STEVE SISOLAK
Governor

LAURA FREED
Board Chair

STATE OF NEVADA
PUBLIC EMPLOYEES' BENEFITS PROGRAM
901 S. Stewart Street, Suite 1001 | Carson City, Nevada 89701
Telephone 775-684-7000 | 1-800-326-5496 | Fax 775-684-7028
www.pebp.state.nv.us

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CORE
Expires 04/01/2021

LAURA RICH
Executive Officer

MEETING NOTICE AND AGENDA

Name of Organization:	Public Employees' Benefits Program Board
Date and Time of Meeting:	March 31, 2020 8:30 a.m.
Toll free Call In:	**1-844-721-7243**
Access Code:	**9989024**

Pursuant to the provisions of Nevada Governor Steve Sisolak's March 12, 2020, Declaration of Emergency, and Directive 006 thereto issued on March 22, 2020, this meeting will be held by teleconference only. Members of the public are invited to participate by using the call-in number provided above. Board members and staff will also be participating in this meeting by telephone only.

Members of the public who wish to make public comment must indicate their desire to do so at the initiation of the call when the operator answers. Any members of the public who prefer to send their public comments in writing, can do so by emailing to wlunz@peb.nv.gov at least two business days prior to the meeting.

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

AGENDA

1. Open Meeting; Roll Call

2. Public Comment

   Public comment will be taken during this agenda item. No action may be taken on any matter raised under this item unless the matter is included on a future agenda as an item on which action may be taken. Public comments to the Board will be taken under advisement but will not be answered during the meeting. Comments may be limited to three minutes per person at the discretion of the chairperson. Additional three minute comment periods may be allowed on individual agenda items at the discretion of the chairperson. These additional comment periods shall be limited to comments relevant to the agenda item under consideration by the

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

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

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

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

4.1 Approval of Action Minutes from the March 3, 2020 PEBP Board Meeting.

4.2 Acceptance of Health Claim Auditors' quarterly audit findings for HealthSCOPE Benefits for the timeframe of October 1, 2019 – December 31, 2019.

4.3 Acceptance of PEBP vendor quarterly reports for the timeframe of October 1, 2019 – December 31, 2019.

4.3.1 Doctor on Demand Engagement report – February 2020

4.3.2 The Standard Insurance – Basic Life and Long-Term Disability Insurance

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

4.3.4 Health Plan of Nevada Performance Standards and Guarantees

4.4 Acceptance of the PEBP Chief Financial Officer quarterly reports for the period ending December 31, 2019.

4.4.1 Budget Report

4.4.2 Utilization Report

4.5 Receipt of the federally mandated Summaries of Benefits and Coverage documents effective July 1, 2020 for individual coverage and family coverage for PEBP's Consumer Driven Health Plan (CDHP) and PEBP's Premier Plan (Exclusive Provider Organization – EPO).

4.5.1 Summary of Benefits and Coverage CDHP – Individual

4.5.2 Summary of Benefits and Coverage CDHP – Family

4.5.3 Summary of Benefits and Coverage EPO – Individual/Family

5. Discussion and possible action of emergency COVID-19 plan benefit design changes and implementation. (Laura Rich, Executive Officer) (**For Possible Action**)
6. Discussion and possible action of the Express Scripts, Inc. Pharmacy Benefits Manager contract amendment to reduce fees and implement greater drug discounts and guaranteed drug rebates. (Laura Rich, Executive Officer) (**For Possible Action**)
7. Discussion and possible action regarding Plan Year 2021 plan and policy changes including:
    - Cancellation of the Chronic Kidney Disease pilot program
    - Deferment of the approved CDHP HSA/HRA enhanced funding
    - Implementation of the SaveOn Copay Assistance Program

    (Laura Rich, Executive Officer) (**For Possible Action**)
8. Discussion and possible action of Bill Draft Request (BDR) to address changes to NRS 287.0475 (Laura Rich, Executive Officer) (**For Possible Action**)
9. Discussion and possible action to include the approval of Plan Year 2021 (July 1, 2020 – June 30, 2021) rates for state and non-state employees, retirees and dependents for the statewide Consumer Driven Health Plan (CDHP), the Southern Nevada Health Maintenance Organization (HMO) plan and the Northern and rural Exclusive Provider Organization (EPO) plan. (Laura Rich, Executive Officer) (**For Possible Action**)
10. Discussion and possible action of Legislative Counsel Bureau audit and corrective action plan. (Laura Rich, Executive Officer) (**For Possible Action**)
11. Executive Officer Report (Laura Rich, Executive Officer) (**For Possible Action**)
12. Public Comment

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

The supporting material to this agenda, also known as the Board Packet, is available, at no charge, on the PEBP website at www.pebp.state.nv.us/meetings-events/board-/meetings (under the Board Meeting date referenced above).
An item raised during a report or public comment may be discussed but may not be deliberated or acted upon unless it is on the agenda as an action item.
All times are approximate. The Board reserves the right to take items in a different order or to combine two or more agenda items for consideration to accomplish business in the most efficient manner. The Board may remove an item from the agenda or delay discussion relating to an item on the agenda at any time.
We are pleased to make reasonable efforts to assist and accommodate persons with physical disabilities who wish to participate in the meeting. If special arrangements for the meeting are necessary, please notify the PEBP in writing, at 901 South Stewart Street, Suite 1001, Carson City, NV 89701, or call Wendi Lunz at (775) 684-7020 or (800) 326-5496, as soon as possible so that reasonable efforts can be made to accommodate the request.

Copies of both the PEBP Meeting Action Minutes and Meeting Transcripts, if such transcripts are prepared, are available for inspection, at no charge, at the PEBP Office, 901 South Stewart Street, Suite 1001, Carson City, Nevada, 89701 or on the PEBP website at www.pebp.state.nv.us. For additional information, contact Wendi Lunz at (775) 684-7020 or (800) 326-5496.
Notice of this meeting was posted on or before 9:00 a.m. on the third working day before the meeting on the PEBP website at www.pebp.state.nv.us, and also posted to the public notice website for meetings at https://notice.nv.gov. In addition, the agenda was mailed to groups and individuals as requested.

1.

1. Open Meeting; Roll Call

2.

2. Public Comment

3.

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

4.

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

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4.5.1 Summary of Benefits and Coverage CDHP – Individual

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4.1

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

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

   4.1 Approval of Action Minutes from the March 3, 2020 PEBP Board Meeting.

STATE OF NEVADA
PUBLIC EMPLOYEES' BENEFITS PROGRAM
BOARD MEETING

The Legislative Building
401 South Carson Street, Room #3138
Carson City, NV 89701

ACTION MINUTES (Subject to Board Approval)
March 3, 2020

MEMBERS PRESENT IN CARSON CITY:	Ms. Laura Freed, Board Chair Ms. Linda Fox, Vice Chair Ms. Jet Mitchell, Member Mr. Don Bailey, Member Mr. Tom Verducci, Member Mr. David Smith, Member Ms. Mandy Hagler, Member
MEMBERS PRESENT IN LAS VEGAS:	Ms. Christine Zack, Member
MEMBERS EXCUSED:	Ms. Leah Lamborn, Member
FOR THE BOARD:	Ms. Brandee Mooneyhan, Deputy Attorney General
FOR STAFF:	Ms. Cari Eaton, Chief Financial Officer Mr. Brett Harvey, Chief Information Officer Ms. Nancy Spinelli, Quality Control Officer Ms. Wendi Lunz, Executive Assistant

1. Open Meeting: Roll Call
   Board Chair Freed opened the meeting at 8:34 a.m.

2. Public Comment
   Public Comment in Carson City:
   - Kent Ervin – Nevada Faculty Alliance
   - Terri Laird – RPEN
   - Priscilla Maloney - AFSCME

   Public Comment in Las Vegas:
   - Doug Unger - Employee Benefits Representative UNLV Faculty Senate

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

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

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

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

BOARD ACTION ON ITEM 4
MOTION: Motion to approve 4.1
BY: Member Don Bailey
SECOND: Member Mandy Hagler
ABSTAIN: Board Chair Laura Freed
VOTE: The motion carried.

5. Discussion regarding the recruitment process for a new permanent Executive Officer of PEBP. **(For Information)**
6. Applicant interviews for position of the Executive Officer of PEBP. **(For Information)**

   6.1. Applicants to be interviewed (approximately one hour per interview):
   - Michael Lynch
   - Robert Nellis/WITHDRAWN
   - Laura Rich

7. Discussion and possible action regarding appointment (from three above named applicants) of the Executive Officer of the Public Employees' Benefits Program, subject to the Governor's approval, per NRS 287.0424(1). **(For Possible Action)**

BOARD ACTION ON ITEM 7

MOTION: Motion to appoint Laura Rich Executive Officer, subject to the requisite reference check, background check and approval from the Governor under the statute.
BY: Member David Smith
SECOND: Member Christine Zack
VOTE: Unanimous; the motion carried.

8. Public Comment

   Public Comment in Carson City:
   - Priscilla Maloney – AFSCME
   - Kent Ervin – Nevada Faculty Alliance

9. Adjournment

   Board Chair Freed adjourned the meeting at 10:48 a.m.

4.2

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

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

   4.2 Acceptance of Health Claim Auditors' quarterly audit findings for HealthSCOPE Benefits for the timeframe of October 1, 2019 – December 31, 2019.

Claims and System Audit Report

for

Nevada PUBLIC EMPLOYEES' BENEFITS PROGRAM

PEBP

Health Matters.

Audit Period: PEBP Plan Year 2020, Quarter Two
October, November and December 2019

Audited Vendor:

HealthSCOPE BENEFITS

Healthy People
Healthy Business
Healthy Futures

Submitted By:
Health Claim Auditors, Inc.
February 2020

TABLE OF CONTENTS

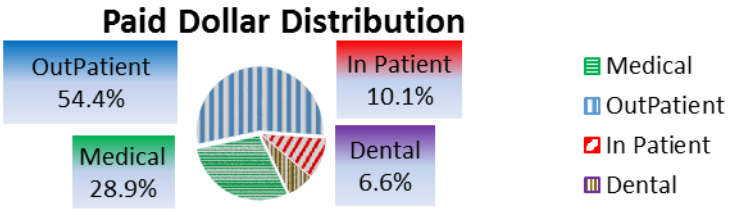
The following categories are reviewed each quarterly audit, however, because of their constant properties, the detail of each category will only be displayed within the first quarter audit of the PEBP fiscal year unless a change or defect is detected:

*HSB System	*HSB Policy/Procedure
*Eligibility	*Deductibles, Benefit Maximums
*Unbundling/Rebundling	*Concurrent Care
*Code Creeping	*Procedure, Diagnosis, Place of Service
*Experimental/Cosmetic Proc	*Medical Necessity Guidelines
*Patterns of Care	*Mandatory Outpatient/Inpatient Procedures
*Duplicate Claim Edits	*Adjusted Claims
*Hospital Discounts	*Hospital Bills and Audits
*Filing Limitation	*Unprocessed Claim Procedures
*R&C/Maximum Allowance	*Membership Procedures
*COBRA	*Provider Credentialing
*Coordination of Benefits	*Medicare
*Controlling Possible Fraud	*Security Access
*Quality Control/Internal Audit	*Internet Capabilities
*Communication, U/R and Claims Depts.	
*Claim Repricing	*Banking and Cash Flow
*Reporting Capabilities	*General System

EXECUTIVE SUMMARY

Audited Random Selection Data

Total number of claims: 500
Total Charge Value of random selection: $1,095,532.25
Total Paid Value of random selection: $ 266,150.68



Performance Guaranteed Metric Results

Metric	Guarantee Measurement	Actual	Pass/Fail
Payment Accuracy	≥ 98% of claims audited are to be paid accurately	98.4%	Pass
Financial Accuracy	≥ 99% of the dollars paid for the audited claims is to be paid accurately	99.71%	Pass
Claim Processing Turnaround Time	- 99% of all claims are to be processed within 30 days.	99.41%	Pass
Customer Service	-Telephone Response Time: ≤ 30 seconds. -Telephone Abandonment Rate: ≤ 2%. -First Call Resolution: ≥ 95%	17 sec. 1.44% 95.89%	Pass Pass Pass
Data Reporting	-100% of standard reports w/in 10 bus. days -Annual/Regulatory Documents w/in 10 business days of Plan Year end	No Exceptions Noted	Pass
Disclosure of Subcontractors	-Report access of PEBP data within 30 c. days -Removal of PEBP member PHI within 3 business days after knowledge	No Exceptions Noted	Pass

The following notations within the Executive Summary section are reported as follow up to previous findings and/or issues considered as an "outlier" of findings typically detected within the PEBP quarterly audits which require attention and/or acknowledgement for possible action(s).

Previous Recommendation(s)

HCA is pleased to report that all previous recommendations accepted by the PEBP Board of Directors has been implemented and/or in the process of application.

Trends/Issues

The audit revealed the following issues or trends detected from the random selection and bias selected claims. Please note: the reference numbers in **bold type** are claims from the random selection and are included within the statistical calculations. Reference numbers in normal type were identified as issues in bias claims as defined earlier and are not included within the statistical calculations of this audit. Specific information regarding supporting reference numbers can be found in the Audit Results Section in numerical sequence, which begins on page 14.

Preventive claim/service paid as medical;
Supporting reference nos. 128, 187, 229, **354** and 367

Incorrect allowable applied; Supporting ref. nos. **156, 194,** 205, 206 and **376**

Medical claim/service paid as preventive; Supporting ref. nos. 062, 186 and 193

Incorrect rate due to network re-pricing; Supporting ref. nos. 383, 504 and 508

Pre-certification penalty not applied; Supporting reference nos. 021 and 076

Incorrect copay applied; Supporting reference nos. **330** and **433**

Duplicate paid; Supporting reference nos. 289 and **490**

Paid at incorrect coinsurance; Supporting reference no. 105

Provider repriced as non-par by network in error; Supporting ref. no. 166

Claim paid at 80% due to RX copay assist; Supporting reference no. 204

Incorrect calculation for bilateral surgery; Supporting reference no. 220

Unbundled lab; Supporting reference no. **351**

Incorrect network used; Supporting reference no. 359

Pre-certification penalty applied in error; Supporting reference no. 431

Claim not reprocessed after requested information received;
Supporting reference no. 480

The audit revealed the following issues, which appear to be administered properly by HSB but should be brought to client attention for proper notification or verification. Specific information regarding supporting reference numbers can be found in the Audit Results Section in numerical sequence, which begins on page 14.

UCS pricing used on VAMC claims if pricing received;
Supporting reference no. 206

CLAIM PROCEDURES/SYSTEM CAPABILITIES/SUPPORT DATA

Introduction

In January 2020, Health Claim Auditors, Inc. (HCA) performed a Claims and System Audit of HealthSCOPE Benefits (HealthSCOPE) located in Little Rock, Arkansas on behalf of The State of Nevada Public Employees' Benefits Program (PEBP).

This audit was performed by collecting information to assure that HealthSCOPE is doing an effective job of controlling claim costs while paying claims accurately within a reasonable period of time. This report was presented to HealthSCOPE for any additional comments and responses on 11 February 2020.

Breakdown of Claims Audited

The individual claims audited were randomly selected from PEBP's claims listings as supplied by HealthSCOPE. These claims had dates of service ranging from September 2018 to December 2019 and were processed by HealthSCOPE from 01 October 2019 through 31 December 2019 (PEBP's Second Quarter Plan Year 2020). These claims were stratified by dollar volume to assure that HCA audited all types of claims. The audit also includes large dollar paid amounts that are considered as bias* selected claims.

*Bias claims are not part of the random selection but were audited by HCA because of some "out of the ordinary" characteristic of the claim. There are multiple criteria to identify the "out of the ordinary" characteristics. Examples are duplicates, CPT up coding, exceeding benefit limits, etc.

The breakdown of the 500 random selected claims audited is as follows:

Type of Service	Charge Amount	Paid Amount	Paid Distribution	No. of Claims
Medical	$ 279,359.18	$ 76,837.32	28.9%	349
Outpt. Hospital	$ 553,245.13	$ 144,769.49	54.4%	57
Inpt. Hospital	$ 222,698.75	$ 26,973.52	10.1%	4
Dental	$ 40,229.19	$ 17,570.35	6.6%	90
TOTAL	**$1,095,532.25**	**$ 266,150.68**	**100%**	**500**

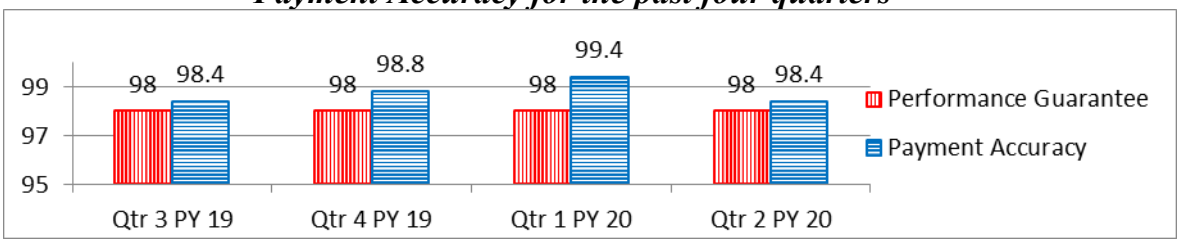
Payment Accuracy

Per PEBP, the Service Performance Standards and Financial Guarantees Agreement for the payment accuracy is to be 98% or above of claims adjudicated are to be paid correctly or a penalty of 2.5% of Quarterly Administration Fees for each percentage (%) point, or fraction thereof, below performance guarantee is to be applied. Payment Accuracy is calculated by dividing the total number of claims not containing payment errors in the audit period by the number of claims audited within the random selection.

The Payment Accuracy Percentage of the number of claims paid correctly from the HealthSCOPE random selection for this audited quarter is 98.4%.

Number of claims:	500
Number of claims paid incorrectly:	8
Percentage of claims paid incorrectly:	1.6%
Number of claims paid correctly:	492
Percentage of claims paid correctly:	98.4%

Payment Accuracy for the past four quarters



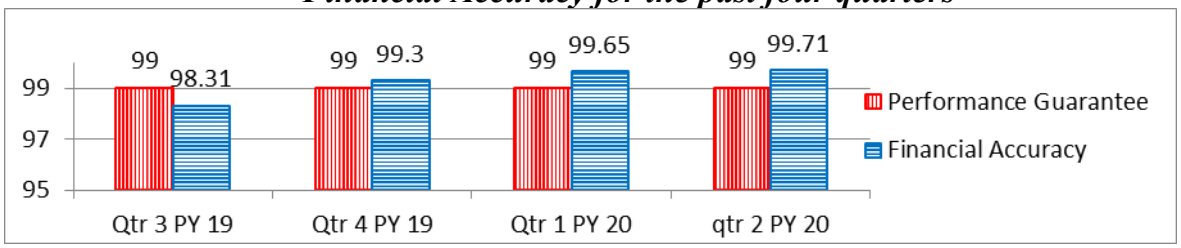
Financial Accuracy

Per PEBP, the Service Performance Standards and Financial Guarantees Agreement for the financial accuracy of the total dollars paid for claims adjudicated is to be paid correctly at 99% or above or a penalty of 2.5% of Quarterly Administration Fees for each percentage (%) point, or fraction thereof, below performance guarantee is to be applied. Financial Accuracy is calculated by dividing the total audited dollars paid correctly by the total audited dollars processed within the random selection.

The Financial Accuracy Percentage of paid dollars remitted correctly on the HealthSCOPE claims selected randomly for this audited quarter is 99.71%. This audit reflected seventy-five and two tenths percent (75.2%) of the audited errors within the valid random selection were overpayments.

Paid dollars audited	$ 266,150.68
Amount of paid dollars remitted incorrectly	$ 774.67
Percentage of Dollars paid incorrectly	0.29%
Paid Dollars of claims paid correctly	$ 265,376.01
Percentage of Dollars Paid correctly	99.71%

Financial Accuracy for the past four quarters



Historical Statistical Data of Performance Guarantees

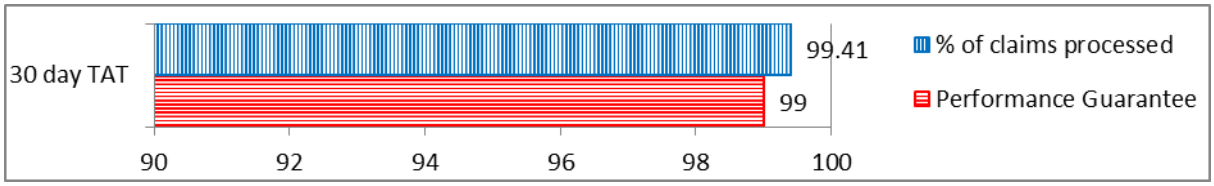
The following reflects the historical statistical data since the origin of PEBP medical claims administration by HealthSCOPE. The entries designated in **bold red type** are measurable categories with underperformance of the Service Performance Guarantees Agreement.

Period Audited	Payment Accuracy	Financial Accuracy	Turnaround Time	Telephone Response	Telephone Abandon Rate	First Call Resolution
1st Qtr PY 2012	95.7%	98.6%	7.6 days	:17	1.43%	N/A
2nd Qtr PY 2012	**93.3%**	**97.3%**	12.7 days	:12	1.16%	N/A
3rd Qtr PY 2012	**96.8%**	**98.6%**	3.7 days	:18	1.32%	N/A
4th Qtr PY 2012	**95.8%**	99.5%	11.4 days	:14	0.93%	N/A
1st Qtr PY 2013	97.2%	99.4%	10.4 days	:20	1.06%	N/A
2nd Qtr PY 2013	98.5%	99.3%	7.3 days	:11	0.87%	N/A
3rd Qtr PY 2013	98.0%	**95.7%**	6.4 days	:25	1.98%	N/A
4th Qtr PY 2013	98.4%	99.7%	6.2 days	:29	1.61%	N/A
1st Qtr PY 2014	98.8%	99.6%	5.4 days	:14	0.84%	N/A
2nd Qtr PY 2014	99.2%	99.2%	5.9 days	:29	1.96%	N/A
3rd Qtr PY 2014	98.0%	**98.5%**	5.2 days	**:30.5**	1.92%	N/A
4th Qtr PY 2014	99.0%	99.8%	4.4 days	:28	1.96%	N/A
1st Qtr PY 2015	98.8%	99.27%	4.9 days	:29.4	1.94%	N/A
2nd Qtr PY 2015	99.0%	99.35%	8.1 days	:22	1.18%	N/A
3rd Qtr PY 2015	98.6%	99.8%	5.9 days	:29.7	1.97%	N/A
4th Qtr PY 2015	99.6%	**95.6%**	4.9 days	:29.4	1.91%	N/A
1st Qtr PY 2016	99.0%	**98.9%**	4.8 days	:29.1	1.94%	N/A
2nd Qtr PY 2016	98.6%	99.7%	3.5 days	:24.0	1.14%	N/A
3rd Qtr PY 2016	98.8%	**98.53%**	5.3 days	:29.0	1.96%	N/A
4th Qtr PY 2016	99.0%	99.52%	6.3 days	:29.5	1.98%	N/A
1st Qtr PY 2017	99.0%	99.23%	6.6 days	:29.8	1.93%	N/A
2nd Qtr PY 2017	99.6%	99.78%	4.3 days	:29.3	1.96%	N/A
3rd Qtr PY 2017	98.2%	**93.83%**	3.7 days	:29.8	1.97%	N/A
4th Qtr PY 2017	99.0%	99.66%	4.6 days	:29.3	1.98%	N/A
1st Qtr PY 2018	99.2%	99.83%	4.4 days	:26.0	1.61%	98.79%
2nd Qtr PY 2018	99.6%	99.9%	4.3 days	:12.8	1.12%	98.28%
3rd Qtr PY 2018	98.6%	99.7%	3.5 days	:28.5	1.97%	98.65%
4th Qtr PY 2018	99.4%	99.5%	4.2 days	:21.0	1.50%	97.65%
1st Qtr PY 2019	98.8%	**98.2%**	5.4 days	:21.0	1.49%	97.85%
2nd Qtr PY 2019	99.6%	99.9%	5.6 days	:21.0	1.40%	97.18%
3rd Qtr PY 2019	98.4%	**98.31%**	5.8 days	:14.0	1.21%	95.89%
4th Qtr PY 2019	98.8%	99.30%	6.7 days	:14.0	1.09%	96.38%
1st Qtr PY 2020	99.4%	99.65%	7.1 days	:20.0	1.66%	95.03%
2nd Qtr PY 2020	**98.4%**	**99.71%**	**5.0 days**	**:17.0**	**1.44%**	**95.89%**

Turnaround Time

Per the Service Performance Standards and Financial Guarantees Agreement, the turnaround time for payments of claims is measured in calendar days from the date HealthSCOPE receives the claim until the date of process. Ninety nine percent (99%) of complete claims adjudicated are to be processed within thirty (30) calendar days, excluding federal holidays, or a penalty of two percent (2.0%) of Quarterly Administration fees for each two and a half percent (2.5%) of non-compliance complete claims is to be applied. HCA had requested the report that reflects the measurement of this issue. This report reflected that 99.41% of "complete" claims were processed within 30 calendar days, in compliance with the performance guarantee. This report also displayed the total turnaround process time for all claims at 5.0 days.

Turnaround Time Measurements



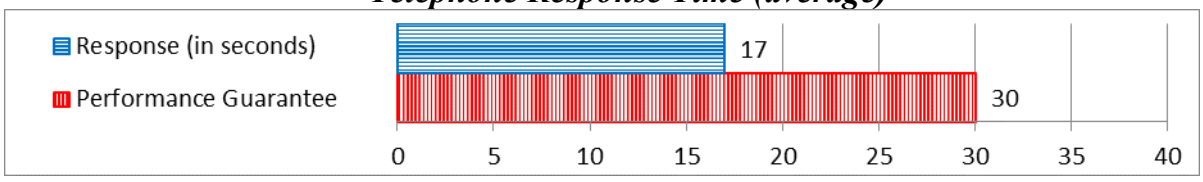
The turnaround time, measured only from the random selected claims, for Medical claims 10.8 calendar days, Out Patient Hospital claims was 10.4 calendar days, In Patient Hospital claims was 1.8 calendar days and Dental claims was 1.6 calendar days.

During the audit period of 01 October 2019 to 31 December 2019, HealthSCOPE had received 1,475 PEBP e-mail inquiries for information via the internet. The average turnaround time for these inquiries was calculated at approximately 7.5 hours.

Customer Service Satisfaction

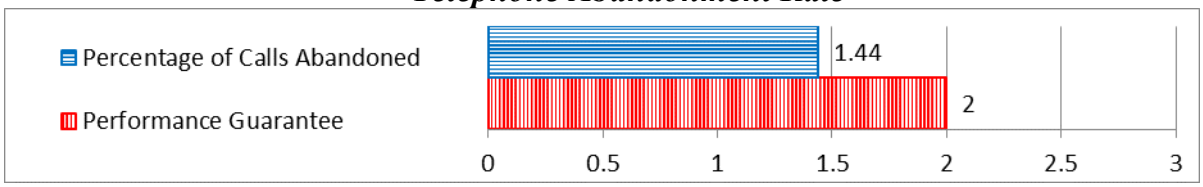
Per the Service Performance Standards and Financial Guarantees Agreement, the telephone response time reflects all calls must be answered within thirty (30) seconds or a penalty of one percent (1%) of Quarterly Administration fees for each second in non-compliance is to be applied. HCA has reviewed the appropriate report for the PEBP second fiscal quarter Plan Year 2020, which revealed the average incoming answer speed to be 17.0 seconds (0:20.0). The telephone response time was 14 seconds for October 2019, 23 seconds for November 2019 and 15 seconds for December 2019.

Telephone Response Time (average)



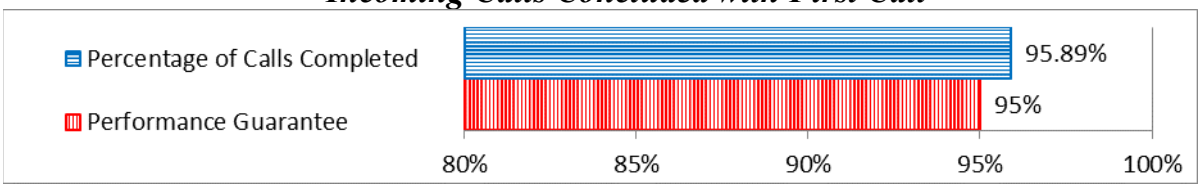
Per the Service Performance Standards and Financial Guarantees Agreement, the abandonment rate must be under two percent (2%) of total calls or a penalty of one percent (1%) of Quarterly Administration fees for each percentage point or fraction thereof in non-compliance is to be applied. HCA has reviewed the appropriate report for the PEBP second fiscal quarter Plan Year 2020, which revealed the abandoned calls ratio to be 1.44%. The telephone abandonment rate was 1.22% for October 2019, 1.94% for November 2019 and 1.22% for December 2019.

Telephone Abandonment Rate



Per the Service Performance Standards and Financial Guarantees Agreement, ninety five percent (95%) of incoming PEBP member problems must be resolved to conclusion on the first call or a penalty of one percent (1%) of Quarterly Administration fees for non-compliance is to be applied. HCA has reviewed the appropriate report for the PEBP second fiscal quarter Plan Year 2020, which revealed that HealthSCOPE documented 95.89% of incoming calls were brought to completion on the first call.

Incoming Calls Concluded with First Call



HealthSCOPE has eighty plus (80+) Customer Service Reps (CSRs), of which, the majority are in the Little Rock office with an average of eight (8) years experience.

Health SCOPE currently has eighteen (18) CSRs dedicated to the PEBP plan.

HealthSCOPE stated that customer service hours of operation will be applied to PEBP direction for proper service levels.

Benefit data is supplied by electronic documentation so that the analyst may explain benefit information to clients, members and providers by HealthSCOPE.

HealthSCOPE stated that the customer service representatives will not have the ability to make system changes.

HealthSCOPE's telephone conversations are documented for future reference.

HealthSCOPE does have an audit process for Customer Service Representatives.

HealthSCOPE is able to monitor trends/errors found through Customer Service.

HealthSCOPE can conduct customer service satisfaction surveys to determine employee satisfaction of claims administration and service upon client request.

Soft Denied Claims

The audit identifies the volume of claims adjudicated and placed in a "soft denied" status. HCA recognizes and respects the need to place certain claims in a soft denied status such as claims that require additional information or special calculation of payment. It is important to include this data within this report to disclose the outstanding unpaid claims that could create an artificial debit/savings during the time that these claims were adjudicated. Note: The measurement of this data was provided as a "snapshot" report. The report reflected the "soft edit" amounts as they were reported on the specific day that the report was recorded. The report for the current claims placed in a "soft denied" status reflect a total of 4,275 claims representing $ 22,248,300.62.

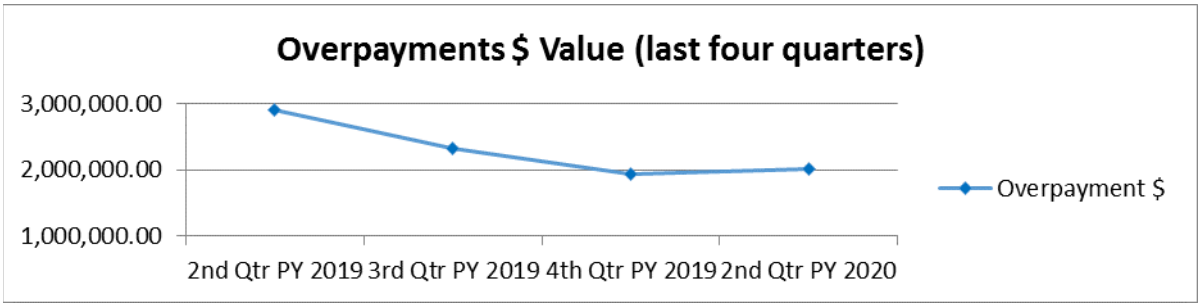
Audit Period	Total Number of Claims	Charge Amount Value of Soft Edits
1st Qtr PY 2012	2,607	$ 7,544,177.55
2nd Qtr PY 2012	4,068	$10,697,954.53
3rd Qtr PY 2012	1,536	$ 6,472,249.56
4th Qtr PY 2012	559	$ 2,205,318.16
1st Qtr PY 2013	1,053	$ 3,413,738.12
2nd Qtr PY 2013	1,107	$ 5,019,961.70
3rd Qtr PY 2013	1,023	$ 4,179,542.34
4th Qtr PY 2013	1,094	$ 3,049,481.74
1st Qtr PY 2014	1,389	$ 3,853,629.07
2nd Qtr PY 2014	1,157	$ 2,510,539.33
3rd Qtr PY 2014	1,621	$ 7,873,432.21
4th Qtr PY 2014	1.487	$ 4,665,197.77
1st Qtr PY 2015	1,404	$ 5,901,903.17
2nd Qtr PY 2015	1,668	$ 6,930,288.41
3rd Qtr PY 2015	2,897	$10,800,874.08
4th Qtr PY 2015	2,498	$10,685,255.24
1st Qtr PY 2016	3,071	$13,027,717.82
2nd Qtr PY 2016	2,543	$13,547,682.34
3rd Qtr PY 2016	2,871	$10,360,017.78
4th Qtr PY 2016	3,107	$15,262,995.27
1st Qtr PY 2017	2,580	$ 8,558,641.28
2nd Qtr PY 2017	3,876	$15,960,661.94
3rd Qtr PY 2017	3,696	$18,864,824.74
4th Qtr PY 2017	4,768	$20,217,736.28
1st Qtr PY 2018	3,926	$15,683,180.63
2nd Qtr PY 2018	4,073	$20,576,701.38
3rd Qtr PY 2018	4,144	$17,375,843.66
4th Qtr PY 2018	4,544	$21,591,987.11
1st Qtr PY 2019	4,624	$24,992,938.88
2nd Qtr PY 2019	5,558	$36,168,714.98
3rd Qtr PY 2019	5,476	$25,662,843.33
4th Qtr PY 2019	5,248	$24,848,496.79
1st Qtr PY 2020	4,992	$24,614,175.86
2nd Qtr PY 2020	**4,275**	**$22,248,300.62**

Overpayments

HCA requested an overpayment report that reflects the identified current outstanding overpayments incurred since the beginning of the contract period with HealthSCOPE. This report reflected a current total potential recovery value of $2,015,568.37 (an increase of $74,637.49). Detailed information regarding outstanding overpayments can be reviewed in a separate Supplemental Report, which for confidentiality purposes, is not included in this report but is made available to PEBP staff should they request it.

HSB's policy is to keep all identified overpayments active for potential recoupment(s The breakout of overpayments identified by the year paid are as follows:

Period	Due/Potential Recovery
- Fiscal Year 2012	$ 104,209.00
- Fiscal Year 2013	$ 143,390.29
- Fiscal Year 2014	$ 61,856.00
- Fiscal Year 2015	$ 152,744.70
- Fiscal Year 2016	$ 181,327.34
- Fiscal Year 2017	$ 104,485.08
- Fiscal Year 2018	$ 342,730.79
- Fiscal Year 2019	$ 178,903.53
- Fiscal Year 2020 (to date)	$ 745,921.64
TOTAL	$2,015,568.37



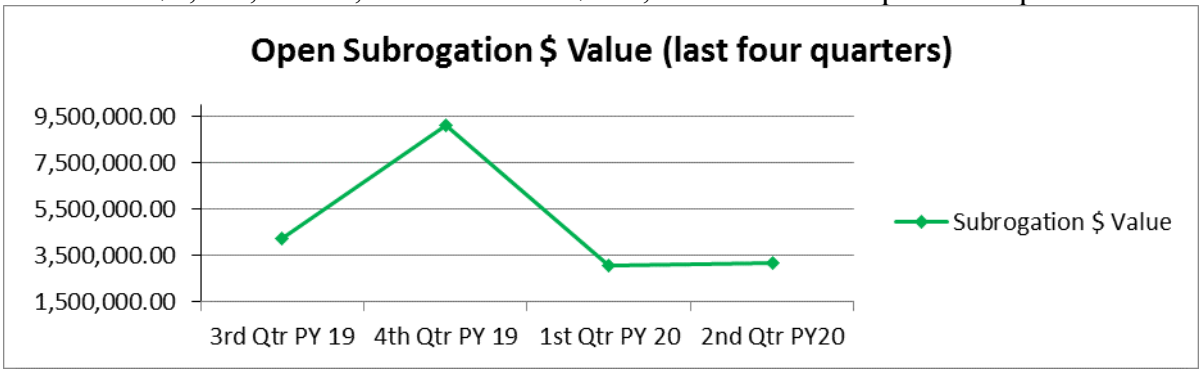
Of the 1,004 most current (Plan Year 2020) identified outstanding overpayments (HSB only), 66% were found to be caused by external sources that are not a cause of the HealthSCOPE adjudication processes. Breakout of the HealthSCOPE's most current overpayments (by claim count) are listed by reason as follows:

34.40%	Corrected HTH Network Pricing
13.56%	Incorrect Benefit Applied
13.06%	Incorrect Rate Applied
11.76%	Provider caused, rebilled, charges billed in error, corrected EOB
8.00%	Retro termination
8.77%	No COB on file
2.09%	Duplicate
1.99%	COB incorrectly calculated or not applied
1.50%	SHO Pricing Correction
1.20%	Previous Information Received
0.70%	Service not covered
0.60%	Category error
0.40%	Processed under incorrect patient
0.30%	Paid NON PPO as PPO
0.30%	Stop Payment
0.30%	Benefit Clarification
0.30%	Subrogation error
0.20%	Processed under the incorrect provider
0.20%	Paid PPO provider as NON PPO
0.20%	Aetna network Pricing
0.10%	Denied in Error
0.10%	Entry Error
0.10%	Multiple Surgery Reduction not applied
0.10%	Incorrect Copayment
0.10%	Pharmacy Deductible Error

Subrogation

HCA requested a subrogation report that can be reviewed in a separate Supplemental Report, which for confidentiality purposes is not included in this report. It is made available to PEBP staff should they request it.

This report reflects open subrogation claims representing a current potential recovery amount of $3,188,870.28; an increase of $139,543.93 from the previous quarter.



Reports received from HealthSCOPE reflect that subrogation recoveries for the audited period was $263,812.58. After contingency fees were paid, PEBP received $197,859.45.

HealthSCOPE system will apply a pursue and pay subrogation policy as directed by PEBP. Per HealthSCOPE, subrogation is determined and pursued on all claims where the total amount paid equals to or exceeds $1000 (one thousand).

HealthSCOPE does identify possible subrogation cases internally. HealthSCOPE utilizes a third party vendor for recovery of monies. Vendors are paid a contingency of which the administrator receives a portion of and disclosed within RFP 1983 for Third Party Claims Administration.

HealthSCOPE does not conduct auditing of outstanding subrogation cases sent to their vendors, but sends any cases not picked up by the main vendor to another vendor for review.

HealthSCOPE depends on the external vendors to conduct the appropriate International Classification of Diseases (ICD) sweep checks for subrogation detections. HealthSCOPE is currently utilizing the new ICD-10 conversions and the coding has been completed within their system.

Per HealthSCOPE, claims related to Worker's Compensation are denied.

Recoupment and payments for subrogation claims are assigned as directed by PEBP.

High Dollar Claimants

Per the request of PEBP staff, HCA has requested a report to identify the number of active, retiree or COBRA elected participants or dependents who have obtained a plan paid level of $750,000.00 or greater.

This report reflected forty-three (43) active members and thirty (30) dependents for a total of 73 active participants, who have obtained this level of plan payment participation representing an accrued dollar paid amount of $100,279,810.91.

Personnel

The audit included a review of the HealthSCOPE personnel dedicated or assigned to PEBP. The current Organization Chart for individuals assigned to the PEBP plan, is, with changes, as follows:

- State of Nevada Manager;
- Vice President – Quality Assurance, **CHANGED;**
- Sr. Vice President Operations Customer Care;
- Executive Account Manager;
- Client Relations Manager;
- Financial Operations Director;
- Provider Maintenance Specialist;
- Financial Analysts, 3 individuals;
- Funding Supervisor;
- Claims Administration Manager;
- Claims Administration Supervisor;
- Claims Analysts, 15 individuals;
- Eligibility Director;
- Eligibility Supervisor;
- Customer Service Vice President;
- Customer Service Director;
- Customer Service Representatives, **CHANGED**, 3 individuals added and 3 removed for a total of 18 individuals;
- Scanning Services Manager;
- Recoveries Manager;
- Recoveries Specialists, 2 individuals;
- Vice President Data Services;
- Senior Data Analyst;
- Chief Information Officer;
- Data Architect
- Computer Domain Hosting (CDH) Services Manager;
- Sr. Vice President-Legal and Compliance;
- COBRA Service Manager, **CHANGED**;
- Customer Care Supervisor;
- Customer Care Representatives, 3 individuals.

HealthSCOPE POLICY/PROCEDURES/SYSTEM CAPABILITIES

This section details the HealthSCOPE adjudication system capabilities and operations as they pertain to the PEBP Health Plan. These operations typically do not change on a regular basis and remain redundant within subsequent audit reports, thereby, are only displayed within the first quarterly audit report for the fiscal year. The quarterly audit includes the review of the following operations, however, if any changes or defects are identified, they will be reported immediately within the audited period report:

- HealthSCOPE Policy/Procedures
- Eligibility
- Deductibles, Out-of-Pocket and Benefit Maximums
- Unbundling/Rebundling
- Concurrent Care
- Code Creeping
- Procedure, Diagnosis and Place of Service
- Experimental and Cosmetic Procedures
- Medical Necessity/Potential Abuse Guidelines and Procedures
- Patterns of Care and Treatment for Physicians
- Mandatory Outpatient/Inpatient Procedures
- Duplicate Claim Edits
- Adjusted Claims
- Hospital and Other Discounts
- Hospital Bills (UB-92) and Audits
- Filing Limitations
- Unprocessed Claims Procedures
- Reasonable/Customary and Maximum Allowances
- Membership Procedures
- COBRA Administration
- Provider Credentialing
- Coordination of Benefits
- Medicare
- Controlling Possible Fraudulent Claims and Security Access
- Quality Control and Internal Audit
- Internet Capabilities
- Communication between Utilization Review (UR) and Claims Department
- Claim Repricing Capabilities
- Banking and Cash Flow
- Reporting Capabilities
- General System
- Security

HCA CLAIM AUDIT PROCEDURES

HCA selects a valid random sampling of claims from the client's current detailed claims listings. The third party administrator is advised of the audit and requested to provide either limited system access or paper reproduction of the entire file associated with each random claim.

Each random claim and file is reviewed comparing eligibility and benefits to information provided by the client. Third party administrator personnel are questioned regarding any discrepancies. Entire files are reviewed to assure the client that deductibles, out-of-pockets benefit maximums and related claims are processed correctly. This allows HCA to verify all details of the client's benefit plan.

Audit statistics involve only those claims chosen in the random selection. If a randomly selected claim HealthSCOPE been recalculated or corrected prior to the release of the random selection for the audit, an error was not charged for the original miscalculation. HCA will, at its opinion, comment on any claim in the random claim history to illustrate situations it feels the client should be aware of or specific areas requiring definition.

A payment error is charged when an error identified in claim processing results in an under/ overpayment or a check being paid to the wrong party. Assignment errors are considered payment errors since the plan could be liable for payment to the correct party.

In situations where there is disagreement between HCA and the third party administrator as to what constitutes an error, both sides are presented in the report. Final determination of error rests with the client.

AUDIT RESULTS

Listed below are the errors or issues of discussion found by this audit while processing the claims for PEBP.

Ref. No. 021 Outpatient Hospital HSB claim no.

NOT charged in statistical calculation. Note to client for information only.
Audited claim paid as: allow 15002.46 – pre-cert penalty 7501.26 – ded 335.25 = 7165.95 x 80% = 5732.75 pd
All other claims (xxxxx ass't surg), (xxxxx surg), (xxxxx lab), (xxxxx anes) did not take pre-cert penalty.
Shouldn't penalty have applied to these four claims?
HSB response: Surgeon – xxxxx is incorrect. Should have assessed pre-cert penalty. Assess penalty on surgeon & facility claims per email attached.
HCA Note: Email dated May 13, 2019 from client states: "Restating our intent regarding precertification penalty: The precert penalty should only apply to the surgeon and facility. The penalty will NOT apply to ancillary services when those services are billed separately."

Ref. No. 062 Medical HSB claim no.

NOT charged in statistical calculation. Note to client for information only.

Audited: Code HM CPT 77063-26 chg 108.00 allow/pd 36.85
HM 77067-26 274.00 46.82

Claim xxxxx same DOS, same provider pd as:

76641-26-LT	chg 114.00	allow/ded 45.08	pd 0.00
76641-26-RT	114.00	45.08	0.00
76376-26-59	32.00	12.14	0.00

Claim xxxxx for facility fee paid as:

REV 402	CPT 76641-TC	chg 562.00	allow/pd 252.90
403	77063-TC	64.00	10.24
403	77067	1011.00	161.76

Should REV 402, CPT 76641-TC have been paid at 80% versus 100% since it is not a routine service? (OOP not met)

HSB response: REV 402, 76641-TC should have been paid at 80% not 100%.

Ref. No. 076 Medical HSB claim no.

NOT charged in statistical calculation. Note to client for information only.

77263	chg 480.00	allow 319.31	penalty 159.66	pd 159.65
77290-26	457.00	155.92	77.96	77.96
77334-26	137.00	115.11	57.56	57.55

Pre-cert penalty applied

Claim xxxxx same DOS for facility services w/CPTs 77290 & 77334 (plus other codes & DOS 10/1-10/29) pd as:

chg 80,734.00 allow/pd 32,293.60

If penalty on audited claim is correct, should facility have had a pre-cert penalty also?

HSB response: Biased claim should have paid w/penalty due to Renown Regional auth on file at time of claim adjudication did not specify radiation therapy.

Ref. No. 105 Medical HSB claim no.

NOT charged in statistical calculation. Note to client for information only.

97803 chg/allow/pd 60.00 DX – E669

1) System does not indicate Obesity Care Mgmt. Why is claim being paid at 100%?

2) Claim xxxxx DOS 10/22/19 for 97803 chg/a/pd 180.00 paid on 10/26/19 would be the 4th visit. Shouldn't this claim have gone to deductible versus paid at 100%?

HSB response: 1) Per page 65 & 66 of MPD services covered as wellness/preventive for up to 3 visits per plan year. Processed correctly.

2) Xxxxx should have applied to deductible. Programming issue that has been corrected.

Ref. No. 128 Medical HSB claim no.

NOT charged in statistical calculation. Note to client for information only.
Audited: 77067-26 chg 94.67 allow/pd 80.47
77063-26 51.26 51.26
Claim xxxxx same DOS for hospital charges pd as:
chg 5769.40 allow 4027.04 ded 1574.63 (x80%) pd 1961.93
Claim contains: REV 403, 77063 chg 37.20
403, 77067 360.50
Shouldn't these 2 services have been paid at 100%?
HSB response: 77063 & 77067 billed under claim xxxxx should pay at 100% of PPO and allow as wellness.

Ref. No. 156 Medical HSB claim no.

Overpayment - $235.11
Provider – Reno VAMC
58300 chg/allow/pd 264.17
Claim has been adjusted on 1/27/20 to pay using UCS pricing.
Now paid as: allow/pd 29.06
Why wasn't UCS pricing used on original processing?
HSB response: Analyst error. Internal audit ran on 12-31-19 and claim was corrected under xxxxx based on report.

Ref. No. 166 Medical HSB claim no.

NOT charged in statistical calculation. Note to client for information only.
Originally paid on 9/4/19 as: 74177-26 chg 236.00 ded 236.00
HTH priced as non-par
Audited is adjusted due to corrected HTH pricing:
74177-26 allow/pd 126.24 (OOP now met)
Appears HTH incorrectly identified provider as non-par.
HSB response: HTH originally returned claim as non-par. HTH repriced claim on 9-30-19.

Ref. No. 186 Medical HSB claim no.

NOT charged in statistical calculation. Note to client for information only.
Audited for routine gyn exam
Claim xxxxx from LabCorp same DOS w/DX R5383 pd as:
83001 chg 136.34 allow/pd 20.91
84443 112.33 16.39
85025 46.33 11.30
Since DX for these services is not routine shouldn't these have gone to deductible? (Note: claim xxxxx same DOS from LabCorp has routine DX – pd at 100% correctly)
HSB response: Yes, xxxxx should have applied to deductible.

Ref. No. 187 Medical HSB claim no.
NOT charged in statistical calculation. Note to client for information only.
Audited - DX Z0000, CPT 36415 chg 21.00 allow/pd 13.00
Claim xxxxx same DOS from LabCorp, same DX allow of 48.59 went to deductible.
Shouldn't this have been paid at 100% since we had a claim from the physician for a venipuncture that we paid at 100%?
HSB response: Claim xxxxx should pay at 100% of PPO allowed.

Ref. No. 193 Outpatient Hospital HSB claim no.
NOT charged in statistical calculation. Note to client for information only.
Code HM REV 490 45380 chg 6286.00 allow/pd 2961.99
HM 490 S9999 296.20 0.00
1) Claim adjusted under xxxxx on 1/2/20 to now pay as SU as:
REV 490 45380 allow 2961.99 (x80%) pd 2369.59
490 S9999 0.00 0.00
Why was claim originally paid at 100% since DX was illness?
2) Claim xxxxx same DOS for lab charge paid at 100% on 1/16/20.
Should this have been paid at 80% due to medical DX?
REV 312 88305 chg 552.00 allow/pd 276.00
HSB response: 1) Should be illness corrected under xxxxx on 1/2/20.
2) Claim xxxxx should pay under SU.

Ref. No. 194 Outpatient Hospital HSB claim no.
Underpayment - $37.98 Provider – LV VAMC
Original is audited claim pd as: allow 153.12 x 80% = 122.50 pd
Claim adjusted under xxxxx on 1/27/20 to pay w/UCS pricing:
allow 200.59 x 80% = 160.48 – 122.50 = 37.98 additional paid
Why wasn't UCS pricing applied on original processing?
HSB response: Analyst error. UCS pricing from xxxxx should have been used. Report ran on 12/31/19 to identify VAMC claims to reconsider and claim corrected on 1/27/20 under xxxxx.

Ref. No. 204 Medical HSB claim no.
NOT charged in statistical calculation. Note to client for information only.
Clm xxxxx DOS 1/21/20 paid 1/27/20, xxxxx DOS 1/14/20 paid 1/27/20, xxxxx DOS 12/17/19 paid 12/26/19, xxxxx DOS 12/10/19 paid 12/19/19, and xxxxx DOS 12/3/19 paid 12/12/19 all paid at 80%
Clm xxxxx DOS 11/19/19 paid 11/28/19, xxxxx DOS 11/5/19 paid 11/18, audited DOS 10/15/19 paid 11/14/19, and xxxxx DOS 10/22/19 paid 10/31
All claims from same provider.
Why are claims prior to DOS 12/3/19 being paid at 100% versus 80%?
HSB response: Claims xxxxx, xxxxx, xxxxx & xxxxx paid at 100% of PPO allowed as a result of RX integration for copay assist. RX claims xxxxx & xxxxx, ESI did not apply the Copays assist until 12/3/19, which negatively affected the member's accumulators.

Ref. No. 205 Outpatient Hospital HSB claim no.
NOT charged in statistical calculation. Note to client for information only.
Provider – Reno VAMC
Chg 127.02 allow/pd 5.24
Claim adjusted under xxxxx on 1/13/20 to pay w/UCS pricing as:
allow/pd 13.97, paying an additional 8.73
Why wasn't UCS pricing used on original processing?
HSB response: Analyst error. UCS pricing from xxxxx should have been used. Report ran on 12/31/19 to identify VAMC claims to reconsider and claim corrected on 1/13/20. Claim corrected prior to audit pull and random extract submitted to HSB on 1/21/20.

