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
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CORE
Expires 04/01/2021

LAURA RICH
Executive Officer

MEETING NOTICE AND AGENDA – Amended 7/17/20

Name of Organization:	Public Employees' Benefits Program Board
Date and Time of Meeting:	July 23, 2020 9:00 a.m.
Place of Meeting:	Pursuant to the Governor's Emergency Directives 006, and 026, this meeting will be conducted via video- and tele-conference only. This meeting can be viewed live over the Internet on the PEBP YouTube channel at https://youtu.be/WSGjD2-lzHM

Members of the public are encouraged to submit public comment in writing by emailing wlunz@peb.nv.gov at least two business days prior to the meeting.

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

Dial: (669) 900-6833. When prompted to provide your Meeting ID, please enter: 942 5886 0678 then press #. When prompted for a Participant ID, please enter #.

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

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

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

AGENDA

1. Open Meeting; Roll Call

2. Public Comment

   Public comment will be taken during this agenda item. No action may be taken on any matter raised under this item unless the matter is included on a future agenda as an item on which action may be taken. Public comments to the Board will be taken under advisement but will

not be answered during the meeting. Comments may be limited to three minutes per person at the discretion of the chairperson. Additional three minute comment periods may be allowed on individual agenda items at the discretion of the chairperson. These additional comment periods shall be limited to comments relevant to the agenda item under consideration by the Board. As noted above, members of the public may make public comment by using the call-in number provided above. Persons unable to attend the meeting by telephone and persons whose comments may extend past the three minute time limit may submit their public comment in writing to PEBP Attn: Wendi Lunz 901 S. Stewart St, Suite 1001 Carson City NV 89701, Fax: (775) 684-7028 or wlunz@peb.state.nv.us at least two business days prior to the meeting. Persons making public comment need to state and spell their name for the record at the beginning of their testimony.

3. PEBP Board disclosures for applicable Board meeting agenda items. (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 May 28, 2020 PEBP Board Meeting

   4.2 Receipt of quarterly staff reports for the period ending March 31, 2020:

      4.2.1 Budget Report

      4.2.2 Utilization Report

   4.3 Receipt of quarterly vendor reports for the period ending March 31, 2020:

      4.3.1 HealthSCOPE Benefits – Obesity Care Management

      4.3.2 HealthSCOPE Benefits – Diabetes Care Management

      4.3.3 American Health Holdings – Utilization and Large Case Management

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

      4.3.5 Towers Watson's One Exchange – Medicare Exchange

      4.3.6 Hometown Health Providers and Sierra Healthcare Options – PPO Network

      4.3.7 HealthPlan of Nevada, Inc. – Southern Nevada HMO

5. Election of Board Vice-Chair pursuant to Nevada Administrative Code (NAC) 287.172. Eligible candidates are Don Bailey, Sr., Linda Fox, Tom Verducci, Marsha Urban, Jennifer Krupp, David Smith and Jet Mitchell (Laura Freed, Board Chair) **(For Possible Action)**

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

7. Discussion and Possible action of Legislative Counsel Bureau Audit Report and Corrective Action Plan (Laura Rich, Executive Officer) (**For Possible Action**)

8. Presentation on results of Request for Information (RFI) for Actuarial Review Services and Benefits Management System (Laura Rich, Executive Officer) (Information/Discussion)

9. Discussion and Possible action of plan design changes to be considered for Fiscal Year 2022/2023 agency request budget submission (Laura Rich, Executive Officer) (**For Possible Action**)
10. Discussion and Possible action of recommended policy changes to be considered for Plan Year 2022 (Laura Rich, Executive Officer) (**For Possible Action**)
11. 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.
12. 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**)

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

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   4.3.2 HealthSCOPE Benefits – Diabetes Care Management

4.3.3 American Health Holdings – Utilization and Large Case Management

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

4.3.5 Towers Watson's One Exchange – Medicare Exchange

4.3.6 Hometown Health Providers and Sierra Healthcare Options – PPO Network

4.1

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

    4.1 Approval of Action Minutes from the May 28, 2020 PEBP Board Meeting.

STATE OF NEVADA
PUBLIC EMPLOYEES' BENEFITS PROGRAM
BOARD MEETING

Telephonic Open Meeting
Carson City and Las Vegas, NV

ACTION MINUTES (Subject to Board Approval)
May 28, 2020

MEMBERS PRESENT VIA TELECONFERENCE:	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. Leah Lamborn, Member Ms. Jennifer Krupp, Member
MEMBERS EXCUSED:	Dr. Marsha Urban, Member
FOR THE BOARD:	Ms. Brandee Mooneyhan, Deputy Attorney General
FOR STAFF:	Ms. Laura Rich, Executive Officer Mr. Nik Proper, Operations Officer 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 9:04 a.m.

2. Public Comment
    - Kent Ervin – Nevada Faculty Alliance
    - Marlene Lockard – RPEN

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**)
    4.1 Approval of Action Minutes from the March 31, April 9, and April 27, 2020 PEBP Board Meetings.

