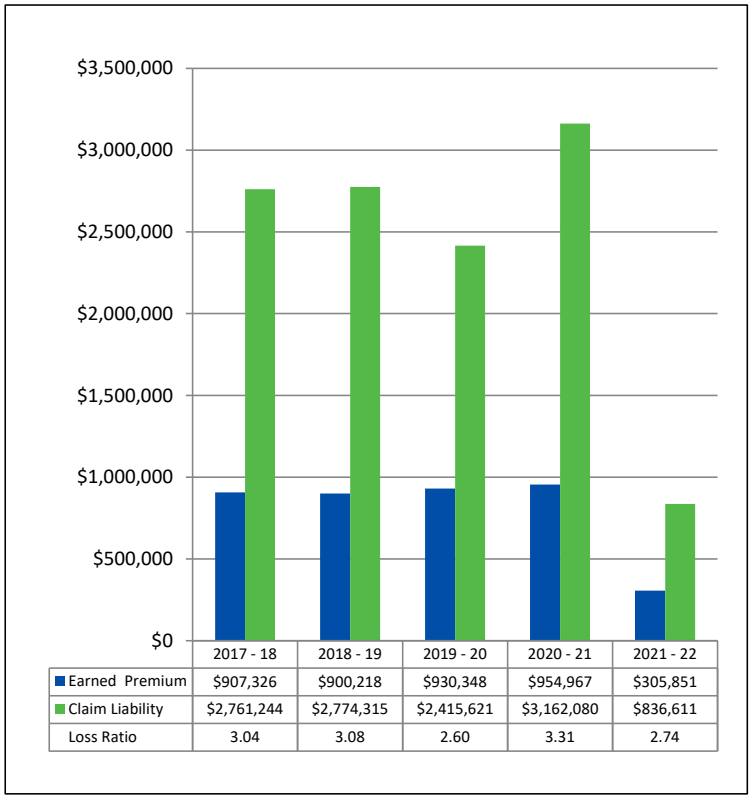


	2017 - 18	2018 - 19	2019 - 20	2020 - 21	2021 - 22
Earned Premium	$1,306,604	$1,267,917	$1,284,882	$1,292,752	$407,795
Claim Liability	$3,485,155	$3,989,557	$3,265,674	$4,465,982	$1,167,170
Loss Ratio	2.67	3.15	2.54	3.45	2.86

Basic Life Retiree Insurance Earned Premiums & Liability by Participant Type

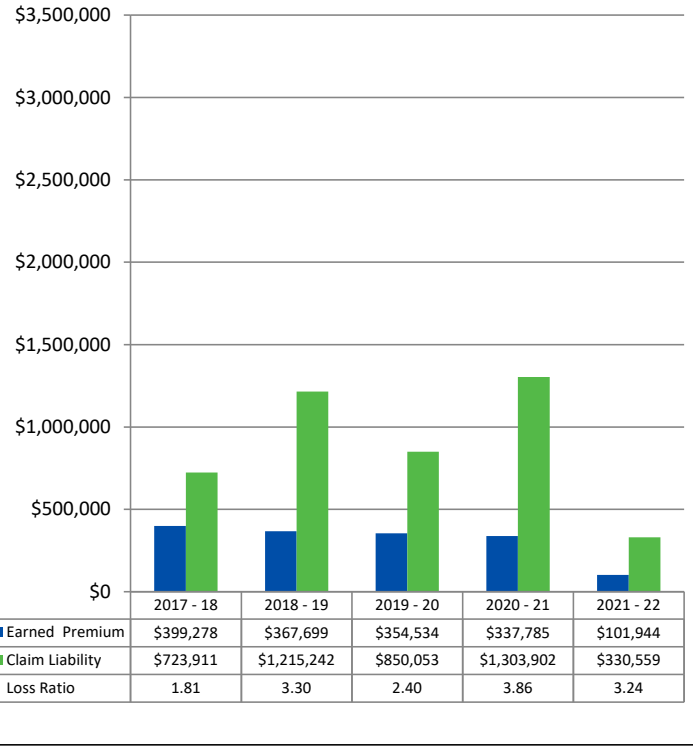
Most Recent Five Plan Years: July 01, 2017 to December 31, 2021

State Retired Participants



	2017 - 18	2018 - 19	2019 - 20	2020 - 21	2021 - 22
Earned Premium	$907,326	$900,218	$930,348	$954,967	$305,851
Claim Liability	$2,761,244	$2,774,315	$2,415,621	$3,162,080	$836,611
Loss Ratio	3.04	3.08	2.60	3.31	2.74

Non-State Retired Participants



	2017 - 18	2018 - 19	2019 - 20	2020 - 21	2021 - 22
Earned Premium	$399,278	$367,699	$354,534	$337,785	$101,944
Claim Liability	$723,911	$1,215,242	$850,053	$1,303,902	$330,559
Loss Ratio	1.81	3.30	2.40	3.86	3.24

Claim Appeals

Quarterly Update for Plan Year to Date July 01, 2021 to December 31, 2021

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

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 December 31, 2021:

        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 Insurance

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

Public Employees Benefit Program

February 10, 2022

Quarterly Update –2nd Quarter Plan Year 2022

Willis Towers Watson's Individual Marketplace

The Public Employees Benefit Program Executive Dashboard

Quarterly Update – 2nd Quarter Plan Year 2022

Executive Summary

Plan Enrollment:

- At the end of FY Q2 2022, PEBP's total enrollment into Medicare policies through Willis Towers Watson's Individual Marketplace decreased to 11,374. Since inception, 114 carriers have been selected by PEBP's retirees with current enrollment in 1,708 different plans.
- Medicare Supplement (MS) plan selection increased to 89% of the total population with the majority of participants selecting AARP and Anthem BCBS of Nevada as their insurer; each carrier holds plans for 6,267 and 2,123 enrollees respectively. The average monthly premium cost for MS plans remained consistent at $146.
- The percentage of Medicare Advantage (MA or MAPD) plans selected decreased to 11%. Top MA carriers include Aetna with 497 individual plan selections and AARP with 258 individual plan selections. The average monthly premium cost to PEBP participants decreased to $13 compared to the prior quarter of $14.

Customer Satisfaction:

- In Q2 2022, PEBP participant satisfaction with Enrollment Calls had an average satisfaction score result of 4.3 out of 5.0 based on 68 surveys returned.
- For Q2 2022, the average satisfaction score for Service Calls was 4.2 out of 5.0 based on 472 surveys returned.
- The combined average satisfaction score for Enrollment Calls and Service Calls was 4.2 out of 5.0 for Q2 2022.

Health Reimbursement Arrangement:

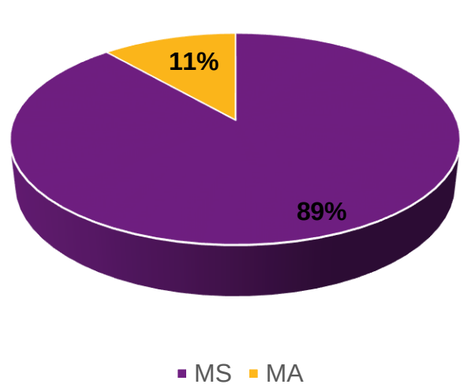
- At the end of Q2 2022 there were 13,613 Health Reimbursement Arrangement (HRA) accounts for PEBP participants.
- There were 85,427 claims processed in Q2, with 95% being submitted via Auto-Reimbursement, meaning that participants did not have to manually submit 81,505 claims for Premium Reimbursement.
- The total reimbursement amount processed for Q2 was $8,112,884.

Summary of Retiree Decisions and Costs

Retiree Plan Selection Through 12/31/2021		Previous Qtr.
Total enrolled through individual marketplace	11,374	12,023
Number of carriers**	114	111
Number of plans**	1,708	1,569

Plan Type Selection Through 12/31/2021		Previous Qtr.
Medicare Advantage (MA, MAPD)	1,306	1,805
Medicare Supplement (MS)	10,088	10,226

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	10,088	$146
Medicare Advantage (MA,MAPD)	1,306	$0 / $13
Part D drug coverage	7,084	$23
Dental coverage	1,085	$38
Vision coverage	2,050	$11

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

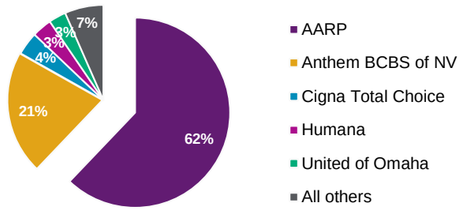
The Public Employees Benefit Program Executive Dashboard

Quarterly Update – 2nd Quarter Plan Year 2022

Summary of Retiree Carrier Choice

Top Medicare Supplement Plans	Total
AARP	6,267
Anthem BCBS of NV	2,123
Cigna Total Choice	396
Humana	340
United of Omaha	298

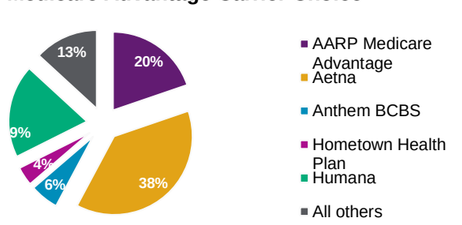
Medicare Supplement Carrier Choice



Cost Data For MS Plans	Cost
Minimum	$22
Average	$146
Median	$140
Maximum	$481

Top Medicare Advantage Plans	Total
AARP Medicare Advantage	258
Aetna	497
Anthem BCBS	77
Hometown Health Plan	51
Humana	251

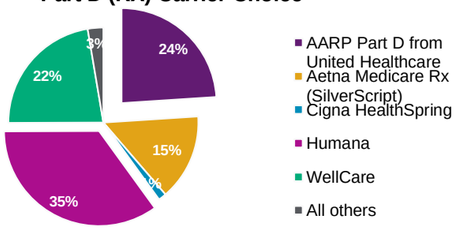
Medicare Advantage Carrier Choice



Cost Data For MA Plans	Cost
Minimum	$0
Average	$13
Median	$0
Maximum	$194

Top Medicare Part D (RX)	Total
AARP Part D from United Healthcare	1,698
Aetna Medicare Rx (SilverScript)	1,041
Cigna HealthSpring	96
Humana	2,474
WellCare	1,587

Part D (RX) Carrier Choice



Cost Data For Part D (RX)	Cost
Minimum	$6
Average	$23
Median	$16
Maximum	$127

The Public Employees Benefit Program Executive Dashboard

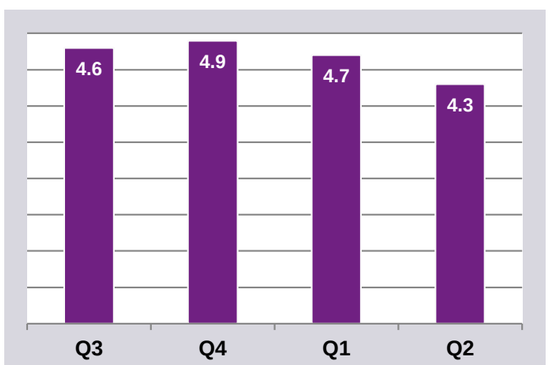
Quarterly Update – 2nd Quarter Plan Year 2022

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

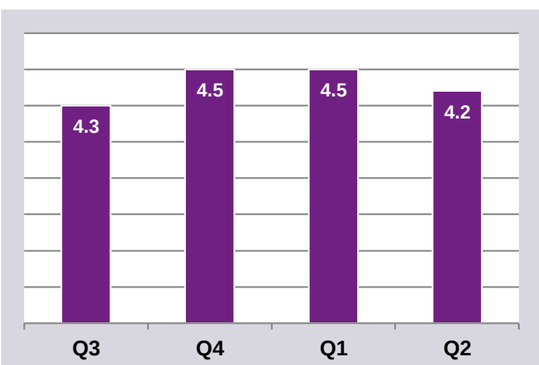
Q2 Enrollment Satisfaction

CSAT score	Count	%
5	39	57%
4	17	25%
3	5	7%
2	4	6%
1	3	4%
	68	**100%**



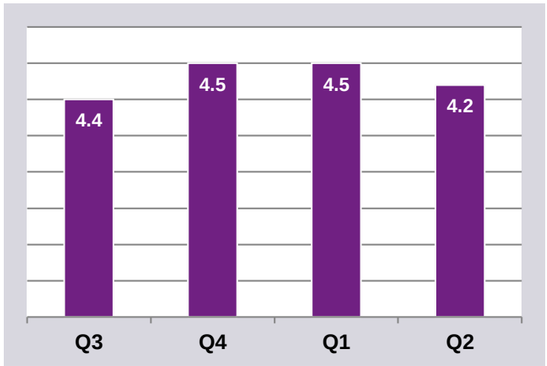
Q2 Service Satisfaction

CSAT score	Count	%
5	285	60%
4	77	16%
3	53	11%
2	20	4%
1	37	8%
	472	**100%**



Q2 Enrollment & Service Combined

CSAT score	Count	%
5	324	60%
4	94	17%
3	58	11%
2	24	4%
1	40	7%
	540	**100%**

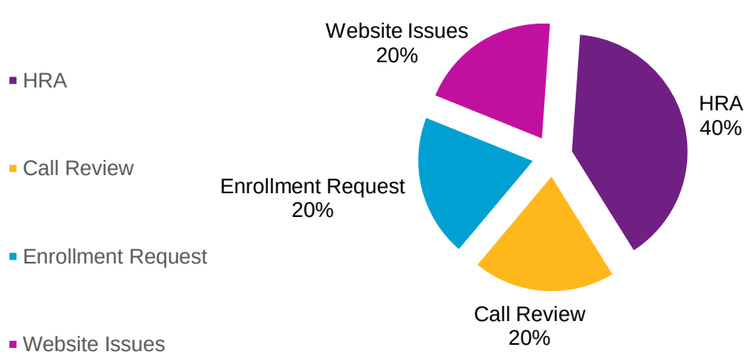


The Public Employees Benefit Program Executive Dashboard

Quarterly Update – 2nd Quarter Plan Year 2022

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 Q2-PY22 is 10 and are associated with the following categories:



Health Reimbursement Account (HRA)

Claim Activity for the Qtr.	Total
HRA accounts	13,616
Number of payments	54,517
Accounts with no balance	7,493
Claims paid amount	$8,112,884.37

Claims By Source	Total 85,427
A/R file	81,505
Mail	1,702
Web	1,679
Mobile App	541

The Public Employees Benefit Program Executive Dashboard

Quarterly Update – 2nd Quarter Plan Year 2022

Performance Guarantees*

Category	Commitment	Outcome	PG MET
Claims Turnaround Time	≤ 2 days	0.49 Days	Yes
Claim Financial Accuracy	≥ 98%	99.04%	Yes
Claim Processing Payment Precision	≥ 98%	Results not Reported on Benefits Accounts	Yes
Reports	≤ 15 business days	Met	Yes
HRA Web Services	≥ 99%	99.30%	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.	8 Minutes 37 Seconds	No
Benefits Administration Customer Service Abandonment Rate Annual	≤ 5%	8.8%	No
Customer Satisfaction	≥ 80%	88.15%	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.

The Public Employees Benefit Program Executive Dashboard

Quarterly Update – 2nd Quarter Plan Year 2022

Operations Report

Medicare Open Enrollment Plan Changes for 2022

The Medicare Open Enrollment Season for 2022 occurred from October 15, 2021 – December 7, 2021. The below chart captures information on the number of participants that made changes in their existing Medicare Medical or Prescription Drug Plan. There a significant increase in the number of participants who changed their Medicare Advantage Plan (MAPD). We saw 1,411 participants change from one MAPD to another MAPD for the 2022 plan year where we saw 888 participants make the same change for plan year 2021. This increase is likely attributed to participants continuing to be more health conscious due to the impacts of COVID-19. We also saw a significant increase in the number of participants who changes Prescription plans for 2022. This year 1,732 Nevada PEBP participants changed Rx plans compared to only 762 changes for 2021. In total, there were 3,262 plan changes for 2022 compared to 1,819 for 2021.

Original Plan	New Plan	1/1/2022 Changes	1/1/2021 Changes
Medicare Supplement	Medicare Supplement	39	77
Medicare Supplement	Medicare Advantage	72	75
Medicare Advantage	Medicare Advantage	1,411	888
Medicare Advantage	Medicare Supplement	8	17
Prescription Drug Plan	Prescription Drug Plan	1,732	762

Spring Retiree Meetings

Historically, WTW and Nevada PEBP hold three days of retiree meetings in the Spring 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 pandemic, we are still not able to have the live in person meetings. Instead, we will be holding two days of virtual meetings with two meetings per day. The virtual meetings will be held on March 21 and 22. Links for participants to register for the meetings are available on the main page of our Nevada PEBP specific Website at https://my.viabenefits.com/PEBP

Meeting Date/Time	Meeting Type
March 21 - 9:30 am PT	Pre-Medicare/Ageing into Medicare
March 21 – 12:00 pm PT	HRA/Medicare Open Enrollment
March 22 – 11:30 am PT	Pre-Medicare/Ageing into Medicare
March 22 - 2:00 pm PT	HRA/Medicare Open Enrollment

The Public Employees Benefit Program Executive Dashboard

Quarterly Update – 2nd Quarter Plan Year 2022

Operations Report

Communications:

Below is information on communications that were mailed or will be coming up.

- Spring Newsletter
  - This communication is sent to participants via email and are generally targeted to be sent in April. 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 Balance Reminder is scheduled to be mailed in mid/late February.

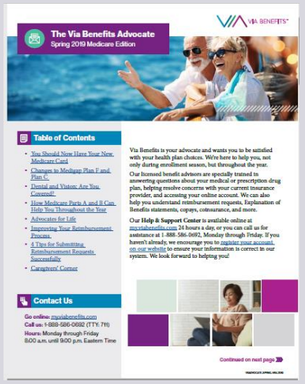

The Via Benefits Advocate
Spring 2019 Medicare Edition

Table of Contents

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

Contact Us

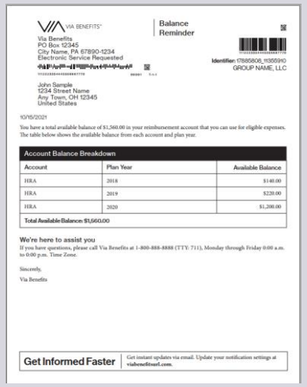
Go online: mypublicbenefits.com
Call us: 1-888-586-0682 (TTY 711)
Hours: Monday through Friday 8:00 a.m. until 9:00 p.m. Eastern Time

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

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

Our **Help & Support Center** is available online at mypublicbenefits.com 24 hours a day, or you can call us for assistance at 1-888-586-0682, Monday through Friday. If you haven't already, we encourage you to register your account on our website to ensure your information is correct in our system. We look forward to helping you!

Continued on next page


Via Benefits
PO Box 12345
City Name, PA 67890-1234
Electronic Service Requested

Balance Reminder

Identifier: 0180808_1055990
GROUP NAME, LLC

John Sample
1234 Street Name
Any Town, OH 12345
United States

10/15/2021

You have a total available balance of $1,560.00 in your reimbursement account that you can use for eligible expenses. The table below shows the available balance from each account and plan year.

Account Balance Breakdown		
Account	Plan Year	Available Balance
HRA	2018	$140.00
HRA	2019	$220.00
HRA	2020	$1,200.00
Total Available Balance: $1,560.00		

We're here to assist you
If you have questions, please call Via Benefits at 1-800-888-8888 (TTY: 711), Monday through Friday 8:00 a.m. to 8:00 p.m. *Time Zone*.

Sincerely,
Via Benefits

Get Informed Faster | Get instant updates via email. Update your notification settings at viabenefitsurl.com.

HRA Available Balance Cap of $8,000:

Effective May 31, 2022, we will process the annual $8,000 HRA Available Balance Cap reduction on accounts with a balance of more then $8,000. Nevada PEBP is planning on sending communications related to this Cap in late March to participants with balances of $7,000 or greater as they are expected to be the ones who will potentially be impacted by the Cap this year. The goal of the communication is to remind participants to submit claims against their balance to reduce it below the $8,000 threshold so they do not lose any of their HRA balance. Once funds are removed because they are over the $8,000 cap, they cannot be added back.

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 December 31, 2021:

        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 Insurance

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

        4.3.6 AETNA Signature Administrators – PPO Network

ASA Performance Guarantee Summary

HealthSCOPE-State of Nevada

	Frequency	Standard	October	November	December	Q4
Reporting by Aetna						
Repricing Accuracy	Quarterly	97%		-----		100%
Timely Claims Repricing within 3 Days	Quarterly	97%		-----		97%
Timely Claims Repricing within 5 Days	Quarterly	99%		-----		98%

4.3.7

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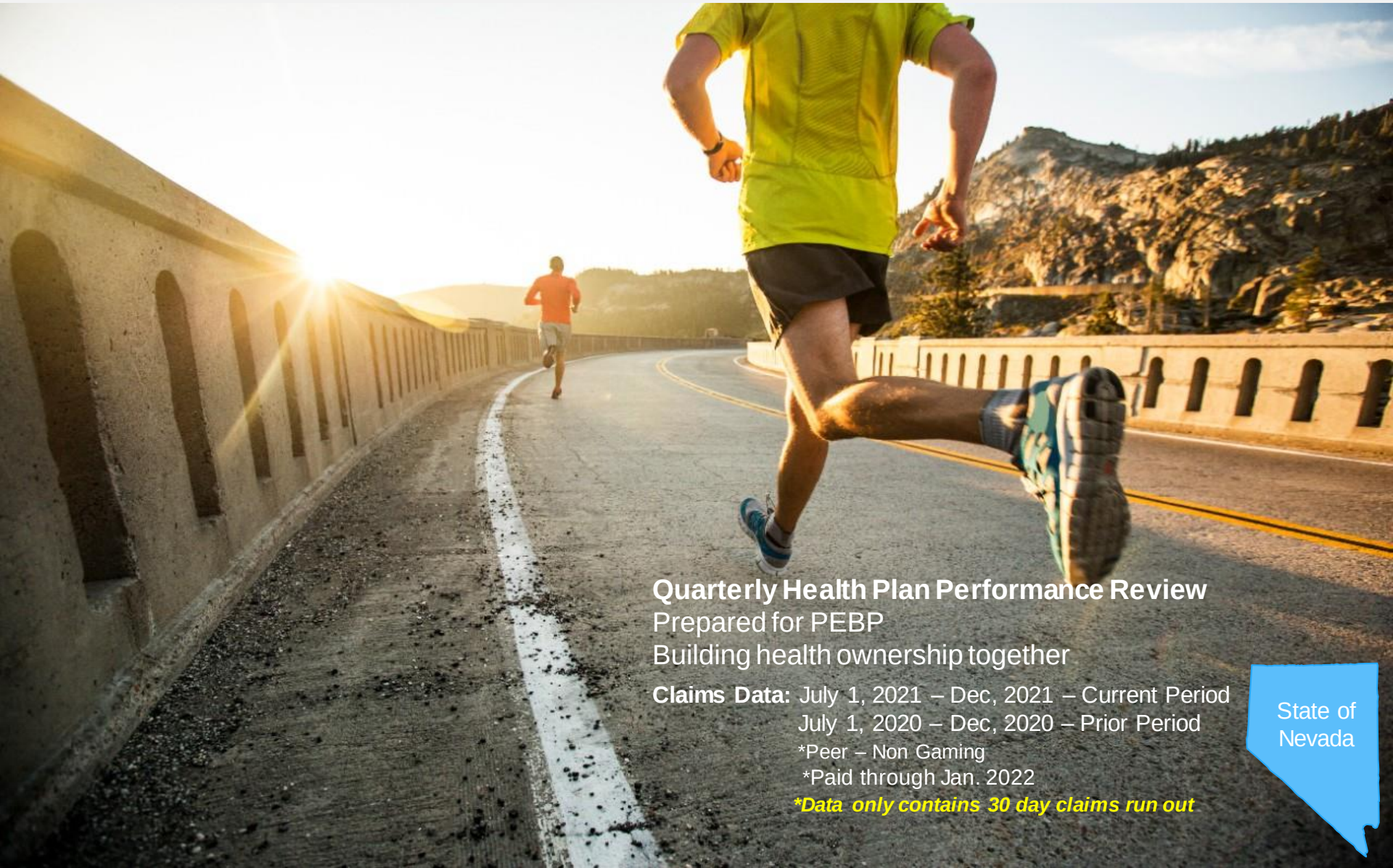
        4.3.6 Hometown Health Providers and Sierra Healthcare Options – PPO Network

        4.3.7 HealthPlan of Nevada, Inc. – Southern Nevada HMO

Power Of Partnership.



Quarterly Health Plan Performance Review
Prepared for PEBP
Building health ownership together

Claims Data: July 1, 2021 – Dec, 2021 – Current Period
July 1, 2020 – Dec, 2020 – Prior Period
*Peer – Non Gaming
*Paid through Jan. 2022
Data only contains 30 day claims run out

State of Nevada

Key Performance Indicators

Includes Demographics And Financials

39 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
- ✓ 2 ambulatory surgery centers
- ✓ 55,000 sq ft state-of-the-art cancer center
- ✓ Saturday appointments with primary care

Enhancements Made for Your Members

- ✓ Provided COVID-19 testing and vaccinations at multiple locations throughout the Las Vegas area, including drive through locations.
- ✓ Introduced the **Tummy2Toddler pregnancy support app** helping mothers stay healthy during every step of pregnancy and early childhood.
- ✓ NowClinic and Walgreens now offering same-day medication delivery
- ✓ Added HCA hospitals and 17 Care Now Urgent Cares to the network
- ✓ Real Appeal weight loss program
- ✓ Dispatch Health to provide at home urgent visits

Demographic and Financial Overview

UnitedHealthcare

Demographics

Membership	Age	Famiy size	Dependents <18	HHS Risk
Members: 6,731 Employees: 3,815 Prior: 6,815 3,918 -1.2%	37.1 Prior : 37.2 Norm: 35.4 -0.3%	1.76 Prior : 1.74 Norm: 1.8 1.4 %	22.9% Prior: 22.5 Norm: 22.7 2.1%	1.47 Prior: 1.49 Norm: 1.24 4.4%

Medical and Rx Spend

10.4%

Medical PMPM
$389.36

Prior $352.70
Norm: $319.55

Utilization

Inpatient: ▲ 1.2%
Outpatient: ▼ -18.0%
Professional: ▲ 1.5%

Spend

Inpatient: ▼ -3.3%
Outpatient: ▲ 7.6%
Professional: ▲ 24.1%

10.5%

Overall PMPM
$535.38

Prior: $484.59
Norm: $421.23

11.6%
Specialty Rx
$61.88

Prior: $55.44
Norm: $53.28

-0.2%
Avg. Scripts PMPY
17.3

Prior: 17.3
Norm: 11.6

10.7%

Rx PMPM
$146.02

*Specialty Rx accounts for **42.4%** of Rx Spend*

Prior: $131.89
Norm: $101.68

Medical and Rx Plan Experience

What Happened

Highlights of Utilization

UnitedHealthcare

Key Metrics			
Utilization Metric	Prior	Current	Δ
Physician Office Vists PMPY	2.5	2.4	-4.8%
Specialist Office Vists PMPY	4.6	4.9	5.9%
ER Visits per K	100.5	103.5	3.0%
UC Visits per K	546.3	833.6	52.6%
On Demand	503.5	585.5	16.3%
OutPatient Surgery			
ASC	120.0	113.2	-5.7%
Facility	42.6	30.0	-29.5%
Inpatient Utilization			
Admissions Per K	60.0	60.8	1.2%
Bed Days Per K	350.7	378.8	8.0%
Average Length of Stay	5.8	6.2	6.7%

**Not representative of all Utilization*

Highlights

- PCP Visits decreased in the current period, down -4.8%
- Specialist Office visits increased 5.9%
- ER utilization increased 3.0%,
  - Average paid per visit decreased -21.4%, due to less emergent cases
- Urgent Care Utilization increased 52.6%
- Outpatient surgeries had decreases at both ASC and OP Facility settings
  - Procedures in ASC settings are more than double than those at OP setting
- IP Admits remained relatively flat from prior period
- Overall IP spend had a slight decreased of -3.3%

- Average length of stay went from an average of 5.8 to 6.2 days per stay Average length of stay increased 6.7%

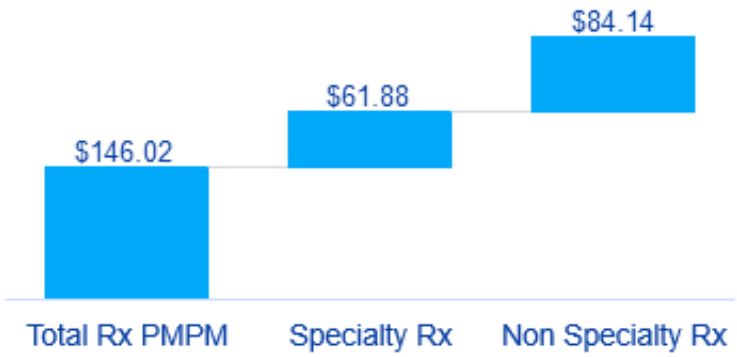
- 7 less maternity stays in the current period, a decrease of -39.5%

- NICU visits had a significant decrease of -43.6% in the current period. NICU avg. length of stay decreased by 64.0%

Pharmacy Data

	Prior	Current	Δ	Peer	Δ
Enrolled Members	6,815	6,731	-1.2%		
Average Prescriptions PMPY	17.3	17.3	-0.2%	11.6	49.5%
Formulary Rate	91.7%	87.7%	-4.4%	85.6%	2.4%
Generic Use Rate	85.4%	81.8%	-4.3%	81.0%	0.9%
Generic Substitution Rate	97.2%	98.2%	1.0%	97.9%	0.3%
Employee Cost Share PMPM	$21.70	$25.44	17.3%	$14.08	80.7%
Avg Net Paid per Prescription	$91.44	$101.46	11.0%	$105.64	-3.9%
Net Paid PMPM	$131.89	$146.02	10.7%	$101.68	43.6%

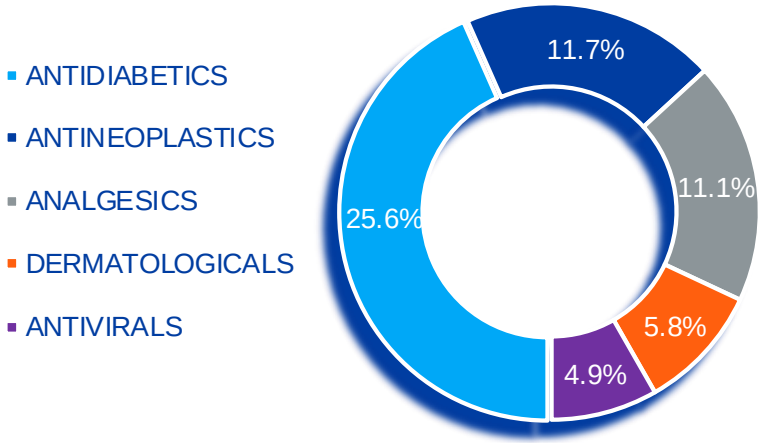
Paid By Benefit and Type



Pharmacy Spend is up 10.7% ($14.13 PMPM)

- Average net paid per script increased 11.0% (up $10.02 PMPM from prior period)
- Consistent with market trends; diabetic compliance is on the rise Antidiabetic Rx Spend increased 4.9%
- Specialty Rx Spend increased 11.6%
  Specialty Rx Drivers:
  *Humira (Analgesics, spend up 4.5%)
  *Stelara (Dermatologic, spend up 199.3%)
  *Aubagio(Psychotherapeutic, spend up 11.8%)
- Avg. Prescriptions PMPY decreased -0.2%

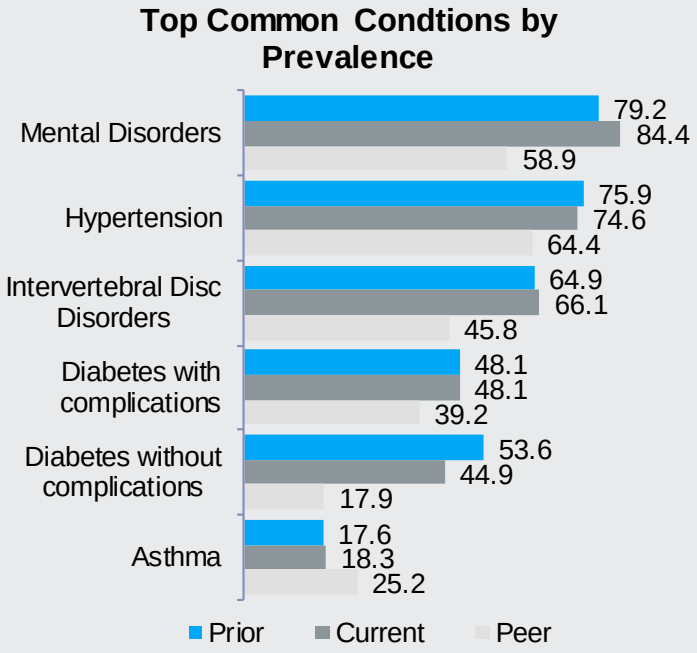
Top 5 Therapeutic Classes by Spend

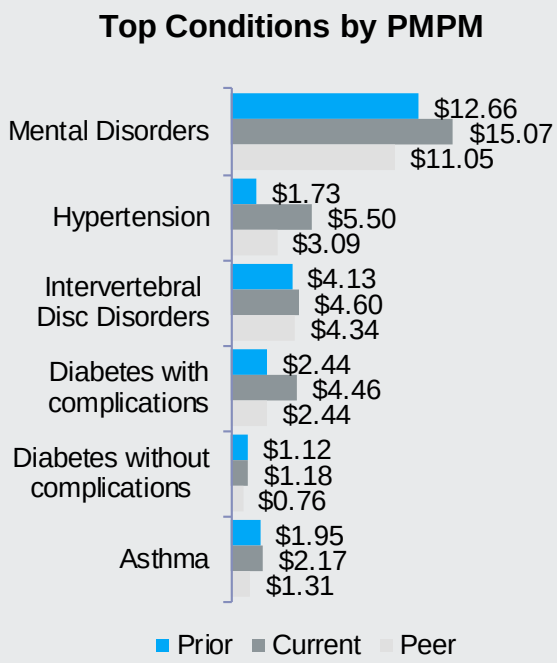


Condition Prevalence

Clinical Drivers

Clinical Conditions and Diagnosis





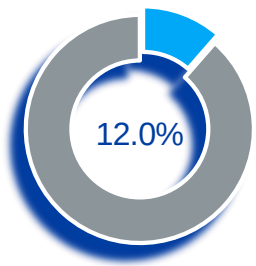
- Chronic illnesses continue to drive the top common conditions
- Mental Disorders, Hypertension and Intervertebral Disc Disorders are the most prevalent clinical conditions within this population for this period
- Mental Disorder prevalence increased 6.5% and had an increased in overall spend increased 19.0% (up,$2.41PMPM) from prior period
  - Spend for Alcohol related disorders increased 80.6%, up $0.91 PMPM from prior period
  - Autism spend increased 44.4% (ABA therapy) up $2.82 PMPM from prior period

Chronic Condition Cost Drivers

85.9% Of Medical spend driven by members with these 4 Chronic Conditions. Average Engagement 97%

Asthma

6.5% of Members

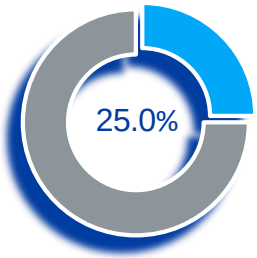


Average paid Per Claimant **$9,041.34**

Member Engagement **95.3%**

Cardio Hypertension

13.1% of Members

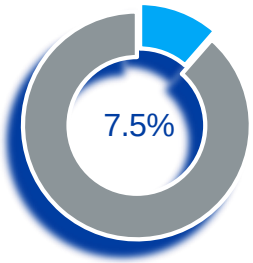


Average paid Per Claimant **$9,342**

Member Engagement **96.6%**

CAD

1.8% of Members

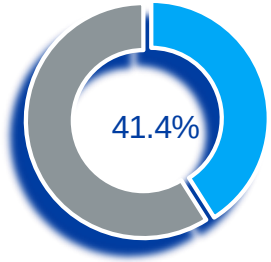


Average paid Per Claimant **$20,802**

Member Engagement **100.0%**

Diabetes

21.8% of Members



Average paid Per Claimant **$9,293**

Member Engagement **94.6%**

**Data obtained for this slide is for Eval period Nov-2020 thru Oct-2021*

Catastrophic Cases

High Cost Claimants

Catastrophic Cases Summary (>$50k)

UnitedHealthcare

6.23 Catastrophic Cases Per 1000

Prior: 4.04 ▲ 54.3%

45 Individuals (29 Prior Period)
0.62% of the population

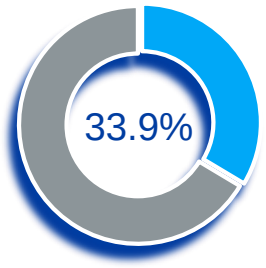
$124,005
Average Paid Per Case

Prior: $141,530 ▼ **12.4%**

% of Total Med/Rx Spend as High Cost: **25.8%**

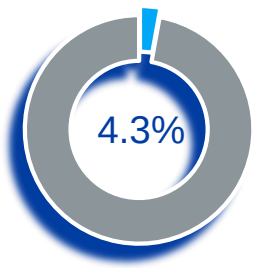
% Paid Attributed to Catastrophic Cases

Medical



HCC Spend ■ Non HCC

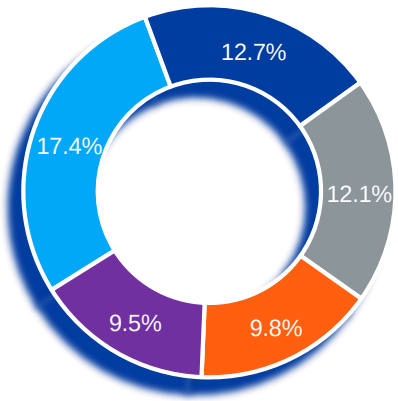
Pharmacy



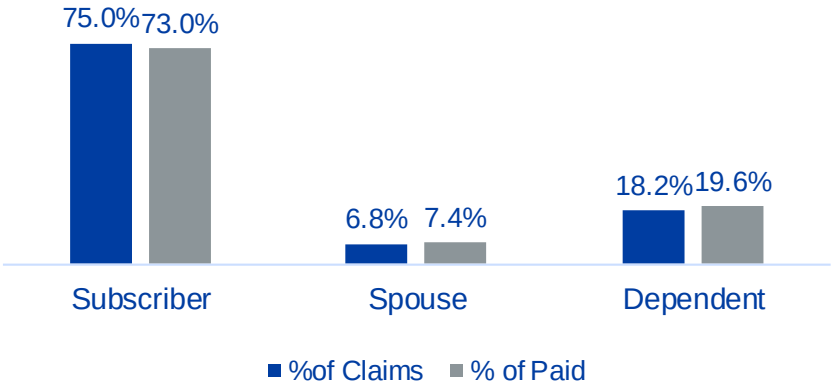
HCC Spend ■ Non HCC

Top 5 AHRQ Chapter Description by Paid

- Endocrine; Metabolic diseases
- Infectious and parasitic diseases
- Diseases of the respiratory system
- Diseases of the circulatory system
- Neoplasms



Claims and Spend by Relationship



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 December 31, 2021:

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 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

4.3.8 Doctor on Demand Engagement Report

State of Nevada
2022-01 Engagement Report

dr. on demand by Included Health

Engagement Summary

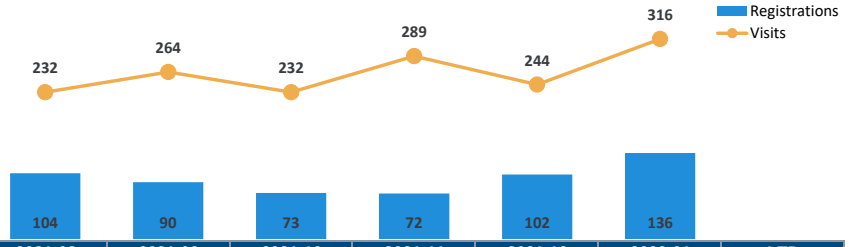
Engagement Metric		As % Of Employee Population: 29,930			As % Of Total Population: 51,831		
		2022-01	YTD Annualized	LTD	2022-01	YTD Annualized	LTD
% Registered		0.5%	5.5%	34.3%	0.3%	3.1%	19.8%
% Unique Engagement	(Visitors / Lives)	0.8%	10.1%	14.7%	0.5%	5.9%	8.5%
% Overall Engagement	(Visits / Lives)	1.1%	12.7%	38.8%	0.6%	7.3%	22.4%

Year To Date Activity

Registration Summary	YTD
# Registered	136

Visit Summary	YTD
# Unique Visitors	253
# Visits	316

Monthly Activity Last Six Months



Registration Summary	Prior	2021-08	2021-09	2021-10	2021-11	2021-12	2022-01	LTD
# Registered	9,693	104	90	73	72	102	136	10,270

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

Visit Summary		Prior	2021-08	2021-09	2021-10	2021-11	2021-12	2022-01	LTD
# Unique Visitors		3,976	196	196	187	231	209	253	4,401
# Visits		10,043	232	264	232	289	244	316	11,620
Visit Frequency	% 1 Visit	52.3%	84.2%	78.1%	84.0%	83.1%	88.5%	83.0%	51.3%
	% 2 Visits	19.3%	14.3%	13.8%	10.2%	10.8%	8.1%	11.9%	18.9%
	% 3+ Visits	28.4%	1.5%	8.2%	5.9%	6.1%	3.3%	5.1%	29.9%

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.

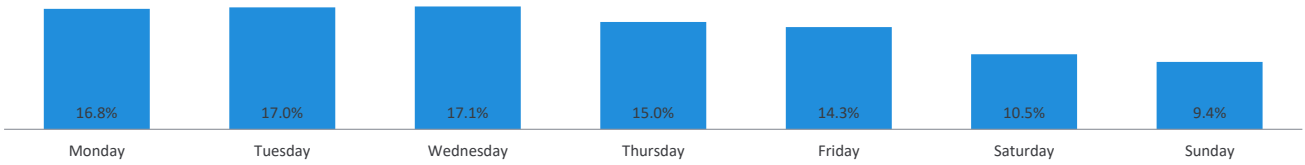
Visit Type Summary		Prior	2021-08	2021-09	2021-10	2021-11	2021-12	2022-01	LTD
Medical		7,973	190	190	179	246	196	254	9,228
Mental Health	Therapy	1,070	22	49	36	29	28	37	1,271
	Psychiatry	1,000	20	25	17	14	20	25	1,121

Benefit Summary	Prior	2021-08	2021-09	2021-10	2021-11	2021-12	2022-01	LTD
# Visits With Benefit Applied	9,782	228	260	227	283	241	312	11,333
# Visits Without Benefit Applied	261	4	4	5	6	3	4	287

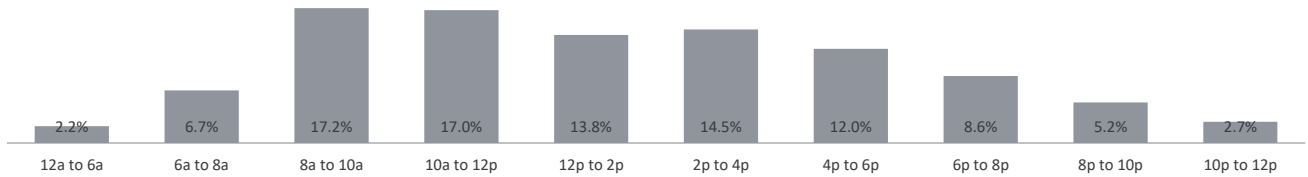
Note: Benefit not applied on visits by ineligible members, visits by members not properly associated to organization / insurance, or on visits where a discount has been applied

Six Month Trends: Visit Time And Demographics

Day Of Week



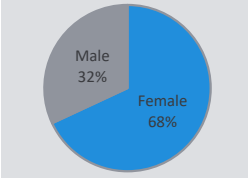
Hour Of Day



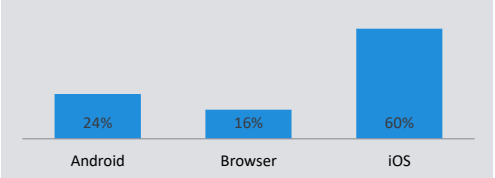
Patient Age

0 to 17 (Custodial)	10%
18 to 29	18%
30 to 49	48%
50 and over	24%

Patient Gender



Visitor App Type



State of Nevada
2022-01 Engagement Report

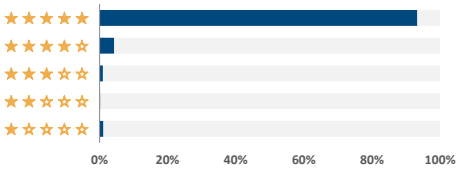
dr. on demand by Included Health

Historical Visit Experience

8,197 Visit Ratings (1-5 Stars):

Average: **4.9**

Stars:



Avg Connection Time (On Demand Visits Only): **11.0 Minutes**

Historical Post Visit Survey Results

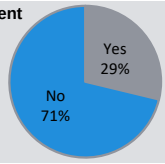
Without Doctor On Demand, where would you have gone to get this issue treated?

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

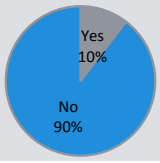
Response	# Responses	% Responses
Emergency Room	161	4%
Urgent Care	2,164	49%
Doctor's Office	1,196	27%
Stayed Home	640	15%
Other	247	6%

Six Month Trends: Visit Initiation

Initiated By Appointment
(Medical Visits Only)

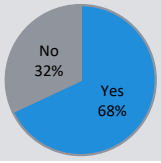


Initiated By Custodian

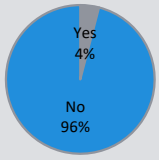


Six Month Trends: Visit Result

Resulted In Rx



Resulted In Lab Order



Historical Top 15 Symptoms

Symptom	# Symptoms	% of All Sym
General Symptoms: Fatigue / weakness	2,458	6%
Head / Neck: Headache	2,416	6%
Chest: Cough	2,366	6%
Head / Neck: Sore throat	2,147	5%
General Symptoms: Difficulty sleeping	2,049	5%
Head / Neck: Congestion / sinus problem	1,863	4%
Head / Neck: Nasal discharge	1,683	4%
General Symptoms: Fever	1,273	3%
General Symptoms: Loss of appetite	1,145	3%
Genitourinary: Discomfort / burning with urination	1,113	3%
Genitourinary: Frequent urination	1,094	3%
Head / Neck: Congestion/sinus problem	989	2%
Head / Neck: Ear pain	778	2%
Head / Neck: Difficulty / pain swallowing	732	2%
Chest: Shortness of breath	724	2%

Historical Top 15 ICD10 Codes

ICD10 Code And Description	# ICD10s	% of All ICD10
N390 - Urinary tract infection, site not specified	1,049	7%
J0190 - Acute sinusitis, unspecified	697	5%
J069 - Acute upper respiratory infection, unspecified	648	5%
F411 - Generalized anxiety disorder	446	3%
J029 - Acute pharyngitis, unspecified	419	3%
Z760 - Encounter for issue of repeat prescription	355	3%
R05 - Cough	337	2%
J209 - Acute bronchitis, unspecified	285	2%
F4323 - Adjustment disorder with mixed anxiety and depressed mo	275	2%
F419 - Anxiety disorder, unspecified	270	2%
J0180 - Other acute sinusitis	214	2%
F331 - Major depressive disorder, recurrent, moderate	202	1%
F339 - Major depressive disorder, recurrent, unspecified	180	1%
U071 - COVID-19	170	1%
Z630 - Problems in relationship with spouse or partner	154	1%

Historical Top 15 Rx

Rx Name	# Rx	% of All Rx
nitrofurantoin	755	7%
predniSONE	755	7%
benzonatate	747	6%
amoxicillin-clavulanate	711	6%
albuterol	689	6%
fluticasone nasal	308	3%
fluconazole	299	3%
sulfamethoxazole-trimethoprim	288	3%
azithromycin	259	2%
FLUoxetine	256	2%
amoxicillin	244	2%
methylPREDNISolone	242	2%
doxycycline	235	2%
sertraline	224	2%
escitalopram	222	2%

Historical Top 15 Lab Orders

Lab Name	# Lab Orders	% of All Orders
TSH with Reflex to Free T4	121	9%
Comprehensive Metabolic Panel	120	9%
CBC+diff	94	7%
Urinalysis, Complete with Reflex	93	7%
Lipid Panel	85	7%
Urine Culture, Routine	81	6%
Hemoglobin A1c	79	6%
Vitamin D	61	5%
Chlamydia/GC, Urine	45	4%
Urinalysis, Complete	44	3%
B12/Folate	34	3%
Basic Metabolic Panel	27	2%
RPR w/ Reflex	23	2%
Stool O&P	19	2%
Stool Culture	18	1%

4.4

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

4.4 Acceptance of Claim technologies Incorporated audit findings for State of Nevada Public Employees' Benefits Program Plans administered by HealthSCOPE Benefits for:

4.4.1 4.4.1 Period October 1, 2020 – December 31, 2020 (FY21.Q2)

4.4.2 4.4.2 Period January 1, 2021 – March 31, 2021 (FY21.Q3)

4.4.3 4.4.3 Period April 1, 2021 – June 30, 2021 (FY21.Q4)

4.4.4 4.4.4 Focus audit for the period February 1, 2020 through September 30, 2021

4.4.1

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

    4.4 Acceptance of Claim technologies Incorporated audit findings for State of Nevada Public Employees' Benefits Program Plans administered by HealthSCOPE Benefits for:

        4.4.1 Period October 1, 2020 – December 31, 2020 (FY21.Q2)

Comprehensive Claim Administration Audit

QUARTERLY FINDINGS REPORT

State of Nevada Public Employees' Benefits Program Plans

Administered by HealthSCOPE Benefits

Audit Period: October 1, 2020 through December 31, 2020
Audit Number 1.FY21.Q2

Presented to

State of Nevada Public Employees' Benefits Program

Revised March 9, 2022

CLAIM TECHNOLOGIES INCORPORATED

TABLE OF CONTENTS

EXECUTIVE SUMMARY 3

AUDIT OBJECTIVES 4

OPERATIONAL REVIEW PERFORMANCE GUARANTEES 5

100% ELECTRONIC SCREENING WITH TARGETED SAMPLE ANALYSIS 6

RANDOM SAMPLE AUDIT 12

DATA ANALYTICS 16

CONCLUSION 25

APPENDIX – Administrator's Response to Draft Report 26

EXECUTIVE SUMMARY

This ***Quarterly Findings Report*** is a compilation of the detailed information, findings, and conclusions drawn from Claim Technologies Incorporated's (CTI's) audit of HealthSCOPE Benefits' (HealthSCOPE) administration of the State of Nevada Public Employees' Benefits Program's (PEBP) medical, dental, and health reimbursement arrangement (HRA) plan.

Scope

CTI performed an audit of HealthSCOPE's administration of the PEBP's medical, dental and HRA for the period of October 1, 2020 through December 31, 2020 (quarter 2 (Q2) for Fiscal Year (FY) 2021). The population of claims and amount paid during the audit period reported by HealthSCOPE Benefits:

Medical and Dental	
Total Paid Amount	$50,948,921
Total Number of Claims Paid/Denied/Adjusted	208,793
Health Reimbursement Arrangement (HRA)	
Total Paid Amount	$1,655,551
Total Number of Claims Paid/Denied/Adjusted	17,483

The audit included the following components which are described in more detail in the following pages.

- Operational Review – Performance Guarantees Only
- 100% Electronic Screening with Targeted Samples
- Random Sample Audit
- Data Analytics

Auditor's Opinion

Based on these findings, and in our opinion:

1. HealthSCOPE provided good customer service to PEBP's members by exceeding telephone response time, abandonment rate, and first call resolution.
2. HealthSCOPE should:
    - Review the 100% Electronic Screening with Targeted Sampled results and focus on the most material findings in Spinal Region Upcoding, Duplicate Claims Payments, Air Ambulance Prior Authorization Requirements, Timely Filing of Claims, and Dental Plan Exclusions.
    - Review the Random Sample Audit results and focus on making system improvements and/or providing coaching and feedback to examiners to prevent similar errors going forward. This will improve performance guarantee results and prevent future penalties from being owed to PEBP.

Summary of HealthSCOPE's Guarantee Measurements

Based on CTI's Random Sample Audit results, HealthSCOPE met both claims processing measurements for PEBP in Q2 FY2021.

Quarterly Guarantee	Measure	Met/Not Met	Penalty
Financial Accuracy	99%	Met – 99.80%	None.
Payment Accuracy	98%	Met – 98.00%	None.

AUDIT OBJECTIVES

This report contains CTI's findings from our audit of HealthSCOPE Benefits' (HealthSCOPE) administration of the State of Nevada Public Employees' Benefits Program (PEBP) plans. We provide this report to PEBP, the plan sponsor, and HealthSCOPE, the claim administrator. A copy of HealthSCOPE's response to these findings can be found in the Appendix of this report.

