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Legislative Commission
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We have completed an audit of the Public Employees' Benefits Program. This audit is part of the ongoing program of the Legislative Auditor as authorized by the Legislative Commission. The purpose of legislative audits is to improve state government by providing the Legislature, state officials, and Nevada citizens with independent and reliable information about the operations of state agencies, programs, activities, and functions. The results of our audit, including findings, conclusions, recommendations, and the agency's response, are presented in this report.

We wish to express our appreciation to the management and staff of the Public Employees' Benefits Program for their assistance during the audit.

Respectfully presented,

Paul V. Townsend, CPA
Legislative Auditor

September 6, 2006
Carson City, Nevada

STATE OF NEVADA
PUBLIC EMPLOYEES' BENEFITS PROGRAM

AUDIT REPORT

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PUBLIC EMPLOYEES' BENEFITS PROGRAM

Background

The Public Employees' Benefits Program (PEBP) was established in 1999 to manage the state's group health insurance program. Its mission, in part, is to design and manage a quality health care program for public employees and retirees of the State of Nevada and other participating public agencies. These agencies include the Nevada System of Higher Education, local governments, and school districts. The program provides health, dental, vision, and life insurance to state and non-state employees, retirees, and their covered dependents.

A nine-member board oversees PEBP's operations. The Board appoints an Executive Officer to direct the day-to-day operations. In fiscal year 2006 PEPB had 32 authorized positions.

Primary funding sources include state and local government contributions and participant premiums. Funding is primarily used for medical expenses, either through Health Maintenance Organization (HMO) premium payments or self-funded claims costs. Expenses for fiscal year 2005 totaled $197 million.

Purpose

The purpose of this audit was to evaluate the effectiveness of PEBP's strategic planning process. We also determined if PEBP's management information is reliable and accurate, and evaluated the adequacy of its contracting practices. Our audit focused on strategic planning, management information, and contracting practices during fiscal years 2005 and 2006.

Results in Brief

The Public Employees' Benefits Program (PEBP) needs to improve its strategic planning. More effective planning would help to address current and future health insurance issues facing employees and retirees. This would include developing consistent methods for setting premium rates and encouraging utilization of preventative services. Although PEBP has taken some steps to improve planning, its strategic plan was not fully developed and was missing several planning elements.

PEBP can improve its reporting of information. During our audit, we identified certain instances where reliable and consistent information was not provided to the Legislature. In addition, some claims information reported by PEBP and its vendors was not always accurate. Although PEBP has strengthened controls over information since our last audit, more work is needed to ensure representations and reports are reliable.

Although PEBP has improved its contracting practices, additional improvements can be made. The process for evaluating proposals contains weaknesses which contribute to inconsistent scoring and could impact vendor selection. In addition, evaluation committee's scores are not part of the final process for selecting vendors.

Principal Findings

- In preparation for plan year 2006 PEBP made several changes that significantly increased Medicare retiree costs. First, PEBP began commingling the claims costs of all state employees and retirees which resulted in the same monthly premium for both Medicare retirees (age 65 and over) and early retirees (under age 65). Second, PEBP adjusted the state

subsidy resulting in the State paying a smaller percentage of Medicare retirees' monthly premium. Third, PEBP decreased the amount it pays on retiree medical claims after Medicare paid, increasing the retirees out-of-pocket costs. (page 11)

- Commingling and adjusting the state subsidy allocation resulted in a significant increase in Medicare retirees' monthly premiums beginning in plan year 2006. For example, from 2004 to 2006 the monthly premium for retiree + spouse coverage increased from $178.91 to $478.72, an increase of 168%. (page 11)

- In plan year 2006, PEBP decreased the amount it would pay on medical claims for Medicare retirees. This decrease occurred because PEBP switched methods for determining the portion of the claim it would pay. For example, on a $1,000 medical claim after deductibles are met, a Medicare retiree's out-of-pocket cost increased from $40 to $200. (page 13)

- Several actions were taken to mitigate Medicare retirees' premium increases. First, PEBP decided to provide Medicare retirees with a monthly check. In 2006 Medicare retirees received a monthly check for $70.80. Second, several reductions to the Medicare retirees' monthly premium were implemented. These include a rate reduction from prescription drug usage and a reduction for groups most impacted by commingling. (page 14)

- Better planning could have resulted in a less confusing process for determining retiree rates. Although PEBP knew in 2001 that commingling could result in problems, sufficient efforts were not made to meet with stakeholders and resolve this issue. Meetings with retirees, legislators, and other stakeholders could have resulted in a better solution to the commingling issue prior to the 2005 Legislative Session. (page 16)

EXECUTIVE SUMMARY

PUBLIC EMPLOYEES' BENEFITS PROGRAM

- Although PEBP used predictive modeling to develop premium rates for plan years 2005 and 2006, it was not used when setting rates for each tier in 2007. Predictive modeling is a state-of-the-art methodology designed to set rates for the next plan year using age, gender, claims information, and other factors to predict health care costs. Predictive modeling was not used in 2007 because the rate increase for one group was higher than the other tiers. However, PEBP did not analyze claims data to determine the accuracy of predictive modeling for each tier. Therefore, if predictive modeling is accurate, premium rates for each tier may fluctuate significantly if PEBP decides to use predictive modeling in future years. (page 17)

- Improved planning could help increase participant's awareness and utilization of wellness programs. PEBP has several wellness programs such as medical screenings and annual wellness fairs. These programs are designed to encourage participants to seek preventative care and maintain good health, and indirectly save the program money. However, these programs were not adequately publicized and utilization has not increased. (page 19)

- PEBP's recently approved strategic plan contains several weaknesses. The plan does not address key areas such as providing catastrophic care or wellness activities, lacks objectives and strategies to help ensure goals are achieved, and lacks valid benchmarks to help assess progress at attaining goals. In addition, the plan does not include timeframes to accomplish goals and performance targets. (page 20)

- PEBP could not provide documentation to support its representations about Medicare retirees' prescription drug usage during the 2005 Legislative Session. When discussing commingling issues, PEBP stated Medicare retirees, on average, use more prescription drugs than early retirees and employees combined. However, our review of information from PEBP's

pharmacy vendor indicates Medicare retirees' prescription drug usage was overstated, accounting for only about one-third of prescription costs. (page 23)

- PEBP could not support information reported to the 2005 Legislature on the cost to fully coordinate Medicare retirees' benefits. Management represented that implementing full coordination of benefits for Medicare retirees would cost $12 to $18 million annually. However, a recent estimate by PEBP's consultant suggests the cost reported to the Legislature was overstated. In February 2006, the cost to fully coordinate benefits was estimated to be about $9.9 million for plan year 2007. (page 24)

- PEBP provided inaccurate information on the percentage of costs paid by employers and participants. Employer costs paid through state and local government contributions were understated. In November 2005, PEBP reported to the Legislative Commission that self-funded plan employers paid about 58% of total health care costs in 2005. However, we found employers paid 63% of health costs in 2005. In addition, the State paid 67% of health costs for its employees and retirees. Therefore, the program is more beneficial for participants than PEBP's information indicated. (page 25)

- PEBP and its consultant improperly reported Medicare Part B reimbursement checks paid to retirees as medical claims. We estimate for fiscal year 2006 these payments will overstate the number of claims by 65,500 and claims costs by $4.4 million. Medicare Part B reimbursement checks and associated costs should be identified separately so trends for actual medical claims and costs are clear. (page 26)

- Although contracting practices have improved since our last audit, additional improvements can be made. The process for evaluating vendor proposals contains weaknesses. For example, evaluation committee members were not provided with sufficient guidance

when scoring proposals. As a result, we found wide variances in scores among evaluators. (page 27)

- The evaluation committee's scores are not part of the final process for selecting vendors. Other than identifying finalists to make a presentation, vendors are selected solely on the Board's scoring. The Board did not review proposals or observe vendor demonstrations. The Board awarded contracts mainly on vendor presentations and their answers to questions. Given the significant time evaluation committees spend reviewing, discussing, and scoring proposals, it would benefit the selection process to consider the committee's scores when selecting vendors. (page 31)

Recommendations

This report contains six recommendations. Three recommendations address improving the strategic planning process and ensuring it contains all key activities. In addition, one recommendation addresses ensuring management information is reliable. Finally, we made two recommendations to improve contracting practices. (page 43)

Agency Response

The agency, in its response to our report, accepted all six recommendations. (page 41)

