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LAURA RICH
Executive Officer

AGENDA ITEM

☐ Action Item

☒ Information Only

Date: July 23, 2020

Item Number: VI

Title: Executive Officer Report

SUMMARY

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

REPORT

PLAN YEAR 21 ENROLLMENT

Every year after Open Enrollment PEBP examines the new enrollment for the upcoming plan year in order to identify any shifts and trends in member plan selections. Historically, there has been a small, but steady migration away from the HMO and EPO plans toward the CDHP but in general, the migration has remained minimal over the last several years. This year is no different. Enrollment selections among primary members saw no significant shifts, despite the increases in premiums – especially among the HMO and EPO plans.

PEBP Primary Member Enrollment Report

Plan	PY2020 Enrollment	PY2021 Enrollment
HMO	3917	3924
CDHP	23371	23318
EPO	4689	4731
Declined	1926	1951

COVID-19 UPDATE

PEBP continues to encourage those staff who can work from home, to continue doing so. PEBP was able to purchase several more laptops and request VPN's, which provided more staff the ability to telecommute. Unfortunately, there are some duties (such as mass mailings) that can only be performed in the office and require staff to be present. We also have call center staff who are unable to perform their job duties from home so we continue to rotate those staff in order to reduce the amount of employees that are present in the office on any given day.

Since the plan is paying all COVID-19 claims at 100%, PEBP has been keeping a close eye on claims costs. Additionally, these figures, along with all other COVID-19 related expenses are being reported to the Governor's Finance Office (GFO) to ensure the program is able to receive reimbursement should there be any applicable federal dollars available.

As of July 13, 2020, the plan has paid approximately $550,000 in COVID-19 claims. Although that number *seems* low, it is important to recognize that these claims occurred during months where Nevada (and many other states) had imposed business closures and encouraged stay-at-home guidelines. Recalling Aon's COVID-19 modeling presented to the Board in May (see below), the scenario highlighting a reopening on July 1, followed by a resurgence and a stay-at-home order on August 1, shows a much more significant impact of COVID-19 claims costs on the program.

Illustrative COVID-19: Self-Funded Medical Impact Scenario w/ Re-Opening

Net impact of COVID-19 could be a cost or a savings, depending on the level of COVID-19 claims and the level of claims suppression

Illustrative – to aid in discussion

Claims Suppression	COVID-19 Claim Costs (in Millions)		
	Low	Medium	High
Low	$8.1 ($4.7) $3.4	$16.3 ($4.7) $11.6	$24.4 ($4.7) $19.7
Medium	$8.1 ($7.7) $0.4	$16.3 ($7.7) $8.6	$24.4 ($7.7) $16.7
High	$8.1 ($10.8) ($2.7)	$16.3 ($10.8) $5.5	$24.4 ($10.8) $13.6

- **Assumes PEBP/State of Nevada moves to Phase 2 on June 1st, nearly a full open on July 1, and then back into Stay-at-home on August 1st**
- Estimates of COVID-19 claims and claims suppression are associated with large uncertainty
- Low scenario assumes costs are 50% of medium, high scenario assumes 150% of medium
- Claims suppression assumes 15%, 25% and 35% of medical claims will be suppressed during a 3-month lockdown, only 50% of which will return in the next 6 months
- Costs based on March 31, 2020 reprojections
- COVID-19 medium scenario reflects cost estimates from Aon's COVID-19 Employee Impact Model

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AON Empower Results®

COVID-19 Coverage

On March 31, 2020 the PEBP Board elected to align with the Governor's emergency regulation by covering all testing, office visits and treatment for COVID-19 at 100% of the plan's maximum allowable charge regardless of network participation with no cost sharing to the member. The emergency regulation was effective through July 3rd, however staff was provided the authority to extend COVID-19 coverage should the regulation be extended or reissued. Regulation R054-20 (Attachment A) was filed on July 2, 2020 intended to replace the March 5 emergency regulation and thereby eliminating the need for the PEBP Board to take any further action. PEBP will continue to provide COVID-19 coverage as previously approved.

SOLICITATIONS UPDATE

PEBP staff, with the assistance of several Board members, have been steadily working on 4 of the 5 Requests for Proposals (RFP) that were approved by the Board in May. Since many of these contracts will need to be fully implemented by the start of the next plan year, PEBP is under pressure to ensure all of the RFP's are developed and posted quickly so that evaluations and negotiations can occur before the November Board meeting and in time for Board of Examiners (BOE) approval in January/February.