Ref. No. 206 Outpatient Hospital HSB claim no.
NOT charged in statistical calculation. Note to client for information only.
Provider – Reno VAMC
Audited claim pd as: allow/pd 48.63
Claim now adjusted under xxxxx on 1/15/20 to now use UCS pricing as:
allow/pd 104.22, with additional 55.59 paid
1) Why wasn't UCS pricing used on original processing?
2) When was it decided to use UCS pricing?
HSB response: 1) Analyst error. UCS pricing from xxxxx should have been used. Report ran on 12/31/19 to identify VAMC claims to reconsider and claim corrected on1/15/20. Claim corrected prior to audit pull and random extract submitted on 1/21/20. 2) On 11/25/19 confirmed to use UCS pricing for DOS prior to 10/1/19 if pricing had been received.

Ref. No. 220 Medical HSB claim no.

NOT charged in statistical calculation. Note to client for information only.
Paid as: allow 2642.58 – penalty 388.31 – ded 33.27 – coins 444.21 = 1776.79 paid

CPT 30140 allow 214.37
30520 1012.89
31257 359.03
31267 319.97
31276 456.64
61782 279.68

Claim adjusted for appended auth & apply no penalty under claim xxxxx paying additional 454.27 on 12/23/19 now allowing 2822.10:

CPT 30140 allow 214.37
30520 1012.89
31257 538.55
31267 319.97
31276 456.64
61782 279.68

Appears incorrect calculation of allow for CPT 31257 done on original processing?
HSB response: Yes, 31257-59-50 had the incorrect allowed amount on original claim. Claim corrected under xxxxx on 12/23/19 once retroactive authorization received from UM vendor.

Ref. No. 229 Medical HSB claim no.

NOT charged in statistical calculation. Note to client for information only.
Claim xxxxx same DOS lab charges w/same DX Z125

REV 300 36415 chg 23.00 allow 1.13 ded 1.13 pd 0.00
301 84153 170.00 16.95 16.95

Why wasn't 36415 venipuncture paid at 100%?
HSB response: 36415 should have paid at 100% of PPO allowed.
Analyst error.

Ref. No. 289 Medical HSB claim no.

NOT charged in statistical calculation. Note to client for information only.
Claim xxxxx same DOS, services & provider paid on 12/31/19 also paying 60.31 after COB w/Medicare.
This claim appears to be a dup of audited claim & should have been denied.
HSB response: Claim paid in error.

Ref. No. 330 Outpatient Hospital HSB claim no.

Underpayment - $100.00

Provider – Renown

REV 255		chg 5.00	allow 2.45
255		31.00	15.19
320	CPT 77002-RT	190.00	79.80
610	73222-RT	1729.00	1556.10
761		291.00	90.21
			1743.75

Claim paid as: allow 1743.75 – 350.00 copay = 1393.75 pd

Per MPD copay for MRI should be $250.00. Appears incorrect copay taken & claim is underpaid $100.00.

HSB response: Agree, claim should have assessed $250 copay.

Ref. No. 351 Medical HSB claim no.

Overpaid $3.17

Claim from Quest contains:

85025	chg 45.50	allow 10.66 (x80%)	pd 8.53
80053	88.07	18.58 "	14.86
84443	130.49	23.05	18.44
		52.29	41.83

1) Shouldn't CPTs 85025, 80053 & 84443 have been rebundled & paid as 80050?

2) Please advise what allowable would be for 80050 for this DOS

HSB response: 1) Yes, it should bundle to 80050. 2) Allowed amount for 80050 = $48.32.

Ref. No. 354 Outpatient Hospital HSB claim no.

Underpayment - $34.40

REV 402	CPT 76641-TC	chg 562.00	allow 252.90	(x80%)	pd 202.32
403	77063-TC	64.00	10.24	"	8.19
403	77067	1011.00	161.76	"	129.41

REV 403 codes 77063 & 77067 for routine mammography for screening Shouldn't these service have been paid at 100% versus 80%? Appears claim underpaid 34.40.

(Note: claim xxxxx for reading was paid at 100%)

HSB response: Yes, 77063-TC and 77067 should have reimbursed at 100% of PPO allowed.

Ref. No. 359 Medical HSB claim no.

NOT charged in statistical calculation. Note to client for information only.
Audited paid as: A7031-NU-KX chg 56.83 allow/pd 28.02
Claim adjusted on 1/10/20 under xxxxx to now pay as: allow/pd 55.90 – an additional 27.88 paid
Appears incorrect discount applied on original (audited) processing?
HSB response: During internal QA audit, EPO claim identified as paying with Aetna in error. Claim corrected on 1/10/20 under xxxxx with correct pricing prior to receipt of random audit extract.

Ref. No. 367 Outpatient Hospital HSB claim no.

NOT charged in statistical calculation. Note to client for information only.
Labs with DX Z113 paid at 100%
Claim xxxxx same DOS & DX for OV 99213 – 102.60 going to ded
Should this have been paid at 100% same as labs?
HSB response: Yes, xxxxx should have paid at 100% of PPO allowed per MPD page 65. Per USPSTF grade B recommendation counseling services related to sexually transmitted infection is allowed as wellness.

Ref. No. 376 Inpatient Hospital HSB claim no.

Overpayment - $232.01
Provider – Summerlin
3 day vaginal delivery
Claim paid as: allow 7880.00 x 80% = 6304.01 paid
Per my calculation shouldn't allowable have been:
Mat (non Csec) 1st day = 2704.00
Add'l day 2443 x 2 = 4886.00
Allow 7590.00 x 80% = 6072.00
Appears claim overpaid 232.01?
HSB response: Agree, $232.01 overpayment, analyst error.

Ref. No. 383 Outpatient Hospital HSB claim no.

NOT charged in statistical calculation. Note to client for information only.
Provider – Renown
Please explain how allowable of 12,131.87 was calculated
(allow 12,131.87 coins 2245.89 pd 9885.98)
Per Renown hospital rates effective 5/1/19 through 12/31/19 calculation reflects allow of $12,047.94

REV 250 $74.00 x 46% = 34.04
255 $65.25 x 49% = 31.97
260 $936.00 x 38% = 355.68
260 $756.00 x 38% = 287.28
CPT 36415 = 1.13
80053 = 15.82
80061 = 15.82
80307 = 7.18
83880 = 16.95
84484 = 11.30
84484-91 = 0.00
86140 = 7.35
85025 = 11.30
85379 = 9.61
85610 = 3.39
85730 = 5.65

REV 324 $623.00 x 30% = 186.90
352 $2017 x 90% = 1815.30
352 $2017 x 90% = 1815.30
450 $4202 x 42% = 1764.84
636 $87.75 x 42% = 36.86
730 $1008 x 88% = 887.04
762 133.55 x 25 units = 3338.75
250 $38.00 x 46% = 17.48
CPT 36415 = 1.13
86140 = 7.35
85652 = 4.52
REV 483 w/CPT 93360-TC = 1358.00

Should have paid as: 12,047.94 – coins 2245.89 = 9802.05. Overpaid 83.93.
HSB response: Lab service fee schedule, multiple rev code priced at % of billed charges, corresponding with amounts indicated in the contract. Observation is a $133.55 per unit. Diagnostic cardiology Rev 433 $1358 per visit when billed with 93306 or 93017.

Ref. No. 431 Outpatient Hospital HSB claim no.

NOT charged in statistical calculation. Note to client for information only.
Original pd 8/30/18 under xxxxx as:
REV 510, CPT 99214 allow 469.02 penalty 469.02 pd 0.00
Audited is adjustment to now pay as: allow 136.43 copay 45 pd 91.43
Why was penalty applied on original claim?
HSB response: Analyst error.

Ref. No. 433 Medical HSB claim no.

Underpayment - $20.00
90791 – psychiatric diagnostic eval
Claim pd as: allow 161.61 copay 40.00 pd 121.61
Should copay have only been $20 for mental health outpatient office visit?
HSB response: Yes. Analyst error.

Ref. No. 480 Medical HSB claim no.

NOT charged in statistical calculation. Note to client for information only.
Audited claim reprocessed after subro info received
Claim xxxxx same DOS for assistant surgeon was also denied for subro info however this claim has not been reprocessed.
Shouldn't it have also been reconsidered as others in history were at the time requested info was received?
HSB response: Yes, claim xxxxx should have been corrected when xxxxx was corrected.

Ref. No. 490 Dental HSB claim no.

Overpayment - $112.00
Provider – Whitney Bryant, DDS, claim pd 12/19/19

Non-PPO pd as:	D0120	chg 41.00	allow 32.00	(x80%)	pd 25.60
	D0274	52.00	39.00	"	31.20
	D1110	77.00	69.00	"	55.20

Claim xxxxx paid 12/16/19 provider Regina Crowley, DDS same DOS & exact same services & charges pd as:

D0120	chg/allow/pd 41.00
D0274	52.00
D1110	77.00

These claims appear to be duplicates. Providers are at same address. Review of history shows only Dr. Crowley as dentist.
HSB response: Records indicate that the provider reached out to DDS and HSB on 1/22/20 to advise that their billing office had submitted claims under incorrect TIN for DOS prior to 2/1/20. A report was ran identifying impacted claims and they are in line for reconsideration.

Ref. No. 504 Inpatient Hospital HSB claim no.

NOT charged in statistical calculation. Note to client for information only.
Provider – Mountain View
HTH repriced & claim processed with allow of 103,708.00
Shouldn't allowable have been:

DRG 219 case rate (1-6 days)	= 55,370.00
1 additional day	= 3,113.00
REV 278 95194.00 x 40%	= 38,077.60
REV 636 10476.00 x 40%	= 4,190.40
	100,751.00

Appears HTH also allowed sur add-on of 2957.00 which would not apply on case rates. Claim overpaid 2957.00
HSB response: HTH response indicating claim priced incorrectly. Yes they did allow addt'l $2957 as indicated. Corrected pricing returned with total allow of $100,751.00.

Ref. No. 508 Inpatient Hospital HSB claim no.

NOT charged in statistical calculation. Note to client for information only.

Provider – Mountain View

HCA calculation:

DRG 791 – 197401.00 x 46% = 90,804.46

REV 636 10589.00 x 40% = 4235.60

95,040.06

We allowed & paid 95,050.06. appears claim overpaid $10.00.

HSB response: Agree, over allowed/paid $10.00.

27 Corporate Hill
Little Rock, AR 72205

February 27, 2020

Public Employees' Benefits Program Board
State of Nevada
901 Stewart Street, Suite 1001
Carson City, NV 89701

Subject: Audit Results October 1, 2019 –December 31, 2019

Dear Public Employees' Benefits Program (PEBP) Board:

HealthSCOPE Benefits appreciates the opportunity to respond to the audit performed by Health Claim Auditors for the second quarter of Plan Year 2020. The audit included 500 claims with paid amounts totaling $266,150.68

HealthSCOPE Benefits is extremely pleased to have met all performance guarantees for this audit period.

We strive to have the highest possible quality and we continue to review improvement opportunities within our organization and our vendor partners.

We are very pleased with cost containment measures we are able to provide on the PEBP account. We saved an additional $1.5M through non-network negotiations, subrogation, clinical edits and transplant savings in the second quarter of PY2020.

We appreciate the quarterly audit process and the interaction between Health Claims Auditors, PEBP, and HealthSCOPE Benefits as it provides for continuous improvement in our service.

Sincerely,

Mary Catherine Person
President

4.3

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

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

   4.3 Acceptance of PEBP vendor quarterly reports for the timeframe of October 1, 2019 – December 31, 2019.

   4.3.1 Doctor on Demand Engagement report – February 2020

   4.3.2 The Standard Insurance – Basic Life and Long-Term Disability Insurance

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

   4.3.4 Health Plan of Nevada Performance Standards and Guarantees

4.3.1

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

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

   4.3 Acceptance of PEBP vendor quarterly reports for the timeframe of October 1, 2019 – December 31, 2019.

   4.3.1 Doctor on Demand Engagement report – February 2020

NVPEB

HealthSCOPE Benefits

2020-02 Engagement Report

dr. on demand

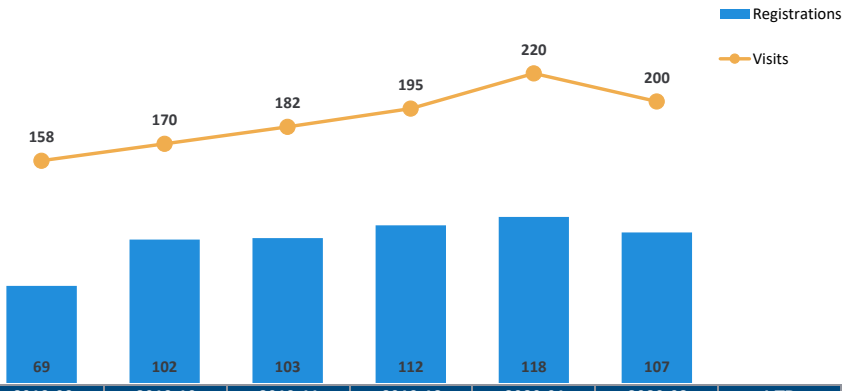
Note: Only Doctor On Demand visits with an associated claim submission to the Payer are included in the Engagement Report -- any free, discounted, uncovered, or other non-claim visits are not included. This is true of all metrics, trends, and aggregations.

Year To Date Activity

Registration Summary	YTD
# Registered	225

Visit Summary	YTD
# Unique Visitors	353
# Visits	420

Monthly Activity



Registration Summary	Prior	2019-09	2019-10	2019-11	2019-12	2020-01	2020-02	LTD
# Registered	7,067	69	102	103	112	118	107	7,678

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

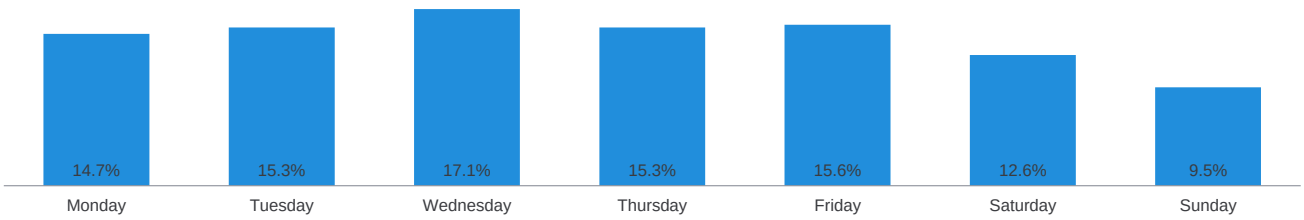
Visit Summary		Prior	2019-09	2019-10	2019-11	2019-12	2020-01	2020-02	LTD
# Unique Visitors		2,104	134	158	161	171	194	181	2,563
# Visits		4,033	158	170	182	195	220	200	5,158
Visit Frequency	% 1 Visit	62.0%	85.1%	93.0%	88.8%	89.5%	88.1%	90.1%	60.0%
	% 2 Visits	20.4%	12.7%	6.3%	9.3%	8.8%	10.3%	9.4%	20.3%
	% 3 Visits Or More	17.5%	2.2%	0.6%	1.9%	1.8%	1.5%	0.6%	19.7%

Note: Because a visitor can be unique in multiple months, but only once over history, Prior + Monthly "# Unique Visitors" will not sum to the Total.

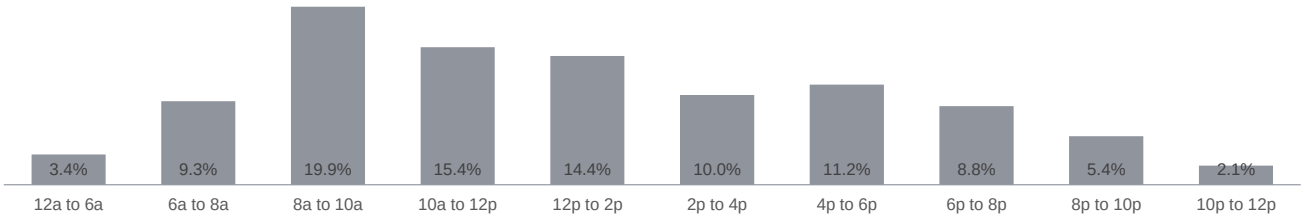
Visit Type Summary		Prior	2019-09	2019-10	2019-11	2019-12	2020-01	2020-02	LTD
Medical		3,361	122	141	153	163	187	175	4,302
Mental Health	Psychology	444	11	8	12	12	13	11	511
	Psychiatry	228	25	21	17	20	20	14	345

Six Month Trends: Visit Time And Demographics

Day Of Week



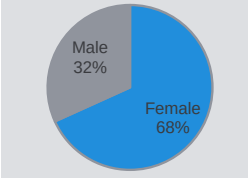
Hour Of Day



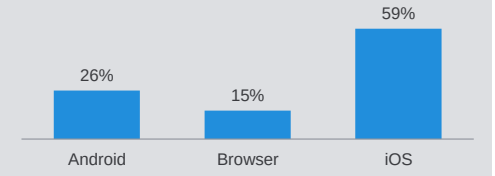
Patient Age

0 to 17 (Custodial)	9%
18 to 29	19%
30 to 49	49%
50 and over	24%

Patient Gender



Visitor App Type



NVPEB

HealthSCOPE Benefits

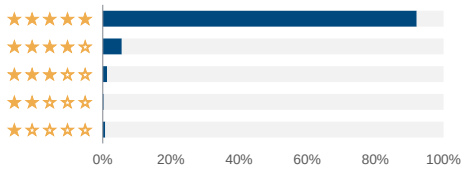
2020-02 Engagement Report

Historical Visit Experience

3,983 Visit Ratings (1-5 Stars):

Average: **4.9**

Stars:



Avg Connection Time (On Demand Visits Only): **6.0 Minutes**

Historical Post Visit Survey Results

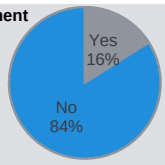
Without Doctor On Demand, where would you have gone to get this issue treated?

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

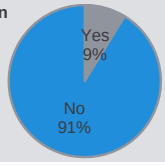
Response	# Responses	% Responses
Emergency Room	46	3%
Urgent Care	965	57%
Doctor's Office	455	27%
Stayed Home	166	10%
Other	58	3%

Six Month Trends: Visit Initiation

Initiated By Appointment
(Medical Visits Only)

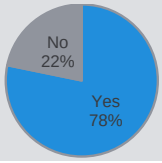


Initiated By Custodian

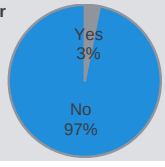


Six Month Trends: Visit Result

Resulted In Rx



Resulted In Lab Order



Historical Top 15 Symptoms

Symptom	# Symptoms	% of All Sym
Chest: Cough	1,452	6.7%
Head / Neck: Headache	1,361	6.2%
General Symptoms: Fatigue / weakness	1,351	6.2%
Head / Neck: Sore throat	1,347	6.2%
Head / Neck: Nasal discharge	1,144	5.2%
General Symptoms: Difficulty sleeping	1,074	4.9%
Head / Neck: Congestion/sinus problem	1,002	4.6%
General Symptoms: Fever	829	3.8%
Head / Neck: Congestion / sinus problem	660	3.0%
General Symptoms: Loss of appetite	642	2.9%
Gastrointestinal: Sore throat	562	2.6%
Genitourinary: Discomfort / burning with urination	495	2.3%
Genitourinary: Frequent urination	485	2.2%
Head / Neck: Difficulty / pain swallowing	383	1.8%
Chest: Shortness of breath	373	1.7%

Historical Top 15 ICD10 Codes

ICD10 Code And Description	# ICD10s	% of All ICD10
N39.0 - Urinary tract infection, site not specified	487	7.4%
J06.9 - Acute upper respiratory infection, unspecified	427	6.5%
J01.90 - Acute sinusitis, unspecified	396	6.0%
J02.9 - Acute pharyngitis, unspecified	220	3.4%
J20.9 - Acute bronchitis, unspecified	190	2.9%
Z63.0 - Problems in relationship with spouse or partner	133	2.0%
R05 - Cough	131	2.0%
F43.23 - Adjustment disorder with mixed anxiety and depressed mo	125	1.9%
Z76.0 - Encounter for issue of repeat prescription	121	1.8%
J01.00 - Acute maxillary sinusitis, unspecified	111	1.7%
J11.1 - Influenza due to unidentified influenza virus with other respi	109	1.7%
J01.80 - Other acute sinusitis	107	1.6%
F41.1 - Generalized anxiety disorder	100	1.5%
F41.9 - Anxiety disorder, unspecified	83	1.3%
J01.10 - Acute frontal sinusitis, unspecified	70	1.1%

Historical Top 15 Rx

Rx	# Visits	% of All Rx
benzonatate	449	8.3%
amoxicillin-clavulanate	428	7.9%
predniSONE	397	7.3%
nitrofurantoin	329	6.1%
albuterol	324	6.0%
methylPREDNISolone	182	3.3%
fluticasone nasal	167	3.1%
azithromycin	163	3.0%
amoxicillin	156	2.9%
oseltamivir	155	2.9%
sulfamethoxazole-trimethoprim	136	2.5%
fluconazole	132	2.4%
ipratropium nasal	117	2.2%
doxycycline	111	2.0%
dextromethorphan-promethazine	93	1.7%

Historical Top 15 Lab Orders

Lab Name	# Lab Orders	% of All Orders
TSH with Reflex to Free T4	41	11.5%
Urinalysis, Complete with Reflex	38	10.6%
Comprehensive Metabolic Panel	25	7.0%
Urine Culture, Routine	24	6.7%
CBC+diff	22	6.1%
Lipid Panel	22	6.1%
Hemoglobin A1c	18	5.0%
Vitamin D	16	4.5%
B12/Folate	15	4.2%
Chlamydia/GC, Urine	13	3.6%
Urinalysis, Complete	13	3.6%
Basic Metabolic Panel	8	2.2%
Glucose, Serum	7	2.0%
RPR w/ Reflex	6	1.7%
T3, Free	5	1.4%

4.3.2

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

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

   4.3 Acceptance of PEBP vendor quarterly reports for the timeframe of October 1, 2019 – December 31, 2019.

   4.3.2 The Standard Insurance – Basic Life and Long-Term Disability Insurance

The Standard

Quarterly Report: Basic Life Insurance and Long Term Disability:
Quarter Ending
December 31, 2019

Report Table of Contents

Basic Life Insurance & Long Term Disability Executive Summary

Most Recent Five Plan Years: July 01, 2015 to December 31, 2019

This is the second quarter report for the 2019-20 plan year, providing information for the period beginning July 1, 2015 and ending December 31, 2019.

Basic Life

At the half-way point of the current plan year, Basic Life incidence (page 4) is up year-over-year for active members and for retirees. At this time last year, the overall incidence rate was 1.9 claims/1,000 lives; this year, it has increased to 2.2. From a loss ratio perspective (page 5), the loss ratio for active members is up from 18% last year to 26% this year. For retirees, the loss ratio is down, from 272% to 241%. Historically, the highest claim activity for PEBP is in the 3rd quarter of the plan year. We'll see how the next quarter impacts results.

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

Long Term Disability

LTD claim incidence (page 7) is reported on an incurred basis, and claims are charged to the plan year in which a disability started. As a result, we typically don't have credible incidence information during the first half of the plan year. At this time last year, there were only 2 LTD claims for the 2018-19 plan year, a small percentage of the 15 claims that were incurred during that plan year. For the 2019-20 plan year, we've already had 8 claims incurred (over half compared to the entire plan 2018-19 plan year). This is a considerable increase compared to last year for the same time period, as well.

LTD loss ratios (page 8) are reported on a cash basis, without regard for the incurred date. At the halfway point, the loss ratio for the 2019-20 plan year is 29%, which is slightly lower than the loss ratio for the 2018-19 plan year of 31%. The 29% loss ratio is lower than the five-year average loss ratio of 43%.

LTD claims by diagnosis (page 7) provides an interesting comparison to your Basic Life results. PEBP's LTD liability for Circulatory claims is higher than our block. However, your Cancer liability is also higher than our public block, in contrast to your life claims results. That means you have worse morbidity but better mortality for Cancer claims. PEBP continues to have significantly better results for Musculoskeletal claims when compared to our block, by almost 50%.

Basic Life Insurance Claims by Plan Year and Participant Type

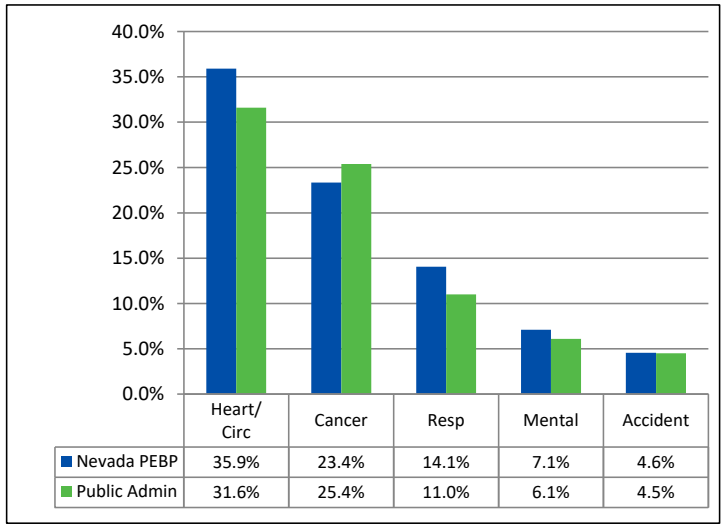
Most Recent Five Plan Years: July 01, 2015 to December 31, 2019

	From Jul-15 Through Jun-16		From Jul-16 Through Jun-17		From Jul-17 Through Jun-18		From Jul-18 Through Jun-19		From Jul-19 Through Jun-20	
Participant Type	**Count**	**Inc./ 1000**	**Count**	**Inc./ 1000**	**Count**	**Inc./ 1000**	**Count**	**Inc./ 1000**	**Count**	**Inc./ 1000**
Actives	41	1.7	51	2.0	41	1.6	47	1.8	14	0.5
Retirees	271	18.4	321	21.6	294	19.4	273	17.4	80	5.0
Totals	**312**	**8.4**	**372**	**9.5**	**335**	**8.4**	**320**	**7.8**	**94**	**2.2**

Basic Life Insurance Claims by Diagnostic Category

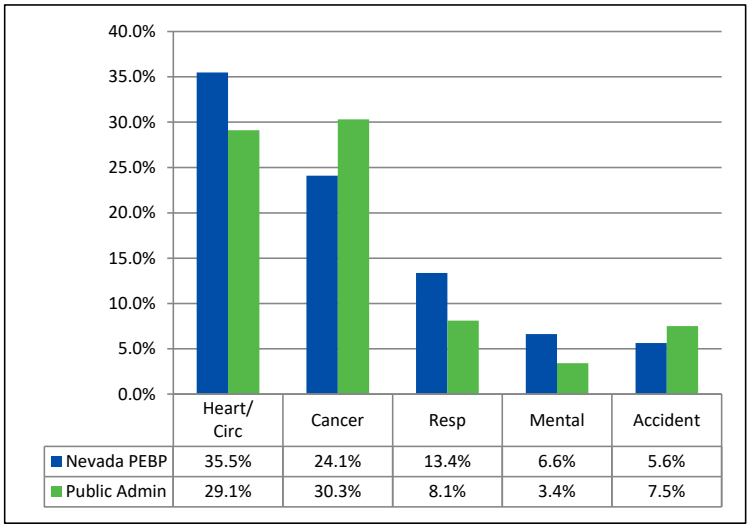
Public Admin benchmark is from SIC book of business for most recent 5 calendar years

Top Five Diagnostic Categories by Incidence



	Heart/ Circ	Cancer	Resp	Mental	Accident
Nevada PEBP	35.9%	23.4%	14.1%	7.1%	4.6%
Public Admin	31.6%	25.4%	11.0%	6.1%	4.5%

Top Five Diagnostic Categories by Liability

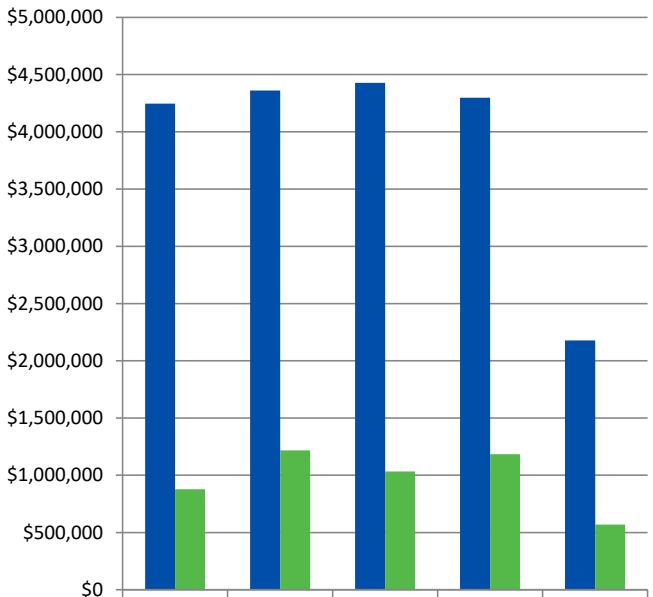


	Heart/ Circ	Cancer	Resp	Mental	Accident
Nevada PEBP	35.5%	24.1%	13.4%	6.6%	5.6%
Public Admin	29.1%	30.3%	8.1%	3.4%	7.5%

Basic Life Insurance Earned Premiums & Liability by Participant Type

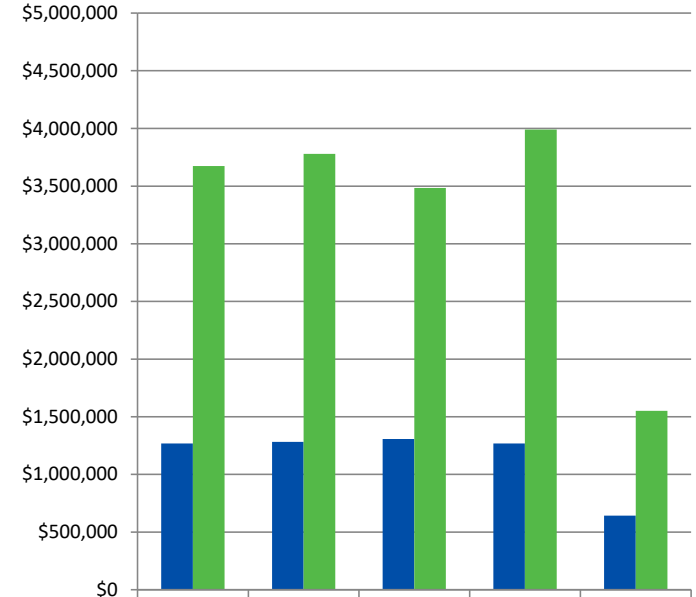
Most Recent Five Plan Years: July 01, 2015 to December 31, 2019

Active Participants



	2015 - 16	2016 - 17	2017 - 18	2018 - 19	2019 - 20
Earned Premium	$4,245,693	$4,360,152	$4,427,366	$4,297,629	$2,178,355
Claim Liability	$877,477	$1,217,375	$1,031,986	$1,184,218	$569,585
Loss Ratio	0.21	0.28	0.23	0.28	0.26

Retired Participants

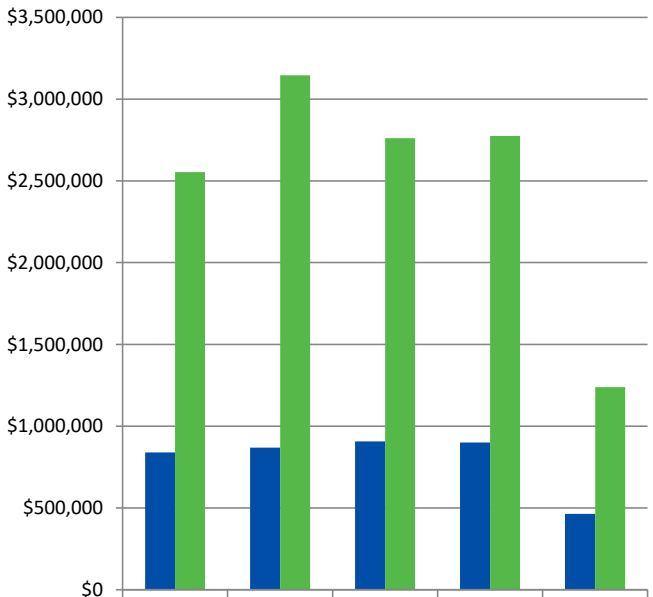


	2015 - 16	2016 - 17	2017 - 18	2018 - 19	2019 - 20
Earned Premium	$1,268,470	$1,282,457	$1,306,604	$1,267,917	$643,768
Claim Liability	$3,674,745	$3,779,175	$3,485,155	$3,989,557	$1,551,552
Loss Ratio	2.90	2.95	2.67	3.15	2.41

Basic Life Retiree Insurance Earned Premiums & Liability by Participant Type

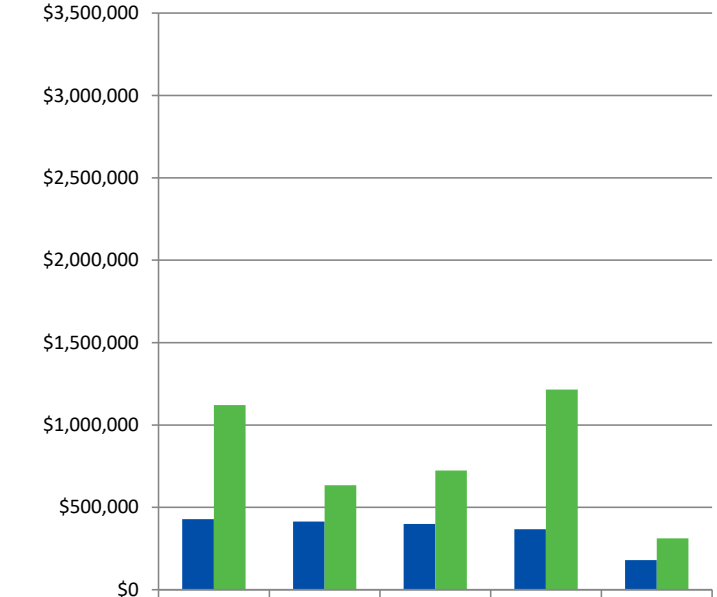
Most Recent Five Plan Years: July 01, 2015 to December 31, 2019

State Retired Participants



	2015 - 16	2016 - 17	2017 - 18	2018 - 19	2019 - 20
Earned Premium	$839,732	$868,775	$907,326	$900,218	$463,823
Claim Liability	$2,553,682	$3,145,175	$2,761,244	$2,774,315	$1,239,349
Loss Ratio	3.04	3.62	3.04	3.08	2.67

Non-State Retired Participants



	2015 - 16	2016 - 17	2017 - 18	2018 - 19	2019 - 20
Earned Premium	$428,738	$413,682	$399,278	$367,699	$179,945
Claim Liability	$1,121,063	$634,000	$723,911	$1,215,242	$312,203
Loss Ratio	2.61	1.53	1.81	3.30	1.73

Long Term Disability Claims by Plan Year

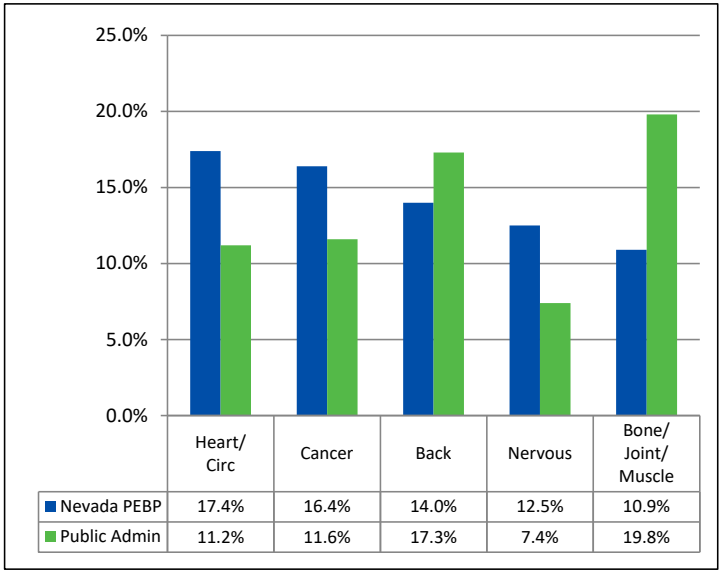
Most Recent Five Plan Years: July 01, 2015 to December 31, 2019

	From Jul-15 Through Jun-16		From Jul-16 Through Jun-17		From Jul-17 Through Jun-18		From Jul-18 Through Jun-19		From Jul-19 Through Jun-20	
	Count	Inc./ 1000	Count	Inc./ 1000	Count	Inc./ 1000	Count	Inc./ 1000	Count	Inc./ 1000
LTD Claims	28	1.1	36	1.4	29	1.1	24	0.9	8	0.3

Long Term Disability Claims by Diagnostic Category

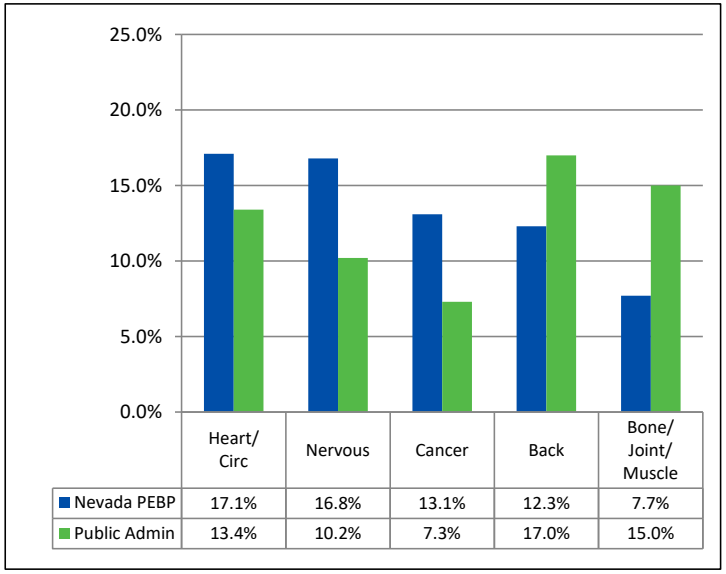
Public Admin benchmark is from SIC book of business for most recent 5 calendar years

Top Five Diagnostic Categories by Incidence



	Heart/ Circ	Cancer	Back	Nervous	Bone/ Joint/ Muscle
Nevada PEBP	17.4%	16.4%	14.0%	12.5%	10.9%
Public Admin	11.2%	11.6%	17.3%	7.4%	19.8%

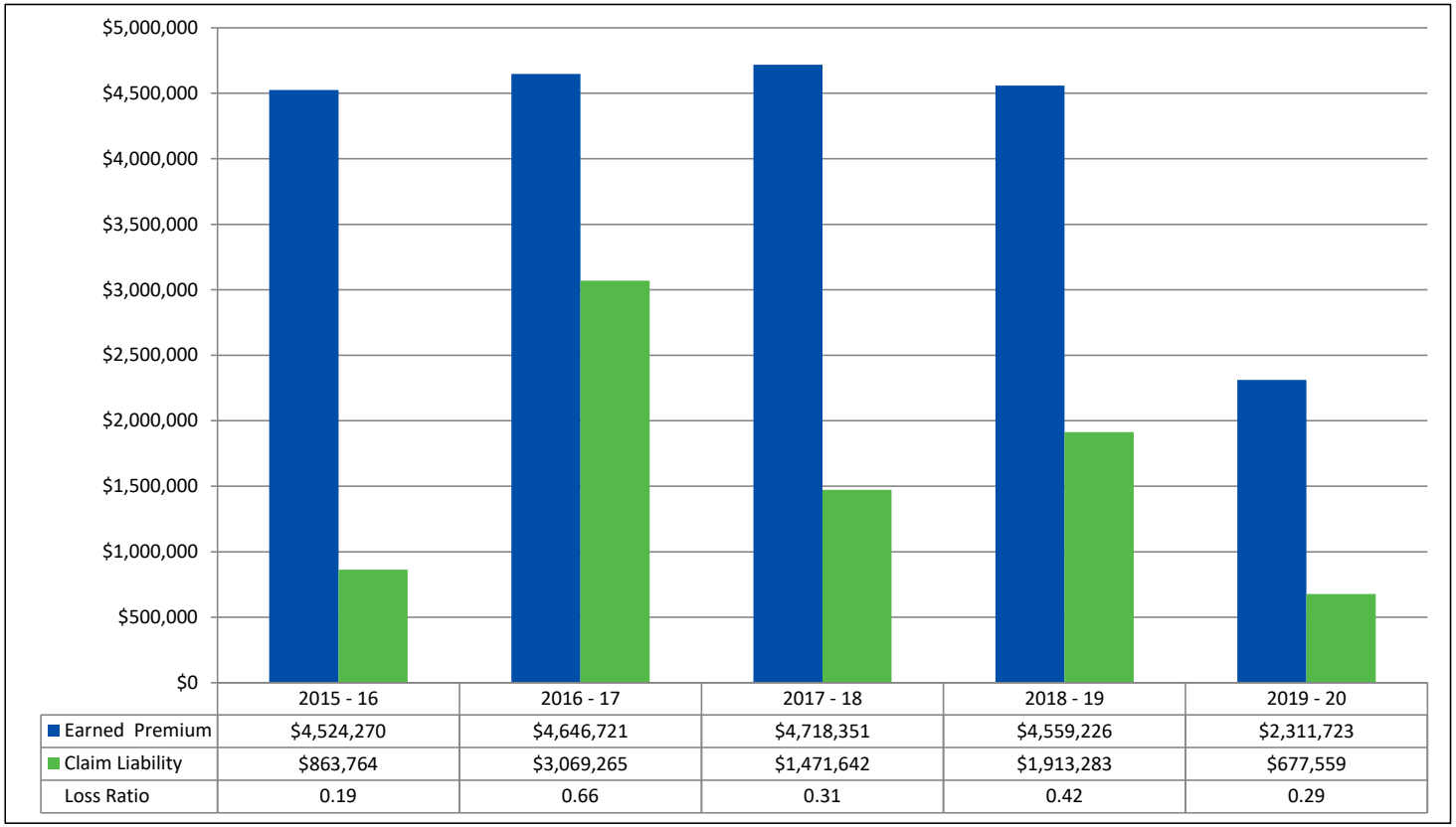
Top Five Diagnostic Categories by Liability



	Heart/ Circ	Nervous	Cancer	Back	Bone/ Joint/ Muscle
Nevada PEBP	17.1%	16.8%	13.1%	12.3%	7.7%
Public Admin	13.4%	10.2%	7.3%	17.0%	15.0%

Long Term Disability Earned Premiums & Liability

Most Recent Five Plan Years: July 01, 2015 to December 31, 2019



	2015 - 16	2016 - 17	2017 - 18	2018 - 19	2019 - 20
Earned Premium	$4,524,270	$4,646,721	$4,718,351	$4,559,226	$2,311,723
Claim Liability	$863,764	$3,069,265	$1,471,642	$1,913,283	$677,559
Loss Ratio	0.19	0.66	0.31	0.42	0.29

Claim Appeals

Quarterly Update for Plan Year to Date July 01, 2019 to December 31, 2019

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

STATE OF NEVADA PUBLIC EMPLOYEES' BENEFITS PROGRAM

Group Policy 642682
State Actives

REFUNDING EXPERIENCE REPORT
Basic Life
Incurred After 7/1/2008

	7/1/2019 through 12/31/2019	7/1/2008 through 12/31/2019
Earned Premium	2,177,708	38,784,728
Paid Claims	505,989	9,815,031
Change in Active Claim Reserves	53,563	1,366,250
Change in IBNR Reserves	10,034	932,702
Conversions	0	7,100
Total Incurred Claims	569,585	12,121,082
Commissions	0	0
Premium Taxes	76,220	1,357,465
Admin Fees	0	0
Other Expenses and Risk Charges	297,002	4,703,539
Total Expenses and Risk Charges	373,222	6,061,004
Balance	1,234,901	20,602,642
Balance From Previous Period	19,367,741	N/A
Prior Paid Refunds	N/A	0
Net Balance	20,602,642	20,602,642
Incurred loss ratio	26%	31%

RPM
1/30/2020

STATE OF NEVADA PUBLIC EMPLOYEES' BENEFITS PROGRAM

Group Policy 642682
Non-State Actives

REFUNDING EXPERIENCE REPORT
Basic Life
Incurred After 7/1/2008

	7/1/2019 through 12/31/2019	7/1/2008 through 12/31/2019
Earned Premium	647	250,437
Paid Claims	0	120,000
Change in Active Claim Reserves	0	19,500
Change in IBNR Reserves	0	275
Conversions	0	0
Total Incurred Claims	0	139,775
Commissions	0	0
Premium Taxes	23	8,765
Admin Fees	0	0
Other Expenses and Risk Charges	86	28,002
Total Expenses and Risk Charges	109	36,767
Balance	538	73,895
Balance From Previous Period	73,357	N/A
Prior Paid Refunds	N/A	0
Net Balance	73,895	73,895
Incurred loss ratio	0%	56%

RPM
1/30/2020

STATE OF NEVADA PUBLIC EMPLOYEES' BENEFITS PROGRAM

Group Policy 642682
State Retirees

REFUNDING EXPERIENCE REPORT
Basic Life
Incurred After 7/1/2008

	7/1/2019 through 12/31/2019	7/1/2008 through 12/31/2019
Earned Premium	463,823	7,040,180
Paid Claims	1,221,875	22,072,662
Change in Active Claim Reserves	15,625	87,500
Change in IBNR Reserves	1,849	70,061
Conversions	0	2,050
Total Incurred Claims	1,239,349	22,232,273
Commissions	0	0
Premium Taxes	16,234	246,407
Admin Fees	0	0
Other Expenses and Risk Charges	79,969	1,122,191
Total Expenses and Risk Charges	96,203	1,368,598
Balance	(871,730)	(16,560,691)
Balance From Previous Period	(15,688,962)	N/A
Prior Paid Refunds	N/A	0
Net Balance	(16,560,691)	(16,560,691)
Incurred loss ratio	267%	316%

RPM
1/30/2020

STATE OF NEVADA PUBLIC EMPLOYEES' BENEFITS PROGRAM

Group Policy 642682
Non-State Retirees

REFUNDING EXPERIENCE REPORT
Basic Life
Incurred After 7/1/2008

	7/1/2019 through 12/31/2019	7/1/2008 through 12/31/2019
Earned Premium	179,945	4,160,538
Paid Claims	343,750	8,323,987
Change in Active Claim Reserves	(31,250)	25,000
Change in IBNR Reserves	(297)	26,868
Conversions	0	0
Total Incurred Claims	312,203	8,375,855
Commissions	0	0
Premium Taxes	6,298	145,619
Admin Fees	0	0
Other Expenses and Risk Charges	29,071	592,597
Total Expenses and Risk Charges	35,369	738,216
Balance	(167,626)	(4,953,534)
Balance From Previous Period	(4,785,907)	N/A
Prior Paid Refunds	N/A	0
Net Balance	(4,953,534)	(4,953,534)
Incurred loss ratio	173%	201%

RPM
1/30/2020

STATE OF NEVADA PUBLIC EMPLOYEES' BENEFITS PROGRAM

Group Policy 642682
All

REFUNDING EXPERIENCE REPORT
Basic Life
Incurred After 7/1/2008

	7/1/2019 through 12/31/2019	7/1/2008 through 12/31/2019
Earned Premium	2,822,123	50,235,883
Paid Claims	2,071,614	40,331,680
Change in Active Claim Reserves	37,938	1,498,250
Change in IBNR Reserves	11,586	1,029,906
Conversions	0	9,150
Total Incurred Claims	2,121,137	42,868,986
Commissions	0	0
Premium Taxes	98,775	1,758,256
Admin Fees	0	0
Other Expenses and Risk Charges	406,128	6,446,330
Total Expenses and Risk Charges	504,903	8,204,586
Balance	196,083	(837,688)
Balance From Previous Period	(1,033,772)	N/A
Prior Paid Refunds	N/A	0
Net Balance	(837,688)	(837,688)
Incurred loss ratio	75%	85%

RPM
1/30/2020

STATE OF NEVADA PUBLIC EMPLOYEES' BENEFITS PROGRAM

Group Policy 642682
State Actives

EXPERIENCE REPORT
Basic Life, Prior Basic AD&D and Prior Dependent Life

	7/1/2019 through 12/31/2019	7/1/2003 through 12/31/2019
Earned Premium	2,177,708	54,990,413
Paid Claims	525,989	16,568,804
Change in Active Claim Reserves	34,063	1,866,750
Change in IBNR Reserves	10,034	932,702
Conversions	0	18,300
Total Incurred Claims	570,085	19,386,556
Commissions	0	0
Premium Taxes	76,220	1,924,665
Admin Fees	0	0
Other Expenses and Risk Charges	297,302	6,346,036
Total Expenses and Risk Charges	373,522	8,270,701
Balance	1,234,101	27,333,157
Incurred loss ratio	26%	35%

RPM
1/30/2020

STATE OF NEVADA PUBLIC EMPLOYEES' BENEFITS PROGRAM

Group Policy 642682
Non-State Actives

EXPERIENCE REPORT
Basic Life, Prior Basic AD&D and Prior Dependent Life

	7/1/2019 through 12/31/2019	7/1/2003 through 12/31/2019
Earned Premium	647	790,038
Paid Claims	0	368,000
Change in Active Claim Reserves	0	19,500
Change in IBNR Reserves	0	275
Conversions	0	0
Total Incurred Claims	0	387,775
Commissions	0	0
Premium Taxes	23	27,651
Admin Fees	0	0
Other Expenses and Risk Charges	86	84,694
Total Expenses and Risk Charges	109	112,345
Balance	538	289,918
Incurred loss ratio	0%	49%

RPM
1/30/2020

STATE OF NEVADA PUBLIC EMPLOYEES' BENEFITS PROGRAM

Group Policy 642682
State Retirees

EXPERIENCE REPORT
Basic Life, Prior Basic AD&D and Prior Dependent Life

	7/1/2019 through 12/31/2019	7/1/2003 through 12/31/2019
Earned Premium	463,823	9,508,334
Paid Claims	1,221,875	30,964,162
Change in Active Claim Reserves	15,625	87,500
Change in IBNR Reserves	1,849	70,061
Conversions	0	2,050
Total Incurred Claims	1,239,349	31,123,773
Commissions	0	0
Premium Taxes	16,234	332,792
Admin Fees	0	0
Other Expenses and Risk Charges	79,969	1,421,414
Total Expenses and Risk Charges	96,203	1,754,206
Balance	(871,730)	(23,369,645)
Incurred loss ratio	267%	327%

RPM
1/30/2020

STATE OF NEVADA PUBLIC EMPLOYEES' BENEFITS PROGRAM

Group Policy 642682
Non-State Retirees

EXPERIENCE REPORT
Basic Life, Prior Basic AD&D and Prior Dependent Life

	7/1/2019 through 12/31/2019	7/1/2003 through 12/31/2019
Earned Premium	179,945	5,328,076
Paid Claims	343,750	10,848,857
Change in Active Claim Reserves	(31,250)	25,000
Change in IBNR Reserves	(297)	26,868
Conversions	0	0
Total Incurred Claims	312,203	10,900,725
Commissions	0	0
Premium Taxes	6,298	186,483
Admin Fees	0	0
Other Expenses and Risk Charges	29,071	724,953
Total Expenses and Risk Charges	35,369	911,436
Balance	(167,626)	(6,484,085)
Incurred loss ratio	173%	205%

RPM
1/30/2020

STATE OF NEVADA PUBLIC EMPLOYEES' BENEFITS PROGRAM

Group Policy 642682
All

EXPERIENCE REPORT
Basic Life, Prior Basic AD&D and Prior Dependent Life

	7/1/2019 through 12/31/2019	7/1/2003 through 12/31/2019
Earned Premium	2,822,123	70,616,861
Paid Claims	2,091,614	58,749,823
Change in Active Claim Reserves	18,438	1,998,750
Change in IBNR Reserves	11,586	1,029,906
Conversions	0	20,350
Total Incurred Claims	2,121,637	61,798,829
Commissions	0	0
Premium Taxes	98,775	2,471,591
Admin Fees	0	0
Other Expenses and Risk Charges	406,428	8,577,096
Total Expenses and Risk Charges	505,203	11,048,687
Balance	195,283	(2,230,656)
Incurred loss ratio	75%	88%