Introduction

Background

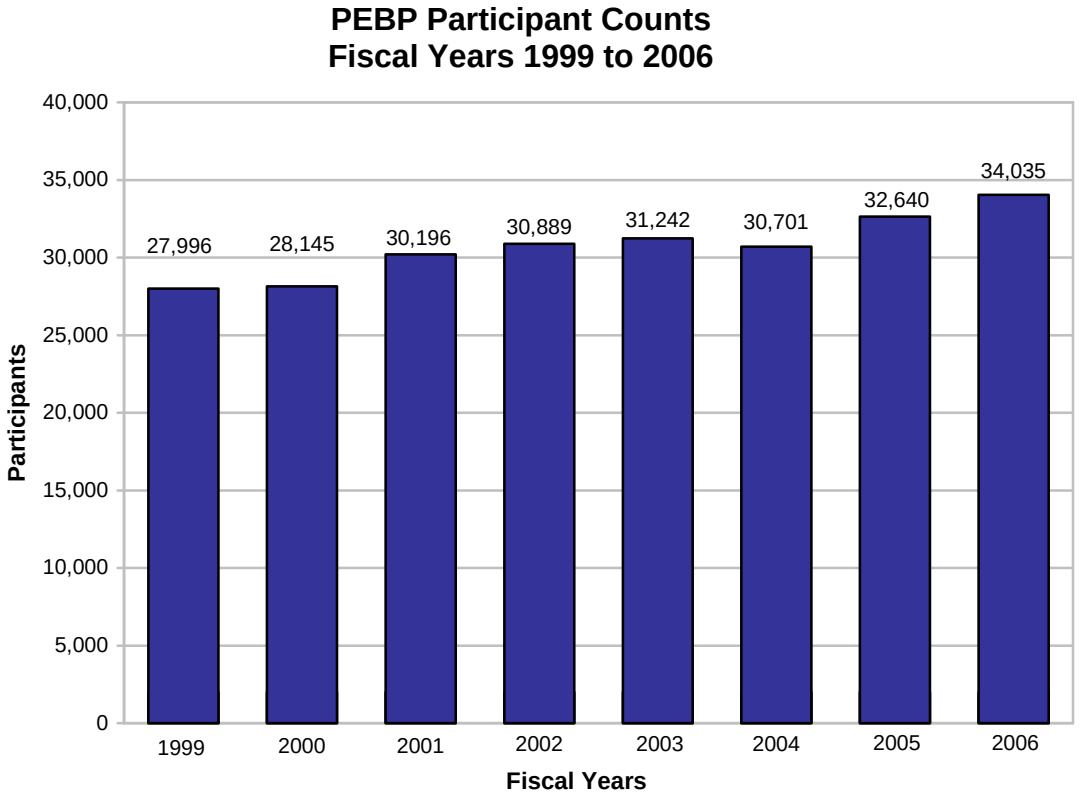
The Public Employees' Benefits Program (PEBP) was established in 1999 to manage the state's group health insurance program. Its mission, in part, is to design and manage a quality health care program for public employees and retirees of the State of Nevada and other participating public agencies. These agencies include the Nevada System of Higher Education, local governments, and school districts. The program provides health, dental, vision, and life insurance to state and non-state employees, retirees, and their covered dependents.

A nine-member board oversees PEBP's operations. The Board appoints an Executive Officer to direct the day-to-day operations. In fiscal year 2006 PEBP had 32 authorized positions. The agency includes the following sections:

- ***Public Information -*** develops and coordinates benefit and open enrollment orientations, PEBP communications, customer surveys, and focus groups.
- ***Accounting -*** assists and oversees rate setting, budgetary planning, financial operations, and payroll and personnel functions.
- ***Quality Control and Operations -*** manages contracts, appeals and complaints, research, customer service, and enrollment and eligibility.
- ***Information Technology -*** oversees document production, records management, and general information systems management.

In 2006, the number of participants totaled about 34,000. Exhibit 1 shows PEBP's participant counts for fiscal years 1999 to 2006.

Exhibit 1



Source: PEBP's records.

Primary funding sources include state and local government contributions and participant premiums. Funding is primarily used for medical expenses, either through Health Maintenance Organization (HMO) premium payments or self-insured claims costs. Exhibit 2 shows PEBP's revenues, expenses, and reserves for fiscal years 2001 to 2005.

Exhibit 2

PEBP Revenues, Expenses, and Reserves
Fiscal Years 2001 to 2005

	2001	2002	2003 [2]	2004	2005
Total Revenues	$ 139,097,924	$ 148,367,399	$ 181,897,885	$ 198,926,555	$ 222,167,058
Expenses					
Operating	2,624,076	2,331,621	3,823,336	4,026,438	4,603,039
Fully Insured Program Costs [1]		25,912,652	22,925,745	22,645,130	47,394,317
Self Insured Administrative Costs	39,368,597	7,926,096	8,460,696	7,303,771	8,112,214
Claim Costs	90,853,007	119,127,811	154,010,114	122,630,262	136,630,282
Total Expenses	132,845,680	155,298,180	189,219,891	156,605,601	196,739,852
Income or (Loss)	$ 6,252,244	$ (6,930,781)	$ (7,322,006)	$ 42,320,954	$ 25,427,206
Reserve Balance	$ 18,704,456	$ 11,773,675	$ 4,451,669	$ 46,772,623	$ 72,199,829

Source: State accounting records.
[1] Fully insured program and self insured administrative costs were combined until fiscal year 2002.
[2] Revenue includes $18 million augmentation to the state subsidy.

Exhibit 2 shows in fiscal years 2002 and 2003 PEBP's operating expenses exceeded revenues. Significant reserves were accumulated in fiscal years 2004 and 2005, in part, because of large increases in state funding and lower than expected claims costs. These reserves include funds set aside for outstanding claims estimated at $23.9 million at the end of fiscal year 2005.

Program History Overview

From 1963 to 1999, the Committee on Benefits oversaw the state's group health insurance program for employees and retirees. Between 1963 and 1983, a private insurance company managed the daily operations of the group health insurance plan. During this time, the Committee on Benefits was responsible for the program's benefit package and selecting an insurance company to run it.

In 1983, the Legislature authorized the Committee on Benefits to establish a self-funded plan. The Committee contracted with several vendors including a third party administrator to pay claims, HMOs, preferred provider networks, and a consultant/actuary. Daily program operations were staffed by the Department of Administration's Risk Management Division.

Due to numerous problems with the program, including an additional appropriation of $26 million, the 1999 Legislature eliminated the Committee on Benefits

and established the PEBP Board. Staff responsible for running the daily operations were moved from the Risk Management Division to PEBP. Despite these changes, the program continued to experience financial problems. The 18th Special Session of the Nevada Legislature in 2002 approved an $18 million increase to PEBP funding.

Assembly Concurrent Resolution 10

The 2003 Legislature approved Assembly Concurrent Resolution 10 (ACR-10), which directed the Legislative Commission to conduct a 4-year interim study of PEBP's operations. A final report is due during the 2007 Legislative Session. Our audit did not include areas identified for study by ACR-10 legislation. Appendix C contains a copy of ACR-10 legislation.

Scope and Objectives

This audit is part of the ongoing program of the Legislative Auditor as authorized by the Legislative Commission, and was made pursuant to the provisions of NRS 218.737 to 218.893. The Legislative Auditor conducts audits as part of the Legislature's oversight responsibility for public programs. The purpose of legislative audits is to improve state government by providing the Legislature, state officials, and Nevada citizens with independent and reliable information about the operations of state agencies, programs, activities, and functions.

This audit included a review of PEBP's practices related to strategic planning, management information, and contracting during fiscal years 2005 and 2006. Selected information and activities from prior fiscal years were reviewed to assist with analyzing strategic planning, premiums, employer and participant costs, claims activity, and contracting practices. Our audit objectives were to:

- Evaluate the effectiveness of PEBP's strategic planning process,
- Determine if PEBP's management information is reliable and accurate, and
- Evaluate the adequacy of PEBP's contracting practices.

Findings and Recommendations

PEBP Lacks an Effective Strategic Planning Process

The Public Employees' Benefits Program (PEBP) needs to improve its strategic planning. More effective planning would help address current and future health insurance issues facing employees and retirees. This would include developing consistent methods for setting premium rates and encouraging utilization of preventative services. Although PEBP has taken some steps to improve planning, its strategic plan was not fully developed and was missing several planning elements.

Inadequate Planning for Setting Retiree Rates

PEBP has experienced complaints, controversies, and criticism for various decisions made in recent years. Participants, Legislators, and others have been critical of how PEBP handled issues affecting rate setting. These stakeholders were particularly critical of how retiree rates were determined. Complaints and controversies could have been avoided or at least mitigated by better strategic planning.