CTI conducted the audit according to accepted standards and procedures for claim audits in the health insurance industry. We based our audit findings on the data and information provided by PEBP and HealthSCOPE. The validity of our findings relies on the accuracy and completeness of that information. We planned and performed the audit to obtain a reasonable assurance claims were adjudicated according to the terms of the contract between HealthSCOPE and PEBP.

CTI would like to note that per Attachment AA4 of the Service Performance Standards, Service Guarantees and Financial Penalties document provided to CTI and executed by HealthSCOPE and PEBP in January 2011, under Service Performance Standards I and II, bullet four, sub-bullet two – *If the claim is corrected by Vendor prior to the date (as determined by the health plan auditor) on which PEBP's health plan auditor sends to Vendor a list of claims to be included in the random sample, the error will not be included in the calculation of the Claim Payment Accuracy and/or Financial Accuracy metrics.* Claims identified that fall into this category are noted under the Additional Observations section of our findings reports and would have otherwise been counted as errors against HealthSCOPE's financial and claim payment accuracy results based on CTI's existing audit methodology and continuous quality improvement philosophy.

CTI specializes in the audit and control of health plan claim administration. Accordingly, the statements we make relate narrowly and specifically to the overall effectiveness of policies, procedures, and systems HealthSCOPE used to pay PEBP's claims during the audit period. While performing the audit, CTI complied with all confidentiality, non-disclosure, and conflict of interest requirements and did not receive anything of value or any benefit of any kind other than agreed upon audit fees.

The objectives of CTI's audit of HealthSCOPE's claim administration were to determine whether:

- HealthSCOPE followed the terms of its contract with PEBP;
- HealthSCOPE paid claims according to the provisions of the plan documents and if those provisions were clear and consistent; and
- members were eligible and covered by PEBP's plans at the time a service paid by HealthSCOPE was incurred.

OPERATIONAL REVIEW PERFORMANCE GUARANTEES

Performance Guarantees

As part of CTI's quarterly audit of PEBP, we reviewed the Performance Guarantees included in its contract with HealthSCOPE. The results for Q2 FY2021 follow.

Metric	Guarantee Measurement	Actual	Met/ Not Met
Financial Accuracy	99% or greater of the dollars paid for the audited medical/dental claims to be paid accurately.	99.80%	Met
Payment Accuracy	98% or greater of medical/dental claims audited are paid accurately.	98.00%	Met
Claim Processing Turnaround	99% of all medical/dental claims are to be processed within 30 days	99.89%	Met
Customer Service	• Telephone Response Time less than 30 seconds for inbound calls. • Telephone Abandonment Rate less than 3% First call Resolution greater or equal to 95%	6 Seconds Less than .5% 97.82%	Met Met Met
Data Reporting	• 100% of standard reports within 10 business days • Annual/Regulatory Documents within 10 business days of the Plan Year	No exceptions noted. NA – Annual Report	Met NA
Disclosure of Subcontractors	• Report access of PEBP data within 30 calendar days • Removal of PEBP member PHI within 3 business days after knowledge	No exceptions noted. No exceptions noted.	Met Met

100% ELECTRONIC SCREENING WITH TARGETED SAMPLE ANALYSIS

Objective

CTI's Electronic Screening and Analysis System (ESAS) software identified and quantified potential claim administration payment errors. PEBP and HealthSCOPE should discuss any verified under- or overpayments to determine the appropriate actions to correct the errors.

Scope

CTI electronically screened 100% of the service lines processed by HealthSCOPE during the audit period for both medical and dental claims. The accuracy and completeness of HealthSCOPE's data directly impacted the screening categories we completed and the integrity of our findings. We screened the following high-level ESAS categories to identify potential amounts at risk:

- Duplicate payments to providers and/or employees
- Plan exclusions and limitations
- Multiple surgical procedures

Methodology

We used ESAS to analyze claim payment accuracy as well as any opportunities for system and process improvement. Using the data file provided by HealthSCOPE, we readjudicated each line on every claim the plan paid or denied during the audit period against the plan's benefits. Our Technical Lead Auditor tested a targeted sample of claims to provide insight into HealthSCOPE's claim administration as well as operational policies and procedures. We followed these procedures to complete our ESAS process:

- ***Electronic Screening Parameters Set*** – We used your plan document provisions to set the parameters in ESAS.
- ***Data Conversion*** – We converted and validated your claim data, reconciled it against control totals, and checked it for reasonableness.
- ***Electronic Screening*** – We systematically screened 100% of the service lines processed and flagged claims not administered according to plan parameters.
- ***Auditor Analysis*** – If claims within an ESAS screening category represented a material amount, our auditors analyzed the findings to confirm results were valid. Note than using ESAS could lead to false positives if there was incomplete claim data. CTI auditors made every effort to identify and remove false positives.
- ***Targeted Sample Analysis*** – From the categories identified with material amounts at risk, we selected the best examples of potential under- or overpayments to test. As cases were not randomly selected, we cannot extrapolate results. We selected 50 cases and sent your administrator a questionnaire for each. Targeted samples verified if the claim data supported our finding and if our understanding of plan provisions matched HealthSCOPE's administration.
- ***Audit of Administrator Response and Documentation*** – We reviewed the responses and redacted the responses to eliminate personal health information. Based on the responses and further analysis of the findings, we removed false positives identified from the potential amounts at risk.

Findings

We are confident in the accuracy of our ESAS results. It should be noted that the dollar amounts associated with the results represent potential payment errors and process improvement opportunities. We would have to perform additional testing to substantiate the findings that could then provide the basis for remedial action planning or reimbursement.

Categories for Process Improvement

The following detail report shows, by category, the number of line items or claimants with process improvement opportunities remaining after our analysis and removal of verified false positives. A CTI auditor reviewed the responses and supporting documentation. The administrator responses are copied directly from HealthSCOPE's reply to audit findings.

Process Improvement Summary Report				
Client: PEBP **Screening Period:** Q2 FY2021				
Category	**Number of Service Codes**	**Number of Members**	**Billed Charge**	**Allowed***
Fraud, Waste and Abuse				
Spinal Region Upcoding – Number of spinal regions treated does not match number of spinal regions billed and allowed.	1,217	424	$81,866	$37,668

**Allowed equals total paid by plan and member combined.*

Electronic screening of all service lines processed revealed the potential for incorrectly paid claims. Analysis confirmed the opportunity for process improvement and further testing is recommended. For each potential error, we sent an ESAS Questionnaire (QID) to HealthSCOPE for written response. After review of the response and additional information provided, CTI confirmed the potential for process improvement. Note that all recommendations for HealthSCOPE process improvements will also be included in the Q4 FY2021 report.

Manually adjudicated claims were processed by an individual claims processor. Auto-adjudicated claims were paid by the system with no manual intervention.

Paid Greater Than Charged – HealthSCOPE paid six service codes for four members for a total allowed amount of $986.00.

Paid Greater than Charged Detail Report				
QID	**Over Paid**	**HealthSCOPE Response**	**CTI Conclusion**	**Manual or System**
M8	$208.40	Agree. Plan pays according to Medicare allowed amount. Claim is from a rural health clinic; Medicare pays more than billed charge. Allowed should have been $86.00 with a $17.20 payment. This claim has not been adjusted.	Procedural deficiency and overpayment remain. HealthSCOPE paid $225.60 and should have only paid $17.20.	☒ M ☐ S

Fraud, Waste, and Abuse (FWA) Detail Report					
QID	**Category**	**Over Paid**	**HealthSCOPE Response**	**CTI Conclusion**	**Manual or System**
M27	Spinal Region Upcoding	$35.00	Disagree. The claim was adjudicated based on the plan guidelines for Chiropractic care based on the agreement with Sierra Healthcare Options. This was in investigated, there were not clinical edits and the claim was paid according to the plan guidelines.	Procedural deficiency and overpayment remain. The description for CPT codes for chiropractic care includes the number of regions of the spine or extraspinal regions treated and should be supported by the diagnosis. The provider billed five or more spinal regions treated; however, the diagnosis billed supported treatment of only two spinal regions. These procedures are spinal region driven and should be billed with appropriate diagnosis codes to support billing.	☐ M ☒ S
M28		$30.97	Disagree. The claim was adjudicated based on the plan guidelines for Chiropractic care based on the agreement with Hometown Healthcare. This was in investigated, there were not clinical edits and the claim was paid according to the plan guidelines.		☐ M ☒ S
M29		$23.65			☐ M ☒ S

Categories for Potential Amount at Risk

The following report shows, by category, the number of line items or claims and the total potential amount at risk remaining at the conclusion of our analysis, targeted samples, and removal of verified false positives. Following the report is a detailed explanation of our results with findings for all screening categories where, in our opinion, process improvement, recovery or savings opportunities exist. The administrator responses are copied directly from HealthSCOPE's reply to audit findings.

Categories for Potential Amount at Risk				
Client: PEBP **Screening Period:** Q2 FY2021				
Category	**Number of Service Codes**	**Number of Members**	**Billed Charge**	**Allowed***
Duplicate Payments				
Providers and/or Employees	205	49	$205,141	$48,679
Plan Limitations				
Air Ambulance Pre-Authorization Required	7	4	$280,523	$51,193
Hearing Aids $1,500/Device Every 3 Years	6	4	$20,025	$6,657
TMJ In-Network Limited to 50%	54	23	$7,980	$3,612
Timely Filing	1,738	313	$3,725,301	$1,237,705
Plan Exclusions				
Dental, Other Surgical Procedures	173	157	$115,766	$54,477
Dental, TMJ	4	3	$3,535	$1,783

**Allowed equals total paid by plan and member combined.*

Electronic screening of all service lines processed revealed the potential for incorrectly paid claims. Analysis confirmed the opportunity for process improvement and further testing is recommended.

Duplicate Payment Detail Report				
QID	**Over Paid**	**HealthSCOPE Response**	**CTI Conclusion**	**Manual or System**
M11	$45.99	Agree. Claim has not been adjusted.	Procedural deficiency and overpayment remain. Provider was paid twice for date of service 06/01/20.	☒ M ☐ S
M16	$335.35	Agree. Auto recoupment of overpayment on 08/30/21.	Procedural deficiency and overpayment remain. Duplicate payment as agreed. Overpayment recouped 08/30/21.	☒ M ☐ S
M17	$1,298.99			☒ M ☐ S
M18	$1,323.32			☒ M ☐ S
M19	$8,511.60			☒ M ☐ S
M20	$3,474.67			☒ M ☐ S
M23	$334.31	Agree. Claim has not been adjusted.	Procedural deficiency and overpayment remain. Duplicate payment as agreed.	☒ M ☐ S
M24	$193.05			☒ M ☐ S

Plan Limitations Detail Report					
QID	**Category**	**Over Paid**	**HealthSCOPE Response**	**CTI Conclusion**	**Manual or System**
D1	Timely Filing – within 12 months from the date of service	$453.50	Disagree. Original claim XXX.XXX3620 was received on 09/10/19. Claim was reconsidered to pay D2740.	Procedural deficiency and overpayment remain. The date of service was 7/10/19 and the claim was initially received on 7/15/19 and paid. The claim was then resubmitted three times on 9/10/19, 3/28/20, and 4/2/20 and each time the claim was denied as a duplicate. The claim was then submitted on 10/27/20 with additional information for reconsideration and an additional $50 was paid out to the provider on 10/29/20.	☒ M ☐ S
D2		$63.20	Disagree. Original claim was received on 04/17/19 and denied for periodontal charting. Provider faxed perio-chart requesting reconsideration on 09/22/20.	Procedural deficiency and overpayment remain. The date of service was 2/27/19 and the claim was initially received on 3/18/19. The claim was denied for periodontal charting. The provider resubmitted the claim a second time without the requested charting on 4/17/19 and was denied again. The claim was received a third and final time on 9/22/20 with the claim adjusted and paid on 11/17/20.	☒ M ☐ S
M3		$40,065.00	Disagree. Original claim XXX.XXX9773 received on 03.16.20 and denied for EOMB. The EOMB received and claim adjusted on	Procedural deficiency and overpayment remain. The date of service was 6/13/19 and the claim was initially received on 11/13/19. The claim was denied	☒ M ☐ S

Plan Limitations Detail Report					
QID	**Category**	**Over Paid**	**HealthSCOPE Response**	**CTI Conclusion**	**Manual or System**
			11/30/20. Claim was manually processed.	for an Explanation of Medicare Benefits (EMOB). The provider resubmitted the claim a second time without the EMOB on 3/16/2020 and was denied again. The claim was received a third and final time on 11/25/20 with the claim adjusted and paid on 11/30/20.	
M33	Hearing Aids $1,500/Device Every Three Years	$887.13	Agree. Claim did exceed the plan limitation. Provider refund check number 90340 received 02/23/21.	Procedural deficiency and overpayment remain. Paid over the plan limit of $3,000.	☒ M ☐ S
M34	TMJ In-Network Limited to 50%	$25.13	Agree. The claim should have paid at 50% of the PPO allowed amount after the deductible. Records were received to support the medical necessity for services. Claim was manually processed.	Procedural deficiency and overpayment remain. After deductible, the plan pays 50%. HealthSCOPE paid $67.01 and should have paid $41.88.	☐ M ☒ S
M35		$10.08	Disagree. Claim was paid based on the physical therapy benefit as described in the plan benefits.	Procedural deficiency and overpayment remain. Claim was incorrectly paid under the physical therapy benefit. The primary diagnosis was left temporomandibular joint disorder, unspecified – which is not considered physical therapy. Benefit should have been 50% after deductible.	☒ M ☐ S
M37	Air Ambulance Pre-Authorization Required	$9,452.66	Waiting for documentation of approval from client (PEBP).	Procedural deficiency and overpayment remain. HealthSCOPE paid for services prior to approval.	☒ M ☐ S

There were also six errors found under the dental benefit plan for excluded services paid. CTI's review indicated four "Other Dental Surgical Procedures" paid for a total of $949.30 including:

- two Sinus Augmentation claims;
- one Collection and Application of Autologous, Blood Concentrate Product claim; and
- one Frenectomy claim.

The remaining two dental claims paid for excluded services were for TMJ and totaled $611.80 including:

- one Arthrocentesis, joint aspiration claim; and
- one reposition of teeth grafting claim.

In CTI's experience the PEBP's dental plan document is vague and/or silent on a number of dental services. We recommend that the language be updated to indicate specifically which services are covered and which are excluded. This will eliminate the option for medical necessity which means any claim currently submitted is being paid.

Additional Observations

During the ESAS review, our auditor observed the following procedures or situations that may not have caused an error on the sampled claim but may impact future claims or overall quality of service.

Observation	QID Number
HealthSCOPE paid more than billed charge. It should consider including lesser of language in its provider contracts to prevent paying more than billed charge.	M9

RANDOM SAMPLE AUDIT

Objectives

The objectives of our Random Sample Audit were to determine if medical and dental claims were paid according to plan specifications and the administrative agreement, to measure and benchmark process quality, and to prioritize areas of administrative deficiency for further review and remediation.

Scope

CTI's statistically valid Random Sample Audit included a stratified random samples of 200 paid or denied claims. HealthSCOPE's performance was measured using the following key performance indicators:

- Financial Accuracy
- Accurate Payment
- Accurate Processing

We also measured claim turnaround time, a commonly relied upon performance measure.

In addition, CTI sampled 50 health reimbursement arrangement (HRA) claims to ensure payment and processing accuracy.

Methodology

Our Random Sample Audit ensures a high degree of consistency in methodology and is based upon the principles of statistical process control with a management philosophy of continuous quality improvement. Our auditors reviewed each sample claim selected to ensure it conformed to plan specifications, agreements, and negotiated discounts. We recorded our findings in our proprietary audit system.

When applicable, we cited claim payment and processing errors identified by comparing the way a selected claim was paid and the information HealthSCOPE had available at the time the transaction was processed**. It is important to note that even if the sampled claim was subsequently corrected prior to CTI's audit, we have still cited the error so you can discuss how to reduce errors and re-work in the future with your administrator.**

CTI communicated with HealthSCOPE in writing about any errors or observations using system-generated response forms. We sent HealthSCOPE a preliminary report for its review and written response. We considered HealthSCOPE's written response, as found in the Appendix, when producing our final reports. Note that the administrator responses have been copied directly from HealthSCOPE's reply.

Financial Accuracy

CTI defines Financial Accuracy as the total correct claim payments made compared to the total dollars of correct claim payments that should have been made for the audit sample.

The claims sampled and reviewed revealed $33.03 in underpayments and $655.05 in overpayments, for an absolute value variance of $688.08.

The weighted Financial Accuracy rate was 99.80%.

Financial Accuracy and Accurate Payment Detail Report						
Error Description	**Audit No.**	**Under/ Over Paid**	**HealthSCOPE Response**	**CTI Conclusion**	**Manual or System**	
Coinsurance	M1082	$632.90 – Over	Agree. The claim was paid with the wellness benefit.	Procedural error and overpayment remain. The out-of-pocket maximum was not satisfied.	☒ M ☐ S	
	M1138	$22.15 – Over	Agree the CPT 17110 should have been considered with coinsurance. The overpayment amount should be $22.15. CPT 99202-25 paid correctly at 100% per guidelines.	Procedural error and overpayment remain. CPT 17110 should have been considered with coinsurance.	☒ M ☐ S	
Subtotal	**2**					
Deductible Error	M1143	$33.03 – Under	Agree. Claim should have paid 100% of PPO allowed amount per plan guidelines.	Procedural error and underpayment remain. HIV screening in adults aged 15 – 65 is a considered preventive.	☒ M ☐ S	
Subtotal	**1**					
TOTALS	**3**	**VARIANCE $688.08**			**M: 3**	**S: 0**

Accurate Payment

CTI defines Accurate Payment as the number of claims paid correctly compared to the total number of claims paid for the audit sample.

The audit sample revealed 3 incorrectly paid claims and 197 correctly paid claims. Note CTI only uses adequately documented claims for this calculation.

Total Claims	Incorrectly Paid Claims		Frequency
	Underpaid Claims	Overpaid Claims	
200	1	2	98.00%

Accurate Processing

CTI defines Accurate Processing as the number of claims processed without errors compared to the total number of claims processed in the audit sample.

Correctly Processed Claims	Incorrectly Processed Claims		Frequency
	System	Manual	
196	0	4	98.00%

Accurate Processing Detail Report				
Error Description	**Audit No.**	**HealthSCOPE Response**	**CTI Conclusion**	**Manual or System**
Policy Provision				
Coinsurance Error	M1082	Agree.	Procedural error remains. The out-of-pocket maximum was not satisfied.	☒ M ☐ S
	M1138	Agree the CPT 17110 should have been considered with coinsurance. The overpayment amount should be $22.15. CPT 99202-25 paid correctly at 100% per guidelines.	Procedural error remains for both billed services. CPT 17110 as agreed, as well as CPT 99205-25 with the diagnosis billed would not be considered preventive at 100%.	☒ M ☐ S

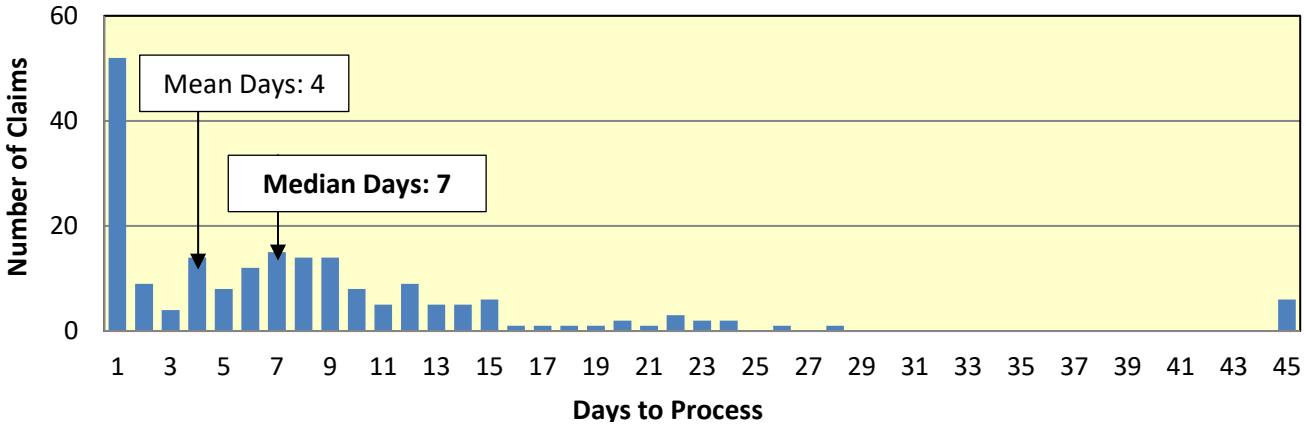
Accurate Processing Detail Report				
Error Description	**Audit No.**	**HealthSCOPE Response**	**CTI Conclusion**	**Manual or System**
Deductible Error	M1143	Agree. Claim should have paid 100% of PPO allowed amount per plan guidelines.	Procedural error remains as agreed. HIV screening in adults aged 15 – 65 is a considered preventive.	☒ M ☐ S
Charting Inconsistency	D2049	Disagree. Paper claim submitted with tooth F. This is the only claim in file for oral surgery for this patient. The system would edit if there were other oral surgery claims for this patient.	Procedural error remains. Claim was submitted for tooth F and the tooth chart received was not reflected to show tooth F; it reflected all teeth when processed.	☒ M ☐ S

Claim Turnaround

CTI defines Claim Turnaround as the number of calendar days required to process a claim – from the date the claim was received by the administrator to the date a payment, denial, or additional information request was processed – expressed as both the Median and Mean for the audit sample.

Claim administrators commonly measure claim turnaround time in mean days. Median days, however, is a more meaningful measure for administrators to focus on when analyzing claim turnaround because it prevents one or just a few claims with extended turnaround time from distorting the true performance picture.

Median and Mean Claim Turnaround



Additional Observations

During the Random Sample Audit, our auditor observed the following procedures or situations that may not have caused an error on the sampled claim but may impact future claims or overall quality of service.

Observation	Audit Number
HealthSCOPE did not take a diagnostic test copay on this out-of-sample claim, and one should have been taken. This resulted in a $75.00 overpayment for the plan.	M1020
PEBP should be aware that HealthSCOPE incorrectly denied a $1,741.65 eligible expense on this sampled claim on 10/19/20, indicating there was no prior authorization. There was, however, an authorization on file dated 7/24/20 for these services. The claim was reconsidered on 12/3/2020, prior to CTI pulling the audit sample. Therefore, per Attachment AA4 of the Service Performance Standards, Service Guarantees and Financial Penalties document provided to CTI and initially executed by HealthSCOPE and PEBP in January 2011, no financial or payment accuracy error can be assessed.	M1089

Health Reimbursement Arrangement (HRA) Findings

CTI also reviewed 50 HRA claims as part of our random sample. We communicated with HealthSCOPE in writing about any errors or observations found using response forms. In addition, we sent HealthSCOPE a preliminary report for its review and written response. We considered HealthSCOPE's written response, as found in the Appendix, when producing our final reports.

Of the 50 claims reviewed, our audit revealed two observations of procedures or situations that may not have caused an error on the sampled claim but may impact future claims or overall quality of service.

Observation	Audit Number
Though the member provided the receipt for the service, the scanned file copy was not completely legible. HealthSCOPE agreed but indicated the original document was no longer accessible.	H1008
The order for durable medical equipment was placed on 10/27/20; however, the items were shipped were 11/05/20, 12/03/20, and 12/97/20. There was no note in the file indicating the order date and shipped dates were different to avoid duplication of payments. HealthSCOPE indicated they would talk to claim processors to ensure the service and delivery dates were noted in the claim file.	H1040

DATA ANALYTICS

Medical Findings

This component of our audit used your electronic claim data to identify improvement opportunities and potential recoveries. The informational categories we analyzed include:

- Network Provider Utilization and Discount Savings;
- Sanctioned Provider Identification;
- Patient Protection and Affordable Care Act (PPACA) Preventive Services Payment Compliance;
- National Correct Coding Initiative (NCCI) Editing Compliance; and
- Global Surgery Prohibited Fee Period Analysis.

The following pages provide the scope and report for each data analytic to enable more-informed decisions about ways PEBP can maximize benefit plan administration and performance.

Network Provider Utilization and Discount Savings

The Network Provider Utilization and Discount Savings report provides an evaluation of provider network discounts obtained during the audit period. Since discounts can be calculated differently by administrators, carriers, and benefit consultants, we believe calculating discounts in the same manner for all our clients will allow for more meaningful comparisons to be made.

Scope

CTI compared submitted charges to allowable charges for all claims paid during the audit period. The review was divided into three subsets:

- In-network
- Out-of-network
- Secondary networks

Each of these subsets was further delineated into four subgroups:

- Ancillary services – such as durable medical equipment
- Non-facility services – such as an office visit
- Facility inpatient – such as services received at a hospital
- Facility outpatient – such as services received at a surgical center

Report

The following report relied on the data and data fields provided by your administrator. We made no assumptions when requested data fields were not provided.

Medical Provider Discount Review Paid Dates 10/1/2020 through 12/31/2020				
Proprietary and Confidential Information. Do not reproduce without express permission of Claim Technologies Inc.				
Total of All Claims				
Claim Type	**Allowed Amount**	**Provider Discount**		**Plan Paid**
Ancillary	$3,160,247	$1,539,223	32.8%	$2,679,453
Non-Facility	$27,159,028	$29,890,633	52.4%	$18,272,186
Facility Inpatient	$11,440,265	$28,523,783	71.4%	$10,531,736
Facility Outpatient	$16,855,395	$32,833,875	66.1%	$13,795,587
Total	**$58,614,935**	**$92,787,515**	**61.3%**	**$45,278,962**
In-Network				
Claim Type	**Allowed Amount**	**Provider Discount**		**Plan Paid**
Ancillary	$3,101,456	$1,538,878	33.2%	$2,664,421
Non-Facility	$26,172,222	$29,886,934	53.3%	$17,930,608
Facility Inpatient	$11,320,640	$28,443,235	71.5%	$10,494,721
Facility Outpatient	$16,613,724	$32,509,757	66.2%	$13,612,883
Total In-Network	**$57,208,042**	**$92,378,804**	**61.8%**	**$44,702,633**
% of Eligible Charge -	97.6%	% Claim Frequency -	84.2%	
Out of Network				
Claim Type	**Allowed Amount**	**Provider Discount**		**Plan Paid**
Ancillary	$58,791	$345	0.6%	$15,032
Non-Facility	$986,806	$3,699	0.4%	$341,579
Facility Inpatient	$119,625	$80,548	40.2%	$37,015
Facility Outpatient	$241,672	$324,118	57.3%	$182,704
Total Out of Network	**$1,406,894**	**$408,711**	**22.5%**	**$576,330**
% of Eligible Charge -	2.4%	% Claim Frequency -	15.8%	

**Paid claim totals exclude claims from members aged 65 and older.*

PEBP's members had utilization of network or secondary network medical providers at 97.6% of all allowed charges and 84.2% of all claims.

Sanctioned Provider Identification

The Sanctioned Provider Identification report identifies services rendered by providers on the Office of Inspector General's (OIG) List of Excluded Individuals/Entities (LEIE). OIG's LEIE provides information to the healthcare industry, patients, and the public about individuals and entities currently excluded from participation in Medicare, Medicaid, and all other federal health care programs.

Scope

We received and converted an electronic data file of all claims processed during the audit period. The claims screened included all medical (not including prescription drug) and dental claims paid or denied during the audit period. Through electronic screening, we identified all claims in the audit universe that were non-facility claims, i.e., claims submitted by providers of service other than hospitals, nursing, or skilled care facilities, or durable medical equipment suppliers. These claims predominantly include physician and other medical professional claims.

Report

We screened 100% of non-facility claims against OIG's LEIE and identified the following providers as sanctioned. Our screening indicated the following providers received payment from the administrator during the audit period.

NPI	Exclusion Date	Reinstatement Date	Exclusion Type	Provider Name	Claim Count	Total Charged	Total Allowed	Total Paid
1104912278	20191219	N/A	1128a4	JAMES SHELBY	5	$3,106	$3,099	$1,607
				Totals	**5**	**$3,106**	**$3,099**	**$1,607**

According to the OIG, James Shelby was excluded on December 19, 2019 with for a felony-controlled substance conviction.

PPACA Preventive Services Coverage Compliance

The Preventive Services Coverage Compliance report confirms that the administrator processed preventive services as required by PPACA and as regulated by the Department of Health and Human Services (HHS). The federal PPACA mandate for all health plans (unless grandfathered) requires that certain preventive services, if performed by a network provider, must be covered at 100% without copayment, coinsurance, or deductible. Our review analyzed in-network preventive care services to determine if your administrator paid services in compliance with PPACA guidelines.

Scope

Our review included all in-network services we believe should be categorized as preventive and paid at 100%. The guidance provided by HHS for the definition of preventive services is somewhat vague, leaving it up to individual health plans to define their own system edits. In addition to the U.S. Preventive Services Task Force recommendations, CTI researched best practices of major health plan administrators to develop a compliance review we believe reflects the industry's most comprehensive overview of procedures to be paid at 100%.

Our review did not include services:

- performed by an out-of-network provider;
- adjusted or paid more than once (duplicate payments) during the audit period; or
- for which PPACA requirements suggest a frequency limitation such as one per year.

Our data analytics parameters relied upon the published recommendations from the sources HHS used to create the list of preventive services for which it has mandated coverage.

Reports

We analyzed the payments to determine if they were compliant. Types of services for which we identified non-compliance (if any) are listed first and the percentage of allowed charge paid is in the last column. To demonstrate full compliance with PPACA's requirements, the last column of this report should show 100% of services performed by network providers were paid and that no deductible, coinsurance, or copayment was applied.

Because services may be denied for reasons other than exclusion or limitation of non-covered services (e.g., a service could be denied because the patient was ineligible at the time it was performed), less than 100% of the preventive services may be paid.

The preventive services compliance review shows the frequency of claims paid at less than required benefit levels (i.e., claims reduced payment due to the application of deductibles, coinsurance, and/or copayments). We electronically screened 78 categories of preventive services that match the preventive care services specified by HHS including immunizations, women's health, tobacco use

counseling, cholesterol and cancer screenings, and wellness examinations. This review either confirms compliance with PPACA or highlights areas for improvement.

CTI's analysis also found that 96.33% of the procedure codes identified as preventive services were paid by HealthSCOPE at 100% when provided in-network. A detailed list of the other 3.67% is available upon request.

The following reports provide an outline for discussion between PEBP and HealthSCOPE.

Preventive Care Services Compliance Review Paid at Less than 100%

PEBP - HealthSCOPE

Audit Period 10/1/2020 - 12/31/2020

Plans: All

Filters: Exclude - out of network, adjustments, edits with frequency limits, claimants 65 or older

		Claim Lines Submitted	Denied	Applied Deductible		Applied Copay		Applied Coinsurance		Paid @100%		
Edit Guideline	Preventive Service Benefit	#	#	#	Amount	#	Amount	#	Amount	#	Amount	%
USPSTF-A	Hypothyroidism screening - 0-90 days	1	0	1	$20	0	$0	0	$0	0	$0	.00%
USPSTF-B	Breast cancer chemoprevention counseling- >17	9	0	5	$346	1	$40	2	$53	1	$159	11.11%
USPSTF-B	BRCA screening counseling - women	29	2	11	$7,456	3	$120	9	$2,228	4	$4,784	14.81%
ACIP	Immunizations - DTP >18	4	0	0	$0	0	$0	3	$18	1	$30	25.00%
HHS	Breastfeeding support and counseling - women	40	0	23	$4,875	1	$40	3	$96	13	$2,568	32.50%
USPSTF-A,B	Rh incompatibility screening - pregnant women	71	0	26	$1,284	12	$622	9	$125	24	$1,439	33.80%
USPSTF-A	HIV screening - pregnant women	27	1	16	$542	0	$0	1	$45	9	$204	34.62%
USPSTF-B	Alcohol misuse - screening and counseling	8	0	5	$118	0	$0	0	$0	3	$47	37.50%
USPSTF-B	Depression screening - >18	25	0	12	$142	0	$0	3	$8	10	$133	40.00%
USPSTF-A	Syphillis screening	51	2	20	$108	0	$0	6	$7	23	$165	46.94%
USPSTF-B	Tobacco use counseling - >18	32	3	11	$174	0	$0	2	$11	16	$391	55.17%
HHS	Gestational Diabetes Mellitus screening - women	171	4	53	$723	0	$0	10	$14	104	$828	62.28%
USPSTF-B	Depression screening - 12-18	33	0	10	$59	0	$0	2	$2	21	$123	63.64%
USPSTF-A	Hepatitis B screening - women	39	0	13	$271	0	$0	0	$0	26	$282	66.67%
USPSTF-A	Syphilis screening - pregnant women	154	2	44	$538	0	$0	6	$6	102	$556	67.11%
USPSTF-A	Urinary tract infection screening - pregnant women	91	2	18	$566	4	$122	5	$55	62	$666	69.66%
USPSTF-B	Hepatitis C Virus (HCV) Screening	235	3	52	$768	0	$0	18	$60	162	$2,436	69.83%
USPSTF-B	Gonorrhea screening - female	375	0	95	$4,764	1	$0	17	$189	262	$11,620	69.87%
USPSTF-A,B	Chlamydia infection screening - women	379	0	95	$4,438	1	$75	17	$184	266	$12,021	70.18%
USPSTF-A	Phenylketonuria (PKU) screening 0-90 days	7	0	1	$8	0	$0	1	$13	5	$67	71.43%
USPSTF-A	HIV screening - >14	185	7	41	$1,442	0	$0	8	$44	129	$3,655	72.47%
USPSTF-B	Healthy diet counseling	293	2	34	$1,776	25	$1,000	18	$373	214	$24,117	73.54%
USPSTF-A	Cholesterol abnormalities screening - men 35-75	594	3	119	$1,774	0	$0	12	$36	460	$8,130	77.83%
USPSTF-A,B	Cholesterol abnormalities screening - women >19	704	1	117	$2,162	0	$0	22	$83	564	$10,500	80.23%
Bright Futures	Tuberculin testing - <21	14	0	2	$35	0	$0	0	$0	12	$187	85.71%
USPSTF-B	Hearing loss screening - 0 - 90 days	36	0	2	$219	0	$0	2	$43	32	$5,017	88.89%
ACIP	Immunizations - Hepatitis A >18	18	0	1	$117	0	$0	0	$0	17	$1,305	94.44%
ACIP	Immunizations - Pneumococcal >18	74	1	2	$158	0	$0	2	$56	69	$8,644	94.52%
Bright Futures	Lead screening - <21	28	7	1	$17	0	$0	0	$0	20	$302	95.24%
Bright Futures	Dyslipidemia screening - 2-20	67	0	3	$35	0	$0	0	$0	64	$1,110	95.52%
Bright Futures	Iron Supplement - <21	130	0	3	$12	0	$0	1	$1	126	$485	96.92%
USPSTF-A	Colorectal cancer screening - 45-75	554	25	13	$790	0	$0	2	$7	514	$184,664	97.16%
USPSTF-B	Breast cancer mammography screening - >39	4,240	2	98	$6,100	12	$240	6	$52	4,122	$325,412	97.26%
ACIP	Immunizations - Herpes Zoster >59	328	1	7	$1,544	0	$0	1	$44	319	$46,155	97.55%
HHS	Contraceptive methods - women	605	5	3	$597	3	$100	3	$1,391	591	$190,821	98.50%
ACIP	Immunizations - Influenza Age >18	2,849	25	11	$360	6	$125	10	$58	2,797	$54,294	99.04%
HHS	Cervical Cancer Screening (HPV DNA) - women >29	804	1	5	$220	0	$0	2	$17	796	$33,867	99.13%
USPSTF-A	Cervical Cancer Screening (Pap) - women	1,377	3	8	$245	0	$0	2	$9	1,364	$63,108	99.27%
HHS	Wellness Examinations - women	2,638	9	10	$1,834	0	$0	3	$92	2,616	$344,562	99.51%
Bright Futures	Developmental Autism screening - <3	235	0	1	$20	0	$0	0	$0	234	$7,347	99.57%
HHS	Wellness Examinations - >18	800	5	2	$175	0	$0	1	$5	792	$101,779	99.62%
ACIP	Immunization Administration - >18	4,066	79	3	$189	3	$90	1	$2	3,980	$104,872	99.82%
ACIP	Immunizations - DTP <19	732	6	1	$58	0	$0	0	$0	725	$48,358	99.86%
HRSA/HHS	Wellness Examinations - <19	2,616	4	2	$229	0	$0	1	$19	2,609	$284,243	99.89%
ACIP	Immunizations - Influenza <19	2,637	4	0	$0	0	$0	2	$7	2,631	$50,991	99.92%
ACIP	Immunization Administration - <19	4,952	34	1	$59	0	$0	0	$0	4,917	$168,889	99.98%

Preventive Care Services Compliance Review Paid at 100%												
PEBP - HealthSCOPE												
Audit Period 10/1/2020 - 12/31/2020												
Plans: All												
Filters: Exclude - out of network, adjustments, edits with frequency limits, claimants 65 or older												
		Claim Lines Submitted	Denied	Applied Deductible		Applied Copay		Applied Coinsurance		Paid @100%		
Edit Guideline	Preventive Service Benefit	#	#	#	Amount	#	Amount	#	Amount	#	Amount	%
ACIP	Immunizations - Human papillomavirus	295	1	0	$0	0	$0	0	$0	294	$65,140	100.00%
ACIP	Immunizations - Meningococcal <19	275	1	0	$0	0	$0	0	$0	274	$35,319	100.00%
ACIP	Immunizations - Rotavirus <19	272	2	0	$0	0	$0	0	$0	270	$27,484	100.00%
ACIP	Immunizations - Hepatitis A <19	262	1	0	$0	0	$0	0	$0	261	$9,635	100.00%
Bright Futures	Hearing Screening 0-21 yrs	191	19	0	$0	0	$0	0	$0	172	$3,349	100.00%
USPSTF-B	Vision screening - 3- 5	165	13	0	$0	0	$0	0	$0	152	$3,789	100.00%
ACIP	Immunizations - Measles, Mumps, Rubella <19	149	2	0	$0	0	$0	0	$0	147	$32,128	100.00%
ACIP	Immunizations - Meningococcal >18	135	0	0	$0	0	$0	0	$0	135	$22,871	100.00%
ACIP	Immunizations - Varicella <19	121	0	0	$0	0	$0	0	$0	121	$18,370	100.00%
ACIP	Immunizations - Hepatitis B <19	80	0	0	$0	0	$0	0	$0	80	$2,367	100.00%
ACIP	Immunizations - Hepatitis B >18	35	2	0	$0	0	$0	0	$0	33	$5,959	100.00%
ACIP	Immunizations - Inactivated Poliovirus <19	24	0	0	$0	0	$0	0	$0	24	$1,183	100.00%
ACIP	Immunizations - Varicella >18	8	0	0	$0	0	$0	0	$0	8	$1,107	100.00%
ACIP	Immunizations adult - Influenza Age (FluMist) 19-4	4	2	0	$0	0	$0	0	$0	2	$47	100.00%
ACIP	Immunizations - Pneumococcal <19	1	0	0	$0	0	$0	0	$0	1	$107	100.00%

NCCI Editing Compliance

While there are no universally accepted correct coding guidelines among private insurers and administrators, the Centers for Medicare & Medicaid Services (CMS), the nation's largest payer for health care, took the initiative to provide valuable guidance for medical benefit plans. Implementation of NCCI mandated several initiatives to prevent improperly billed claims from being paid under Medicare and Medicaid.

Scope

The two NCCI initiatives that can offer the greatest return benefit to self-funded employee benefit plans are the Procedure-to-Procedure (PTP) Edits and Medically Unlikely Edits (MUEs).

Our claim system code editing analysis identified services submitted to the plan and paid by HealthSCOPE that Medicare and Medicaid would have denied. **Since HealthSCOPE paid the billed charges, the payments represent a potential savings opportunity to PEBP.**

It is difficult to establish the extent to which administrators and carriers use NCCI edits; however, CTI recommends these reports be discussed with your administrator to determine the extent to which they incorporate CMS edits. Using these edits typically reduces claim expense and furthers efforts toward achieving standardized code-editing systems for all payers.

PTP Edits Reports

PTP Edits compare procedure codes from multiple claim lines on the same day to identify when procedures submitted on the same claim cannot be billed together. Our reports are grouped by outpatient hospital services and non-facility claims using CMS' quarterly updated data. If your administrator is not currently using these CMS edits, CTI's reports will help you evaluate the savings you would have realized had the PTP Edits been in place.

Procedure to Procedure Edits								
PEBP - HealthSCOPE								
Based on Paid Dates 10/1/2020 through 12/31/2020								
Outpatient Hospital Services (facility claims with codes not designated inpatient)								
Primary		**Secondary**		**Mod**	**Primary Description**	**Secondary Description**	**Line**	**Secondary**
Code	**Mod**	**Code**	**Mod**	**Use**			**Count**	**Allowable Benefit**
63081		22551		YES	Remove vert body dcmprn crvl	NECK SPINE FUSE&REMOV BEL C2	1	$6,874
					More extensive procedure			
70496		70450		YES	CT ANGIOGRAPHY HEAD	CT HEAD/BRAIN W/O DYE	6	$3,622
					Misuse of column two code with column one code			
37241		75831	TC	YES	Vascular embolization or occlusion	VEIN X-RAY KIDNEY	1	$2,633
					CPT Manual or CMS manual coding instructions			
74177	TC	96374		YES	CT ABD & PELV W/CONTRAST	THER/PROPH/DIAG INJ IV PUSH	7	$2,509
					Standards of medical / surgical practice			
93975		76770		YES	VASCULAR STUDY	US EXAM ABDO BACK WALL COMP	2	$2,355
					Misuse of column two code with column one code			
93975		76856		YES	VASCULAR STUDY	US EXAM PELVIC COMPLETE	5	$2,308
					Misuse of column two code with column one code			
77280	TC	77336		YES	SET RADIATION THERAPY FIELD	RADIATION PHYSICS CONSULT	4	$1,970
					Misuse of column two code with column one code			
29876	SG	29877	SG,59	NO	KNEE ARTHROSCOPY/SURGERY	KNEE ARTHROSCOPY/SURGERY	2	$1,841
					Misuse of column two code with column one code			
74177	TC	96365		YES	CT ABD & PELV W/CONTRAST	THER/PROPH/DIAG IV INF INIT	5	$1,792
					Standards of medical / surgical practice			
74177		96365		YES	CT ABD & PELV W/CONTRAST	THER/PROPH/DIAG IV INF INIT	4	$1,537
					Standards of medical / surgical practice			
						Top 10 TOTAL	**37**	**$27,440**
						GRAND TOTAL	**638**	**$95,373**

Non-Facility (non-facility claims with CPT codes:00100 - 99999)								
Primary		**Secondary**		**Mod**	**Primary Description**	**Secondary Description**	**Line**	**Secondary**
Code	**Mod**	**Code**	**Mod**	**Use**			**Count**	**Allowable Benefit**
90471		99396		YES	IMMUNIZATION ADMIN	PREV VISIT EST AGE 40-64	11	$1,014
					CPT Manual or CMS manual coding instructions			
90471		99214		YES	IMMUNIZATION ADMIN	Office/outpatient visit for E&M of	8	$930
					CPT Manual or CMS manual coding instructions			
63030		69990	59	NO	LOW BACK DISK SURGERY	MICROSURGERY ADD-ON	1	$617
					Misuse of column two code with column one code			
22551		69990		NO	NECK SPINE FUSE&REMOV BEL C2	MICROSURGERY ADD-ON	1	$467
					Misuse of column two code with column one code			
90460		99211	25	NO	IM ADMIN 1ST/ONLY COMPONENT	OFFICE/OUTPATIENT VISIT EST	16	$414
					CPT Manual or CMS manual coding instructions			
00790	AA,P3	95955	26,59	NO	ANESTH SURG UPPER ABDOMEN	EEG DURING SURGERY	2	$308
					Standard preparation / monitoring services for anesthesia			
01400	AA	95955	26,59	NO	ANESTH KNEE JOINT SURGERY	EEG DURING SURGERY	2	$308
					Standard preparation / monitoring services for anesthesia			
63047		69990		NO	Remove spine lamina 1 lmbr	MICROSURGERY ADD-ON	1	$300
					Misuse of column two code with column one code			
90471		99203		YES	IMMUNIZATION ADMIN	Office/outpatient visit for E&M of	2	$275
					CPT Manual or CMS manual coding instructions			
96372		99204		YES	THER/PROPH/DIAG INJ SC/IM	Office/outpatient visit for E&M of	1	$219
					Standards of medical / surgical practice			
						Top 10 TOTAL	**45**	**$4,853**
						GRAND TOTAL	**165**	**$9,180**

MUE Reports

An MUE is an edit that tests claim lines for the same beneficiary, procedure code, date of service, and billing provider against a maximum allowable number of service units. The MUE rule for a given code is the maximum number of service units a provider should report for a single day of service. MUE errors could be caused by incorrect coding, inappropriate services performed, or fraud. MUEs do not require Medicare contractors to perform a manual review or suspend claims; rather, claim lines are denied and must be correctly resubmitted by providers, typically with a lesser payment amount.

CTI's MUE analyses are grouped into three separate reports:

- Outpatient hospital
- Non-facility
- Ancillary

NCCI MUE Edits				
PEBP - HealthSCOPE				
Based on Paid Dates 10/1/2020 through 12/31/2020				
Outpatient Hospital Services (facility claims with codes not designated inpatient)				
Procedure Code	**Service Unit Limit**	**Procedure Description**	**Line Count Exceeding Limit**	**Gross Benefit Allowed**
C1880	2	VENA CAVA FILTER	1	$19,570
		Rationale: Clinical: Data		
29823	1	debridement, extensive, 3 or more discrete	1	$9,852
		Rationale: CMS Policy		
90999	1	DIALYSIS PROCEDURE	3	$7,124
		Rationale: Clinical: CMS Workgroup		
90945	1	DIALYSIS ONE EVALUATION	10	$6,838
		Rationale: Nature of Service/Procedure		
36558	2	INSERT TUNNELED CV CATH	1	$6,161
		Rationale: Clinical: Data		
69436	1	CREATE EARDRUM OPENING	1	$4,918
		Rationale: CMS Policy		
99152	2	MOD SED SAME PHYS/QHP INITIAL 15	28	$4,893
		Rationale: Nature of Service/Procedure		
10140	2	DRAINAGE OF HEMATOMA/FLUID	1	$4,638
		Rationale: Clinical: Data		
99153	12	MOD SED SAME PHYS/QHP EACH ADDL 15	18	$4,430
		Rationale: Clinical: CMS Workgroup		
80307	1	DRUG TEST PRSMV INSTRMNT CHEMISTRY	4	$3,854
		Rationale: Code Descriptor / CPT Instruction		
		Top 10 TOTAL	**68**	**$72,278**
		GRAND TOTAL	**167**	**$118,998**

Non-Facility (non-facility claims with CPT codes:00100 - 99999)				
Procedure Code	Service Unit Limit	Procedure Description	Line Count Exceeding Limit	Gross Benefit Allowed
95165	30	ANTIGEN THERAPY SERVICES	13	$15,701
		Rationale: Clinical: Data		
97155	24	ADAPT BHV TX PRTCL MODIFICAJ	11	$10,290
		Rationale: Clinical: Society Comment		
97157	16	MULTIPLE FAM GROUP BHV TX GDN	6	$9,375
		Rationale: Clinical: CMS Workgroup		
97799	1	PHYSICAL MEDICINE PROCEDURE	13	$9,052
		Rationale: Clinical: Data		
97156	16	FAMILY ADAPT BHV TX GDN PHYS/QHP EA	7	$7,310
		Rationale: Clinical: CMS Workgroup		
88374	5	Morphometric analysis, in situ	6	$2,811
		Rationale: Clinical: Data		
95004	80	PERCUT ALLERGY SKIN TESTS	4	$2,789
		Rationale: Clinical: CMS Workgroup		
88377	5	Morphometric analysis, in situ	1	$2,398
		Rationale: Clinical: Data		
88307	8	TISSUE EXAM BY PATHOLOGIST	2	$2,317
		Rationale: Clinical: Data		
56515	1	DESTROY VULVA LESION/S COMPL	1	$2,141
		Rationale: Anatomic Consideration		
		Top 10 TOTAL	**64**	**$64,184**
		GRAND TOTAL	**165**	**$90,128**

Ancillary (All other claims not flagged Inpatient, Outpatient Hospital, or non-facility)				
Procedure Code	Service Unit Limit	Procedure Description	Line Count Exceeding Limit	Gross Benefit Allowed
A4253	1	BLOOD GLUCOSE/REAGENT STRIPS	23	$2,617
		Rationale: Nature of Equipment		
K0001	1	STANDARD WHEELCHAIR	26	$1,185
		Rationale: Nature of Equipment		
E0443	1	PORTABLE 02 CONTENTS, GAS	7	$1,094
		Rationale: Code Descriptor / CPT Instruction		
E0465	2	Home ventilator, any type, used with	1	$887
		Rationale: Nature of Equipment		
E0730	1	TENS FOUR LEAD	1	$697
		Rationale: Nature of Equipment		
A7520	1	TRACH/LARYN TUBE NON-CUFFED	3	$662
		Rationale: Published Contractor Policy		
E0601	1	CONT AIRWAY PRESSURE DEVICE	2	$630
		Rationale: Nature of Equipment		
E0202	1	PHOTOTHERAPY LIGHT W/ PHOTOM	2	$450
		Rationale: Nature of Equipment		
B4035	1	ENTERAL FEED SUPP PUMP PER D	1	$412
		Rationale: Code Descriptor / CPT Instruction		
A5114	3	FOAM/FABRIC LEG STRAP	3	$231
		Rationale: Clinical: CMS Workgroup		
		Top 10 TOTAL	**69**	**$8,865**
		GRAND TOTAL	**113**	**$10,711**

Global Surgery Prohibited Fee Period Analysis

CMS created the definition of global surgical package to make payments for services provided by a surgeon before, during, and after procedures. The objective of CTI's Global Surgery Prohibited Fee Period Analysis is to compare paid surgical claims to Medicare's payment guidelines and identify instances of unbundling and improper use of evaluation and management (E/M) coding.

Scope

The scope of the Global Surgery Prohibited Fee Period Analysis is surgery charges provided in any setting, including inpatient hospital, outpatient hospital, ambulatory surgical center (ASC), and physician's office. Claims for surgeon visits in intensive care or critical care units are also included in the global surgical package. Our analysis encompasses the three types of procedures with global surgical packages: simple, minor, and major. Each type has specific global periods:

- Simple – One day
- Minor – Ten days
- Major – Ninety days

CMS allows providers to bill for an E/M service after surgery if the patient's condition required a significant, separately identifiable E/M service beyond the usual pre-operative and post-operative care. When this occurs, the provider can add a modifier 24, 25, or 57 to the E/M service procedure code but must submit supporting documentation with the claim.

Report

The following report provides a summary of:

- top 10 providers with and without E/M charges during prohibited periods and associated charges;
- analysis of same providers' surgeries with modifier 24, 25, or 57 when Medicare would have required supporting documentation before payment; and
- analysis of the same providers' surgeries without modifier 24, 25, or 57 when Medicare would have denied payment.

Payment of unbundled, post-surgical E/M services during the global fee period increases the cost of a claim. While there are no universally accepted guidelines for global surgery fee periods with 24, 25, or 57 modifiers, some states and groups mandate providers accept assignment of benefits on those claims. This mitigates the financial impact of unbundling and improper coding. When we discuss our findings, we will help you identify strategies to monitor and eliminate unbundling within your plan.

PEBP - HealthSCOPE									
Audit Period 10/1/2020 - 12/31/2020									
	Surgeries with 'CMS Defined' Prohibited Global Fee Periods					Evaluation and Management Services using Same ID as Surgeon and Within Prohibited Global Fee Period			
	Surgeries without E/M Procedures during Prohibited Global Fee Periods		Surgery with E/M Charge during Prohibited Global Fee Periods			E/M Procedure Codes with Modifier 24, 25, or 57		E/M Procedure Codes without Modifier 24, 25, or 57	
Provider Id	Count	Allowed Charge	Count	% Surgeries with E/M Charges during Prohibited Global Fee Periods	Allowed Charge	Total Count; 0,10 & 90 days	Allowed Charge	Total Count; 0,10 & 90 days	Allowed Charge
880176637	1	$310	4	80.0%	$5,456	0	$0	12	$2,400
880103557	244	$106,315	29	10.6%	$2,387	16	$855	12	$922
946004062	6	$2,451	2	25.0%	$1,608	1	$173	1	$302
300520570	12	$1,199	2	14.3%	$1,389	1	$106	3	$225
880502320	0	$0	2	100.0%	$206	1	$71	2	$172
880133501	111	$38,272	23	17.2%	$4,242	20	$1,697	2	$172
880310956	32	$9,520	3	8.6%	$394	3	$361	1	$47
880341714	47	$20,778	4	7.8%	$908	3	$205	1	$44
880454760	11	$2,402	2	15.4%	$53	0	$0	1	$32
910858192	41	$19,396	23	35.9%	$2,106	22	$1,669	1	$32
Top 10	**505**	**$200,642**	**94**	**15.7%**	**$18,749**	**67**	**$5,136**	**36**	**$4,349**
Overall Total	**2,989**	**$1,027,970**	**507**	**14.5%**	**$96,875**	**458**	**$44,353**	**36**	**$4,349**

CONCLUSION

We consider it a privilege to have worked for, and with, your staff and administrator. Thank you again for choosing CTI.

