JOE LOMBARDO
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

JACK ROBB
Board Chair

MEETING NOTICE AND AGENDA – Amended 03.16.23

Name of Organization:	Public Employees' Benefits Program Board
Date and Time of Meeting:	March 23, 2023 8:30 a.m.
Place of Meeting:	PEBP Board Room 901 S. Stewart St. Carson City, NV 89701
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://www.youtube.com/watch?v=LihFjUCOVLA

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 "Place of Meeting" field above.

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

Option #1 **Join the webinar as an attendee** https://us06web.zoom.us/j/87155671256

This link is only for those who want to make public comment. If you are just listening to the webinar, please use the YouTube Link located in the "Place of Meeting" field above.

Option #2 **Dial: (669) 900-6833. When prompted to provide your Meeting ID, please enter: 871 5567 1256 then press #. When prompted for a Participant ID, please enter #.**

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

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

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

AGENDA

1. Open Meeting; Roll Call

2. Public Comment

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

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

4. Consent Agenda (Jack Robb, Board Chair) (**All Items for Possible Action**)

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

   4.1 Approval of Action Minutes from the January 26, 2023 PEBP Board Meeting

   4.2 Clifton Larson Allen Audited Financial Statements of Public Employees' Benefits Program Self-Insurance Trust Fund and the Retirees' Health & Welfare Benefits Fund for FY22.

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

6. Discussion and possible action on Diabetes Prevention/Diabetes Self-Management Education and Support pilot program (Laura Rich, Executive Officer) (**For Possible Action**)

7. Discussion and possible action on recommended changes to Master Plan Documents for Plan Year 24 to include the removal of IUI benefit on the Low Deductible and EPO plans (July 1, 2023 – June 30, 2024) (Laura Rich, Executive Officer) (**For Possible Action**)

   7.1. Master Plan Document Recommended Changes

7.2. HRA Summary Plan Description

8. Discussion and possible action on Executive Order 2023-003 (Laura Rich, Executive Officer) (**For Possible Action**)

9. Discussion and acceptance of Claim Technologies Incorporated audit findings for State of Nevada Public Employees' Benefits Program Plans administered by UMR Benefits for the period July 1, 2022 – September 30, 2022. (Laura Rich, Executive Officer) (**For Possible Action**)

9.1. UMR Remediation Plan

10. Presentation on PEBP claims experience and trend (Richard Ward, Segal) (Information/Discussion)

11. Discussion and possible action to include approving Plan Year 24 (July 1, 2023 – June 30, 2024) rates for State and Non-State employees, retirees and their dependents for the Consumer Driven Health Plan (CDHP), Low Deductible (LD) Plan, Exclusive Provider Organization (EPO) Plan, and Health Maintenance Organization (HMO) Plan (Laura Rich, Executive Officer) (**For Possible Action**)

12. Information and discussion regarding the Office of Project Management statewide ERP implementation and the integration of PEBP's enrollment and eligibility functionality. (Laura Rich, Executive Officer) (Information/Discussion)

13. 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)**

    13.1 Contract Overview

    13.2 New Contracts

    13.3 Contract Amendments

        13.3.1 Segal

    13.4 Contract Solicitations

    13.5 Status of Current Solicitations

        13.5.1 Enrollment and Eligibility System RFP

14. 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.

15. 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, and also posted to the public notice website for meetings at https://notice.nv.gov. In addition, the agenda was mailed to groups and individuals as requested.

1.

1. Open Meeting; Roll Call

2.

2. Public Comment

3.

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

4.

4. Consent Agenda (Jack Robb, Board Chair) (**All Items for Possible Action**)

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

4.1 Approval of Action Minutes from the January 26, 2023 PEBP Board Meeting

4.2 Clifton Larson Allen Audited Financial Statements of Public Employees' Benefits Program Self-Insurance Trust Fund and the Retirees' Health & Welfare Benefits Fund for FY22.

4.1

4. Consent Agenda (Jack Robb, Board Chair) (**All Items for Possible Action**)

4.1 Approval of Action Minutes from the January 26, 2023 PEBP Board Meeting.

STATE OF NEVADA
PUBLIC EMPLOYEES' BENEFITS PROGRAM
BOARD MEETING

Video/Telephonic Open Meeting

ACTION MINUTES (Subject to Board Approval)
January 26, 2023

MEMBERS PRESENT VIA TELECONFERENCE:	Mr. Jack Robb, Board Chair Mr. Jim Barnes, Vice Chair Ms. Linda Fox, Member Mr. Tom Verducci, Member Ms. Betsy Aiello, Member Ms. April Caughron, Member Ms. Michelle Kelley, Member Ms. Leslie Bittleston, Member Ms. Janell Woodward, Member Dr. Jennifer McClendon, Member
FOR THE BOARD:	Mr. Mike Detmer, 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:	Chris Garcia – WTW Richard Ward – Segal Amy Dunn – Segal Rhonda Huckaby – UMR Joanna Balogh-Reynolds - Segal

1. Open Meeting; Roll Call

    - Board Chair Robb opened the meeting at 9:01 a.m.

2. Public Comment
    - Kent Ervin – Nevada Faculty Alliance
    - Brooke Maylath
    - Joan Operario – SHO Prior Authorization
    - Tess Opferman – AFSCME Retiree
    - Doug Unger – Nevada Faculty Alliance

3. PEBP Board disclosures for applicable Board meeting agenda items. (Mike Detmer, Chief Deputy Attorney General) (Information/Discussion)

4. Consent Agenda (Jack Robb, 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 December 5, 2022 PEBP Board Meeting

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

        4.2.1 Budget Report

        4.2.2 Utilization Report

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

        4.3.1 UMR – Obesity Care Management

        4.3.2 UMR – Diabetes Care Management

        4.3.3 UnitedHealthcare – Utilization and Large Case Management paid through October 31, 2022

        4.3.4 UnitedHealthcare – Basic Life Insurance

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

        4.3.6 Sierra Healthcare Options – PPO Network

        4.3.7 HealthPlan of Nevada, Inc. – Southern Nevada HMO

        4.3.8 Doctor on Demand Engagement Report through September 2022

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

BOARD ACTION ON ITEM 4
MOTION: Motion to approve the consent agenda items other than pulled items 4.2.1, 4.3.5 and 4.3.6
BY: Member Leslie Bittleston
SECOND: Member April Caughron
VOTE: Unanimous; the motion carried

BOARD ACTION ON ITEMS 4.2.1, 4.3.5 and 4.3.6
MOTION: Motion to pass items 4.2.1, 4.3.5 and 4.3.6
BY: Member Tom Verducci
SECOND: Member Leslie Bittleston
VOTE: Unanimous; the motion carried

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

6. Presentation on PEBP portion of the Governor's Recommended Budget (Laura Rich, Executive Officer) (Information/Discussion)

7. Discussion and possible action on recommended changes to Master Plan Documents for Plan Year 24 (July 1, 2023 – June 30, 2024) (Laura Rich, Executive Officer) (**For Possible Action**)

    7.1 Consumer Driven Health Plan (CDHP)

    7.2 Low Deductible (LD) Plan

    7.3 Exclusive Provider Organization (EPO) Plan

    7.4 Enrollment & Eligibility

    7.5 Flexible Spending Account

    7.6 Medicare Health Reimbursement Arrangement

    7.7 Section 125

    7.8 Dental and Life Insurance

    7.9 Active Health Welfare Wrap

    7.10 Retiree Health Welfare Wrap

BOARD ACTION ON ITEM 7
MOTION: Motion to approve staff's recommendations on the changes to the Master Plan Document, all except for item 22, which I would like to have held over to another meeting until we can fully evaluate current usage of that benefit and perhaps a better way to move forward.
BY: Member Michelle Kelley
SECOND: Member Betsy Aiello
VOTE: Unanimous; the motion carried

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

    - Contract Overview
    - New Contracts

        8..1 Capitol Reporters

    - Contract Amendments
    - Contract Solicitations
    - Status of Current Solicitations

BOARD ACTION ON ITEM 8
MOTION: Motion to approve Item Number 8 as recommended.
BY: Member Leslie Bittleston
SECOND: Member April Caughron
VOTE: Unanimous; the motion carried

9 Public Comment

- No Public Comment

10 Adjournment

- Board Chair Robb adjourned the meeting at 11:21 a.m.

4.2

4. Consent Agenda (Jack Robb, Board Chair) (**All Items for Possible Action**)

    4.1 Approval of Action Minutes from the January 26, 2023 PEBP Board Meeting.

    4.2 Clifton Larson Allen Audited Financial Statements of Public Employees' Benefits Program Self-Insurance Trust Fund and the Retirees' Health & Welfare Benefits Fund for FY22.

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

YEARS ENDED JUNE 30, 2022 AND 2021

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STATE OF NEVADA
SELF INSURANCE TRUST FUND
PUBLIC EMPLOYEES' BENEFITS PROGRAM
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YEARS ENDED JUNE 30, 2022 AND 2021

CliftonLarsonAllen LLP
CLAconnect.com

INDEPENDENT AUDITORS' REPORT

Board of the Public Employees' Benefits Program
State of Nevada

Report on the Audit of the Financial Statements

Opinion

We have audited the accompanying financial statements of the Self Insurance Trust Fund, Public Employees' Benefits Program of the State of Nevada (the Fund), as of and for the years ended June 30, 2022 and 2021, and the related notes to the financial statements, which collectively comprise the Self Insurance Trust Fund, Public Employees' Benefits Program of the State of Nevada's basic financial statements as listed in the table of contents.

In our opinion, the financial statements referred to above present fairly, in all material respects, the respective financial position of the Self Insurance Trust Fund, Public Employees' Benefits Program of the State of Nevada, as of June 30, 2022 and 2021, and the respective changes in financial position, and cash flows thereof for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Basis for Opinion

We conducted our audits in accordance with auditing standards generally accepted in the United States of America (GAAS) and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States. Our responsibilities under those standards are further described in the Auditors' Responsibilities for the Audit of the Financial Statements section of our report. We are required to be independent of the Self Insurance Trust Fund, Public Employees' Benefits Program of the State of Nevada and to meet our other ethical responsibilities, in accordance with the relevant ethical requirements relating to our audit. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinions.

Emphasis of a Matter

Reporting Entity

As discussed in Note 1, the financial statements of the Self Insurance Trust Fund, Public Employees' Benefits Program of the State of Nevada are intended to present the net position, and changes in net position of the Fund. They do not purport to, and do not, present fairly the financial position of the state of Nevada, as of June 30, 2022 and 2021, and the changes in its net position, and cash flows thereof for the years then ended, in conformity with accounting principles generally accepted in the United States of America. Our opinion is not modified with respect to this matter.

Responsibilities of Management for the Financial Statements

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

In preparing the financial statements, management is required to evaluate whether there are conditions or events, considered in the aggregate, that raise substantial doubt about the Self Insurance Trust Fund, Public Employees' Benefits Program of the State of Nevada's ability to continue as a going concern for 12 months beyond the financial statement date, including any currently known information that may raise substantial doubt shortly thereafter.

Auditors' Responsibilities for the Audit of the Financial Statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditors' report that includes our opinions. Reasonable assurance is a high level of assurance but is not absolute assurance and therefore is not a guarantee that an audit conducted in accordance with GAAS and *Government Auditing Standards* will always detect a material misstatement when it exists. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control. Misstatements are considered material if there is a substantial likelihood that, individually or in the aggregate, they would influence the judgment made by a reasonable user based on the financial statements.

In performing an audit in accordance with GAAS and *Government Auditing Standards*, we:

- Exercise professional judgment and maintain professional skepticism throughout the audit.
- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements.
- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Self Insurance Trust Fund, Public Employees' Benefits Program of the State of Nevada's internal control. Accordingly, no such opinion is expressed.
- Evaluate the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluate the overall presentation of the financial statements.
- Conclude whether, in our judgment, there are conditions or events, considered in the aggregate, that raise substantial doubt about the Self Insurance Trust Fund, Public Employees' Benefits Program of the State of Nevada's ability to continue as a going concern for a reasonable period of time.

We are required to communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit, significant audit findings, and certain internal control related matters that we identified during the audit.

Required Supplementary Information

Accounting principles generally accepted in the United States of America require that the schedule of changes in pension liability, schedule of the fund's proportionate share of the net OPEB liability, and related ratios and the schedule of contributions be presented to supplement the basic financial statements. Such information is the responsibility of management and, although not a part of the basic financial statements, is required by the Governmental Accounting Standards Board who considers it to be an essential part of financial reporting for placing the basic financial statements in an appropriate operational, economic, or historical context. We have applied certain limited procedures to the required supplementary information in accordance with GAAS, which consisted of inquiries of management about the methods of preparing the information and comparing the information for consistency with management's responses to our inquiries, the basic financial statements, and other knowledge we obtained during our audit of the basic financial statements. We do not express an opinion or provide any assurance on the information because the limited procedures do not provide us with sufficient evidence to express an opinion or provide any assurance.

Management has omitted the management's discussion and analysis that accounting principles generally accepted in the United States of America require to be presented to supplement the basic financial statements, Such missing information, although not a part of the basic financial statements, is required by the Governmental Accounting Standards Board who considers it to be an essential part of financial reporting for placing the basic financial statements in an appropriate operational, economic, or historical context. Our opinion on the basic financial statements are not affected by this missing information.

Other Reporting Required by *Government Auditing Standards*

In accordance with *Government Auditing Standards*, we have also issued our report dated February 22, 2023 on our consideration of the Self Insurance Trust Fund, Public Employees' Benefits Program's internal control over financial reporting and on our tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements and other matters. The purpose of that report is solely to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing, and not to provide an opinion on the effectiveness the Self Insurance Trust Fund, Public Employees' Benefits Program's internal control over financial reporting or on compliance. That report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering the Self Insurance Trust Fund, Public Employees' Benefits Program's internal control over financial reporting and compliance.

CliftonLarsonAllen LLP

CliftonLarsonAllen LLP

Broomfield, Colorado
February 22, 2023

STATE OF NEVADA
SELF INSURANCE TRUST FUND
PUBLIC EMPLOYEES' BENEFITS PROGRAM
STATEMENTS OF NET POSITION
JUNE 30, 2022 AND 2021

	2022	2021
ASSETS		
CURRENT ASSETS		
Cash and Cash Equivalents	$ 140,185,989	$ 158,708,980
Prepaid Insurance	14	3,519
Receivables		
Accounts Receivables, Net	13,772,307	8,239,150
Intergovernmental Receivable	4,190,641	4,445,275
Due From Other Funds	892,560	854,330
Due From Fiduciary Funds	25,046,900	12,100,467
Due From Component, Units, Net	1,105,541	37,153
Total Current Assets	185,193,952	184,388,874
CAPITAL ASSETS		
Property and Equipment	154,663	268,533
Less Accumulated Depreciation	(144,356)	(257,895)
Total Capital Assets (Net of Accumulated Depreciation)	10,307	10,638
Total Assets	185,204,259	184,399,512
DEFERRED OUTFLOWS OF RESOURCES		
Pension Related Amounts	1,312,782	560,666
OPEB Related Amounts	125,886	162,413
Total Deferred Outflows of Resources	1,438,668	723,079
LIABILITIES AND NET POSITION		
CURRENT LIABILITIES		
Bank Overdraft	3,413,547	2,210,420
Accounts Payable	1,301,408	1,579,157
Accrued Payroll and Related Benefits	102,946	101,608
Due to Other Funds	46,105	54,100
Unearned Revenue	5,435,806	3,483,494
Compensated Absences	158,007	183,415
Reserve for Losses	79,492,071	83,584,731
Total Current Liabilities	89,949,890	91,196,925
NONCURRENT LIABILITIES		
Compensated Absences	70,554	67,169
Net Pension Liability	2,265,928	3,537,451
Net OPEB Liability	1,395,724	1,405,629
Total Noncurrent Liabilities	3,732,206	5,010,249
Total Liabilities	93,682,096	96,207,174
DEFERRED INFLOWS OF RESOURCES		
Pension Related Amounts	1,916,469	216,072
OPEB Related Amounts	56,929	99,825
Total Deferred Inflows of Resources	1,973,398	315,897
NET POSITION		
Investment in Capital Assets	10,307	10,638
Restricted Expendable - Losses	90,977,126	88,588,882
Total Net Position (Restated)	$ 90,987,433	$ 88,599,520

See accompanying Notes to Financial Statements.

STATE OF NEVADA
SELF INSURANCE TRUST FUND
PUBLIC EMPLOYEES' BENEFITS PROGRAM
STATEMENTS OF REVENUES, EXPENDITURES, AND CHANGES IN FUND NET POSITION
YEARS ENDED JUNE 30, 2022 AND 2021

	2022	2021
OPERATING REVENUES		
Insurance Premiums	$ 359,639,820	$ 371,045,254
Other	21,183	3,683
Total Operating Revenues	359,661,003	371,048,937
OPERATING EXPENSES		
Salaries and Benefits	2,024,758	2,161,431
Operating	5,082,430	3,073,204
Claims Expense	304,752,973	300,583,601
Depreciation	3,237	14,447
Insurance Premiums and Contractual Obligations	58,244,946	62,625,892
Total Operating Expenses	370,108,344	368,458,575
OPERATING INCOME (LOSS)	(10,447,341)	2,590,362
NONOPERATING REVENUES (EXPENSES)		
Intergovernmental Revenue	16,516,757	9,467,584
Investment Income (Expense)	(4,702,251)	(1,341,413)
Interest Income (Expense)	1,020,748	823,146
Total Nonoperating Revenues	12,835,254	8,949,317
CHANGE IN NET POSITION	2,387,913	11,539,679
Net Position - Beginning of Year	88,599,520	77,059,841
NET POSITION - END OF YEAR	$ 90,987,433	$ 88,599,520

See accompanying Notes to Financial Statements.

STATE OF NEVADA
SELF INSURANCE TRUST FUND
PUBLIC EMPLOYEES' BENEFITS PROGRAM
STATEMENTS OF CASH FLOWS
YEARS ENDED JUNE 30, 2022 AND 2021

	2022	2021
CASH FLOWS FROM OPERATING ACTIVITIES		
Receipts From Customers and Users	$ 257,500,729	$ 269,103,073
Receipts From Component Units	97,511,041	99,723,488
Payments to Suppliers, Other Governments and Beneficiaries	(371,959,715)	(373,438,687)
Change in Due From Other Funds Related to Operations	(12,992,658)	629,472
Payments to Employees	(1,669,370)	(2,419,901)
Net Cash Used by Operating Activities	(31,609,973)	(6,402,555)
CASH FLOWS FROM NONCAPITAL AND RELATED FINANCING ACTIVITIES		
Grants Received	16,771,391	5,992,614
Net Cash Provided by Noncapital and Financing Activities	16,771,391	5,992,614
CASH FLOWS FROM INVESTING ACTIVITIES		
Net Interest on Investments	1,017,842	823,146
Net Cash Used by Investing Activities	1,017,842	823,146
Net Decrease in Cash and Cash Equivalents	(13,820,740)	413,205
Cash - Beginning of Year	158,256,356	157,843,151
CASH - END OF YEAR	$ 144,435,616	$ 158,256,356
RECONCILIATION OF OPERATING INCOME (LOSS) TO NET CASH USED BY OPERATING ACTIVITIES		
Operating Income	$ (10,447,341)	$ 2,590,362
Adjustments to Reconcile Operating Income to Net Cash Provided (Used) by Operating Activities		
Depreciation	3,237	14,447
Allowance for Doubtful Accounts	(107,470)	(107,470)
Changes in Assets and Liabilities		
(Increase) Decrease in Receivables	(6,494,075)	(2,108,645)
(Increase) Decrease in Due From Other Funds	(12,992,658)	629,472
(Increase) Decrease in Prepaid Expenses	3,505	(317)
(Increase) Decrease in Deferred Outflows - Pension	(752,116)	102,608
(Increase) Decrease in Deferred Outflows - OPEB	36,527	(92,671)
Increase (Decrease) in Payables and Accruals	(3,187,967)	(7,106,874)
Increase (Decrease) in Unearned Revenue	1,952,312	(6,261)
Increase (Decrease) in Net Pension Obligation	(1,271,523)	(296,198)
Increase (Decrease) in Net OPEB Liability	(9,905)	104,425
Increase (Decrease) in Deferred Inflows - Pension	1,700,397	(146,208)
Increase (Decrease) in Deferred Inflows - OPEB	(42,896)	20,775
Total Adjustments	(21,162,632)	(8,992,917)
Net Cash Used by Operating Activities	$ (31,609,973)	$ (6,402,555)
NONCASH INVESTING, CAPITAL AND FINANCING ACTIVITIES		
Change in Fair Value of Investments	(4,249,627)	452,624

See accompanying Notes to Financial Statements.

NOTE 1 SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

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

Plan Description

The Self Insurance Trust Fund was created in 1983 by the Nevada Legislature to administer group health, life and disability insurance for covered employees, both active and retired, of the State, and certain other participating public employers within the state of Nevada. All public employers in the State are eligible to participate in the activities of the Self Insurance Trust Fund and currently, in addition to the State, there were four public employers participating at June 30, 2022 whose employees are covered under the plan. Additionally, all retirees of public employers contracted with PEBP to provide coverage to their employees are eligible to join the program subsequent to their retirement. Public employers are required to subsidize their retirees who participate in the plan in the same manner the State subsidizes its retirees. Currently, the State, the Nevada System of Higher Education and 165 public employers within the state of Nevada are billed for retiree subsidies. The Self Insurance Trust Fund provides medical, dental, vision, long-term disability, mental health, substance abuse, and life insurance benefits. The Self Insurance Trust Fund is overseen by the Public Employees' Benefits Program Board. The board is composed of ten members, nine members appointed by the governor, and the director of the department of administration or their designee.

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

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

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

NOTE 1 SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

Plan Description (Continued)

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

Reporting Entity

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

Fund Accounting

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

Basis of Accounting

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

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

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

Cash Equivalents:

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

NOTE 1 SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

Receivables

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

The third party administrator that processes claims payments on behalf of the Self Insurance Trust Fund has identified overpayments in the amount of $3,192,254 and $2,210,420 as of June 30, 2022 and 2021, respectively. Overpayments are followed up on every 30 days until recovery is made. These amounts have not been accrued as a receivable on the statement of net position, but are recorded as a reduction to claims expense in the period in which recovery is received. Collection attempts cease when the overpayment is greater than four years old.

The Self Insurance Trust Fund administers an additional pass-through budget account, the Active Employee Group Insurance Subsidy (AEGIS) budget account. This budget account is utilized for recording the payments made by the State and received by the Self Insurance Trust Fund on behalf of active employees. Agencies contribute a fixed dollar amount per employee into this budget account. However, insurance premiums are earned by the main operating budget account in accordance with the PEBP approved rate for insurance coverage for the plan and tier to which each employee belonged. The difference between cash contributions and revenue recognition resulted in a surplus of contributions over premiums of $5,248,361 and $3,464,250 for the years ended June 30, 2022 and 2021, respectively. These amounts were allocated among all state entities that paid the AEGIS subsidy proportionate to their size and were included in the subsequent year's budget.

The Self Insurance Trust Fund considers $170,248 and $170,248 in participant premiums as uncollectible as of June 30, 2022 and 2021, respectively. Pursuant to NRS 353C.220, only accounts that have been approved by the State of Nevada Board of Examiners may be written off. Of the uncollectible premiums listed above, $-0- and $-0- were approved for write-off by the State of Nevada Board of Examiners as of June 30, 2022 and 2021, respectively. The State has a policy in which all uncollectible amounts are remitted to the State Controller's Office for continued collection attempts and are eventually written off. In accordance with this policy, the Self Insurance Trust Fund created an allowance to account for the remaining uncollectible amounts that have been remitted to the State Controller's Office, but not yet been approved by the State of Nevada Board of Examiners for write off.

Property and Equipment

Fixed assets are capitalized and depreciated using the straight line method of depreciation over the assets' estimated useful lives ranging from three to ten years. Capital acquisitions for the years ended June 30, 2022 and 2021 were $-0- and $-0-, respectively. Capital dispositions for the years ended June 30, 2022 and 2021 were $116,776 and $192,491, respectively.

NOTE 1 SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

Estimated Claims

The Self Insurance Trust Fund contracted with Aon, a provider of consulting and actuarial services, to estimate its liability for incurred but not reported claims, claims reported but not yet paid and administrative expenses expected to be incurred in conjunction with processing incurred but not reported claims as of June 30, 2022 and 2021, respectively. This liability is estimated by the actuary based on industry trends and claims lag information reported by the third party administrator. Such liabilities are necessarily based on estimates, and, while management believes the amount is adequate, the ultimate liability may be in excess of, or less than, the amounts provided. The methods for making such estimates and for establishing the resulting liability are reviewed on an annual basis and any adjustments are currently reflected in net income from operations.

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

Compensated Absences

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

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

Pensions

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

NOTE 1 SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

Post Employment Benefits Other Than Pensions (OPEB)

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

Deferred Outflows/Inflows of Resources

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

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

Net Position

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

Operating and Nonoperating Revenues and Expenses

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

NOTE 1 SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

Operating and Nonoperating Revenues and Expenses (Continued)

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

Reinsurance

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

Use of Estimates

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

NOTE 2 COMPLIANCE WITH NEVADA REVISED STATUTES AND THE NEVADA ADMINISTRATIVE CODE

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

NOTE 3 CASH AND DEPOSITS

	2022	2021
Bank Overdraft		
Overdraft Accounts	$ (3,413,547)	$ (2,210,420)
Deposits with State Treasurer		
State Treasurer's Investment Pool	$ 144,435,616	$ 158,256,356
GASB 31 Adjustment	(4,249,627)	452,624
Total Cash and Deposits with State Treasurer	140,185,989	158,708,980
Total Cash and Deposits	$ 136,772,442	$ 156,498,560

The Self Insurance Trust Fund has three checking accounts with Wells Fargo Bank at June 30, 2022 and 2021. These accounts contain $639,140 and $1,082,774 (of the total overdraft accounts balances above) in stale outstanding checks for the years ended June 30, 2022 and 2021, respectively. Additionally, certain Bank of America and Wells Fargo Bank zero balance accounts were closed in previous fiscal years. These closed accounts contain $-0- and $-0- in stale outstanding checks as of June 30, 2022 and 2021, respectively. Checks presented for payment from the closed accounts are rejected by the bank, voided, and reissued by the Self Insurance Trust Fund using the controlled disbursement account. The controlled disbursement account is presented as a liability on the statement of net position and is funded only when checks are presented for payment. The negative balance represents outstanding checks issued that have not been presented for payment. In accordance with NRS 353.140, the Self Insurance Trust Fund honors outstanding stale warrants presented for payment within six years from the date of origination. For insurance and collateral purposes, the account is commingled with all of the cash accounts of the state of Nevada. All cash and deposits are recorded at fair value.

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

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

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

NOTE 4 PENSION PLAN

Plan Description.

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

Funding Policy

Plan members' benefits are funded under one of two methods. Under the employer paid contribution plan, the Self Insurance Trust Fund is required to contribute all amounts due under the plan. The rate for those contributions was 29.75%, 29.25%, and 29.25% for regular members on all covered payroll for the years ended June 30, 2022, 2021, and 2020, respectively. The second funding mechanism for providing benefits is the employer/employee paid contribution plan. Under this method, employees are required to contribute a percentage of their compensation to the plan while the Self Insurance Trust Fund is required to match that contribution. The rate for regular employees under this plan was 15.50%, 15.25%, and 15.25% for the years ended June 30, 2022, 2021 and 2020, respectively. The contribution requirements of plan members and the Self Insurance Trust Fund are established by NRS Chapter 286. The funding may only be amended through legislation. The Self Insurance Trust Fund's contributions to PERS for the years ended June 30, 2022, 2021, and 2020 were $246,551, $260,407, and $267,388, respectively, equal to the required contributions for the year.

Pension Liability

At June 30, 2022 and 2021 the Self Insurance Trust Fund reported a liability of $2,265,928 and $3,537,451, respectively, for its proportionate share of the net pension liability. The net pension liability was measured as of June 30, 2021 and 2020, and the total pension liability used to calculate the net pension liability was determined by an actuarial valuation as of that date. The Self Insurance Trust Fund's proportion of the net pension liability is based on their combined employer and member contributions relative to the total combined employer and member contributions for all employers for the period ended June 30, 2022 and 2021. The Self Insurance Trust Fund's proportionate share is approximately 0.0245% and 0.0254% as of June 30, 2022 and 2021, respectively.