Due to an expected one-year implementation period requirement, the Benefits Management System RFP had the tightest timeline. This RFP has been finalized and was posted by the Purchasing Division on June 30, 2020. The medical network, dental network and HMO RFP's are in the process of being finalized and are expected to be posted in the next several weeks. Fortunately, the financial auditor RFP will not need to be completed until early in 2021 since the current contract does not expire until 12/31/2021.

CONCLUSION

With so many major solicitations running concurrently, budget building, and the consistent challenges in the face of the COVID-19 pandemic, PEBP staff will be extremely busy for the remainder of the year.

APPROVED REGULATION OF THE

COMMISSIONER OF INSURANCE

LCB File No. R054-20

Filed July 2, 2020

EXPLANATION – Matter in ***italics*** is new; matter in brackets **[~~omitted material~~]** is material to be omitted.

AUTHORITY: §§1-8, NRS 414.070, 679B.120 and 679B.130.

A REGULATION relating to health insurance; requiring a health insurer to provide certain coverage and information relating to COVID-19; and providing other matters properly relating thereto.

Legislative Counsel's Digest:

Existing law allows an agency to adopt an emergency regulation without following the process for adopting a permanent regulation by submitting a statement of the emergency to the Governor. (NRS 233B.0613) If the Governor endorses the statement of emergency, the regulation becomes effective immediately upon filing the regulation with the Office of the Secretary of State. (NRS 233B.070) An emergency regulation is effective for not more than 120 days and may only be submitted through the process for an emergency regulation one time. For the regulation to continue, the agency must adopt a permanent regulation which is substantially similar to the emergency regulation in accordance with the procedures set forth in the Administrative Procedures Act within 120 days, after which the emergency regulation automatically expires. (NRS 233B.0613) On March 5, 2020, the Commissioner of Insurance submitted an emergency regulation along with a statement of emergency for the adoption of a regulation which was endorsed by the Governor. This regulation is submitted to replace that emergency regulation.

On March 12, 2020, the Governor declared a state of emergency due to the COVID-19 pandemic. (Declaration of Emergency for COVID-19, issued on March 12, 2020) Existing law authorizes the Governor to perform and exercise such functions, powers and duties as are necessary to promote and secure the safety and protection of the civilian population during a state of emergency or declaration of disaster. (NRS 414.070) The Nevada Insurance Code: (1) provides that the Commissioner of Insurance has such powers and duties as may be provided by the laws of this State; and (2) authorizes the Commissioner to adopt regulations as necessary to administer the Code. (NRS 679B.120, 679B.130) The Code prescribes separate requirements for: (1) individual health insurance; (2) group health insurance; (3) health insurance for small employers; (4) fraternal benefit societies; (5) nonprofit corporations for hospital or medical services; (6) health maintenance organizations; and (7) managed care organizations. (Chapters 689A, 689B, 689C, 695A, 695B, 695C and 695G of NRS) **Sections 1-7** of this regulation

prohibit each of those types of health insurer from imposing cost sharing or medical management techniques to restrict access by an insured to screening, testing or a vaccine for COVID-19. **Sections 1-7** also require such a health insurer to provide to each insured and provider of health care that participates in the network plan of the insurer with information concerning certain benefits and services related to COVID-19. Finally, **sections 1-7** require such an insurer to cover a prescription drug that is not included in the formulary of the insurer if: (1) no drug included in the formulary is available that would be effective to treat the condition; and (2) the unavailability of such drugs is due to a disruption in the supply of the drugs. **Section 8** of this regulation: (1) declares the purpose of this regulation; and (2) provides that this regulation expires on the same date as the state of emergency.

Section 1. Chapter 689A of NAC is hereby amended by adding thereto a new section to read as follows:

1. An insurer that issues a policy of health insurance shall not require an insured to pay a higher deductible or any copayment, coinsurance or other form of cost-sharing for or use any medical management technique to restrict access by an insured to:

(a) A visit to the office of a provider of health care, an urgent care center, an independent center for emergency medical care, the emergency room of a hospital or a COVID-19 screening or testing site, if the purpose of the visit is to determine whether the insured has COVID-19;

(b) A test to determine whether the insured has COVID-19 if the attending provider of health care determines, in accordance with generally accepted medical standards, that the test is appropriate; or

(c) A vaccine to prevent the insured from contracting COVID-19.

2. An insurer that issues a policy of health insurance shall provide information concerning available benefits, options for medical advice and treatment through telehealth and preventative measures related to COVID-19 to each insured and provider of health care that participates in the network plan of the insurer.

