STEVE SISOLAK
Governor

STATE OF NEVADA
PUBLIC EMPLOYEES' BENEFITS PROGRAM
901 S. Stewart Street, Suite 1001 | Carson City, Nevada 89701
Telephone 775-684-7000 | 702-486-3100 | 1-800-326-5496
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:	December 5, 2022 9:00 a.m.
Place of Meeting:	4150 Technology Way Carson City, NV 89706 Third Floor Conference Room
Video Conferencing:	This meeting will be available by means of a remote technology system pursuant to NRS 241.023 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/STZtAhBjcrg

To submit written public comment, please upload your document to the *Public Comment Upload Form* located under *Contact Us* on the PEBP website, *pebp.state.nv.us,* no later than two business days prior to the meeting.

To listen to and view the PEBP Board Meeting please click on the YouTube Link located in "Video Conferencing" 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/89187285231
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 "Video Conferencing" field above.

Option #2 **Dial: (669) 900-6833. When prompted to provide your Meeting ID, please enter: 891 8728 5231 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 by uploading their document to the *Public Comment Upload Form* located under *Contact Us* on the PEBP website, *pebp.state.nv.us*, at least two business days prior to the meeting. Persons making public comment need to state and spell their name for the record at the beginning of their testimony.

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

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

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

   4.1 Approval of Action Minutes from the September 29, 2022 PEBP Board Meeting

   4.2 Acceptance of Claim Technologies Incorporated audit findings for State of Nevada Public Employees' Benefits Program Health Reimbursement Arrangement Plan administered by Via Benefits from Willis Towers Watson for the period of July 1, 2021 through June 30, 2022.

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

6. Acceptance of Claim Technologies Incorporated audit findings for State of Nevada Public Employees' Benefits Program Third-Party Administrator, HealthSCOPE Benefits for the period of April 1, 2022 – June 30, 2022. (Claim Technologies Incorporated) **(For Possible Action)**

7. Acceptance of Biennial Compliance Report including possible action on, but not limited to, the following items:

   7.1 Mental Health Parity

   7.2 Excepted Benefits

   (Laura Rich, Executive Officer) **(For Possible Action)**

8. Presentation of proposed changes to Dental Master Plan Document for Plan Year 2023 (Laura Rich, Executive Officer) **(For Possible Action)**

9. Presentation of wage and benefit survey results (Laura Rich, Executive Officer)(Information/Discussion)

10. Discussion and possible action on potential program design changes for Plan Year 2024 (July 1, 2023 to June 30, 2024) including, but not limited to the following:

    10.1 Real Appeal

    10.2 Hinge Health

    10.3 Doctor on Demand

    10.4 Expanded Travel Benefit

    10.5 Medical Travel Program

    10.6 Cancer Concierge

    10.7 Dental Plan Annual Maximum Limits

    10.8 Premium Credits

    10.9 HRA Credits

    10.10 Lifestyle Spending Account

    (Laura Rich, Executive Officer) **(For Possible Action)**

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

    11.1 Contract Overview

    11.2 New Contracts

        11.2.1 Contract with Former State Employee

    11.3 Contract Amendments

    11.4 Contract Solicitations

    11.5 Status of Current Solicitations

12. Public Comment

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

13. Adjournment

The supporting material to this agenda, also known as the Board Packet, is available, at no charge, on the PEBP website at 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 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 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. (Radhika Kunnel, Deputy Attorney General) (Information/Discussion)

4.

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

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

4.1 Approval of Action Minutes from the September 29, 2022 PEBP Board Meeting

4.2 Acceptance of Claim Technologies Incorporated audit findings for State of Nevada Public Employees' Benefits Program Health Reimbursement Arrangement Plan administered by Via Benefits from Willis Towers Watson for the period of July 1, 2021 through June 30, 2022.

4.1

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

4.1 Approval of Action Minutes from the September 29, 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)
September 29, 2022

MEMBERS PRESENT VIA TELECONFERENCE:	Ms. Laura Freed, Board Chair Ms. Linda Fox, Vice Chair Mr. Tom Verducci, Member Ms. Betsy Aiello, Member Ms. April Caughron, Member Ms. Michelle Kelley, Member Mr. Jim Barnes, Member Ms. Leslie Bittleston, Member Ms. Janell Woodward, 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:	Nathan Maier – UMR Rhonda Huckaby – UMR Darren Ashby – UMR Michelle Suckow – CTI Julie Weissmann – CTI Nancy Langeland – ESI Richard Ward – Segal

1. Open Meeting; Roll Call

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

2. Public Comment

    - Terri Laird – RPEN
    - Kent Ervin – Nevada Faculty Alliance
    - Tess Opferman – AFSCME
    - Natalia Filsom – Private Dental Practice Administrator
    - Brooke Maylath
    - Dr. Constance Sheltren – Licensed Psychologist
    - Doug Unger – Nevada Faculty Alliance

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 July 28, 2022 PEBP Board Meeting

    4.2 Receipt of quarterly staff reports for the period ending June 30, 2022:

    4.2.1 Budget Report

    4.2.2 Utilization Report

    4.3 Receipt of quarterly vendor reports for the period ending June 30, 2022:

    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 for August 2022

BOARD ACTION ON ITEM 4
MOTION: Motion to accept all of the items on 4 except for 4.2.1
BY: Member Leslie Bittleston
SECOND: Member Michelle Kelley
VOTE: Unanimous; the motion carried

BOARD ACTION ON ITEM 4.2.1
MOTION: Motion to accept the Budget Report
BY: Member Tom Verducci
SECOND: Member Janelle Woodward
VOTE: Unanimous; the motion carried

5. Election of Board Vice-Chair pursuant to Nevada Administrative Code (NAC) 287.172. Eligible candidates are Linda Fox, Tom Verducci, April Caughron, Betsy Aiello, Michelle Kelley, Jim Barnes, Leslie Bittleston, Janell Woodward and Jennifer McClendon. (Laura Freed, Board Chair) (**For Possible Action**)

BOARD ACTION ON ITEM 5
MOTION: Motion to have Mr. Barnes serve for the next year as Vice Chair of the PEBP Board.
BY: Member Tom Verducci
SECOND: Member Linda Fox
VOTE: Unanimous; the motion carried

6. Informational report on claims payment accuracy and timeliness since the transition from HealthSCOPE Benefits to UMR. (UMR) (For Information Only)

7. Discussion and acceptance of Claim Technologies Incorporated audit findings for State of Nevada Public Employees' Benefits Program Plans for HealthSCOPE Benefits for period January 1, 2022 – March 31, 2022 (CTI) (**For Possible Action**)

BOARD ACTION ON ITEM 7
MOTION: Motion to accept CTI's audit of HealthSCOPE
BY: Member Leslie Bittleston
SECOND: Member April Caughron
VOTE: Unanimous; the motion carried

8. Discussion and acceptance of Claim Technologies Incorporated audit findings for State of Nevada Public Employees' Benefits Program Plans for ExpressScripts for period July 1, 2020 – June 30, 2021 (CTI) (**For Possible Action**)

BOARD ACTION ON ITEM 8
MOTION: Motion to accept CTI's audit of ExpressScripts
BY: Vice Chair Jim Barnes
SECOND: Member Betsy Aiello
VOTE: Unanimous; the motion carried

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

10. Discussion and possible direction from the Board to staff on potential program design changes for Plan Year 2024 (July 1, 2023 to June 30, 2024) for which the Board requests additional information and costs to be presented at the December 5, 2022 meeting. (Laura Rich, Executive Officer) (**For Possible Action)**

BOARD ACTION ON ITEM 10
MOTION: Motion to ask PEBP staff to research Real Appeal, Hinge Health, Cancer Concierge, Medical Travel, premium credits and incentivization of Doctor on Demand for behavioral health.
BY: Member Tom Verducci
SECOND: Member Leslie Bittleston
VOTE: Unanimous; the motion carried

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

    11.1 Contract Overview

    11.2 New Contracts

    11.3 Contract Amendments

    11.4 Contract Solicitations

    11.5 Status of Current Solicitations

12. Public Comment

- Kent Ervin – Nevada Faculty Alliance
- Doug Unger – Nevada Faculty Alliance

13. Adjournment

- Board Chair Freed adjourned the meeting at 12:39 p.m.

4.2

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

4.1 Approval of Action Minutes from the September 29, 2022 PEBP Board Meeting.

4.2 Acceptance of Claim Technologies Incorporated audit findings for State of Nevada Public Employees' Benefits Program Health Reimbursement Arrangement Plan administered by Via Benefits from Willis Towers Watson for the period of July 1, 2021 through June 30, 2022.

Draft as of October 11, 2022

Claim Administration Audit

HEALTH REIMBURSEMENT ARRANGEMENT

State of Nevada Public Employees' Benefits Program Health Reimbursement Arrangement Plan
Administered by Via Benefits from Willis Towers Watson

Audit Period: July 1, 2021 through June 30, 2022
Plan Year 2022

Presented to

State of Nevada Public Employees' Benefits Program

October 7, 2022

CLAIM TECHNOLOGIES INCORPORATED

TABLE OF CONTENTS

EXECUTIVE SUMMARY

This Comprehensive Audit Report is a compilation of the detailed information, findings, and conclusions drawn from Claim Technologies Incorporated's (CTI's) audit of Via Benefits from Willis Towers Watson's (Via Benefits) administration of the State of Nevada Public Employees' Benefits Program (PEBP) Medicare Exchange Health Reimbursement Arrangement (HRA) plan.

Scope

CTI performed an audit of Via Benefits' administration of the PEBP HRA for the period of July 1, 2021 through June 30, 2022 (plan year 2022). The population of claims and amount paid during the audit period was taken from the paid claim file provided by Via Benefits.

Total Paid Amount	$22,353,547.40
Total Number of Claims Paid/Denied/Adjusted	236,770

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

- Operational Review
- Random Sample Audit
- Eligibility Verification

Auditor's Opinion

Based on these findings, and in our opinion:

1. Via Benefits provided good service to PEBP's members by exceeding its performance guarantee for all four quarters for the Customer Satisfaction Quarter Review goal. Via Benefits exceeded the goal by more than 8% each quarter during plan year 2022 despite missing the Customer Service Abandonment Rate and Average Speed of Answer performance goals for FY 2022 Q2 and Q3.
2. Although Via Benefits provided good service to PEBP's members, CTI recommends the following areas for improvement:
    - Track the reasons for overpayments to understand why overpayments occur and prevent them going forward.
    - Provide claim processors with coaching on the processing errors identified during the audit.
    - Implement a contingency plan for handling increased call volumes during Q2 and Q3 as Speed to Answer continues to exceed the agreed upon goals for those quarters.

Summary of Via Benefits Guarantee Measurements

Based on CTI's Random Sample Audit results, Via Benefits met all three of its claims processing measurements for the PEBP.

FY 2022 Annual Metrics	Met/Not Met	Penalty
Claim Processing Turnaround Time	Met	NA
Claim Processing Payment Precision	Met	NA
Claim Financial Payment Precision	Met	NA

As a follow up to the FY 2021 audit, CTI confirmed Via Benefits issued an ACH credit to PEBP on 3/7/22 for the following missed metrics:

- Annual Customer Service Abandonment Rate – $7,500 penalty
- FY 2021 Q2 and Q3 Customer Average Speed to Answer – $2,000 penalty
- Annual Claim Processing Payment Precision – $10,000 penalty

OPERATIONAL REVIEW

Objectives

CTI's Operational Review evaluates Via Benefits' claims system, staffing, and procedures related to administration including enrollment, customer service, and overpayment recovery. We also used the Operational Review to verify compliance with contract terms and in support of our Random Sample Audit activities.

Scope

The scope of our review included:

1. Claim administrator information
    - Insurance and bonding
    - Conflicts of interest
    - Performance standards
    - Business continuity planning
    - System software
    - Offsite claim administration
2. Claim funding:
    - Claim funding mechanism
    - Check processing and security
3. Claim adjudication, customer service, and eligibility maintenance procedures:
    - Contributions and rollovers
    - Claim processing
    - Customer service call and inquiry handling
    - Overpayment and adjustments
    - System security
4. Privacy and security compliance

Methodology

CTI used an Operational Review Questionnaire to gather information from Via Benefits. We reviewed Via Benefits' responses and any supporting documentation supplied to gain an understanding of the procedures, staffing, and systems used to administer the PEBP's HRA plan. This allowed us to conduct the audit more effectively.

Findings

In our review we observed the following:

- Via Benefits provided the following insurance coverage information.

Coverage	Amount
Errors and Omissions	$5,000,000 Aggregate Limit
Crime	$1,000,000
Cyber Liability	$5,000,000
General Liability	$5,000,000

- Willis Towers Watson indicated that it had been audited by KPMG LLP, for compliance with the standards of the American Institute of Certified Public Accountants through the issuance of a Service Organization Controls (SOC) 1 Report. We have asked WTW to forward a copy of the report to PEBP. Any questions regarding the report and impact should be discussed with WTW.
- Compliance with Performance Guarantees

Metric	Guarantee Measurement	Actual	Met/ Not Met
Claim Processing Turnaround Time Annual Review	Processing will average two business days. Additionally, 98% of claims will be processed within five business days.	0.37 days 100% processed within five business days	Met Met
Claim Processing Payment Precision Annual Review	Processing average precision will be at least 98% or better.	98.0%	Met
Claim Financial Payment Precision Annual Review	Financial Accuracy will be 98% or better.	99.14%	Met
Reports Annual Review	Reports provided within 15 days.	Met	Met
HRA Web Services Annual Review	99% availability of web services for benefit information and HRA information exclusive of scheduled maintenance.	99.67%	Met
Customer Service Abandon Rate Annual Review	The percentage of incoming calls abandoned by participants be 5% or less.	8.8%	Not Met
Customer Service Speed to Answer Quarter Review	Incoming telephone calls answered in less than or equal to: Ninety seconds in Q1 PY 2022 Five minutes in Q2 PY 2022 Two minutes in Q3 PY 2022 Ninety seconds in Q4 PY 2022	 Q1 PY 2022 – 0:48 Q2 PY 2022 – 7:57 Q3 PY 2022 – 4:16 Q4 PY 2022 – 0:18	 Met – Q1 PY 2022 Not Met – Q2 PY 2022 Not Met – Q3 PY 2022 Met – Q4 PY 2022
Customer Satisfaction Quarter Review	At least 80% of participants surveyed will be satisfied with services.	Q1 PY 2022 – 94.69% Q2 PY 2022 – 88.15% Q3 PY 2022 – 90.77% Q4 PY 2022 – 94.06%	Met
Disclosure of Subcontractors Per Violation	Additional subcontractors shall not be engaged, unless at least 60 days prior to the engagement is given.	Individual Marketplace Subcontractor list dated April 15, 2021	Met
Unauthorized Transfer of Data Per Violation	All data will be stored, processed, and maintained on designated servers. Any changes must have 60 days notification.	No changes reported	Met

- Via Benefits reported for FY 2021 it made payment on 3/7/22 of $19,500 due to missed performance guarantees for Average Speed of Answer ($2,000), Call Center Abandonment Rate ($7,500), and Claim Processing Payment Precision ($10,000).
- Via Benefits reported using the Acclaim system, an in-house application that was developed for claim adjudication and payment purposes. The system has been used for 21 years.

- The business continuity plan provided by Via Benefits included two approaches to data protection; 1) continuous off-site replication to a second, geographically distant location and, 2) the use of daily backups of files and databases.
- Via Benefits indicated no claim processing functions are outsourced.
- All refunds and return checks are forwarded to PEBP to deposit to their bank account.
- Via Benefits indicated PEBP provided the allocation amount that participants were eligible for. Effective May 31, 2021, PEBP implemented an $8,000 cap on the available balance.
- Via Benefits provided an overpayment report for plan year 2022, that showed:
    - Overpayment Total: $21,085.64
    - Recovered Total: $937.90
    - Unrecovered Total: $20,147.74
- Via Benefits did not provide the reason for overpayments on the report; however, it did indicate lost eligibility was the biggest reason for recovering medical expenses.
- Customer service operations were available via phone Monday through Friday from 5:00 AM to 6:00 PM PST. Effective July 1, 2022, customer service hours changed to 5:00 AM to 4:00 PM PST.
- The member online portal allows claim submission, check claim status, check participant balances, supporting documents submittal, and viewing of historical information.
- Via Benefits communicated with account holders via mail or email. It provided newsletters twice a year, a one-time enrollment guide mailing when a participant aged into Medicare, and a one-time HRA welcome packet mailing upon initial qualification.
- Via Benefits reported it used secure system passwords and system authorization, as well as separation of duties. It also limited access to eligibility maintenance and claim adjudication.
- Via Benefits' internal system control document provided a thorough overview including detail on data entry logic, duplicate logic, and overpayment logic as examples.
- Web-based security and compliance training was provided by Via Benefits annually.
- Via Benefits reported that there were no privacy or security breaches identified during the audit period.

RANDOM SAMPLE AUDIT

Objective

The objective of the Random Sample Audit was to identify any administrative process deficiencies in PEBP's health reimbursement arrangement claims.

Scope

The scope of our Random Sample Audit for the PEBP included a review of 200 random sample HRA claims paid by Via Benefits for the period of July 1, 2021 through June 30, 2022. Performance was measured for the following key performance categories:

- Financial Accuracy
- Payment Accuracy
- Claim Turnaround Time

Methodology

The Random Sample Audit was conducted remotely at CTI's Des Moines, Iowa office. A CTI auditor reviewed each claim to determine if it was paid or processed correctly based on member eligibility or plan provisions as defined in the plan documents or amendments.

CTI cited errors when a sampled claim was determined to have been paid or processed incorrectly. Payment errors were observed based on how the selected claim was paid and the information Via Benefits had at the time the transaction was processed.

Findings

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 sampled claims were selected from the PEBP HRA claims. Note: procedural accuracy includes both financial and procedural errors. A summary of each finding follows the chart below.

Performance Measure	Claims Sampled		Sampled Claims with Errors		Results
	Claims	Dollars Paid	Claims	Dollars Paid	
Financial Accuracy	200	$20,552.57	1	$6.80	99.97%
Procedural Accuracy	200		3		98.00%
Claim Turnaround Time	Guarantee – 98% of claims reimbursed within 5 business days				100%

Audit Number	CTI's Observation	Via Benefits Response	CTI's Conclusion
Financial Errors			
1122	Letter from member states the renewal premium of $91.18 goes into effect on March 1, 2022. This premium amount was applied towards Jan and Feb premium payments. An adjudication error is cited with an overpayment of $6.80.	Agree.	Error and $6.80 overpayment remain. Paid incorrect premium amount.
1	**Financial Error**		

Audit Number	CTI's Observation	Via Benefits Response	CTI's Conclusion
Procedural Errors			
1062	The claim was submitted online for the spouse and processed for the employee. An adjudication error is cited and overpayment of $133.59.	Agree with procedural error.	Procedural error remains. Claim processed under the incorrect claimant. No financial error assessed.
1071	The claim was submitted online for the spouse and member. All charges were processed under the member. An adjudication error is cited and overpayment of $255.	Agree with procedural error.	Procedural error remains. Claim processed under the incorrect claimant. No financial error assessed.
1119	There were two separate expenses from the pharmacy for $27.40, both filled on 01/13/2022 and were picked up on 1/14/2022. One of the expenses was processed using the fill date of 01/13/2022, both should use the receipt date 01/14/2022. An adjudication error is cited.	Agree.	Procedural error remains. Incorrect date of service was used to process claim.
3	**Procedural Errors**		
4	**TOTAL ERRORS**		

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
The claim was received on 11/1/2021; however, the claim was not moved to the queue for processing until five days after receipt.	1028, 1039
Via Benefit's protocol is to process claims as one payment for multiple receipts. Best practice is to separate the charges to identify and prevent duplicate payments.	1047
The member submitted the monthly premium request for 2022 as $165.10. The claims were also received from Pass Thru at $170.10, therefore the following (out of sample) months have been overpaid – March, April, May, June, and partial payment for July. Total overpayment $719.92.	1110
The member submitted the monthly premium request for 2021 as $297.00. The claims were also received from Pass Thru at $148.50, therefore the following (out of sample) months have been overpaid – Feb- June in the amount of $742.50. A refund has been requested from the member.	1114

ELIGIBILITY VERIFICATION

Our electronic comparison of dates of service to PEBP's eligibility file revealed 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:

Description	Claim Lines	Members	*Paid Amount
Member Not on File	602	65	$74,667.07
Incurred After Member Benefit End Date	146	36	$15,555.88
Incurred Prior to Member Benefit Begin Date	666	167	$70,789.08
TOTALS	**1,414**	**268**	**$161,012.03**

**CTI notes that 1.2% of PEBP's total medical spend processed by Via Benefits was identified as paid for members who may not have been eligible for coverage. These results are slightly higher than the less than 1% CTI generally reports.*

Due to the brief change in eligibility vendors to BenefitFocus in January of 2022, PEBP eligibility data was not available for January 2022 through April 2022. Claims processed and incurred during that period were removed from CTI's eligibility analysis. With those claims removed, the total paid claims during the 8-month period were $13,144,193.

In our experience, there are occasionally eligibility data issues that affect screening quality and reliability. CTI has provided LifeWorks with detail reports listing individuals with flagged claims to validate eligibility data provided for this screening was correct and did not generate false positives.

RECOMMENDATIONS

Based on the findings of our annual audit of Via Benefits, CTI recommends the following:

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.

2. Via Benefits should coach its claims processors on errors identified during the audit:
    - Overlooked charges in claim file
    - Incorrect amount entered
    - Incorrect date of service entered
    - Grouping claims together for family members or paying under wrong family member

3. Via Benefits should implement a contingency plan for handling increased call volumes during Q2 and Q3 as Speed to Answer continues to exceed the agreed upon goals for those quarters.

CONCLUSION

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

APPENDIX – ADMINISTRATOR RESPONSE TO DRAFT REPORT

Additional information submitted to CTI from the administrator in response to the draft report is reviewed and observations may be removed prior to the final report being published. While a removed observation will not be included in the final report, it may be referenced in the administrator's response to the draft report.

wtw

September 24, 2022

State of Nevada Public Employees Benefits Program:

On behalf of Willis Towers Watson (WTW) in regards to the draft report of the Audit of the State of Nevada Public Employees' Benefits Program Health Savings Account and Health Reimbursement Arrangement for the period of July 2021-June 2022 please see our response to the report and the auditor's recommendations below:

- Claim Technologies Incorporated noted that of the 200 claims reviewed there were two financial errors after review with the auditors, WTW disagrees to these findings. WTW agrees to one financial error.
    - Claim #1056 for $148.50 was received via the mobile app on 1/24/2022 it was processed and paid on 1/26/2022. Along with the online submission the participant uploaded an incomplete claim form with two lines on it for reimbursement, one line for the Dec 2021 Med Part B at $148.50 and one line for Jan 2022 Med Part B at $170.10. On the same day in a separate request via the mobile app they also submitted another reimbursement request with the same incomplete claim form for the Jan 2022 Med Part B at $170.10 which was also processed and paid on 1/26/2022.
        - It is our opinion that both of these claims were processed and paid correctly and should not result in an error.
- Claim Technologies Incorporated noted that of the 200 claims reviewed there were three procedural errors, after review with the auditors, WTW agrees to these findings.

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.

Response to Audit Report for PEBP Page 1 of 3

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.
- We are continuing to work on improving the overpayment process and participants can now resolve their overpayments through the portal. They have the option to pay online or submit a help ticket. The amount of calls we take regarding overpayments has decreased more than half because of this change.

Recommendation #2:
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 #3:

Via Benefits should implement a contingency plan for handling increased call volumes during Q2 and Q3 as Speed to Answer continues to exceed the agreed upon goals for

those quarters.

WTW Response:

Our plan to manage increased call volume during Q2 and Q3 includes hiring staff earlier in the year for Q2 and Q3 2023, which will allow us to meet our staffing targets earlier in the year. We are seeing better retention with those colleagues. During the hiring process, we better set expectations regarding work hours, explaining colleagues will be scheduled for more than 40 hours during the busiest days/weeks during the Medicare Open Enrollment period. As we on board new colleagues, we are leveraging enhanced scenario-based learning with more in-depth Medicare knowledge, soft skills and guided system activities, enabling associates to continuously be prepared for Open Enrollment. We are currently staffed above forecasted needs and are continuing our work from home model, which allowed us to expand our hiring pool. We have improved rewards for our call center colleagues during peak periods. These actions should help minimize attrition which was a driving factor for the Average Speed to Answer being missed last year.

We at WTW 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.

CLAIM TECHNOLOGIES
INCORPORATED

100 Court Avenue – Suite 306 • Des Moines, IA 50309
(515) 244-7322 • claimtechnologies.com

5.

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

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

AGENDA ITEM

☐ Action Item
☒ Information Only

Date: December 5, 2022

Item Number: V

Title: Executive Officer Report

SUMMARY

This report provides the Board and members of the public updates on agency operations.

REPORT

STAFFING UPDATE

Staffing levels continue to fluctuate, particularly in the member services unit (MSU) where turnover is most frequent. MSU staff are the front line and assist members with inquiries relating to eligibility and redirect members with claims specific questions to our vendor partners, so staffing shortages and turnover have a direct impact on PEBP's ability to provide accurate and thorough customer service to members.

PEBP's current vacancy rate is 27%.

OFFICE MOVE UPDATE

PEBP has been making progress toward a potential February 1, 2023 move. However, supply chain issues, labor shortages, and necessary building improvements may affect the anticipated move date. PEBP anticipates the lease agreement to be considered at the Board of Examiners meeting in January. Once BOE provides final approval, the actual move date will be dependent on IT equipment installation and vendor availability.

BUDGET UPDATE

The budget impact of the November gubernatorial election is yet to be determined. The timeline to deliver the Governor's Recommended Budget does not change, so agency budgets will likely be one of the top priorities of the new administration. PEBP staff will continue to advocate on behalf of its members as we work with the new administration and its transition team.

INTERIM RETIREMENT AND BENEFITS COMMITTEE

IRBC has been scheduled for December 14th at 10am, with PEBP presenting first on the agenda. In accordance with NRS 287.0425, PEBP will be presenting information relating to Plan Year 2022. In addition to the required reports already supplied to the committee, a supplemental report summarizing the decisions made at the December 5th PEBP Board meeting will be delivered and presented as well.

LEGISLATIVE REMINDER

PEBP would like to remind the Board and public that additional Board meetings will be scheduled during legislative session. These meetings will be focused on reviewing and voting on Board position of potential legislation. PEBP will schedule these virtual meetings in advance to allow for appropriate planning; however, it is likely changes will be necessary as session gets underway.

6.

6. Acceptance of Claim Technologies Incorporated audit findings for State of Nevada Public Employees' Benefits Program Third-Party Administrator, HealthSCOPE Benefits for the period of April 1, 2022 – June 30, 2022. (Claim Technologies Incorporated) (For Possible Action)

Comprehensive Claim Administration Audit

QUARTERLY FINDINGS REPORT
and Annual Operational Review

State of Nevada Public Employee's Benefits Plans

Administered by HealthSCOPE Benefits

Audit Period: April 1, 2022 – June 30, 2022
Audit Number 1.FY22.Q4

Presented to

State of Nevada Public Employee's Benefits

October 28, 2022

CLAIM TECHNOLOGIES
INCORPORATED

TABLE OF CONTENTS

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's) administration of the State of Nevada Public Employee's Benefits (PEBP) medical, dental, and health reimbursement arrangement (HRA) plan. This is the final audit report for HealthSCOPE as PEBP's administrator, future audit reports will be for the successor administrator, UMR.

Scope

CTI performed an audit for the period of April 1, 2022 through June 30, 2022 (quarter 4 (Q4) for Fiscal Year (FY) 2022). The population of claims and amount paid during the audit period reported by HealthSCOPE Benefits:

Medical and Dental	
Total Paid Amount	$52,980,341
Total Number of Claims Paid/Denied/Adjusted	189,022
Health Reimbursement Arrangement (HRA)	
Total Paid Amount	$835,298
Total Number of Claims Paid/Denied/Adjusted	8,492

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's Financial Accuracy and Payment Accuracy decreased in Q4 FY2022 and a penalty of 2.5% of administrative fees is owed.
2. HealthSCOPE should:
    - Review the financial errors identified in our random sample audit and determine if system changes or claim processor training could help reduce or eliminate errors of a similar nature in the future.
    - Review the 100% Electronic Screening with Targeted Sample results and focus on the most material findings.
    - Where appropriate, verify claim processor coaching, feedback, and retraining has occurred because most errors were manually processed.

Summary of HealthSCOPE's Guarantee Measurements

Based on CTI's Random Sample Audit results, HealthSCOPE did not meet one of the claims processing measurements for PEBP in Q4 FY2022 and a penalty is owed.

Quarterly Metric	Guarantee	Met/Not Met	Penalty
Financial Accuracy (p.13)	99%	Not Met – 98.92%	$28,267.93

AUDIT OBJECTIVES

This report contains CTI's findings from our audit of HealthSCOPE Benefits' (HealthSCOPE) administration of the State of Nevada Public Employee's Benefits (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 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.

ANNUAL OPERATIONAL REVIEW

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
  - Financial reporting
  - Business continuity planning
  - Claim payment system and coding protocols
  - Data and system security
- Claim funding:
  - Claim funding mechanism
  - Check processing and security
  - Large claim payment process
- Claim adjudication, customer service, and eligibility maintenance procedures:
  - Exception claim processing
  - Eligibility maintenance and investigation
  - Other insurance coverage and adjudication
  - Overpayment recovery
  - Network utilization
  - Utilization review, case management, and disease management
  - Subrogation and other third-party liability
  - 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.

Findings

We observed the following:

- HealthSCOPE provided the following insurance coverage information:

Coverage	Amount
Errors and Omissions	$10,000,000
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 SOC 1, 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 for the period of November 1, 2020, to October 31, 2021. A bridge letter dated August 25, 2022 was also provided noting the transition of network architecture and associated computing environment to systems supported by UnitedHealth Group (UHG); which they anticipate will have an improved positive impact. PEBP should request a copy of the SOC 1 report from HealthSCOPE benefits.
- 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.
- 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 64% of claims received were auto adjudicated.
- HealthSCOPE reported it did not have a minimum dollar threshold to recoup an overpayment and can automatically recoup a refund from the next payment made to the same provider. An overpayment recovery report was not provided for FY2022.
- HealthSCOPE outsourced subrogation recovery to Luper Neidenthal & Logan. The vendor has worked directly with PEBP on authority limits to reduce or waive a lien. Its fee was 18% of recovery amounts. HealthSCOPE provided subrogation detail reports for FY2022. The reports provided showed 2,671 cases were opened and 282 cases were closed, the remainder were open and pending. HealthSCOPE reported total recoveries over the fiscal year of $2,467,745 of $24,290,839 cases opened for a 10% recovery rate.
- The minimum threshold 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 appeal report for FY2022. This report showed a total of 291 member appeals. Of those appeals, 225 were processed timely while 66 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 Administrative Code 287.670.