BOARD ACTION ON ITEM 4
MOTION: Motion to approve with a correction on page two of Action Minutes from March 31. Mr. Ranft's, from AFSCME, last name is misspelled.
BY: Member Tom Verducci
SECOND: Member Jet Mitchell
VOTE: Unanimous; the motion carried

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

6. Presentation on impact of COVID-19 on the Plan (Stephanie Messier, Aon Hewitt) (Information/Discussion)

7. Update on Morneau Shepell Performance Improvement Plan instituted on 07/25/2019 (Morneau Shepell) (Information/Discussion)

8. Discussion and possible action of Contract Solicitation Report addressing solicitations necessary due to upcoming expiration of PEBP contracts, including:
    1) Benefits Management System
    2) Health Maintenance Organization (HMO)
    3) Dental PPO Network
    4) PPO/EPO Statewide Network
    5) Financial Auditor
    (Laura Rich, Executive Officer) (**For Possible Action**)

BOARD ACTION ON ITEM 8
MOTION: Motion to proceed with the RFP process for these five.
BY: Member David Smith
SECOND: Member Jet Mitchell
VOTE: Unanimous; the motion carried

BOARD ACTION ON ITEM 8 (1)
MOTION: Motion to not honor the contract extension with Morneau until 12/31/2023 owing to Morneau's failure to meet its deliverables which they have already acknowledged they failed to make.
BY: Member Jet Mitchell
SECOND: Vice Chair Linda Fox
VOTE: Unanimous; the motion carried

9. Discussion and possible action of contract amendments to Aon Hewitt and HealthSCOPE Benefits contracts (Cari Eaton, Chief Financial Officer) (**For Possible Action**)

BOARD ACTION ON ITEM 9
MOTION: Motion to approve the processing of these two contract amendments.
BY: Member Don Bailey
SECOND: Member Jennifer Krupp
VOTE: Unanimous; the motion carried

10. Health Claim Auditors, Inc. quarterly audit of HealthSCOPE Benefits for the timeframe January 1, 2020 – March 31, 2020: (1) Report from Health Claim Auditors; (2) HealthSCOPE Benefits response to audit report; and (3) for possible action to accept audit report findings and assess penalties, if applicable, in accordance with the performance guarantees included in the contract pursuant to the recommendation of Health Claim Auditors (Robert Carr, Health Claim Auditors) (**For Possible Action**)

BOARD ACTION ON ITEM 10
MOTION: Motion to accept the audit.
BY: Member David Smith
SECOND: Member Don Bailey
VOTE: Unanimous; the motion carried

11. Health Claim Auditors, Inc. yearly audit of Express Scripts, Inc. (ESI) for the timeframe July 1, 2018 – June 30, 2019 (Robert Carr, Health Claim Auditors) (**For Possible Action**)

BOARD ACTION ON ITEM 11
MOTION: Motion to accept the conclusions and recommendations in this audit, to include the 1,924,753 dollar under-performance guarantee and the 6,301 dollar penalty.
BY: Member Don Bailey
SECOND: Member Jet Mitchell
VOTE: Unanimous; the motion carried

12. Public Comment
    - Deborah McGill – UNLV Employee
    - Kent Ervin – Nevada Faculty Alliance
    - Priscilla Maloney – AFSCME
    - Marlene Lockard – RPEN
    - Kevin Ranft – AFSCME

13. Adjournment
    - Board Chair Freed adjourned the meeting at 11:32 a.m.

4.2

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

    4.2 Receipt of quarterly staff reports for the period ending March 31, 2020:

        4.2.1 Budget Report

        4.2.2 Utilization Report

4.2.1

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

4.2 Receipt of quarterly staff reports for the period ending March 31, 2020:

4.2.1 Budget Report

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LAURA RICH
Executive Officer

AGENDA ITEM

[X] Action Item
[ ] Information Only

Date: July 23, 2020

Item Number: IV.II.I

Title: Chief Financial Officer Budget Report

Summary

This report addresses the Operational Budget as of March 31, 2020 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 March 31, 2020 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 $270.4 million as of March 31, 2020 compared to $278.3 million as of March 31, 2019 or a decrease of 2.8%. Total expenses for the period have increased by $32.3 million or 12.1% for the same period.

The budget status report shows Realized Funding Available (cash) at $122.0 million. This compares to $155.0 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 a shortfall of $15.4 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 3/31/2020	Work Program	Percent	Actual as of 3/31/2019	Fiscal Year 2019 Close	Percent
Beginning Cash	150,276,433	150,276,433	100%	143,129,728	143,129,728	100%
Premium Income	258,232,490	382,017,605	68%	269,852,064	363,123,752	74%
All Other Income	12,213,121	9,151,598	133%	8,472,586	13,001,438	65%
Total Income	270,445,611	391,169,203	69%	278,324,649	376,125,190	74%
Personnel Services	1,852,664	2,835,868	65%	1,918,136	2,721,398	70%
Operating - Other than Personnel	1,441,925	2,383,964	60%	1,572,186	2,142,352	73%
Insurance Program Expenses	294,976,801	391,635,970	75%	262,174,182	363,036,252	72%
All Other Expenses	444,061	669,431	66%	781,802	1,078,483	72%
Total Expenses	298,715,452	397,525,233	75%	266,446,306	368,978,485	72%
Change in Cash	(28,269,841)	(6,356,030)		11,878,344	7,146,705	
REALIZED FUNDING AVAILABLE	122,006,592	143,920,403	85%	155,008,072	150,276,433	103%
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	(15,387,611)	6,526,200		31,632,016	26,900,377	

Current Budget Projections

The following table represents projections for FY 2020 based on data available as of March 31, 2020. The projection reflects total income to be more than budgeted by 0.7% ($545.5 million vs $541.4 million), total expenditures are projected to be less than budgeted by 2.2% ($388.6 million vs $397.5 million); total reserves are projected to be more than budgeted by 9.2% ($157.2 million vs $143.9 million).