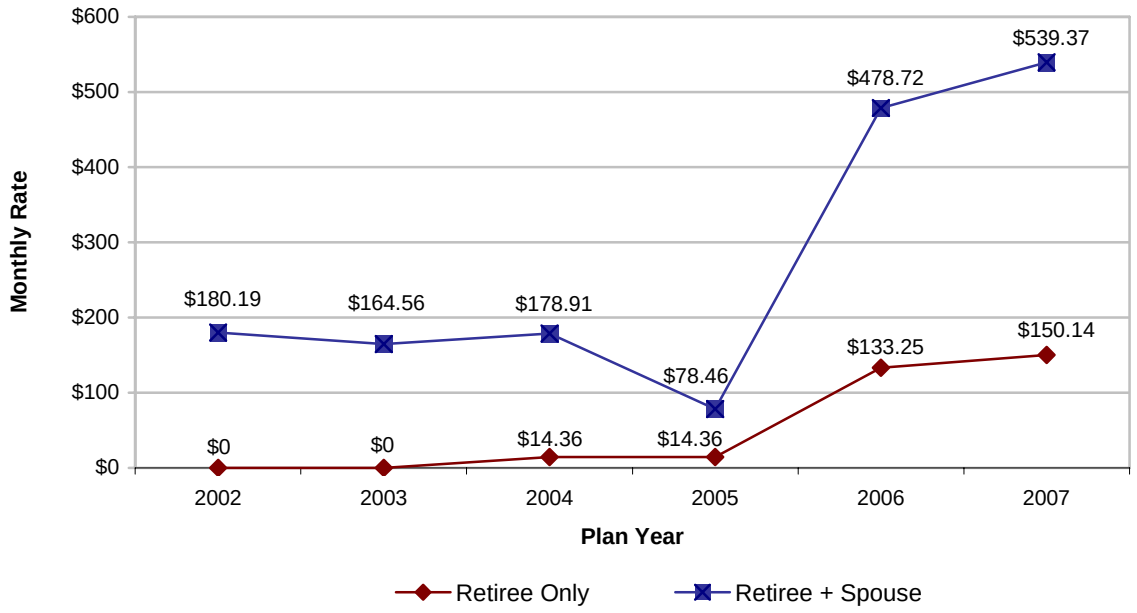
Plan Year 2006 Changes Significantly Increased Costs for Medicare Retirees

In preparation for plan year 2006 PEBP made several changes that significantly increased costs for Medicare retirees. First, PEBP began commingling the claims costs of all state employees and retirees which resulted in the same monthly premium rate for both Medicare retirees (age 65 and over) and early retirees (under age 65). Second, PEBP adjusted the state subsidy allocation resulting in the State paying the same percentage of the monthly premium for both Medicare and early retirees. Third, PEBP decreased the amount it pays on retirees medical claims after Medicare paid, increasing the retirees out-of-pocket costs.

Commingling and adjusting the subsidy allocation resulted in a significant increase in Medicare retirees' monthly premium rates beginning in plan year 2006. Exhibit 3 shows the monthly rates paid by Medicare retirees for retiree only coverage and retiree + spouse coverage in plan years 2002 to 2007.

Exhibit 3

Medicare Retiree Monthly Rates
for Retiree Only and Retiree + Spouse Coverage
Plan Years 2002 to 2007



Source: PEBP records and auditor analysis.

The exhibit shows a large increase in rates beginning in plan year 2006. For example, between 2004 to 2006 the monthly premium for retiree + spouse coverage increased from $178.91 to $478.72, an increase of 168%.

Implementing Commingling Has Been Controversial

During the 2001 Legislative Session, the Legislature passed Assembly Bill 564 requiring PEBP to commingle the claims expense of state employees and retirees for setting premium rates. The legislation went into effect on January 1, 2002, and was intended to reduce volatility in premiums caused by large increases in retiree claims. In 2003, the Legislature also passed Assembly Bill 286 requiring PEBP to commingle the claims expense of all non-state employees and retirees to set their rates.

In August 2001, PEBP was advised by legal counsel that Assembly Bill 564 required commingling Medicare retirees claims expense with early retirees and active employees. Based on legal advice, PEBP believes commingling results in the same

rate for state employees and retirees based on plan tier.[1] This results in the same rate for both early and Medicare retirees even though PEBP is secondary insurance for Medicare retirees. PEBP realized this caused an inequity for Medicare retirees.

Because of this inequity, PEBP did not commingle medical costs for Medicare retirees with early retirees and employees to determine rates for plan years 2002 through 2005. However, PEBP did commingle dental, vision, and prescription drug costs. In preparation for plan year 2006, PEBP decided to commingle the medical claims expense of Medicare retirees with early retirees and employees.

State Subsidy Changes Increase Medicare Retiree Premiums

In addition to commingled rates, Medicare retiree monthly premiums increased because PEBP decreased the percentage paid by the State. Beginning in plan year 2006, PEBP set the state subsidy allocation (percentage of premium paid by the State) for both early and Medicare retirees at 67%. Previously, the State paid a higher percentage of Medicare retiree monthly premiums than early retirees. For example, in 2005 the State paid about 95% of the premium for the Medicare retiree only tier. If the State had paid 95% of the Medicare retiree premium in 2006, the retiree's monthly rate would have been $20.19 instead of $133.25, as shown in Exhibit 3.

Coordination of Benefits Change Increased Retiree Out-of-Pocket Costs

The third change for 2006 that impacted Medicare retirees occurred because PEBP decreased the amount it pays on claims after Medicare paid. This decrease occurred because PEBP switched methods for determining the portion of the claim it would pay. For example, on a $1,000 medical claim after deductibles are met, a Medicare retiree's out-of-pocket cost increased from $40 to $200. Exhibit 4 shows a comparison between the integration of benefits method and the maintenance of benefits method for coordinating insurance used from plan years 2005 to 2007.

[1] The State's health plan has four main premium rate tiers: participant only, participant + spouse, participant + family, and participant + children.

Exhibit 4

Comparison Between Integration and Maintenance of Benefits Methods of Coordinating Insurance
Plan Years 2005 to 2007
(Example of $1,000 Medical Claim)

	2005 Integration of Benefits	2006 Maintenance of Benefits	2007 Integration of Benefits
Medicare Pays	$ 800	$ 800	$ 800
PEBP Pays	160	-	160
Medicare Retiree Pays	40	200	40
Total Claim	$ 1,000	$ 1,000	$ 1,000

Source: Auditor analysis of methods of coordinating benefits.
Note: Calculations assume all deductibles have been met.

Exhibit 4 shows Medicare retirees pay a larger out-of-pocket amount under the maintenance of benefits method. PEBP switched to the maintenance of benefits method in 2006 so all participants; employees, early retirees, and Medicare retirees would pay at least 20% of the total medical bill. However, since Medicare retirees pay premiums for both primary (Medicare) and secondary (PEBP) insurance coverage, they would expect out-of-pocket expenses to be less. PEBP decided to return to the integration of benefits method in 2007.

Reimbursement Checks Issued to Offset Commingling Problem

To mitigate the increases discussed above PEBP decided to reimburse Medicare retirees 80% of their monthly federal Medicare Part B (medical insurance) premium. Beginning in July 2005, Medicare retirees received a monthly check equaling 80% of their monthly Medicare premium or $62.56. When Medicare premiums increased in January 2006, the monthly reimbursement rose to $70.80. Retirees in the participant + spouse tier receive double this amount or $141.60.

Medicare Part D Reimbursement Used to Reduce Medicare Retiree Rates

PEBP will provide Medicare retirees with an additional rate reduction of $52 through the Medicare Part D reimbursement beginning in plan year 2007. Medicare Part D is the new federal prescription drug program for Medicare eligible individuals. Because PEBP provides prescription drug coverage to Medicare retirees, the Federal Government will reimburse the State a portion of the costs it incurs. Typically the reimbursement equals 28% of certain prescription drug costs paid by PEBP and the

retiree. PEBP's consulting firm estimated the federal reimbursement to the State would be about $3.3 million in plan year 2007, or $52 per retiree per month.

Additional Subsidy Programs Help Further Reduce Medicare Retiree Costs

Additional rate reductions are available for some retirees through various subsidies. These include a subsidy based on years of service and the temporary supplemental subsidy approved by the 2005 Legislature.

State retirees receive a rate adjustment based on their years of service. Retirees with more than 15 years of service can receive a reduction in their monthly rate. The maximum subsidy for plan year 2007 is $126.36 monthly. Retirees with less than 15 years incur an increase in their rate. The rate adjustments based on years of service for state retirees are shown in Appendix D.

At PEBP's request, the 2005 Legislature also approved a supplemental subsidy for those rate tiers most impacted by commingling and other plan year 2006 changes. The tiers receiving this subsidy include retiree + spouse; surviving spouse; and retiree + spouse one with, one without Medicare. The supplemental subsidy for plan year 2006 will be cut in half for 2007 and eliminated in 2008. For example, the state retiree + spouse supplemental subsidy in 2006 was $118.72, and dropped to $59.36 for 2007.

Multiple Changes and Adjustments Result in a Confusing Rate Structure

The various rate changes and adjustments discussed above results in a confusing rate structure. Exhibit 5 shows the 2007 monthly premium costs for Medicare and early retirees in the participant only tier with at least 20 years or more of service.