- 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 Q4 there were sampled claims which HealthSCOPE paid more than billed charge. In Q4 the cases identified were paid in accordance with the Aetna contract.
- HealthSCOPE indicated HIPAA training is provided by the compliance department and training is provided annually to its employees. HealthSCOPE reported no breeches during the audit period.

QUARTERLY PERFORMANCE GUARANTEE VALIDATION

As part of CTI's quarterly audit of PEBP, we reviewed the Performance Guarantees included in its contract with HealthSCOPE. The results for Q4 FY2022 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	98.92%	Not Met
Claims Payment Accuracy	98% or greater of medical/dental claims audited are paid accurately	98.50%	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%	3.3 Seconds 0.06% 97.97%	Met Met Met
Data Reporting	• 100% of standard reports within 10 business days of completion	Delivered 8/11/22	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
- Patient cost share
- Fraud, waste, and abuse
- Timely filing
- Subrogation/right of recovery from third party
- Workers' Compensation
- Coordination of benefits
- Large claim review
- Case and disease management
- Specific reinsurance reimbursement

Methodology

We used ESAS to analyze claim payment and eligibility maintenance 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 dollar amounts associated with the results represent potential payment errors and process improvement opportunities. To substantiate the findings, CTI would have to perform additional testing to 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 HealthSCOPE's 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.**

Categories for Potential Amount at Risk				
Client: PEBP **Screening Period:** Q4 FY2022				
Category	**Number of Line Items**	**Number of Claimants**	**Billed Charge**	**Allowed Amount***
Duplicate Payments				
Providers and/or Employees	190	42	$78,603	$12,767
Exclusions				
Experimental/Investigational	19	15	$55,281	$12,872
Fraud, Waste, and Abuse				
Spinal Region Upcoding – Number of spinal regions treated does not match number of spinal regions billed and allowed.	1,042	374	$73,539	$35,690
Preventive Services				
Deductible Applied	341	243	$50,419	$16,094
Coinsurance Applied	323	197	$59,049	$23,056

**Allowed amount 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 any additional information provided, CTI confirmed the potential for process improvement.

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

ESAS Findings Detail Report				
QID	**Under/ Over Paid**	**HealthSCOPE Response**	**CTI Conclusion**	**Manual or System**
Duplicate Payments				
30	$228.00	Agree. The refund has not been received.	Procedural deficiency and overpayment remain. HealthSCOPE paid duplicate charges.	☒ M ☐ S
Plan Exclusions				
Experimental/Investigational				
49	$840.00	Agree. Analyst should have requested medical records.	Procedural deficiency and overpayment remain. Per page 94 of the SPD experimental treatment is excluded.	☒ M ☐ S
Potential Fraud, Waste, and Abuse				
Spinal Region Upcoding				
39	$83.99	Disagree. Services paid per plan guidelines.	Procedural deficiency and overpayments 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 three or four spinal regions treated; however, the diagnosis billed supported treatment of only one spinal region. These procedures are spinal region driven and should be billed with appropriate diagnosis codes to support billing.	☒ M ☐ S
40	$56.64			☒ M ☐ S
41	$67.19			☒ M ☐ S
Preventive Services				
Deductible Applied				
8	($1,737.57)	Agree. Claim should have paid at the routine benefit.	Procedural deficiency and underpayment remain. Deductible should have been waived.	☒ M ☐ S
9	($68.01)			☒ M ☐ S
With Coinsurance Applied				
12	($70.00)	Agree. Claim should have paid at the routine benefit.	Procedural deficiency and underpayment remain. Coinsurance should have been waived.	☒ M ☐ S

Through the targeted screening process, CTI observed instances where an error was not cited on the sampled case; however, an issue existed that PEBP should be aware of.

Observation	QID
NCCI Medically Unlikely Edits were not applied as the claims were paid according to the Aetna contract in place.	1, 2, 3
NCCI Procedure to Procedure Edits were not applied as the claims were paid according to the Aetna contract in place.	4, 5
CTI noted these claims paid greater than billed charges because the Aetna network contract does not include “lessor of” language.	21, 22

Annual Eligibility Verification

CTI electronically compared dates of service for FY2022 Q1 through 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	$2,212,097
Payments Prior to Effective Date	$1,052,300
Payments During Gaps in Coverage	$835
After Termination Date of Employee's Coverage	$56,748
Subtotal	$3,321,980
Dependent Eligibility Screening Subcategory	**Amount Paid**
No Identification Match to Any Eligible Employee	$780,842
Payments Prior to Effective Date	$560,857
Payments During Gaps in Coverage	$3,892
After Termination Date of Employee's Coverage	$32,036
Subtotal	$1,377,626
COMBINED TOTAL*	**$4,699,606**

**CTI notes that 3.6% of the PEBP's total medical expense 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.*

Due to the brief change in eligibility vendors to BenefitFocus in January of 2022, PEBP eligibility data was not available for January 2022 through April 2022. Claims processed and incurred during that period were removed from CTI's eligibility analysis. With those claims removed, the total paid claims during the 8-month period were $130,088,521.

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
- Claims Payment Accuracy
- Claims Processing Accuracy

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 total paid in the 200-claim audit sample was $273,631.44. The claims sampled and reviewed revealed $413.15 in underpayments and $7,160.00 in overpayments, for an absolute value variance of $7,573.15. This reflects a weighted Financial Accuracy rate of 98.92% over the stratified sample. Detail provided in the table below, Random Sample Findings Detail Report.

HealthSCOPE did not meet the Performance Guarantee for PEBP in Q4 FY2022 of 99% for this measure. The penalty owed is 2.5% of the administrative fees of $1,130,717.25 or $28,267.93.

Claims Payment Accuracy

CTI defines Claims Payment Accuracy 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. Detail provided in the table below, Random Sample Findings Detail Report.

Total Claims	Incorrectly Paid Claims		Frequency
	Underpaid Claims	Overpaid Claims	
200	2	1	98.50%

Claims Processing Frequency

CTI defines Claims Processing Accuracy as the number of claims processed without errors compared to the total number of claims processed in the audit sample. Detail provided in the table below, Random Sample Findings Detail Report.

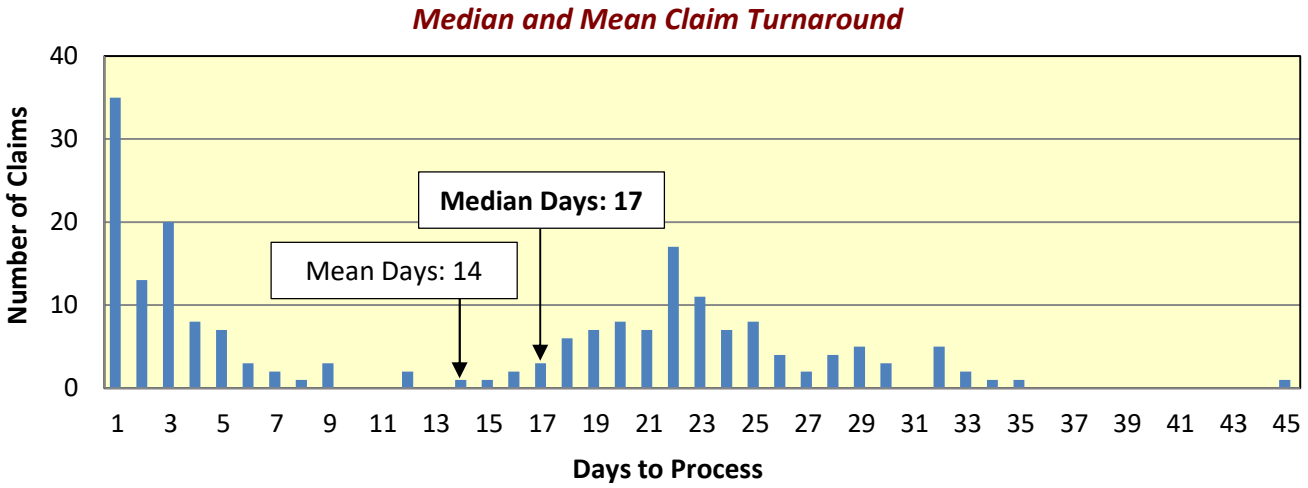
Correctly Processed Claims	Incorrectly Processed Claims		Frequency
	System	Manual	
197	0	3	98.50%

Random Sample Findings Detail Report				
Audit No.	Under/ Over Paid	HealthSCOPE Response	CTI Conclusion	Manual or System
Copay Calculation				
1026	($400.00)	Agree. PY2022 Premier page 37 outpatient surgery copay is $350	Procedural error and underpayment remain. The copay should have been $350.00 for outpatient surgery, and it was $750.00.	☒ M ☐ S
Denied Eligible Expense				
1113	($13.15)	Agree. Per the 2022 MPD routine hearing exam is covered under the plan.	Procedural error and underpayment remain. A hearing test is a component of a hearing exam. Per page 70 of the plan booklet, it is a covered expense.	☒ M ☐ S
PPO Discount				
1037	$7,160.00	Agree. Original claim xxxxx349 received and denied for accident details. HSB reconsidered on claim xxxxx115 and analyst did not transfer original Aetna pricing on reconsideration in error.	Procedural error and overpayment remain. No discount was applied on this free-standing surgical facility claim from a participating provider.	☒ 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 just a few claims with extended turnaround time from distorting the true performance picture.



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
CTI notes it took 68 days to process this claim through the high dollar claim process.	1073
Since this newborn was not added as a covered dependent and only covered for the first 31 days, only the individual deductible and out of pocket were required to be satisfied. The plan document language should be updated to reflect this administrative policy.	1096
PEBP should be aware of the HealthSCOPE processing protocol in which two routine ultrasounds per pregnancy are covered with no patient cost share. CTI notes HealthSCOPE paid six ultrasound services (sample 1137 – member history) with no patient cost-share. HealthSCOPE should review claims xxxxx707, xxxxx405, xxxxx406 and xxxxx973 and explain why these ultrasounds were paid with no patient cost-share.	1128, 1137
PEBP should be aware that HealthSCOPE does not apply a frequency limit on composite restorations performed on the same tooth and surface. In this case a one surface composite restoration was performed six months previous on the tooth in question.	2013
Per page 37 of the dental plan, facings on crowns or pontics posterior to the second bicuspid are considered cosmetic and not covered. Typically, the claim administrator will benefit a less expensive service. For a crown this would be the plan benefit for a metal crown. The plan document should be updated to be align with administration and plan intent.	2042, 2049

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 HRA claims.

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.

Provider Discount Review PEBP - HealthSCOPE Paid Dates 4/1/2022 through 6/30/2022				
Proprietary and Confidential Information. Do not reproduce without express permission of Claim Technologies Inc.				
Total of All Claims				
Claim Type	**Allowed Amount**	**Provider Discount**		**Paid**
Ancillary	$2,846,208	$5,543,503	66.1%	$2,483,935
Non-Facility	$25,704,109	$29,568,170	53.5%	$18,510,205
Facility Inpatient	$14,794,708	$29,222,437	66.4%	$13,695,244
Facility Outpatient	$17,020,694	$35,620,692	67.7%	$14,080,499
Total	**$60,365,719**	**$99,954,801**	**62.3%**	**$48,769,883**
In-Network				
Claim Type	**Allowed Amount**	**Provider Discount**		**Paid**
Ancillary	$2,731,088	$5,543,503	67.0%	$2,410,930
Non-Facility	$24,629,301	$29,568,170	54.6%	$18,118,108
Facility Inpatient	$13,957,772	$28,215,883	66.9%	$13,091,230
Facility Outpatient	$16,711,412	$35,009,047	67.7%	$13,862,097
Total In-Network	**$58,029,573**	**$98,336,603**	**62.9%**	**$47,482,365**
% of Eligible Charge -	96.1%	% Claim Frequency -	97.0%	
Out of Network				
Claim Type	**Allowed Amount**	**Provider Discount**		**Paid**
Ancillary	$115,120	$0	0.0%	$73,004
Non-Facility	$1,074,807	$0	0.0%	$392,098
Facility Inpatient	$836,936	$1,006,554	54.6%	$604,014
Facility Outpatient	$309,282	$611,644	66.4%	$218,402
Total Out of Network	**$2,336,146**	**$1,618,198**	**40.9%**	**$1,287,519**
% of Eligible Charge -	3.9%	% Claim Frequency -	3.0%	
Secondary				
Claim Type	**Allowed Amount**	**Provider Discount**		**Paid**
Ancillary	$0	$0	0.0%	$0
Non-Facility	$0	$0	0.0%	$0
Facility Inpatient	$0	$0	0.0%	$0
Facility Outpatient	$0	$0	0.0%	$0
Total Secondary	**$0**	**$0**	**0.0%**	**$0**
% of Eligible Charge -	0.0%	% Claim Frequency -	0.0%	

Note: Paid claim totals exclude claims from Medicare eligible members aged 65 and older that may skew discount data.

PEBP's members had utilization of network or secondary network medical providers at 96.1% of all allowed charges and 97.0% 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	4	$2,973	$2,935	$746
1548342025	20130820	N/A	1128b14	SIXTH DENTAL PARTNER	1	$1,560	$1,523	$761
				Totals	**5**	**$4,533**	**$4,458**	**$1,508**

According to the OIG, James Shelby was excluded on December 19, 2019 with for a felony-controlled substance conviction; Sixth Dental Partner was excluded on August 20, 2013 for default on health education loan.

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 96.41% of the procedure codes identified as preventive services were paid by HealthSCOPE at 100% when provided in-network. A detailed list of the other 3.59% is available upon request.

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

Preventive Care Services Compliance Review								
PEBP - HealthSCOPE								
Audit Period 4/1/2022 - 6/30/2022								
Filters: Exclude - out of network, adjustments, edits with frequency limits, claimants 65 or older								
Edit Guideline	Preventive Service Benefit	Number of Claim Lines	Number Denied	Number Applied	Number Applied	Number Applied	Paid @100%	
							Number	Percent
USPSTF-B	Breast cancer chemoprevention counseling- >17	11	0	5	1	4	0	.00%
USPSTF-A	Ambulatory blood pressure screening - adult	2	0	0	0	2	0	.00%
HHS	Breastfeeding support and counseling - women	38	5	3	14	7	9	27.27%
USPSTF-B	BRCA screening counseling - women	24	3	3	7	3	8	38.10%
USPSTF-A,B	Rh incompatibility screening - pregnant women	80	27	9	6	13	25	47.17%
USPSTF-A	Urinary tract infection screening - pregnant women	118	12	22	2	22	60	56.60%
USPSTF-A	Hepatitis B screening - women	33	1	6	1	6	19	59.38%
USPSTF-B	Healthy diet counseling	225	2	19	11	58	135	60.54%
USPSTF-A	Phenylketonuria (PKU) screening 0-90 days	12	0	1	0	3	8	66.67%
USPSTF-B	Depression screening - >18	74	3	10	6	6	49	69.01%
USPSTF-B	Tobacco use counseling - >18	25	2	3	0	4	16	69.57%
HHS	Gestational Diabetes Mellitus screening - women	104	0	9	0	20	75	72.12%
USPSTF-B	Depression screening - 12-18	33	0	2	5	2	24	72.73%
USPSTF-A	HIV screening - pregnant women	9	1	0	0	2	6	75.00%
USPSTF-B	Hepatitis C Virus (HCV) Screening	184	0	28	0	16	140	76.09%
USPSTF-A	HIV screening - >14	194	5	28	0	17	144	76.19%
USPSTF-A	Syphillis screening	48	0	4	0	6	38	79.17%
USPSTF-A	Syphilis screening - pregnant women	146	1	13	0	14	118	81.38%
ACIP	Immunizations - Influenza Age >18	42	0	4	0	2	36	85.71%
USPSTF-A,B	Chlamydia infection screening - women	293	1	22	0	16	254	86.99%
USPSTF-B	Gonorrhea screening - female	286	1	20	0	17	248	87.02%
Bright Futures	Dyslipidemia screening - 2-20	37	1	2	0	2	32	88.89%
USPSTF-A,B	Cholesterol abnormalities screening - women >19	725	0	42	0	22	661	91.17%
USPSTF-A	Cholesterol abnormalities screening - men 35-75	531	2	30	0	12	487	92.06%
Bright Futures	Iron Supplement - <21	99	1	4	0	2	92	93.88%
ACIP	Immunizations - Hepatitis A >18	19	0	0	0	1	18	94.74%
USPSTF-B	Alcohol misuse - screening and counseling	25	1	0	0	1	23	95.83%
USPSTF-A	Colorectal cancer screening - 45-75	695	2	13	3	8	668	96.39%
ACIP	Immunizations - Herpes Zoster >59	172	1	0	1	5	165	96.49%
Bright Futures	Hearing Screening 0-21 yrs	166	10	2	0	3	151	96.79%
ACIP	Immunizations - Pneumococcal >18	34	1	0	0	1	32	96.97%
HHS	Contraceptive methods - women	442	1	2	0	4	435	98.64%
HHS	Wellness Examinations - >18	736	0	6	0	2	728	98.91%
ACIP	Immunization Administration - >18	777	24	5	0	3	745	98.94%
USPSTF-B	Breast cancer mammography screening - >39	3,227	2	12	0	8	3,205	99.38%
USPSTF-A	Cervical Cancer Screening (Pap) - women	1,312	0	5	0	3	1,304	99.39%
Bright Futures	Developmental Autism screening - <3	190	1	1	0	0	188	99.47%
ACIP	Immunizations - Human papillomavirus	198	0	0	0	0	197	99.49%
HHS	Wellness Examinations - women	2,280	11	5	0	2	2,262	99.69%
HRSA/HHS	Wellness Examinations - <19	1,943	5	1	2	2	1,933	99.74%
ACIP	Immunizations - DTP <19	486	1	0	0	1	484	99.79%

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 4/1/2022 through 6/30/2022								
Outpatient Hospital Services (facility claims with codes not designated inpatient)								
Primary		Secondary		Mod Use	Primary Description	Secondary Description	Line Count	Amount CMS Would Deny
Code	Mod	Code	Mod					
63081		22551		YES	Remove vert body dcmprn crvl	NECK SPINE FUSE&REMOV BEL C2	2	$10,246
					More extensive procedure			
74177	TC	96374		YES	CT ABD & PELV W/CONTRAST	THER/PROPH/DIAG INJ IV PUSH	10	$7,805
					Standards of medical / surgical practice			
86825		88185		YES	HLA X-MATH NON-CYTOTOXIC	FLOWCYTOMETRY/TC ADD-ON	1	$5,200
					CPT Manual or CMS manual coding instructions			
92526	GN	97110	GP	YES	ORAL FUNCTION THERAPY	THERAPEUTIC EXERCISES	14	$3,748
					Misuse of column two code with column one code			
71275	TC	96374		YES	CT ANGIOGRAPHY CHEST	THER/PROPH/DIAG INJ IV PUSH	4	$3,496
					Standards of medical / surgical practice			
74177	TC	96365		YES	CT ABD & PELV W/CONTRAST	THER/PROPH/DIAG IV INF INIT	3	$2,787
					Standards of medical / surgical practice			
96374		96372		YES	THER/PROPH/DIAG INJ IV PUSH	THER/PROPH/DIAG INJ SC/IM	10	$2,441
					CPT Manual or CMS manual coding instructions			
74177		96374		YES	CT ABD & PELV W/CONTRAST	THER/PROPH/DIAG INJ IV PUSH	12	$2,194
					Standards of medical / surgical practice			
94640		99285	CS,CR	YES	AIRWAY INHALATION TREATMENT	EMERGENCY DEPT VISIT	1	$2,159
					CPT Manual or CMS manual coding instructions			
94660		99285		YES	POS AIRWAY PRESSURE CPAP	EMERGENCY DEPT VISIT	1	$2,092
					CPT Manual or CMS manual coding instructions			
						Top 10 TOTAL	**58**	**$42,169**
						GRAND TOTAL	**413**	**$88,613**

Non-Facility (non-facility claims with CPT codes:00100 - 99999)								
Primary		Secondary		Mod Use	Primary Description	Secondary Description	Line Count	Amount CMS Would Deny
Code	Mod	Code	Mod					
29881	RT	29877	RT	NO	KNEE ARTHROSCOPY/SURGERY	KNEE ARTHROSCOPY/SURGERY	1	$804
					Misuse of column two code with column one code			
90471		99396		YES	IMMUNIZATION ADMIN	PREV VISIT EST AGE 40-64	5	$506
					CPT Manual or CMS manual coding instructions			
32551		99292		YES	INSERTION OF CHEST TUBE	CRITICAL CARE ADDL 30 MIN	1	$439
					CPT Manual or CMS manual coding instructions			
44340		49000		NO	REVISION OF COLOSTOMY	EXPLORATION OF ABDOMEN	1	$411
					CPT "separate procedure" definition			
90471		99386		YES	IMMUNIZATION ADMIN	PREV VISIT NEW AGE 40-64	1	$310
					CPT Manual or CMS manual coding instructions			
99219		99218		NO	INITIAL OBSERVATION CARE	INITIAL OBSERVATION CARE	1	$276
					HCPCS/CPT procedure code definition			
90471		99385		YES	IMMUNIZATION ADMIN	PREV VISIT NEW AGE 18-39	1	$275
					CPT Manual or CMS manual coding instructions			
99218		99282		NO	INITIAL OBSERVATION CARE	EMERGENCY DEPT VISIT	1	$219
					CPT Manual or CMS manual coding instructions			
96372		99214		YES	THER/PROPH/DIAG INJ SC/IM	Office/outpatient visit for E&M of estab pat	2	$214
					Standards of medical / surgical practice			
29880	59	29874	59	NO	KNEE ARTHROSCOPY/SURGERY	KNEE ARTHROSCOPY/SURGERY	1	$191
					Misuse of column two code with column one code			
						Top 10 TOTAL	**15**	**$3,645**
						GRAND TOTAL	**103**	**$6,985**

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, and ancillary.

NCCI MUE Edits				
PEBP - HealthSCOPE				
Based on Paid Dates 4/1/2022 through 6/30/2022				
Outpatient Hospital Services (facility claims with codes not designated inpatient)				
Procedure Code	**Service Unit Limit**	**Procedure Description**	**Line Count Exceeding Limit**	**Amount CMS Would Deny**
75705	20	ARTERY X-RAYS SPINE	1	$68,248
		Rationale: Clinical: Data		
57425	1	LAPAROSCOPY SURG COLPOPEXY	1	$19,048
		Rationale: Anatomic Consideration		
58571	1	TLH W/T/O 250 G OR LESS	1	$19,048
		Rationale: Anatomic Consideration		
A9588	10	FLUCICLOVINE F-18	1	$11,688
		Rationale: Prescribing Information		
36215	2	PLACE CATHETER IN ARTERY	1	$11,219
		Rationale: Clinical: Data		
C1732	3	CATH, EP, DIAG/ABL, 3D/VECT	1	$8,937
		Rationale: Clinical: Data		
36245	3	INS CATH ABD/L-EXT ART 1ST	1	$7,337
		Rationale: Clinical: Data		
74177	2	CT ABD & PELV W/CONTRAST	1	$6,428
		Rationale: Clinical: Data		
36226	1	Place cath vertebral art	1	$6,204
		Rationale: CMS Policy		
88185	35	FLOWCYTOMETRY/TC ADD-ON	2	$5,366
		Rationale: Clinical: Data		
		Top 10 TOTAL	**11**	**$163,524**
		GRAND TOTAL	**84**	**$206,103**

Non-Facility (non-facility claims with CPT codes:00100 - 99999)				
Procedure Code	**Service Unit Limit**	**Procedure Description**	**Line Count Exceeding Limit**	**Amount CMS Would Deny**
97799	1	PHYSICAL MEDICINE PROCEDURE	35	$21,170
		Rationale: Clinical: Data		
31298	1	Nasal/sinus endoscopy, w dilation (balloon dilation) frontal & sphenoid sinus ostia, transnasal	1	$4,404
		Rationale: CMS Policy		
88374	5	Morphometric analysis, in situ hybridization (quantitative or semi-quantitative), using computer-ass	10	$4,396
		Rationale: Clinical: Data		
90868	1	TCRANIAL MAGN STIM TX DELI	1	$1,935
		Rationale: Nature of Service/Procedure		
88342	4	IMMUNOHISTOCHEMISTRY	1	$1,840
		Rationale: Clinical: Data		
67028	1	INJECTION EYE DRUG	4	$1,271
		Rationale: CMS Policy		
J3480	40	INJ POTASSIUM CHLORIDE	8	$1,200
		Rationale: Clinical: Data		
97155	24	ADAPT BHV TX PRTCL MODIFICAJ PHYS/QHP EA 15 MIN	2	$1,193
		Rationale: Clinical: Society Comment		
88341	13	Immunohistochemistry or immunocytochemistry, per specimen; each additional single antibody stain pro	2	$959
		Rationale: Clinical: Data		
87502	1	INFLUENZA DNA AMP PROBE	6	$885
		Rationale: Code Descriptor / CPT Instruction		
		Top 10 TOTAL	**70**	**$39,253**
		GRAND TOTAL	**159**	**$52,076**

Ancillary (All other claims not flagged Inpatient, Outpatient Hospital, or non-facility)				
Procedure Code	**Service Unit Limit**	**Procedure Description**	**Line count Exceeding Limit**	**Amount CMS Would Deny**
E0465	2	Home ventilator, any type, used with invasive interface, (e.g., tracheostomy tube)	14	$12,429
		Rationale: Nature of Equipment		
E2402	1	NEG PRESS WOUND THERAPY PUMP	1	$4,657
		Rationale: Nature of Equipment		
E0443	1	PORTABLE 02 CONTENTS, GAS	16	$1,140
		Rationale: Code Descriptor / CPT Instruction		
E0277	1	POWERED PRES-REDU AIR MATTRS	1	$950
		Rationale: Nature of Equipment		
E0260	1	HOSP BED SEMI-ELECTR W/ MATT	2	$478
		Rationale: Nature of Equipment		
K0001	1	STANDARD WHEELCHAIR	4	$448
		Rationale: Nature of Equipment		
A4253	1	BLOOD GLUCOSE/REAGENT STRIPS	8	$444
		Rationale: Nature of Equipment		
V2521	2	CNTCT LENS HYDROPHILIC TORIC	5	$440
		Rationale: Anatomic Consideration		
E0630	1	PATIENT LIFT HYDRAULIC	2	$342
		Rationale: Nature of Equipment		
A7520	1	TRACH/LARYN TUBE NON-CUFFED	4	$309
		Rationale: Published Contractor Policy		
		Top 10 TOTAL	**57**	**$21,638**
		GRAND TOTAL	**84**	**$22,888**

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 including simple – one day, minor – ten days, and 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 4/1/2022 - 6/30/2022									
	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
860800150	18	$13,009	4	18.2%	$9,517	2	$747	2	$540
910858192	106	$36,324	30	22.1%	$2,851	27	$2,535	2	$233
880218251	2	$119	1	33.3%	$645	0	$0	1	$131
813419791	48	$14,068	4	7.7%	$867	3	$465	1	$123
825259010	2	$100	1	33.3%	$114	1	$106	1	$106
860881749	10	$1,602	3	23.1%	$249	2	$230	1	$98
202523414	18	$1,464	2	10.0%	$1,442	1	$152	1	$95
880104714	38	$12,398	2	5.0%	$974	1	$80	1	$80
300047065	18	$2,563	1	5.3%	$1,191	0	$0	2	$77
942854057	16	$1,918	1	5.9%	$631	0	$0	1	$72
Top 10	**276**	**$83,564**	**49**	**15.1%**	**$18,479**	**37**	**$4,313**	**13**	**$1,555**
Overall Total	**4,877**	**$1,360,932**	**442**	**8.3%**	**$95,682**	**413**	**$47,277**	**14**	**$1,622**

FY2022 RECOMMENDATIONS

CTI has the following recommendations that represent recurring issues identified in the FY 2022 quarterly audits:

1. HealthSCOPE should review each of the financial errors identified in our FY2022 random sample audits and determine if system changes or claim processor 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.
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. HealthSCOPE should adjust claims when subrogation recoveries are received. This is not currently taking place and it is impacting member total out-of-pocket limits.
4. PEBP should discuss the subrogation recovery rate with HealthSCOPE. The recovery rate was lower in this period, with only a 10% recovery rate.
5. 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.
6. 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.
7. PEBP should request regular member appeal reports that include the reason for appeal, as well as received and closed dates.
8. PEBP should request regular overpayment reports including overpayment reasons. Tracking the reason for overpayments will allow both PEBP to understand why overpayments occur.
9. HealthSCOPE should exclude from claim payment providers on the Office of Inspector General's (OIG) List of Excluded Individuals/Entities (LEIE).

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.

Additional information submitted to CTI from the administrator in response to the draft report is reviewed and observations may be removed prior to the final report being published. While a removed observation will not be included in the final report, it may be referenced in the administrator's response to the draft report.

27 Corporate Hill Drive
Little Rock, AR 72205

October 14, 2022

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

Dear Ms. Suckow,

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.

Summary of HealthSCOPE's Guarantee Measurements:
Quarterly Guarantee:
HealthSCOPE Benefits would like to request CTI to review the Random Sample Audit results for the financial accuracy and payment accuracy.

- Financial Accuracy Q4– 87.74% - **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.

- Payment Accuracy Q4– 95% - **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.

HealthSCOPE Benefits has reviewed Audit Number 1.FY22.Q4 draft report and would like to add the response to the conclusions within the audit report.

TARGETED SAMPLE ANALYSIS

ESAS Findings Detail Report:

Duplicate Payments:

QID 30 – HSB does agree with CTI conclusion. The duplicate edit was overridden by the analyst in error. Claim 11999741 was adjusted to deny as a duplicate claim and request a refund.

Plan Exclusions:

QID 49- HSB does agree with CTI conclusion. Analyst should have requested medical records.

Potential Fraud, Waste, and Abuse:

QID 39 – HSB does not agree with CTI conclusion. The claim was paid according to the plan guidelines under the Chiropractic benefit.

QID 40 – HSB does not agree with CTI conclusion. The claim was paid according to the plan guidelines under the Chiropractic benefit.

QID 41 – HSB does not agree with CTI conclusion. The claim was paid according to the plan guidelines under the Chiropractic benefit.

Preventive Services:

QID 8 – HSB does agree with CTI conclusion. The claim should have paid at the routine benefit.

QID 9 – HSB does agree with CTI conclusion. The claim should have paid at the routine benefit.

QID 12 – HSB does agree with CTI conclusion. The claim should have paid at the routine benefit.

Procedure to Procedure:

QID 4 – HSB does not agree with CTI conclusion. The claim was paid correctly and priced with the Aetna contract agreement.

QID 5 – HSB does not agree with CTI conclusion. A corrected claim was received from the facility and corrected pricing received from HTH. There is no outstanding overpayment on the account for these services. The claim was paid correctly.

Medically Unlikely Edits:

QID 1 – HSB does not agree with CTI conclusion. Authorization number 6158080 on file for services rendered. Claim was priced with the Aetna contract agreement.