RPM
1/30/2020

STATE OF NEVADA PUBLIC EMPLOYEES' BENEFITS PROGRAM

Group Policy 642682
All Actives

EXPERIENCE REPORT
Additional Life, Additional AD&D and Additional Dependent

	7/1/2019 through 12/31/2019	7/1/2003 through 12/31/2019
Earned Premium	1,320,234	24,057,786
Paid Claims	486,769	12,775,292
Change in Active Claim Reserves	(132,375)	960,000
Change in IBNR Reserves	213,575	469,369
Conversions	0	8,200
Total Incurred Claims	567,969	14,212,860
Commissions	0	0
Premium Taxes	46,208	842,154
Admin Fees	21,286	3,146,606
Other Expenses and Risk Charges	195,663	2,854,069
Total Expenses and Risk Charges	263,157	6,842,829
Balance	489,108	3,002,096
Incurred loss ratio	43%	59%

RPM
1/30/2020

STATE OF NEVADA PUBLIC EMPLOYEES' BENEFITS PROGRAM

Group Policy 642682
All Retirees

EXPERIENCE REPORT
Additional Life

	7/1/2019 through 12/31/2019	7/1/2003 through 12/31/2019
Earned Premium	808,152	11,477,308
Paid Claims	215,000	7,623,529
Change in Active Claim Reserves	(15,000)	0
Change in IBNR Reserves	53,505	121,595
Conversions	0	8,610
Total Incurred Claims	253,505	7,753,734
Commissions	0	0
Premium Taxes	28,285	401,409
Admin Fees	7,250	1,445,073
Other Expenses and Risk Charges	118,708	1,404,120
Total Expenses and Risk Charges	154,243	3,250,602
Balance	400,404	472,972
Incurred loss ratio	31%	68%

RPM
1/30/2020

STATE OF NEVADA PUBLIC EMPLOYEES' BENEFITS PROGRAM
Option A
7 Day Benefit Waiting Period
Group Policy 642682

EXPERIENCE REPORT
Short Term Disability

	7/1/2019 through 12/31/2019	7/1/2007 through 12/31/2019
Earned Premium	95,827	1,822,366
Paid Claims	48,813	937,687
Change in IBNR Reserves	34	30,726
Employer FICA	0	0
Total Incurred Claims	48,848	968,414
Commissions	0	0
Premium Taxes	3,354	63,800
Admin Fees	1,760	188,969
Other Expenses and Risk Charges	24,643	418,418
Total Expenses and Risk Charges	29,758	671,187
Balance	17,222	182,766
Incurred loss ratio	51%	53%

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1/30/2020

STATE OF NEVADA PUBLIC EMPLOYEES' BENEFITS PROGRAM
Option B
14 Day Benefit Waiting Period
Group Policy 642682

EXPERIENCE REPORT
Short Term Disability

	7/1/2019 through 12/31/2019	7/1/2007 through 12/31/2019
Earned Premium	130,884	2,104,588
Paid Claims	124,148	1,330,246
Change in IBNR Reserves	(818)	41,907
Employer FICA	0	0
Total Incurred Claims	123,330	1,372,153
Commissions	0	0
Premium Taxes	4,581	73,680
Admin Fees	2,401	217,363
Other Expenses and Risk Charges	42,855	513,277
Total Expenses and Risk Charges	49,837	804,320
Balance	(42,283)	(71,884)
Incurred loss ratio	94%	65%

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1/30/2020

STATE OF NEVADA PUBLIC EMPLOYEES' BENEFITS PROGRAM
Option C
30 Day Benefit Waiting Period
Group Policy 642682

EXPERIENCE REPORT
Short Term Disability

	7/1/2019 through 12/31/2019	7/1/2007 through 12/31/2019
Earned Premium	151,482	2,476,755
Paid Claims	75,123	1,532,355
Change in IBNR Reserves	(2,115)	63,557
Employer FICA	0	0
Total Incurred Claims	73,008	1,595,912
Commissions	0	0
Premium Taxes	5,302	86,706
Admin Fees	2,774	256,342
Other Expenses and Risk Charges	38,629	599,465
Total Expenses and Risk Charges	46,706	942,513
Balance	31,768	(61,670)
Incurred loss ratio	48%	64%

RPM
1/30/2020

STATE OF NEVADA PUBLIC EMPLOYEES' BENEFITS PROGRAM
All

Group Policy 642682

EXPERIENCE REPORT
Short Term Disability

	7/1/2019 through 12/31/2019	7/1/2007 through 12/31/2019
Earned Premium	378,193	6,403,709
Paid Claims	248,084	3,800,288
Change in IBNR Reserves	(2,898)	136,191
Employer FICA	0	0
Total Incurred Claims	245,186	3,936,479
Commissions	0	0
Premium Taxes	13,237	224,186
Admin Fees	6,936	662,674
Other Expenses and Risk Charges	106,127	1,531,160
Total Expenses and Risk Charges	126,300	2,418,019
Balance	6,707	49,211
Incurred loss ratio	65%	61%

RPM
1/30/2020

STATE OF NEVADA PUBLIC EMPLOYEES' BENEFITS PROGRAM
State Actives

Group Policy 642682

REFUNDING EXPERIENCE REPORT
Long Term Disability - Incurred After 7/1/2008

	7/1/2019 through 12/31/2019	7/1/2008 through 12/31/2019
Earned Premium	2,311,037	42,406,110
Paid Claims	945,587	20,409,849
Change in Active Claim Reserves	(298,143)	9,519,022
Change in IBNR Reserves	30,023	2,772,553
Employer FICA	93	8,786
Total Incurred Claims	677,559	32,710,210
Commissions	0	0
Premium Taxes	80,886	1,484,215
Other Expenses and Risk Charges	575,058	10,729,642
Total Expenses and Risk Charges	655,944	12,213,857
Balance	977,533	(2,517,956)
Incurred loss ratio	29%	77%

RPM
1/30/2020

STATE OF NEVADA PUBLIC EMPLOYEES' BENEFITS PROGRAM
Non-State Actives

Group Policy 642682

REFUNDING EXPERIENCE REPORT
Long Term Disability - Incurred After 7/1/2008

	7/1/2019 through 12/31/2019	7/1/2008 through 12/31/2019
Earned Premium	686	219,053
Paid Claims	0	202,064
Change in Active Claim Reserves	0	0
Change in IBNR Reserves	0	817
Employer FICA	0	173
Total Incurred Claims	0	203,054
Commissions	0	0
Premium Taxes	24	7,666
Other Expenses and Risk Charges	143	59,327
Total Expenses and Risk Charges	167	66,993
Balance	519	(50,994)
Incurred loss ratio	0%	93%

RPM
1/30/2020

STATE OF NEVADA PUBLIC EMPLOYEES' BENEFITS PROGRAM
All

Group Policy 642682

REFUNDING EXPERIENCE REPORT
Long Term Disability - Incurred After 7/1/2008

	7/1/2019 through 12/31/2019	7/1/2008 through 12/31/2019
Earned Premium	2,311,723	42,625,163
Paid Claims	945,587	20,611,913
Change in Active Claim Reserves	(298,143)	9,519,022
Change in IBNR Reserves	30,023	2,773,370
Employer FICA	93	8,958
Total Incurred Claims	677,559	32,913,263
Commissions	0	0
Premium Taxes	80,910	1,491,881
Other Expenses and Risk Charges	575,201	10,788,968
Total Expenses and Risk Charges	656,111	12,280,849
Balance	978,053	(2,568,950)
Incurred loss ratio	29%	77%

RPM
1/30/2020

STATE OF NEVADA PUBLIC EMPLOYEES' BENEFITS PROGRAM
All

Group Policy 642682

REFUNDING EXPERIENCE REPORT
Long Term Disability - Incurred After 7/1/2008

	7/1/2019 through 12/31/2019	7/1/2008 through 12/31/2019
Earned Premium	2,311,723	42,625,163
Paid Claims	945,587	20,611,913
Change in Active Claim Reserves	(298,143)	9,519,022
Change in IBNR Reserves	30,023	2,773,370
Employer FICA	93	8,958
Total Incurred Claims	677,559	32,913,263
Commissions	0	0
Premium Taxes	80,910	1,491,881
Other Expenses and Risk Charges	575,201	10,788,968
Total Expenses and Risk Charges	656,111	12,280,849
Balance	978,053	(2,568,950)
Prior Balance Carried Forward	(3,547,003)	N/A
Prior CFR Deposits /(Withdrawals)	N/A	0
Current Refundable Balance	(2,568,950)	(2,568,950)
Current CFR Deposit/(Withdrawal)	0	0
Final Balance	(2,568,950)	(2,568,950)

RPM
1/30/2020

STATE OF NEVADA PUBLIC EMPLOYEES' BENEFITS PROGRAM

Group Policy 642682

TOTAL EXPERIENCE REPORT
Long Term Disability

	7/1/2019 through 12/31/2019	7/1/2003 through 12/31/2019
Earned Premium	2,311,723	55,460,899
Paid Claims	1,042,858	34,075,666
Change in Active Claim Reserves	(382,090)	10,074,769
Change in IBNR Reserves	30,023	2,773,370
Employer FICA	93	15,865
Total Incurred Claims	690,884	46,939,670
Commissions	0	0
Premium Taxes	80,910	1,941,132
Other Expenses and Risk Charges	584,928	14,242,841
Total Expenses and Risk Charges	665,838	16,183,973
Balance	955,001	(7,662,744)
Incurred loss ratio	30%	85%

RPM
1/30/2020

The Standard

Quarterly Report: Voluntary Life Insurance and Short Term Disability:
Quarter Ending
December 31, 2019

Board Meeting Date: March 31, 2020

Report Table of Contents

Voluntary Life Insurance & Short-Term Disability Executive Summary

Most Recent Five Plan Years: July 01, 2015 to December 31, 2019

This is the second quarter report for the 2019-20 plan year, providing information for the period beginning July 1, 2015 and ending December 31, 2019.

Voluntary Life

At the halfway point of the current plan year, Voluntary Life claim incidence (page 4) is up compared to last year, from 2.5 claims per thousand to 4.0 claims per thousand. Both active employees and retirees contributed to the higher result; active employee incidence is 1.7 claims compared to 0.4 claims per thousand last year. Retiree incidence is 7.5 claims per thousand, compared to 6.0 last year.

Year-to-date loss ratios (page 5) are also up for both active employees and retirees: from 11% this time last year to 43% this year for active employees and 20% last year to 31% this year for retirees. It's worth noting that last year's results for Voluntary Life improved from the prior year's results. It looks like the current plan year is trending negatively compared to last year for this time period, so we will keep an eye on the results for the remaining periods of this year.

Short Term Disability

STD experience results have become much more consistent over the past several years. Prior to that time, we'd seen a steady increase in claim incidence and loss ratio. Claim incidence (page 6) is up slightly year-over-year, from 1.5 claims per hundred last year to 1.9 this year. The year-to-date loss ratio (page 7) is down, from 71% in 2018-19 to 65% in 2019-20. The loss ratio has been very consistent over the last 3 total periods: 74% for the 2016-17 plan year, 71% for 2017-18 plan year, and 76% for the 2018-19 plan year. Our target loss ratio for STD is around 68%, so the plan has been performing at a slight loss over the past 3 years. Hopefully, this years' experience will continue its positive trend for the remaining two periods.

Experience by plan option remains very inconsistent for the plan year so far, when comparing each plan option, as well as results from last year for each specific option. Option A (7 day waiting period) has a loss ratio of 51% (101% for last year), Option B (14 day waiting period) has a loss ratio of 94% (47% for last year), and Option C has a loss ratio of 48% (74% for last year).

Voluntary Life Insurance Claims by Plan Year and Participant Type

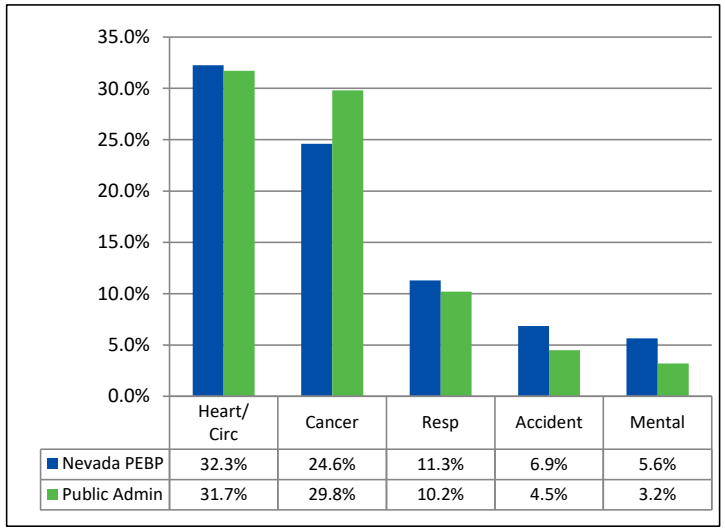
Most Recent Five Plan Years: July 01, 2015 to December 31, 2019

	From Jul-15 Through Jun-16		From Jul-16 Through Jun-17		From Jul-17 Through Jun-18		From Jul-18 Through Jun-19		From Jul-19 Through Jun-20	
Participant Type	**Count**	**Inc./ 1000**	**Count**	**Inc./ 1000**	**Count**	**Inc./ 1000**	**Count**	**Inc./ 1000**	**Count**	**Inc./ 1000**
Actives	4	1.6	11	4.8	13	5.8	10	4.1	4	1.7
Retirees	53	30.3	35	21.5	57	35.8	39	26.1	11	7.5
Totals	**57**	**13.5**	**46**	**11.7**	**70**	**18.3**	**49**	**12.5**	**15**	**4.0**

Voluntary Life Insurance Claims by Diagnostic Category

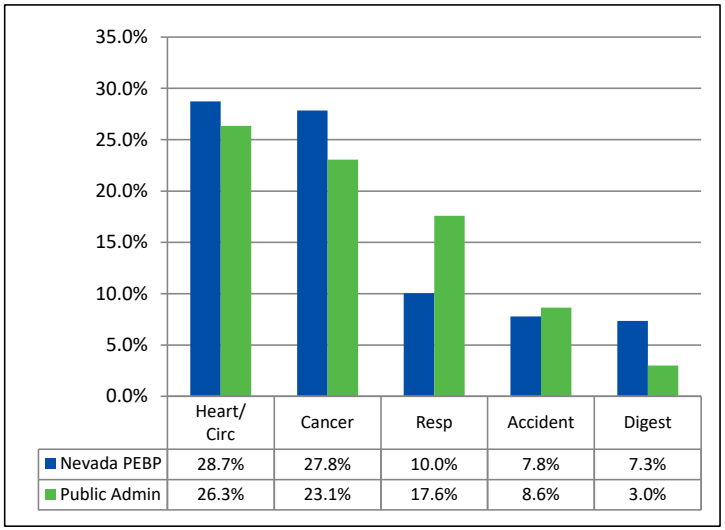
Public Admin benchmark is from SIC book of business for most recent 5 calendar years

Top Five Diagnostic Categories by Incidence



	Heart/ Circ	Cancer	Resp	Accident	Mental
Nevada PEBP	32.3%	24.6%	11.3%	6.9%	5.6%
Public Admin	31.7%	29.8%	10.2%	4.5%	3.2%

Top Five Diagnostic Categories by Liability

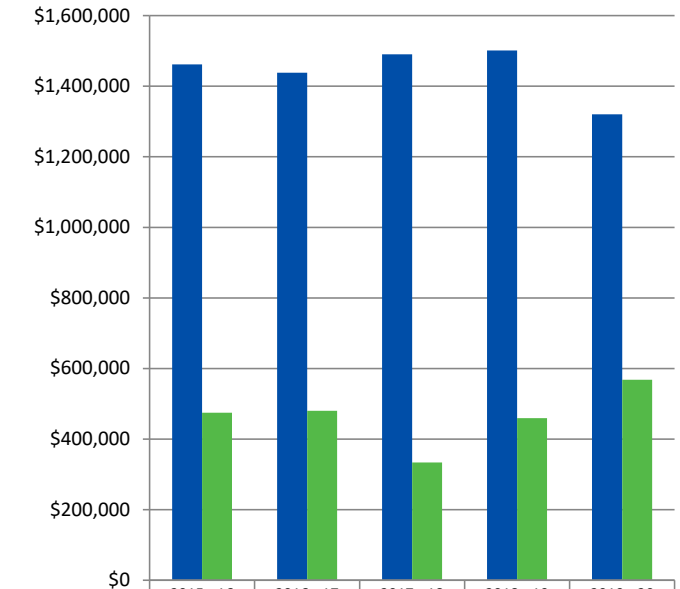


	Heart/ Circ	Cancer	Resp	Accident	Digest
Nevada PEBP	28.7%	27.8%	10.0%	7.8%	7.3%
Public Admin	26.3%	23.1%	17.6%	8.6%	3.0%

Voluntary Life Insurance Earned Premiums & Liability by Participant Type

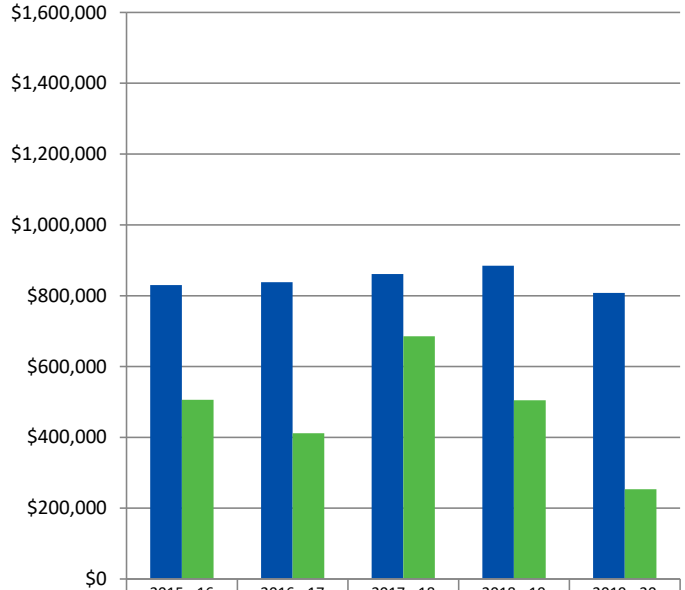
Most Recent Five Plan Years: July 01, 2015 to December 31, 2019

Active Participants



	2015 - 16	2016 - 17	2017 - 18	2018 - 19	2019 - 20
Earned Premium	$1,461,598	$1,437,863	$1,490,326	$1,501,201	$1,320,234
Claim Liability	$474,493	$479,950	$333,582	$459,080	$567,969
Loss Ratio	0.32	0.33	0.22	0.31	0.43

Retired Participants



	2015 - 16	2016 - 17	2017 - 18	2018 - 19	2019 - 20
Earned Premium	$830,266	$838,158	$861,463	$884,986	$808,152
Claim Liability	$505,980	$411,382	$685,667	$504,722	$253,505
Loss Ratio	0.61	0.49	0.80	0.57	0.31

Short Term Disability Claims by Plan Year

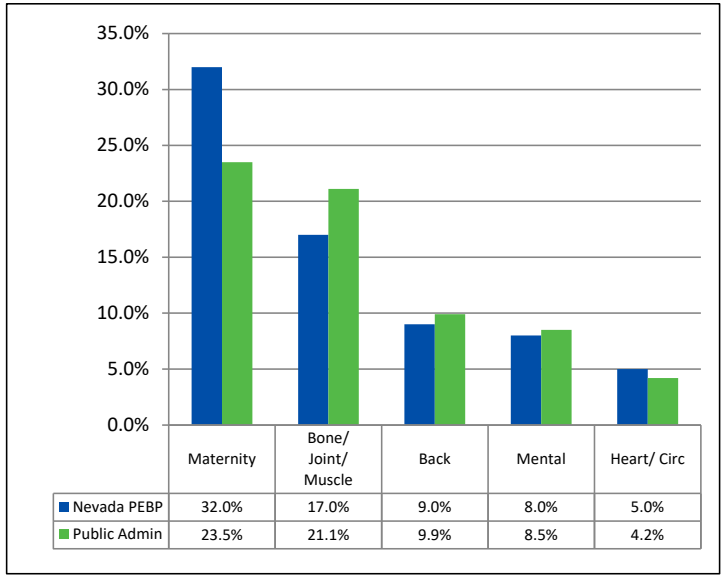
Most Recent Five Plan Years: July 01, 2015 to December 31, 2019

	From Jul-15 Through Jun-16		From Jul-16 Through Jun-17		From Jul-17 Through Jun-18		From Jul-18 Through Jun-19		From Jul-19 Through Jun-20	
	Count	Inc./ 100	Count	Inc./ 100	Count	Inc./ 100	Count	Inc./ 100	Count	Inc./ 100
STD Claims	55	3.8	77	4.9	99	6.5	84	4.2	34	1.9

Short Term Disability Claims by Diagnostic Category

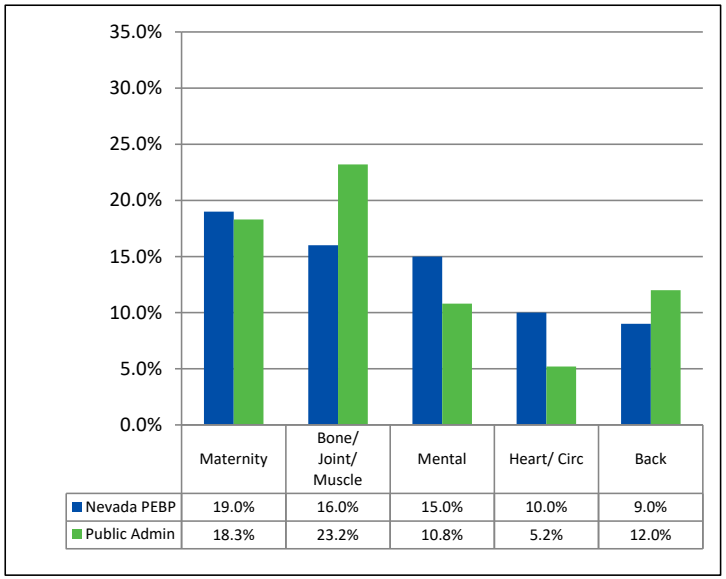
Public Admin benchmark is from SIC book of business for most recent 5 calendar years

Top Five Diagnostic Categories by Incidence



	Maternity	Bone/ Joint/ Muscle	Back	Mental	Heart/ Circ
Nevada PEBP	32.0%	17.0%	9.0%	8.0%	5.0%
Public Admin	23.5%	21.1%	9.9%	8.5%	4.2%

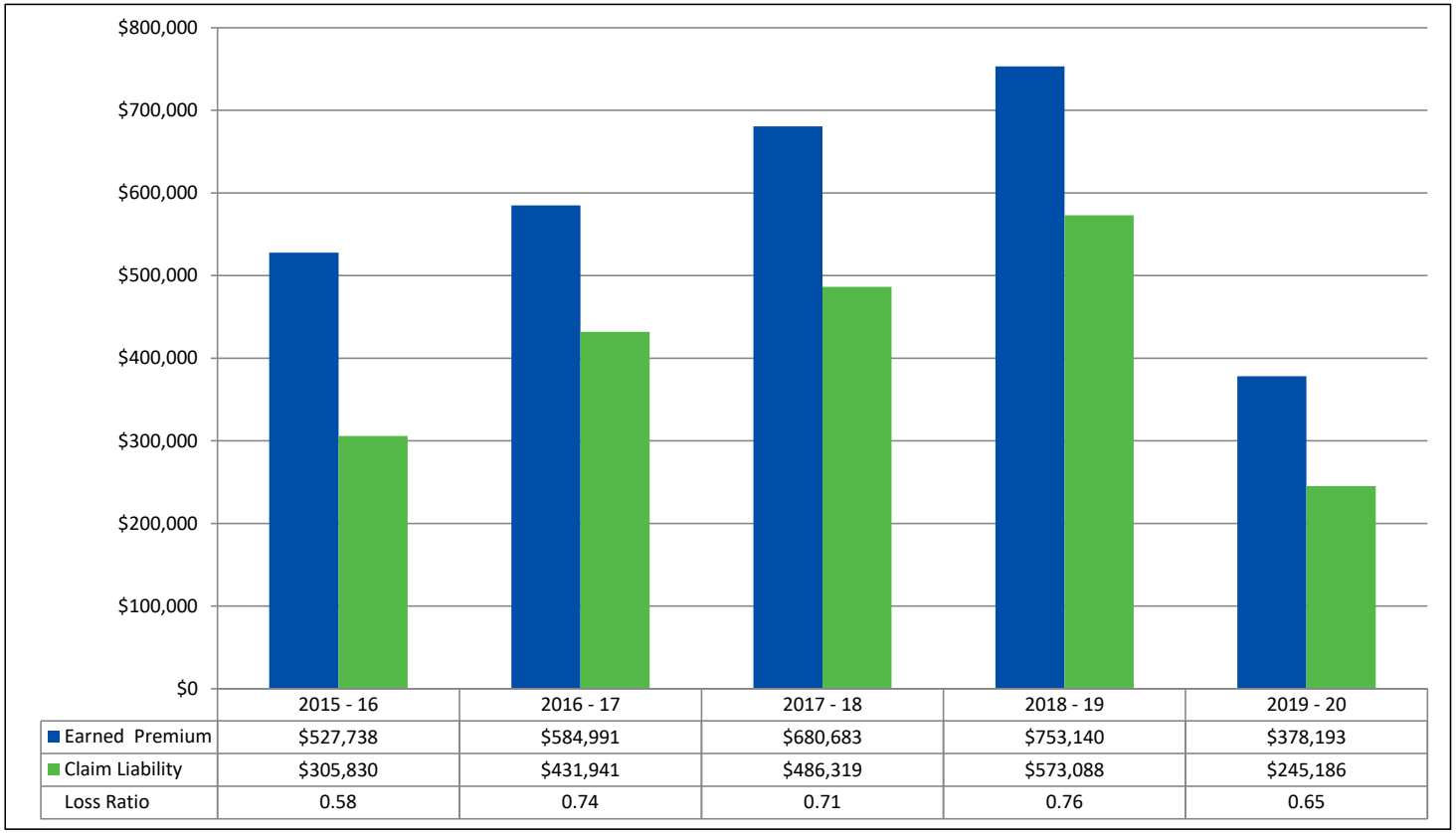
Top Five Diagnostic Categories by Liability



	Maternity	Bone/ Joint/ Muscle	Mental	Heart/ Circ	Back
Nevada PEBP	19.0%	16.0%	15.0%	10.0%	9.0%
Public Admin	18.3%	23.2%	10.8%	5.2%	12.0%

Short Term Disability Earned Premiums & Liability

Most Recent Five Plan Years: July 01, 2015 to December 31, 2019



	2015 - 16	2016 - 17	2017 - 18	2018 - 19	2019 - 20
Earned Premium	$527,738	$584,991	$680,683	$753,140	$378,193
Claim Liability	$305,830	$431,941	$486,319	$573,088	$245,186
Loss Ratio	0.58	0.74	0.71	0.76	0.65

4.3.3

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

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

   4.3 Acceptance of PEBP vendor quarterly reports for the timeframe of October 1, 2019 – December 31, 2019.

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

Nevada Public Employees Benefit Program

Quarterly Update – 2nd Quarter Plan Year 2020

Willis Towers Watson's Individual Marketplace

March 2, 2020

Willis Towers Watson

The Public Employees Benefit Program Executive Dashboard

Quarterly Update – 2nd Quarter Plan Year 2020

Executive Summary

Plan Enrollment:

- At the end of Q2 2020, PEBP's total enrollment into Medicare policies through Willis Towers Watson's Individual Marketplace increased to 12,952. Since inception, 102 carriers have been selected by PEBP's retirees with current enrollment in 1,402 different plans.
- Medicare Supplement (MS) plan selection remained consistent at 80% of the total population with the majority of participants selecting AARP and Anthem BCBS of Nevada as their insurer; each carrier holds plans for 6,479 and 2,200 enrollees respectively. The average monthly premium cost for MS plans remained consistent at $149.
- The percentage of Medicare Advantage (MA or MAPD) plans selected remaining consistent at 20%. Top MA carriers include Hometown Health Plan with 1,165 individual plan selections and AARP with 350 individual plan selections. The average monthly premium cost to PEBP participants is $24.

Customer Satisfaction:

- In Q2 2020, PEBP participant satisfaction with Enrollment Calls had an average satisfaction score result of 4.5 out of 5.0 based on 425 surveys returned.
- For Q2 2020, the average satisfaction score for Service Calls was 4.2 out of 5.0 based on 626 surveys returned.
- The combined average satisfaction score for Enrollment Calls and Service Calls was 4.3 out of 5.0 for Q2 2020.
- For Funding Calls, PEBP customer satisfaction was 3.9 out of 5.0. This was a slight decrease when compared to Q1 2020. There were 76 survey responses in Q2.

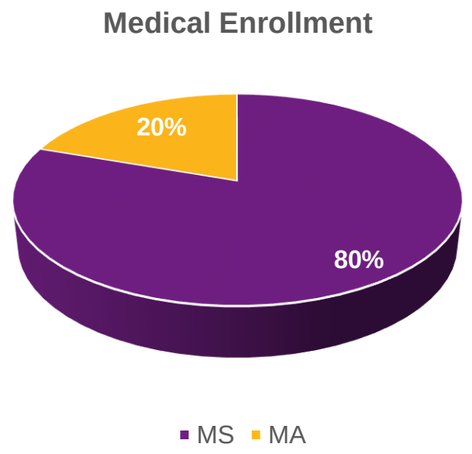
Health Reimbursement Arrangement:

- At the end of Q2 2020 there were 12,381 Health Reimbursement Arrangement (HRA) accounts for PEBP participants.
- There were 88,005 claims submitted against the HRA for reimbursement in Q2, with 80% being submitted via Auto-Reimbursement, meaning that participants did not have to manually submit 70,460 claims for Premium Reimbursement.
- The total reimbursement amount processed for Q2 was $7,736,783.

Summary of Retiree Decisions and Costs

Retiree Plan Selection Through 12/31/2019		Previous Qtr
Total enrolled through individual marketplace	12,952	12,863
Number of carriers**	102	101
Number of plans**	1,402	1,264

Plan Type Selection Through 12/31/2019		Previous Qtr
Medicare Advantage (MA, MAPD)	2,554	2,550
Medicare Supplement (MS)	10,428	10,323



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

Plan Type	Number Enrolled	Average Premium
Medicare Supplement	10.428	$149
Medicare Advantage (MA,MAPD)	2,554	$5 / $23
Part D drug coverage	7,896	$27
Dental coverage	1,160	$33
Vision coverage	1,952	$13

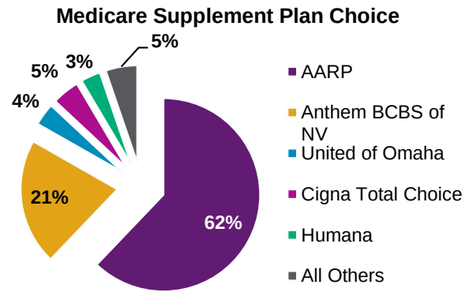
** Reflects total carriers and plans that PEBP participants have enrolled in nationwide, since inception.

The Public Employees Benefit Program Executive Dashboard

Quarterly Update – 2nd Quarter Plan Year 2020

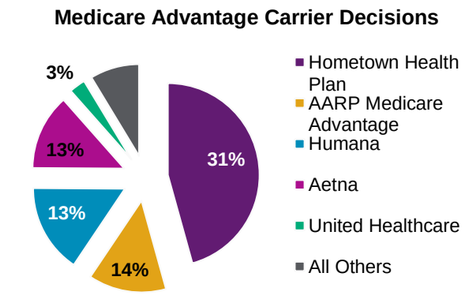
Summary of Retiree Carrier Choice

Top Medicare Supplement Plans	Total
AARP	6,479
Anthem BCBS of NV	2,200
Cigna Total Choice	473
Humana	340
United of Omaha	388



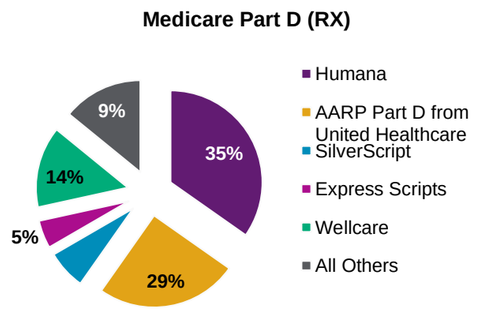
Cost Data For MS Plans	Cost
Minimum	$22
Average	$149
Median	$143
Maximum	$459

Top Medicare Advantage Plans	Total
AARP Medicare Advantage	350
Aetna	341
Hometown Health Plan	1,165
Humana	400
United Healthcare	73



Cost Data For MA Plans	Cost
Minimum	$0
Average	$24
Median	$0
Maximum	$205

Top Medicare Part D (RX)	Total
AARP Medicare Advantage	2,161
Express Scripts Medicare	425
Humana	3,002
SilverScript	595
WellCare	1,237



Cost Data For Part D (RX)	Cost
Minimum	$10
Average	$26
Median	$23
Maximum	$130

The Public Employees Benefit Program Executive Dashboard

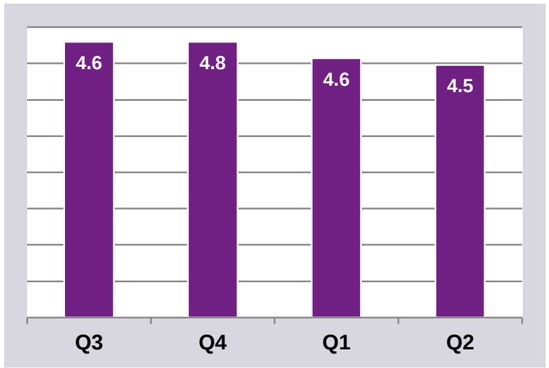
Quarterly Update – 2nd Quarter Plan Year 2020

Customer Service – Voice of the Customer (VoC)

Individual Marketplace conducts phone and email surveys of all participant transactions. Each survey contains approximately 12-16 questions. Responses are scanned by IBM Mindshare Analytics which expose trends within an hour, alerting Individual Marketplace of issues and allowing for real-time feedback and adjustments

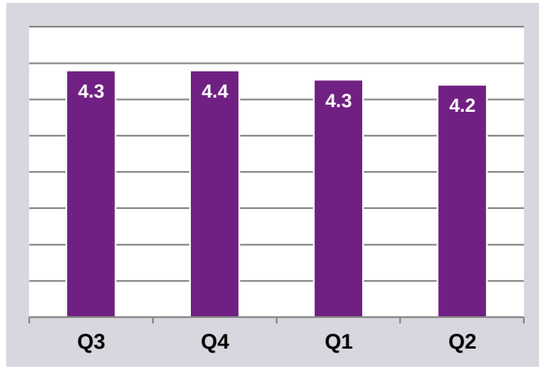
Q2 Enrollment Satisfaction

CSAT score	Count	%
5	289	68%
4	85	20%
3	25	6%
2	17	4%
1	9	2%
	425	**100%**



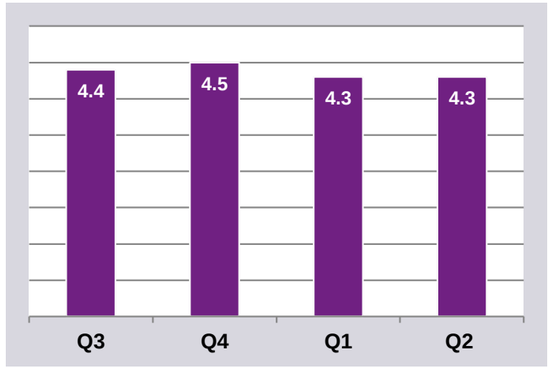
Q2 Service Satisfaction

CSAT score	Count	%
5	380	61%
4	114	18%
3	52	8%
2	33	5%
1	47	8%
	626	**100%**



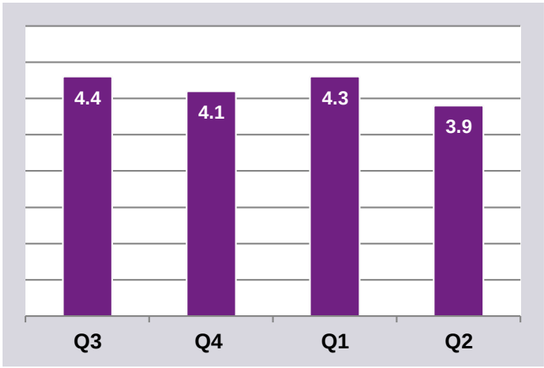
Q2 Enrollment & Service Combined

CSAT score	Count	%
5	669	64%
4	199	19%
3	77	7%
2	50	5%
1	56	5%
	1,051	**100%**



Q2 HRA Satisfaction

CSAT score	Count	%
5	34	45%
4	18	24%
3	14	18%
2	2	3%
1	8	11%
	76	**100%**

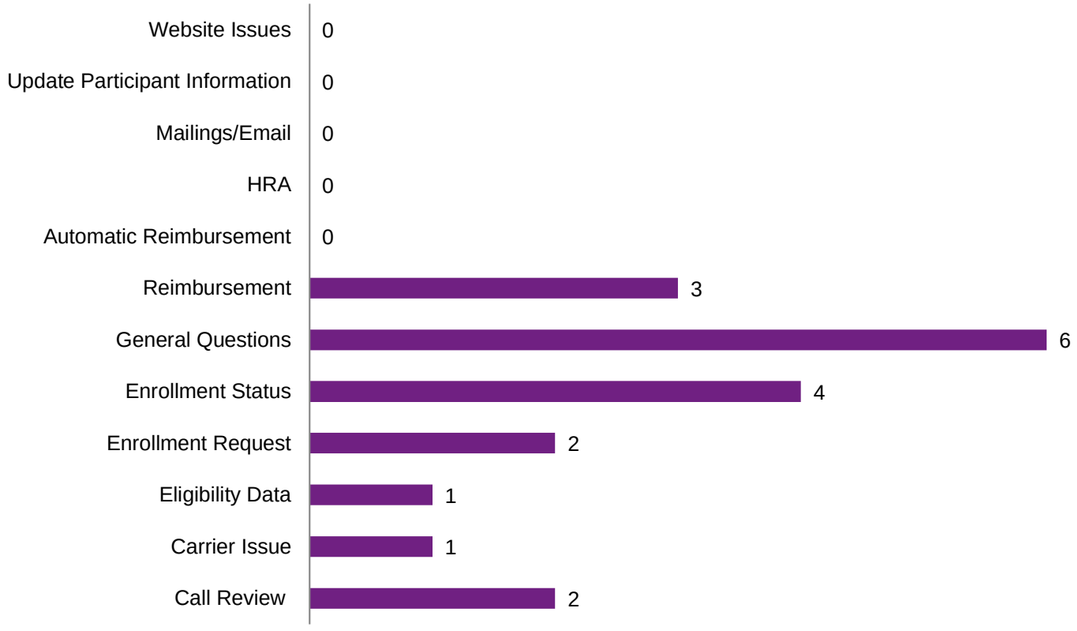


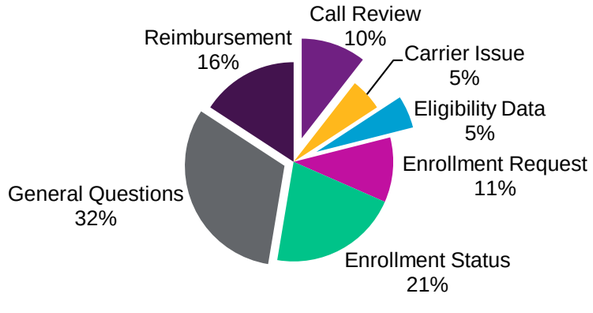
The Public Employees Benefit Program Executive Dashboard

Quarterly Update – 2nd Quarter Plan Year 2020

Customer Service – Issues Log Resolution

Each quarter a certain number of participant inquiries are received by both PEBP and Willis Towers Watson that require escalation to Individual Marketplace Issues Log. Items on the Issues Log are carefully evaluated and continuously monitored by seasoned Willis Towers Watson staff until resolution is reached. The total number of inquiries reviewed during Q2-PY20 is 19 and are associated with the following categories:





Health Reimbursement Account (HRA)

Claim Activity for the Qtr.	Total
HRA accounts	12,381
Number of claims paid	84,409
Accounts with no balance	6,509
Claims paid amount	$7,736,783

Claims By Source	Total
A/R file	70,460
Mail	13,832
Web	3,713

Call Category	Total
General / Instructional	1,397
Denial Reason Explanation	82
Available Balance	75
Dedicated / Designated Call Transfer	58
Date EFT / Mail Issued	43

The Public Employees Benefit Program Executive Dashboard

Quarterly Update – 2nd Quarter Plan Year 2020

Performance Guarantees*

Category	Commitment	Outcome	PG MET
Claims Turnaround Time	≤ 2 days	0.16 Days	Yes
Claim Financial Accuracy	≥ 98%	99.23%	Yes
Claim Processing Financial Accuracy	≥ 98%	98.79%	Yes
Reports	≤ 15 business days	Met	Yes
HRA Web Services	≥ 99%	>99%	Yes
Benefits Administration Customer Service Avg. Speed to Answer	≤ 2 min. in Q1 ≤ 90 sec in Q2 and Q3 ≤ 5 minutes in Q4 Note - Quarters listed are based on calendar year.	7 Minutes	No
Benefits Administration Customer Service Abandonment Rate	≤ 5%	11.92%	No
Customer Satisfaction	≥ 80%	93%	Yes
Disclosure of Subcontractors	100%	100%	Yes
Unauthorized Transfer of PEBP Data	100%	100%	Yes

*Please note that the performance guarantees are ultimately measured based on the annual audit period.

The Public Employees Benefit Program Executive Dashboard

Quarterly Update – 2nd Quarter Plan Year 2020

Operations Report

Medicare Annual Enrollment Period:

The Medicare Annual Enrollment (AE) Period occurred from October 15 to December 7. During that time period, WTW received 7,565 inbound calls with an average handle time of 35m 26s per call. The Average Speed to Answer (ASA) calls during this time was 8 minutes 55 seconds, which was much longer than projected for AE. The longer ASA was driven by high call volume. For comparison, we only received 4,893 inbound calls during AE 2018.

The higher call volume is believed to be due to the following factors:

- More changes to Rx plans compared to prior years, prompted by high premium increases from one of the most popular carriers and plans (Humana Walmart)
- Late breaking carrier changes due to MACRA legislation impacting 2020 Medigap plans, causing multiple enrollment calls and status inquiries
- Increased phone calls from retirees who required assistance with online Multi-Factor Authentication (MFA) enhancements

Below is a chart showing the number of Nevada PEBP participants that made changes to their plans effective 1/1/2020. There is a also column showing the number of changes that were made for 1/1/2019. The number of people who changed Rx plans for 2020 nearly doubled compared to the changes made for 2019.

Original Plan	New Plan	1/1/2020 Changes	1/1/2019 Changes
Medicare Supplement	Medicare Supplement	62	51
Medicare Supplement	Medicare Advantage	49	30
Medicare Advantage	Medicare Advantage	247	224
Medicare Advantage	Medicare Supplement	60	27
Prescription Drug Plan	Prescription Drug Plan	1,052	631

Funding Platform Change:

Beginning March 18, 2020, PayFlex will no longer serve as the administrator of the HRA for Nevada PEBP. Instead, claim processing will be administered directly through Willis Towers Watson's Funding platform. Between March 18 and April 2 the reimbursement website will be unavailable while improvements are made and on April 3 participants will experience an upgraded website and a new mobile app will be available for claim submission. This change will also result in an integrated customer service center, ability for participants to receive text and email notifications, and streamlined reimbursement processes.

An announcement communication is being sent to participants the week of March 5 which will also advise that no changes are being made to the phone number they use to contact WTW, the URL they use to access their site, their user name or password, bank account information for Direct Deposit, or reimbursement request forms.

The Public Employees Benefit Program Executive Dashboard

Quarterly Update – 2nd Quarter Plan Year 2020

Operations Report

Spring Retiree Meetings:

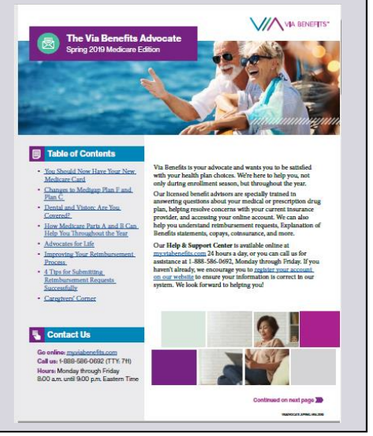
The Spring Retiree Meetings will be held on March 11, March 12, and March 13 in Las Vegas, Carson City, and Reno. At each location there will two meetings per day with the morning meeting focusing on participants aging-in to Medicare and the afternoon meeting focusing on the HRA for those that are already Medicare eligible. The below chart includes information about the meetings.

Date	Location	Comments
March 11	College of Southern Nevada North Las Vegas Campus A Building - Lecture Hall 1772 3200 E. Cheyenne Ave North Las Vegas, NV 89030	
March 14	Nevada Army National Guard Auditorium 2460 Fairview Dr. Carson City, NV 89701	Be prepared to show I.D. at the gate.
March 15	Truckee Meadows Community College Sierra Building, Room 105 7000 Dandini Boulevard Reno, NV 89512	

Communications:

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

- Spring Balance Reminder
  - This communication is mailed to participants who have not had any claims reimbursement in the last 90 days but have an available HRA Balance. This communication started to mail out in mid-February.
- Spring Newsletter
  - This communication is sent to participants via email and is typically sent the week of May 27.. The intent of this communication is to educate participants on different areas like Medicare, HRA, Direct Deposit, and Auto-Reimbursement functionality.



The Public Employees Benefit Program Executive Dashboard

Quarterly Update – 2nd Quarter Plan Year 2020

Nevada PEBP Historical Call Statistics

The below charts reflect the historical call statistics for Nevada PEBP for 2020.

Month	Average Wait Time	Total Calls	Abandoned Calls	Average Handle Time	Outreach Attempts
January	4m 36s	2,958	244	23m 48s	394
February	1m 11s	2,100	60	22m 19s	178
March					
April					
May					
June					
July					
August					
September					
October					
November					
December					

The Public Employees Benefit Program Executive Dashboard

Quarterly Update – 2nd Quarter Plan Year 2020

Nevada PEBP Historical Call Statistics

The below charts reflect the historical call statistics for Nevada PEBP for 2019.

Month	Average Wait Time	Total Calls	Abandoned Calls	Average Handle Time	Outreach Attempts
January	1m 10s	2,623	89	22m 17s	356
February	24s	1,732	11	22m 23s	160
March	14s	1,584	5	23m 24s	228
April	14s	1,602	6	24m 00s	230
May	15s	1,780	3	24m 41s	192
June	15s	1,475	4	26m 58s	201
July	15s	2,070	3	25m 38s	227
August	15s	1,706	6	25m 31s	246
September	15s	1,494	7	26m 17s	193
October	1m 07s	2,958	72	31m 16s	409
November	6m 52s	4,050	605	35m 05s	450
December	12m 21s	4,251	668	27m 10s	459

The Public Employees Benefit Program Executive Dashboard

Quarterly Update – 2nd Quarter Plan Year 2020

Nevada PEBP Historical Call Statistics

The below charts reflect the historical call statistics for Nevada PEBP for 2018.

Month	Average Wait Time	Total Calls	Abandoned Calls	Average Handle Time	Outreach Attempts
January	03m 32s	2,671	223	21m 39s	266
February	25s	1,890	8	18m 01s	318
March	22s	2,001	13	19m 03s	354
April	13s	1,750	7	21m 01s	170
May	14s	1,653	3	22m 45s	192
June	13s	1,615	8	23m 47s	329
July	16s	1,589	2	25m 18s	282
August	15s	1,379	0	26m 19s	224
September	15s	1,686	1	22m 56s	336
October	37s	2,484	36	29m 16s	357
November	33s	2,441	23	32m 10s	271
December	34s	2,241	24	25m 27s	322

4.3.4

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

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

   4.3 Acceptance of PEBP vendor quarterly reports for the timeframe of October 1, 2019 – December 31, 2019.

   4.3.4 Health Plan of Nevada Performance Standards and Guarantees

Health Plan of Nevada

Quarterly
Update for
October-December 2019

HEALTH PLAN OF NEVADA
A UnitedHealthcare Company

Nevada PUBLIC EMPLOYEES' BENEFITS PROGRAM
PEBP
Health Matters.

February 14th, 2020

Health Plan of Nevada HMO

Performance Standards and Guarantees- Self Reported

Quarterly Report for October – December 2019

Service Performance Standard (Metric)	Guarantee Measurement	Actual	Pass/Fail
I. Claims Processing	**97%** - Claims Financial Accuracy	100%	Pass
	95% - Claims Procedural Accuracy	100%	Pass
	95% in 30 working days - Clean claims turnaround for unaffiliated providers	100%	Pass
II. Participant Correspondence	ID Card Turnaround- Mailed within 10 working days of date of eligibility input	7 days	Pass
	Membership materials (electronic)- Available within 10 working days of date of eligibility input	9 days	Pass
III. Customer Service- Telephone	Speed to queue and answer by live voice- Within 60 seconds	42 sec	Pass
	5% or less - Telephone abandonment rate	3%	Pass
IV. Other Customer Service	**98%** - Resolved resolution within 30 days of receipt of written correspondence (i.e. complaint or appeal)	100%	Pass
	Notification to member regarding PCP disenrollment - within 30 working days	100%	Pass
	Primary Care Physician /Member Ratio - 1 to 2450	1 to 311	Pass

4.4

4.4 Acceptance of the PEBP Chief Financial Officer quarterly reports for the period ending December 31, 2019.

4.4.1 Budget Report

4.4.2 Utilization Report

4.4.1

4.4 Acceptance of the PEBP Chief Financial Officer quarterly reports for the period ending December 31, 2019.

4.4.1 Budget Report

STEVE SISOLAK
Governor

LAURA FREED
Board Chair

STATE OF NEVADA
PUBLIC EMPLOYEES' BENEFITS PROGRAM
901 S. Stewart Street, Suite 1001 | Carson City, Nevada 89701
Telephone 775-684-7000 | 1-800-326-5496 | Fax 775-684-7028
www.pebp.state.nv.us

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CORE
Expires 04/01/2021

LAURA RICH
Executive Officer

AGENDA ITEM

[X] Action Item
[ ] Information Only

Date: March 31, 2020

Item Number: IV.IV.I

Title: Chief Financial Officer Budget Report

Summary

This report addresses the Operational Budget as of December 31, 2019 to include:

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

Budget Account 1338 – Operational Budget – Shown below is a summary of the operational budget account status as of December 31, 2019 with comparisons to the same period in Fiscal Year 2019. The budget status is reported on a cash basis and does not include incurred expenses and income owed to the fund.

The budget status report reflects actual income of $195.7 million as of December 31, 2019 compared to $182.6 million as of December 31, 2018 or an increase of 7.2%. Total expenses for the period have increased by $28.6 million or 16.6% for the same period.

The budget status report shows Realized Funding Available (cash) at $144.4 million. This compares to $152.8 million for last year. After subtracting $58.8 million for reserves for Incurred but not Reported (IBNR) claims, $42.4 million for the Catastrophic Reserve and $36.2 million for the HRA Reserve, the remaining balance is $7 million in Excess reserves. The table below reflects the actual revenue and expenditures for the period.