Exhibit 5

2007 Monthly Premium for Medicare and Early Retirees
Participant Only Tier With 20 Years of Service
Low Deductible Plan

	Medicare Retiree	Early Retiree
Premium	$150.14	$150.14
20 Years Reduction	(126.36)	(126.36)
Medicare Part D Reduction	(52.00)	-
Adjusted Premium [(1)]	$ 0	$ 23.78
PEBP Payment to Retiree	$ 70.80	$ -

Source: Auditor analysis of retiree rates.
[(1)] Adjusted premium is not less than zero.

Exhibit 5 shows the Medicare retiree receives various reductions resulting in no monthly premium to be paid while the early retiree pays $23.78. Additionally, PEPB pays the Medicare retiree $70.80, representing 80% of the monthly Medicare Part B premium.

Several adjustments are also available to the participant + spouse tier. Exhibit 6 shows plan year 2007 monthly premiums for Medicare and early retirees in the participant + spouse tier with 20 years or more of service.

Exhibit 6

2007 Monthly Premiums for Medicare and Early Retirees
Participant + Spouse Tier With 20 Years of Service
Low Deductible Plan

	Medicare Retiree + Spouse	Early Retiree + Spouse
Premium	$ 539.37	$ 539.37
20 Years Reduction	(126.36)	(126.36)
Medicare Part D Reduction	(104.00)	-
Supplemental Subsidy	(59.36)	-
Adjusted Premium	$ 249.65	$ 413.01
PEBP Payment to Retiree	$ 141.60	$ -

Source: Auditor analysis of retiree rates.

Exhibit 6 shows a Medicare retiree receives rate reductions for years of service, Medicare Part D, and the supplemental subsidy. PEBP also pays the Medicare retiree an additional $141.60 monthly.

Although the above changes provide retirees with lower rates, the number of adjustments result in a confusing process. Early retirees may question their monthly premium costs in comparison to Medicare retirees. Some stakeholders may question why certain retirees have no monthly premium but still receive a check. In addition, regardless of the premium amount or future plan changes, some retirees may expect a monthly check.

Better Planning Could Improve the Rate Setting Process for Retirees

Better planning could have resulted in a less confusing process for determining retiree rates. Although PEBP knew in 2001 that commingling could result in problems, sufficient efforts were not made to meet with stakeholders to resolve the issue.

Meetings with retirees, legislators, and other stakeholders could have resulted in a less confusing solution to commingling prior to the 2005 Legislative Session. In addition to commingling, planning could have resulted in a better approach when adjusting the premium percentage paid by the State and switching the coordination of benefits methods for plan year 2006.

The Legislative Commission's interim study committee on PEBP (ACR 10, 2003 Legislative Session) recently discussed requesting a bill draft for the 2007 Legislative Session to address commingling. The committee discussed reducing the Medicare retirees' PEBP premium by the percentage of the retirees' current medical claims paid by federal Medicare. For example, if federal Medicare paid 60% of all Medicare retirees' medical claims, then the commingled PEPB rate would be reduced by 60%. This approach could eliminate some complaints and confusion. First, it would result in different rates for early and Medicare retirees. Second, the monthly reimbursement check would no longer be needed. Third, it would eliminate the need for additional adjustments such as the supplemental subsidy. Had PEBP met with stakeholders prior to the 2005 Legislative Session, commingling issues could have been addressed sooner.

Plan for Rate Setting Not Carried Out

Although PEBP used predictive modeling to develop premium rates for plan years 2005 and 2006, it was not used when setting rates for each tier in 2007. Predictive modeling was not used for 2007 because the rate increase for one group was significantly higher than the other tiers. However, PEBP did not analyze claims data to determine the accuracy of predictive modeling for each tier. Therefore, if predictive modeling is accurate, premium rates for each tier may fluctuate significantly if PEBP decides to use predictive modeling in future years.

Predictive modeling is a state-of-the-art methodology designed to set rates for the next plan year. It uses age, gender, claims information, and other factors to infer which medical problems are present for each individual and their likely effect on health care cost for the coming year. PEBP's consulting firm used predictive modeling to develop rates among the tiers for plan years 2005 and 2006.

Although PEBP's consulting firm calculated 2007 rate adjustments for each tier using predictive modeling, these calculations were not used to adjust rates for each tier. Instead of adjusting rates for each tier as done in 2005 and 2006, PEBP used the predictive modeling calculations to estimate the increase needed in total funding. This amount was then spread in equal percentages among the tiers, resulting in a 12.7% increase per tier. Exhibit 7 shows for state employees a comparison of monthly rates by tier for plan year 2007 based on predictive modeling and the 12.7% increase used by PEBP.

Exhibit 7

Comparison of 2007 Rates Based on Predictive Modeling and 12.7% Increase by PEBP

State Employees Low Deductible Plan	2006 Rates	2007 Rates Using: Predictive Modeling[(1)]	2007 Rates Using: 12.7% Increase
Participant Only	$ 20.81	$ 25.65	$ 23.44
Participant + Spouse	$177.84	$169.59	$200.37
Participant + Children	$ 47.67	$ 32.13	$ 53.71
Participant + Family	$114.54	$107.68	$129.06

Source: PEBP records and auditor analysis.
(1) Based on predictive modeling increases and PEBP's rate setting formula.

The exhibit shows that PEBP's increase of 12.7% for each tier results in different rates than if predictive modeling had been used to set rates based on the costs of each tier. The 12.7% increase results in a lower rate for the participant only tier and higher rates for the remaining three tiers. Because predictive modeling was implemented in 2005 to assign premium rates based on the claims costs of each tier, the departure from predictive modeling may result in one tier subsidizing another tier. If predictive modeling is accurate, then 2007 rates are not based on projected claims cost by tier, and the participant only rate is too low. However, PEBP has not analyzed claims results from plan year 2005 to determine predictive modeling's accuracy.

The handling of predictive modeling demonstrates the need for better planning. Improved planning would have included a thorough analysis of 2005 claims to determine if predictive modeling accurately projected claims costs. These results would have been available to PEBP when considering rates for 2007.

Better Planning Could Improve Wellness Utilization

Improved planning could help increase participant's awareness and utilization of wellness programs. PEBP has several wellness programs such as medical screenings and annual wellness fairs. These programs are designed to encourage participants to seek preventative care and maintain good health, and indirectly save the program money. However, these programs were not adequately publicized and utilization has not increased.

Beginning in plan year 2006, PEBP increased the wellness benefit for each person from $600 to $2,500 annually. PEBP will pay up to $2,500 for each individual on wellness items such as the annual wellness fair, annual physical, flu shots, various lab tests, and other preventive exams and tests. Despite the increase in wellness dollars utilization did not increase during the first 8 months of plan year 2006 compared to 2005. Additionally, PEBP reported only about 10% of participants attended the wellness fairs.

Wellness Program Not Adequately Publicized

Information provided to participants did not adequately publicize wellness activities. Although plan year 2006 open enrollment materials identified the wellness benefit increase to $2,500, complete information was not provided. For example, a complete listing of procedures covered by the wellness program was not provided to participants. In addition, information did not adequately explain how to access wellness services or where certain medical screenings were provided. Furthermore, plan year 2007 open enrollment materials did not address wellness fairs or screenings. Increasing awareness among participants could help increase wellness utilization.

PEBP Has Recently Taken Steps to Increase Participant's Awareness of Wellness Activities

During our audit, PEBP began taking steps to increase participant's awareness and understanding of wellness programs. The Board discussed possible improvements to the wellness program at its March and May 2006 meetings. The Board also formed a subcommittee to address wellness issues. In addition, PEBP plans to focus wellness fairs more on educating participants about their health and encouraging participants to visit physicians for ongoing medical review. Furthermore, PEBP plans to send

brochures on the wellness program to all participants. Increasing awareness among participants could increase wellness utilization.

PEBP Has Taken Some Steps to Improve Planning

PEBP has acknowledged the need to improve strategic planning. The Board held several strategic planning sessions in 2004 and 2005. A variety of issues were discussed at these sessions including the need to:

- Prioritize issues and determine plan direction for the next 3 to 5 years and beyond;
- Promote the wellness benefit, educating participants about their health, and preventing illness rather than just paying claims;
- Protect participants from catastrophic events;
- Ensure flexibility in plan design; and
- Develop a mission, vision, philosophy, goals, objectives, and guiding principles.

The Board developed a strategic plan that was finalized in October 2005. The Board also approved a 2-year planning calendar that includes a review and possible changes to the strategic plan each November. In subsequent meetings, the Board discussed possible changes and issues affecting the plan over the next 1 to 3 years.

Strategic Plan Not Fully Developed

PEBP's recently approved strategic plan contains several weaknesses. First, the plan does not address key areas such as providing catastrophic coverage and wellness activities. Second, the plan lacks objectives and strategies to help ensure goals are achieved. Third, performance measures lack valid benchmarks to help PEBP assess its progress at attaining goals. Finally, the plan does not include established timeframes to accomplish goals and performance targets.