NOTE 4 PENSION PLAN (CONTINUED)

Pension Expense, Deferred Outflows of Resources and Deferred Inflows of Resources Related to Pensions

As of June 30, 2022 and 2021, the total employer pension expense is ($90,548) and ($82,105), respectively. Amounts totaling $260,407 resulting from Fund contributions subsequent to the measurement date will be recognized as a reduction of the net pension liability in the year ended June 30, 2022. At June 30, 2022 and 2021, the Self Insurance Trust Fund reported deferred outflows of resources and deferred inflows of resources related to pensions from the following sources:

	2022		2021	
	Deferred Outflows of Resources	Deferred Inflows of Resources	Deferred Outflows of Resources	Deferred Inflows of Resources
Differences Between Expected and Actual Experience	$ 250,996	$ 15,947	$ 109,906	$ 45,677
Change of Assumptions	752,327	-	99,364	-
Net Difference Between Projects and Actual Earnings on Investments	-	1,848,925	-	133,630
Changes in Proportion and Differences Between Actual Contributions and Proportionate Share of Contributions	62,908	51,597	90,989	36,765
System Contributions Subsequent to the Measurement Date	246,551	-	260,407	
Total	$ 1,312,782	$ 1,916,469	$ 560,666	$ 216,072

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

Year Ending June 30	Amount
2023	$ (253,988)
2024	(249,827)
2025	(259,147)
2026	(277,758)
2027	167,117
2028	23,365
	$ (850,238)

NOTE 4 PENSION PLAN (CONTINUED)

The net difference between projected and actual investment earnings on pension plan investments will be recognized over five years, all the other above deferred outflows and deferred inflows will be recognized over the average expected remaining service lives, which was 6.14 years for the measurement period ending June 30, 2021.

Reconciliation of Net Pension Liability	2022	2021
Beginning Net Pension Liability		
Pension Expense	$ 3,537,451	$ 3,833,649
Employer Contributions	(76,693)	(82,105)
Net Deferred (Inflows)/Outflows	(260,407)	(264,674)
Ending Net Pension Liability	(934,423)	50,581
	$ 2,265,928	$ 3,537,451

Actuarial Assumptions

The Fund's net pension liability was measured as of June 30, 2021 and 2020 and the total pension liability used to calculate the net pension liability was determined by an actuarial valuation as of that date. The total pension lability was determined using the following actuarial assumptions, applied to all periods included in the measurement, unless otherwise specified:

Inflation	2.50%
Productivity Pay Increase	0.50%
Projected Salary Increase	Regular: 4.20% to 9.10%, depending on service Rates include inflation and productivity increases
Investment Rate of Return	7.25%
Other Assumptions	Same as those used in the June 30, 2021 funding actuarial valuation

Actuarial assumptions used in the June 30, 2021 valuation were based on the results of the experience study for the period July 1, 2016 through June 30, 2020.

Investment Policy

The following was the Retirement Board's adopted policy target asset allocation as of June 30, 2021:

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

*As of June 30, 2021, PERS' long-term inflation assumption was 2.50%.

NOTE 4 PENSION PLAN (CONTINUED)

Discount Rate and Pension Liability Discount Rate Sensitivity

The following presents the net pension liability of the PERS as of June 30, 2021, calculated using the discount rate of 7.25%, as well as what the PERS net pension liability would be if it were calculated using a discount rate that is 1 percentage-point lower (6.25%) or 1 percentage-point higher (8.25%) than the current discount rate.

For the year ended June 30, 2022:

	1% Decrease in Discount Rate (6.25%)	Discount Rate (7.25%)	1% Increase in Discount Rate (8.25%)
Net Pension Liability	$ 4,511,389	$ 2,265,928	$ 413,606

For the year ended June 30, 2021:

	1% Decrease in Discount Rate (6.50%)	Discount Rate (7.50%)	1% Increase in Discount Rate (8.50%)
Net Pension Liability	$ 5,517,056	$ 3,537,451	$ 1,891,556

Pension Plan Fiduciary Net Position

Additional information supporting the schedule of employer allocations and the schedule of pension amounts by employer is located in the PERS Annual Comprehensive Financial Report (ACFR) available on the PERS website at www.nvpers.org under Quick Links – Publications.

NOTE 5 OTHER POST EMPLOYMENT RETIREMENT BENEFITS

Plan Description

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

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

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

NOTE 5 OTHER POST EMPLOYMENT RETIREMENT BENEFITS (CONTINUED)

Benefits

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

Contributions

Per NRS 287 contribution requirements of the participating entities and covered employees are established and may be amended by the PEBP Board. The Fund's contractually required contribution for the years ended June 30, 2022 and 2021 were $35,622 and $37,136, respectively, actuarially determined as an amount that is expected to finance the costs of benefits earned by employees during the year. Employees are not required to contribute to the OPEB plan.

OPEB Liabilities, OPEB Expenses, and Deferred Outflows of Resources and Deferred Inflows of Resources Related to OPEB. At June 30, 2022 and 2021, the Fund reported a liability of $1,395,724 and $1,405,629, respectively, for its proportionate share of the collective net OPEB liability. The collective net OPEB liability was measured as of July 1, 2021, and the total OPEB liability used to calculate the collective net OPEB liability was determined by an actuarial valuation as of that date. The Fund's proportion of the collective net OPEB liability was based on a projection of the Fund's long-term share of contributions to the OPEB plan relative to the projected contributions of all participating entities, actuarially determined. For the year ended June 30, 2022 and 2021, respectively, the Fund's proportion was 0.0906% and 0.0938%.

For the years ended June 30, 2022 and 2021, respectively, the Fund recognized OPEB expense of $119,971 and $81,719. At June 30, 2022 and 2021, the Fund Reported deferred outflows of resources and deferred inflows of resources related to OPEB for the following sources:

	2022		2021	
	Deferred Outflows of Resources	Deferred Inflows of Resources	Deferred Outflows of Resources	Deferred Inflows of Resources
Changes of Assumptions	$ 90,264	$ 6,048	$ 125,277	$ 28,432
Changes in Experience	-	50,881	-	71,393
Fund Contributions Subsequent to the Measurement Date	35,622	-	37,136	-
	$ 125,886	$ 56,929	$ 162,413	$ 99,825

NOTE 5 OTHER POST EMPLOYMENT RETIREMENT BENEFITS (CONTINUED)

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

Year Ending June 30	Amount
2023	$ 7,231
2024	15,447
2025	10,778
2026	(121)
	$ 33,335

Actuarial Assumptions

The total OPEB liability in the June 30, 2022 actuarial valuation was determined using the following actuarial assumptions, applied to all periods included in the measurement, unless otherwise specified:

Inflation	2.50%
Salary Increases	Dependent upon pension system ranging from 1.00% to 10.65%, including inflation
Discount Rate	3.51% based on bond buyer general obligation 20-bond municipal bond index
Healthcare Cost Trend Rates	For medical prescription drug benefits the current amount is 6.25% and decreases to 4.50% long-term trend rate after six years. For dental benefits and Part B premiums the trend rate is 4.00% and 4.50% respectively.
Actuarial Method	Entry Age Normal Level % of Pay

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

The actuarial assumptions used in the June 30, 2021 valuation were based on the results of an actuarial experience study for the period July 1, 2017 to June 30, 2018. As a result of the 2018 actuarial experience study, the expectation of life after disability was adjusted in the January 1, 2018 actuarial valuation to more closely reflect actual experience.

Discount Rate

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

NOTE 5 OTHER POST EMPLOYMENT RETIREMENT BENEFTIS (CONTINUED)

Discount Rate (Continued)

Sensitivity of the Net OPEB Liability to Changes in the Discount Rate. The following presents the net OPEB liability of the Retirees' Fund, as well as what the Retirees' Fund's net OPEB liability would be if it were calculated using a discount rate that is 1-percentage-point lower (1.16%) or 1-percentage-point higher (3.16%) than the current discount rate.

For the year ended June 30, 2022:

	1% Decrease in Discount Rate 1.16%	Discount Rate 2.16%	1% Increase in Discount Rate 3.16%
Total OPEB Liability	$ (1,536,372)	$ (1,386,691)	$ (1,346,802)
Plan Fiduciary Net Position	(9,033)	(9,033)	(9,033)
Net OPEB Liability	$ (1,545,405)	$ (1,395,724)	$ (1,355,835)

For the year ended June 30, 2021:

	1% Decrease in Discount Rate 1.21%	Discount Rate 2.21%	1% Increase in Discount Rate 3.16%
Total OPEB Liability	$ (1,677,076)	$ (1,399,978)	$ (1,346,802)
Plan Fiduciary Net Position	(5,651)	(5,651)	(5,651)
Net OPEB Liability	$ (1,682,727)	$ (1,405,629)	$ (1,352,453)

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

For the year ended June 30, 2022:

	1% Decrease in Discount Rate	Health Care Cost	1% Increase in Discount Rate
Total OPEB Liability	$ 1,282,566	$ (1,386,691)	$ (1,490,153)
Plan Fiduciary Net Position	(9,033)	(9,033)	(9,033)
Net OPEB Liability	$ 1,273,533	$ (1,395,724)	$ (1,499,186)

NOTE 5 OTHER POST EMPLOYMENT RETIREMENT BENEFTIS (CONTINUED)

Discount Rate (Continued)

For the year ended June 30, 2021:

	1% Decrease in Discount Rate	Health Care Cost	1% Increase in Discount Rate
Total OPEB Liability	$ (1,400,818)	$ (1,399,978)	$ (1,614,471)
Plan Fiduciary Net Position	(5,651)	(5,651)	(5,651)
Net OPEB Liability	$ (1,406,469)	$ (1,405,629)	$ (1,620,122)

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

NOTE 6 COMMITMENTS

The Self Insurance Trust Fund is committed to the following contracts or policies after June 30, 2022:

Contractor	Contract Rate	Expiration Date
American Health Holding, Inc.	Varies by Case Volume	6/30/2023
AON Consulting	Hourly Rate	6/30/2022
Claim Technologies (Brown & Brown)	Varies by Audit	6/30/2027
CliftonLarsonAllen	Hourly Rate	12/31/2024
Diversified Dental Services	Per Participant per Month	6/3/2026
Express Scripts	Per Participant per Month Admin Fee, Claims Costs	6/30/2022
HealthSCOPE Benefits (PPO)	Varies by Service	6/30/2022
HealthSCOPE Benefits (TPA)	Varies by Service	6/30/2022
HealthSCOPE Dental	Varies by Service	6/30/2022
Labyrinth Solutions, Inc.	Per Participant Per Month	6/30/2027
Morneau Shepell	Per Participant per Month Fee for Services Rendered	6/30/2027
The Standard Insurance	Varies	6/30/2022
United Healthcare	Varies	6/30/2026
UMR Inc.	Varies by Service	6/30/2028
Segal Company	Hourly Rate	6/30/2027
Health Plan of Nevada	Per Participant Premium by Tier	6/30/2025
Lifeworks	Per Participant per Month Fee for Services Rendered	12/31/2026

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

NOTE 7 RISK MANAGEMENT

Estimated Claims Liabilities

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

NOTE 7 RISK MANAGEMENT (CONTINUED)

Unpaid Claims Liabilities

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

Unpaid Claims Liabilities

	2022	2021
Reserve for Claims Balance		
Beginning Balance	$ 52,286,000	$ 51,514,000
Claims and Changes in Estimates	277,858,690	271,862,209
Claims Payments	(279,114,690)	(271,090,209)
Ending Balance Reserve for Claims Balance	51,030,000	52,286,000
HRA Liability		
Beginning Balance	$ 31,298,731	$ 38,188,313
Incurred	34,243,392	31,850,782
Paid	(37,080,052)	(38,740,364)
Ending Balance HRA Liability	28,462,071	31,298,731
Ending Balance	$ 79,492,071	$ 83,584,731

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

NOTE 8 CONTINGENCIES

Contingent Liabilities

In accordance with NRS 353.140, the Self Insurance Trust Fund honors outstanding stale warrants presented for payment within six years from the date of origination. Management has estimated the total amount of outstanding stale warrants less than six years old to be $639,140 and $1,082,774 as of June 30, 2022 and June 30, 2021, respectively. Management has assessed that it is not probable that these warrants will be presented for payment during the statutory time frame. However these warrants will continue to be recorded as a liability as after the statutory six year period the funds will be turned over to the Nevada State Treasurer as unclaimed property.

NOTE 9 SUBSEQUENT EVENTS

Management has evaluated the activities and transactions subsequent to June 30, 2022 to determine the need for any adjustments to and disclosure within the financial statements for the year ended June 30, 2022. Management has evaluated subsequent events through February 22, 2023, the date which the financial statements were available to be issued.

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

NOTE 10 LITIGATION

Public Employees Benefit Program of the Self Insurance Trust Fund is involved in pending litigation. The outcome of the litigation cannot be predicted at this time.

STATE OF NEVADA
SELF INSURANCE TRUST FUND
PUBLIC EMPLOYEES' BENEFITS PROGRAM
REQUIRED SUPPLEMENTARY INFORMATION – PENSION
SCHEDULE OF CHANGES IN NET PENSION LIABILITY
LAST TEN FISCAL YEARS*

	Measurement Dates							
	2021	2020	2019	2018	2017	2016	2015	2014
Proportionate of the Net Pension Liability (Asset)	0.0245%	0.0254%	0.0281%	0.0260%	0.0253%	0.0270%	0.0262%	0.0254%
Proportionate Share of the Net Pension Liability (Asset)	$ 2,265,928	$ 3,537,451	$ 3,833,649	$ 3,547,239	$ 3,361,917	$ 3,633,788	$ 3,003,622	$ 2,681,426
Proportionate Share of Covered-Payroll	$ 1,594,419	$ 1,532,510	$ 1,684,981	$ 1,509,506	$ 1,374,657	$ 1,333,326	$ 1,344,932	$ 1,451,686
Proportionate Share of the Net Pension Liability (Asset) as a Percentage of its Covered-Payroll	142.12%	230.83%	227.52%	234.99%	244.56%	272.54%	223.33%	184.71%
Plan Fiduciary Net Position as a Percentage of the Total Pension Liability	86.51%	77.04%	76.46%	75.24%	74.42%	72.23%	75.13%	76.31%

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

STATE OF NEVADA
SELF INSURANCE TRUST FUND
PUBLIC EMPLOYEES' BENEFITS PROGRAM
REQUIRED SUPPLEMENTARY INFORMATION – PENSION
SCHEDULE OF CONTRIBUTIONS
LAST TEN FISCAL YEARS*

Fiscal Year	2022	2021	2020	2019	2018	2017	2016	2015
Contractually Required Contribution	$ 246,551	$ 260,407	$ 267,388	$ 270,930	$ 241,784	$ 220,384	$ 228,943	$ 281,658
Contributions in Relation to the Contractually Required Contribution	(246,551)	(260,407)	(267,388)	(270,930)	(241,784)	(220,384)	(228,943)	(281,658)
Contribution Deficiency (Excess)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Fund's Covered-Payroll	$ 1,629,320	$ 1,594,419	$ 1,532,510	$ 1,684,981	$ 1,509,506	$ 1,374,657	$ 1,333,326	$ 1,344,932
Contributions as a Percentage of Covered Payroll	15.13%	16.33%	17.45%	16.08%	16.02%	16.03%	17.17%	20.94%

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

STATE OF NEVADA
SELF INSURANCE TRUST FUND
PUBLIC EMPLOYEES' BENEFITS PROGRAM
REQUIRED SUPPLEMENTARY INFORMATION – PENSION
SCHEDULE OF THE FUND'S PROPORTIONATE SHARE OF THE OPEB LIABILITY
LAST TEN FISCAL YEARS*

	2021	2020	2019	2018	2017
Proportion of the Net OPEB Liability (Asset)	0.0906%	0.0938%	0.0934%	0.1070%	0.1029%
Proportionate Share of the Net OPEB Liability (Asset)	$ 1,395,724	$ 1,405,629	$ 1,301,204	$ 1,417,507	$ 1,339,747
Proportionate Share of Covered Payroll	$ 1,594,419	$ 1,532,510	$ 1,684,981	$ 1,509,506	$ 1,374,657
Proportionate Share of the Net OPEB Liability (Asset) as a Percentage of Covered Payroll	87.54%	91.72%	77.22%	93.91%	97.46%
Plan Fiduciary Net Position as a Percentage of the Total OPEB Liability	0.02%	0.02%	0.02%	0.12%	0.11%

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

STATE OF NEVADA
SELF INSURANCE TRUST FUND
PUBLIC EMPLOYEES' BENEFITS PROGRAM
REQUIRED SUPPLEMENTARY INFORMATION – PENSION
SCHEDULE OF THE FUND'S CONTRIBUTIONS
LAST TEN FISCAL YEARS*

	2022	2021	2020	2019	2018
Contractually Required Contribution	$ 35,622	$ 37,136	$ 41,705	$ 44,268	$ 39,801
Contributions	(35,622)	(37,136)	(41,705)	(44,268)	(39,801)
Contribution Deficiency (Excess)	$ -	$ -	$ -	$ -	$ -
Fund's Covered Payroll	$ 1,629,320	$ 1,594,419	$ 1,532,510	$ 1,684,981	$ 1,509,506
Contributions as a Percentage of Covered Payroll	2.19%	2.33%	2.72%	2.63%	2.64%

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

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

Board of the Public Employees' Benefits Program
State of Nevada

We have audited, in accordance with the auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards* issued by the Comptroller General of the United States, the basic financial statements of the Self Insurance Trust Fund, Public Employees' Benefits Program of the State of Nevada, as of and for the year ended June 30, 2022, and the related notes to the financial statements, which collectively comprise Self Insurance Trust Fund, Public Employees' Benefits Program of the State of Nevada's basic financial statements, and have issued our report thereon dated February 22, 2023.

Report on Internal Control Over Financial Reporting

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

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

Our consideration of internal control was for the limited purpose described in the first paragraph of this section and was not designed to identify all deficiencies in internal control that might be material weaknesses or significant deficiencies and therefore, material weaknesses or significant deficiencies may exist that were not identified. We identified certain deficiencies in internal control, described in the accompanying schedule of findings as item 2022-001 that we consider to be a material weakness.

Report on Compliance and Other Matters

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

The Self Insurance Trust Fund, Public Employees' Benefits Program of the State of Nevada's Response to Finding

Government Auditing Standards requires the auditor to perform limited procedures on the Self Insurance Trust Fund, Public Employees' Benefits Program of the State of Nevada's response to the findings identified in our audit and described in the accompanying schedule of findings. The Self Insurance Trust Fund, Public Employees' Benefits Program of the State of Nevada's response was not subjected to the other auditing procedures applied in the audit of the financial statements and, accordingly, we express no opinion on the response.

Purpose of This Report

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

CliftonLarsonAllen LLP

CliftonLarsonAllen LLP

Broomfield, Colorado
February 22, 2023

STATE OF NEVADA
SELF INSURANCE TRUST FUND
PUBLIC EMPLOYEES' BENEFITS PROGRAM
SCHEDULE OF FINDINGS
FOR THE YEAR ENDED JUNE 30, 2022

Section II – Financial Statement Findings

2022 – 001 Cash Over Draft and Claims Amounts

Type of Finding: Material Weakness in Internal Control over Financial Reporting

Condition: Through testing of outstanding checks as of June 30, 2022, it was found that the amounts recorded related to cash over drafts (a liability) and claims expenses were recorded twice, which resulted in an overstatement of liabilities and expenses for $3,192,254.

Criteria: Amounts should be recorded in accordance with generally accepted accounting standards.

Context: During testing of liabilities, it was found that amounts were incorrect for liabilities and claims expenses as a journal entry was recorded twice.

Effect: As a result of this issue, the following adjustment was required to by posted Public Employees Benefit Program:

- Self-Insurance Trust Fund – An adjustment to decrease cash over draft liabilities and claims expenses by an amount of $3,192,254.

Cause: Accrual entries for liabilities and claims expense were not recorded correctly.

Repeat Finding: This is a not repeat finding.

Recommendation: We recommend the Public Employees Benefit Program increase its review of accrual entries recorded at the end of the fiscal year.

Views of responsible officials and planned corrective actions: The Public Employees Benefit Program agrees with the finding and has adjusted liabilities and claims expenses accordingly. Public Employees Benefit Program will improve for yearend accrual entries.

Responsible Official: Cari Eaton, CFO

STATE OF NEVADA
SELF INSURANCE TRUST FUND
PUBLIC EMPLOYEES' BENEFITS PROGRAM
SCHEDULE OF FINDINGS
FOR THE YEAR ENDED JUNE 30, 2022

Section III – Prior Year Financial Statement Findings

2021 – 001 Claims Expenses

Condition: Expenses and liabilities related to accrual entries at the end of the fiscal year recorded for claims were not recorded correctly.

Recommendation: We recommend the Public Employees' Benefits Program increase its review of accrual entries recorded at the end of the fiscal year.

Current Year Status: Through work performed during fiscal year 2022, prior year material weakness appears to have been resolved.

2021 – 002 Accounts Receivable

Condition: Premium revenue and related receivables related to accrual entries at the end of the fiscal year recorded for claims were not recorded correctly.

Recommendation: We recommend the Public Employees' Benefits Program increase its review of accrual entries recorded at the end of the fiscal year.

Current Year Status: Through work performed during fiscal year 2022, prior year material weakness appears to have been resolved.

2021 – 003 Prior Period Restatement

Condition: Premium revenue and related receivables related to accrual entries at the end of the fiscal year recorded for claims were not recorded correctly.

Recommendation: We recommend the Public Employees' Benefits Program increase its review of accrual entries recorded at the end of the fiscal year.

Current Year Status: Through work performed during fiscal year 2022, prior year material weakness appears to have been resolved.

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

JUNE 30, 2022 AND 2021

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STATE OF NEVADA
STATE RETIREES' HEALTH & WELFARE BENEFITS FUND
PUBLIC EMPLOYEES' BENEFITS PROGRAM
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YEARS ENDED JUNE 30, 2022 AND 2021

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INDEPENDENT AUDITORS' REPORT

Board of the Public Employees' Benefits Program
State of Nevada

Report on the Audit of the Financial Statements

Opinion

We have audited the accompanying financial statements of the State Retirees' Health & Welfare Benefits Fund, Public Employees' Benefits Program of the State of Nevada (the Fund), as of and for the years ended June 30, 2022 and 2021, and the related notes to the financial statements, which collectively comprise the State Retirees' Health & Welfare Benefits Fund, Public Employees' Benefits Program of the State of Nevada's basic financial statements as listed in the table of contents.

In our opinion, the financial statements referred to above present fairly, in all material respects, the respective financial position of the State Retirees' Health & Welfare Benefits Fund, Public Employees' Benefits Program of the State of Nevada, as of June 30, 2022 and 2021, and the respective changes in financial position for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Basis for Opinion

We conducted our audits in accordance with auditing standards generally accepted in the United States of America (GAAS) and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States. Our responsibilities under those standards are further described in the Auditors' Responsibilities for the Audit of the Financial Statements section of our report. We are required to be independent of the State Retirees' Health & Welfare Benefits Fund, Public Employees' Benefits Program of the State of Nevada and to meet our other ethical responsibilities, in accordance with the relevant ethical requirements relating to our audit. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinions.

Emphasis of a Matter

Reporting Entity

As discussed in Note 1, the financial statements of the State Retirees' Health & Welfare Benefits Fund, Public Employees' Benefits Program of the State of Nevada are intended to present the net position, and changes in net position of the Fund. They do not purport to, and do not, present fairly the financial position of the state of Nevada, as of June 30, 2022 and 2021, and the changes in its net position, for the years then ended, in conformity with accounting principles generally accepted in the United States of America. Our opinion is not modified with respect to this matter.

Responsibilities of Management for the Financial Statements

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

In preparing the financial statements, management is required to evaluate whether there are conditions or events, considered in the aggregate, that raise substantial doubt about the State Retirees' Health & Welfare Benefits Fund, Public Employees' Benefits Program of the State of Nevada's ability to continue as a going concern for 12 months beyond the financial statement date, including any currently known information that may raise substantial doubt shortly thereafter.

Auditors' Responsibilities for the Audit of the Financial Statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditors' report that includes our opinions. Reasonable assurance is a high level of assurance but is not absolute assurance and therefore is not a guarantee that an audit conducted in accordance with GAAS and *Government Auditing Standards* will always detect a material misstatement when it exists. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control. Misstatements are considered material if there is a substantial likelihood that, individually or in the aggregate, they would influence the judgment made by a reasonable user based on the financial statements.

In performing an audit in accordance with GAAS and *Government Auditing Standards*, we:

- Exercise professional judgment and maintain professional skepticism throughout the audit.
- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements.
- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the State Retirees' Health & Welfare Benefits Fund, Public Employees' Benefits Program of the State of Nevada's internal control. Accordingly, no such opinion is expressed.
- Evaluate the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluate the overall presentation of the financial statements.
- Conclude whether, in our judgment, there are conditions or events, considered in the aggregate, that raise substantial doubt about the State Retirees' Health & Welfare Benefits Fund, Public Employees' Benefits Program of the State of Nevada's ability to continue as a going concern for a reasonable period of time.

We are required to communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit, significant audit findings, and certain internal control related matters that we identified during the audit.

Required Supplementary Information

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

Management has omitted the management's discussion and analysis that accounting principles generally accepted in the United States of America require to be presented to supplement the basic financial statements, Such missing information, although not a part of the basic financial statements, is required by the Governmental Accounting Standards Board who considers it to be an essential part of financial reporting for placing the basic financial statements in an appropriate operational, economic, or historical context. Our opinions on the basic financial statements are not affected by this missing information.

Other Reporting Required by *Government Auditing Standards*

In accordance with *Government Auditing Standards*, we have also issued our report dated February 22, 2023 on our consideration of the State Retirees' Health & Welfare Benefits Fund, Public Employees' Benefits Program's internal control over financial reporting and on our tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements and other matters. The purpose of that report is solely to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing, and not to provide an opinion on the effectiveness the State Retirees' Health & Welfare Benefits Fund, Public Employees' Benefits Program's internal control over financial reporting or on compliance. That report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering the State Retirees' Health & Welfare Benefits Fund, Public Employees' Benefits Program's internal control over financial reporting and compliance.

CliftonLarsonAllen LLP

CliftonLarsonAllen LLP

Broomfield, Colorado
February 22, 2023

STATE OF NEVADA
STATE RETIREES' HEALTH & WELFARE BENEFITS FUND
PUBLIC EMPLOYEES' BENEFITS PROGRAM
STATEMENTS OF FIDUCIARY NET POSITION
JUNE 30, 2022 AND 2021

	2022	2021
ASSETS		
ASSETS		
Cash with Treasurer	$ 3,491,998	$ 2,118,781
Intergovernmental Receivable	20,584	6,716
Due From Other Funds	107,288	7,142
Due From Component, Units, Net	1,334,319	-
Total Assets	4,954,189	2,132,639
LIABILITIES AND NET POSITION		
CURRENT LIABILITIES		
Due to Other Funds	25,046,900	12,100,467
Total Liabilities	25,046,900	12,100,467
NET POSITION		
Net Position Restricted for Other Postemployment Benefits	$ (20,092,711)	$ (9,967,828)

See accompanying Notes to Financial Statements.

STATE OF NEVADA
STATE RETIREES' HEALTH & WELFARE BENEFITS FUND
PUBLIC EMPLOYEES' BENEFITS PROGRAM
STATEMENTS OF CHANGES IN FIDUCIARY NET POSITION
YEARS ENDED JUNE 30, 2022 AND 2021

	2022	2021
ADDITIONS		
Contributions		
Employer Contributions	$ 39,621,208	$ 39,563,787
Investment Income		
Interest and Dividends	19,046	34,923
Net Appreciation in Fair Value of Investments	(111,936)	273,081
Investment Expense	-	(453)
Total Net Investment Income	(92,890)	307,551
Total Additions	39,528,318	39,871,338
Deductions		
Benefit Payments	49,653,201	44,187,551
Total Deductions	49,653,201	44,187,551
CHANGE IN NET POSITION	(10,124,883)	(4,316,213)
Net Position - Beginning of Year	(9,967,828)	(5,651,615)
NET POSITION - END OF YEAR	$ (20,092,711)	$ (9,967,828)

See accompanying Notes to Financial Statements.