3. An insurer that issues a policy of health insurance that provides coverage for prescription drugs and uses a formulary shall cover a prescription drug that is not included in the formulary at no additional cost to the insured if:

(a) No prescription drug that is effective in treating the insured and included in the formulary is available; and

(b) The prescription drug is not available because of a disruption in the supply of those drugs.

4. As used in this section:

(a) "Hospital" has the meaning ascribed to it in NRS 449.012.

(b) "Independent center for emergency medical care" has the meaning ascribed to it in NRS 449.013.

(c) "Medical management technique" means a practice which is used to control the cost or utilization of health care services. The term includes, without limitation, the use of step therapy, prior authorization or categorizing drugs and devices based on cost, type or method of administration.

(d) "Network plan" means a policy of health insurance offered by an insurer under which the financing and delivery of medical care, including items and services paid for as medical care, are provided, in whole or in part, through a defined set of providers under contract with the insurer. The term does not include an arrangement for the financing of premiums.

(e) "Provider of health care" has the meaning ascribed to it in NRS 629.031.

(f) "Telehealth" has the meaning ascribed to it in NRS 629.515.

Sec. 2. Chapter 689B of NAC is hereby amended by adding thereto a new section to read as follows:

1. An insurer that issues a policy of group health insurance shall not require an insured to pay a higher deductible or any copayment, coinsurance or other form of cost-sharing for or use any medical management technique to restrict access by an insured to:

(a) A visit to the office of a provider of health care, an urgent care center, an independent center for emergency medical care, the emergency room of a hospital or a COVID-19 screening or testing site, if the purpose of the visit is to determine whether the insured has COVID-19;

(b) A test to determine whether the insured has COVID-19 if the attending provider of health care determines, in accordance with generally accepted medical standards, that the test is appropriate; or

(c) A vaccine to prevent the insured from contracting COVID-19.

2. An insurer that issues a policy of group health insurance shall provide information concerning available benefits, options for medical advice and treatment through telehealth and preventative measures related to COVID-19 to each insured and provider of health care that participates in the network plan of the insurer.

3. An insurer that issues a policy of group health insurance that provides coverage for prescription drugs and uses a formulary shall cover a prescription drug that is not included in the formulary at no additional cost to the insured if:

(a) No prescription drug that is effective in treating the insured and included in the formulary is available; and

(b) The prescription drug is not available because of a disruption in the supply of those drugs.

4. As used in this section:

(a) "Hospital" has the meaning ascribed to it in NRS 449.012.

(b) "Independent center for emergency medical care" has the meaning ascribed to it in NRS 449.013.

(c) "Medical management technique" means a practice which is used to control the cost or utilization of health care services. The term includes, without limitation, the use of step therapy, prior authorization or categorizing drugs and devices based on cost, type or method of administration.

(d) "Network plan" means a policy of group health insurance offered by an insurer under which the financing and delivery of medical care, including items and services paid for as medical care, are provided, in whole or in part, through a defined set of providers under contract with the insurer. The term does not include an arrangement for the financing of premiums.

(e) "Provider of health care" has the meaning ascribed to it in NRS 629.031.

(f) "Telehealth" has the meaning ascribed to it in NRS 629.515.

Sec. 3. Chapter 689C of NAC is hereby amended by adding thereto a new section to read as follows:

1. A carrier that issues a health benefit plan shall not require an insured to pay a higher deductible or any copayment, coinsurance or other form of cost-sharing for or use any medical management technique to restrict access by an insured to:

(a) A visit to the office of a provider of health care, an urgent care center, an independent center for emergency medical care, the emergency room of a hospital or a COVID-19 screening or testing site, if the purpose of the visit is to determine whether the insured has COVID-19;

(b) A test to determine whether the insured has COVID-19 if the attending provider of health care determines, in accordance with generally accepted medical standards, that the test is appropriate; or

(c) A vaccine to prevent the insured from contracting COVID-19.

2. A carrier that issues a health benefit plan shall provide information concerning available benefits, options for medical advice and treatment through telehealth and preventative measures related to COVID-19 to each insured and provider of health care that participates in the network plan of the carrier.

3. A carrier that issues a health benefit plan that provides coverage for prescription drugs and uses a formulary shall cover a prescription drug that is not included in the formulary at no additional cost to the insured if:

(a) No prescription drug that is effective in treating the insured and included in the formulary is available; and

(b) The prescription drug is not available because of a disruption in the supply of those drugs.

4. As used in this section:

(a) "Hospital" has the meaning ascribed to it in NRS 449.012.

(b) "Independent center for emergency medical care" has the meaning ascribed to it in NRS 449.013.

(c) "Medical management technique" means a practice which is used to control the cost or utilization of health care services. The term includes, without limitation, the use of step therapy, prior authorization or categorizing drugs and devices based on cost, type or method of administration.