QID 2 – HSB does not agree with CTI conclusion. Authorization number 6264924 on file for services rendered. Copy of the claim was provided to CTI to identify the date span listed on the service line. The claim was priced with the Aetna contract agreement.

QID 3 – HSB does not agree with CTI conclusion. The claim was priced with the Aetna contract agreement in place with this facility. The claim was paid correctly.
HealthSCOPE Benefits would like to ask CTI to update the HSB response outlined on QID 3 of the Draft report as it was entered with the incorrect response. The authorization number identified in QID 3 should be identified in QID 2 as outlined on the HSB response.

OBSERVATION:

QID 21 – QID 21 was processed with the Aetna contract agreement.

QID 22 – QID 22 was processed with the Aetna contract agreement.

RANDOM SAMPLE AUDIT:

Accurate Processing Detail Report:

Audit No. 1032 – HSB does not agree with CTI conclusion. On page 9 of the MPD it explains the Out-of-Pocket maximum. The Out-of-Pocket Maximum is the costs you pay toward your deductible and coinsurance. The member had an Individual Deductible amount of $1,782.01 and an Individual Coinsurance amount of $5067.99 that equals the total of $6,850.

Audit No. 1065 – HSB does not agree with CTI conclusion. The lab claim was received on 06/13/2022 and processed on 06/15/2022 as billed by the provider. The physician claim was received on 07/14/2022 and processed on 07/18/2022. The lab bill was processed correctly based on the claim received and on file at the time of adjudication. Received email directive from the client regarding routine lab.

Audit No. 1096 – HSB does not agree with CTI conclusion. The claim was considered under the newborn for services rendered. The Enrollment Eligibility MPD does define the Newborn eligibility. The newborn will be covered for the first 31 days under the plan. The newborn was not added to the policy and the benefit calculations were for individual coverage only. The newborn service applied coinsurance to satisfy the individual Out-of-Pocket maximum.

Audit No. 1012 – HSB does not agree with CTI conclusion. Per the 2022 MPD it states that this service is a $25 copay. See information below outlined from the 2022 MPD.

Page 42
Alcohol and Substance-Abuse Treatment
Intensive Outpatient Treatment Program: Copay was reduced to $25 Copay per Visit.
Outpatient Treatment: Copay was reduced to $25 Copay per Visit.

Audit No. 1026 – HSB does agree with CTI conclusion. The outpatient surgery copay is $350.

Audit No. 1041 – HSB does not agree with CTI conclusion. The member did meet the individual In-network deductible of $1,750 on this claim. The member has *employee only coverage* effective 07/01/2017.

Audit No. 1113 – HSB does agree with CTI conclusion. Per the 2022 MPD routine hearing exam is covered under the plan.

Audit No. 1121 – HSB does not agree with CTI conclusion. Eligibility file feed issue from Benefit Focus that terminated the coverage for this member retroactively to 01/01/2022. The claim was adjudicated and denied for no coverage based on the eligibility provided at that time. Claim was reconsidered after resolution of the issue. There is no outstanding underpayment on this account.

Audit No. 1037 – HSB does agree with CTI conclusion. Original claim was received and denied for accident details. The claim was reconsidered, and the analyst did not transfer the original Aetna pricing on reconsideration in error.

Audit No. 1141 – HSB does not agree with CTI conclusion. The patient went to the emergency room on 03/21/2022. The patient was transferred by Intermountain Life Flight to another facility for emergency surgery and was admitted as inpatient. The Low Deductible 2022 MPD does specify the following language as outlined below.

> Precertification is not required for medically necessary emergency services when a medical condition that manifests itself by symptoms of such sufficient severity that a prudent person would believe that the absence of immediate medical attention could result in:
> • Serious jeopardy to the health of the participant.
> • Serious jeopardy to the health of an unborn child.
> • Serious impairment of a bodily function; or
> • Serious dysfunction of any bodily organ or part.

The Plan further distinguishes the difference between Air/Flight Schedule Inter-Facility Transfer and Emergency Air Ambulance on page 41. Emergency air ambulance does not require prior authorization.

Audit No. 2042 – HSB does not agree with CTI conclusion. Services were rendered for tooth number 18. Tooth number 18 is the lower left mandibular and a second molar. The services billed were D2950 Core Build Up and D2740 Crown – Porcelain/Ceramic Substrate. HSB does not apply the dental alternate benefit provision per PEBP's directive.

Observation:

Audit Number 1073 – The claim was received and submitted for Aetna pricing. Once the pricing was received the claim was then submitted for Bill Review audit to verify services were billed appropriately. Once the claim did go through the workflow then the claim was processed and sent to management for review and to release the claim for payment.

Audit Number 1128 – Routine Ultrasounds, two routine per pregnancy are allowed and two routine ultrasounds were paid on this account. This is a different member from Audit Number 1137.

Audit Number 1137 – Routine Ultrasounds, two routine per pregnancy are allowed and two routine ultrasounds were paid on this account (11613707 and 11852973). Claim 11734406 did take coinsurance. This is a different member from Audit Number 1128.

Audit Number 2013 – Dental procedure D2391 is paid as a Basic Service as outlined in the Dental MPD.

RECOMMENDATIONS:

1. HealthSCOPE Benefits does review the valid financial errors from each quarterly audit. The errors are reviewed with the claims management team in order to identify if there are system programming updates necessary or additional examiner training for claims processing.
2. HealthSCOPE Benefits does review the focused audit error from each quarterly audit. The errors are reviewed with the claims management team in order to identify if there are system programming updates necessary or additional examiner training for claims processing.
3. The administrator is taking a pro-active approach to adjust claims if necessary due to plan changes, benefit calculations or other types of claim adjustments.
4. Client directive was for the member to retain the credit for any cost share assessed on a medical claim in the event of a third-party settlement.
5. The subrogation vendor does provide the client with quarterly reports. HSB would like to ask CTI for additional detail regarding the recovery analysis and how the 10% was calculated.

Thank you,

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

CLAIM TECHNOLOGIES
INCORPORATED

100 Court Avenue – Suite 306 • Des Moines, IA 50309
(515) 244-7322 • claimtechnologies.com

7.

7. Acceptance of Biennial Compliance Report including possible action on, but not limited to, the following items:

(Laura Rich, Executive Officer) (**For Possible Action**)

7.1 Mental Health Parity

7.2 Excepted Benefits

STEVE SISOLAK
Governor

STATE OF NEVADA
PUBLIC EMPLOYEES' BENEFITS PROGRAM
901 S. Stewart Street, Suite 1001 | Carson City, Nevada 89701
Telephone 775-684-7000 | 702-486-3100 | 1-800-326-5496
www.pebp.state.nv.us

LAURA RICH
Executive Officer

LAURA FREED
Board Chair

AGENDA ITEM

[X] Action Item
[ ] Information Only

Date: December 5, 2022

Item Number: VII

Title: Biennial Compliance Report

SUMMARY

NRS 287.0425 requires PEBP to conduct a biennial review of the program to determine whether the program complies with federal and state laws relating to taxes and employee benefits. The review must be conducted by an attorney who specializes in employee benefits. PEBP enlisted the consulting services of Segal and their legal counsel to perform a thorough review and assessment of the PEBP program.

REPORT

COMPLIANCE REPORT

See Attachment A

PEBP RESPONSE

FINDING	PEBP RESPONSE
Mental Health Parity and Addiction Equity Act – MHPAEA (refer to section 3)	PEBP accepts this finding and will take action to ensure MHPAEA compliance. PEBP understands that to accomplish this, the program has the following options: • Opt-out – this allows the program to continue offering equal treatment of mental health and substance abuse disorders while eliminating the administratively burdensome federal requirements.

	• Continue to Opt-in (default) – PEBP will have to complete the following on an annual basis: 1. Review current financial requirements and quantitative treatment limitations (QTLs) described in the plan document applicable to mental health and substance use disorder benefits as compared to medical/surgical benefits 2. Review nonquantitative treatment limitations (NQTLs) under the plan both as written as well as applied in operation 3. Have a documented comparative analysis regarding how any NQTLs that apply to mental health/substance use disorder are applied as compared to when applied to medical/surgical benefits. 4. Collect information from appropriate benefit administrators; medical, mental health, pharmacy, and utilization management
Excepted Benefits – Dental (refer to section 4)	PEBP accepts this finding and will take action to ensure compliance with the Affordable Care Act (ACA). PEBP understands that to accomplish this, the program has the following options: • Unbundle dental by allowing members to opt-out of dental coverage. This move will ensure it meets the requirements of an "excepted benefit". • Administratively unbundle dental by securing a separate TPA to process dental claims. This action will ensure it meets the requirements of an "excepted benefit". • Extend ACA required pediatric dental essential health benefit by eliminating the dental annual maximum for children under the age of 19. This action will not result in dental being considered an excepted benefit but will instead allow PEBP to be in compliance with the ACA.
Nondiscrimination Testing	PEBP accepts this finding and will take appropriate action to ensure this is completed.
Summary of Benefits and Coverage language	PEBP has incorporated suggested language.
Preventive Care	PEBP is actively working with vendor partners to incorporate suggested changes to MPD's. The proposed changes will be brought to the Board for approval in January 2023.
Provider Nondiscrimination	PEBP is actively working with vendor partners to incorporate suggested changes to MPD's. The proposed changes will be brought to the Board for approval in January 2023.

Notice of Right to Continue Care	PEBP accepts this finding and will work with the TPA and network to ensure compliance. A process is already in place today but does not meet the requirement because it relies on a request triggered by the member rather than a notification to the member. PEBP will need to determine how to proactively identify members that meet the criteria.
No Surprises Act – Emergency Services	PEBP is actively working with vendor partners to incorporate suggested changes to MPD's. The proposed changes will be brought to the Board for approval in January 2023.
Group Health Plan Transparency Rule 1/1/23	PEBP will work with the TPA to ensure the self-service tools offered through the member portal meet the requirements.
Qualified Medical Child Support Order	PEBP has incorporated suggested language to corresponding MPD.
Dependent Care FSA	PEBP is actively working with vendor partners to incorporate suggested changes to MPD's. The proposed changes will be brought to the Board for approval in January 2023.
Coordination with Health FSA	PEBP is actively working with vendor partners to incorporate suggested changes to MPD's. The proposed changes will be brought to the Board for approval in January 2023.
Sickle Cell Anemia	PEBP is actively working with vendor partners to incorporate suggested changes to MPD's. The proposed changes will be brought to the Board for approval in January 2023.

STAFF RECOMMENDATION:

1. **MPHPEA: Opt-out but continue providing parity for mental health and substance abuse disorders through plan benefit design decisions. This relieves the program of burdensome federal requirements and removes the risk of federal audits and potential program liability.**

2. **Excepted Benefit (dental): Eliminate the annual maximum for pediatric dental. At a relatively low cost projection of $40,000 year, this option is both the least disruptive and least costly for the program.**

Public Employees' Benefits Program

Biennial Compliance Review

November 28, 2022

Segal

Table of Contents

Section 1. Introduction

At the request of the Public Employees' Benefits Program ("PEBP"), Segal performed a review of certain plan documents and administration processes provided by PEBP to enable PEBP to comply with applicable federal and state laws.

Our compliance review is based on documents received, statutes, and regulations as existing and in effect for PEBP's July 1, 2022—June 30, 2023 plan year ("PY 2023"). We requested from PEBP staff members certain documents and answers to specific questions relevant to PEBP. We did not attempt to verify actual administration of PEBP through sampling techniques, discussions with third party vendors/administrators, or otherwise. In addition, we did not perform any claim audits related to PEBP, or consider issues related to payroll practices, workers' compensation, unemployment compensation, classification of employees, or other non-benefits-related aspects of any federal or state law.

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

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

Section 2. Summary of Findings

The following highlights key findings. Please reference Section 3, Section 4, and Appendices A and B for detailed information and recommended actions.

Federal Law

Nondiscrimination Testing

- The IRC (and the regulations) require that certain welfare benefits be provided on a nondiscriminatory basis and also provide tests to assure that plans do not discriminate.
- PEBP should consider nondiscrimination testing of the self-funded medical plan, cafeteria plan and dependent care flexible spending account plan as imposed by Internal Revenue Code Sections 105(h), 125(h) and 129, respectively.
- Based on testing results, plan design changes may be necessary.

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

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

Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008

- Segal is not aware of PEBP performing a quantitative treatment limitations (QTL) or nonquantitative treatment limitations (NQTL) analysis or filed for a federal opt-out. PEBP should determine if it will elect the federal opt and also determine a plan for performing QTL and NQTL analysis.
- Options:
  - PEBP can opt-out on a year to year basis prior to the beginning of each plan year. A detailed discussion of the opt-out process is included in Section 3. This includes:
    - Annual Federal filing
    - Annual participant notice
  - › Can opt-out and still maintain compliance with MHPAEA requirements
    - Can still perform QTL and NQTL analysis and maintain documentation to support compliance

        - Opt-out elections for self-funded non-Federal governmental plans are posted on the CMS website.
    - Current compliance needs as a non-opt-out plan
        - Review all current financial requirements and QTLs described in the plan document applicable to mental health and substance use disorder benefits as compared to medical/surgical benefits
        - Review NQTLs under the plan both as written as well as applied in operation
        - Have a documented comparative analysis regarding how any NQTLs that apply to mental health/substance use disorder are applied as compared to when applied to medical/surgical benefits.
        - Collect information from appropriate benefit administrators; medical, mental health, pharmacy and utilization management.
- Refer to Section 3 for detailed information.

Excepted Benefit – Dental Program

- Our understanding is that the self-funded PPO dental plan is integrated with the medical plan. Participants are not charged a separate contribution for the coverage, and participants cannot opt-out of this coverage after electing medical coverage. The medical and dental benefits are both administered by UMR. Thus, we believe the dental PPO benefit is not an excepted benefit.
- Options:
    - Provide participants the ability to opt-out of dental.
        - A separate employee contribution is not required, nor is it necessary to revise the employee contribution amount. The participant needs to have the opportunity to decline dental coverage.
    - Have a separate contract from the claims administration for any other benefits under the plan.
    - Remove dental benefit plan year maximum for individuals up to age 19.
        - Segal's actuarial team estimates this would increase dental costs by $40,000 annually
- Refer to Section 4 for detailed information.

State Law

- PEBP should review the benefit requirements as listed under NRS 287.04335 – (Compliance with certain provisions required to provide health insurance through plan of self-insurance) that pertain to PEBP and update the Master Plan Documents (MPDs) as necessary.
- PEBP should review the MPDs and confirm the appropriate state laws applicable to PEBP.

Section 3. Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008

Summary

- MHPAEA generally requires parity between medical/surgical and mental health/substance use disorder benefits.
- Under MHPAEA plans are required to comply with parity with respect to both financial requirements and quantitative treatment limitations (QTLs) (such as copayments, coinsurance, day or visit limits) and nonquantitative treatment limitations (NQTLs). NQTLs refer to wide range of medical management techniques such as prior authorization, network admission standards, and fail first policies. MHPAEA also imposes disclosure requirements.
- Congress amended MHPAEA to impose clearer expectations around NQTL compliance. The Consolidated Appropriations Act, 2021 was signed into law on December 27, 2020. The *Strengthening Parity in Mental Health and Substance Use Disorder Benefits* provisions amend the MHPAEA, requiring group health plans to perform and document comparative analyses of the design and application of NQTLs.
- The Act requires group health plans to be prepared to make these comparative analyses available to the Federal Departments of Labor, Health and Human Services (HHS) and Treasury upon request beginning 45 days after the date of enactment (February 10, 2021).
- Additionally, self-funded non-federal governmental plans are permitted to elect an exemption (or opt-out) from certain provisions of federal law, including the parity provisions.
- Segal is not aware of PEBP performing a QTL or NQTL analysis or filed for a federal opt-out. PEBP should determine if it will elect the federal opt and also determine a plan for performing QTL and NQTL analysis.

Background on MHPAEA

Final regulations implementing the Mental Health Parity and Addiction Equity Act (MHPAEA)[1] were issued by the Departments of Health and Human Services, Labor and the Treasury (the Departments) on November 13, 2013. The final rule generally became applicable for plan years beginning on or after July 1, 2014. As a result of additional legislation, the opioid crisis, and Federal

[1] The final rule is available at http://www.gpo.gov/fdsys/pkg/FR-2013-11-13/pdf/2013-27086.pdf. The Departments also released a set of Answers to Frequently Asked Questions on the final rule, available at http://www.dol.gov/ebsa/faqs/faq-aca17.html.

regulatory initiatives, the Departments have worked since then to build a strong MHPAEA compliance assistance and enforcement program.

MHPAEA generally requires parity between medical/surgical (Med/Surg) and mental health/substance use disorder (MH/SUD) benefits. Under MHPAEA plans are required to comply with parity with respect to both financial requirements and quantitative treatment limitations (QTLs) (such as copayments, coinsurance, day or visit limits) and nonquantitative treatment limitations (NQTLs). NQTLs refer to wide range of medical management techniques such as prior authorization, network admission standards, and fail first policies. MHPAEA also imposes disclosure requirements.

The final rule requires plan sponsors to measure parity within six separate benefit classifications: 1) inpatient, in-network; 2) inpatient, out-of-network; 3) outpatient, in-network; 4) outpatient, out-of-network; 5) emergency care; and 6) prescription drugs.

Congress amended MHPAEA to impose clearer expectations around NQTL compliance. The Consolidated Appropriations Act, 2021 was signed into law on December 27, 2020. The *Strengthening Parity in Mental Health and Substance Use Disorder Benefits* provisions amend the MHPAEA, requiring group health plans to perform and document comparative analyses of the design and application of NQTLs. The Act requires group health plans to be prepared to make these comparative analyses available to the Departments upon request beginning 45 days after the date of enactment (February 10, 2021). The law also calls on the Federal Departments of Labor, Health and Human Services (HHS) and Treasury to issue additional implementing guidance. The Departments released Answers to Frequently Asked Questions on April 2, 2021. On January 25, 2022, the Departments issued the 2022 MHPAEA Report to Congress: Realizing Parity, Reducing Stigma, and Raising Awareness, along with the FY 21 MHPAEA enforcement fact sheet. No further guidance has been issued as of the date of this report.

The Department of Health and Human Services actively enforces the MHPAEA requirements with respect to nonfederal governmental plans.

Opt-Out Option

Sponsors of self-funded non-federal governmental plans are able to opt out of the requirements of MHPAEA. Specifically, self-funded non-federal governmental plans are permitted to elect an exemption from certain provisions of federal law, including the parity provisions.[2] By opting out of MHPAEA, PEBP could still choose to cover mental health and/or substance use disorder benefits, and can seek to achieve parity. However, plans that opt out are not subject to Federal oversight of the MHPAEA provisions. Federal audits often raise complex inquiries related to parity compliance and can be a resource intensive process. Further, if PEBP's self-funded plan is found out of compliance with MHPAEA, PEBP would not be liable for any period during which the opt-out was elected.

[2] In addition to MHPAEA, such plans may also opt out of the following federal laws: the Newborns' and Mothers' Health Protection Act (addressing the length of hospital stays for childbirth), the Women's Health and Cancer Rights Act (addressing reconstructive surgery following mastectomies) and Michelle's Law (addressing extended coverage for students on a medically necessary leave of absence).

Opt-Out Requirements

Electronic Filing

Plans generally must file an election with the Centers for Medicare & Medicaid Services (CMS) before the first day of the plan year (however, there are some special timing rules for collectively bargained plans). The filing is submitted electronically through the Non-Federal Governmental Plans Module in the Health Insurance Oversight System (HIOS).[3] Registering with HIOS and submitting the opt-out election can be time consuming so plan sponsors should begin the process well in advance of the applicable plan year. New HIOS users will need to register in the Enterprise Identity Management system through CMS's Enterprise Portal, available at https://portal.cms.gov. More information about the HIOS system can be found in the User Manual, available at https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/HIOS-NonFed-UserManual.pdf.

Notice

Plans must notify each affected enrollee in writing of the election and explain the consequences. HHS has provided model notice language.[4] The plan can provide the notice by prominently including it in the summary plan description or equivalent descriptive materials provided to enrollees at the time of enrollment and annually. Initial notices must be provided prior to the first day of that plan year, and renewal notices must be provided no later than the last day of each plan year. New opt-out submissions must provide a copy of the notice with the election document. Renewal opt-out submissions must certify that notice has been or will be sent.

Detailed Requirements

An opt-out election for the PEBP plan must meet the following requirements:

- Be made in an electronic format;
- Be made in conformance with all the PEBP's rules, including any public hearing requirements;
- Specify the beginning and end dates of the period to which the election is to apply. This period can be either a single specified plan year or the "term of the agreement" for collectively bargained plans;
- Specify the name of the plan and the name and address of the plan administrator, and include the name and telephone number of a person CMS may contact regarding the election;
- State that the plan does not include health insurance coverage, or identify which portion of the plan is not funded through health insurance coverage;
- Specify each requirement from which PEBP elects to exempt the plan;

[3] Additional information is available at https://www.cms.gov/CCIIO/Resources/Files/hipaa_exemption_election_instructions_04072011.html

[4] http://www.cms.gov/CCIIO/Resources/Files/Downloads/model_enrollee_notice_04072011.pdf

- Certify that the person signing the election document, including (if applicable) a third party plan administrator, is legally authorized to do so by PEBP;
- For initial elections, include as an attachment, a copy of the notice to plan enrollees; and
- For renewal elections, certify that the notice has been or will be provided to enrollees.[5]

[5] https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/hipaa-exemption-guidance-7212014.pdf

Section 4. Excepted Benefits – Dental

Summary

Excepted benefits are exempt from several provisions in the Affordable Care Act (ACA), including its market reforms (e.g., restrictions on annual limits, age 26 rule, first-dollar preventive care), the research effectiveness (PCORI) fee, the requirement to provide a Uniform Summary of Benefits and Coverage (SBC), and the requirement to report the cost of the benefits on the employee's W-2. Additionally, "excepted" benefits are exempt from the HIPAA portability rules.

For self-funded benefits, limited scope dental benefits qualify as excepted benefits if they are not an integral part of the group health plan. Benefits are not an integral part of a group health plan (whether the benefits are provided through the same plan, a separate plan, or as the only plan offered to participants) if either:

(A) Participants may decline coverage. For example, a participant may decline coverage if the participant can opt out of the coverage upon request, whether or not there is a participant contribution required for the coverage.

(B) Claims for the benefits are administered under a contract separate from claims administration for any other benefits under the plan. [Source: 45 CFR §146.145(b)(3)(ii))].

Our understanding is that the self-funded PPO dental plan is integrated with the medical plan. Participants are not charged a separate contribution for the coverage, and participants cannot opt-out of this coverage after electing medical coverage. The medical and dental benefits are both administered by UMR. Thus, we believe the dental PPO benefit is not an excepted benefit.

Considerations

Plan changes for the dental benefit to be an "excepted benefit"

1) Allow the dental opt-out. A separate employee contribution is not required, nor is it necessary to revise the employee contribution amount. The participant needs to have the opportunity to decline dental coverage.

2) Confirm the contractual arrangement with UMR.

Plan changes to the dental benefit because it is not an "excepted benefit"

1) Essential Health Benefits under ACA. Under the Affordable Care Act, plans cannot have annual or lifetime maximums on "Essential Health Benefits". One of the ten categories of Essential Health Benefits include pediatric dental services. To address this, a plan design change as highlighted below to the Dental PPO could include the following:

Plan Year Maximum Dental Benefits

The Plan Year maximum dental benefits payable for any individual covered under this Plan *age 19 years and over* is $1,500. The Plan Year maximum dental benefit is combined to include both in-network and out-of-network services. Under no circumstances will the combination of in-network and out-of-network benefit payments exceed the $1,500 Plan Year maximum benefit. This maximum does not include your Deductible or any amounts over Usual and Customary. Benefits paid for eligible preventive dental services do not apply to the annual maximum dental benefit. *There is no Plan Year Maximum on dental benefits for individuals up to age 19.* Segal's actuarial team estimates removing the Plan Year Maximum for individuals up to age 19 would increase dental costs by $40,000 annually.

Appendix A. Summary of Findings - Federal

Description		Findings	Action Required
I. IRS Requirements			
Form W-2	Employers must report the cost of health coverage and Dependent Care Assistance Program and Health Flexible Spending Arrangement (FSA) benefits on an annual Form W-2, along with other information.	PEBP's Eligibility and Enrollment vendor Lifeworks sends the necessary data for reporting on individual employee W-2s to the applicable state employers.	Complete.
Nondiscrimination Testing	The IRC (and the regulations) require that certain welfare benefits be provided on a nondiscriminatory basis and also provide tests to assure that plans do not discriminate. Certain exceptions apply, particularly for collectively bargained plans: • Section 79- Group term life • Section 105(h)- Self-insured health plans • Section 125- Cafeteria plan, including employer and employee HSA contributions • Section 127- Educational assistance (PEBP does not have) • Section 129- Dependent care FSA • Section 137- Adoption assistance (PEBP does not have)	PEBP has not recently performed nondiscrimination testing.	To be in compliance, PEBP should perform ND testing of its plans.

Description		Findings	Action Required
II. ACA (Patient Protection and Affordable Care Act) Requirements			
Summary of Benefits and Coverage	Plans must provide a Summary of Benefits and Coverage (SBC) that accurately summarize key features of the plan, such as covered benefits, cost-sharing provisions and coverage limitations.	PY2023 SBCs provided: • PY2023 CDHP SBC Family • PY2023 CDHP SBC Individual • PY2023 EPO SBC Individual Family • PY2023 HPN HMO SBC • PY2023 LD PPO SBC Family • PY2023 LD PPO SBC Individual SBCs are posted on the PEBP website. SBCs are referenced in the annual Benefits Guide with a statement that the SBCs "are available by logging on to your E-PEBP Portal at www.pebp.state.nv.us or by calling PEBP and requesting a copy be mailed to you."	Segal has provided comments for PEBP review and incorporation as necessary.
Patient-Centered Outcomes Research Institute (PCORI) Fee	Plans and insurers pay fees to fund PCORI, which funds evidence-based research projects with the goal to advance quality of care. Fee is filed with IRS on Form 720. Payment is due 7/31 of calendar year immediately following last day of plan year to which fees apply. Applies through plan years ending before 10/01/29.	PEBP states it has paid the PCORI fee for all medical plans except the HMO. PEBP states that Health Plan of Nevada pays the PCORI fee for the HMO plan.	Complete.

Coverage for children up to age 26	Health plans that provide coverage of dependent children must make coverage available for adult children up to age 26, regardless of the child's student or marital status. Coverage must be provided through the end of the month in which the child turns 26 to meet employer penalty rules. The age 26 mandate requirements do not apply to children who are outside the scope of the definition in Internal Revenue Code section 152(f)(1).	Per the MPD, Dependent children are covered through the end of the month in which they turn 26. With respect to coverage beyond the required children, foster children are not eligible for dependent coverage. Unmarried children under age 19 who are under a legal permanent guardianship may be enrolled as a dependent. To continue coverage after age 19 (to age 26), the child must be unmarried and either reside with the participant or be enrolled as a full-time student at an accredited institution and satisfy certain conditions 1. Is eligible to be claimed as a dependent on the federal income tax return of the participant or his spouse/domestic partner for the preceding calendar year; and 2. Dependent is a grandchild, brother, sister, stepbrother, step-sister, or descendent of such relative. 3. Children covered under legal guardianship are not eligible to continue benefits under the provision of a disabled dependent.	Complete.
90-Day Waiting Period Rule	Plans must cover employees within 90 days of the date on which an employee is otherwise eligible.	MPD states new hire employees are eligible for coverage on the first day of the month concurrent with or following the date of hire.	Complete.
No Rescission	Plans may not rescind coverage retroactively (with limited exceptions).	MPD discusses no retroactive rescission with limited exceptions.	Complete.
Preexisting Condition Exclusions	Plans may not have preexisting condition exclusions or limitations. Hidden preexisting conditions are also prohibited.	MPD states that PPACA group market (insurance) reforms that apply to all grandfathered and non-grandfathered group health plan Benefit Options under the Plan that are not exempt or excepted benefits under Section 2791 of the PHSA, including prohibition of preexisting condition exclusions under PHSA 2704.	Complete.

No annual or lifetime dollar limits on Essential Health Benefits (EHBs)	Plans may not impose an annual or lifetime dollar limitation on EHBs. Plans may adopt a benchmark that excludes a benefit from EHB and have dollar limit on those benefits.	It does not appear that the PEBP plan imposes annual or lifetime dollar limitations on EHBs in the medical plan. However, the dental program appears to be bundled with the medical and contains an annual maximum benefit for children up to age 19. Pediatric dental is an EHB under the ACA. PEBP should adopt a benchmark plan. This includes selecting one of the 51 EHB base-benchmark plans from 2022 applicable in a State or DC, or to one of the 3 FEHBP EHB-base benchmark plans for purposes of justifying any lifetime or annual dollar limits being imposed by the plan.	See Section 4 for discussion regarding dental program status. PEBP should select benchmark plan if annual or lifetime dollar limits will be implemented.

Preventive Care	Non-grandfathered group health plans must provide certain specified preventive health services without cost sharing. Contraceptive care is provided in accordance with recent guidance and that an exceptions process is available for medical necessity exceptions (FAQ 54).	Per the MPD: Preventive Care/Wellness Benefits are covered 100% in-network not subject to the deductible. The CDHP plan covers mammograms – "the first 2-D or 3-D mammogram of the Plan Year is covered at 100% for women aged 40 years and older, regardless of diagnosis, or beginning at age 35 for members with a high-risk of breast cancer. UMR has confirmed the plan "covering the first mammogram of year as routine regardless of diagnosis." If the specific mammogram service is considered preventive it should be covered at 100% and not subject to the deductible. However, if the specific mammogram service is not considered preventive, then the service is subject to the deductible. To have a CDHP that is an IRS qualified High Deductible Health Plan, and to be eligible for an HSA, an individual can have no other coverage (other than preventive care) before the CDHP deductible is satisfied. UMR and ESI confirmed that contraceptive care is provided in accordance with recent guidance (FAQ 54) and that an exceptions process is available for medical necessity exceptions.	The CDHP MPD and administration should clarify when the mammogram service is considered preventive versus not preventive. If the mammogram is preventive it is not subject to the deductible. If the mammogram is not preventive it is subject to the deductible.
Cost-Sharing Rules **Out-of-Pocket Maximums**	Non-grandfathered plans must have limits on out-of-pocket cost sharing. The cost sharing limits only apply to a plan's essential health benefits (EHB). 2023 limits:$9,100 for an individual plan and $18,200 for a family plan before marketplace subsidies; maximum deductible is the same as the out-of-pocket maximum.	Per the MPD: OOP maximums: HDHP - $4,000/$8,000 (in-network) Low PPO - $4,000/$8,000 (in-network) EPO - $5,000/$10,000 (in-network)	Complete.