NOTE 1 SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Reporting Entity

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

Basis of Accounting

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

Method Used to Value Investments

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

Plan Description and Contribution Information

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

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

NOTE 1 SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

Plan Description and Contribution Information (Continued)

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

- Has at least five years of public service and who was initially hired by the State prior to January 1, 2010; or
- Has at least 15 years of public service and who was initially hired by the State on or after January 1, 2010, but before January 1, 2012; or
- Has at least five years of public service, who has a disability and who was initially hired by the State on or after January 1, 2010, but before January 1, 2012; or
- Any PEBP covered retirees with state service whose last employer was not the State or a participating local government entity and who has been continuously covered under PEBP as a retiree since November 30, 2008.

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

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

Contributions to the fund are paid by the state of Nevada through an assessment of actual payroll paid by each State entity. The assessment is set by the Governor's Finance Office based on an amount provided by the Legislature each biennium in session law. The assessment was 2.34% and 2.34% of actual payroll for the years ending June 30, 2022 and 2021, respectively. Benefits are paid to the Public Employees' Benefits Program Self Insurance Trust Fund as necessary to offset retiree premiums pursuant to NRS 287.046. Funds not required to pay benefits are invested in the Retiree Benefits Investment Fund established pursuant to NRS 355.220 or are held in the state of Nevada general portfolio pursuant to NRS 226.110 as approved in the legislatively approved budget. Administrative costs of the Retirees' Fund are absorbed by the Self Insurance Trust Fund.

NOTE 1 SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (CONTINUED)

Plan Description and Contribution Information (Continued)

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

Active Plan Members*	10,183
Inactive Plan Members or Beneficiaries Currently Receiving Benefit**	13,900
Inactive Plan Members Entitled to but Not Yet Receiving Benefit Payments	2,280
Total Plan Members	26,363

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

State participating employers consisted of the following as of the actuarial valuation date:

Total Participating Employers	24

The Retirees' Fund is governed by the Public Employees Benefits Program Board of Trustees which consists of 10 members who are appointed by the Governor of the State of Nevada. Each appointee represents a specific class of public employees and retirees including the Nevada System of Higher Education, retired public employees, state employees, and local government employees. Additionally, two members must have substantial and demonstrated experience in risk management, health care administration, or employee benefits programs. One member must be employed in a managerial capacity for the Nevada State Department of Administration. These requirements are all in accordance with NRS 287.041.

NOTE 2 NET OPEB LIABILITY

Funding Status and Funding Progress

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

Net OPEB Liability of the Retirees' Fund

The components of the net OPEB liability of the Retiree's Fund at June 30, 2022 and 2021, were as follows:

	2022 (in thousands)	2021 (in thousands)
Total OPEB Liability	$ (1,540,183)	$ (1,498,059)
Plan Fiduciary Net Position	(9,968)	(5,651)
Net OPEB Liability	$ (1,550,151)	$ (1,503,710)
Plan Fiduciary Net Position as a Percentage of Total OPEB Liability	0%	0%
OPEB Expense	$ 76,323	$ 85,777

NOTE 2 NET OPEB LIABILITY (CONTINUED)

Actuarial Assumptions

The total OPEB liability was determined by an actuarial valuation as of July 1, 2020, using the following actuarial assumptions, applied to all periods included in the measurement, unless otherwise specified:

Inflation	2.50%
Salary Increases	2.75%
Discount Rate	2.16%, Based on Bond Buyer General Obligation 20-Bond Municipal Bond Index
Healthcare Cost Trend Rates	For medical prescription drug benefits the current amount is 6.25% and decreases to 4.50% long-term trend rate after eleven years. For dental benefits and Part B Premiums the trend rate is 4.00% and 4.50%, respectively.
Actuarial Method	Entry Age Normal Level % of Pay

Healthy Mortality Officers: Pub-2010 Public Retirement Plans Safety Mortality Table weighted by Headcount, projected by MP-2019 Civilians: Pub-2010 Public Retirement Plans General Mortality Table weighted by Headcount, projected by MP-2019

Disabled Mortality Officers: Pub-2010 Public Retirement Plans Safety Disabled Mortality Table weighted by Headcount, projected by MP-2019 Civilians: Pub-2010 Public Retirement Plans General Disabled Mortality Table weighted by Headcount, projected by MP-2019

The actuarial assumptions used in the January 1, 2020 valuation were based on the results of an actuarial experience study for the period July 1, 2019 to June 30, 2020.

As the Retirees' Fund is funded on a pay-as-you-go basis, the discounted rate is equal to the Bond Buyer General Obligation 20-Bond Municipal Bond Index rate of 2.21%.

Discount rate

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

The discount rates used for fiscal years ended June 30, 2022 and 2021 are 2.16% and 2.21%, respectively.

NOTE 2 NET OPEB LIABILITY (CONTINUED)

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

The following presents the net OPEB liability of the Retirees' Fund, as well as what the Retirees' Fund's net OPEB liability would be if it were calculated using a discount rate that is 1-percentage-point lower (1.21%) or 1-percentage-point higher (3.21%) than the current discount rate:

	1% Decrease (1.21%) (in thousands)	Discount Rate (2.21%) (in thousands)	1% Increase (3.21%) (in thousands)
Total OPEB Liability (Ending)	$ (1,695,388)	$ (1,540,183)	$ (1,370,270)
Plan Fiduciary Net Position (Ending)	(9,968)	(9,968)	(9,968)
Net OPEB Liability (Ending)	$ (1,705,356)	$ (1,550,151)	$ (1,380,238)

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

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

	1% Decrease (in thousands)	Trend Rates (in thousands)	1% Increase (in thousands)
Total OPEB Liability (Ending)	$ (1,415,313)	$ (1,540,183)	$ (1,644,385)
Plan Fiduciary Net Position (Ending)	(9,968)	(9,968)	(9,968)
Net OPEB Liability (Ending)	$ (1,425,281)	$ (1,550,151)	$ (1,654,353)

NOTE 3 CASH AND DEPOSITS WITH THE STATE TREASURER

	2022	2021
Cash		
Deposits with State Treasurer:		
State Treasurer's Investment Pool	$ 3,597,890	$ 2,112,737
GASB 31 Adjustment	(105,892)	6,044
Total Cash and Deposits	$ 3,491,998	$ 2,118,781

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

NOTE 3 CASH AND DEPOSITS WITH THE STATE TREASURER (CONTINUED)

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

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

NOTE 4 INTERFUND BALANCES

Interfund balances at June 30, 2022 and 2021 consisted of the following:

	2022	2021
Due to Fiduciary Fund From:		
General Funds	$ 102,744	$ 7,142
Internal Service Funds	4,544	-
Total Due to Fiduciary Fund From Other Funds	$ 107,288	$ 7,142
Due to Fiduciary Fund From:		
All Others	$ 1,334,319	$ -
Total Due to Fiduciary Fund From Component Units	$ 1,334,319	$ -
Due From Fiduciary Fund:		
Internal Service Funds	$ 25,046,900	$ 12,100,467
Total Due to Internal Service Funds From Fiduciary Fund	$ 25,046,900	$ 12,100,467

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

NOTE 5 RETIREMENT BENEFITS INVESTMENT FUND

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

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

NOTE 6 FAIR VALUE

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

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

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

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

NOTE 6 FAIR VALUE (CONTINUED)

The following table presents fair value measurements as of June 30, 2022:

	Level 1
U.S. Treasury Securities and Equities	$ -
Total Investments	$ -

The following table presents fair value measurements as of June 30, 2021:

	Level 1
U.S. Treasury Securities and Equities	$ -
Total Investments	$ -

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

NOTE 7 SUBSEQUENT EVENTS

Management has evaluated the activities and transactions subsequent to June 30, 2022 to determine the need for any adjustments to and disclosure within the financial statements for the year ended June 30, 2022. Management has evaluated subsequent events through February 22, 2023, the date which the financial statements were available to be issued.

NOTE 8 RISKS AND UNCERTAINTIES

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

NOTE 9 LITIGATION

Public Employees Benefit Program of the State Retirees' Health & Welfare Fund is involved in pending litigation. The outcome of the litigation cannot be predicted at this time.

STATE OF NEVADA
STATE RETIREES' HEALTH & WELFARE BENEFITS FUND
PUBLIC EMPLOYEES' BENEFITS PROGRAM
REQUIRED SUPPLEMENTARY INFORMATION
SCHEDULE OF CHANGES IN NET OPEB LIABILITY AND RELATED RATIOS
LAST TEN FISCAL YEARS* (UNAUDITED)

	Fiscal Year Ending June 30					
	2022	2021	2020	2019	2018	2017
Total OPEB Liability						
Service Cost	$ 55,710	$ 53,039	$ 51,349	$ 51,882	$ 59,309	$ 49,794
Interest Cost	33,853	49,915	52,488	47,795	39,469	45,361
Changes of Benefit Terms	-	-	-	-	-	-
Differences Between Expected and Actual Experiences	(2,313)	(72,984)	(31,485)	-	-	-
Changes of Assumptions	(938)	124,245	37,971	(36,851)	(102,300)	123,519
Gross Benefit Payments	(44,188)	(49,969)	(42,490)	(39,710)	(38,069)	(35,932)
Net Change in Total OPEB Liability	42,124	104,246	67,833	23,116	(41,591)	182,742
Total OPEB Liability - Beginning of Year	1,498,059	1,393,813	1,325,980	1,302,864	1,344,455	1,161,713
Total OPEB Liability - End of Year	$ 1,540,183	$ 1,498,059	$ 1,393,813	$ 1,325,980	$ 1,302,864	$ 1,344,455
Plan Fiduciary Net Position						
Contributions - Employer	$ 39,564	$ 43,882	$ 40,943	$ 39,669	$ 38,049	$ 32,213
Contributions - Member	-	-	-	-	-	-
Net Investment Income	308	205	181	162	164	55
Gross Benefit Payments	(44,188)	(49,969)	(42,490)	(39,710)	(38,069)	(35,932)
Administrative Expenses			-	-		
Other			-	-		
Net Change in Plan Fiduciary Net Position	(4,316)	(5,882)	(1,366)	121	144	(3,664)
Plan Fiduciary Net Position - Beginning of Year	(5,651)	231	1,597	(8,516)	(8,660)	(4,996)
Plan Fiduciary Net Position - End of Year	$ (9,967)	$ (5,651)	$ 231	$ (8,395)	$ (8,516)	$ (8,660)
Total Net OPEB Liability	$ 1,550,150	$ 1,503,710	$ 1,393,582	$ 1,334,375	$ 1,311,380	$ 1,353,115
Net Position as a Percentage of OPEB Liability	0%	0%	0%	0%	0%	0%
Covered Employee Payroll	$ 2,090,282	$ 2,046,678	$ 1,991,456	$ 1,890,946	$ 1,663,856	$ 1,627,517
Net OPEB Liability as a Percentage of Payroll	74%	73%	70%	70%	78%	83%

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

Plan Change: None

Assumption Change: The valuation reflects a change of assumption in that the discount rate used at June 30, 2020 was 3.51% , the discount rate used at June 30, 2021 was 2.21%, and the discount rate used at June 30, 2022 was 2.16%.

STATE OF NEVADA
STATE RETIREES' HEALTH & WELFARE BENEFITS FUND
PUBLIC EMPLOYEES' BENEFITS PROGRAM
REQUIRED SUPPLEMENTARY INFORMATION
SCHEDULE OF CONTRIBUTIONS
LAST TEN FISCAL YEARS* (UNAUDITED)

	Fiscal Year Ending June 30					
	2022	2021	2020	2019	2018	2017
Actuarially Determined Contribution	N/A	N/A	N/A	N/A	N/A	N/A
Contributions Made in Relation to the Actuarially Determined Contribution	N/A	N/A	N/A	N/A	N/A	N/A
Contribution Deficiency (Excess)	N/A	N/A	N/A	N/A	N/A	N/A
Covered Employee Payroll**	$ 2,090,282	$ 2,046,678	$ 1,991,456	$ 1,890,946	$ 1,663,856	$ 1,627,517
Contributions as a Percentage of Payroll	N/A	N/A	N/A	N/A	N/A	N/A

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

**Covered payroll for all fiscal years were provided by the State.

Notes to Schedule

Valuation Date	January 1, 2020
Methods and Assumptions Used to Determine Contribution Rates:	
Actuarial Cost Method	Entry Age Normal - Level % of Salary
Asset Valuation Method	Market Value of Assets
Retirement Age***	Varies by Age and Service
Morality	Pub-2010 Public Retirement Plans Mortality Table weighted by Headcount,

*** Weighted average retirement age based on January 1, 2020 census data and retirement rates provided in the "Actuarial Assumptions and Methods" section of the report.

CliftonLarsonAllen LLP
CLAconnect.com

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

Board of the Public Employees' Benefits Program
State of Nevada

We have audited, in accordance with the auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards* issued by the Comptroller General of the United States, the financial statements State Retirees' Health & Welfare Benefits Fund, Public Employees' Benefits Program of the State of Nevada (the Fund), as of and for the year ended June 30, 2022, and the related notes to the financial statements, which collectively comprise State Retirees' Health & Welfare Benefits Fund, Public Employees' Benefits Program of the State of Nevada's basic financial statements, and have issued our report thereon dated February 22, 2023.

Report on Internal Control Over Financial Reporting

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

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

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

Report on Compliance and Other Matters

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

Purpose of This Report

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

CliftonLarsonAllen LLP

CliftonLarsonAllen LLP

Broomfield, Colorado
February 22, 2023

5.

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

JOE LOMBARDO
Governor

STATE OF NEVADA
PUBLIC EMPLOYEES' BENEFITS PROGRAM
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LAURA RICH
Executive Officer

JACK ROBB
Board Chair

AGENDA ITEM

☐ Action Item
☒ Information Only

Date: March 23, 2023

Item Number: V

Title: Executive Officer Report

SUMMARY

This report provides the PEBP Board and members of the public with information regarding PEBP operations.

REPORT

Staffing

Vacancies continue to hover between 25%-30% (currently at 29%). Our recruitment efforts continue to be challenging. The most recent call center staff recruitment received a list of 25 candidates, of which 16 were invited to interview. Of those, only three accepted interviews but none of the candidates were offered the position after determining the candidates were not a good fit for the position. An additional recruitment received 10 applicants and all 10 were invited to interview. Five of the 10 accepted interviews but only two candidates showed up (one of them being a current PEBP employee). The internal employee has been promoted from receptionist to MSU and the other candidate was also offered the position but did not accept the position. While the additional staff in MSU will help tremendously, a reception position (which historically has been difficult to fill), will likely remain vacant for some time.

As Open Enrollment nears, PEBP will be adjusting operations and staffing to ensure the needs of our members are met to the best of our abilities; all staff will be assisting with calls/member emails during open enrollment and annual leave time will be severely limited. Despite this, it is likely members will experience long call wait times and delayed email responses.

Office Move

PEBP expects to move offices the first week of April; however, the exact date will be dependent on security and IT related services being fully functional. It is likely PEBP will require periodic

downtimes during the last week of March as part of that process where some operations, such as call center operations, will have to fully shut down while others can be performed remotely.

Legislative Matters

PEBP provided a budget presentation to the Joint Senate Finance and Assembly Ways and Means and Committee on February 17th. As anticipated, there appears to be significant focus from the legislature on finding ways to fund increases to employee wages and benefits, so staff has been working with LCB staff to provide supplemental information requested by the committee as well as individual legislators.

During the committee hearing, PEBP testified that the agency will accommodate any desires the legislature may request; however, it was important to note that most budgetary changes made by the legislature during session years have a significant impact on Open Enrollment in terms of legal noticing timelines, member disruption, and staffing. Although PEBP has managed to navigate these difficult and time sensitive situations in the past, staffing shortages now make last-minute changes challenging to implement. This appears to have resonated with the committee and we are pleased to report that this has led to many productive conversations.

PEBP will be attending an additional committee meeting on March 30 focused on employee wages and benefits. Although PEBP is not expected to present, staff will be available to provide any information requested by the committee.

6.

6. Discussion and possible action on Diabetes Prevention/Diabetes Self-Management Education and Support pilot program (Laura Rich, Executive Officer) (**For Possible Action**)

Nevada Business Group on Health
State of Nevada
DPP/DSMES
Grant

Pilot Program for Public Employees Benefit Program

Nevada Business Group on Health (NVBGH)
Nevada Health Partners (NHP)

NVBGH is a partnership between public and private sectors formed to provide quality and cost-effective health care for the mutual benefit of employers, employees and families.

Two Organizations – both non-profit

- **NVBGH** – Focus on Data, Community Health, Education
- **NHP** – Contracting
  - Direct Hospital – 60%+ Discount Rates
  - Direct Ancillary Services (ACS, EAP, Dental) – 57%+ Discount Rates
  - Direct Pharmacy, EAP, Dental

The National Alliance

Approximately 50 healthcare purchaser coalitions across the US, serving nearly every major metropolitan area and multiple primarily rural states

Supports over 12,000 healthcare purchasers providing health coverage to over 45 million Americans

Represents a cross-section of private sector, public sector, non-profit and Taft-Hartley organizations

Driving improvements in health, well-being and value across the US

National Alliance
of Healthcare Purchaser Coalitions
Driving Innovation, Health and Value

DPP

National Diabetes Prevention Program

This is a public-private partnership of community organizations, private insurers, health care organizations, employers, and government agencies. Partners work to establish local evidence-based lifestyle change programs for people at high risk for type 2 diabetes.

What is National DPP?

Overview:

Evidence-based lifestyle change program for preventing Type 2 diabetes.

Year-long program focused on long-term changes.

Sessions are weekly for 6 months and then monthly for 6 months.

Participants make real lifestyle changes.

Participants meet with a trained lifestyle coach and a small group of people who are also making lifestyle changes to prevent diabetes.

This proven program cut participants' risk of developing Type 2 diabetes by 50%.

National DPP

Learning objectives for participants:

- Eating healthy
- Exercising
- Managing stress
- Navigating challenges and how to get back on track when derailed
- Setting goals
- Tracking diet and exercise
- Staying motivated

National DPP

Delivery methods:

In-person

- Face-to-face with group members and the lifestyle coach.

Online

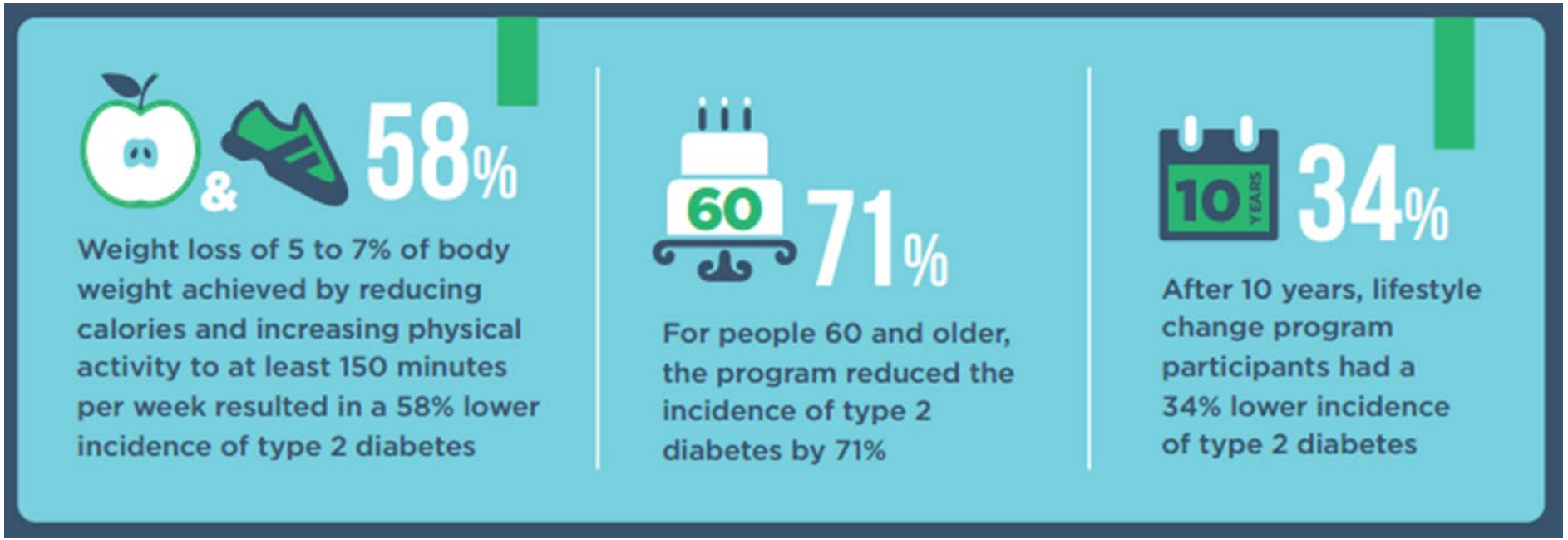
- 100% online delivery of sessions with multiple opportunities for live lifestyle coach interaction.

Distance Learning

- Delivered by Lifestyle Coaches via remote classroom or telehealth.

Combination

- A combination of any of the previously defined delivery modes.



Results of the CDC's National DPP

The Simple Math

Type 2 diabetics cost $10,000 (2.3x more than non-diabetics)

DPP cost $150-$600

Diabetes Self-Management Education and Support (DSMES) Programs

DSMES

Diabetes Self-Management Education and Support (DSMES)

Diabetes self-management education and support (DSMES) provides an evidence-based foundation to empower people with diabetes to navigate self-management decisions and activities. DSMES is a cost-effective tool proven to help improve health behaviors and health outcomes for people with diabetes.

DSMES Program

Overview:

- Evidence-based educational program to reduce symptoms and improve quality of life.
- A 6-week group program for people with type 2 diabetes.
- Sessions are 2.5 hours per week for 6 weeks.
- Participants meet with trained leaders, at lease one of whom has a chronic condition, and a small group of people who are also diagnosed with diabetes.

PEBP – Exposure
Why is this program important?

- Data provided from the PEBP Third Party Administrator showed that within PEBP, there are approximately:
  - 3700 diabetics
  - 2400 pre-diabetics

In addition, CDC statistics show that 8 out of 10 adults have pre-diabetes and do not know it.

Nevada Business Group on Health Program

Overview:

- CDC/State of Nevada Grant Received to bring employers to the table to consider coverage of DPP and DSMES in their benefit program
- NVBGH has partnered with several agencies to provide a 'pilot' program to employers to determine if the program is successful – **At No Cost to Employers**
- Confidentiality of Member date preserved
- Reporting out at a group level only
- Very little additional work-load to the agency

What we are asking?

- Permission to move ahead to identify potential pilot group
- Communication of the program
- Identification of potential eligible members
- Review of program results
- Consideration to cover DPP and DSMES in self-funded benefit plan moving forward.

Thank You!

Questions?

7.

7. Discussion and possible action on recommended changes to Master Plan Documents for Plan Year 24 to include the removal of IUI benefit on the Low Deductible and EOP plans (July 1, 2023 – June 30, 2024) (Laura Rich, Executive Officer) (**For Possible Action**)

    7.1 Master Plan Document Recommended Changes

    7.2 HRA Summary Plan Changes

7.1

7. Discussion and possible action on recommended changes to Master Plan Documents for Plan Year 24 to include the removal of IUI benefit on the Low Deductible and EOP plans (July 1, 2023 – June 30, 2024) (Laura Rich, Executive Officer) (**For Possible Action**)

    7.1 Master Plan Document Recommended Changes

    7.2 HRA Summary Plan Changes

JOE LOMBARDO
Governor

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LAURA RICH
Executive Officer

JACK ROBB
Board Chair

AGENDA ITEM

[X] Action Item
[ ] Information Only

Date: March 23, 2023

Item Number: VII.I

Title: Updates to the Plan Year 2024 Master Plan Documents (MPDs)

SUMMARY

This report will go over the benefit changes to the Master Plan Documents (MPD) for plan year 2024 for the following MPDs:

- Consumer Driven Health Plan Master Plan Document
- Low Deductible Master Plan Document
- Exclusive Provider Organization Master Plan Document
- Dental PPO and Life Insurance Master Plan Document
- Health Reimbursement Arrangement Summary Plan Document

To see every change please visit https://pebp.state.nv.us/meetings-events/board-meetings/ for digital, PDF copies of plan documents. This is due to file size.

BACKGROUND

PEBP staff and its vendor partners, have identified several more necessary changes to the Consumer Driven Health Plan (CDHP), Low Deductible PPO (LD), and the Exclusive Provider Organization (EPO) Master Plan Documents. The proposed changes stem from input received from the subject matter experts – some changes being simply housekeeping efforts, while others are regulatory and compliance matters. Additional edits will likely be necessary once testing relating to the Mental Health Parity and Addiction Equity Act is conducted later this year.

REPORT

UPDATES TO THE CDHP, LD, AND EPO

There were several updates and changes implemented across the health plan documents. These include the following list of changes:

Plan Changes for the CDHP, LD, and EPO

Prescription Drug Benefits			
Item #	**Change Type**	**Proposed Change**	**Justification**
1	Clarification	Insulin pumps and supplies are covered under the pharmacy benefit's base day and quantity limits, subject to copayments, deductibles, or coinsurance.	Insulin Pump and Insulin Pump supplies were previously added to the plan documents under the prescription benefit. This clarification addresses the applicable cost to the member.

Benefit Limitations and Exclusions			
Item #	**Change Type**	**Proposed Change**	**Justification**
2	Clarification	Added exception to Biofeedback exclusion to be "unless included with psychotherapy."	Per the Third-Party Administrator, biofeedback claims are identified by diagnosis and covered when conducted in conjunction with psychotherapy.

Appeals			
Item #	**Change Type**	**Proposed Change**	**Justification**
3	Update	Updated prescription drug review and appeals to include "those cases related to specialty drugs dispensed through Accredo specialty pharmacy."	Per the PBM, Express Scripts, to educate members that Specialty Pharmacy determinations can be appealed.
4	Update	Updated the contact information under "How to request a Clinical Coverage Review"	Per the Express Scripts' request to help expedite coverage reviews.

Participant Contact Guide			
Item #	**Change Type**	**Proposed Change**	**Justification**
5	Update	Updated the Pharmacy Benefit Manager contact information.	Per Express Scripts

Benefits			
Item #	**Change Type**	**Proposed Change**	**Justification**
6	Removal	Coronavirus (COVID-19) Benefits	The federal government confirmed that May 11, 2023 will be the end of the public health emergency (PHE); therefore, this section can be removed from plan documents as standard benefits and cost share will apply.
7	Update	Added section for Smoking/Tobacco Cessation from the CDHP to the LD and EPO plans.	It was recently recognized that the Low Deductible and Exclusive Provider Organization plans historically did not explicitly state this benefit.

SPECIFIC BENEFIT CHANGES

The following changes were made specific to the listed plans and are noted on the respective Master Plan Document, respectively.

Exclusive Provider Organization			
Item #	**Change Type**	**Proposed Change**	**Justification**
8	Update	Removed "ages 18 and older" from Gender Dysphoria Related Services	Erroneously included in this plan document. This is updated to coincide with other plan documents.

Health Reimbursement Arrangement SPD			
Item #	**Change Type**	**Proposed Change**	**Justification**
9	Update	Created Summary Plan Document for the Health Reimbursement Arrangement, (see 7.2, attached)	Due to expanding a Health Reimbursement Arrangement to other PEBP Plans, a Summary Plan Document is necessary for notification to members. Conforming changes to other plan documents will be made upon approval.

Dental and Life Master Plan Document			
Item #	**Change Type**	**Proposed Change**	**Justification**
10	Clarification	Added "or medically unnecessary" to Non-Eligible Dental Expenses	Clarifying update to Plan document that medically unnecessary services are not covered.
11	Clarification	Updated definition of Medically Unnecessary Services of Supplies to include an example.	Clarified benefit exclusions for Procedures that are not indicated due to insufficient evidence of efficacy.

Intrauterine Insemination (IUI)

PEBP staff and its vendor partners reviewed claims history for the Consumer Driven Health Plan (CDHP), Low Deductible PPO (LD), and the Exclusive Provider Organization (EPO) regarding IUI for plan years 2020 through 2022. The proposed changes stem from input received from the subject matter experts.

Currently, the plan's infertility benefits are limited to Intrauterine insemination (IUI), which is not generally covered by health plans because it is not recognized as clinically effective infertility treatment. It is also not widely utilized. For each of the last three years, there have been fewer than 20 claimants with a low success rate.

Unique Claimant Count			
Plan Year	**Total**	**Pregnancy**	**Non-Pregnancy**
2020	17	6	11
2021	14	5	9
2022	18	3	15

Costs are about $300 per treatment. Some patients have multiple treatments, but the total plan costs per year are generally $10,000 or less.