APPENDIX – ADMINISTRATOR RESPONSE TO DRAFT REPORT

Your administrator's response to the draft report follows.

27 Corporate Hill Drive
Little Rock, AR 72205

December 17, 2021
Amended on February 25, 2022

Claim Technologies Incorporated
100 Court Avenue Suite 306
Des Moines, IA 50309

Dear Ms. Nisius,

Thank you for the opportunity to work with CTI on our mutual client State of Nevada Public Employees' Benefit Program.

Appendix – Administrator's Response to Draft Report for State of Nevada Public Employees' Benefit Program.

Performance Guarantees: Administrator's Response to the Draft Report regarding the State of Nevada Public Employees' Benefit program.
Metrics

- Payment Accuracy Q2– 96.5% - **HSB Response**: Disagree with CTI conclusion regarding the payment accuracy detail information. There are errors that are calculated in the detail that should be re-evaluated based on the documentation and information provided to CTI.
- Financial Accuracy Q2– 97.51% - **HSB Response**: Disagree with CTI conclusion regarding the financial accuracy detail information. There are errors that are calculated in the detail that should be re-evaluated based on the documentation and information provided to CTI.
- Claim Processing Turnaround Q2– 98% - **HSB Response**: The original implementation with the State of Nevada Public Employees' Benefit Program, HealthSCOPE Benefits and the PEBP appointed auditor, agreed that HealthSCOPE Benefits would self-report turnaround time results using reporting from the HealthSCOPE claims processing system. HealthSCOPE Benefits has been providing the quarterly turnaround time reports since inception of the plan to the State of Nevada as well as the PEBP appointed auditor.
- Data Reporting Q2– **HSB Response**: Disagree with CTI conclusion regarding the data reporting was not met. February 14, 2021 falls on a Sunday and the reports were delivered to the State of Nevada the following business day which was Monday February 15, 2021.

HealthSCOPE Benefits has reviewed the draft report and would like to add the additional information due to the conclusions within the audit report.

TARGETED SAMPLE ANALYSIS:

Invalid Procedures Codes Detail Report:

QID M10 – HSB does not agree with CTI conclusion. The invoice received is a payment for a covered Breast Pump. Per the MPD * Contact the third-party Claims Administrator for the purchase of covered breast pumps.
Commit Developers LLC, dba Breast Pump Direct which is a Breast Pump vendor that is utilized to purchase Breast Pumps. HealthSCOPE Benefits does have a contract with the vendor.

Fraud, Waste, and Abuse Detail Report:

QID M27 - HSB does not agree with CTI conclusion. The claim was adjudicated based on the plan guidelines for Chiropractic care based on the agreement with Sierra Healthcare Options.

QID M28 – HSB does not agree with CTI conclusion. The claim was adjudicated based on the plan guidelines for Chiropractic care based on the agreement with Hometown health.

QID M29 – HSB does not agree with CTI conclusion. The claim was adjudicated based on the plan guidelines for Chiropractic care based on the agreement with Hometown health.

Duplicate Payment Detail Report:

QID M16 – HSB does not agree with CTI conclusion. There is not an outstanding overpayment on the account for QID M16. The overpayment was satisfied on 08/30/2021 on the account.

QID M17 - HSB does not agree with CTI conclusion. There is not an outstanding overpayment on the account for QID M17. The overpayment was satisfied on 08/30/2021 on the account. **M17** is the same claim number as **M16**.

QID M18 – HSB does not agree with CTI conclusion. There is not an outstanding overpayment on the account for QID M18. The overpayment was satisfied on 08/30/2021 on the account. **M18** is the same claim number as **M16**.

QID M19 – HSB does not agree with CTI conclusion. There is not an outstanding overpayment on the account for QID M19. The overpayment was satisfied on 08/30/2021 on the account. **M19** is the same claim number as **M16**.

QID M20 – HSB does not agree with CTI conclusion. There is not an outstanding overpayment on the account for QID M20. The overpayment was satisfied on 08/30/2021 on the account. **M20** is the same claim number as **M16**.

Plan Limitations Detail Report:

QID D1 – HSB does not agree with CTI conclusion. There is not an outstanding overpayment on the account for QID D1. The claim was received prior to the timely filing deadline per the MPD guidelines. This claim was a reconsideration of the original claim.

QID D2 – HSB does not agree with CTI conclusion. There is not an outstanding overpayment on the account for QID D2. The claim was received prior to the timely filing deadline per the MPD guidelines. This claim was a reconsideration with additional information that was requested.

QID M3 – HSB does not agree with CTI conclusion. Update response for QID M3. Original claim was received prior to the timely filing deadline per the MPD. The claim was denied to investigate Medicare coverage for this member. Provider submitted a new claim with information and this claim was a reconsideration of the original claim.

QID M33 – HSB does not agree with CTI conclusion. There is not an outstanding overpayment on the account for QID M33. The provider submitted refund check # 90340 that was received 02/23/2021 and applied to the account and satisfied the amount due on the account.

QID M35 - HSB does not agree with CTI conclusion. The claim had additional diagnosis code to include cervicalgia.

QID M37 – HSB does not agree with CTI conclusion. Client did provide verbal approval to pay the claim according to the Hometown Health contract. The client did not want the member to be balanced billed for any service due to the critical treatment for the member.

Plan Exclusion Detail Report:

QID D3 – HSB does not agree with CTI conclusion. There is not an outstanding overpayment on the account for QID D3. The services were billed due to code D7240 which is removal of impacted tooth – completely bony.

QID D4 – HSB does not agree with CTI conclusion. There is not an outstanding overpayment on the account for QID D4. Code D7952 is augmentation of the sinus to increase alveolar height by vertical access through the ridge crest by raising the floor of the sinus and grafting as necessary. This includes obtaining the bone or bone substitutes due to code D7210 which is a surgical removal of erupted tooth requiring removal of bone and/or sectioning of the tooth.

QID D5 - HSB does not agree with CTI conclusion. There is not an outstanding overpayment on the account for QID D5. Code D7951 is augmentation of the sinus and includes obtaining the bone or bone substitutes due to code D7210 which is a surgical removal of erupted tooth requiring removal of bone and/or sectioning of the tooth.

QID D6 – HSB does not agree with CTI conclusion. The claim, procedure notes as well as a copy of the x-rays were provided with the response on QID D6 for D7960.

QID D8 - HSB does not agree with CTI conclusion. Code D7870 is a procedure to remove the synovial fluid accumulated around the joints.

QID D10 – HSB does not agree with CTI conclusion. The procedure code D7290 is surgical repositioning of teeth due to bone replacement graft.

Observation:

QID M9 – Claim was considered and priced based on the Aetna contracted pricing. Aetna confirmed the pricing per the contracted rate and that the pricing is correct. Per Aetna, PPO contract does not have lesser of language.

RANDOM SAMPLE AUDIT:

Financial Accuracy and Accurate payment Detail Report: HealthSCOPE Benefit will request that CTI review the additional information on the following audits and re-evaluate the Financial Accuracy for the State of Nevada Q2 audit findings.

Audit No. 1089 – HSB update for response on final draft. M1089 was identified during an internal audit and the claim was reconsidered on 12/03/2020. This claim was reconsidered prior to the CTI audit.

Audit No. M1106 – HSB does not agree with CTI conclusion. This claim was processed correctly per client's directive. Primary diagnosis is routine, and this is the first EKG of the year.

Audit No. M1136 - HSB does not agree with CTI conclusion. The plan has allowed screening mammograms for women under the age of 40 with a diagnosis billed as family history of malignant cancer.

Audit No. M1105 – HSB does not agree with CTI conclusion. Due to the National Emergency declared on March 1, 2020, the Employee Benefits Security Administration, Department of Labor, Internal Revenue Service and the Department of the Treasury extended certain timeframes to ease the burden of maintaining benefits and compliance with notice obligations. To help providers and members meet timely filing rules the period from March 1, 2020, to 60 days after the announced end of the National Emergency will not count towards timely filing requirements. Currently, there is no end date. There was an extension to the timely filing period. The claim does fall into the extension and was processed correctly.

Accurate Processing Detail Report:

Audit No. M1106 – HSB does not agree with CTI conclusion. This claim was processed correctly per client's directive. Primary diagnosis is routine, and this is the first EKG of the year.

Audit No. M1136 - HSB does not agree with CTI conclusion. The plan has allowed screening mammograms for women under the age of 40 with a diagnosis billed as family history of malignant cancer.

Audit No. D2049 - HSB does not agree with CTI conclusion. The paper claim that was submitted does reflect tooth number/letter F. The current system is set to edit for possible duplicates based on the parameters provided to CTI. The system will look at Date of service, Tax ID, Procedure Code, Modifiers, Tooth numbers.

Audit No. M1105 – HSB does not agree with CTI conclusion. Due to the National Emergency declared on March 1, 2020, the Employee Benefits Security Administration, Department of Labor, Internal Revenue Service and the Department of the Treasury extended certain timeframes to ease the burden of maintaining benefits and compliance with notice obligations. To help providers and members meet timely filing rules the period from March 1, 2020, to 60 days after the announced end of the National Emergency will not count towards timely filing requirements. Currently, there is no end date. There was an extension to the timely filing period. The claim does fall into the extension and was processed correctly.

Thank you,

Jennifer Spencer, Associate Director of Quality Assurance
HealthSCOPE Benefits, Inc

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4.4.2

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

    4.4 Acceptance of Claim technologies Incorporated audit findings for State of Nevada Public Employees' Benefits Program Plans administered by HealthSCOPE Benefits for:

        4.4.1 Period October 1, 2020 – December 31, 2020 (FY21.Q2)

        4.4.2 Period January 1, 2021 – March 31, 2021 (FY21.Q3)

Comprehensive Claim Administration Audit

QUARTERLY FINDINGS REPORT

State of Nevada Public Employees' Benefits Program Plans

Administered by HealthSCOPE Benefits

Audit Period: January 1, 2021 through March 31, 2021
Audit Number 1.FY21.Q3

Presented to

State of Nevada Public Employees' Benefits Program

Revised March 9, 2022

CLAIM TECHNOLOGIES
INCORPORATED

TABLE OF CONTENTS

EXECUTIVE SUMMARY 3

AUDIT OBJECTIVES 4

OPERATIONAL REVIEW PERFORMANCE GUARANTEES 5

100% ELECTRONIC SCREENING WITH TARGETED SAMPLE ANALYSIS 6

RANDOM SAMPLE AUDIT 9

DATA ANALYTICS 13

CONCLUSION 21

APPENDIX – Administrator's Response to Draft Report 22

EXECUTIVE SUMMARY

This ***Quarterly Findings Report*** is a compilation of the detailed information, findings, and conclusions drawn from Claim Technologies Incorporated's (CTI's) audit of HealthSCOPE Benefits' (HealthSCOPE) administration of the State of Nevada Public Employees' Benefits Program's (PEBP) medical, dental, and health reimbursement arrangement (HRA) plan.

Scope

CTI performed an audit of HealthSCOPE's administration of the PEBP's medical, dental and HRA for the period of January 1, 2021 through March 31, 2021 (quarter 3 (Q3) for Fiscal Year (FY) 2021). The population of claims and amount paid during the audit period reported by HealthSCOPE Benefits:

Medical and Dental	
Total Paid Amount	$56,776,162
Total Number of Claims Paid/Denied/Adjusted	206,359
Health Reimbursement Arrangement (HRA)	
Total Paid Amount	$1,239,023
Total Number of Claims Paid/Denied/Adjusted	13,330

The audit included the following components which are described in more detail in the following pages.

- Operational Review – Performance Guarantees Only
- 100% Electronic Screening with Targeted Samples
- Random Sample Audit
- Data Analytics

Auditor's Opinion

Based on these findings, and in our opinion:

1. HealthSCOPE improved its Financial Accuracy measurement in Q3 FY2021 and no penalty is owed.
2. HealthSCOPE should:
    - Review the 100% Electronic Screening with Targeted Sample results and focus on the most material findings in Paid Greater than Charged, Spinal Region Upcoding, and Duplicate Claims Payments.
    - Review the Random Sample Audit results and focus on providing coaching and feedback to examiners to prevent similar manual errors going forward.

Summary of HealthSCOPE's Guarantee Measurements

Based on CTI's Random Sample Audit results, HealthSCOPE met both claims processing measurements for the PEBP in Q3 FY2021.

Quarterly Guarantee	Measure	Met/Not Met	Penalty
Financial Accuracy	99%	Met – 99.88%	None.
Payment Accuracy	98%	Met – 99.00%	None.

AUDIT OBJECTIVES

This report contains CTI's findings from our audit of HealthSCOPE Benefits' (HealthSCOPE) administration of the State of Nevada Public Employees' Benefits Program (PEBP) plans. We provide this report to PEBP, the plan sponsor, and HealthSCOPE, the claim administrator. A copy of HealthSCOPE's response to these findings can be found in the Appendix of this report.

CTI conducted the audit according to accepted standards and procedures for claim audits in the health insurance industry. We based our audit findings on the data and information provided by PEBP and HealthSCOPE. The validity of our findings relies on the accuracy and completeness of that information. We planned and performed the audit to obtain a reasonable assurance claims were adjudicated according to the terms of the contract between HealthSCOPE and PEBP.

CTI specializes in the audit and control of health plan claim administration. Accordingly, the statements we make relate narrowly and specifically to the overall effectiveness of policies, procedures, and systems HealthSCOPE used to pay PEBP's claims during the audit period. While performing the audit, CTI complied with all confidentiality, non-disclosure, and conflict of interest requirements and did not receive anything of value or any benefit of any kind other than agreed upon audit fees.

The objectives of CTI's audit of HealthSCOPE's claim administration were to determine whether:

- HealthSCOPE followed the terms of its contract with PEBP;
- HealthSCOPE paid claims according to the provisions of the plan documents and if those provisions were clear and consistent; and
- members were eligible and covered by PEBP's plans at the time a service paid by HealthSCOPE was incurred.

OPERATIONAL REVIEW PERFORMANCE GUARANTEES

Performance Guarantees

As part of CTI's quarterly audit of PEBP, we reviewed the Performance Guarantees included in its contract with HealthSCOPE. The results for Q3 FY2021 follow.

Metric	Guarantee Measurement	Actual	Met/ Not Met
Financial Accuracy	99% or greater of the dollars paid for the audited medical/dental claims to be paid accurately.	99.88%	Met
Payment Accuracy	98% or greater of medical/dental claims audited are paid accurately.	99.00%	Met
Claim Processing Turnaround	99% of all medical/dental claims are to be processed within 30 days	99.92%	Met
Customer Service	• Telephone Response Time less than 30 seconds for inbound calls. • Telephone Abandonment Rate less than 3% First call Resolution greater or equal to 95%	9 Seconds Less than .01% 99.58%	Met Met Met
Data Reporting	• 100% of standard reports within 10 business days • Annual/Regulatory Documents within 10 business days of the Plan Year	Delivered 5/14/21. NA – Annual Report	Met NA
Disclosure of Subcontractors	• Report access of PEBP data within 30 calendar days • Removal of PEBP member PHI within 3 business days after knowledge	No exceptions noted No exceptions noted	Met Met

100% ELECTRONIC SCREENING WITH TARGETED SAMPLE ANALYSIS

Objective

CTI's Electronic Screening and Analysis System (ESAS) software identified and quantified potential claim administration payment errors. PEBP and HealthSCOPE should discuss any verified under- or overpayments to determine the appropriate actions to correct the errors.

Scope

CTI electronically screened 100% of the service lines processed by HealthSCOPE during the audit period for both medical and dental claims. The accuracy and completeness of HealthSCOPE's data directly impacted the screening categories we completed and the integrity of our findings. We screened the following high-level ESAS categories to identify potential amounts at risk:

- Duplicate payments to providers and/or employees
- Plan exclusions and limitations
- Multiple surgical procedures

Methodology

We used ESAS to analyze claim payment accuracy as well as any opportunities for system and process improvement. Using the data file provided by HealthSCOPE, we readjudicated each line on every claim the plan paid or denied during the audit period against the plan's benefits. Our Technical Lead Auditor tested a targeted sample of claims to provide insight into HealthSCOPE's claim administration as well as operational policies and procedures. We followed these procedures to complete our ESAS process:

- ***Electronic Screening Parameters Set*** – We used your plan document provisions to set the parameters in ESAS.
- ***Data Conversion*** – We converted and validated your claim data, reconciled it against control totals, and checked it for reasonableness.
- ***Electronic Screening*** – We systematically screened 100% of the service lines processed and flagged claims not administered according to plan parameters.
- ***Auditor Analysis*** – If claims within an ESAS screening category represented a material amount, our auditors analyzed the findings to confirm results were valid. Note than using ESAS could lead to false positives if there was incomplete claim data. CTI auditors made every effort to identify and remove false positives.
- ***Targeted Sample Analysis*** – From the categories identified with material amounts at risk, we selected the best examples of potential under- or overpayments to test. As cases were not randomly selected, we cannot extrapolate results. We selected 50 cases and sent your administrator a questionnaire for each. Targeted samples verified if the claim data supported our finding and if our understanding of plan provisions matched HealthSCOPE's administration.
- ***Audit of Administrator Response and Documentation*** – We reviewed the responses and redacted the responses to eliminate personal health information. Based on the responses and further analysis of the findings, we removed false positives identified from the potential amounts at risk.

Findings

We are confident in the accuracy of our ESAS results. It should be noted that the dollar amounts associated with the results represent potential payment errors and process improvement opportunities. We would have to perform additional testing to substantiate the findings that could then provide the basis for remedial action planning or reimbursement.

Categories for Process Improvement

The following detail report shows, by category, the number of line items or claimants with process improvement opportunities remaining after our analysis and removal of verified false positives. A CTI auditor reviewed the responses and supporting documentation. The administrator responses are copied directly from HealthSCOPE's reply to audit findings.

Process Improvement Summary Report				
Client: PEBP **Screening Period:** Q3 FY2021				
Category	**Number of Service Codes**	**Number of Members**	**Billed Charge**	**Allowed***
Paid Greater than Charged	11	5	$3,597	$8,925
Fraud, Waste and Abuse				
Spinal Region Upcoding – Number of spinal regions treated does not match number of spinal regions billed and allowed.	1,108	368	$76,788	$32,685

**Allowed equals total paid by plan and member combined.*

Electronic screening of all service lines processed revealed the potential for incorrectly paid claims. Analysis confirmed the opportunity for process improvement and further testing is recommended. For each potential error, we sent an ESAS Questionnaire (QID) to HealthSCOPE for written response. After review of the response and additional information provided, CTI confirmed the potential for process improvement. Note that all recommendations for HealthSCOPE process improvements will also be included in the Q4 FY2021 report.

Manually adjudicated claims were processed by an individual claims processor. Auto-adjudicated claims were paid by the system with no manual intervention.

Paid Greater Than Charged Detail Report					
QID	**Category**	**Over Paid**	**HealthSCOPE Response**	**CTI Conclusion**	**Manual or System**
24	Paid Greater Than Charged	$4,789.98	Disagree. The claim was paid with Aetna contracted pricing.	Procedural deficiency and overpayments remain. HealthSCOPE paid more than billed charges on this claim and should consider adding lessor of language to its provider contracts.	☐ M ☒ S
25		$158.40	Agree. This claim should have been considered with the Medicare coinsurance due of $34.00. The overpayment amount would be $158.40. This claim has not been reconsidered to request refund as of yet.		☐ M ☒ S

Fraud, Waste, and Abuse Detail Report					
QID	**Category**	**Over Paid**	**HealthSCOPE Response**	**CTI Conclusion**	**Manual or System**
41	Spinal Region Upcoding	$17.03	Disagree. The claim was adjudicated based on the plan guidelines for Chiropractic care based on the agreement with Hometown Health. This was not investigated, there were no clinical edits and the claim was paid according to the plan guidelines.	Procedural deficiency and overpayment remain. The description for CPT codes for chiropractic care includes the number of regions of the spine or extraspinal regions treated and should be supported by the diagnosis. The provider billed five or more spinal regions treated; however, the diagnosis billed supported treatment of only two spinal regions. These procedure are spinal region driven and should be billed with appropriate diagnosis codes to support billing.	☐ M ☒ S
42		$27.87			☐ M ☒ S

Categories for Potential Amount at Risk

The following report shows, by category, the number of line items or claims and the total potential amount at risk remaining at the conclusion of our analysis, targeted samples, and removal of verified false positives. Following the report is a detailed explanation of our results with findings for all screening categories where, in our opinion, process improvement, recovery or savings opportunities exist. The administrator responses are copied directly from HealthSCOPE's reply to audit findings.

Categories for Potential Amount at Risk				
Client: PEBP **Screening Period:** Q3 FY2021				
Category	**Number of Service Codes**	**Number of Members**	**Billed Charge**	**Allowed***
Duplicate Payments				
Providers and/or Employees	303	41	$551,147	$210,289

**Allowed equals total paid by plan and member combined.*

Electronic screening of all service lines processed revealed the potential for incorrectly paid claims. Analysis confirmed the opportunity for process improvement and further testing is recommended.

Duplicate Payments Detail Report				
QID	**Under/ Over Paid**	**HealthSCOPE Response**	**CTI Conclusion**	**Manual or System**
35	$972.00	Agree. NEV.XXXX3321 has not been corrected under the account.	Procedural deficiency and overpayment remain. HealthSCOPE paid duplicate charges.	☒ M ☐ S

There were no errors found under the dental benefit plan.

In CTI's experience the PEBP's dental plan document is vague and/or silent on a number of dental services. We recommend that the language be updated to indicate specifically which services are covered and which are excluded. This will eliminate the option for medical necessity which means any claim currently submitted is being paid.

RANDOM SAMPLE AUDIT

Objectives

The objectives of our Random Sample Audit were to determine if medical and dental claims were paid according to plan specifications and the administrative agreement, to measure and benchmark process quality, and to prioritize areas of administrative deficiency for further review and remediation.

Scope

CTI's statistically valid Random Sample Audit included a stratified random samples of 200 paid or denied claims. HealthSCOPE's performance was measured using the following key performance indicators:

- Financial Accuracy
- Accurate Payment
- Accurate Processing

We also measured claim turnaround time, a commonly relied upon performance measure.

In addition, CTI sampled 50 health reimbursement arrangement (HRA) claims to ensure payment and processing accuracy.

Methodology

Our Random Sample Audit ensures a high degree of consistency in methodology and is based upon the principles of statistical process control with a management philosophy of continuous quality improvement. Our auditors reviewed each sample claim selected to ensure it conformed to plan specifications, agreements, and negotiated discounts. We recorded our findings in our proprietary audit system.

When applicable, we cited claim payment and processing errors identified by comparing the way a selected claim was paid and the information HealthSCOPE had available at the time the transaction was processed**. It is important to note that even if the sampled claim was subsequently corrected prior to CTI's audit, we have still cited the error so you can discuss how to reduce errors and re-work in the future with your administrator.**

CTI communicated with HealthSCOPE in writing about any errors or observations using system-generated response forms. We sent HealthSCOPE a preliminary report for its review and written response. We considered HealthSCOPE's written response, as found in the Appendix, when producing our final reports. Note that the administrator responses have been copied directly from HealthSCOPE's reply.

Financial Accuracy

CTI defines Financial Accuracy as the total correct claim payments made compared to the total dollars of correct claim payments that should have been made for the audit sample.

The claims sampled and reviewed revealed $500.00 in underpayments and $26.88 in overpayments, for an absolute value variance of $526.88.

The weighted Financial Accuracy rate was 99.88%.

Financial Accuracy Detail Report						
Error Description	**Audit No.**	**Under/ Over Paid**	**HealthSCOPE Response**	**CTI Conclusion**	**Manual or System**	
Copay Calculation	1035	$500.00 – Under	Agree. Claim should have been considered at 100% of the PPO allowed with no copayment.	Procedural error and underpayment remain. This COVID-19 claim should have no cost-share.	☒ M ☐ S	
Subtotal	**1**					
Coinsurance	1050	$26.88 – Over	Agree. Claim was manually adjudicated incorrectly. The maximum out of pocket was not met.	Procedural error and overpayment remain. The out of pocket was not met and cost share should have been applied.	☒ M ☐ S	
Subtotal	**2**					
TOTALS	**2**	**VARIANCE $526.88**			**M: 2**	**S: 0**

Accurate Payment

CTI defines Accurate Payment as the number of claims paid correctly compared to the total number of claims paid for the audit sample.

The audit sample revealed 2 incorrectly paid claims and 198 correctly paid claims. Note CTI only uses adequately documented claims for this calculation.

Total Claims	Incorrectly Paid Claims		Frequency
	Underpaid Claims	Overpaid Claims	
200	1	1	99.00%

Accurate Processing

CTI defines Accurate Processing as the number of claims processed without errors compared to the total number of claims processed in the audit sample.

Correctly Processed Claims	Incorrectly Processed Claims		Frequency
	System	Manual	
198	0	2	99.00%

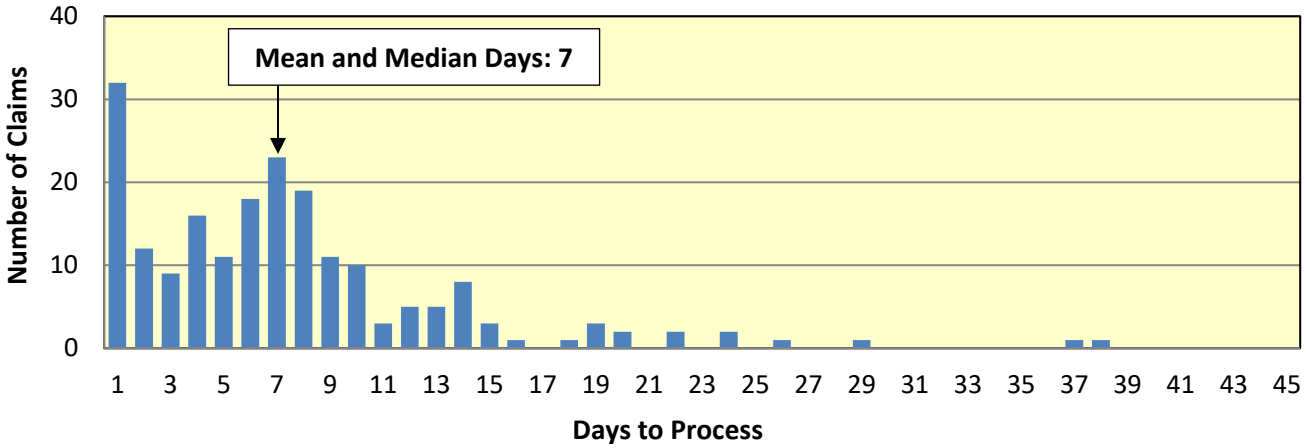
Accurate Processing Detail Report				
Error Description	**Audit No.**	**HealthSCOPE Response**	**CTI Conclusion**	**Manual or System**
Managed Care				
Copay Calculation	1035	Agree. Claim should have been considered at 100% of the PPO allowed with no copayment.	Procedural error remains. This COVID-19 claim should have no cost-share.	☒ M ☐ S
Policy Provision				
Coinsurance	1050	Agree. Claim was manually adjudicated incorrectly. The maximum out of pocket was not met.	Procedural error remains. The out of pocket was not met and cost share should have been applied.	☒ M ☐ S

Claim Turnaround

CTI defines Claim Turnaround as the number of calendar days required to process a claim – from the date the claim was received by the administrator to the date a payment, denial, or additional information request was processed – expressed as both the Median and Mean for the audit sample.

Claim administrators commonly measure claim turnaround time in mean days. Median days, however, is a more meaningful measure for administrators to focus on when analyzing claim turnaround because it prevents one or just a few claims with extended turnaround time from distorting the true performance picture.

Median and Mean Claim Turnaround



Additional Observations

During the Random Sample Audit, our auditor observed the following procedures or situations that may not have caused an error on the sampled claim but may impact future claims or overall quality of service.

Observation	Audit Number
HealthSCOPE is denying any claim with a diagnosis code range of M70 – M79.9 (other soft tissue disorders sometimes associated with an accident) pending completion of an accident report. In this instance, the diagnosis code of M79.7 (fibromyalgia) was listed in the 9th diagnostic position. The primary diagnosis and the reason the patient was being seen was for malignant neoplasm of the rectum. This is clearly not due to an accident.	1031
HealthSCOPE is denying any claim with a diagnosis code range of M46.0 – M54.9 (back pain) pending completion of an accident report. In this instance, the diagnosis code of M54.42 and M54.41 (lumbago with sciatica) was listed in the 9th and 10th diagnostic positions. The primary diagnosis and the reason the patient was being seen was for a chronic ulcer of the right ankle. This is clearly not due to an accident.	1059
HealthSCOPE is denying any claim with a diagnosis code range of S00 – T88.9 (Injury, poisoning and certain other consequences of external causes) pending completion of an accident report. In this instance, the diagnosis code of T86.5 (complications of stem cell transplant) was listed in the 6th diagnostic position. The primary diagnosis and the reason the patient was being seen was for systemic sclerosis, unspecified. This is clearly not due to an accident.	1098

Health Reimbursement Arrangement (HRA) Findings

CTI also reviewed 50 HRA claims as part of our random sample. We communicated with HealthSCOPE in writing about any errors or observations found using response forms. In addition, we sent HealthSCOPE a preliminary report for its review and written response. We considered HealthSCOPE's written response, as found in the Appendix, when producing our final reports.

Of the 50 claims reviewed, our audit revealed one observation of procedures or situations that may not have caused an error on the sampled claim but may impact future claims or overall quality of service.

Observation	Audit Number
A claim was received via the Consumer Portal. The claim was processed correctly, but the examiner did not document the dates of service, provider name, or amount per the training procedures.	HRA1017

DATA ANALYTICS

Medical Findings

This component of our audit used your electronic claim data to identify improvement opportunities and potential recoveries. The informational categories we analyzed include:

- Network Provider Utilization and Discount Savings;
- Sanctioned Provider Identification;
- Patient Protection and Affordable Care Act (PPACA) Preventive Services Payment Compliance;
- National Correct Coding Initiative (NCCI) Editing Compliance; and
- Global Surgery Prohibited Fee Period Analysis.

The following pages provide the scope and report for each data analytic to enable more-informed decisions about ways PEBP can maximize benefit plan administration and performance.

Network Provider Utilization and Discount Savings

The Network Provider Utilization and Discount Savings report provides an evaluation of provider network discounts obtained during the audit period. Since discounts can be calculated differently by administrators, carriers, and benefit consultants, we believe calculating discounts in the same manner for all our clients will allow for more meaningful comparisons to be made.

Scope

CTI compared submitted charges to allowable charges for all claims paid during the audit period. The review was divided into three subsets:

- In-network
- Out-of-network
- Secondary networks

Each of these subsets was further delineated into four subgroups:

- Ancillary services – such as durable medical equipment
- Non-facility services – such as an office visit
- Facility inpatient – such as services received at a hospital
- Facility outpatient – such as services received at a surgical center

Report

The following report relied on the data and data fields provided by your administrator. We made no assumptions when requested data fields were not provided.

Paid Dates 1/1/2021 through 3/31/2021				
Proprietary and Confidential Information. Do not reproduce without express permission of Claim Technologies Inc.				
Total of All Claims				
Claim Type	**Allowed Amount**	**Provider Discount**		**Plan Paid**
Ancillary	$3,355,416	$2,385,617	41.6%	$2,956,809
Non-Facility	$28,480,314	$29,832,564	51.2%	$20,670,342
Facility Inpatient	$13,180,176	$30,673,189	69.9%	$12,621,593
Facility Outpatient	$16,399,471	$33,193,455	66.9%	$13,584,457
Total	**$61,415,377**	**$96,084,825**	**61.0%**	**$49,833,200**
In-Network				
Claim Type	**Allowed Amount**	**Provider Discount**		**Plan Paid**
Ancillary	$3,290,759	$2,381,839	42.0%	$2,934,174
Non-Facility	$26,305,617	$29,747,095	53.1%	$19,154,538
Facility Inpatient	$13,123,617	$30,620,673	70.0%	$12,586,884
Facility Outpatient	$16,161,986	$32,818,170	67.0%	$13,427,300
Total In-Network	**$58,881,980**	**$95,567,776**	**61.9%**	**$48,102,896**
% of Eligible Charge - 95.9%		% Claim Frequency - 86.5%		
Out of Network				
Claim Type	**Allowed Amount**	**Provider Discount**		**Plan Paid**
Ancillary	$64,657	$3,778	5.5%	$22,635
Non-Facility	$2,174,697	$85,470	3.8%	$1,515,804
Facility Inpatient	$56,558	$52,516	48.1%	$34,709
Facility Outpatient	$237,485	$375,285	61.2%	$157,156
Total Out of Network	**$2,533,397**	**$517,049**	**16.9%**	**$1,730,305**
% of Eligible Charge - 4.1%		% Claim Frequency - 13.5%		

**Paid claim totals exclude claims from members aged 65 and older.*

PEBP's members had utilization of network or secondary network medical providers at 95.9% of all allowed charges and 86.5% of all claims.

Sanctioned Provider Identification

The Sanctioned Provider Identification report identifies services rendered by providers on the Office of Inspector General's (OIG) List of Excluded Individuals/Entities (LEIE). OIG's LEIE provides information to the healthcare industry, patients, and the public about individuals and entities currently excluded from participation in Medicare, Medicaid, and all other federal health care programs.

Scope

We received and converted an electronic data file of all claims processed during the audit period. The claims screened included all medical (not including prescription drug) and dental claims paid or denied during the audit period. Through electronic screening, we identified all claims in the audit universe that were non-facility claims, i.e., claims submitted by providers of service other than hospitals, nursing, or skilled care facilities, or durable medical equipment suppliers. These claims predominantly include physician and other medical professional claims.

Report

We screened 100% of non-facility claims against OIG's LEIE and no sanctioned providers were identified as receiving payment from the administrator during the audit period.

PPACA Preventive Services Coverage Compliance

The Preventive Services Coverage Compliance report confirms that the administrator processed preventive services as required by PPACA and as regulated by the Department of Health and Human Services (HHS). The federal PPACA mandate for all health plans (unless grandfathered) requires that certain preventive services, if performed by a network provider, must be covered at 100% without copayment, coinsurance, or deductible. Our review analyzed in-network preventive care services to determine if your administrator paid services in compliance with PPACA guidelines.

Scope

Our review included all in-network services we believe should be categorized as preventive and paid at 100%. The guidance provided by HHS for the definition of preventive services is somewhat vague, leaving it up to individual health plans to define their own system edits. In addition to the U.S. Preventive Services Task Force recommendations, CTI researched best practices of major health plan administrators to develop a compliance review we believe reflects the industry's most comprehensive overview of procedures to be paid at 100%.

Our review did not include services:

- performed by an out-of-network provider;
- adjusted or paid more than once (duplicate payments) during the audit period; or
- for which PPACA requirements suggest a frequency limitation such as one per year.

Our data analytics parameters relied upon the published recommendations from the sources HHS used to create the list of preventive services for which it has mandated coverage.

Reports

We analyzed the payments to determine if they were compliant. Types of services for which we identified non-compliance (if any) are listed first and the percentage of allowed charge paid is in the last column. To demonstrate full compliance with PPACA's requirements, the last column of this report should show 100% of services performed by network providers were paid and that no deductible, coinsurance, or copayment was applied.

Because services may be denied for reasons other than exclusion or limitation of non-covered services (e.g., a service could be denied because the patient was ineligible at the time it was performed), less than 100% of the preventive services may be paid.

The preventive services compliance review shows the frequency of claims paid at less than required benefit levels (i.e., claims reduced payment due to the application of deductibles, coinsurance, and/or copayments). We electronically screened 78 categories of preventive services that match the preventive care services specified by HHS including immunizations, women's health, tobacco use counseling, cholesterol and cancer screenings, and wellness examinations. This review either confirms compliance with PPACA or highlights areas for improvement.

CTI's analysis also found that 95.51% of the procedure codes identified as preventive services were paid by HealthSCOPE at 100% when provided in-network. A detailed list of the other 4.49% is available upon request.

The following reports provide an outline for discussion between PEBP and HealthSCOPE.

Preventive Care Services Compliance Review Paid at Less than 100%

PEBP - HealthSCOPE
Audit Period 1/1/2021 - 3/31/2021
Plans: All
Filters: Exclude - out of network, adjustments, edits with frequency limits, claimants 65 or older

		Claim Lines Submitted	Denied	Applied Deductible		Applied Copay		Applied Coinsurance		Paid @100%		
Edit Guideline	Preventive Service Benefit	#	#	#	Amount	#	Amount	#	Amount	#	Amount	%
HHS	Breastfeeding support and counseling - women	36	1	19	$4,523	0	$0	10	$431	6	$1,204	17.14%
USPSTF-B	Depression screening - >18	37	0	12	$142	5	$30	7	$20	13	$141	35.14%
USPSTF-B	BRCA screening counseling - women	37	1	10	$6,463	3	$120	10	$1,791	13	$14,144	36.11%
USPSTF-B	Alcohol misuse - screening and counseling	12	0	4	$79	0	$0	3	$9	5	$158	41.67%
USPSTF-A,B	Rh incompatibility screening - pregnant women	139	8	40	$2,043	2	$281	30	$339	59	$984	45.04%
USPSTF-A	HIV screening - pregnant women	40	1	16	$551	1	$17	4	$22	18	$868	46.15%
USPSTF-A	Phenylketonuria (PKU) screening 0-90 days	6	0	1	$11	0	$0	2	$3	3	$32	50.00%
USPSTF-B	Healthy diet counseling	260	1	30	$2,917	34	$1,341	26	$484	169	$17,906	65.25%
USPSTF-A	Urinary tract infection screening - pregnant women	118	0	24	$1,073	3	$84	13	$114	78	$1,177	66.10%
USPSTF-A	Syphillis screening	43	4	11	$80	0	$0	2	$2	26	$138	66.67%
USPSTF-B	Breast cancer chemoprevention counseling- >17	9	0	1	$48	0	$0	2	$19	6	$948	66.67%
HHS	Gestational Diabetes Mellitus screening - women	160	0	40	$314	0	$0	13	$30	107	$834	66.88%
USPSTF-A	Syphilis screening - pregnant women	144	2	38	$360	0	$0	8	$10	96	$689	67.61%
USPSTF-B	Gonorrhea screening - female	351	3	83	$4,323	0	$0	25	$261	240	$11,194	68.97%
USPSTF-A,B	Chlamydia infection screening - women	355	3	84	$4,131	0	$0	25	$258	243	$11,084	69.03%
USPSTF-A	HIV screening - >14	169	9	36	$1,051	0	$0	12	$69	112	$3,467	70.00%
USPSTF-B	Tobacco use counseling - >18	35	3	6	$194	0	$0	3	$11	23	$564	71.88%
USPSTF-A	Hepatitis B screening - women	67	3	11	$228	1	$11	5	$8	47	$999	73.44%
USPSTF-A,B	Cholesterol abnormalities screening - women >19	667	1	117	$2,090	0	$0	48	$182	501	$9,138	75.23%
USPSTF-A	Cholesterol abnormalities screening - men 35-75	523	12	92	$1,716	0	$0	21	$68	398	$6,171	77.89%
USPSTF-B	Depression screening - 12-18	37	0	7	$89	0	$0	1	$8	29	$179	78.38%
USPSTF-B	Hepatitis C Virus (HCV) Screening	203	10	25	$416	0	$0	11	$35	157	$2,348	81.35%
Bright Futures	Hearing Screening 0-21 yrs	169	9	5	$458	1	$11	10	$285	144	$3,016	90.00%
Bright Futures	Dyslipidemia screening - 2-20	48	0	1	$18	0	$0	3	$11	44	$652	91.67%
Bright Futures	Tuberculin testing - <21	13	0	1	$6	0	$0	0	$0	12	$119	92.31%
USPSTF-B	Hearing loss screening - 0 - 90 days	40	0	2	$652	0	$0	1	$65	37	$9,371	92.50%
USPSTF-A	Colorectal cancer screening - 45-75	714	28	15	$926	1	$40	10	$177	660	$211,541	96.21%
USPSTF-A	Cervical Cancer Screening (Pap) - women	1,393	5	26	$860	1	$29	14	$108	1,347	$62,029	97.05%
HHS	Contraceptive methods - women	538	1	4	$885	3	$91	6	$1,043	524	$148,976	97.58%
ACIP	Immunizations - Pneumococcal >18	50	0	1	$72	0	$0	0	$0	49	$5,236	98.00%
HHS	Cervical Cancer Screening (HPV DNA) - women >29	863	2	14	$635	1	$39	2	$19	844	$35,290	98.03%
Bright Futures	Developmental Autism screening - <3	205	0	2	$42	1	$20	1	$5	201	$6,036	98.05%
USPSTF-B	Breast cancer mammography screening - >39	3,891	0	40	$2,589	4	$80	21	$244	3,826	$299,261	98.33%
ACIP	Immunizations - Influenza Age >18	496	5	4	$127	0	$0	3	$16	484	$9,666	98.57%
HHS	Wellness Examinations - >18	725	2	6	$423	2	$60	2	$46	713	$92,527	98.62%
ACIP	Immunizations - Herpes Zoster >59	276	1	3	$662	0	$0	0	$0	272	$39,444	98.91%
Bright Futures	Iron Supplement - <21	94	0	0	$0	1	$3	0	$0	93	$360	98.94%
HHS	Wellness Examinations - women	2,522	2	6	$486	2	$40	5	$449	2,507	$336,948	99.48%
ACIP	Immunizations - Influenza <19	551	1	1	$17	0	$0	1	$3	548	$11,012	99.64%
ACIP	Immunizations - DTP <19	626	1	1	$121	0	$0	0	$0	624	$42,551	99.84%
ACIP	Immunization Administration - >18	5,355	42	4	$258	1	$50	2	$6	5,306	$143,226	99.87%
HRSA/HHS	Wellness Examinations - <19	2,163	1	1	$25	0	$0	1	$21	2,160	$234,900	99.91%

PPACA Preventive Services Coverage Compliance Detail Report

QID	Error Description	Under/ Over Paid	HealthSCOPE Response	CTI Conclusion	Manual or System
11	Copayment Applied	$40.00 – under	Agree. Claim did take a $40 specialist copay for surgery in a specialist office in error.	Procedural deficiency and underpayment remain. HealthSCOPE applied a copayment to a preventive service.	☐ M ☒ S
10	Deductible Applied	$327.67 – under	Agree. NEV.XXXX2307 should have been considered preventive at 100%.		☐ M ☒ S
12	Coinsurance Applied	$52.16 – under	Agree. Hearing exam should have paid at 100%.		☐ M ☒ S

PPACA Preventive Services Coverage Compliance Detail Report					
QID	Error Description	Under/ Over Paid	HealthSCOPE Response	CTI Conclusion	Manual or System
15		$806.00 – under	Agree. Outpatient surgical center for sterilization processed with coinsurance in error.		☐ M ☒ S

Preventive Care Services Compliance Review Paid at 100%

PEBP - HealthSCOPE

Audit Period 1/1/2021 - 3/31/2021

Plans: All

Filters: Exclude - out of network, adjustments, edits with frequency limits, claimants 65 or older

		Claim Lines Submitted	Denied	Applied Deductible		Applied Copay		Applied Coinsurance		Paid @100%		
Edit Guideline	Preventive Service Benefit	#	#	#	Amount	#	Amount	#	Amount	#	Amount	%
ACIP	Immunization Administration - <19	2,779	12	0	$0	0	$0	0	$0	2,767	$106,786	100.00%
ACIP	Immunizations - Rotavirus <19	258	0	0	$0	0	$0	0	$0	258	$27,847	100.00%
ACIP	Immunizations - Human papillomavirus	233	0	0	$0	0	$0	0	$0	233	$52,422	100.00%
ACIP	Immunizations - Hepatitis A <19	232	1	0	$0	0	$0	0	$0	231	$8,991	100.00%
ACIP	Immunizations - Meningococcal <19	188	0	0	$0	0	$0	0	$0	188	$24,903	100.00%
ACIP	Immunizations - Measles, Mumps, Rubella <19	144	0	0	$0	0	$0	0	$0	144	$32,889	100.00%
ACIP	Immunizations - Meningococcal >18	127	0	0	$0	0	$0	0	$0	127	$21,692	100.00%
USPSTF-B	Vision screening - 3- 5	119	11	0	$0	0	$0	0	$0	108	$2,852	100.00%
ACIP	Immunizations - Varicella <19	91	0	0	$0	0	$0	0	$0	91	$14,626	100.00%
ACIP	Immunizations - Hepatitis B <19	79	1	0	$0	0	$0	0	$0	78	$2,110	100.00%
ACIP	Immunizations - Hepatitis B >18	31	2	0	$0	0	$0	0	$0	29	$2,062	100.00%
ACIP	Immunizations - Inactivated Poliovirus <19	30	0	0	$0	0	$0	0	$0	30	$1,508	100.00%
Bright Futures	Lead screening - <21	25	6	0	$0	0	$0	0	$0	19	$287	100.00%
ACIP	Immunizations - Hepatitis A >18	9	0	0	$0	0	$0	0	$0	9	$849	100.00%
ACIP	Immunizations - Varicella >18	9	0	0	$0	0	$0	0	$0	9	$1,322	100.00%
ACIP	Immunizations adult - Influenza Age (FluMist) 19-49	2	0	0	$0	0	$0	0	$0	2	$47	100.00%
ACIP	Immunizations - Pneumococcal <19	2	0	0	$0	0	$0	0	$0	2	$144	100.00%

NCCI Editing Compliance

While there are no universally accepted correct coding guidelines among private insurers and administrators, the Centers for Medicare & Medicaid Services (CMS), the nation's largest payer for health care, took the initiative to provide valuable guidance for medical benefit plans. Implementation of NCCI mandated several initiatives to prevent improperly billed claims from being paid under Medicare and Medicaid.

Scope

The two NCCI initiatives that can offer the greatest return benefit to self-funded employee benefit plans are the Procedure-to-Procedure (PTP) Edits and Medically Unlikely Edits (MUEs).

Our claim system code editing analysis identified services submitted to the plan and paid by HealthSCOPE that Medicare and Medicaid would have denied. **Since HealthSCOPE paid the billed charges, the payments represent a potential savings opportunity to PEBP.**

It is difficult to establish the extent to which administrators and carriers use NCCI edits; however, CTI recommends these reports be discussed with your administrator to determine the extent to which they incorporate CMS edits. Using these edits typically reduces claim expense and furthers efforts toward achieving standardized code-editing systems for all payers.

PTP Edits Reports

PTP Edits compare procedure codes from multiple claim lines on the same day to identify when procedures submitted on the same claim cannot be billed together. Our reports are grouped by outpatient hospital services and non-facility claims using CMS' quarterly updated data. If your administrator is not currently using these CMS edits, CTI's reports will help you evaluate the savings you would have realized had the PTP Edits been in place.

Outpatient Hospital Services (facility claims with codes not designated inpatient)								
Primary		Secondary			Primary Description	Secondary Description	Line	Allowable
Code	Mod	Code	Mod	Mod Use			Count	Benefit
78803	TC	C2616		YES	Radiopharmaceutical localization of tumor, infla	BRACHYTX, NON-STR,YTTRIUM-90	1	$20,790
					Misuse of column two code with column one code			
C9600		93454		YES	Percutaneous transcatheter placement of drug elu	CORONARY ARTERY ANGIO S&I	1	$11,002
					CPT Manual or CMS manual coding instructions			
37243		75726	TC	YES	Vascular embolization or occlusion	ARTERY X-RAYS ABDOMEN	1	$9,652
					CPT Manual or CMS manual coding instructions			
74177	TC	96374		YES	CT ABD & PELV W/CONTRAST	THER/PROPH/DIAG INJ IV PUSH	13	$4,168
					Standards of medical / surgical practice			
70553		70544		YES	Mri brain stem w/o & w/dye	MR ANGIOGRAPHY HEAD W/O DYE	1	$3,653
					Misuse of column two code with column one code			
22551		95939	TC	YES	NECK SPINE FUSE&REMOV BEL C2	C MOTOR EVOKED UPR&LWR LIMBS	2	$3,021
					Misuse of column two code with column one code			
22853		22845		YES	INSJ BIOMCHN DEV INTERVERTEBRAL DSC SPC W/A	INSERT SPINE FIXATION DEVICE	1	$2,864
					HCPCS/CPT procedure code definition			
76857		93975		YES	US EXAM PELVIC LIMITED	VASCULAR STUDY	2	$2,331
					Misuse of column two code with column one code			
96374		96372		YES	THER/PROPH/DIAG INJ IV PUSH	THER/PROPH/DIAG INJ SC/IM	12	$2,243
					CPT Manual or CMS manual coding instructions			
74176		74160		YES	CT ABD & PELVIS	CT ABDOMEN W/DYE	1	$1,524
					CPT Manual or CMS manual coding instructions			
						Top 10 TOTAL	**35**	**$61,249**
						GRAND TOTAL	**554**	**$126,281**

Non-Facility (non-facility claims with CPT codes:00100 - 99999)								
Primary		Secondary			Primary Description	Secondary Description	Line	Secondary
Code	Mod	Code	Mod	Mod Use			Count	Allowable
95865	26	95868	26	YES	MUSCLE TEST LARYNX	MUSCLE TEST CRAN NERVE BILAT	1	$1,137
					Mutually exclusive procedures			
22842		76000	26	YES	INSERT SPINE FIXATION DEVICE	FLUOROSCOPE EXAMINATION	1	$750
					Standards of medical / surgical practice			
63030	80	63056	80	YES	LOW BACK DISK SURGERY	Decompress spinal cord lmbr	1	$680
					Mutually exclusive procedures			
90471		99396		YES	IMMUNIZATION ADMIN	PREV VISIT EST AGE 40-64	6	$551
					CPT Manual or CMS manual coding instructions			
22612		69990		NO	LUMBAR SPINE FUSION	MICROSURGERY ADD-ON	1	$477
					Misuse of column two code with column one code			
22551	59	69990		NO	NECK SPINE FUSE&REMOV BEL C2	MICROSURGERY ADD-ON	1	$467
					Misuse of column two code with column one code			
00537	AA,P3	95955	26,59	NO	ANESTH CARDIAC ELECTROPHYS	EEG DURING SURGERY	1	$450
					Standard preparation / monitoring services for anesthesia			
94760		99213		YES	MEASURE BLOOD OXYGEN LEVEL	Office/outpatient visit for E&M of estab pat	3	$345
					CPT Manual or CMS manual coding instructions			
63056	80	63707	80	YES	Decompress spinal cord lmbr	REPAIR SPINAL FLUID LEAKAGE	1	$320
					Standards of medical / surgical practice			
63030		99223		YES	LOW BACK DISK SURGERY	INITIAL HOSPITAL CARE	1	$279
					CPT Manual or CMS manual coding instructions			
						Top 10 TOTAL	**17**	**$5,456**
						GRAND TOTAL	**114**	**$9,813**

MUE Reports

An MUE is an edit that tests claim lines for the same beneficiary, procedure code, date of service, and billing provider against a maximum allowable number of service units. The MUE rule for a given code is the maximum number of service units a provider should report for a single day of service. MUE errors could be caused by incorrect coding, inappropriate services performed, or fraud. MUEs do not require Medicare contractors to perform a manual review or suspend claims; rather, claim lines are denied and must be correctly resubmitted by providers, typically with a lesser payment amount.