Clinical Trials	Non-grandfathered plans must cover routine patient costs for items and services furnished in connection with participation in an approved clinical trial for cancer or other life-threatening conditions.	Per the MPD – "The routine medical treatment costs, including all items and services that are otherwise generally available to Plan participants, received as part of a clinical trial or study, may be covered."	Complete.
Provider Nondiscrimination	Plans cannot discriminate against a health care provider acting within the scope of his or her license.	The MPD has reference to provider non-discrimination under PHSA 2706 in the Compliance with Federal Group Health Plan Benefits and Coverage Mandates section. Additionally, the definition of Health Care Practitioner includes a **"**physician, behavioral health practitioner, chiropractor, dentist, nurse, nurse practitioner, physician assistant, podiatrist, or occupational, physical, respiratory or speech therapist or speech pathologist, master's prepared audiologist, optometrist, optician for vision Plan benefits, oriental medicine doctor for acupuncture or Christian Science Practitioner, who is legally licensed and/or legally authorized to practice or provide certain health care services under the laws of the state or jurisdiction where the services are rendered: and acts within the scope of his or her license and/or scope of practice."	PEBP to review physician references in MPD and revise to Health Care Practitioner if appropriate.

Excepted Benefits	Excepted benefits are exempt from numerous provisions in the Affordable Care Act (ACA), including its market reforms (e.g., restrictions on annual limits, age 26 rule, first-dollar preventive care), the research effectiveness (PCORI) fee, the requirement to provide a Uniform Summary of Benefits and Coverage (SBC), and the requirement to report the cost of the benefits on the employee's W-2. Additionally, "excepted" benefits are exempt from the HIPAA portability rules. Limited-scope dental benefits on a self-funded basis qualify as excepted benefits if they are not an integral part of a group health plan. This is met if one of the following conditions is satisfied: • Participants may decline coverage (for example, participants may opt out of the coverage upon request); or • Claims for benefits are administered under a contract separate from claims administration for any other benefits under the plan.	Per the Aon compliance report of 2020: "Based on documentation reviewed, self-insured dental coverage does not appear to be an excepted benefit as it is: (1) bundled with medical coverage for active employees; and (2) the claims administrator for both dental and medical coverage is HealthSCOPE. PEBP discussed with legal counsel and determined that the dental plan is an excepted benefit." For PY 2023 - Active employees cannot independently elect dental coverage without also enrolling in medical coverage. Dental claims are not administered under a separate contract from medical claims. UMR is the TPA for both the medical and dental plans.	The dental benefits do not appear to qualify as limited scope excepted benefits. This has been confirmed with PEBP's legal counsel. See Section 4 for further discussion on the dental benefits.
Employer Shared Responsibility Penalty **I.R.C. Sections 4980H(a) and 4980H(b).**	Employer responsible for counting hours and determining who is a full-time employee eligible for coverage. Medical coverage offered must meet minimum value standard and be affordable (monthly contribution amount for employee-only coverage in the lowest cost plan is below Federal Poverty Line) Employers classified as applicable large employers (ALEs) generally those with 50 or more full-time employees and full-time equivalent employees—may face excise tax penalties if they do not offer health coverage or do not offer coverage that meets certain minimum value and affordability standards.	Employees working 80 hours a month are defined as full-time. The employers may have received the Employer Shared Responsibility Payment notice from the IRS. No concerns reported.	Complete.
Minimum Value	Coverage must meet minimum value standard (60 percent)	SBCs state the plans meet minimum value.	Complete.

Affordability	Employer-offered coverage is considered affordable for an employee if the employee's required premium contribution (if any) is no more than 9.5% of that employee's household income (indexed annually) (9.83% for 2021, 9.61% for 2022, and 9.12% for 2023). For this test, look at the employee's cost of enrolling in the least expensive self-only coverage offered by the employer that provides minimum value, even if the employee elects more expensive coverage or coverage that does not provide minimum value. For the rate of pay safe harbor, for an hourly employee, the employer uses an assumed rate of 130 hours per calendar month multiplied by an hourly employee's rate of pay, regardless of whether the employee actually works more or less than 130 hours during a calendar month. An offer of coverage to a non-hourly employee is treated as affordable for a calendar month if the employee's required contribution for the calendar month for the lowest-cost self-only coverage that provides minimum value does not exceed 9.5% (as indexed) of the employee's monthly salary, as of the first day of the coverage period (instead of 130 multiplied by the hourly rate of pay); provided that if the monthly salary is reduced, including due to a reduction in work hours, the safe harbor is not available.	PEBP uses the state of Nevada minimum wage for affordability. (Rate of Pay). Nevada minimum wage: $9.50 for employers offering qualifying health coverage. ($9.50 x 130 hours) = $1,235. $1,235 x 9.61% = $118.68 The lowest cost employee only contributions per month is $46.96 for the CDHP PPO plan.	Complete.
Form 1095-B and Form 1094-B	Group health plans as well as employers that are not large employers, that offer self-insured minimum essential coverage must provide participants with Form 1095-B, documenting enrollment in plan coverage, and file all such forms with IRS (along with Form 1094-B transmittal). Forms for the previous reporting year are generally due to participants by 1/31 (extended to 3/2/22 for 2021 reporting) and filed with IRS by 3/31 if filed electronically (by 2/ 28 for paper filing). Employers filing more than 250 reporting forms are required to file electronically. Employers can use IRS Form 8809 for an automatic 30-day extension.	PEBP works with central payroll and specific 1095 software. PEBP sends out the 1095-B and 1094-B forms when necessary, and files with the IRS. This is administered in house using 1099 Pro. No concerns reported.	Complete.

Form 1095-C and Form 1094-C	Large employers (50 or more full-time employees, including equivalents), must provide full-time employees with Form 1095-C, documenting offer of coverage, and file all such forms with IRS (along with Form 1094-C transmittal). Forms for the previous reporting year are generally due to employees by 1/31 (extended to 3/2/22 for 2021 reporting) and filed with IRS by 3/31 if filed electronically (or 2/28 for paper filing). Employers filing more than 250 reporting forms are required to file electronically. Employers use IRS Form 8809 for an automatic 30-day extension of time.	PEBP works with central payroll and specific 1095 software. PEBP sends out the 1095-C and 1094-C forms, and files with the IRS. This is administered in house using 1099 Pro. No concerns reported.	Complete.
Notice of Choice of Providers (Patient Protection)	Group health plans that require a designation of a primary care provider (PCP) must provide the following disclosure: notice of the right to choose a PCP, pediatrician, or ob/gyn in SPD or other descriptions of benefits. Effective for plan years beginning on and after January 1, 2022, the No Surprises Act recodified the patient protections regarding choice of health care professional and extended to grandfathered health plans.	The Plan does not require a designation of a primary care physician.	Complete.
Notice of Coverage Options in the ACA Marketplace	Employer subject to the Fair Labor Standards Act required to provide new employees within 14 days of hire with notice about health insurance marketplaces, their options for health coverage, and information about premium tax credits, regardless of the employee's plan enrollment status or of part-time or full-time status. Note – this is an employer requirement, not a health plan requirement.	Included within the link here: Mandatory Notices (state.nv.us)	Complete. This is an employer requirement. PEBP does not distribute this notice on behalf of the employers, but includes this in its Mandatory Notices on its website.
Notice of Grandfathered Status	A grandfathered plan must include a statement to that effect in any and all materials describing benefits under the plan.	N/A. The plan is not grandfathered.	N/A.
Notice of Rescission	Advance written notice of retroactive termination of coverage due to fraud or intentional misrepresentation of material facts by participant must be provided to the participant at least 30 days before coverage may be retroactively terminated.	The MPD defines rescission and the Plan has not rescinded coverage retroactively.	Complete.

Section 1557 Notice (or Statement) of Nondiscrimination with Taglines	ACA §1557 prohibits discrimination on the basis of race, color, national origin, disability, age, and sex in health plans that receive federal financial assistance or are administered by HHS such as Medicare Part D. Covered entities must provide participants/beneficiaries with a notice conveying information about §1557 nondiscrimination requirements in significant publications, communications, websites, and physical locations. HHS' 2020 Rule repealed the requirement that covered entities provide taglines (short statements advising language services are available in the state's top 15 languages) in all significant communications. However, covered entities must continue to provide taglines whenever such taglines are necessary to ensure meaningful access by Limited-English Proficient (LEP) individuals to a covered program or activity. New proposed regulations may modify this if finalized.	MPD includes Section 1557 Notice. While not currently required, it is expected that the Section 1557 notice may be reinstated within 2023.	Complete. PEBP may want to keep the notice within the MPD while awaiting future guidance.

Description		Findings	Action Required
III. COBRA			
Initial or General Rights Notice	Provides basic information regarding COBRA and the rights and responsibilities of qualified beneficiaries to ensure they have the information they need before the occurrence of a qualifying event.	General notice provided.	Complete.
COBRA Continuation Coverage Election Notice	Plans must send notices to qualified beneficiaries after a qualifying event. Employers have to alert the COBRA administrator within 30 days of terminating a worker. Once the COBRA\ administrator is notified, it has 14 days to send a notice to qualified beneficiary(ies). However, if the employer administers COBRA, the deadline to send the notice is 14 days.	Election notice provided.	Complete.
Notice of Unavailability of COBRA	Individuals who have sent the plan a qualifying event notice must be notified about why COBRA is not available. The notice must be provided within 14 days after the plan administrator is notified of the qualifying event.	Notice of Unavailability provided.	Complete.
Notice of Termination of COBRA	Qualified beneficiaries must be notified about early termination of COBRA. The notice is required as soon as practicable after the plan's determination that COBRA can be terminated prior to the applicable 18-, 36-, or 29-month period.	Notice of Termination example provided.	Complete.
Notice of Insufficient Payment of COBRA Premium	Qualified beneficiaries must be notified that a COBRA payment was less than the correct amount required before terminating COBRA. Plan must provide a reasonable period to cure the deficiency before terminating COBRA. A 30-day grace period is considered to be a reasonable period.	Notice of Late payment provided. A premium payment shortfall is insignificant if it is less than or equal to the lesser of (a) $50; or (b) 10% of the COBRA premium required by the plan. Payment of such an amount will be deemed to satisfy the COBRA payment requirement unless the plan notifies the qualified beneficiary of the amount of the deficiency and grants a reasonable period of time for payment of the deficiency.	If needed, provide a notice of insufficient payment.

Description		Findings	Action Required
IV. Health Insurance Portability and Accountability Act (HIPAA)			
HIPAA Notice of Special Enrollment Rights	HIPAA requires group health plans to provide notice of special enrollment opportunities outside of the plans' regular enrollment periods in the following situations: • A loss of eligibility for other health coverage; • Termination of eligibility for Medicaid or a state Children's Health Insurance Program (CHIP); • The acquisition of a new spouse or dependent by marriage, birth, adoption or placement for adoption; and • Becoming eligible for a premium assistance subsidy under Medicaid or a state CHIP. Notice must be provided on or before the date the participant is offered the opportunity to enroll in the plan.	Provided in Enrollment and Eligibility MPD under "HIPAA Special Enrollment Notice" and within Annual Notices. The Annual Notices were emailed to all Active and Retired PEBP members October 27, 2022.	Complete.
HIPAA Prohibition Against Discrimination on account of Health Factor	HIPAA also prohibits discrimination against employees and their dependents based on any health factors they may have, including prior medical conditions, previous claims experience, and genetic information. Cannot be denied eligibility or ongoing eligibility to enroll in the plan because of a health factor; Cannot be charged a greater amount for coverage than an individual in a similar situation on account of any health factor.	MPD states PPACA group market (insurance) reforms that apply to all grandfathered and non-grandfathered group health plan Benefit Options under the Plan that are not exempt or excepted benefits under Section 2791 of the PHSA including: • Prohibiting discrimination against Participants and beneficiaries based on a health factor under PHSA 2705.	Complete.
Wellness Incentives	Plans that provide wellness incentives must meet 5-factor test, including 30 percent test and reasonable accommodations standards.	N/A. PEBP does not have a wellness program.	N/A.
Plan Sponsor Certification of Group Health Plan HIPAA Compliance	HIPAA requires plan sponsor to certify understanding of and compliance with certain HIPAA requirements before the plan may disclose PHI to the plan sponsor or its authorized representatives.	Section 7.2 of the Section 125 H&W Benefits Plan Document. "HIPAA Privacy and Security of Protected Health Information". "The Plan Sponsor certifies that this Article incorporates the provisions set forth in 45 CFR 164.504(f)(2)(ii) and the Plan Sponsor agrees to such provisions in accordance with 45 CFR Section 164.504(f)(2)(ii)"	Complete.

HIPAA Notice of Privacy Practices (NPP)	A notice to participants describing their rights, plan's legal duties with respect to Protected Health Information (PHI) and the plan's uses and disclosures of PHI must be included on the plan's website and provided upon enrollment. In general, any material revision to the notice must be provided within 60 days of the revisions. If a plan posts the revision on its website by the revision's effective date, then individual notices can be sent at the time of the next annual mailing. The notice must also be provided upon request.	The Privacy Notice – Disclosure and Access to Medical Information is located on the PEBP website (Mandatory Notices (state.nv.us)	Complete.
HIPAA Notice of Privacy Practices Reminder	Covered individuals must be notified at least once every three years of the availability of the NPP. Not required if the NPP is provided annually.	The Privacy Notice – Disclosure and Access to Medical Information is located on the PEBP website (Mandatory Notices (state.nv.us). The reminder notice is included in the Annual Notices were emailed to all Active and Retired PEBP members October 27, 2022.	Complete.
HIPAA Privacy Policy and Procedures	A covered entity must develop and implement written privacy policies and procedures that are consistent with the HIPAA Privacy Rule.	Privacy and Security of Protected Health Information (PHI) policy – updated 08.10.2021	Complete.
HIPAA Security Policy and Procedures	A covered entity must adopt reasonable and appropriate policies and procedures to comply with the provisions of the Security Rule.	Privacy and Security of Protected Health Information (PHI) policy – updated 08.10.2021	Complete.
HIPAA Security Risk Analysis	HIPAA Security Rule requires covered entities to perform risk analysis as part of their security management processes, risk analysis should be an ongoing process, in which a covered entity regularly reviews its records to track access to e-PHI and detect security incidents, periodically evaluates the effectiveness of security measures put in place, and regularly reevaluates potential risks to e-PHI.	PEBP has conducted a security risk assessment through the use of the Security Risk Assessment Tool as provided through healthit.gov. We recommend supplementing this assessment with an additional review addressing issues such as how information is identified as PHI, when is PHI encrypted or destroyed for purposes of rendering it secure under the HITECH Act, and providing details about items such as reporting events, training, and how the plan assures business associate contracts are in place.	Complete. .
HIPAA Training	A covered entity must train all workforce members on its privacy and security policies and procedures.	HIPAA Privacy and Data Security Training – conducted August 2021. PEBP keeps training attestations.	Complete.

Breach of Unsecured PHI	Plan must file notice with HHS (and prominent media outlets) within 60 days of discovery if the breach affects 500 or more individuals. Plan must file annually with HHS if the breach affects fewer than 500 individuals, no later than 60 days after the end of calendar year.	Privacy and Security of Protected Health Information (PHI) policy – updated 08.10.2021	Follow breach notification procedures if a breach occurs.
Business Associate Agreements (BAA)	A BAA is a required agreement between the covered entity (i.e., the plan) and a vendor, TPA, or individual that performs functions or activities on behalf of, or provides a service to, the plan that involves access to Protected Health Information (PHI) under the plan.		PEBP should continue to inventory current BAAs.

Description		Findings	Action Required
V. Medicare			
Medicare Part D Notices	Participants and beneficiaries eligible for Part D must be notified in writing, before October 15 each year, whether a plan's prescription drug coverage is, on average, at least as good as standard coverage under Medicare Part D.	PEBP mailed and emailed the Medicare Part D notices July 2022.	Complete
Creditable Coverage Disclosure to CMS	Provide written disclosure to CMS stating whether the plan's prescription drug coverage is, on average, at least as good as standard Medicare Part D coverage is due 60 days after beginning of the plan year (generally March 1 for a calendar year plan). Plan must also provide within 30 days of the plan's termination of drug coverage or change in creditable status of the plan. No penalty.	PEBP submits on CMS website every year.	Complete.
Retiree Drug Subsidy Application	RDS application (along with retiree list and attestation) is due at least 90 days prior to the start of the plan year (typically October 3 for a calendar year plan, unless extended for 30 days until November 2). Reconciliation must be completed within 15 months after the end of the applicable plan year, unless 30-day extension.	PEBP requests info from ESI and Health Plan NV and report and reconcile this information.	Complete.

Medicare Secondary Payer (MSP) Data Reporting	Plans (including HRAs with annual benefit levels of $5,000 or more as of the beginning of the plan year) must report to CMS medical and prescription drug coverage (since 2020) information about participants and beneficiaries who are also Medicare enrollees. Plans should be registered with CMS and reporting electronically on a quarterly basis.	UMR has stated that they "submits the quarterly Mandatory Insurer Reporting for Group Health Plans (also known as CMS Section 111 or MSP) files for our customers with medical administration. The regulations do require pharmacy benefit information to be reported on a quarterly basis. For groups that are UMR/OptumRx integrated customers we include the pharmacy benefit information in our MSP files that are submitted on a quarterly basis. For groups that are direct contracts with OptumRx, OptumRx files with CMS. For groups that direct contract with other PBMs, the PBM would be responsible for reporting." PEBP confirmed the ESI contract was amended to reflect this requirement is met.	Complete.

Description		Findings	Action Required
VI. Transparency – No Surprises Act			
Disclosure Notice Regarding Patient Protections Against Surprise Billing	Effective for plan years beginning on or after January 1, 2022, Section 104 of the No Surprises Act requires group health plans and health insurance issuers offering group or individual health insurance coverage to make publicly available, post on a public website of the plan or issuer, and include on each explanation of benefits for an item or service with respect to which the requirements of the No Surprises Act apply.	PEBP has posted this notice on its website.	Complete.
Notice of Right to Continue Care	Under the No Surprises Act, beginning January 1, 2022, group health plans must notify each individual who is a "continuing care patient" at the time of a provider or facility network contract termination and permit the individual to continue transitional care from the provider or facility at in-network rates.	UMR has confirmed that under the NSA the plan must permit the Continuing Care Patient to elect to continue to have benefits provided under the plan/coverage under the same terms and conditions as they would have been covered had no change occurred beginning on the date the notice was provided and ending either 90 days later or the date on which the patient is no longer undergoing continuing care by that provider/facility, whichever is earlier. Patient must meet the definition of continuing care patient based on specific conditions to continue care.	PEBP should confirm with UMR how this process will work for a Continuing Care Patient and confirm how the participant will be notified about qualifying as a Continuing Care Patient..
Group Health Plan Transparency Rule for Public Disclosure (Machine-Readable Files)	Effective 1/1/2022. non-grandfathered plans must post on public website the following information online using three machine-readable files, which must be updated monthly: 1. In-network rates 2. Out-of-network allowed amounts and 3. Prescription drug negotiated rates Enforcement delayed until future rulemaking for prescription drug negotiated rate file.	Provided on website: https://pebp.state.nv.us/plans/mandatory-notices/ including the link to the machine-readable files provided by URL: https://transparency-in-coverage.uhc.com/	Complete.
Insurance Identification Cards	For plan years beginning on and after 1/1/2022, Plans must include plan deductibles, out-of-pocket (OOP) maximums and consumer assistance contact information (phone number and	PEBP has confirmed that UMR has updated the identification cards.	Complete.

	website) in clear writing on any physical or electronic plan or insurance identification card.		
Prescription Drug Reporting (RxDC Report)	Under Section 204 (of Title II, Division BB) of the Consolidated Appropriations Act, 2021 (CAA), insurance companies and employer-based health plans must submit information about prescription drugs and health care spending.		PEBP should continue to coordinate with its medical and PBM vendors to confirm filing status due 12.27.2022 and ongoing.
No Surprises Act: Emergency Services	Effective for plan years beginning 1/1/2022, Plans must cover emergency services at non-participating facility, services/items provided by non-participating provider at a participating facility, or non-participating provider air ambulance services with the same participant cost-sharing whether the services are from a participating or non-participating provider or facility. Providers and facilities are banned from balance billing.	Per nv.doi.gov: The new federal Surprise Billing law covers everything protected under current Nevada state law and more. In situations where the state has stricter statutes to protect consumers, or rules in place determining the rate of compensation due to the out-of-network providers, the federal law defers to the state law. This would be the case for out-of-network providers that were previously in-network within the last 24 months. In this situation Nevada law specifies the formula for computing the rate of compensation.	PEBP could consider language enhancements in MPD to highlight when balance billing is not permitted.
Group Health Plan Transparency Rule (Internet-Based Price Comparison Tool)	For plan years beginning on or after 1/1/2023, for 500 items and services (on or after 1/1/2024 for all covered items and services) non-grandfathered plans must provide cost-sharing information and rate information that is accurate at the time of the request to participants on a searchable, internet-based, self-service tool; and must provide a notice when the tool is used.		PEBP should determine how its service providers will meet this requirement.

Description		Findings	Action Required
VII. Families First Coronavirus Response Act ("FFCRA"), as amended by the Coronavirus Aid, Relief, and Economic Security Act ("CARES ACT") and IRS Notices 2020-29, 2020-33, 2021-15			
COVID-19 related testing and related services	Effective March 18, all group health plans — whether self-insured, fully insured, grandfathered or non-grandfathered — must cover COVID-19 testing and related services without cost sharing. This coverage mandate applies for the duration of the public health emergency,	Per the MPD, the "Plan shall comply with the CARES Act to the extent it applies. The Plan shall cover COVID-19 diagnostic testing and certain COVID-19 testing related items and services without cost sharing (deductibles, coinsurance, copayments), prior authorization, or other medical management requirements. This coverage includes the COVID-19 diagnostic test and COVID-19 diagnostic testing-related visit to order or administer the test. A testing related visit may occur in a physician's office, via telehealth, in an urgent care center or emergency room. In-network and Out-of-Network costing sharing will not apply. To the extent it applies, this Plan will cover qualifying items, services, or immunizations intended to prevent or mitigate COVID-19 (qualifying coronavirus preventive services) without imposing cost sharing."	Complete.
OTC Medical Product reimbursable.	OTC Medications and Menstrual Care Products qualifying medical expenses after 12/31/2019. No amendment needed if plan simply refers to expenses allowed under Code Section (Section 213(d)).	Per the MPD, effective January 1, 2020, "individuals may use HSAs, FSAs, and HRAs to purchase over-the-counter medicines without a prescription, and to purchase menstrual care products."	Complete.
Diagnostic testing with no cost-sharing /payment of testing to provider required.	CARES Act provides that health plans must cover an in vitro diagnostic test and the administration of such a test, for the detection of COVID-19, without any cost sharing (including deductibles, copayments, and coinsurance) requirements or prior authorization or other medical management requirements, where (a) the test is approved, cleared or authorized by the FDA; (b) the test developer has requested emergency use authorization or fails to do so within a reasonable time; or (c) the test is developed in and authorized by a State that has notified the Department of HHS of its intention to review tests intended to diagnose COVID-19.	Per the MPD, the Plan shall cover COVID-19 diagnostic testing and certain COVID-19 testing related items and services without cost sharing (deductibles, coinsurance, copayments), prior authorization, or other medical management requirements.	Complete.

COVID-19 vaccine covered with no cost-sharing	CARES Act requires non-grandfathered group health plans and issuers to cover a COVID-19 vaccine or other preventive service — once available — without cost sharing upon the recommendation from the United States Preventive Services Task Force (USPSTF) or the Centers for Disease Control and Prevention (CDC).	Per the MPD, the "Plan will cover qualifying items, services, or immunizations intended to prevent or mitigate COVID-19 (qualifying coronavirus preventive services) without imposing cost sharing. To be covered, the services must be either (i) an evidenced-based item or service that has a "A" or "B" rating in the current recommendations from the United States Preventive Services Task Force, or (ii) an immunization with a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.	Complete.
Telehealth and Health Savings Accounts (HSAs)	CARES Act provides a temporary safe harbor allowing high-deductible health plans (HDHPs) to cover telehealth and other remote care services before participants have met their deductibles. The act also provides that having telehealth coverage outside of an HDHP will not make an individual ineligible for HSA contributions. This expansion of permissible telehealth for individuals with HDHPs and HSAs applies to all types of care, not just COVID-19 care. These changes took effect March 27, 2020, but only apply for plan years beginning on or before December 31, 2021. For calendar-year plans the temporary changes expire December. 31, 2021, but are renewed for the period April 1, 2022 – December 31, 2022.	The CDHP MPD highlights the plan will pay for telehealth services after the deductible is met.	Complete.
COVID-19 relief for HDHPs	CARES Act provides that a plan shall not fail to be treated as a high deductible health plan (HDHP) by reason of failing to have a deductible for telehealth and other remote care services IRS Notice 2020-15 allows HDHPs to cover COVID-19 testing and treatment before individuals have met their deductibles, without affecting eligibility for HSA contributions.	The CDHP MPD states that COVID-19 testing, COVID-19 testing related visits, COVID-19 Preventive Health Services, Laboratory Services related to COVID-19 will be paid at 100% of the Maximum Allowable Charge, both, In-and Out-of-Network during the national public health emergency period.	Complete.

Description		Findings	Action Required
VIII. Other Laws Affecting Group Health Plans			
Age Discrimination in Employment Act of 1967	The Older Workers Benefit Protection Act of 1990 (OWBPA) amended the ADEA to specifically prohibit employers from denying benefits to older employees. Only in limited circumstances (e.g., life insurance), an employer may be permitted to reduce benefits based on age, as long as the cost of providing the reduced benefits to older workers is the same as the cost of providing benefits to younger workers. Employers are permitted to coordinate retiree health benefit plans with eligibility for Medicare or a comparable state-sponsored health benefit.	PEBP does not reduce benefits based on age.	Complete.
Americans with Disabilities Act of 1990, as amended ("ADA")	Under the ADA, workers with disabilities must have equal access to all benefits and privileges of employment that are available to similarly situated employees without disabilities. Prohibits exclusion from participation or denial of benefits in "services, programs or activities of a public entity." Website accessibility is a current litigation risk under the ADA.	Per the MPD - To the extent applicable, the Plan shall comply with the Americans with Disability Act (ADA), including the requirement that any condition that substantially limits a major life activity will be considered a disability, even if the individual can offset or compensate for the disability with the mitigating measures such as hearing aids or artificial limbs. Website pages regarding ADA accessibility: Americans With Disabilities Act (nv.gov) Accessibility Information (nv.gov)	Complete.
Family and Medical Leave Act of 1993 ("FMLA")	Employers must continue an employee's insurance coverage under the company's group health plan during FMLA leave, just as if the employee had worked continuously rather than out on leave. The employer may require employees on FMLA leave to pay their share of premium payments in any of the following ways: (1) Due at the same time as it would be made if by payroll deduction; (2) Due on the same schedule as payments are made under COBRA; (3) Prepaid pursuant to a cafeteria plan at the employee's option; (4) Using employer's existing rules for payment by employees on leave without pay provided that such rules do not require payment prior to the commencement of the leave of the premiums that will become due during a	Per the Eligibility and Enrollment MPD: "During FMLA leave, the employer must maintain the employee's health coverage under any employer group health plan on the same terms as if the employee had continued to work, regardless of whether the employee is on paid or unpaid leave." Per the Active Wrap plan document: "If a Participant fails to pay Participant Contributions during a Leave of Absence and the Plan Administrator in its discretion continues coverage under any Component Benefit in effect during such Leave of Absence, any unpaid Participant	Complete.

	period of unpaid FMLA leave or payment of higher premiums than if the employee had continued to work instead of taking leave; or, (5) Another system voluntarily agreed to between the employer and the employee, which may include prepayment of premiums (e.g., through increased payroll deductions when the need for the FMLA leave is foreseeable).	Contributions during such period will be collected in arrears through payroll deductions through the Cafeteria Plan, or as otherwise directed by the Plan Administrator upon the Participant's return to employment with the Employer or expiration of the Participant's Leave of Absence, as applicable."	
Genetic Information Nondiscrimination Act of 2008 ("GINA")	• Group health plans cannot adjust premiums or contribution amounts for a plan, or a group of similarly situated individuals under the plan, based on genetic information of one or more individuals in the group. (However, premiums may be increased for the group based upon the manifestation of a disease or disorder of an individual enrolled in the plan.) • Prohibits plans and issuers from requesting or requiring an individual to undergo a genetic test. However, a health care professional providing health care services to an individual is permitted to request a genetic test. A plan or issuer may request the results of a genetic test to determine payment of a claim for benefits, but only the minimum amount of information necessary in order to determine payment. Also, a research exception. • Prohibits plans from collecting genetic information (including family medical history) from an individual prior to or in connection with enrollment in the plan, or at any time for underwriting purposes. • Plans and issuers are generally prohibited from offering rewards in return for the provision of genetic information, including family medical history information collected as part of a Health Risk Assessment.	Per the Active Wrap plan document: "**Genetic Information Non-discrimination Act of 2008 (GINA).** The Plan shall comply with the Genetic Information Non-discrimination Act of 2008 (GINA) to the extent applicable including: Title I (regarding genetic nondiscrimination in group health plans) and Title II (regarding genetic nondiscrimination in employment). Under GINA, the Plan shall not base enrollment decisions, premium costs, or Participant contributions on genetic information. The Plan shall not require that individuals undergo genetic testing. PEBP is prevented from conditioning hiring or firing decisions based on genetic information. Lastly, GINA will extend medical privacy and confidentiality rules to the disclosure of genetic information. Currently, PEBP and the State of Nevada do not use genetic information regarding either employment or the determination of benefits."	Complete.
Heroes Earnings Assistance and Relief Tax Act of 2008 ("HEART Act")	Heart Act allows – but doesn't require — a health FSA to permit reservists called to active duty for 180 days or more to withdraw all or a portion of any unused money (notwithstanding the normal "use it or lose it" rule). The distribution of these funds must be made during the period from the date of call-up until the last day the benefits could normally be reimbursed for the plan year.	Per the FSA MPD: "Under the Heroes Earnings Assistance & Relief Tax Act of 2008, employees called to active military duty for a period of at least six months can receive a taxable distribution of the HCFSA funds to avoid forfeiture."	Complete.
Newborns' and Mothers' Health Protection Act	Plans may not restrict hospital stays in connection with childbirth to less than 48 hours following a vaginal delivery or 96 hours following a caesarean delivery.	Per the MPD: "Hospital length of stay for childbirth: This Plan complies with federal law that prohibits restricting benefits for any	Complete.

		hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section, or requiring a health care practitioner to obtain authorization from the Plan or its UM Company for prescribing a length of stay not more than those periods. However, federal law generally does not prohibit the mother's or newborn's attending health care practitioner, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, if applicable)."	
Pregnancy Discrimination Act ("PDA")	Any health insurance provided by an employer must cover and reimburse expenses for pregnancy related conditions on the same basis as expenses for other medical conditions. Insurance coverage for expenses arising from abortion is not required, except where the life of the mother is endangered, or medical complications arise from an abortion. The amounts payable by the insurance provider can be limited only to the same extent as costs for other conditions. No additional or larger deductible can be imposed.	Per the MPD: "Prenatal and delivery is covered for a female employee or spouse only. For covered dependent children, only prenatal coverage is provided for maternity, except for complications of pregnancy for the dependent child." "Elective termination of pregnancy is covered only when the attending physician certifies that the mother's health would be endangered if the fetus were carried to term."	Complete.
Title VII of the Civil Rights Act of 1964	Supreme Court held in *Bostock v. Clayton County* (2020) that Title VII of the Civil Rights Act of 1964 protects transgender, gay and lesbian employees (and prospective employees) from workplace discrimination based on sex. Bostock. This protective authority of Title VII generally extends to employer-sponsored healthcare benefits. Supreme Court held in *Newport News Shipbuilding Co. v. EEOC* (1983) that Title VII requires equally comprehensive coverage to both male and female employees, mandating that employer-provided health plans may not discriminate on sex-based characteristics (e.g., employer-provided health plans must cover pregnancy, childbirth and related medical conditions).	PEBP revised the Plan Year 2023 MPD to reflect enhancements in plan design for gender dysphoria treatment.	PEBP will continue to monitor ongoing developments from the EEOC, and continue to review and revise plan documentation accordingly.
Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA")	• Reemployed service members are entitled to the seniority and all rights and benefits based on seniority that they would have attained with reasonable certainty had they remained continuously employed.	Per the MPD: "Employees who go into active military service for up to 31 days can continue their health care coverage during that leave period if they continue to pay their	Complete.