(d) "Network plan" means a health benefit plan offered by a carrier under which the financing and delivery of medical care, including items and services paid for as medical care, are provided, in whole or in part, through a defined set of providers under contract with the carrier. The term does not include an arrangement for the financing of premiums.

(e) "Provider of health care" has the meaning ascribed to it in NRS 629.031.

(f) "Telehealth" has the meaning ascribed to it in NRS 629.515.

Sec. 4. Chapter 695A of NAC is hereby amended by adding thereto a new section to read as follows:

1. A society that issues a benefit contract shall not require an insured to pay a higher deductible or any copayment, coinsurance or other form of cost-sharing for or use any medical management technique to restrict access by an insured to:

(a) A visit to the office of a provider of health care, an urgent care center, an independent center for emergency medical care, the emergency room of a hospital or a COVID-19 screening or testing site, if the purpose of the visit is to determine whether the insured has COVID-19;

(b) A test to determine whether the insured has COVID-19 if the attending provider of health care determines, in accordance with generally accepted medical standards, that the test is appropriate; or

(c) A vaccine to prevent the insured from contracting COVID-19.

2. A society that issues a benefit contract shall provide information concerning available benefits, options for medical advice and treatment through telehealth and preventative measures related to COVID-19 to each insured and provider of health care that participates in the network plan of the society.

3. A society that issues a benefit contract that provides coverage for prescription drugs and uses a formulary shall cover a prescription drug that is not included in the formulary at no additional cost to the insured if:

(a) No prescription drug that is effective in treating the insured and included in the formulary is available; and

(b) The prescription drug is not available because of a disruption in the supply of those drugs.

4. As used in this section:

(a) "Hospital" has the meaning ascribed to it in NRS 449.012.

(b) "Independent center for emergency medical care" has the meaning ascribed to it in NRS 449.013.

(c) "Medical management technique" means a practice which is used to control the cost or utilization of health care services. The term includes, without limitation, the use of step therapy, prior authorization or categorizing drugs and devices based on cost, type or method of administration.

(d) "Network plan" means a benefit contract offered by a society under which the financing and delivery of medical care, including items and services paid for as medical care, are provided, in whole or in part, through a defined set of providers under contract with the society. The term does not include an arrangement for the financing of premiums.

(e) "Provider of health care" has the meaning ascribed to it in NRS 629.031.

(f) "Telehealth" has the meaning ascribed to it in NRS 629.515.

Sec. 5. Chapter 695B of NAC is hereby amended by adding thereto a new section to read as follows:

1. An insurer that issues a contract for hospital or medical services shall not require an insured to pay a higher deductible or any copayment, coinsurance or other form of cost-sharing for or use any medical management technique to restrict access by an insured to:

(a) A visit to the office of a provider of health care, an urgent care center, an independent center for emergency medical care, the emergency room of a hospital or a COVID-19 screening or testing site, if the purpose of the visit is to determine whether the insured has COVID-19;

(b) A test to determine whether the insured has COVID-19 if the attending provider of health care determines, in accordance with generally accepted medical standards, that the test is appropriate; or

(c) A vaccine to prevent the insured from contracting COVID-19.

2. An insurer that issues a contract for hospital or medical services shall provide information concerning available benefits, options for medical advice and treatment through telehealth and preventative measures related to COVID-19 to each insured and provider of health care that participates in the network plan of the insurer.

3. An insurer that issues a contract for hospital or medical services that provides coverage for prescription drugs and uses a formulary shall cover a prescription drug that is not included in the formulary at no additional cost to the insured if:

(a) No prescription drug that is effective in treating the insured and included in the formulary is available; and

(b) The prescription drug is not available because of a disruption in the supply of those drugs.

4. As used in this section:

(a) "Hospital" has the meaning ascribed to it in NRS 449.012.

(b) "Independent center for emergency medical care" has the meaning ascribed to it in NRS 449.013.

(c) "Medical management technique" means a practice which is used to control the cost or utilization of health care services. The term includes, without limitation, the use of step therapy, prior authorization or categorizing drugs and devices based on cost, type or method of administration.

(d) "Network plan" means a contract for hospital or medical services offered by an insurer under which the financing and delivery of medical care, including items and services paid for as medical care, are provided, in whole or in part, through a defined set of providers under contract with the insurer. The term does not include an arrangement for the financing of premiums.

(e) "Provider of health care" has the meaning ascribed to it in NRS 629.031.

(f) "Telehealth" has the meaning ascribed to it in NRS 629.515.