Budgeted and Projected Income (Budget Account 1338)					
Description	**Budget**	**Actual 3/31/20**	**Projected**	**Difference**	
Carryforward	150,276,433	150,276,433	150,276,433	0	0.0%
State Subsidies	286,540,424	189,615,175	292,360,928	5,820,504	2.0%
Non-State Subsidies	29,202,769	19,024,578	28,187,570	(1,015,199)	-3.5%
Premium	66,274,412	38,569,931	57,836,447	(8,437,965)	-12.7%
All Other	9,151,598	11,883,525	16,816,231	7,664,633	83.8%
Total	541,445,636	409,369,642	545,477,609	4,031,973	0.7%
Budgeted and Projected Expenses (Budget Account 1338)					
Description	**Budget**	**Actual 3/31/20**	**Projected**	**Difference**	
Operating	5,889,263	3,382,417	5,391,262	498,002	8.5%
State Employee Ins Cost	294,710,442	195,938,341	279,252,127	15,458,315	5.2%
State Retirees Ins Cost	41,439,426	35,198,569	57,675,778	(16,236,352)	-39.2%
Non-State Employees Ins Cost	140,039	59,342	162,870	(22,831)	-16.3%
Non-State Retirees Ins Cost	15,384,713	6,914,303	11,413,986	3,970,727	25.8%
State Medicare Ret Ins Cost	23,155,087	14,871,237	20,384,856	2,770,231	12.0%
Non-State Medicare Ret Ins Cost	16,806,263	9,289,189	14,362,911	2,443,352	14.5%
Total Insurance Costs	391,635,970	262,270,980	383,252,528	8,383,442	2.1%
Total Expenses	397,525,233	265,653,397	388,643,790	8,881,444	2.2%
Restricted Reserves	137,394,203	137,394,203	139,294,953	(1,900,750)	-1.4%
Excess Reserves for Benefit Enhancements	6,526,200	6,322,042	17,866,322	(11,340,122)	-173.8%
Total Reserves	143,920,403	143,716,245	157,161,276	(13,240,873)	-9.2%
Total of Expenses and Reserves	541,445,636	409,369,642	545,805,065	(4,359,429)	-0.8%

State Subsidies are projected to be more than the budgeted amount by $5.8 million (2.0%), Non-State Subsidies are projected to be less than budgeted by $1.0 million (3.5%), and Premium Income is projected to be less than budgeted by $8.4 million (12.7%). This overall increase in projected revenue is due in part to an increase in Rx Rebate and Treasurer's Interest revenue.

Expenses for Fiscal Year 2020 are projected to be $8.9 million (2.2%) less than budgeted when changes to reserves are excluded. Operating expenses are projected to be less than budgeted by $0.5 million (8.5%). Employee and Retiree insurances costs are projected to be less than budgeted by $8.4 million (2.1%) when taken in total (see table above for specific information). This overall decrease in projected expenditures is due in part to a decrease in claims and utilization of the plan when taking COVID-19 into consideration for total year projections.

Recommendations

None.

4.2.2

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

    4.2 Receipt of quarterly staff reports for the period ending March 31, 2020:

        4.2.1 Budget Report

        4.2.2 Utilization Report

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Executive Officer

AGENDA ITEM

[X] Action Item
[ ] Information Only

Date: July 23, 2020

Item Number: IV.II.II

Title: Self-Funded CDHP and EPO Plan Utilization Report for the period ending March 31, 2020

This report addresses medical, dental, prescription drug and HSA/HRA utilization for the Plan Year ending March 31, 2020. 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 Q3 of Plan Year 2020 compared to Q3 of Plan Year 2019 is summarized below.

- Population:
  - 0.6% increase for primary participants
  - 0.2% increase for primary participants plus dependents (members)
- Medical Cost:
  - 14.1% increase for primary participants
  - 14.6% increase for primary participants plus dependents (members)
- High Cost Claims:
  - There were 142 High Cost Claimants accounting for 31.2% of the total plan paid for Q3 in Plan Year 2020
  - 0.4% increase in High Cost Claimants per 1,000 members
  - 12.9% increase in average cost of High Cost Claimant paid
- Top three highest cost clinical classifications include:
  - Neoplasms ($8.8 million) – 25.8% of paid claims
  - Injury and Poisoning ($7.5 million) – 22.1% of paid claims
  - Diseases of the Circulatory System ($5.5 million) – 16.2% of paid claims
- Emergency Room:
  - ER visits per 1,000 members increased by 4.5%
  - Average paid per ER visit increased 15.5%
- Urgent Care:
  - Urgent Care visits per 1,000 members increased by 22.9%
  - Average paid per Urgent Care visit increased 29.7%
- Network Utilization:
  - 96% of claims are from In-Network providers
  - Q3 of Plan Year 2020 In-Network utilization increased 0.4% over PY 2019
  - Q3 of Plan Year 2020 In-Network discounts decreased 0.1% over PY 2019
- Preventive Services:
  - Overall Preventive Services Compliance Rates increased from Plan Year 2019 in all categories apart from Cervical Cancer Screenings in women between 21-29 years old. This preventive service decreased 1.9%.
- Prescription Drug Utilization:
  - Overall:
    - Total Net Claims increased 7.5%
    - Total Gross Claims Costs increased 5.8% ($2.0 million)
    - Average Total Cost per Claim decreased 1.6%
      - From $94.39 to $92.88
  - Member*:
    - Total Member Cost increased 31.8%
    - Average Participant Share per Claim increased 22.6%
    - Net Member PMPM increased 31.5%