Plan Allowed for IUI			
Plan Year	**Total**	**Resulted in Pregnancy**	**Did Not Result in Pregnancy**
2020	$10,361	$4,192	$6,169
2021	$8,206	$3,624	$4,582
2022	$7,611	$570	$7,901

Total costs for maternity and pregnancy for the patients where IUI did result in pregnancy were under $100,000 per year:

Plan Allowed for IUI		
Plan Year	**Claimants**	**Maternity and Pregnancy Costs**
2020	6	$61,163
2021	5	$89,731
2022	3	$31,528

While recent IUI related births appear to have been somewhat routine, we should note that pregnancies resulting from IUI treatments come with a higher risk of complications. The low prevalence rate does not provide a credible indication of how all future IUI related pregnancies will turn out.

Intrauterine insemination (IUI) clinically can often lead to multiple births, high risk pregnancy, neonatal ICU admissions, and a higher rate of unnecessary medical care. Many local OBGYN's perform IUI without having a member evaluated by a reproductive endocrinologist. There could be other undetected underlying medical conditions that go unaddressed with this pathway.

Infertility benefits that are focused on coverage for IUI treatments generally do not provide coverage for the most clinically sound, or effective, treatments available today and can result in high-risk pregnancies.

The Consumer Driven Health Plan has historically never had an IUI benefit so the recommended benefit change will only affect the LD and EPO plans**.**

Low Deductible and EPO			
Item #	**Change Type**	**Proposed Change**	**Justification**
12	Removal	Remove IUI coverage	Infertility benefits that are focused on coverage for IUI treatments do not provide coverage for the most clinically sound, or effective treatments available today and can result in high-risk pregnancies.

RECOMMENDATION

Approve the proposed updates to the health Master Plan Documents for Plan Year 2024:

- Consumer Driven Health Plan Master Plan Document
- Low Deductible Master Plan Document
- Exclusive Provider Organization Master Plan Document
- Dental PPO and Life Insurance Master Plan Document
- Health Reimbursement Arrangement Summary Plan Document

7.2

7. Discussion and possible action on recommended changes to Master Plan Documents for Plan Year 24 to include the removal of IUI benefit on the Low Deductible and EOP plans (July 1, 2023 – June 30, 2024) (Laura Rich, Executive Officer) (**For Possible Action**)

    7.1 Master Plan Document Recommended Changes

    7.2 HRA Summary Plan Changes

NEVADA PUBLIC EMPLOYEES' BENEFITS PROGRAM

Access.
Quality.
Affordability.

HEALTH REIMBURSEMENT ARRANGEMENT (HRA) SUMMARY PLAN DESCRIPTION (SPD)

PLAN YEAR 2024

Effective July 1, 2023 – June 30, 2024

Administered By
HSA Bank
P O Box 2744
Fargo, ND 58108-2744
www.hsabank.com
833-228-9364

Table of Contents

Amendment Log

Any amendments, changes or updates to this document will be listed here. The amendment log will include what sections are amended and where the changes can be found.

Welcome PEBP Participant

Welcome to the State of Nevada Public Employees' Benefits Program (PEBP). PEBP provides a variety of benefits such as medical, HRA, HSA, dental, life insurance, flexible spending accounts, and other voluntary insurance benefits for eligible State and local government employees, retirees, and their eligible dependents.

As a PEBP participant, you may access whichever benefit plan (the Consumer Driven Health Plan, Low Deductible PPO Plan (LD PPO), the Exclusive Provider Organization (EPO) Plan, or Health Maintenance Organization (HMO) Plan) is offered in your geographical area that best meets your needs, subject to specific eligibility and Plan requirements. You are also encouraged to research Plan provider access and quality of care in your service area.

All PEBP participants choosing a Plan should examine this document, the PEBP Self-Funded PPO Dental Plan Master Plan Document (MPD), the PEBP Active Employee Health and Welfare Wrap Plan Document, PEBP Retiree Health and Welfare Wrap Plan Document, the Section 125 Document, and the PEBP Enrollment and Eligibility MPD. These documents are available at www.pebp.state.nv.us.

MPD's are a comprehensive description of the benefits available to you. Relevant statutes and regulations are noted throughout this document for reference. In addition, helpful material is available from PEBP or any PEBP vendor listed in the Participant Contact Guide.

PEBP encourages you to stay informed of the most up to date information regarding your health care benefits. It is your responsibility to know and follow the requirements as described in PEBP's Master Plan Documents.

Sincerely,

Public Employees' Benefits Program

Accessing Other Information

You will also want to access the following documents for information related to dental, life, enrollment and eligibility, COBRA, third-party liability and subrogation, HIPAA and Privacy and Security and mandatory notices. These documents are available on your member E-PEBP portal account which can be accessed at www.pebp.state.nv.us and clicking on the orange log in icon, or by contacting PEBP at 775-684-7000 or 800-326-5496.

- State of Nevada PEBP Active Employee Health and Welfare Wrap Plan Document
- State of Nevada PEBP Retiree Health and Welfare Wrap Plan Document
- Consumer Driven Health Plan (CDHP) Master Plan Document; CDHP Summary of Benefits and Coverage for Individual and Family
- Low Deductible PPO (LD PPO) Master Plan Document; Low Deductible PPO Plan Summary of Benefits and Coverage for Individual and Family
- PEBP PPO Dental Plan and Summary of Benefits for Life Insurance Master Plan Document
- EPO Plan Master Plan Document; EPO Plan Summary of Benefits and Coverage for Individual and Family
- Health Plan of Nevada Evidence of Coverage (EOC) and Summary of Benefits and Coverage
- PEBP Enrollment and Eligibility Master Plan Document
- Flexible Spending Accounts (FSA) Summary Plan Description
- Health Reimbursement Arrangement Summary Plan Description (SPD)
- Section 125 Health and Welfare Benefits Plan Document
- Medicare Retiree Health Reimbursement Arrangement Summary Plan Description

This Plan is administered in accordance with regulations of Section 125, 105 and 106 of the Internal Revenue Code. For information regarding Section 105, 106, and 125, please see the Active Employee Health and Welfare Wrap Plan Document available at www.pebp.state.nv.us.

Introduction

Health Reimbursement Arrangement

This Summary Plan Description (SPD) provides, in general terms, the main features of the State of Nevada Public Employees' Benefits Program Health Reimbursement Arrangement ("HRA"), how it can work for you, and how it can benefit you. Definitions of all capitalized terms in this SPD are contained in the Definitions section of this document.

The purpose of the Health Reimbursement Arrangement (HRA) is to reimburse for Eligible Employees', up to certain limits, for their own, and their Eligible Spouse' and Dependents' qualifying Health Care Expenses. Reimbursements for Health Care Expenses paid by the HRA generally are excluded from taxable income.

You should read this Summary Pan Description carefully so that you understand the provisions of the HRA and the benefits you will receive. PEBP wants you to be fully informed of the benefits available to you under the HRA while you are a Participant. You should direct any questions you have to PEBP (Plan Administrator) or the HRA Administrator. A copy of the HRA Summary Plan Description is available at www.pebp.state.nv.us or by request by calling the PEBP office at 775-684-7000 or 800-326-5496.

Administrative Information

The Public Employees' Benefits Program (PEBP) is the Plan Administrator for the HRA. The HRA is intended to qualify as an Employer-funded Health Care reimbursement plan under IRS Code §105 and 106 and the regulations issued thereunder, and as a Health Reimbursement Arrangement as defined under IRS Notice 2002-45. The Plan Administrator's failure to enforce any provision of the HRA shall not affect its rights to later enforce that provision or any other provision of the HRA.

PEBP has retained HSA Bank as the HRA the third-party administrator and provide certain administrative services associated with the HRA. HSA Bank is not a fiduciary of the HRA. HSA Bank has no discretionary authority to interpret HRA provisions or issues arising under the HRA, such as issues with eligibility, coverage, and benefits.

Nothing herein will be construed to require PEBP or HSA Bank to maintain any fund or to segregate any amount for the benefit of any Participant, and no Participant or other person shall have any claim against, right to, or security or other interest in any fund, account, or asset of the PEBP from which any payment under this HRA may be made. The HRA is paid for by the State of Nevada Public Employees' Benefits Program and funded with contributions from participating Employers and Eligible Participants, held in an internal service fund. There is no trust or other fund from which benefits are paid. HSA Bank does not finance or insure the HRA. While PEBP has complete responsibility for the payment of benefits out of its internal service fund, it may hire an unrelated third-party HRA Administrator to make Benefit payments on its behalf.

If there is a conflict between this Summary Plan Description and the Master Plan Document, the Master Plan Document will take precedence.

The provisions of the HRA, as initially adopted or subsequently amended and restated are effective July 1, 2023 – June 30, 2024.

Per NRS 287.0458 no officer or employee has an inherent right to benefits provided under the PEBP.

General Information About the HRA

What is the amount PEBP will contribute to the HRA?

For Plan Year 2024, (July 1, 2023 – June 30, 2024), PEBP will contribute $300 for each Eligible Employee covered on a PEBP medical plan on July 1, 2023. The contribution amount for Employees hired after July 1, 2023, who enroll in a PEBP medical plan, the contribution amount is prorated based on the coverage effective date and the remaining months in the Plan Year.

What is the HRA?

The HRA is PEBP funded reimbursement account. The HRA works as follows:

- PEBP establishes a notional account called a Health Reimbursement Arrangement for each Eligible Employee enrolled in a PEBP-sponsored medical plan (CDHP, LD, EPO, and HMO) with coverage effective on or after July 1, 2023.
- Each Plan Year, PEBP has the discretion to set the HRA funding amount. HRA funding is not guaranteed from one Plan Year to the next Plan Year.
- HRAs are employer-funded accounts.
- Employees do not contribute to the HRA.
- Unlike Health FSA amounts, Employees do not forfeit unused HRA dollars while covered under the same PEBP-sponsored medical plan.

What is the purpose of the HRA?

The HRA is intended to reimburse Eligible Employees, up to certain limits, for their own and their Spouses' and Dependents' qualified Health Care Expenses in accordance with Section 213(d) of the IRS code.

Are there any limitations on benefits available from the HRA?

A Health Care Expense is an expense that is related to the diagnosis, care, mitigation, treatment, or prevention of disease. Some examples of Health Care Expenses include, but are not limited no, (a) insulin; (b) prescribed drugs and medications (whether or not the drug or medicine could be purchased without a prescription), (c) medical devices such as crutches, bandages, and diagnostic devices such as blood-sugar test kits; (d) dental expenses € dermatology; (f) physical therapy; and (g) contact lenses or gasses used to correct a vision impairment.

Some examples of expenses that are not eligible for reimbursement include the following:

- Over-the-counter drugs or medicines that are purchased without a prescription.

- Health insurance premiums for any other plan. (Notwithstanding the foregoing, the HRA Account may reimburse COBRA premiums that a Participant pays on an after-tax basis under the Employer's major medical or other health insurance plan.)
- Cosmetic surgery not covered under a Plan.
- The salary expenses of a nurse to care for a healthy newborn at home.
- Funeral and burial expenses.
- Household and domestic help (even if recommended by a qualified physician due to an Employee's, Spouse's, or Dependent's inability to perform physical housework).
- Home or automobile improvements.
- Custodial care.
- Costs for sending a problem child to a special school for benefits that the child may receive from the course of study and disciplinary methods.
- Social activities, such as dance lessons (even if recommended by a physician for general health improvement).
- Bottled water.
- Maternity clothes.
- Diaper service or diapers.
- Cosmetics, toiletries, toothpaste, etc.
- Uniforms or special clothing, such as maternity clothing.
- Automobile insurance premiums.
- Marijuana and other controlled substances that are in violation of federal laws, even if prescribed by a physician.
- Any item that does not constitute “medical care” as defined under IRS Code §213(d).

Is the HRA offered separately as a stand-alone option?

The HRA is not offered as a stand-alone option. Instead, it is integrated with a PEBP-sponsored medical plan, this means, Employees must be enrolled in a PEBP medical plan to qualify for the HRA.

Are the HRA dollars transferrable to another PEBP medical plan?

No, generally, the HRA dollars are not transferrable from one PEBP medical plan to another PEBP medical plan.

Who is eligible for the HRA?

Eligible Employees enrolled in a PEBP-sponsored medical plan with coverage effective on or after **July 1, 2023**.

Eligible Employees are permitted to enroll in a PEBP-sponsored medical plan during their new hire initial enrollment period, the annual open enrollment period, or during the Plan Year to the extent permitted by the PEBP-sponsored medical plan (e.g., due to a Qualifying Event or a Special Enrollment Period). For information regarding Qualifying Events and Special Enrollment Opportunities, refer to the Enrollment and Eligibility Master Plan Document available at www.pebp.state.nv.us.

Are my spouse and dependents eligible for reimbursement of Eligible Medical Expenses under the HRA?

Reimbursements under an HRA can be made to the following individuals:

1. Employees,
2. Spouses and dependents of those employees,
3. Any person you could have claimed as a dependent on your return except that:
    a. The person filed a joint return.
    b. The person had a gross income of $4,400 or more; or
    c. You, or your spouse if filing jointly, could be claimed as dependent on someone else's 2022 return.
    d. Your child under age 27 at the end of the tax year.
    e. Spouses and dependents of deceased employees.

Note: A child of parents that are divorced, separated, or living apart for the last 6 months of the calendar year is treated as the dependent of both parents whether the custodial parent releases the claim to the child's exemption. See IRS Publication 969

What benefits are offered through the HRA?

The HRA will maintain an "HRA Account" for Eligible Employees to keep a record of the amounts available for reimbursement of Eligible Health Care expenses. The HRA Account is merely a recordkeeping account; it is not funded (all reimbursements are paid by HSA Bank from PEBP's internal fund), and it does not bear interest or accrue earnings.

Are there limitations on prescriptions under the HRA?

Reimbursement for prescriptions is limited to IRS Code 213(d) eligible expenses.

How will the HRA work?

The HRA will reimburse you for eligible Health Care Expenses to the extent that you have a positive balance in your HRA Account. If you have a claim under your PEBP medical plan or other

health insurance plan, you should follow the claims procedure applicable to that plan, as described in the Master Plan Document or Summary Plan Description.

For claims associated with the HRA, you should file your claim for reimbursement as soon as possible after you have incurred the expense. All claims must be substantiated or verified as an eligible expense. Submitting claims can be done online, mobile app, or by mail. HSA Bank issues a debit card with the HRA which provides easy access to HRA dollars, especially at pharmacies and doctors' offices.

Claims must be submitted within 365 days of the incurred expense date in accordance with NAC 287.610. For information regarding how to file a claim, visit the HSA Bank website at www.hsabank.com/

Does HSA Bank offer direct deposit?

Yes, HSA Bank only offers direct deposit. There is no option for a mailed check.

What happens if I received an overpayment?

If you receive reimbursement and it is later determined that you received an overpayment or payment was made in error (e.g., you were reimbursed for an expense that is later paid by an insurance plan), you will be required to refund the improper payment to HSA Bank. If you do not refund the improper payment, the Plan Administrator reserves the right to offset future reimbursement equal to the improper payment. If all other attempts to recoup the improper payment are unsuccessful, PEBP may treat the overpayment as a bad debt, which may have income tax consequences for you.

What if I have a Flexible Spending Account (FSA) in addition to my HRA?

If an expense is eligible for reimbursement under both the HRA and a FSA, reimbursement should be requested first from the FSA before the HRA.

What is a carryover of Account Balance of unused funds?

The HRA allows for a carryover of the account balance. Unused funds in the HRA are not forfeit at the end of each year but remain available to reimburse Eligible Heath Care Expenses incurred in later years. Note: Employees must remain covered under the same medical plan to qualify for carryover of unused funds.

May I elect to permanently opt out of your HRA Account?

You may elect to permanently opt out of and waive any right to future reimbursement from your HRA Account. The opt out option will be offered at initial new hire enrollment, open enrollment, and at termination. Opting out of the HRA also includes declining coverage under a PEBP medical plan.

What if I terminate my employment or lose eligibility during the Plan Year?

If you cease to be an Eligible Employee (for example, if you die, retire, or terminate employment), your participation in the HRA will terminate unless you qualify for and elect COBRA continuation coverage as described below.

- Upon termination of employment, you failure to elect continuation of coverage under COBRA for your medical plan will result in the waiver of future reimbursements. The remaining balance of the HRA will be forfeited.

What if I go out on Family Medical Leave Act ("FMLA") or the Uniformed Services Employment and Reemployment Rights Act ("USERRA")?

If you decline coverage while on a FMLA or USERRA, you may have rights to reinstate the HRA upon returning from leave if you enroll in the same medical plan that you were enrolled in prior to taking leave.

What if I go out on unpaid Leave Without Pay or Workers' Compensation?

Your coverage under a Plan with a HRA during a paid or unpaid leave of absence will be treated in the same manner that your coverage under the medical plan is treated during a leave of absence. Upon returning from leave, you must be enrolled in the same medical plan prior to taking leave. For details regarding leave of absences, refer to the Enrollment and Eligibility Master Plan Document available at www.pebp.state.nv.us.

What is COBRA continuation coverage? What happens if terminate my employment during the Plan Year? If I or my Spouse or Dependent has a COBRA Qualifying Event, can I continue coverage under the same medical plan?

Consolidated Omnibus Budget Reconciliation Act (COBRA) is a federal law that gives certain Employees, Spouses, and Dependent children of Employees the right to temporary continue health care coverage under the medical plan. If you, your Spouse, or your Dependent children incur an event known as a "Qualifying Event," and if such individual is covered under the PEBP's medical plan when the Qualifying Event occurs, the individual incurring the Qualifying Event will be entitled under COBRA to elect to continue his or her coverage under the medical plan if he or she pays the applicable premium for such coverage. "Qualifying Events" are certain types of events that would cause, except for the application of COBRA's rules, an individual to lose his or her health insurance coverage. A Qualifying Event includes the following events:

- Your termination from employment or reduction of hours.
- Your divorce or legal separation from your Spouse.
- Your becoming eligible to receive Medicare benefits.

- Your Dependent child ceasing to qualify as a Dependent.

If the Qualifying Event is termination from employment, then the COBRA continuation coverage runs for a period of 18 months following the date that regular coverage ended. COBRA continuation of coverage may be extended to 36 months if another Qualifying Event occurs. during the initial 18-month period. You are responsible for informing your Employer of the second Qualifying Event within 60 days after the second Qualifying Event occurs. COBRA continuation coverage may also be extended to 29 months in the case of an individual who becomes disabled within 60 days after the date the entitlement to COBRA continuation coverage initially arose and who continues to be disabled at the end of the 18 months. (In the event that family coverage is continued under COBRA, the Employee, Spouse, and Dependents may all extend coverage to 29 months regardless of which individual has become disabled.) In all other cases to which COBRA applies, COBRA continuation coverage shall be for a period of 36 months.

For more information, refer to the Enrollment and Eligibility Master Plan Document at www.pebp.state.nv.us

Are my HRA benefits taxable?

The HRA is intended to meet certain requirements of existing federal tax laws, under which the benefits that you receive under the HRA generally are not taxable to you. However, PEBP and HSA Bank cannot guarantee the tax treatment to any given Participant, since individual circumstances may produce differing results. If there is any doubt, you should consult your own tax advisor.

Claim Denials and Appeal Process

What happens if my claim for HRA Benefits is denied?

If your claim for Benefits is denied, then you have the right to be notified of the denial and to appeal the denial, both within certain time limits. The rules regarding denied claims for Benefits under the HRA are discussed below.

When must I receive a decision on my claim?

You are entitled to notification of the decision on your claim within 30 days after HSA Bank receives the claim. This 30-day period may be extended if necessary due to conditions beyond HSA Bank's control, such as situations where a claim is incomplete. HSA Bank is required to notify you of the need for the extension and the time by which you will receive a determination on your claim. If the extension is necessary because of your failure to submit the information necessary to decide the claim, then HSA Bank will notify you regarding what additional information you are required to submit. If you do not submit the additional information, HSA Bank will make the decision based on the information that it has.

What information will a notice of denial of claim contain?

If your claim is denied, the notice that you receive from HSA Bank will include the following information:

- The specific reason and references for the denial.
- Any denial code (and its corresponding meaning) that was used in denying the claim.
- A description of any additional material or information necessary for you to perfect your claim and an explanation of why such material or information is necessary.
- A description of the HRA's internal appeal process and external review procedures and the time limits applicable to such procedures, including a statement of your rights following a denial on review; and
- If HSA Bank relied on an internal rule, guideline, protocol, or similar criteria in making its determination, either a copy of the specific rule, guideline, or protocol, or a statement that such a rule, guideline, protocol, or similar criterion was relied upon in making the determination and that a copy of such rule, guideline, protocol, or similar criterion will be provided to you, free of charge, upon request.

Do I have a right to appeal a denied claim?

Yes, you have the right to file an appeal with HSA Bank. Additional information regarding your review rights is available by request from PEBP or HSA Bank.

What are the requirements of my Level 1 appeal?

Your internal appeal must be in writing, must be provided to HSA Bank and must include the following information:

- Your name and address.
- The fact that you are disputing a denial of a claim or HSA Bank's act or omission.
- The date of the notice that HSA Bank informed you of the denied claim; and
- The reason(s), in clear and concise terms, for disputing the denial of the claim or HSA Bank's act or omission. You should also include any documentation that you have not already provided to HSA Bank.

Is there a deadline for filing my Level 1 appeal?

Yes. Your internal appeal must be delivered to HSA Bank within 180 days after reviewing the denial notice or HSA Bank's act or omission. If you do not file your internal appeal within this 180-day period, you lose your right to appeal. Your internal appeal will be heard and decided by HSA Bank. (NAC 287.670)

How will my Level 1 appeal be reviewed?

Prior to the internal appeal deadline, you may submit copies of all relevant documents, records, written comments, testimony, and other information to HSA Bank. The HRA is required to provide you with reasonable access to and copies of all documents, records, and other information related to the claim. When reviewing your internal appeal, HSA Bank will consider all relevant documents, records, comments, and other information that you have provided regarding the claim, regardless of whether such information was submitted or considered in the initial determination. If HSA Bank receives new or additional evidence that it considered, relied upon, or generated in connection with the claim, other than evidence that you have provided to it, you will be provided with this information and given a reasonable opportunity to respond to the evidence before the due date for HSA Bank's notice of final internal adverse benefit determination. Similarly, if HSA Bank identifies a new or additional reason for denying your claim, that new or additional reason will be disclosed to you, and you will be given a reasonable opportunity to respond to that new rationale before the due date for HSA Bank's notice of final internal adverse benefit determination.

The appeal determination will not afford deference to the initial determination and will be conducted by a fiduciary of the HRA who is not: (1) the individual who made the original determination; (2) an individual who is a subordinate of the individual who made the initial determination; or (3) an individual whose terms and conditions of employment are affected by

the results of his or her decision. If the internal appeal determination will be based on the medical judgment of a health care professional retained by HSA Bank, the health care.

When will I be notified of the decision of my Level 1 appeal?

You will be notified of the decision of your appeal generally within 60 days following receipt of your request for review.

What information is included in the notice of denial of my Level 1 appeal?

If your Level 1 appeal is denied, the notice that you receive from HSA Bank that will include supplemental information for the denial. This may include, but is not limited to:

- Information about your claim, including the date of service, health care provider, claim amount, and any diagnosis and treatment code and their corresponding meanings, to the extent such information is available;
- The specific reason for the denial upon review;
- A reference to the specific HRA provision(s) on which the denial is based;
- Any denial code (and its corresponding meaning) that was used in denying the claim;
- A statement providing that you are required to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to your claim for benefits;
- If an internal rule, guideline, protocol, or similar criterion was relied upon in making the review determination, either the specific rule, guideline, or protocol, or a statement that such a rule, guideline, protocol, or similar criterion was relied upon in making the review determination and that a copy of such rule, guideline, protocol, or similar criterion will be provided to you free of charge upon request; and
- A statement of your right to request a Level 2 appeal.

Do I have the right to seek review of a denied claim to an external review?

You have the right to an external review of the denial of your claim, and any subsequent internal appeals process determination to uphold that denial, unless the Benefit denial was based on your (or your Spouse's or Dependent's) failure to meet the HRA's eligibility requirements.

What are the requirements of an external review?

After exhausting the initial appeal process, you may file a request for external review. which is done by calling HSA Bank's Client Assistance Center at 1-833-228-9364 or writing appeal on the internal appeal denial letter and submitting it to HSA Bank. The appeal will then be sent to a third party for review and decision making

When will I be notified of the decision on my external appeal?

The external reviewer must notify you and PEBP of its decision on your external appeal within 45 days after it receives the complete information. The external reviewer's decision is binding upon the parties unless other State or Federal law remedies are available. Such remedies may or may not exist. Therefore, unless another legal right exists under your claim, use of the external review process may terminate your right to bring a lawsuit on your claim.

Definitions

In this document, the following terms, when capitalized, shall have the following meanings unless a different meaning is clearly required by the context.

Plan Administrator. Public Employees' Benefits Program.

Benefits. The reimbursement benefits for Health Care Expenses described in the HRA.

COBRA. The Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

CODE. The Internal Revenue Code of 1986, as amended.

Dependent. A Dependent is a Participant's child as defined in Code §152(f)(1) who has not attained age 27, or a Dependent as defined in Code §105(b); provided, however, that any child to whom Code §152(e) applies shall be treated as a dependent of both parents. Note that the Code §105(b) definition is similar to the Code §152 definition that is used to determine your tax dependents, except that an individual's status as a Dependent is determined without regard to the gross income limitation for a "qualifying relative" and certain other provisions of Code §152. The HRA will provide Benefits in accordance with the applicable requirements of any qualified medical child support order, even if the child does not meet the definition of Dependent.

Electronic Protected Health Information or EPHI. Has the meaning described in 45 CFR §160.103 and generally includes Protected Health Information that is transmitted by electronic media or maintained in electronic media. Unless otherwise specifically noted, Electronic Protected Health Information shall not include enrollment/disenrollment information and summary health information (as such terms are defined in HIPAA).

Eligible Employee. An Employee who has met the eligibility requirements to enroll in a PEBP-sponsored medical plan.

Employee. An Employee of the Employer who receives Compensation from the Employer.

ERISA. The Employee Retirement Income Security Act of 1974, as amended.

Health FSA. A Health Flexible Spending Account as defined in Prop. Treas. Reg. §1.125- 5(a)(1).

HIPAA. The Health Insurance Portability and Accountability Act of 1996, as amended.

HRA Account. The recordkeeping account established in your name by the Plan Administrator based on which eligible Health Care Expenses will be paid or reimbursed.

HRA. The Public Employees' Benefits Program Health Reimbursement Arrangement (HRA) Plan, as amended or restated from time to time.

Health Care Expenses. A Health Care Expense is an expense that is related to the diagnosis, care, mitigation, treatment, or prevention of disease. Some examples of Health Care Expenses are (a) insulin; (b) prescribed drugs and medicines (whether the drug or medicine could be purchased without a prescription); (c) medical devices such as crutches, bandages, and diagnostic devices such as blood-sugar test kits; (d) dental expenses; (e) dermatology; (f) physical therapy; and (g) contact lenses or glasses used to correct a vision impairment.

Participant. An Eligible Employee who becomes a Participant in the HRA.

Protected Health Information or PHI. This generally includes all information, whether written or oral, in connection with the HRA that (1) is created or received by the HRA; (2) relates to your past, present, or future physical or mental health, the provision of health care to you, or the past, present, or future payment for the provision of health care; and (3) identifies you or could be used to identify you.

Privacy Rule. The regulations that were issued by the Department of Health and Human Services in accordance with the requirements of HIPAA. Information regarding the HIPAA Privacy and Security of Protected Health Information is available in the Active Employee Health and Welfare Wrap Plan Document at www.pebp.state.nv.us.

Spouse. An individual of same-sex or opposite sex who is legally married to a Participant as determined under applicable federal and/or state law (and who is treated as a Spouse under the Code).

Third Party Administrator. An organization that processes insurance claims or certain aspects of employee benefit plans for a separate entity. For purposes of this document, the Third-Party Administrator is HSA Bank.

Miscellaneous

Effect of the HRA on Your Employment Rights
The HRA is not to be construed as giving you any rights against the HRA except those expressly described in this document. The HRA is not a contract of employment between you and the Employer.

Prohibition Against Assignment of Benefits
No Benefit payable at any time under the HRA shall be subject in any manner to alienation, sale, transfer, assignment, pledge, attachment, or encumbrance of any kind.

Overpayments or Errors
If it is later determined that you and/or your Spouse or Dependent(s) received an overpayment or a payment was made in error, you will be required to refund the overpayment or erroneous reimbursement to the HRA. If you do not refund the overpayment or erroneous payment, the HRA and the Employer reserve the right to offset future reimbursement equal to the overpayment or erroneous payment or, if that is not feasible, to withhold such funds from your pay. If all other attempts to recoup the improper payment are unsuccessful, PEBP may treat the overpayment as a bad debt, which may have income tax consequences for you.