Key Programs Not Included in Plan

Key programs including catastrophic care, wellness screenings, annual wellness fairs, and the disease management program are not adequately addressed in the strategic plan. Board members and PEPB staff have indicated the most important

principle for the program is to provide participants with coverage for catastrophic events. However, catastrophic coverage is not specifically addressed in the strategic plan.

During strategic planning sessions Board members expressed an interest in focusing the program more on preventive care rather than just paying claims. The Board also expressed an interest in enhancing wellness, including health screenings and the disease management program. As discussed above, wellness includes various medical screenings and wellness fairs to enhance the early detection of potentially serious medical conditions. It also includes a disease management program which provides assessment, support, and education to assist participants with certain medical conditions. Including these programs in the strategic plan would help ensure adequate attention is given to preventative care and containing costs.

Strategic Plan Lacks Objectives and Strategies

PEBP's strategic plan lacks objectives and strategies. Therefore, it is unclear what activities PEBP will use to help ensure agency goals are achieved. Without objectives and strategies it is less likely that PEBP will accomplish its goals.

Objectives are specific measurable targets for achieving goals. Objectives should be specific, measurable, achievable, realistic, and time-specific. Each goal may have several objectives or only a few. For example, PEBP has a goal "to provide effective communications so that participants understand the plan, and are able to maximize their benefits." Examples of objectives to achieve this goal could include targeted improvements in customer surveys and decreases in complaints.

Strategies are the "how" part of a strategic plan. Strategies detail specific steps an agency will take to achieve goals and objectives. PEBP has a goal "to provide accurate and timely information to all plan stakeholders." Examples of strategies for this goal could include staff training, customer surveys, and PEBP's quarterly newsletter.

During strategic planning sessions the Board discussed the need for objectives and strategies. However, specific objectives and strategies for each goal were not included in the strategic plan. Developing strategies and objectives would help PEBP achieve goals. It would also help with developing performance measures.

Performance Measure Benchmarks Not Valid

Benchmarks for some performance measures are not valid. These include benchmarks: 1) that do not provide a realistic standard, and 2) lack specific targets. Valid and achievable benchmarks are needed to help PEBP achieve its goals.

Several benchmarks do not provide a realistic standard. In these cases PEBP is already exceeding the benchmark. For example, PEBP has a performance measure addressing expense ratio or overhead costs. This measure compares overhead (e.g., personnel, operating, contracting fees, information services) to premium revenue. PEBP has indicated the insurance industry standard or benchmark for overhead is 13% to 14% of premium revenue. However, PEBP has outperformed this benchmark. In fiscal year 2005 overhead costs were 7.4%, totaling about $13 million. For PEBP's overhead cost to reach 13% of premium revenue overhead would need to increase to about $22 million. Therefore, PEBP's current benchmark for expense ratio is not realistic. PEBP is also outperforming benchmarks for other performance measures. These include measures comparing claims expense to premium revenue, and the number of participants to appeals and complaints received.

Some performance measures lack targets to adequately assess progress towards achieving goals. For example, PEBP has established a goal "to provide accurate and timely information to all plan stakeholders." However, PEBP has not developed performance measures addressing if plan stakeholders receive information in a timely manner. In addition, established measures for accuracy of information were not always clear. Therefore, staff cannot adequately measure progress towards achieving this goal. PEBP should ensure all goals include performance measures with clear and measurable targets.

Strategic Plan Lacks Timeframes

The strategic plan approved in October 2005 did not include established timeframes to accomplish goals and meet performance targets. Therefore, it is unclear when PEBP expects to accomplish its goals and achieve performance targets. In addition, the Board has discussed the need to plan 3 to 5 years into the future and beyond. However, most planning has been on an annual or biennial basis. PEBP

would benefit from establishing short- and long-term timeframes to achieve its goals, objectives, and performance targets.

Management Information Can Be Improved

PEBP can improve its reporting of information. During our audit, we identified certain instances where reliable and consistent information was not provided to the Legislature. In addition, some medical claims information reported by PEBP and its vendors was not always accurate. Although PEBP has strengthened controls over information since our last audit, more work is needed to ensure representations and reports are reliable.

Reliable Information Not Always Provided

PEBP did not always provide reliable information to the Legislature. For example, the agency overstated Medicare retirees' prescription drug usage and the cost to fully coordinate Medicare retirees' benefits. In addition, the percentage of plan costs paid by employers was understated and inconsistent numbers were provided for reserves and large dollar claims.

Medicare Retiree Prescription Drug Usage Overstated

PEBP could not provide documentation to support its representation about Medicare retirees' prescription drug usage during the 2005 Legislative Session. When discussing commingling issues, PEBP stated Medicare retirees, on average, use nearly three times the number of prescriptions used by employees and early retirees combined. After further discussion, PEBP stated Medicare retirees use more prescription drugs than early retirees and employees combined. However, our review of information from PEBP's pharmacy vendor indicates Medicare retiree prescription drug usage was overstated, accounting for only about one-third of prescriptions.

Although PEBP's pharmacy vendor does not track prescription drug use by Medicare status, information was available for prescription use by age. Because participants become eligible for Medicare at age 65, this information can be used to estimate Medicare retiree prescription drug use. Based on reports from PEBP's pharmacy vendor, participants 65 years and older incurred about one-third of all prescriptions and costs in fiscal years 2004 and 2005. Exhibit 8 shows total prescription

drug claims and costs for participants 65 years and older compared with other participants during fiscal years 2004 and 2005.

Exhibit 8

Prescription Drug Utilization by Participant Age
Fiscal Years 2004 and 2005

Fiscal Year	Participant Age	Rx Claims	Percentage	Rx Costs	Percentage
2004	Age 65 and Older	156,213	28%	$ 9,576,794	29%
	Under Age 65	393,544	72%	23,374,556	71%
	Totals	549,757	100%	$ 32,951,350	100%
2005	Age 65 and Older	177,890	32%	$ 11,567,838	33%
	Under Age 65	380,949	68%	23,618,789	67%
	Totals	558,839	100%	$ 35,186,627	100%

Source: PEBP pharmacy vendor.

The overstatement on Medicare prescription drug usage occurred during a discussion on commingling. According to testimony, Medicare prescription drug usage was one reason that Medicare retirees' premium costs would increase if their claims experience was not commingled.

Unsupported Cost Information for Full Coordination of Benefits

PEBP could not support information reported to the 2005 Legislature on the cost to fully coordinate Medicare retirees' benefits. Management represented that implementing full coordination of benefits for Medicare retirees would cost $12 to $18 million annually. However, a recent estimate by PEBP's consultant suggests the cost reported to the Legislature was overstated. In February 2006, the cost to fully coordinate benefits was estimated to be about $9.9 million for plan year 2007.

The full coordination of benefits methodology provides that PEBP typically pays the portion of the medical expense not paid by Medicare — after participants meet their deductibles. For example, on a $100 medical claim, if Medicare paid $80, PEBP would pay $20.

According to agency personnel, the $12 to $18 million estimate came from a 2001 or 2002 consultant's report. However, the agency could not provide a copy of the report. PEBP reported the costs for full coordination of benefits when the Legislature was discussing a bill that would subject the program to additional oversight by the Nevada Commissioner of Insurance.

Plan Cost Paid by Employers and Participants Not Accurate

PEBP provided inaccurate information on the percentage of costs paid by employers and participants. Employer costs paid through state or local government contributions were understated; and participant costs, which include monthly premiums, deductibles, co-pays, and co-insurance were overstated.

In September 2005, PEBP reported to the Legislative Commission that self-funded plan employers paid about 50% of total health care costs in 2004 and about 58% in 2005. However, we found employers pay a higher percentage of the total plan costs than reported. Exhibit 9 shows the percentage of costs paid by employers and participants for fiscal years 2004 and 2005, comparing PEBP reported numbers to our analysis.

Exhibit 9

Percentage of Costs Paid by Employers and Participants
Fiscal Years 2004 and 2005

Fiscal Year		Reported by PEBP	Auditor Analysis	
		All Participants	All Participants	State Participants
2004	Employer	50%	58%	61%
	Participant	50%	42%	39%
2005	Employer	58%	63%	67%
	Participant	42%	37%	33%

Source: PEBP and auditor analysis.

Exhibit 9 shows employers paid a higher percentage of program costs than reported by PEBP. Additionally, the State paid an even larger percentage of costs for its employees and retirees. Therefore, the program is more beneficial for participants than PEBP's information indicated.

Our review of the data used to calculate these percentages found PEBP's reported information used budgeted instead of actual revenues and expenses. In addition, the agency's calculations did not accurately assign some costs.

Information Is Not Always Consistent

PEBP has not provided the Legislature with consistent information regarding reserve levels and large dollar claims. In November 2005, PEBP reported to the Legislative Commission two different amounts for its fiscal year 2005 ending reserve

level. However, an explanation for the difference was not provided in the report. The first number totaling $72.2 million came from the state's accounting system and the second number of $78.8 million was based on PEBP's audited financial statements. Although both numbers were correct, clear and consistent information was not provided.