        - From $20.64 to $27.14
    - Plan
        - Total Plan Cost decreased 1.8%
        - Average Plan Share per Claim decreased 8.6%
        - Net Plan PMPM decreased 2.0%
            - From $70.90 to $69.45
        - Net Plan PMPM factoring rebates decreased 7.0%
            - From $55.14 to $51.25

*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 Q3 of Plan Year 2020 compared to the complete Plan Year 2019 is summarized below.

- Population:
    - 3.3% increase for primary participants
    - 3.5% increase for primary participants plus dependents (members)
- Medical Cost:
    - 21.1% increase for primary participants
    - 20.8% increase for primary participants plus dependents (members)
- High Cost Claims:
    - There were 35 High Cost Claimants accounting for 16.5% of the total plan paid for Q3 in Plan Year 2020
    - 13.4% decrease in High Cost Claimants per 1,000 members (compared to PY19)
    - 37.3% decrease in average cost of High Cost Claimant paid
- Top three highest cost clinical classifications include:
    - Neoplasms ($1million) – 15.8% of paid claims
    - Diseases of the Musculoskeletal System and Connective Tissue ($0.75 million) – 11.9% of paid claims
    - Endocrine; Nutritional; and Metabolic Diseases and Immunity Disorders ($0.72 million) – 11.4% of paid claims
- Emergency Room:
    - ER visits per 1,000 members increased by 33.7%
    - Average paid per ER visit remained unchanged
- Urgent Care:
    - Urgent Care visits per 1,000 members increased by 33.7%
    - Average paid per Urgent Care visit increased 11.4%
- Network Utilization:
    - 97.3% of claims are from In-Network providers
    - In-Network utilization decreased 1%
    - In-Network discounts decreased 0.1%
- Preventive Services:
    - Overall Preventive Services Compliance Rates increased from Plan Year 2019 in all categories.

- Prescription Drug Utilization:
    - Overall:
        - Total Net Claims increased 7.4%
        - Total Gross Claims Costs increased 22.5% ($2.7 million)
        - Average Total Cost per Claim increased 14.0%
            - From $98.77 to $112.64
    - Member:
        - Total Member Cost increased 9.1%
        - Average Participant Share per Claim increased 1.6%
        - Net Member PMPM increased 5.3%
            - From $25.69 to $27.05
    - Plan
        - Total Plan Cost increased 25.0%
        - Average Plan Share per Claim increased 16.4%
        - Net Plan PMPM increased 20.7%
            - From $133.29 to $160.91
        - Net Plan PMPM factoring rebates increased 20.2%
            - From $101.94 to $122.58

DENTAL PLAN

The Dental Plan experience for Q3 of Plan Year 2020 is summarized below.

- Dental Cost:
    - Total of $19,435,917 paid for Dental claims
        - Preventative claims account for 42.2% ($8.2 million)
        - Basic claims account for 29.3% ($5.7 million)
        - Major claims account for 21.2% ($4.1 million)
        - Periodontal claims account for 7.4% ($1.4 million)

HEALTH REIMBURSEMENT ARRANGEMENT

The table below provides a list of CDHP HRA account balances as of March 31, 2020.

HRA Account Balances as of March 31, 2020			
$Range	**# Accounts**	**Total Account Balance**	**Average Per Account Balance**
0	1,355	0	0
$.01 - $500.00	2,605	557,646	214
$500.01 - $1,000	1,686	1,201,062	712
$1,000.01 - $1,500	1,654	1,998,785	1,208
$1,500.01 - $2,000	803	1,388,786	1,729
$2,000.01 - $2,500	511	1,147,374	2,245
$2,500.01 - $3,000	285	783,879	2,750
$3,000.01 - $3,500	209	677,335	3,241
$3,500.01 - $4,000	202	753,188	3,729
$4,000.01 - $4,500	165	697,122	4,225
$4,500.01 - $5,000	108	511,745	4,738
$5,000.01 +	**883**	**6,856,295**	**223,152**
Total	**10,466**	**$ 16,573,216.12**	**$ 1,583.53**

CONCLUSION

The information in this report provides plan experience for the Consumer Driven Health Plan (CDHP) and the PEBP Premier Plan (EPO) for the third quarter of Plan Year 2020. The CDHP total plan paid costs increased 19.6% over the third quarter of Plan Year 2019. The EPO total plan paid costs through the third 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 – March 31, 2020