Sec. 6. Chapter 695C of NAC is hereby amended by adding thereto a new section to read as follows:

1. A health maintenance organization that issues a health care plan shall not require an enrollee to pay a higher deductible or any copayment, coinsurance or other form of cost-sharing for or use any medical management technique to restrict access by an enrollee to:

(a) A visit to the office of a provider of health care, an urgent care center, an independent center for emergency medical care, the emergency room of a hospital or a COVID-19 screening or testing site, if the purpose of the visit is to determine whether the enrollee has COVID-19;

(b) A test to determine whether the enrollee has COVID-19 if the attending provider of health care determines, in accordance with generally accepted medical standards, that the test is appropriate; or

(c) A vaccine to prevent the enrollee from contracting COVID-19.

2. A health maintenance organization that issues a health care plan shall provide information concerning available benefits, options for medical advice and treatment through telehealth and preventative measures related to COVID-19 to each enrollee and provider of health care that participates in the network plan of the health maintenance organization.

3. A health maintenance organization that issues a health care plan that provides coverage for prescription drugs and uses a formulary shall cover a prescription drug that is not included in the formulary at no additional cost to the enrollee if:

(a) No prescription drug that is effective in treating the enrollee and included in the formulary is available; and

(b) The prescription drug is not available because of a disruption in the supply of those drugs.

4. As used in this section:

(a) "Hospital" has the meaning ascribed to it in NRS 449.012.

(b) "Independent center for emergency medical care" has the meaning ascribed to it in NRS 449.013.

(c) "Medical management technique" means a practice which is used to control the cost or utilization of health care services. The term includes, without limitation, the use of step therapy, prior authorization or categorizing drugs and devices based on cost, type or method of administration.

(d) "Network plan" means a health care plan offered by a health maintenance organization under which the financing and delivery of medical care, including items and services paid for as medical care, are provided, in whole or in part, through a defined set of providers under contract with the health maintenance organization. The term does not include an arrangement for the financing of premiums.

(e) "Provider of health care" has the meaning ascribed to it in NRS 629.031.

(f) "Telehealth" has the meaning ascribed to it in NRS 629.515.

Sec. 7. Chapter 695G of NAC is hereby amended by adding thereto a new section to read as follows:

1. A managed care organization that issues a health care plan shall not require an insured to pay a higher deductible or any copayment, coinsurance or other form of cost-sharing for or use any medical management technique to restrict access by an insured to:

(a) A visit to the office of a provider of health care, an urgent care center, an independent center for emergency medical care, the emergency room of a hospital or a COVID-19 screening or testing site, if the purpose of the visit is to determine whether the insured has COVID-19;

(b) A test to determine whether the insured has COVID-19 if the attending provider of health care determines, in accordance with generally accepted medical standards, that the test is appropriate; or

(c) A vaccine to prevent the insured from contracting COVID-19.

2. A managed care organization that issues a health care plan shall provide information concerning available benefits, options for medical advice and treatment through telehealth

and preventative measures related to COVID-19 to each insured and provider of health care that participates in the network plan of the managed care organization.

3. A managed care organization that issues a health care plan that provides coverage for prescription drugs which uses a formulary shall cover a prescription drug that is not included in the formulary at no additional cost to the insured if:

(a) No prescription drug that is effective in treating the insured and included in the formulary is available; and

(b) The prescription drug is not available because of a disruption in the supply of those drugs.

4. As used in this section:

(a) "Hospital" has the meaning ascribed to it in NRS 449.012.

(b) "Independent center for emergency medical care" has the meaning ascribed to it in NRS 449.013.

(c) "Medical management technique" means a practice which is used to control the cost or utilization of health care services. The term includes, without limitation, the use of step therapy, prior authorization or categorizing drugs and devices based on cost, type or method of administration.

(d) "Network plan" means a health care plan offered by a managed care organization under which the financing and delivery of medical care, including items and services paid for as medical care, are provided, in whole or in part, through a defined set of providers under contract with the managed care organization. The term does not include an arrangement for the financing of premiums.

(e) "Provider of health care" has the meaning ascribed to it in NRS 629.031.

(f) "Telehealth" has the meaning ascribed to it in NRS 629.515.

Sec. 8. This regulation:

1. Is adopted for the purpose of collaborating in the worldwide effort to contain COVID-19 and ensuring adequate access to prescription drugs if the COVID-19 pandemic or related events disrupt the supply chain for prescription drugs.

2. Expires by limitation on the date on which the emergency declared in the Declaration of Emergency for COVID-19 issued by Governor Steve Sisolak on March 12, 2020, expires.