Operational Budget 1338

	FISCAL YEAR 2020			FISCAL YEAR 2019		
	Actual as of 12/31/2019	Work Program	Percent	Actual as of 12/31/2018	Fiscal Year 2019 Close	Percent
Beginning Cash	150,276,433	150,276,433	100%	143,129,728	143,129,728	100%
Premium Income	187,733,763	382,017,605	49%	177,248,452	363,123,752	49%
All Other Income	7,959,417	9,151,598	87%	5,352,384	13,001,438	41%
Total Income	195,693,181	391,169,203	50%	182,600,836	376,125,190	49%
Personnel Services	1,244,900	2,835,868	44%	1,269,566	2,721,398	47%
Operating - Other than Personnel	967,249	2,383,964	41%	1,040,040	2,142,352	49%
Insurance Program Expenses	199,101,863	391,635,970	51%	170,146,158	363,036,252	47%
All Other Expenses	299,417	669,431	45%	521,305	1,078,483	48%
Total Expenses	201,613,428	397,525,233	51%	172,977,069	368,978,485	47%
Change in Cash	(5,920,248)	(6,356,030)		9,623,767	7,146,705	
REALIZED FUNDING AVAILABLE	144,356,185	143,920,403	100%	152,753,495	150,276,433	102%
Incurred But Not Reported Liability	(58,790,000)	(58,790,000)		(51,800,000)	(51,800,000)	
Catastrophic Reserve	(42,400,000)	(42,400,000)		(39,900,000)	(39,900,000)	
HRA Reserve	(36,204,203)	(36,204,203)		(31,676,056)	(31,676,056)	
NET REALIZED FUNDING AVAILABLE	6,961,982	6,526,200		29,377,439	26,900,377	

Current Budget Projections

The following table represents projections for FY 2020 based on data available as of December 31, 2019. The projection reflects total income to be more than budgeted by 0.9% ($546.1 million vs $541.4 million), total expenditures are projected to be more than budgeted by 1.0% ($402 million vs $397.5 million); total reserves are projected to be more than budgeted by 0.3% ($144.4 million vs $143.9 million).

Budgeted and Projected Income (Budget Account 1338)					
Description	**Budget**	**Actual 12/31/19**	**Projected**	**Difference**	
Carryforward	150,276,433	150,276,433	150,276,433	0	0.0%
State Subsidies	286,540,424	144,428,607	292,599,916	6,059,492	2.1%
Non-State Subsidies	29,202,769	14,341,867	28,931,666	(271,103)	-0.9%
Premium	66,274,412	28,963,290	57,771,856	(8,502,556)	-12.8%
All Other	9,151,598	7,959,417	16,481,390	7,329,792	80.1%
Total	541,445,636	345,969,614	546,061,261	4,615,625	0.9%
Budgeted and Projected Expenses (Budget Account 1338)					
Description	**Budget**	**Actual 12/31/19**	**Projected**	**Difference**	
Operating	5,889,263	2,511,566	5,444,107	445,156	7.6%
State Employee Ins Cost	294,710,442	151,616,029	284,262,964	10,447,478	3.5%
State Retirees Ins Cost	41,439,426	24,377,396	62,718,211	(21,278,785)	-51.3%
Non-State Employees Ins Cost	140,039	47,380	165,669	(25,630)	-18.3%
Non-State Retirees Ins Cost	15,384,713	5,022,451	12,053,593	3,331,120	21.7%
State Medicare Ret Ins Cost	23,155,087	11,399,259	21,197,543	1,957,544	8.5%
Non-State Medicare Ret Ins Cost	16,806,263	6,639,347	15,810,628	995,635	5.9%
Total Insurance Costs	391,635,970	199,101,863	396,208,609	(4,572,639)	-1.2%
Total Expenses	397,525,233	201,613,428	401,652,716	(4,127,483)	-1.0%
Restricted Reserves	137,394,203	137,394,203	141,342,651	(3,948,448)	-2.9%
Excess Reserves for Benefit Enhancements	6,526,200	6,961,982	3,065,894	3,460,306	53.0%
Total Reserves	143,920,403	144,356,185	144,408,545	(488,142)	-0.3%
Total of Expenses and Reserves	541,445,636	345,969,614	546,061,261	(4,615,625)	-0.9%

State Subsidies are projected to be more than the budgeted amount by $6.1 million (2.1%), Non-State Subsidies are projected to be less than budgeted by $0.3 million (0.9%), and Premium Income is projected to be less than budgeted by $8.5 million (12.8%). This overall increase in projected revenue is due in part to a slight increase in actual rates as compared to the budgeted rates as well as a decrease in average enrollment as compared to budgeted enrollment and a change in the mix of plan tiers. The mix of participants is as follows:

- 0.79% fewer state actives,
- 0.51% fewer state non-Medicare retirees,
- 0% fewer non-state actives,
- 1.12% fewer non-state, non-Medicare retirees
- 2.04% fewer state Medicare retirees, and
- 1.52% fewer non-state Medicare retirees.

Expenses for Fiscal Year 2020 are projected to be $4.2 million (1.0%) more than budgeted when changes to reserves are excluded. Operating expenses are projected to be less than budgeted by $0.4 million (7.6%). Employee and Retiree insurances costs are projected to be more than budgeted by $4.6 million (1.2%) when taken in total (see table above for specific information).

Total reserves for the year ending June 30, 2020 are projected to be $144.4 million. Reserves include $58.8 million for Incurred but not Reported (IBNR) claims, $42.4 million for the Catastrophic Reserve to insure plan solvency, $40.2 million in HRA reserves, and excess of the required reserves of $3.1 million.

A projected shortfall in State Retiree Insurance Costs of $21.3 million and in Non-State Employee Insurance Costs of $0.03 million will need to be funded with Catastrophic Reserve authority. This will leave a projected shortfall in the Catastrophic Reserve authority at the end of the year of $21.3 million.

Recommendations

None.

4.4.2

4.4 Acceptance of the PEBP Chief Financial Officer quarterly reports for the period ending December 31, 2019.

4.4.2 Utilization Report

STEVE SISOLAK
Governor

LAURA FREED
Board Chair

STATE OF NEVADA
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ACCREDITED
CORE
Expires 04/01/2021

LAURA RICH
Executive Officer

AGENDA ITEM

[X] Action Item
[ ] Information Only

Date: March 31, 2020

Item Number: IV.IV.II

Title: Self-Funded CDHP and EPO Plan Utilization Report for the period ending December 31, 2019

This report addresses medical, dental, prescription drug and HSA/HRA utilization for the Plan Year ending December 31, 2019. Included are:

- Executive Summary – provides a utilization overview.
- HealthSCOPE CDHP Utilization Report – provides graphical supporting details for the information included in the Executive Summary.
- HealthSCOPE EPO Utilization Report – provides graphical supporting details for the information included in the Executive Summary.
- Express Scripts Utilization Report – provides details supporting the prescription drug information included in the Executive Summary.
- Health Plan of Nevada Utilization – see Appendix C for Plan Year 2020 utilization data.

Executive Summary

CONSUMER DRIVEN HEALTH PLAN (CDHP)

The Consumer Driven Health Plan (CDHP) experience for Q2 of Plan Year 2020 compared to Q2 of Plan Year 2019 is summarized below.

- Population:
  - 0.7% increase for primary participants
  - 0.3% increase for primary participants plus dependents (members)
- Medical Cost:
  - 18.6% increase for primary participants
  - 19.1% increase for primary participants plus dependents (members)
- High Cost Claims:
  - There were 86 High Cost Claimants accounting for 27.1% of the total plan paid for Q2 in Plan Year 2020
  - 14.2% increase in High Cost Claimants per 1,000 members
  - 18.8% increase in average cost of High Cost Claimant paid
- Top three highest cost clinical classifications include:
  - Neoplasms ($4.7 million) – 25.2% of paid claims
  - Injury and Poisoning ($4.4 million) – 23.8% of paid claims
  - Diseases of the Circulatory System ($2.8 million) – 15.3% of paid claims
- Emergency Room:
  - ER visits per 1,000 members increased by 12.6%
  - Average paid per ER visit increased 12.2%
- Urgent Care:
  - Urgent Care visits per 1,000 members increased by 26.8%
  - Average paid per Urgent Care visit increased 24.1%
- Network Utilization:
  - 95.9% of claims are from In-Network providers
  - Q2 of Plan Year 2020 In-Network utilization increased 0.3% over PY 2019
  - Q2 of Plan Year 2020 In-Network discounts decreased 0.4% over PY 2019
- Preventive Services:
  - Overall Preventive Services Compliance Rates increased from Plan Year 2019 in all categories.
- Prescription Drug Utilization:
  - Overall:
    - Total Net Claims increased 7.3%
    - Total Gross Claims Costs increased 5.7% ($1.3 million)
    - Average Total Cost per Claim decreased 1.6%
      - From $91.54 to $90.12
  - *Member:
    - Total Member Cost increased 28.2%
    - Average Participant Share per Claim increased 19.4%
    - Net Member PMPM increased 27.7%
      - From $23.12 to $29.52

- Plan
  - Total Plan Cost decreased 2.4%
  - Average Plan Share per Claim decreased 9.1%
  - Net Plan PMPM decreased 2.8%
    - From $64.25 to $62.44
  - Net Plan PMPM factoring rebates decreased 9.5%
    - From $49.44 to $44.75

*The primary reason for the increase in cost share has to do with the increase in Out-of-Pocket Protection dollars.

PEBP PREMIER PLAN (EPO)

The PEBP Premier Plan (EPO) experience for Q2 of Plan Year 2020 compared to the complete Plan Year 2019 is summarized below.

- Population:
  - 3.7% increase for primary participants
  - 4.1% increase for primary participants plus dependents (members)
- Medical Cost:
  - 15.0% increase for primary participants
  - 14.5% increase for primary participants plus dependents (members)
- High Cost Claims:
  - There were 15 High Cost Claimants accounting for 11.3% of the total plan paid for Q2 in Plan Year 2020
  - 63.0% decrease in High Cost Claimants per 1,000 members (compared to PY19)
  - 33.3% decrease in average cost of High Cost Claimant paid
- Top three highest cost clinical classifications include:
  - Certain Conditions Originating in The Perinatal Period ($0.44 million) – 16% of paid claims
  - Diseases of the Musculoskeletal System and Connective Tissue ($0.43 million) – 15.7% of paid claims
  - Endocrine; Nutritional; and Metabolic Diseases and Immunity Disorders ($0.35 million) – 12.6% of paid claims
- Emergency Room:
  - ER visits per 1,000 members increased by 31.6%
  - Average paid per ER visit increased by 0.5%
- Urgent Care:
  - Urgent Care visits per 1,000 members increased by 23.3%
  - Average paid per Urgent Care visit increased 14.3%
- Network Utilization:
  - 97.4% of claims are from In-Network providers
  - In-Network utilization decreased 0.9%
  - In-Network discounts decreased 1%
- Preventive Services:
  - Overall Preventive Services Compliance Rates increased from Plan Year 2019 in all categories.

- Prescription Drug Utilization:
    - Overall:
        - Total Net Claims increased 7.3%
        - Total Gross Claims Costs increased 26.9% ($2.1 million)
        - Average Total Cost per Claim increased 18.3%
            - From $94.19 to $111.41
    - Member:
        - Total Member Cost increased 9.2%
        - Average Participant Share per Claim increased 1.8%
        - Net Member PMPM increased 4.9%
            - From $27.30 to $28.64
    - Plan
        - Total Plan Cost increased 30.8%
        - Average Plan Share per Claim increased 22.0%
        - Net Plan PMPM increased 25.7%
            - From $122.90 to $154.46
        - Net Plan PMPM factoring rebates increased 25.5%
            - From $93.15 to $116.94

DENTAL PLAN

The Dental Plan experience for Q2 of Plan Year 2020 is summarized below.

- Dental Cost:
    - Total of $13,349,718 paid for Dental claims
        - Preventative claims account for 41.1% ($5.5 million)
        - Basic claims account for 29.5% ($3.9 million)
        - Major claims account for 22.5% ($3.0 million)
        - Periodontal claims account for 6.9% ($0.9 million)

HEALTH REIMBURSEMENT ARRANGEMENT

The table below provides a list of CDHP HRA account balances as of December 31, 2019.

HRA Account Balances as of December 31, 2019			
$Range	**# Accounts**	**Total Account Balance**	**Average Per Account Balance**
0	805	0	0
$.01 - $500.00	1,733	390,342	225
$500.01 - $1,000	1,915	1,390,638	726
$1,000.01 - $1,500	2,011	2,423,568	1,205
$1,500.01 - $2,000	932	1,613,395	1,731
$2,000.01 - $2,500	572	1,287,549	2,251
$2,500.01 - $3,000	327	896,707	2,742
$3,000.01 - $3,500	202	654,929	3,242
$3,500.01 - $4,000	226	841,503	3,723
$4,000.01 - $4,500	175	737,476	4,214
$4,500.01 - $5,000	114	539,761	4,735
$5,000.01 +	**919**	**7,144,332**	**223,089**
Total	**9,931**	**$ 17,920,199.80**	**$ 1,804.47**

CONCLUSION

The information in this report provides plan experience for the Consumer Driven Health Plan (CDHP) and the PEBP Premier Plan (EPO) for the second quarter of Plan Year 2020. The CDHP total plan paid costs increased 19.6% over the second quarter of Plan Year 2019. The EPO total plan paid costs through the second quarter of Plan Year 2020 are 56% of the total plan paid costs for Plan Year 2019. For HMO utilization and cost data please see the report provided in Appendix C.

PEBP staff and its partners continue to monitor data, research options and implement measures to provide cost savings to the plan while also providing the care our participants require.

Appendix A

Index of Tables
HealthSCOPE – CDHP Utilization Review for PEBP
July 1, 2019 – December 31, 2019

HSB DATASCOPE™

Nevada Public Employees' Benefits Program
HDHP Plan

July 2019 – December 2019

HealthSCOPE BENEFITS

Overview

***Please note the majority of this report compares 2Q20 to the 2nd quarter of PY19; it will be full plan year, where noted.**

- Total Medical Spend for 2Q20 was $68,852,282 of which 72.1% was spent in the State Active population. When compared to 2Q19, 2Q20 reflected an increase of 19.6% in plan spend, with State Actives having an increase of 16.3%.
  - When compared to 2Q18, 2Q20 reflected an increase of 18.8% in plan spend, with State Actives having an increase of 18.8%.
- On a PEPY basis, 2Q20 reflected an increase of 18.7% when compared to 2Q19. The largest group, State Actives, increased 14.7%.
  - When compared to 2Q18, 2Q20 reflected a increase in PEPY of 15.9%, with State Actives increasing by 14.3%.
- 92.3% of the Average Membership had paid Medical claims less than $2,500, with 27.8% of those having no claims paid at all during the reporting period.
- There were 86 High Cost Claimants (HCC's) over $100K, that account for 27.1% of the total spend. HCC's accounted for 23.8% of total spend during 2Q19, with 75 members hitting the $100K threshold. The largest claimant had a primary diagnosis in the Injury and Poisoning Grouper, with plan spend of $2,927,022.
- IP Paid per Admit was $19,991 which is an increase of 8.9% over 2Q19 Paid per Admit of $18,364.
- ER Paid per Visit is $2,047, which is an increase of 12.2% from 2Q19 ER Paid per Visit of $1,825.
- 95.9% of all Medical spend dollars were to In Network providers. The average In Network discount was 65.0%, which is slightly lower than PY19 discount of 65.4%.

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

Paid Claims by Age Group								
	2Q19							
Age Range	Med Net Pay	Med PMPM	Rx Net Pay	Rx PMPM	Dental Net Pay	Dental PMPM	Net Pay	PMPM
<1	$ 2,759,369	$1,381	$ 7,179	$4	$ 2,495	$1	$ 2,769,043	$1,386
1	$ 320,198	$137	$ 15,180	$7	$ 21,565	$7	$ 356,943	$151
2 - 4	$ 567,224	$71	$ 30,551	$4	$ 195,738	$18	$ 793,513	$93
5 - 9	$ 670,517	$43	$ 155,395	$10	$ 598,655	$29	$ 1,424,567	$82
10 - 14	$ 1,457,624	$87	$ 147,715	$9	$ 601,347	$26	$ 2,206,685	$121
15 - 19	$ 1,555,779	$86	$ 369,756	$20	$ 739,514	$30	$ 2,665,048	$136
20 - 24	$ 3,477,681	$170	$ 369,754	$18	$ 492,227	$18	$ 4,339,662	$206
25 - 29	$ 2,143,593	$129	$ 422,863	$25	$ 490,068	$24	$ 3,056,523	$178
30 - 34	$ 2,817,629	$161	$ 546,553	$31	$ 591,013	$26	$ 3,955,195	$219
35 - 39	$ 2,782,539	$141	$ 738,196	$37	$ 691,540	$27	$ 4,212,276	$206
40 - 44	$ 2,625,352	$148	$ 1,089,738	$62	$ 708,162	$30	$ 4,423,252	$240
45 - 49	$ 3,898,525	$199	$ 1,533,761	$78	$ 807,758	$30	$ 6,240,044	$306
50 - 54	$ 6,653,340	$327	$ 1,845,329	$91	$ 937,333	$33	$ 9,436,002	$451
55 - 59	$ 7,290,939	$324	$ 3,153,162	$140	$ 1,143,936	$36	$ 11,588,036	$500
60 - 64	$ 12,306,369	$479	$ 4,311,394	$168	$ 1,426,908	$39	$ 18,044,671	$685
65+	$ 6,250,280	$471	$ 2,902,235	$218	$ 3,106,803	$40	$ 12,259,318	$729
Total	**$ 57,576,958**	**$ 225**	**$ 17,638,758**	**$ 69**	**$ 12,555,063**	**$ 31**	**$ 87,770,779**	**$ 325**

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

Paid Claims by Age Group										
	2Q20								% Change	
Age Range	Med Net Pay	Med PMPM	Rx Net Pay	Rx PMPM	Dental Net Pay	Dental PMPM	Net Pay	PMPM	Net Pay	PMPM
<1	$ 3,125,930	$ 1,476	$ 4,958	$ 2	$ 9,126	$ 3	$ 3,140,014	$ 1,481	13.4%	6.9%
1	$ 405,172	$ 171	$ 8,214	$ 3	$ 25,737	$ 8	$ 439,123	$ 183	23.0%	20.9%
2 - 4	$ 627,536	$ 78	$ 138,668	$ 17	$ 205,909	$ 19	$ 972,113	$ 115	22.5%	23.2%
5 - 9	$ 854,517	$ 56	$ 71,289	$ 5	$ 661,689	$ 31	$ 1,587,495	$ 92	11.4%	12.4%
10 - 14	$ 1,812,800	$ 106	$ 223,825	$ 13	$ 641,514	$ 27	$ 2,678,139	$ 146	21.4%	20.4%
15 - 19	$ 1,834,410	$ 101	$ 391,533	$ 22	$ 776,827	$ 31	$ 3,002,771	$ 154	12.7%	13.1%
20 - 24	$ 2,927,770	$ 143	$ 423,423	$ 21	$ 524,971	$ 19	$ 3,876,164	$ 183	-10.7%	-11.1%
25 - 29	$ 2,583,979	$ 154	$ 462,009	$ 28	$ 528,795	$ 25	$ 3,574,783	$ 207	17.0%	16.4%
30 - 34	$ 3,924,676	$ 220	$ 827,755	$ 46	$ 612,847	$ 26	$ 5,365,279	$ 292	35.7%	33.5%
35 - 39	$ 3,370,512	$ 170	$ 1,301,560	$ 66	$ 742,642	$ 29	$ 5,414,714	$ 264	28.5%	28.1%
40 - 44	$ 3,236,736	$ 180	$ 875,944	$ 49	$ 725,414	$ 30	$ 4,838,095	$ 258	9.4%	7.5%
45 - 49	$ 5,042,049	$ 259	$ 1,605,357	$ 82	$ 886,480	$ 32	$ 7,533,887	$ 373	20.7%	22.0%
50 - 54	$ 6,211,742	$ 306	$ 1,934,321	$ 95	$ 972,069	$ 34	$ 9,118,132	$ 435	-3.4%	-3.6%
55 - 59	$ 8,096,492	$ 361	$ 2,821,175	$ 126	$ 1,178,205	$ 37	$ 12,095,872	$ 524	4.4%	4.9%
60 - 64	$ 16,905,310	$ 669	$ 3,469,129	$ 137	$ 1,435,524	$ 40	$ 21,809,963	$ 847	20.9%	23.6%
65+	$ 7,892,651	$ 575	$ 2,050,922	$ 149	$ 3,421,967	$ 43	$ 13,365,540	$ 768	9.0%	5.3%
Total	**$ 68,852,282**	**$ 268**	**$ 16,610,084**	**$ 65**	**$ 13,349,718**	**$ 32**	**$ 98,812,083**	**$ 365**	**12.6%**	**12.2%**

Financial Summary - Quarter comparison (p. 1 of 2)

	Total				State Active				Non-State Active			
Summary	**2Q18**	**2Q19**	**2Q20**	**Variance to Prior Year**	**2Q18**	**2Q19**	**2Q20**	**Variance to Prior Year**	**2Q18**	**2Q19**	**2Q20**	**Variance to Prior Year**
Enrollment												
Avg # Employees	23,087	23,482	23,652	0.7%	19,009	19,494	19,761	1.4%	4	4	4	0.0%
Avg # Members	41,936	42,703	42,850	0.3%	36,259	37,031	37,257	0.6%	7	7	7	0.0%
Ratio	1.8	1.8	1.8	-0.5%	1.9	1.9	1.9	-0.5%	1.7	1.8	1.8	0.0%
Financial Summary												
Gross Cost	$79,977,800	$79,638,308	$94,029,865	18.1%	$59,194,922	$60,229,544	$69,915,428	16.1%	$26,159	$10,236	$32,755	220.0%
Client Paid	$57,966,202	$57,576,958	$68,852,282	19.6%	$41,800,895	$42,715,160	$49,660,887	16.3%	$19,382	$7,062	$23,556	233.6%
Employee Paid	$22,011,598	$22,061,195	$25,177,583	14.1%	$17,394,027	$17,514,229	$20,254,541	15.6%	$6,778	$3,174	$9,198	189.8%
Client Paid-PEPY	$5,022	$4,904	$5,822	18.7%	$4,398	$4,382	$5,026	14.7%	$9,303	$3,531	$11,778	233.6%
Client Paid-PMPY	$2,765	$2,697	$3,214	19.2%	$2,306	$2,307	$2,666	15.6%	$5,409	$2,018	$6,730	233.5%
Client Paid-PEPM	$418	$409	$485	18.6%	$367	$365	$419	14.8%	$775	$294	$982	234.0%
Client Paid-PMPM	$230	$225	$268	19.1%	$192	$192	$222	15.6%	$451	$168	$561	233.9%
High Cost Claimants (HCC's) > $100k												
# of HCC's	62	75	86	14.7%	39	52	59	13.5%	0	0	0	0.0%
HCC's / 1,000	1.5	1.8	2.0	14.2%	1.1	1.4	1.6	12.9%	0.0	0.0	0.0	0.0%
Avg HCC Paid	$214,667	$182,390	$216,669	18.8%	$231,450	$183,935	$175,311	-4.7%	$0	$0	$0	0.0%
HCC's % of Plan Paid	23.0%	23.8%	27.1%	13.9%	21.6%	22.4%	20.8%	-7.1%	0.0%	0.0%	0.0%	0.0%
Cost Distribution by Claim Type (PMPY)												
Facility Inpatient	$867	$878	$1,133	29.0%	$678	$740	$846	14.3%	$0	$0	$0	0.0%
Facility Outpatient	$899	$827	$981	18.6%	$743	$683	$819	19.9%	$1,908	$333	$2,975	793.4%
Physician	$909	$928	$1,023	10.2%	$817	$836	$938	12.2%	$3,346	$1,563	$3,470	122.0%
Other	$89	$64	$76	18.8%	$68	$48	$63	31.3%	$155	$121	$285	0.0%
Total	$2,765	$2,697	$3,214	19.2%	$2,306	$2,307	$2,666	15.6%	$5,409	$2,018	$6,730	233.5%
	Annualized	Annualized	Annualized		Annualized	Annualized	Annualized		Annualized	Annualized	Annualized	

Financial Summary - Quarter comparison (p. 2 of 2)

	State Retirees				Non-State Retirees				
Summary	**2Q18**	**2Q19**	**2Q20**	**Variance to Prior Year**	**2Q18**	**2Q19**	**2Q20**	**Variance to Prior Year**	**HSB Peer Index**
Enrollment									
Avg # Employees	3,169	3,222	3,245	0.7%	904	762	642	-15.8%	
Avg # Members	4,676	4,800	4,848	1.0%	994	865	739	-14.6%	
Ratio	1.5	1.5	1.5	0.0%	1.1	1.1	1.2	1.8%	1.8
Financial Summary									
Gross Cost	$15,688,206	$14,750,103	$20,854,519	41.4%	$5,068,513	$4,648,425	$3,227,164	-30.6%	
Client Paid	$12,002,656	$10,981,049	$16,734,691	52.4%	$4,143,270	$3,873,687	$2,433,148	-37.2%	
Employee Paid	$3,685,551	$3,769,054	$4,119,828	9.3%	$925,243	$774,738	$794,016	2.5%	
Client Paid-PEPY	$7,574	$6,816	$10,313	51.3%	$9,165	$10,167	$7,582	-25.4%	$6,209
Client Paid-PMPY	$5,134	$4,575	$6,904	50.9%	$8,338	$8,960	$6,588	-26.5%	$3,437
Client Paid-PEPM	$631	$568	$859	51.2%	$764	$847	$632	-25.4%	$517
Client Paid-PMPM	$428	$381	$575	50.9%	$695	$747	$549	-26.5%	$286
High Cost Claimants (HCC's) > $100k									
# of HCC's	16	18	27	50.0%	8	8	4	-50.0%	
HCC's / 1,000	3.4	3.8	5.6	48.5%	8.1	9.3	5.4	-41.4%	
Avg HCC Paid	$199,999	$129,001	$287,451	122.8%	$135,355	$224,076	$132,243	-41.0%	
HCC's % of Plan Paid	26.7%	21.1%	46.4%	119.9%	26.1%	46.3%	21.7%	-53.1%	
Cost Distribution by Claim Type (PMPY)									
Facility Inpatient	$1,723	$1,262	$3,063	142.7%	$3,724	$4,647	$2,962	-36.3%	$1,057
Facility Outpatient	$1,770	$1,641	$2,062	25.7%	$2,480	$2,467	$2,058	-16.6%	$1,145
Physician	$1,389	$1,514	$1,597	5.5%	$2,011	$1,621	$1,480	-8.7%	$1,122
Other	$252	$159	$182	14.5%	$123	$225	$88	-60.9%	$113
Total	$5,134	$4,575	$6,904	50.9%	$8,338	$8,960	$6,588	-26.5%	$3,437
	Annualized	Annualized	Annualized		Annualized	Annualized	Annualized		

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

	Total				State Active				Non-State Active			
Summary	**PY18**	**PY19**	**2Q20**	**Variance to Prior Year**	**PY18**	**PY19**	**2Q20**	**Variance to Prior Year**	**PY18**	**PY19**	**2Q20**	**Variance to Prior Year**
Enrollment												
Avg # Employees	23,155	23,569	23,652	0.4%	19,100	19,612	19,761	0.8%	4	4	4	0.0%
Avg # Members	42,071	42,776	42,850	0.2%	36,389	37,138	37,257	0.3%	7	7	7	0.0%
Ratio	1.8	1.8	1.8	0.0%	1.9	1.9	1.9	0.0%	1.7	1.8	1.8	0.0%
Financial Summary												
Gross Cost	$164,211,622	$172,993,213	$94,029,865		$123,145,285	$129,947,874	$69,915,428		$42,221	$105,325	$32,755	
Client Paid	$125,066,281	$133,179,670	$68,852,282		$91,783,613	$97,851,639	$49,660,887		$32,607	$96,469	$23,556	
Employee Paid	$39,145,341	$39,813,543	$25,177,583		$31,361,671	$32,096,235	$20,254,541		$9,615	$8,857	$9,198	
Client Paid-PEPY	$5,401	$5,651	$5,822	3.0%	$4,805	$4,989	$5,026	0.7%	$7,985	$24,117	$11,778	-51.2%
Client Paid-PMPY	$2,973	$3,113	$3,214	3.2%	$2,522	$2,635	$2,666	1.2%	$4,603	$13,781	$6,730	-51.2%
Client Paid-PEPM	$450	$471	$485	3.0%	$400	$416	$419	0.7%	$665	$2,010	$982	-51.1%
Client Paid-PMPM	$248	$259	$268	3.5%	$210	$220	$222	0.9%	$384	$1,148	$561	-51.1%
High Cost Claimants (HCC's) > $100k												
# of HCC's	164	198	86		108	124	59		0	0	0	
HCC's / 1,000	3.9	4.6	2.0		3.0	3.3	1.6		0.0	0.0	0.0	
Avg HCC Paid	$211,524	$219,374	$216,669	-1.2%	$212,840	$218,720	$175,311	-19.8%	$0	$0	$0	0.0%
HCC's % of Plan Paid	27.7%	32.6%	27.1%	-16.9%	25.0%	27.7%	20.8%	-24.9%	0.0%	0.0%	0.0%	0.0%
Cost Distribution by Claim Type (PMPY)												
Facility Inpatient	$900	$1,071	$1,133	5.8%	$719	$847	$846	-0.1%	$0	$3,087	$0	0.0%
Facility Outpatient	$974	$925	$981	6.1%	$814	$782	$819	4.7%	$1,064	$6,561	$2,975	-54.7%
Physician	$1,016	$1,045	$1,023	-2.1%	$924	$948	$938	-1.1%	$3,394	$4,006	$3,470	-13.4%
Other	$82	$72	$76	5.6%	$64	$58	$63	8.6%	$146	$129	$285	0.0%
Total	$2,973	$3,113	$3,214	3.2%	$2,522	$2,635	$2,666	1.2%	$4,603	$13,781	$6,730	-51.2%
			Annualized				Annualized				Annualized	

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

	State Retirees				Non-State Retirees				
Summary	**PY18**	**PY19**	**2Q20**	**Variance to Prior Year**	**PY18**	**PY19**	**2Q20**	**Variance to Prior Year**	**HSB Peer Index**
Enrollment									
Avg # Employees	3,165	3,224	3,245	0.7%	868	729	642	-12.0%	
Avg # Members	4,681	4,799	4,848	1.0%	958	832	739	-11.2%	
Ratio	1.5	1.5	1.5	0.0%	1.1	1.1	1.2	0.9%	1.8
Financial Summary									
Gross Cost	$31,539,962	$34,175,219	$20,854,519		$9,484,154	$8,764,794	$3,227,164		
Client Paid	$25,259,022	$27,761,940	$16,734,691		$7,991,039	$7,469,622	$2,433,148		
Employee Paid	$6,280,940	$6,413,280	$4,119,828		$1,493,115	$1,295,172	$794,016		
Client Paid-PEPY	$7,981	$8,612	$10,313	19.8%	$9,204	$10,246	$7,582	-26.0%	$6,209
Client Paid-PMPY	$5,397	$5,785	$6,904	19.3%	$8,338	$8,983	$6,588	-26.7%	$3,437
Client Paid-PEPM	$665	$718	$859	19.6%	$767	$854	$632	-26.0%	$517
Client Paid-PMPM	$450	$482	$575	19.3%	$695	$749	$549	-26.7%	$286
High Cost Claimants (HCC's) > $100k									
# of HCC's	50	58	27		18	16	4		
HCC's / 1,000	10.7	12.1	5.6		18.8	19.2	5.4		
Avg HCC Paid	$169,470	$220,380	$287,451	30.4%	$179,428	$220,793	$132,243	-40.1%	
HCC's % of Plan Paid	33.5%	46.0%	46.4%	0.9%	40.4%	47.3%	21.7%	-54.1%	
Cost Distribution by Claim Type (PMPY)									
Facility Inpatient	$1,822	$2,155	$3,063	42.1%	$3,299	$4,794	$2,962	-38.2%	$1,057
Facility Outpatient	$1,842	$1,787	$2,062	15.4%	$2,839	$2,295	$2,058	-10.3%	$1,145
Physician	$1,521	$1,677	$1,597	-4.8%	$2,073	$1,732	$1,480	-14.5%	$1,122
Other	$212	$166	$182	9.6%	$127	$163	$88	-46.0%	$113
Total	$5,397	$5,785	$6,904	19.3%	$8,338	$8,983	$6,588	-26.7%	$3,437
			Annualized				Annualized		

Paid Claims by Claim Type – State Participants

Net Paid Claims - Total State Participants	2Q19				2Q20				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical									
Inpatient	$ 16,049,697	$ 2,630,700	$ 930,676	$ 19,611,073	$ 18,568,451	$ 6,456,930	$ 1,752,662	$ 26,778,043	36.5%
Outpatient	$ 26,665,587	$ 6,342,593	$ 1,077,079	$ 34,085,260	$ 31,092,436	$ 7,623,448	$ 901,651	$ 39,617,535	16.2%
Total - Medical	$ 42,715,285	$ 8,973,293	$ 2,007,755	$ 53,696,333	$ 49,660,887	$ 14,080,379	$ 2,654,313	$ 66,395,578	23.7%
Dental	$ 8,514,222	$ 1,029,708	$ 252,743	$ 9,796,674	$ 9,090,617	$ 1,071,864	$ 298,172	$ 10,460,654	6.8%
Dental Exchange	$ -	$ -	$ 1,488,119	$ 1,488,119	$ -	$ -	$ 1,616,736	$ 1,616,736	8.6%
Total	**$ 51,229,507**	**$ 10,003,002**	**$ 3,748,617**	**$ 64,981,126**	**$ 58,751,504**	**$ 15,152,243**	**$ 4,569,221**	**$ 78,472,968**	**20.8%**

Net Paid Claims - Per Participant per Month	2Q19				2Q20				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical	$ 365	$ 573	$ 547	$ 394	$ 419	$ 891	$ 724	$ 481	22.1%
Dental	$ 53	$ 51	$ 57	$ 53	$ 56	$ 53	$ 67	$ 56	4.6%
Dental Exchange	$ -	$ -	$ 50	$ 50	$ -	$ -	$ 51	$ 51	1.5%

Paid Claims by Claim Type – Non-State Participants

Net Paid Claims - Total Non-State Participants	2Q19				2Q20				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical									
Inpatient	$ -	$ 1,577,363	$ 558,675	$ 2,136,038	$ 204	$ 568,876	$ 591,343	$ 1,160,423	-45.7%
Outpatient	$ 7,062	$ 1,520,537	$ 216,987	$ 1,744,586	$ 23,352	$ 972,837	$ 300,091	$ 1,296,281	-25.7%
Total - Medical	$ 7,062	$ 3,097,900	$ 775,662	$ 3,880,624	$ 23,556	$ 1,541,713	$ 891,435	$ 2,456,704	-36.7%
Dental	$ 2,485	$ 223,893	$ 104,908	$ 331,285	$ 1,300	$ 162,757	$ 123,500	$ 287,557	-13.2%
Dental Exchange	$ -	$ -	$ 938,985	$ 938,985	$ -	$ -	$ 984,771	$ 984,771	4.9%
Total	**$ 9,547**	**$ 3,321,792**	**$ 1,819,555**	**$ 5,150,894**	**$ 24,856**	**$ 1,704,470**	**$ 1,999,706**	**$ 3,729,032**	**-27.6%**

Net Paid Claims - Per Participant per Month	2Q19				2Q20				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical	$ 294	$ 1,020	$ 505	$ 844	$ 982	$ 673	$ 571	$ 634	-24.9%
Dental	$ 52	$ 44	$ 42	$ 44	$ 27	$ 43	$ 49	$ 45	3.8%
Dental Exchange	$ -	$ -	$ 44	$ 44	$ -	$ -	$ 45	$ 45	4.3%

Paid Claims by Claim Type – Total

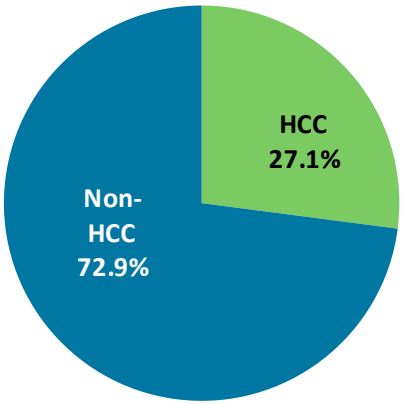
Net Paid Claims - Total Total Participants	2Q19				2Q20				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical									
Inpatient	$ 16,049,697	$ 4,208,063	$ 1,489,351	$ 21,747,112	$ 18,568,655	$ 7,025,807	$ 2,344,005	$ 27,938,466	28.5%
Outpatient	$ 26,672,649	$ 7,863,130	$ 1,294,066	$ 35,829,846	$ 31,115,789	$ 8,596,285	$ 1,201,742	$ 40,913,816	14.2%
Total - Medical	$ 42,722,347	$ 12,071,193	$ 2,783,417	$ 57,576,958	$ 49,684,443	$ 15,622,092	$ 3,545,747	$ 68,852,282	19.6%
Dental	$ 8,516,707	$ 1,253,601	$ 357,651	$ 10,127,959	$ 9,091,917	$ 1,234,621	$ 421,673	$ 10,748,210	6.1%
Dental Exchange	$ -	$ -	$ 2,427,104	$ 2,427,104	$ -	$ -	$ 2,601,507	$ 2,601,507	7.2%
Total	**$ 51,239,054**	**$ 13,324,794**	**$ 5,568,172**	**$ 70,132,020**	**$ 58,776,360**	**$ 16,856,713**	**$ 6,568,926**	**$ 82,201,999**	**17.2%**

Net Paid Claims - Per Participant per Month	2Q19				2Q20				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	
Medical	$ 365	$ 646	$ 535	$ 409	$ 419	$ 863	$ 678	$ 485	18.7%
Dental	$ 53	$ 50	$ 52	$ 53	$ 56	$ 51	$ 61	$ 55	4.7%
Dental Exchange	$ -	$ -	$ 47	$ 47	$ -	$ -	$ 49	$ 49	2.8%

Cost Distribution – Medical Claims

2Q19							2Q20					
Avg # of Members	% of Members	Total Paid	% of Paid	EE Paid	% EE Paid	Paid Claims Category	Avg # of Members	% of Members	Total Paid	% of Paid	EE Paid	% EE Paid
63	0.1%	$13,630,985	23.7%	$496,662	2.3%	$100,000.01 Plus	74	0.2%	$18,633,518	27.1%	$506,733	2.0%
103	0.2%	$8,162,390	14.2%	$671,311	3.0%	$50,000.01-$100,000.00	109	0.3%	$8,454,203	12.3%	$613,144	2.4%
196	0.5%	$7,539,865	13.1%	$968,449	4.4%	$25,000.01-$50,000.00	256	0.6%	$9,512,393	13.8%	$1,245,066	4.9%
584	1.4%	$9,457,137	16.4%	$2,587,894	11.7%	$10,000.01-$25,000.00	665	1.6%	$11,037,796	16.0%	$2,936,073	11.7%
810	1.9%	$6,027,661	10.5%	$2,559,029	11.6%	$5,000.01-$10,000.00	946	2.2%	$7,060,747	10.3%	$3,009,034	12.0%
1,059	2.5%	$4,047,813	7.0%	$2,372,941	10.8%	$2,500.01-$5,000.00	1,257	2.9%	$4,721,615	6.9%	$2,851,639	11.3%
19,580	45.9%	$8,711,106	15.1%	$9,882,996	44.8%	$0.01-$2,500.00	20,477	47.8%	$9,432,010	13.7%	$11,212,169	44.6%
7,173	16.8%	$0	0.0%	$2,521,913	11.6%	$0.00	7,152	16.7%	$0	0.0%	$2,803,725	11.1%
13,136	30.8%	$0	0.0%	$0	-0.2%	No Claims	11,914	27.8%	$0	0.0%	$0	0.0%
42,703	**100.0%**	**$57,576,958**	**100.0%**	**$22,061,195**	**100.0%**		**42,850**	**100.0%**	**$68,852,282**	**100.0%**	**$25,177,583**	**100.0%**

Distribution of HCC Medical Claims Paid



HCC – High Cost Claimant over $100K

HCC's by AHRQ Clinical Classifications Chapter			
AHRQ Chapter	Patients	Total Paid	% Paid
(CCS 2) Neoplasms	37	$4,702,037	25.2%
(CCS 16) Injury And Poisoning	45	$4,425,540	23.8%
(CCS 7) Diseases Of The Circulatory System	58	$2,846,074	15.3%
(CCS 15) Certain Conditions Originating In The Perinatal Period	8	$1,540,204	8.3%
(CCS 13) Diseases Of The Musculoskeletal System And Connective Tissue	45	$821,634	4.4%
(CCS 17) Symptoms; Signs; And Ill-Defined Conditions And Factors Influencing Health Status	79	$710,214	3.8%
(CCS 3) Endocrine; Nutritional; And Metabolic Diseases And Immunity Disorders	46	$633,584	3.4%
(CCS 6) Diseases Of The Nervous System And Sense Organs	58	$617,291	3.3%
(CCS 5) Mental Illness	23	$553,390	3.0%
(CCS 8) Diseases Of The Respiratory System	49	$490,199	2.6%
(CCS 9) Diseases Of The Digestive System	42	$468,035	2.5%
(CCS 1) Infectious And Parasitic Diseases	35	$362,664	1.9%
(CCS 10) Diseases Of The Genitourinary System	37	$293,124	1.6%
(CCS 18) Residual Codes; Unclassified; All E Codes [259. And 260.]	48	$62,660	0.3%
(CCS 12) Diseases Of The Skin And Subcutaneous Tissue	28	$54,676	0.3%
(CCS 4) Diseases Of The Blood And Blood-Forming Organs	30	$39,010	0.2%
(CCS 14) Congenital Anomalies	5	$11,615	0.1%
(CCS 11) Complications Of Pregnancy; Childbirth; And The Puerperium	2	$1,567	0.0%
Overall	**----**	**$18,633,518**	**100.0%**

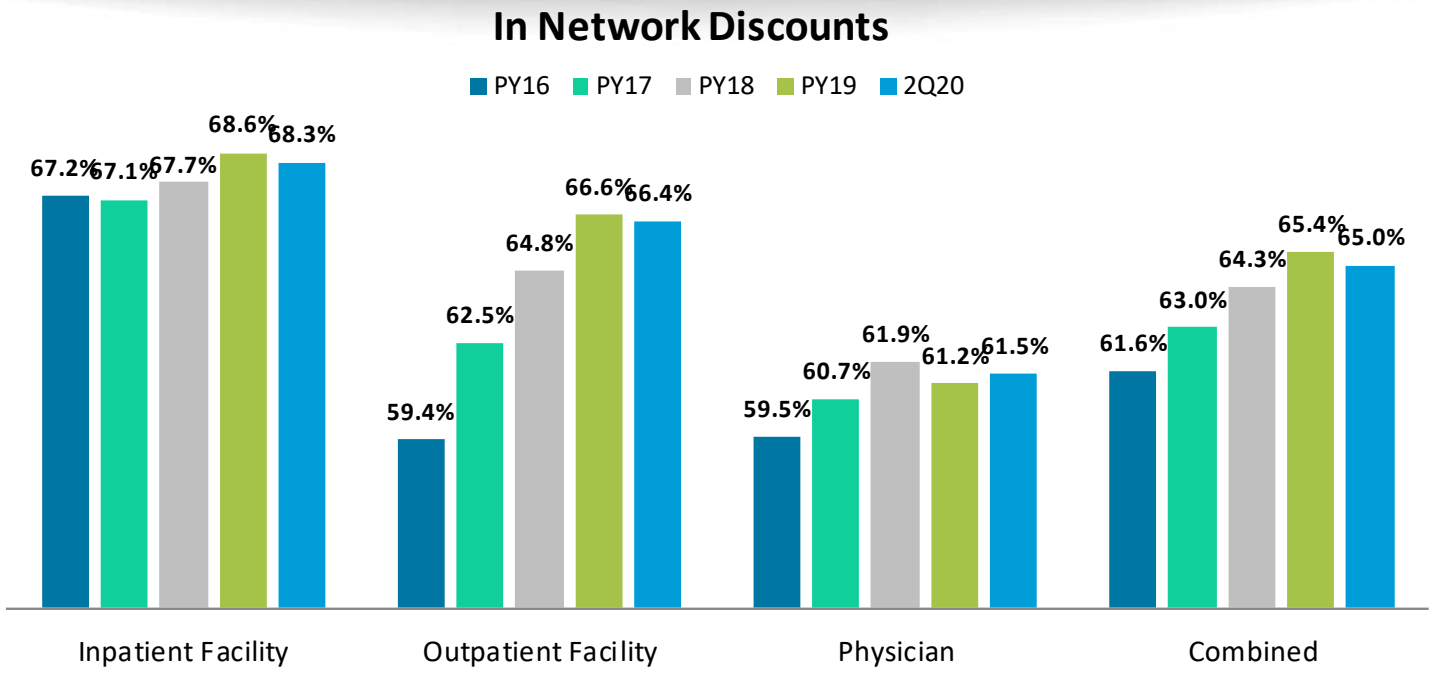
Utilization Summary (p. 1 of 2)

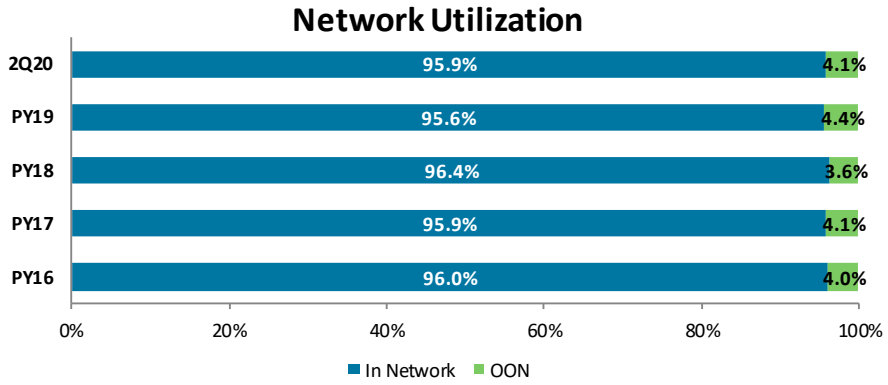
	Total				State Active				Non-State Active			
Summary	**2Q18**	**2Q19**	**2Q20**	**Variance to Prior Year**	**2Q18**	**2Q19**	**2Q20**	**Variance to Prior Year**	**2Q18**	**2Q19**	**2Q20**	**Variance to Prior Year**
Inpatient Facility												
# of Admits	1,074	1,078	1,239		804	841	970		0	0	0	
# of Bed Days	4,793	7,353	6,314		3,380	4,000	4,723		0	0	0	
Paid Per Admit	$18,626	$18,364	$19,991	8.9%	$17,295	$17,473	$16,727	-4.3%	$0	$0	$0	0.0%
Paid Per Day	$4,174	$2,702	$3,923	45.2%	$4,114	$3,674	$3,435	-6.5%	$0	$0	$0	0.0%
Admits Per 1,000	51	51	58	13.7%	44	45	52	15.6%	0	0	0	0.0%
Days Per 1,000	229	344	295	-14.2%	186	216	254	17.6%	0	0	0	0.0%
Avg LOS	4.5	6.8	5.1	-25.0%	4.2	4.8	4.9	2.1%	0	0	0	0.0%
Physician Office												
OV Utilization per Member	3.5	3.4	3.8	11.8%	3.2	3.2	3.6	12.5%	10	3.7	8.3	124.3%
Avg Paid per OV	$41	$40	$41	2.5%	$41	$40	$41	2.5%	$74	$73	$66	-9.6%
Avg OV Paid per Member	$142	$136	$156	14.7%	$131	$127	$146	15.0%	$748	$271	$548	102.2%
DX&L Utilization per Member	7.4	7.3	8.4	15.1%	6.7	6.8	7.8	14.7%	9.8	0	0	0.0%
Avg Paid per DX&L	$56	$59	$55	-6.8%	$53	$54	$52	-3.7%	$55	$0	$0	0.0%
Avg DX&L Paid per Member	$413	$432	$461	6.7%	$356	$363	$410	12.9%	$541	$0	$0	0.0%
Emergency Room												
# of Visits	3,470	3,232	3,635		2,833	2,610	2,972		2	0	2	
# of Admits	498	499	517		349	369	384		0	0	0	
Visits Per Member	0.17	0.15	0.17	13.3%	0.16	0.14	0.16	14.3%	0.56	0	0.57	0.0%
Visits Per 1,000	165	151	170	12.6%	156	141	160	13.5%	558	0	571	0.0%
Avg Paid per Visit	$1,762	$1,825	$2,047	12.2%	$1,707	$1,755	$2,055	17.1%	$1,342	$0	$1,803	0.0%
Admits Per Visit	0.14	0.15	0.14	-6.7%	0.12	0.14	0.13	-7.1%	0.00	0.00	0.00	0.0%
Urgent Care												
# of Visits	4,169	4,466	5,683		3,706	4,001	5,123		2	0	1	
Visits Per Member	0.20	0.21	0.27	28.6%	0.20	0.22	0.28	27.3%	0.56	0.00	0.29	0.0%
Visits Per 1,000	199	209	265	26.8%	204	216	275	27.3%	558	0	286	0.0%
Avg Paid per Visit	$32	$29	$36	24.1%	$28	$28	$34	21.4%	$140	$0	$170	0.0%
	Annualized	Annualized	Annualized		Annualized	Annualized	Annualized		Annualized	Annualized	Annualized	

Utilization Summary (p. 2 of 2)

	State Retirees				Non-State Retirees				
Summary	**2Q18**	**2Q19**	**2Q20**	**Variance to Prior Year**	**2Q18**	**2Q19**	**2Q20**	**Variance to Prior Year**	**HSB Peer Index**
Inpatient Facility									
# of Admits	186	179	212		84	58	57		
# of Bed Days	1,018	914	1,302		395	2,439	289		
Paid Per Admit	$22,084	$17,608	$34,625	96.6%	$23,712	$34,692	$21,100	-39.2%	$16,173
Paid Per Day	$4,035	$3,448	$5,638	63.5%	$5,043	$825	$4,162	404.5%	$3,708
Admits Per 1,000	80	75	87	16.0%	169	134	154	14.9%	61
Days Per 1,000	435	381	537	40.9%	795	5,641	782	-86.1%	264
Avg LOS	5.5	5.1	6.1	19.6%	4.7	42.1	5.1	-87.9%	4.3
Physician Office									
OV Utilization per Member	4.9	4.7	5.3	12.8%	6.2	6.3	7.3	15.9%	3.3
Avg Paid per OV	$43	$42	$41	-2.4%	$35	$34	$30	-11.8%	$50
Avg OV Paid per Member	$210	$198	$221	11.6%	$214	$216	$221	2.3%	$167
DX&L Utilization per Member	10.7	10.6	12.1	14.2%	14.1	13.4	14.4	7.5%	8.3
Avg Paid per DX&L	$72	$79	$66	-16.5%	$59	$85	$58	-31.8%	$67
Avg DX&L Paid per Member	$766	$836	$799	-4.4%	$835	$1,133	$835	-26.3%	$554
Emergency Room									
# of Visits	484	476	513		151	146	148		
# of Admits	108	98	103		41	32	30		
Visits Per Member	0.21	0.20	0.21	5.0%	0.3	0.34	0.40	17.6%	0.17
Visits Per 1,000	207	198	212	7.1%	304	338	401	18.6%	174
Avg Paid per Visit	$2,025	$2,136	$2,159	1.1%	$1,961	$2,052	$1,489	-27.4%	$1,684
Admits Per Visit	0.22	0.21	0.20	-4.8%	0.27	0.22	0.20	-9.1%	0.14
Urgent Care									
# of Visits	372	373	467		89	92	92		
Visits Per Member	0.16	0.16	0.19	18.8%	0.18	0.21	0.25	19.0%	0.24
Visits Per 1,000	159	155	193	24.5%	179	213	249	16.9%	242
Avg Paid per Visit	$69	$35	$53	51.4%	$46	$33	$36	9.1%	$74
	Annualized	Annualized	Annualized		Annualized	Annualized	Annualized		