HSB DATASCOPE™

Nevada Public Employees' Benefits Program
HDHP Plan

July 2019 – March 2020

HealthSCOPE BENEFITS

Overview

***Please note the majority of this report compares 3Q20 to the 3rd quarter of PY19; it will be full plan year, where noted.**

- Total Medical Spend for 3Q20 was $108,693,905 of which 72.2% was spent in the State Active population. When compared to 3Q19, 3Q20 reflected an increase of 14.6% in plan spend, with State Actives having an increase of 12.9%.
  - When compared to 3Q18, 3Q20 reflected an increase of 20.6% in plan spend, with State Actives having an increase of 18.4%.
- On a PEPY basis, 3Q20 reflected an increase of 14.0% when compared to 3Q19. The largest group, State Actives, increased 11.5%.
  - When compared to 3Q18, 3Q20 reflected a increase in PEPY of 17.9%, with State Actives increasing by 14.2%.
- 88.5% of the Average Membership had paid Medical claims less than $2,500, with 20.4% of those having no claims paid at all during the reporting period.
- There were 142 High Cost Claimants (HCC's) over $100K, that account for 31.2% of the total spend. HCC's accounted for 31.5% of total spend during 3Q19, with 141 members hitting the $100K threshold. The largest claimant had a primary diagnosis in the Injury and Poisoning Grouper, with plan spend of $4,891,414.
- IP Paid per Admit was $21,368 which is an increase of 2.6% over 3Q19 Paid per Admit of $20,821.
- ER Paid per Visit is $2,179, which is an increase of 15.5% from 3Q19 ER Paid per Visit of $1,887.
- 96.0% of all Medical spend dollars were to In Network providers. The average In Network discount was 65.3%, which is slightly lower than PY19 discount of 65.4%.

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

Paid Claims by Age Group												
	3Q19											
Age Range	Med Net Pay		Med PMPM		Rx Net Pay		Rx PMPM		Dental Net Pay		Dental PMPM		Net Pay		PMPM	
<1	$	5,240,277	$	1,759	$	25,493	$	9	$	3,727	$	1	$	5,269,497	$	1,769
1	$	482,100	$	139	$	31,336	$	9	$	33,637	$	7	$	547,073	$	155
2 - 4	$	823,194	$	68	$	58,526	$	5	$	305,875	$	19	$	1,187,595	$	92
5 - 9	$	1,133,889	$	49	$	242,226	$	10	$	917,085	$	29	$	2,293,200	$	89
10 - 14	$	2,790,226	$	110	$	229,974	$	9	$	899,175	$	26	$	3,919,375	$	145
15 - 19	$	3,734,186	$	137	$	607,634	$	22	$	1,124,398	$	30	$	5,466,218	$	190
20 - 24	$	5,114,682	$	166	$	564,135	$	18	$	738,719	$	19	$	6,417,536	$	203
25 - 29	$	3,268,700	$	131	$	658,787	$	26	$	723,886	$	23	$	4,651,373	$	181
30 - 34	$	5,012,192	$	190	$	850,063	$	32	$	847,702	$	25	$	6,709,957	$	248
35 - 39	$	4,579,926	$	155	$	1,118,833	$	38	$	1,007,385	$	26	$	6,706,144	$	219
40 - 44	$	4,084,118	$	153	$	1,776,657	$	67	$	1,032,720	$	29	$	6,893,495	$	249
45 - 49	$	7,341,156	$	249	$	2,628,176	$	89	$	1,195,744	$	29	$	11,165,076	$	368
50 - 54	$	9,972,479	$	327	$	2,834,092	$	93	$	1,356,008	$	32	$	14,162,580	$	452
55 - 59	$	11,562,746	$	342	$	4,911,992	$	145	$	1,690,087	$	36	$	18,164,824	$	523
60 - 64	$	19,094,477	$	496	$	6,565,512	$	171	$	2,067,138	$	37	$	27,727,127	$	704
65+	$	10,596,389	$	528	$	4,135,782	$	206	$	4,570,375	$	39	$	19,302,546	$	774
Total	**$**	**94,830,736**	**$**	**246**	**$**	**27,239,217**	**$**	**71**	**$**	**18,513,661**	**$**	**30**	**$**	**140,583,615**	**$**	**348**