Family and Medical Leave Act and USERRA (if applicable)
If you go on a qualifying leave under the Family and Medical Leave Act of 1993 (FMLA) or Uniformed Services Employment and Reemployment Rights Act (USERRA), then to the extent required by the FMLA or USERRA, as applicable, the Employer will continue to maintain HRA Benefits on the same terms and conditions as if the Participant were still an active Eligible Employee. If you go on a leave of absence that is not subject to the FMLA or USERRA, you will be treated as having terminated participation.

Other Notices Which May be Required by Law

Mandatory notices can be found on PEBP's website.

Newborns' and Mothers' Health Protection Act of 1996 (NMPHA)
Group health plans generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery or to less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Women's Health and Cancer Rights Act of 1998 (WHCRA)
The Women's Health and Cancer Rights Act of 1998 (WHCRA) is a federal law that provides protections to patients who choose to have breast reconstruction in connection with a mastectomy. This law applies generally both to persons covered under group health plans and persons with individual health insurance coverage. But WHCRA does NOT require health plans or issuers to pay for mastectomies. If a group health plan or health insurance issuer chooses to cover mastectomies, then the plan or issuer is generally subject to WHCRA requirements.

Michelle's Law
"Michelle's Law", enacted October 9, 2008, requires group and individual health plans to continue to cover otherwise eligible dependent children taking a medical leave of absence from a postsecondary educational institution (e.g., a college, university, or vocational school) due to a serious illness or injury. Dependent children on a leave of absence must be covered until the earlier of one year from the first day of the leave of absence or the date on which the coverage otherwise would terminate.

The Genetic Information Nondiscrimination Act of 2008 (GINA)
GINA prohibits discrimination by health insurers and Employers based on individuals' genetic information. Genetic information includes the results of genetic tests to determine whether someone is at increased risk of acquiring a condition in the future, as well as an individual's family medical history. GINA imposes the following restrictions prohibits the use of genetic information in making employment decisions restricts the acquisition of genetic information by Employers and others; imposes strict confidentiality requirements; and prohibits retaliation against individuals who oppose actions made unlawful by GINA or who participate in proceedings to vindicate rights under the law or aid others in doing so.

Health Information Technology for Economic and Clinical Health Act (HITECH Act)

HITECH was passed as part of the American Recovery and Reinvestment Act of 2009 to strengthen the privacy and security protection of health information, and to improve the workability and effectiveness of HIPAA Rules.

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008
This law amends ERISA, the Public Health Service Act (PHSA), and the Internal Revenue Code (IRC) and applies to all ERISA group health plans and to health insurers that provide insurance coverage to group health plans. In general, this new law requires group health plans that provide mental health or substance use disorder benefits to provide such benefits on par with medical-surgical benefits.

Effective Date of the HRA
The Effective Date of the modifications herein is **July 1, 2023**.

Plan Administrator
The Plan is administered by PEBP and has been established and shall be maintained for the exclusive benefit of the employees of the employer. PEBP is the Plan Administrator and functions as the Plan Administrator, unless another individual or entity is appointed by the Plan Administrator. The Plan Administrator shall have full charge of the operation and management of the plan. The Plan Administrator has retained the services of HSA Bank to administer the HRA benefits described in this Summary Plan Description.

HRA Administrator
PEBP has contracted with HSA Bank to process claims for the HRA program. Contact HSA Bank if you have questions regarding claims or eligible expenses.

Address:	**HSA Bank HRA Claim Submission** **PO Box 2744** **Fargo, ND 58108-2744**
Web:	**www.hsabank.com**
Phone:	**833-228-9364**

Plan Fiduciary
PEBP is the Plan Fiduciary under the plan. The Plan Fiduciary shall have maximum legal discretionary authority to construe and interpret the terms and conditions of the plan, to review all denied claims for benefits under the Plan with respect to which it has been designated named Fiduciary, to make determinations regarding issues which relate to eligibility for benefits, to decide disputes which may arise relative to a participant's rights, and to decide questions of Plan interpretation and those of fact relating to the plan. The decisions of the Plan Fiduciary will be final and binding on all interested parties. Every Fiduciary and other person who handles funds or other property of this Plan shall be bonded as required by law.

Plan Changes

PEBP reserves the right to amend the HRA at its sole discretion. Any amendments to the Plan will be incorporated in writing into the master copy of the Plan on file with PEBP, or a written copy will be kept with the master copy of the plan.

Prohibition Against Rescission

Under Section 2712 of the PHSA, the Plan Administrator is prohibited from rescinding or retroactively terminating the coverage of a cover person under a Benefit Option that is a group health plan that is not excepted or exempt under Section 2712 of the PHSA, unless such covered person commits and at, practice, omission that constitutes fraud, or an intentional misrepresentation of a material fact including, but not limited to, false information relating to another person's eligibility or status as a Dependent; provided, however, that the foregoing prohibition shall not prohibit retroactive termination in the event: (i) a Participant fails to timely pay premiums towards the cost of coverage; (ii) the Plan erroneously covers an ex-spouse of a Participant because the Participant failed to timely report a divorce to the Plan Administrator; (iii) the Plan erroneously covers a Participant due to a reasonable administrative delay in terminating coverage; or (iv) any other circumstance under which retroactive termination would not violate PPACA.

No Guarantee of Tax Consequences

Neither the Employer nor the Plan Administrator makes any commitment or guarantee that any amounts paid or allocated to or for the benefit of a Participant under the Plan, HRA or any component benefit will be excludable from Participant's gross income for federal, state, and/or local income tax purposes, or that any federal, state, and/or local tax treatment will apply or be available to a Participant. It shall be the obligation of each Participant to determine whether any coverage, benefit, or other payment under the Plan is excludable from the Participant's gross income for federal, state, and/or local income tax purposes, and to notify the Employer if the Participant has reason to believe that any such payment treated by the Employer if the Participant has reason to believe that any such payment by the Employer as nontaxable is, in fact, not so excludable.

Nondiscrimination

The Plan Administrator shall not operate the Plan in a manner that causes discrimination in favor of those Participants or Employees who are (or were) officers or highly compensated Employees or key Employees of the Employer. In addition, whenever, in the administration of the Plan any discretionary action by the Plan Administrator is required, the Plan Administrator shall exercise authority in a nondiscriminatory manner so that all persons similarly situated shall receive substantially the same treatment.

8.

8. Discussion and possible action on Executive Order 2023-003 (Laura Rich, Executive Officer) (**For Possible Action**)

JOE LOMBARDO
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

JACK ROBB
Board Chair

AGENDA ITEM

[X] Action Item
[ ] Information Only

Date: March 23, 2023

Item Number: VIII

Title: Executive Order Report

SUMMARY

This report provides options for PEBP to adhere to Executive Order 2023-003.

BACKGROUND

On January 12, 2023, Governor Lombardo issued Executive Order 2023-003, requiring every executive branch department, agency, board, and commission to provide a list of not less than ten regulations recommended for removal, ranking them in descending order of priority.

REPORT

PEBP Staff have reviewed NAC 287 and are proposing the following regulations for submission:

	NAC	Description	Justification
1	287.318	**Enrollment forms: Required information.** Enrollment forms that are submitted to the Program must include, without limitation: 1. The name, address, social security number, if any, and signature of the person who is enrolling in the Program; and 2. The name and social security number, if any, of any dependent that the person chooses to cover under the Program.	This can be included in Master Plan Documents, rather than a regulation.
2	287.319	**Notification of change of address by participant to Program.** A participant shall	This can be included in Master Plan

		notify the Program within 30 days after a change of address of the participant.	Documents rather than a regulation.
3	287.510	**Coverage of persons returning to work with previous employer within 1 year after leaving employment. (**NRS 287.043**,** 287.045**)** If a person other than a retired officer or employee returns to work for a participating public agency with which the person was previously employed within 1 year after leaving employment: 1. The person may select any coverage and insurance offered to participants in the Program at the time that the person returns to work; and 2. Coverage and insurance for the person is effective: (a) If the effective date of reemployment is on the first day of a month, on the effective date of reemployment; or (b) If the effective date of reemployment is not on the first day of a month, on the first day of the month immediately following the effective date of reemployment.	This can be included in Master Plan Documents rather than a regulation.
4	287.515	**Coverage of retired participants upon reemployment with participating public agency. (**NRS 287.043**,** 287.045**)** (a) If the effective date of reemployment is on the first day of a month, on the effective date of reemployment; or (b) If the effective date of reemployment is not on the first day of a month, on the first day of the month immediately following the effective date of reemployment. Ê Except for a retired officer or employee who was enrolled in the Program on November 30, 2008, and continues his or her participation in the Program, coverage of a retired officer or employee pursuant to this subsection terminates on the date on which the participating local governmental agency with which the retired officer or employee returns to full-time employment terminates its participation in the Program……..	This can be included in Master Plan Documents, rather than a regulation.

5	287.3125	**Dependents: Terms and conditions of certain changes.** Except during a period of open enrollment, the right to change coverage or insurance for a dependent or to add or change dependents is governed by the terms and conditions of any applicable plan, insurance policy or law.	This can be included in Master Plan Documents rather than a regulation.
6-10	287.170-287.178 (5 total)	NAC addressing Chair/Vice Chair duties, agenda and meeting minutes requirements, and approval of actions	Much of what is contained in these NAC's are either already covered in NRS 241 (Open Meeting Law) or can be incorporated into one single NAC that refers back to Robert's Rules of Order.
Total: 10			

RECOMMENDATION:
Staff recommend the Board approve the above NAC's, and/or any additional NAC's for submission to the Governor's Office.

9.

9. Discussion and acceptance of Claim Technologies Incorporated audit findings for State of Nevada Public Employees' Benefits Program Plans administered by UMR Benefits for the period July 1, 2022 – September 30, 2022. (Laura Rich, Executive Officer) (**For Possible Action**)

    9.1 UMR Remediation Plan

DRAFT 03/15/2023

Comprehensive Claim Administration Audit

QUARTERLY FINDINGS REPORT

State of Nevada Public Employees Benefits Program Plans

Administered by UMR Insurance Company

Audit Period: July 1, 2022 – September 30, 2022
Audit Number 1.FY23.Q1

Presented to

State of Nevada Public Employees Benefits Program

Revised as of March 15, 2023

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 UMR Insurance Company's (UMR's) administration of the State of Nevada Public Employees Benefits Program (PEBP) medical and dental plans.

Scope

CTI performed an audit for the period of July 1, 2022 through September 30, 2022 (quarter 1 (Q1) for Fiscal Year (FY) 2023). The population of claims and amount paid during the audit period reported by UMR:

Medical and Dental	
Total Paid Amount	$19,802,190
Total Number of Claims Paid/Denied/Adjusted	121,231

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

- Quarterly 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. UMR's Financial Accuracy, Overall Accuracy and Claim Turnaround Time did not meet the service objective and a penalty is owed (breakdown in summary below).
2. UMR 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. Specific focus should be directed towards the identification of duplicate payments.
   - 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 UMR's Guarantee Measurements

Based on CTI's Random Sample Audit results, UMR did not meet the claims processing measurements for PEBP in Q1 FY2023 and a penalty is owed. Reported administrative fees for the quarter totaled $1,303,565.40.

Quarterly Metric	Guarantee	Met/Not Met	Penalty	Calculated Penalty
Financial Accuracy (p.15)	99.4%	Not Met – 98.23%	1.5%	$19,553.48
Overall Accuracy (p.16)	98%	Not Met – 91.0%	1%	$13,035.65
Turnaround Time	92% in 14 Days	Not Met – 89.2%	1%	$13,035.65
	99% in 30 Days	Not Met – 92.9%	1%	$13,035.65
Total Penalty			4.5%	$55,660.44

AUDIT OBJECTIVES

This report contains CTI's findings from our audit of UMR Insurance Company's (UMR) administration of the State of Nevada Public Employees Benefits Program (PEBP) plans. We provide this report to PEBP, the plan sponsor, and UMR, the claim administrator. A copy of UMR'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 UMR. 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 UMR 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 UMR 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 UMR's claim administration were to determine whether:

- UMR followed the terms of its contract with PEBP;
- UMR 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 UMR was incurred.

QUARTERLY PERFORMANCE GUARANTEE VALIDATION

As part of CTI's quarterly audit of PEBP, we reviewed the Performance Guarantees included in its contract and reports provided by UMR. The self-reported results for Q1 FY2023 are in the table below.

	Metric	Service Objective	Actual	Met/ Not Met
CLAIMS ADMINISTRATION – SERVICES AND PERFORMANCE GUARANTEES				
1.4	**Claim Adjustment Processing Time:** measured from the time a prior claim submission requiring an adjustment is identified through the date the claim adjustment is processed by service facility personnel.	95.00% 7 Calendar/ 5 Business Days	84.0%	Not Met
1.5	**Telephone Service Factor:** Defined as the percentage of the Client telephone inquiries answered by facility Customer Service Representatives (CSRs) within 30 seconds. Measured from the time the caller completes the prompts of the automated telephone system to the time the caller reaches a CSR.	85.00% Calls answered within 30 seconds	63.3%	Not Met
1.6	**Call Abandonment Rate:** total number of participant and provider calls abandoned, divided by the total number of calls received by the facility's customer service telephone system.	3.00%	7.4%	Not Met
1.7	**First Call Resolution Rate:** the percentage of telephone inquiries completely resolved within a 'window period' of time. A call is considered 'resolved' when the same participant or a family member under the same subscriber ID has not contacted the administrator's customer service facility again regarding the same issue within 60 calendar days of the initial call.	95.00%	95.1%	Met
1.8	**Open Inquiry Closure:** addresses the time taken in hours and/or days by CSRs at the administrator's service facility to close open inquiries placed by participants of PEBP to the facility.	90.00% 48 Hours 98.00% 5 Business Days	99.3% 99.5%	Met
1.9	**CSR Audit, or Quality Scores:** determined by the process used to evaluate the effectiveness and accuracy of participant telephone call handling at the administrator's customer service facility.	97.00%	94.0%	Not Met
1.10	**CSR Callback Performance:** measured from the CSR commitment data in hours and/or days to the time the actual callback was placed to the participant.	90.00% Within 24 Hours	Unable to Report*	Unable to Report*
1.11	**Participant Email Response Performance:** measured from the time an email is received by the administrator's response team to the time in hours or days to the time the actual email response is sent to the participant.	90.00% Within 8 Hours 95.00% Within 24 Hours	0.0% 55%	Not Met Not Met
1.12	**Member Satisfaction:** At least 95%-member satisfaction with the services. Measured as the number of satisfied to highly satisfied survey ratings divided by the total number of survey responses. Survey tool and survey methodology to be mutually agreed upon by Offeror and PEBP.	95.0%	NA	Reported Annually
1.13	**Account Management – Plan will guarantee that the services provided by the TPA's team during the guarantee period will be satisfactory to PEBP. Areas of satisfaction will include:**			
	Knowledge/Capabilities – Account representative demonstrates competence in getting issues and problems resolved.	Agree	NA	Met
	Responsiveness – All calls returned within at most 24 hours; along with an alternate person identified who can assist with service issues when account representative is unavailable.			

	Metric	Service Objective	Actual	Met/ Not Met
	Ability to meet deadlines – Supplying all requested materials accurately and in a timely manner, along with all necessary documentation (i.e., enrollment kits, rate confirmations, plan performance work plans, group contracts, ZIP code file, etc.).			
	Professionalism – Demonstrates objectivity and empathy with customer problems.			
	Flexibility – Ability to meet client-specific needs.			
	Participation in periodic meetings – Attendance at all required client meetings or conference calls.			
	Guarantee measured with staff responses to internal questionnaire. A scale from 1 to 5 will be used to measure performance, where 1 means 'very dissatisfied' and 5 means 'very satisfied'; and 2 through 4 are defined, respectively.			
	Periodic program reports will be provided and presented with recommended actions. Standard program reports, within 30 days to quarter-end. Year-end activity report, within 45 days of program year end.			
	Open Enrollment Support: Accurate materials will be provided at least 60 days prior to the open enrollment period starting on April 1 each year. Representative will be available, if requested, for up to 5 employee benefit fairs.			
	Service Objective (out of a score of 5 on internal questionnaire):	350		
1.14	**Eligibility Processing:** Confirm daily and weekly eligibility and enrollment within specified business days of the receipt of the eligibility information, given that information is complete and accurate.	98.00% 2 Business Days	100.00%	Met
1.15	**Data Reporting:** Offeror will provide PEBP with 100% of the applicable reports (within 10 business days for standard reports and within 10 business days of Plan year-end for Annual Reports and Regulatory documents).	100% 10 Business Days	NA	PEBP Waived 10-day requirement
1.16	**Implementation Satisfaction:** Offeror shall effectively manage program implementation and resolve any issues identified with implementation in a timeframe mutually agreed by PEBP and the Account Executive. PEBP program manager will determine if expectations are met.	Agree	NA	PEBP Waived
	Pre-Implementation Audit: Offeror will fully fund (up to $35,000) and pass a pre-implementation audit focusing on its phone and claims system and will have any issues identified during the audit resolved prior to the July 1, 2022 effective date. At least 90% of audit claims processed correctly, and all audit issues corrected prior to effective date.	90%	NA	PEBP Waived
1.17	**ID Card Production and Distribution**	100% 10 Business Days	100%	Met
1.18	**Disclosure of Subcontractors:** Offeror will provide the identity of the subcontractors who have access to PEBP member PHI. Provide identity of subcontractors who have access to PHI within 30 calendar days of the subcontractors' gaining access.	100% 30 Calendar Days	100%	Met
1.19	**PHI:** Offeror will store PEBP member PHI data on designated servers. Must remove PEBP member PHI within 3 business days after offeror knows or should have known using commercially reasonable efforts that such PHI is not store on a designated server.	100% 30 Business Days	100%	Met
NETWORK ADMINISTRATION – SERVICES AND PERFORMANCE GUARANTEES				
2.1	**EDI Claims Re-Pricing Turnaround Time:** At least 97% of medical claims covered under the PEBP Medical PPO Network must be electronically re-priced within business 3 days and 99% within business 5 days.	97.00% 3 Business Days 99.00% 5 Business Days	96% 99%	Not Met Met
2.2	**EDI Claims Re-Pricing Accuracy:** At least 97% of claims re-priced by the PPO Network must be accurate and must not cause a claim adjustment by PEBP's TPA.	97.00%	99.9%	Met
2.3	**Data Reporting – Standard Reports (Quarterly reporting to include Service Performance Standards, Guarantee, Method of Measurement, Actual Performance Results, and Pass/Fail indicator.)**	100% 10 Business Days	NA	PEBP Waived 10-day requirement

	Metric	Service Objective	Actual	Met/ Not Met
	Standard reports must be delivered within business 10 days of end of reporting period or event as determined by PEBP.			
2.4	**Subcontractor Disclosure:** 100% of all subcontractors used by vendor are disclosed prior to any work done on behalf of PEBP. Business Associate Agreements completed by all subcontractors.	100%	NA	Reported Annually
2.5	**Provider Directory:** Best efforts to resolve 100% of complaints within 10 business days. Provider Directory issue resolution log maintained by Vendor and periodically reviewed with PEBP.	100% 10 Business Days	100%	Met
2.6	**Website:** A website hosting a reasonably accurate and updated Provider directory must be available and accessible on all major browsers 99% of time.	99.00%	100%	Met
UTILIZATION MANAGEMENT/CASE MANAGEMENT – SERVICES AND PERFORMANCE GUARANTEES				
3.1	**Data Reporting – Standard Reports (Quarterly reporting to include Service Performance Standards, Guarantee, Method of Measurement, Actual Performance Results, and Pass/Fail indicator.)** Standard reports must be delivered within calendar 10 days of end of reporting period or event as determined by PEBP.	100% 10 Calendar Days	100%	Met
3.2	**Notification of potential high expense cases. High expense case is defined as a single claim or treatment plan expected to exceed $100,000.00.** Designated PEBP staff will be notified within 5 business days of the UM/CM vendors initial notification of the requested Service.	100% 5 Business Days	0%	Not Met
3.3	**Pre-Certification Requests:** Precertification requests from healthcare providers shall be completed in accordance with URAC/NCQA standards and turn-around timeframes; completed Pre-certifications shall be communicated to PEBP's Third Party Administrator using an approved method e.g., electronically, within 5 business days of UM completing Precertification determination.	98.00% 5 Business Days	NA	Reported Annually
3.4	**Concurrent Hospital Reviews:** Concurrent hospital reviews shall be completed in accordance with URAC/NCQA standards; completed reviews shall be communicated to the provider using an approved method e.g., electronically within 2 business days of determination decision.	98.00% 2 Business Days	NA	Reported Annually
3.5	**Retrospective Hospital Reviews:** Retrospective reviews must be completed in accordance with URAC/NCQA standards; completed reviews shall be communicated using an approved method e.g., electronically within 5 business days of determination decision.	98.00% 5 Business Days	NA	Reported Annually
3.6	**Implementation (Tasks) – Initial transition from current UM/CM vendor and future transition to incoming UM/CM vendor during and after the termination of this contract.** Percent of tasks complete on time pursuant to the implementation or transition plan in the RFP response or as mutually agreed to by vendor and PEBP.	98.00%	100%	Met
3.7	**Implementation (Problem Resolution) – Initial transition from current UM/CM vendor and future transition to incoming UM/CM vendor during and after the termination of this contract.** Percent of problems documented within 2 business days and resolved within 10 business days or later if agreed to by PEBP.	98.00% 2 Business Days 98.00% 10 Business Days	100% 100%	Met
3.8	**Hospital Discharge Planning:** CM will contact or attempt to contact 95% of patients discharged from any facility within 3 business days of notification of discharge with clinical coaching and discharge planning assistance.	95.00% 3 Business Days	NA	Reported Annually

	Metric	Service Objective	Actual	Met/ Not Met
3.9	**Large Case Management:** CM will identify and initiate case management for chronic disease, high dollar claims, and ER usage.	95.00%	NA	Reported Annually
3.10	**Utilization Management for Medical Necessity and Center of Excellence Usage:** UM review to determine medical necessity in accordance with the MPDs. Services to be performed at a Center of Excellence to be managed through the Case Management process.	98.00%	NA	Reported Annually
3.11	**Return On Investment (ROI) Guarantee – Utilization Management/Case Management:** 2:1 Savings to Fees for Utilization Management/Case Management.	100%	NA	Reported Annually
3.12	**Disclosure of Subcontractors:** All subcontractors who have access to PHI or PII data and physical locations where PEBP PHI or PII data is maintained and/or stored must be identified in this contract. Any changes to those subcontractors or physical locations where PEBP data is stored must be communicated to PEBP at least 60 days prior to implementation of services by the subcontractor. Implementation will not be in effect until PEBP has provided written authorization.	100% 60 Calendar Days	NA	Reported Annually
3.13	**Unauthorized Transfer of PEBP Data:** All PEBP PHI or PII data will be stored, processed, and maintained solely on currently designated servers and storage devices identified in this contract. Any changes to those designated systems during the life of this agreement shall be reported to PEBP at least 60 calendar days prior to the changes being implemented. Implementation will not be in effect until PEBP has provided written authorization.	100% 60 Calendar Days	NA	Reported Annually

**Note for 1.10 from UMR Leadership: "The CSR Callback performance guarantee is not something UMR has tracked or reported on previously. We found through the development and verification of the callback report that how we are entering and tracking the results will not work for properly reporting on the performance guarantee. UMR is in the process of implementing a new policy in recording callback data so that it can be properly reported as a performance guarantee going forward. We will be able to supply callback performance guarantee results starting with 1/1/2023 calls going forward."*

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 UMR 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 UMR during the audit period for both medical and dental claims. The accuracy and completeness of UMR'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
- Coordination of benefits
- Large claim review
- Case and disease management
- Specific reinsurance reimbursement

Methodology

We used ESAS to analyze claim payment accuracy as well as any opportunities for system and process improvement. Using the data file provided by UMR, 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 UMR'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. This quarter's targeted sample was expanded to 150 from the normal 50 samples at the request of PEBP. We selected 150 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 UMR's administration.

- ***Audit of Administrator Response and Documentation*** – We reviewed the responses and redacted the responses to eliminate personal health information. Based on the responses and further analysis of the findings, we removed false positives identified from the potential amounts at risk.

Findings

We are confident in the accuracy of our ESAS results. It should be noted that 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 UMR's responses and supporting documentation. The administrator responses are copied directly from UMR'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:** Q1 FY2023				
Category	**Number of Line Items**	**Number of Claimants**	**Billed Charge**	**Allowed Amount***
Duplicate Payments				
Providers and/or Employees	88	26	$17,215	$14,215
Exclusions				
Marriage Counseling	2,808	858	$299,741	$207,444
Massage Therapy	3	2	$60	$30
Fraud, Waste, and Abuse				
Specialty Medications – Non-hospital	176	86	$426,454	$222,672

**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 UMR 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.

The detailed report is longer than normal due to the expanded sample.

ESAS Findings Detail Report				
QID	**Under/ Over Paid**	**UMR Response**	**CTI Conclusion**	**Manual or System**
Duplicate Payments				
71	$43.99	Agree.	Procedural deficiency and overpayment remain for duplicate claim payments.	☒ M ☐ S
73	$31.36			☒ M ☐ S
79	$18.58			☒ M ☐ S
80	$451.05			☒ M ☐ S
83	$22.58			☒ M ☐ S
89	$6,138.88			☒ M ☐ S
91	$30.00			☒ M ☐ S
95	$18.58			☒ M ☐ S
96	$18.37			☒ M ☐ S
97	$13.32			☒ M ☐ S
98	$25.49			☒ M ☐ S
99	$9.42			☒ M ☐ S
100	$8.87			☒ M ☐ S
102	$36.71			☒ M ☐ S
103	$85.00			☒ M ☐ S
104	$65.00			☐ M ☒ S
106	$38.66			☒ M ☐ S
77	$0.00	Agree. This was a manual processing error. Additional coaching and training have taken place with the CFR. This resulted in a $0.00 payment as there was no payment made. The claim was adjusted and denied on 10-24-2022.	Procedural deficiency and overpayment remain. Duplicate claims processed and applied to the deductible.	☒ M ☐ S
78	$252.00	Disagree. These are not duplicate claims. Each claim has different diagnosis. Claim xxxxxxx433 auto adjudicated, Claim xxxxxxx664 was manually processed.	Procedural deficiency and overpayment remain. Duplicate charges for an opthalmological exam (92014) on same day for services rendered by the same physician should have been investigated as a potential duplicate claim. Claims were not billed with a modifier indicating repeat procedure.	☒ M ☒ S
82	$0.00	Disagree. The provider submitted claims for the same date of service with different billed amounts. The duplicate logic considers these as 2 separate claims. The provider identified the billing error on their end and notified UMR. The overpayment was credited back on 11-1-2022 in the amount of $231.00.	Procedural deficiency and deductible overapplication of $17 identified. Duplicate claims paid. UMR corrected the claim on 11/1/22, prior to the audit beginning 11/14/22.	☐ M ☒ S
Plan Exclusions				
Marriage Counseling				
143	$52.80	Agree. Marriage Counseling is excluded on this plan. Coding in the UMR system has been updated to deny all future claims billed with this type of diagnosis. This claim will be adjusted to deny, and an overpayment	Procedural deficiency and overpayment identified. Per page 94 of the plan document, marriage/ couples therapy is not a covered expense. The diagnosis code billed Z63.0 is for problems in relationship with spouse or partner.	☒ M ☐ S

ESAS Findings Detail Report				
QID	**Under/ Over Paid**	**UMR Response**	**CTI Conclusion**	**Manual or System**
		request will be sent to the provider. This results in a $52.80 overpayment. UMR has requested an impact report and can provide results to PEBP upon completion of the review.		
Massage Therapy				
147	$10.00	Agree. Claims are identified by diagnosis and procedure code selections. Code 97124 was allowed in error. This results in a $10.00 overpayment.	Procedural deficiency and overpayment identified. Massage therapy is excluded on page 115 of the plan document.	☒ M ☐ S
Potential Fraud, Waste, and Abuse				
Specialty Medications				
110	$3,753.79 sampled claim and $20,339.29 on entire claim.	Agree. This error is the result of a manual repricing error. Additional coaching and training have taken place. This results in a $20,339.29 overpayment. The claim has been adjusted and an overpayment request send to the provider.	Procedural deficiency and overpayment identified. The allowance for J0878 should have been $44.94 paid at 80%.	☒ M ☐ S

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. UMR'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.