CTI's MUE analyses are grouped into three separate reports:

- Outpatient hospital
- Non-facility
- Ancillary

Outpatient Hospital Services (facility claims with codes not designated inpatient)				
Procedure Code	**Service Unit Limit**	**Procedure Description**	**Line Count Exceeding Limit**	**Gross Benefit Allowed**
90999	1	DIALYSIS PROCEDURE	81	$325,374
		Rationale: Clinical: Data		
93580	1	TRANSCATH CLOSURE OF ASD	1	$23,833
		Rationale: Anatomic Consideration		
C1880	2	VENA CAVA FILTER	1	$20,337
		Rationale: Clinical: Data		
14301	2	Tis trnfr any 30.1-60 sq cm	1	$14,968
		Rationale: Clinical: Data		
C1732	3	CATH, EP, DIAG/ABL, 3D/VECT	2	$14,642
		Rationale: Clinical: Data		
57425	1	LAPAROSCOPY SURG COLPOPEXY	1	$10,779
		Rationale: Anatomic Consideration		
27447	1	TOTAL KNEE ARTHROPLASTY	1	$9,933
		Rationale: CMS Policy		
A9520	1	TECHNETIUMTC-99M SULFUR CLLD	2	$8,923
		Rationale: Clinical: Society Comment		
29806	1	SHOULDER ARTHROSCOPY/SURGERY	1	$8,138
		Rationale: CMS Policy		
23430	1	REPAIR BICEPS TENDON	1	$8,138
		Rationale: CMS Policy		
		Top 10 TOTAL	**92**	**$445,065**
		GRAND TOTAL	**351**	**$551,125**

Non-Facility (non-facility claims with CPT codes:00100 - 99999)				
Procedure Code	**Service Unit Limit**	**Procedure Description**	**Line Count Exceeding Limit**	**Gross Benefit Allowed**
J9355	105	INJ TRASTUZUMAB EXCL BIOSIMI	3	$43,341
		Rationale: CMS Policy		
97799	1	PHYSICAL MEDICINE PROCEDURE	23	$17,680
		Rationale: Clinical: Data		
64714	1	REVISE LOW BACK NERVE(S)	1	$7,620
		Rationale: CMS Policy		
95165	30	ANTIGEN THERAPY SERVICES	5	$6,140
		Rationale: Clinical: Data		
88374	5	Morphometric analysis, in situ hybridization (quantitativ	8	$5,756
		Rationale: Clinical: Data		
97155	24	ADAPT BHV TX PRTCL MODIFICAJ PHYS/QHP EA 15 MIN	5	$4,170
		Rationale: Clinical: Society Comment		
31298	1	Nasal/sinus endoscopy, w dilation (balloon dilation) fro	1	$3,254
		Rationale: CMS Policy		
J0475	8	BACLOFEN 10 MG INJECTION	2	$2,234
		Rationale: Prescribing Information		
99494	2	Initial or subsequent psychiatric collaborative care mana	4	$2,150
		Rationale: Clinical: Data		
97151	8	BEHAVIOR ID ASSESSMENT BY PHYS/QHP EA 15 MIN	3	$1,630
		Rationale: Clinical: CMS Workgroup		
		Top 10 TOTAL	**55**	**$93,975**
		GRAND TOTAL	**161**	**$108,383**

Ancillary (All other claims not flagged Inpatient, Outpatient Hospital, or non-facility)				
Procedure Code	Service Unit Limit	Procedure Description	Line Count Exceeding Limit	Gross Benefit Allowed
E0465	2	Home ventilator, any type, used with invasive interface, (e	12	$14,306
		Rationale: Nature of Equipment		
E0466	2	Home ventilator, any type, used with non-invasive interfa	5	$7,581
		Rationale: Nature of Equipment		
E0471	1	RAD W/BACKUP NON INV INTRFC	1	$2,212
		Rationale: Nature of Equipment		
A4253	1	BLOOD GLUCOSE/REAGENT STRIPS	16	$2,145
		Rationale: Nature of Equipment		
E0443	1	PORTABLE 02 CONTENTS, GAS	19	$1,966
		Rationale: Code Descriptor / CPT Instruction		
E0470	1	RAD W/O BACKUP NON-INV INTFC	1	$1,127
		Rationale: Nature of Equipment		
B4035	1	ENTERAL FEED SUPP PUMP PER D	2	$824
		Rationale: Code Descriptor / CPT Instruction		
E0601	1	CONT AIRWAY PRESSURE DEVICE	1	$540
		Rationale: Nature of Equipment		
K0001	1	STANDARD WHEELCHAIR	10	$382
		Rationale: Nature of Equipment		
E0630	1	PATIENT LIFT HYDRAULIC	1	$171
		Rationale: Nature of Equipment		
		Top 10 TOTAL	**68**	**$31,253**
		GRAND TOTAL	**92**	**$32,281**

Global Surgery Prohibited Fee Period Analysis

CMS created the definition of global surgical package to make payments for services provided by a surgeon before, during, and after procedures. The objective of CTI's Global Surgery Prohibited Fee Period Analysis is to compare paid surgical claims to Medicare's payment guidelines and identify instances of unbundling and improper use of evaluation and management (E/M) coding.

Scope

The scope of the Global Surgery Prohibited Fee Period Analysis is surgery charges provided in any setting, including inpatient hospital, outpatient hospital, ambulatory surgical center (ASC), and physician's office. Claims for surgeon visits in intensive care or critical care units are also included in the global surgical package. Our analysis encompasses the three types of procedures with global surgical packages: simple, minor, and major. Each type has specific global periods:

- Simple – One day
- Minor – Ten days
- Major – Ninety days

CMS allows providers to bill for an E/M service after surgery if the patient's condition required a significant, separately identifiable E/M service beyond the usual pre-operative and post-operative care. When this occurs, the provider can add a modifier 24, 25, or 57 to the E/M service procedure code but must submit supporting documentation with the claim.

Report

The following report provides a summary of:

- top 10 providers with and without E/M charges during prohibited periods and associated charges;
- analysis of same providers' surgeries with modifier 24, 25, or 57 when Medicare would have required supporting documentation before payment; and
- analysis of the same providers' surgeries without modifier 24, 25, or 57 when Medicare would have denied payment.

Payment of unbundled, post-surgical E/M services during the global fee period increases the cost of a claim. While there are no universally accepted guidelines for global surgery fee periods with 24, 25, or 57 modifiers, some states and groups mandate providers accept assignment of benefits on those claims. This mitigates the financial impact of unbundling and improper coding. When we discuss our findings, we will help you identify strategies to monitor and eliminate unbundling within your plan.

Audit Period 1/1/2021 - 3/31/2021									
Provider Id	Surgeries with 'CMS Defined' Prohibited Global Fee Periods					Evaluation and Management Services using Same ID as Surgeon and Within Prohibited Global Fee Period			
	Surgeries without E/M Procedures during Prohibited Global Fee Periods		Surgery with E/M Charge during Prohibited Global Fee Periods			E/M Procedure Codes with Modifier 24, 25, or 57		E/M Procedure Codes without Modifier 24, 25, or 57	
	Count	Allowed Charge	Count	% Surgeries with E/M Charges during Prohibited Global Fee Periods	Allowed Charge	Total Count; 0,10 & 90 days	Allowed Charge	Total Count; 0,10 & 90 days	Allowed Charge
880103557	268	$118,664	33	11.0%	$4,921	20	$1,273	12	$900
860800150	4	$2,450	4	50.0%	$2,254	1	$188	3	$716
880310956	20	$10,652	2	9.1%	$2,044	1	$169	1	$297
208628418	42	$21,019	10	19.2%	$5,588	9	$1,785	1	$240
770465765	13	$23,422	2	13.3%	$7,899	0	$0	1	$239
260816957	3	$1,265	2	40.0%	$149	0	$0	2	$232
880236758	35	$5,799	2	5.4%	$455	1	$183	1	$148
203395567	150	$28,797	2	1.3%	$179	1	$191	1	$120
880382265	1	$43	2	66.7%	$119	1	$51	1	$113
880060272	0	$0	1	100.0%	$58	0	$0	1	$101
Top 10	**536**	**$212,112**	**60**	**10.1%**	**$23,667**	**34**	**$3,841**	**24**	**$3,107**
Overall Total	**3,311**	**$1,125,304**	**512**	**13.4%**	**$105,792**	**445**	**$45,470**	**28**	**$3,383**

CONCLUSION

We consider it a privilege to have worked for, and with, your staff and administrator. Thank you again for choosing CTI.

APPENDIX – ADMINISTRATOR RESPONSE TO DRAFT REPORT

Your administrator's response to the draft report follows.

27 Corporate Hill Drive
Little Rock, AR 72205

January 18, 2022

Claim Technologies Incorporated
100 Court Avenue Suite 306
Des Moines, IA 50309

Dear Ms. Nisius,

Thank you for the opportunity to work with CTI on our mutual client State of Nevada Public Employees' Benefit Program.

Appendix – Administrator's Response to Draft Report for State of Nevada Public Employees' Benefit Program.

HealthSCOPE Benefits has reviewed the Q3 draft report and would like to add the response to the conclusions within the audit report.

TARGETED SAMPLE ANALYSIS:

Invalid Procedures Codes Detail Report:

QID 19 – HSB does not agree with CTI conclusion. No overpayment on the member account. Case management was performed by American Health Holding on case # [redacted].

QID 20 - HSB does not agree with CTI conclusion. No overpayment on the member account. High dollar policy and procedures were followed, and this high dollar claim did go through the review process and released by VP of claims. Case management was performed on case # [redacted].

QID 21- HSB does not agree with CTI conclusion. No overpayment on the member account. First day of dialysis was on 05/17/2017. Medicare ESRD coverage was investigated and the dates are identified under the member account. The plan is primary during the coordination period.

QID 22 - HSB does not agree with CTI conclusion. No overpayment on the member account. The claim was reviewed by LNL (subrogation vendor) and no third party liability for this date of service.

QID 23 - HSB does not agree with CTI conclusion. No overpayment on the member account. Accident detail information reviewed by LNL (subrogation vendor) and this is not work related and no third party liability.

QID 24 - HSB does not agree with CTI conclusion. No overpayment on the member account. Claim was paid with the pricing under the Aetna contract.

QID 25 - HSB does agree with CTI conclusion. The overpayment on this account should be $158.40. The claim was coordinated incorrectly.

QID 26 - HSB does not agree with CTI conclusion. No overpayment on the member account. Claim was paid based on the agreement with Hometown Health.

QID 27 - HSB does not agree with CTI conclusion. No overpayment on the member account. This member was out of the country and rendered services in Turkey. The documentation was provided on the response to CTI for QID 27.

QID 28 - HSB does not agree with CTI conclusion. No overpayment on the member account. This claim was paid under the dental benefits under root canal treatment per the MPD.

QID 29 - HSB does not agree with CTI conclusion. No overpayment on the member account. The member was inpatient for 37 days in ICU. Authorization on file for the member and services rendered.

QID 30 - HSB does not agree with CTI conclusion. No overpayment on the member account. This claim was paid under the dental benefits under oral surgery per the MPD.

QID 31 - HSB does not agree with CTI conclusion. No overpayment on the member account. This claim was paid under the dental benefits under prosthodontics per the MPD.

QID 32 - HSB does not agree with CTI conclusion. No overpayment on the member account. This claim was paid under the dental benefits under oral surgery per the MPD.

QID 33 - HSB does not agree with CTI conclusion. No overpayment on the member account. This claim was paid under the dental benefits under oral surgery per the MPD.

Fraud, Waste, and Abuse Detail Report:

QID 40 - HSB does not agree with CTI conclusion. No overpayment on the member account. The claim was adjudicated based on plan guidelines and based on the agreement with Hometown Health. The authorization number # 5399492 on file for services.

QID 41 – HSB does not agree with CTI conclusion. No overpayment on the member account. The claim was adjudicated based on the plan guidelines for Chiropractic care based on the agreement with Hometown Health.

QID 42 – HSB does not agree with CTI conclusion. No overpayment on the member account. The claim was adjudicated based on the plan guidelines for Chiropractic care based on the agreement with Hometown Health.

QID 43 – HSB does not agree with CTI conclusion. No overpayment on the member account. The provider is contracted under the Aetna network and adjudicated based on the Aetna agreement for service rendered.

Duplicate Payment Detail Report:

QID 34 – HSB does not agree with CTI conclusion. No overpayment on the member account. This is not a duplicate claim. Claim [redacted]1574 was a corrected claim that was received.

QID 35 - HSB does agree with CTI conclusion. Duplicate claim on file and paid. [redacted]3321 has not been corrected under the account.

QID 36 – HSB does not agree with CTI conclusion. Claim NEV.10394358 was billed with J0878 and S9494 and [redacted]8272 was billed with J1335 and S9494.

QID 37 – HSB does not agree with CTI conclusion. No overpayment on the member account. This is not a duplicate claim. Claim [redacted]9729 was a reconsideration of [redacted]1902.

QID 38 – HSB does not agree with CTI conclusion. No overpayment on the member account. This is not a duplicate claim. Claim [redacted]9507 was a reconsideration due to a corrected claim that was received.

QID 39 - HSB does not agree with CTI conclusion. No overpayment on the member account. This claim was a reconsideration with corrected pricing.

Plan Limitations Detail Report:

QID 16 – HSB does not agree with CTI conclusion. No overpayment on the member account. The claim was paid per the COVID-19 timely filing guidelines.

QID 17 – HSB does not agree with CTI conclusion. No overpayment on the member account. The claim was paid per the COVID-19 timely filing guidelines.

QID 18 – HSB does not agree with CTI conclusion. No overpayment on the member account. The claim was paid per the COVID-19 timely filing guidelines.

Plan Exclusion Detail Report:

QID 44 – HSB does not agree with CTI conclusion. No overpayment on the member account. The claim was considered with CDT D9951 for an occlusal adjustment. The exclusion is for expenses for *athletic* mouth guards and associated devices.

QID 45 – HSB does not agree with CTI conclusion. No overpayment on the member account. The claim was considered with CDT D9943 for an occlusal adjustment. The exclusion is for expenses for *athletic* mouth guards and associated devices.

QID 46 - HSB does not agree with CTI conclusion. No overpayment on the member account. Medical necessity was requested and received and provided to CTI regarding acquired deformities of foot/feet.

QID 47 – HSB does not agree with CTI conclusion. No overpayment on the member account. Services were investigated based on plan guidelines. These services are covered under the MPD.

QID 48 - HSB does not agree with CTI conclusion. No overpayment on the member account. Services were investigated based on plan guidelines. There is an authorization number # 5536967 on file for services.

QID 49 – HSB does agree with CTI conclusion. The analyst should review plan guidelines and review procedures as well as records received for services. The operative report was provided to CTI as an attachment.

QID 50 - HSB does not agree with CTI conclusion. No overpayment on the member account. Services were investigated based on plan guidelines. There is an authorization number # 5539902 on file for services. Operative records were provided to CTI as an attachment.

RANDOM SAMPLE AUDIT:

Financial Accuracy and Accurate payment Detail Report:

Audit No. 1035 – HSB does agree with CTI conclusion. The claim should have been considered at 100% of PPO allowed amount with no copayment.

Audit No. 1050 - HSB does agree with CTI conclusion. The claim was manually adjudicated incorrectly.

Accurate Processing Detail Report:

Audit No. 1035 – HSB does agree with CTI conclusion. The claim should have been considered at 100% of PPO allowed amount with no copayment.

Audit No. 1050 - HSB does agree with CTI conclusion. The claim was manually adjudicated incorrectly.

PPACA Preventive Services Coverage Compliance Detail Report:

QID 9 - HSB does not agree with CTI conclusion. No overpayment on the member account. Nutritional therapy was considered based on the information in the MPD. This wellness/preventive benefit is limited to three (3) Health Diet/Physical Activity Counseling or Obesity Screening/Counseling sessions per Plan yea.

QID 10 - HSB does agree with CTI conclusion. Claim [redacted]2307 should have been considered preventive at 100% per plan guidelines.

QID 11 - HSB does agree with CTI conclusion. Claim [redacted]3392 did take a $40 specialist copay for surgery in a specialist office in error.

QID 12 - HSB does agree with CTI conclusion. Claim should have paid at 100% for Hearing exam per the plan guidelines.

QID 13 - HSB does not agree with CTI conclusion. No overpayment on the member account. Claim [redacted]9965 was reversed on 05/21/2021 to pay at 100% without deductible or copayment.

QID 14 - HSB does not agree with CTI conclusion. No overpayment on the member account. Claim was billed with diagnosis of 099281, E039, 099511 and Z3A13.

QID 15 - HSB does agree with CTI conclusion. The outpatient claim was manually adjudicated with coinsurance in error.

Procedure to Procedure Edits Detail Report:

QID 4 - HSB does not agree with CTI conclusion. No overpayment on the member account. Claim was paid based on the agreement with Hometown Health.

QID 5 - HSB does not agree with CTI conclusion. No overpayment on the member account. Provider did submit modifier 59 with CPT code 95868 correctly.

QID 6 - HSB does not agree with CTI conclusion. No overpayment on the member account. Claim was paid based on the pricing under the Aetna contract.

Medically Unlikely Edits Detail Report:

QID 1 - HSB does not agree with CTI conclusion. No overpayment on the member account. Durable medical equipment was considered with rental up to purchase price per MPD DME guidelines.

QID 2 - HSB does not agree with CTI conclusion. No overpayment on the member account. Claim was paid based on the pricing under the Aetna contracted case rate.

QID 3 - HSB does not agree with CTI conclusion. No overpayment on the member account. Claim was paid based on plan guidelines and based on the agreement with Hometown Health. The authorization number # 5626720 on file for services.

Global Surgery Prohibited Fee Period Evaluation and Management Service Detail Report:

QID 7 - HSB does not agree with CTI conclusion. No overpayment on the member account. The claim numbers referenced on QID 7 does have two different claim numbers and two different providers. [redacted]2449 was billed by [redacted], Hematology, Internal Medicine, Medical Oncology. Claim [redacted]2450 was billed by [redacted], General Surgery, Obstetrics & Gynecology.

QID 8 - HSB does not agree with CTI conclusion. No overpayment on the member account. Claim [redacted]6760 was billed as part of a free standing ER visit. The initial visit and services provider by the ER Physician.

Thank you,

Jennifer Spencer, Associate Director of Quality Assurance
HealthSCOPE Benefits, Inc

CLAIM TECHNOLOGIES INCORPORATED

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4.4.3

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

    4.4 Acceptance of Claim technologies Incorporated audit findings for State of Nevada Public Employees' Benefits Program Plans administered by HealthSCOPE Benefits for:

        4.4.1 Period October 1, 2020 – December 31, 2020 (FY21.Q2)

        4.4.2 Period January 1, 2021 – March 31, 2021 (FY21.Q3)

        4.4.3 Period April 1, 2021 – June 30, 2021 (FY21.Q4)

Comprehensive Claim Administration Audit

QUARTERLY FINDINGS REPORT

State of Nevada Public Employees' Benefits Program Plans

Administered by HealthSCOPE Benefits

Audit Period: April 1, 2021 through June 30, 2021
Audit Number 1.FY21.Q4

Presented to

State of Nevada Public Employees' Benefits Program

Revised March 9, 2022

CLAIM TECHNOLOGIES INCORPORATED

TABLE OF CONTENTS

EXECUTIVE SUMMARY 3

AUDIT OBJECTIVES 4

OPERATIONAL REVIEW AND PERFORMANCE GUARANTEE VALIDATION 5

100% ELECTRONIC SCREENING WITH TARGETED SAMPLE ANALYSIS 9

RANDOM SAMPLE AUDIT 14

DATA ANALYTICS 15

RECOMMENDATIONS 26

CONCLUSION 27

APPENDIX – Administrator's Response to Draft Report 28

EXECUTIVE SUMMARY

This ***Quarterly Findings Report*** is a compilation of the detailed information, findings, and conclusions drawn from Claim Technologies Incorporated's (CTI's) audit of HealthSCOPE Benefits' (HealthSCOPE) administration of the State of Nevada Public Employees' Benefits Program (PEBP) medical, dental, and health reimbursement arrangement (HRA) plan.

Scope

CTI performed an audit of HealthSCOPE's administration of the PEBP's medical, dental and HRA for the period of April 1, 2021 through June 30, 2021 (quarter 4 (Q4) for Fiscal Year (FY) 2021). The population of claims and amount paid during the audit period reported by HealthSCOPE Benefits:

Medical and Dental	
Total Paid Amount	$54,896,231
Total Number of Claims Paid/Denied/Adjusted	208,088
Health Reimbursement Arrangement (HRA)	
Total Paid Amount	$1,105,972
Total Number of Claims Paid/Denied/Adjusted	11,152

The audit included the following components which are described in more detail in the following pages.

- Operational Review and Performance Guarantees Validation
- 100% Electronic Screening with Targeted Samples
- Random Sample Audit
- Data Analytics

Auditor's Opinion

Based on these findings, and in our opinion:

1. HealthSCOPE improved its Financial Accuracy measurement in Q4 FY2021 and no penalty is owed.
2. HealthSCOPE should:
    - Review the 100% Electronic Screening with Targeted Sample results and focus on the most material findings in Paid Greater than Charged, Spinal Region Upcoding, and Duplicate Claims Payments.
    - Of the Electronic Screening Results, 13 of the 15 errors were manually processed. HealthSCOPE should confirm processor coaching, feedback, and retraining has occurred to prevent similar errors in the future.

Summary of HealthSCOPE's Guarantee Measurements

Based on CTI's Random Sample Audit results, HealthSCOPE met both claims processing measurements for PEBP in Q4 FY2021.

Quarterly Guarantee	Measure	Met/Not Met	Penalty
Financial Accuracy	99%	Met – 99.73%	None.
Payment Accuracy	98%	Met – 99.50%	None.

AUDIT OBJECTIVES

This report contains CTI's findings from our audit of HealthSCOPE Benefits' (HealthSCOPE) administration of the State of Nevada Public Employees' Benefits Program (PEBP) plans. We provide this report to PEBP, the plan sponsor, and HealthSCOPE, the claim administrator. A copy of HealthSCOPE's response to these findings can be found in the Appendix of this report.

CTI conducted the audit according to accepted standards and procedures for claim audits in the health insurance industry. We based our audit findings on the data and information provided by PEBP and HealthSCOPE. The validity of our findings relies on the accuracy and completeness of that information. We planned and performed the audit to obtain a reasonable assurance claims were adjudicated according to the terms of the contract between HealthSCOPE and PEBP.

CTI specializes in the audit and control of health plan claim administration. Accordingly, the statements we make relate narrowly and specifically to the overall effectiveness of policies, procedures, and systems HealthSCOPE used to pay PEBP's claims during the audit period. While performing the audit, CTI complied with all confidentiality, non-disclosure, and conflict of interest requirements and did not receive anything of value or any benefit of any kind other than agreed upon audit fees.

The objectives of CTI's audit of HealthSCOPE's claim administration were to determine whether:

- HealthSCOPE followed the terms of its contract with PEBP;
- HealthSCOPE paid claims according to the provisions of the plan documents and if those provisions were clear and consistent; and
- members were eligible and covered by PEBP's plans at the time a service paid by HealthSCOPE was incurred.

OPERATIONAL REVIEW AND PERFORMANCE GUARANTEE VALIDATION

Objective

CTI's Operational Review evaluates HealthSCOPE's claim administration systems, staffing, and procedures to identify any deficiencies that materially affect its ability to control risk and pay claims accurately on behalf of the plans.

Scope

The scope of the Operational Review included:

- Claim administrator information
    - Insurance and bonding
    - Conflicts of interest
    - Internal audit
    - Financial reporting
    - Business continuity planning
    - Claim payment system and coding protocols
    - Data and system security
    - Staffing
- Claim funding:
    - Claim funding mechanism
    - Check processing and security
    - COBRA/direct pay premium collections
- Claim adjudication, customer service, and eligibility maintenance procedures:
    - Exception claim processing
    - Eligibility maintenance and investigation
    - Overpayment recovery
    - Customer service call and inquiry handling
    - Network utilization
    - Utilization review, case management, and disease management
    - Appeals processing
- HIPAA compliance

Methodology

CTI used an Operational Review Questionnaire to gather information from HealthSCOPE. We modeled our questionnaire after the audit tool used by certified public accounting firms when conducting an SSAE 18 audit of a service administrator. We modified that tool to elicit information specific to the administration of your plans.

We reviewed HealthSCOPE's responses and any supporting documentation supplied to gain an understanding of the procedures, staffing, and systems used to administer PEBP's plans. This allowed us to conduct the audit more effectively.

In addition to the questionnaire, we used our proprietary Electronic Screening and Analysis System (ESAS®) software to identify the best cases to test operational processes. We selected a targeted sample of 50 cases and provided a substantive testing questionnaire to HealthSCOPE to collect information for each. We used the responses provided to validate that HealthSCOPE followed procedures to control risk and accurately pay claims.

Following is a list of sample screening categories used to identify candidate cases for operational testing:

ESAS Screening Categories
Fraud, Waste, and Abuse
Subrogation/Right of Recovery from Third Party
Workers' Compensation
Coordination of Benefits (COB)
Large Claim Review
Case Management
Specific Reinsurance Reimbursements

Findings

Claim Administrator Information

CTI reviewed information about HealthSCOPE including:

- Background information
- Financial reports
- Insurance protection types and levels
- Dedicated staffing
- Systems and software
- Fee and commission disclosure
- Performance standards
- Internal audit practices

We observed the following:

- HealthSCOPE provided the following insurance coverage information:

Coverage	Amount
Errors and Omissions	Not provided
Crime	$5,000,000
Cyber Liability	$10,000,000

- HealthSCOPE indicated it had been audited by BDO USA, L.L.P (BDO), for compliance with the standards of the American Institute of Certified Public Accountants through the issuance of a Service Organization Controls (SOC) 1 Report. Under the SOC1, the administrator is required to provide a description of its system, and controls, which the service auditor validates. CTI received a copy of the report from the period of November 1, 2019, to October 31, 2020. There were no exceptions noted.

  HealthSCOPE also provided CTI a second SOC report audited by BDO USA, L.L.P (BDO) dated November 1, 2020, to October 31, 2021. There were four exceptions noted in the report.

Claim Funding
CTI reviewed HealthSCOPE's claim check controls and procedures for:

- Claim funding
- Fund reconciliation
- Refund and returned check handling
- Large check approval
- Security
- Stale check disposition
- Audit trail reports
- COBRA and retiree/direct pay premium collection

We observed the following:

- HealthSCOPE reports it honors assignment of benefits for non-network providers which allows non-network providers to receive payment directly from HealthSCOPE versus having to pay the member who would then have to pay the non-network provider. This is a best practice.

Claim Adjudication, Customer Service, and Eligibility Maintenance Procedures
CTI reviewed HealthSCOPE's enrollment, eligibility maintenance, and claim processing controls and procedures. We observed the following:

- HealthSCOPE had adequately documented training, workflow, procedures, and systems.
- Verification of initial or continued COB was not required by HealthSCOPE.
- HealthSCOPE reported 80% of claims were received electronically during the audit period and 63.5% of claims were auto adjudicated.
- HealthSCOPE reported it did not have a minimum dollar amount to recoup an overpayment and has the ability to automatically recoup a refund from the next payment made to the same provider.
- The overpayment report provided by HealthSCOPE for FY 2021, shows $91,939.67 potential recovery.
- HealthSCOPE outsourced subrogation recovery to Luper Neidenthal & Logan. The vendor worked directly with PEBP on authority limits to reduce or waive a lien. Its fee was 18% of recovery amounts.
- HealthSCOPE provided a subrogation report titled Quarterly Subrogation Case Report for Nevada Public Employees' Benefit Program for FY 2021. The report indicated 549 open and 248 closed cases. HealthSCOPE reported total recoveries of $2,263,565.44 of $2,912,061.06 for a 77.73% recovery rate.
- The minimum amount to prompt a subrogation investigation was $1,000 in aggregate claim payments. HealthSCOPE stated recoveries did not result in claim adjustments.
- HealthSCOPE provided a member appeals report for Q2 and Q3 of FY 2021. This report showed a total of 42 member appeals – 12 in Q2 and 30 in Q3. Of those appeals, 30 were processed timely while 12 took greater than 20 days to close. According to HealthSCOPE all member

appeals should have a decision within 20 days of receipt to correspond to Nevada's state statute.

- HealthSCOPE provided a second appeals report and while this report did not include received, assigned, or closed dates, it did indicate a total of 38 PEBP member appeals in Q4 2021.
- HealthSCOPE reported it used software specifically designed to identify potential provider fraud but did not use external resources to identify providers who have been sanctioned for having committed fraud. It also reported it worked with its PPO networks to identify provider fraud.
- 100% of rebates received for processing specialty drugs are shared with PEBP.
- HealthSCOPE indicated the plan never allows more than billed charges. However, in Q2 and Q3 there were sampled claims in which HealthSCOPE paid more than billed charge.

HIPAA Compliance

CTI reviewed information about the systems and processes HealthSCOPE had in place to maintain compliance with HIPAA regulations. The objective was to determine if the administrator was aware of the HIPAA regulations and was compliant at the time of the audit. We observed the following:

- HealthSCOPE indicated HIPAA training is provided by the compliance department and training is provided annually to its employees.

Performance Guarantees

As part of CTI's quarterly audit of PEBP, we reviewed the Performance Guarantees included in its contract with HealthSCOPE. The results for Q4 FY2021 follow.

Metric	Guarantee Measurement	Actual	Met/ Not Met
Financial Accuracy	99% or greater of the dollars paid for the audited medical/dental claims to be paid accurately	99.73%	Met
Payment Accuracy	98% or greater of medical/dental claims audited are paid accurately	99.50%	Met
Claim Processing Turnaround	99% of all medical/dental claims are to be processed within 30 days	99.98%	Met
Customer Service	• Telephone Response Time less than 30 seconds for inbound calls • Telephone Abandonment Rate less than 3% • First call Resolution greater or equal to 95%	9 Seconds Less than .01% 98.71%	Met Met Met
Data Reporting	• 100% of standard reports within 10 business days • Annual/Regulatory Documents within 10 business days of the Plan Year	Delivered 8/16/21 Delivered 12/6/21	Met Met
Disclosure of Subcontractors	• Report access of PEBP data within 30 calendar days • Removal of PEBP member PHI within 3 business days after knowledge	No exceptions noted No exceptions noted	Met Met

100% ELECTRONIC SCREENING WITH TARGETED SAMPLE ANALYSIS

Objective

CTI's Electronic Screening and Analysis System (ESAS) software identified and quantified potential claim administration payment errors. PEBP and HealthSCOPE should discuss any verified under- or overpayments to determine the appropriate actions to correct the errors.

Scope

CTI electronically screened 100% of the service lines processed by HealthSCOPE during the audit period for both medical and dental claims. The accuracy and completeness of HealthSCOPE's data directly impacted the screening categories we completed and the integrity of our findings. We screened the following high-level ESAS categories to identify potential amounts at risk:

- Duplicate payments to providers and/or employees
- Plan exclusions and limitations
- Multiple surgical procedures

Methodology

We used ESAS to analyze claim payment accuracy as well as any opportunities for system and process improvement. Using the data file provided by HealthSCOPE, we readjudicated each line on every claim the plan paid or denied during the audit period against the plan's benefits. Our Technical Lead Auditor tested a targeted sample of claims to provide insight into HealthSCOPE's claim administration as well as operational policies and procedures. We followed these procedures to complete our ESAS process:

- ***Electronic Screening Parameters Set*** – We used your plan document provisions to set the parameters in ESAS.
- ***Data Conversion*** – We converted and validated your claim data, reconciled it against control totals, and checked it for reasonableness.
- ***Electronic Screening*** – We systematically screened 100% of the service lines processed and flagged claims not administered according to plan parameters.
- ***Auditor Analysis*** – If claims within an ESAS screening category represented a material amount, our auditors analyzed the findings to confirm results were valid. Note using ESAS could lead to false positives if there was incomplete claim data. CTI auditors made every effort to identify and remove false positives.
- ***Targeted Sample Analysis*** – From the categories identified with material amounts at risk, we selected the best examples of potential under- or overpayments to test. As cases were not randomly selected, we cannot extrapolate results. We selected 50 cases and sent your administrator a questionnaire for each. Targeted samples verified if the claim data supported our finding and if our understanding of plan provisions matched HealthSCOPE's administration.
- ***Audit of Administrator Response and Documentation*** – We reviewed the responses and redacted the responses to eliminate personal health information. Based on the responses and further analysis of the findings, we removed false positives identified from the potential amounts at risk.
- ***Eligibility Verification of Every Claim by Date of Service*** – We used ESAS to compare service dates against the eligibility periods provided to us to look for claims paid for ineligible members.

Findings

We are confident in the accuracy of our ESAS results. It should be noted that the dollar amounts associated with the results represent potential payment errors and process improvement opportunities. We would have to perform additional testing to substantiate the findings that could then provide the basis for remedial action planning or reimbursement.

Categories for Process Improvement

The following detail report shows, by category, the number of line items or claimants with process improvement opportunities remaining after our analysis and removal of verified false positives. A CTI auditor reviewed the responses and supporting documentation. The administrator responses are copied directly from HealthSCOPE's reply to audit findings. **It is important to note that even if the sampled claim was subsequently corrected prior to CTI's audit, we have still cited the error so you can discuss how to reduce errors and re-work in the future with your administrator.**

Process Improvement Summary Report				
Client: PEBP **Screening Period:** Q4 FY2021				
Category	**Number of Service Codes**	**Number of Members**	**Billed Charge**	**Allowed***
Paid Greater than Charged	9	5	$1,899	$2,432
Fraud, Waste and Abuse				
Spinal Region Upcoding – Number of spinal regions treated does not match number of spinal regions billed and allowed.	1,164	419	$78,715	$37,041
Large Payment to Member	504	274	$86,978	$41,683

**Allowed equals total paid by plan and member combined.*

Electronic screening of all service lines processed revealed the potential for incorrectly paid claims. Analysis confirmed the opportunity for process improvement and further testing is recommended. For each potential error, we sent an ESAS Questionnaire (QID) to HealthSCOPE for written response. After review of the response and additional information provided, CTI confirmed the potential for process improvement.

Manually adjudicated claims were processed by an individual claims processor. Auto-adjudicated claims were paid by the system with no manual intervention.

Paid Greater Than Charged Detail Report					
QID	**Category**	**Over Paid**	**HealthSCOPE Response**	**CTI Conclusion**	**Manual or System**
25	Paid Greater Than Charged	$203.20	Agree. We should have allowed billed charges and paid $22.80 coinsurance assessed by Medicare.	Procedural deficiency and overpayments remain.	☒ M ☐ S

Fraud, Waste, and Abuse Detail Report					
QID	**Category**	**Over Paid**	**HealthSCOPE Response**	**CTI Conclusion**	**Manual or System**
37	Spinal Region Upcoding	$55.00	Disagree. Reviewed for medical necessity.	Procedural deficiency and overpayment remain. The description for CPT codes for chiropractic care includes the number of regions of the spine or extraspinal regions treated and should be supported by the diagnosis. The provider billed five or more spinal regions treated; however, the	☐ M ☒ S
38		$55.00			☐ M ☒ S

Fraud, Waste, and Abuse Detail Report					
QID	**Category**	**Over Paid**	**HealthSCOPE Response**	**CTI Conclusion**	**Manual or System**
				diagnosis billed supported treatment of only two spinal regions. These procedures are spinal region driven and should be billed with appropriate diagnosis codes to support billing.	
35	Large Payment to Member	$669.87	Agree. This was a pre-treatment estimate and payment should not have been issued. Refund was requested from member and received on 06/09/21, check number 223332567.	Procedural deficiency and overpayments remain.	☒ M ☐ S

Categories for Potential Amount at Risk

The following report shows, by category, the number of line items or claims and the total potential amount at risk remaining at the conclusion of our analysis, targeted samples, and removal of verified false positives. Following the report is a detailed explanation of our results with findings for all screening categories where, in our opinion, process improvement, recovery or savings opportunities exist. The administrator responses are copied directly from HealthSCOPE's reply to audit findings.

Categories for Potential Amount at Risk				
Client: PEBP **Screening Period:** Q4 FY2021				
Category	**Number of Service Codes**	**Number of Members**	**Billed Charge**	**Allowed***
Duplicate Payments				
Providers and/or Employees	314	77	$332,102	$66,828
Exclusions				
Dental, Other Surgical Procedures	120	109	$71,517	$50,516
Dental, TMJ	1	1	$240	$180
Limitations				
Timely Filing	1,306	295	$3,344,468	$1,166,438

**Allowed equals total paid by plan and member combined.*

Electronic screening of all service lines processed revealed the potential for incorrectly paid claims. Analysis confirmed the opportunity for process improvement and further testing is recommended.

Duplicate Payments Detail Report				
QID	**Over Paid**	**HealthSCOPE Response**	**CTI Conclusion**	**Manual or System**
31	$1,215.00	Agree. XXX.XXXX6511 pending reconsideration to request $1,215.00 refund of duplicate payment.	Procedural deficiency and overpayment remain. HealthSCOPE paid duplicate charges.	☒ M ☐ S
32	$300.00	Agree. XXX.XXXX6511 pending reconsideration to request $300.00 refund of duplicate payment.		☒ M ☐ S
33	$634.00	Agree. XXX.XXXX1664 pending reconsideration to request $634.00 refund of duplicate payment.		☒ M ☐ S

Timely Filing Detail Report				
QID	**Over Paid**	**HealthSCOPE Response**	**CTI Conclusion**	**Manual or System**
18	$1,346.75	Disagree. Original claim was received on XXX.XXX0699 on 02/12/2019. The claim denied to request accident details. The subrogation vendor LNL sent out original letter in 03/06/2019, then follow-ups were submitted on 03/26/2019 and 04/18/2019. The member contacted the subrogation vendor on 05/07/2021 in response to the accident questionnaire. Claim was reconsidered after notification received from LNL that there was no SUBRO and to apply plan benefits.	Procedural deficiency and overpayment remain. Claim was processed 28 months after the service date.	☒ M ☐ S
19	$3,864.00	Disagree. Claim originally received on 02/28/2018 and denied requesting additional information regarding possible other health insurance. The transplant network provided this information, along with proof of timely filing on 05/14/21. Claim was then reconsidered at that time.	Procedural deficiency and overpayment remain. Claim was processed 49 months after service date. Did not provide reasons why timely filing should be extended.	☒ M ☐ S

There were also four errors found under the dental benefit plan for services paid. CTI's review indicated four "Dental Surgical Procedures" paid for a total of $234.20 including:

- two Collection and Application of Autologous, Blood Concentrate Product claim;
- one Sinus Augmentation claims; and
- one Frenectomy claim.

One additional dental claim paid for excluded services for TMJ and totaled $144.00.

In CTI's experience the PEBP dental plan document is vague and/or silent on a number of dental services. We recommend that the language be updated to indicate specifically which services are covered and which are excluded.

Eligibility Verification

CTI electronically compared dates of service for FY21 Q2, Q3, and Q4 and PEBP's electronic eligibility file revealed that some services were paid during the audit period for potentially ineligible claimants. At this time, potentially overpaid amounts have been flagged into one of the following categories:

Employee Eligibility Screening Subcategory	Amount Paid
No Identification Match to Any Eligible Employee	$1,621,216
Payments Prior to Effective Date	$1,775,583
Payments During Gaps in Coverage	$2,893
After Termination Date of Employee's Coverage	$72,444
Subtotal	$3,472,136
Dependent Eligibility Screening Subcategory	**Amount Paid**
No Identification Match to Any Eligible Employee	$932,380
Payments Prior to Effective Date	$239,684
Payments During Gaps in Coverage	$1,155
After Termination Date of Employee's Coverage	$87,748
Subtotal	$1,260,967
COMBINED TOTAL*	**$4,733,103**

**CTI notes that 2.9% of the PEBP's total medical spend processed by HealthSCOPE was identified as paid for members who may not have been eligible for coverage. These results are high compared to the less than 1% CTI generally reports.*

RANDOM SAMPLE AUDIT

Objectives

The objectives of our Random Sample Audit were to determine if medical and dental claims were paid according to plan specifications and the administrative agreement, to measure and benchmark process quality, and to prioritize areas of administrative deficiency for further review and remediation.

Scope

CTI's statistically valid Random Sample Audit included a stratified random sample of 200 paid or denied claims. HealthSCOPE's performance was measured using the following key performance indicators:

- Financial Accuracy
- Accurate Payment
- Accurate Processing

We also measured claim turnaround time, a commonly relied upon performance measure.

In addition, CTI sampled 50 health reimbursement arrangement (HRA) claims to ensure payment and processing accuracy.

Methodology

Our Random Sample Audit ensures a high degree of consistency in methodology and is based upon the principles of statistical process control with a management philosophy of continuous quality improvement. Our auditors reviewed each sample claim selected to ensure it conformed to plan specifications, agreements, and negotiated discounts. We recorded our findings in our proprietary audit system.

When applicable, we cited claim payment and processing errors identified by comparing the way a selected claim was paid and the information HealthSCOPE had available at the time the transaction was processed**. It is important to note that even if the sampled claim was subsequently corrected prior to CTI's audit, we have still cited the error so you can discuss how to reduce errors and re-work in the future with your administrator.**

CTI communicated with HealthSCOPE in writing about any errors or observations using system-generated response forms. We sent HealthSCOPE a preliminary report for its review and written response. We considered HealthSCOPE's written response, as found in the Appendix, when producing our final reports. Note that the administrator responses have been copied directly from HealthSCOPE's reply.

Financial Accuracy

CTI defines Financial Accuracy as the total correct claim payments made compared to the total dollars of correct claim payments that should have been made for the audit sample.

The claims sampled and reviewed revealed $250.00 in underpayments and no overpayments, for an absolute value variance of $250.00.

The weighted Financial Accuracy rate was 99.73%.

Financial Accuracy Detail Report						
Error Description	**Audit No.**	**Under Paid**	**HealthSCOPE Response**	**CTI Conclusion**	**Manual or System**	
Copay Calculation	1036	$250.00	Agree. Claim should have only one $250 copayment.	Procedural error and underpayment remain.	☐ M ☒ S	
TOTALS	**1**	**VARIANCE $250.00**			**M: 0**	**S: 1**

Accurate Payment

CTI defines Accurate Payment as the number of claims paid correctly compared to the total number of claims paid for the audit sample.

The audit sample revealed 1 incorrectly paid claims and 199 correctly paid claims. Note CTI only uses adequately documented claims for this calculation.

Total Claims	Incorrectly Paid Claims		Frequency
	Underpaid Claims	Overpaid Claims	
200	1	0	99.50%

Accurate Processing

CTI defines Accurate Processing as the number of claims processed without errors compared to the total number of claims processed in the audit sample.

Correctly Processed Claims	Incorrectly Processed Claims		Frequency
	System	Manual	
199	1	0	99.50%

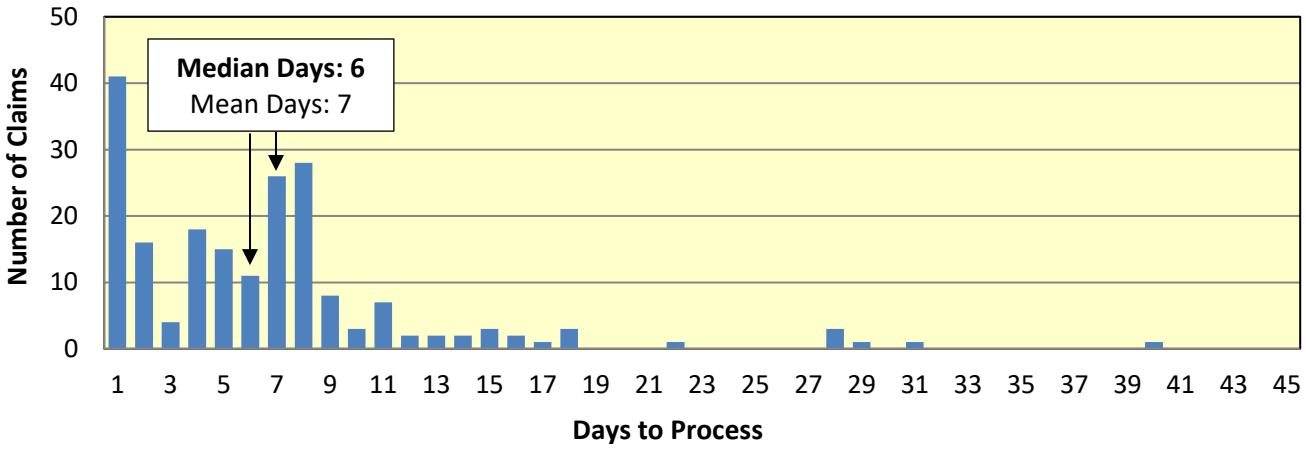
Accurate Processing Detail Report				
Error Description	**Audit No.**	**HealthSCOPE Response**	**CTI Conclusion**	**Manual or System**
Managed Care				
Copay Calculation	1036	Agree. Claim should have only one $250 copayment.	Procedural error remains.	☐ M ☒ S

Claim Turnarounds

CTI defines Claim Turnaround as the number of calendar days required to process a claim – from the date the claim was received by the administrator to the date a payment, denial, or additional information request was processed – expressed as both the Median and Mean for the audit sample.

Claim administrators commonly measure claim turnaround time in mean days. Median days, however, is a more meaningful measure for administrators to focus on when analyzing claim turnaround because it prevents one or just a few claims with extended turnaround time from distorting the true performance picture.

Median and Mean Claim Turnaround



Additional Observations

During the Random Sample Audit, our auditor observed the following procedures or situations that may not have caused an error on the sampled claim but may impact future claims or overall quality of service.

Observation	Audit Number
HealthSCOPE did not remove a remark code stating a COVID-19 test was 100% covered on the Explanation of Benefits (EOB) when in fact, the member was no longer covered and the test was not paid for.	1070

Health Reimbursement Arrangement (HRA) Findings

CTI also reviewed 50 HRA claims as part of our random sample. We communicated with HealthSCOPE in writing about any errors or observations found using response forms. In addition, we sent HealthSCOPE a preliminary report for its review and written response. We considered HealthSCOPE's written response, as found in the Appendix, when producing our final reports.

Our audit revealed no procedures or situations that may have caused an error on the sampled claim.

DATA ANALYTICS

Medical Findings

This component of our audit used your electronic claim data to identify improvement opportunities and potential recoveries. The informational categories we analyzed include:

- Network Provider Utilization and Discount Savings;
- Sanctioned Provider Identification;
- Patient Protection and Affordable Care Act (PPACA) Preventive Services Payment Compliance;
- National Correct Coding Initiative (NCCI) Editing Compliance; and
- Global Surgery Prohibited Fee Period Analysis.

The following pages provide the scope and report for each data analytic to enable more-informed decisions about ways PEBP can maximize benefit plan administration and performance.

Network Provider Utilization and Discount Savings

The Network Provider Utilization and Discount Savings report provides an evaluation of provider network discounts obtained during the audit period. Since discounts can be calculated differently by administrators, carriers, and benefit consultants, we believe calculating discounts in the same manner for all our clients will allow for more meaningful comparisons to be made.

Scope

CTI compared submitted charges to allowable charges for all claims paid during the audit period. The review was divided into three subsets:

- In-network
- Out-of-network
- Secondary networks

Each of these subsets was further delineated into four subgroups:

- Ancillary services – such as durable medical equipment
- Non-facility services – such as an office visit
- Facility inpatient – such as services received at a hospital
- Facility outpatient – such as services received at a surgical center

Report

The following report relied on the data and data fields provided by your administrator. We made no assumptions when requested data fields were not provided.

Paid Dates 4/1/2021 through 6/30/2021				
Proprietary and Confidential Information. Do not reproduce without express permission of Claim Technologies Inc.				
Total of All Claims				
Claim Type	**Allowed Amount**	**Provider Discount**		**Plan Paid**
Ancillary	$3,100,919	$2,385,912	43.5%	$2,825,261
Non-Facility	$28,585,095	$31,575,791	52.5%	$21,270,216
Facility Inpatient	$10,532,712	$23,993,676	69.5%	$9,923,749
Facility Outpatient	$15,521,006	$33,939,861	68.6%	$13,250,504
Total	**$57,739,732**	**$91,895,240**	**61.4%**	**$47,269,729**
In-Network				
Claim Type	**Allowed Amount**	**Provider Discount**		**Plan Paid**
Ancillary	$3,027,986	$2,385,912	44.1%	$2,773,776
Non-Facility	$27,594,677	$31,570,202	53.4%	$20,909,408
Facility Inpatient	$10,518,434	$23,926,034	69.5%	$9,917,439
Facility Outpatient	$15,455,734	$33,689,083	68.6%	$13,210,347
Total In-Network	**$56,596,832**	**$91,571,231**	**61.8%**	**$46,810,970**
% of Eligible Charge -	98.0%	% Claim Frequency -	87.7%	
Out of Network				
Claim Type	**Allowed Amount**	**Provider Discount**		**Plan Paid**
Ancillary	$72,933	$0	0.0%	$51,485
Non-Facility	$990,418	$5,589	0.6%	$360,808
Facility Inpatient	$14,277	$67,642	82.6%	$6,309
Facility Outpatient	$65,272	$250,778	79.3%	$40,157
Total Out of Network	**$1,142,900**	**$324,008**	**22.1%**	**$458,759**
% of Eligible Charge -	2.0%	% Claim Frequency -	12.3%	

**Paid claim totals exclude claims from members aged 65 and older.*

PEBP's members had utilization of network or secondary network medical providers at 98.00% of all allowed charges and 87.70% of all claims.

Sanctioned Provider Identification

The Sanctioned Provider Identification report identifies services rendered by providers on the Office of Inspector General's (OIG) List of Excluded Individuals/Entities (LEIE). OIG's LEIE provides information to the healthcare industry, patients, and the public about individuals and entities currently excluded from participation in Medicare, Medicaid, and all other federal health care programs.

Scope

We received and converted an electronic data file of all claims processed during the audit period. The claims screened included all medical (not including prescription drug) and dental claims paid or denied during the audit period. Through electronic screening, we identified all claims in the audit universe that were non-facility claims, i.e., claims submitted by providers of service other than hospitals, nursing, or skilled care facilities, or durable medical equipment suppliers. These claims predominantly include physician and other medical professional claims.

Report

We screened 100% of non-facility claims against OIG's LEIE and identified the following providers as sanctioned. Our screening indicated the following providers received payment from the administrator during the audit period.

NPI	Exclusion Date	Reinstatement Date	Exclusion Type	Provider Name	Claim Count	Total Charged	Total Allowed	Total Paid
1104912278	20191219	N/A	1128a4	JAMES SHELBY	3	$1,253	$1,253	$264
				Totals	**3**	**$1,253**	**$1,253**	**$264**

According to the OIG, James Shelby was excluded on December 19, 2019 with for a felony-controlled substance conviction.

PPACA Preventive Services Coverage Compliance

The Preventive Services Coverage Compliance report confirms that the administrator processed preventive services as required by PPACA and as regulated by the Department of Health and Human Services (HHS). The federal PPACA mandate for all health plans (unless grandfathered) requires that certain preventive services, if performed by a network provider, must be covered at 100% without copayment, coinsurance, or deductible. Our review analyzed in-network preventive care services to determine if your administrator paid services in compliance with PPACA guidelines.

Scope

Our review included all in-network services we believe should be categorized as preventive and paid at 100%. The guidance provided by HHS for the definition of preventive services is somewhat vague, leaving it up to individual health plans to define their own system edits. In addition to the U.S. Preventive Services Task Force recommendations, CTI researched best practices of major health plan administrators to develop a compliance review we believe reflects the industry's most comprehensive overview of procedures to be paid at 100%. Our review did not include services:

- performed by an out-of-network provider;
- adjusted or paid more than once (duplicate payments) during the audit period; or
- for which PPACA requirements suggest a frequency limitation such as one per year.

Our data analytics parameters relied upon the published recommendations from the sources HHS used to create the list of preventive services for which it has mandated coverage.

Reports

We analyzed the payments to determine if they were compliant. Types of services for which we identified non-compliance (if any) are listed first and the percentage of allowed charge paid is in the last column. To demonstrate full compliance with PPACA's requirements, the last column of this report should show 100% of services performed by network providers were paid and that no deductible, coinsurance, or copayment was applied.

Because services may be denied for reasons other than exclusion or limitation of non-covered services (e.g., a service could be denied because the patient was ineligible at the time it was performed), less than 100% of the preventive services may be paid.

The preventive services compliance review shows the frequency of claims paid at less than required benefit levels (i.e., claims reduced payment due to the application of deductibles, coinsurance, and/or copayments). We electronically screened 78 categories of preventive services that match the

preventive care services specified by HHS including immunizations, women's health, tobacco use counseling, cholesterol and cancer screenings, and wellness examinations. This review either confirms compliance with PPACA or highlights areas for improvement.

CTI's analysis also found that 95.23% of the procedure codes identified as preventive services were paid by HealthSCOPE at 100% when provided in-network. A detailed list of the other 4.77% is available upon request.

The following reports provide an outline for discussion between PEBP and HealthSCOPE.