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

Paid Claims by Age Group																
	3Q20														% 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	$	4,656,377	$	1,478	$	60,016	$	19	$	11,447	$	2	$	4,727,839	$	1,500	-10.3%	-15.2%
1	$	638,379	$	181	$	14,515	$	4	$	37,735	$	8	$	690,629	$	193	26.2%	24.4%
2 - 4	$	983,913	$	82	$	409,088	$	34	$	313,076	$	19	$	1,706,077	$	135	43.7%	46.2%
5 - 9	$	1,244,088	$	54	$	121,675	$	5	$	989,682	$	31	$	2,355,444	$	91	2.7%	2.6%
10 - 14	$	2,625,760	$	102	$	398,223	$	16	$	962,569	$	27	$	3,986,552	$	145	1.7%	0.0%
15 - 19	$	3,856,680	$	142	$	703,428	$	26	$	1,157,646	$	31	$	5,717,754	$	199	4.6%	4.7%
20 - 24	$	4,585,968	$	149	$	701,924	$	23	$	770,925	$	19	$	6,058,818	$	191	-5.6%	-5.9%
25 - 29	$	4,510,221	$	180	$	811,926	$	32	$	767,118	$	24	$	6,089,265	$	237	30.9%	30.9%
30 - 34	$	5,615,717	$	208	$	1,315,927	$	49	$	899,017	$	26	$	7,830,661	$	283	16.7%	14.4%
35 - 39	$	5,147,255	$	172	$	2,439,602	$	82	$	1,061,225	$	27	$	8,648,082	$	281	29.0%	28.2%
40 - 44	$	5,918,972	$	218	$	1,618,685	$	60	$	1,078,206	$	29	$	8,615,863	$	307	25.0%	23.1%
45 - 49	$	8,116,195	$	278	$	2,568,411	$	88	$	1,262,488	$	31	$	11,947,094	$	397	7.0%	7.9%
50 - 54	$	9,140,377	$	300	$	3,456,281	$	113	$	1,395,373	$	32	$	13,992,031	$	446	-1.2%	-1.4%
55 - 59	$	12,989,223	$	388	$	4,757,409	$	142	$	1,682,153	$	36	$	19,428,785	$	566	7.0%	8.2%
60 - 64	$	26,932,000	$	715	$	5,931,841	$	157	$	2,066,968	$	39	$	34,930,810	$	911	26.0%	29.5%
65+	$	11,732,779	$	566	$	3,641,965	$	176	$	4,980,290	$	42	$	20,355,034	$	783	5.5%	1.3%
Total	**$**	**108,693,905**	**$**	**282**	**$**	**28,950,916**	**$**	**75**	**$**	**19,435,917**	**$**	**31**	**$**	**157,080,737**	**$**	**388**	**11.7%**	**11.7%**

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

	Total				State Active				Non-State Active			
Summary	**3Q18**	**3Q19**	**3Q20**	**Variance to Prior Year**	**3Q18**	**3Q19**	**3Q20**	**Variance to Prior Year**	**3Q18**	**3Q19**	**3Q20**	**Variance to Prior Year**
Enrollment												
Avg # Employees	23,133	23,523	23,655	0.6%	19,072	19,549	19,776	1.2%	4	4	4	0.0%
Avg # Members	42,024	42,747	42,850	0.2%	36,359	37,090	37,262	0.5%	7	7	7	0.0%
Ratio	1.8	1.8	1.8	-0.5%	1.9	1.9	1.9	-1.1%	1.7	1.8	1.8	0.0%
Financial Summary												
Gross Cost	$121,095,837	$126,187,313	$143,839,796	14.0%	$91,012,617	$94,673,980	$106,842,232	12.9%	$36,985	$28,186	$40,378	43.3%
Client Paid	$90,136,905	$94,830,736	$108,693,905	14.6%	$66,302,270	$69,590,772	$78,511,281	12.8%	$28,475	$21,172	$30,241	42.8%
Employee Paid	$30,958,932	$31,356,576	$35,145,891	12.1%	$24,710,347	$25,083,207	$28,330,951	12.9%	$8,510	$7,014	$10,137	44.5%
Client Paid-PEPY	$5,195	$5,375	$6,127	14.0%	$4,635	$4,746	$5,293	11.5%	$9,235	$7,057	$10,080	42.8%
Client Paid-PMPY	$2,860	$2,958	$3,382	14.3%	$2,431	$2,502	$2,809	12.3%	$5,339	$4,033	$5,760	42.8%
Client Paid-PEPM	$433	$448	$511	14.1%	$386	$396	$441	11.4%	$770	$588	$840	42.9%
Client Paid-PMPM	$238	$246	$282	14.6%	$203	$208	$234	12.5%	$445	$336	$480	42.9%
High Cost Claimants (HCC's) > $100k												
# of HCC's	105	141	142	0.7%	67	88	101	14.8%	0	0	0	0.0%
HCC's / 1,000	2.5	3.3	3.3	0.4%	1.8	2.4	2.7	14.2%	0.0	0.0	0.0	0.0%
Avg HCC Paid	$221,352	$211,913	$239,171	12.9%	$236,431	$216,402	$196,453	-9.2%	$0	$0	$0	0.0%
HCC's % of Plan Paid	25.8%	31.5%	31.2%	-1.0%	23.9%	27.4%	25.3%	-7.7%	0.0%	0.0%	0.0%	0.0%
Cost Distribution by Claim Type (PMPY)												
Facility Inpatient	$890	$1,048	$1,179	12.5%	$718	$844	$866	2.6%	$0	$937	$0	0.0%
Facility Outpatient	$934	$858	$1,040	21.2%	$784	$717	$871	21.5%	$1,351	$378	$2,423	541.0%
Physician	$954	$987	$1,082	9.6%	$866	$891	$1,004	12.7%	$3,837	$2,596	$3,045	17.3%
Other	$82	$65	$81	24.6%	$63	$50	$68	36.0%	$151	$121	$292	0.0%
Total	$2,860	$2,958	$3,382	14.3%	$2,431	$2,502	$2,809	12.3%	$5,339	$4,033	$5,760	42.8%
	Annualized	Annualized	Annualized		Annualized	Annualized	Annualized		Annualized	Annualized	Annualized	