Provider Network Summary

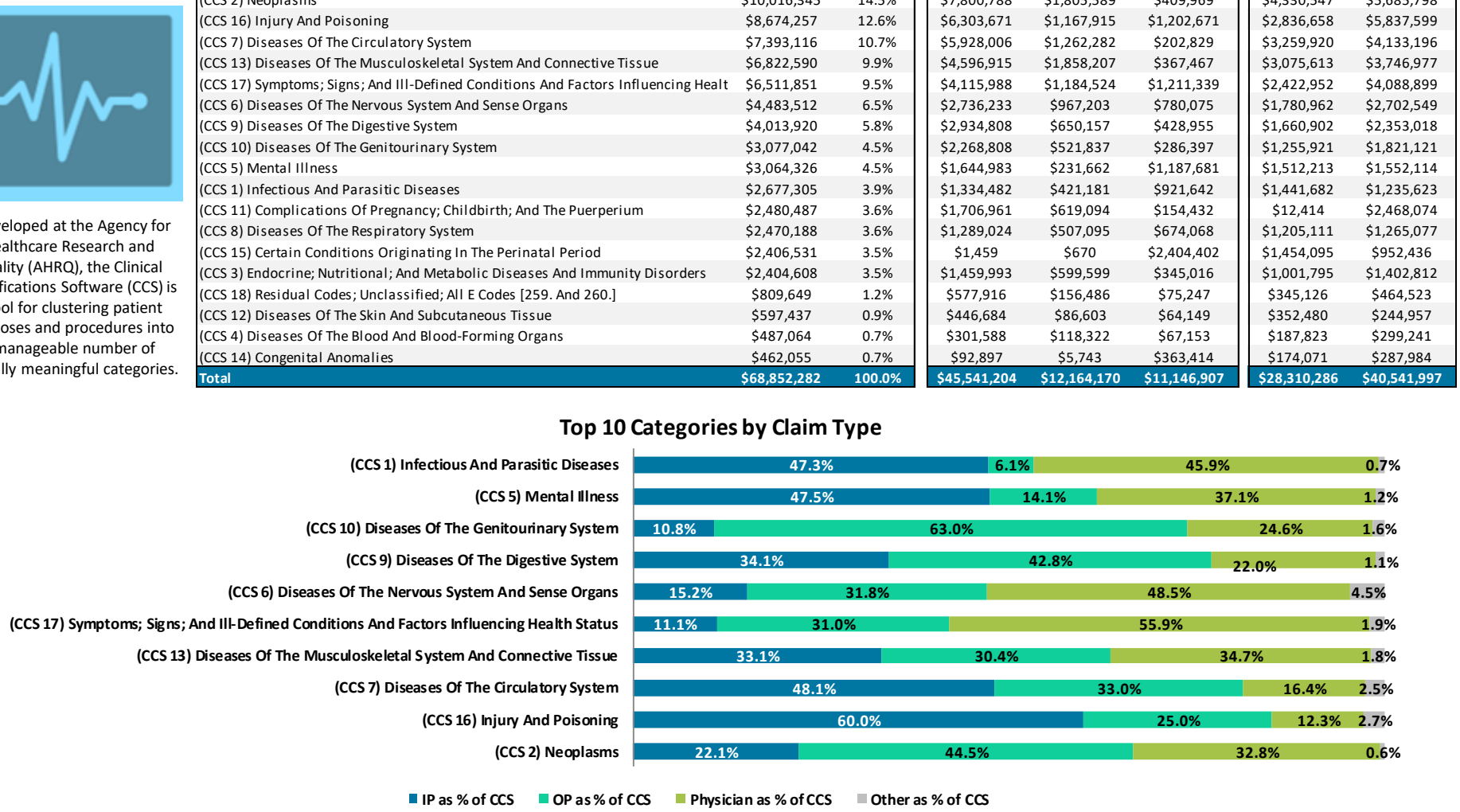




AHRQ* Clinical Classifications Summary

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

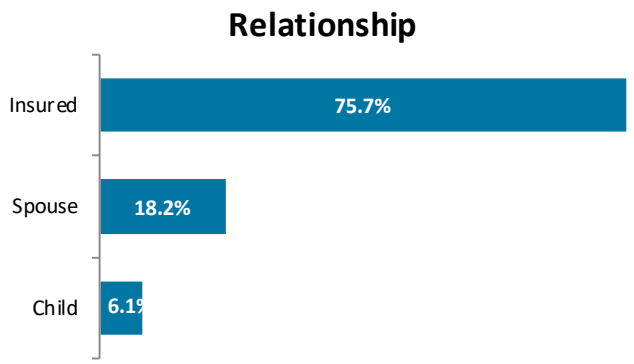
AHRQ Clinical Classifications Chapter	Total Paid	% Paid	Insured	Spouse	Child	Male	Female
(CCS 2) Neoplasms	$10,016,345	14.5%	$7,800,788	$1,805,589	$409,969	$4,330,547	$5,685,798
(CCS 16) Injury And Poisoning	$8,674,257	12.6%	$6,303,671	$1,167,915	$1,202,671	$2,836,658	$5,837,599
(CCS 7) Diseases Of The Circulatory System	$7,393,116	10.7%	$5,928,006	$1,262,282	$202,829	$3,259,920	$4,133,196
(CCS 13) Diseases Of The Musculoskeletal System And Connective Tissue	$6,822,590	9.9%	$4,596,915	$1,858,207	$367,467	$3,075,613	$3,746,977
(CCS 17) Symptoms; Signs; And Ill-Defined Conditions And Factors Influencing Healt	$6,511,851	9.5%	$4,115,988	$1,184,524	$1,211,339	$2,422,952	$4,088,899
(CCS 6) Diseases Of The Nervous System And Sense Organs	$4,483,512	6.5%	$2,736,233	$967,203	$780,075	$1,780,962	$2,702,549
(CCS 9) Diseases Of The Digestive System	$4,013,920	5.8%	$2,934,808	$650,157	$428,955	$1,660,902	$2,353,018
(CCS 10) Diseases Of The Genitourinary System	$3,077,042	4.5%	$2,268,808	$521,837	$286,397	$1,255,921	$1,821,121
(CCS 5) Mental Illness	$3,064,326	4.5%	$1,644,983	$231,662	$1,187,681	$1,512,213	$1,552,114
(CCS 1) Infectious And Parasitic Diseases	$2,677,305	3.9%	$1,334,482	$421,181	$921,642	$1,441,682	$1,235,623
(CCS 11) Complications Of Pregnancy; Childbirth; And The Puerperium	$2,480,487	3.6%	$1,706,961	$619,094	$154,432	$12,414	$2,468,074
(CCS 8) Diseases Of The Respiratory System	$2,470,188	3.6%	$1,289,024	$507,095	$674,068	$1,205,111	$1,265,077
(CCS 15) Certain Conditions Originating In The Perinatal Period	$2,406,531	3.5%	$1,459	$670	$2,404,402	$1,454,095	$952,436
(CCS 3) Endocrine; Nutritional; And Metabolic Diseases And Immunity Disorders	$2,404,608	3.5%	$1,459,993	$599,599	$345,016	$1,001,795	$1,402,812
(CCS 18) Residual Codes; Unclassified; All E Codes [259. And 260.]	$809,649	1.2%	$577,916	$156,486	$75,247	$345,126	$464,523
(CCS 12) Diseases Of The Skin And Subcutaneous Tissue	$597,437	0.9%	$446,684	$86,603	$64,149	$352,480	$244,957
(CCS 4) Diseases Of The Blood And Blood-Forming Organs	$487,064	0.7%	$301,588	$118,322	$67,153	$187,823	$299,241
(CCS 14) Congenital Anomalies	$462,055	0.7%	$92,897	$5,743	$363,414	$174,071	$287,984
Total	**$68,852,282**	**100.0%**	**$45,541,204**	**$12,164,170**	**$11,146,907**	**$28,310,286**	**$40,541,997**

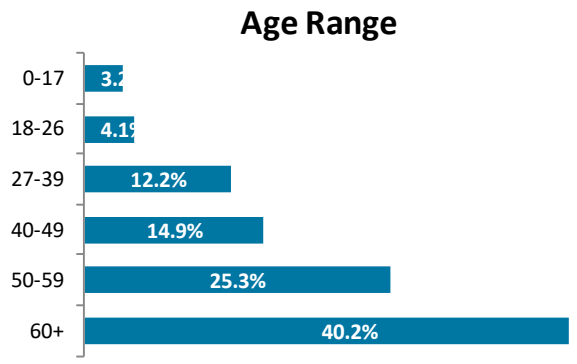


AHRQ Category – Neoplasms

Diagnosis Category	Patients	Claims	Total Paid	% Paid
Maintenance Chemotherapy; Radiotherapy [45.]	85	652	$2,050,596	20.5%
Cancer Of Breast [24.]	288	2201	$1,425,556	14.2%
Cancer; Other Primary	166	918	$1,164,582	11.6%
Cancer Of Lymphatic And Hematopoietic Tissue	95	991	$1,115,060	11.1%
Benign Neoplasms	1,818	3,231	$924,288	9.2%
Secondary Malignancies [42.]	74	325	$685,798	6.8%
Cancer Of Skin	396	1,028	$602,513	6.0%
Other Gastrointestinal Cancer	34	486	$521,503	5.2%
Colorectal Cancer	63	644	$405,845	4.1%
Cancer Of Male Genital Organs	140	718	$350,892	3.5%
Cancer Of Bronchus; Lung [19.]	25	357	$212,116	2.1%
Cancer Of Uterus And Cervix	154	449	$206,908	2.1%
Neoplasms Of Unspecified Nature Or Uncertain Behavior [44.]	1,349	2,197	$157,395	1.6%
Cancer Of Ovary And Other Female Genital Organs	36	258	$79,791	0.8%
Cancer Of Urinary Organs	53	282	$63,392	0.6%
Malignant Neoplasm Without Specification Of Site [43.]	22	72	$50,110	0.5%
Overall	**----**	**----**	**$10,016,345**	**100.0%**

*Patient and claim counts are unique only within the category

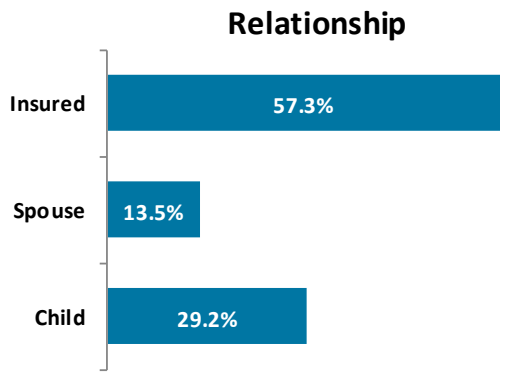


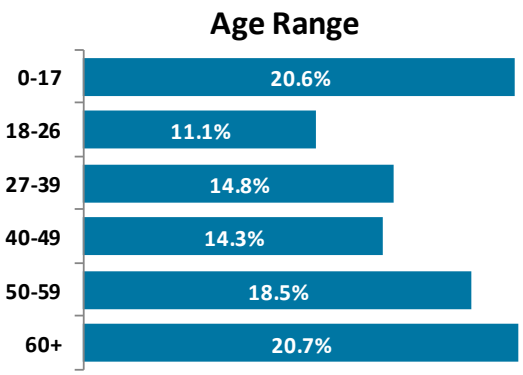


AHRQ Category – Injury & Poisoning

Diagnosis Category	Patients	Claims	Total Paid	% Paid
Burns [240.]	42	118	$2,849,355	32.8%
Complications	430	1,583	$1,841,675	21.2%
Fractures	627	3,714	$1,488,618	17.2%
Crushing Injury Or Internal Injury [234.]	49	132	$486,477	5.6%
Joint Disorders And Dislocations; Trauma-Related [225.]	492	2,140	$485,997	5.6%
Sprains And Strains [232.]	1,018	3,204	$474,625	5.5%
Open Wounds	536	1,389	$283,491	3.3%
Other Injuries And Conditions Due To External Causes [244.]	931	1,749	$282,263	3.3%
Superficial Injury; Contusion [239.]	562	1,055	$236,176	2.7%
Intracranial Injury [233.]	78	257	$214,248	2.5%
Poisoning	67	138	$30,862	0.4%
Spinal Cord Injury [227.]	6	11	$470	0.0%
	----	----	**$8,674,257**	**100.0%**

*Patient and claim counts are unique only within the category

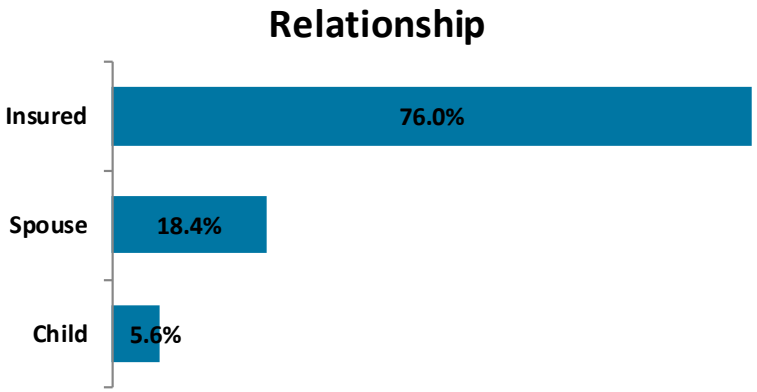


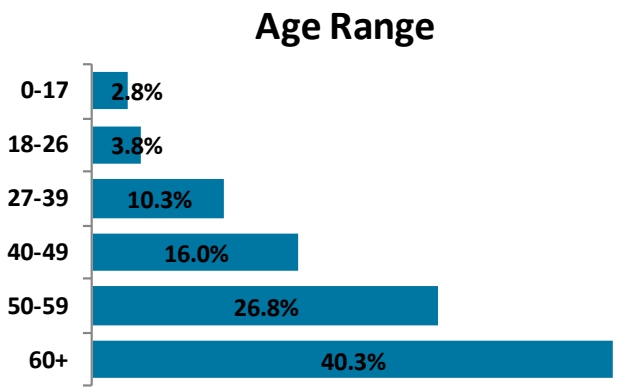


AHRQ Category – Diseases of the Circulatory System

Diagnosis Category	Patients	Claims	Total Paid	% Paid
Diseases Of The Heart	2,464	8,426	$4,864,847	65.8%
Cerebrovascular Disease	273	1,060	$891,877	12.1%
Hypertension	2,596	4,856	$772,295	10.4%
Diseases Of Veins And Lymphatics	500	1,365	$585,588	7.9%
Diseases Of Arteries; Arterioles; And Capillaries	730	1,237	$278,510	3.8%
Overall	**----**	**----**	**$7,393,116**	**100.0%**

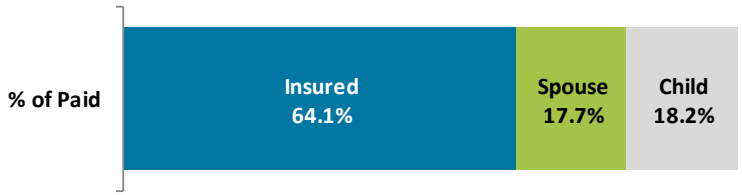
*Patient and claim counts are unique only within the category

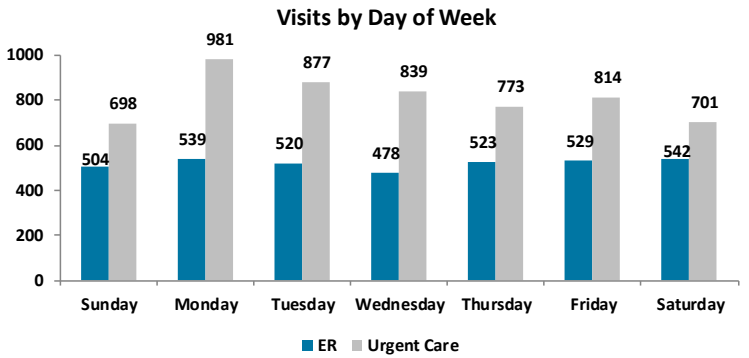




Emergency Room / Urgent Care Summary

	2Q19		2Q20		HSB Peer Index	
ER/Urgent Care	**ER**	**Urgent Care**	**ER**	**Urgent Care**	**ER**	**Urgent Care**
Number of Visits	3,232	4,466	3,635	5,683		
Number of Admits	499	----	517	----		
Visits Per Member	0.15	0.21	0.17	0.27	0.17	0.24
Visits/1000 Members	151	209	170	265	174	242
Avg Paid Per Visit	$1,825	$29	$2,047	$36	$1,684	$74
Admits per Visit	0.15	----	0.14	----	0.14	
% of Visits with HSB ER Dx	77.6%	----	76.2%	----		
% of Visits with a Physician OV*	77.8%	72.9%	76.9%	73.2%		
Total Plan Paid	**$5,893,731**	**$128,707**	**$7,436,737**	**$203,082**		
*looks back 12 months from ER visit	Annualized	Annualized	Annualized	Annualized		



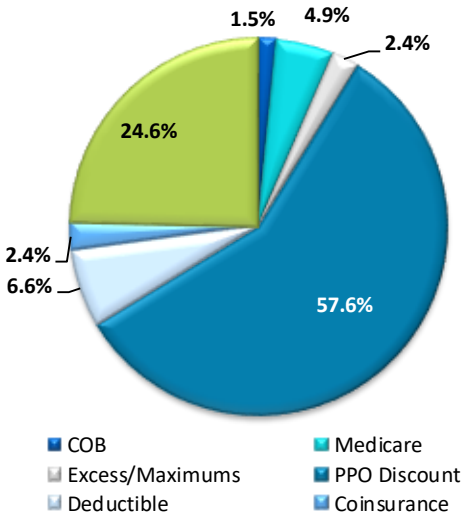


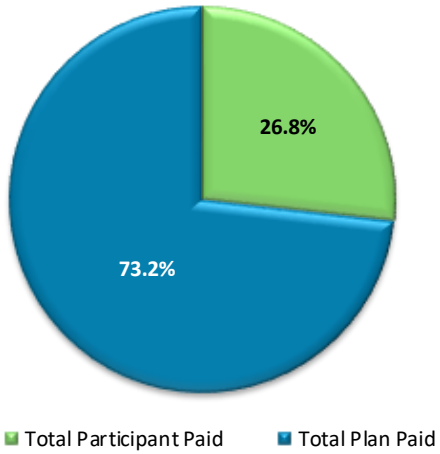
ER / UC Visits by Relationship						
Relationship	**ER**	**Per 1,000**	**Urgent Care**	**Per 1,000**	**Total**	**Per 1,000**
Insured	2,119	90	3,364	142	5,483	232
Spouse	567	102	623	112	1,190	214
Child	949	70	1,696	124	2,645	194
Total	**3,635**	**85**	**5,683**	**133**	**9,318**	**217**

Savings Summary – Medical Claims

Description	Dollars	PPPM	% of Eligible
Eligible Charges	$279,546,528	$1,970	100.0%
COB	$4,175,963	$29	1.5%
Medicare	$13,663,557	$96	4.9%
Excess/Maximums	$6,671,426	$47	2.4%
PPO Discount	$161,005,717	$1,135	57.6%
Deductible	$18,454,488	$130	6.6%
Coinsurance	$6,723,095	$47	2.4%
Total Participant Paid	**$25,177,583**	**$177**	**9.0%**
Total Plan Paid	**$68,852,282**	**$485**	**24.6%**

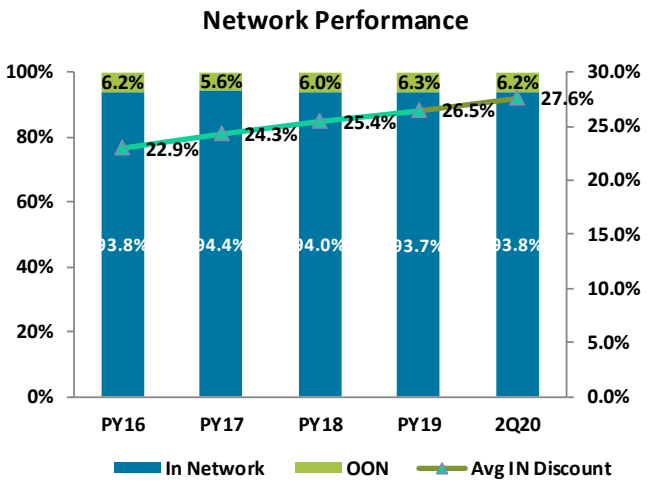
Total Participant Paid - PY19	**$141**
Total Plan Paid - PY19	**$471**



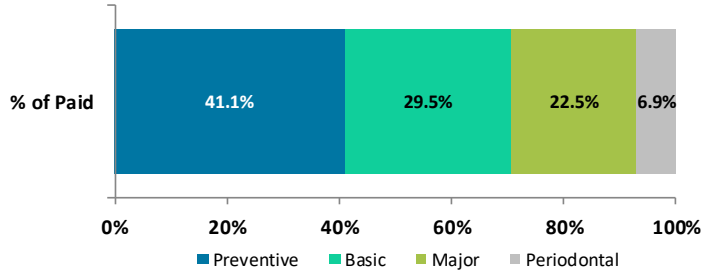


Dental Claims Analysis

Cost Distribution								
Paid Claims Category	Avg # of Members	% of Members	# Claims	# of Claims	Total Paid	% of Paid	Total EE Paid	% of EE Paid
$1,000.01 Plus	3,241	4.7%	12,004	16.2%	$4,759,512	35.7%	$3,203,580	47.4%
$750.01-$1,000.00	1,407	2.0%	4,259	5.7%	$1,243,642	9.3%	$766,627	11.4%
$500.01-$750.00	2,614	3.8%	7,085	9.6%	$1,640,353	12.3%	$994,011	14.7%
$250.01-$500.00	5,656	8.2%	13,048	17.6%	$1,968,917	14.7%	$781,417	11.6%
$0.01-$250.00	26,738	38.9%	36,868	49.7%	$3,737,294	28.1%	$954,351	14.1%
$0.00	843	1.2%	911	1.2%	$0	-0.1%	$53,639	0.8%
No Claims	28,175	41.0%	0	0.0%	$0	0.0%	$0	0.0%
Total	**68,674**	**100.0%**	**74,175**	**100.0%**	**$13,349,718**	**100.0%**	**$6,753,624**	**100.0%**



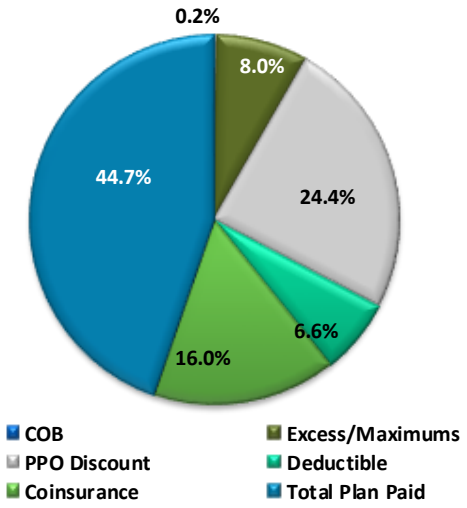
Claim Category	Total Paid	% of Paid
Preventive	$5,485,470	41.1%
Basic	$3,937,096	29.5%
Major	$3,009,522	22.5%
Periodontal	$917,630	6.9%
Total	**$13,349,718**	**100.0%**

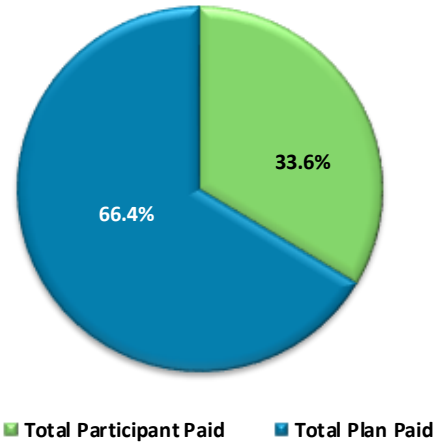


Savings Summary – Dental Claims

Description	Dollars	PPPM	% of Eligible
Eligible Charges	$29,864,301	$72	100.0%
COB	$68,928	$0	0.2%
Excess/Maximums	$2,395,068	$6	8.0%
PPO Discount	$7,296,963	$18	24.4%
Deductible	$1,970,831	$5	6.6%
Coinsurance	$4,782,793	$12	16.0%
Total Participant Paid	**$6,753,624**	**$16**	**22.6%**
Total Plan Paid	**$13,349,718**	**$32**	**44.7%**

Total Participant Paid - PY19	**$14**
Total Plan Paid - PY19	**$30**





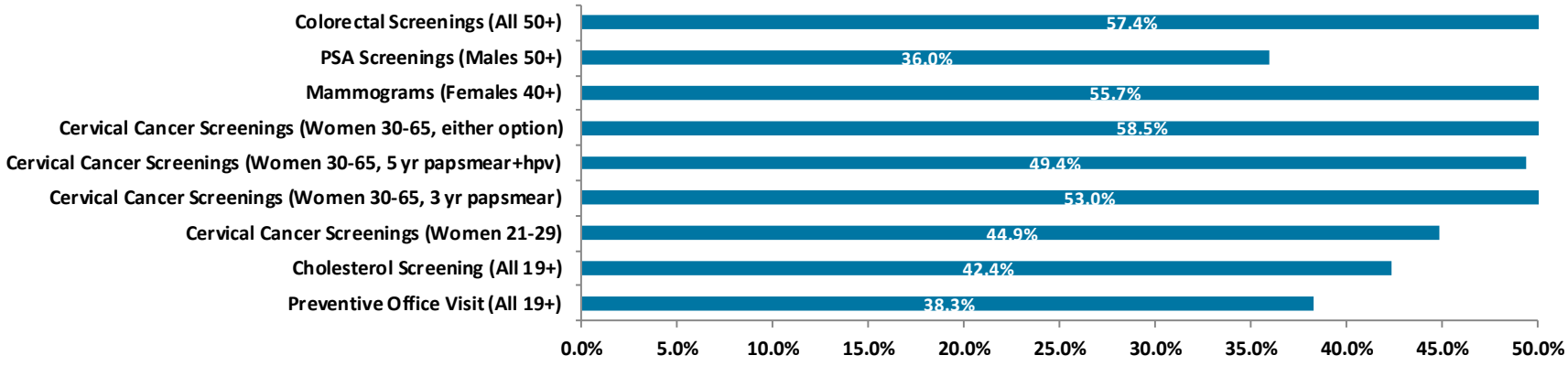
Preventive Services Compliance

*Based on 15 mo. of utilization/12 mo. paid data on members with 9 mo. of service or greater;

Colorectal screenings look back to July 2011.

	Female			Male			Total		
Service	Eligible	Compliant	% Compliant	Eligible	Compliant	% Compliant	Eligible	Compliant	% Compliant
Preventive Office Visit (All 19+)	17,232	8,633	50.1%	15,110	3,762	24.9%	32,342	12,396	38.3%
Cholesterol Screening (All 19+)	17,232	7,961	46.2%	15,110	5,757	38.1%	32,342	13,718	42.4%
Cervical Cancer Screenings (Women 21-29)	2,762	1,240	44.9%	----	----	----	2,762	1,240	44.9%
Cervical Cancer Screenings (Women 30-65, 3 yr papsmear)	12,982	6,880	53.0%	----	----	----	12,982	6,880	53.0%
Cervical Cancer Screenings (Women 30-65, 5 yr papsmear+hpv)	12,982	6,413	49.4%	----	----	----	12,982	6,413	49.4%
Cervical Cancer Screenings (Women 30-65, either option)	12,982	7,594	58.5%	----	----	----	12,982	7,594	58.5%
Mammograms (Females 40+)	10,680	5,949	55.7%	----	----	----	10,680	5,949	55.7%
PSA Screenings (Males 50+)	----	----	----	6,394	2,302	36.0%	6,394	2,302	36.0%
Colorectal Screenings (All 50+)	7,425	4,425	59.6%	6,394	3,510	54.9%	13,819	7,936	57.4%

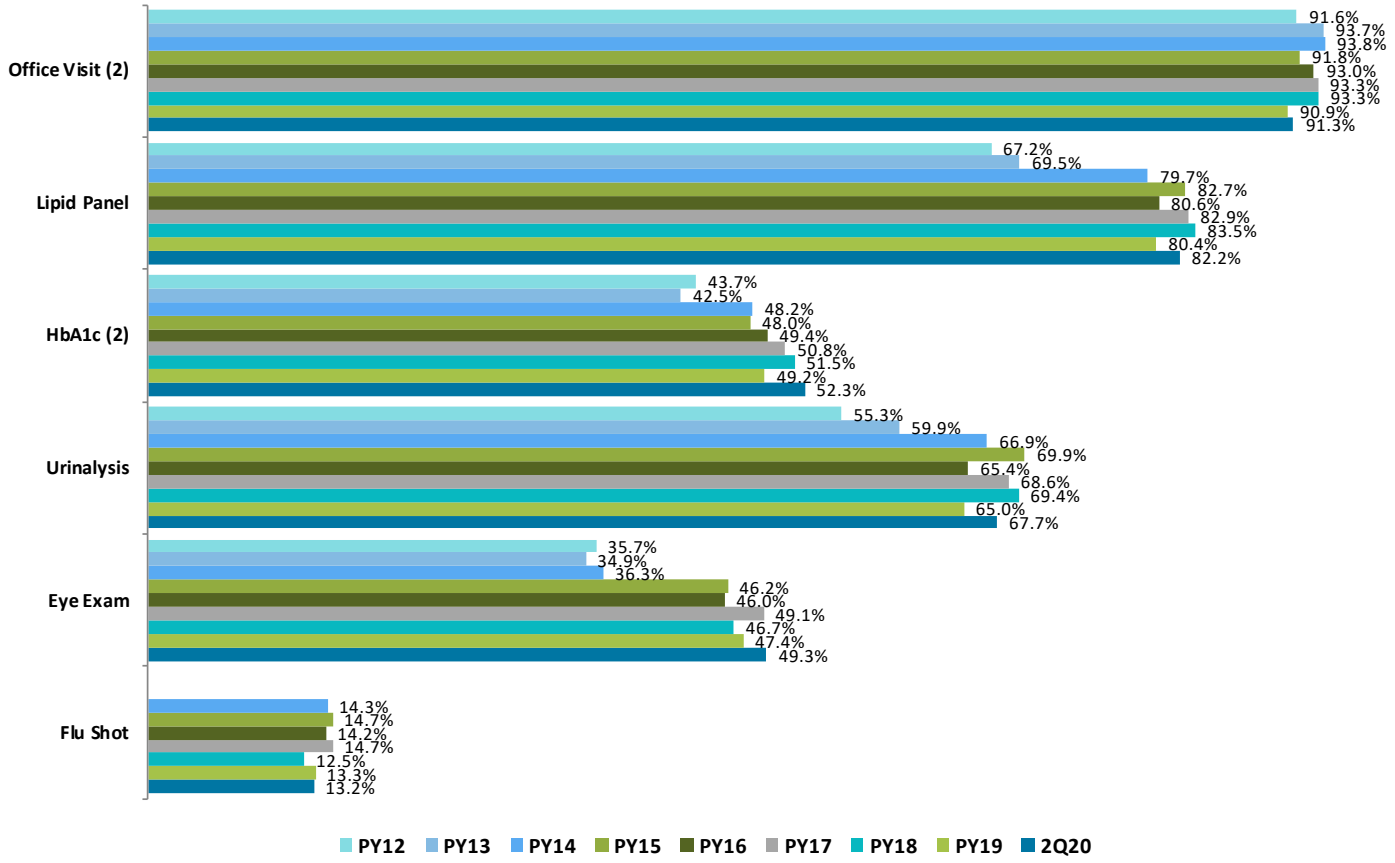
Overall Preventive Services Compliance Rates



Diabetic Disease Compliance

*Based on 15 mo. of utilization/12 mo. paid data on members with 9 mo. of service or greater;

Diabetic Population									
Year	PY12	PY13	PY14	PY15	PY16	PY17	PY18	PY19	2Q20
Members	1,651	1,643	1,555	1,676	1,693	1,704	1,747	1,838	1,890

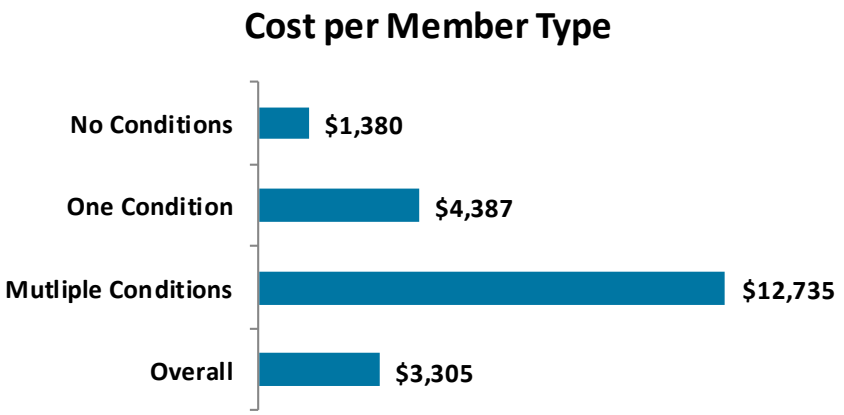


Chronic Conditions Summary

*Based on 15 mo. of utilization/12 mo. paid data on members with 9 mo. of service or greater;

Condition	Total Members	Avg Members	Per 1,000	Avg Age	Total Cost	Average Cost	Compliance Rate	Compliance Measure
Asthma	1,200	1,125	28	37	$7,346,636	$6,122	99.3%	1 Office Visit
Cancer	1,384	1,306	32	59	$30,516,109	$22,049	----	----
Chronic Kidney Disease	333	315	8	60	$7,948,673	$23,870	----	----
Chronic Obstructive Pulmonary Disease (COPD)	260	245	6	60	$5,633,788	$21,668	96.9%	1 Office Visit
Congestive Heart Failure (CHF)	149	135	3	62	$10,804,550	$72,514	18.1%	1 Office Visit, 1 Lipid Profile, 1 Wellness Visit
Coronary Artery Disease (CAD)	668	635	16	62	$16,076,709	$24,067	27.1%	1 Office Visit, 1 Lipid Profile, 1 Wellness Visit
Depression	1,512	1,400	35	40	$15,559,571	$10,291	95.8%	1 Office Visit
Diabetes	1,890	1,772	44	56	$16,993,384	$8,991	22.1%	2 Office Visits, 1 Lipid Profile, 2 HbA1c's, 1 Urinalysis, 1 Eye Exam, 1 Flu Shot
Hyperlipidemia	3,393	3,249	79	54	$16,584,778	$4,888	43.5%	1 Office Visit, 1 Lipid Profile, 1 Wellness Visit
Hypertension	3,767	3,565	88	57	$31,181,204	$8,277	28.1%	1 Office Visit, 1 Lipid Profile, 1 Wellness Visit
Obesity	849	804	20	44	$5,253,989	$6,188	----	----

# of Conditions	Avg Members	Average Age	Relationship		
			Insured	Spouse	Child
No Conditions	28,987	31	47.1%	11.8%	41.1%
One Condition	8,838	46	69.7%	16.8%	13.5%
Multiple Conditions	4,899	55	79.1%	18.1%	2.8%
Overall	**42,724**	**36**	**54.6%**	**13.4%**	**32.0%**



Public Employees' Benefits Program - RX Costs
PY 2020 - Quarter Ending December 31, 2019

Express Scripts

Membership Summary	2Q FY2020	2Q FY2019	Difference	% Change
			Membership Summary	
Member Count (Membership)	42,842	42,681	161	0.4%
Utilizing Member Count (Patients)	26,112	25,283	829	3.3%
Percent Utilizing (Utilization)	60.9%	59.2%	0.02	2.9%
Claim Summary			**Claims Summary**	
Net Claims (Total Rx's)	262,306	244,415	17,891	7.3%
Claims per Elig Member per Month (Claims PMPM)	1.02	0.95	0.07	7.4%
Total Claims for Generic (Generic Rx)	225,793	209,031	16,762.00	8.0%
Total Claims for Brand (Brand Rx)	36,513	35,384	1,129.00	3.2%
Total Claims for Brand w/Gen Equiv (Multisource Brand Claims)	3,910	3,899	11.00	0.3%
Total Non-Specialty Claims	260,319	242,485	17,834.00	7.4%
Total Specialty Claims	1,987	1,930	57.00	3.0%
Generic % of Total Claims (GFR)	**86.1%**	**85.5%**	0.01	0.7%
Generic Effective Rate (GCR)	**98.3%**	**98.2%**	0.00	0.1%
Mail Order Claims	43,677	32,088	11,589.00	36.1%
Mail Penetration Rate*	19.2%	15.1%	0.04	4.1%
Claims Cost Summary			**Claims Cost Summary**	
Total Prescription Cost (Total Gross Cost)	$23,638,445.00	$22,373,141.00	$1,265,304.00	5.7%
Total Generic Gross Cost	$3,925,502.00	$4,391,937.00	($466,435.00)	-10.6%
Total Brand Gross Cost	$19,712,943.00	$17,981,204.00	$1,731,739.00	9.6%
Total MSB Gross Cost	$815,657.00	$564,801.00	$250,856.00	44.4%
Total Ingredient Cost	$23,415,102.00	$22,158,133.00	$1,256,969.00	5.7%
Total Dispensing Fee	$214,539.00	$207,415.00	$7,124.00	3.4%
Total Other (e.g. tax)	$8,804.00	$7,593.00	$1,211.00	15.9%
Avg Total Cost per Claim (Gross Cost/Rx)	**$90.12**	**$91.54**	($1.42)	-1.6%
Avg Total Cost for Generic (Gross Cost/Generic Rx)	$17.39	$21.01	($3.62)	-17.2%
Avg Total Cost for Brand (Gross Cost/Brand Rx)	$539.89	$508.17	$31.72	6.2%
Avg Total Cost for MSB (MSB Gross Cost/MSB ARx)	$208.61	$144.86	$63.75	44.0%
Member Cost Summary			**Member Cost Summary**	
Total Member Cost	**$7,588,859.00**	**$5,920,831.00**	$1,668,028.00	28.2%
Total Copay	$3,350,749.00	$2,275,034.00	$1,075,715.00	47.3%
Total Deductible	$4,238,110.00	$3,645,797.00	$592,313.00	16.2%
Avg Copay per Claim (Copay/Rx)	$12.77	$9.31	$3.47	37.2%
Avg Participant Share per Claim (Copay+Deductible/RX)	**$28.93**	**$24.22**	**$4.71**	**19.4%**
Avg Copay for Generic (Copay/Generic Rx)	$10.14	$10.88	($0.74)	-6.8%
Avg Copay for Brand (Copay/Brand Rx)	$145.16	$103.04	$42.12	40.9%
Avg Copay for Brand w/ Generic Equiv (Copay/Multisource Rx)	$80.11	$73.85	$6.26	8.5%
Net PMPM (Participant Cost PMPM)	**$29.52**	**$23.12**	$6.40	27.7%
Copay % of Total Prescription Cost (Member Cost Share %)	32.1%	26.5%	5.6%	21.3%
Plan Cost Summary			**Plan Cost Summary**	
Total Plan Cost (Plan Cost)	**$16,049,586.00**	**$16,452,310.00**	**($402,724.00)**	**-2.4%**
Total Non-Specialty Cost (Non-Specialty Plan Cost)	$6,870,325.00	$7,238,957.00	($368,632.00)	-5.1%
Total Specialty Drug Cost (Specialty Plan Cost)	$9,179,261.00	$9,213,353.00	($34,092.00)	-0.4%
Avg Plan Cost per Claim (Plan Cost/Rx)	**$61.19**	**$67.31**	($6.13)	-9.1%
Avg Plan Cost for Generic (Plan Cost/Generic Rx)	$7.25	$10.13	($2.88)	-28.4%
Avg Plan Cost for Brand (Plan Cost/Brand Rx)	$394.73	$405.14	($10.41)	-2.6%
Avg Plan Cost for MSB (MSB Plan Cost/MSB ARx)	$128.50	$71.01	$57.49	81.0%
Net PMPM (Plan Cost PMPM)	**$62.44**	**$64.25**	**($1.81)**	**-2.8%**
PMPM for Specialty Only (Specialty PMPM)	$4,619.66	$35.98	$4,583.68	12739.5%
PMPM without Specialty (Non-Specialty PMPM)	$26.39	$28.27	($1.88)	-6.7%
Rebates (Q1-Q2 FY2020 estimated)	$4,545,329.73	$3,827,465.00	$717,864.73	18.8%
Net PMPM (Plan Cost PMPM factoring Rebates)	**$44.75**	**$49.44**	**($4.68)**	**-9.5%**
PMPM for Specialty Only (Specialty PMPM)	$29.96	$31.82	($1.86)	-5.8%
PMPM without Specialty (Non-Specialty PMPM)	$14.80	$17.62	($2.82)	-16.0%

Appendix B

Index of Tables
HealthSCOPE – EPO Utilization Review for PEBP
July 1, 2019 – December 31, 2019

HSB DATASCOPE™

Nevada Public Employees' Benefits Program
EPO Plan

July 2019 – December 2019

HealthSCOPE BENEFITS

Overview

- Total Medical Spend for 2Q20 was $24,249,744 with an annualized plan cost per employee per year of $10,055. This is an increase of 15.0% when compared to PY19.
  - IP Cost per Admit is $12,601 which is 38.2% lower than PY19.
  - ER Cost per Visit is $2,620 which is on track with PY19.
- Employees shared in 10.2% of the medical cost.
- Inpatient facility costs were 13.0% of the plan spend.
- 82.0% of the Average Membership had paid Medical claims less than $2,500, with 15.9% of those having no claims paid at all during the reporting period.
- 15 members exceeded the $100k high cost threshold during the reporting period, which accounted for 11.3% of the plan spend. The highest diagnosis category was Conditions Originating in the Perinatal Period, accounting for 16.0% of the high cost claimant dollars.
- Total spending with in-network providers was 97.4%. The overall in-network discount was 57.0%.

Paid Claims by Age Group

Paid Claims by Age Group																
	PY19						2Q20						% Change	
Age Range	Med Net Pay	Med PMPM	Rx Net Pay	Rx PMPM	Net Pay	PMPM	Med Net Pay	Med PMPM	Rx Net Pay	Rx PMPM	Net Pay	PMPM	Net Pay	PMPM
<1	$ 1,874,215	$ 1,698	$ 9,149	$ 8	$ 1,883,364	$ 1,706	$ 1,046,671	$ 1,544	$ 9,366	$ 14	$ 1,056,037	$ 1,558	-43.9%	-8.7%
1	$ 264,791	$ 245	$ 14,535	$ 13	$ 279,326	$ 259	$ 181,130	$ 332	$ 5,393	$ 10	$ 186,523	$ 342	-33.2%	32.1%
2 - 4	$ 372,210	$ 117	$ 14,845	$ 5	$ 387,055	$ 122	$ 309,366	$ 176	$ 7,602	$ 4	$ 316,968	$ 180	-18.1%	48.1%
5 - 9	$ 502,906	$ 81	$ 95,811	$ 16	$ 598,717	$ 97	$ 398,927	$ 127	$ 55,969	$ 18	$ 454,896	$ 144	-24.0%	49.1%
10 - 14	$ 1,277,258	$ 167	$ 244,065	$ 32	$ 1,521,323	$ 198	$ 754,875	$ 191	$ 125,494	$ 32	$ 880,369	$ 223	-42.1%	12.4%
15 - 19	$ 1,537,283	$ 186	$ 292,943	$ 35	$ 1,830,226	$ 222	$ 1,388,355	$ 321	$ 189,229	$ 44	$ 1,577,584	$ 365	-13.8%	64.7%
20 - 24	$ 1,082,265	$ 156	$ 409,392	$ 59	$ 1,491,657	$ 215	$ 856,924	$ 233	$ 254,799	$ 69	$ 1,111,723	$ 303	-25.5%	40.5%
25 - 29	$ 1,215,987	$ 295	$ 301,168	$ 73	$ 1,517,155	$ 369	$ 662,698	$ 295	$ 196,674	$ 88	$ 859,372	$ 383	-43.4%	3.9%
30 - 34	$ 2,784,920	$ 515	$ 341,212	$ 63	$ 3,126,132	$ 578	$ 1,245,650	$ 422	$ 165,854	$ 56	$ 1,411,504	$ 478	-54.8%	-17.2%
35 - 39	$ 2,361,827	$ 366	$ 734,028	$ 114	$ 3,095,855	$ 480	$ 1,810,197	$ 531	$ 374,946	$ 110	$ 2,185,143	$ 641	-29.4%	33.7%
40 - 44	$ 2,437,647	$ 381	$ 784,468	$ 123	$ 3,222,115	$ 504	$ 1,521,462	$ 449	$ 626,476	$ 185	$ 2,147,938	$ 634	-33.3%	25.8%
45 - 49	$ 2,770,287	$ 331	$ 1,525,758	$ 182	$ 4,296,045	$ 513	$ 2,167,308	$ 500	$ 727,893	$ 168	$ 2,895,201	$ 668	-32.6%	30.3%
50 - 54	$ 5,152,391	$ 559	$ 2,107,261	$ 229	$ 7,259,652	$ 788	$ 2,468,319	$ 520	$ 1,127,782	$ 238	$ 3,596,101	$ 758	-50.5%	-3.8%
55 - 59	$ 5,436,354	$ 503	$ 2,751,284	$ 254	$ 8,187,638	$ 757	$ 3,707,542	$ 688	$ 1,626,073	$ 302	$ 5,333,615	$ 990	-34.9%	30.7%
60 - 64	$ 9,774,054	$ 815	$ 3,034,480	$ 253	$ 12,808,534	$ 1,067	$ 4,254,644	$ 712	$ 1,871,243	$ 313	$ 6,125,887	$ 1,025	-52.2%	-4.0%
65+	$ 1,920,336	$ 395	$ 1,343,189	$ 276	$ 3,263,525	$ 672	$ 1,475,677	$ 610	$ 731,274	$ 302	$ 2,206,951	$ 913	-32.4%	35.9%
Total	**$ 40,764,731**	**$ 400**	**$ 14,003,588**	**$ 137**	**$54,768,319**	**$ 537**	**$ 24,249,744**	**$ 458**	**$ 8,096,067**	**$ 153**	**$ 32,345,812**	**$ 611**	**-40.9%**	**13.9%**

Financial Summary (p. 1 of 2)

	Total			State Active			Non-State Active		
Summary	**PY19**	**2Q20**	**Variance to Prior Year**	**PY19**	**2Q20**	**Variance to Prior Year**	**PY19**	**2Q20**	**Variance to Prior Year**
Enrollment									
Avg # Employees	4,653	4,823	3.7%	3,878	4,074	5.0%	4	4	0.0%
Avg # Members	8,488	8,819	3.9%	7,445	7,808	4.9%	5	5	0.0%
Ratio	1.8	1.8	0.5%	1.9	1.9	0.0%	1.3	1.3	0.0%
Financial Summary									
Gross Cost	$45,094,672	$26,998,382	-40.1%	$35,711,039	$23,079,745	-35.4%	$45,961	$38,573	-16.1%
Client Paid	$40,764,731	$24,249,744	-40.5%	$32,097,283	$20,843,376	-35.1%	$40,931	$35,593	-13.0%
Employee Paid	$4,329,941	$2,748,639	-36.5%	$3,613,757	$2,236,369	-38.1%	$5,030	$2,979	-40.8%
Client Paid-PEPY	$8,745	$10,055	15.0%	$8,277	$10,233	23.6%	$10,233	$17,797	73.9%
Client Paid-PMPY	$4,794	$5,499	14.7%	$4,311	$5,339	23.8%	$8,186	$14,237	73.9%
Client Paid-PEPM	$729	$838	15.0%	$690	$853	23.6%	$853	$1,483	73.9%
Client Paid-PMPM	$400	$458	14.5%	$359	$445	24.0%	$682	$1,186	73.9%
High Cost Claimants (HCC's) > $100k									
# of HCC's	39	15	-61.5%	27	14	-48.1%	0	0	0.0%
HCC's / 1,000	4.6	1.7	-63.0%	3.6	1.8	-50.6%	0.0	0.0	0.0%
Avg HCC Paid	$274,612	$183,130	-33.3%	$246,453	$189,023	-23.3%	$0	$0	0.0%
HCC's % of Plan Paid	26.3%	11.3%	-57.0%	20.7%	12.7%	-38.6%	0.0%	0.0%	0.0%
Cost Distribution by Claim Type (PMPY)									
Facility Inpatient	$1,218	$1,060	-13.0%	$944	$1,025	8.6%	$3,360	$5,856	74.3%
Facility Outpatient	$1,506	$1,727	14.7%	$1,395	$1,674	20.0%	$1,369	$1,978	44.5%
Physician	$1,923	$2,534	31.8%	$1,844	$2,480	34.5%	$3,030	$6,126	102.2%
Other	$148	$178	20.3%	$127	$161	26.8%	$427	$277	-35.1%
Total	$4,794	$5,499	14.7%	$4,311	$5,339	23.8%	$8,186	$14,237	73.9%
		Annualized			Annualized			Annualized	

Financial Summary (p. 2 of 2)

	State Retirees			Non-State Retirees			
Summary	**PY19**	**2Q20**	**Variance to Prior Year**	**PY19**	**2Q20**	**Variance to Prior Year**	**HSB Peer Index**
Enrollment							
Avg # Employees	599	592	-1.2%	181	154	-14.6%	
Avg # Members	826	811	-1.8%	227	195	-14.0%	
Ratio	1.4	1.4	-0.7%	1.3	1.3	0.0%	1.8
Financial Summary							
Gross Cost	$7,418,807	$3,433,058	-53.7%	$1,918,864	$447,006	-76.7%	
Client Paid	$6,863,148	$2,999,537	-56.3%	$1,763,370	$371,237	-78.9%	
Employee Paid	$555,659	$433,521	-22.0%	$155,495	$75,769	-51.3%	
Client Paid-PEPY	$11,461	$10,142	-11.5%	$9,769	$4,816	-50.7%	$6,209
Client Paid-PMPY	$8,313	$7,397	-11.0%	$7,777	$3,808	-51.0%	$3,437
Client Paid-PEPM	$955	$845	-11.5%	$814	$401	-50.7%	$517
Client Paid-PMPM	$693	$616	-11.1%	$648	$317	-51.1%	$286
High Cost Claimants (HCC's) > $100k							
# of HCC's	9	1	-88.9%	3	0	0.0%	
HCC's / 1,000	10.9	1.2	-88.7%	13.2	0.0	0.0%	
Avg HCC Paid	$339,256	$100,633	-70.3%	$334,114	$0	0.0%	
HCC's % of Plan Paid	44.5%	3.4%	-92.5%	56.8%	0.0%	0.0%	
Cost Distribution by Claim Type (PMPY)							
Facility Inpatient	$3,028	$1,510	-50.1%	$3,554	$465	-86.9%	$1,057
Facility Outpatient	$2,243	$2,401	7.0%	$2,477	$1,064	-57.0%	$1,145
Physician	$2,713	$3,160	16.5%	$1,587	$2,028	27.8%	$1,122
Other	$328	$326	-0.6%	$158	$250	58.2%	$113
Total	$8,313	$7,397	-11.0%	$7,777	$3,808	-51.0%	$3,437
		Annualized			Annualized		

Paid Claims by Claim Type – State Participants

Net Paid Claims - Total State Participants	PY19				2Q20				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical									
Inpatient	$ 8,762,274	$ 2,599,386	$ 160,727	$ 11,522,387	$ 5,252,388	$ 573,417	$ 167,097	$ 5,992,901	-48.0%
Outpatient	$ 23,335,008	$ 3,620,613	$ 482,422	$ 27,438,043	$ 15,590,988	$ 1,829,887	$ 429,137	$ 17,850,012	-34.9%
Total - Medical	**$ 32,097,283**	**$ 6,219,999**	**$ 643,149**	**$ 38,960,431**	**$ 20,843,376**	**$ 2,403,304**	**$ 596,234**	**$ 23,842,913**	**-38.8%**