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 UMR 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 UMR in writing about any errors or observations using system-generated response forms. We sent UMR a preliminary report for its review and written response. We considered UMR's written response, as found in the Appendix, when producing our final reports. Note that the administrator responses have been copied directly from UMR'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 $203,086.07. The claims sampled and reviewed revealed $2,458.86 in underpayments and $161.00 in overpayments, for an absolute value variance of $2,619.86. This reflects a weighted Financial Accuracy rate of 98.23% over the stratified sample. Detail provided in the table below, Random Sample Findings Detail Report.

UMR did not meet the Performance Guarantee for PEBP in Q1 FY2023 of 99.4% for this measure. The penalty owed is 1.5% of the administrative fees of $1,303,565.40 or $19,553.48.

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 16 incorrectly paid claims and 184 correctly paid claims. Detail provided in the table below, Random Sample Findings Detail Report.

Total Claims	Incorrectly Paid Claims		Accuracy
	Underpaid Claims	Overpaid Claims	
200	3	13	92.0%

Overall Accuracy

CTI defines Overall 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.

UMR did not meet the Performance Guarantee for PEBP in Q1 FY2023 of 98% for this measure. The penalty owed is 1.0% of the administrative fees of $1,303,565.40 or $13,035.65.

Correctly Processed Claims	Incorrectly Processed Claims		Accuracy
	System	Manual	
182	7	11	91.0%

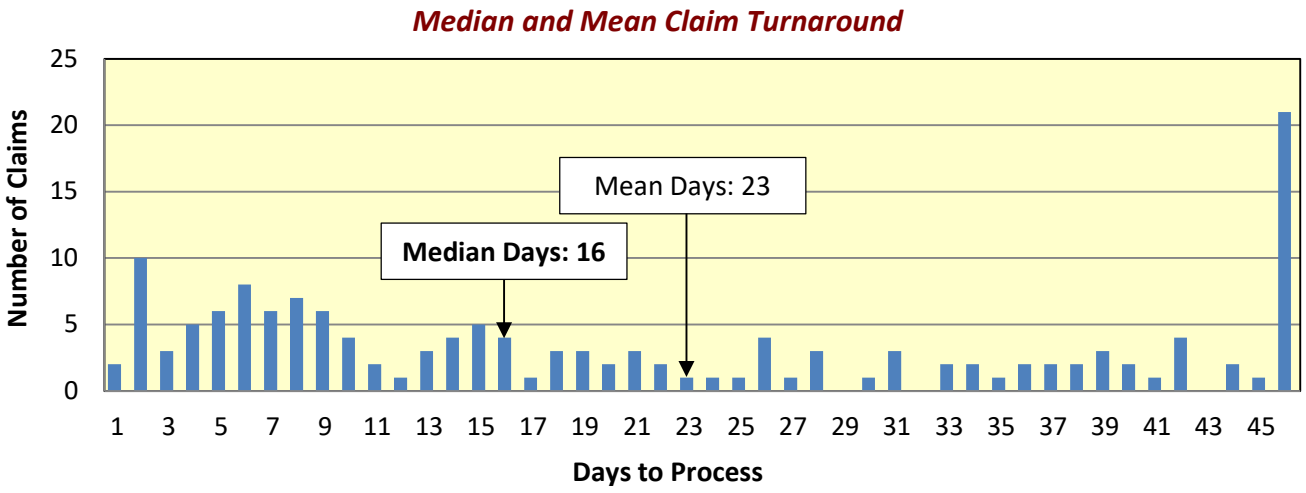
Random Sample Findings Detail Report				
Audit No.	**Under/ Over Paid**	**UMR Response**	**CTI Conclusion**	**Manual or System**
Coinsurance Calculation				
2002	$4.60	Agree. Code 0220 is on procedure selection to pay at deductible then 80%. Th(ese) claim(s) paid at 100% in error. UMR has requested an impact review and can provide results to PEBP upon complete of their review.	Adjudication error and overpayment identified. The coinsurance applied for the periapical film should have been 80% and it was $0.00. The plan states on page 13, film fees, including examination and diagnosis are covered under Basic Services.	☐ M ☒ S
2007	$4.20			☐ M ☒ S
2008	$4.60			☐ M ☒ S
2009	$5.20			☐ M ☒ S
2011	$3.20			☐ M ☒ S
2018	$4.60			☒ M ☐ S
2024	$4.60			☐ M ☒ S
2031	$5.80			☒ M ☐ S
2048	$4.20			☒ M ☐ S
Deductible Calculation				
2005	$21.00	Agree. Code 0220 is on procedure selection to pay at deductible then 80%. Th(ese) claim(s) paid at 100% in error. UMR has requested an impact review and can provide results to PEBP upon complete of their review.	Adjudication error and overpayment identified. The deductible should have been applied for the periapical film and it was not. The plan states on page 13, film fees, including examination and diagnosis are covered under Basic Services.	☐ M ☒ S
2019	$21.00			☒ M ☐ S
2023	$28.00			☒ M ☐ S
Denied Eligible Expense				
1085	$0	Agree. The claim should have been priced per the contract and allow $1987.00 with a discount of $1317.00 for rev code 450 CPT	Adjudication error and deductible under accumulation of $1,317.00 identified for	☒ M ☐ S

Random Sample Findings Detail Report				
Audit No.	**Under/ Over Paid**	**UMR Response**	**CTI Conclusion**	**Manual or System**
		99283. The full $1987.00 would apply to the members deductible. This results in a $0.00 payment error.	denial of eligible emergency room charge.	
1127	($271.66)	Agree. This claim was denied for COB in error. This results in a $271.66 underpayment.	Adjudication error and underpayment identified. The sample claim was submitted with no indication of other insurance and the other insurance review reflects no other coverage. However, the claim was denied for primary coverage EOB.	☒ M ☐ S
Copayment Calculation				
1008	($20.00)	Agree. A $20.00 PCP copay should have applied to this claim. This results in a $20.00 underpayment.	Adjudication error underpayment identified. The copay should have been $20.00, and it was $40.00.	☒ M ☐ S
1143	$50.00	Agree. A specialist copay should have been applied to this claim. This results in a $50.00 overpayment.	Adjudication error overpayment identified. The copay should have been $50.00, and it was $0.00.	☒ M ☐ S
PPO Discount				
1102	($2,167.20)	Agree. This claim should have been priced utilizing the Mountain View Hospital contract. Revenue code 450 CPT 99284 $4,180.00 allowable amount is $2,709.00. $4,180 - $1,471 (discount) = $2,709 x 80% = $2,167.20 payment. This results in a $2,167.20 underpayment.	An adjudication error and underpayment identified. The entire claim amount of $19,485.00 was denied as a discount in error. This claim should have been priced utilizing the Mountain View Hospital contract.	☐ M ☒ S
Incorrect COB With Medicare				
1053	NA	Agree. UMR did not coordinate this claim correctly with Medicare. $688.55 is the correct amount to apply to this member's deductible and $1190.31 is the amount that was overapplied to the member's OOP for the plan year. UMR will adjust this claim accordingly and review the member's file. This results in a $0.00 payment error as there was no payment made.	Adjudication error, deductible and coinsurance over accumulation identified. Benefits were not correctly coordinated with Medicare. The Medicare EOMB states the patient responsibility is $78.66.	☒ 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 a few claims with extended turnaround time from distorting the true performance picture.



UMR did not meet the Performance Guarantees for PEBP in Q1 FY2023 of 92% processed within 14 days and 99% processed within 30 days for this measure. The penalty owed for each of the Performance Guarantee is 1.0% of the administrative fees of $1,303,565.40 or $26,071.31.

The increased claim turnaround time observed during this audit period may have impacted the total paid amount and volume of claims processed because these are notably lower than in prior audits.

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 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

We were unable to calculate provider discounts for PEBP because UMR did not provide the data in their electronic claim data file.

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 there were no claims paid to providers on the OIG's LEIE. This is an improvement from prior audits.

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 99.74% of the procedure codes identified as preventive services were paid by UMR at 100% when provided in-network. The following reports provide an outline for discussion between PEBP and UMR. This is an improvement from prior audits

Preventive Care Services Compliance Review												
		Claim Lines Submitted	Denied	Applied Deductible		Applied Copay		Applied Coinsurance		Paid @100%		
Edit Guideline	Preventive Service Benefit	#	#	#	Amount	#	Amount	#	Amount	#	Amount	%
HHS	Breastfeeding support and counseling - women	34	6	7	$1,517	3	$150	2	$67	16	$1,755	57.14%
USPSTF-A,B	Cholesterol abnormalities screening - women >19	578	37	0	$0	0	$0	0	$0	521	$9,500	96.30%
USPSTF-A	Cholesterol abnormalities screening - men 35-75	428	36	0	$0	0	$0	0	$0	381	$5,611	97.19%
HHS	Gestational Diabetes Mellitus screening - women	91	11	0	$0	0	$0	1	$1	79	$1,050	98.75%

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 UMR that Medicare and Medicaid would have denied. **Since UMR 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 - UMR								
Based on Paid Dates 7/1/2022 through 9/30/2022								
Outpatient Hospital Services (facility claims with codes not designated inpatient)								
Primary		Secondary			Primary Description	Secondary Description	Line	Amount CMS
Code	Mod	Code	Mod	Mod Use			Count	Would Deny
94760		99284	2	YES	MEASURE BLOOD OXYGEN LEVEL	EMERGENCY DEPT VISIT	7	$14,755
					CPT Manual or CMS manual coding instructions			
94760		99285	2	YES	MEASURE BLOOD OXYGEN LEVEL	EMERGENCY DEPT VISIT	3	$7,469
					CPT Manual or CMS manual coding instructions			
90471		99285	2	YES	IMMUNIZATION ADMIN	EMERGENCY DEPT VISIT	3	$7,321
					CPT Manual or CMS manual coding instructions			
94640		99285	2	YES	AIRWAY INHALATION TREATMENT	EMERGENCY DEPT VISIT	4	$5,087
					CPT Manual or CMS manual coding instructions			
99152		99285	2	YES	MOD SED SAME PHYS/QHP INITIAL 15 MINS 5/> YR	EMERGENCY DEPT VISIT	2	$4,721
					Standards of medical / surgical practice			
45385	3	45380	05,03	YES	LESION REMOVAL COLONOSCOPY	COLONOSCOPY AND BIOPSY	7	$4,595
					More extensive procedure			
90471		99282		YES	IMMUNIZATION ADMIN	EMERGENCY DEPT VISIT	5	$4,530
					CPT Manual or CMS manual coding instructions			
90471		99284	2	YES	IMMUNIZATION ADMIN	EMERGENCY DEPT VISIT	3	$4,302
					CPT Manual or CMS manual coding instructions			
90471		99283	2	YES	IMMUNIZATION ADMIN	EMERGENCY DEPT VISIT	4	$4,247
					CPT Manual or CMS manual coding instructions			
22853		22845	5	YES	INSJ BIOMCHN DEV INTERVERTEBRAL DSC SPC W/A	INSERT SPINE FIXATION DEVICE	1	$3,067
					HCPCS/CPT procedure code definition			
						Top 10 TOTAL	**39**	**$60,093**
						GRAND TOTAL	**291**	**$130,060**

Non-Facility (non-facility claims with CPT codes:00100 - 99999)								
Primary		Secondary			Primary Description	Secondary Description	Line	Amount CMS
Code	Mod	Code	Mod	Mod Use			Count	Would Deny
90460		99394	2	YES	IM ADMIN 1ST/ONLY COMPONENT	PREV VISIT EST AGE 12-17	205	$26,946
					CPT Manual or CMS manual coding instructions			
90460		99392	2	YES	IM ADMIN 1ST/ONLY COMPONENT	PREV VISIT EST AGE 1-4	210	$25,126
					CPT Manual or CMS manual coding instructions			
90471		99396	2	YES	IMMUNIZATION ADMIN	PREV VISIT EST AGE 40-64	86	$18,307
					CPT Manual or CMS manual coding instructions			
90460		99391	2	YES	IM ADMIN 1ST/ONLY COMPONENT	Per pm reeval est pat infant	136	$14,619
					CPT Manual or CMS manual coding instructions			
90471		99214	2	YES	IMMUNIZATION ADMIN	Office/outpatient visit for E&M of estab	82	$14,144
					CPT Manual or CMS manual coding instructions			
90460		99393	2	YES	IM ADMIN 1ST/ONLY COMPONENT	PREV VISIT EST AGE 5-11	100	$12,241
					CPT Manual or CMS manual coding instructions			
17000		99213	2	YES	DESTRUCT PREMALG LESION	Office/outpatient visit for E&M of estab	123	$12,176
					CPT Manual or CMS manual coding instructions			
11102		99213	2	YES	TANGENTIAL BIOPSY SKIN SINGLE LESION	Office/outpatient visit for E&M of estab	105	$9,990
					CPT Manual or CMS manual coding instructions			
17110		99213	2	YES	DESTRUCT B9 LESION 1-14	Office/outpatient visit for E&M of estab	101	$9,022
					CPT Manual or CMS manual coding instructions			
96372		99214	2	YES	THER/PROPH/DIAG INJ SC/IM	Office/outpatient visit for E&M of estab	40	$5,659
					Standards of medical / surgical practice			
						Top 10 TOTAL	**1,188**	**$148,232**
						GRAND TOTAL	**3,666**	**$386,395**

Medically Unlikely Edits (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. Note: UMR's Outpatient Hospital screening had no results.

NCCI MUE Edits				
PEBP - UMR				
Based on Paid Dates 7/1/2022 through 9/30/2022				
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**
95165	30	ANTIGEN THERAPY SERVICES	10	$6,719
		Rationale: Clinical: Data		
31295	1	Nasal/sinus endoscopy, surgical, w dilation (balloon dila	5	$4,824
		Rationale: CMS Policy		
97155	24	ADAPT BHV TX PRTCL MODIFICAJ PHYS/QHP EA 15 MIN	2	$1,800
		Rationale: Clinical: Society Comment		
86255	5	FLUORESCENT ANTIBODY SCREEN	1	$1,632
		Rationale: Clinical: Data		
96133	7	NEUROPSYCHOLOGICAL TST EVAL PHYS/QHP EA ADDL HR	1	$1,215
		Rationale: Nature of Service/Procedure		
31255	1	REMOVAL OF ETHMOID SINUS	2	$995
		Rationale: CMS Policy		
30140	1	RESECT INFERIOR TURBINATE	4	$684
		Rationale: CMS Policy		
J3480	40	INJ POTASSIUM CHLORIDE	3	$450
		Rationale: Clinical: Data		
31256	1	EXPLORATION MAXILLARY SINUS	1	$266
		Rationale: CMS Policy		
84182	6	PROTEIN WESTERN BLOT TEST	2	$240
		Rationale: Clinical: Data		
		Top 10 TOTAL	**31**	**$18,825**
		GRAND TOTAL	**48**	**$20,376**

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**
K0553+336:5	1	THER CGM SUPPLY ALLOWANCE	4	$3,885
		Rationale: Code Descriptor / CPT Instruction		
V2520	2	CONTACT LENS HYDROPHILIC	6	$565
		Rationale: Anatomic Consideration		
A7520	1	TRACH/LARYN TUBE NON-CUFFED	1	$232
		Rationale: Published Contractor Policy		
K0001	1	STANDARD WHEELCHAIR	2	$224
		Rationale: Code Descriptor / CPT Instruction		
E0443	1	PORTABLE 02 CONTENTS, GAS	1	$214
		Rationale: Code Descriptor / CPT Instruction		
V2523	2	CNTCT LENS HYDROPHIL EXTEND	2	$110
		Rationale: Anatomic Consideration		
V2500	2	CONTACT LENS PMMA SPHERICAL	1	$110
		Rationale: Anatomic Consideration		
A7035	1	POS AIRWAY PRESS HEADGEAR	2	$84
		Rationale: Published Contractor Policy		
A4253	1	BLOOD GLUCOSE/REAGENT STRIPS	4	$62
		Rationale: Nature of Equipment		
K0003	1	LIGHTWEIGHT WHEELCHAIR	1	$51
		Rationale: Code Descriptor / CPT Instruction		
		Top 10 TOTAL	**24**	**$5,537**
		GRAND TOTAL	**29**	**$5,607**

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 - UMR									
Audit Period 7/1/2022 - 9/30/2022									
Provider Id	Surgeries with 'CMS Defined' Prohibited Global Fee Periods					Evaluation and Management Services using Same ID as Surgeon and Within Prohibited Global Fee Period			
	Surgeries without E/M Procedures during Prohibited Global Fee Periods		Surgery with E/M Charge during Prohibited Global Fee Periods			E/M Procedure Codes with Modifier 24, 25, or 57		E/M Procedure Codes without Modifier 24, 25, or 57	
	Count	Allowed Charge	Count	% Surgeries with E/M Charges during Prohibited Global Fee Periods	Allowed Charge	Total Count; 0,10 & 90 days	Allowed Charge	Total Count; 0,10 & 90 days	Allowed Charge
813253496	862	$169,927	134	13.5%	$20,044	0	$0	117	$13,968
880103557	312	$178,545	106	25.4%	$13,310	0	$0	95	$8,320
880175775	406	$73,162	75	15.6%	$10,674	0	$0	69	$5,850
880133501	290	$86,930	41	12.4%	$7,460	0	$0	43	$5,640
203395567	196	$36,264	22	10.1%	$18,059	0	$0	21	$3,670
270028866	92	$79,803	23	20.0%	$11,808	0	$0	21	$2,808
20566741	40	$27,815	22	35.5%	$1,951	0	$0	19	$2,790
880498458	23	$10,537	15	39.5%	$2,661	0	$0	16	$2,782
208628418	80	$36,521	18	18.4%	$7,224	0	$0	16	$2,674
680405220	66	$96,298	13	16.5%	$2,963	0	$0	13	$2,341
Top 10	**2,367**	**$795,803**	**469**	**16.5%**	**$96,155**	**0**	**$0**	**430**	**$50,843**
Overall Total	**5,359**	**$1,823,740**	**1,257**	**19.0%**	**$268,342**	**0**	**$0**	**1,145**	**$129,213**

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

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.

Your administrator's response to the draft report follows.

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

Revised-March 9, 2023

Joni,

Thank you for the opportunity to respond to the recent review of the State of Nevada Public Employees' Benefit Program audit draft report.

Performance Guarantees: UMR Account Management Team has provided CTI with the requested reports noted in the report.

Targeted Sample Analysis:

Duplicate Payment

QID 71, 73, 79, 80, 83, 89, 95, 96, 97, 98, 99, 100, 102, 103, and 106 – UMR agrees with these errors. These were manual processing errors. Additional coaching and training have taken place with the Customer First Representative (CFR). These claims will be adjusted to deny, and an overpayment request sent to the provider of service. This results in a $6813.59 overpayment. UMR has requested an impact report and can provide results to PEBP upon completion of the review.

QID 77 – UMR agrees with this error. This was a manual processing error. Additional coaching and training have taken place with the CFR. This resulted in a $0.00 payment as there was no payment made. The claim was adjusted and denied on 10-24-2022.

QID 78 – UMR disagrees with this error. UMR has enhanced duplicate logic programming in place. The logic is reviewed regularly as we continue to find ways of improving and finding specific criteria to alleviate duplicate claim submission payments. The sample claim has a different referring physician and diagnosis from the identified related claim. These differences are considered a new claim and will not be flagged for duplicate. These claims are allowed appropriately.

QID 82 – UMR disagrees with this error. The provider submitted claims for the same date of service with different billed amounts. The duplicate logic considers these as 2 separate claims. The provider identified the billing error on their end and notified UMR. The overpayment was credited back on 11-1-2022 in the amount of $231.00.

QID 91 – UMR agrees with this error. This was a manual processing error. Additional coaching and training have taken place with the CFR. This resulted in a $20.00 overpayment. The claim was adjusted and denied on 12-5-2022.

QID 104 – UMR agrees with this error. This was a system limitation error due to the code not having a maximum frequency. This results in a $0.00 payment error as there was no payment made. This claim was adjusted on 11-23-2022.

715-841-7262 Julie.Frahm@UMR.com

Plan Exclusions

QID 143 – UMR agrees with this error. Marriage Counseling is excluded on this plan. Coding in the UMR system has been updated to deny all future claims billed with this type of diagnosis. This claim will be adjusted to deny, and an overpayment request will be sent to the provider. This results in a $52.80 overpayment. UMR has requested an impact report and can provide results to PEBP upon completion of the review.

QID 147 – UMR agrees with this error. Massage Therapy is excluded on this plan. Coding in the UMR system has been updated to deny all future claims billed with this type of procedure. This results in a $10.00 overpayment. This claim has been adjusted and an overpayment request send to the provider. UMR has requested an impact report and can provide results to PEBP upon completion of the review.

Potential Fraud, Waste, and Abuse

QID 110 – After further review UMR agrees with is error. This error is the result of a manual repricing error. Additional coaching and training have taken place. This results in a $20,339.29 overpayment. The claim has been adjusted and an overpayment request send to the provider.

Random Sample Audit

Coinsurance Calculation

Samples 2002, 2007, 2008, 2009 2011, 2018, 2024, 2031, and 2048 – UMR agrees with these errors. Coding update was completed on 10/18/22 to pay this code at 80% per plan intent. Claims are in the process of being adjusted with correct coinsurance. This results in a $41 overpayment. UMR has requested an impact review and can provide results to PEBP upon completion of the review

Deductible Calculation

Samples 2005, 2019 and 2023 – UMR agrees with these errors. Coding update was completed on 10/18/22 to apply the deductible per plan intent. Claims are in the process of being adjusted with correct deductible and coinsurance. This results in a $70 overpayment. UMR has requested an impact review and can provide results to PEBP upon completion of the review.

Denied Eligible Expense

Sample 1085 – UMR agrees with this error. This claim was manually repriced incorrectly by the repricing analyst. An incorrect allowable amount was applied. Additional coaching and training have taken place. The claim has been adjusted and additional payment of $1589.60 was issued to the provider.

Sample 1127 – UMR agrees with this error. Coordination of Benefits logic has been updated in the system per the plan intent. Controls have been put into place to remediate the error. This claim was adjusted and additional payment of $271.66 has been issued to the provider. UMR has requested an impact review and can provide results to PEBP upon completion of the review.

Sample 2036 – UMR disagrees with this error. Per the plan intent, these services require Xray's, and UMR denied the claims for additional review. The review was completed on 10/10/22. The claim was adjusted on 10/11/22 issuing payment of $924.50 per plan benefits.

Sample 2048 – After further review, UMR agrees with this error. No frequency applies to inlays per plan intent. The claim has been adjusted and payment issued to the provider. This results in a $214.80 underpayment.

715-841-7262 Julie.Frahm@UMR.com

Sample 1008 – UMR agrees with this error. The CFR did not follow the procedures that are in place to apply the correct copay for this type of claim. Additional coaching and training have taken place. This claim has been adjusted with additional payment of $20.00 issued to the provider.
Sample 1143 – UMR agrees with this error. This was a system error. The claim has been adjusted and overpayment request sent to the provider. This results in a $50 overpayment. UMR has requested an impact review and can provide results to PEBP upon completion of the review.

PPO Discount

Sample 1102 – UMR agrees with this error. This claim was manually repriced in correctly by the repricing team. An incorrect allowable amount was applied. Additional training and coaching have taken place. The claim was adjusted on 11-22-2022 with additional payment of $2167.20 issued to the provider.

Incorrect COB with Medicare
Sample 1053 – UMR agrees with this error. This was a manual processing error by the CFR. COB with Medicare was not correctly entered. Additional coaching and training have taken place. This claim has been adjusted to deny per receipt of corrected claim 22285301314. This results in a $0.00 payment as no payment was made.

UMR is dedicated to improving the overall experience for the State of Nevada PEBP members and will work diligently on addressing any items during this review. If you have any questions or concerns regarding our responses, please feel free to contact me at 715-841-7262.

Sincerely,

Julie Frahm
SR. External/Regulatory Audit Coordinator
UMR External Audit Department

CLAIM TECHNOLOGIES
INCORPORATED

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JOE LOMBARDO
Governor

STATE OF NEVADA
PUBLIC EMPLOYEES' BENEFITS PROGRAM
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Telephone 775-684-7000 | 702-486-3100 | 1-800-326-5496
www.pebp.state.nv.us

LAURA RICH
Executive Officer

JACK ROBB
Board Chair

Date: March 23, 2023

Item Number: IX - Supplemental

SUMMARY

This report provides the PEBP Board and members of the public with supplemental information regarding CTI's audit of PEBP's Third-Party Administrator, UMR, and the performance guarantees that were not part of the Random Sample Audit results. The tables below illustrate additional penalties being assessed by PEBP for self-reported, unmet performance guarantees not captured in the Q1 audit.

REPORT

Claims Administration

There are a total of nineteen (19) measurement categories of service and performance guarantees related to claims administration. In addition to the exceptions noted in the audited performance guarantees, there were six guarantees reported to be "Not Met" with penalties calculated against total fees of $1,303,565.40:

Performance Guarantee	Result	Fees at Risk	Calculated Penalty
1.4 Claim Adjustment Processing Time	NOT MET	1.0%	$13,035.65
1.5 (Customer Service) Telephone Service Factor	NOT MET	1.0%	$13,035.65
1.6 Call Abandonment Rate	NOT MET	1.0%	$13,035.65
1.9 CSR Audit	NOT MET	1.0%	$13,035.65
1.11 Participant Email Response Performance - 8 Hours	NOT MET	1.0%	$13,035.65
1.11 Participant Email Response Performance - 24 Hours	NOT MET	1.0%	$13,035.65
Total			**$78,213.92**

Network Administration

There are a total of six (6) measurement categories of service and performance guarantees related to network administration. There was one (1) guarantee reported to be "Not Met" with penalties calculated against total fees of $664,716.60:

Performance Guarantee	Result	Fees at Risk	Calculated Penalty
2.1 EDI Claims Repricing Turnaround Time	NOT MET	2.0%	$13,294.33
Total			**$13,294.33**

Utilization Management and Case Management

There are a total of thirteen (13) measurement categories of service and performance guarantees related to Utilization Management and Case Management. There was one (1) guarantee reported to be "Not Met" with penalties calculated as the number of unreported high-cost claims (12 claims) against fees of $1,000.00 per occurrence:

Performance Guarantee	Result	Fees at Risk	Calculated Penalty
3.2 Notification of high-cost claims (per occurrence)	NOT MET	$1,000 per occurrence	$12,000.00
Total			**$12,000.00**

Summary

This is a brief summary of the performance guarantees where the measurements were determined to be "Not Met:"

Performance Guarantee	Calculated Penalty
1. Claims Administration	$78,213.92
2. Network Administration	$13,294.33
3. Utilization Management and Case Management	$12,000.00
Total	**$103,508.25**

The penalties, totaling $103,508.25, are administratively and automatically assessed by PEBP to the vendor. This is in conjunction with the audited penalties totaling $58,660.44. The calculated penalties for the period ending 09/30/2022 total **$162,168.69.**

9.1

9. Discussion and acceptance of Claim Technologies Incorporated audit findings for State of Nevada Public Employees' Benefits Program Plans administered by UMR Benefits for the period July 1, 2022 – September 30, 2022. (Laura Rich, Executive Officer) (**For Possible Action**)

9.1 UMR Remediation Plan

March 9, 2023

State of Nevada Public Employees' Benefit Program Board

Subject: UMR Audit Results for Q1 PY2023

Dear PEBP Board Members:

UMR appreciates the opportunity to respond to the quarterly audit performed by Claims Technologies for the first quarter.

UMR is extremely disappointed to have missed Performance Guarantees for this audit period. We take the quality of our work very seriously and will continue to review quality improvement opportunities within our organization.

Financial and Overall Claims Accuracy: Not Met
To address the inventory, we added resources to the PEBP account resulting in quality errors by the staff. As we progressed, we were able to reduce the level of assistance needed. Going forward, we are continuing to meet with the staff daily and weekly to go over the quality reports, identifying trending errors, initiating refresher training for any skill gap, and using this data to improve the overall quality of the staff. As a follow up from the Q1 audit, we have added an additional quality measure for duplicates as of mid-January 2023. Any claim considered an exact and/or potential duplicate, as identified by our system logic, will have an additional quality step to review claim for accuracy.

Turnaround Time and Claim Adjustment Processing: Not Met
The remaining staff from HealthSCOPE Benefits has been trained on the UMR system and is ramping up as we work toward improving turnaround time over next reporting period.