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

	State Retirees				Non-State Retirees				
Summary	**3Q18**	**3Q19**	**3Q20**	**Variance to Prior Year**	**3Q18**	**3Q19**	**3Q20**	**Variance to Prior Year**	**HSB Peer Index**
Enrollment									
Avg # Employees	3,170	3,225	3,247	0.7%	887	745	629	-15.6%	
Avg # Members	4,681	4,803	4,856	1.1%	978	847	725	-14.4%	
Ratio	1.5	1.5	1.5	0.7%	1.1	1.1	1.2	0.9%	1.8
Financial Summary									
Gross Cost	$22,936,715	$24,697,760	$32,275,680	30.7%	$7,109,520	$6,787,387	$4,681,506	-31.0%	
Client Paid	$17,934,707	$19,493,426	$26,541,571	36.2%	$5,871,453	$5,725,366	$3,610,812	-36.9%	
Employee Paid	$5,002,008	$5,204,334	$5,734,109	10.2%	$1,238,067	$1,062,021	$1,070,694	0.8%	
Client Paid-PEPY	$7,545	$8,060	$10,900	35.2%	$8,826	$10,253	$7,658	-25.3%	$6,209
Client Paid-PMPY	$5,109	$5,412	$7,287	34.6%	$8,007	$9,008	$6,641	-26.3%	$3,437
Client Paid-PEPM	$629	$672	$908	35.1%	$735	$854	$638	-25.3%	$517
Client Paid-PMPM	$426	$451	$607	34.6%	$667	$751	$553	-26.4%	$286
High Cost Claimants (HCC's) > $100k									
# of HCC's	30	40	42	5.0%	13	13	4	-69.2%	
HCC's / 1,000	6.4	8.3	8.7	3.9%	13.3	15.3	5.5	-64.0%	
Avg HCC Paid	$176,624	$203,103	$320,627	57.9%	$161,724	$208,635	$163,538	-21.6%	
HCC's % of Plan Paid	29.5%	41.7%	50.7%	21.6%	35.8%	47.4%	18.1%	-61.8%	
Cost Distribution by Claim Type (PMPY)									
Facility Inpatient	$1,742	$1,963	$3,344	70.4%	$3,245	$4,793	$2,789	-41.8%	$1,057
Facility Outpatient	$1,735	$1,685	$2,170	28.8%	$2,654	$2,336	$2,162	-7.4%	$1,145
Physician	$1,411	$1,605	$1,596	-0.6%	$2,005	$1,701	$1,601	-5.9%	$1,122
Other	$222	$159	$177	11.3%	$103	$178	$89	-50.0%	$113
Total	$5,109	$5,412	$7,287	34.6%	$8,007	$9,008	$6,641	-26.3%	$3,437

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

	Total				State Active				Non-State Active			
Summary	**PY18**	**PY19**	**3Q20**	**Variance to Prior Year**	**PY18**	**PY19**	**3Q20**	**Variance to Prior Year**	**PY18**	**PY19**	**3Q20**	**Variance to Prior Year**
Enrollment												
Avg # Employees	23,155	23,569	23,655	0.4%	19,100	19,612	19,776	0.8%	4	4	4	0.0%
Avg # Members	42,071	42,776	42,850	0.2%	36,389	37,138	37,262	0.3%	7	7	7	0.0%
Ratio	1.8	1.8	1.8	0.0%	1.9	1.9	1.9	-0.5%	1.7	1.8	1.8	0.0%
Financial Summary												
Gross Cost	$164,211,622	$172,993,213	$143,839,796		$123,145,285	$129,947,874	$106,842,232		$42,221	$105,325	$40,378	
Client Paid	$125,066,281	$133,179,670	$108,693,905		$91,783,613	$97,851,639	$78,511,281		$32,607	$96,469	$30,241	
Employee Paid	$39,145,341	$39,813,543	$35,145,891		$31,361,671	$32,096,235	$28,330,951		$9,615	$8,857	$10,137	
Client Paid-PEPY	$5,401	$5,651	$6,127	8.4%	$4,805	$4,989	$5,293	6.1%	$7,985	$24,117	$10,080	-58.2%
Client Paid-PMPY	$2,973	$3,113	$3,382	8.6%	$2,522	$2,635	$2,809	6.6%	$4,603	$13,781	$5,760	-58.2%
Client Paid-PEPM	$450	$471	$511	8.5%	$400	$416	$441	6.0%	$665	$2,010	$840	-58.2%
Client Paid-PMPM	$248	$259	$282	8.9%	$210	$220	$234	6.4%	$384	$1,148	$480	-58.2%
High Cost Claimants (HCC's) > $100k												
# of HCC's	164	198	142		108	124	101		0	0	0	
HCC's / 1,000	3.9	4.6	3.3		3.0	3.3	2.7		0.0	0.0	0.0	
Avg HCC Paid	$211,524	$219,374	$239,171	9.0%	$212,840	$218,720	$196,453	-10.2%	$0	$0	$0	0.0%
HCC's % of Plan Paid	27.7%	32.6%	31.2%	-4.3%	25.0%	27.7%	25.3%	-8.7%	0.0%	0.0%	0.0%	0.0%
Cost Distribution by Claim Type (PMPY)												
Facility Inpatient	$900	$1,071	$1,179	10.1%	$719	$847	$866	2.2%	$0	$3,087	$0	0.0%
Facility Outpatient	$974	$925	$1,040	12.4%	$814	$782	$871	11.4%	$1,064	$6,561	$2,423	-63.1%
Physician	$1,016	$1,045	$1,082	3.5%	$924	$948	$1,004	5.9%	$3,394	$4,006	$3,045	-24.0%
Other	$82	$72	$81	12.5%	$64	$58	$68	17.2%	$146	$129	$292	0.0%
Total	$2,973	$3,113	$3,382	8.6%	$2,522	$2,635	$2,809	6.6%	$4,603	$13,781	$5,760	-58.2%
			Annualized				Annualized				Annualized	