A similar problem was observed with the agency's reporting of changes in large dollar claims from one plan year to the next. When reporting large dollar claims amounts, PEBP used thresholds of $10,000 and $100,000. However, these dollar thresholds were not always identified. For example, in September 2005, the Legislative Commission was provided information on the number of participants with claims over $100,000 and the percent of total these claims represented. In November 2005, PEBP provided the Legislative Commission information on savings from decreases in large claims. However, the dollar threshold for large claims was not identified. PEBP staff later told us the threshold was $10,000. Therefore, PEBP needs to clearly identify information provided to decision makers.

Claims Numbers Not Always Accurate

Although PEBP has strengthened controls over its claims information since our last audit, we identified areas for improvement. Our review of claims information identified: 1) reimbursement checks were improperly reported as medical claims, and 2) claims information was not always consistent.

PEBP and its consultant improperly reported reimbursement checks as medical claims. The agency and its consultant periodically report claim and cost numbers to the Board. However, these numbers include Medicare Part B reimbursement payments which are not medical claims. These payments are reimbursements for Medicare retirees' premium payments as explained previously in this report. Based on information provided by PEBP, we estimate these payments will overstate the number of claims by 66,500 and claims cost by $4.4 million for fiscal year 2006. Medicare Part B claims and associated costs should be identified separately so trends for actual medical claims and costs are clear.

The agency has also experienced problems obtaining consistent claims processed information. Information provided to the Board indicated 180,000 claims were processed from July to September 2005. A subsequent report indicated 161,000

claims were processed during the same period. Although Medicare Part B payments accounted for part of the disparity, unresolved differences remain between the two reports.

Contracting Can Be Strengthened

Although PEBP has improved its contracting practices since our last audit, additional improvements can be made. The process for evaluating proposals contains weaknesses which contribute to inconsistent scoring. In addition, evaluation committee's scores are not part of the final process for selecting vendors.

Vendor Selection Process Can Be Improved

PEBP did not provide evaluators with sufficient guidance when scoring proposals and selecting vendors. As a result, we found wide variances in scores among evaluators including inconsistent scoring of vendor proposals. In addition, evaluation committee scores were not included in the final selection process. Improvements in these areas will help ensure the most qualified vendor is selected at the best price.

State law requires that agencies consider and score certain factors when evaluating proposals. These include: conformance with the request for proposal (RFP) terms, experience and financial stability of firms submitting proposals, and price. Agencies may also use other factors. In addition, contracts should be awarded based on the best interest of the State as determined by the scores assigned to each proposal.

Although PEBP is required to use the Purchasing Division when contracting for services, PEBP and the Board have flexibility over the selection process. Our review of the process for selecting two key vendors found PEBP has significant control over the evaluation and selection process. For example, PEBP determines the scoring scale, scoring weights, and some evaluation criteria. In addition, evaluation committee members are primarily from PEBP. Furthermore, PEBP has a unique process whereby the Board evaluates, rescores, and selects vendors after the evaluation committee has evaluated, scored, and selected finalists for the Board's consideration.

Wide Variances in Scoring

Evaluators have not received adequate guidance to score vendor proposals. This results in a wide range in scores among evaluators and could impact vendor selection. Exhibit 10 shows scores given by each evaluator for conformance with the RFP terms from the recent third party administrator solicitation using PEBP's 1 to 5 scoring scale.

Exhibit 10

Evaluator Scores for Conformance With the RFP Terms
Third Party Administrator Solicitation

Vendor	Eval 1	Eval 2	Eval 3	Eval 4	Eval 5	Range in Scores
A	5.0	3.0	5.0	5.0	5.0	3.0 - 5.0
B	4.0	3.0	5.0	2.0	5.0	2.0 - 5.0
C	2.0	0.0	1.0	0.0	2.0	0.0 - 2.0
D	3.0	2.0	3.0	1.0	3.0	1.0 - 3.0
E	1.0	1.0	5.0	0.0	1.0	0.0 - 5.0

Source: Analysis of evaluation committee scoring sheets.

Exhibit 10 shows a wide range in vendor scores among evaluators. For example, scores for vendor B ranged from 2 to 5, a wide range on a 1 to 5 scale. Scores for vendor E were even further apart, ranging from 0 to 5.

We also noted a wide variance in scores on another proposal. Exhibit 11 shows scores given by each evaluator for conformance with the RFP terms from the recent eligibility and enrollment system solicitation.

Exhibit 11

Evaluator Scores for Conformance With the RFP Terms
Eligibility and Enrollment System Solicitation

Vendor	Eval 1	Eval 2	Eval 3	Eval 4	Range in Scores
F	4.0	4.0	2.0	3.0	2.0 - 4.0
G	3.5	5.0	5.0	4.0	3.5 - 5.0
H	4.0	5.0	1.0	3.5	1.0 - 5.0
I	5.0	5.0	4.0	4.0	4.0 - 5.0
J	4.0	5.0	4.0	3.0	3.0 - 5.0
K	2.0	3.0	1.0	2.0	1.0 - 3.0

Source: Analysis of evaluation committee scoring sheets.

The exhibit also shows a wide range in scores among evaluators. For example, vendor H received scores ranging from 1 (poor) to a score of 5 (excellent). In addition,

the exhibit shows a wide range in scores for vendors F, J, and K. Since conformance with the RFP terms involves determining if proposals contain all information required by the RFP, evaluator's individual scores for a specific vendor should be fairly close.

Inconsistent scoring occurred on proposals because evaluation committees did not receive adequate guidance. We noted the following weaknesses:

- Confusing Scoring Instructions – Although scoring sheet instructions directed evaluators to score proposals based on a 1 to 5 scale, other guidance indicated a zero score could be given for nonconformance with the RFP requirements. This resulted in some evaluators giving zero scores contrary to instructions.
- All Scoring Levels Not Clearly Defined – Evaluators were asked to score proposals using a scale ranging from 1 to 5. Although a score of 1 is defined as "poor" and 5 as "excellent," other scoring levels were not clearly defined. Most evaluators gave only whole points for scoring areas while some evaluators gave half-points. Because PEBP uses a tight range for awarding points, all scoring levels including the ability to give half-points or quarter-points should be defined.
- Proposal Not Understood by Evaluator – An evaluator scoring the eligibility and enrollment system proposals did not understand one vendor's proposal, and gave each proposal area a score of 1 or poor. This lowered the vendor's overall score, which may have resulted in the vendor being excluded from further consideration. The evaluation committee did not attempt to resolve the evaluator's misunderstanding or address the impact it had on the one vendor's overall score.
- Confusion Over Creative Pricing Alternative – The eligibility and enrollment system RFP encouraged vendors to submit creative pricing alternatives. One vendor submitted a proposal with three cost options. When scoring this proposal neither the evaluation committee nor the Board determined in advance which cost option should be scored. As a result, the vendor received inconsistent scores ranging from 2 to 5 for cost.

Vendor Cost Evaluation Process Can Be Improved

Evaluators did not always consistently score vendor cost proposals. The cost portion from proposals is scored using a 1 to 5 scale. However, evaluators were not given further instruction for scoring vendor costs, which lead to inconsistencies. Implementing a formula to score costs should eliminate these inconsistencies.

As part of the RFP process PEBP requests that vendors submit a cost proposal. Exhibit 12 shows the evaluation committee's scoring of the cost proposals from the recent eligibility and enrollment system RFP.

Exhibit 12

Comparison of Evaluator's Scores for Cost Eligibility and Enrollment System Solicitation

Vendor	Cost Proposal	Eval 1	Eval 2	Eval 3	Eval 4	Range in Scores
F	$4,844,000	4.0	4.0	4.0	5.0	4.0 - 5.0
G	$4,904,272	4.0	5.0	4.0	5.0	4.0 - 5.0
H	$5,895,000	1.0	3.0	1.0	4.0	1.0 - 4.0
I	$7,303,800	4.0	4.0	3.0	3.5	3.0 - 4.0
J	$7,500,000	4.0	4.0	3.0	3.5	3.0 - 4.0
K	$11,109,200	1.0	1.0	1.0	1.0	1.0 - 1.0

Source: Analysis of evaluation committee scoring sheets.
Note: Vendor F submitted three cost proposals. The exhibit shows the lowest overall cost proposal.

Exhibit 12 shows a wide range in scores for some proposals. For example, vendor H received scores ranging from 1 to 4. Although vendor H had third lowest proposed cost, it received two scores of 1 indicating its cost proposal was poor. The exhibit shows additional inconsistencies. For example, evaluators 1 and 2 gave the same score for cost to vendors F, I, and J, even though vendor F's cost proposal was considerably lower than the other two vendors. We also noted inconsistent scores for cost when proposals were scored by the Board. PEBP could avoid these inconsistencies by using a formula to score proposed costs.