Preventive Care Services Compliance Review Paid at Less than 100%

PEBP - HealthSCOPE

Audit Period 4/1/2021 - 6/30/2021

Plans: All

Filters: Exclude - out of network, adjustments, edits with frequency limits, claimants 65 or older

		Claim Lines Submitted	Denied	Applied Deductible		Applied Copay		Applied Coinsurance		Paid @100%		
Edit Guideline	Preventive Service Benefit	#	#	#	Amount	#	Amount	#	Amount	#	Amount	%
HHS	Breastfeeding support and counseling - women	49	1	17	$3,523	2	$80	18	$798	11	$2,722	22.92%
USPSTF-B	Depression screening - >18	69	0	18	$127	15	$90	8	$18	28	$323	40.58%
USPSTF-A,B	Rh incompatibility screening - pregnant women	120	2	32	$1,121	4	$411	31	$350	51	$1,458	43.22%
USPSTF-B	Breast cancer chemoprevention counseling- >17	11	0	4	$362	0	$0	2	$16	5	$831	45.45%
USPSTF-B	Tobacco use counseling - >18	23	1	6	$141	0	$0	5	$10	11	$277	50.00%
USPSTF-B	BRCA screening counseling - women	18	2	1	$1,825	2	$40	5	$855	8	$4,452	50.00%
USPSTF-A	HIV screening - pregnant women	28	2	8	$356	0	$0	4	$21	14	$391	53.85%
USPSTF-A	Syphillis screening	40	2	13	$76	0	$0	3	$3	22	$134	57.89%
USPSTF-A	HIV screening - >14	172	5	46	$1,401	0	$0	20	$147	101	$2,828	60.48%
USPSTF-B	Healthy diet counseling	296	0	33	$2,199	36	$1,422	28	$691	199	$21,558	67.23%
USPSTF-A	Urinary tract infection screening - pregnant women	101	0	15	$224	2	$75	16	$228	68	$733	67.33%
USPSTF-A	Hepatitis B screening - women	62	2	13	$552	1	$2	5	$10	41	$411	68.33%
USPSTF-A,B	Chlamydia infection screening - women	307	3	65	$3,608	2	$114	22	$226	215	$9,675	70.72%
USPSTF-A	Syphilis screening - pregnant women	133	3	30	$196	0	$0	8	$13	92	$646	70.77%
USPSTF-B	Gonorrhea screening - female	305	3	65	$3,641	1	$36	20	$200	216	$9,874	71.52%
USPSTF-B	Hepatitis C Virus (HCV) Screening	224	3	34	$572	0	$0	25	$92	162	$2,615	73.30%
HHS	Gestational Diabetes Mellitus screening - women	164	2	21	$173	0	$0	22	$111	119	$1,065	73.46%
USPSTF-B	Alcohol misuse - screening and counseling	17	1	2	$29	0	$0	2	$6	12	$314	75.00%
USPSTF-A	Phenylketonuria (PKU) screening 0-90 days	12	0	0	$0	0	$0	3	$5	9	$194	75.00%
USPSTF-B	Hearing loss screening - 0 - 90 days	4	0	0	$0	1	$40	0	$0	3	$841	75.00%
USPSTF-A	Cholesterol abnormalities screening - men 35-75	577	8	89	$1,680	2	$22	46	$124	432	$6,699	75.92%
USPSTF-A,B	Cholesterol abnormalities screening - women >19	713	1	113	$2,367	1	$19	47	$192	551	$10,088	77.39%
USPSTF-B	Depression screening - 12-18	49	0	7	$46	1	$9	3	$3	38	$395	77.55%
Bright Futures	Hearing Screening 0-21 yrs	230	6	10	$752	0	$0	22	$539	192	$6,474	85.71%
Bright Futures	Dyslipidemia screening - 2-20	39	1	0	$0	0	$0	4	$11	34	$546	89.47%
ACIP	Immunizations - Hepatitis A >18	11	0	1	$117	0	$0	0	$0	10	$738	90.91%
ACIP	Immunizations - Influenza Age >18	73	4	2	$89	0	$0	1	$8	66	$1,617	95.65%
ACIP	Immunizations - Pneumococcal >18	48	1	0	$0	1	$59	1	$18	45	$4,484	95.74%
ACIP	Immunizations - Hepatitis B >18	29	3	0	$0	0	$0	1	$16	25	$4,415	96.15%
USPSTF-A	Colorectal cancer screening - 45-75	713	33	13	$1,373	1	$20	10	$186	656	$240,799	96.47%
USPSTF-A	Cervical Cancer Screening (Pap) - women	1,357	4	32	$1,235	1	$29	13	$76	1,307	$60,838	96.60%
Bright Futures	Iron Supplement - <21	99	2	2	$7	0	$0	1	$1	94	$355	96.91%
ACIP	Immunizations - Herpes Zoster >59	235	1	1	$148	0	$0	4	$249	229	$31,578	97.86%
USPSTF-B	Breast cancer mammography screening - >39	3,499	2	20	$2,017	6	$160	23	$435	3,448	$283,348	98.60%
HHS	Cervical Cancer Screening (HPV DNA) - women >29	849	1	9	$564	0	$0	2	$18	837	$35,410	98.70%
HHS	Wellness Examinations - >18	847	2	5	$860	0	$0	4	$53	836	$108,791	98.93%
HHS	Contraceptive methods - women	537	5	2	$343	1	$40	1	$55	528	$141,839	99.25%
ACIP	Immunizations - DTP <19	616	2	1	$72	0	$0	2	$46	611	$42,029	99.51%
HHS	Wellness Examinations - women	2,572	4	3	$286	0	$0	5	$29	2,560	$345,825	99.69%
ACIP	Immunization Administration - >18	5,007	36	3	$134	0	$0	3	$44	4,965	$176,427	99.88%
HRSA/HHS	Wellness Examinations - <19	2,188	6	1	$25	0	$0	1	$5	2,180	$234,092	99.91%
ACIP	Immunization Administration - <19	2,386	8	0	$0	0	$0	1	$20	2,377	$96,005	99.96%

PPACA Preventive Services Coverage Compliance Detail Report					
QID	**Error Description**	**Under Paid**	**HealthSCOPE Response**	**CTI Conclusion**	**Manual or System**
8	Coinsurance Applied	$112.41	Agree. Preventive charge paid with coinsurance.	Procedural deficiency and underpayment remain.	☒ M ☐ S
10		$767.60	Claim should have paid at 100% of the PPO allowed for procedure 81162 based on diagnosis.		☒ M ☐ S
9	Copay Applied	$40.00	Agree. Copayment in error based on surgical procedure performed in specialty care physician's office.		☒ M ☐ S
11	Denied	$37.12	Agree. Procedure G0442 should have been paid at 100% of PPO allowed per ACA guidelines.		☒ M ☐ S

Preventive Care Services Compliance Review Paid at 100%

PEBP - HealthSCOPE

Audit Period 4/1/2021 - 6/30/2021

Plans: All

Filters: Exclude - out of network, adjustments, edits with frequency limits, claimants 65 or older

		Claim Lines Submitted	Denied	Applied Deductible		Applied Copay		Applied Coinsurance		Paid @100%		
Edit Guideline	**Preventive Service Benefit**	**#**	**#**	**#**	**Amount**	**#**	**Amount**	**#**	**Amount**	**#**	**Amount**	**%**
ACIP	Immunizations - Human papillomavirus	266	0	0	$0	0	$0	0	$0	266	$62,354	100.00%
ACIP	Immunizations - Rotavirus <19	214	0	0	$0	0	$0	0	$0	214	$22,688	100.00%
ACIP	Immunizations - Meningococcal <19	207	0	0	$0	0	$0	0	$0	207	$28,894	100.00%
Bright Futures	Developmental Autism screening - <3	203	0	0	$0	0	$0	0	$0	203	$5,738	100.00%
ACIP	Immunizations - Hepatitis A <19	203	0	0	$0	0	$0	0	$0	203	$7,745	100.00%
USPSTF-B	Vision screening - 3- 5	136	15	0	$0	0	$0	0	$0	121	$2,985	100.00%
ACIP	Immunizations - Measles, Mumps, Rubella <19	126	0	0	$0	0	$0	0	$0	126	$29,361	100.00%
ACIP	Immunizations - Meningococcal >18	108	0	0	$0	0	$0	0	$0	108	$17,821	100.00%
ACIP	Immunizations - Hepatitis B <19	87	0	0	$0	0	$0	0	$0	87	$2,526	100.00%
ACIP	Immunizations - Varicella <19	87	0	0	$0	0	$0	0	$0	87	$14,122	100.00%
ACIP	Immunizations - Influenza <19	77	0	0	$0	0	$0	0	$0	77	$1,611	100.00%
Bright Futures	Lead screening - <21	21	3	0	$0	0	$0	0	$0	18	$297	100.00%
ACIP	Immunizations - Inactivated Poliovirus <19	18	1	0	$0	0	$0	0	$0	17	$690	100.00%
ACIP	Immunizations - Varicella >18	11	0	0	$0	0	$0	0	$0	11	$1,430	100.00%
Bright Futures	Tuberculin testing - <21	6	0	0	$0	0	$0	0	$0	6	$78	100.00%
	Totals	**26,599**	**181**	**737**	**$32,239**	**80**	**$2,668**	**442**	**$5,930**	**25,159**	**$2,092,478**	**95.23%**

NCCI Editing Compliance

While there are no universally accepted correct coding guidelines among private insurers and administrators, the Centers for Medicare & Medicaid Services (CMS), the nation's largest payer for health care, took the initiative to provide valuable guidance for medical benefit plans. Implementation of NCCI mandated several initiatives to prevent improperly billed claims from being paid under Medicare and Medicaid.

Scope

The two NCCI initiatives that can offer the greatest return benefit to self-funded employee benefit plans are the Procedure-to-Procedure (PTP) Edits and Medically Unlikely Edits (MUEs).

Our claim system code editing analysis identified services submitted to the plan and paid by HealthSCOPE that Medicare and Medicaid would have denied. **Since HealthSCOPE paid the billed charges, the payments represent a potential savings opportunity to PEBP.**

It is difficult to establish the extent to which administrators and carriers use NCCI edits; however, CTI recommends these reports be discussed with your administrator to determine the extent to which they

incorporate CMS edits. Using these edits typically reduces claim expense and furthers efforts toward achieving standardized code-editing systems for all payers.

PTP Edits Reports

PTP Edits compare procedure codes from multiple claim lines on the same day to identify when procedures submitted on the same claim cannot be billed together. Our reports are grouped by outpatient hospital services and non-facility claims using CMS' quarterly updated data. If your administrator is not currently using these CMS edits, CTI's reports will help you evaluate the savings you would have realized had the PTP Edits been in place.

Outpatient Hospital Services (facility claims with codes not designated inpatient)								
Primary		Secondary		Mod	Primary Description	Secondary Description	Line Count	Secondary Allowable Benefit
Code	Mod	Code	Mod	Use				
74177	TC	96374		YES	CT ABD & PELV W/CONTRAST	THER/PROPH/DIAG INJ IV PUSH	15	$5,425
					Standards of medical / surgical practice			
29881	RT	29877	XS,RT	NO	KNEE ARTHROSCOPY/SURGERY	KNEE ARTHROSCOPY/SURGERY	1	$4,356
					Misuse of column two code with column one code			
63081		22551		YES	Remove vert body dcmprn crvl	NECK SPINE FUSE&REMOV BEL C2	1	$4,219
					More extensive procedure			
70553		70544		YES	Mri brain stem w/o & w/dye	MR ANGIOGRAPHY HEAD W/O DYE	1	$3,567
					Misuse of column two code with column one code			
92960		93005		YES	CARDIOVERSION ELECTRIC EXT	ELECTROCARDIOGRAM TRACING	6	$2,730
					Standards of medical / surgical practice			
22551		95939	TC	YES	NECK SPINE FUSE&REMOV BEL C2	C MOTOR EVOKED UPR&LWR LIMBS	4	$2,727
					Misuse of column two code with column one code			
70551		70544		YES	Mri brain stem w/o dye	MR ANGIOGRAPHY HEAD W/O DYE	2	$2,336
					Misuse of column two code with column one code			
70496		70450		YES	CT ANGIOGRAPHY HEAD	CT HEAD/BRAIN W/O DYE	1	$2,317
					Misuse of column two code with column one code			
51702		96366		YES	INSERT TEMP BLADDER CATH	THER/PROPH/DIAG IV INF ADDON	1	$2,153
					Misuse of column two code with column one code			
74177	TC	96365		YES	CT ABD & PELV W/CONTRAST	THER/PROPH/DIAG IV INF INIT	4	$1,794
					Standards of medical / surgical practice			
						Top 10 TOTAL	**36**	**$31,624**
						GRAND TOTAL	**619**	**$121,086**

Non-Facility (non-facility claims with CPT codes:00100 - 99999)								
Primary		Secondary		Mod	Primary Description	Secondary Description	Line Count	Secondary Allowable Benefit
Code	Mod	Code	Mod	Use				
95955	TC	95940		YES	EEG DURING SURGERY	Ionm in operatng room 15 min	1	$3,053
					CPT Manual or CMS manual coding instructions			
22853		22845		YES	INSJ BIOMCHN DEV INTERVERTEBRAL DSC SPC W/A	INSERT SPINE FIXATION DEVICE	1	$1,785
					HCPCS/CPT procedure code definition			
29875	RT	29877	59,RT	NO	KNEE ARTHROSCOPY/SURGERY	KNEE ARTHROSCOPY/SURGERY	1	$757
					Misuse of column two code with column one code			
22551		69990		NO	NECK SPINE FUSE&REMOV BEL C2	MICROSURGERY ADD-ON	2	$599
					Misuse of column two code with column one code			
00530	AA,P3	95955	26,59	NO	ANESTH PACEMAKER INSERTION	EEG DURING SURGERY	1	$450
					Standard preparation / monitoring services for anesthesia			
00537	AA,P3	95955	26,59	NO	ANESTH CARDIAC ELECTROPHYS	EEG DURING SURGERY	1	$450
					Standard preparation / monitoring services for anesthesia			
90471		99386		YES	IMMUNIZATION ADMIN	PREV VISIT NEW AGE 40-64	3	$449
					CPT Manual or CMS manual coding instructions			
29882	51	29877	59,51	NO	KNEE ARTHROSCOPY/SURGERY	KNEE ARTHROSCOPY/SURGERY	1	$382
					Misuse of column two code with column one code			
29882		29877		NO	KNEE ARTHROSCOPY/SURGERY	KNEE ARTHROSCOPY/SURGERY	2	$374
					Misuse of column two code with column one code			
99205	25	97802		NO	Office/outpatient visit for E&M of new patient. 60	MEDICAL NUTRITION INDIV IN	6	$259
					Misuse of column two code with column one code			
						Top 10 TOTAL	**19**	**$8,559**
						GRAND TOTAL	**126**	**$14,172**

Procedure to Procedure Detail Report					
QID	**Error Description**	**Over Paid**	**HealthSCOPE Response**	**CTI Conclusion**	**Manual or System**
4	Non-Facility	$3,052.80	Agree. Claim should have been denied based on system edits. Refund of $3,052.80 has been requested.	Procedural deficiency and overpayment remain.	☒ M ☐ S
5	Outpatient	$1,088.95.	Agree. Claim was calculated incorrectly, and benefit exceeded is $1,088.95.	Procedural deficiency and overpayment remain.	☒ M ☐ S

MUE Reports

An MUE is an edit that tests claim lines for the same beneficiary, procedure code, date of service, and billing provider against a maximum allowable number of service units. The MUE rule for a given code is the maximum number of service units a provider should report for a single day of service. MUE errors could be caused by incorrect coding, inappropriate services performed, or fraud. MUEs do not require Medicare contractors to perform a manual review or suspend claims; rather, claim lines are denied and must be correctly resubmitted by providers, typically with a lesser payment amount.

CTI's MUE analyses are grouped into three separate reports:

- Outpatient hospital
- Non-facility
- Ancillary

Outpatient Hospital Services (facility claims with codes not designated inpatient)				
Procedure Code	**Service Unit Limit**	**Procedure Description**	**Line Count Exceeding Limit**	**Gross Benefit Allowed**
90999	1	DIALYSIS PROCEDURE	59	$265,111
		Rationale: Clinical: CMS Workgroup		
20999	1	MUSCULOSKELETAL SURGERY	1	$20,551
		Rationale: Clinical: CMS Workgroup		
A9588	10	FLUCICLOVINE F-18	2	$19,928
		Rationale: Prescribing Information		
20680	3	REMOVAL OF SUPPORT IMPLANT	2	$17,062
		Rationale: Clinical: Data		
97799	1	PHYSICAL MEDICINE PROCEDURE	20	$11,534
		Rationale: Clinical: CMS Workgroup		
C1732	3	CATH, EP, DIAG/ABL, 3D/VECT	1	$7,071
		Rationale: Clinical: Data		
J9070	55	CYCLOPHOSPHAMIDE 100 MG INJ	1	$6,998
		Rationale: Clinical: Data		
27870	1	FUSION OF ANKLE JOINT OPEN	1	$5,389
		Rationale: CMS Policy		
J0585	600	INJECTION,ONABOTULINUMTOXINA	2	$5,352
		Rationale: Clinical: Data		
99152	2	MOD SED SAME PHYS/QHP INITIAL 15 MINS 5/> YRS	23	$4,768
		Rationale: Nature of Service/Procedure		
		Top 10 TOTAL	**112**	**$363,763**
		GRAND TOTAL	**299**	**$421,896**

Non-Facility (non-facility claims with CPT codes:00100 - 99999)				
Procedure Code	Service Unit Limit	Procedure Description	Line Count Exceeding Limit	Gross Benefit Allowed
J9355	105	INJ TRASTUZUMAB EXCL BIOSIMI	4	$49,891
		Rationale: CMS Policy		
97799	1	PHYSICAL MEDICINE PROCEDURE	36	$23,100
		Rationale: Clinical: Data		
95165	30	ANTIGEN THERAPY SERVICES	10	$9,601
		Rationale: Clinical: Data		
88374	5	Morphometric analysis, in situ hybridization (quantitativ	10	$7,770
		Rationale: Clinical: Data		
87799	3	DETECT AGENT NOS DNA QUANT	5	$5,487
		Rationale: Clinical: Data		
88341	13	Immunohistochemistry or immunocytochemistry, per spe	5	$3,190
		Rationale: Clinical: Data		
97154	18	GROUP ADAPTIVE BHV TX BY PROTOCOL TECH EA 15 MIN	5	$2,831
		Rationale: Clinical: CMS Workgroup		
99494	2	Initial or subsequent psychiatric collaborative care mana	11	$2,321
		Rationale: Clinical: Data		
J0475	8	BACLOFEN 10 MG INJECTION	1	$2,313
		Rationale: Prescribing Information		
96127	2	Brief emotional/behavioral assessment (eg, depression in	19	$1,695
		Rationale: Nature of Service/Procedure		
		Top 10 TOTAL	**106**	**$108,200**
		GRAND TOTAL	**203**	**$128,866**

Ancillary (All other claims not flagged Inpatient, Outpatient Hospital, or non-facility)				
Procedure Code	Service Unit Limit	Procedure Description	Line Count Exceeding Limit	Gross Benefit Allowed
E0466	2	Home ventilator, any type, used with non-invasive interfa	10	$13,742
		Rationale: Nature of Equipment		
E0465	2	Home ventilator, any type, used with invasive interface, (e	7	$8,045
		Rationale: Nature of Equipment		
E1390	1	OXYGEN CONCENTRATOR	1	$2,881
		Rationale: Nature of Equipment		
A4253	1	BLOOD GLUCOSE/REAGENT STRIPS	16	$2,052
		Rationale: Nature of Equipment		
E0956	4	W/C LATERAL TRUNK/HIP SUPPOR	3	$566
		Rationale: Nature of Equipment		
K0001	1	STANDARD WHEELCHAIR	8	$407
		Rationale: Nature of Equipment		
V2520	2	CONTACT LENS HYDROPHILIC	3	$288
		Rationale: Anatomic Consideration		
E0260	1	HOSP BED SEMI-ELECTR W/ MATT	3	$192
		Rationale: Nature of Equipment		
V2521	2	CNTCT LENS HYDROPHILIC TORIC	1	$110
		Rationale: Anatomic Consideration		
V2522	2	CNTCT LENS HYDROPHIL BIFOCL	1	$110
		Rationale: Anatomic Consideration		
		Top 10 TOTAL	**53**	**$28,393**
		GRAND TOTAL	**63**	**$28,801**

Global Surgery Prohibited Fee Period Analysis

CMS created the definition of global surgical package to make payments for services provided by a surgeon before, during, and after procedures. The objective of CTI's Global Surgery Prohibited Fee Period Analysis is to compare paid surgical claims to Medicare's payment guidelines and identify instances of unbundling and improper use of evaluation and management (E/M) coding.

Scope

The scope of the Global Surgery Prohibited Fee Period Analysis is surgery charges provided in any setting, including inpatient hospital, outpatient hospital, ambulatory surgical center (ASC), and physician's office. Claims for surgeon visits in intensive care or critical care units are also included in the global surgical package. Our analysis encompasses the three types of procedures with global surgical packages: simple, minor, and major. Each type has specific global periods:

- Simple – One day
- Minor – Ten days
- Major – Ninety days

CMS allows providers to bill for an E/M service after surgery if the patient's condition required a significant, separately identifiable E/M service beyond the usual pre-operative and post-operative care. When this occurs, the provider can add a modifier 24, 25, or 57 to the E/M service procedure code but must submit supporting documentation with the claim.

Report

The following report provides a summary of:

- top 10 providers with and without E/M charges during prohibited periods and associated charges;
- analysis of same providers' surgeries with modifier 24, 25, or 57 when Medicare would have required supporting documentation before payment; and
- analysis of the same providers' surgeries without modifier 24, 25, or 57 when Medicare would have denied payment.

Payment of unbundled, post-surgical E/M services during the global fee period increases the cost of a claim. While there are no universally accepted guidelines for global surgery fee periods with 24, 25, or 57 modifiers, some states and groups mandate providers accept assignment of benefits on those claims. This mitigates the financial impact of unbundling and improper coding. When we discuss our findings, we will help you identify strategies to monitor and eliminate unbundling within your plan.

Audit Period 4/1/2021 - 6/30/2021									
	Surgeries with 'CMS Defined' Prohibited Global Fee Periods					Evaluation and Management Services using Same ID as Surgeon and Within Prohibited Global Fee Period			
	Surgeries without E/M Procedures during Prohibited Global Fee		Surgery with E/M Charge during Prohibited Global Fee Periods			E/M Procedure Codes with Modifier 24, 25, or 57		E/M Procedure Codes without Modifier 24, 25, or 57	
Provider Id	Count	Allowed Charge	Count	% Surgeries with E/M Charges during Prohibited Global Fee Periods	Allowed Charge	Total Count; 0,10 & 90 days	Allowed Charge	Total Count; 0,10 & 90 days	Allowed Charge
880103557	289	$164,071	34	10.5%	$2,532	26	$1,291	8	$590
330571597	1	$327	2	66.7%	$5,933	0	$0	1	$507
680334324	12	$5,287	1	7.7%	$283	0	$0	1	$461
860800150	3	$2,300	2	40.0%	$1,074	1	$172	1	$404
910858192	49	$15,720	26	34.7%	$1,827	22	$1,760	2	$246
880313907	20	$3,107	14	41.2%	$1,648	13	$1,730	1	$139
416011702	5	$5,239	3	37.5%	$3,033	0	$0	1	$129
880310956	24	$9,368	2	7.7%	$1,908	0	$0	1	$122
270028866	47	$85,837	9	16.1%	$7,671	7	$1,248	1	$117
880454760	15	$975	2	11.8%	$53	0	$0	2	$111
Top 10	**465**	**$292,231**	**95**	**17.0%**	**$25,963**	**69**	**$6,202**	**19**	**$2,827**
Overall Total	**3,476**	**$1,229,616**	**572**	**14.1%**	**$119,924**	**515**	**$54,310**	**34**	**$3,808**

Q2, Q3, and Q4 FY2021 RECOMMENDATIONS

CTI has the following recommendations:

1. HealthSCOPE should review each of the financial errors identified in our Q2, Q3, and Q4 FY2021 random sample audits and determine if system changes or examiner training could help reduce or eliminate errors of a similar nature in the future. It should focus specifically on steps necessary to improve Financial Accuracy, Accurate Payment Frequency, and Accurate Processing Frequency.
2. HealthSCOPE should conduct a focused analysis of the errors identified through ESAS to determine if overpayment recovery and/or system improvements are possible and to reduce or eliminate similar errors going forward. For the issues identified by ESAS, CTI can prepare claim detail for HealthSCOPE to use in its analysis.
3. PEBP should carefully review any new contract signed with its administrators to ensure its ability to audit is not limited by restrictive conditions such as errors adjusted prior to date of audit or lesser than a certain dollar amount.
4. Based on Q3 2021 findings, PEBP and HealthSCOPE should discuss which diagnosis codes and diagnosis positions should trigger an accident questionnaire to be sent to the member. Member claims are currently being denied until a questionnaire is returned for an illness that is clearly not accident related. This is causing member disruption.
5. HealthSCOPE should adjust impacted claims when subrogation recoveries are received. This is not currently taking place and it is impacting member total out-of-pocket limits.
6. PEBP should review the results of the eligibility screening and perform causal analysis to identify workflow and/or system improvements to reduce or eliminate paying claims on ineligible claimants.
7. PEBP should talk to HealthSCOPE about its Coordination of Benefits (COB) processes and procedures. HealthSCOPE indicated it is not currently part of their service to review any COB indicators on a submitted claim.
8. HealthSCOPE's self-reported auto-adjudication rate is 63.5%. In CTI's experience, this is very low. We typically see 80% - 85% auto-adjudication. HealthSCOPE should consider ways to automate claims processing. This will also help reduce the number of manual errors that are occurring with HealthSCOPE's current adjudication.
9. In CTI's experience PEBP's dental plan document is vague and/or silent on a number of dental services. We recommend that the language be updated to indicate specifically which services are covered and which are excluded.
10. PEBP should request regular member appeal reports that include the reason for appeal, as well as received and closed dates. Currently it appears that HealthSCOPE is calculating appeal decision dates based on when the appeal was assigned, not when the appeal was received as stated on page 101 of PEBP's Consumer Driven Health Plan Master Plan for Plan Year 2021.
11. When generating PEBP's overpayment report, HealthSCOPE should specify the reason for overpayments. Tracking the reason for overpayments will allow both PEBP and HealthSCOPE to understand why overpayments occur and help determine the steps necessary to prevent them going forward.

CONCLUSION

We consider it a privilege to have worked for, and with, your staff and administrator. Thank you again for choosing CTI.

APPENDIX – ADMINISTRATOR RESPONSE TO DRAFT REPORT

Your administrator's response to the draft report follows.

27 Corporate Hill Drive
Little Rock, AR 72205

February 18, 2022

Claim Technologies Incorporated
100 Court Avenue Suite 306
Des Moines, IA 50309

Dear Ms. Nisius,

Thank you for the opportunity to work with CTI on our mutual client State of Nevada Public Employees' Benefit Program.

Appendix – Administrator's Response to Draft Report for State of Nevada Public Employees' Benefit Program.

HealthSCOPE Benefits has reviewed the Q4 draft report and would like to add the response to the conclusions within the audit report.

Performance Guarantees: HSB provided CTI with the copy of the email notification to the State of Nevada regarding the Annual/Regulatory Documents.

TARGETED SAMPLE ANALYSIS:

Paid Greater Thank Charged Detail Report:

QID 25 – HSB does agree with CTI conclusion. The claim was coordinated incorrectly.

Fraud, Waste, and Abuse Detail Report:

QID 37 - HSB does not agree with CTI conclusion. The claim was reviewed for medical necessity and records were provided to CTI with the audit.

QID 38- HSB does not agree with CTI conclusion. The claim was reviewed for medical necessity and records were provided to CTI with the audit.

QID 35 - HSB does not agree with CTI conclusion regarding an outstanding overpayment on this account. This was a pre-treatment estimate and the payment was issued. The refund check was received on 06/09/2021 to satisfy the account.

Duplicate Payment Detail Report:

QID 31 - HSB does agree with CTI conclusion. [redacted]6511 pending reconsideration to request a refund on the account. [redacted]6511 is a duplicate payment to [redacted]2031.

QID 32 – Questionnaire ID 32 is the same as QID 31. [redacted]6511 pending reconsideration to request a refund on the account. [redacted]6511 is a duplicate payment to [redacted]2031.

QID 33 - HSB does agree with CTI conclusion. Claim pending reconsideration to request refund of duplicate payment.

Timely Filing Detail Report:

QID 18 - HSB does not agree with CTI conclusion. The original claim was received with in the timely filing guidelines. The accident questionnaire was sent to the member from the subrogation vendor LNL. The member contacted LNL regarding the status of this information. The claim was reconsidered after notification from LNL that there was no third party liability and to apply plan benefits.

QID 19 - HSB does not agree with CTI conclusion. No overpayment on the member account. The original claim was received and denied requesting additional information regarding possible other health insurance. The transplant network provided this information to include proof of timely filing. The claim was reconsidered with the proof of timely filing.

RANDOM SAMPLE AUDIT:

Financial Accuracy Detail Report:

Audit No. 1036 – HSB does agree with CTI conclusion. The claim should have only one $250 copayment.

Accurate Processing Detail Report:

Audit No. 1036 – HSB does agree with CTI conclusion. The claim should have only one $250 copayment.

Observation:

Audit No. 1070 – The claim was denied correctly on the account. The EOB comment code should have been removed from the claim.

PPACA Preventive Services Coverage Compliance Detail Report:

QID 8 – HSB does agree that claim lines 2-3 were paid at coinsurance in error.

QID 10 – HSB does agree that the claim should have paid at 100% of the PPO allowed for procedure 81162 based on diagnosis billed.

QID 9 – HSB does agree that this claim was paid with a copayment in error based on the surgical procedure performed in a specialty care physician's office.

QID 11 – HSB does agree that procedure G0442 should have been paid at 100% of PPO allowed amount.

Procedure to Procedure Detail Report:

QID 4 - HSB does agree the claim was originally paid incorrectly. The claim was reconsidered with the appropriate NCCI edits and refund was requested.

QID 5 - HSB does agree that the claim was considered incorrectly. The claim was calculated incorrectly, and the overpayment should be $1088.95.

RECOMMENDATIONS:

HealthSCOPE has reviewed the recommendations from CTI as outlined. HealthSCOPE will continue to review each of the errors identified in the CTI FY 2021 random sample audits and continue to use the samples for training opportunities as well as system enhancements. The HealthSCOPE team will meet internally to discuss any open items or issues to continue focusing on accuracy as well as training. The claim management team will have a copy of the full audit for FY 2021 to evaluate any areas of concern.

HealthSCOPE has requested the list of open cases from LNL for FY 2021. Once the report is received this will be submitted to CTI for review.

HealthSCOPE did provide CTI the appeals report that is also submitted to the PEBP's Quality Control Officer for their appeal and complaints summary vendor report requirement. The summary report provided does go back to 01/01/2020.

Thank you,

Jennifer Spencer, Associate Director of Quality Assurance
HealthSCOPE Benefits, Inc

CLAIM TECHNOLOGIES INCORPORATED

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(515) 244-7322 • claimtechnologies.com

4.4.4

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

    4.4 Acceptance of Claim technologies Incorporated audit findings for State of Nevada Public Employees' Benefits Program Plans administered by HealthSCOPE Benefits for:

        4.4.1 Period October 1, 2020 – December 31, 2020 (FY21.Q2)

        4.4.2 Period January 1, 2021 – March 31, 2021 (FY21.Q3)

        4.4.3 Period April 1, 2021 – June 30, 2021 (FY21.Q4)

        4.4.4 Focus audit for the period February 1, 2020 through September 30, 2021

Focused COVID-19 Claim Administration Audit

FINDINGS REPORT

State of Nevada Public Employees' Benefits Program Medical Plans Administered by HealthSCOPE Benefits

Audit Period: February 1, 2020 through September 30, 2021

Presented to

State of Nevada Public Employees' Benefits Program

Revised February 22, 2022

CLAIM TECHNOLOGIES INCORPORATED

TABLE OF CONTENTS

INTRODUCTION 3

FOCUSED AUDIT WITH TARGETED SAMPLE ANALYSIS 3

RECOMMENDATION 4

CONCLUSION 5

APPENDIX – Administrator's Response to Draft Report 6

INTRODUCTION

This ***Findings Report*** contains CTI's findings and recommendations from the focused audit of COVID-19 claims from HealthSCOPE Benefits' (HealthSCOPE) administration of the State of Nevada Public Employees' Benefits Program (PEBP) plans. We provide this report to PEBP, the plan sponsor, and HealthSCOPE, the claims administrator. A copy of HealthSCOPE's response to these findings can be found in the Appendix of this report.

CTI conducted the audit according to accepted standards and procedures for claim audits in the health insurance industry. We based our audit findings on the data and information provided by PEBP and HealthSCOPE. The validity of our findings relies on the accuracy and completeness of that information. We planned and performed the audit to obtain a reasonable assurance claims were adjudicated according to the terms of the contract between HealthSCOPE and PEBP and the guidelines for processing COVID-19 claims.

CTI specializes in the audit and control of health plan claim administration. Accordingly, the statements we make relate narrowly and specifically to the overall effectiveness of policies, procedures, and systems HealthSCOPE used to pay PEBP's COVID-19 related claims during the audit period. While performing the audit, CTI complied with all confidentiality, non-disclosure, and conflict of interest requirements and did not receive anything of value or any benefit of any kind other than agreed upon audit fees.

Audit Objectives

The objectives of CTI's audit of HealthSCOPE's claim administration were to determine whether:

- HealthSCOPE paid claims according to the provisions of the COVID-19 directives and if those instructions were clear and consistent;
- any claim administration systems or processes need improvement.

Audit Scope

CTI conducted a focused audited of 250 claims of HealthSCOPE's administration of COVID-19 claims for the period of February 1, 2020 through September 30, 2021. To ensure we identified all PEBP members' claims that included a COVID-19 test, treatment, or diagnosis, we requested data for every claim processed during the audit period – not just those the administrator identified as COVID-19 related.

	Total Claims Processed	Total Claims Paid
Paid	933,361	$294,364,901
Denied	129,295	$0
Adjusted	49,668	$27,196,144
TOTAL	**1,112,324**	**$321,561,045**

FOCUSED AUDIT FINDINGS

We used CTI's proprietary Electronic Screening and Analysis System (ESAS®) to test HealthSCOPE's controls and procedures for administering COVID-19 claims by selecting specific claim cases processed during the audit period.

Electronic screening of all service lines processed revealed the potential for incorrectly paid claims. CTI's analysis confirmed the opportunity for process improvement and further testing was recommended. We sent our findings to HealthSCOPE for written response. After review of the response and additional information provided, CTI confirmed the potential for process improvement.

Incorrect Cost Share

During CTI's ESAS review, we found that on 64 of the 250 claims reviewed, HealthSCOPE applied a cost share incorrectly to claims that should have been processed without one. In those instances, a PEBP member was seen either in person or via a Telehealth or Teledoc visit, and the provider billed one or more diagnosis codes related to COVID-19 testing or a COVID-19 diagnosis. The breakdown of cost-share errors follows.

Incorrect Cost Share	Claims	Underpayment
Coinsurance	33	$357.66
Deductible	24	$2,238.71
Copayment	7	$1,138.14
TOTAL	**64**	**$3,734.51**

Of the 64 incorrect cost share applications, 56 were for in-person visits, six were for Telehealth and two were for Teledoc.

Additional Observations

CTI notes three additional observations during this focused audit.

- HealthSCOPE paid one provider $3,795.75 each for 15 COVID-19 tests for services provided February 1, 2021, through May 24, 2021, for a total of $56,932.50. The average payment for a COVID-19 test made to all other providers during the audit period was $347.47. After May 24, 2021, HealthSCOPE denied claims for COVID-19 tests from this provider.
- CTI identified one claim for a member whose hospital claim was billed with a diagnosis code for Unspecified Acute Appendicitis. This claim paid correctly with required cost share. The corresponding professional fee, however, was billed with a COVID-19 diagnosis, and that claim was paid with no cost share.
- Note that PEBP's primary concern, that any claim billed in conjunction with a test for COVID-19 was being paid with no cost share, was not substantiated.

RECOMMENDATIONS

CTI has the following recommendations based on our findings in this focused audit.

1. HealthSCOPE should conduct root cause analysis to determine why the application of cost-share was handled incorrectly on 64 of the 250 claims reviewed. HealthSCOPE agreed to these errors and should update its processes, procedures, and systems to ensure cost-share is applied correctly going forward.
2. HealthSCOPE should refer the provider identified in our additional observation to its Special Investigations Unit for review. A copy of this provider's COVID-19-related claims can be provided to HealthSCOPE for further review and investigation.

CONCLUSION

We consider it a privilege to have worked for, and with, your staff and administrator. Thank you again for choosing CTI.

APPENDIX – ADMINISTRATOR RESPONSE TO DRAFT REPORT

27 Corporate Hill Drive
Little Rock, AR 72205

February 4, 2022

Claim Technologies Incorporated
100 Court Avenue Suite 306
Des Moines, IA 50309

Dear Ms. Nisius,

Thank you for the opportunity to work with CTI on our mutual client State of Nevada Public Employees' Benefit Program.

Appendix – Administrator's Response to Draft Report for State of Nevada Public Employees' Benefit Program.

HealthSCOPE Benefits has reviewed the Focused COVID-19 findings report from CTI and provided a response to the audit report outlined below.

FOCUSED AUDIT FINDINGS:

CTI conducted a focused audit of 250 COVID-19 claims for dates of service February 1, 2020 through September 30, 2021. CTI had identified 64 claims that were considered with a cost share during this timeframe.

- HealthSCOPE Benefits has reviewed the claims identified by CTI and does agree that the lab code should have been paid with no cost share.

Additional Observations:

- There were 15 claims for 15 dates of service that were paid for one provider under the plan. The provider was flagged in the claim system for investigation and a letter of medical necessity for services rendered.
- The claim that is submitted by the provider will be adjudicated based on the information received on the claim to include the diagnosis as well as the services provided.

RECOMMENDATIONS:

- HealthSCOPE Benefits has reviewed the claims that applied a cost share and have notified the Claims Manager to educate the staff regarding the benefit.
- HealthSCOPE Benefits did contact the provider as well as flagged the provider in the claim system to deny for investigation.

Thank you,

Jennifer Spencer, Associate Director of Quality Assurance
HealthSCOPE Benefits, Inc

CLAIM TECHNOLOGIES INCORPORATED

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4.5

4.5 Willis Towers Watson (WTW) response to the recommendations from Claim Technologies Incorporated (CTI) to the Audit of the State of Nevada Public Employees' Benefits Program Health Reimbursement Arrangement for the period of July 2020 – June 2021

February 24, 2022

State of Nevada Public Employees Benefits Program

To whom it may concern,

Below is the Willis Towers Watson (WTW) response to the recommendations from Claim Technologies Incorporated (CTI) to the Audit of the State of Nevada Public Employees' Benefits Program Health Reimbursement Arrangement for the period of July 2020-June 2021:

Recommendation #1:

The overpayment report provided by Via Benefits' should specify the reason for overpayments. If the reasons are not currently captured and tracked, CTI recommends doing so. Tracking the reason for overpayments will allow both the PEBP and Via Benefits to understand why overpayments occur and help determine the steps necessary to prevent them going forward.

WTW Response:

The Overpayment Report does identify the type of overpayment that was created in two categories as described below.

- "Negative Account Balance" - In many cases these overpayments happen due to a late notification that the participant has passed away so funding is removed from the

account and claims paid from those funds are then denied and placed into overpayment. This can also happen if a participant has a retroactive loss of their HRA funding qualification.

- "Claims Overpayment" - These overpayments can be tied a claim that was approved but then later determined to be an ineligible expense, for example a claim that was later identified a duplicate claim.

Our current overpayment report does not provide more detailed information on why a specific overpayment occurred on an account. Manual research would need to occur on the individual participant to confirm the specific reason for an overpayment. WTW is currently working on reviewing improvements on the reports that we can provide to clients related to the HRA. One of those reports under review is the Overpayment report, however we are currently unable to confirm if additional detail can be added to the report at this time.

Recommendation #2:

Via Benefits and LifeWorks need to work together to determine how to best update eligibility in a timely manner. Via Benefits reported 146 members with a negative account balance for a total of $67,561.82

Response:

Nevada PEBP has changed their data vendor from LifeWorks to BenefitFocus effective for 2022. WTW has been working with BenefitFocus on the eligibility and HRA files that we need to receive to manage participant data. Part of this process is to improve the timing of when the files are scheduled to be sent to help expedite account updates. Many of the negative account balances identified by CTI can occur due to a death status update. This means that WTW will not be updated with the death status until after Nevada PEBP is updated and then WTW receives the update via the file. We are hopeful that the new files we will receive from BenefitFocus will allow us to receive account updates more timely to help minimize accounts having negative account balances due to a late notification of a deceased status.

One item to note is that WTW is currently working on a tool called OneView that would allow clients and authorized Third Party Eligibility Administrators to access/review/and edit participant account information in real time without having to send a file. This tool would be designed to help resolve/update an account that is an escalation due to a data issue and could be ideal to help resolve an update of a deceased status on an account. OneView is currently in development and is expected to be live in 2023, though access may be rolled in out phases.

Recommendation 3:

Via Benefits should coach examiners on the claim processing errors identified during the audit:

- Overlooked charges in claim file
- Incorrect amount entered
- Incorrect date of service entered
- Allowed payment under incorrect benefit type

WTW Response:

WTW's Claims Manager has confirmed that claim processors are coached on all identified errors, and we have shared the report broadly with the onshore team.

Recommendation 4:

Via Benefits should develop a process to track claim turnaround time.

WTW Response:

WTW's Claims Manager has confirmed that we do have a process to track turnaround time (TAT).

- We have several controls to monitor aging inventory on a daily and weekly basis through reporting and dashboards
- We receive reports monthly and determine Service Level Agreements quarterly
- We do not have a "TAT on demand" type of report as the above controls eliminate the need

Recommendation 5:

Performance Guarantee Metrics included in PEBP's contract with Via Benefits should be measurable to allow for outside validation of the metric being met.

WTW Response:

WTW has confirmed the following related to the Performance Guarantees included in PEBP's contract with Via Benefits being measurable for outside validation.

Please note that Dawn Nisius from Claims Technologies Incorporated advised that this recommendation did not apply to the claims focused Performance Guarantees since those were measurable as part of the audit.

Metric	Comments on Reporting Validation

Claim Processing Turnaround Time	This metric is already measurable as part of the HRA Audit.
Claim Financial Precision	This metric is already measurable as part of the HRA Audit.
Claim Processing Payment Precision	This metric is already measurable as part of the HRA Audit.
Reports	This metric cannot be validated by a TPA as the reports are either 1) automatically generated at the end of each month and made available in BenefitView, or 2) run on demand by Nevada PEBP through BenefitView.
HRA Web Services	WTW's Reporting Manager has advised that the data for these reports can be provided for review by a TPA for future HRA Audits.
Benefits Administration Customer Service Call Center Abandon Rate	WTW's Reporting Manager has advised that the data for these reports can be provided for review by a TPA for future HRA Audits.
Benefits Administration Customer Service Average Speed to Answer	WTW's Reporting Manager has advised that the data for these reports can be provided for review by a TPA for future HRA Audits.
Customer Satisfaction	WTW's Reporting Manager has advised that the data for these reports can be provided for review by a TPA for future HRA Audits.
Disclosure of Subcontractors	This metric cannot be validated by a TPA outside of reviewing emails that the WTW Client Service Manager sends to Nevada PEBP.
Unauthorized Transfer of PEBP Data	This metric cannot be validated by a TPA as this item would only come up if there was an unauthorized transfer of PEBP Data and notification was provided to Nevada PEBP accordingly.

Recommendation 6:
PEBP should verify that missed performance goals have been credited back to the plan.

WTW Response:

Nevada PEBP will need to respond to this recommendation item.

We appreciate the partnership with Claim Technologies Incorporated and the State of Nevada Public Employees' Benefits Program and look forward to building on a strong audit for last plan year.

Sincerely,

Cara Smouse

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4.6

4.6 Clifton Larson Allen Audited Financial Statements of Public Employees' Benefits Program Self-Insurance Trust Fund for FY21

CliftonLarsonAllen LLP
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Board of
Nevada Public Employees' Benefit Program
State of Nevada

We have audited the financial statements of the Self Insurance Trust Fund and the State Retirees' Health and Welfare Benefits Fund of Nevada Public Employees' Benefit Program as of and for the year ended June 30, 2021, and have issued our report thereon dated February 22, 2022. We have previously communicated to you information about our responsibilities under auditing standards generally accepted in the United States of America and *Government Auditing Standards*, as well as certain information related to the planned scope and timing of our audit. Professional standards also require that we communicate to you the following information related to our audit.

Significant audit findings

Qualitative aspects of accounting practices

Accounting policies

Management is responsible for the selection and use of appropriate accounting policies. The significant accounting policies used by Nevada Public Employees' Benefit Program are described in Note 1 to the financial statements.

Public Employees Benefit Program adopted Governmental Accounting Standards Board (GASB) Statement No. 84, Fiduciary Activities, Governmental Accounting Standards Board (GASB) Statement No. 88, Certain Disclosures Related to Debt, Including Direct Borrowings and Direct Placements, Governmental Accounting Standards Board (GASB) Statement No. 90, Majority Equity Interests, and Governmental Accounting Standards Board (GASB) Statement No. 97, 457 Deferred Compensation Plans in fiscal year 2020. The adoptions of these standards had no impact on Public Employees Benefit Program's financial statements.

Accounting estimates

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

- Management's estimate of the accounts receivable and uncollectible allowance for uncollectible premium revenue based on specific rates established by plan documents and an analysis of the collectability of individual accounts We evaluated the key factors and assumptions used to develop the estimate in determining that it is reasonable in relation to the financial statements taken as a whole.

- Management's estimate of the depreciation expense is based on estimated useful lives of assets from the date they are placed into service. We evaluated the key factors and assumptions used to develop the depreciation expense in determining that it is reasonable in relation to the financial statements taken as a whole.

- Management's estimate of the reserve for losses and loss adjustment expenses is determined based upon claim evaluations and independent actuarial projections, and includes a provision for incurred but not reported losses. The actuarial projections of losses on reported claims and the estimate of claims incurred but not reported were based primarily on the Pool's historical paid and incurred losses, industry-wide loss information, and exposure. We evaluated the key factors and assumptions used to develop the reserve in determining that it is reasonable in relation to the financial statements taken as a whole

- Management's estimate of the OPEB liability is based on actuarial analysis performed by State of Nevada Postretirement Health and Life Insurance Plan.

- Management's estimate of net pension liability is based on actuarial analysis performed by Public Employee's Retirement System of Nevada.

Financial statement disclosures

Certain financial statement disclosures are particularly sensitive because of their significance to financial statement users. There were no particularly sensitive financial statement disclosures.

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

Difficulties encountered in performing the audit

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

Uncorrected misstatements

Professional standards require us to accumulate all misstatements identified during the audit, other than those that are clearly trivial, and communicate them to the appropriate level of management. Management has corrected all such misstatements.

Corrected misstatements

The attached schedule summarizes material misstatements detected as a result of audit procedures that were corrected by management.

Disagreements with management

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

Management representations

We have requested certain representations from management that are included in the attached management representation letter dated February 22, 2022.

Management consultations with other independent accountants

In some cases, management may decide to consult with other accountants about auditing and accounting matters, similar to obtaining a "second opinion" on certain situations. If a consultation involves application of an accounting principle to the entity's financial statements or a determination of

the type of auditors' opinion that may be expressed on those statements, our professional standards require the consulting accountant to check with us to determine that the consultant has all the relevant facts. To our knowledge, there were no such consultations with other accountants.

Significant issues discussed with management prior to engagement

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

Audits of group financial statements

We noted no matters related to the group audit that we consider to be significant to the responsibilities of those charged with governance of the group.

Other information in documents containing audited financial statements

With respect to the required supplementary information (RSI) accompanying the financial statements, we made certain inquiries of management about the methods of preparing the RSI, including whether the RSI has been measured and presented in accordance with prescribed guidelines, whether the methods of measurement and preparation have been changed from the prior period and the reasons for any such changes, and whether there were any significant assumptions or interpretations underlying the measurement or presentation of the RSI. We compared the RSI for consistency with management's responses to the foregoing inquiries, the basic financial statements, and other knowledge obtained during the audit of the basic financial statements. Because these limited procedures do not provide sufficient evidence, we did not express an opinion or provide any assurance on the RSI.

Our auditors' opinion, the audited financial statements, and the notes to financial statements should only be used in their entirety. Inclusion of the audited financial statements in a document you prepare, such as an annual report, should be done only with our prior approval and review of the document.

* * *

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

CliftonLarsonAllen LLP

CliftonLarsonAllen LLP

Broomfield, CO
February 22, 2022

Client:	*011-05743400 - Nevada Public Employees' Benefit Program*
Engagement:	*2020 - Nevada Public Employees' Benefit Program*
Period Ending:	*6/30/2021*
Trial Balance:	*0900.02 - SITF Fund 625*
Workpaper:	*0921.00 - SITF Journal Entries Report*

Account	Description	W/P Ref	Debit	Credit
Adjusting Journal Entries				
Adjusting Journal Entries JE # 1				
AJEs posted for entry posted backwards by PEBP				
625-2015-000	Accounts Payable		2,210,420.00	
625-8819-950	CLAIMS EXPNS		3,582,567.00	
625-2820-000	Cash Overdraft			3,582,567.00
625-2820-000	Cash Overdraft			2,210,420.00
Total			**5,792,987.00**	**5,792,987.00**
Adjusting Journal Entries JE # 2		**2010.00**		
To increase the HRA liability.				
625-8819-950	CLAIMS EXPNS		1,536,265.00	
625-2450-000	Reserve for Outstanding Losses			1,536,265.00
Total			**1,536,265.00**	**1,536,265.00**
Adjusting Journal Entries JE # 3		**1300.05**		
To record Rx Rebates for Jan-June 2021				
625-1600-000	Accounts Receivable - 23.0 Rep		3,472,522.00	
625-1600-000	Accounts Receivable - 23.0 Rep		4,543,187.00	
625-4218-950	PPO RX Rebates			3,472,522.00
625-4218-950	PPO RX Rebates			4,543,187.00
Total			**8,015,709.00**	**8,015,709.00**
Adjusting Journal Entries JE # 4		**1305.00**		
To record estimate for uncollectible receivables not recorded .				
625-8815-950	Bad Debt		170,248.00	
625-1604-000	Allowance for Doubtful Accounts			170,248.00
Total			**170,248.00**	**170,248.00**
Adjusting Journal Entries JE # 5		**1300.02**		
To remove duplicated revenue and receivables recorded by PEBP.				
625-4319-950	AVIATN INSUR		34,601,578.00	
625-1680-000	Due From Local Government			34,601,578.00
Total			**34,601,578.00**	**34,601,578.00**
Adjusting Journal Entries JE # 6		**1300.02**		

To record restatement of 2020 premium revenue for amount double recorded as revenue and accounts receivable.				
625-4319-950	AVIATN INSUR		7,532,761.16	
625-1680-000	Due From Local Government			7,532,761.16
Total			**7,532,761.16**	**7,532,761.16**
Adjusting Journal Entries JE # 8		**1300.05**		
To reclassify intergovernmental revenue recorded as interfund activity as of 6/30/21.				
625-4860-000	General Fund Transfers		4,219,514.00	
625-CLA	Intergovernmental Revenue			4,219,514.00
Total			**4,219,514.00**	**4,219,514.00**
	Total Adjusting Journal Entries		**61,869,062.16**	**61,869,062.16**
	Total All Journal Entries		**61,869,062.16**	**61,869,062.16**

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

YEARS ENDED JUNE 30, 2021 AND 2020

WEALTH ADVISORY | OUTSOURCING
AUDIT, TAX, AND CONSULTING

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STATE OF NEVADA
SELF INSURANCE TRUST FUND
PUBLIC EMPLOYEES' BENEFITS PROGRAM
TABLE OF CONTENTS
YEARS ENDED JUNE 30, 2021 AND 2020

INDEPENDENT AUDITORS' REPORT	1
FINANCIAL STATEMENTS	
STATEMENTS OF NET POSITION	4
STATEMENTS OF REVENUES, EXPENSES, AND CHANGES IN FUND NET POSITION	5
STATEMENTS OF CASH FLOWS	6
NOTES TO FINANCIAL STATEMENTS	7
REQUIRED SUPPLEMENTARY INFORMATION	
SCHEDULE OF CHANGES IN NET PENSION LIABILITY	24
SCHEDULE OF CONTRIBUTIONS	25
SCHEDULE OF THE FUND'S PROPORTIONATE SHARE OF THE NET OPEB LIABILITY	26
SCHEDULE OF THE FUND CONTRIBUTIONS	27
INDEPENDENT AUDITORS' 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*	28
SCHEDULE OF FINDINGS	30

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INDEPENDENT AUDITORS' REPORT

Board of the Public Employees' Benefits Program
State of Nevada

Report on the Financial Statements

We have audited the accompanying financial statements of Self Insurance Trust Fund, Public Employees' Benefits Program of the State of Nevada, as of June 30, 2021, and the related notes to the financial statements, which collectively comprise the Self Insurance Trust Fund, Public Employees' Benefit 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.

Auditors' 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 auditors' 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 Self Insurance Trust Fund, Public Employees' Benefits Program of the State of Nevada as of June 30, 2021, and the changes in net 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

Correction of Error

As discussed in Note 10 to the financial statements, the entity has restated net position, premium revenue, and accounts receivable. These adjustments were recorded as of July 1, 2020 and for the year ended June 30, 2020. Our opinion is not modified with respect to this matter.

Reporting Entity

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 net position, and changes in net position of the program. They do not purport to, and do not, present fairly the financial position of the State of Nevada, as of June 30, 2021, and the changes in its net position, for the years then ended, in conformity with accounting principles generally accepted in the United States of America. Our opinion is not modified with respect to this matter.

Other Matters

Report on Supplementary Information

Accounting principles generally accepted in the United States of America require that the Schedule of Changes in Pension Liability, Schedule of the Fund's proportionate share of the Net OPEB Liability, and Related Ratios and the Schedule of Contributions on pages 24-27 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 the information because the limited procedures do not provide us with sufficient evidence to express an opinion or provide any assurance.

Management has omitted the management's discussion and analysis that accounting principles generally accepted in the United States of America require to be presented to supplement the basic financial statements, Such missing information, although not a part of the basic financial statements, is required by the Governmental Accouning 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 historicl context. Our opinion on the basic financial statements is not affected by this missing information.