Net Paid Claims - Per Participant per Month	PY19				2Q20				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical	$ 690	$ 1,018	$ 596	$ 725	$ 853	$ 794	$ 1,144	$ 852	17.5%

Paid Claims by Claim Type – Non-State Participants

Net Paid Claims - Total Non-State Participants	PY19				2Q20				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical									
Inpatient	$ 23,542	$ 854,839	$ 10,077	$ 888,459	$ 22,498	$ 36,045	$ 25,860	$ 84,403	-90.5%
Outpatient	$ 17,389	$ 754,444	$ 144,009	$ 915,842	$ 13,096	$ 261,312	$ 48,020	$ 322,427	-64.8%
Total - Medical	**$ 40,931**	**$ 1,609,283**	**$ 154,087**	**$ 1,804,301**	**$ 35,593**	**$ 297,357**	**$ 73,880**	**$ 406,830**	**-77.5%**

Net Paid Claims - Per Participant per Month	PY19				2Q20				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical	$ 853	$ 1,048	$ 242	$ 813	$ 1,483	$ 489	$ 233	$ 429	-47.3%

Paid Claims by Claim Type – Total

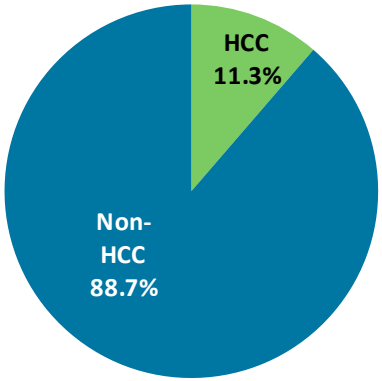
Net Paid Claims - Total Total Participants	PY19				2Q20				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical									
Inpatient	$ 8,785,816	$ 3,454,225	$ 170,805	$ 12,410,846	$ 5,274,885	$ 609,462	$ 192,957	$ 6,077,305	-51.0%
Outpatient	$ 23,352,397	$ 4,375,057	$ 626,431	$ 28,353,885	$ 15,604,084	$ 2,091,199	$ 477,156	$ 18,172,439	-35.9%
Total - Medical	**$ 32,138,214**	**$ 7,829,282**	**$ 797,236**	**$ 40,764,731**	**$ 20,878,969**	**$ 2,700,661**	**$ 670,113**	**$ 24,249,744**	**-40.5%**

Net Paid Claims - Per Participant per Month	PY19				2Q20				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical	$ 690	$ 1,024	$ 465	$ 729	$ 853	$ 743	$ 800	$ 838	15.0%

Cost Distribution – Medical Claims

PY19							2Q20					
Avg # of Members	% of Members	Total Paid	% of Paid	EE Paid	% EE Paid	Paid Claims Category	Avg # of Members	% of Members	Total Paid	% of Paid	EE Paid	% EE Paid
32	0.4%	$10,660,448	26.2%	$223,955	5.2%	$100,000.01 Plus	13	0.2%	$2,746,956	11.3%	$45,675	1.7%
63	0.7%	$4,489,989	11.0%	$285,075	6.6%	$50,000.01-$100,000.00	36	0.4%	$2,530,493	10.4%	$151,023	5.5%
148	1.7%	$5,378,700	13.2%	$370,909	8.6%	$25,000.01-$50,000.00	105	1.2%	$3,738,843	15.4%	$228,042	8.3%
489	5.7%	$7,901,863	19.4%	$770,638	17.8%	$10,000.01-$25,000.00	344	3.9%	$5,501,828	22.7%	$441,304	16.1%
592	7.0%	$4,367,753	10.7%	$713,266	16.5%	$5,000.01-$10,000.00	402	4.6%	$2,957,706	12.2%	$411,946	15.0%
935	11.0%	$3,470,368	8.5%	$766,356	17.7%	$2,500.01-$5,000.00	690	7.8%	$2,474,881	10.2%	$481,384	17.5%
5,310	62.5%	$4,495,610	11.0%	$1,195,579	27.6%	$0.01-$2,500.00	5,801	65.8%	$4,299,037	17.7%	$981,193	35.8%
16	0.2%	$0	0.0%	$4,162	0.1%	$0.00	25	0.3%	$0	0.0%	$8,071	0.3%
918	10.8%	$0	0.0%	$0	0.0%	No Claims	1,404	15.9%	$0	0.0%	$0	-0.1%
8,503	**100.0%**	**$40,764,731**	**100.0%**	**$4,329,941**	**100.0%**		**8,819**	**100.0%**	**$24,249,744**	**100.0%**	**$2,748,639**	**100.0%**

Distribution of HCC Medical Claims Paid



HCC – High Cost Claimant over $100K

HCC's by AHRQ Clinical Classifications Chapter			
AHRQ Chapter	Patients	Total Paid	% Paid
(CCS 15) Certain Conditions Originating In The Perinatal Period	2	$440,439	16.0%
(CCS 13) Diseases Of The Musculoskeletal System And Connective Tissue	8	$432,603	15.7%
(CCS 3) Endocrine; Nutritional; And Metabolic Diseases And Immunity Disorders	9	$347,111	12.6%
(CCS 4) Diseases Of The Blood And Blood-Forming Organs	6	$320,406	11.7%
(CCS 5) Mental Illness	6	$269,886	9.8%
(CCS 2) Neoplasms	4	$208,007	7.6%
(CCS 9) Diseases Of The Digestive System	9	$202,037	7.4%
(CCS 6) Diseases Of The Nervous System And Sense Organs	10	$184,881	6.7%
(CCS 16) Injury And Poisoning	9	$113,033	4.1%
(CCS 17) Symptoms; Signs; And Ill-Defined Conditions And Factors Influencing Health Status	14	$80,674	2.9%
(CCS 10) Diseases Of The Genitourinary System	7	$71,551	2.6%
(CCS 8) Diseases Of The Respiratory System	12	$32,882	1.2%
(CCS 7) Diseases Of The Circulatory System	7	$15,238	0.6%
(CCS 14) Congenital Anomalies	2	$12,069	0.4%
(CCS 18) Residual Codes; Unclassified; All E Codes [259. And 260.]	11	$10,325	0.4%
(CCS 1) Infectious And Parasitic Diseases	7	$5,165	0.2%
(CCS 12) Diseases Of The Skin And Subcutaneous Tissue	2	$648	0.0%
Overall	**----**	**$2,746,956**	**100.0%**

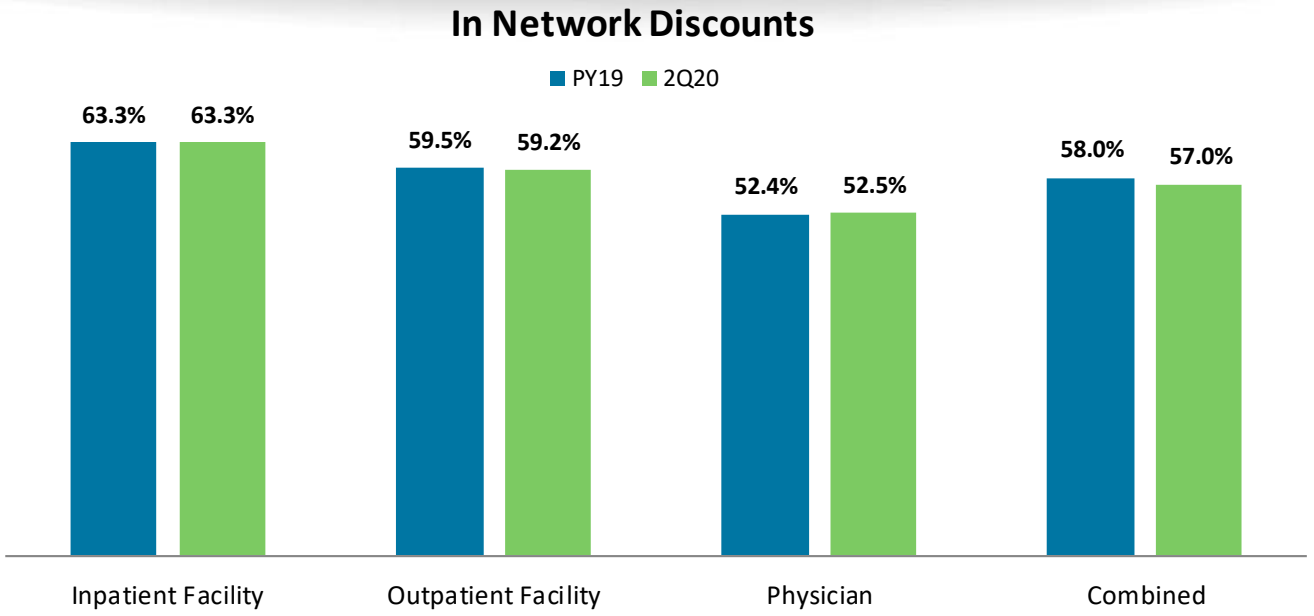
Utilization Summary (p. 1 of 2)

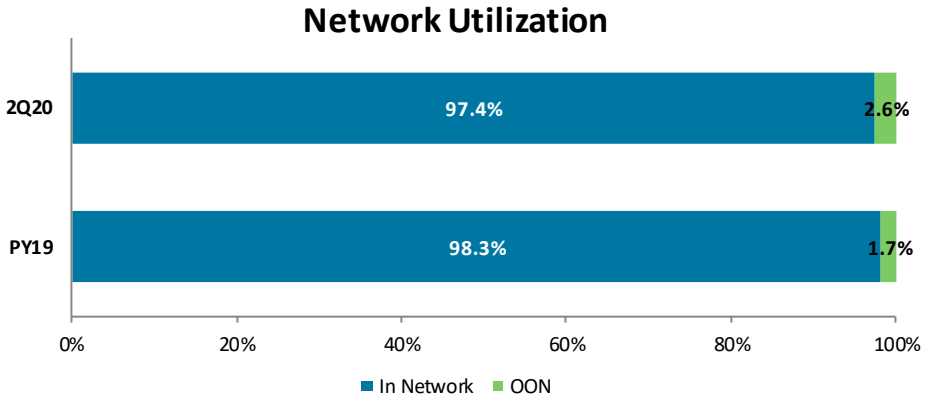
	Total			State Active			Non-State Active		
Summary	**PY19**	**2Q20**	**Variance to Prior Year**	**PY19**	**2Q20**	**Variance to Prior Year**	**PY19**	**2Q20**	**Variance to Prior Year**
Inpatient Facility									
# of Admits	507	372	-26.6%	441	319	-27.7%	1	1	0.0%
# of Bed Days	2,491	1,722	-30.9%	2,026	1,492	-26.4%	2	2	0.0%
Paid Per Admit	$20,394	$12,601	-38.2%	$15,930	$12,608	-20.9%	$16,801	$14,640	0.0%
Paid Per Day	$4,151	$2,722	-34.4%	$3,468	$2,696	-22.3%	$8,401	$7,320	0.0%
Admits Per 1,000	60	84	40.0%	59	82	39.0%	200	400	0.0%
Days Per 1,000	293	391	33.4%	272	382	40.4%	400	800	0.0%
Avg LOS	4.9	4.6	-6.1%	4.6	4.7	2.2%	2	2	0.0%
Physician Office									
OV Utilization per Member	4.4	5.4	22.7%	4.2	5.2	23.8%	5.6	8.0	0.0%
Avg Paid per OV	$94	$101	7.4%	$95	$103	8.4%	$105	$97	0.0%
Avg OV Paid per Member	$410	$546	33.2%	$402	$535	33.1%	$587	$775	0.0%
DX&L Utilization per Member	8.9	11.1	24.7%	8.4	10.5	25.0%	14	20	0.0%
Avg Paid per DX&L	$78	$71	-9.0%	$75	$72	-4.0%	$106	$107	0.0%
Avg DX&L Paid per Member	$690	$784	13.6%	$629	$755	20.0%	$1,491	$2,141	0.0%
Emergency Room									
# of Visits	1,453	993	-31.7%	1,261	849	-32.7%	0	1	0.0%
# of Admits	192	150	-21.9%	154	115	-25.3%	0	0	0.0%
Visits Per Member	0.17	0.23	35.3%	0.17	0.22	29.4%	0	0.4	0.0%
Visits Per 1,000	171	225	31.6%	169	217	28.4%	0	400	0.0%
Avg Paid per Visit	$2,608	$2,620	0.5%	$2,546	$2,715	6.6%	$0	$3,495	0.0%
Admits Per Visit	0.13	0.15	15.4%	0.12	0.14	16.7%	0.00	0.00	0.0%
Urgent Care									
# of Visits	2,450	1,565	-36.1%	2,232	1,437	-35.6%	0	0	0.0%
Visits Per Member	0.29	0.35	20.7%	0.30	0.37	23.3%	0.00	0.00	0.0%
Visits Per 1,000	288	355	23.3%	300	368	22.7%	0	0	0.0%
Avg Paid per Visit	$140	$160	14.3%	$140	$162	15.7%	$0	$0	0.0%
		Annualized			Annualized			Annualized	

Utilization Summary (p. 2 of 2)

	State Retirees			Non-State Retirees			
Summary	**PY19**	**2Q20**	**Variance to Prior Year**	**PY19**	**2Q20**	**Variance to Prior Year**	**HSB Peer Index**
Inpatient Facility							
# of Admits	52	47	-9.6%	13	5	-61.5%	
# of Bed Days	361	215	-40.4%	102	13	-87.3%	
Paid Per Admit	$47,923	$12,883	-73.1%	$61,977	$9,066	-85.4%	$16,173
Paid Per Day	$6,903	$2,816	-59.2%	$7,899	$3,487	-55.9%	$3,708
Admits Per 1,000	63	116	84.1%	57	51	-10.5%	61
Days Per 1,000	437	530	21.3%	450	133	-70.4%	264
Avg LOS	6.9	4.6	-33.3%	7.8	2.6	-66.7%	4.3
Physician Office							
OV Utilization per Member	5.6	7.3	30.4%	5.0	6.8	36.0%	3.3
Avg Paid per OV	$85	$89	4.7%	$86	$78	-9.3%	$50
Avg OV Paid per Member	$473	$650	37.4%	$431	$533	23.7%	$167
DX&L Utilization per Member	12.1	15.9	31.4%	12.2	14.7	20.5%	8.3
Avg Paid per DX&L	$88	$64	-27.3%	$104	$64	-38.5%	$67
Avg DX&L Paid per Member	$1,069	$1,017	-4.9%	$1,274	$938	-26.4%	$554
Emergency Room							
# of Visits	158	128	-19.0%	94	15	-84.0%	
# of Admits	30	32	6.7%	8	3	-62.5%	
Visits Per Member	0.19	0.32	68.4%	0.41	0.15	-63.4%	0.17
Visits Per 1,000	191	316	65.4%	415	154	-62.9%	174
Avg Paid per Visit	$2,991	$2,119	-29.2%	$1,195	$1,415	18.4%	$1,684
Admits Per Visit	0.19	0.25	31.6%	0.09	0.20	122.2%	0.14
Urgent Care							
# of Visits	158	88	-44.3%	60	40	-33.3%	
Visits Per Member	0.19	0.22	15.8%	0.26	0.41	57.7%	0.24
Visits Per 1,000	191	217	13.6%	265	410	54.7%	242
Avg Paid per Visit	$154	$169	9.7%	$96	$103	7.3%	$74
		Annualized			Annualized		

Provider Network Summary



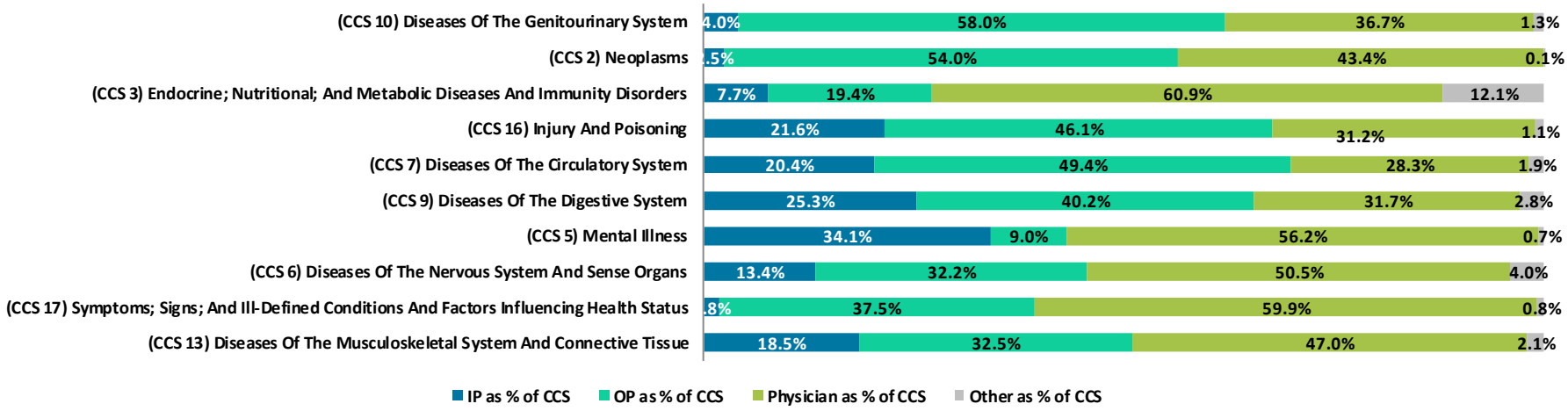


AHRQ* Clinical Classifications Summary

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

AHRQ Clinical Classifications Chapter	Total Paid	% Paid	Insured	Spouse	Child	Male	Female
(CCS 13) Diseases Of The Musculoskeletal System And Connective Tissue	$3,390,607	14.0%	$2,278,850	$766,957	$344,800	$1,478,179	$1,912,428
(CCS 17) Symptoms; Signs; And Ill-Defined Conditions And Factors Influencing Healt	$2,093,002	8.6%	$1,280,745	$311,065	$501,192	$672,676	$1,420,326
(CCS 6) Diseases Of The Nervous System And Sense Organs	$2,067,767	8.5%	$1,281,333	$363,701	$422,733	$838,329	$1,229,437
(CCS 5) Mental Illness	$1,975,977	8.1%	$1,068,281	$219,691	$688,005	$646,432	$1,329,545
(CCS 9) Diseases Of The Digestive System	$1,886,258	7.8%	$1,225,257	$317,500	$343,501	$820,881	$1,065,376
(CCS 7) Diseases Of The Circulatory System	$1,782,299	7.3%	$1,356,929	$343,845	$81,526	$919,489	$862,810
(CCS 16) Injury And Poisoning	$1,605,127	6.6%	$986,568	$220,557	$398,002	$810,197	$794,929
(CCS 3) Endocrine; Nutritional; And Metabolic Diseases And Immunity Disorders	$1,499,454	6.2%	$1,169,463	$203,590	$126,401	$497,210	$1,002,244
(CCS 2) Neoplasms	$1,395,760	5.8%	$1,088,496	$269,193	$38,071	$323,711	$1,072,049
(CCS 10) Diseases Of The Genitourinary System	$1,213,084	5.0%	$936,380	$162,568	$114,136	$397,751	$815,334
(CCS 8) Diseases Of The Respiratory System	$1,202,976	5.0%	$742,427	$112,038	$348,511	$541,566	$661,410
(CCS 11) Complications Of Pregnancy; Childbirth; And The Puerperium	$944,793	3.9%	$709,418	$157,205	$78,170	$20,628	$924,166
(CCS 1) Infectious And Parasitic Diseases	$789,880	3.3%	$370,317	$93,912	$325,651	$325,757	$464,124
(CCS 15) Certain Conditions Originating In The Perinatal Period	$760,791	3.1%	$8,820	$225	$751,746	$196,592	$564,199
(CCS 18) Residual Codes; Unclassified; All E Codes [259. And 260.]	$550,583	2.3%	$424,277	$83,211	$43,096	$241,608	$308,976
(CCS 12) Diseases Of The Skin And Subcutaneous Tissue	$430,499	1.8%	$273,997	$94,908	$61,593	$180,682	$249,817
(CCS 4) Diseases Of The Blood And Blood-Forming Organs	$406,611	1.7%	$75,475	$326,327	$4,809	$18,011	$388,600
(CCS 14) Congenital Anomalies	$254,274	1.0%	$8,508	$5,421	$240,345	$177,717	$76,558
Total	**$24,249,744**	**100.0%**	**$15,285,540**	**$4,051,916**	**$4,912,288**	**$9,107,416**	**$15,142,328**

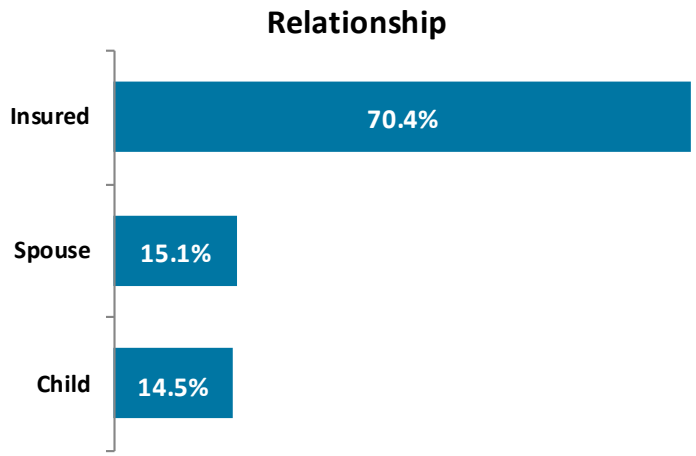
Top 10 Categories by Claim Type

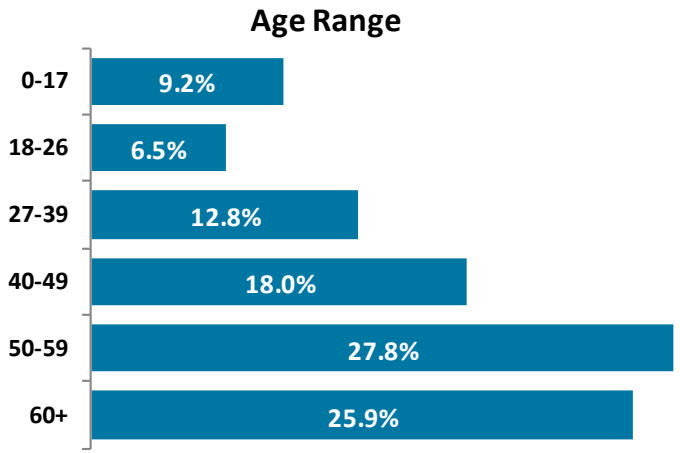


AHRQ Category – Diseases of the Musculoskeletal System & Connective Tissue

Diagnosis Category	Patients	Claims	Total Paid	% Paid
Spondylosis; Intervertebral Disc Disorders; Other Back Problems [205.]	998	5,836	$1,491,823	44.0%
Non-Traumatic Joint Disorders	1,079	4,732	$1,010,986	29.8%
Other Connective Tissue Disease [211.]	976	2,846	$482,004	14.2%
Other Bone Disease And Musculoskeletal Deformities [212.]	359	1,348	$208,244	6.1%
Acquired Deformities	155	380	$162,084	4.8%
Osteoporosis [206.]	43	79	$15,937	0.5%
Systemic Lupus Erythematosus And Connective Tissue Disorders [210.]	32	112	$12,777	0.4%
Infective Arthritis And Osteomyelitis (Except That Caused By Tb Or Std) [201.]	5	41	$4,246	0.1%
Pathological Fracture [207.]	5	6	$2,506	0.1%
	----	----	$3,390,607	100.0%

*Patient and claim counts are unique only within the category

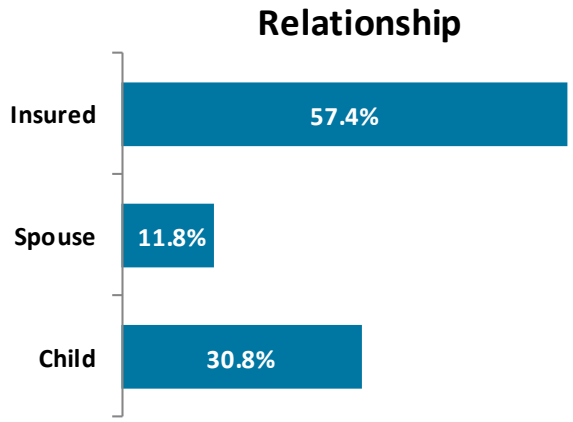


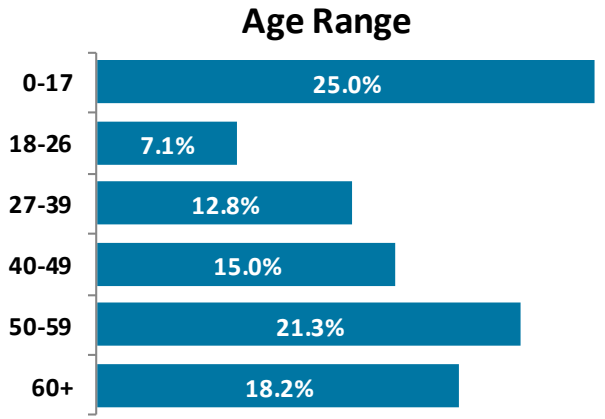


AHRQ Category – Symptoms, Signs; and Ill-defined Conditions & Factors Inf Health

Diagnosis Category	Patients	Claims	Total Paid	% Paid
Factors Influencing Health Care	4,071	8,883	$1,391,202	66.5%
Symptoms; Signs; And Ill-Defined Conditions	1,236	2,619	$701,801	33.5%
	----	----	**$2,093,002**	**100.0%**

*Patient and claim counts are unique only within the category

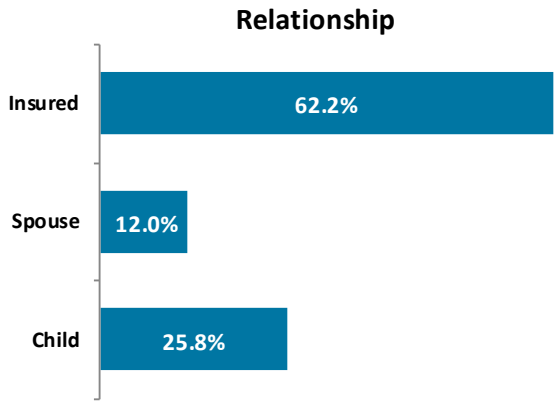


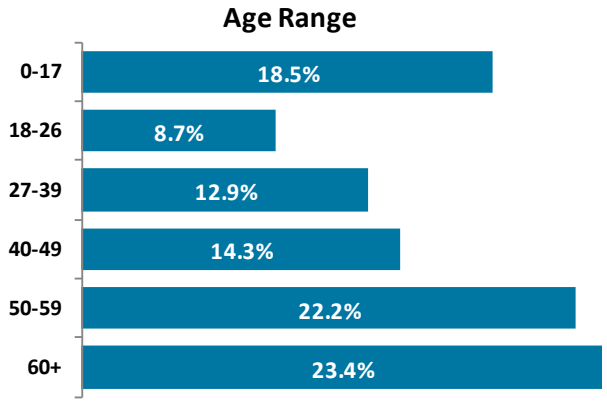


AHRQ Category – Diseases of the Nervous System & Sense Organs

Diagnosis Category	Patients	Claims	Total Paid	% Paid
Eye Disorders	2,019	3,538	$611,096	29.6%
Other Nervous System Disorders [95.]	428	1,350	$536,930	26.0%
Headache; Including Migraine [84.]	282	635	$207,576	10.0%
Ear Conditions	506	887	$195,077	9.4%
Epilepsy; Convulsions [83.]	70	271	$189,554	9.2%
Hereditary And Degenerative Nervous System Conditions	68	205	$120,052	5.8%
Paralysis [82.]	12	55	$104,341	5.0%
Central Nervous System Infection	3	12	$85,791	4.1%
Coma; Stupor; And Brain Damage [85.]	18	27	$17,351	0.8%
	----	----	$2,067,767	100.0%

*Patient and claim counts are unique only within the category

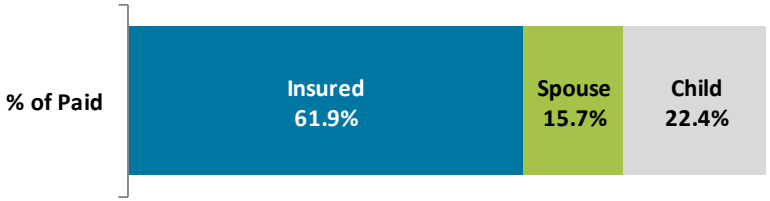


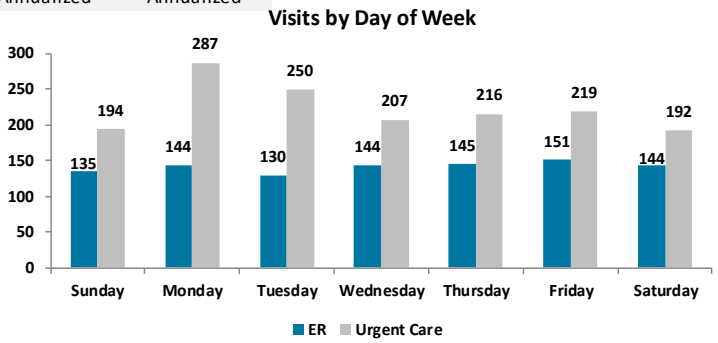


Emergency Room / Urgent Care Summary

	PY19		2Q20		HSB Peer Index	
ER/Urgent Care	ER	Urgent Care	ER	Urgent Care	ER	Urgent Care
Number of Visits	1,454	2,449	993	1,565		
Number of Admits	192	----	150	----		
Visits Per Member	0.17	0.29	0.23	0.35	0.17	0.24
Visits/1000 Members	171	288	225	355	174	242
Avg Paid Per Visit	$2,606	$139	$2,620	$160	$1,684	$74
Admits per Visit	0.13	----	0.15	----	0.14	
% of Visits with HSB ER Dx	79.4%	----	79.2%	----		
% of Visits with a Physician OV*	67.9%	67.3%	83.6%	81.7%		
Total Plan Paid	**$3,788,451**	**$341,606**	**$2,568,193**	**$251,114**		
			Annualized	Annualized		

*looks back 12 months from ER visit



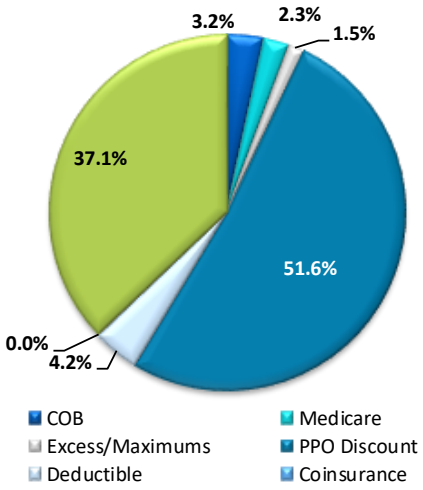


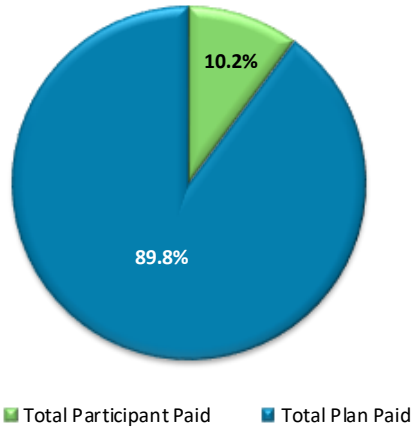
ER / UC Visits by Relationship						
Relationship	ER	Per 1,000	Urgent Care	Per 1,000	Total	Per 1,000
Insured	585	121	880	182	1,465	304
Spouse	131	136	140	146	271	282
Child	277	91	545	180	822	271
Total	**993**	**113**	**1,565**	**177**	**2,558**	**290**

Savings Summary – Medical Claims

Description	Dollars	PPPM	% of Eligible
Eligible Charges	$65,353,299	$2,258	100.0%
COB	$2,121,727	$73	3.2%
Medicare	$1,495,243	$52	2.3%
Excess/Maximums	$983,558	$34	1.5%
PPO Discount	$33,754,389	$1,166	51.6%
Deductible	$2,748,639	$95	4.2%
Coinsurance	$0	$0	0.0%
Total Participant Paid	**$2,748,639**	**$95**	**4.2%**
Total Plan Paid	**$24,249,744**	**$838**	**37.1%**

Total Participant Paid - PY18	**$77**
Total Plan Paid - PY18	**$729**





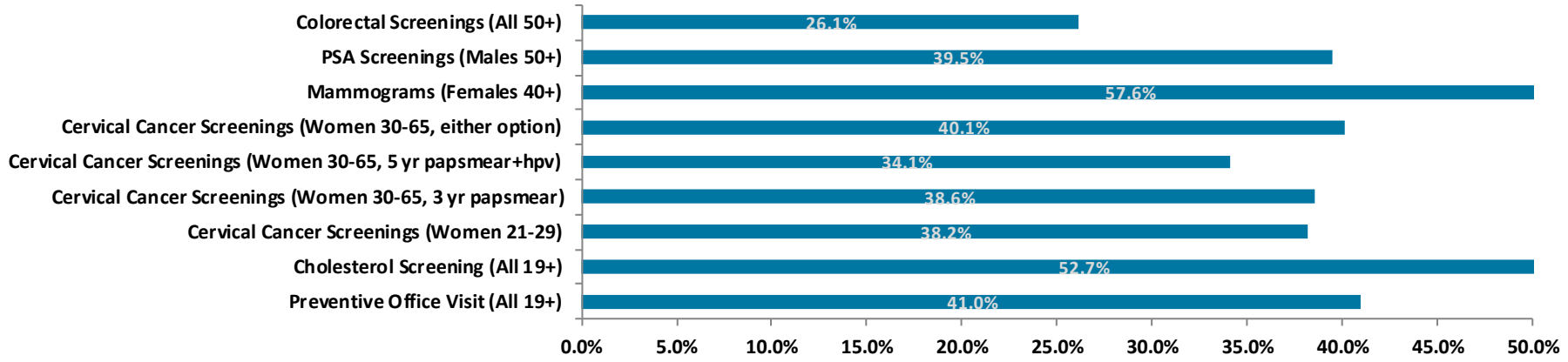
Preventive Services Compliance

*Based on 15 mo. of utilization/12 mo. paid data on members with 9 mo. of service or greater;

Colorectal screenings look back to July 2011.

	Female			Male			Total		
Service	Eligible	Compliant	% Compliant	Eligible	Compliant	% Compliant	Eligible	Compliant	% Compliant
Preventive Office Visit (All 19+)	3,717	1,903	51.2%	2,744	746	27.2%	6,461	2,649	41.0%
Cholesterol Screening (All 19+)	3,717	2,026	54.5%	2,744	1,380	50.3%	6,461	3,406	52.7%
Cervical Cancer Screenings (Women 21-29)	453	173	38.2%	----	----	----	453	173	38.2%
Cervical Cancer Screenings (Women 30-65, 3 yr papsmear)	2,938	1,134	38.6%	----	----	----	2,938	1,134	38.6%
Cervical Cancer Screenings (Women 30-65, 5 yr papsmear+hpv)	2,938	1,002	34.1%	----	----	----	2,938	1,002	34.1%
Cervical Cancer Screenings (Women 30-65, either option)	2,938	1,178	40.1%	----	----	----	2,938	1,178	40.1%
Mammograms (Females 40+)	2,479	1,428	57.6%	----	----	----	2,479	1,428	57.6%
PSA Screenings (Males 50+)	----	----	----	1,358	536	39.5%	1,358	536	39.5%
Colorectal Screenings (All 50+)	1,773	498	28.1%	1,358	320	23.6%	3,131	819	26.1%

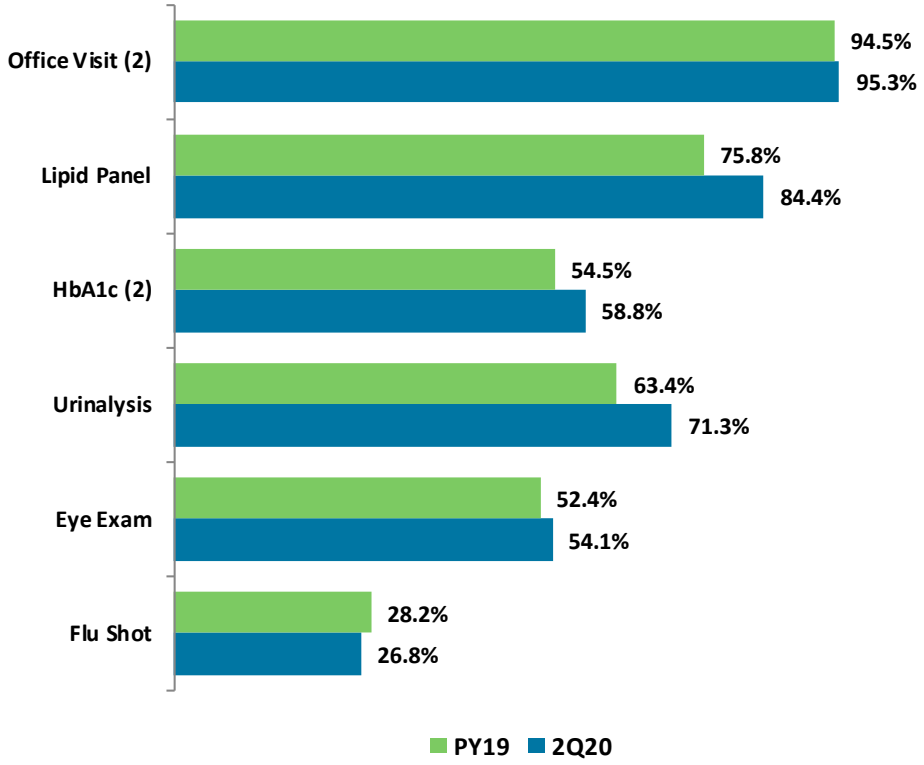
Overall Preventive Services Compliance Rates



Diabetic Disease Compliance

*Based on 15 mo. of utilization/12 mo. paid data on members with 9 mo. of service or greater;

Diabetic Population		
Year	PY19	2Q20
Members	525	571

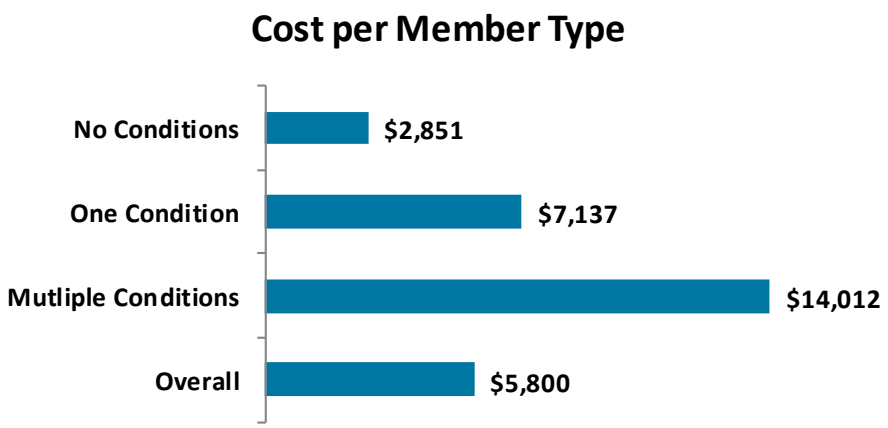


Chronic Conditions Summary

*Based on 15 mo. of utilization/12 mo. paid data on members with 9 mo. of service or greater;

Condition	Total Members	Avg Members	Per 1,000	Avg Age	Total Cost	Average Cost	Compliance Rate	Compliance Measure
Asthma	411	391	47	39	$4,157,022	$10,114	99.5%	1 Office Visit
Cancer	312	293	36	58	$6,225,383	$19,953	----	----
Chronic Kidney Disease	72	66	8	56	$1,655,084	$22,987	----	----
Chronic Obstructive Pulmonary Disease (COPD)	96	93	11	61	$1,864,461	$19,421	97.9%	1 Office Visit
Congestive Heart Failure (CHF)	30	29	3	58	$2,760,153	$92,005	13.3%	1 Office Visit, 1 Lipid Profile, 1 Wellness Visit
Coronary Artery Disease (CAD)	143	134	16	60	$2,421,461	$16,933	26.6%	1 Office Visit, 1 Lipid Profile, 1 Wellness Visit
Depression	608	567	69	40	$6,245,396	$10,272	98.4%	1 Office Visit
Diabetes	571	539	65	55	$5,945,017	$10,412	27.8%	2 Office Visits, 1 Lipid Profile, 2 HbA1c's, 1 Urinalysis, 1 Eye Exam, 1 Flu Shot
Hyperlipidemia	788	756	90	55	$6,660,797	$8,453	35.9%	1 Office Visit, 1 Lipid Profile, 1 Wellness Visit
Hypertension	869	824	99	57	$8,912,548	$10,256	29.0%	1 Office Visit, 1 Lipid Profile, 1 Wellness Visit
Obesity	271	255	31	46	$2,738,659	$10,106	0.0%	----

# of Conditions	Avg Members	Average Age	Relationship		
			Insured	Spouse	Child
No Conditions	5,083	29	41.3%	9.4%	49.3%
One Condition	2,212	45	69.2%	13.5%	17.3%
Multiple Conditions	1,465	54	79.4%	17.1%	3.5%
Overall	**8,760**	**37**	**53.7%**	**11.5%**	**34.8%**



Public Employees' Benefits Program - RX Costs
PY 2020 - Quarter Ending December 31, 2019

Express Scripts

Membership Summary	2Q FY2020 EPO	2Q FY2019 EPO	Difference	% Change
			Membership Summary	
Member Count (Membership)	8,821	8,475	346	4.1%
Utilizing Member Count (Patients)	6,510	6,037	473	7.8%
Percent Utilizing (Utilization)	73.8%	71.2%	0	3.6%
Claim Summary			**Claims Summary**	
Net Claims (Total Rx's)	86,984	81,094	5,890	7.3%
Claims per Elig Member per Month (Claims PMPM)	1.64	1.59	0.05	3.1%
Total Claims for Generic (Generic Rx)	74,713	69,897	4,816.00	6.9%
Total Claims for Brand (Brand Rx)	12,271	11,197	1,074.00	9.6%
Total Claims for Brand w/Gen Equiv (Multisource Brand Claims)	1,423	1,291	132.00	10.2%
Total Non-Specialty Claims	86,243	80,534	5,709.00	7.1%
Total Specialty Claims	741	560	181.00	32.3%
Generic % of Total Claims (GFR)	**85.9%**	**86.2%**	(0.00)	-0.3%
Generic Effective Rate (GCR)	**98.1%**	**98.2%**	(0.00)	-0.1%
Mail Order Claims	8,402	6,691	1,711.00	25.6%
Mail Penetration Rate*	10.8%	9.2%	0.02	1.6%
Claims Cost Summary			**Claims Cost Summary**	
Total Prescription Cost (Total Gross Cost)	$9,690,928.00	$7,637,854.00	$2,053,074.00	26.9%
Total Generic Gross Cost	$1,737,360.00	$1,803,070.00	($65,710.00)	-3.6%
Total Brand Gross Cost	$7,953,568.00	$5,834,784.00	$2,118,784.00	36.3%
Total MSB Gross Cost	$316,532.00	$190,587.00	$125,945.00	66.1%
Total Ingredient Cost	$9,639,368.00	$7,592,199.00	$2,047,169.00	27.0%
Total Dispensing Fee	$49,844.00	$44,723.00	$5,121.00	11.5%
Total Other (e.g. tax)	$1,717.00	$932.00	$785.00	84.2%
Avg Total Cost per Claim (Gross Cost/Rx)	**$111.41**	**$94.19**	$17.23	18.3%
Avg Total Cost for Generic (Gross Cost/Generic Rx)	$23.25	$25.80	($2.55)	-9.9%
Avg Total Cost for Brand (Gross Cost/Brand Rx)	$648.16	$521.10	$127.06	24.4%
Avg Total Cost for MSB (MSB Gross Cost/MSB ARx)	$222.44	$147.63	$74.81	50.7%
Member Cost Summary			**Member Cost Summary**	
Total Member Cost	**$1,515,722.00**	**$1,388,288.00**	$127,434.00	9.2%
Total Copay	$1,515,722.00	$1,388,288.00	$127,434.00	9.2%
Total Deductible	$0.00	$0.00	$0.00	0.0%
Avg Copay per Claim (Copay/Rx)	$17.43	$17.12	$0.31	1.8%
Avg Participant Share per Claim (Copay+Deductible/RX)	**$17.43**	**$17.12**	**$0.31**	**1.8%**
Avg Copay for Generic (Copay/Generic Rx)	$7.36	$6.38	$0.98	15.4%
Avg Copay for Brand (Copay/Brand Rx)	$78.72	$84.14	($5.42)	-6.4%
Avg Copay for Brand w/ Generic Equiv (Copay/Multisource Rx)	$28.59	$26.26	$2.33	8.9%
Net PMPM (Participant Cost PMPM)	**$28.64**	**$27.30**	$1.34	4.9%
Copay % of Total Prescription Cost (Member Cost Share %)	15.6%	18.2%	-2.5%	-14.0%
Plan Cost Summary			**Plan Cost Summary**	
Total Plan Cost (Plan Cost)	**$8,175,206.00**	**$6,249,566.00**	**$1,925,640.00**	**30.8%**
Total Non-Specialty Cost (Non-Specialty Plan Cost)	$4,255,830.00	$4,039,120.00	$216,710.00	5.4%
Total Specialty Drug Cost (Specialty Plan Cost)	$3,919,376.00	$2,210,446.00	$1,708,930.00	77.3%
Avg Plan Cost per Claim (Plan Cost/Rx)	**$93.99**	**$77.07**	$16.92	22.0%
Avg Plan Cost for Generic (Plan Cost/Generic Rx)	$15.90	$19.41	($3.51)	-18.1%
Avg Plan Cost for Brand (Plan Cost/Brand Rx)	$569.44	$436.96	$132.48	30.3%
Avg Plan Cost for MSB (MSB Plan Cost/MSB ARx)	$193.85	$121.36	$72.49	59.7%
Net PMPM (Plan Cost PMPM)	**$154.46**	**$122.90**	**$31.56**	**25.7%**
PMPM for Specialty Only (Specialty PMPM)	$74.05	$43.47	$30.58	70.3%
PMPM without Specialty (Non-Specialty PMPM)	$80.41	$79.43	$0.98	1.2%
Rebates (Q1-Q2 FY2020 estimated)	$1,985,878.94	$1,508,587.15	**$477,291.79**	**31.6%**
Net PMPM (Plan Cost PMPM factoring Rebates)	**$116.94**	**$93.15**	**$23.79**	**25.5%**
PMPM for Specialty Only (Specialty PMPM)	$61.59	$35.45	$26.14	73.7%
PMPM without Specialty (Non-Specialty PMPM)	$55.36	$57.71	($2.35)	-4.1%

Appendix C

Index of Tables
Health Plan of Nevada –Utilization Review for PEBP
July 1, 2019 – December 31, 2019

KEY PERFORMANCE INDICATORS

PRESCRIPTION DRUG COSTS

Power Of Partnership.

Quarterly Performance Review

Health Plan of Nevada, Inc. – Southern NV HMO

Reporting Period:
Current Period: July 1, 2019 – December 31, 2019, paid through January 31, 2020
Prior Period: July 1, 2018 – December 31, 2018

37 years experience caring for Nevadans and their families

Member Centered Solutions

Access to Southwest Medical/OptumCare

Cost Structure & Network Strength

Local Service & Wellness Resources

On-Site Hospital Case Managers

Our Care Delivery Assets in Nevada

- ✓ 45 OptumCare locations and expanding
- ✓ Over 450 providers practicing evidence-based medicine
- ✓ 6 high acuity urgent cares with home waiting room option
- ✓ Patient portal with e-visit capabilities
- ✓ Robust integrated EMR
- ✓ Access to schedule, renew script and view test results
- ✓ 7 convenient care walk-in locations
- ✓ 2 ambulatory surgery centers
- ✓ Brand new 55,000 sq ft state-of-the-art cancer center
- ✓ Saturday appointments with primary care

Enhancements Made for Your Members

- ✓ Added HCA hospitals and 17 Care Now Urgent Cares to the network
- ✓ Launched new HPN App
- ✓ Adding new and more ways for your members to receive the care they need when they need it
- ✓ Continued expansion of specialty network
- ✓ Real Appeal weight loss program
- ✓ Dispatch Health to provide at home urgent visits
- ✓ Pilot on continuous glucose monitoring for diabetics to improve outcomes and management of medication

Key Performance Indicators

Demographics & Cost Data

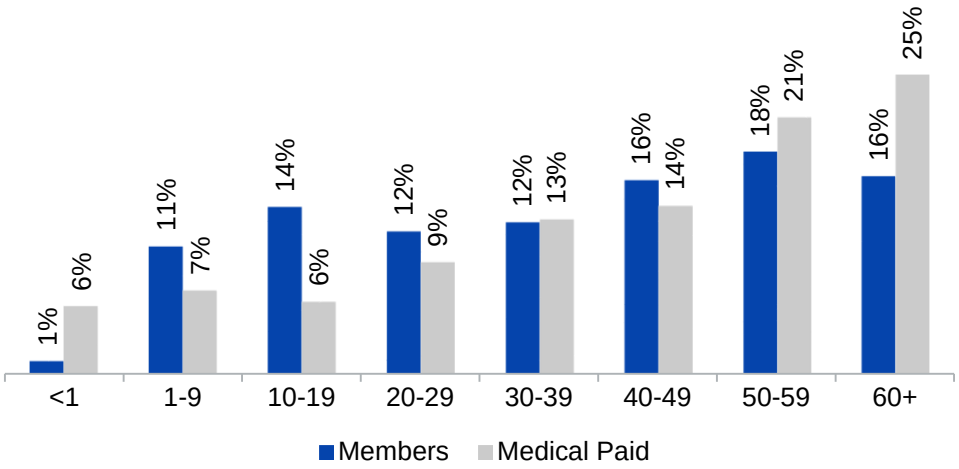
Data Definitions:

- **Prior Period** - July 1, 2018 through December 31, 2018
- **Current Period** - July 1, 2019 through December 31, 2019
  - Note: Claims may be understated for current period due to timing of report generation

Demographic Overview

HEALTH PLAN OF NEVADA
A UnitedHealthcare Company

Population Measure	Prior	Current	Δ	Peer	Δ
Employees	3,886	3,950	1.7%		
Average Age	49.4	48.9	-1.0%	44.6	9.8%
% Female	61.6%	61.8%	0.4%	51.3%	20.5%
Membership	6,706	6,859	2.3%		
Average Age	37.9	37.3	-1.6%	35.9	4.1%
% Female	56.9%	56.9%	-0.1%	51.9%	9.5%
% Female (20 -44)	18.3%	19.2%	4.7%	21.0%	-8.6%
% Children (<18)	21.7%	22.2%	2.6%	20.6%	7.8%
% Dependents (18-25)	11.3%	11.5%	1.7%	11.4%	0.2%
Average Family Size	1.73	1.74	0.6%	1.74	-0.2%
Age Gender Factor	1.20	1.18	-1.6%	1.08	9.8%
HHS Population Risk Factor	1.72	1.71	-0.5%	1.39	22.9%



Population Insights

Membership increased **2.3% to 6,859** covered under the medical plan

Females make up **56.9%** of the membership and drive **63.3%** of medical spend

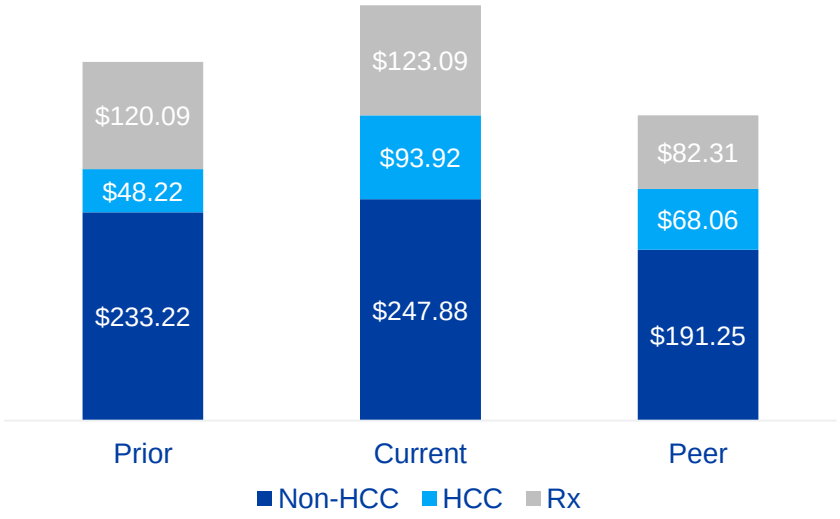
Members over the age of **60** account for **16.3%** of the membership and drive **24.6%** of medical spend

HHS Risk Factor decreased **-0.5%** and is well below peer

Financial Highlights

HEALTH PLAN OF NEVADA
A UnitedHealthcare Company

	Prior	Current	Δ		Peer	Δ
Financial						
Medical Paid PMPM	$281.44	$341.81	21.4%	▲	$259.31	31.8%
Non-Catastrophic	$233.22	$247.88	6.3%		$191.25	29.6%
Catastrophic	$48.22	$93.92	94.8%	▲	$68.06	38.0%
Plan Cost Share	70.1%	73.5%	4.9%		75.9%	-3.1%
Pharmacy PMPM	$120.09	$123.09	2.5%		$82.31	49.5%
Catastrophic						
Catastrophic Cases	19	42	121.1%	▲		
% of Members	0.26%	0.57%	115%		0.34%	68.9%
Average Net Paid	$103,245	$93,306	-9.6%		$111,284	-16.2%
% of Dollars as High Cost	12.1%	20.5%	68.7%		20.8%	-1.7%



Changes Period over Period

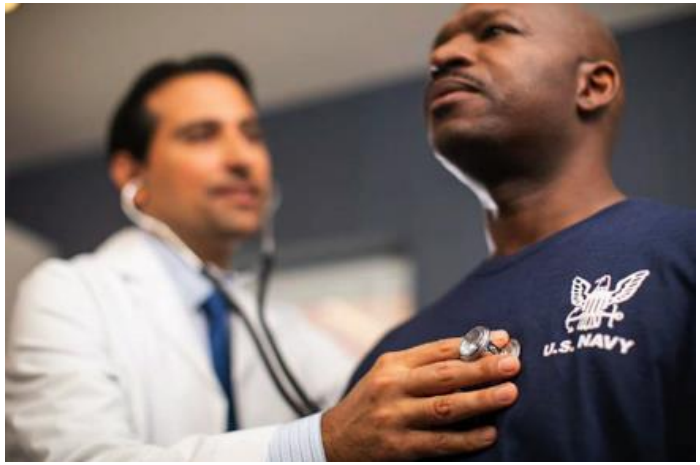
- Medical PMPM Trend: **21.4%**
- Rx PMPM Trend: **2.5%**
- Combined PMPM Change: **15.8%**

WORKING TO MAKE HEALTHCARE
EASIER FOR EVERYONE

Emergency Room/Urgent Services

HEALTH PLAN OF NEVADA
A UnitedHealthcare Company

	Prior	Current	Δ	Peer	Δ
ER Visits	365	456	25.0%		
ER Paid	$975,130	$1,226,183	25.7%		
ER Net Paid / Visit	$2,675	$2,691	0.6%	$2,393	12.5%
ER Visits per K	54	66	22.2%	42	57.1%
UC Visits	1,860	1,908	2.6%		
UC Paid	$37,591	$37,262	-0.9%		
UC Net Paid / Visit	$94	$84	-11.0%	$84	-0.7%
UC Visits per K	277	278	0.3%	259	7.4%



- ER Utilization increased **22.2%** on a Per K basis
- Average Net paid per Visit for ER stayed flat compare to prior period
- Urgent Care utilization remained relatively flat from prior period.