Several formula methods for scoring cost are available. Exhibit 13 shows the evaluation committee's average scores for cost on the recent eligibility and enrollment system RFP compared with scores when using the "ratio of costs" formula.[2]

[2] Cost Formula – Lowest Cost = $ (F)
Cost of Proposal to Evaluate = $ (G)
Points Awarded = (F/G) x Maximum Points Available

Exhibit 13

Comparison of Scores for Cost and Rank Between Evaluation Committee and Cost Formula

		Evaluation Committee		Auditor Analysis Using Cost Formula	
Vendor	Cost Proposal	Average Score	Rank	Points Awarded	Rank
F	$4,844,000	4.25	2	5.00	1
G	$4,904,272	4.50	1	4.94	2
H	$5,895,000	2.25	5	4.11	3
I	$7,303,800	3.63	3	3.32	4
J	$7,500,000	3.63	3	3.23	5
K	$11,109,200	1.00	6	2.18	6

Source: Evaluation committee scoring sheets and auditor analysis.
Note: Vendor F submitted three cost proposals. The exhibit shows the lowest overall cost proposal.

Exhibit 13 demonstrates inconsistent scoring by the evaluation committee when compared to the scoring formula for cost. Although vendor H had a lower cost proposal ($5,895,000) than vendors I ($7,303,800) and J ($7,500,000) and should have received a higher score, the evaluation committee gave vendor H a lower score. The exhibit also shows when using a cost formula, the scores and rankings are consistent with the cost proposed. The cost formula results in vendor H correctly receiving more points than vendors I and J. Implementing a formula would help ensure consistent scores when evaluating cost.

Evaluation Committee Scores Not Included in Final Vendor Selection

The evaluation committee's scores are not part of the final process for selecting vendors. Currently, other than identifying the finalists to make a presentation, vendors are selected based solely on the Board's scoring. PEBP has followed this process for several years.

The evaluation committee reviews and score proposals, then identifies finalists to make a presentation and answer questions from the Board. The committee also recommends a vendor from among the finalists and may indicate strengths and weaknesses. Exhibit 14 shows criteria and scoring weights used by the evaluation committee and Board to score the recent eligibility and enrollment system proposals.

Exhibit 14

Evaluation Committee and PEBP Board Scoring Criteria
Eligibility and Enrollment System RFP

Evaluation Committee		PEBP Board	
Criteria	Scoring Weight	Criteria	Scoring Weight
1. Conformance with RFP	25%	1. Questions and Answers	40%
2. System Functionality	20%	2. Formal Presentation	30%
3. Creativity/Alternative Solutions	15%	3. Vendor References	15%
4. Implementation Requirements	15%	4. Reasonableness of Cost	15%
5. Experience in Comparable Jobs	10%		
6. Expertise/Key Staff Available	10%		
7. Reasonableness of Cost	5%		

Score: Eligibility and enrollment system RFP and scoring sheets.

The exhibit shows the Board used much different criteria and scoring weights than the evaluation committee. In addition, the Board rescored cost at 15% of the total points, after the evaluation committee had already scored cost based on 5% of total points. Since the committee had evaluated cost, it seems unnecessary for the Board to rescore this area.

Other than the evaluation committee recommending a specific vendor based on their work, the final selection was based solely on the Board's scoring. The Board did not review proposals or observe vendor demonstrations of their computer system's capabilities. The Board awarded the contract mainly on vendor presentations and their answers to questions.

The rescoring process affected vendor selection for the eligibility system contract. Exhibit 15 compares the evaluation committee's and Board's scores for the three finalists.

Exhibit 15

Comparison of Evaluation Committee to PEBP Board Scores
for the Three Finalists on the Eligibility and Enrollment System RFP

	Evaluation Committee		PEBP Board	
Vendor	Average Score	Rank	Average Score	Rank
F	4.2	1	3.2	2
G	3.8	3	4.8	1
I	4.1	2	3.0	3

Source: Analysis of evaluation committee and Board scoring sheets.

Exhibit 15 shows the evaluation committee scored the three finalists fairly close. Although the evaluation committee recommended vendor F, the Board selected vendor G. This vendor received a near perfect score (4.8 out of 5) based primarily on presentation and answering questions. As a result, the evaluation committee's third choice was selected by the Board. Given the significant amount of time the evaluation committee spent reviewing, discussing, and scoring proposals, it would benefit the selection process to consider the committee's scores when selecting vendors.

Recommendations

1. Implement a comprehensive strategic planning process that includes short and long-term goals, objectives, and strategies.
2. Revise strategic plan to include key areas such as rate setting, catastrophic care, and wellness activities.
3. Ensure benchmarks for performance measures are valid.
4. Ensure information provided to the Legislature and Board is reliable.
5. Develop policies, procedures, and instructions to ensure evaluation committee members have clear guidance on the proposal evaluation process including scoring levels and the use of a formula when evaluating cost.
6. Consider scores from the evaluation committee's review of proposals in the vendor selection process.

Appendices

Appendix A
Audit Methodology

To gain an understanding of the Public Employees' Benefits Program (PEBP), we reviewed state laws and regulations, interviewed management and staff, and reviewed policies and procedures significant to PEBP's operations. In addition, we reviewed prior audit reports, financial reports, budgets, state accounting records, plan design and premium rates, minutes of various legislative committees and the PEBP Board, and other information describing PEBP's activities. We also documented key control processes and assessed their susceptibility to risk.

To evaluate planning practices, we reviewed PEBP's strategic plan for significant elements including mission, goals, objectives, strategies, and performance measures. We compared PEBP's plan with State and other guidance on strategic planning. We also evaluated the validity of certain performance measure benchmarks. We reviewed the minutes and related documents from Board meetings addressing strategic planning and discussed these with management. In addition, we reviewed PEBP's implementation of commingling, predictive modeling, and other rate setting practices. We then analyzed the impact these actions had on participants' premiums and discussed these practices with agency management. Finally, we reviewed the wellness program and noted recent efforts to increase utilization.

To determine if reliable information is provided to the Legislature and PEBP Board, we reviewed minutes and information provided to the Legislature during the 2005 Legislative Session. In addition, we reviewed information provided to PEBP's Board in fiscal years 2005 and 2006. This included analyzing supporting documentation to ensure completeness and accuracy of the data. Our analysis included discussions with PEBP's management and vendors, and comparisons with similar data from other sources.

To evaluate contract management practices, we identified laws, regulations, policies, and procedures pertaining to soliciting and awarding contracts. In addition, for

two contract awards we reviewed proposals, attended evaluation committee meetings, and observed vendor demonstrations and presentations before the Board. We discussed evaluation committee and Board scores, and scoring criteria, with State Purchasing and PEBP staff. We judgmentally selected six vendor contracts and reviewed contract terms, including reporting requirements and services to be performed. We also requested copies of available contractor reports and reviewed them for compliance with contract requirements. In addition, we reviewed monitoring activities by PEBP and its health claims auditor, including enforcement of contract performance guarantees. Finally, we reviewed contractor billings and payments.

Our audit work was conducted from September 2005 to May 2006 in accordance with generally accepted government auditing standards.

In accordance with NRS 218.821, we furnished a copy of our preliminary report to PEBP's Executive Officer. On August 22, 2006, we met with agency officials to discuss the results of the audit and requested a written response to the preliminary report. That response is contained in Appendix E, which begins on page 41.

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Appendix B

Prior Audit Recommendations

Our 1998 audit of the Group Health Insurance Program contained 13 recommendations. Three of the 13 recommendations were within the scope of our current audit. These recommendations addressed the contract assignment, notice to terminate contract, and establishing a fair and objective contract award process. As part of the current audit, we evaluated the status of these recommendations and determined all three were fully implemented.

Appendix C

Assembly Concurrent Resolution No. 10
(2003 Legislative Session)

Assembly Concurrent Resolution No. 10–Committee on Elections, Procedures, and Ethics

FILE NUMBER 91

ASSEMBLY CONCURRENT RESOLUTION—Directing the Legislative Commission to conduct an interim study of the operations of the Public Employees' Benefits Program.