Telephone Service Factor: Not Met
Additional staff have been trained for PEBP account. Beginning in January 2023, we expect to be meeting or exceeding this metric. Six additional staff were added bringing the total to twenty-two dedicated call staff. We also have staff on a sister team fully trained on PEBP used as backup during busy times. We have been impacted with workforce shortages, especially earlier in 2022. With the changes made to our recruiting process and other areas, we were able to fill classes the last half of 2022 and continue to have success so far this year. Turnover in a call center is always a challenge, but we have implemented many different changes to help with turnover and continue to monitor and focus on specific areas of concern. The positive is we retained a good percentage of our staff due to promoting into other roles within UMR/UHC.

Call Abandonment Rate: Not Met
Additional staff has been trained for PEBP account. Beginning in January 2023, we expect to be meeting or exceeding this metric.

CSR Audit, or Quality Scores: Not Met
Through additional coaching and training on PEBP's unique plan, we expect to continue to trend toward meeting third quarter call quality goals.

CSR Callback Performance: Not Met
A Callback Performance Guarantee is not something UMR has tracked and reported in the past. We found through the development and verification that how we are entering, and tracking results will not work for properly reporting the performance guarantee. We will be able to supply callback results starting with 1/1/2023 calls going forward.

Participant Email Response Performance: Not Met
Additional staff has been trained to complete this task.

EDI Claims Re-Pricing Turnaround Time: Not Met
Day 3 TAT was not met due to a backlog of claims at UHC coming off the Labor Day holiday, and an influx of clearinghouse receipts after the same holiday, which slowed the TAT for network repricing and missed the goal by 1%. UHC's repricing workflow was re-reviewed to ensure bandwidth for claim volumes from UMR. Additional measures were put into place to increase the daily claim thresholds to accommodate not only current claim volumes, but also for an increase of daily claim volume from UMR, reducing the chance for reoccurrence.

Notification of potential high expense cases: Not Met
The UM/CM vendor provides a report of pre-claim submission, potential high-cost claimants for pre-service authorization and concurrent review cases. A variety of criterion was used to identify potential HCC, such as NICU admissions, longer lengths of stay, and chemotherapy. SHO received approval from PEBP on 10/10/22 to provide on weekly basis and the report began distribution on 10/18/22. There have been no gaps in notification since that time. While we will likely not meet for Q2 2022, SHO expects to fully meet for Q3.

UMR is dedicated to improving the overall experience for State of Nevada members and will work diligently to address all items during this review.

Sincerely,

Helmut Braun
UMR Chief Operating Officer

10.

10. Presentation on PEBP claims experience and trend (Richard Ward, Segal) (Information/Discussion)

State of Nevada – Public Employees' Benefit Program

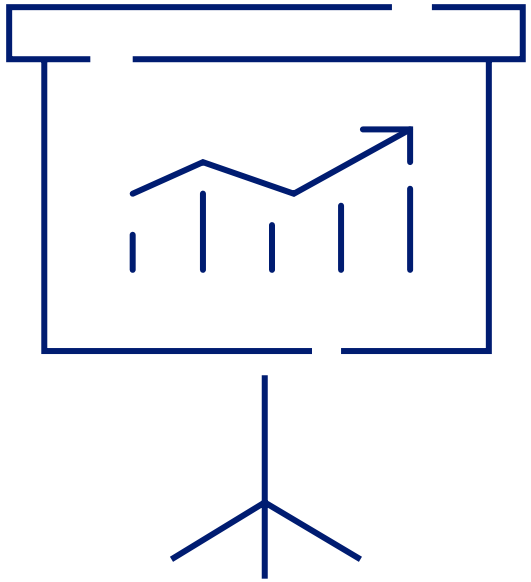
Trend Presentation

March 23, 2023

Segal

Agenda

- Historical plan cost trends
- Results of 2023 *Segal Health Plan Cost Trend Survey*
- FY2024 Pricing methodology and assumptions
- Questions



Executive Summary

⇓Medical claims trend has declined recently, projected to be 3.3% for PY23

⇑Pharmacy claims trend is running at higher levels than in the past

- ⇑8%+ for plan years 2021 and 2022
- ⇑Projected to be 10.5% for PY23
- ⇓Rebate and contracting improvements in new PBM contract reduce projected NET Rx trend to -4.4%
  - ⇒Rebate guarantees are consistent over the life of contract. So, this is a one-time reset.

⇓Dental claims trend continues to run low post-COVID, 0.3% in PY22 and projected to be -5.2% for PY23

[1] NV PEBP historical trends are shown on a plan year basis.

Executive Summary

⇔ These trends assume no plan design changes. PEBP is implementing several initiatives to reduce costs, which reduces budgeting trend expectations.

⇔ Segal is projecting moderate medical claims trend, higher Rx claims trends and low dental claims trend. These are lower than industry expectations

2023-2024 Projected		
	PEBP	**Industry**
Medical	4.0%	7.4%
Pharmacy	8.0%	9.8%
Dental	1.0%	4.0%

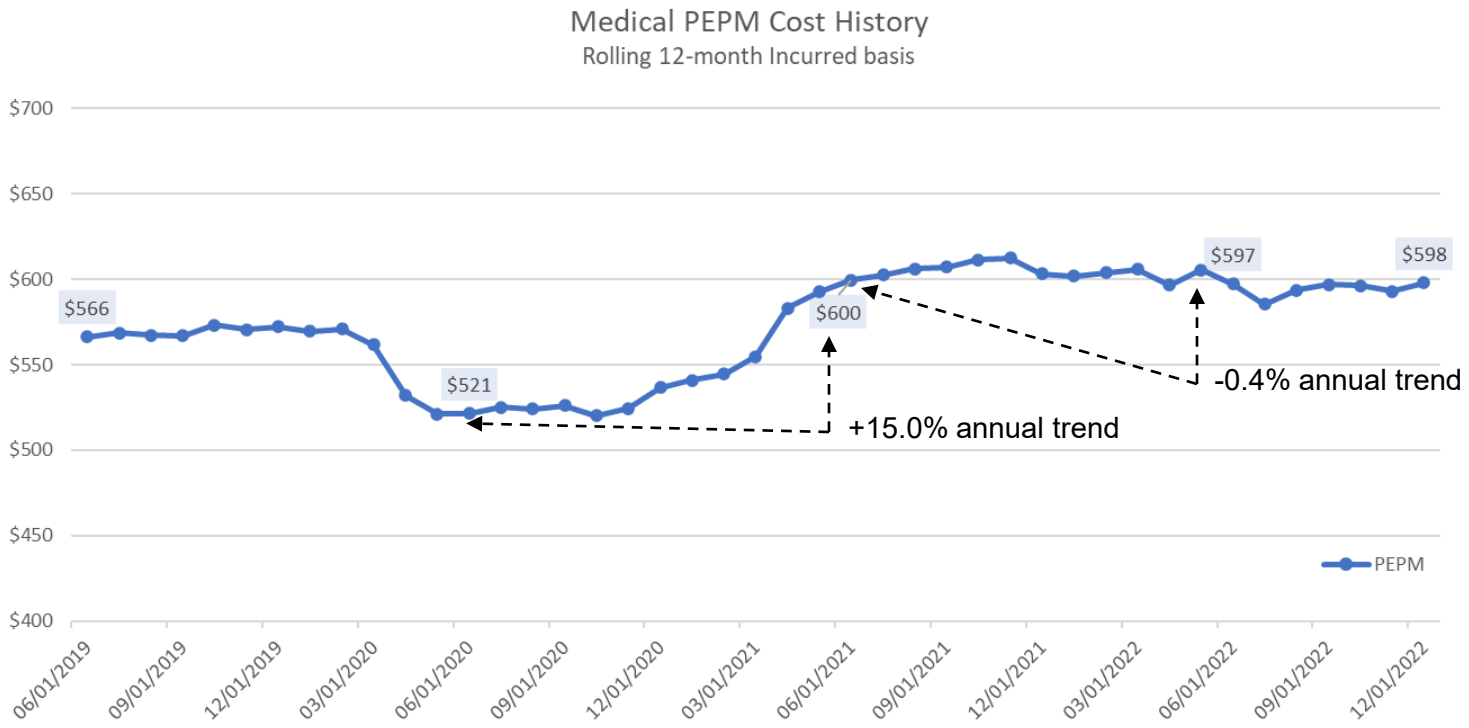
⇔ For 2019-2021:

- ⇓ PEBP medical trend has run below industry
- ⇓ Pharmacy (gross claims) has run below industry
- ⇑ Dental has run slightly higher than industry

2019-2021 Actual		
	PEBP[1]	**Industry**
Medical	2.7%	7.2%
Pharmacy	5.1%	7.6%
Dental	0.7%	0.5%

[1] NV PEBP historical trends are shown on a calendar year basis to align with Industry trend figures.

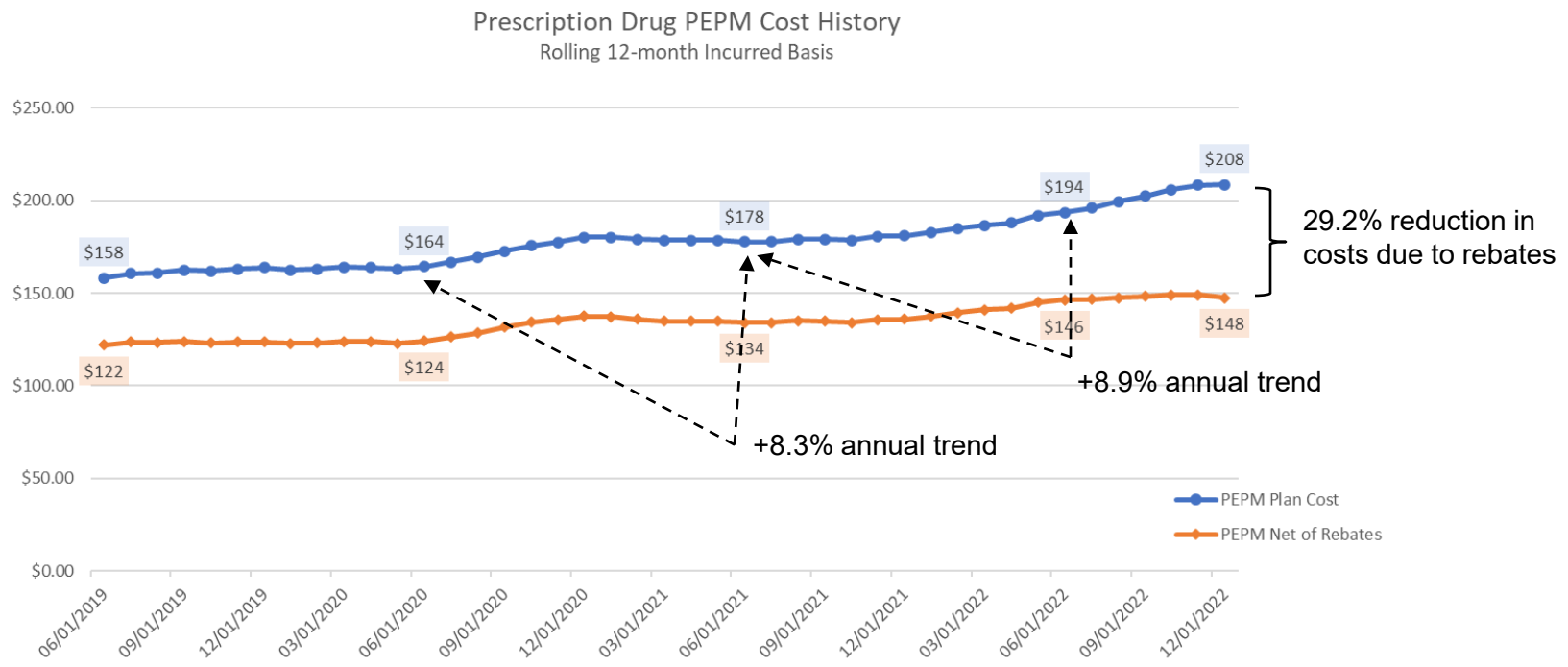
Historical Trend - Medical



Plan Year	Governor's Budget Trend	Pricing Trend[1]	Actual[2]
2020	1.63%	4.0 – 7.0%	-7.9%
2021	5.33%	5.0 – 7.0%	15.0%
2022	3.52%	3.00%	-0.4%
2023[3]	3.52%	5.43%	3.3%
2024	3.91%	4.00%	TBD

[1] Expected trends are based on the pricing trend assumed when setting each Plan Year's rates
[2] Actual trends are based on incurred claims data as reported by HealthScope and/or UMR with runout paid through December 31, 2022
[3] The actual trend shown for PY2023 is estimated based on actual claims incurred year-to-date with a projection of expected claim cost. Therefore, actual PY2023 trends may change as experience develops.

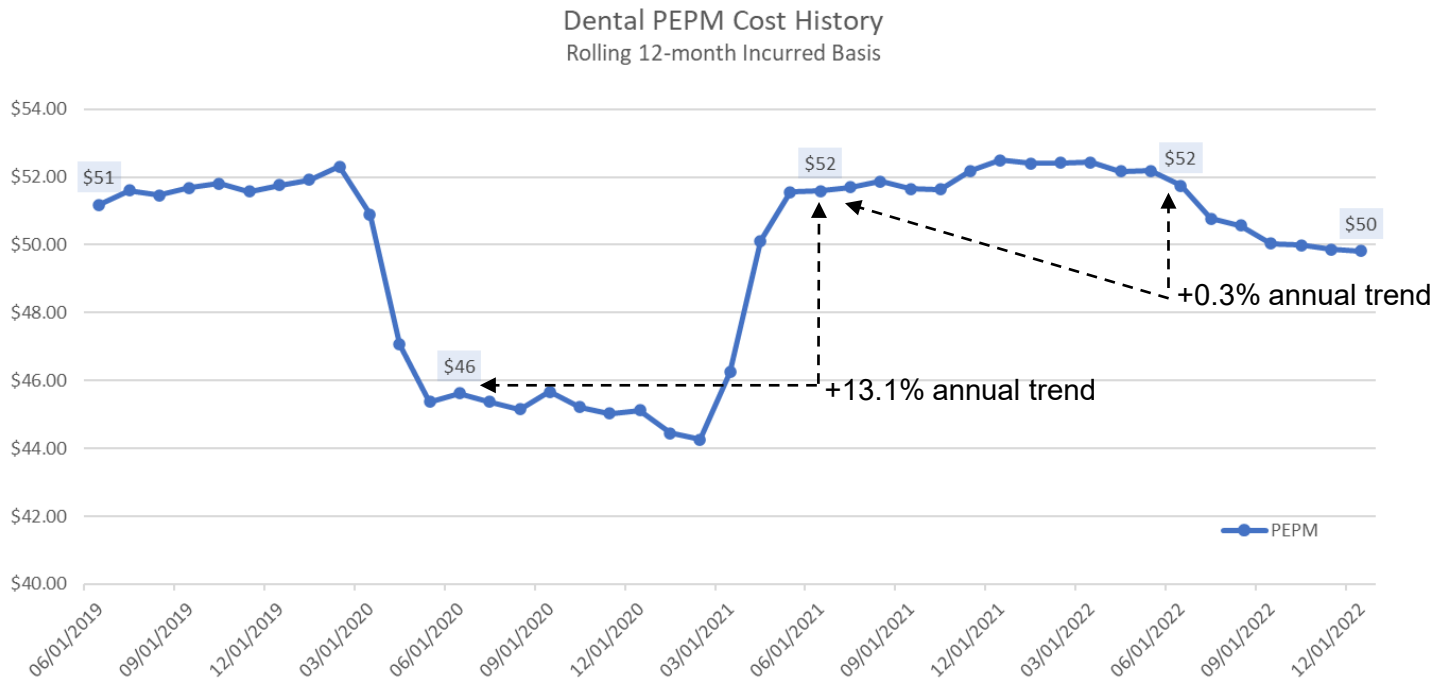
Historical Trend – Rx



Plan Year	Governor's Budget Trend	Pricing Trend[1]	Actual[2] (Gross)	Actual[2] (Net)
2020	16.9%	4.0 – 7.0%	3.9%	1.9%
2021	20.61%	5.0 – 7.0%	8.3%	8.0%
2022	4.00%	7.00%	8.9%	9.0%
2023[3]	4.00%	6.69%	10.5%	-4.4%
2024	3.67%	8.00%	TBD	TBD

[1] Expected trends are based on the pricing trend assumed when setting each Plan Year's rates
[2] Actual trends are based on incurred claims data as reported by ESI with runout paid through December 31, 2022
[3] The actual trend shown for PY2023 is estimated based on actual claims incurred year-to-date with a projection of expected claim cost. Therefore, actual PY2023 trends may change as experience develops.
[4] Pharmacy trends are shown on both a gross and net plan cost basis (i.e., before and after the application of manufacturer rebates).

Historical Trend - Dental



Plan Year	Governor's Budget Trend	Pricing Trend[1]	Actual[2]
2020	0.13%	1.0-3.0%	-10.8%
2021	3.13%	2.0 – 4.0%	13.1%
2022	1.75%	1.75%	0.3%
2023[3]	1.75%	3.00%	-5.2%
2024	2.00%	1.00%	TBD

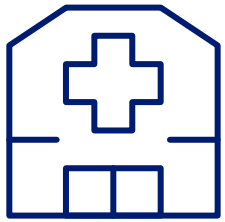
[1] Expected trends are based on the pricing trend assumed when setting each Plan Year's rates
[2] Actual trends are based on incurred claims data as reported by HealthScope and/or UMR with runout paid through December 31, 2022
[3] The actual trend shown for PY2023 is estimated based on actual claims incurred year-to-date with a projection of expected claim cost. Therefore, actual PY2023 trends may change as experience develops.

About the Segal Health Plan Cost Trend Survey

- The 2023 Segal Health Plan Cost Trend Survey is our 26th annual survey of managed care organizations, health insurers, PBMs and TPAs. We conducted the survey during the summer of 2022
- Respondents reported 2023 trend forecasts for medical, prescription drug, dental and vision coverage. In addition, the survey respondents reported actual allowed health cost trends for 2021 based on their group health plan experience.
- Respondents include national and regional insurance carriers, administrators and pharmacy benefit managers.
  - This year we received input from 323 respondents
- Collectively, the survey respondents represent more than 80 percent of the commercially insured and self-insured market.
- Four categories of active and early retiree coverage are tracked in the survey

Open Access PPO/POS Plans

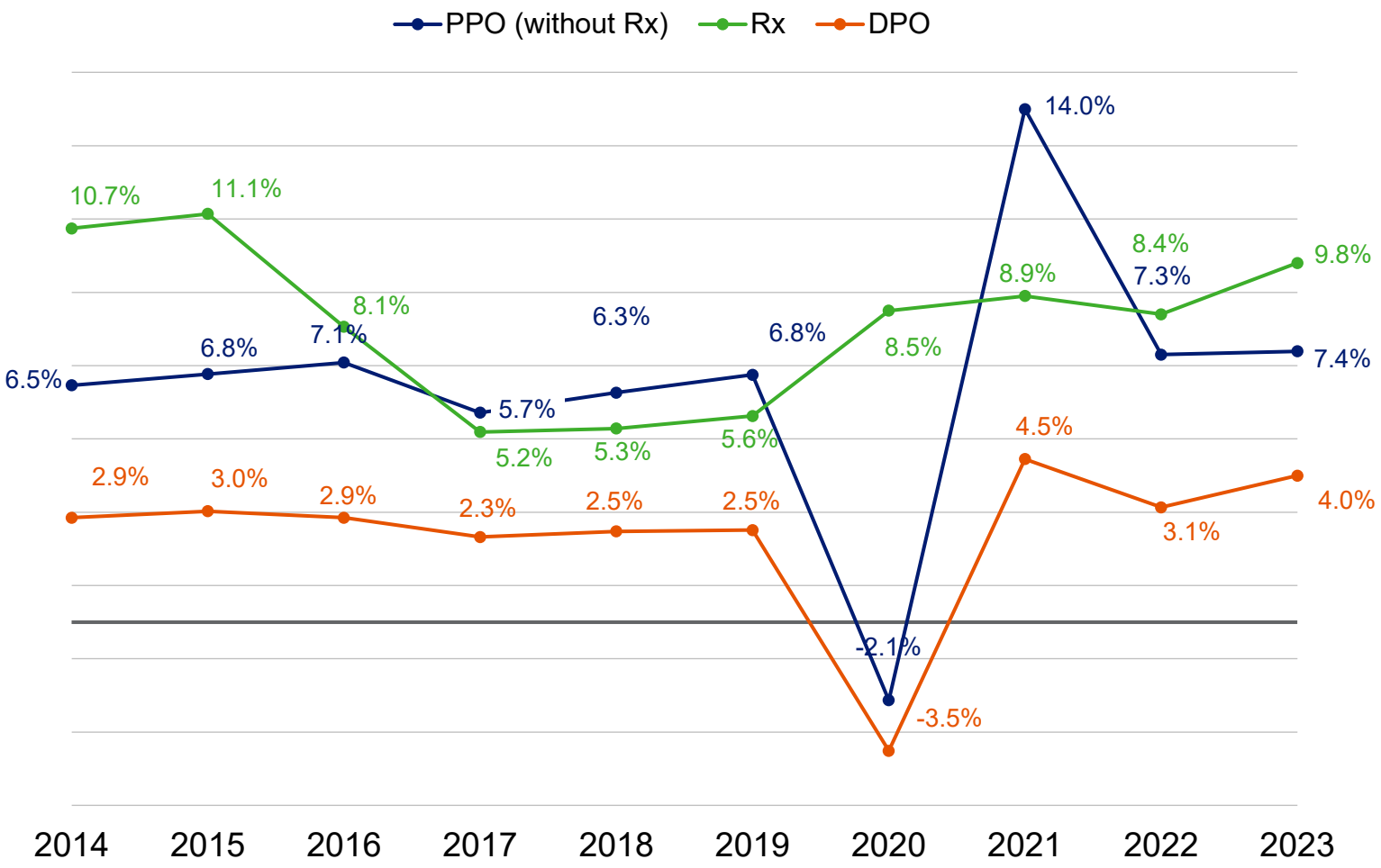
PPO/POS Plans with PCP gatekeepers



HMO/EPO Plans

HSA-Qualified HDHPs

Ten-Year Summary of Selected Medical, Prescription Drug Carve-Out and Dental Trends: 2014–2021 Actual and 2022 and 2023 Projected[1]

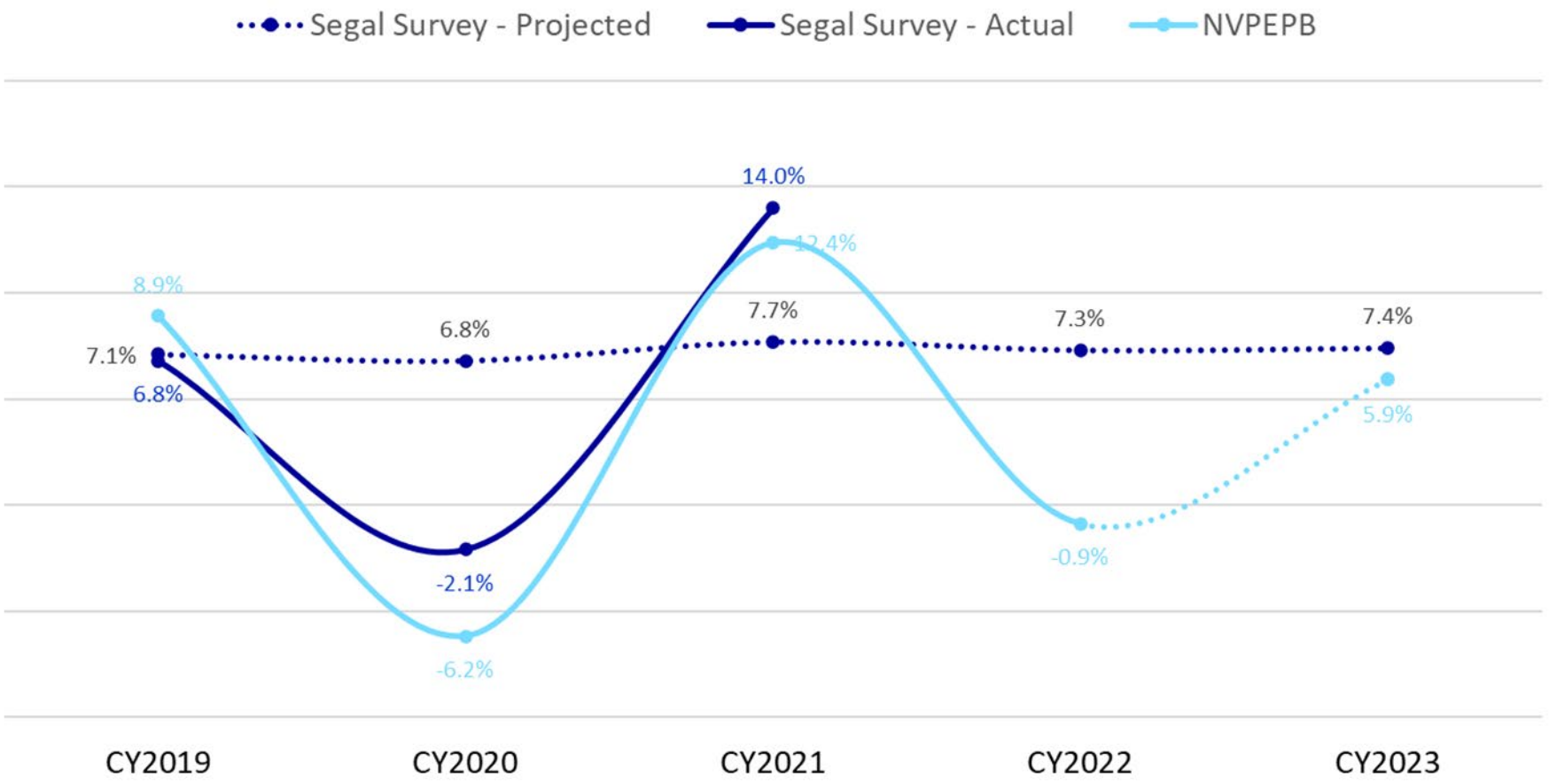


Source: 2023 *Segal Health Plan Cost Trend Survey*

[1] All trends are illustrated for actives and retirees under age 65, except for MA HMOs.

[2] Prescription drug trend is combined for retail and mail order delivery channels.

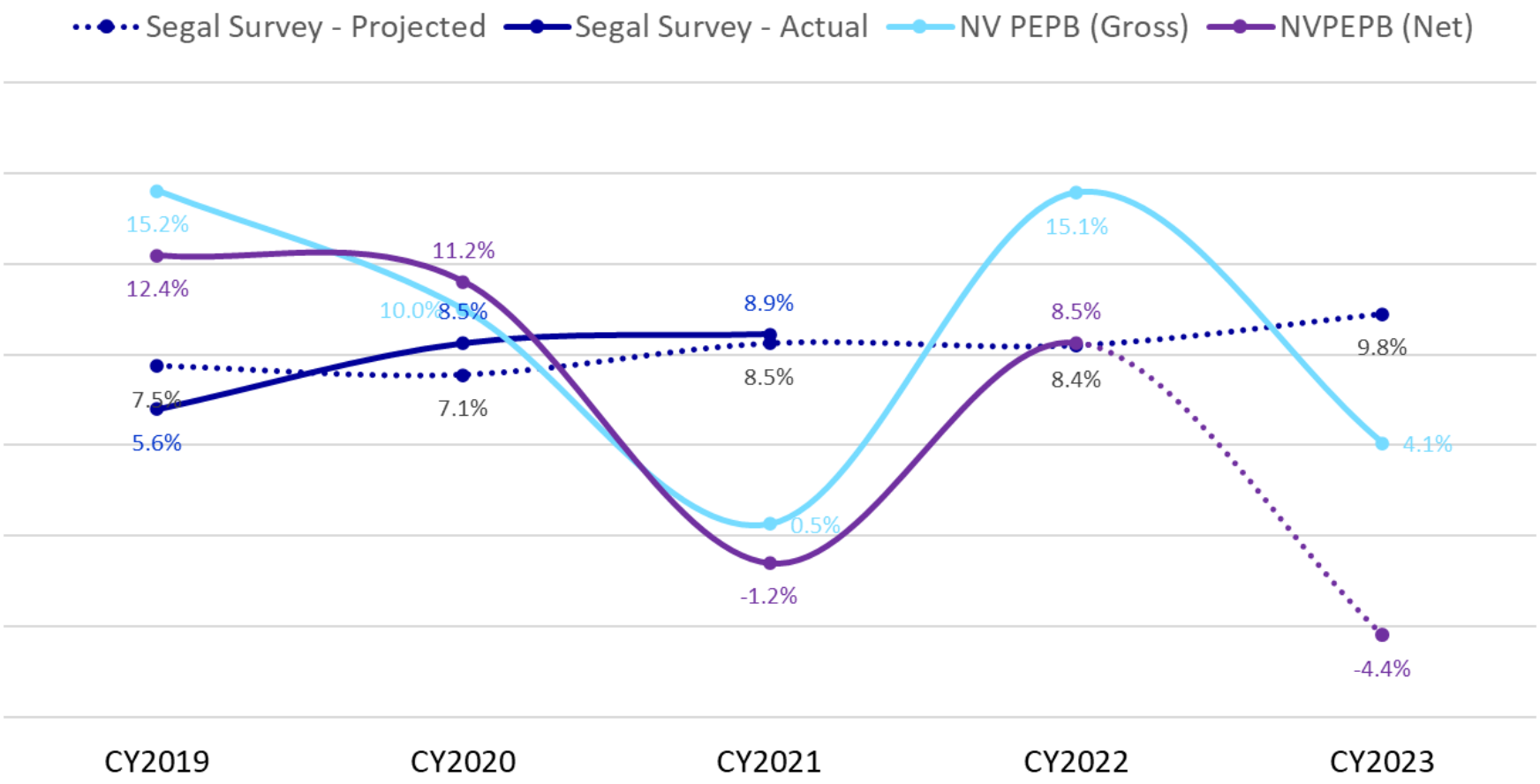
Five-Year Summary of Selected Medical Trends
Calendar Year 2019–2021 Actual and 2022 and 2023 Projected



[1] Source: 2023 *Segal Health Plan Cost Trend Survey* All trends are illustrated for actives and retirees under age 65, except for MA HMOs, in the Segal Survey.