	• During a period of service, the employees must be treated as if they are on a leave of absence and are entitled to participate in any rights and benefits not based on seniority that are available to employees on comparable. nonmilitary leaves of absence, whether paid or unpaid. If there is a variation in benefits among different types of nonmilitary leaves of absence, the service member is entitled to the most favorable treatment so long as the nonmilitary leave is comparable. • Service member entitled to benefits that become effective during their service and that are provided to similarly situated employees on furlough or leave of absence. • Service members may be required to pay the employee cost, if any, of any funded benefit to the extent that other employees on leave of absence are so required.	contributions for that coverage during the period of that leave. State employees who go into active military service for 31 days or more are eligible to enroll in health care coverage provided by the military the day the employee is activated for military duty. This coverage is also available to dependents. The employee is also eligible to purchase continued health care coverage through PEBP for up to 24 months in a manner like the provisions of COBRA. When the employee returns from military leave within the required reemployment period, there will be an immediate reinstatement of PEBP-sponsored medical coverage with no waiting period. Questions regarding entitlement to this leave and to the continuation of health care coverage should be referred to PEBP. Questions regarding reemployment rights should be addressed with the employer."	
Women's Health and Cancer Rights Act	Plans that cover mastectomies must cover certain reconstructive surgery and services.	Per the MPD: "This Plan complies with the Women's Health and Cancer Rights Act of 1998 (WHCRA) Breast reconstructive surgery and the internal or external prosthetic devices are covered for members who have undergone mastectomies or other treatments for breast cancer. Treatment will be provided in a manner determined in consultation with the physician and the member. For any covered individual who is receiving mastectomy-related benefits, coverage will be provided for: • All stages of reconstruction of the breast on which the mastectomy has been performed. • Surgery and reconstruction of the other breast to produce a symmetrical appearance; and • External prostheses that are needed before or during reconstruction; and	Complete.

		• Treatment of physical complications of all stages of the mastectomy, including lymphedema (fluid build-up in the arm and chest on the side of the surgery). Treatment of leaking breast implant is covered when the breast implant surgery was performed for reconstructive services following a partial or complete mastectomy as mandated by the Women's Health and Cancer Rights Act."	

Description		Findings	Action Required
IX. Certain Required Notices			
Women's Health and Cancer Rights Act (WHCRA) Notice	Plans must provide a description of benefits under WHCRA both upon enrollment and annually thereafter.	PEBP's Annual Notices document includes: Women's Health and Cancer Rights Act. The Annual Notices were emailed to all Active and Retired PEBP members October 27, 2022.	Complete.
Children's Health Insurance Program Reauthorization Act (CHIPRA) Notice	Employers in states with Medicaid or CHIP premium assistance programs must annually notify employees of these opportunities by the first day of the plan year. Frequently provided in open enrolment materials. Model notice updated 7/31/2022. https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/chipra	PEBP's Annual Notices document includes: CHIP Notice– Medicaid and Children's Health Insurance. The Annual Notices were emailed to all Active and Retired PEBP members October 27, 2022.	Complete.
Section 125 Cafeteria Plan	While there is no reporting or disclosure requirement for the Section 125 plan, employers typically make the plan document available to employees on a website or upon request.	The PEBP Section 125 Health and Welfare Plan Document is accessible on the PEBP website.	Complete.
Change in Status Events	Employers typically make information available in the SPD about mid-year change in status events, including forms for changing enrollment elections.	The PEBP Section 125 Health and Welfare Plan Document includes a section of the mid-year change events and is accessible on the PEBP website.	Complete.
Wellness Program Notice of Reasonable Alternative	Plans must disclose availability of a reasonable alternative standard to qualify for the wellness program's reward in all plan materials that describe health-contingent wellness programs. Also, must provide contact information for obtaining the alternative standard and a statement that recommendations of an individual's personal physician will be accommodated The information must be included in the SPD, enrollment materials and other materials discussing wellness.	PEBP does not have a wellness program.	N/A.

Wellness Notice (required by EEOC)	If wellness program includes disability-related inquiries, genetic information, or medical examinations, the plan sponsor must provide participants with a notice describing what medical information will be obtained, how it will be used and how it will be protected from improper disclosure. Programs that permit spouses to participate must provide similar notice and obtain the spouse's authorization if genetic information is being requested. Notice must be provided before the participant is asked to answer disability-related questions or undergo a medical exam.	PEBP does not have a wellness program.	N/A.
Newborns' and Mothers' Notice	Plans must provide notice describing requirements for minimum length of hospital stay in connection with childbirth required within SPD time frame.	PEBP's Annual Notices document includes: Newborns' and Mothers' Health Protection Act; and is referenced within the MPD. The Annual Notices were emailed to all Active and Retired PEBP members October 27, 2022.	Complete.

Michelle's Law Notice	Only if coverage provided based on student status (age 26 or older), plans must provide notice regarding ability to extend coverage for post-secondary students on medical leave.	Per the Active Employee Wrap Plan Document: **"Michelle's Law.** The Plan shall comply with Michelle's Law to the extent it applies to Dependent Child(ren)'s eligibility for health coverage conditioned on maintaining full-time student status as described in the Master Plan Document for the PEBP Enrollment and Eligibility. Should Michelle's Law apply and a Dependent Child takes a medically necessary leave of absence for a serious illness or injury that causes loss of full-time student status, the Plan shall not terminate his or her coverage before the date that is the earlier of: (1) one year after the first day of the medically necessary leave of absence; or (2) the date on which such coverage would otherwise terminate under the terms of the PEBP. A written certification stating that the Dependent Child is suffering from a serious illness or injury and that the leave of absence is medically necessary must be provided by a treating physician of the Dependent Child to PEBP for eligibility and coverage to continue." PEBP has confirmed that coverage has been extended for students on a medical leave of absence	Complete. .

Qualified Medical Child Support Notice	Plans must acknowledge receipt of medical child support order and notify participants that its QMCSO procedures for determining whether the order is qualified are available free of charge. Within a reasonable time after its receipt, the plan must also issue notice of whether the order is qualified.	The Plan shall provide benefits in accordance with the applicable requirements of any Qualified Medical Child Support Order (QMCSO) as set forth in the MPD for the PEBP Enrollment and Eligibility. Qualified Medical Child Support Orders (QMCSO): QMCSOs are state court orders requiring a parent to provide medical support to a child often because of legal separation or divorce. A QMCSO may require the Plan to make coverage available to your child even though, for income tax or Plan purposes, the child is not your dependent. To qualify, a medical support order must be a judgment, decree, or order (including approval of a settlement agreement) issued by a court of competent jurisdiction or by an administrative agency, which: o Specifies your last known name and address and the child's last known name and address. o Describes the type of coverage to be provided, or how the type of coverage will be determined. o States the period to which it applies; and o Specifies each plan to which it applies. The QMCSO cannot require the Plan to cover any type or form of benefit that they do not currently cover. The Plan must pay benefits directly to the child, or to the child's custodial parent or legal guardian, consistent with the terms of the order and Plan provisions. You and the affected child will be notified if an order is received.	Recommend adding language to the MPD You and the affected child will be notified if an order is received *and a copy of the procedures is available free of charge upon request*.

Description		Findings	Action Required
X. Cafeteria Plan, FSAs, HSA/HDHPs, HRAs			
CAFETERIA PLAN			
Plan year requirement	A cafeteria plan year must continue for 12 consecutive months, as established by the plan document. A plan year of less than 12 months is only allowed for a valid business purpose, e.g., first plan year, last plan year.	Plan year is defined as the 12-month period beginning each July 1st and ending each June 30th.	Complete.
Written plan document	Section 125 requires a written plan document. While there is no reporting or disclosure requirement, employers typically make the plan document available to employees on a website or upon request.	PEBP has a written Section 125 Health and Welfare Benefits Plan Document.	Complete.
Salary reduction agreement	Required for participant to pay for benefits on a pre-tax basis	Defined and referenced throughout Section 125 plan document.	Complete.
Annual participation and contribution elections generally must be irrevocable for the plan year	Exceptions: • contributions to HSAs • status or cost/coverage changes as adopted under the plan. • To comply with HIPAA special enrollment rights • To comply with a judgment, decree, or order to provide coverage for a dependent child in connection with a change in marital status or custody • To reflect a change in entitlement to Medicare or Medicaid • The Family and Medical Leave Act grants employees on FMLA leave the right to revoke or change an existing election for accident or health plan coverage. • Limited exception for administrative error: Although the election change regulations do not address mistakes, based on the informal IRS "doctrine of mistake" an election may be corrected when there is "clear and convincing evidence" a mistake has been made. For example, if an employee with no eligible dependents makes a dependent care election, rather than a health FSA election, there is clearly an error. If there is evidence that an individual has made a mistake in an election, or that the employer has made an administrative mistake in recording that election, then the election can be undone, even retroactively, to correct the mistake.	Permitted mid-year events referenced in Status Change Elections; Special Enrollment; Other Election Changes section of the Section 125 plan document.	Complete.

Participants limited to current or former employees	Individuals who are self-employed, such as sole proprietors or partners in a partnership, and individuals who are 2% shareholders in an S corporation, are not employees for this purpose. Though only employees may participate, spouses and dependents may benefit from the plan.	Active Legislators pay 100% of their own contributions after tax. There are no subsidies.	Complete.
Paid Time Off (PTO)	A cafeteria plan can offer elective PTO (i.e., PTO that can be purchased or sold under the cafeteria plan) as a permitted taxable benefit, including through the application of flex-credits.	N/A. The cafeteria plan does not offer PTO that can be purchased or sold.	N/A.
Non-elective Employer Contributions (flex credits)	The employer may make contributions on behalf of participants to be used for non-taxable qualified benefits. The contribution amount (or maximum) must be specified in the cafeteria plan document, as either a fixed amount or a percentage of compensation. Participants can allocate these employer contributions among different qualified and/or taxable benefits offered through the plan.	No flex credits.	N/A.
Nondiscrimination testing	Cafeteria plans are subject to the following nondiscrimination tests: (i) Eligibility Test: plan must benefit employees who qualify under an eligibility classification that does not discriminate in favor of highly compensated individuals (HCIs).(ii) Benefits and Contributions Test: contributions or benefits may not discriminate in favor of highly compensated participants; (iii) Key Employee Concentration Test: no more than 25% of the aggregate statutory non-taxable benefits provided to all employees through the cafeteria plan can be provided to key employees.	PEBP has not recently performed nondiscrimination testing.	To be in compliance, PEBP should perform ND testing.

HEALTH FSA				
Maximum annual employee contribution election		For 2022: $2,850	The limit for calendar year 2021 is $2,850 for the medical FSA or the Limited Purpose FSA.	Complete.
Employer contribution		An employer may match up to $500, regardless of whether or not the employee contributes to a health FSA themselves. Above $500, employers may only make a dollar-for-dollar match to the employee's contribution. But see rules for Excepted Benefit FSA below.	N/A	N/A.
Uniform coverage rule		The full amount of reimbursement available under a health FSA (less amounts previously reimbursed for the plan year) must be available throughout the plan year. This rule does not apply to DCFSA.	Per the FSA MPD: "You may be paid the full amount of your claim or the balance of your annual election, whichever is less, whenever you file a qualifying claim. Payment under the medical FSA is not limited to the amount in your account at the time of your claim. Your monthly contributions will continue for the remainder of the Plan Year."	Complete.
Grace period (optional)	***Cannot have both a grace period and a carryover***	Allows costs to be incurred up to 2½ months after the end of the plan year.	N/A	N/A
Carryover (optional)		Maximum carryover amount indexed to 20 percent of the annual maximum election. For 2021 ($550); For 2022 & 2023 ($570). Not applicable to DCFSA.	The $2,850 limit does not include the potential carryover of up to $550 remaining in your HCFSA or Limited Purpose FSA from one Plan Year to another.	Complete.
Run-out period (optional)		A predetermined amount of time (generally set by the employer) that allows reimbursement after the plan year ends. Most run-out periods are 90 days, starting the day after the plan year ends.	Per the MPD - Claims for expenses incurred during the Plan Year must be submitted to UMR by October 31st following the end of the Plan Year.	Complete.
Significant cost or coverage changes		Does not apply to an election change with respect to a health FSA (or on account of a change in cost or coverage under a health FSA).	MPD confirms this does not apply to the health FSA or limited purposes states the change applies when the cost charged to employee for a benefits package option significantly increases or decreases.	Complete.
Qualified medical expenses		Qualified medical expenses are those specified in the plan that are paid for care as described in Section 213 (d) of the Internal Revenue Code that are not otherwise reimbursed. See Pub. 502. Expenses incurred after December 31, 2019, for over-the-counter medicine (whether or not prescribed) and menstrual care products are considered medical care and are considered a covered expense.	Per the MPD - Qualifying expenses are those expenses which are incurred by the taxpayer or their eligible dependents during the Plan Year for medical care as defined in Section 213(d) of the Internal Revenue Code, excluding all insurance premiums and long-term care expenses.	Complete.

Substantiation		An independent third party must substantiate medical expenses paid or reimbursed from a health FSA. Substantiation for health care expenses includes: information describing the service or product; the date of service or sale; and the amount of the expense.	Section in MPD "When Do I Have to Turn in Paperwork" discusses substantiation.	Complete.
Limited Purpose Health FSA (LPFSA)		Qualified medical expenses are limited to eligible dental and vision costs.	The LPFSA is set up to reimburse only eligible FSA dental and vision expenses.	Complete.
Excepted Benefit FSA		Employer contributions should not exceed $500 per plan year for a health care FSA to maintain excepted benefit status, which avoids making it subject to certain ACA and HIPAA requirements.	No employer contributions to health FSA.	N/A.
Integration with HSA		Employees with an HSA can only have a Limited Purpose FSA.	Per MPD - IRS provisions do permit enrollment in both an HSA and a LPFSA as LPFSA reimbursement is restricted to only vision and dental expenses.	Complete.
Nondiscrimination testing		Health Care FSA must pass the Eligibility Test and the Benefits Test, as required by Code § 105(h). A highly compensated individual is (a) one of the five highest-paid offers; (b) a more than 10% shareholder of the company; or (c) among the highest paid 25% of all employees (other than excludable employees). Eligibility Test (plan must benefit: (i) 70% or more of all nonexcludable employees; (ii) 80% or more of all employees who are eligible to benefit if 70% or more of all nonexcludable employees are eligible to participate in the plan; or (ii) the nondiscriminatory classification test (classification does not discriminate in favor of HCIs). Benefits Test: test consists of two requirements (i) benefits must be nondiscriminatory on the face of the plan and in operation (benefits provided to HCIs must be provided NHCIs) and (ii) required contributions must be the same for all benefit levels, and the maximum benefit cannot be based on percentage of compensation, age or years of service.	PEBP has not recently performed nondiscrimination testing.	To be in compliance, PEBP should perform ND testing.
COBRA	**Special Exception (not required to offer COBRA to qualified beneficiaries who have "Overspent" their FSA amounts)**	An employer determines whether a participant has "overspent" or "underspent" his or her health FSA account by looking at: (1) the participant's maximum benefit for the plan year; (2) the amount of reimbursable claims submitted to the FSA for the plan year before the qualifying event; and (3) the maximum amount that the employer is permitted to charge for COBRA coverage under the health FSA for the remainder of the plan year.	Per the MPD – "COBRA FSA benefits will end on the earlier of: • You cease paying the monthly administration fee; • Your remaining FSA balance is depleted; or, • At the end of the applicable Plan Year."	Complete.

			"If COBRA is elected, it will be available only for the remainder of the applicable Plan Year. Such continuation coverage shall be subject to all conditions and limitations under COBRA."	
	Premium	IRS regulations indicate that the maximum COBRA premium for FSA coverage is based on the annual coverage amount under the FSA, which includes both employee and employer contributions (and any carryover).	PEBP does not charge a COBRA premium for the Health FSA.	Complete.
DEPENDENT CARE FSA				
Eligibility		both parents working one spouse not working: generally, can qualify if (i) Job-related: the spending must enable participant and spouse to work or look for a new job and (ii) Earned income: Spouse must make money through employment during the year to exceed the DCFSA contribution spouse disabled: can use a DCFSA when only one parent is working, when one spouse is physically or mentally incapable of self-care or disabled (person is physically or mentally incapable of performing regular job duties) fulltime student: parent is working when the other is a full-time student attending classes at an authorized school. IRS rules define when they impute earned income during the month. Full-time definition: enrolled in classes for at least five calendar months, with enough credit hours to exceed the school-defined part-time definition Authorized intuitions: high schools, colleges, universities, plus technical, trades, and mechanical schools Unauthorized institutions: correspondence classes and internet-based online learning programs	A DCFSA is an option for active employees covered under the PEBP Consumer Driven Health Plan (CDHP), HMO or Premier EPO Plan.	PEBP should consider independent eligibility for the DCFSA from the medical plans. PEBP should also conduct ND testing.
Qualifying Individuals		A qualifying individual(s) who is: o A qualifying child who has not attained age 13; or o A dependent of the taxpayer who is physically or mentally incapable of caring for himself or herself and who has the same principal place of abode as the taxpayer for more than ½ of the tax year; or o The spouse of the taxpayer, if the spouse is physically or mentally incapable of caring for himself or herself and has the same principal place of abode as the taxpayer for more than one-half of the tax year.	Per the FSA MPD: "Day care expenses are limited to care for children under age 13, for whom you have more than 50% custody, or for a spouse or dependent who is physically or mentally incapable of caring for himself or herself and who lives in your home at least 8 hours each day. The expenses may not be paid to a child of yours who is under the age of 19 at the end of the year in which the expenses are	Complete.

		incurred or to an individual for whom you or your spouse is entitled to a personal tax exemption as a dependent."	
Annual Contribution Limits	$5,000 a year for individuals or married couples filing jointly, or $2,500 for a married person filing separately.	DCFSA is limited to $5,000 for single taxpayers and $2,500 for married individuals filing separately.	Complete.
Use-it-or-lose-it	Under the "use or lose" rule, costs payable under all three types of FSAs are required to be incurred during the plan year (except for grace period)	Per the FSA MPD: "If you have funds remaining in your DCFSA account at the end of the year, that amount will be forfeited by you as required by federal regulations."	Complete.
Grace Period (optional)	Allows costs to be incurred up to 2½ months after the end of the plan year.	There is no grace period.	N/A.
Run-Out Period (optional)	A predetermined amount of time (generally set by the employer) that allows reimbursement after the plan year ends. Most run-out periods are 90 days, starting the day after the plan year ends.	Per the FSA MPD, all claims must be filed by October 31st following the end of the Plan Year.	Complete.
Qualifying Expenses	As set forth in the plan, payment for provision of services, which if paid for by the employee would be considered, employment related expenses under I.R.C. § 21(b)(2). DCAP-eligible expenses (i.e., expenses paid to enable the taxpayer to be gainfully employed) while the taxpayer is gainfully employed or is in active search for gainful employment. Expenses paid for household services and services for the care of a qualifying individual with respect to the taxpayer, but only if the expenses are incurred to enable the taxpayer to be gainfully employed. Expenses paid for household services performed in connection with the care of a qualifying individual. Expenses paid for the performance in and around the taxpayer's home of ordinary and usual services necessary to the maintenance of a household Expenses paid for services provided for the primary purpose of a qualifying individual's well-being and protection, including expenses for benefits which are incident to and inseparably a part of the qualifying care services. Expenses paid for services provided in dependent care centers that provide care for more than six individuals and are compensated in fees, payments, or grants for providing services for any of the individuals.	Per the FSA MPD: "Expenses necessary for you to be gainfully employed: • Expenses paid to a dependent care center. • Expenses paid to a "babysitter". • Expenses paid for care of a dependent under age 13. • Expenses paid for care of a dependent who is physically or mentally incapable of caring for herself or himself."	Complete.

Payments to Related Persons	No amount paid or incurred during the taxable year of an employee by an employer in providing dependent care assistance to such employee shall be excluded from income (a) if such amount was paid or incurred to an individual—(1) with respect to whom, for such taxable year, a deduction is allowable under section 151(c) (relating to personal exemptions for dependents) to such employee or the spouse of such employee, or (2) who is a child of such employee (within the meaning of section 152(f)(1)) under the age of 19 at the close of such taxable year.	Per the FSA MPD: "The expenses may not be paid to a child of yours who is under the age of 19 at the end of the year in which the expenses are incurred or to an individual for whom you or your spouse is entitled to a personal tax exemption as a dependent."	Complete.
Substantiation Requirements	Receipts must include specific information to prove that the payment was for qualified expenses. Specifically, the receipt must note: Recipient's Name—the name of the person who received the service Provider's Name—the name, address, and taxpayer identification number of the person performing the services are included on the return to which the exclusion relates, or if such person is a 501(3)€ organization; the name and address of such person are included on the return to which the exclusion relates Date of Service—the date when services were provided Type of Service—a detailed description of the service provided Cost—the amount paid for the service	Per the FSA MPD "UMR will review your claim, and if approved will reimburse you. Claim reimbursements are issued within one business day of the receipt of your claim up to the amount that you have on deposit in your account. If your claim exceeds your available funds, the difference will be recorded and paid as funds become available from your payroll contributions. You must submit a completed claim form along with copies of invoices or statements to serve as proof that you have incurred a qualified expense to receive payment. Statements are required to be from the provider/store stating the date of service/purchase, a description of services/products, the expense amount, the name of the service provider/store and the person for whom the service was provided."	Complete.
Nondiscrimination testing	DCFSA must pass four nondiscrimination tests per Code § 129: Eligibility Test (reasonable classification test); Contributions and Benefits Test; More Than 5% Owner Concentration Test; 55% Average Benefits Test. The average DCFSA benefits provided to non-highly compensated employees must be at least 55% of the average benefits provided to highly compensated employees. An HCE is a more than 5% owner during the current or preceding year, or an individual with compensation during the preceding year over the IRS dollar limit ($130,000 for 2021; $135,000 for 2022).	PEBP has not recently performed discrimination testing on the DCFSA plan.	To be in compliance, PEBP should perform ND testing.

DCFSA required notification	Employers must provide reasonable notification to employees of the availability of the program. Each employee must be furnished, on or before Jan. 31, a written statement showing the amounts paid or expenses incurred under the DCFSA during the previous calendar year. This requirement is usually met by reporting the amounts on the employee's Form W-2.	PEBP's Eligibility and Enrollment vendor Lifeworks sends the necessary data for reporting on individual employee W-2s to the applicable state employers.	Complete.
ADDITIONAL FSA RULES			
Cannot transfer funds between the two accounts	Cannot transfer funds between the Health FSA and the DCFSA.	PEBP has confirmed that funds cannot be transferred between the Health FSA and the DCFSA.	Complete.
DEBIT CARDS			
Card limit	The use of the card is limited to the maximum dollar amount of coverage available in the employee's health FSA or HRA.	PEBP has confirmed that the card is limited to the maximum dollar amount of coverage available in the employee's health FSA or HRA.	Complete. .
Where can be used for health expenses	The card can only be used at merchants and service providers that have merchant category codes related to health care, such as physicians, pharmacies, dentists, vision care offices, hospitals, and other medical care providers.	Per the FSA MPD: "Per IRS regulations, the FSA debit card can only be used at health care providers (based upon the Merchant Category Code) and at stores that have implemented an Inventory Information Approval System (IIAS)."	Complete.
Substantiation rules	Flexible Spending Account (FSA) claims paid with a debit card must include the required substantiation, containing all of the information normally required for a claim submitted for reimbursement through means such as an online portal or mobile app. Expenses must be substantiated by an independent third party with the following information: name of the individual receiving the eligible service or purchasing the eligible item; date(s) the service was provided, or item was purchased (start and end dates if applicable); description of the service provided, or product purchased (e.g., prescription, copay, office visit, glasses, daycare); name of the service provider or merchant where the item was purchased; and claim amount (dollar amount spent for the service or item).	Per the FSA MPD: "Debit card transactions can be accepted by the FSA administrator without any follow up if the merchant is an acceptable merchant type such as a physician's office or hospital and at least one of four other criteria are met. Transactions are electronically substantiated if: The dollar amount of the transaction at a health care provider equals the dollar amount of the co-payment or any combination of any known co-pays up to five times the highest known co-pay, for the employer-sponsored medical, vision or dental plan that participant has elected; • The expense is a recurring expense that matches expenses previously approved as to	Complete.

	In addition, the Health FSA sponsor may coordinate with an individual's insurance provider to use information provided in an explanation of benefits to substantiate a debit card charge without requiring more information.	amount, provider, and time period (e.g., for an employee who pays a monthly fee for orthodontia at the same provider for the same amount); or • The merchant maintains a compliant Inventory Information Approval System (IIAS) for over-the-counter supplies and prescription medication (this system is allowable only if the merchant approves only qualifying items; all other purchased items must be paid for in a split tender transaction.) "	
Auto-substantiation	Exception for expenses from certain providers (e.g., pharmacies) that can be auto-substantiated by the Merchant Category Code (MCC) of the provider's debit card machine and when the item or service is identified by an Inventory Information Approval System (IIAS). Automatic substantiation is allowed at merchants that have an IIAS in place to ensure that cards are used only for eligible health-related expenses.	Per the FSA MPD: "Per IRS regulations, the FSA debit card can only be used at health care providers (based upon the Merchant Category Code) and at stores that have implemented an Inventory Information Approval System (IIAS)."	Complete.
Prohibition against self- substantiation	Section 105 and § 125 require the substantiation of all medical expenses as a precondition of payment or reimbursement. "Self-substantiation" or "self-certification" of an expense by an employee-participant does not constitute the required substantiation.	Per the FSA MPD: "All claims for Benefits offered through the Plan's Code §125 cafeteria plan feature must be substantiated by information provided by an independent third party in accordance with applicable regulations before benefits may be paid."	Complete.
Use of Debit Card for DCFSA	An employer may use a payment card program to provide benefits under its DCFSA. However, dependent care expenses may not be reimbursed before the expenses are incurred. For this purpose, dependent care expenses are treated as having been incurred when the dependent care services are provided, not when the expenses are formally billed, charged for, or paid by the participant. Thus, if a dependent care provider requires payment before the dependent care services are provided, those expenses cannot be reimbursed at the time of payment, even through the use of a payment card program.	PEBP uses the debit card for DCFSA. Per the MPD: "Dependent care expenses are incurred when the day care is provided. You must receive the dependent care services before you file a claim for those services."	Complete.
HSA/HDHP			
Only employees enrolled in a HDHP can enroll in the HSA		Per the MPD, "Employees may not establish or contribute to a Health Savings Account if any of the following apply: The employee is covered under other medical insurance	Complete.

		coverage unless that medical insurance coverage: (1) is also a High Deductible Health Plan as defined by the IRS; (2) covers a specific disease state (such as cancer insurance); or (3) only reimburses expenses after the Deductible is met."	
Annual limits	HSA Contribution Limit: 2022 2023 Self-only $3,650 $3,850 Family $7,300 $7,750 HSA Catch-up Contributions: Age 55 + $1,000 $1,000 HDHP Minimum Deductible: Self-only $1,400 $1,500 Family $2,800 $3,000 HDHP Maximum Out-of-pocket Expense Limit (deductibles, copayments and other amounts, but not premiums) Self-only $7,050 $7,500 Family $14,100 $15,000	Per the MPD: 2022 HSA contribution: $3,650/$7,300 2023 HSA contribution: $3,850/$7,750 HSA Catch Up Contribution: $1,000 HDHP Min. Ded. $1,500/$3,000 (ind./family) HDHP – OOP Max - $4,000/$8,000 (in-network) (ind/family)	Complete.
Funds can rollover indefinitely	HSAs have no use-it-or-lose-it provision. Any funds still in the plan at the end of the year can be rolled over indefinitely.	HSAs are employee-owned accounts, meaning the funds in the HSA remain with the employee and carry over from one year to the next.	Complete.
FSA carryover/grace period conflict	A participant who has FSA carryover amount who wants to switch to an HDHP with HSA for the next plan year is prohibited from contributing to the HSA for the entire plan year. Or if they have funds remaining in the health FSA and there is a grace period, contributions would be prohibited to an HSA during the grace period. Two ways to resolve the carryover issue are (1) to move the FSA funds to a limited purpose health FSA (dental and vision only) or (2) to allow the participant to decline the carryover and waive the funds prior to the end of the FSA plan year (it is not generally permissible to decline a grace period, however). Employers may allow participants to choose whether to convert a carryover amount to a limited purpose health FSA, but a health FSA having a grace period is generally not	Per the FSA MPD: "The $550 HCFSA carryover will make you ineligible for the PEBP health savings account. To be eligible for the PEBP health savings account you may either elect to decline the carryover prior to the next Plan Year or switch your enrollment to the Limited Purpose FSA and carry over the unused funds to your new account."	Complete.

		permitted to offer each participant that choice (but may impose a mandatory conversion for all participants).		
HRAs				
Permitted Contributions		Employer contributions only	Per FSA MPD: Active HRA: Participants cannot contribute to a CDHP HRA. If the annual funds in the CDHP HRA are exhausted, neither PEBP nor the participant will contribute any additional funds. Per Medicare Exchange HRA MPD: This is a Medicare Exchange HRA, Also referred to as a "benefit credit" is the amount of money determined by your years of service and retirement date that is deposited to your HRA account on a schedule determined by the Plan Administrator. Retired public employees enrolled in a medical plan through the Via Benefits may qualify for an HRA contribution based on the date of hire, date of retirement, and total years of service credit earned with each Nevada public employer	Complete.
Integrated HRA		Must be integrated with employer group health plan that meets the ACA's market reform requirements. HRAs so integrated are deemed to comply with those requirements.	Per the Active Wrap Plan Doc: "Health Reimbursement Arrangement is intended to be integrated for purposes of PPACA and related guidance."	Complete.
Retiree-Only HRA		Terminated/Retired employees only (limited to less than 2 active employees) Can reimburse their Medicare Part A, Part B and Part D premiums. Not subject to ACA market reforms, but must satisfy: Reporting of minimum essential coverage (6055 reporting generally only for pre-Medicare retirees and dependents) and PCOR fee. For purposes of nondiscrimination testing, a key employee includes a retiree who was a key employee when he or she retired.	Per the Medicare HRA MPD: The Medicare Exchange HRA Plan is considered a retiree only arrangement and is not subject to PPACA group market reforms.	Complete.
COBRA	**Eligibility**	Integrated HRA:can elect COBRA for HRA only if COBRA is elected for group health plan.	COBRA is offered for the HRA.	Complete. .
	Premium	At the beginning of each plan year, the employer should calculate a reasonable premium for the HRA, both for single	PEBP does not charge an additional COBRA premium.	Complete.

		and family coverage. The IRS has defined two methods for determining the COBRA premium: the actuarial method and the past-cost method.		
Coordination with Health FSA		While an employee can have both an HRA and an FSA at the same time, the same expense cannot be reimbursed from both accounts. The IRS states that special coordination rules should be implemented to determine whether the HRA or FSA should be used first. As a general rule, the HRA funds must be used first prior to the FSA. IRS Notice 2002-45.	Health Scope Benefits has confirmed that the participant signs an attestation including that the expenses are not eligible for reimbursement under any other health plan. While the general purpose FSA is permitted with the HRA, the FSA SPD does not discuss whether the HRA or FSA should pay first.	The FSA SPD should add language to discuss the order of payment for the HRA and FSA.