Comparative Financial Statements

The financial statements of Self Insurance Trust Fund, Public Employees' Benefits Program of the State of Nevada as of June 30, 2020, were audited by other auditors whose report dated November 16, 2020, expressed an unmodified opinion on those financial statements. As discussed in Note 10 to the financial statements, the Company has adjusted its June 30, 2021 financial statements to correct an error in accounting for premium receivables and revenues not correctly reported as of June 30, 2020. The other auditors reported on the financial statements before the correction.

As part of our audit of the 2021 financial statements, we also audited the adjustments to the 2020 financial statements to correct the error described above in accounting as described in Note 10. In our opinion, such adjustments are appropriate and have been properly applied. We were not engaged to audit, review, or apply any procedures to Self Insurance Trust Fund, Public Employees' Benefits Program of the State of Nevada's 2020 financial statements other than with respect to the adjustments and, accordingly, we do not express an opinion or any other form of assurance on the 2020 financial statements as a whole.

Other Reporting Required by *Government Auditing Standards*

In accordance with *Government Auditing Standards*, we have also issued our February 22, 2022, 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 solely to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing, and not to provide an opinion on the effectiveness of Self Insurance Trust Fund, Public Employees' Benefits Program of the State of Nevada's internal control over financial reporting or on compliance. That report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering Self Insurance Trust Fund, Public Employees' Benefits Program of the State of Nevada's internal control over financial reporting and compliance.

CliftonLarsonAllen LLP

CliftonLarsonAllen LLP

Broomfield, CO
February 22, 2022

STATE OF NEVADA
SELF INSURANCE TRUST FUND
PUBLIC EMPLOYEES' BENEFITS PROGRAM
STATEMENTS OF NET POSITION
JUNE 30, 2021 AND 2020

	2021	2020 (Restated)
ASSETS		
CURRENT ASSETS		
Cash and Cash Equivalents	$ 158,708,980	$ 159,637,188
Prepaid Insurance	3,519	3,202
Receivables		
Accounts Receivables, Net	8,239,150	6,055,621
Intergovernmental Receivable	4,854,166	1,379,196
Due From Other Funds	445,439	1,441,984
Due From Fiduciary Funds	12,100,467	11,699,729
Due From Component, Units, Net	37,153	4,567
Total Current Assets	184,388,874	180,221,487
CAPITAL ASSETS		
Property and Equipment	268,533	461,025
Less Accumulated Depreciation	(257,895)	(435,940)
Total Capital Assets (Net of Accumulated Depreciation)	10,638	25,085
Total Assets	184,399,512	180,246,572
DEFERRED OUTFLOWS OF RESOURCES		
Pension Related Amounts	560,665	663,273
OPEB Related Amounts	162,413	69,742
Total Deferred Outflows of Resources	723,078	733,015
LIABILITIES AND NET ASSETS		
CURRENT LIABILITIES		
Bank Overdraft	2,210,420	3,428,332
Accounts Payable	1,579,156	1,409,272
Accrued Payroll and Related Benefits	101,608	98,393
Due to Other Funds	54,100	20,435
Unearned Revenue	3,483,494	3,489,755
Compensated Absences	183,415	156,804
Reserve for Losses	83,584,731	89,702,313
Total Current Liabilities	91,196,924	98,305,304
NONCURRENT LIABILITIES		
Compensated Absences	67,169	38,259
Net Pension Liability	3,537,451	3,833,649
Net OPEB Liability	1,405,629	1,301,204
Total Noncurrent Liabilities	5,010,249	5,173,112
Total Liabilities	96,207,173	103,478,416
DEFERRED INFLOWS OF RESOURCES		
Pension Related Amounts	216,072	362,280
OPEB Related Amounts	99,825	79,050
Total Deferred Inflows of Resources	315,897	441,330
NET POSITION		
Investment in Capital Assets	10,638	25,085
Restricted Expendable - Losses	88,588,882	77,034,756
Total Net Position (Restated)	$ 88,599,520	$ 77,059,841

See accompanying Notes to Financial Statements.

STATE OF NEVADA
SELF INSURANCE TRUST FUND
PUBLIC EMPLOYEES' BENEFITS PROGRAM
STATEMENTS OF REVENUES, EXPENDITURES, AND CHANGES IN FUND NET POSITION
YEARS ENDED JUNE 30, 2021 AND 2020

	2021	2020 (Restated)
OPERATING REVENUES		
Insurance Premiums	$ 371,045,254	$ 383,589,858
Other	3,683	5,520
Total Operating Revenues	371,048,937	383,595,378
OPERATING EXPENSES		
Salaries and Benefits	2,161,431	2,793,277
Operating	3,073,204	2,356,630
Claims Expense	300,583,601	303,888,916
Depreciation	14,447	40,542
Insurance Premiums and Contractual Obligations	62,625,892	59,748,805
Total Operating Expenses	368,458,575	368,828,170
OPERATING INCOME (LOSS)	2,590,362	14,767,208
NONOPERATING REVENUES (EXPENSES)		
Intergovernmental Revenue	9,467,584	408,891
Investment Income (Expense)	(1,341,413)	1,407,557
Interest Income (Expense)	823,146	2,343,660
Total Nonoperating Revenues	8,949,317	4,160,108
Income Before Transfers	11,539,679	18,927,316
CHANGE IN NET POSITION	11,539,679	18,927,316
Net Position - Beginning of Year (Restated for 2021)	77,059,841	58,132,525
NET POSITION - END OF YEAR	$ 88,599,520	$ 77,059,841

See accompanying Notes to Financial Statements.

	2021	2020 (Restated)
CASH FLOWS FROM OPERATING ACTIVITIES		
Receipts From Customers and Users	$ 269,103,073	$ 297,335,333
Receipts From Component Units	99,723,488	85,972,472
Payments to Suppliers, Other Governments and Beneficiaries	(373,438,687)	(381,262,135)
Payments to Employees	(2,419,901)	(2,592,613)
Net Cash Provided (Used) by Operating Activities	(7,032,027)	(546,943)
CASH FLOWS FROM NON-CAPITAL AND RELATED FINANCING ACTIVITIES		
Grants Received	5,992,614	-
Change in Due From Other Funds	629,472	-
Net Cash Provided (Used) by Non-Capital and Financing Activities	6,622,086	-
CASH FLOWS FROM CAPITAL AND RELATED FINANCING ACTIVITIES		
Purchase of Capital Assets	-	(10,678)
Net Cash Provided (Used) by Financing Activities	-	(10,678)
CASH FLOWS FROM INVESTING ACTIVITIES		
Interest on Investments	(518,267)	4,286,191
Net Cash Provided (Used) by Investing Activities	(518,267)	4,286,191
Net Increase (Decrease) in Cash and Cash Equivalents	(928,208)	3,728,570
CASH - BEGINNING OF YEAR	159,637,188	155,908,618
CASH - END OF YEAR	$ 158,708,980	$ 159,637,188
RECONCILIATION OF OPERATING INCOME (LOSS) TO NET CASH USED BY OPERATING ACTIVITIES		
Operating Income	2,590,362	14,767,208
Adjustments to Reconcile Operating Income to Net Cash Provided (Used) by Operating Activities		
Depreciation	14,447	40,542
Allowance for Doubtful Accounts	(107,470)	3,595
Changes in Assets and Liabilities		
(Increase) Decrease in Receivables	(2,108,645)	(6,935,464)
(Increase) Decrease in Prepaid Expenses	(317)	409
(Increase) Decrease in Deferred Outflows - Pension	102,608	(21,449)
(Increase) Decrease in Deferred Outflows - OPEB	(92,671)	(25,474)
Increase (Decrease) in Payables and Accruals	(7,106,874)	(8,462,288)
Increase (Decrease) in Unearned Revenue	(6,261)	(173,143)
Increase (Decrease) in Net Pension Obligation	(296,198)	286,410
Increase (Decrease) in Net OPEB Liability	104,425	(116,303)
Increase (Decrease) in Deferred Inflows - Pension	(146,208)	105,011
Increase (Decrease) in Deferred Inflows - OPEB	20,775	(15,997)
Total Adjustments	(9,622,389)	(15,314,151)
Net Cash Provided (Used) by Operating Activities	$ (7,032,027)	$ (546,943)

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, 2021 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.

NOTE 1 SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

Plan Description (Continued)

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.

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.

NOTE 1 SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

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 $2,210,420 and $3,428,332 as of June 30, 2021 and 2020, 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 position, 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 $3,464,250 and $3,196,058 for the years ended June 30, 2021 and 2020, 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.

The Self Insurance Trust Fund considers $170,248 and $277,718 in participant premiums as uncollectible as of June 30, 2021 and 2020, 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 $-117,792- were approved for write-off by the State of Nevada Board of Examiners as of June 30, 2021 and 2020, 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, 2021 and 2020 were $0 and $10,678, respectively. Capital dispositions for the years ended June 30, 2021 and 2020 were $192,491 and $15,753, respectively.

NOTE 1 SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

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, 2021 and 2020, 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.

NOTE 1 SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

Operating and Non-operating Revenues and Expenses (Continued)

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.

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.

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

	2021	2020
Bank Overdraft		
Overdraft Accounts	$ (2,210,420)	$ (3,428,332)
Deposits with State Treasurer		
State Treasurer's Investment Pool	$ 158,256,356	$ 157,843,151
GASB 31 Adjustment	452,624	1,794,037
Total Cash and Deposits with State Treasurer	158,708,980	159,637,188

The Self Insurance Trust Fund has three checking accounts with Wells Fargo Bank at June 30, 2021 and 2020. These accounts contain $1,082,774 and $1,171,735 (of the total overdraft accounts balances above) in stale outstanding checks for the years ended June 30, 2021 and 2020, respectively. Additionally, certain Bank of America and Wells Fargo Bank zero balance accounts were closed in previous fiscal years. These closed accounts contain $0 and $48,637 in stale outstanding checks as of June 30, 2021 and 2020, 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 presented as a liability on the statement of net position and is funded only when checks are presented for payment. The negative balance represents outstanding checks issued that have not been presented for payment. In accordance with NRS 353.140, the Self Insurance Trust Fund honors outstanding stale warrants presented for payment within six years from the date of origination. For insurance and collateral purposes, the account is commingled with all of the cash accounts of the State of Nevada. All cash and deposits are recorded at fair value.

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

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

A copy of the State of Nevada Comprehensive Annual Financial Report can be obtained online at 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%, 29.25%, and 28.00% for regular members on all covered payroll for the years ended June 30, 2021, 2020, and 2019, 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%, 15.25%, and 14.50% for the years ended June 30, 2021, 2020 and 2019, 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, 2021, 2020, and 2019 were $260,407, $267,388, and $270,646, respectively, equal to the required contributions for the year.

Pension Liability

At June 30, 2021 and 2020 the Self Insurance Trust Fund reported a liability of $3,537,451 and $3,833,649, respectively, for its proportionate share of the net pension liability. The net pension liability was measured as of June 30, 2020 and 2019, 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, 2021 and 2020. The Self Insurance Trust Fund's proportionate share is approximately 0.02540% and 0.02811% as of June 30, 2021 and 2020, respectively.

NOTE 4 PENSION PLAN (CONTINUED)

Pension Expense, Deferred Outflows of Resources and Deferred Inflows of Resources Related to Pensions

As of June 30, 2021 and 2020, the total employer pension expense is ($82,105) and $637,076, respectively. Amounts totaling $260,407 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, 2021 and 2020, the Self Insurance Trust Fund reported deferred outflows of resources and deferred inflows of resources related to pensions from the following sources:

	2021		2020	
	Deferred Outflows of Resources	Deferred Inflows of Resources	Deferred Outflows of Resources	Deferred Inflows of Resources
Differences Between Expected and Actual Experience	$ 109,906	$ 45,677	$ 143,758	$ 110,577
Change of Assumptions	99,364	-	156,014	-
Net Difference Between Projects and Actual Earnings on Investments	-	133,630	-	190,710
Changes in Proportion and Differences Between Actual Contributions and Proportionate Share of Contributions	90,989	36,765	96,113	60,993
System Contributions Subsequent to the Measurement Date	260,407		267,388	-
Total	$ 560,666	$ 216,072	$ 663,273	$ 362,280

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
2022	$ (157,163)
2023	78,197
2024	90,308
2025	63,183
2026	9,024
2027	637
	$ 84,186

NOTE 4 PENSION PLAN (CONTINUED)

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 6.13 years for the measurement period ending June 30, 2020.

Reconciliation of Net Pension Liability	2021	2020
Beginning Net Pension Liability	$ 3,833,649	$ 3,547,239
Pension Expense	(82,105)	637,076
Employer Contributions	(264,674)	(270,646)
Net Deferred (Inflows)/Outflows	50,581	(80,020)
Ending Net Pension Liabilities	$ 3,537,451	$ 3,833,649

Actuarial Assumptions

The Fund's net pension liability was measured as of June 30, 2020 and 2019 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, 2020 funding actuarial valuation

Actuarial assumptions used in the June 30, 2020 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, 2020:

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, 2020, PERs' long-term inflation assumption was 2.75%.

NOTE 4 PENSION PLAN (CONTINUED)

Discount Rate and Pension Liability Discount Rate Sensitivity

The following presents the net pension liability of the PERS as of June 30, 2020, 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	$ 5,517,056	$ 3,537,451	$ 1,891,556

Pension Plan Fiduciary Net Position

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

NOTE 5 OTHER POST EMPLOYMENT RETIREMENT BENEFITS

Plan Description

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

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

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

Benefits

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

NOTE 5 OTHER POST EMPLOYMENT RETIREMENT BENEFITS (CONTINUED)

Contributions

Per NRS 287 contribution requirements of the participating entities and covered employees are established and may be amended by the PEBP Board. The Fund's contractually required contribution for the years ended June 30, 2021 and 2020 were $37,136 and $41,705, 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, 2021 and 2020, the Fund reported a liability of $1,405,629 and $1,301,204, respectively, for its proportionate share of the collective net OPEB liability. The collective net OPEB liability was measured as of July 1, 2020, 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, 2021 and 2020, respectively, the Fund's proportion was 0.0938% and 0.0934%.

For the years ended June 30, 2021 and 2020, respectively, the Fund recognized OPEB expense of 81,719 and ($122,109). At June 30, 2021 and 2020, the Fund Reported deferred outflows of resources and deferred inflows of resources related to OPEB for the following sources:

	2021		2020	
	Deferred Outflows of Resources	Deferred Inflows of Resources	Deferred Outflows of Resources	Deferred Inflows of Resources
Changes of Assumptions	$ 125,277	$ 28,432	$ 28,037	$ 55,581
Changes in Experience	-	71,393	-	23,469
Fund Contributions Subsequent to the Measurement Date	37,136		41,705	-
	$ 162,413	$ 99,825	$ 69,742	$ 79,050

NOTE 5 OTHER POST EMPLOYMENT RETIREMENT BENEFTIS (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 Ended June 30	Amount
2022	$ (3,885)
2023	1,857
2024	3,646
2025	23,835
	$ 25,452

Actuarial Assumptions

The total OPEB liability in the June 30, 2021 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 4.50% 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.

NOTE 5 OTHER POST EMPLOYMENT RETIREMENT BENEFTIS (CONTINUED)

Discount Rate (Continued)

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

	1% Decrease in Discount Rate 1.21%	Discount Rate 2.21%	1% Increase in Discount Rate 3.21%
Total OPEB Liability	$ 1,677,076	$ 1,399,978	$ 1,346,802
Plan Fiduciary Net Position	5,651	5,651	5,651
Net OPEB Liability	$ 1,682,727	$ 1,405,629	$ 1,352,453

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	$ 1,400,818	$ 1,399,978	$ 1,614,471
Plan Fiduciary Net Position	5,651	5,651	5,651
Net OPEB Liability	$ 1,406,469	$ 1,405,629	$ 1,620,122

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, 2021:

Contractor	Contract Rate	Expiration Date
American Health Holding, Inc.	Varies by Case Volume	6/30/23
AON Consulting	Hourly Rate	6/30/22
Claim Technologies	Varies by Audit	6/30/27
CliftonLarsonAllen	Hourly Rate	12/31/24
Diversified Dental Services	Per Participant per Month	6/30/21
Express Scripts	Per Participant per Month Admin Fee, Claims Costs	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
Labyrinth Solutions, Inc.	Per Participant Per Month	6/30/27
Morneau Shepell	Per Participant per Month Fee for Services Rendered	6/30/27
The Standard Insurance	Varies	6/30/22

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.

NOTE 7 RISK MANAGEMENT (CONTINUED)

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

	2021	2020
Reserve for Claims Balance		
Beginning Balance	$ 51,514,000	$ 58,790,000
Claims and Changes in Estimates	271,862,209	258,939,546
Claims Payments	(271,090,209)	(266,215,546)
Ending Balance Reserve for Claims Balance	52,286,000	51,514,000
HRA Liability		
Beginning Balance	$ 38,188,313	$ 36,091,428
Incurred	31,850,782	44,596,089
Paid	(38,740,364)	(42,499,204)
Ending Balance HRA Liability	31,298,731	38,188,313
Ending Balance	$ 83,584,731	$ 89,702,313

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 $1,082,979 and $1,220,372 as of June 30, 2021 and June 30, 2020, 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, 2021 to determine the need for any adjustments to and disclosure within the financial statements for the year ended June 30, 2021. Management has evaluated subsequent events through February 22, 2022, 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.

NOTE 10 PRIOR PERIOD RESTATEMENT

Self Insurance Trust Fund restated beginning net position due to revenue overstated in the prior period. These adjustments were recorded as of July 1, 2020 and during fiscal year 2020.

Net Position as of June 30, 2020	Restatement	Net Position as of June 30, 2020 Restated
$ 84,591,878	$ (7,532,037)	$ 77,059,841

Accounts Receivable as of June 30, 2020	Restatement	Accounts Receivable as of June 30, 2020 Restated
$ 8,911,233	$ (7,532,037)	$ 1,379,196

Revenue as of June 30, 2020	Restatement	Revenue as of June 30, 2020 Restated
$ 391,121,895	$ (7,532,037)	$ 383,589,858

NOTE 11 LITIGATION

Public Employees Benefit Program of the Self Insurance Trust Fund is involved in pending litigation. The outcome of the litigigation cannot be predicted at this time.

STATE OF NEVADA
SELF INSURANCE TRUST FUND
PUBLIC EMPLOYEES' BENEFITS PROGRAM
REQUIRED SUPPLEMENTARY INFORMATION – PENSION
SCHEDULE OF CHANGES IN NET PENSION LIABILITY
LAST TEN FISCAL YEARS*

	Measurement Dates						
	2020	2019	2018	2017	2016	2015	2014
Proportionate of the Net Pension Liability (Asset)	0.0254%	0.0281%	0.0260%	0.0253%	0.0270%	0.0262%	0.0254%
Proportionate Share of the Net Pension Liability (Asset)	$ 3,537,451	$ 3,833,649	$ 3,547,239	$ 3,361,917	$ 3,633,788	$ 3,003,622	$ 2,681,426
Proportionate Share of Covered-Payroll	$ 1,532,510	$ 1,684,981	$ 1,509,506	$ 1,374,657	$ 1,333,326	$ 1,344,932	$ 1,451,686
Proportionate Share of the Net Pension Liability (Asset) as a Percentage of its Covered-Payroll	230.83%	227.52%	234.99%	244.56%	272.54%	223.33%	184.71%
Plan Fiduciary Net Position as a Percentage of the Total Pension Liability	77.04%	76.46%	75.24%	74.42%	72.23%	75.13%	76.31%

* Only seven 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 PROGRAM
REQUIRED SUPPLEMENTARY INFORMATION – PENSION
SCHEDULE OF CONTRIBUTIONS
LAST TEN FISCAL YEARS*

Fiscal Year	2021	2020	2019	2018	2017	2016	2015
Contractually Required Contribution	$ 260,407	$ 267,388	$ 270,930	$ 241,784	$ 220,384	$ 228,943	$ 281,658
Contributions in Relation to the Contractually Required Contribution	(260,407)	(267,388)	(270,930)	(241,784)	(220,384)	(228,943)	(281,658)
Contribution Deficiency (Excess)	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Fund's Covered-Payroll	$ 1,594,419	$ 1,532,510	$ 1,684,981	$ 1,509,506	$ 1,374,657	$ 1,333,326	$ 1,344,932
Contributions as a Percentage of Covered Payroll	16.33%	17.45%	16.08%	16.02%	16.03%	17.17%	20.94%

* Only seven 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 PROGRAM
REQUIRED SUPPLEMENTARY INFORMATION – PENSION
SCHEDULE OF THE FUND'S PROPORTIONATE SHARE OF THE OPEB LIABILITY
LAST TEN FISCAL YEARS*

	2020	2019	2018	2017
Proportion of the Net OPEB Liability (Asset)	0.0938%	0.0934%	0.1070%	0.1029%
Proportionate Share of the Net OPEB Liability (Asset)	$ 1,405,628	$ 1,301,204	$ 1,417,507	$ 1,339,747
Proportionate Share of Covered Payroll	$ 1,532,510	$ 1,684,981	$ 1,509,506	$ 1,374,657
Proportionate Share of the Net OPEB Liability (Asset) as a Percentage of Covered Payroll	91.72%	77.22%	93.91%	97.46%
Plan Fiduciary Net Position as a Percentage of the Total OPEB Liability	0.02%	0.02%	0.12%	0.11%

* Only four 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 PROGRAM
REQUIRED SUPPLEMENTARY INFORMATION – PENSION
SCHEDULE OF THE FUNDCONTRIBUTIONS
LAST TEN FISCAL YEARS*

	2021	2020	2019	2018
Contractually Required Contribution	$ 37,136	$ 41,705	$ 44,268	$ 39,801
Contributions	(37,136)	(41,705)	(44,268)	(39,801)
Contribution Deficiency (Excess)	$ -	$ -	$ -	$ -
Fund's Covered Payroll	$ 1,594,419	$ 1,532,510	$ 1,684,981	$ 1,509,506
Contributions as a Percentage of Covered Payroll	2.33%	2.72%	2.63%	2.64%

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

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INDEPENDENT AUDITORS' 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*

Board of the Public Employees' Benefits Program
State of Nevada

We have audited, in accordance with the auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards* issued by the Comptroller General of the United States, the 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, 2021, and the related notes to the financial statements, which collectively comprise Self Insurance Trust Fund, Public Employees' Benefits Program of the State of Nevada's basic financial statements, and have issued our report thereon dated February 22, 2022.

Internal Control Over Financial Reporting

In planning and performing our audit of the financial statements, we considered Self Insurance Trust Fund, Public Employees' Benefits Program of the State of Nevada's internal control over financial reporting (internal control) as a basis for designing 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 Self Insurance Trust Fund, Public Employees' Benefits Program of the State of Nevada's internal control. Accordingly, we do not express an opinion on the effectiveness of Self Insurance Trust Fund, Public Employees' Benefits Program of the State of Nevada'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 and therefore, material weaknesses or significant deficiencies may exist that have not been identified. We did identify certain deficiencies in internal control, described in the accompanying schedule of findings as items 2021-001, 2021-002, and 2021-003 that we consider to be material weaknesses.

Compliance and Other Matters

As part of obtaining reasonable assurance about whether Self Insurance Trust Fund, Public Employees' Benefits Program of the State of Nevada'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*.

Self Insurance Trust Fund, Public Employees' Benefits Program of the State of Nevada's Response to Findings

Self Insurance Trust Fund, Public Employees' Benefits Program of the State of Nevada's response to the findings identified in our audit is described in the accompanying schedule of findings. Self Insurance Trust Fund, Public Employees' Benefits Program of the State of Nevada's response was not subjected to the auditing procedures applied in the audit of the financial statements and, accordingly, we express no opinion on it.

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.

CliftonLarsonAllen LLP

CliftonLarsonAllen LLP

Broomfield, Colorado
February 22, 2022

STATE OF NEVADA
SELF INSURANCE TRUST FUND
PUBLIC EMPLOYEES' BENEFITS PROGRAM
SCHEDULE OF FINDINGS
FOR THE YEAR ENDED JUNE 30, 2021

Section II – Financial Statement Findings

2021 – 001 Claims Expenses

Type of Finding: Material Weakness in Internal Control over Financial Reporting

Condition: Expenses and liabilities related to accrual entries at the end of the fiscal year recorded for claims were not recorded correctly.

Criteria: Governmental Accounting Standards Board Statement No. 6, *Recognition and Measurement of Certain Liabilities and Expenditures in Governmental Fund Financial Statements – An Interpretation of NCGA Statements 1, 4, and 5; NCGA Interpretation 8; And GASB Statements No. 10, 16, and 18*, and subsequent amendments to this guidance define accrual accounting and provide guidance for proper accounting of these liabilities.

Context: During testing of claim expenses and related liabilities, it was noted that invoices applicable to work performed in 2021 were not recorded as expenditures for Public Employees Benefit Program. Also, loss on reserve calculation was understated.

Effect: As a result of this issue, the following adjustments were required to by posted Public Employees Benefit Program:

- Self-Insurance Trust Fund – An adjustment to increase claims expenses and related liabilities by an amount of $5,792,987. Also, an adjustment to reduce claims expense and loss on reserve by $1,536,265.

Cause: Accrual entries for claims activity were not recorded correctly.

Repeat Finding: This is not a repeat finding.

Recommendation: We recommend the Public Employees Benefit Program increase its review of accrual entries recorded at the end of the fiscal year.

Views of responsible officials and planned corrective actions: The Public Employees Benefit Program agrees with the finding and has adjusted claims expenses and related liabilities accordingly. Public Employees Benefit Program will improve the process for yearend accrual entries

Responsible Official: Cari Eaton, CFO

STATE OF NEVADA
SELF INSURANCE TRUST FUND
PUBLIC EMPLOYEES' BENEFITS PROGRAM
SCHEDULE OF FINDINGS
FOR THE YEAR ENDED JUNE 30, 2021

2021 – 002 Accounts Receivable

Type of Finding: Material Weakness in Internal Control over Financial Reporting

Condition: Premium Revenue and related receivables related to accrual entries at the end of the fiscal year recorded for claims were not recorded correctly.

Criteria: Based on the guidance in Governmental Accounting Standards Board Statement No. 10, *Accounting and Financial Reporting for Risk Financing and Related Insurance Issues*, premium revenue should be recognized as revenue over the contract period in proportion to the amount of risk protection provided.

Context: During testing of premium revenue and related receivables, it was noted the Public Employees Benefit Program did not record year end accruals correctly.

Effect: As a result of this issue, the following adjustments were required to by posted Public Employees Benefit Program:

- Self-Insurance Trust Fund – An adjustment to increase premium revenue and related receivables by $8,015,709. Also, an adjustment to decrease premium revenue and related receivable by $34,601,578.

Cause: Accrual entries for revenue recognition were not recorded correctly.

Repeat Finding: This is not a repeat finding.

Recommendation: We recommend the Public Employees Benefit Program increase its review of accrual entries recorded at the end of the fiscal year.

Views of responsible officials and planned corrective actions: The Public Employees Benefit Program agrees with the finding and has adjusted premium revenue and related receivables accordingly. Public Employees Benefit Program will improve for yearend accrual entries.

Responsible Official: Cari Eaton, CFO

STATE OF NEVADA
SELF INSURANCE TRUST FUND
PUBLIC EMPLOYEES' BENEFITS PROGRAM
SCHEDULE OF FINDINGS
FOR THE YEAR ENDED JUNE 30, 2021

2021 – 003 Prior Period Restatement

Type of Finding: Material Weakness in Internal Control over Financial Reporting

Condition: Premium Revenue and related receivables related to accrual entries at the end of the fiscal year recorded for claims were not recorded correctly.

Criteria: Based on the guidance in Governmental Accounting Standards Board Statement No. 10, *Accounting and Financial Reporting for Risk Financing and Related Insurance Issues*, premium revenue should be recognized as revenue over the contract period in proportion to the amount of risk protection provided.

Context: During testing of premium revenue and related receivables, it was noted the Public Employees Benefit Program did not record year end accruals correctly from the prior period resulting in overstated revenue, receivables, and net position.

Effect: As a result of this issue, the following adjustments were required to by posted Public Employees Benefit Program:

- Self-Insurance Trust Fund - An adjustment to decrease premium revenue and related receivables by $7,532,761 which resulted in net position being restated by $7,532,761.

Cause: Accrual entries for revenue recognition were not recorded correctly.

Repeat Finding: This is not a repeat finding.

Recommendation: We recommend the Public Employees Benefit Program increase its review of accrual entries recorded at the end of the fiscal year. .

Views of responsible officials and planned corrective actions: The Public Employees Benefit Program agrees with the finding and has adjusted premium revenue and related receivables accordingly. Public Employees Benefit Program will improve for yearend accrual entries.

Responsible Official: Cari Eaton, CFO

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

JUNE 30, 2021 AND 2020

STATE OF NEVADA
STATE RETIREES' HEALTH & WELFARE BENEFITS FUND
PUBLIC EMPLOYEES' BENEFITS PROGRAM
TABLE OF CONTENTS
YEARS ENDED JUNE 30, 2021 AND 2020

INDEPENDENT AUDITORS' REPORT	1
FINANCIAL STATEMENTS	
STATEMENTS OF FIDUCIARY NET POSITION	4
STATEMENTS OF CHANGES IN FIDUCIARY NET POSITION	5
NOTES TO FINANCIAL STATEMENTS	6
REQUIRED SUPPLEMENTARY INFORMATION	
SCHEDULES OF CHANGES IN NET OPEB LIABILITY AND RELATED RATIOS	15
SCHEDULES OF CONTRIBUTIONS	16
COMPLIANCE SECTION	
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*	17

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INDEPENDENT AUDITORS' REPORT

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

Report on the Financial Statements

We have audited the accompanying financial statements of State Retirees' Health & Welfare Benefits Fund, Public Employees' Benefits Program of the State of Nevada, as of June 30, 2021, and the related notes to the financial statements, which collectively comprise the State Retirees' Health & Welfare Benefits Fund, Public Employees' Benefit 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.

Auditors' 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 auditors' 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 State Retirees' Health & Welfare Benefits Fund, Public Employees' Benefits Program of the State of Nevada as of June 30, 2021, and the changes in fiduciary net position thereof for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Emphasis of a Matter

As discussed in Note 1, the financial statements of the State Retirees' Health & Welfare Benefits Fund, Public Employees' Benefits Program of the State of Nevada are intended to present the net position, and changes in net position of the program. They do not purport to, and do not, present fairly the financial position of the State of Nevada, as of June 30, 2021, and the changes in its net position, for the years then ended, in conformity with accounting principles generally accepted in the United States of America. Our opinion is not modified with respect to this matter.

Other Matters

Report on Supplementary Information

Accounting principles generally accepted in the United States of America require that the Schedule of Changes in Net OPEB Liability and Related Ratios and the Schedule of Contributions on pages 14 and 15 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 the information because the limited procedures do not provide us with sufficient evidence to express an opinion or provide any assurance.

Management has omitted the management's discussion and analysis and required supplementary information for the Moneyweighted Rate of Return schedule which accounting principles generally accepted in the United States of America require to be presented to supplement the basic financial statements, Such missing information, although not a part of the basic financial statements, is required by the Governmental Accouning 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. Our opinion on the basic financial statements is not affected by this missing information.

Comparative Financial Statements

The 2020 financial statements of the State Retirees' Health & Welfare Benefits Fund, Public Employees' Benefits Program of the State of Nevada were audited by other auditors whose report dated November 16, 2020, expressed an unmodified opinion on those statements.

Other Reporting Required by *Government Auditing Standards*

In accordance with *Government Auditing Standards*, we have also issued our February 22, 2022, on our consideration of the State Retirees' Health & Welfare Benefits Fund, Public Employees' Benefits

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

CliftonLarsonAllen LLP

CliftonLarsonAllen LLP

Broomfield, CO
February 22, 2022

STATE OF NEVADA
STATE RETIREES' HEALTH & WELFARE BENEFITS FUND
PUBLIC EMPLOYEES' BENEFITS PROGRAM
STATEMENTS OF FIDUCIARY NET POSITION
JUNE 30, 2021 AND 2020

	2021	2020
ASSETS		
ASSETS		
Cash with Treasurer	$ 2,118,781	$ 2,570,445
Intergovernmental Receivable	6,716	22,806
Due From Other Funds	7,142	130,776
Due From Component, Units, Net	-	1,480,374
Investments at Fair Value	-	1,843,713
Total Assets	2,132,639	6,048,114
LIABILITIES AND NET POSITION		
CURRENT LIABILITIES		
Due to Other Funds	12,100,467	11,699,729
Total Liabilities	12,100,467	11,699,729
NET POSITION		
Net Position Restricted for Other Postemployment Benefits	$ (9,967,828)	$ (5,651,615)

See accompanying Notes to Financial Statements.

STATE OF NEVADA
STATE RETIREES' HEALTH & WELFARE BENEFITS FUND
PUBLIC EMPLOYEES' BENEFITS PROGRAM
STAETMENTS OF CHANGES IN FIDUCIARY NET POSITION
YEARS ENDED JUNE 30, 2021 AND 2020

	2021	2020
ADDITIONS		
Contributions		
Employer Contributions	$ 39,563,787	$ 43,881,808
Investment Income		
Interest and Dividends	34,923	100,811
Net Appreciation in Fair Value of Investments	273,081	103,941
Investment Expense	(453)	(474)
Total Investment Income	307,551	204,278
Total Additions	39,871,338	44,086,086
Deductions		
Benefit Payments	44,187,551	49,969,098
Total Deductions	44,187,551	49,969,098
CHANGE IN NET POSITION	(4,316,213)	(5,883,012)
Net Position - Beginning of Year	(5,651,615)	231,397
NET POSITION - END OF YEAR	$ (9,967,828)	$ (5,651,615)

See accompanying Notes to Financial Statements.

NOTE 1 SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Reporting Entity

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

Basis of Accounting

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

Method Used to Value Investments

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

Plan Description and Contribution Information

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

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

NOTE 1 SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

Plan Description and Contribution Information (Continued)

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

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

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

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

Contributions to the fund are paid by the State of Nevada through an assessment of actual payroll paid by each State entity. The assessment is set by the Governor's Finance Office based on an amount provided by the Legislature each biennium in session law. The assessment was 2.34% and 2.34% of actual payroll for the years ending June 30, 2021 and 2020, respectively. Benefits are paid to the Public Employees' Benefits Program Self Insurance Trust Fund as necessary to offset retiree premiums pursuant to NRS 287.046. Funds not required to pay benefits are invested in the Retiree Benefits Investment Fund established pursuant to NRS 355.220 or are held in the State of Nevada general portfolio pursuant to NRS 226.110 as approved in the legislatively approved budget. Administrative costs of the Retirees' Fund are absorbed by the Self Insurance Trust Fund.

NOTE 1 SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

Plan Description and Contribution Information (Continued)

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

Active Plan Members*	10,183
Inactive Plan Members or Beneficiaries Currently Receiving Benefit**	13,900
Inactive Plan Members Entitled to but Not Yet Receiving Benefit Payments	2,280
Total Plan Members	26,363

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

State participating employers consisted of the following as of the actuarial valuation date:

Total Particpating Employers	24

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

NOTE 2 NET OPEB LIABILITY

Funding Status and Funding Progres

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

Net OPEB Liability of the Retirees' Fund

The components of the net OPEB liability of the Retiree's Fund at June 30, 2021 and 2020, were as follows:

	2021 (in thousands)	2020 (in thousands)
Total OPEB Liability	$ 1,498,059	$ 1,393,813
Plan Fiduciary Net Position	5,651	(231)
Net OPEB Liability	$ 1,503,710	$ 1,393,582
Plan Fiduciary Net Position as a Percentage of Total OPEB Liability	0%	0%
OPEB Expense	$ 80,182	$ 70,937

NOTE 2 NET OPEB LIABILITY (CONTINUED)

Actuarial Assumptions

The total OPEB liability was determined by an actuarial valuation as of July 1, 2020, using the following actuarial assumptions, applied to all periods included in the measurement, unless otherwise specified:

Inflation	2.50%
Salary Increases	2.75%
Discount Rate	2.21%, Based on Bond Buyer General Obligation 20-Bond Municipal Bond Index
Healthcare Cost Trend Rates	For medical prescription drug benefits the current amount is 6.25% and decreases to 4.50% long-term trend rate after eleven 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

Healthy Mortality Officers: Pub-2010 Public Retirement Plans Safety Mortality Table weighted by Headcount, projected by MP-2019 Civilians: Pub-2010 Public Retirement Plans General Mortality Table weighted by Headcount, projected by MP-2019

Disabled Mortality Officers: Pub-2010 Public Retirement Plans Safety Disabled Mortality Table weighted by Headcount, projected by MP-2019 Civilians: Pub-2010 Public Retirement Plans General Disabled Mortality Table weighted by Headcount, projected by MP-2019

The actuarial assumptions used in the January 1, 2020 valuation were based on the results of an actuarial experience study for the period July 1, 2019 to June 30, 2020.

As the Retirees' Fund is funded on a pay-as-you-go basis, the discounted rate is equal to the Bond Buyer General Obligation 20-Bond Municipal Bond Index rate of 2.21%.

Discount rate

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

The discount rates used for fiscal years ended June 30, 2021 and 2020 are 2.21% and 3.51%, respectively.

NOTE 2 NET OPEB LIABILITY (CONTINUED)

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

The following presents the net OPEB liability of the Retirees' Fund, as well as what the Retirees' Fund's net OPEB liability would be if it were calculated using a discount rate that is 1-percentage-point lower (1.21%) or 1-percentage-point higher (3.21%) than the current discount rate:

	1% Decrease (1.21%) (in thousands)	Discount Rate (2.21%) (in thousands)	1% Increase (3.21%) (in thousands)
Total OPEB Liability (Ending)	$ 1,677,076	$ 1,498,059	$ 1,346,802
Plan Fiduciary Net Position (Ending)	5,651	5,651	5,651
Net OPEB Liability (Ending)	$ 1,682,727	$ 1,503,710	$ 1,352,453

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

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

	1% Decrease (in thousands)	Trend Rates (in thousands)	1% Increase (in thousands)
Total OPEB Liability (Ending)	$ 1,400,818	$ 1,498,059	$ 1,614,471
Plan Fiduciary Net Position (Ending)	5,651	5,651	5,651
Net OPEB Liability (Ending)	$ 1,406,469	$ 1,503,710	$ 1,620,122

NOTE 3 CASH AND DEPOSITS WITH THE STATE TREASURER

	2021	2020
Cash		
Deposits with State Treasurer:		
State Treasurer's Investment Pool	$ 2,112,737	$ 2,541,127
GASB 31 Adjustment	6,044	29,318
Total Cash and Deposits	$ 2,118,781	$ 2,570,445

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

NOTE 3 CASH AND DEPOSITS WITH THE STATE TREASURER (CONTINUED)

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

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

NOTE 4 INTERFUND BALANCES

Interfund balances at June 30, 2021 and 2020 consisted of the following:

	2021	2020
Due to Fiduciary Fund From:		
General Funds	$ 7,142	$ 125,626
Internal Service Funds	-	5,150
Total Due to Fiduciary Fund From Other Funds	$ 7,142	$ 130,776
Due to Fiduciary Fund From:		
All Others	$ -	$ 1,480,374
Total Due to Fiduciary Fund From Component Units	$ -	$ 1,480,374
Due From Fiduciary Fund:		
Internal Service Funds	$ 12,100,467	$ 11,699,729
Total Due to Internal Service Funds From Fiduciary Fund	$ 12,100,467	$ 11,699,729

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

NOTE 5 RETIREMENT BENEFITS INVESTMENT FUND

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

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

NOTE 6 FAIR VALUE

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

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

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

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

NOTE 6 FAIR VALUE (CONTINUED)

The following table presents fair value measurements as of June 30, 2021:

	Level 1
U.S. Treasury Securities and Equities	$ -
Total Investments	$ -

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

	Level 1
U.S. Treasury Securities and Equities	$ 1,843,713
Total Investments	$ 1,843,713

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

NOTE 7 SUBSEQUENT EVENTS

Management has evaluated the activities and transactions subsequent to June 30, 2021 to determine the need for any adjustments to and disclosure within the financial statements for the year ended June 30, 2021. Management has evaluated subsequent events through February 22, 2022, the date which the financial statements were available to be issued.

NOTE 8 RISKS AND UNCERTAINTIESLITIGATION

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

NOTE 9 LITIGATION

Public Employees Benefit Program of the State Retirees' Health & Welfare Fund is involved in pending litigation. The outcome of the litigigation cannot be predicted at this time.

STATE OF NEVADA
STATE RETIREES' HEALTH & WELFARE
BENEFITS FUND
PUBLIC EMPLOYEES' BENEFITS PROGRAM
REQUIRED SUPPLEMENTARY INFORMATION
SCHEDULE OF CHANGES IN NET OPEB LIABILITY AND RELATED RATIOS
LAST TEN FISCAL YEARS* (UNAUDITED)

	Fiscal Year Ending June 30				
	2021	2020	2019	2018	2017
Total OPEB Liability					
Service Cost	$ 53,039	$ 51,349	$ 51,882	$ 59,309	$ 49,794
Interest Cost	49,915	52,488	47,795	39,469	45,361
Differences Between Expected and Actual Experiences	(72,984)	(31,485)	-	-	-
Changes of Assumptions	124,245	37,971	(36,851)	(102,300)	123,519
Gross Benefit Payments	(49,969)	(42,490)	(39,710)	(38,069)	(35,932)
Net Change in Total OPEB Liability	104,246	67,833	23,116	(41,591)	182,742
Total OPEB Liability - Beginning of Year	1,393,813	1,325,980	1,302,864	1,344,455	1,161,713
Total OPEB Liability - End of Year	$ 1,498,059	$ 1,393,813	$ 1,325,980	$ 1,302,864	$ 1,344,455
Plan Fiduciary Net Position					
Contributions - Employer	$ 43,882	$ 40,943	$ 39,669	$ 38,049	$ 32,213
Contributions - Member	-	-	-	-	-
Net Investment Income	205	181	162	164	55
Gross Benefit Payments	(49,969)	(42,490)	(39,710)	(38,069)	(35,932)
Administrative Expenses		-	-		
Other		-	-		
Net Change in Plan Fiduciary Net Position	(5,882)	(1,366)	121	144	(3,664)
Plan Fiduciary Net Position - Beginning of Year	231	1,597	(8,516)	(8,660)	(4,996)
Plan Fiduciary Net Position - End of Year	$ (5,651)	$ 231	$ (8,395)	$ (8,516)	$ (8,660)
Total Net OPEB Liability	$ 1,503,710	$ 1,393,582	$ 1,334,375	$ 1,311,380	$ 1,353,115
Net Position as a Percentage of OPEB Liability	0%	0%	0%	0%	0%
Covered Employee Payroll	$ 2,046,678	$ 1,991,456	$ 1,890,946	$ 1,663,856	$ 1,627,517
Net OPEB Liability as a Percentage of Payroll	73%	70%	70%	78%	83%

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

Plan Change: None

Assumption Change: The valuation reflects a change of assumption in that the discount rate used at June 30, 2020 was 3.51% and the discount rate used at June 30, 2021 was 2.21%.

STATE OF NEVADA
STATE RETIREES' HEALTH & WELFARE BENEFITS FUND
PUBLIC EMPLOYEES' BENEFITS PROGRAM
REQUIRED SUPPLEMENTARY INFORMATION
SCHEDULE OF CONTRIBUTIONS
LAST TEN FISCAL YEARS* (UNAUDITED)

	Fiscal Year Ending June 30				
	2021	2020	2019	2018	2017
Actuarially Determined Contribution	N/A	N/A	N/A	N/A	N/A
Contributions Made in Relation to the Actuarially Determined Contribution	N/A	N/A	N/A	N/A	N/A
Contribution Deficiency (Excess)	N/A	N/A	N/A	N/A	N/A
Covered Employee Payroll**	$ 2,046,678	$ 1,991,456	$ 1,890,946	$ 1,663,856	$ 1,627,517
Contributions as a Percentage of Payroll	N/A	N/A	N/A	N/A	N/A

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

**Covered payroll for all fiscal years were provided by the State.

Notes to Schedule

Valuation Date	January 1, 2020
Methods and Assumptions Used to Determine Contribution Rates:	
Actuarial Cost Method	Entry Age Normal - Level % of Salary
Asset Valuation Method	Market Value of Assets
Retirement Age***	Varies by Age and Service
Morality	Pub-2010 Public Retirement Plans Mortality Table weighted by Headcount, projected by MP-2019 (See Actuarial Assumptions and Methods section for additional details)

*** Weighted average retirement age based on January 1, 2020 census data and retirement rates provided in the "Actuarial Assumptions and Methods" section of the report.

CliftonLarsonAllen LLP
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INDEPENDENT AUDITORS' 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*

Board of the Public Employees' Benefits Program
State of Nevada

We have audited, in accordance with the auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards* issued by the Comptroller General of the United States, the basic financial statements of the State Retirees' Health & Welfare Benefits Fund, Public Employees' Benefits Program of the State of Nevada, as of and for the year ended June 30, 2021, and the related notes to the financial statements, which collectively comprise State Retirees' Health & Welfare Benefits Fund, Public Employees' Benefits Program of the State of Nevada's basic financial statements, and have issued our report thereon dated February 22, 2022.

Internal Control Over Financial Reporting

In planning and performing our audit of the financial statements, we considered State Retirees' Health & Welfare Benefits Fund, Public Employees' Benefits Program of the State of Nevada's internal control over financial reporting (internal control) as a basis for designing 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 State Retirees' Health & Welfare Benefits Fund, Public Employees' Benefits Program of the State of Nevada's internal control. Accordingly, we do not express an opinion on the effectiveness of State Retirees' Health & Welfare Benefits Fund, Public Employees' Benefits Program of the State of Nevada'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 State Retirees' Health & Welfare Benefits Fund, Public Employees' Benefits Program of the State of Nevada'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.

CliftonLarsonAllen LLP

CliftonLarsonAllen LLP

Broomfield, Colorado
February 22, 2022

4.7

4.7 AON June 30, 2021 IBNP Report

Empower Results®

August 9, 2021

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

Subject: Incurred But Not Paid (IBNP) Liability and Catastrophic Reserve as of June 30, 2021 for PEBP's Self-Insured Health and Welfare Plans

Dear Cari:

Aon has estimated the Incurred But Not Paid (IBNP) liability for the State of Nevada Public Employees' Benefits Program (PEBP) self-insured active & retiree medical, prescription drug, and dental plans to be **$52,286,000** as of June 30, 2021. This is an increase of $772,000, or 1.5%, from the prior reserve estimate as of June 30, 2020. The change in medical and dental liabilities from the previous reserve estimate is attributable to the following:

- An overall decrease in CDHP membership of around -1.5% (approximately -$611,000) and in Premier (EPO) membership of around -2.8% (approximately -$279,000)
- An overall decrease in CDHP claims per person for Medical/Rx of around -3.6% (approximately -$1,508,000)
- The addition of an expense reserve for claims runout termination fees from HealthSCOPE Benefits, Inc. and Hometown Health
    - For HealthSCOPE Benefits, Inc., included 2 months of ASO fees for CDHP and Premier and 1 month of ASO fees for Dental (approximately $1,971,000)
    - For Hometown Health, estimated at $1,395,000; contract termination on June 30, 2021
- An overall increase in Premier claims per person for Medical/Rx of around 8.5% (approximately $840,000) – driven by several large claimants
- Estimated temporary claims suppression due to COVID-19, offset by an increase in claims payment processing times starting June 2021 (combined approximately -$1,036,000)

The components of the reserve are shown below:

Benefit Plan	FY2020 CDHP	FY2020 EPO	FY2021 CDHP	FY2021 EPO
Medical	$39,003,000	$9,122,000	$32,472,000	$12,177,000
Prescription Drugs	$1,596,000	$784,000	$2,180,000	$957,000
Total Medical IBNR	$40,599,000	$9,906,000	$34,652,000	$13,134,000
Medical Expense Margin*	$0	$0	$2,606,584	$654,416
Dental	$1,009,000		$1,134,000	
Dental Expense Margin	$0		$105,000	
Total IBNR	$51,514,000		$48,920,000	
Total Expense Margin	$0		$3,366,000	
Total All Reserves	**$51,514,000**		**$52,286,000**	

*Medical Expense Margin reflects the termination run-out fees from HealthSCOPE Benefits, Inc., and Hometown Health network

As of April 9, 2020, PEBP's board decided to move to a 10% load on the CDHP and Premier plan IBNP reserves for medical and dental claims. Due to the speed at which prescription drug claims are paid by PEBP, it has historically been excluded from a margin load, and we maintained that practice going forward.

This IBNP estimate does not reflect any of the following items that may have been incurred but not yet received: prescription drug rebates and Retiree Drug Subsidy reimbursements. IBNP is also commonly referred to as IBNR. Although used synonymously, IBNR is technically a subset of IBNP which also includes claims reported but not processed and processed but not paid. The IBNP amount above includes all liability components incurred but not yet paid. The COVID-19 adjustments for 2020 incurred claims estimates are discussed in the actuarial method and assumptions section.

In addition to the IBNP liability, a non-actuarial liability which can exist is a "float" liability, which is based on the difference between the checks issued and the checks cleared. This liability can typically be assessed with 100% accuracy a day or two after the close of the period. It is an appropriate GAAP liability, but a non-actuarial liability, and as such is not addressed by this actuarial opinion.

The estimated number of months of claims covered by the IBNP reserve determined as of June 30, 2020 and 2021 by benefit plan is illustrated in the following table:

Estimated No. of Months Covered (prior to margin load)				
	FY2020		FY2021	
Benefit Plan	**CDHP**	**EPO**	**CDHP**	**EPO**
Medical	2.9	2.0	2.7	2.5
Prescription Drugs	0.5	0.5	0.6	0.6
Dental	0.5		0.5	
Total IBNR	2.8	1.9	2.5	2.4

Shown below is a comparison of historical IBNP estimates. Please note this illustration excludes the expense and catastrophic reserve margins, and represent medical, dental, and prescription drug claims IBNPs only.

Medical and Dental Claims Only IBNP								
	FY2020		FY2021		$ Change		% Change	
Group	CDHP	EPO	CDHP	EPO	CDHP	EPO	CDHP	EPO
Medical State								
Active	$26,660,000	$6,874,000	$21,850,000	$8,734,000	($4,810,000)	$1,860,000	-18.0%	27.1%
Retiree	$7,762,000	$1,290,000	$6,214,000	$1,598,000	($1,548,000)	$308,000	-19.9%	23.9%
Total	$34,422,000	$8,164,000	$28,064,000	$10,332,000	($6,358,000)	$2,168,000	-18.5%	26.6%
Medical Non-State								
Active	$14,000	$9,000	$9,000	$16,000	-$5,000	$7,000	-35.7%	77.8%
Retiree	$1,021,000	$121,000	$1,447,000	$722,000	$426,000	$601,000	41.7%	496.7%
Total	$1,035,000	$130,000	$1,456,000	$738,000	$421,000	$608,000	40.7%	467.7%
Prescription Drugs	$1,596,000	$784,000	$2,180,000	$957,000	$584,000	$173,000	36.6%	22.1%
Subtotal	**$37,053,000**	**$9,078,000**	**$31,700,000**	**$12,027,000**	**($5,353,000)**	**$2,949,000**	**-14.4%**	**32.5%**
Dental State								
Active	$626,000		$704,000		$78,000		12.5%	
Retiree	$202,000		$232,000		$30,000		14.9%	
Total	$828,000		$936,000		$108,000		13.0%	
Dental Non-State								
Active	$100		$200		$100		100.0%	
Retiree	$88,600		$94,700		$6,100		6.9%	
Total	$88,700		$94,900		$6,200		7.0%	
Grand Total	**$47,047,700**		**$44,757,900**		**($2,289,800)**		**-4.9%**	

Employee Count as of June 2021			
	Medical		Dental
Group	CDHP	EPO	
State			
Active	19,067	3,826	26,228
Retiree	3,261	585	9,753
Total	22,328	4,411	35,981
Non-State			
Active	4	4	8
Retiree	484	109	4,260
Total	488	113	4,268
Total	**22,816**	**4,524**	**40,249**

Actuarial Methods and Assumptions

Liabilities for medical, dental and prescription drug benefits were estimated based on the Developmental Method. The underlying principle of the Developmental Method is that the progression of claims payment follows runoff patterns that are assumed to remain stable over time. HealthSCOPE Benefits, Inc. and

Express Scripts provided historical medical, dental, and prescription drug claims data summarized by incurred and paid period from July 1, 2017 through June 30, 2021, with emphasis on the last twenty-four months. Claims were adjusted as necessary for historical plan design changes. The results, produced by applying the Developmental Method to this data, were then adjusted for months where data was deemed non-credible. These adjustments were made using the Projection Method, which is based on the change in costs per exposure unit over time. The IBNP was determined using a June 30, 2021 measurement date.