[2] NV PEBP trends are shown on a PEPM basis by calendar year

Five-Year Summary of Selected Prescription Drug Carve-Out Trends
Calendar Year 2019–2021 Actual and 2022 and 2023 Projected

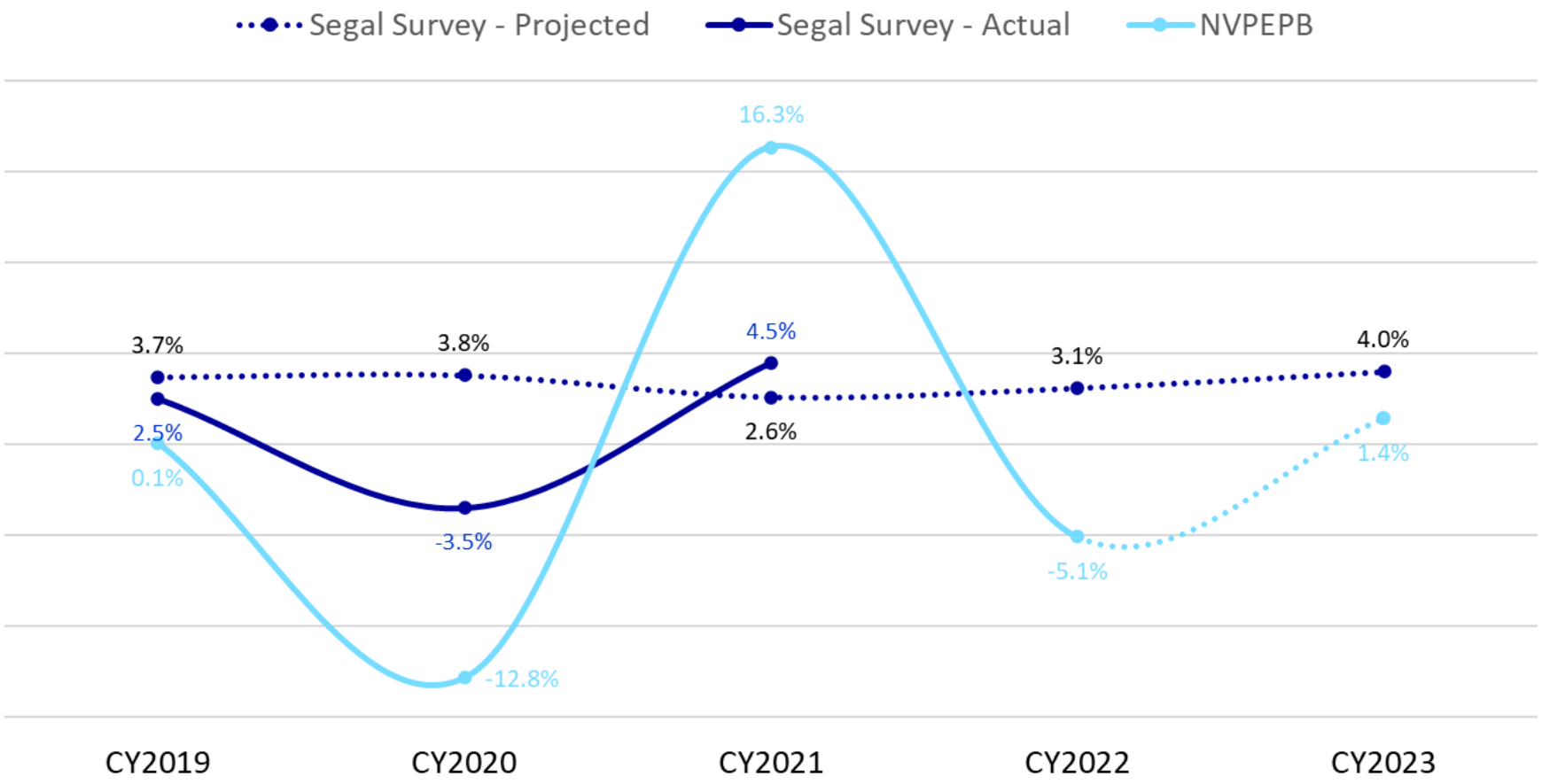


[1] Source: 2023 *Segal Health Plan Cost Trend Survey* All trends are illustrated for actives and retirees under age 65, except for MA HMOs, in the Segal Survey.

[2] Prescription drug trend is combined for retail and mail order delivery channels

[3] NV PEBP trends are shown on a PEPM basis by calendar year

Five-Year Summary of Selected Dental Trends
Calendar Year 2019–2021 Actual and 2022 and 2023 Projected



[1] Source: 2023 *Segal Health Plan Cost Trend Survey* All trends are illustrated for actives and retirees under age 65, except for MA HMOs, in the Segal Survey.

[2] NV PEBP trends are shown on a PEPM basis by calendar year

What's Behind the Numbers
(what the Survey's respondents said)

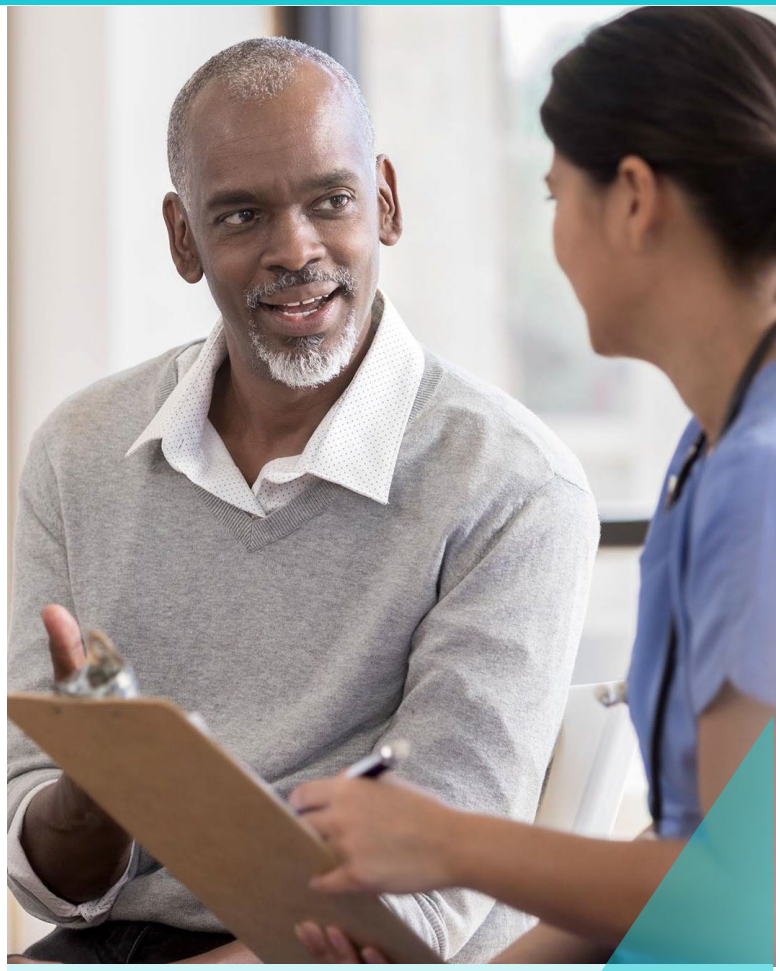
1. Our latest claims analysis show per employee per month medical claim costs increases at a rate of 7% to 8%

2. Price inflation is the primary component of health plan cost increases.
   - Pressure by providers to generate higher rates of reimbursement from private payers for health services and supplies is escalating as wages increase and more of their revenue comes from Medicare and Medicaid patients, which have lower reimbursement rates.
   - This is likely to be a growing problem through 2023.

3. Specialty drug trend remains in the double-digits, driven by:
   - High list price increases
   - Successful marketing by the pharmaceutical industry of new to market, more expensive medications, replacing current drug therapies that have lower prices. In some cases, without strong evidence of superior outcomes.

What Drives Trend?

- New treatments, therapies and technology
- Greater emphasis on detection and diagnostics
- Medical inflation, impacting the cost of care delivery
- Provider price increases
- Increased demand from increased health risks due to aging populations or rise in obesity
- Increased treatment burden due to the aging population and rise in obesity
- Social and economic factors, which can influence utilization or care decisions
- Provider cost shifting from reduced payment by Medicare and Medicaid
- Erosion effect of fixed deductibles and copayments[1]



[1] This is a driver of net paid claim cost trends, not gross per capita claims cost increases.

Pricing Methodology Overview

1

Historical Claims and Enrollment

Medical, pharmacy and dental claims + shared savings fees + capitation fees, less pharmacy rebates

2

Project to Experience Period

Pricing trend assumptions, plan design changes, demographic and seasonality adjustments

3

Administrative Fees

Medical, pharmacy, dental ASO fees and other applicable fees or credits

4

Rates & Contributions

Develop budget rates by coverage tier as the basis for setting employee and retiree contributions

Pricing Methodology and Assumptions

1 | Historical Claims and Enrollment[1]

- Historical claims and enrollment from October 2020 through September 2022 were used as the basis of the projection. Data was provided by the NV PEBP vendors: HealthScope, UMR, ESI and LifeWorks.

2 | Project to Experience Period

- Claims costs are projected on an incurred basis with 70% weighting to the most recent 12-month experience period
- Trend assumptions
  - Assumptions are based on a combination of factors: actual PEPM NV PEBP cost changes, Segal's Book of Business trend norms and expected unit cost changes in the Nevada marketplace
  - Annual claims trend assumption rates are market expectations for per capita increases assuming no plan changes and do not necessarily equal net NV PEBP trend rates
  - These are trend rates prior to any actions employed to mitigate trend, such as plan migration, plan design changes and mix of services

Medical	**4%**
Rx	**8%**
Dental	**1%**

- Costs/savings projections for the following programs were included in the projection:
  - Real Appeal
  - Hinge Health
  - Abortion Travel Benefit
  - Medical Travel/COE Benefit
  - Oncology Program
  - Second Level Claims Review
- Pharmacy rebates are modeled based on the minimum guarantees for PY2024 in the current ESI contract.

[1] In conducting our analysis, we have relied on data provided by NV PEBP's vendors. We have accepted the data without audit and relied upon the sources for the accuracy of the data.

Pricing Methodology and Assumptions

3 Administrative Fees

- Administrative Fees
  - Medical ASO
  - Rx ASO
  - Dental ASO
  - General Administration fees
  - Life/LTD premiums
- Fully Insured HMO premiums for PY2024, which included a 9% increase over current rates, were provided by UHC
  - Renewal is at the maximum 9% cap allowed in the contract

4 Rates & Contributions

- AEGIS and REGI amounts set forth in the Governor's Budget, January 2023

Thank You

11.

11. Discussion and possible action to include approving Plan Year 24 (July 1, 2023 – June 30, 2024) rates for State and Non-State employees, retirees and their dependents for the Consumer Driven Health Plan (CDHP), Low Deductible (LD) Plan, Exclusive Provider Organization (EPO) Plan, and Health Maintenance Organization (HMO) Plan (Laura Rich, Executive Officer) (**For Possible Action**)

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AGENDA ITEM

[X] Action Item
[ ] Information Only

Date: March 23, 2023

Item Number: XI

Title: Plan Year 2024 (PY24) Proposed Rates

SUMMARY

This report provides the PEBP Board and members of the public with information on PY24 proposed rates.

BACKGROUND

Rate Development

Step 1: Underwriting

PEBP Board policy requires its actuary, Segal, to set rates/trend aggressively – a 50% chance rates will be sufficient to cover expected claims costs and a 50% chance they will be short.

1. Segal gathers claims data (medical/Rx/dental) for the previous 12-24 months.
2. Claims are completed based on prior seasonality and claims lag and trended forward to PY24.
3. Plan design changes, changes to contracts, PBM market checks and any other projected savings are applied.
4. Enrollment expectations by tier and plan are applied along with utilization assumptions and actuarial values.
5. Base Rates Per Participant Per Month (PPPM) are then established for the three plan offerings (CDHP, LD, and EPO) separated by Medical, Pharmacy, and Dental expected Claims. EPO and HMO rates are blended.

Step 2: Enrollment weighting

Assumptions such as overall growth or decline, plan enrollment, assumed workforce changes or retirement influxes.

Step 3: Admin loads applied

Administrative loads such as administrative fees, HSA/HRA funding for the CHDP, and PEBP operating costs are applied appropriately.

Step 4: Tiering

The base rate is weighted by projected enrollment by tier. Per PEBP Board policy the following tiering methodology is then applied:

Participant = X
Participant + Spouse = 2X
Participant + children = X+Y
Participant + family = 2X + Y

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

Step 5: Addition of Life Insurance

PPPM Life insurance costs are then added to each tier of the three plans to arrive at final overall rates. Life insurance costs differ for actives and retirees and life insurance costs for those on the Exchange is absorbed entirely by members on self-funded plans.

REPORT

Fortunately, PEBP has had favorable claims experience overall and the addition of several programs with projected savings will also have a positive impact on rates. Although the EPO/HMO have experienced a high loss ratio, the CDHP and LD have more than offset the deficiencies through lower than projected cost and utilization. Additionally, the PBM market check, along with new programs such as Hinge Health, Cancer Concierge and Medical Travel are expected to reduce future costs to the plan.

Flat Rates and Planned Surplus

The application of the standard rate development methodology would have resulted in a slight reduction of rates for all plans; however, staff is proposing the retention of flat rates to mitigate potential increases to premiums during the legislative "off-year" (PY25).

The Governor's Recommended Budget includes a trend of 3.91% for medical, 3.67% for pharmacy, and 2% for dental; however, Segal has provided different trend projections of 4%, 8%, 1%, respectively. The projected pharmacy trend is higher than that used for budgeting purposes,

but that may be partially offset by enhanced rebates. Dental trend is projected to continue to be lower than used for budgeting. PEBP must consider the possibility that the higher trends will materialize and the shortfall will have to be funded entirely through employee premiums since there is no mechanism to adjust subsidy levels outside of legislative session.

The proposed flat premiums for all plans are expected to create a planned excess of $2.4M, which can be considered a "safety net" for PY25. The planned excess can be used to mitigate rate increases in PY25 (should budgeted trend be lower than actual trend) or in a best-case scenario, rates do not increase, and the planned excess can instead be redistributed to members in the form of HSA/HRA funding in PY25.

Attachment A – rate tables

RECOMMENDATION:
Staff recommends the Board approve Plan Year 24 rates as proposed with the ability to make technical adjustments if necessary.

Plan Year 2024 State Rates - Active Employees

State Active Employees	Statewide CDHP				Copay PPO				EPO/HMO			
	Rate	Base Subsidy	Adjustments	Participant Premium	Rate	Base Subsidy	Adjustments	Participant Premium	Rate	Base Subsidy	Adjustments	Participant Premium
Employee Only	652.46	620.09	(14.59)	46.96	685.44	620.09	(2.79)	68.14	790.68	620.09	9.59	161.00
Employee + Spouse	1,295.56	1,069.66	(25.10)	251.00	1,361.48	1,069.66	(1.54)	293.36	1,571.98	1,069.66	23.22	479.10
Employee + Child(ren)	893.62	788.68	(18.52)	123.46	938.94	788.68	(2.34)	152.60	1,083.66	788.68	14.68	280.30
Employee + Family	1,536.72	1,238.24	(29.04)	327.52	1,615.00	1,238.24	(1.06)	377.82	1,864.96	1,238.24	28.32	598.40

Plan Year 2024 State Rates - Retirees

State Retirees Non-Medicare	Statewide CDHP				Copay PPO				EPO/HMO			
	Rate	Base Subsidy	Adjustments	Participant Premium	Rate	Base Subsidy	Adjustments	Participant Premium	Rate	Base Subsidy	Adjustments	Participant Premium
Retiree only	648.62	419.50	(12.14)	241.26	681.60	419.50	(0.34)	262.44	786.84	419.50	12.04	355.30
Retiree + Spouse	1,291.72	723.64	(20.88)	588.96	1,357.64	723.64	2.66	631.34	1,568.14	723.64	27.44	817.06
Retiree + Child(ren)	889.78	533.55	(15.41)	371.64	935.10	533.55	0.77	400.78	1,079.82	533.55	17.79	528.48
Retiree + Family	1,532.88	837.69	(24.17)	719.36	1,611.16	837.69	3.81	769.66	1,861.12	837.69	33.19	990.24
Surviving/Unsubsidized Dependent	648.62	-	-	648.62	681.60	-		681.60	786.84	-		786.84
Surviving/Unsubsidized Spouse + Child(ren)	889.78	-	-	889.78	935.10	-		935.10	1,079.82	-		1,079.82

Plan Year 2024 Non-State Rates - Active Employees

Non-State Active Employees	Statewide CDHP			Copay PPO			EPO/HMO		
	Rate	Base Subsidy	Participant Premium	Rate	Base Subsidy	Participant Premium	Rate	Base Subsidy	Participant Premium
Employee Only	914.11	-	914.11	973.25	-	973.25	971.19	-	971.19
Employee + Spouse/DP	1,818.84	-	1,818.84	1,937.12	-	1,937.12	1,933.01	-	1,933.01
Employee + Child(ren)	1,253.38	-	1,253.38	1,334.70	-	1,334.70	1,331.88	-	1,331.88
Employee + Family	2,158.11	-	2,158.11	2,298.57	-	2,298.57	2,293.69	-	2,293.69

Plan Year 2024 Non-State Rates - Retirees

Non-State Retirees Non-Medicare	Statewide CDHP				Copay PPO				EPO/HMO			
	Rate	Base Subsidy	Adjustments	Participant Premium	Rate	Base Subsidy	Adjustments	Participant Premium	Rate	Base Subsidy	Adjustments	Participant Premium
Retiree only	910.28	688.61	(19.59)	241.26	969.42	729.92	(22.94)	262.44	967.36	622.70	(10.64)	355.30
Retiree + Spouse/DP	1,815.00	1,259.92	(33.89)	588.97	1,933.28	1,342.52	(40.58)	631.34	1,929.18	1,128.09	(15.97)	817.06
Retiree + Child(ren)	1,249.54	902.87	(24.97)	371.64	1,330.86	959.64	(29.56)	400.78	1,328.04	812.19	(12.63)	528.48
Retiree + Family	2,154.28	1,474.16	(39.24)	719.36	2,294.74	1,572.29	(47.21)	769.66	2,289.86	1,317.59	(17.97)	990.24
Surviving/Unsubsidized	910.28	-	-	910.28	969.42	-	-	969.42	967.36	-	-	967.36
Surviving/Unsubsidized	1,249.54	-	-	1,249.54	1,330.86	-	-	1,330.86	1,328.04	-	-	1,328.04

12.

12. Information and discussion regarding the Office of Project Management statewide ERP implementation and the integration of PEBP's enrollment and eligibility functionality. (Laura Rich, Executive Officer)
(Information/Discussion)

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AGENDA ITEM

☐ Action Item
☒ Information Only

Date: March 23, 2023

Item Number: XII

Title: Integration of Enrollment and Eligibility Functionality to Office of Project Management/Statewide ERP Implementation

SUMMARY

This report provides the PEBP Board and members of the public with information regarding PEBP's enrollment and eligibility (E&E) system and the partnership with the Office of Project Management.

BACKGROUND

On March 24, 2022, the PEBP Board approved the recommendation to terminate PEBP's contract with LSI as a result of an unsuccessful implementation and "go-live." PEBP contracted with its previous enrollment and eligibility vendor (Lifeworks). The Board approved staff move forward with a Request for Proposal (RFP) for an eligibility and enrollment system, with a proposed go-live date of January 2025.

In 2019, LSI was also chosen as the contracted vendor to integrate the Silver State Modernization Approach for Resources and Technology in the 21st Century (Smart 21). The objective of the Smart 21 project was to overhaul the state's antiquated financial and human resource systems. Shortly after PEBP approved LSI's early contract termination, the State issued its own termination to LSI for its role in the Smart 21 project.

PEBP, with the assistance of Segal IT consultants, has since developed a comprehensive requirements document to begin work on the E&E RFP. The Office of Project Management (OPM) has also been working towards contracting with a new integrator for the project previously known as Smart 21. OPM is currently engaged in the decision-making process with executive state leaders to determine an appropriate vendor to continue the integration and implementation of the financial and HR systems. A path forward has been identified, and work continues with vendor selection and contract finalization. Communications on those decisions will be forthcoming in the immediate future.

Although PEBP and Smart 21 experienced significant setbacks throughout respective implementations, one of the lessons that came from that experience is PEBP's significant overlap of HR and payroll processes. State employees are PEBP's largest group; therefore, it is imperative that PEBP's enrollment and eligibility system functionality be aligned with statewide financial and HR systems.

REPORT

PEBP began working with OPM and their partner SAP Software Solutions to capture the specific requirements necessary to include in the PEBP E&E RFP. As a result of these discussions, as well as our experiences with the prior attempt to integrate and implement technology solutions, it became clear that it would be in PEBP's and the State's best interest to work collaboratively on our respective projects to ensure the chosen vendors would be able to integrate the functionality within the respective systems. Performing separate implementations would risk a potential repeat of the previous implementation because although it was the same contracted integrator, both systems were not set up to coordinate and work with each other from the start. Collaborative, joint implementations are in the best interest of employees and PEBP members due to connectivity of the respective systems.

OPM currently has a service agreement (99SWC-NV23-13299:1) authorized by the Board of Examiners under a statewide contract for cloud solutions with Carahsoft (99SWC-NV23-13299) awarded via a NASPO ValuePoint national cooperative contract led by the State of Utah. The contract is for assessment of the project; however, OPM will likely be executing a new service agreement under the same statewide contract for a system integrator and full implementation of the project.

The same procurement process and contract vehicle is available to PEBP under NRS 333.475. PEBP would not join the OPM contract but would create its own statewide contract through a similar mechanism. PEBP would leverage the state's current contract through OPM (rather than go out to RFP) and negotiate its own contract through the existing vendor relationships. A very similar process would be used through this mechanism as through the RFP process; the potential vendors would be carefully vetted by PEBP and its IT consultants to ensure any selected partner is able to satisfy the necessary requirements at a competitive price.

Advantages:

- This process allows PEBP, with the assistance of Segal IT consultants, to assess possible solutions in a more comprehensive manner. PEBP would work with OPM's chosen integrator to vet industry solutions through various vendors using a process similar to that used during an RFP but with more flexibility.
- This path also grants an additional year of runway that can be used for a longer implementation to increase the probability of a successful "go-live."

- The Smart 21 project will be exploring opportunities to improve and enhance the current HR and financial systems. PEBP's participation will likely help break down the existing inefficient and siloed processes that are currently in place, which will ultimately help PEBP's E&E functionality.

The Governor's Office has directed PEBP to work together with OPM and their contracted vendor using NRS 333.475. Once a contract has been developed, it will be brought to the PEBP Board for discussion and approval prior to getting final approval through the Board of Examiners.

13.

13. 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**)

    13.1 Contract Overview

    13.2 New Contracts

    13.3 Contract Amendments

        13.3.1 Segal

    13.4 Contract Solicitations

    13.5 Status of Current Solicitations

        13.5.1 Enrollment and Eligibility System RFP

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AGENDA ITEM

[X] Action Item
[ ] Information Only

Date: March 23, 2023

Item Number: XIII

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

13.1 Contracts Overview

Below is a listing of the active PEBP contracts as of February 28, 2023.

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	$ 101,420.00	$ 111,065.00
Health Plan of Nevada Inc	Southern Nevada HMO	23802	7/1/2021	6/30/2025	$ 192,093,848.00	$ 68,192,391.59	$ 123,901,456.41
Diversified Dental Services Inc.	Dental PPO	23810	7/1/2021	6/30/2026	$ 1,601,613.00	$ 510,152.32	$ 1,091,460.68
Lifeworks	Benefits Management System	25935	5/10/2022	12/31/2026	$ 6,145,600.00	$ 1,651,214.90	$ 4,494,385.10
Express Scripts, Inc.	Pharmacy Benefit Manager	25582	5/10/2022	6/30/2026	$ 332,109,496.00	$ 47,342,207.78	$ 284,767,288.22
United Healtcare Insurance	Group Basic Life Insurance	25607	7/1/2022	6/30/2026	$ 12,824,248.00	$ 2,038,472.48	$ 10,785,775.52
Brown & Brown of Massachusetts	Health Plan Auditor	24030	4/13/2021	6/30/2027	$ 1,581,662.00	$ 260,760.00	$ 1,320,902.00
Segal Company, Inc.	Consulting Services	25557	7/1/2022	6/30/2027	$ 3,990,000.00	$ 486,865.00	$ 3,503,135.00
HAT LTD, DBA Manpower	Temporary Employment	23928	1/1/2023	12/31/2023	$ 67,600.00	$ 13,065.00	$ 54,535.00
Capitol Reporters	Court Reporting	27029	2/1/2023	6/30/2025	$ 31,932.00	$ 844.00	$ 31,088.00
UMR, Inc.	TPA and Other Services	25155	7/1/2022	6/30/2028	$ 65,413,106.00	$ 6,392,126.49	$ 59,020,979.51

Recommendation

No action necessary

13.2 New Contracts

PEBP does not currently have any new contracts for ratification.

13.3 Contract Amendment Ratifications

13.3.1 SEGAL

PEBP contracted with Segal for actuarial consulting services which became effective April 12, 2022 and has a termination date of June 30, 2027. PEBP has utilized Segal for several unplanned projects this year, including an in-depth biennial compliance review, MPD review and assistance with multiple requests for proposals. This amendment is necessary to increase the contract authority maximum throughout the duration of the contract from $3,990,000 to $4,285,410. This contract amendment will be brought to the April 11, 2023 Board of Examiners meeting for approval.

Recommendation

PEBP recommends the Board authorize staff to amend the contract between PEBP and Segal for actuarial consulting services to increase the maximum contract authority.

13.4 Contract Solicitation Ratifications

13.4.1 ELIGIBILITY AND ENROLLMENT

The PEBP Board ratified the release of a Request for Proposal (RFP) for a new Enrollment and Eligibility System vendor March 24, 2022 in response to the early termination of the LSI contract. Staff, with the assistance of IT consultants, have created a comprehensive requirements document and will now use this to collaborate with the State Office of Project Management to identify a vendor for the PEBP Eligibility and Enrollment solution and the State's ERP (formerly known as Smart 21) project. Due to this new path, an RFP is no longer necessary.

Recommendation

PEBP recommends the Board cancel the solicitation ratification for an Eligibility and Enrollment RFP that was approved on March 24, 2022.

13.5 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 & Enrollment System	Requested Cancellation			
Cancer Concierge	TBD			
Medical Management	TBD			

14.

14. Public Comment

15.

15. Adjournment