Appendix B. Summary of Findings - State

Description		Findings	Action Required
Eligibility and Participation: Definition of "Dependent" NAC 287.035 NAC 287.311 NAC 287.312 NAC 287.3125 NAC 287.313 NRS 689B.035	• Dependent: defined. • Dependents: Enrollment and disenrollment. • Dependents: Eligibility of child of participant, spouse or domestic partner. • Dependents: Terms and conditions of certain changes. • Responsibility for final determinations concerning eligibility. • Required provision in certain policies concerning termination of coverage on dependent child.	MPD defines dependent child and outlines eligibility.	Complete.
Eligibility and Participation: Definition of "Domestic Partner" NAC 287.035	• Dependent: defined.	MPD defines domestic partner and outlines eligibility.	Complete.
Eligibility and Participation: Definition of "Participant" NAC 287.095 NAC 287.135 NAC 287.150 NAC 287.313	• Participant: defined. • "Retired officer or employee" defined. • "Full-time employment" interpreted. • Responsibility for final determinations concerning eligibility.	MPD defines participant and eligibility.	Complete.
Eligibility and Participation: Definition of "Full-Time Employment" and Eligibility Waiting Periods NRS 287.045 NAC 287.150 NAC 287.313	• Persons eligible to participate in Program; receipt of notice of eligibility; automatic enrollment; limited affiliation period. • "Full-time employment" interpreted. • Responsibility for final determinations concerning eligibility.	MPD outlines eligibility, full-time employment.	Complete.

Description		Findings	Action Required
Eligibility and Participation: Retirees NAC 287.135 NAC 287.440 NAC 287.530 NAC 287.540 NAC 287.542 NAC 287.544 NAC 287.546 NAC 287.548 NRS 287.023 NRS 287.047	• "Retired officer or employee" defined. • Payment of premiums or contributions by retired officers & employees. • Coverage of retired person, spouse, domestic partner or surviving dependent. • Coverage of participating employee of State who reenrolls upon retirement or total disability, coverage of nonparticipating employee of State. • Coverage of participating employee of local governmental agency who retires on or before September 1, 2008 and reenrolls upon retirement or total disability. • Coverage of nonparticipating employee of local governmental agency who retires on or before September 1, 2008 and enrolls upon retirement or total disability. • Coverage of participating employee of local governmental agency who retires after September 1, 2008 and reenrolls upon retirement or total disability. • Coverage of nonparticipating employee of local governmental agency who retires after September 1, 2008. • Option of retired officer or employee or dependent to cancel or continue group insurance, plan of benefits, medical and hospital service or coverage under Public Employees' Benefits Program; notice of selection of option; payment of costs for coverage. • Retention by certain retired state officers and employees of membership in and dependents' coverage under Program.	MPD outlines retiree eligibility and enrollment process.	Complete.
Eligibility and Participation: Seasonal Employees and Employees on a Biennial Plan NAC 287.095 NAC 287.150 NRS 287.0467	• "Participant" defined. • "Full-time employment" interpreted. • Retention by certain short-term state employees of membership in and dependents' coverage under Program.	PEBP states that the employers report employee eligibility.	Complete.
Eligibility and Participation: Rehired Employees NAC 287.510 NAC 287.515	• Coverage of persons returning to work with previous employer within 1 year after leaving employment. • Coverage of retired participants upon reemployment with participating public agency	No exceptions noted.	Complete.
Eligibility and Participation: Individual as Both Employee and	• Coverage of person qualified as both employee and dependent; change of status from employee to dependent.	Per the MPD: • Any spouse or domestic partner that is eligible for coverage as both a primary	Complete.

Description		Findings	Action Required
Dependent NAC 287.520		participant and a dependent shall be enrolled as a primary participant. • A child that is eligible as both a primary participant and a dependent may enroll as a primary participant or continue coverage as a dependent of a PEBP participant until age 26 years.	
Eligibility and Participation: Surviving Spouse/ Dependents NAC 287.530 NRS 287.021 NRS 287.0475 NRS 287.0477	• Coverage of retired person, spouse, domestic partner or surviving dependent. • Option of surviving spouse or child of police officer or firefighter killed in line of duty to accept or continue coverage for group insurance, plan of benefits or medical and hospital service; notification; payment of costs for coverage; duration of eligibility. • Reinstatement of insurance by retired public officer or employee or surviving spouse. • Option of surviving spouse or child of police officer, firefighter or volunteer firefighter killed in line of duty to join or continue coverage under Public Employees' Benefits Program; notification; payment of costs for coverage; duration of eligibility.	MPD outlines surviving spouse/dependents eligibility.	Complete.
Eligibility and Participation: Surviving Spouse/Child of a Police Officer, Firemen or Volunteer Firemen Killed in the Line of Duty NRS 287.0477 NRS 287.021	• Option of surviving spouse or child of police officer, firefighter or volunteer firefighter killed in line of duty to join or continue coverage under Public Employees' Benefits Program; notification; payment of costs for coverage; duration of eligibility. • Option of surviving spouse or child of police officer or firefighter killed in line of duty to accept or continue coverage for group insurance, plan of benefits or medical and hospital service; notification; payment of costs for coverage; duration of eligibility.	MPD highlights that the surviving spouse and any surviving child of a police officer or firefighter who was employed by a participating public agency and who was killed in the line of duty may join or continue coverage under PEBP if the police officer or firefighter was eligible to participate on the date of the death of the police officer or firefighter. If the surviving dependent elects to join or discontinue coverage under the PEBP pursuant to this section, the dependent or legal guardian of the dependent must notify the participating public agency that employed the police officer or firefighter in writing within 60 days after the date of death of the police officer or firefighter.	Complete.
Eligibility and Participation: Coverage of Newly Born and Adopted Children NRS 689B.033	• Certain policies covering family members required to include certain coverage for insured's newly born and adopted children and children placed with insured for adoption.	Per the MPD, newborn dependent child(ren) of a PEBP participant will automatically be covered under a PEBP medical Plan option from the date of birth to 31 days following the date of birth (referred to as the initial coverage period) NRS 689B.033. If the newborn is covered under more than one	Complete.

Description		Findings	Action Required
		health insurance plan, the PEBP Plan reserves the right to coordinate benefits as stated in the Coordination of Benefits section of the PEBP Consumer Driven Health Plan, Low Deductible PPO Plan, and Premier Plan Master Plan Documents or HMO Evidence of Coverage Certificate (as applicable).	
Eligibility and Participation: Applications for Participation in PEBP by Local Government Agencies NAC 287.310 NRS 287.010 NRS 287.017 NRS 287.040	• Prerequisites to participation; fees; establishment of rates; provision to agency of report on history of claims. • Local governmental agency may adopt system of group insurance; payment of costs of premiums or contributions; provision of group insurance to members of board of trustees of school district and to officers and employees of legal services organization. • Trust fund for future retirement benefits of local governmental employees and their spouses and dependents. • Payments for group insurance, plan of benefits, medical and hospital services, coverage under Public Employees' Benefits Program or contributions to certain trust funds not compulsory for local governmental agency; assignment of wages or salary for such coverage not compulsory.	PEBP reports no applications for participation in PEBP by local government agencies have been made.	None.
Eligibility and Participation: Orientation Program NAC 287.314 NAC 287.317	• Provision of information about Program to participants, representatives of participating public agencies and employees of Program. • Participating public agency to notify Program of appointment of persons eligible to participate in Program or of termination of appointment; enrollment.	PEBP provides enrollment materials; notices and MPDs to eligible participants.	None.
Eligibility and Participation: Terminating Interlocal Contract and Withdrawing from Program NAC 287.320 NAC 287.355 NAC 287.357 NAC 287.359 NAC 287.361 NAC 287.363 NAC 287.367 NAC 287.369 NRS 287.0479	• Withdrawal from Program: Procedure; termination of coverage; limitation on reentry; eligibility of certain officers and employees after exclusion of group; liability of Program. • Procedure for applying to leave Program. • Application to leave Program: Contents. • Application to leave Program: Contents. • Application to leave Program: Considerations for approval or denial; basis for findings by Board. • Approval of application by Board: Format and contents of decision; responsibilities of and noncompliance by group. • Denial of application by Board: Procedure for reconsideration. • Effective date of departure from Program; coverage by Program until departure. • Option of large group of state officers and employees to leave Program and obtain group insurance from insurer or employee benefit plan; approval of proposed contracts by Board; disbursement of premiums and contributions; regulations.	PEBP reports there are no opt-out plans maintained by local government agencies.	None.

Description		Findings	Action Required
Eligibility and Participation: Opt-out Plan Administration NAC 287.371 NAC 287.373 NAC 287.375 NAC 287.379 NAC 287.381 NAC 287.383 NAC 287.385 NAC 287.387 NAC 287.389 NRS 287.010	• Eligibility of officer or employee to join opt-out plan; ineligibility of officer or employee to continue participation in opt-out plan. • Notification of Program regarding certain changes in status and court orders. • Eligibility for coverage under opt-out plan: Administration of requirements by Program; compliance with determinations of Program. • Options for coverage under opt-out plan: Annual notification of Program; effective period. • Premiums or contributions for participants in opt-out plans: General administrative duties of Program. • Premiums or contributions for participants in opt-out plans: Requirements for billing. • Premiums or contributions for participants in opt-out plans: Remittance or transfer of payments; nonpayment by participant. • Administrative fee: Establishment by Program; calculation; notice. • Duties of Program: Accounting for and remittance of payments; monthly reports. • Local governmental agency may adopt system of group insurance; payment of costs of premiums or contributions; provision of group insurance to members of board of trustees of school district and to officers and employees of legal services organization.	PEBP reports there are no opt-out plans maintained by local government agencies.	Complete.
Eligibility and Participation Definition of "Open Enrollment" NAC 287.085	• "Open enrollment" defined.	Per the MPD, open enrollment is typically held May 1 - May 31 and any changes made during open enrollment become effective on July 1st, immediately following the open enrollment period.	Complete.
Benefits Coverage: Definition of "Plan Year" NAC 287.100	• "Plan year" defined.	Per the MPD, the Plan Year typically is the 12-month period from July 1 through June 30.	Complete.
Benefits Coverage NRS 287.0433 NRS 287.04062 NRS 695G.160 NRS 287.0485	• Power to establish plan of life, accident or health insurance; reinsurance; power to use list of preferred prescription drugs developed by Department of Health and Human Services and obtain prescription drugs through certain purchasing agreements. • "Program Fund" defined. • Written criteria concerning coverage of health care services and standards for quality of health care services. • No inherent right to certain benefits.	No exceptions noted. Per the MPD no officer, employee, or retiree of the State has any inherent right to benefits provided under PEBP.	Complete.

Description		Findings	Action Required
Benefits Coverage: Reinstatement of Coverage by Retired Public Officer, Employee or Surviving Spouse NRS 287.0205 NRS 287.0475	• Reinstatement of insurance by retired public officer or employee or surviving spouse.	Per the MPD, a retired public officer or employee or the surviving spouse thereof, may reinstate insurance, except life insurance, under the Public Employees' Benefits Program, if the retired public officer or employee (1) did not have more than one period during which he or she was not covered by insurance under the Program on or after October 1, 2011; (2) retired from a nonparticipating local governmental agency; (3) was enrolled in the Program as a retiree on November 30, 2008; and (4) is enrolled in Medicare Parts A and B at the time of the request for reinstatement. For Plan Year 2022 and this section only, retirees or the surviving spouse thereof, may apply for reinstatement by submitting the required reinstatement enrollment form(s) between July 1, 2021 – May 31, 2022. For Plan Years 2023 and beyond, requests for reinstatement must be completed through the submission of the required forms to the PEBP office between May 1st and May 31st.	Complete.
Benefits Coverage: Oral Chemotherapy Parity NRS 695G.167 NRS 287.04335	• Plan covering treatment of cancer through use of chemotherapy: Prohibited acts related to orally administered chemotherapy. • Compliance with certain provisions required to provide health insurance through plan of self-insurance.	Under NRS 287.04335, NRS 695G.167 is made applicable to self-insured health plans. MPDs indicate that the health plans cover orally administered chemotherapy.	Complete.
Benefits: Coverage: Services Provided Through Telehealth NRS 695G.162 NRS 287.04335	• Required provision concerning coverage for services provided through telehealth to same extent and in same amount as though provided in person or by other means; exception; prohibited acts. [Effective through 1 year after the date on which the Governor terminates the emergency described in the Declaration of Emergency for COVID-19 issued on March 12, 2020, if the Governor terminates that emergency before July 1, 2022, or June 29, 2023, if the Governor terminates that emergency on or after July 1, 2022.] • Compliance with certain provisions required to provide health insurance through plan of self-insurance.	The NRS generally requires insurance to cover telehealth services to the same extent as services provided in-person or by other means. MPDs reflect COVID-19 related telemedicine provisions.	Complete. Note potential changes to reflect the termination of the Declaration of Emergency.

Description		Findings	Action Required
Benefits: Coverage: Continued Medical Treatment NRS 695G.164 NRS 287.04335	• Required provision in certain plans concerning coverage for continued medical treatment; exceptions; regulations. • Compliance with certain provisions required to provide health insurance through plan of self-insurance.	Under NRS 287.04335, NRS 695G.164 is made applicable to self-insured health plans. MPDs reflect continuation of coverage provisions.	Complete.
Benefits Coverage: Autism Spectrum Disorders NRS 695G.1645 NRS 287.04335	• Required provision in plan for group coverage concerning coverage for autism spectrum disorders for certain persons; prohibited acts. • Compliance with certain provisions required to provide health insurance through plan of self-insurance.	Under NRS 287.04335, NRS 695G.1645 is made applicable to self-insured health plans. MPDs reflect autism coverage.	Complete.
Benefits Coverage: Medically Necessary Emergency Services NRS 695G.170 NRS 287.04335	• Required provision concerning coverage for medically necessary emergency services at any hospital; prohibited acts. • Compliance with certain provisions required to provide health insurance through plan of self-insurance.	Under NRS 287.04335, NRS 695G.170 is made applicable to self-insured health plans. MPDs do not require precertification for medically necessary emergency services provided at any hospital.	Complete.
Benefits Coverage: Required Provision Concerning Coverage for Human Papillomavirus Vaccine NRS 695G.171 NRS 287.04335	• Required provision concerning coverage for certain tests and vaccines relating to human papillomavirus; prohibited acts. • Compliance with certain provisions required to provide health insurance through plan of self-insurance.	Under NRS 287.04335, NRS 695G.171 is made applicable to self-insured health plans. MPDs provide coverage for HPV testing and vaccine.	Complete.
Benefits Coverage: Treatment Received as Part of a Clinical Trial or Study NRS 695G.173 NRS 287.04335	• Required provision concerning coverage for certain treatment received as part of clinical trial or study for treatment of cancer or chronic fatigue syndrome; authority of managed care organization to require certain information; immunity from liability. • Compliance with certain provisions required to provide health insurance through plan of self-insurance.	Under NRS 287.04335, NRS 695G.173 is made applicable to self-insured health plans. MPDs provide coverage for Experimental and/or Investigational Services as provided under NRS 695G.173.	Complete.
Benefits Coverage: Required Provisions for Prescription Drugs Irregularly Dispensed for	• Required provision in plan covering prescription drugs concerning coverage for prescription drugs irregularly dispensed for purpose of synchronization of chronic medications; prohibited acts; exception. • Compliance with certain provisions required to provide health insurance through plan of self-insurance.	Under NRS 287.04335, NRS 695G.1665 is made applicable to self-insured health plans.	Complete.

Description		Findings	Action Required
Synchronization of Chronic Medications NRS 695G.1665 NRS 287.04335		MPDs provide provision concerning coverage for prescription drugs irregularly dispensed for the synchronization.	
Benefits Coverage: Required Provisions for Early Refills of Topical Ophthalmic Products NRS 695G.172 NRS 287.04335	• Plan covering prescription drugs: Denial of coverage prohibited for early refills of otherwise covered topical ophthalmic products. • Compliance with certain provisions required to provide health insurance through plan of self-insurance.	Under NRS 287.04335, NRS 695G.172 is made applicable to self-insured health plans. MPDs provide required provision concerning coverage for early refills of topical ophthalmic products.	Complete.
Benefits Coverage: Required Provisions for Coverage for Prostate Cancer Screening NRS 695G.177 NRS 287.04335	• Required provision in plans covering treatment of prostate cancer concerning coverage for prostate cancer screening; prohibited acts. • Compliance with certain provisions required to provide health insurance through plan of self-insurance.	Under NRS 287.04335, NRS 695G.177 is made applicable to self-insured health plans. MPDs provide this benefit is covered as preventive care service.	Complete.
Benefits Coverage: Claims Involving Intoxication NRS 695G.405 NRS 287.04335	• Managed care organization prohibited from denying coverage solely because applicant or insured was intoxicated or under the influence of controlled substance; exceptions. • Compliance with certain provisions required to provide health insurance through plan of self-insurance.	Under NRS 287.04335, NRS 695G.405 is made applicable to self-insured health plans. MPDs provide this benefit is covered as preventive care service.	Complete.
Benefits Coverage: Sickle Cell Anemia Treatment NRS 695G.174 NRS 287.04335	• Required provision concerning coverage for management and treatment of sickle cell disease and its variants; plan covering prescription drugs required to provide coverage for medically necessary prescription drugs to treat sickle cell disease and its variants. • Compliance with certain provisions required to provide health insurance through plan of self-insurance.	Under NRS 287.04335, NRS 695G.174 is made applicable to self-insured health plans.	PEBP to confirm coverage and administration with UMR of sickle cell anemia, and include in the MPD.
Benefits Coverage: Gestational Maternity Care NRS 695G.1716 NRS 287.04335	• Health care plan covering maternity care: Prohibited acts by managed care organization if insured is acting as gestational carrier; child deemed child of intended parent for purposes of plan. • Compliance with certain provisions required to provide health insurance through plan of self-insurance.	Under NRS 287.04335, NRS 695G.1716 is made applicable to self-insured health plans. Per the MPD -	Complete.

Description		Findings	Action Required
		Medically necessary maternity services for pregnant participants are covered. No exclusions for gestational carriers noted.	.
Benefits Coverage: Claims NRS 689B.255 NRS 287.04335	• Claims relating to health insurance coverage: Approval or denial; payment of claims and interest; requests for additional information; award of costs and attorney's fees; compliance with requirements; imposition of administrative fine or suspension or revocation of certificate of registration for failure to comply. • Compliance with certain provisions required to provide health insurance through plan of self-insurance.	Under NRS 287.04335, NRS 689B.255 is made applicable to self-insured health plans. No exceptions noted.	Complete.
Benefits Coverage: Prescription Drug Coverage NRS 287.0433	• Power to establish plan of life, accident or health insurance; reinsurance; power to use list of preferred prescription drugs developed by Department of Health and Human Services and obtain prescription drugs through certain purchasing agreements.	No exceptions noted.	None.
Funding Requirements: Non-retiree plans NRS 287.0435 NRS 287.0434	• Creation; investment; disbursements; administration by State Treasurer; checking account for payment of claims. • Power to use assets, contract for services and charge and collect certain fees and payments. [Effective through December 31, 2025.]	No exceptions noted.	None.
Funding Requirements: Retiree Plans NRS 287.0434 NRS 287.0436 NRS 287.04362 NRS 287.04364 NRS 287.046	• Power to use assets, contract for services and charge and collect certain fees and payments. [Effective through December 31, 2025.] • Creation; purpose. • Limitation on use; investment and administration; sources; interest and income; no reversion of balance to State General Fund. • Uses; fiduciary duty of Board. • Office of Finance to establish assessment to pay portion of premiums or contributions for participating retirees with state service; amounts assessed to be deposited in Retirees' Fund; adjustments to portion paid to Program by Retirees' Fund.	No exceptions noted.	None.
Funding Requirements: Payment of Premiums NAC 287.420	• Employer may agree with employee to defer compensation; investment of withheld money. • Action by Program to recover delinquent payments, penalties or late fees; statute of limitations.	Per the Aon report from 2020" "NAC 287.420 provides penalties to be assessed in the event of nonpayment by the participating public agency.	Confirmed.

Description		Findings	Action Required
NRS 287.04385 NRS 287.044	• Payment of premiums or contributions to Program; coverage of dependents; allocation of money paid to Program; establishment of Active Employee Group Insurance Subsidy Account.	In previous reviews, Aon was told that specific procedures exist regarding the billing and payment of premiums by participating employers to the PEBP. Accounting Unit Policies and Procedures, Collections and Bad Debt Write-Off, provides a process overview and procedures for collection of past due group accounts. Per conference call with PEBP on December 20, 2016, and again in conference call on 8/3/2018, PEBP provided that procedures: (1) exist for billing/monitoring invoicing of local government entities; and (2) identify who is responsible for payment of invoices. PEBP provided that they would send procedures to Aon, and PEBP provided local government agency application instructions. These instructions did not address the above-referenced procedures. Aon requested copy of procedures on January 13, 2017. Per conference call with PEBP on January 20, 2017, PEBP: (1) confirmed that the same procedures apply to local government entities; and (2) provided that they identify by role (other than by name) who is responsible for payment of invoices. Per conference call on September 15, 2020, PEBP confirmed no changes." PEBP has again confirmed no changes for 2022.	
Funding Requirements: Direct Payment of Premiums for Retirees, LOAs Without Pay and LOAs due to Work Injury NAC 287.430	• Direct payment of premiums or contributions: Date due; cancellation of coverage. • Payment of premiums or contributions by retired officers and employees. • Employees on leave without pay: Conditions for payment of premiums or contributions by participating public agency; continuation of or eligibility for coverage or insurance; coverage and insurance upon return to full-time employment.	MPD states that a State agency that employs an individual who is on Leave without pay shall not pay any amount of the cost of premium or contributions for group insurance for that employee, unless the employee receives a minimum compensation of 80 hours in the month for work actually performed, accrued annual leave or sick leave, or any combination thereof.	None.

Description		Findings	Action Required
NAC 287.440 NAC 287.450 NAC 287.460 NRS 287.046 NRS 287.0439 NRS 287.0445	• Officers and employees on leave because of injuries in course of employment: Payment of premiums or contributions; reports of change in status; coverage of dependents upon return to work. • Office of Finance to establish assessment to pay portion of premiums or contributions for participating retirees with state service; amounts assessed to be deposited in Retirees' Fund; adjustments to portion paid to Program by Retirees' Fund. • Participating public agency required to furnish certain notice and information to Board and make records available for inspection; reimbursement of Program for premiums or contributions if agency fails to notify Program of change in status of employee. • Payment of premiums or contributions for state officer or employee injured in course of employment while member of Program.		
Funding Requirements: Procedures Regarding Handling Over/ Underpayments of Premiums NAC 287.470	• Overpayment or underpayment of premiums or contributions. • Powers and duties.	Per the Aon 2020 report: Not clear from MPDs whether in the event of an underpayment of premiums, PEBP notifies the applicable entity. Per conference call with PEBP on December 20, 2016, PEBP described their collections process. In the event of an underpayment of premiums, PEBP notifies the applicable entity. In the event of an overpayment of premiums, it is a net-pay situation; the next month's premium is reduced by a certain amount. Confirmed again with PEBP in conference call of 8/3/2018. ▪ Confirmed again on conference call of September 15, 2020. ▪ PEBP has confirmed that billing reflects under and over payment situations..	Complete.
Subrogation to Rights of Officer, Employee or Dependent NRS 287.0465	• Board subrogated to rights of member; lien upon proceeds of recovery from person liable for illness or injury.	The Active Wrap Plan Document highlights the subrogation rights.	Complete.
Claims and Appeals Procedures NAC 287.610 NAC 287.620	• Period for submission. • Assumption regarding availability of benefits under Medicare; coordination under Medicare. • Notification of adverse determination; grounds for appeal. • Appeal of adverse determination: Requirements; duties of Appeals Manager.	The Active Wrap Plan Document and medical MPDs outline the claims and appeals procedures.	Complete.

Description		Findings	Action Required
NAC 287.660 NAC 287.670 NAC 287.680 NAC 287.690 NRS 287.043 NRS 287.04335 NRS 689B.255	• Appeal of decision of Appeals Manager: Requirements; duties of Executive Officer or designee. • Request for external review. • Powers and duties. • Compliance with certain provisions required to provide health insurance through plan of self-insurance. • Approval or denial of claims; payment of claims and interest; requests for additional information; award of costs and attorney's fees; compliance with requirements; imposition of administrative fine or suspension or revocation of certificate of authority for failure to comply.		
Claims and Appeals Procedures: Complaint System; Notice Requirements to Insured NAC 287.750 NRS 695G.200 NRS 695G.220 NRS 695G.230 NRS 287.04335	• System for resolving complaints of insureds: Requirements for approval and annual report. • Establishment; approval; requirements; assistance for persons filing complaints; examination. • Annual report; managed care organization required to maintain records of and report complaints concerning something other than health care services. • Written notice required by carrier to insured explaining rights of insureds regarding decision to deny coverage; written notice to insured when health carrier denies coverage of health care service. • Compliance with certain provisions required to provide health insurance through plan of self-insurance.	PEBP has confirmed they have a complaint resolution system to the Division of Insurance as noted in NAC 287.750.	Complete.
Claims and Appeals Procedures: Notice to Insured; Expedited Review Process NRS 695G.210 NRS 695G.230 NRS 287.04335	• Review board; appeal; right to expedited review of complaint; notice to insured. • Written notice required by carrier to insured explaining rights of insureds regarding decision to deny coverage; written notice to insured when health carrier denies coverage of health care service. • Compliance with certain provisions required to provide health insurance through plan of self-insurance.	No exceptions noted.	None.
Claims and Appeals Procedures: External Review Process NRS 695G.241 NRS 695G.300 NRS 695G.310	• Circumstances under which adverse determination may be subject to external review; exceptions. • Submission of complaint of covered person to independent review organization. • Annual report; requirements. • Compliance with certain provisions required to provide health insurance through plan of self-insurance.	No exceptions noted.	None.

Description		Findings	Action Required
NRS 287.04335			
Family Medical Leave Provisions NAC 284.52345 NAC 284.581 NAC 284.5811 NAC 284.5813 NAC 284.52315 NAC 284.5237	• "Family and Medical Leave Act" defined. • Adoption by reference of federal law and regulations. • Family and medical leave: Maximum amount in 12-month period; eligibility; use. • Family and medical leave: Records. • "Child" defined. • "Parent" defined.	No exceptions noted.	None.
Leave of Absence for Military Duty NAC 284.5875	• Military leave with pay: Annual period of eligibility.	No exceptions noted.	None.
PEBP Board Authority and Duties NRS 287.04062 NRS 287.0415 NRS 287.0424 NRS 287.0426 NRS 287.043 NRS 287.0487 NRS 287.04335 NRS 287.0402 NRS 287.041 NRS 287.0434	• "Program Fund" defined. • Quorum; Chair; meetings; closed sessions; posting of transcripts of meetings and closed sessions on website; advisory committees. • Executive Officer: Employment; unclassified service; delegation by Board of powers, duties and functions; qualifications; restrictions on other employment and participation in business enterprises and investments; salary. • Staff. • Powers and duties. • Participant in Program may seek assistance from Office for Consumer Health Assistance regarding coverage. • Compliance with certain provisions required to provide health insurance through plan of self-insurance. • Definitions. • Creation; composition; qualifications; terms; vacancies; removal. • Power to use assets, contract for services and charge and collect certain fees and payments. [Effective through December 31, 2025.]	No exceptions noted.	None.

Description		Findings	Action Required
Miscellaneous NAC 287.005 NAC 287.145	• Definitions. • "Vendor" defined.	No exceptions noted.	None.

8.

8. Presentation of proposed changes to Dental Master Plan Document for Plan Year 2023 (Laura Rich, Executive Officer) (**For Possible Action**)

STEVE SISOLAK
Governor

STATE OF NEVADA
PUBLIC EMPLOYEES' BENEFITS PROGRAM
901 S. Stewart Street, Suite 1001 | Carson City, Nevada 89701
Telephone 775-684-7000 | 702-486-3100 | 1-800-326-5496
www.pebp.state.nv.us

LAURA RICH
Executive Officer

LAURA FREED
Board Chair

AGENDA ITEM

[X] Action Item
[ ] Information Only

Date: December 5, 2022

Item Number: VIII

Title: Proposed Changes to the Dental Master Plan Document (MPD)

SUMMARY

When PEBP onboarded to the new Third-Party Administrator, UMR, PEBP plan rules were applied as written in the MPD; however, this identified several unanticipated discrepancies in how plan rules were being applied in practice versus the actual language of the Master Plan Document. In many cases, the plan language was found to be vague and thus, the interpretations between HealthSCOPE Benefits and UMR differed. This was further highlighted during audits performed by Claims Technologies Inc. (CTI) and has been the subject of provider complaints.

As a result, PEBP, CTI, and UMR staff reviewed the MPD in-depth to identify areas that could be improved immediately, without any impact to coverage or benefits and avoiding a special open enrollment period.

This report proposes plan language changes to the Dental Master Plan Document for clarity in the current plan year (PY2023) and going forward.