WHEREAS, The Public Employees' Benefits Program was established in 1999 as the state agency legislatively approved to provide group life, accident or health insurance, or any combination of these, for state and nonstate public active and retired employees, and surviving spouses and children of certain persons formerly employed by a participating public agency; and

WHEREAS, As of January 2003, there were 22,345 active state employees and 5,105 retired state employees who rely on the Program for their group health insurance coverage; and

WHEREAS, In addition, another 1,706 active nonstate public employees and 1,570 retired nonstate public employees, and 288 eligible survivors rely on this health insurance coverage as well; and

WHEREAS, In recent months, allegations have been raised regarding the effectiveness, efficiency and efficacy of the Program; and

WHEREAS, Public employees and public employers across Nevada are experiencing cost increases for this coverage and they recognize that larger groups have stronger buying power when seeking coverage; and

WHEREAS, Many public employees are covered under collective bargaining agreements which need to be changed if a statewide public employee insurance plan is to be established; and

WHEREAS, Many of the employees and retirees and their families who are covered under the group health insurance provided by the Program are asking for assistance in resolving an untenable situation which has resulted in extraordinarily high premiums for this coverage; now, therefore, be it

RESOLVED BY THE ASSEMBLY OF THE STATE OF NEVADA, THE SENATE CONCURRING, That the Legislative Commission is hereby directed to appoint a committee composed of three members of the Assembly and three members of the Senate to conduct an interim study of the operations of the Public Employees' Benefits Program relating to the provision of group health insurance; and be it further

RESOLVED, That the Legislative Commission shall designate a Chairman of the committee who shall appoint an advisory committee of at least nine members, who are not Legislators, as follows:

1. At least one representative of the Retired Public Employees of Nevada or its successor organization;

2. At least one representative of the Nevada Association of Counties, or its successor organization, or the Nevada League of Cities, or its successor organization;

3. At least one representative of the State of Nevada Employees Association or its successor organization;

4. At least one person who possesses knowledge concerning the management of risk or the management of insurance trusts;

5. At least one provider of health insurance;

6. The Executive Officer of the Board of the Public Employees' Benefits Program; and

7. Representatives of other local public employee organizations and representatives of public employers; and be it further

RESOLVED, That the study must include, without limitation:

1. An examination of the methods used for determining premiums, equitable employee contributions based upon actual costs to this state and coverage for active and retired state and nonstate public employees and their dependents;

2. A review of the administration and solvency of the Fund for the Public Employees' Benefits Program;

3. A review of the financial contributions, if any, that nonstate public employers have made to assist their retired employees in maintaining health insurance coverage;

4. The feasibility of soliciting proposals for a contract that would take over the entire statewide operation or the regional operation of group health insurance funded by public employees and public employers;

5. An examination of relevant facts to determine whether all members of the Public Employees' Retirement System should be required to participate in a statewide program of health insurance funded by public employees and public employers;

6. The desirability of eliminating or changing the composition of the Board of the Public Employees' Benefits Program;

7. Consideration of whether it is feasible or desirable to allow voluntary participation of public employees and public employers in such a Program;

8. The feasibility and desirability of establishing a program similar to the Federal Employees Health Benefits Program, which provides a choice through local and national carriers;

9. Consideration of how the nonstate public employers should contribute to the costs of insurance for employees who retire from their service;

10. Consideration of requiring nonstate public employers' benefit plans to include reinstatement rights for their retirees, as currently required by the Public Employees' Benefits Program;

11. Consideration of options for prefunding retiree health benefits for all members of the Public Employees' Benefits Program;

12. Consideration of a state subsidy mechanism providing for a specific dollar amount or a specific percentage of the cost for employees and separately for their dependents, including an appropriate funding method;

13. A review of this state's retiree subsidy formula for past, present and future retirees and an appropriate funding method to address the current structural deficit;

14. Consideration of the feasibility, desirability and financial impact of authorizing large groups of participants to withdraw from the Public Employees' Benefits Program to obtain group insurance from other sources;

15. Consideration of the feasibility and financial impact of the State of Nevada forming one or more purchasing coalitions with surrounding states or private entities, or both; and

16. An analysis and review of issues related to:

(a) Pharmaceutical programs that are designed to reduce the price of prescription drugs for:

(1) Persons of low income in this state;

(2) Enrollees in this state's health benefits plan; and

(3) Participants in programs administered by this state that make available or provide prescription drugs;

(b) Prescription drug buying clubs that are used in other states and the potential for such clubs to assist the residents of this state in reducing their expenses for prescription drugs;

(c) Methods to access manufacturer rebates for prescription drugs to assist the residents of this state in reducing their expenses for prescription drugs;

(d) Interagency bulk purchasing and interstate buying of prescription drugs to reduce the prices of prescription drugs for this state's programs and health benefits plan;

(e) Methods to negotiate for lower prices on prescription drugs and a plan to carry out the methods; and

(f) Methods to control the prices of prescription drugs for this state's programs that provide pharmaceutical assistance to persons of low income in this state and for enrollees in this state's health benefits plan; and be it further

RESOLVED, That any recommended legislation proposed by the committee must be approved by a majority of the members of the Assembly and a majority of the members of the Senate appointed to the committee; and be it further

RESOLVED, That the Legislative Commission shall submit a progress report of the results of the study and any recommendations for legislation to the 73rd Session of the Nevada Legislature and a final report of the results of the study and any recommendations for legislation to the 74th Session of the Nevada Legislature.

Appendix D

State Retiree Years of Service Adjustments
Plan Year 2007

Years of Service	Adjustment to Monthly Premium
5	$252.73
6	$227.45
7	$202.18
8	$176.91
9	$151.64
10	$126.36
11	$101.09
12	$75.82
13	$50.55
14	$25.27
15	$0.00
16	-$25.27
17	-$50.55
18	-$75.82
19	-$101.09
20 +	-$126.36

Source: PEBP records.

Note: Pursuant to NRS 287.046(2), state employees retiring on or after January 1, 1994 are subject to the above adjustment to their monthly rate based on their years of service. Years of service adjustments for those who retired before January 1, 1994 are already reflected in the state rate.

Appendix E

Response From the Public Employees' Benefits Program

STATE OF NEVADA

PUBLIC EMPLOYEES' BENEFITS PROGRAM

901 S. Stewart Street, Suite 1001

Carson City, Nevada 89701

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KENNY C. GUINN
Governor

P. FORREST THORNE
Executive Officer

TERRY JOHNSON
Board Chairman

DATE: September 1, 2006

TO: Paul V. Townsend, CPA, Legislative Auditor

FROM: P. Forrest Thorne, Executive Officer

SUBJECT: Legislative Audit of the Public Employees' Benefits Program

Please find below the Public Employees' Benefits Program (PEBP) responses to recommendations contained in the recent audit conducted by your office. PEBP's response to recommendations one through three, pertaining to the strategic plan, have been consolidated into a single comment. Likewise, PEBP's response to recommendations five and six, regarding the vendor evaluation process, have been consolidated.

#1 Implement a comprehensive strategic planning process that includes short and long-term goals, objectives, and strategies.

#2 Revise strategic plan to include key areas such as rate setting, catastrophic care, and wellness activities.

#3 Ensure benchmarks for performance measures are valid.

PEBP Response:

Agree. PEBP agrees that improvements can be made to the strategic planning process and to the plan itself in the areas noted in the recommendations. The strategic plan is an important instrument in establishing PEBP's basic operating tenets, goals and objectives.

The PEBP Board calendar provides that the Strategic Plan be reviewed annually. At the November 2006 meeting, staff will propose adjustments that pertain to key programs, objectives and strategies, timeframes, and updating the performance indicators.

PEBP staff will also consider how the strategic planning process could impact the concerns raised in the audit report about the rate setting process. Currently, the

Board has defined the rate setting process in the PEBP Duties, Policies, and Procedures document which was approved after several public hearings on the matter. Many of the concerns raised in the audit report can be addressed most effectively through improved communications with the key stakeholders for the Program. PEBP staff will make every effort to do so in the future.

#4 Ensure information provided to the Legislature and Board is reliable.

PEBP Response:

Agree. It is important to assure the Legislature and every stakeholder for the Program that PEBP staff has never intentionally provided any information that could be deemed "unreliable". The subject matter that PEBP deals with is by its nature complex, changing, and difficult to present in a concise manner. PEBP understands however, that it is part of our job to explain information in as straightforward a manner as possible.

Each concern raised in the audit report related to this recommendation has some validity. At the same time, each concern has either been addressed or could be addressed through clarifying the context under which the information is presented in the future. PEBP staff will strive to better explain data provided during legislative testimony or in written documents in the future.

#5 Develop policies, procedures, and instructions to ensure evaluation committee members have clear guidance on the proposal evaluation process including scoring levels and the use of a formula when evaluating cost.

#6 Consider scores from the evaluation committee's review of proposals in the vendor selection process.

PEBP Response:

Agree. PEBP has modified its evaluation committee scoring instructions to better define the scoring levels and instructions for their use. PEBP will discuss the manner in which cost components are scored in the future with State Purchasing. Finally, PEBP agrees that the evaluation committee scores be provided as information to the Board members making the final selection.

Public Employees' Benefits Program
Response to Audit Recommendations

Recommendation Number		Accepted	Rejected
1	Implement a comprehensive strategic planning process that includes short and long-term goals, objectives, and strategies	X	
2	Revise strategic plan to include key areas such as rate setting, catastrophic care, and wellness activities	X	
3	Ensure benchmarks for performance measures are valid	X	
4	Ensure information provided to the Legislature and Board is reliable	X	
5	Develop policies, procedures, and instructions to ensure evaluation committee members have clear guidance on the proposal evaluation process including scoring levels and the use of a formula when evaluating cost.	X	
6	Consider scores from the evaluation committee's review of proposals in the vendor selection process	X	
	TOTALS	6	0