Top ER Diagnosis By Spend	ER Visits
Abdominal Pain	24
Urinary Tract Infections	19
Headache; Including Migraine	11

Opportunities

- On Demand Care Services
  - Now Clinic
  - Telephone Advise Nurse
- Increase Member Decision Making
  - Site of Care

TAN Outcomes			
Reason for Call	Calls	ER Outcomes	% to ER
Abdominal Pain	17	4	24%
Headache	5	0	0%
Urinary	5	1	20%
Total	**27**	**5**	**18.5%**

On-Demand Care Services

HEALTH PLAN OF NEVADA
A UnitedHealthcare Company

ADVICE NURSE for care guidance, treatment alternatives and options

24/7

VIRTUAL VISITS through NowClinic to see a provider from any location

Advice Nurse Utilization

Prior	Current
298	299

NowClinic Visits

Prior	Current
148	175

Top Outcomes of Advice Nurse Call	Prior	Current
Sent to Urgent Care	101	91
Scheduled Appointment with Provider	58	57
Provided Self-Care Options	28	43
Sent to Emergency Room	39	32
Information or Advice Only	18	27
Call 911	6	10

High Cost Claimant (HCC) Data

HEALTH PLAN OF NEVADA
A UnitedHealthcare Company

Overview of High Cost Claimants

HCC Summary	Prior	Current	Δ	Peer	Δ
High Cost Members (>= $50,000)	19	42	121.1%		
HCC's per 1,000	2.65	5.69	115.2%	3.37	68.9%
% of Members as High Cost	0.26%	0.57%	115.2%	0.34%	68.9%
% of Dollars as High Cost	12.1%	20.5%	68.7%	20.8%	-1.7%
HHS Risk Score	33.74	29.67	-12.1%	35.62	-16.7%
High Cost Claimant Average Cost	**$103,245**	**$93,306**	**-9.6%**	**$111,284**	**-16.2%**
High Cost Claimant Average Med Cost	$102,128	$92,032	-9.9%	$106,392	-13.5%
High Cost Claimant Average Rx Cost	$1,117	$1,274	14.1%	$4,892	-74.0%

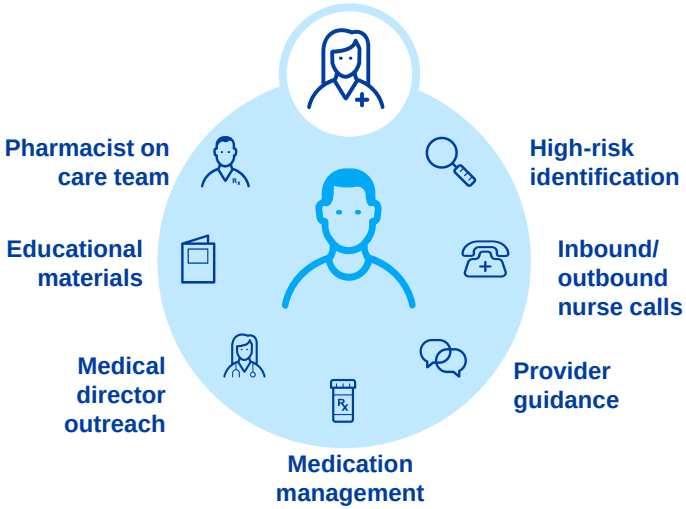
- HCC Defined as **$50,000**+ in spend during measurement period
- High cost claimant paid dollars increased **5.5%** from prior period
- Less complex cases caused a decrease in the average medical cost per claim by **-9.9%**
- Complications of Child Birth accounted for **20.4% of** Total High Cost Spend

High Cost Claimant (HCC) Details

HEALTH PLAN OF NEVADA
A UnitedHealthcare Company

Largest 10 Cases by Paid in Current Period

Case	AHRQ_Category Description	Relationship	Paid	Eligible
1	Aortic; peripheral; and visceral artery aneurysms	Spouse	$262,638	YES
2	Secondary malignancies	Subscriber	$223,353	NO
3	Coagulation and hemorrhagic disorders	Subscriber	$180,903	YES
4	Normal pregnancy and/or delivery	Dependent	$156,183	YES
5	Normal pregnancy and/or delivery	Dependent	$153,880	NO
6	Hypertension with complications and secondary hypertension	Spouse	$151,243	YES
7	Diabetes mellitus without complication	Subscriber	$141,070	YES
8	Acute myocardial infarction	Subscriber	$132,697	YES
9	Normal pregnancy and/or delivery	Dependent	$116,902	NO
10	Diverticulosis and diverticulitis	Subscriber	$111,969	YES



- Care management team engagement
- 7 of the 10 high cost claimants are currently eligible
- Largest claimant is under $300,000
- Medical management works to ensure services are medically necessary and received at the appropriate level

Pharmacy Data

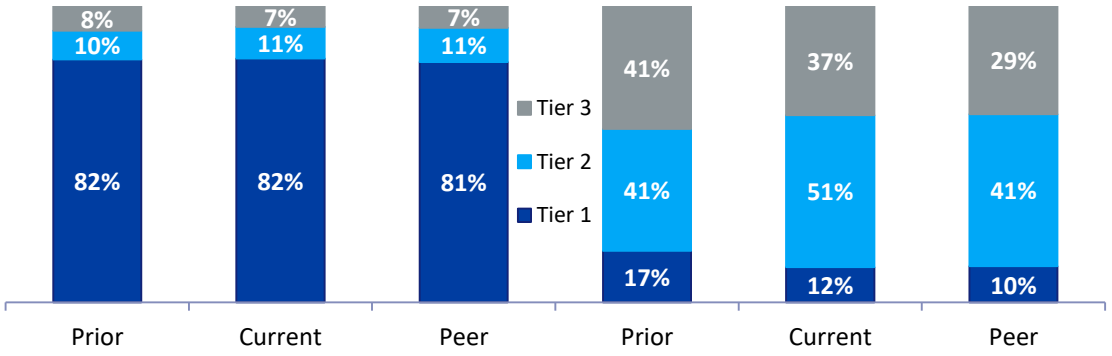
HEALTH PLAN OF NEVADA
A UnitedHealthcare Company

	Prior	Current	Δ	Peer	Δ
Enrolled Members	6,706	6,859	2.3%		
Average Prescriptions PMPY	17.5	17.6	0.7%	11.3	55.8%
Formulary Rate	92.7%	92.5%	-0.2%	91.0%	1.6%
Generic Use Rate	86.9%	86.6%	-0.3%	86.3%	0.4%
Generic Substitution Rate	97.6%	97.3%	-0.3%	96.6%	0.7%
Employee Cost Share PMPM	$16.77	$18.14	8.2%	$11.79	53.9%
Avg Net Paid per Prescription	$82.40	$83.85	1.8%	$87.36	-4.0%
Net Paid PMPM	$120.09	$123.09	2.5%	$82.31	49.5%

Pharmacy PMPM Change is 2.5%

- Average net paid per script increased **1.8%** from prior period
- **82.0%** of prescriptions were in Tier 1 and drove only **12.0%** of spend
- **Tier 3** utilization decreased -**14.7%** and spend decreased **-11.1%** from prior period
- Top 10 Theraclass spend remained flat year over year

Prescriptions by Tier

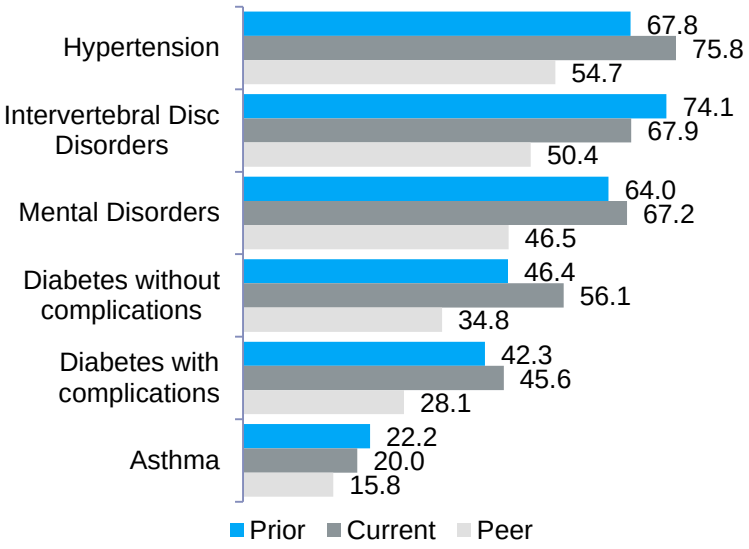


Net Paid by Tier

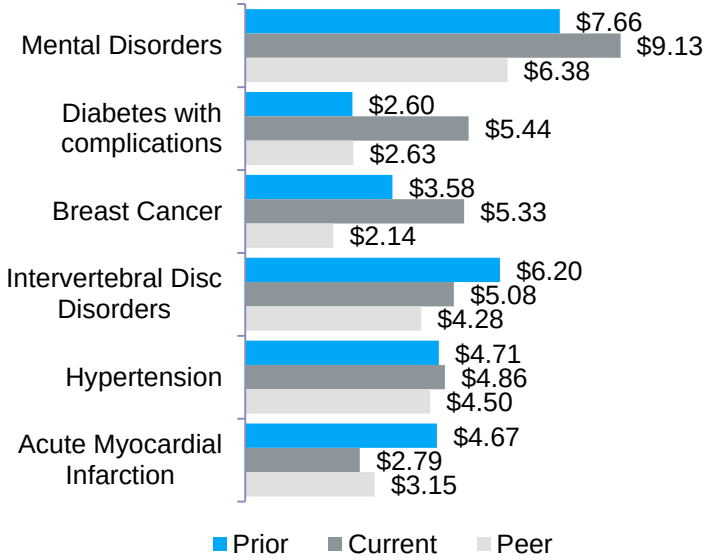
Common Diagnosis Categories

HEALTH PLAN OF NEVADA
A UnitedHealthcare Company

Top Common Condtions by Prevalence



Top Conditions by PMPM



- Hypertension, Intervertebral Disc Disorders, and Mental Disorders are the most prevalent clinical conditions within the population.
- Approximately 10% of the population has a diabetes diagnosis
- Prevalence of Diabetes with and without complications increased from prior period
- Spend in both Diabetes with and without Complications increased year over year
- Mental Disorders top condition driving spend at $9.13 PMPM
- Chronic illnesses are driving the top common conditions

4.5

4.5 Receipt of the federally mandated Summaries of Benefits and Coverage documents effective July 1, 2020 for individual coverage and family coverage for PEBP's Consumer Driven Health Plan (CDHP) and PEBP's Premier Plan (Exclusive Provider Organization – EPO).

- 4.5.1 Summary of Benefits and Coverage CDHP – Individual
- 4.5.2 Summary of Benefits and Coverage CDHP – Family
- 4.5.3 Summary of Benefits and Coverage EPO – Individual/Family

4.5.1

4.5 Receipt of the federally mandated Summaries of Benefits and Coverage documents effective July 1, 2020 for individual coverage and family coverage for PEBP's Consumer Driven Health Plan (CDHP) and PEBP's Premier Plan (Exclusive Provider Organization – EPO).

4.5.1 Summary of Benefits and Coverage CDHP – Individual

Public Employees' Benefits Program

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services

Coverage Period: 07/01/2020 – 06/30/2021
Coverage for: Individual | **Plan Type:** CDHP

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.
This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.pebp.state.nv.us. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.dol.gov/ebsa/healthreform or call 775-684-7000 1-800-326-5496 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Individual $1,500	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care services are covered before you meet your deductible.	This plan covers some items and services even if you have not yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services in the CDHP Master Plan Document at www.pebp.state.nv.us.
Are there other deductibles for specific services?	No.	You do not have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For network providers $3,900 for out-of-network providers $10,600	Out-of-pocket limit is the most you could pay in a plan year for covered services. If you have other family members on the plan, they have to meet their own out-of-pocket limits until the family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Penalty for failure to obtain pre-authorization for certain services, premiums, balance-billing charges, excluded services and prescription drug copay assistance.	Even though you pay these expenses, they do not count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See **www.pebp.state.nv.us or call 1-800-336-0123 or 1-888-763-8232** for a list of participating providers.	You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work).
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance	50% coinsurance	Balance billing applies to out-of-network claims.
	Specialist visit	20% coinsurance	50% coinsurance	Balance billing applies to out-of-network claims.
	Preventive care/screening/ immunization	No charge.	Not Covered.	Preventive services must be provided in-network. Refer to the Plan Document for additional limitations.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	50% coinsurance	Routine labs covered only when performed at a free-standing lab (i.e. LabCorp or Quest). Balance billing applies to out-of-network claims.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	50% coinsurance	May require preauthorization. Balance billing applies to out-of-network claims.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.pebp.state.nv.us	Generic drugs	20% coinsurance	Not Covered.	Non-preferred generic and non-preferred brand drugs are not covered and do not apply to deductible and out-of-pocket maximum. Drug copay assistance does not apply to deductible and out-of-pocket maximum. Plan does not coordinate Rx benefits.
	Preferred brand drugs	20% coinsurance	Not Covered.	
	Non-preferred brand drugs	Not Covered.	Not Covered.	
	Specialty drugs	20% coinsurance	Not Covered.	30-day supply through Accredo specialty pharmacy. Some Specialty drugs require preauthorization. Drug copay assistance does not apply to deductible and out-of-pocket maximum. Plan does not coordinate Rx benefits.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	50% coinsurance	Requires preauthorization or 50% penalty applies. Balance billing applies to out-of-network claims.
	Physician/surgeon fees	20% coinsurance	50% coinsurance	
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	Balance billing applies to out-of-network claims. See Plan Document for air ambulance benefits and limitations.
	Emergency medical transportation	20% coinsurance	20% coinsurance	
	Urgent care	20% coinsurance	50% coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	50% coinsurance	Requires preauthorization or 50% penalty applies. Balance billing applies to out-of-network claims.
	Physician/surgeon fees	20% coinsurance	50% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	50% coinsurance	See Plan Document for Preauthorization requirements.
	Inpatient services	20% coinsurance	50% coinsurance	Preauthorization required. If preauthorization is not obtained, benefits may be reduced by 50%.
If you are pregnant	Office visits	20% coinsurance	50% coinsurance	Balance billing applies to out-of-network claims.
	Childbirth/delivery professional services	20% coinsurance	50% coinsurance	See Plan Document for preventive prenatal services. Balance billing applies to out-of-network claims.
	Childbirth/delivery facility services	20% coinsurance	50% coinsurance	Preauthorization required only if vaginal delivery exceeds 48 hours or cesarean section delivery exceeds 96 hours. Balance billing applies to out-of-network provider claims.
If you need help recovering or have other special health needs	Home health care	20% coinsurance	50% coinsurance	Preauthorization required. Limited to 60 visits per person plan year. Balance billing applies to out-of-network provider claims.
	Rehabilitation services	20% coinsurance	50% coinsurance	Preauthorization required. See Plan Document for details. Balance billing applies to out-of-network claims.
	Habilitation services	20% coinsurance	50% coinsurance	Preauthorization required. See Plan Document for details. Balance billing applies to out-of-network claims.
	Skilled nursing care	20% coinsurance	50% coinsurance	Preauthorization required. Limited to 60 days per Plan Year related to the same cause.
	Durable medical equipment	20% coinsurance	50% coinsurance	Preauthorization required for equipment over $1,000.
	Hospice services	20% coinsurance	50% coinsurance	Maximum lifetime benefit limited to 185 days.
If your child needs dental or eye care	Children's eye exam	$25 copayment	$25 copayment	Limited to 1 routine vision exam plan year. $95 maximum benefit.
	Children's glasses	Not covered.	Not covered.	
	Children's dental check-up	Not covered.	Not covered.	Coverage available under separate dental plan.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Cosmetic surgery
- Infertility treatment
- Long-term care
- Non-FDA approved drugs
- Routine foot care
- Orthodontia expenses

Refer to the Consumer Driven Health Plan Master Plan Document for benefits and contact information at www.pebp.state.nv.us.

Other Covered Services (Limitations may apply to these services. This is not a complete list. Please see your plan document.)		
• Acupuncture	• Chiropractic care	• Vision exam (limited to one screening exam)
• Obesity Care Management Program	• Hearing aids	• Bariatric surgery

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: 1-800-326-5496 or 775-684-7000. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about benefits, contact HealthSCOPE Benefits Customer Service at 1-888-763-8232

Does this plan provide Minimum Essential Coverage? Yes.
If you do not have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? Yes.
If your plan does not meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$1,500
Specialist *[coinsurance]*	20%
Hospital (facility) *[coinsurance]*	20%
Other *[coinsurance]*	20%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	None
Coinsurance	$2,260
What is not covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,820**

Managing Joe's type 2 Diabetes*
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$1,500
Specialist *[coinsurance]*	20%
Hospital (facility) *[coinsurance]*	20%
Other *[coinsurance]*	20%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	None
Coinsurance	$1,180
What is not covered	
Limits or exclusions	$60
The total Joe would pay is	**$2,740**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$1,500
Specialist *[coinsurance]*	20%
Hospital (facility) *[coinsurance]*	20%
Other *[coinsurance]*	20%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$1,925**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	None
Coinsurance	$85
What is not covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,585**

The **plan** would be responsible for the other costs of these EXAMPLE covered services.

Attachment A

Language Access Services

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-763-8232.

[Spanish (Español): Para obtener asistencia en Español, llame al 1-888-763-8232.

[Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-888-763-8232.

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-888-763-8232.

[PAUNAWA]: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-326-5496 (TTY: 1-800-545-8279).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-326-5496 (TTY: 1-800-545-8279).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.번으로 전화해 주십시오. 1-800-326-5496 (TTY: 1-800-545-8279).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-326-5496 (TTY: 1-800-545-8279). (TTY: 1-800-545-8279).

ማስታወሻ: የሚናገሩት ቋንቋ ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዘዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-800-326-5496 (መስማት ለተሳናቸው:1-800-545-8279).

เรียน: ถ้าคณุพดู ภาษา ไทยคณุสามารถ ใช้บริการชว่ ยเหลือทางภาษา ได้ฟรี โทร 1-800-326-5496 (TTY: 1-800-545-8279)

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-326-5496 (TTY: 1-800-545-8279）まで、お電話にてご連絡ください。.

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم (رقم هاتف الصم والبكم: 1-800-326-5496 (TTY: 1-800-545-8279)

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-326-5496 (телетайп: 1-800-545-8279).

Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-326-5496 (1-800-545-8279).

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. بتماس بگیرید. 1

MO LOU SILAFIA: Afai e te tautala Gagana fa'a Sāmoa, o loo iai auaunaga fesoasoan, e fai fua e leai se totogi, mo oe, Telefoni mai: 1-800-326-5496 (TTY: 1-800-545-8279).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-326-5496 (TTY: 1-800-545-8279).

PAKDAAR: Nu saritaem ti Ilocano, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Awagan ti 1-800-326-5496 (TTY: 1-800-545-8279).

4.5.2

4.5 Receipt of the federally mandated Summaries of Benefits and Coverage documents effective July 1, 2020 for individual coverage and family coverage for PEBP's Consumer Driven Health Plan (CDHP) and PEBP's Premier Plan (Exclusive Provider Organization – EPO).

4.5.2 Summary of Benefits and Coverage CDHP – Family

Public Employees' Benefits Program

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services

Coverage Period: 07/01/2020 – 06/30/2021
Coverage for: Family| **Plan Type:** CDHP

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.
This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.pebp.state.nv.us. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.dol.gov/ebsa/healthreform or call 775-684-7000 1-800-326-5496 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Family $3,000 / Individual $2,800	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care services are covered before you meet your deductible.	This plan covers some items and services even if you have not yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services in the CDHP Master Plan Document at www.pebp.state.nv.us.
Are there other deductibles for specific services?	No.	You do not have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Network providers: Individual $6,850 / Family $7,800; out-of-network Individual $10,600 / Family $21,200	Out-of-pocket limit is the most you could pay in a plan year for covered services. If you have other family members on the plan, they have to meet their own out-of-pocket limits until the family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Penalty for failure to obtain pre-authorization for certain services, premiums, balance-billing charges, excluded services and prescription drug copay assistance.	Even though you pay these expenses, they do not count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See **www.pebp.state.nv.us or call 1-800-336-0123 or 1-888-763-8232** for a list of participating providers.	You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work).
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance	50% coinsurance	Balance billing applies to out-of-network claims.
	Specialist visit	20% coinsurance	50% coinsurance	Balance billing applies to out-of-network claims.
	Preventive care/screening/ immunization	No charge.	Not Covered.	Preventive services must be provided in-network. Refer to the Plan Document for additional limitations.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	50% coinsurance	Routine labs covered only when performed at a free-standing lab (i.e. LabCorp or Quest). Balance billing applies to out-of-network claims.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	50% coinsurance	May require preauthorization. Balance billing applies to out-of-network claims.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.pebp.state.nv.us	Generic drugs	20% coinsurance	Not Covered.	Non-preferred generic and non-preferred brand drugs are not covered and do not apply to deductible and out-of-pocket maximum. Drug copay assistance does not apply to deductible and out-of-pocket maximum. Plan does not coordinate Rx benefits.
	Preferred brand drugs	20% coinsurance	Not Covered.	
	Non-preferred brand drugs	Not Covered.	Not Covered.	
	Specialty drugs	20% coinsurance	Not Covered.	30-day supply through Accredo specialty pharmacy. Some Specialty drugs require preauthorization. Drug copay assistance does not apply to deductible and out-of-pocket maximum. Plan does not coordinate Rx benefits.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	50% coinsurance	Requires preauthorization or 50% penalty applies. Balance billing applies to out-of-network claims.
	Physician/surgeon fees	20% coinsurance	50% coinsurance	
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	Balance billing applies to out-of-network claims. See Plan Document for air ambulance benefits and limitations.
	Emergency medical transportation	20% coinsurance	20% coinsurance	
	Urgent care	20% coinsurance	50% coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	50% coinsurance	Requires preauthorization or 50% penalty applies. Balance billing applies to out-of-network claims.
	Physician/surgeon fees	20% coinsurance	50% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	50% coinsurance	See Plan Document for Preauthorization requirements.
	Inpatient services	20% coinsurance	50% coinsurance	Preauthorization required. If preauthorization is not obtained, benefits may be reduced by 50%.
If you are pregnant	Office visits	20% coinsurance	50% coinsurance	Balance billing applies to out-of-network claims.
	Childbirth/delivery professional services	20% coinsurance	50% coinsurance	See Plan Document for preventive prenatal services. Balance billing applies to out-of-network claims.
	Childbirth/delivery facility services	20% coinsurance	50% coinsurance	Preauthorization required only if vaginal delivery exceeds 48 hours or cesarean section delivery exceeds 96 hours. Balance billing applies to out-of-network provider claims.
If you need help recovering or have other special health needs	Home health care	20% coinsurance	50% coinsurance	Preauthorization required. Limited to 60 visits per person plan year. Balance billing applies to out-of-network provider claims.
	Rehabilitation services	20% coinsurance	50% coinsurance	Preauthorization required. See Plan Document for details. Balance billing applies to out-of-network claims.
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	Skilled nursing care	20% coinsurance	50% coinsurance	Preauthorization required. Limited to 60 days per Plan Year related to the same cause.
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	Hospice services	20% coinsurance	50% coinsurance	Maximum lifetime benefit limited to 185 days.
If your child needs dental or eye care	Children's eye exam	$25 copayment	$25 copayment	Limited to 1 routine vision exam plan year. $95 maximum benefit.
	Children's glasses	Not covered.	Not covered.	
	Children's dental check-up	Not covered.	Not covered.	Coverage available under separate dental plan.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Cosmetic surgery
- Infertility treatment
- Long-term care
- Non-FDA approved drugs
- Routine foot care
- Orthodontia expenses

Refer to the Consumer Driven Health Plan Master Plan Document for benefits and contact information at www.pebp.state.nv.us.

Other Covered Services (Limitations may apply to these services. This is not a complete list. Please see your plan document.)		
• Acupuncture	• Chiropractic care	• Vision exam (limited to one screening exam)
• Obesity Care Management Program	• Hearing aids	• Bariatric surgery

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: 1-800-326-5496 or 775-684-7000. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

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If you do not have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? Yes.
If your plan does not meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$3,000
Specialist *[coinsurance]*	20%
Hospital (facility) *[coinsurance]*	20%
Other *[coinsurance]*	20%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2,800
Copayments	$0.00
Coinsurance	$2,000
What is not covered	
Limits or exclusions	$60
The total Peg would pay is	**$4,860**

Managing Joe's type 2 Diabetes*
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$3,000
Specialist *[coinsurance]*	20%
Hospital (facility) *[coinsurance]*	20%
Other *[coinsurance]*	20%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$2,800
Copayments	$0.00
Coinsurance	$920
What is not covered	
Limits or exclusions	$60
The total Joe would pay is	**$3,780**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$3,000
Specialist *[coinsurance]*	20%
Hospital (facility) *[coinsurance]*	20%
Other *[coinsurance]*	20%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$1,925**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$2,800
Copayments	$0.00
Coinsurance	$0.00
What is not covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,925**

The **plan** would be responsible for the other costs of these EXAMPLE covered services.

Refer to the Consumer Driven Health Plan Master Plan Document for benefits and contact information at www.pebp.state.nv.us.

Attachment A

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[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-763-8232.

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ማስታወሻ: የሚናገሩት ቋንቋ ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዘዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-800-326-5496 (መስማት ለተሳናቸው:1-800-545-8279).

เรียน: ถ้าคณุพดู ภาษา ไทยคณุสามารถ ใช้บริการชว่ ยเหลือทางภาษา ได้ฟรี โทร 1-800-326-5496 (TTY: 1-800-545-8279)

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توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. بتماس بگیرید. 1

MO LOU SILAFIA: Afai e te tautala Gagana fa'a Sāmoa, o loo iai auaunaga fesoasoan, e fai fua e leai se totogi, mo oe, Telefoni mai: 1-800-326-5496 (TTY: 1-800-545-8279).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-326-5496 (TTY: 1-800-545-8279).

PAKDAAR: Nu saritaem ti Ilocano, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Awagan ti 1-800-326-5496 (TTY: 1-800-545-8279).

4.5.3

4.5 Receipt of the federally mandated Summaries of Benefits and Coverage documents effective July 1, 2020 for individual coverage and family coverage for PEBP's Consumer Driven Health Plan (CDHP) and PEBP's Premier Plan (Exclusive Provider Organization – EPO).

4.5.3 Summary of Benefits and Coverage EPO – Individual/Family

Public Employees' Benefits Program

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services **Coverage Period: 07/01/2020 – 06/30/2021**

Coverage for: Individual and Family | **Plan Type:** EPO (Premier Plan)

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.pebp.state.nv.us. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at **www.dol.gov/ebsa/healthreform** or call 775-684-7000 1-800-326-5496 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In Network: $0 Person/$0 Family Out of Network: N/A Individual / N/A Family	This Plan does not require deductibles.
Are there services covered before you meet your deductible?	Yes. Preventive care services are covered before you meet your deductible.	This Plan does not require a deductible, a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible.
Are there other deductibles for specific services?	No.	This Plan does not require deductibles.
What is the out-of-pocket limit for this plan?	For network providers $7,150 individual / $14,300 Family for out-of-network providers	Out-of-pocket limit is the most you could pay in a plan year for covered services. If you have other family members on the plan, they have to meet their own out-of-pocket limits until the family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Penalty for failure to obtain pre-authorization for certain services, premiums, balance-billing charges, and health care this plan does not cover.	Even though you pay these expenses, they do not count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See www.pebp.state.nv.us or call 1-800-336-0123 or 1-888-763-8232 for a list of participating providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work).
Do you need a referral to see a specialist?	No.	You can see a specialist within the Plan's exclusive provider network without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copayment	Not Covered.	None.
	Specialist visit	$40 copayment	Not Covered.	None.
	Preventive care/screening/ immunization	$0 copayment	Not Covered.	With certain limitations. See Plan Document for details.
If you have a test	Diagnostic test (x-ray, blood work)	X-ray: Depends on site of service; routine lab work: No charge	Not Covered.	*Out-of-Network labs paid in-network if no in-network provider within 50 miles/residence (balance billing applies to out-of-network provider claims); all non-pre-operative labs must be performed at a free-standing laboratory facility i.e. Labcorp, Quest
	Imaging (CT/PET scans, MRIs)	CT/MRI: $250 copay PET: $350 copay	Not Covered.	*May require preauthorization.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.pebp.state.nv.us	Generic drugs	$10 copayment 30-day	Not Covered.	Plan does not coordinate prescription drug benefits.
	Preferred brand drugs	$40 copayment 30-day	Not Covered.	Plan does not coordinate prescription drug benefits.
	Non-preferred brand drugs	$75 copayment 30-day supply	Not Covered.	*Plan does not coordinate prescription drug benefits. Single-source non-preferred brand.
	Specialty drugs	20% coinsurance	Not Covered.	*Covered only when ordered from Specialty pharmacy; limited to a 30-day supply; Some Specialty drugs require preauthorization.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$350 copay	Not Covered.	*Some services requires preauthorization.
	Physician/surgeon fees	PCP: $0 copay Specialist: $0 copay	Not Covered.	Primary Care or Specialty Office visit copay applies when services are performed in a physician's office.
If you need immediate medical attention	Emergency room care	$500 copayment	$500 copayment	Balance billing applies to out-of-network provider claims.
	Emergency medical transportation	$200 copayment (air) (air) plus amount exceeding 250% of	$200 copayment (air) plus amount exceeding 250% of Medicare allowable.	Balance billing for amounts exceeding 250% of Medicare allowable rate.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
		Medicare allowable. $150 copayment (ground)	$150 copayment (ground)	
	Urgent care	$50 copay /visit	$50 copayment	Balance billing applies to out-of-network provider claims.
If you have a hospital stay	Facility fee (e.g., hospital room)	$500 copay/admission	Not Covered.	Preauthorization required.
	Physician/surgeon fees	$0 copayment	Not Covered.	*Preauthorization required.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 copay /visit	Not Covered.	*See plan document for details.
	Inpatient services	$500 copay/admission	Not Covered.	*Preauthorization required.
If you are pregnant	Office visits	$0 copay /visit	Not Covered.	Routine prenatal care obtained from a Plan provider is covered at no charge. Maternity care may include tests and services described elsewhere in the SBC (i.e. Lab)
	Childbirth/delivery professional services	$0 copay/delivery	Not Covered.	Childbirth/delivery professional services includes Anesthesia and Physician Surgical Services.
	Childbirth/delivery facility services	$500 copay/admission	Not Covered.	Preauthorization required only if vaginal delivery exceeds 48 hours or cesarean section delivery exceeds 96 hours.
If you need help recovering or have other special health needs	Home health care	$20 copay /visit	Not Covered.	Preauthorization required. Limited to 60 visits per person plan year.
	Rehabilitation services	$500 copay/admission $20 copay /visit	Not Covered.	Inpatient: Preauthorization required; limited to 60 days per Plan Year. Outpatient subject to a combined maximum benefit of 90 visits for OT, ST, PT per Plan Year.
	Habilitation services	$500 copay/admission $20 copay /visit	Not Covered.	Inpatient: Preauthorization required; limited to 60 days per Plan Year. Outpatient subject to a combined maximum benefit of 90 visits for OT, ST, PT per Plan Year.
	Skilled nursing care	$500 copay/admission $20 copay /visit	Not Covered.	Inpatient: Preauthorization required and limited to 100 days per Plan Year. Outpatient: Preauthorization required; limited to 60 days per Plan Year related to the same cause.
	Durable medical equipment	$0 copay	Not Covered.	Preauthorization required for equipment over

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
				$1,000.
	Hospice services	$500 copay/admission $0 copay /visit	Not Covered.	Precertification required after 185 days.
If your child needs dental or eye care	Children's eye exam	$10 copayment	$10 copayment	Limited to 1 routine preventive care/screening per plan year; $100 maximum benefit.
	Children's glasses	Not covered.	Not covered.	
	Children's dental check-up	Not covered.	Not covered.	Coverage available under separate dental plan.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Cosmetic surgery
- Long-term care
- Routine foot care
- Personal/custodial care
- Non-FDA approved drugs
- Orthodontia expenses

Other Covered Services (Limitations may apply to these services. This is not a complete list. Please see your plan document.)

- Acupuncture
- Chiropractic care
- Routine eye care (limited to one screening exam)
- Obesity Care Management Program
- Hearing aids
- Bariatric surgery

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: 1-800-326-5496 or 775-684-7000. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: HealthSCOPE Benefits Customer Service at 1-888-763-8232.

Does this plan provide Minimum Essential Coverage? Yes.
If you do not have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? Yes.
If your plan does not meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$0
Specialist *[copayment]*	$40
Hospital (facility) *[copayment]*	$500
Other *[Specialty drugs]*	*20%*

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0.00
Copayments	$540
Coinsurance	$0.00
What is not covered	
Limits or exclusions	$60
The total Peg would pay is	**$600**

Managing Joe's type 2 Diabetes*
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$0
Specialist *[copayment]*	$40
Hospital (facility) *[copayment]*	$500
Other *[Specialty drugs]*	20%

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0.00
Copayments	$1,060
Coinsurance	$0.00
What is not covered	
Limits or exclusions	$60
The total Joe would pay is	**$1,120**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$0
Specialist *[copayment]*	$40
Hospital (facility) *[copayment]*	$500
Other *[Specialty drugs]*	20%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$1,925**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0.00
Copayments	$540
Coinsurance	$0.00
What is not covered	
Limits or exclusions	$0
The total Mia would pay is	**$540**

The plan would be responsible for the other costs of these EXAMPLE covered services.

Attachment A

Language Access Services

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-763-8232.

[Spanish (Español): Para obtener asistencia en Español, llame al 1-888-763-8232.

[Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-888-763-8232.

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-888-763-8232.

[PAUNAWA]: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-326-5496 (TTY: 1-800-545-8279).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-326-5496 (TTY: 1-800-545-8279).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.번으로 전화해 주십시오. 1-800-326-5496 (TTY: 1-800-545-8279).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-326-5496 (TTY: 1-800-545-8279). (TTY: 1-800-545-8279).

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เรียน: ถ้าคุณพูด ภาษา ไทยคุณสามารถ ใช้ บริการช่วย เหลือ ทางภาษา ได้ฟรี โทร 1-800-326-5496 (TTY: 1-800-545-8279)

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MO LOU SILAFIA: Afai e te tautala Gagana fa'a Sāmoa, o loo iai auaunaga fesoasoan, e fai fua e leai se totogi, mo oe, Telefoni mai: 1-800-326-5496 (TTY: 1-800-545-8279).

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PAKDAAR: Nu saritaem ti Ilocano, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Awagan ti 1-800-326-5496 (TTY: 1-800-545-8279).

5.

5. Discussion and possible action of emergency COVID-19 plan benefit design changes and implementation. (Laura Rich, Executive Officer) (**For Possible Action**)

STEVE SISOLAK
Governor

LAURA FREED
Board Chair

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

AGENDA ITEM

[X] Action Item
[ ] Information Only

Date: March 31, 2020

Item Number: V

Title: COVID-19

SUMMARY

This report will provide the Board, participants, public, and other stakeholders information and recommendations related to benefits and coverage for COVID-19

REPORT

In response to COVID-19, Governor Sisolak adopted an emergency regulation on March 5, 2020 (effective March 5 – July 3, 2020) to ensure that Nevadans covered by health insurance policies regulated by the Division of Insurance can obtain medical services and prescription drugs related to COVID-19 without cost sharing. Specifically, the regulation prohibits a health plan from imposing an out-of-pocket cost for a provider, urgent care center, or emergency room visit when the purpose of the visit is for testing for COVID-19. The regulation also prohibits charging for the COVID-19 test or an immunization when it becomes available. Furthermore, it requires coverage for non-formulary prescription drugs if a formulary drug is not available for treatment.

PEBP's self-funded Consumer Driven Health (CDHP) and Premier EPO Plans are not regulated by the DOI; however, the Board has the discretionary authority to implement plan changes in response to COVID-19. The following options are presented for Board consideration with Option 1 aligning with the Governor's emergency regulation.

Option 1: Effective March 5 through July 3, 2020, cover all testing, associated office visit, and treatment for COVID-19 at 100% of the plan's maximum allowable charge regardless of network participation status with no cost sharing to the member. Cover formulary medications for the treatment of COVID-19 with no cost sharing and non-formulary medications without prior authorization when supply shortages exist.

Option 2: Effective March 5 through July 3, 2020, cover all testing and associated office visit at 100% of the plan's maximum allowable charge regardless of network participation status with no

cost sharing to the member. Cover formulary medications for the treatment of COVID-19 with no cost sharing and non-formulary medications without prior authorization when supply shortages exist.

Option 3: Do not extend coverage for the testing and treatment associated with COVID-19.

Recommendation: PEBP recommends implementing Option 1 to align with state emergency regulations passed on March 5, 2020. PEBP also recommends providing staff the authority to extend the coverage beyond the July 3, 2020 expiration date should the emergency regulations be extended or reissued.

6.

6. Discussion and possible action of the Express Scripts, Inc. Pharmacy Benefits Manager contract amendment to reduce fees and implement greater drug discounts and guaranteed drug rebates. (Laura Rich, Executive Officer) (**For Possible Action**)

STEVE SISOLAK
Governor

LAURA FREED
Board Chair

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LAURA RICH
Executive Officer

AGENDA ITEM

[X] Action Item
[ ] Information Only

Date: March 31, 2020

Item Number: VI

Title: Contract Amendment Report – Express Scripts, Inc.

SUMMARY

This report requests the Board authorize staff to complete a contract amendment between PEBP and Express Scripts, Inc. to amend the negotiated points and pricing proposal through the contract term.

REPORT

EXPRESS SCRIPTS, INC.

PEBP contracted with Express Scripts Inc. (ESI) for Pharmacy Benefits Manager (PBM) Services which began July 1, 2016. Pursuant to the contract, PEBP may perform, or have performed on its behalf, a market check or an assessment of market conditions, pharmaceutical pricing, dispensing fees, and any other matters, services, or price drivers pertaining to this contract to determine if the terms of the contract are competitive with the then current market conditions.
AON Consulting performed a market check and based on the results, ESI has agreed to additional negotiated discounts that are anticipated to save the CDHP and EPO plans approximately $4.5 million per year.

RECOMMENDATION

PEBP recommends the Board authorize staff to complete a contract amendment between PEBP and Express Scripts, Inc. for PBM services in contract # 17551 to amend the negotiated points and pricing proposal through the contract term.

7.

7. Discussion and possible action regarding Plan Year 2021 plan and policy changes including:
    - Cancellation of the Chronic Kidney Disease pilot program
    - Deferment of the approved CDHP HSA/HRA enhanced funding
    - Implementation of the SaveOn Copay Assistance Program

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

STEVE SISOLAK
Governor

LAURA FREED
Board Chair

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LAURA RICH
Executive Officer

AGENDA ITEM

[X] Action Item
[ ] Information Only

Date: March 31, 2020

Item Number: VII

Title: Plan Year 2021 Plan Benefit Design and Policy Changes

SUMMARY

This report provides information and recommendations on additional Plan Year 2021 plan benefit design and policy changes.

REPORT

CDHP HSA/HRA SUPPLEMENTAL FUNDING

During the 80th Legislative Session, the Legislature approved PEBP's budget with a Plan Year 2021 CDHP enhanced HSA/HRA funding of $125 per primary participant. The Board also approved the enhanced funding at the November 2019 PEBP Board meeting.

Due to the availability of projected reserves at the time, the approximate $3M cost was intended to be funded using excess reserves. The current budget projections available today, however, indicate there may not be sufficient excess reserves to cover this cost. PEBP is recommending deferring the $125 enhanced funding for the Board to reconsider in November. If at that time it is determined there are sufficient excess reserves to cover the cost, the enhancements will be provided to CDHP members in January 2021. Deferring the funding until January avoids any tax-related impacts that may come from providing HSA dollars at the end of the calendar year.

PEBP Recommendation: PEBP recommends deferring the $125 enhanced HSA/HRA funding to be reconsidered at the November 2020 PEBP Board meeting.

CHRONIC KIDNEY DISEASE PILOT PROGRAM UPDATE

In November 2019, the PEBP Board approved the implementation of a Chronic Kidney Disease (CKD) pilot program. The intent of the program was for American Health Holdings (AHH), PEBP's utilization management/case management partners to provide specialized case management services for those members diagnosed with CKD. Through this program, specialized case managers perform medical necessity reviews, early identification, steerage to alternate care settings and member assistance. The cost of these services was estimated to be approximately $20,000/month, however PEBP would be guaranteed a 1:1 Return on Investment (ROI).

As PEBP began to explore this option further, it was determined that the opportunity for cost savings was challenging and it would be unlikely that AHH would be able to guarantee any ROI. First, although some members already receive (or have received) existing case management services offered through AHH, 20 of the top 100 members CKD members (94% of total CKD spend) had declined these services. Based on that, those individuals are likely to decline CKD specialized case management as well. Additionally, of the top 100 CKD members, only 45 have claims greater than $36,000. This means that even if AHH were to provide coaching to those members, the opportunity to generate any savings is minimal.

Essentially, many of the best candidates for this type of program have already had outreach and received case management and coaching opportunities. PEBP is exploring other options, including mandated case management that may be presented to the Board in the future.

PEBP Recommendation: PEBP recommends cancelling the CKD Pilot Program previously approved for PY21. Without guaranteed savings, the program incurs a fiscal cost that has not been accounted for in the PEBP budget and therefore will require legislative approval through the Interim Finance Committee (IFC).

SAVEON

At the January 23, 2020 Board meeting, PEBP presented the Express Scripts SaveOn Program as a cost savings option to be considered for inclusion in PEBP's upcoming biennial budget request. Due to the potential for immediate savings to the plan as well as the benefit enhancement it offers to members receiving copay assistance dollars, PEBP believes it is in the best interest of the program to implement SaveOn for PY21, beginning July 1, 2020.

Attachment A provides an overview of the program.

PEBP Recommendation: PEBP recommends implementing the SaveOn Program for PY21, effective July 1, 2020.

Copay Assistance Program & Solutions

REDUCING FINANCIAL BARRIERS AND OVERALL PLAN COST

EXPRESS SCRIPTS®

CHAMPIONS FOR BETTER™

COPAY ASSISTANCE

The $15B[1] investment driving up plan spend

Did you know?

80% of all specialty medications have a copayment assistance program

Manufacturers fund copay assistance programs to help drive brand loyalty

Prior to out of pocket (OOP) protection, these programs resulted in members meeting their out-of-pocket maximum in as little as 3 fills — perhaps without the member ever contributing a single dollar

Your CDHP members used $2M in specialty copay assistance from July to December 2019.

1.The 2020 economic report on U.S. pharmacies and pharmacy benefit managers, Fein, Adam, March 2020, https://drugchannelsinstitute.com/products/industry_report/pharmacy/

PEBP's benefit structure prior to OOP protection

Coinsurance: 20%, no per-claim cap
Individual deductible: $1,500
Individual MOOP: $3,900

Plan pays	Copay Assistance Pays	Member Pays	Member's deductible	OOP Max	Total Cost
1st Fill – $5,000 drug; manufacturer will pay up to $1,000/claim for 12 claims/year					
$3,500	$1,000	$500	$1,500 (MET)	$1,500	$5,000
2nd Fill					
$4,000	$1,000	$0	MET	$2,500	$5,000
3rd Fill					
$4,000	$1,000	$0	MET	$3,500	$5,000
4th Fill					
$4,600	$400	$0	MET	$3,900 (MET)	$5,000
5th Fill					
$5,000	$0	$0	MET	MET	$5,000

- PEBP is currently capturing the maximum per-fill assistance available with their 20% coinsurance (no cap)
- By the time the member meets their MOOP upon the 4th fill, the manufacturer has contributed $3,400 toward the drug costs
- The manufacturer has an additional $8,600 in funding available, which is not being captured due to the member hitting their MOOP and the plan being responsible for 100% of the drug costs

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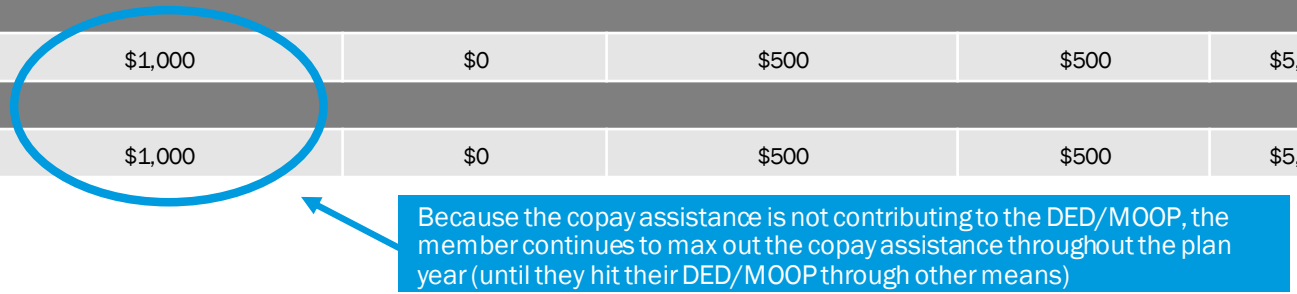
Current benefit structure w/ OOP Protection

OOP protection was implemented for the CDHP plan on 7/1/2019

Coinsurance: 20%, no per-claim cap
Individual deductible: $1,500
Individual MOOP: $3,900

Plan pays	Copay Assistance Pays	Member Pays	Member's deductible	OOP Max	Total Cost
1st Fill – $5,000 drug; manufacturer will pay up to $1,000/claim for 12 claims/year					
$3,500	$1,000	$500	$500	$500	$5,000
2nd Fill					
$4,000	$1,000	$0	$500	$500	$5,000
3rd Fill					
$4,000	$1,000	$0	$500	$500	$5,000
4th Fill					
$4,000	$1,000	$0	$500	$500	$5,000
5th Fill					
$4,000	$1,000	$0	$500	$500	$5,000



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STATE OF NEVADA

Current benefit structure w/ SaveonSP

SaveonSP copay: $1,000
DED/MOOP are out of scope for SaveonSP claims

Plan pays *(+ a shared savings fee to SaveonSP)*	Copay Assistance Pays	Member Pays	Member's deductible	OOP Max	Total Cost
1st Fill – $5,000 drug; manufacturer will pay up to $1,000/claim for 12 claims/year					
$4,000	$1,000	$0	N/A	N/A	$5,000
2nd Fill					
$4,000	$1,000	$0	N/A	N/A	$5,000
3rd Fill					
$4,000	$1,000	$0	N/A	N/A	$5,000
4th Fill					
$4,000	$1,000	$0	N/A	N/A	$5,000
5th Fill					
$4,000	$1,000	$0	N/A	N/A	$5,000

Because the SaveonSP drugs are non-essential health benefits, the claims adjudicate with a *copay only* (no DED/MOOP); the member continues to max out the copay assistance throughout the plan year regardless of whether they hit their DED/MOOP through other means

EXPRESS SCRIPTS® CHAMPIONS FOR BETTER™

SAVEONSP

SaveonSP savings

About the Program

- Utilizes Affordable Care Act (ACA) state benchmark to **change client plan design**
- Select drugs designated as **Non-Essential Health Benefits** as defined by Affordable Care Act
- Copays set to **maximize manufacturer assistance dollars**
- Targets **150+** specialty drugs in **19** therapy classes
- Reduces patient's responsibility to **zero**

Estimated Savings is $1.9M for Nevada PEBP (CDHP and EPO)

Sample Medications Covered

Highest Utilized Therapy Classes	Average Assistance/Fill
Hepatitis C	$7,500
Cystic Fibrosis	$2,300
Multiple Sclerosis	$2,000
Inflammatory	$1,666
Hemophilia	$1,666
Oncology	$1,250
Pulmonary Arterial Hypertension	$1,200
Blood Cell Deficiency	$1,000
Hereditary Angioedema	$1,000
Asthma & Allergy	$850

*Net of program shared savings fee. Savings may vary based on sponsor's actual utilization or a different benchmark or formulary. Savings do not represent any type of guarantee by SaveonSP or ESI.