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

COVID-19 in 2020 and 2021:

The COVID-19 pandemic has greatly impacted the U.S. health care landscape in 2020 and 2021. The number of COVID-19 cases in the U.S. continues to fluctuate and it is unclear when the rate of infection will diminish. There are many uncertainties associated with the impact of COVID-19 on employer health care claims costs and as a result our IBNP estimate may exhibit more volatility than in a typical year. In addition to direct COVID-19 expenditures due to testing, vaccination and treatment of members with COVID-19, elective procedures and nonemergency visits may continue to be deferred, resulting in significant changes to the types and frequency of claims incurred by members of employer-sponsored plans. At this point in time there is no consistent emerging data across carriers of a change in payment speed, but there is clear evidence of a change in the types and level of claims incurred during the COVID-19 pandemic. Payment speed pattern changes may also emerge as more data becomes available.

Aon has developed a model to estimate COVID-19 claims impacts which incorporates two offsetting cost factors – direct COVID-19 claims costs and cost reductions due to deferral of unnecessary services. In the early stages of the pandemic, the savings due to the deferral of services has generally exceeded the additional direct claims costs due to COVID-19 for most employers. This may result in a temporary reduction in IBNP reserves required, though the impact to a particular employer can vary based on related industry, geography, and demographic considerations. While COVID-19 impacts may result in a reduction to the IBNP in the short term, it is very likely that many deferred services will return later in the year or next year. As a result, many employers may experience greater increases in their IBNP later in the year or in subsequent years than typical amounts due only to seasonality.

Using historical payment and enrollment patterns, Aon has only adjusted claims between March 2020 and December 2020 for the medical and dental coverages. For prescription drug claims, after reviewing the claims lag, we did not notice significant deviations due to COVID-19 and thus, did not adjust for any impacts of COVID-19.

Volatility

There can be significant volatility in IBNP estimates depending upon the measurement period. As the medical, dental, and prescription drug carriers / PBMs have significantly increased their claim processing speeds over the last several years; the outstanding IBNP amount at any point in time has become a much

smaller amount in relation to annual paid claims under the plan. Smaller amounts tend to have greater volatility (on a percentage basis).

Source of Information

In performing our estimate of IBNP liability, we relied on medical/dental claims data provided by HealthSCOPE Benefits, Inc. and prescription drug claims data provided by Express Scripts. Enrollment data was provided by PEBP. We reviewed the data for reasonableness but have not audited it; as such, we are not certifying herein as to its accuracy.

Catastrophic Reserve

At the April 9, 2020 Board Meeting, PEBP's Board elected to move from the 95% confidence interval on their Catastrophic Reserve (which amounted to approximately 62 days of claims payments on hand) to a 60 days of claims payments on hand methodology. Later, at the April 29, 2020 Board Meeting, this was moved to 50 days. We have estimated the catastrophic reserve to be $34.9 million as of June 30, 2021. This catastrophic reserve includes PEBP's CDHP and Premier plans.

Catastrophic Reserve	6/30/2020	6/30/2021
CDHP	$25,630,000	$25,114,000
EPO	$9,205,000	$9,761,000
Total	**$34,835,000**	**$34,875,000**

Actuarial Certification

We certify that to the best of our knowledge, the methods and assumptions used to develop the estimated IBNP liability are reasonable and are calculated in accordance with generally accepted actuarial principles as promulgated by Actuarial Standards of Practice Number 5 (pertaining to estimating incurred health claim liabilities) and Number 23 (pertaining to data quality). It should be noted that Aon's conclusions are based on certain assumptions that appear reasonable at the time of reserve development. Actual experience can vary from projected experience, and this difference may be material.

This report is intended for the sole use of PEBP. Aon acknowledges the IBNP liability may be used by PEBP's auditors in collaboration with PEBP financial statements. Reliance on information contained within this report by anyone for other than the intended purposes puts the relying entity at risk of being misled because of confusion or failure to understand applicable assumptions, methodologies, or limitations of the report's conclusions.

The actuary whose signature appears below is a Member of the American Academy of Actuaries and meets the qualification Standards of the American Academy of Actuaries to render the actuarial opinion contained herein.

Aon's relationship with the Plan and the Plan Sponsor is strictly professional. There are no aspects of the relationship that may impair the objectivity of Aon's work.

If you have any questions or need additional information, please call me at 202-674-7692 or email me at shun.yu@aon.com.

Sincerely,

Shun Yu

Shun Yu, FSA, MAAA
Aon

cc: Laura Rich, CEO, Public Employees' Benefits Program
Stephanie Messier, Aon
Lisa Volek, Aon
Jeff Attl, Aon
Karen Young, Aon

4.8

4.8 Proposed summary revisions to the Plan Year 2023 Master Plan Documents for the Consumer Driven High Deductible Plan, Low Deductible Plan and Exclusive Provider Organization Plan

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Governor

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LAURA RICH
Executive Officer

LAURA FREED
Board Chair

AGENDA ITEM

[X] Action Item
[ ] Information Only

Date: March 24, 2022

Item Number: IV.VIII

Title: Proposed Revisions to Plan Documents for Plan Year 2023

SUMMARY

This report will go over the benefit changes to the Master Plan Document's for plan year 2023 for the Consumer Driven Health Plan, Low Deductible Plan, and the EPO Premier Plan.

REPORT

OVERALL CHANGES

There were several updates and changes implemented across the plan documents:

- Plan documents were updated to match the approved benefit changes from the Board Meeting on December 2, 2021. This was agenda item 7. The proposed changes that were selected by the Board were Option #2.

- Plan documents dates were updated to reflect the appropriate period for Plan Year 2023: July 1, 2022 through June 30, 2023.

- Augmentation Devices were included under the definition of Durable Medical Equipment by the request of the Third-Party Administrator.

- The Autism Spectrum Disorders Services benefits are limited to a maximum actuarial value of $72,000 per Plan Year according to NRS 695G.1645. A review of the Mental Health Parity and Addiction Equity Act (MHPAEA) revealed the NRS cap on autism benefits cannot be imposed. Therefore, the cap was removed.

- Information regarding the Healthcare Bluebook Pricing Tool and Healthcare Bluebook Incentive Reward was removed from the plan documents due to contract termination.

- Information in the Participant Contact Guide was updated according to vendor contracts.

BENEFIT CHANGES BY PLAN TYPE

The following changes were made specific to the listed plans and are noted on the Master Plan Documents, respectively.

Consumer Driven Health Plan

- The Health Savings Accounts (HSA) contribution limits were updated per IRS guidelines.
- The HSA administrator information was updated to reflect the new vendor.
- The Utilization Management was updated for continuity between plans for the following:
  - Added "Delivery of Services"
  - Added "Pregnancy"
  - Added "Second Opinion"
- The following benefits were enhanced:
  - Mammogram benefits were enhanced to include services beginning at age 35 for members with a high-risk of breast cancer to comply with USPFTF standards.
- The following Prescription Drug Benefits was updated for continuity between plans.
  - Prescription Retail Drugs information was added.
  - The Generics Preferred Program was added for continuity between plans.
- Benefit Limitations and Exclusions were expanded for continuity between plans or for compliance with federal law to include the following topics:
  - Expenses That Do Not Accumulate Toward Your Out-of-Pocket Maximum
  - Benefit Limitations
  - Lifetime Maximum
  - Chronic Medication Synchronization
  - Continued Medical Treatment
  - Contraception or its Therapeutic Equivalent
  - Controlled Substance or Intoxicated
  - Cosmetic Services and Surgery
  - Dental Services
  - Experimental and/or Investigational Services
  - Fertility and Infertility Treatment
  - Foot/Hand Care
  - Home Health Care
  - Human Papillomavirus Vaccine
  - Intensive Outpatient Program
  - Internet/Virtual Office Visit
  - Medically Necessary Emergency Services
  - Ophthalmic Products
  - Orally Administered Chemotherapy

- Partial Hospitalization Service
- Prostate Screening
- Telehealth
- Topical Ophthalmic Products
- Other Benefit Exclusions

Low Deductible Plan
The approved plan design reduced the Low Deductible's deductible to zero. Therefore, the Low Deductible Plan is also referred to as the PPO Plan.

The Utilization Management was updated for continuity between plans for the following:

- "Pregnancy" was added

The following benefits were enhanced:

- Mammogram benefits were enhanced to include services beginning at age 35 for members with a high-risk of breast cancer Benefits: Mammogram benefits were enhanced to include services beginning at age 35 for members with a high-risk of breast cancer.

Benefit Limitations and Exclusions were expanded for continuity between plans or for compliance with federal law to include the following topics:

- Gym Fees
- Hair

Premier Plan
The title was updated to include "Exclusive Provider Organization."

The Utilization Management was updated for continuity between plans for the following:

- "Pregnancy" was added
- "Other Exceptions" was added

Benefit Limitations and Exclusions were expanded for continuity between plans or for compliance with federal law to include the following topics:

- Growth Hormone
- Gym Fees
- Hair
- Prophylactic Surgery or Treatment
- Prospective Payment System (PPS)

5.

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

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LAURA RICH
Executive Officer

LAURA FREED
Board Chair

AGENDA ITEM

[X] Action Item
[ ] Information Only

Date: March 24, 2022

Item Number: V

Title: Executive Officer Report

SUMMARY

This report provides the Board and members of the public information on PEBP operations.

REPORT

STAFFING UPDATE

PEBP continues to face staffing challenges, particularly in the member services unit (call center). Recent promotional opportunities to other agencies and retirements have resulted in more vacancies at PEBP. Although supervisory staff are actively working to fill these vacancies, there is significant training required in most of these roles, so having sufficient staffing available during the Open Enrollment time frame is an on-going concern.

Of 34 total staff, PEBP has nine vacancies, five of which are in the member services unit.

BUDGET AND LEGISLATIVE SESSION PREPARATION

On March 9th, the Governor's Finance Office (GFO) held the state's budget kick off meeting. State agencies were given the direction to maintain flat budgets when building their agency request budgets, due on September 1. Due to the rising costs of healthcare, flat budgets for PEBP essentially amount to budget cuts. For example, with a 5% claims trend, the same subsidy dollars would not stretch as far, resulting in benefit cuts in order to stay within the same budget requirements.

Recognizing this, PEBP immediately communicated it's concerns to the Governor's Office and GFO and is already in discussions regarding possible solutions and/or alternatives to avoid future benefit cuts.

In addition to budget building, bill draft requests (BDR) are another area that must be considered as we prepare for legislative session. Program changes that must be addressed statutorily will require a BDR. Non-Budgetary BDRs are due by May 20, 2022 and Budgetary BDRs that have a fiscal impact greater than $2,000 are due by September 1, 2022.

PEBP will be bringing budget enhancements and possible budgetary BDR proposals to the Board for consideration in May. Board members are also encouraged to propose suggestions and ideas for staff to research.

FSA UPDATE

Flexible Spending Arrangements (FSA) are currently offered through a no cost contract through HealthScope Benefits. Because of the low utilization and work required to maintain a $0 contract, PEBP chose to offer this product as a voluntary benefit. Initially, BenefitFocus had indicated they would be able to support this decision and could offer it through their voluntary benefits platform, however PEBP recently received confirmation that this is no longer the case. As a result, PEBP will instead be implementing this benefit through the UMR contract. Since it was included as part of the RFP and will not increase the contract amount, no contract amendments will be necessary.

6.

6. COVID-19 Status Update including possible action to eliminate COVID-19 surcharges (Laura Rich, Executive Officer) (**For Possible Action**)

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LAURA RICH
Executive Officer

LAURA FREED
Board Chair

AGENDA ITEM

[X] Action Item
[ ] Information Only

Date: March 24, 2022

Item Number: VI

Title: COVID-19 Update

SUMMARY

This report provides the PEBP Board and members of the public an update on COVID related topics.

REPORT

BACKGROUND

Effective February 21, 2022, the Governor reinstated the weekly testing requirements for unvaccinated employees, and the administration and costs were transitioned from the Division of Public and Behavioral Health to PEBP. Through a partnership with HealthSCOPE Benefits and Quest Labs, as of 03/14/2022, PEBP has since purchased and distributed approximately 40,300 tests to state agencies at a cost of roughly $1.3M to cover the higher costs associated with testing and treatment of unvaccinated members, the PEBP Board approved the implementation of COVID surcharges for unvaccinated members and their dependents starting July 1, 2022.

UPDATE ON WORKFORCE TESTING AND SURCHARGES

PEBP has continued to work closely with the Governor's Office and DPBH to track and monitor the impact of COVID on the employee workforce and on health plan costs. Recent data shows a steady downward trend in cases and positive results among the state workforce have dropped to less than 1% of the workforce. The employee vaccination and testing program was designed as a public safety measure to ensure the health of the state workforce, and data shows the state is achieving its goals. In response, the Governor's Office has provided department directors with

guidance and has provided each agency head discretionary authority to administer testing in a way that best manages their workforce; however, the State will be formally dropping its weekly testing requirements for unvaccinated employees moving forward.

Along with the sharp increase in vaccinations, the state has seen a decline in both the number of employees with COVID and the severity of those requiring hospitalization. This, coupled with the end of a formalized testing program lessens the fiscal impact on PEBP and thus, the need for a future surcharge. Instead, the Governor's Office and Governor's Finance Office will be supporting PEBP with other funds to cover the cost of employee mandated testing incurred up to this point and prepare for any potential spikes moving forward.

Recommendation:
The commitment from the Governor's Office to provide fiscal support for COVID costs eliminates the need for PEBP to impose the policy to add COVID surcharges effective July 1, 2022, approved by the Board on December 2, 2021. Staff recommends the removal of COVID surcharges.

COVID RELATED UTILIZATION ON SELF-INSURED PLANS

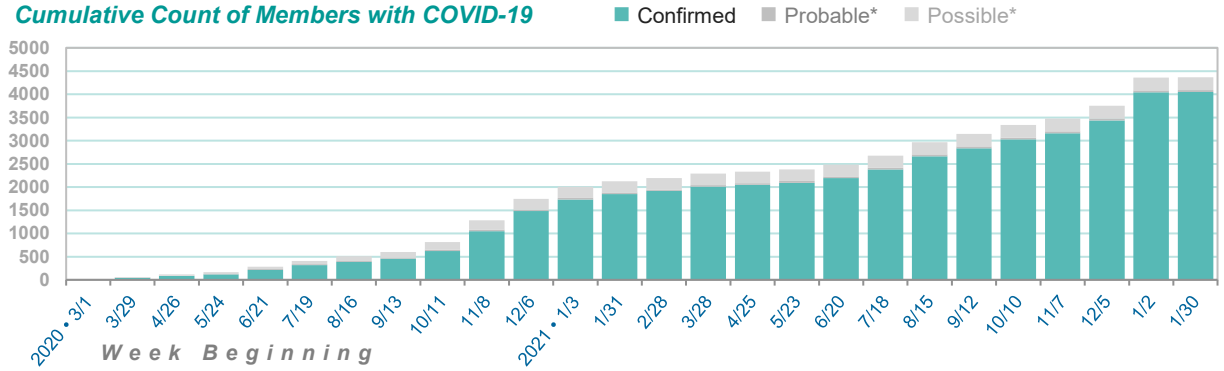
See attachment A

COVID-19 Summary through 2/10/2022
Nevada Public Employees' Benefit Program

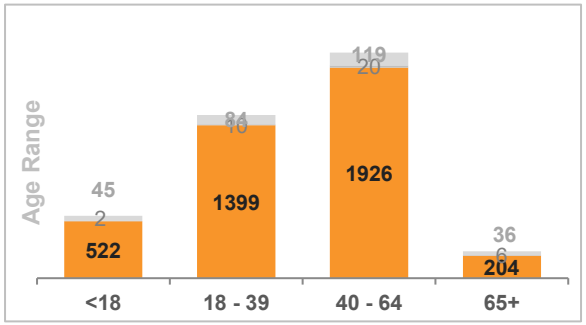
Members Diagnosed with COVID-19 *(see Appendix for detailed criteria)*

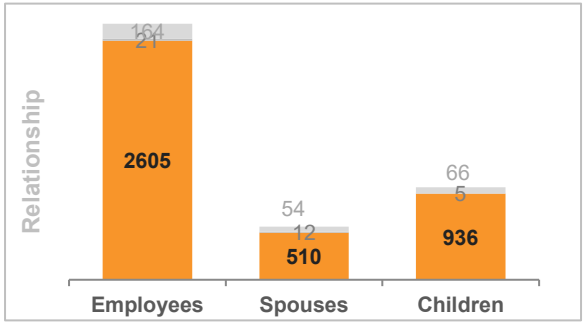
COVID-19 Diagnosis	# of Members	Dollars Paid by Year			Total Dollars		Average Cost per Member	
		2020	2021	2022	Allowed	Paid	Allowed	Paid
Confirmed	4,051	$2,264,036	$11,491,952	$1,938,244	$16,291,144	$15,694,233	$4,021.51	$3,874.16
Probable*	38	$4,996	$2,168	$200	$7,650	$7,364	$201.31	$193.79
Possible*	284	$1,708,957	$1,296,522	$2,090	$3,525,460	$3,007,569	$12,413.59	$10,590.03
Total	4,373	$3,977,989	$12,790,643	$1,940,534	$19,824,254	$18,709,166	$4,533.33	$4,278.34

Cumulative Count of Members with COVID-19



Members with COVID-19 Demographic Breakout





ER & Inpatient Services within 14 days of a COVID-19 Diagnosis *(see Appendix for detailed criteria)*

COVID-19 Diagnosis	# of Members	# with ER	*% with ER*	# with Inpatient	*% with Inpatient*	# with ICU	# with Ventilator
Confirmed	4,051	671	16.6%	378	9.3%	66	25
Probable*	38	2	5.3%	2	5.3%	1	0
Possible*	284	37	13.0%	196	69.0%	31	6

* *Probable* and *Possible* cases are based on diagnosis codes that were used before structured ICD10 codes for COVID-19 were adopted. Some—but not all—of these codes truly represented COVID-19, but they are now grayed out since providers are now consistently coding COVID-19, and newer *Probable* and *Possible* cases are unlikely to be COVID-19.

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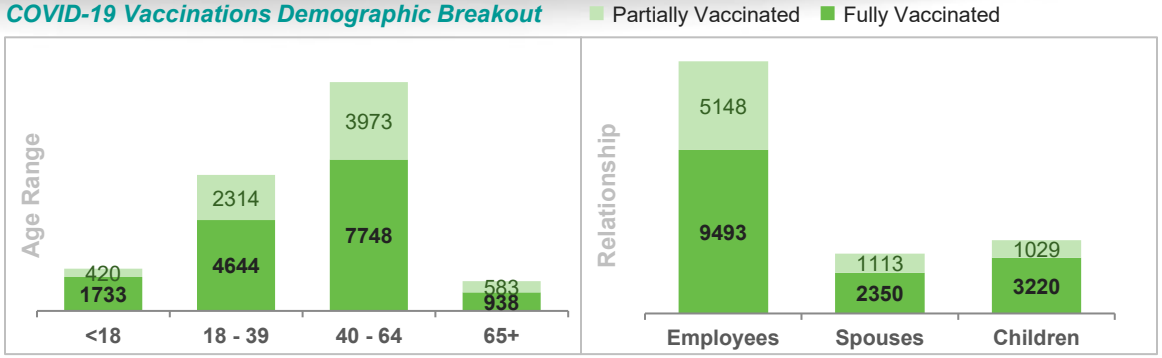
COVID-19 Summary through 2/10/2022
Nevada Public Employees' Benefit Program

COVID-19 Testing Summary

Test	Measure	#
Viral	Unique Members Tested:	**20,434**
Antibody	Unique Members Tested:	**2,142**
All Tests Combined	Allowed per Member:	**$177.48**
	Paid per Member	**$175.37**

COVID-19 Vaccinations Demographic Breakout



COVID-19 Vaccination Summary *(Med data through 2/10/2022; Rx data through 1/31/2022. See Appendix for detailed criteria)*

Vaccine Manufacturer	# Partially Vaccinated	# Fully Vaccinated	*# Received Booster**	Total Members Any Vax Status	Total # of Doses	Total Paid	Paid per Dose
Pfizer	4,250	8,928	177	13,178	24,438	$880,140	$36.02
Moderna	3,040	5,316	339	8,356	14,946	$552,472	$36.96
Janssen (J&J)	0	819	2	819	860	$28,887	$33.59
All Vaccines	**7,290**	**15,063**	**518**	**22,353**	**40,244**	**$1,461,499**	**$36.32**

Telemedicine & Telehealth – All Claims *(see Appendix for additional criteria)*

Claim Type	Definition	# of Patients	# of Claims	Total Paid
Telemedicine	Dedicated, national telemedicine providers (e.g. Teladoc®)	2,842	5,931	$148,390
Telehealth	Standard providers seen via remote electronic means (e.g. Skype)	14,604	62,319	$5,205,431

COVID-19 Summary
Appendix: Report Data & Coding Criteria

There are 7 known coronaviruses (including COVID-19) that infect humans, including some that cause mild upper-respiratory tract illnesses like the common cold. COVID-19 is a novel corona virus, meaning it is a new strain. Because it is new, there was no COVID-19 specific diagnosis code available for providers to use. **New codes were approved for diagnosing confirmed COVID-19 cases beginning April 1, 2020.**

In the interim, the Centers for Disease Control (CDC) directed providers to use the non-specific coronavirus code B97.29 that was historically used to report on non-COVID-19 coronaviruses. The interim B97.29 code is not conclusive for a COVID-19 diagnosis. COVID-related codes have been grouped together based upon the likelihood of a positive diagnosis and are presented within this report. Reporting of COVID-19 cases may be understated for several reasons:

- Testing and diagnosis may be understated due to provider coding and billing processes.
- Claims may be submitted with a presenting diagnosis (e.g., 'respiratory illness') and may not include any diagnosis directly related to COVID.
- Reporting is based on claim experience and does not account for members who do not seek medical care.
- Claims with newer coding may be pended while reimbursement logic is updated and will not appear in this report until holds are released.
- Reporting may be understated as claims for most recent services may not have yet processed.

Date Range. Most measures derive from medical claims data.

- **COVID-19 Claims, Telemedicine & Telehealth:** Medical claims both serviced and paid from 1/1/2020 through the report date indicated in the report header.
- **Vaccinations:** Med claims serviced and paid from 12/1/2020 through the report date and Rx claims serviced and paid from 12/1/2020 through the prior month end (usually available within the first five days of the subsequent month).

Members Diagnosed with COVID-19. Members are stratified in the highest category to date in which they are identified based on ICD-10 Diagnosis Code, and all diagnosis positions are considered (through position 25). Dollars are from all claims with any COVID-19 diagnosis.

- **Confirmed Case**
  - ICD10 Dx Code In (U07.1, J12.82, M35.81, M35.89)
- **Probable Case**
  - Presumptive Diagnosis - ICD10 Dx Code = U07.2
  - Likely Diagnosis - ICD10 Dx Code = B97.29
- **Possible Case**
  - Tier1: ICD10 Dx In (B34.2, B97.21, J12.81, J12.89, J12.9)
  - Tier2: ICD10 Dx In (B34.9, J22, Z20.828) for Inpatient Only

Vaccinations. Members are counted as partially or fully vaccinated based on the CPT Procedure Codes for vaccination administration, which indicate the specific dose number. This is supplemented by Rx data if your PBM sends UMR a detailed monthly file: vaccines not submitted to the medical plan may be identified by their 11-digit National Drug Code (NDC), and member status is determined by count of services. Boosters and additional doses are counted separate from member status.

Vaccination Date Range. Med claims serviced and paid from 12/1/2020 through the report date and Rx claims from 12/1/2020 through the prior month end (usually available within the first five days of the subsequent month).

ER & Inpatient Services. Services are counted if they occurred within 14 days of any claim with a with a COVID-19 diagnosis regardless of the Dx attached to the specific service.

- **Emergency Room:** Service Category is ER Facility
- **Inpatient Claim:** Claim Category is Inpatient
- **ICU (Intensive Care Unit):** Revenue Code Category is ICU (Hospital Revenue Codes between 0200 – 0209)
- **Ventilator:** CPT In (94002, 94003) or between 33946 - 33989

COVID-19 Testing. Test counts are based on the following:

- **Viral Testing**
  - HCPCS Procedure Code In (U0001, U0002, U0003, U0004, U0005)
  - CPT Code In (87426, 87635, 87636, 87637, 0202U, 0223U, 0225U, 0240U, 0241U)
- **Antibody Testing:** CPT In (86328, 86408, 86409, 86413, 86769, 0224U, 0226U)
- **Specimen Collection:** Applies to cost only, not counts.
  - HCPCS Procedure Code In (C9803, G2023, G2024)

Vaccine Manufacturer	Vax CPT	Administration CPTs				NDC (National Drug Code)
		Dose 1	Dose 2	Dose 3	Booster	
Pfizer	91300	0001A	0002A	0003A	0004A	59267-1000-##
	91305	0051A	0052A	0053A	0054A	59267-1000-##
~ Pediatric	91307	0071A	0072A	n/a	n/a	59267-1055-##
Moderna	91301	0011A	0012A	0013A	n/a	80777-0273-##
~ Booster	91306	n/a	n/a	n/a	0064A	80777-0273-##
AstraZeneca	91302	0021A	0022A	n/a	n/a	00310-1222-##
Janssen (J&J)	91303	0031A	n/a	n/a	0034A	59676-0580-##
Novavax	91304	0041A	0042A	n/a	n/a	80631-1000-##

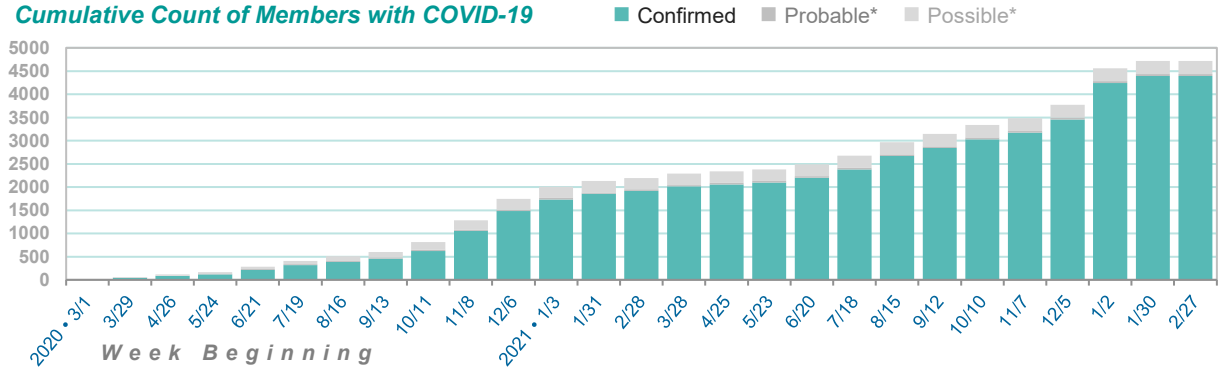
We are constantly reviewing new coding and coding practices and analyzing our data to determine the best way to define report logic and present the COVID-19 activity. We attempt to keep the code set as stable as possible; however, this analysis will sometimes result in enhancements to our logic which will impact results.

COVID-19 Summary through 3/10/2022
Nevada Public Employees' Benefit Program

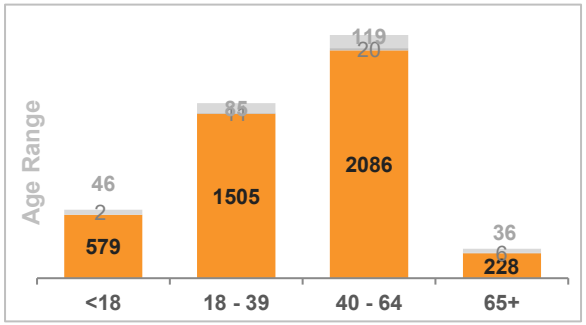
Members Diagnosed with COVID-19 *(see Appendix for detailed criteria)*

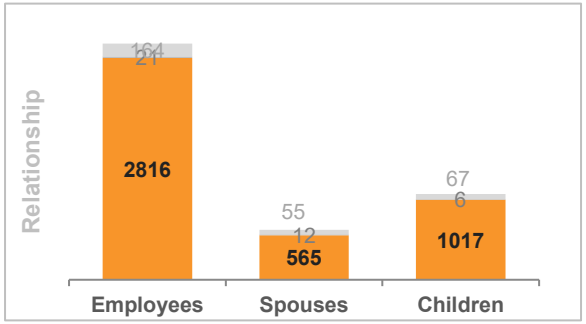
COVID-19 Diagnosis	# of Members	Dollars Paid by Year			Total Dollars		Average Cost per Member	
		2020	2021	2022	Allowed	Paid	Allowed	Paid
Confirmed	4,398	$2,298,995	$11,514,751	$3,281,305	$17,733,922	$17,095,052	$4,032.27	$3,887.01
Probable*	39	$5,066	$2,168	$400	$7,920	$7,634	$203.07	$195.74
Possible*	286	$1,686,429	$1,296,733	$26,087	$3,529,428	$3,009,250	$12,340.66	$10,521.85
Total	4,723	$3,990,490	$12,813,652	$3,307,793	$21,271,270	$20,111,935	$4,503.76	$4,258.30

Cumulative Count of Members with COVID-19



Members with COVID-19 Demographic Breakout





ER & Inpatient Services within 14 days of a COVID-19 Diagnosis *(see Appendix for detailed criteria)*

COVID-19 Diagnosis	# of Members	# with ER	*% with ER*	# with Inpatient	*% with Inpatient*	# with ICU	# with Ventilator
Confirmed	4,398	713	16.2%	397	9.0%	70	26
Probable*	39	2	5.1%	2	5.1%	1	0
Possible*	286	37	12.9%	196	68.5%	31	6

* *Probable* and *Possible* cases are based on diagnosis codes that were used before structured ICD10 codes for COVID-19 were adopted. Some—but not all—of these codes truly represented COVID-19, but they are now grayed out since providers are now consistently coding COVID-19, and newer *Probable* and *Possible* cases are unlikely to be COVID-19.

HealthSCOPE BENEFITS
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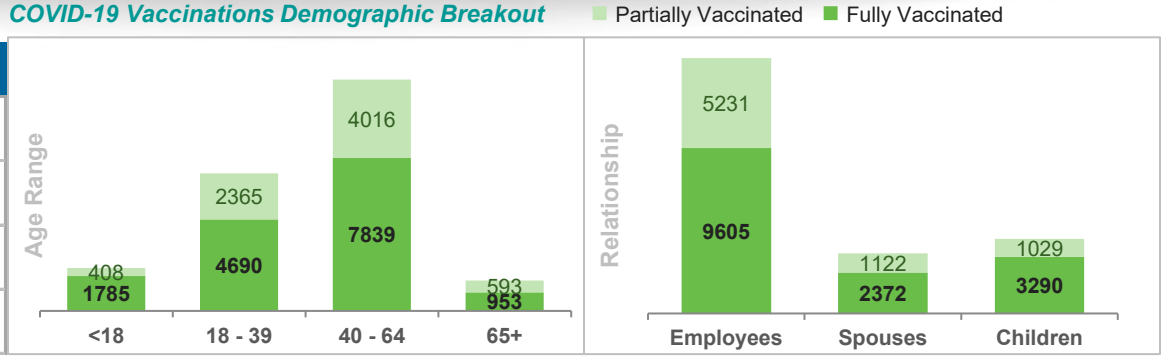
Healthy Business
Healthy Futures

COVID-19 Summary through 3/10/2022
Nevada Public Employees' Benefit Program

COVID-19 Testing Summary

Test	Measure	#
Viral	Unique Members Tested:	21,085
Antibody	Unique Members Tested:	2,169
All Tests Combined	Allowed per Member:	$181.77
	Paid per Member	$179.89

COVID-19 Vaccinations Demographic Breakout



COVID-19 Vaccination Summary *(Med data through 3/10/2022; Rx data through 2/28/2022. See Appendix for detailed criteria)*

Vaccine Manufacturer	# Partially Vaccinated	# Fully Vaccinated	*# Received Booster**	Total Members Any Vax Status	Total # of Doses	Total Paid	Paid per Dose
Pfizer	4,256	9,021	183	13,277	24,667	$889,874	$36.08
Moderna	3,126	5,428	378	8,554	15,340	$566,725	$36.94
Janssen (J&J)	0	818	4	818	865	$29,201	$33.76
All Vaccines	**7,382**	**15,267**	**565**	**22,649**	**40,872**	**$1,485,800**	**$36.35**

Telemedicine & Telehealth – All Claims *(see Appendix for additional criteria)*

Claim Type	Definition	# of Patients	# of Claims	Total Paid
Telemedicine	Dedicated, national telemedicine providers (e.g. Teladoc®)	2,918	6,122	$154,509
Telehealth	Standard providers seen via remote electronic means (e.g. Skype)	14,836	64,184	$5,380,939

COVID-19 Summary
Appendix: Report Data & Coding Criteria

There are 7 known coronaviruses (including COVID-19) that infect humans, including some that cause mild upper-respiratory tract illnesses like the common cold. COVID-19 is a novel corona virus, meaning it is a new strain. Because it is new, there was no COVID-19 specific diagnosis code available for providers to use. **New codes were approved for diagnosing confirmed COVID-19 cases beginning April 1, 2020.**

In the interim, the Centers for Disease Control (CDC) directed providers to use the non-specific coronavirus code B97.29 that was historically used to report on non-COVID-19 coronaviruses. The interim B97.29 code is not conclusive for a COVID-19 diagnosis. COVID-related codes have been grouped together based upon the likelihood of a positive diagnosis and are presented within this report. Reporting of COVID-19 cases may be understated for several reasons:

- Testing and diagnosis may be understated due to provider coding and billing processes.
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- Reporting is based on claim experience and does not account for members who do not seek medical care.
- Claims with newer coding may be pended while reimbursement logic is updated and will not appear in this report until holds are released.
- Reporting may be understated as claims for most recent services may not have yet processed.

Date Range. Most measures derive from medical claims data.

- **COVID-19 Claims, Telemedicine & Telehealth:** Medical claims both serviced and paid from 1/1/2020 through the report date indicated in the report header.
- **Vaccinations:** Med claims serviced and paid from 12/1/2020 through the report date and Rx claims serviced and paid from 12/1/2020 through the prior month end (usually available within the first five days of the subsequent month).

Members Diagnosed with COVID-19. Members are stratified in the highest category to date in which they are identified based on ICD-10 Diagnosis Code, and all diagnosis positions are considered (through position 25). Dollars are from all claims with any COVID-19 diagnosis.

- **Confirmed Case**
  - ICD10 Dx Code In (U07.1, J12.82, M35.81, M35.89)
- **Probable Case**
  - Presumptive Diagnosis - ICD10 Dx Code = U07.2
  - Likely Diagnosis - ICD10 Dx Code = B97.29
- **Possible Case**
  - Tier1: ICD10 Dx In (B34.2, B97.21, J12.81, J12.89, J12.9)
  - Tier2: ICD10 Dx In (B34.9, J22, Z20.828) for Inpatient Only

Vaccinations. Members are counted as partially or fully vaccinated based on the CPT Procedure Codes for vaccination administration, which indicate the specific dose number. This is supplemented by Rx data if your PBM sends UMR a detailed monthly file: vaccines not submitted to the medical plan may be identified by their 11-digit National Drug Code (NDC), and member status is determined by count of services. Boosters and additional doses are counted separate from member status.

Vaccination Date Range. Med claims serviced and paid from 12/1/2020 through the report date and Rx claims from 12/1/2020 through the prior month end (usually available within the first five days of the subsequent month).

ER & Inpatient Services. Services are counted if they occurred within 14 days of any claim with a with a COVID-19 diagnosis regardless of the Dx attached to the specific service.

- **Emergency Room:** Service Category is ER Facility
- **Inpatient Claim:** Claim Category is Inpatient
- **ICU (Intensive Care Unit):** Revenue Code Category is ICU (Hospital Revenue Codes between 0200 – 0209)
- **Ventilator:** CPT In (94002, 94003) or between 33946 - 33989

COVID-19 Testing. Test counts are based on the following:

- **Viral Testing**
  - HCPCS Procedure Code In (U0001, U0002, U0003, U0004, U0005)
  - CPT Code In (87426, 87635, 87636, 87637, 0202U, 0223U, 0225U, 0240U, 0241U)
- **Antibody Testing:** CPT In (86328, 86408, 86409, 86413, 86769, 0224U, 0226U)
- **Specimen Collection:** Applies to cost only, not counts.
  - HCPCS Procedure Code In (C9803, G2023, G2024)

Vaccine Manufacturer	Vax CPT	Administration CPTs				NDC (National Drug Code)
		Dose 1	Dose 2	Dose 3	Booster	
Pfizer	91300	0001A	0002A	0003A	0004A	59267-1000-##
	91305	0051A	0052A	0053A	0054A	59267-1000-##
~ Pediatric	91307	0071A	0072A	n/a	n/a	59267-1055-##
Moderna	91301	0011A	0012A	0013A	n/a	80777-0273-##
~ Booster	91306	n/a	n/a	n/a	0064A	80777-0273-##
AstraZeneca	91302	0021A	0022A	n/a	n/a	00310-1222-##
Janssen (J&J)	91303	0031A	n/a	n/a	0034A	59676-0580-##
Novavax	91304	0041A	0042A	n/a	n/a	80631-1000-##

We are constantly reviewing new coding and coding practices and analyzing our data to determine the best way to define report logic and present the COVID-19 activity. We attempt to keep the code set as stable as possible; however, this analysis will sometimes result in enhancements to our logic which will impact results.

7.

7. Enrollment and Eligibility System Implementation Update including possible action regarding changes to contract and vendor relationships and vendor payments

   (Nik Proper, Operations Officer)

   (For Possible Action)

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LAURA RICH
Executive Officer

LAURA FREED
Board Chair

AGENDA ITEM

[X] Action Item
[ ] Information Only

Date: March 24, 2022

Item Number: VII

Title: Enrollment and Eligibility System

SUMMARY

This report will provide the Board, participants, public, and other stakeholders information on the roll out of PEBP's new enrollment and eligibility system.

REPORT

ENROLLMENT AND ELIGIBILITY SYSTEM UPDATE

PEBP's new enrollment and eligibility system, Benefitplace managed by Benefitfocus, went live on 1/3/22. While PEBP's contract is with LSI, the bulk of the sub-contracted work is performed by Benefitfocus. There have been challenges and risks identified since the system went live. These are Data Discrepancies, Demographic File Feeds, Accounting and Billing, System Functionality, and Vendor File Integrations.

Current Challenges and Risks:

- Data Discrepancies
  Data integrity and reconciliations are part of system changes and since "go-live" there continues to be data discrepancies for the conversion. For example, some retiree years of service subsidies were calculated differently or removed entirely. Currently, staff is continuing to do their best to attempt to manually reconcile these accounts and resolve issues immediately such as performing urgent updates direct with vendors so services can be accessed. While Benefitfocus has audited and reconciled data from PEBP's previous vendor, this was not done properly. When looking up historical data, it is different to

how Benefitfocus converted it. This includes members in a certain status or coverage tier (retired, active, terminated, on COBRA, primary only, family, etc.) that are different in the new system. Many times, staff come across an error for one individual that impacts hundreds after further investigation.
Impact: Volume unknown as staff is relying on member feedback, internal audits, and feedback from carriers and agencies.
Mitigation: PEBP staff is correcting account statuses, coverages, and tiers, including years of service subsidies as they are made aware.

- Demographic File Feeds
  This implementation focused heavily on creating demographic file feeds with Central Payroll and NSHE. This idea was that agencies know what statuses their employees are supposed to be in, but there have been too many complications, added workload on all sides, and member coverages being affected.
  Impact: Central Employee and NSHE employees are no longer able to have one address in their HR system and another with PEBP. This affects employees who wish to have confidential addresses only with their HR. Seasonal and critical hires entered in both systems are coming over on the demographic files overriding and canceling out their retiree coverages and PERS deductions. Further configuration is required to on both the Central Payroll/Smart 21 and NSHE side.
  Mitigation: We have stopped the demographic file with Smart 21 and moved back to a manual entry process we used prior. This will help ensure members are in the correct status with minimal disruption. The demographic file with NSHE is paused but NSHE is submitting a manual change file that is uploaded into Benefitplace with correct changes being conveyed in lieu of the demographic file.

- Accounting and Billing Reconciliation/Deduction Files
  PEBP staff and members still do not have access to the billing platform to view or make payments. Invoices continue to not be produced and employees in a direct billed status have not received a bill for their health insurance causing PEBP to ask direct billed members and groups to send payments based off old invoices. Deduction files with PERS, Central Payroll, and NSHE continues to need fixes and development work for deductions to be conveyed appropriately. File integrations with our Medicare Exchange vendor, Via Benefits, needs new file development so members can be reimbursed appropriately. Rates are configured incorrectly on survivors and unsubsidized members.
  Impact: Volume of impacted members is unknown. Some members are continuing to have incorrect deductions (premiums and HSA) without being refunded three months since go live. These issues have continued to cause heavy reconciliation efforts with frustration on staff, members, and agencies. A custom PEBP billing solution that can take up to 12 months to be finalized with unknown costs. Direct billed members with voluntary benefits have not received their bills. The long-term effects of billing not being available is that PEBP will not have the required documentation needed to provide auditors for this time period which will lead to delayed audit results and likely lead to audit exceptions.
  Mitigation: PEBP staff coordinating with agencies to keep track of members needing refunds or different deductions without visibility to a billing platform.

- Benefitplace System Functionality for Staff and Members
  Benefitplace serves as the member portal and the Admin/Staff portal. It is not a true CRM system as it lacks much needed functionality for PEBP staff and members. Benefitfocus notified us in January of some fixes to the message center to be deployed in February that never happened. Staff cannot add notes directly into a member's record. Staff and members cannot cancel an event they started, needing a case to be created for Benefitfocus' team to cancel. Staff cannot manually correct accounts in many instances. If a member uploads a document without a pending task it is not added to a work queue and is automatically added without approval, forcing staff to run reports and do searches for potential outstanding work items. PEBP's open enrollment rules are to keep it a passive enrollment, meaning that members who wish to do nothing, will keep their same exact coverage or elections for the upcoming plan year. It was recently conveyed that members in an HSA plan will have to re-attest their eligibility, essentially turning a passive enrollment into an active enrollment for everyone with an HSA account. This will cause thousands of tasks on Eligibility staff to approve and heavy communication to everyone.
  Impact: Internal operational processes and procedures taking longer and being more manual which means new coverage, terminations, and coverage changes will take longer to take effect. This delay impacts member coverage and added workload on PEBP staff and vendors.
  Mitigation: The current system functionality will remain, contributing to the continuation of issues.

- Vendor File Integrations
  File integrations with our vendors are still not set up and working as expected with multiple integration calls continuing weekly. PEBP recently found out, through our own research, when members initiate a qualifying life event and have a pending task or have an expired event, they are not sent on files to carriers until documentation is loaded; essentially causing the entire family or tier coverage to be disenrolled from coverage and unable to access services. Benefitfocus is unable to send to our TPA, HealthScope Benefits, (soon UMR) Care Management enrollments appropriately on dependents. This was not conveyed until recently causing PEBP, HealthScope Benefits, and ESI to potentially pursue a new care management file integration without Benefitfocus, with an estimated cost of $10,000. With this direction, care management enrollments would not be reflected in Benefitplace, forcing PEBP staff and members having to reach out to HSB/UMR and ESI to confirm enrollments.
  Impact: Members being dropped or conveyed inaccurately on carrier files not allowing them to access services. Added manual workload on PEBP staff, carriers, and agencies.
  Mitigation: The current system functionality will remain, contributing to the continuation of issues and forcing work arounds on all parties to accommodate the lack of system functionality. Potentially pursuing a new care management file integration with HSB/UMR and ESI with current estimated cost of $10,000.

File Integration Work/Change Orders totaling $470,494.00
Prior to just receiving these invoices, and after the fact, it was never communicated to PEBP the potential costs, scope, or needs of these below orders. The below files are either a combination of being in scope, not working as expected, and/or still in the testing, configuration, or creation process.

1. Central Payroll Advantage Payroll Integration due to Smart 21 delay- $261,424.00
LSI owns the Smart 21 and PEBP contracts, and this shift was caused by a Smart 21 go-live delay, not due to anything in PEBP or Central Payroll's control. The only option presented from Benefitfocus to PEBP was to continue with Lifeworks for January 2022 which was not possible at the time. The file integration is not working as deductions are incorrect for all members (either HSA, voluntary benefits, or premiums due to the one cent rounding rule) and there are not adjustment files being sent to provide members with necessary refunds. Central Payroll and PEBP accounting staff are manually keeping track of members needing refunds to their premiums.

2. ESI File - $19,205.00 currently (estimated to be around $39,205.00)
The file is not working as expected with some members having disruption in coverage. The proposed next step towards a potential solution would be a second change order (currently estimated to be another $20k on top of the $19,205) so Benefitfocus can convey the necessary information in a manner that ESI can load into the system, so members can hopefully maintain coverage without disruption.

3. HSB File - $26,450.00
HealthScope Benefit's IT department has spent hundreds of hours customizing, configuring, and creating brand new files and formats to accommodate Benefitfocus with members still not being sent to HSB properly with constant member disruption. Benefitfocus cannot accommodate conveying care management enrollments appropriately (despite this being in the RFP) which was not conveyed until recently when we have been having integration calls for over a year.

4. WTW HRA File - $75,698.75
A HRA dental reimbursement file has not been created, so all retirees relying on the automatic HRA reimbursement process have to manually submit receipts, causing manual work on WTW to process each claim individually. Years of service is calculated incorrectly on many members changing the amount of their HRA causing more manual research and processes on PEBP and WTW.

5. WTW Eligibility File - $68,310.00
File is still in the testing and QA process with an estimated QA date of 3/24. We just recently finalized requirements and specifications with Benefitfocus after over a year of integration calls. The outcome of these changes is unknown currently. WTW as a good partner, also waived a $10,000 vendor change fee from this transition and implementation assuming this integration would be simplified.

6. Medicaid File - $19,406.25
File is still in the testing and QA process without an estimated completion and go-live date requiring further configurations on both the Benefitfocus and Medicaid side.

Due to the continuation of risks and issues, PEBP is presenting three different options to the Board.

Options:

1. Stay the course with LSI and Benefitfocus.
Positive outcomes: System and offerings remain the same for the members.
Risks: Functionality to suit PEBP's needs and processes does not exist due to lack of system functionality or inefficient processes with Benefitfocus. PEBP processes and functions will continue to take longer. File integrations with vendors and agencies still need solutioning requiring development work on all sides. A complete billing solution to meet PEBP's needs is 9-12 months away, requiring a one-off custom development specifically for PEBP with added costs. Hundreds of thousands of dollars of invoices for file integrations that continue to not work properly causing more manual work on PEBP staff, vendors, agencies, and member coverage disruption.

2. LSI pursue a new sub-contractor to replace Benefitfocus.
Positive outcomes: Unknown currently.
Risks: Disruption to members and carriers since it will be a change of systems including voluntary benefit changes, requiring heavy communications. Starting a new implementation process again with all vendors, agencies, carriers, and staff will take another 12-18 months with an unknown outcome. There would be reluctancy from carriers, staff, and agencies to participate in a new implementation with an unknown vendor. Additional fees will be incurred by PEBP since all vendors will be required to integrate with the new E&E vendor.

3. PEBP pursue an emergency contract using a solicitation waiver to contract with prior Enrollment and Eligibility vendor Lifeworks and concurrently releasing a new RFP.
Positive outcomes: System functionality, PEBP processes, file integrations with vendors and agencies, and billing processes work to suit all parties' and members' needs.
Risks: Short notice disruption to members and carriers since it will be a change of systems including some voluntary benefit changes, requiring heavy communications. Data conversion and reconciliation will be a new process as some data coming from Benefitfocus is incorrect and unable to be trusted. If Smart 21 payroll goes live for July,

the timeline to integrate and test with a new system and vendor is shortened. With this option, comes a recommendation to change the dates of PEBP's Open Enrollment to Monday, May 16th – May 31st.

Voluntary Benefits
PEBP and Lifeworks are currently researching solutions and gaps. A verbal update will be provided to the Board.

Recommendations:

1. **Staff recommends not paying the costs of file integration work orders as they are either: 1) not working as expected 2) arguably in scope 3) still in the testing and creation process or 4) a combination thereof.**
2. **Staff recommends Option 3 to pursue an solicitation waiver with Lifeworks while releasing a new RFP in the future**
3. **Due to the challenges with the system, regardless of what option is selected, staff recommends delaying Open Enrollment to May 16 – May 31st.**

Employee Benefits Administration & Management Solution [SOLUTION] Project Initiative

Invenio-LSI/BenefitFocus - Current Status of PEBP SOLUTION Project Initiative

EXECUTIVE SUMMARY – As of March 17th, 2022

Project Status - Program Management - Viewpoint and Perspective:
The SOLUTION has been LIVE in production for approx. 2 ½ months and continues to go through the normal, expected Stabilization and Maturity process, when transitioning from a 15+ year, old, very customized (specific to the State of NV) Employee Benefits Management Solution.

Invenio-LSI/BenefitFocus has had considerable challenges with fully delivering the remaining key component of the overall SOLUTION (Direct and Group Billing) due to the overall complexity and specific State Requirements for this functionality. We have however, developed (since the last PEBP Board Mtg) a detailed plan to deliver this functionality, as contractually committed, by April 18th, 2022 - and have been meeting committed milestones of this plan to PEBP since sharing the plan with PEBP on February 11th, 2022. In the interim – Invenio-LSI/BenefitFocus has committed to PEBP to develop customized reporting to address the need for Billing visibility. Due to the complexity of this required reporting and that it also involves SMART21, State Legacy Payroll, NSHE, PERS … we are working as diligently as possible to deliver PEBP what is needs to accommodate payment and cost visibility - ASAP

Invenio-LSI/BenefitFocus absolutely acknowledges and shares the frustrations which PEBP Members are having as this new SOLUTION is fully deployed. We are continually finding data quality and data validation issues and challenges from the PEBP's old provider/solution which contribute to these challenges. In addition, because of the non-universal processes and requirements across PEBP's main entries (STATE, NSHE and PERS), this has caused the need for immediate analysis and workarounds pertaining to Eligibility rules, workflow and processing, which Invenio-LSI/BenefitFocus is doing our best to accommodate. With a complex Enterprise Technology and Service Transformation of this nature – it is not reasonable or feasible that until Full Stabilization and Maturity occurs – there will not be some level of data/integration issues to deal with. The challenge we have collectively (my organization, PEBP, PERS, NSHE, SMART21, State Payroll) faced is remediating all identified issues in real time, while other implementation and operational requirements/processes continue.

Invenio-LSI/BenefitFocus also acknowledges how challenging this has been for PEBP. Based on having to support a fully enterprise Transformation Initiative of the nature (the move to the new SOLUTION), coupled with the integrating to and utilizing the new State SMART21 Platform, as well as needing to operate and address required day-to-day Employee Benefits Administration & Management has strained the PEBP resources. Given all of this however – PEBP continues to work very diligently to overcome these challenges, especially when utilizing a SOLUTION which is going through final Stabilization and Maturity. The PEBP Leadership has been fully supported of my Invenio-LSI/BenefitFocus team and I, as we have worked hard to collectively overcome each challenge, which has been identified.

Invenio-LSI/BenefitFocus - Current Status of PEBP SOLUTION Project Initiative

EXECUTIVE SUMMARY – As of January 21st, 2022

With Technology Transformation Project Initiatives of this scale and complexity (especially transitioning from a 15 year+ customized system to a modern, best-practice-based Software-as-a-Service (SaaS) based Solution) there is going to be a period of required Stabilization and Maturity. We absolutely believe however that this period will come to an end before the next Open Enrollment (scheduled for May 1st, 2022) and have committed this to PEBP as such.

We believe that in the 2 ½ months since the SOLUTION's Go-Live, Invenio-LSI/BenefitFocus continues to proactively support and address any/all issues, challenges, constraints which PEBP brings to our attention in the most expeditious manner possible. Each challenge/constraint and issue - requires analysis, remediation, testing and validation, to fully address.

This Transformation project has been challenged with a number of unseen factors, COVID-19, Key Personnel Transition, sub-optimal oversight in the beginning part of the Project, primarily (due to COVID-19) remote execution and interactions, fully understanding the PEBP's requirements and needs, data quality and support from the previous provider, the transition to the State's new SMART21 Solution… Nevertheless – Invenio-LSI/BenefitFocus absolutely remains fully committed to addressing and working through each of these challenges towards delivering a complete, comprehensive, reliable SOLUTION to PEBP.

To that end, Invenio-LSI specifically put in place (since late last year, prior to Go-Live) significantly expanded oversight and program management resources and capabilities to assist PEBP. This level of committed oversight and program management will continue – to ensure complete transparency, responsiveness and remediation are provided to deliver a complete SOLUTION to PEBP and its Members.

As part of this commitment and acknowledgement of the challenges experienced to date – Invenio-LSI/BenefitFocus has provided Service Credits well above and beyond the what the contract outlines. In the spirit of continued partnership – Invenio-LSI/BenefitFocus will continue to leverage our 14+ month experience and knowledge in working with PEBP towards fully understanding what PEBP needs within our SOLUTION to deliver what was outlined in the Contract, per the Project Charter, Goal & Objectives and per feasibility/best-practices.