REPORT

OVERVIEW

When conducting the review, it was noted that updating targeted sections in the plan document would create conflict with other parts of the Master Plan Document. These conflicts are also addressed. The overall intent of the proposed changes is to clarify any potential conflicts in the plan's language.

PROPOSED PLAN LANGUAGE CHANGES

The entirety of the current plan document can be found here: https://pebp.state.nv.us/wp-content/uploads/2022/05/FINAL-PY2023-Dental-Life-MDP-20220526.pdf, however the specific pages where changes are being proposed are attached as **Attachment B**.

The following is a summary of clarifications and changes by page identifier and heading:

Page 13 - Basic Services, Explanation and Limitations
The language of the plan document needed to be clarified for oral surgery due to language conflict between the Dental and Medical benefit.

Removed

- Oral surgery, limited to alveoplasty or alveolectomy, removal of cysts or tumors, torus, and impacted wisdom teeth, including local anesthesia and postoperative care
- Appliance for thumb sucking (individuals under 16 years of age) or night guard for bruxism (grinding teeth). This had confusing language that caused additional processing time because the nightguard could be used for periodontal disease. This is updated in the subsequent ending two bullet points, below.

Added

- Emergency palliative treatment for pain.
- Uncomplicated oral surgery is surgery not identified as "complex oral surgery." Oral surgery is limited to removal of teeth, incision, and drainage.
- Complex oral surgery means procedures including surgical extractions of teeth, impactions, alveoloplasty or alveolectomy, vestibuloplasty, and residual root removal, including local anesthesia and postoperative care.
- Appliance for thumb sucking (for individuals under 16 years of age)
- occlusal guard or night guard. A requirement for "Bruxism" was removed to coincide with industry standards.

Page 21 – Dental Claims Administration
Removed the requirement for invoices to pay claims. This requirement caused an extensive delays in claims processing. While this is required for medical due to heavy mark up of medical devices, this is not a concern for dental and only creates more manual interventions and delays.

Page 37-38 – Participant Contact Guide
Added United Healthcare for Basic Life Insurance

For Diversified Dental Services the contact information was updated.
Added bullet point reflecting Principal Dental Network for providers outside of Nevada.

Page 40-44 – Key Terms and Definitions
The definition for Cost-Efficient was removed because claims were being repriced for cost-efficient services. This is removed to avoid conflict when updating "Medically Necessary," below.

Definition for Dental was updated. Injury was removed and clarified to "see Injury to Sound and Natural Teeth." This was conflict noted in during the review of the plan document that needed to be clarified.

Updated definition of Injury to Sound and Natural Teeth to exclude "this does not include an injury to the teeth caused by any intrinsic force, such as the force of biting or chewing." This was conflict noted in during the review of the plan document that needed to be clarified.

Updated definition of "Medically Necessary" to exclude references to "cost-efficient" and "appropriate." Numerous claims were repriced due to a more cost-efficient benefit, namely resin-composite fillings when compared to silver Amalgam fillings. By removing these references, claims will pay based on how they are submitted by the provider.

STAFF RECOMMENDATION

Approve the proposed changes for the Dental and Life Master Plan Document for Plan Year 2023 going forward.

ATTACHMENT B

Schedule of Dental Benefits

(All benefits are subject to the Deductible except where noted)
See also the *Exclusions*, and *Key Terms and Definitions* Sections of this document for important information)

Benefit Description	In-Network	Out-of-Network
Basic Services	After the Deductible is met, the Plan pays 80% of the discounted allowed fee schedule	After the Deductible is met, Plan pays 50% of the in-network provider fee schedule for the Las Vegas service area. For services outside of Nevada, the Plan will reimburse at the U&C rates

Explanations and Limitations

- Plan Year Deductible applies
- Dental visit during regular office hours for treatment and observation of injuries to teeth and supporting structures (other than for routine operative procedures)
- After hours for emergency dental care
- Consultation by a specialist for case presentation when a general dentist has performed diagnostic procedures
- Emergency treatment
- Film fees, including examination and diagnosis, except for injuries
- Dental CT scans are allowed at varying frequencies depending on the type of service.
- Periapical, entire dental film series (14 films), including bitewings as necessary every 36 months **or** panoramic survey covered once every 36 months
- Basic services are subject to the individual Plan Year maximum dental benefit.
- Full-mouth periodontal maintenance cleanings, payable four times per Plan Year. Even if your dentist recommends more than four periodontal maintenance cleanings, the Plan will only consider four for benefit purposes. You will be responsible for charges in excess of four cleanings in a single Plan Year
- Laboratory services, including cultures necessary for diagnosis and/or treatment of a specific dental condition
- For multiple restorations, one tooth surface will be considered a single restoration
- Out-of-Network: After deductible, the Plan pays 80% of the in-network provider fee schedule for the Las Vegas service area. For services outside of Nevada, the Plan will reimburse at the U&C rates.
- Biopsy, examination of oral tissue, study models, microscopic exam
- Emergency palliative treatment for pain.
- Uncomplicated oral surgery is surgery not identified as "complex oral surgery." Oral surgery is limited to removal of teeth, incision, and drainage.
- Complex oral surgery means procedures including surgical extractions of teeth, impactions, alveoloplasty or alveolectomy, vestibuloplasty, and residual root removal, including local anesthesia and postoperative care

- ~~Oral surgery, limited to alveoplasty or alveolectomy, removal of cysts or tumors, torus, and impacted wisdom teeth, including local anesthesia and postoperative care~~
- Amalgam restorations for primary and permanent teeth, synthetic, silicate, plastic and composite fillings, retention pin when used as part of restoration other than a gold restoration
- Appliance for thumb sucking (individuals under 16 years of age) or night guard for bruxism (grinding teeth)
- Dental CT scans, depending on the type and necessity are allowed by the Plan. Contact the claims administrator for more information. You must have the CDT code of your requested procedure before calling
- Initial installation of a removable, fixed or cemented inhibiting appliance to correct thumb sucking is payable for individuals under age 16 years
- No coverage for root canal therapy when the pulp chamber was opened before coverage under this dental plan began
- Out-of-Network: After deductible, the Plan pays 80% of the in-network provider fee schedule for the Las Vegas service area. For services outside of Nevada, the Plan will reimburse at the U&C rates.

Schedule of Dental Benefits

(All benefits are subject to the Deductible except where noted)
See also the *Exclusions*, and *Key Terms and Definitions* Sections of this document for important information)

Benefit Description	In-Network	Out-of-Network
Major Services	After the Deductible is met, Plan pays 50% of the discounted allowed fee schedule.	After the Deductible is met, Plan pays 50% of the in-network provider fee schedule for the Las Vegas service area For services outside of Nevada, the Plan will reimburse at the U&C rates

Explanations and Limitations

- Plan Year Deductible applies to Major services
- Major services are subject to the individual Plan Year maximum dental benefit
- No coverage for a crown, bridge, or gold restoration when the tooth was prepared before coverage under the dental Plan began
- Facings on crowns or pontics posterior to the second bicuspid are considered cosmetic and not covered. Gold restorations (inlays and onlays) covered only when teeth cannot be restored with a filling material

- Date(s) the services or supplies were provided.
- Patient's name.
- Provider's name, address, phone number, and professional degree or license.
- Provider's federal tax identification number (TIN).
- Provider's signature.

Please review your bills to be sure they are appropriate and correct. Report any discrepancies in billing to the third-party administrator. This can reduce costs to you and the Plan. Complete a separate claim form for each person for whom Plan benefits are being requested. If another plan is the primary payer, send a copy of the other plan's explanation of benefits (EOB) along with the claim you submit to this Plan.

To assure that medical, pharmacy or dental expenses you incur are eligible under this Plan, the Plan has the right to request additional information from any hospital, facility, physician, laboratory, radiologist, dentist, pharmacy or any other eligible medical or dental provider. For example, the Plan has the right to deny deductible credit or payment to a provider if the provider's bill does not include or is missing one or more of the following components. This is not an all-inclusive list.

- Itemized bill to include but not be limited to: Proper billing codes such as CPT, HCPCS, Revenue Codes, CDT, ICD 9, and ICD 10.
- Date(s) of service.
- Place of service.
- Provider's Tax Identification Number.
- Provider's signature.
- Operative report.
- Patient ledger.
- Emergency room notes.
- ~~For providers such as hospitals and facilities that bill for items such as orthopedic devices/implants or other types of biomaterial, the Plan has the right to request a copy of the invoice from the organization that supplied the device/implant/biomaterial to the hospital or facility. The Plan has the right to deny payment for such medical devices until a copy of the invoice is provided to the Plan's claims administrator.~~

NOTE: Claims are processed by PEBP's third-party administrator in the order they are received. If a claim is held or "soft denied" that means that PEBP's third-party administrator is holding the claim to receive additional information, either from the participant, the provider or to get clarification on benefits to be paid. A claim that is held or soft denied will be paid or processed when the requested additional information is received. Claims filed while another is held or soft denied may be paid or processed even though they were received at a later date.

NOTE: It is your responsibility to maintain copies of the explanation of benefits provided to you by PEBP's third party administrator or prescription drug administrator. Explanation of benefits

Participant Contact Guide

Express Scripts Pharmacy Benefit Administrator Customer Service and Prior Authorization (855) 889-7708 *www.Express-Scripts.com* **Express Scripts Home Delivery** PO Box 66566 St. Louis, MO 63166-6566 Customer Service: (855) 889-7708 **Accredo Specialty Pharmacy** Customer Service: (855) 889-7708 **Express Scripts Benefit Coverage Review Department** PO Box 66587, St. Louis, MO 63166-6587 Phone: 800-946-3979 **Express Scripts Clinical Appeals Department** PO Box 66588 St. Louis, MO 63166-6588 Phone: 800-753-2851 Fax: 877-852-4070 **MCMC LLC** **Attn: Express Scripts Appeal Program** 300 Crown Colony Dr. Suite 203 Quincy, MA 02169-0929 617-375-7700 ext. 28253 / Fax: 617-375-7683	Pharmacy Benefit Manager for the CDHP, LD PPO Plan, and Premier Plan Prescription drug information • Retail network pharmacies • Prior authorization • Price a Medication tool • Home Delivery service and Mail Order forms • Preferred Mail Order for diabetic supplies • Accredo Specialty Drug Services • Coverage and Clinical reviews, appeals
Diversified Dental Services 5470 Kietzke Lane, Ste 300~~PO Box 36100~~ ~~Las Vegas, NV 89133-6100~~ Reno, NV 89511 ProviderRelations@ddsppo.com ~~1-Northern Nevada: (866) 270-8326~~ ~~Southern Nevada: (800) 249-3538~~866-270-8326 diversifieddental.com~~www.ddsppo.com~~	PPO Dental Network • Statewide PPO Dental Providers • ~~National PPO Dental Providers~~ • Dental Provider directory • National PPO Dental Providers outside of Nevada utilizes the Principal Dental Network
Health Plan of Nevada (702) 242-7300 or (877) 545-7378 *www.stateofnv.healthplanofnevada.com*	Southern Nevada Health Maintenance Organization (HMO) • Medical claims/provider network
VIA Benefits 10975 Sterling View Drive, Suite A1	Medicare Exchange • Medigap (Supplemental) plans

Participant Contact Guide

South Jordan, UT 84095 (888)598-7545 *https://my.viabenefits.com/pebp* Phone: (888) 598-7545; Fax: (402) 231-4310	• Medicare Advantage Plans (HMO and PPO) • Voluntary Vision • Voluntary Dental • HRA claims administrator
United Healthcare Group Number: 370074 Customer Service: 1-888-763-8232 UnitedHealthcare Specialty Benefits P.O. Box 7149 Portland, ME 04112-7149	• Basic Life Insurance for eligible active and retirees
The Standard Insurance Company 900 SW Fifth Avenue Portland, OR 97204 (888) 288-1270 *www.standard.com/mybenefits*	• ~~Basic Life Insurance~~ • Voluntary (Supplemental) Life Insurance • Voluntary Short-Term Disability • Travel Assistance • Beneficiary designations
Office for Consumer Health Assistance 555 E. Washington Avenue, Suite 4800 Las Vegas, NV 89101 Customer Service: (702) 486-3587 or (888) 333-1597 *http://dhhs.nv.gov/Programs/CHA/Contact_Gov CHA/*	**Consumer Health Assistance** • Concerns and problems related to coverage • Provider billing issues • External review information
The Living Will Lockbox c/o Nevada Secretary of State 101 North Carson St., Ste. 3 Carson City, NV 89701 Phone: (775) 684-5708; Fax: (775) 684-7177 https://www.nvsos.gov/sos/online-services/nevada-lockbox	**Living Will Information** • Declaration governing life-sustaining treatment/do not resuscitate order • Durable power of attorney for health care decisions

Base Plan: The Self-Funded Consumer Driven Health Plan (CDHP). The base Plan is also defined as the "default Plan" where applicable in this document and other communication materials produced by PEBP.

Benefit, Benefit Payment, Plan Benefit: The amount of money payable for a claim, based on the usual and customary charge, after calculation of all Deductibles, Coinsurance, and copayments, and after determination of the Plan's exclusions, limitations, and maximums.

Bitewing X-Rays (dental): Dental x-rays showing the coronal (crown) halves of the upper and lower teeth when the mouth is closed.

Bridge, Bridgework (dental) Fixed: A prosthesis that replaces one or more teeth and is cemented in place to existing abutment teeth. It consists of one or more pontics and one or more retainers (crowns or inlays). The patient cannot remove the prosthesis.

Business Day: Refers to all weekdays, except Saturday or Sunday, or a state or federal holiday.

Claims Administrator: The person or company retained by the Plan to administer claim payment responsibilities and other administration or accounting services as specified by the Plan.

Coinsurance: That portion of eligible medical expenses for which the covered person has financial responsibility. In most instances, the covered individual is responsible for paying a percentage of covered medical expenses in excess of the Plan's Deductible. The Coinsurance varies depending on whether in-network or out-of-network providers are used.

Coordination of Benefits (COB): The rules and procedures applicable to the determination of how plan benefits are payable when a person is covered by two or more health care plans. (See also the *Coordination of Benefits* section).

Cosmetic Surgery or Treatment: Surgery or medical treatment to improve or preserve physical appearance, but not physical function. Cosmetic surgery or treatment includes (but is not limited to) removal of tattoos, breast augmentation, or other medical, dental, or surgical treatment intended to restore or improve physical appearance, as determined by the Plan Administrator or its designee.

~~**Cost-Efficient:** See the definition of medically necessary for the definition of cost-efficient as it applies to dental services that are medically necessary.~~

Course of Treatment (Dental): The planned program of one or more services or supplies, provided by one or more dentists, to treat a dental condition diagnosed by the attending dentist as a result of an oral examination. The course of treatment begins when a dentist first renders a service to correct or treat the diagnosed dental condition.

Covered Dental Expenses: See the definition of *Eligible Dental Expenses*.

Crown (Dental): The portion of a tooth covered by enamel. An artificial crown is a dental prosthesis used to return a tooth to proper occlusion, contact and contour, as used as a restoration or an abutment for a fixed prosthesis.

Customary Charge: See the definition of Usual and Customary Charge.

Deductible: The amount of eligible dental expenses you are responsible for paying before the Plan begins to pay benefits. The amount of deductibles is discussed in the *Dental Expense Coverage* section of this document.

Dental: As used in this document, dental refers to any services performed by (or under the supervision of) a dentist, or supplies (including dental prosthetics). Dental services include treatment to alter, correct, fix, improve, remove, replace, reposition, restore or treat: teeth; the gums and tissues around the teeth; the parts of the upper or lower jaws that contain the teeth (the alveolar processes and ridges); the jaw, any jaw implant, or the joint of the jaw (the temporomandibular joint); bite alignment, or the meeting of upper or lower teeth, or the chewing muscles; and/or teeth, gums, jaw or chewing muscles because of pain, ~~injury,~~ decay, malformation, disease or infection. Dental services and supplies are covered under the dental expense coverage plan and are not covered under the medical expense coverage of the Plan unless the medical plan specifically indicates otherwise in the Schedule of Medical Benefits.

For injury to teeth see *Injury to Sound and Natural Teeth*, below.

Dental Care Provider: A dentist, dental hygienist nurse, or other health care practitioner (as those terms are specifically defined in this section of the document) who is legally licensed and who is a dentist or performs services under the direction of a licensed dentist; and acts within the scope of his or her license; and is not the patient or the parent, spouse, sibling (by birth or marriage) or child of the patient.

Dental Subspecialty Areas:

Subspecialty Area	Services related to the diagnosis, treatment, or prevention of diseases
Endodontics	The dental pulp and its surrounding tissues.
Implantology	Attachment of permanent artificial replacement of teeth directly to the jaw using artificial root structures.
Oral Surgery	Extractions and surgical procedures of the mouth.
Orthodontics	Abnormally positioned or aligned teeth.
Pedodontics	Treatment of dental problems of children.

Maximum has been reached, if certain services were denied and why, amounts you need to pay to the provider, etc.

Fixed Appliance: A device that is cemented to the teeth or attached by adhesive materials.

Fluoride: A solution applied to the surface of teeth, or a prescription drug (usually in pill form) to prevent dental decay.

Food and Drug Administration (FDA): The U.S. government agency responsible for administration of the Food, Drug and Cosmetic Act and whose approval is required for certain prescription drugs and other medical services and supplies to be lawfully marketed.

Health Care Practitioner: A physician, behavioral health practitioner, chiropractor, dentist, nurse, nurse practitioner, physician assistant, podiatrist, or occupational, physical, respiratory or speech therapist or speech pathologist, master's prepared audiologist, optometrist, optician for vision plan benefits, oriental medicine doctor for acupuncture or Christian Science Practitioner, who is legally licensed and/or legally authorized to practice or provide certain health care services under the laws of the state or jurisdiction where the services are rendered: and acts within the scope of his or her license and/or scope of practice.

Health Care Provider: A health care practitioner as defined above, or a hospital, ambulatory surgical facility, behavioral health treatment facility, birthing center, home health care agency, hospice, skilled nursing facility, or sub-acute care facility (as those terms are defined in this *Definitions* section).

HIPAA: Health Insurance Portability and Accountability Act of 1996. Federal Regulation affecting portability of coverage; electronic transmission of claims and other health information; privacy and confidentiality protections of health information.

HIPAA Special Enrollment: Enrollment rights under HIPAA for certain employees and dependents who experience a loss of other coverage and when there is an adoption, placement for adoption, birth, or marriage.

Impression: A negative reproduction of the teeth and gums from which models of the jaws are made. These models are used to study certain conditions and to make dental appliances and prostheses.

Injury to Sound and Natural Teeth (ISNT): An injury to the teeth caused by trauma from an external source. ~~This does not include an injury to the teeth caused by any intrinsic force, such as the force of biting or chewing.~~ Benefits for injury to sound and natural teeth are payable under the medical plan (see also the definition of Sound and Natural Teeth).

Inlay: A restoration made to fit a prepared tooth cavity and then cemented into place (see the definition of restoration).

In-Network Services: Services provided by a health care provider that is a member of the Plan's Preferred Provider Organization (PPO), as distinguished from out-of-network services that are provided by a health care provider that is not a member of the PPO network.

In-Network Contracted Rate: The negotiated amount determined by the PPO network to be the maximum amount charged by the PPO provider for a covered service. In some cases, the in-network contracted amount may be applied to out-of-network provider charges.

Medically Necessary: A medical or dental service or supply will be determined to be "medically necessary" by the Plan Administrator or its designee if it:

- is provided by or under the direction of a physician or other duly licensed health care practitioner who is authorized to provide or prescribe it (or dentist if a dental service or supply is involved); and
- is determined by the Plan Administrator or its designee to be necessary in terms of generally accepted American medical and dental standards; and
- is determined by the Plan Administrator or its designee to meet all the following requirements:
  - It is consistent with the symptoms or diagnosis and treatment of the illness or injury; and
  - It is not provided solely for the convenience of the patient, physician, dentist, hospital, health care provider, or health care facility; and
  - It is an "appropriate" service or supply given the patient's circumstances and condition; and
  - It is a ~~"cost-efficient" supply or~~ level of service that can be safely provided to the patient; and
  - ~~It is safe and effective for the illness or injury for which it is used.~~

  ~~A medical or dental service or supply will be considered to be "appropriate" if:~~

  ~~It is a diagnostic procedure that is called for by the health status of the patient and is: as likely to result in information that could affect the course of treatment as; and no more likely to produce a negative outcome than any alternative service or supply, both with respect to the illness or injury involved and the patient's overall health condition.~~

  ~~It is care or treatment that is: as likely to produce a significant positive outcome as; and no more likely to produce a negative outcome than any alternative service or supply, both with respect to the illness or injury involved and the patient's overall health condition.~~

~~A medical or dental service or supply will be considered to be "cost-efficient" if it is no more costly than any alternative appropriate service or supply when considered in relation to all health care expenses incurred in connection with the service or supply. The fact that your physician or dentist may provide, order, recommend or approve a service or supply does not mean that the~~

~~service or supply will be considered to be medically necessary for the medical or dental coverage provided by the Plan.~~

o

A hospitalization or confinement to a health care facility will not be considered to be medically necessary if the patient's illness or injury could safely and appropriately be diagnosed or treated while not confined.

A medical or dental service or supply that can safely and appropriately be furnished in a physician's or dentist's office or other less costly facility will not be considered to be medically necessary if it is furnished in a hospital or health care facility or other more costly facility.

- The non-availability of a bed in another health care facility, or the non-availability of a health care practitioner to provide medical services will not result in a determination that continued confinement in a hospital or other health care facility is medically necessary.
- A medical or dental service or supply will not be considered to be medically necessary if it does not require the technical skills of a dental or health care practitioner or if it is furnished mainly for the personal comfort or convenience of the patient, the patient's family, any person who cares for the patient, any dental or health care practitioner, hospital or health care facility.

Non-Network: See Out-of-Network Services.

Non-Participating Provider: A health care provider who does not participate in the Plan's Preferred Provider Organization (PPO).

Office Visit: A direct personal contact between a dentist or other dental care practitioner and a patient in the dental care practitioner's office for diagnosis or treatment associated with the use of the appropriate office visit code in the Current Dental Terminology (CDT) manual of the American Dental Association and with documentation that meets the requirement of such CDT coding.

Onlay: An inlay restoration that is extended to cover the biting surface of the tooth, but not the entire tooth. It is often used to restore lost and weakened tooth structure.

Oral Surgery: The specialty of dentistry concerned with surgical procedures in and about the mouth and jaw.

Orthodontics, Orthodontia: The science of the movement of teeth to correct a malocclusion or "crooked teeth."

Orthognathic Services: Services dealing with the cause and treatment of malposition of the bones of the jaw, such as prognathism, retrognathism or TMJ syndrome. See the definitions of Prognathism, Retrognathism and TMJ.

9.

9. Presentation of wage and benefit survey results (Laura Rich, Executive Officer)(Information/Discussion)

STEVE SISOLAK
Governor

STATE OF NEVADA
PUBLIC EMPLOYEES' BENEFITS PROGRAM
901 S. Stewart Street, Suite 1001 | Carson City, Nevada 89701
Telephone 775-684-7000 | 702-486-3100 | 1-800-326-5496
www.pebp.state.nv.us

LAURA RICH
Executive Officer

LAURA FREED
Board Chair

AGENDA ITEM

☐ Action Item
☒ Information Only

Date: December 5, 2022

Item Number: IX

Title: Results of 2022 Employee Wage and Benefits Survey

SUMMARY

Earlier this year, the Governor's Office established a working group tasked with developing suggestions and opportunities to create a more robust wage and benefits package for state employees. The working group included leadership from the Governor's Finance Office, Division of Human Resource Management (DHRM), PERS, PEBP, and the Governor's Office.

As part of this process, the group composed and released a short survey to all state employees (including NSHE), which included questions regarding employees' desires relating to wages and benefits. PEBP was given permission to share the results with the PEBP Board in anticipation of PY24 benefit design considerations.

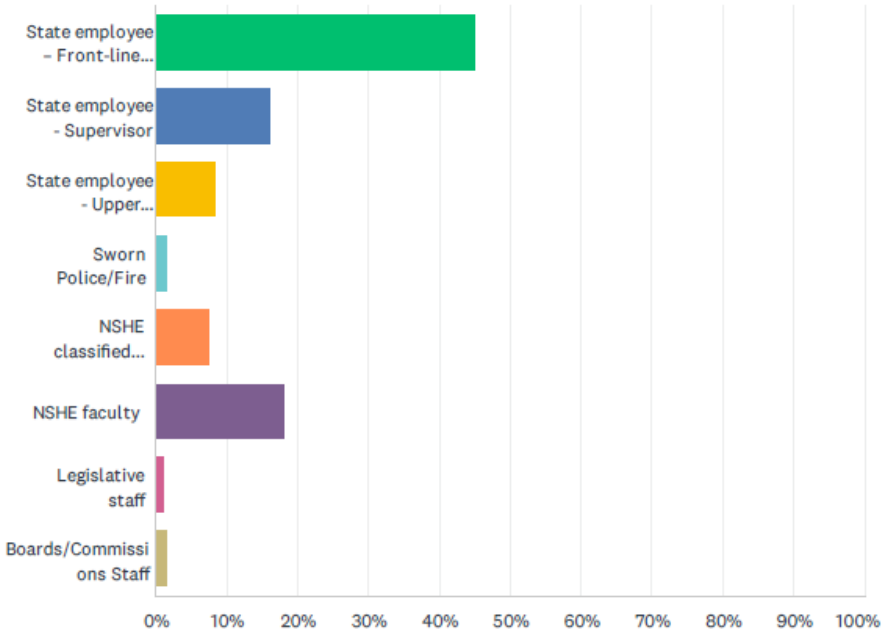
REPORT

The survey was released on October 25th and remained active through November 1. With 7,413 responses, it had a much higher response rate than any of the benefit-specific surveys previously put out by PEBP.

The following illustrations show each question and corresponding responses:

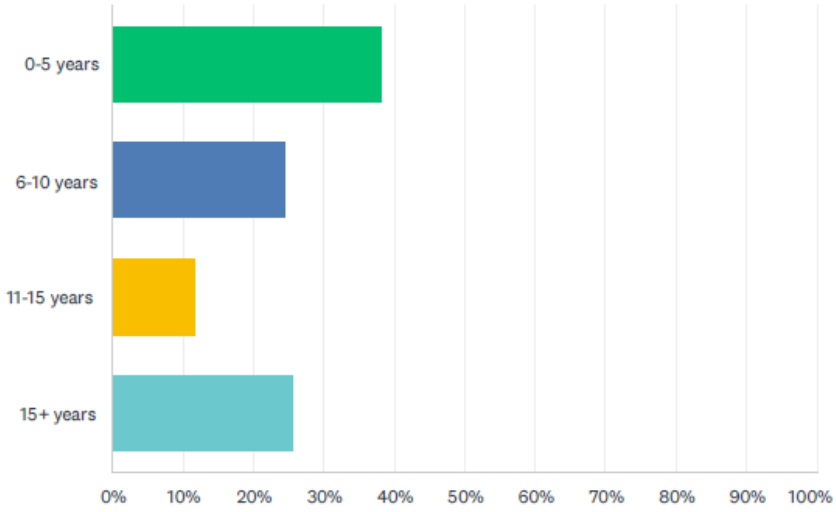
Q1 Which best describes your role in state government?

Answered: 7,413 Skipped: 24



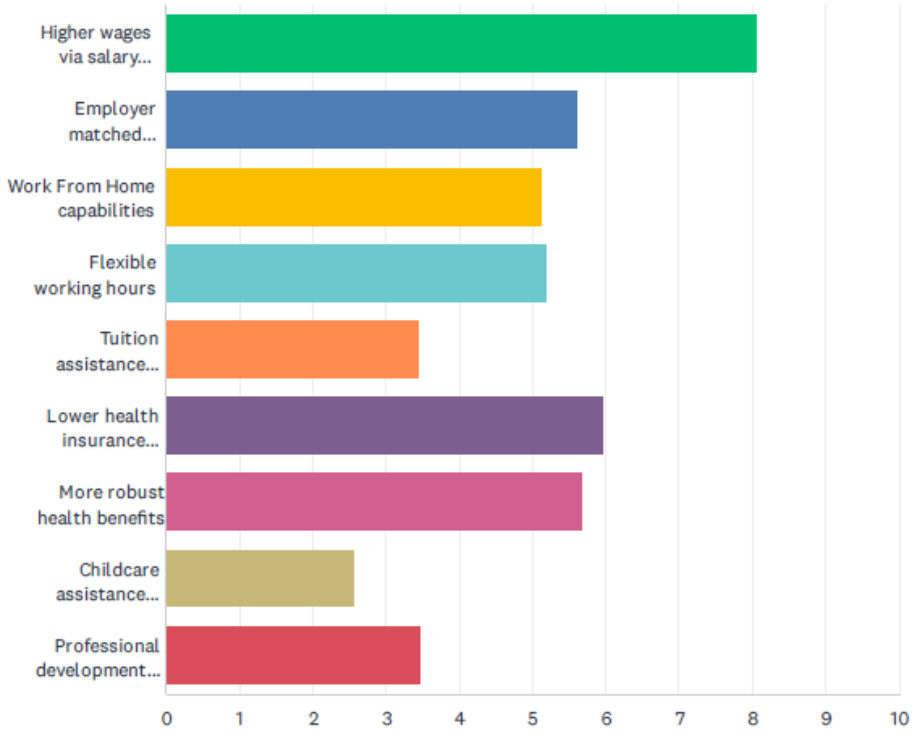
Q2 Select how many years of service you have as a State of Nevada/NSHE employee

Answered: 7,420 Skipped: 17



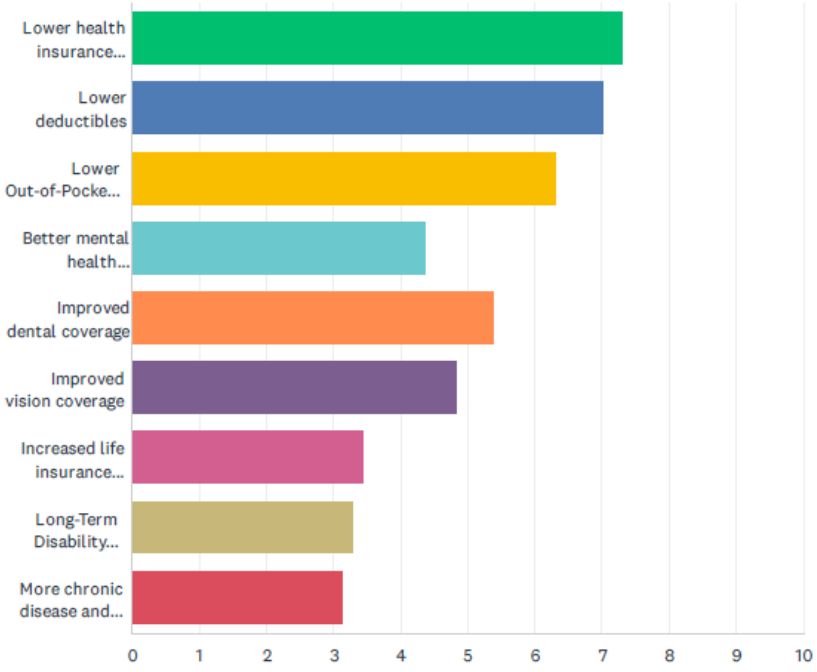
Q3 Please rate the following employee benefits you find most important from an employee perspective (rank from most important to least important)

Answered: 7,400 Skipped: 37



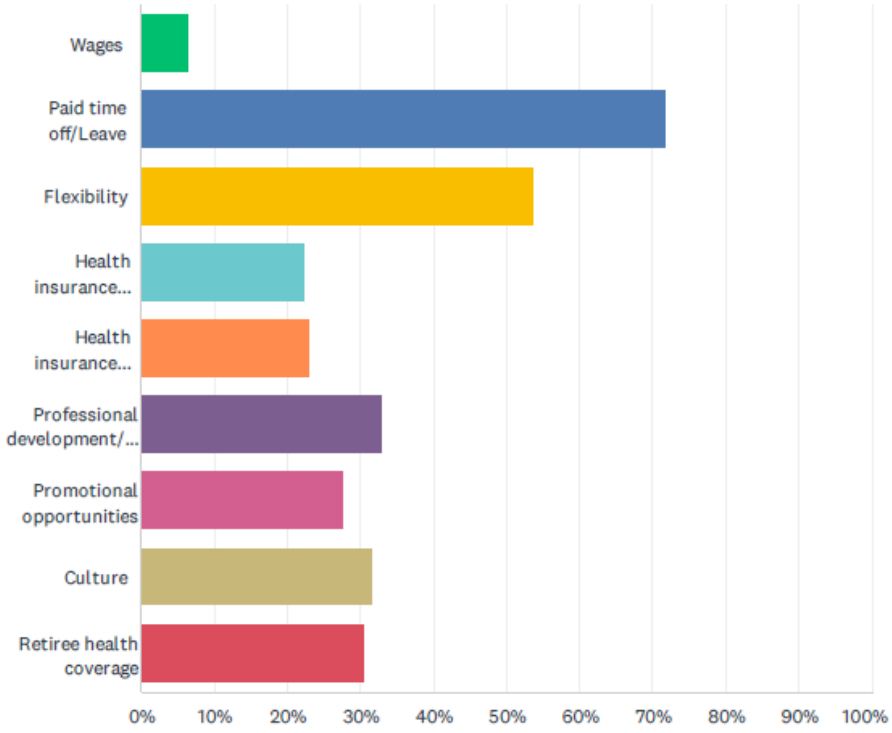
Q4 As a state employee, please rate the following potential improvements to PEBP/health insurance related benefits (current benefit levels found here: https://pebp.state.nv.us/plans/plan-documents/) you would find most important: (rank from most important to least important)

Answered: 7,279 Skipped: 158



Q5 When compared to other public and private sector employers, I believe the State of Nevada provides better than average benefits in the following categories: (select top 3)

Answered: 7,437 Skipped: 0



Employee Benefits Package Survey

Q6 Please provide additional comments regarding employee benefits:

Answered: 3,704 Skipped: 3,733

This question allowed respondents to provide additional comments and input in a freeform text field.