EXPRESS SCRIPTS® CHAMPIONS FOR BETTER™

SAVEONSP

CDHP and EPO Savings

CLIENT SUMMARY

- **51.6 K** total lives
- **481** members benefiting
- **3,760** impacted claims
- **$1,267** average member copay per rx

BENEFIT FOR PATIENTS AND THE CLIENT

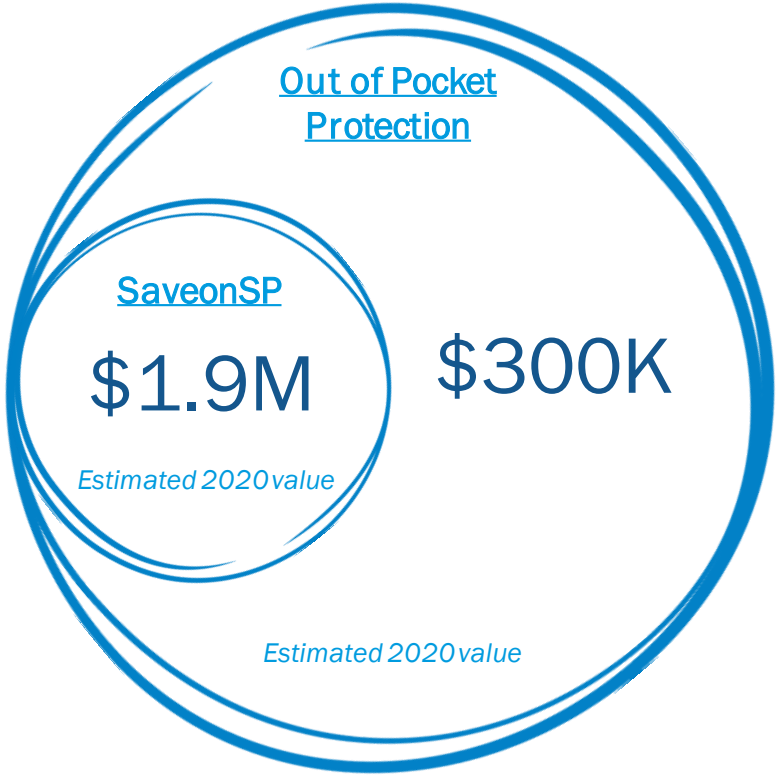
- **$1.9 M** annual plan savings *
- **$3.14** PMPM client savings*
- **$0** remaining member cost

Every month you lose $162,046 without SaveonSP setup

*Net of program shared savings fee. Savings based on sponsor's utilization, the most restrictive state benchmark and ESI National Preferred, Basic and High Performance Formulary. Savings may vary based on sponsor's actual utilization or a different benchmark or formulary. Savings do not represent any type of guarantee by SaveonSP or ESI.

SAVEONSP & OOP PROTECTION

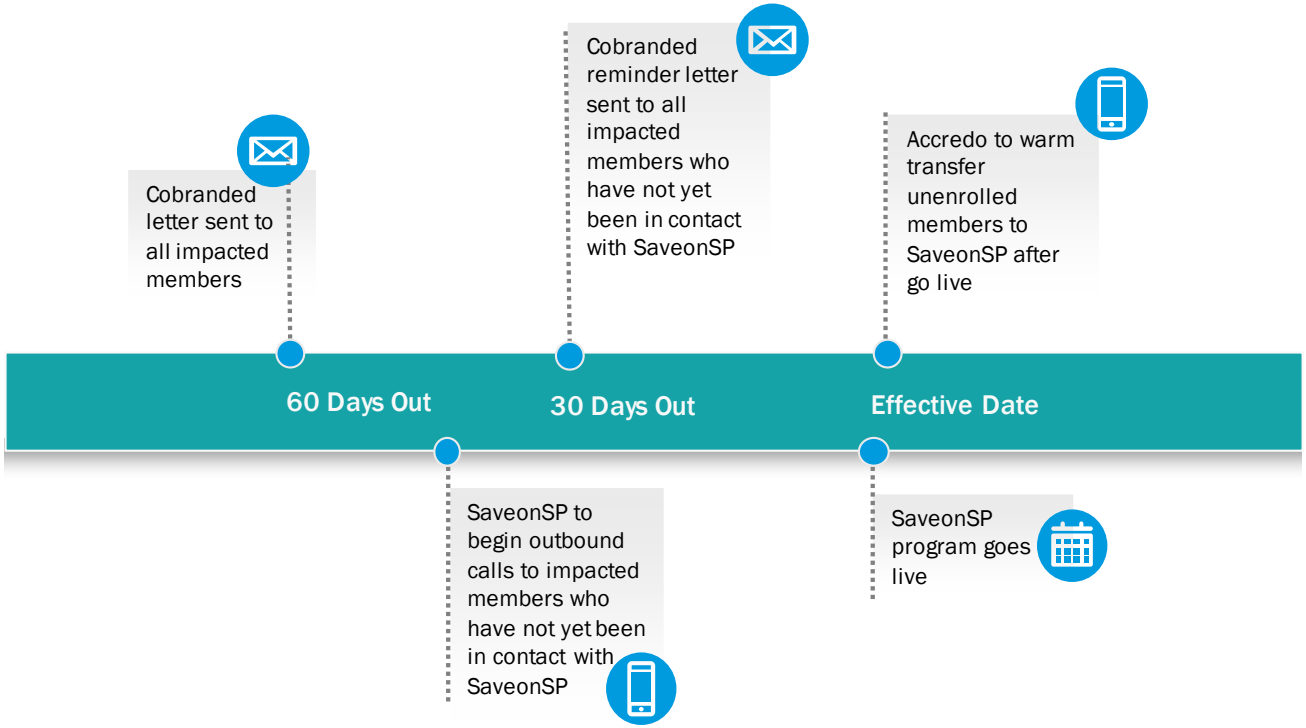
Product savings differentiation



Combined Estimated Product Value of
$2.2M

SAVEONSP

Member communication timeline



ATTACHMENT B

The following report was presented as part of Agenda Item XI to the Board at the November 29, 2018 Board meeting.

Disallow Patient Assistance from Applying to Accumulators

PEBP and Express Scripts performed initial analysis on implementing a copay accumulator program to control specialty drug costs. This program is not new and many large employers have implemented it across the nation.

To simplify the program, a copay "accumulator" recognizes when an employee uses a drug maker discount card and makes sure that money does not apply toward their annual out-of-pocket spending requirement. When the copay card runs out of money, a patient must either cover the Plan Year 2020 Plan Benefit Design November 29, 2018 Page 3 full copay cost, get a new discount card, or stop filling the prescription. The program can apply to almost any drug coupon used at a pharmacy working with the pharmacy benefit manager. Estimates show there are more than 41 million Americans in plans that use an accumulator. A recent article in U.S. News describes how two large companies (Walmart and Home Depot) are adopting these programs moving forward. (https://money.usnews.com/investing/news/articles/2018-11-13/walmart-home-depot-adopthealth-insurer-tactic-in-drug-copay-battle)

PEBP had numerous conversations with both our Third Party Administrator (HealthSCOPE Benefits) and Pharmacy Benefits Manager (Express Scripts), and we concur there is significant money available by the drug manufacturers that is being left on the table because of our lower out-of-pocket maximums. Pharmacy manufacturers set drug prices accounting for copay accumulator programs like this and therefore PEBP and its members are effectively paying more for these drugs than we should.

Unfortunately, there is no way today to develop a cost savings amount as changes to copay assist cards and coupons will most assuredly change between now and July 1, 2019 when this program can go live. Savvy drug manufacturers can and will circumvent these types of programs, but doing nothing ensures PEBP pays too much for these high cost drugs.

PEBP Recommendation: PEBP believes we can no longer sit by and allow the plan, the members, and the Nevada taxpayer pay more for high cost drugs than most employers with these programs allow. Therefore we recommend implementing a copay accumulator program next year. If approved, PEBP will come back to the plan in March with some current savings numbers and address additional opportunities for excess reserve expenditures to offset those savings at that time. Smart90 Mandatory Network Express Scripts (ESI) is recommending Smart90 Mandatory Network for the State of Nevada

Approved by PEBP Board on November 29, 2018. Implemented on July 1, 2019.

8.

8. Discussion and possible action of Bill Draft Request (BDR) to address changes to NRS 287.0475 (Laura Rich, Executive Officer) (**For Possible Action**)

STEVE SISOLAK
Governor

LAURA FREED
Board Chair

STATE OF NEVADA
PUBLIC EMPLOYEES' BENEFITS PROGRAM
901 S. Stewart Street, Suite 1001 | Carson City, Nevada 89701
Telephone 775-684-7000 | 1-800-326-5496 | Fax 775-684-7028
www.pebp.state.nv.us

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CORE
Expires 04/01/2021

LAURA RICH
Executive Officer

AGENDA ITEM

[X] Action Item
[ ] Information Only

Date: March 31, 2020

Item Number: VIII

Title: Bill Draft Request to amend NRS 287.0475

BACKGROUND

Prior to November 30, 2008, local governmental retirees were eligible to join the Public Employees' Benefits Program (PEBP) regardless of their former employer's participation in the program. However, Senate Bill 544 of the 2007 legislative session amended PEBP's eligibility provisions by disallowing retirees of local governments to join PEBP if the local government that employed the retiree did not participate in the program. NAC 287.095 defines who is eligible to participate in PEBP and incorporates those members who were grandfathered into the program on November 30, 2008. Currently, PEBP has 8 active non-state local government employees and 6,133 non-state retirees which are primarily the non-state population grandfathered into the plan on November 30, 2008.

As of 2011, PEBP requires (with some exceptions) Medicare eligible retirees to participate on the Medicare Exchange by enrolling in a plan directly through Via Benefits. Retirees enrolled through Via Benefits receive a years-of-service subsidy which is provided in the form of a monthly Health Reimbursement Account (HRA) contribution. Retiree's may be eligible for up to $240/month which can be used to reimburse eligible medical expenses and Medicare plan or dental plan premiums. If a retiree fails to enroll in a plan through Via Benefits or disenrolls from a plan through Via Benefits, they are terminated from the program.

REPORT

NON-STATE RETIREE DISENROLLMENT

NRS 287.0475 addresses the reinstatement of insurance by a retired public officer, employee or surviving spouse. The statute as it currently reads allows retirees from a participating state

agency or local government to reinstate coverage if they have no more than one period not covered under the program. This allows retirees from the state and participating local governments one opportunity to return to the program as "late enrollees" during open enrollment should they disenroll. It does not, however provide the same opportunity to the majority of non-state retirees.

Since 2011, numerous state and non-state Medicare Exchange retirees have been affected by this rule and many non-state retirees have permanently lost their benefits. Retirees enrolled through Via Benefits have the opportunity every year to change plans during the Medicare Open Enrollment period. It is usually during this period that retirees mistakenly enroll directly through the carrier which results in an agent of record change. Once the agent of record is changed, the retiree is no longer covered in a medical plan through Via Benefits. In other cases, Medicare plans are discontinued and retirees are required to choose a new plan. If the retiree fails to actively choose another plan, the carrier (per insurance regulations) is required to crosswalk those individuals on to a comparable plan. Similarly, this results in an agent of record change away from Via Benefits and to the new carrier - in this case, the retiree may be completely unaware that this is occurring.

In both of the cases described above retirees are no longer considered enrolled in a medical plan through Via Benefits and are subsequently disenrolled from the program and terminated by PEBP. It is not until they receive termination notices from PEBP that they begin to realize the consequences of their actions. Recognizing this, PEBP includes language stressing the importance of making any plan changes through Via Benefits in all retiree guides, resources and trainings. Additionally, PEBP sends reminder notices prior to each Medicare open enrollment period and has also engaged in aggressive communications to those who have been identified as participating in a plan which is set to expire. Unfortunately, there are always retirees who disenroll and end up losing their HRA subsidy. State retirees can mitigate the damage by reinstating during PEBP Open Enrollment as "late enrollees" but non-state retirees lose their ability to participate in the program, and their HRA subsidies, permanently.

Based on enrollment data, PEBP estimates that approximately 750 non-state retirees have disenrolled from the plan in this manner and lost their HRA subsidies since 2011.

PEBP believes it is reasonable to provide non-state retirees the same opportunity state retirees are offered to reinstate their Medicare Exchange plan. This change does not have a budgetary impact to PEBP since HRA subsidies are funded by the local governments.

Since this is a statutory change, it requires a Bill Draft Request (BDR) submission. The deadline to submit a non-budgetary BDR is May 20th. PEBP has coordinated with our Deputy Attorney General to include preliminary language that adds non-state retirees from a non-participating agency to the statute. The language also specifically captures those who are eligible for the Medicare Exchange:

NRS 287.0475 Reinstatement of insurance by retired public officer or employee or surviving spouse.

1. Except as otherwise provided in subsection 3, a retired public officer or employee or the surviving spouse of a retired public officer or employee who is deceased may reinstate any insurance under the Program, except life insurance, that, at the time of reinstatement, is provided by the Program if the retired public officer or employee:

(a) Retired:

(1) Pursuant to NRS 1A.350 or 1A.480, or 286.510 or 286.620, from a participating state agency or was enrolled in a retirement program provided pursuant to NRS 286.802; or

(2) Pursuant to NRS 1A.350 or 1A.480, or 286.510 or 286.620, from employment with a county, school district, municipal corporation, political subdivision, public corporation or other local governmental agency of the State which is a participating local governmental agency at the time of the request for reinstatement; or

(3) Pursuant to NRS 1A.350 or 1A.480, or 286.510 or 286.620, from employment with a county, school district, municipal corporation, political subdivision, public corporation or other local governmental agency of the State which is not a participating public agency and:

(I) Was enrolled in the Program as a retiree on November 30, 2008; and

(II) Is enrolled in Medicare Part A, as established pursuant to Title XVIII of the Social Security Act, 42 U.S.C. §§ 1395c et seq., and Medicare Part B, as established pursuant to Title VVIII of the Social Security Act, 42 U.S.C. §§ 1395j et seq.; and

(b) Did not have more than one period during which the retired public officer or employee was not covered by insurance under the Program on or after October 1, 2011, or on or after the date of retirement of the public officer or employee, whichever is later.

2. Reinstatement pursuant to subsection 1 must be requested by:

(a) Giving written notice to the Program of the intent of the public officer or employee or surviving spouse to reinstate the insurance not later than 31 days before the commencement of the plan year;

(b) Accepting the Program's current plan of insurance and any subsequent changes thereto; and

(c) Except as otherwise provided in NRS 287.046, paying any portion of the premiums or contributions for coverage under the Program, in the manner set forth in NRS 1A.470 or 286.615, which are due from the date of reinstatement and not paid by the public employer.

3. If a retired public officer or employee retired pursuant to NRS 1A.350 or 1A.480, or 286.510 or 286.620, from employment with a county, school district, municipal corporation, political subdivision, public corporation or other local governmental agency, the retired public officer or employee, or the surviving spouse of such a retired public officer or employee who is deceased, may not reinstate health insurance pursuant to subsection 1 if he or she is excluded from participation in the Program pursuant to sub-subparagraph (III) of subparagraph (2) of paragraph (h) of subsection 2 of NRS 287.043.

(Added to NRS by 1987, 503; A 1993, 482; 1999, 3037; 2001 Special Session, 98; 2003, 2740, 3256, 3271; 2007, 2880; 2009, 1593, 2358; 2011, 536, 2745

PEBP Recommendation: PEBP recommends the approval of the Bill Draft Request and approval for staff to submit by the May 20, 2020 deadline.

9.

9. Discussion and possible action to include the approval of Plan Year 2021 (July 1, 2020 – June 30, 2021) rates for state and non-state employees, retirees and dependents for the statewide Consumer Driven Health Plan (CDHP), the Southern Nevada Health Maintenance Organization (HMO) plan and the Northern and rural Exclusive Provider Organization (EPO) plan. (Laura Rich, Executive Officer) (**For Possible Action**)

PY20 Financial Outlook
PY21 Rates and
PEBP Board Considerations

March 31st, 2020 PEBP Board Meeting

Prepared by Aon
Health Solutions

Empower Results®

Today's Agenda

PEBP Financials

- Looking back
- Projected PY20 close
- PEBPs Population
- What does this mean?

PY21 Rates

- Methodology
- Base Rates
- Admin Fees
- HSA/HRA
- Overall Rates
- Premiums

Board Considerations

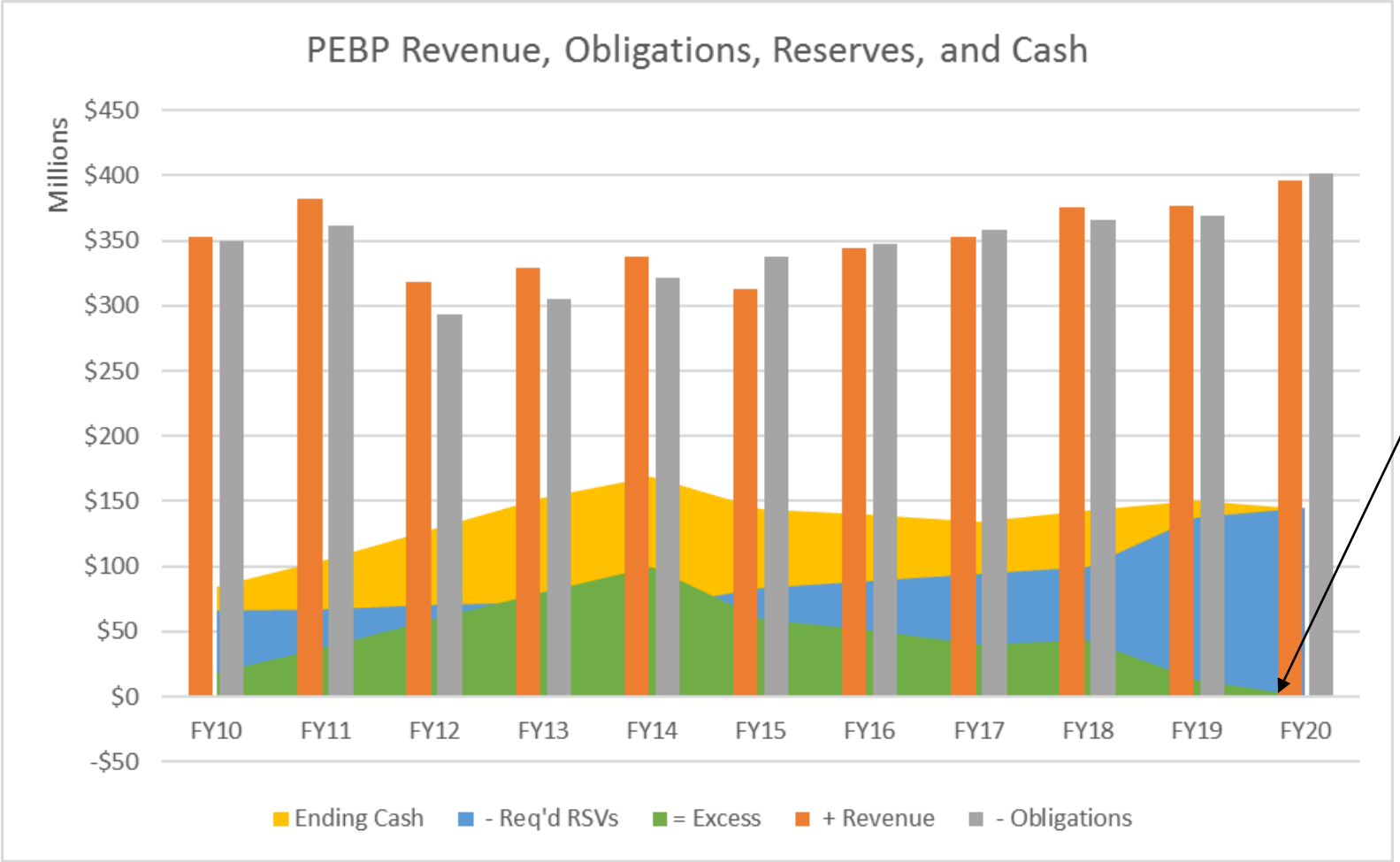
- Required Reserve Policies for IBNP
- Required Reserve Policies for Catastrophic

PEBP Financials

History of Revenues, Obligations, Reserves and Excess Cash

For each plan year:

Revenue minus Obligations = Ending Cash minus Required Reserves = Excess



PEBP's current best estimate of year end Excess for FY20 is between -$1M and $1M

Empower Results®

Required Reserves – FY10 to FY20

PEBP's "required" reserves have more than doubled in size over the past decade

HRA Reserve

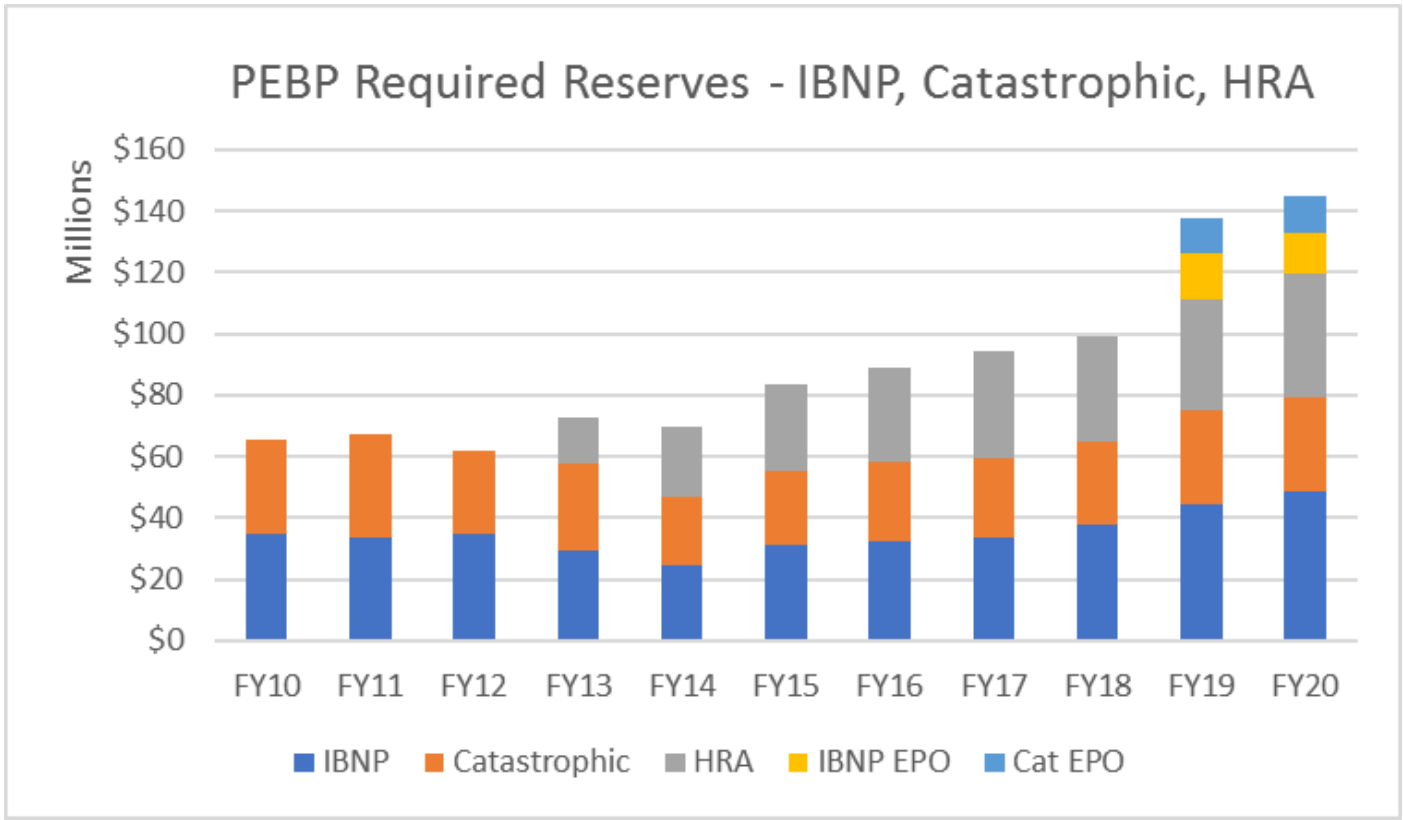
- The most notable increase comes in the HRA Reserve, which began at $15M in FY13
- Has grown 2.6x that amount to an estimated $40M by the end of FY20

IBNP Reserve

- Recent large claims in FY19 and FY20 have increased the IBNP Reserve as their slower speed to pay creates a longer lag
- The 95% confidence interval in periods of volatility results in a larger load

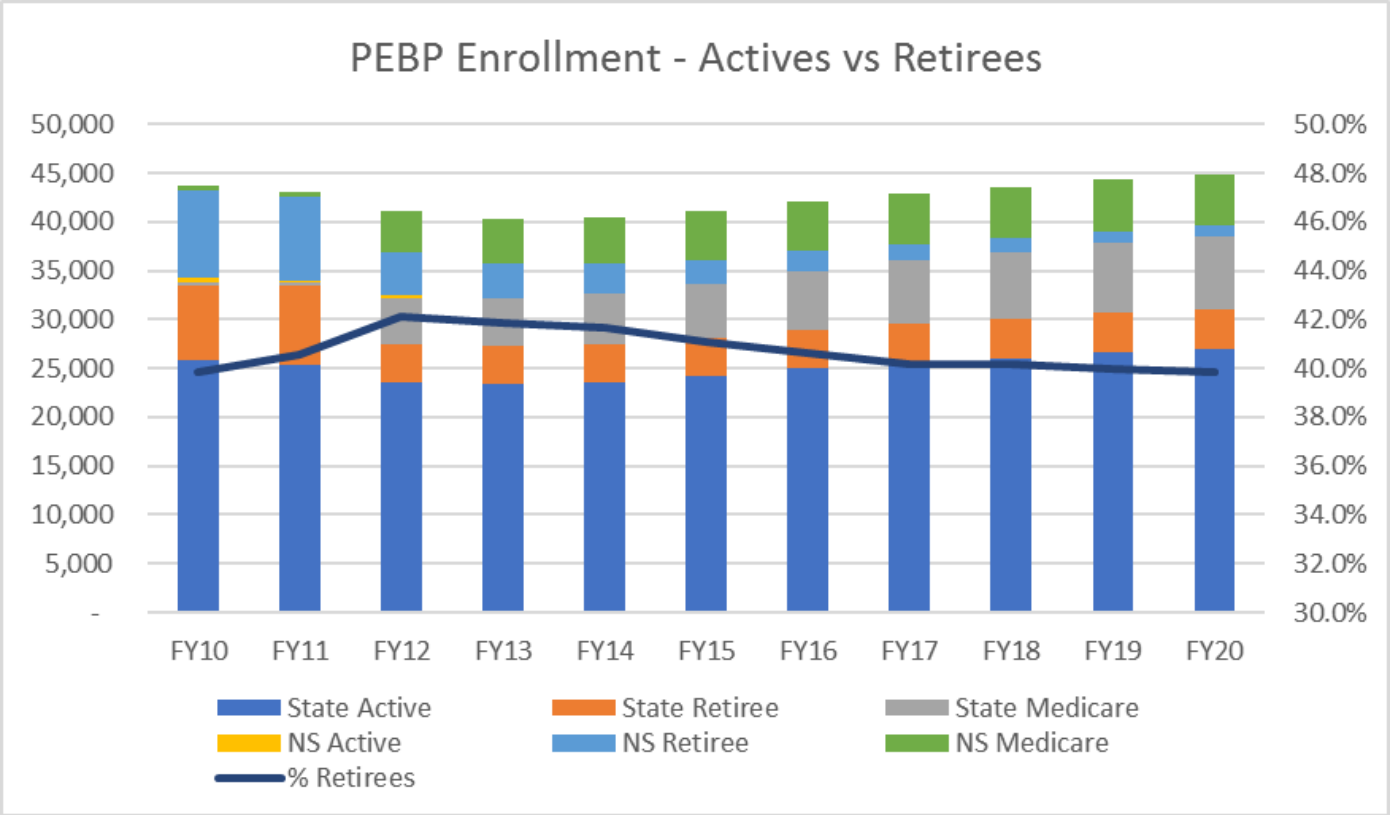
Premier Reserve

- Moving the HHP HMO plan to EPO self-funding in FY19 increased required reserves by $26M



Empower Results®

PEBP's Population Mix



PEBP's population as a whole has remained fairly stable – between 40k and 45k

Non-State participation has dropped from 23% of the population in FY10 to 14% in FY20

Retirees have consistently made up 39.8% to 42.1% of the population over the past decade

What Does this Mean?

For the first time in over a decade, as reserve policy exists today, PEBP will start PY21 with little to no excess reserve dollars

During the last budget cycle, the Legislature approved supplemental HSA/HRA funding for PY21, this funding was to come from excess reserves and is estimated to cost $3M

Due to the uncertainty of available excess reserves to begin PY21, PEBP is recommending a delay on funding this supplemental HSA/HRA amounts until January 2021 when a more clear assessment of available funding can be made

If current projections were indicating a shortfall of more than $1M in excess reserves, this shortfall amount should be added into the PY21 rates in order to get the plan and it's required reserves back to fully funded

Now may be a good time to revisit Board policy for each of it's Required Reserves:

IBNP (95% confidence interval, can this be lowered to 10% margin)

Catastrophic Reserves (95% confidence interval = 62 days on hand)

HRA Reserves (currently 100% funded and no cap on rollover amounts)

PY21 Rates

Rate Setting Methodology Refresher

Experience * Projected Trend = Base Rates

Base Rates + Administrative Costs + HSA/HRA Funding = Overall Rates

Overall Rates – Employer Contributions (Subsidy) = Member Share (Premiums)

Step 1

- Aon gathers claims data from PEBP vendors and conducts Pharmacy Market Check
- This year's market check resulted in a price decrease of 9%

Step 2

- Aon evaluates past experience and trends it forward to PY21, applies results of Pharmacy Market Check, to create Base Rates

Step 3

- PEBP Financial staff takes the Base Rates and adds on Administrative Fees as well as HSA/HRA loads to create Overall Rates

Step 4

- PEBP Financial staff applies Budget approved Employer Contributions from AEGIS/REGI to calculate Member Share (Premiums)

Base Rates – Comparing PY21 over PY20

	Medical/Rx	Dental	Total Change
State CDHP	9.6%	0.1%	8.8%
State EPO	13.8%	0.1%	13.1%
State HPN	7.0%	0.1%	6.6%
Non-State CDHP	-13.9%	0.5%	-13.4%
Non-State EPO	-1.4%	0.5%	-1.3%
Non-State HPN	7.0%	0.5%	6.6%

While Dental Experience has remained favorable to established base rates, Medical and Pharmacy Costs have not

HPN provided PEBP with a 7% renewal for PY21 as they too are seeing costs rise

Due to the shrinking size of the Non-State population, their experience is becoming far less credible and increasingly volatile, with the most recent experience being far more favorable than in years past

Per PEBP Board direction, we continue to set rates aggressively – with a 50% chance they will be sufficient to cover claims costs and a 50% chance they will be short

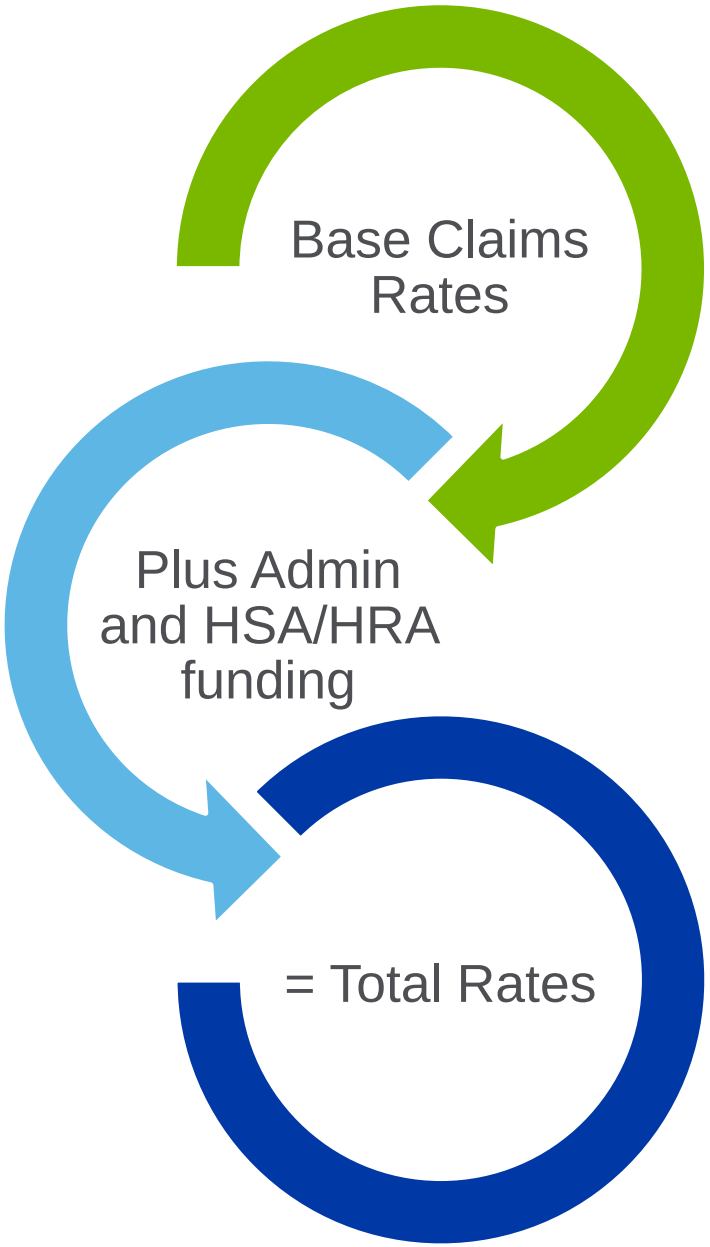
Administrative Fees and HSA/HRA Expense Loads

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

- Active CDHP = $40.51
- Active HMO = $41.32*
- Retiree CDHP = $19.48**
- Retiree HMO = $19.61

HSA/HRA Funding for Active and Retirees not on the WTW Exchange:

- $700 per Participant plus
- $200 per Dependent up to 3



*Pharmacy Rebates are subtracted from Admin fees for both self-funded plans, CDHP and EPO

**Retiree Admin Fees are lower than the Actives due to lower Life Insurance Premiums as well as the cost of LTD being added to the Actives

Overall Rates – Before Contributions and Premiums

State Employees		
Tier	CDHP	EPO/HMO
Employee Only	640.07	874.78
Employee + Spouse	1,197.96	1,708.24
Employee + Child(ren)	874.91	1,285.48
Employee + Family	1,432.79	2,118.94

State Retirees		
Tier	CDHP	EPO/HMO
Employee Only	619.04	853.07
Employee + Spouse	1,176.93	1,686.53
Employee + Child(ren)	853.88	1,263.77
Employee + Family	1,411.76	2,097.23

Non-State Retirees		
Tier	CDHP	EPO/HMO
Employee Only	1,059.18	810.86
Employee + Spouse	2,057.20	1,602.11
Employee + Child(ren)	1,721.45	1,258.69
Employee + Family	2,719.49	2,049.94

State Employee Premiums

State Active Employees	Statewide PPO			Statewide EPO/HMO		
	Consumer Driven Health Plan			PEBP EPO and HPN HMO		
Tier	PY20	PY21	Change	PY20	PY21	Change
Employee Only	30.95	47.38	16.43	137.47	169.73	32.26
Employee + Spouse	160.01	200.26	40.25	415.95	498.14	82.19
Employee + Child(ren)	82.97	111.74	28.77	275.84	331.56	55.72
Employee + Family	212.02	264.61	52.59	554.32	659.97	105.65

State/Non-State Retiree Premiums

State Active Employees	Statewide PPO			Statewide EPO/HMO		
	Consumer Driven Health Plan			PEBP EPO and HPN HMO		
Tier	PY20	PY21	Change	PY20	PY21	Change
Employee Only	203.33	226.43	23.10	362.56	414.41	51.85
Employee + Spouse	482.10	542.08	59.98	859.32	985.98	126.66
Employee + Child(ren)	315.68	359.30	43.61	609.39	696.06	86.67
Employee + Family	594.45	674.94	80.48	1,106.15	1,267.63	161.48

Board Considerations

Required Reserve Policy Considerations

IBNP: Per our presentation at the November 2019 board meeting, PEBP is one of the most conservative State entities in their approach to having a 95% confidence interval load on their IBNP

Consideration:

PEBP could move to a 10% margin load on their IBNP from the current 25% This would release **$7.04M** from the year end required reserves and give PEBP a cushion moving in to PY21, especially in light of COVID-19 and it's unknown impact on claims in the next 12-18

Catastrophic: Similarly to IBNP, PEBP is conservative in their approach to a 95% confidence interval for unknown claims (which currently equals about 62 days of claims on hand)

Consideration:

PEBP could move modestly to holding 60 days on hand

This would release an additional **$1.4M** into excess for PY21 and may be necessary to cover any shortfall that occurs at the end of PY20

If the PEBP Board wanted to get more aggressive, they could move to 50 days on hand which would release $8.4M from current levels. A full comparison chart of options is available in the Appendix.

Appendix—
Detailed Catastrophic Reserve Funding Options

Catastrophic Reserve Options

As a reminder, the **Catastrophic Reserve** is a separate and distinct fund from the catastrophic load on the IBNP and this fund is held at a 95% confidence interval

- IBNP reserve provides for claim dollars attributable to services incurred on or prior to a specific valuation date, and paid after that measurement date, with margins covering potential large claim amounts to be paid after the valuation date that were not known as of the valuation date
- Catastrophic reserve protects from unforeseen events that could cause a large increase in aggregate claim dollars paid by the Plan beyond actuarial forecasts

PEBP Projected June 30, 2020 Catastrophic Reserve Options

Plan	Current Method (Equivalent to 62 days of claims)	45 Days of Claims	50 Days of Claims	60 Days of Claims	75 Days of Claims
Premier	$12,200,000	$8,800,000	$9,800,000	$11,800,000	$14,700,000
HDHP	$31,000,000	$22,500,000	$25,000,000	$30,000,000	$37,500,000
Total	**$43,200,000**	**$31,300,000**	**$34,800,000**	**$41,800,000**	**$52,200,000**
$ Change from Current		*-$11,900,000*	*-$8,400,000*	*-$1,400,000*	*$9,000,000*
% Change from Current		*-28%*	*-19%*	*-3%*	*21%*

10.

10. Discussion and possible action of Legislative Counsel Bureau audit and corrective action plan. (Laura Rich, Executive Officer) (**For Possible Action**)

STEVE SISOLAK
Governor

LAURA FREED
Board Chair

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Expires 04/01/2021

LAURA RICH
Executive Officer

AGENDA ITEM

[X] Action Item
[ ] Information Only

Date: March 31, 2020

Item Number: X

Title: Legislative Counsel Bureau IT Audit – Corrective Action Plan

SUMMARY

In January 2019, PEBP was notified by the Legislative Counsel Bureau (LCB) Audit Division that it would be performing an Information Technology and Security audit of the agency. Throughout the year, PEBP staff have been working diligently to assist the auditors and have collected all requested data and information required by the auditors to perform this function. On January 9, 2020, the LCB provided the agency with an initial draft of the final findings to which PEBP was required to submit a written response indicating acceptance or disagreement.

The report indicates PEBP's need to strengthen information system controls to better protect its physical resources, minimize security vulnerabilities and ensure continuation of critical services. PEBP accepted all 14 findings and provided an initial plan on how the agency intended to rectify the deficiencies identified in the report.

The findings and associated responses were presented to and accepted by the Legislative Commission's Audit Subcommittee on February 18, 2020. PEBP must provide an initial 60-day corrective action plan followed by a subsequent six-month status report due at a later date.

REPORT

See Attachment A

STEVE SISOLAK
Governor

LAURA FREED
Board Chair

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LAURA RICH
Executive Officer

March 31, 2020

Daniel L. Crossman, CPA
Legislative Council Bureau
Legislative Building
401. S. Carson Street
Carson City, NV 89701

Dear Mr. Crossman,

Thank you for the information provided in your audit report dated January 9, 2020 and the opportunity to present on PEBP's responses to the Legislative Audit Subcommittee on February 18, 2020. We appreciate the Legislative Council Bureau's professionalism during this audit process and believe the audit was a valuable experience for PEBP.

Attached is PEBP's initial response to the audit recommendations, indicating PEBP's acceptance of the recommendations as well as the updates to actions that have been taken since.

Thank you again for the recommendations to improve the Public Employee Benefits Program's IT operations and security.

Sincerely,

Laura Rich, Executive Officer
Public Employee Benefits Program

Recommendation 1: Obtain additional training to utilize the full capabilities of the OS and anti-virus management applications to improve computer administration.

Response: PEBP accepts this recommendation.
PEBP is addressing this recommendation by implementing new policies and procedures that include: Moving hardware to an EITS facility; utilizing a tool named Smartsheet that will allow us to document procedures, create reminders & forms, while also providing an audit trail. Additionally, PEBP will utilize the tools provided by EITS including Altiris (patches/updates management), SEP (virus definitions management) and Nagios (monitor servers and network). The new tools will improve our IT operations and resolve anti-virus, patching and computer administration issues.

Recommendation Update:
PEBP plans to finalize the hardware migration to EITS and utilize their tools (Altiris, SEP and Nagios) on servers and desktops to produce scheduled reports that will ensure proper patching and system administration. PEBP has purchased and installed software (Smartsheet) which will allow PEBP to document, track and ensure these procedures are being followed and provide an audit trail.

Recommendation 2: Develop procedures to routinely detect and correct failed computer OS and anti-virus update installations.

Response: PEBP accepts this recommendation.
As stated in the response to recommendation 1, PEBP will utilize Smartsheet and the tools provided by EITS (Altiris, SEP and Nagios) to monitor and install operating system updates and anti-virus file definitions. We will develop procedures/routines to monitor monthly/quarterly.

Recommendation Update:
PEBP has started using the tools stated in recommendation 1 and is in the process of building reports, procedures and routines to monitor and ensure proper patching and updates are performed.

Recommendation 3: Install and configure encryption software on laptops.

Response: PEBP accepts this recommendation.
PEBP has enabled and is currently using BitLocker encryption software on all Laptops. This process will be added to PEBP's inventory spreadsheet and checklist to ensure BitLocker is enabled on all laptops moving forward.

Recommendation Update:
PEBP has and installed and configured BitLocker encryption software on all laptops. All new laptops will have BitLocker enabled/installed and utilized.

Recommendation 4: Update existing policies and procedures to ensure MDA's are signed and kept on file.

Response: PEBP accepts this recommendation.
PEBP will maintain Mobile device agreements for all state staff that use (handheld) mobile devices (smartphones/tablets) on the state network and/or store state data. These agreements will be scanned and kept on a network drive and included as part of the onboarding and offboarding process.

Recommendation Update:
PEBP has ensured all signed mobile device agreements are stored in the appropriate network folder. This will be added to the employee onboarding and offboarding process and will be reflected in PEBP's Personnel Security Policy.

Recommendation 5: Modify the overwrite settings on the multifunction device to ensure the data is adequately erased.

Response: PEBP accepts this recommendation.
PEBP has altered the settings in the multifunction device (HP LaserJet flow MFP M830) to comply with the finding.

Recommendation Update:
The Multifunction device was updated accordingly to comply with the finding.

Recommendation 6: Review the existing multifunction device (HP LaserJet flow MFP M830) configurations and determine a viable method to manage faxes

Response: PEBP accepts this recommendation.
PEBP is in the process of researching a viable method to manage faxes through a standalone fax machine in a secure room or cabinet only accessible to authorized staff. PEBP will be retiring the fax server and not forwarding faxes from the MFP.

Recommendation Update:
PEBP has purchased and installed a secure cabinet and a standalone fax machine that is only accessible by authorized staff. PEBP has requested EITS Telecom staff move existing fax lines to ensure we fully satisfy and comply with this recommendation.

Recommendation 7: Periodically review the multifunction for firmware and software updates.

Response: PEBP accepts this recommendation.
PEBP has updated the firmware on the multi-function device (HP LaserJet flow MFP M830) to the latest version and will schedule quarterly reviews on the firmware to check for updates. Reviews will be scheduled using Smartsheet.

Recommendation Update:
PEBP has updated the firmware on all MFD's and printers in the office and will utilize Smartsheet to create reminders to check for future firmware updates.

Recommendation 8: Configure encryption on the wireless access point.

Response: PEBP accepts this recommendation.
PEBP will complete a factory reset on the wireless access point and perform a new installation that includes encryption.

Recommendation Update:
This will be completed by March 31, 2020.

Recommendation 9: Develop policies and procedures to ensure quarterly review of 1) network user and service accounts; 2) critical business applications user access' 3) accounts within the building access system.

Response: PEBP accepts this recommendation.

1. Network user and service accounts have moved over to EITS on to a child domain. By utilizing Smartsheet PEBP will schedule quarterly reviews of accounts using reminders and onboarding/offboarding forms that confirm the tasks have been completed and establishes an audit trail.
2. Critical business application user access (Call Copy, 1099 Pro and Ariel) will also be addressed utilizing Smartsheet by scheduling and tracking quarterly reviews of accounts.
3. Building access will also be addressed and tracked utilizing Smartsheet. PEBP will setup reminders and schedule monthly reviews. This will also be included in the onboarding/offboarding process.

Recommendation Update:
PEBP is in the process of creating work flow reminders and forms in Smartsheet to facilitate scheduled reviews of Active Directory accounts, network service accounts, critical business applications, as well as managing the onboarding/offboarding process.

Recommendation 10: Follow the establish procedure for revoking system access by disabling accounts immediately upon termination or change of responsibilities of an employee or contractor.

Response: PEBP accepts this recommendation.
This will be added to the offboarding and employee change procedures referred in the response to recommendation 9. Once an employee is terminated it will trigger the offboarding process and the disabling of the building access. If an employee moves to a different group within PEBP then we will have a form generated that will explain any building access changes. Additionally, PEBP will be requesting proper system training from EITS to ensure responsible staff have a better understanding of the system.

Recommendation Update:
This will be included as part of the offboarding process and will be formalized by utilizing Smartsheet. A separate formal process will be established to address staff who move between groups within the agency. PEBP will request and schedule training from EITS staff to ensure responsible staff have a complete understanding of the system.

Recommendation 11: Enhance the existing process to ensure IT contractors with access to PEBP's systems have background checks.

Response: PEBP accepts this recommendation.
PEBP will establish a process to ensure applicable vendor and contractor staff with access to PEBP data undergo appropriate background checks. This will also be tracked through the Smartsheet tool.

Recommendation Update:
PEBP will perform background checks on all applicable vendor and contractor staff with access to PEBP data. Applicable vendor and contractor staff as defined per NRS 239B and the State of NV

Information Security Committee Standard S.3.04.01 "Personnel Security". PEBP has contacted the Division of Human Resource Management for guidance on this matter.

Recommendation 12: Update existing policy to define roles and responsibilities of individuals to monitor and ensure all employees, consultants and IT contractors take the initial and annual security awareness training.

Response: PEBP accepts this recommendation.
PEBP will modify its existing policy to define the roles and responsibilities of individuals tasked with the responsibility of ensuring all employees, consultants and contractors meet the initial and annual security awareness training requirements. To aid in this process, PEBP will be using Smartsheet to facilitate tracking.

Recommendation Update:
PEBP's Executive Assistant is currently responsible for tracking this information using an Excel spreadsheet. This will be upgraded to utilize Smartsheet with automated reminders to track annual training and be part of the onboarding process for the initial training.

Recommendation 13: Ensure the systems recovery and business continuity plan is reviewed and kept up to date at least annually

Response: PEBP accepts this recommendation.
PEBP will review and update the existing Disaster Recovery and Business Continuity plans to ensure the plans are updated annually, this will also be an activity tracked using Smartsheet.

Recommendation Update:
PEBP is in the process of reviewing and updating the Disaster Recovery and Business Continuity plans that will include semiannual testing.

Recommendation 14: Update existing policies and procedures to define scheduling, testing and documenting of the recovery processes at least semiannually.

Response: PEBP accepts this recommendation.
PEBP will update existing policies and procedures to reflect PEBP's recent transition to EITS. Additionally, the semiannual testing and documenting will be scheduled and tracked with Smartsheet.

Recommendation Update:
As mentioned in recommendation 13, PEBP will schedule, test, document and update the Disaster Recovery and Business Continuity Plans at least semiannually. This will be tracked in Smartsheet.

11.

11. Executive Officer Report (Laura Rich, Executive Officer) (**For Possible Action**)

STEVE SISOLAK
Governor

LAURA FREED
Board Chair

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LAURA RICH
Executive Officer

AGENDA ITEM

☐ Action Item
☒ Information Only

Date: March 31, 2020

Item Number: XI

Title: Executive Officer Report

SUMMARY

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

REPORT

COVID-19 RELATED WORKFORCE AND STAFFING CHANGES

On March 14th, Governor Sisolak held a press briefing which outlined a series of directives related to our state executive branch workforce. He announced that all state offices would be making every attempt to wind down in-person public services and would transition to online and over-the-phone services. Additionally, the Governor issued a hiring freeze effective immediately. With the exception of certain identified positions, executive branch positions (both classified and unclassified) will not be filled until further notice.

Recognizing that each agency faces its own unique challenges, the Governor's Office also issued additional guidance to executive branch agencies and delegated the authority to each agency heads to decide what works best for their organization. In response, PEBP took the following measures to ensure the health of our employees while continuing to be able to meet the critical functions of the agency:

- Instituted work from home for many employees
- Granted Administrative leave to employees determined to be high risk or those experiencing hardship due to school closures
- Cancelled all in-person meetings, training and travel

- Employees that cannot perform their duties remotely have been assigned rotating days to perform their essential job functions. No more than 6 staff are present on any given day and workstations and other surfaces are disinfected daily. The reduced on-site staffing accomplishes practical social distancing strategies while still ensuring essential agency functions are being carried out.
- Changes to call center:
    - Eliminated walk-ins
    - Reduced staffing from 10 call center staff to 2-3. Rotating staff and granting admin leave to those employees not scheduled to work.
    - Call greeting encourages members to send in questions and requests through their member portal account. Assigned call center staff working remotely from home are easily able to respond to member communication.

The hiring freeze will have a significant affect on PEBP. Currently, we have 6 of the 34 positions at PEBP vacant; three in the call center (including a front desk receptionist), an Admin Assistant in eligibility, a Management Analyst in operations and a Health Program Officer in Quality Control. Luckily, the Operations Officer and IT Professional positions were filled prior to the hiring freeze going into effect.

PEBP is also in the process of reassessing Open Enrollment meetings that are held every year prior to open enrollment. This year, it is very likely that these meetings will be held via webinar. Retiree meetings and other in-person trainings have also been cancelled and will be transitioned to webinars as well.

TRANSITION TO PAPERLESS

On March 2nd, PEBP launched a new Agency Representative portal. This portal allows agency HR representatives to submit their employee information electronically to PEBP by logging on to an online portal. In the past, agencies have had to submit original barcoded forms to PEBP by mail, so this process is not only expected to be more efficient for the agency HR representatives, but it also reduces the workload on PEBP staff and decreases the amount of time it takes for new hires to get access to their own PEBP account.

CONCLUSION

PEBP will certainly be facing some unprecedented challenges in the wake of the COVID-19 crisis. There are many unknowns in these early stages but PEBP will be carefully monitoring the effects to the program and to the State.

12.

12. Public Comment

13.

13. Adjournment