We have also discussed with PEBP Leadership, from a proactive perspective – Options which we would fully support, at no additional cost to PEBP, (should they wish to exercise these Options) – to address their concerns with our Technology/Service Provider (BenefitFocus) Service Quality & Responsiveness, should PEBP desire to move to our recommended, alternative different Technology/Service provider, going forward.

PEBP has invested over 14+ months into this Transformation and we firmly believe that this investment will be rewarded within the next (2-3) months as Invenio-LSI/BenefitFocus delivers:

- The required and expected Direct and Consolidate Billing Solution
- A Successful FY23 Open Enrollment (Starting May 1st, 2023)
- Fully addressing and remediating the Data Quality/Data Validation challenges and issues
- Fully addressing and remediating the Data Integration challenges and issues
- Providing PEBP the Reporting and Analytics needs for Payment and Cost visibility/reconciliation

Abandoning this Investment and confirmed near term remediation efforts in our respectful opinion will not materially solve the original Goals/Objectives of this PEBP Transformation Initiative. The State had a Solution provider and Solution which was in place for 15+ years, customized to specifically what the State of NV required. This Transformation Initiative requires business process changes to fully adapt to a modern, SaaS Solution. Getting through the next 2 Months within the Stabilization/Maturity/Readiness for Open Enrollment period – will significantly chart out a viable path forward for PEBP with the new Invenio-LSI/BenefitFocus Solution /Service.

In summary, Invenio-LSI/BenefitFocus objectively believes that PEBP and PEBP Member satisfaction will dramatically improve over the next 2-3 months as we exit the Stabilization and Maturity period, especially as the STATE/PEBP Board implements the new changes for Plan Year FY23. From an overall disruption and Member satisfaction perspective – getting to this point will be beneficial – for PEBP to fully meet its overall Goals and Objectives for this PEBP Employee Benefits Administration & Management Solution Transformation.

Best Regards,

Scott

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Invenio-LSI/BenefitFocus - Current Status of PEBP SOLUTION Project Initiative

EXECUTIVE SUMMARY – As of January 21st, 2022

HIGH LEVEL
Project Status
Overall:

- SOLUTION has been in LIVE Production Status for (2) of the (3) major components
  - ✓ Voluntary Benefits (December 1st, 2021)
  - ✓ Main SOLUTION (January 3rd, 2022)
- SOLUTION – Member Participation & Utilization:
  - ✓ 43,000(+) Members
- The SOLUTION remains in an overall "Stabilization and Maturity" mode to fully address all of the identified key/critical issues. Invenio-LSI/BenefitFocus is targeting to exit this mode by the end of April-2022 overall and the end of March-2022 for many of the identified Key/Critical Issues, which are outlined in this Executive Summary Report.
- Overall, from an Invenio-LSI/BenefitFocus perspective – the overall Status is "orange" from the previous status of yellow (last Board Report).
  This is due to a mixture of elements:

  - Overall Reliability and Operation of the CORE Solution – GREEN
  - Overall Reliability and Operation of the Voluntary Benefits Solution – GREEN
  - Ability to Process Day-to-Day Benefits Administration (Member Access & Utilization) – GREEN
  - Data Quality/Validation – YELLOW
  - Data Integrations – YELLOW
  - Direct/Consolidated Billing – RED
  - Visibility for Billing and Cost Information - RED
  - Upcoming PEBP Open Enrollment Support and Readiness - YELLOW
- Invenio-LSI/BenefitFocus continues to work diligently – based on the defined contractual support and remediation processes to assist PEBP with remediating and addressing issues/challenges/constraints as they arise.

- Continued Challenges Remain - in transitioning from PEBP's (15+) Year Solution, which was customized for the State of NV-PEBP organization over this time period, to specifically fit/address the State of NV Employee Benefits Administration needs and requirements. Specifically:
  - ✓ Data Quality & Data Validation
  - ✓ State's existing Payroll Systems (for PERS – Pension Deduct) different and somewhat inflexible to fully accommodate integration to the new SOLUTION – causing required workarounds
  - ✓ Non-Universal Processes and Requirements across the main PEBP entities (State, NSHE and PERS) – requiring workarounds
  - ✓ Concurrent Transitioning over to the State's new SMART21 Solution requires detailed process changes and alignment between PEBP and State Payroll
  - ✓ PEBP's requirements for Financial Accounting and Management is not inherent in modern Software-as-a-Service (SaaS) based Employee Benefits Administration & Management Solutions offered today (such as the SOLUTION which Invenio-LSI/BenefitFocus is providing).
    - Best Practice is to locate this in a true financial accounting and management system
    - Invenio-LSI has recommended this process be moved over to a fully integrated "mini-SMART21 Financial Management application" which will be consistent with what the State will be utilizing for all of its Financial Operations and Management going forward.

RISKS

- Some Members effected by Data Quality and Validation – indicating no coverage will continue until all Data Validation & Quality areas are fully remediated
  - Amount and Frequency seems to be decreasing – Plan to fully and practically remediate in place
- No current Billing Visibility for PEBP to issue Group Invoices (Consolidated Billing)
  - Invenio-LSI/BenefitFocus actively working on interim reporting and analytics to provide to PEBP
- Potential for State's Health Services Vendor Service disruptions, based on Billing Platform not yet in Production
  - Invenio-LSI/BenefitFocus proactively working with PEBP to immediately mitigate any Member issues

- Ensuring PEBP's New Open Enrollment for new Plan Year is a complete success – given all of the anticipated changes and requirements from the PEBP Board Mtg (3/24/2022)
  - Invenio-LSI/BenefitFocus proactively working with PEBP put a plan in place to ensure a successful, upcoming OE
  - Presentation and Review of this Plan – scheduled for 3/21/2022

Expected – "Post Go-Live Challenges:

- Data Quality and Consistency within Legacy Solution
- Data Integration Maturity and Optimization
- Maturing and Optimizing Eligibility Logic
- Overall Change Management Optimization
- Single-Sign On/ First Time User Access

Unexpected Post Go-Live Challenges:

- Lack of integration flexibility of State's existing Payroll Platform
- Number of different processes and requirements across PEBP Agencies (STATE, NSHE, PERS...)
- Required SMART21 HR Demographic Changes not previously planned for.
- New Eligibility and Process/Rules Requirements from previous legacy solution provider/solution
- Complete Financial Processing and Management expectations and requirements from PEBP, which was facilitated in their previous Solution

Invenio-LSI/BenefitFocus – Identified Challenges [Looking Back – What could we have done differently]

- Conducting the session, we had with PEBP Operations and Leadership [Detailed Whiteboard Process Review Session around Direct and Consolidated Billing) much earlier
- Allocating more resources to handle the amount of Member Data Issues during Stabilization and Maturity Period
- Putting in place more quickly – an enhanced oversight and governance capability
- Putting in place more quickly an interim reporting and analytics capability for PEBP while Direct & Consolidated Billing which has been delayed
- Improving the level and quality of communications with PEBP

Invenio-LSI/BenefitFocus – Corrective Actions / Proactive Partnership based Support to PEBP [Since last PEBP Board Mtg 1/24/2022]

- "All-Hands-On-Deck" Approach from Invenio-LSI/BenefitFocus to assist PEBP
- Finding and implementing as quickly as possible – Remediations and Workarounds to assist PEBP
- Making needed Key Personnel Changes where appropriate to improve the level of responsiveness and support to PEBP

Invenio-LSI/BenefitFocus - Current Status of PEBP SOLUTION Project Initiative

EXECUTIVE SUMMARY – As of January 21st, 2022

HIGH LEVEL

Key/Critical Identified Challenges – Current High-Level Status

Data Quality in SOLUTION

Invenio-LSI/BenefitFocus Perspective:

- Issues Identified and Conveyed by PEBP
- Invenio-LSI/BenefitFocus remediating each and every Issue/Challenge
- Most of the Challenges are a function of transitioning from previous provider

Remediation Plan

- Continued diligent work effort to remediate all identified challenges
- Committed Plan to PEBP – All identified challenges will be remediated by 3/31/2022

Data Integration and Interfaces

Invenio-LSI/BenefitFocus Perspective:

- Issues Identified and Conveyed by PEBP
- Invenio-LSI/BenefitFocus remediating each and every Issue/Challenge
- Challenges are in (4) buckets
  - State Legacy Payroll
  - State – SMART21
  - HSB
  - PERS - Remittance

Remediation Plan

- Continued diligent work effort to remediate all identified challenges
- Committed Plan to PEBP – All identified challenges will be remediated by 3/31/2022

Upcoming – New Plan Year PEBP Open Enrollment

Invenio-LSI/BenefitFocus Perspective:

- Concerns and Requirements – Provided by PEBP 2/15/2022
- Invenio-LSI/BenefitFocus putting Plan in place to address each and every concern/ requirement

Remediation Plan

- Updated/Enhanced OE Plan for Readiness and Requirements – Mtg scheduled for 3/21/2022
- Invenio-LSI/BenefitFocus does not see any issues meeting PEBP's Requirements for upcoming OE- scheduled for 5/1/2022

Required Refunds/ Charges

Invenio-LSI/BenefitFocus Perspective:

- ✓ Issues Identified and Conveyed by PEBP
- ✓ Invenio-LSI/BenefitFocus working with STATE Payroll and PERS to find a viable Solution / Remediation

Remediation Plan

- ✓ State Payroll Challenges will be Remediated in SMART21

Outstanding Issue

- ! Still working through the "Penny" charge challenge based on rounding rules, requiring either refunds/and or credits to PEBP Members

Invenio-LSI/BenefitFocus - Current Status of PEBP SOLUTION Project Initiative

EXECUTIVE SUMMARY – As of January 21st, 2022

Direct & Consolidated Billing

Invenio-LSI/BenefitFocus Perspective:

- ✓ Full & Complete Remediation Plan to deliver Direct and Consolidated Billing Functionality – presented to PEBP on 2/11/2022
- ✓ Invenio-LSI/BenefitFocus remains on-schedule – per the plan

Remediation Plan

- ✓ Execute each and every detailed Step in the Remediation plan – on-time and in a quality manner
- ✓ Continue to provide transparent updates to PEBP on Plan Status
- ✓ Be as flexible to PEBP as possible as they test/validate Direct & Group Billing Functionality

Outstanding Issue

- ! Detailed Financial Management & Process Functionality

Direct & Group Billing Functionality
Go Live Milestones – Status as of 3/16/22

Milestone	Start Date	Completion Date	Status
Review & Confirmation of Subsidy Requirements	2/3/2022	2/10/2022	Completed 2/10/2022
PEBP Final Approval of Subsidy Requirements (Verbally approved in 2/3/22 Billing Meeting, no changes)	2/11/2022	2/14/2022	Completed 2/13/2022
Establish & Agree on Go Live Criteria	2/14/2022	2/18/2022	Criteria reviewed and verbally approved on 3/9/2022 Billing Kickoff mtg
Load Subsidy/Billing Data & Generate Test Invoices	2/11/2022	2/22/2022	Completed 2/22/2022
Benefitfocus Invoice Review & Validation	2/23/2022	3/15/2022	Completed 3/15/2022
PEBP Initial Review & Validation of ALL Invoices & Aging Balances (10 day lag after BNFT validation begins)	3/9/2022	3/22/2022	Started 3/9/2022 and in progress. Yellow due to short timeline for PEBP to complete validation and all issues to be resolved. Benefitfocus to confirm ability to accommodate all requests/feedback/issues and timeline.
PEBP approval on all invoices (PEBP, Employer & Member)	3/23/2022	3/23/2022	Contingent upon confirming timeline for accommodating issues/feedback equated to a "Major" or above severity level
Billing Production Readiness, Go Live Communication & Production Deployment	3/24/2021	3/31/2022	
Benefitfocus Production Invoice Review	4/1/2022	4/7/2022	
PEBP Production Invoice Review	4/8/2022	4/15/2022	
Go Live (invoices mailed to employers/presented to members)	4/18/2022	4/18/2022	

NOTES:
1. Daily stand-up meetings will be scheduled to ensure we stay on track with the timeline and work through any issues timely
2. BNFT and PEBP invoice validation may require more or less time than estimated, which would impact overall go live date

Benefitfocus® InvenioLSI

InvenioLSI Benefitfocus

8.

8. 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**)

    8.1 Contract Overview

    8.2 New Contracts

        8.2.1 Segal Actuarial Consulting

        8.2.2 United Healthcare Life Insurance

        8.2.3 Vivo Technologies

        8.2.4 LifeWorks, LTD

    8.3 Contract Amendments

        8.3.1 Healthscope Benefits Third Party Administration

        8.3.2 UMR, Inc.

    8.4 Contract Solicitations

        8.4.1 Eligibility and Enrollment System

    8.5 Status of Current Solicitations

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LAURA RICH
Executive Officer

LAURA FREED
Board Chair

AGENDA ITEM

[X] Action Item
[ ] Information Only

Date: March 24, 2022

Item Number: VIII

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

8.1 Contracts Overview

Below is a listing of the active PEBP contracts as of February 28, 2022.

PEBP Active Contracts Summary

Vendor	Service	Contract #	Effective Date	Termination Date	Contract Max	Current Expenditures	Amount Remaining
Morneau Shepell LTD	Benefits Management System	15941	1/1/2015	12/31/2021	$ 8,623,789.00	$ 6,452,631.63	$ 2,171,157.37
AON Consulting	Consulting Services	17596	7/1/2016	6/30/2022	$ 3,651,585.00	$ 3,305,012.96	$ 346,572.04
HealthScope Benefits	Dental Claims	14574	7/9/2013	6/30/2022	$ 6,100,000.00	$ 5,535,250.59	$ 564,749.41
The Standard	Group Basic Life Insurance	14276	7/1/2013	6/30/2022	$ 80,587,091.00	$ 78,867,857.76	$ 1,719,233.24
Hometown Health Providers	In-state PPO Network	15510	7/1/2014	6/30/2022	$ 9,955,139.00	$ 8,564,330.59	$ 1,390,808.41
HealthScope Benefits	National PPO	13330	7/1/2012	6/30/2022	$ 15,455,000.00	$ 12,620,697.23	$ 2,834,302.77
HealthScope Benefits	TPA	11825	2/8/2011	6/30/2022	$ 62,600,000.00	$ 61,425,208.66	$ 1,174,791.34
HealthScope Benefits	Voluntary Flexible Spending Account	14465	7/1/2013	6/30/2022	$ 125,000.00	$ -	$ 125,000.00
Express Scripts, Inc.	Pharmacy Benefit Manager	17551	4/12/2016	6/30/2022	$302,920,638.00	$277,295,452.79	$ 25,625,185.21
American Health Holdings	PPO Utilization Management Case Management	21376	7/1/2019	6/30/2023	$ 8,000,000.00	$ 5,284,134.56	$ 2,715,865.44
Standard Insurance Company	Voluntary Life Insurance	15503	7/1/2014	6/30/2023	$ 80,587,091.00	$ 78,867,857.76	$ 1,719,233.24
CliftonLarsonAllen	Financial Auditor	24088	5/15/2021	12/31/2024	$ 212,485.00	$ 50,710.00	$ 161,775.00
Extend Health, Inc	Medicare Exchange	16468	7/1/2015	6/30/2025	$ 1,546,000.00	$ 1,233,741.92	$ 312,258.08
Health Plan of Nevada Inc	Southern Nevada HMO	23802	7/1/2021	6/30/2025	$192,093,848.00	$ 26,739,339.59	$165,354,508.41
Diversified Dental Services Inc.	Dental Contract	23810	7/1/2021	6/30/2026	$ 1,601,613.00	$ 229,589.12	$ 1,372,023.88
Aetna	PPO Network	23846	7/1/2021	6/30/2026	$ 7,127,250.00	$ 987,292.00	$ 6,139,958.00
Labyrinth Solutions, Inc.	Benefits Management System	23678	12/8/2020	6/30/2027	$ 7,328,667.00	$ -	$ 7,328,667.00
Claim Technologies	Health Plan Auditor	24030	4/13/2021	6/30/2027	$ 1,551,662.00	$ 16,000.00	$ 1,535,662.00
UMR, Inc.	TPA and Other Services	25155	7/1/2022	6/30/2028	$ 62,789,120.00	$ -	$ 62,789,120.00

Recommendation

No action necessary

8.2 New Contracts

On March 25, 2021, the PEBP Board approved the solicitation for an Actuarial Consultant and a Life Insurance provider. Request for Proposals were released, and PEBP staff has successfully negotiated contracts for Actuarial Consulting and Life Insurance services.

8.2.1 SEGAL

On October 18, 2021, the Public Employees' Benefits Program released Request for Proposal (RFP) 95PEBP-S1797 for Actuary and Consulting Services. Vendor responses were scored based on the following criteria:

- Experience and Qualifications
- Technical
- Customer Service
- Financial
- Finalist Presentations

On November 29, 2021, PEBP received three (3) proposals in response to RFP 95PEBP-S1797. The evaluation period began on November 30, 2021 and ended on December 20, 2021. The five-member evaluation committee included one PEBP Board member and other subject matter experts. Segal received the highest score by the evaluation committee and PEBP began contract negotiations with the winning vendor. Some of the highest scoring areas by the evaluators were:

- Vendor Experience
- Technical Response
- Cost

Segal will be a new vendor for PEBP so some disruption is expected, however transition work has already begun to ensure Segal is properly briefed and prepared in advance.

The effective date of the contract is anticipated to be April 12, 2022 (upon BOE approval) through June 30, 2027. Services and fees are expected to begin on June 1, 2022.

Recommendation

Ratify and approve the evaluation committee's recommendation to contract with Segal for Actuarial Consulting services beginning July 1, 2022.

8.2.2 UNITED HEALTHCARE

On October 14, 2021, the Public Employees' Benefits Program released Request for Proposal (RFP) 95PEBP-S1790 for Life and Disability Services. Vendor responses were scored based on the following criteria:

- Experience and Qualifications
- Technical
- Customer Service
- Financial
- Finalist Presentations

On November 08, 2021, PEBP received six (6) proposals in response to RFP 95PEBP-S1790. The evaluation period began on December 13, 2021 and ended on January 5, 2022. The five-member evaluation committee included one PEBP Board member and other subject matter experts. United Healthcare received the highest score by the evaluation committee and PEBP has successfully negotiated a contract. Some of the highest scoring areas by the evaluators were:

- Vendor Experience
- Technical Response
- Cost

United Healthcare will be a new vendor for PEBP so some disruption is possible, but it is expected to be minimal.

The effective date of the contract is anticipated to be April 12, 2022 (upon BOE approval) through June 30, 2026. Services and fees are expected to begin on June 1, 2022.

Recommendation

Ratify and approve the evaluation committee's recommendation to contract with United Healthcare for Basic Life Insurance services beginning July 1, 2022.

8.2.3 VIVO

In order to upgrade the PEBP Board Room with technology to accommodate hybrid in-person and virtual meeting solutions, PEBP Information Technology staff purchased a fully engineered solution by a third party, Vivo Tech. The final product will result in a room capable of integrating both in-person and virtual attendance by board members and other meeting participants, with ceiling-mounted microphones, high-definition cameras and displays, and a simplification of the room layout. The system will be portable should the need arise to change the physical office location for PEBP, however there would be some cost in terms of mounting hardware, microphones, wiring, etc., in any new location.

The equipment for this project is being purchased through the State Purchasing requisition process; however, because the equipment needs to be installed professionally, PEBP is required to enter into a short-term service contract.

The effective date of the contract will be upon Clerk of the Board approval through April 30, 2022. The total cost of the services for this contract are not to exceed $6,480.

Recommendation

Ratify the contract with Vivo for Installation Technology short-term services.

8.2.4 LIFEWORKS LTD

If the PEBP Board approves Option 3 in Agenda Item VII, PEBP will need to complete a solicitation waiver to enter into a new contract with LifeWorks LTD. PEBP is in the process of negotiating a contract for a term of four years and a contract not to exceed $4,745,890 (subject to change).

Recommendation

If this option is chosen, PEBP recommends the Board authorize staff to contract with LifeWorks LTD for Eligibility and Enrollment System Services while a new Request for Proposal (RFP) is developed, and a new system is implemented.

8.3 Contract Amendment Ratifications

Below are the contract amendment ratification requests.

8.3.1 HEALTHSCOPE BENEFITS

PEBP contracted with Healthscope Benefits for Third Party Administration (TPA) services which became effective February 8, 2011, and has a termination date of June 30, 2022. This amendment increases the contract maximum from $62,600,000 to $62,894,027. This increase adds additional authority to pay for TPA services through the remainder of the contract.

Recommendation

PEBP recommends the Board authorize staff to amend the contract between PEBP and Healthscope Benefits for TPA services in contract #11825 to increase the contract maximum.

8.3.2 UMR, INC.

PEBP contracted with UMR Inc. for Third Party Administration (TPA) and other services which became effective December 14, 2021 and has a termination date of June 30, 2028. This amendment increases the contract maximum from $62,789,120 to $65,413,106. This increase adds additional authority to pay for claims runout services for 1 year after the contract terminates.

Recommendation

PEBP recommends the Board authorize staff to amend the contract between PEBP and UMR, Inc. for TPA and other services in contract #25155 to increase the contract maximum and add language for run in and runout services.

8.4 Contract Solicitation Ratifications

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

8.4.1 Enrollment and Eligibility Benefits Management System

PEBP contracted with LSI Consulting for Eligibility and Enrollment Benefits Management Services on December 8, 2020 for services to begin on January 1, 2022. LSI Consulting has subcontracted with BenefitFocus to implement and manage the system technology.

Although PEBP staff have been working with LSI and BenefitFocus to ensure a successful implementation, staff brought an update to the January 27, 2022 board meeting and again on March 24, 2022 noting many serious issues that have arisen during the implementation process and post go-live. As it becomes clear that there are continuous system capability issues and growing frustration with staff and participants, staff will need to be prepared with an alternative solution.

Recommendation

This recommendation relates to Agenda Item VII. Should the decision be made to terminate the contract with LSI, PEBP recommends the Board authorize staff to complete a Request for Proposal for an Enrollment and Eligibility Benefits Management System.

8.5 Status of Current Solicitations

PEBP does not currently have any contract solicitations in progress.

9.

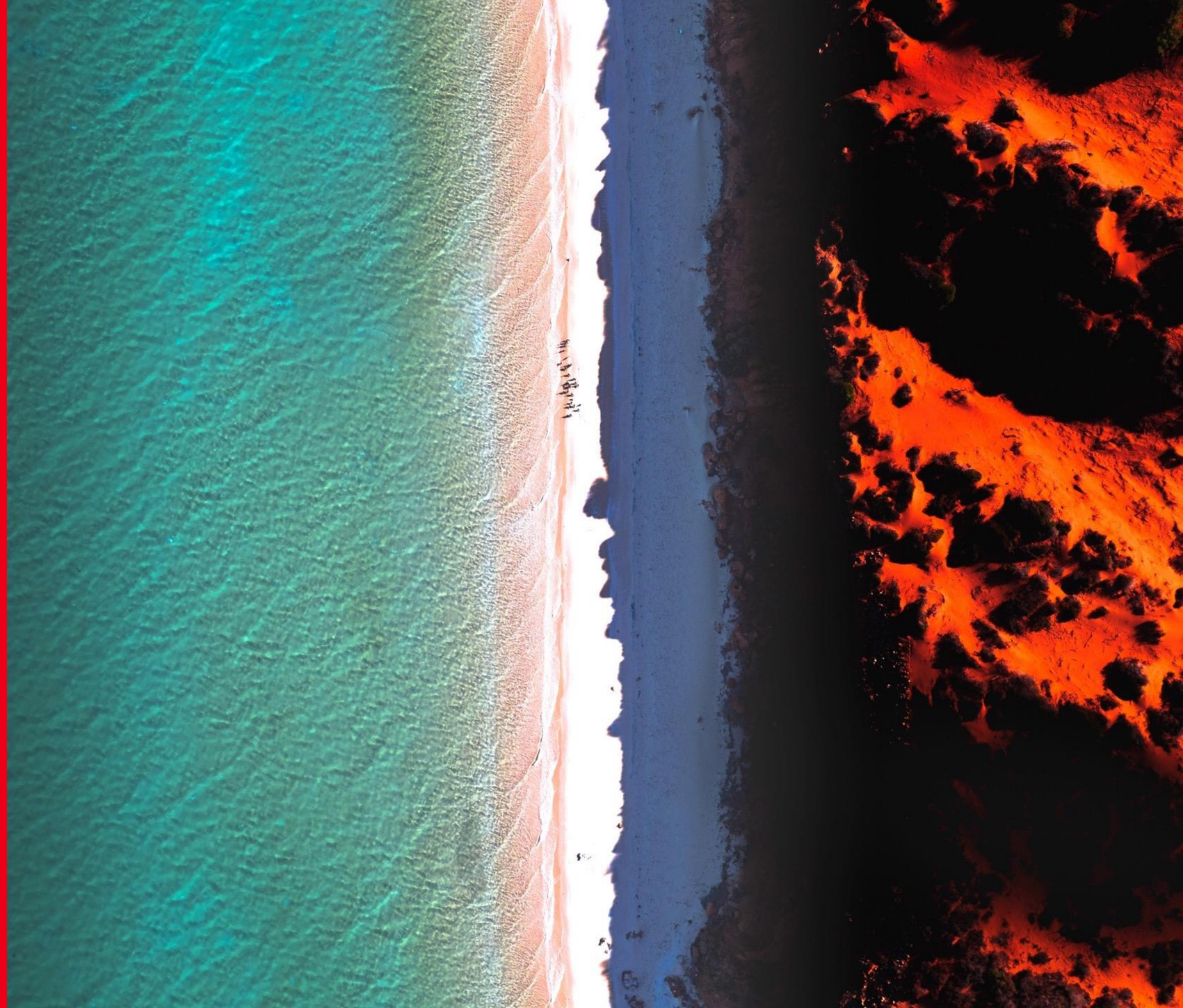
9. Presentation on PEBP claims experience and trend (Collen Huber, Aon) (Information/Discussion)

AON

Trend Presentation

PEBP

March 24, 2022



Public Employees' Benefits Program

Trend Presentation Exhibit

CDHP + EPO	FY2018	FY2019	FY2020	FY2021
Enrollment Medical/Rx	331,622	335,797	338,534	332,688
Total Medical Incurred Claims	$172,311,724	$190,451,169	$176,348,802	$198,845,888
Total Rx Incurred Claims (Net of Rebates)	$41,524,622	$43,578,545	$41,787,256	$45,386,049
Total Medical/Rx Incurred Claims	$213,836,346	$234,029,714	$218,136,058	$244,231,937

Dental	FY2018	FY2019	FY2020	FY2021
Enrollment Dental	476,237	485,281	492,776	488,270
Total Dental Incurred Claims	$24,760,129	$25,032,833	$22,481,880	$25,171,343

Claims Trend	FY2018	FY2019	FY2020	FY2021
Medical Incurred Claims PEPM	$520	$567	$521	$598
Medical Claims Trend		9%	-8%	15%
Rx Incurred Claims PEPM	$125	$130	$123	$136
Rx Claims Trend		4%	-5%	11%
Medical/Rx Incurred Claims PEPM	$645	$697	$644	$734
Medical/Rx Claims Trend		8%	-8%	14%
Dental Incurred Claims PEPM	$52	$52	$46	$52
Dental Claims Trend		-1%	-12%	13%
Medical/Rx/Dental Claims PEPM	$697	$749	$690	$786
Experience Trend		**7%**	**-8%**	**14%**

Note: EPO and CDHP claims are combined while the EPO was fully insured in FY18 and prior

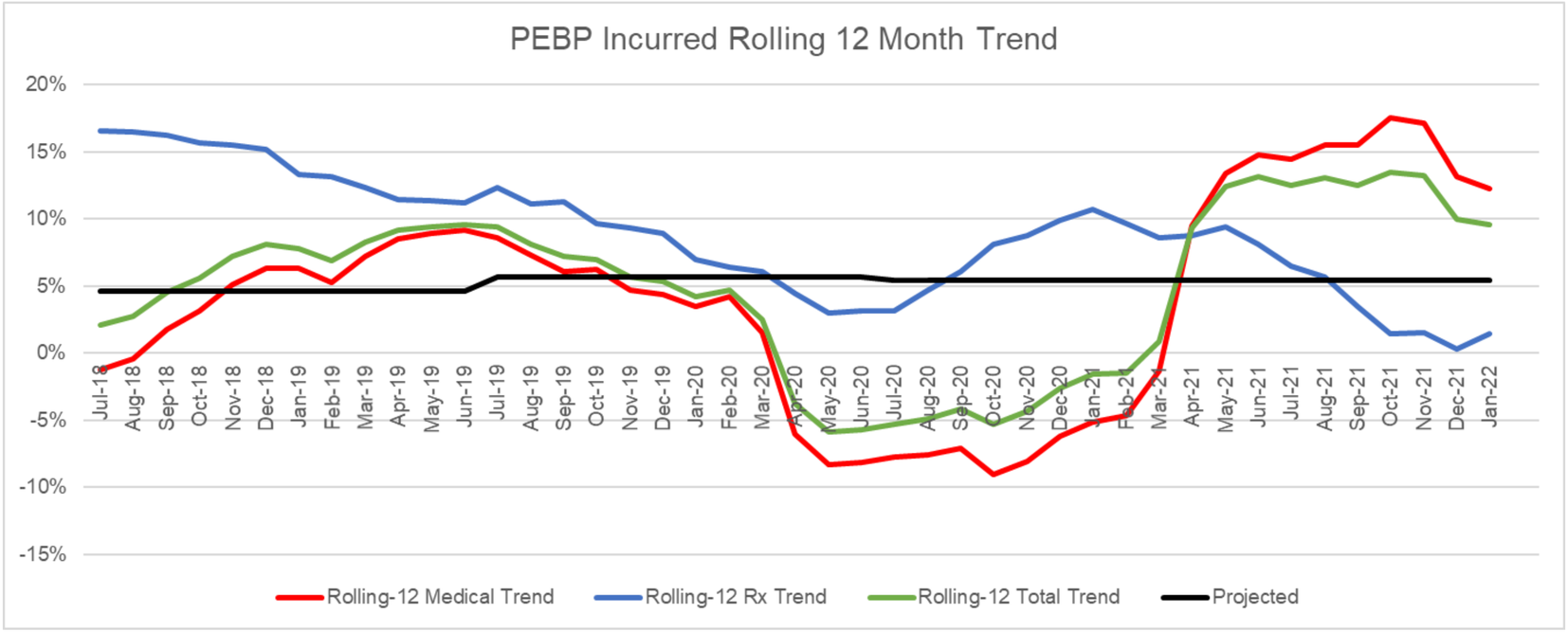
- FY2020 is impact by the claims suppression due to COVID-19
- FY2021 increase looks larger since it is compared to FY2020 with the claims suppression

AON

Healthcare Trend Exhibit

The below graph shows the ebbs and flows over the last several years.

- Note- no adjustments are made for plan design or contract changes
- Medical trend peaked in October 2021 and it is slowly decreasing



What Will Change Going Forward?

Previous COVID-19 Waves

The last 15 to 18 months of medical claims experience (since about July 2020) contains the impacts of 4 separate periods of COVID-19 lulls and outbreaks

This claims experience includes these COVID-19-related elements:

- COVID-19 testing costs
- Vaccine costs
- COVID-19 treatment costs
- Suppression of other claims to make room for COVID-19 patients

Future COVID-19 Waves

At this point, the expectation is for continuing seasonal COVID-19 waves, with these same elements included in each

How much will each element change in subsequent waves?

Costs expected to be the same as or slightly less than previous COVID-19 waves

Deferred Care

Initial expectations assumed there would be a rebound of deferred care claims — which has yet to occur

A stabilizing market indicates this seems unlikely in the near term; we are watching other indicators such as healthcare employment levels, cancer costs and specialty drug pricing for potential cost increases

Little to no expected net cost impact

Inflation Impacts

In addition, U.S. inflation rates are at the highest levels since the 1980s; inflation is linked to healthcare spending through healthcare wages

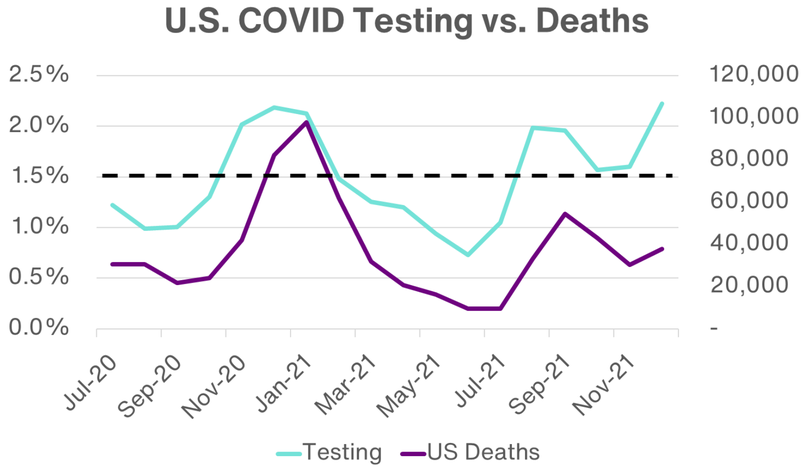
Economy-wide inflation is expected to add around 1 point to medical trends from 2021 → 2022 and from 2022 → 2023

Medical only trend projected for both 2021 → 2022 and 2022 → 2023 is 1 point higher

COVID-19 Testing Costs and Vaccine Costs

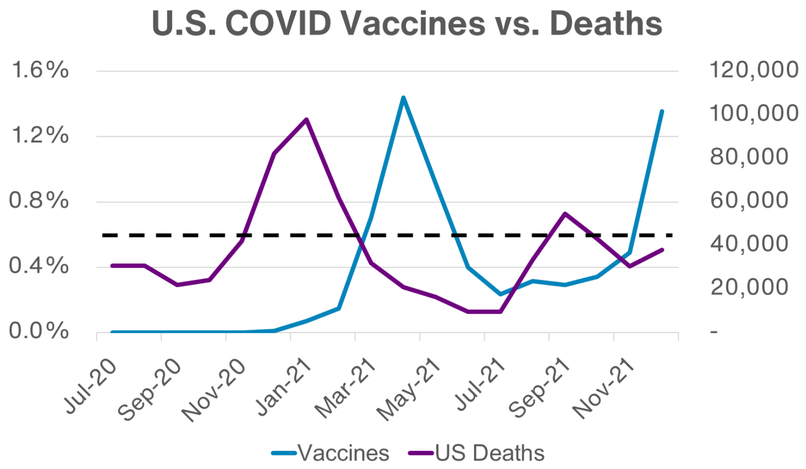
COVID-19 Testing Costs

- Waning concerns about COVID-19 likely means that **future testing costs will be no larger than past costs**
- Maintaining the same expected level of testing costs is likely to be slightly conservative
- A 33% reduction in testing costs only reduces total medical budgets by 0.5%



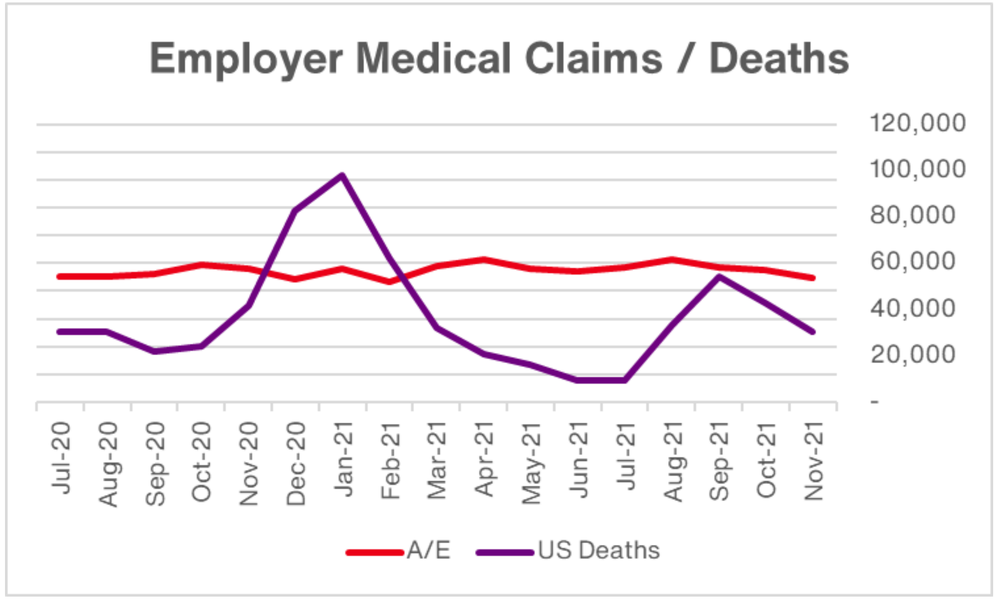
COVID-19 Vaccine Costs

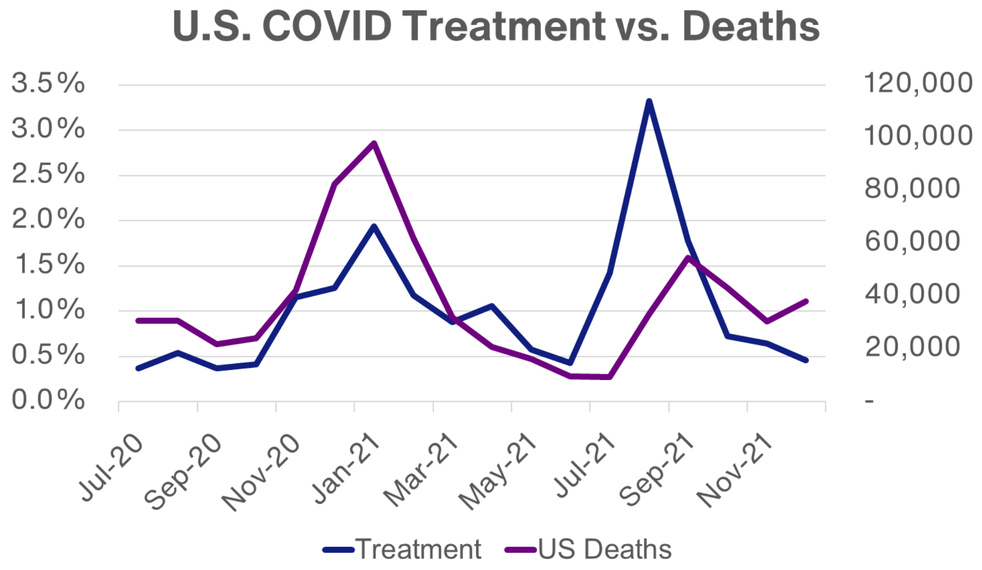
- Vaccine costs are likely to be lower in 2022 because of the reduced number of shots and reduced interest in shots
- A 50% reduction in vaccine costs only reduces total medical budgets by 0.3%
- 2023 vaccine costs could be even lower; however, the government may stop paying the vaccine costs and instead transfer that cost to health plans
- **Net impact is likely to be no cost increase over 2021, but possibly a small decrease**



COVID-19 Treatment Costs and Suppression of Other Claims

- Even as COVID-19 treatment costs rise and fall, other costs fall and rise
- Net medical costs are expected to remain fairly stable





Will Deferred Care Rebound?

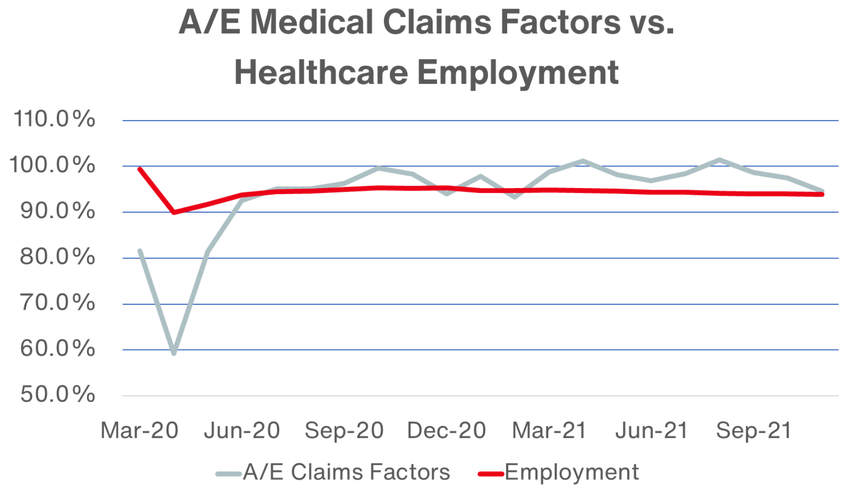
Where are the deferred claims?

When COVID-19 began, many expected March 2020 to May 2020 deferred services and costs to return once the pandemic was over, in addition to "normal" costs for the second half of 2020

- This would result in a temporary period of "above normal" cost
- However, two years after the onset of the pandemic, this has yet to occur

Will long COVID-19 or deferred preventive care result in new costs that wouldn't have happened without COVID?

- The healthcare system appears to have **returned to an equilibrium state**
- The human component of medical care means most costs don't scale much faster than employment
- Additional costs for long COVID-19 or other conditions are likely to displace other care
- Aon's trend team is monitoring utilization and costs for specific conditions such as cancer and long COVID-19 for signs of increases
- Specialty drug costs are scalable, so treatments that use expensive drugs could drive up costs
- Aon's pharmacy practice is monitoring expected drug trends



Note: *A/E medical claims factors based on Aon clients; healthcare employment levels as reported by Bureau of Labor Statistics*

Future Trends: Impact of Inflation

- Economy-wide inflation will likely drive up wages in the healthcare sector, which may in turn drive up negotiated prices
- For most national medical carriers, price increases will be slow to appear in medical claims because provider contracts are only renegotiated every 2 to 4 years
  - Historically, healthcare prices have trended a couple of points higher than underlying inflation — will providers be able to maintain that spread in upcoming negotiations?
  - Aon is monitoring medical claims and provider negotiations very frequently to be able to provide early warning
- Expected trends from 2021 → 2022 and 2022 → 2023 are **higher by 1 point in each year** than in 2021 trend guidance which is approximately $9M per year

10.

10. Discussion and possible action to include approving Plan Year 23 (July 1, 2022 – June 30, 2023) rates for State and Non-State employees, retirees and their dependents for the Consumer Driven Health Plan (CDHP), Low Deductible (LD) Plan, Exclusive Provider Organization (EPO) Plan, and Health Maintenance Organization (HMO) Plan (Laura Rich, Executive Officer) (**For Possible Action**)

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LAURA RICH
Executive Officer

LAURA FREED
Board Chair

AGENDA ITEM

[X] Action Item
[ ] Information Only

Date: March 24, 2022

Item Number: X

Title: Plan Year 23 Rates for State and Non-State employees, retirees and dependents

SUMMARY

This report provides the PEBP Board and members of the public information on PY23 rate development and proposed rates.

REPORT

RATE DEVELOPMENT

Step 1: Underwriting

PEBP Board policy requires Aon to set rates/trend aggressively – a 50% chance rates will be sufficient to cover expected claims costs and a 50% chance they will be short

1. *Aon gathers claims data (medical/Rx/dental) for the previous 12-24 months*
2. Claims are completed based on prior seasonality and claims lag and trended forward to PY23.
3. Plan design changes, changes to contracts, PBM market checks and any other projected savings are applied.
4. Enrollment expectations by tier and plan are applied along with utilization assumptions and actuarial values
5. Base Rates Per Participant Per Month (PPPM) are then established for the three plan offerings (CDHP, Copay, and EPO) separated by Medical, Pharmacy, and Dental expected Claims. EPO and HMO rates are blended.

Step 2: Enrollment weighting

Assumptions such as overall growth or decline, plan enrollment, assumed workforce changes or retirement influxes.

Step 3: Admin loads applied

Administrative loads such as administrative fees, HSA funding, and PEBP operating costs are applied appropriately.

Step 4: Tiering

The base rate is weighted by projected enrollment by tier. Per PEBP Board policy the following tiering methodology is then applied:

Participant = X
Participant + Spouse = 2X
Participant + children = X+Y
Participant + family = 2X + Y

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

Step 5: Addition of Life Insurance

PPPM Life insurance costs are then added to each tier of the three plans to arrive at final overall rates. Life insurance costs differ for actives and retirees and life insurance costs for those on the Exchange is absorbed entirely by members on self-funded plans.

PLAN YEAR 23 RATES

PY 2023 premiums are increasing **6.6% in aggregate**, including 2.3% from plan design enhancements that will be paid from excess reserves. Rates were determined by utilizing the most recent 12 months (12/2020-11/2021) of incurred claims experience paid through February 2022. Aon did not incorporate prior claims experience as it was impacted by the COVID-19 claims suppression. It is important to note that in order to avoid significant increases to premiums, which in the second year of the budget biennium are absorbed entirely by the employee, little to no conservatism was applied.

COVID-19 Impact:

1. Baseline COVID-19 Impact- **There is no COVID-19 adjustment** to recent claims experience as the last 12 of medical claims experience contains the impact of COVID-19 lulls and outbreaks. This claims experience includes COVID-19 testing and treatment costs, vaccine administrative costs, and suppression of other claims to make room for COVID-19 patients.
2. Future COVID-19 Waves- The expectation is for continuing seasonal COVID-19 waves. Costs are expected to be the same as or slightly less than previous COVID-19 waves.

3. Deferred Care- Initial expectations assumed there would be a rebound of deferred care claims but this has yet to occur. A stabilizing market indicates this seems unlikely in the near term however, actuaries continue to monitor other indicators such as healthcare employment levels, cancer costs and specialty drug pricing for potential cost increases. Hence, little to no expected net cost impact.

Trend Impact: Medical trend of 5.4% and 6.7% pharmacy

U.S. inflation rates are at the highest levels since the 1980s; inflation is linked to healthcare spending through healthcare wages. Economy-wide inflation is expected to add around 1 point to medical trends from 2021 → 2022 and from 2022 → 2023. For plan year 2023, Aon utilized healthcare trend closer to historical PEBP experience and **did not include an extra 1%** due to inflation but it is recommended to monitor trend levels.

Plan Design Change:
The benefit enhancements are worth 2.3% funded through differential cash.

Procurement Savings:
All of the contractual changes are incorporated into the premium rates including PBM contract, life insurance, HRA/HSA, transparency, and telemedicine.

Contributions:
State contributions are increasing in aggregate by 5.8%, which includes an additional subsidy of **$3M** to limit the increase in state active and retiree premiums. The additional subsidy was not applied to non-states since this group did not experience overall increases.

State Active Employees	Dollar Increase			Percentage Increase			Enrollment			
	CDHP	Copay	EPO/HMO	CDHP	Copay	EPO/HMO	CDHP	Copay	EPO/HMO	TOTAL
Employee Only	$ 2.33	$ 3.87	$ 16.82	5%	6%	12%	9,143	2,008	3,564	14,715
Employee + Spouse	$ 10.23	$ 13.32	$ 39.23	4%	5%	9%	1,195	406	569	2,170
Employee + Child(ren)	$ 5.28	$ 7.41	$ 25.24	4%	5%	10%	2,968	943	1,749	5,660
Employee + Family	$ 13.20	$ 16.84	$ 47.63	4%	5%	9%	1,942	668	687	3,297

State Retirees Non-Medicare	Dollar Increase			Percentage Increase			Enrollment			
	CDHP	Copay	EPO/HMO	CDHP	Copay	EPO/HMO	CDHP	Copay	EPO/HMO	TOTAL
Retiree Only	$ 6.98	$ 8.53	$ 21.48	3%	3%	6%	1,888	220	650	2,758
Retiree + Spouse	$ 18.00	$ 21.09	$ 47.00	3%	3%	6%	580	82	90	752
Retiree + Child(ren)	$ 11.10	$ 13.23	$ 31.06	3%	3%	6%	249	55	76	380
Retiree + Family	$ 22.14	$ 25.78	$ 56.57	3%	3%	6%	209	40	37	286

Plan Year 2023 State Rates - Active Employees

State Active Employees	Statewide CDHP					Copay PPO					EPO/HMO				
	Rate	Base Subsidy	Design Spend Down	Excess Subsidy	Participant Premium	Rate	Base Subsidy	Design Spend Down	Excess Subsidy	Participant Premium	Rate	Base Subsidy	Design Spend Down	Excess Subsidy	Participant Premium
Employee Only	674.67	605.16	16.30	6.25	**46.96**	695.83	605.16	16.28	6.25	**68.14**	783.32	605.16	10.91	6.25	**161.00**
Employee + Spouse	1,340.02	1,043.90	32.62	12.50	**251.00**	1,382.33	1,043.90	32.56	12.50	**293.37**	1,557.32	1,043.90	21.82	12.50	**479.10**
Employee + Child(ren)	924.17	769.69	22.43	8.59	**123.46**	953.27	769.69	22.39	8.59	**152.60**	1,073.57	769.69	14.99	8.59	**280.30**
Employee + Family	1,589.52	1,208.43	38.72	14.84	**327.53**	1,639.77	1,208.43	38.68	14.84	**377.82**	1,847.58	1,208.43	25.91	14.84	**598.40**

Plan Year 2023 State Rates - Non-Medicare Retirees

State Retirees Non-Medicare	Statewide CDHP					Copay PPO					EPO/HMO				
	Rate	Base Subsidy	Design Spend Down	Excess Subsidy	Participant Premium	Rate	Base Subsidy	Design Spend Down	Excess Subsidy	Participant Premium	Rate	Base Subsidy	Design Spend Down	Excess Subsidy	Participant Premium
Retiree Only	670.83	407.01	16.31	6.25	**241.26**	691.99	407.01	16.28	6.25	**262.45**	779.48	407.01	10.91	6.25	**355.31**
Retiree + Spouse	1,336.18	702.09	32.62	12.50	**588.97**	1,378.49	702.09	32.56	12.50	**631.34**	1,553.48	702.09	21.82	12.50	**817.07**
Retiree + Child(ren)	920.33	517.67	22.43	8.59	**371.64**	949.43	517.67	22.39	8.59	**400.78**	1,069.73	517.67	14.99	8.59	**528.48**
Retiree + Family	1,585.68	812.75	38.72	14.84	**719.37**	1,635.93	812.75	38.68	14.84	**769.66**	1,843.74	812.75	25.91	14.84	**990.24**
Surviving/Unsubsidized Dependent	670.83	-	16.31	-	**654.52**	691.99	-	16.28	-	**675.71**	779.48	-	10.91	-	**768.57**
Surviving/Unsubsidized Spouse + Child(ren)	920.33	-	22.43	-	**897.90**	949.43	-	22.39	-	**927.04**	1,069.73	-	14.99	-	**1,054.74**

Plan Year 2023 Non-State Rates - Active Employees

Non-State Active Employees	Statewide CDHP					Copay PPO					EPO/HMO				
	Rate	Base Subsidy	Design Spend Down	Excess Subsidy	Participant Premium	Rate	Base Subsidy	Design Spend Down	Excess Subsidy	Participant Premium	Rate	Base Subsidy	Design Spend Down	Excess Subsidy	Participant Premium
Employee Only	974.53	-	-	-	**974.53**	1,019.85	-	-	-	**1,019.85**	931.73	-	-	-	**931.73**
Employee + Spouse	1,939.75	-	-	-	**1,939.75**	2,030.39	-	-	-	**2,030.39**	1,854.14	-	-	-	**1,854.14**
Employee + Child(ren)	1,336.49	-	-	-	**1,336.49**	1,398.80	-	-	-	**1,398.80**	1,277.63	-	-	-	**1,277.63**
Employee + Family	2,301.70	-	-	-	**2,301.70**	2,409.34	-	-	-	**2,409.34**	2,200.04	-	-	-	**2,200.04**

Plan Year 2023 Non-State Rates - Non-Medicare Retirees

Non-State Retirees Non-Medicare	Statewide CDHP					Copay PPO					EPO/HMO				
	Rate	Base Subsidy	Design Spend Down	Excess Subsidy	Participant Premium	Rate	Base Subsidy	Design Spend Down	Excess Subsidy	Participant Premium	Rate	Base Subsidy	Design Spend Down	Excess Subsidy	Participant Premium
Retiree Only	970.69	706.87	24.29	-	**239.53**	1,016.01	731.03	24.05	-	**260.93**	927.89	557.96	14.62	-	**355.31**
Retiree + Spouse	1,935.91	1,301.82	48.60	-	**585.49**	2,026.55	1,350.15	48.11	-	**628.29**	1,850.30	1,003.99	29.24	-	**817.07**
Retiree + Child(ren)	1,332.65	929.99	33.41	-	**369.25**	1,394.96	963.20	33.07	-	**398.69**	1,273.79	725.21	20.10	-	**528.48**
Retiree + Family	2,297.86	1,524.93	57.70	-	**715.23**	2,405.50	1,582.32	57.13	-	**766.05**	2,196.20	1,171.24	34.72	-	**990.24**
Surviving/Unsubsidized Dependent	970.69	-	24.29	-	**946.40**	1,016.01	-	24.05	-	**991.96**	927.89	-	14.62	-	**913.27**
Surviving/Unsubsidized Spouse + Child(ren)	1,332.65	-	33.41	-	**1,299.24**	1,394.96	-	33.07	-	**1,361.89**	1,273.79	-	20.10	-	**1,253.69**

11.

11. Public Comment

12.

12. Adjournment