- The overwhelming majority of comments were related to wages. Many comments highlighted the disparity between state and private sector and other public sector pay while others focused on PERS matching as a way to increase pay. Additionally, many comments included statements regarding consistently low COLA increases.

- Another area that received a lot of attention was regarding telecommuting and flexibility. It was consistently communicated that this benefit is highly desired and helps create a work/life balance.
- Many remarks regarding the high cost of healthcare (premiums and deductibles), some specifically around urgent care and emergency room visits.
- Several comments regarding the need for HR onboarding/offboarding and advocacy/assistance to navigate the complex health insurance program.
- A desire for longevity pay to be reinstated.
- Several comments regarding the need for consistency in PEBP (benefits, networks, providers, etc).
- Respondents **did not** like being forced to pick 3 in Q5. Most said PTO was the only perk they would have picked if they were not forced to pick 3.

10.

10. Discussion and possible action on potential program design changes for Plan Year 2024 (July 1, 2023 to June 30, 2024) including, but not limited to the following:

    (Laura Rich, Executive Officer) (**For Possible Action**)

    10.1 Real Appeal

    10.2 Hinge Health

    10.3 Doctor on Demand

    10.4 Expanded Travel Benefit

    10.5 Medical Travel Program

    10.6 Cancer Concierge

    10.7 Dental Plan Annual Maximum Limits

    10.8 Premium Credits

    10.9 HRA Credits

    10.10 Lifestyle Spending Account

STEVE SISOLAK
Governor

STATE OF NEVADA
PUBLIC EMPLOYEES' BENEFITS PROGRAM
901 S. Stewart Street, Suite 1001 | Carson City, Nevada 89701
Telephone 775-684-7000 | 702-486-3100 | 1-800-326-5496
www.pebp.state.nv.us

LAURA RICH
Executive Officer

LAURA FREED
Board Chair

AGENDA ITEM

[X] Action Item
[ ] Information Only

Date: December 5, 2022

Item Number: X

Title: Potential Program Design Changes for Plan Year 2024

BACKGROUND

At the September 29th PEBP Board meeting, staff reported that PEBP is left with a projected balance of approximately $9.5M in excess cash that can be allocated toward new benefits, incentives, or other enhancements. PEBP also presented a list of potential programs and plan design options so that staff could perform additional research and analysis to bring back to the December Board meeting for final consideration. With the assistance of vendor partners, PEBP completed the analysis on the Board requested items and also identified several other solutions being brought forth for Board consideration.

REPORT

Refer to Attachment C

RECOMMENDATION

1. Approve implementation of Real Appeal, Hinge Health, Expanded Travel Benefit, Cancer Concierge to begin July 1, 2023. These programs will provide enhanced benefits to members and have been identified as an overall cost savings to PEBP.
2. Approve the implementation of one or more plan design options that will spend down a total of $9.5M.

Nevada Public Employees' Benefits

Potential Programs, Changes, and Impact for Plan Year 2024

December 5, 2022 PEBP Board Meeting

Segal

Agenda

1. Real Appeal
2. Hinge Health
3. Doctor on Demand
4. Expanded Travel Benefit
5. Medical Travel Program
6. Oncology Concierge
7. Dental Plan Maximum
8. Premium Credits
9. HRA Credits
10. Lifestyle Spending Account

1. REAL APPEAL

About Real Appeal:

Digital Weight Loss Program

- ✓ Online application access
- ✓ Coaching Sessions
- ✓ Tools and Equipment
  - Digital food scale
  - Digital weight scale
  - Recipes
  - Workouts
- ✓ Provides weight tracking module within the EEOC/ADA wellness program rules.

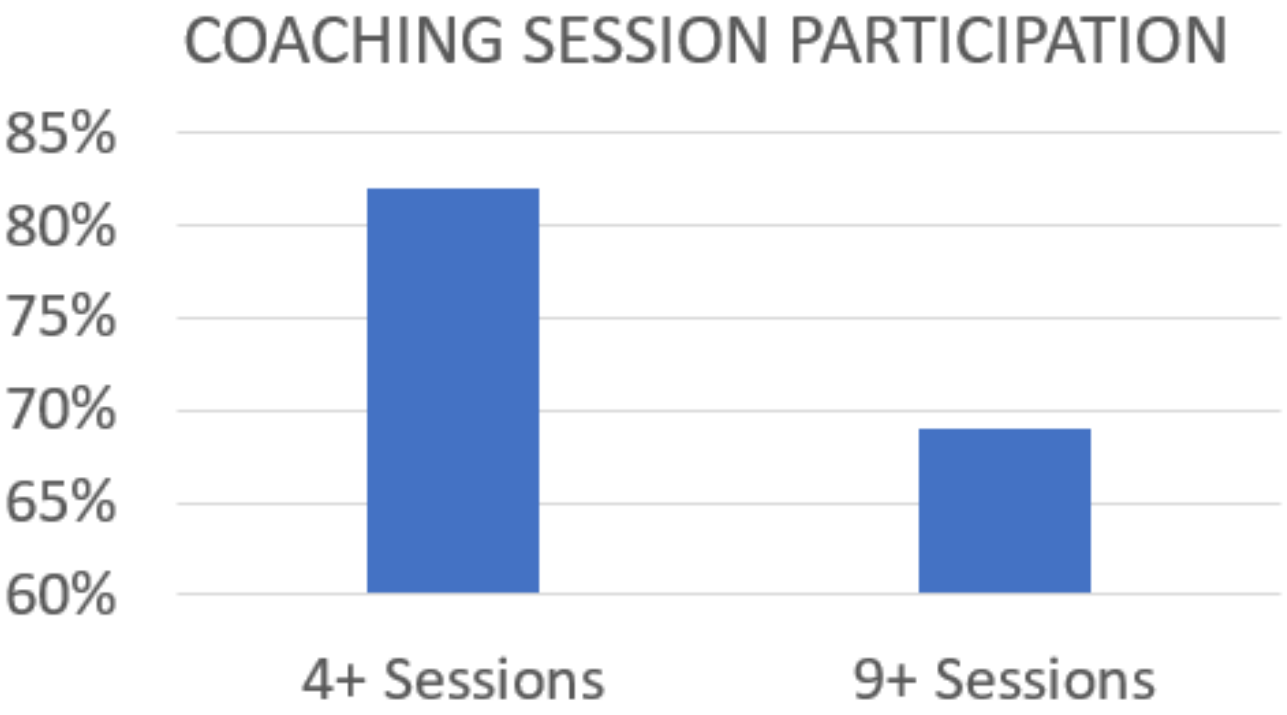
Eligibility

✓ All PEBP members over the age of 18 can participate

.

Real Appeal: Current Experience

- ✓ Currently offered on HMO Plan in Southern Nevada
- ✓ 250 members enrolled
- ✓ Most have participated for more than 6 months



Real Appeal: Implementation

EQUITABLE

- ✓ HDHP, LDHP, and EPO will match the HMO

EASY

- ✓ Implements through existing TPA contract, no contract amendment required

LOW COST

- ✓ Sessions are $49 processed as a claim – billed as preventive care, resulting in no cost share for members in all plans

EDUCATION

- ✓ Flyers for website, ID cards, and Open Enrollment.
- ✓ Web link to UMR resources

SUPPLEMENTS CURRENT PROGRAMS OFFERED

- ✓ Obesity Care Management Program (OCM)

Real Appeal: Impact

- ✓ 2,100 - known members on PEBP plans are morbidly obese (BMI 40+)*
- ✓ Additional members with BMI 30-40 and comorbidities (higher risk)
- ✓ ~ 50% are engaged in OMP

Significant Savings are associated with improved weight, blood p**

Starting BMI	Height/weight	Reduction	Annual Savings
40	5' 8" / 262 lbs	5%	$2,137
35	5' 8" / 230 lbs	5%	$528
30	5' 8" / 197 lbs	5%	$69

*HSB DataScope July-December 2021 Report, presented during the 03/24/2022 Board meeting
**https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4486410/

Real Appeal: Projected Savings

Assumptions:

- ✓10% of 1,100 morbidly obese enroll, participate in 9 sessions and 50% of those reduce weight by 5%
  - Net savings = $70,000
- ✓There are also avoided costs for members with lower BMIs that do not gain the same weight they would otherwise gain over time
  - Additonal net savings = $100,000

TOTAL ESTIMATED ANNUAL SAVINGS: $170,000

2. Hinge Health

Hinge Health: What is it?

Digital Musculoskeletal Care via Motion Technology

- ✓ Virtual Physical Therapy
  - Prevention
  - Acute Injury
  - Chronic and surgical care programs
- ✓ Pelvic Floor Therapy
- ✓ Enso Devise: non-addictive pain management using Transcutaneous electrical nerve stimulation (TENS)
- ✓ Expert medical opinion consultation
- ✓ Health education

Hinge Health: Implementation

WHY

- ✓ MSK ranks 6th on plan spend and accounts for about 6% of total spend.

EASY

- ✓ Implements through existing ESI contract, however contract will need to be amended to budget for associated PMPM fees.

LOW COST

- ✓ $995 Per Engaged Participant Per Year

BENEFITS

- ✓ Increases access, particularly in rural areas
- ✓ Provides on-going coaching, guidance and progress tracking without the need to see a PT each time
- ✓ Positive feedback from other public sector clients who use Hinge Health

Hinge Health: Who is Eligible?

- ✓ Member's MSK condition is assessed to identify where they are on the MSK continuum of care.
- ✓ Member completes clinically validated screening process to assess which digital MSK program is right for them.
  - Screener leverages data analytics and algorithms combined with a dedicated clinical care team review to match each member's personal needs with the right program tools and resources.
  - Member screeners are reviewed by a licensed doctor of physical therapy and/or Hinge Health medical directors.

If a member has a condition that is inappropriate for the Hinge Health program, they are contacted for clarification on their condition, and there is also potential follow up with their PCP for any additional clarification.

Hinge Health – Projected Savings

	Key Metrics	
Targeted Population	**Estimated # Targeted Members** (All members)	48,755
	Estimated Participants (4% of targeted)	1,950
Financial Impact Year 1	**Estimated Annual Healthcare Savings**	$3,357,024
	Annual Program Fees ($995 PPPY x active participant)	$1,942,240
	Estimated Annual Savings TOTAL (**Savings after program investment**)	$1,414,784
	Year 1 ROI	1.73
Financial Impact Year 2	**Estimated Annual Healthcare Savings**	$4,380,288
	Annual Program Fees ($995 PPPY x active participant per month)	$1,942,240
	Estimated Annual Savings TOTAL (Savings after program investment)	$2,438,048
	Year 2 ROI	2.26

Assumption: 50% of population has a musculoskeletal condition

Hinge Health

Initial savings estimate is conservative compared to other programs' experience

	Alaska	Arizona	Kentucky	Boston
Implemented	Sept 2021	Jan 2022	March 2022	July 2021
Total Members	14,000	48,000	200,000	27,000
Participants	430	340	3,500	740
Pain Reduction	51%	48%	52%	56%
Gross Savings ($70 per % in pain reduction)	$1.2M	$800K	$9.0M	$2.0M
Program Costs	$430K	$340K	$3.5M	$740K
Net Savings	$770K	$560K	$5.5M	$1.3M
ROI	**2.8**	**2.4**	**2.6**	**2.7**
Per Participant Net Annual Savings	$1,800	$1,650	$1,570	$1,760
Satisfaction Score	8.5	8.5	8.7	8.9

3. Doctor on Demand

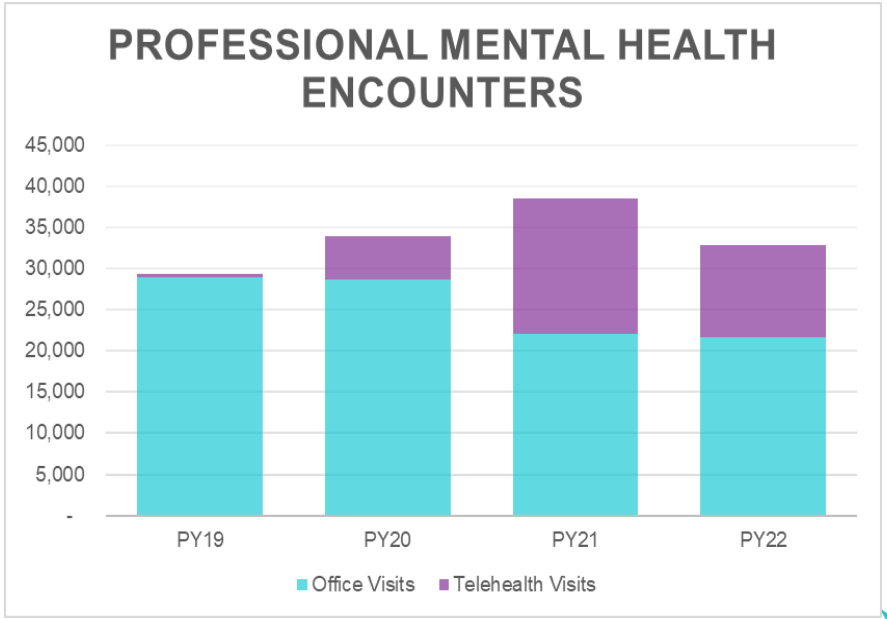
Doctors on Demand and Behavioral Health

WHY?

- ✓ Virtual Utilization & Acceptance increased in 2020-21 and has since waned

Access, Convenience, Low cost

- ✓ Rural
- ✓ More Providers
- ✓ Deductibles/Copays



Doctors on Demand and Behavioral Health

- ✓ Reduce member costs to $5 per visit for Behavioral Health sessions
  - After deductible in HDHP
- ✓ Anticipated impact
  - Increase in access to virtual visits
  - Some in-person visits replaced by virtual

TOTAL ESTIMATED INCREASE IN ANNUAL COSTS: $250,000

**will require IFC approval*

4. Expanded Travel Benefit

Additional Travel Benefit for Medically Necessary Abortions

- ✓ PEBP currently provides coverage for medically necessary abortions
- ✓ Total covered medically necessary abortions on PEBP range from 50-60 annually.
- ✓ As a result of the recent Supreme Court Decision, members and dependents who live in states where abortion care is restricted may not have access to medically necessary abortion care.

Approximately 500-700 females between 18 and 50 are estimated to reside outside of NV. NV residents may be impacted as well when traveling

Proposal extends PEBP travel benefit to members who are required a medically necessary abortion but are unable to receive the care where they reside.

Can be implemented immediately or at start of plan year.

While the IRS has determined that (where not illegal) abortions are medical care per IRS Publication 502, the conditions surrounding employers paying for travel to have an abortion are yet to be determined given existing and changes to state law

Additional Travel Benefit – Projected Costs

- ✓ Estimate 5-10 instances annually where it will be necessary to travel to a different state to receive care
- ✓ Regular commercial travel can be used in most cases. Some instances will require emergency medical transportation (air or ground ambulance)
- ✓ Total PEBP costs estimated to be **$25,000-$50,000** annually

**will require IFC approval*

5. Medical Travel Program

Medical Travel Program

Provides access for members to seek medical care away from their hometown

- ✓ Travel to COE (center of excellence) for certain high-cost, schedulable surgical procedures
  - Joint replacements
  - Cardiac care
  - Bariatric surgery
  - ENT
  - Orthopedic
  - Gastroenterology
- ✓ COE networks = value based, bundled-service contracts
- ✓ Generally results in lower costs and improved outcomes

Medical Travel Program

- ✓ Travel provided using a concierge model that minimizes out-of-pocket expenditures.
- ✓ Vendor reviews local costs compared to COE network costs and if viable provides member with 2-4 choices.
- ✓ Vendor makes travel arrangements
- ✓ Can provide a loaded debit card for meals and incidental expenses

Expenses for travel and lodging (up to established dollar amounts) are generally considered medical expenses per IRS code and are not taxable. Meals are generally considered taxable.

Medical Travel Program

- ✓ Can utilize member incentives
  - waiving deductible on LDHP, EPO
  - Waiving all member costs on LDHP, EPO
  - Waiving all costs after deductible on CHDP
- ✓ Can be implemented mid-year
- ✓ RFP likely to be necessary

Net Annual Savings ~$1,000,000 - $1,500,000

Medical Travel Program

- ✓ Costs can vary widely for same procedure:

$20,000 ← Knee Replacement → $60,000

$15,000 ← Hip Replacement → $40,000

Alaska Case Study

- ✓ Implemented in 2019
- ✓ 14,000 total members
- ✓ Annual activity:
  - 120 cases considered
  - 35 procedures
  - $900,000 in direct annual savings from lower procedure costs
  - Additional $100,000 in annual savings for avoided procedures due to higher quality outcomes

	Procedures	TPA Network	COE Network	Savings
Bariatric	8	$460,000	$170,000	$290,000
Orthopedic	6	$240,000	$90,000	$150,000
General	3	$140,000	$40,000	$100,000
Gastro/Intestinal	6	$22,000	$15,000	$8,000

6. Oncology Concierge Program

Oncology Concierge Program

Current Oncology Case Management – optimizes the quality and cost-effective care focusing management on the highest stage malignancies with acute and catastrophic needs including inpatient and surgical care, metastatic cancer, hospice, and opportunistic infections

An enhanced program can go beyond acute catastrophic needs:

	Current UMR	Enhanced/Concierge
Care coordination	X	X
Focus on most acute cases	X	X
SDoH considerations		X
Dietary counseling with RD		X
Pharmacy management with channel management		X
Second opinions		X
Narrow COE with Travel	X	
COE network		X
Assistance with personal care needs	Basic	Enhanced

Oncology Concierge

Implementation

- ✓ Can be implemented mid-year
- ✓ Review and consider enhanced UMR options or possible RFP

Savings Projections

- ✓ Cancer is second highest cost diagnosis in HDHP and LDHP; Number 4 in EPO
- ✓ $20M in annual claims costs, representing about 1,500 patients
- ✓ Cost PMPM anticipated to be $2.00-5.00
- ✓ Concierge programs can reduce cancer costs by 5-10%, representing a **savings of about $1M-$2M annually.**

:

7. Dental Plan Maximum

Dental Plan Max

PEBP $1,500 Annual Benefit Limit (ABL) in place since 2011

Benchmarking Data

- ✓ UMR book of business - $1,500 most prevalent
  - Many considering increasing to $2,000 due to rising costs

Industry Survey

- ✓ 40-50% of public sector and large employers have an ABL between $1,500-$2,000[1]
- ✓ Another 40% have an ABL $2,000 or greater[1]
- ✓ Another 5% have plans with no ABL[1]
- ✓ For those that have an ABL, western employers tend to have higher limits ($2,250 vs. $1,750 national average)[2]

Procedures, such implants, crowns, periodontal surgery, etc. have members meeting the ABL with a single claim.

[1] CompData annual benefits survey, October 1, 2021
[2] Economic Research Institute 15th Annual Benefits Benchmarking Survey, 2022

Dental Plan

Single Claim:

- ✓ Procedures, such implants, crowns, periodontal surgery, etc. have members meeting the ABL with a single claim.
- ✓ 8% of members met the $1,500 ABL in PY22
- ✓ Increasing the ABL would increase dental costs and rates:

Increased ABL	Cost increase - $	Cost increase - % (Dental)	Dollar impact on Single Premiums
$1,750	$600K	2.5%	$1-2
$2,000	$750K	3.1%	$1-2

**will require IFC approval*

8. Premium Credits

Premium Credits

- ✓ PEBP may apply excess cash toward premium credits
- ✓ Advantage: Immediate reduction to employee premiums
- ✓ Disadvantage: There is no guarantee the credit can be continued beyond one plan year.

State Monthly Premium Credit			
	$25/Month Premium Credit	$15/Month Premium Credit	$10/Month Premium Credit
State Active Employees (enrollment - 27,039)	$ 8,111,700	$ 4,867,020	$ 3,244,680
State Non-Medicare Retirees (enrollment - 4,086)	$ 1,225,800	$ 735,480	$ 490,320
Total Premium Credit Projected Expense	$ 9,337,500	$ 5,602,500	$ 3,735,000

Average 2020 enrollment used for projections

**will require IFC approval*

9. HRA Credits

One Time HRA Credit

- ✓ Use current surplus to provide one-time HRA credit
- ✓ Would not impact HSA contribution requirements
- ✓ Recommend limit timeframe to use credits to manage admin costs
- ✓ Potential options include:

State Participant HRA Credit			
	$300 HRA Credit	$200 HRA Credit	$100 HRA Credit
State Active Employees (enrollment - 27,039)	$ 8,111,700	$ 5,407,800	$ 2,703,900
State Non-Medicare Retirees (enrollment - 4,086)	$ 1,225,800	$ 817,200	$ 408,600
Total Participant HRA Credit Projected Expense	$ 9,337,500	$ 6,225,000	$ 3,112,500

Average 2020 enrollment used for projections

**will require IFC approval*

10. Lifestyle Spending Account

Lifestyle Spending Account (LSA)

WHAT and HOW

- ✓ Allows an employer to fund an account that supports everyday needs that aren't typically covered by traditional benefits
  - Similar to HRA or FSA where eligible expenses are reimbursed
  - Post-tax, only taxable when spent
  - Employer can establish eligible expenses
  - Recommendation to focus on health and wellness expenses
  - Funded on an annual basis. Unused funds reverted back to PEBP.
  - Potentially helps toward recruitment and retention challenges

Lifestyle Spending Account (LSA)

Implementation

- ✓ Offered by both UMR and HSA Bank
  - HSA Bank - $0.75 PMPM
  - UMR – pending
- ✓ Will require contract amendment
- ✓ Can be implemented as early as March 1 or on July 1.

State Lifestyle Spending Account Contribution					
	$300 Premium Credit	$250 Premium Credit	$200 Premium Credit	$150 Premium Credit	$100 Premium Credit
State Active Employees (enrollment - 27,039)	$ 8,111,700	$ 6,759,750	$ 5,407,800	$ 4,055,850	$ 2,703,900
Lifestyle Spending Account Fee ($0.75 Per Account Per Month)	$ 243,351	$ 243,351	$ 243,351	$ 243,351	$ 243,351
Total Lifestyle Credit Projected Expense	$ 8,355,051	$ 7,003,101	$ 5,651,151	$ 4,299,201	$ 2,947,251

Average 2020 enrollment used for projections

**will require IFC approval*

Lifestyle Spending Account (LSA)

Sample Eligible Expenses	
Gym memberships	Dance classes
Fitness classes	Estate and retirement planning
Personal training	Financial planning
Alternative Healing	Childcare
Massage Therapy	Elder care
Nutrition/weight loss counseling	Pet Care
Fitness equipment	WFH expenses (internet, office equipment)
Sports equipment	Education courses
Athletic event registration	Tutoring
Life coaching	Athletic gear
Cooking classes	Fitness trackers
Personal counseling	State/National Park passes
Vitamins & Nutritional Supplements	LTD, Life insurance, other premiums
Legal expenses	Identity theft
Hunting/fishing licenses	Student loan repayment

Summary

Option	Description	PY24 Cost/(Savings)
Real Appeal	Weight Loss	($170,000)
Hinge Health	Virtual PT	($1,400,000)
Doctor on Demand	Virtual Behavioral Health	$250,000
Abortion Travel	Travel Benefit	$25,000 - $50,000
Medical Travel	Travel Benefit and COE Network	($1,000,000 - $1,500,000)
Oncology Program	Concierge Services and COE Network	($1,000,000 - $2,000,000)
Dental	Increase ABL	$600,000 - $750,000
Premium Credits	Share Surplus with Members	$3,700,000 - $9,300,000
One Time HRA	Share Surplus with Members	$3,100,000 - $9,300,000
Lifestyle Spending Account	Share Surplus with Members	$2,900,000 - $8,400,000

Thank You

11.

11. 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**)

    11.1 Contract Overview

    11.2 New Contracts

        11.2.1 Contract with Former State Employee

    11.3 Contract Amendments

    11.4 Contract Solicitations

    11.5 Status of Current Solicitations

STEVE SISOLAK
Governor

STATE OF NEVADA
PUBLIC EMPLOYEES' BENEFITS PROGRAM
901 S. Stewart Street, Suite 1001 | Carson City, Nevada 89701
Telephone 775-684-7000 | 702-486-3100 | 1-800-326-5496
www.pebp.state.nv.us

LAURA RICH
Executive Officer

LAURA FREED
Board Chair

AGENDA ITEM

[X] Action Item
[ ] Information Only

Date: December 5, 2022

Item Number: XI

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

11.1 Contracts Overview

Below is a listing of the active PEBP contracts as of November 30, 2022.

PEBP Active Contracts Summary							
Vendor	Service	Contract #	Effective Date	Termination Date	Contract Max	Current Expenditures	Amount Remaining
CliftonLarsonAllen	Financial Auditor	24088	5/1/2021	12/31/2024	$ 212,485.00	$ 50,710.00	$ 161,775.00
Health Plan of Nevada Inc	Southern Nevada HMO	23802	7/1/2021	6/30/2025	$ 192,093,848.00	$ 54,253,120.73	$ 137,840,727.27
Diversified Dental Services Inc.	Dental PPO	23810	7/1/2021	6/30/2026	$ 1,601,613.00	$ 433,972.48	$ 1,167,640.52
Lifeworks	Benefits Management System	25935	5/10/2022	12/31/2026	$ 6,145,600.00	$ 1,401,408.60	$ 4,744,191.40
Express Scripts, Inc.	Pharmacy Benefit Manager	25582	5/10/2022	6/30/2026	$ 332,109,496.00	$ 27,357,754.11	$ 304,751,741.89
United Healtcare Insurance	Group Basic Life Insurance	25607	7/1/2022	6/30/2026	$ 12,824,248.00	$ -	$ 12,824,248.00
Brown & Brown of Massachusetts	Health Plan Auditor	24030	4/13/2021	6/30/2027	$ 1,581,662.00	$ 217,794.00	$ 1,363,868.00
Segal Company, Inc.	Consulting Services	25557	7/1/2022	6/30/2027	$ 3,990,000.00	$ 204,040.00	$ 3,785,960.00
UMR, Inc.	TPA and Other Services	25155	7/1/2022	6/30/2028	$ 65,413,106.00	$ -	$ 65,413,106.00

Recommendation

No action necessary

11.2 New Contracts

11.2.1 Former State Employee

The Public Employees' Benefits Program is requesting to contract with a former employee, Nancy Spinelli, through the use of Manpower Temporary Services. The request is made in accordance with the State Administrative Manual Chapter 0323. In her previous position, Ms. Spinelli oversaw the PEBP Quality Control Department, where her primary responsibility was to ensure compliance across all areas of the agency. After nearly 20 years with the agency, Ms. Spinelli was considered a subject matter expert within all areas of PEBP and her understanding and familiarity with the programs complex coverage and benefits is remarkable.

Through this contract, Ms. Spinelli will work with our current Quality Control Officer to assist with various compliance related projects that will be required as part of a recently completed compliance audit. In addition, she will be assisting PEBP staff with legislative analysis and assessments throughout the legislative session and if necessary, the implementation of passed legislation. Her specialized knowledge will provide much needed relief given the Department's current vacancy and turnover rates.

Recommendation

PEBP recommends the Board authorize staff to request to contract with a former state employee, Nancy Spinelli and submit for final approval at the Board of Examiners.

11.3 Contract Amendment Ratifications

PEBP does not currently have any contract amendments for ratification.

11.4 Contract Solicitation Ratifications

PEBP does not currently have any contract solicitations for ratification.

11.5 Status of Current Solicitations

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

Service	Anticipated/ Actual RFP release date	Anticipated/ Actual NOI	Winning Vendor	Anticipated Board Approval
Eligibility and Enrollment System	TBD			

12.

12. Public Comment

13.

13. Adjournment