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

	State Retirees				Non-State Retirees				
Summary	**PY18**	**PY19**	**3Q20**	**Variance to Prior Year**	**PY18**	**PY19**	**3Q20**	**Variance to Prior Year**	**HSB Peer Index**
Enrollment									
Avg # Employees	3,165	3,224	3,247	0.7%	868	729	629	-13.8%	
Avg # Members	4,681	4,799	4,856	1.2%	958	832	725	-12.8%	
Ratio	1.5	1.5	1.5	0.7%	1.1	1.1	1.2	0.9%	1.8
Financial Summary									
Gross Cost	$31,539,962	$34,175,219	$32,275,680		$9,484,154	$8,764,794	$4,681,506		
Client Paid	$25,259,022	$27,761,940	$26,541,571		$7,991,039	$7,469,622	$3,610,812		
Employee Paid	$6,280,940	$6,413,280	$5,734,109		$1,493,115	$1,295,172	$1,070,694		
Client Paid-PEPY	$7,981	$8,612	$10,900	26.6%	$9,204	$10,246	$7,658	-25.3%	$6,209
Client Paid-PMPY	$5,397	$5,785	$7,287	26.0%	$8,338	$8,983	$6,641	-26.1%	$3,437
Client Paid-PEPM	$665	$718	$908	26.5%	$767	$854	$638	-25.3%	$517
Client Paid-PMPM	$450	$482	$607	25.9%	$695	$749	$553	-26.2%	$286
High Cost Claimants (HCC's) > $100k									
# of HCC's	50	58	42		18	16	4		
HCC's / 1,000	10.7	12.1	8.7		18.8	19.2	5.5		
Avg HCC Paid	$169,470	$220,380	$320,627	45.5%	$179,428	$220,793	$163,538	-25.9%	
HCC's % of Plan Paid	33.5%	46.0%	50.7%	10.2%	40.4%	47.3%	18.1%	-61.7%	
Cost Distribution by Claim Type (PMPY)									
Facility Inpatient	$1,822	$2,155	$3,344	55.2%	$3,299	$4,794	$2,789	-41.8%	$1,057
Facility Outpatient	$1,842	$1,787	$2,170	21.4%	$2,839	$2,295	$2,162	-5.8%	$1,145
Physician	$1,521	$1,677	$1,596	-4.8%	$2,073	$1,732	$1,601	-7.6%	$1,122
Other	$212	$166	$177	6.6%	$127	$163	$89	-45.4%	$113
Total	$5,397	$5,785	$7,287	26.0%	$8,338	$8,983	$6,641	-26.1%	$3,437
			Annualized				Annualized		

Paid Claims by Claim Type – State Participants

Net Paid Claims - Total State Participants	3Q19				3Q20				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical									
Inpatient	$ 27,278,109	$ 6,209,937	$ 1,627,848	$ 35,115,894	$ 28,646,209	$ 10,922,760	$ 2,226,347	$ 41,795,316	19.0%
Outpatient	$ 42,312,663	$ 10,138,286	$ 1,517,355	$ 53,968,304	$ 49,865,072	$ 11,970,906	$ 1,421,558	$ 63,257,536	17.2%
Total - Medical	$ 69,590,772	$ 16,348,222	$ 3,145,204	$ 89,084,198	$ 78,511,281	$ 22,893,665	$ 3,647,906	$ 105,052,852	17.9%
Dental	$ 12,618,555	$ 1,501,902	$ 377,501	$ 14,497,957	$ 13,248,160	$ 1,534,360	$ 424,290	$ 15,206,811	4.9%
Dental Exchange	$ -	$ -	$ 2,169,604	$ 2,169,604	$ -	$ -	$ 2,368,216	$ 2,368,216	9.2%
Total	**$ 82,209,327**	**$ 17,850,124**	**$ 5,692,308**	**$ 105,751,760**	**$ 91,759,441**	**$ 24,428,026**	**$ 6,440,412**	**$ 122,627,878**	**16.0%**

Net Paid Claims - Per Participant per Month	3Q19				3Q20				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical	$ 396	$ 695	$ 572	$ 435	$ 441	$ 964	$ 665	$ 507	16.7%
Dental	$ 52	$ 50	$ 56	$ 52	$ 54	$ 50	$ 48	$ 53	2.3%
Dental Exchange	$ -	$ -	$ 48	$ 48	$ -	$ -	$ 50	$ 50	2.5%

Paid Claims by Claim Type – Non-State Participants

Net Paid Claims - Total Non-State Participants	3Q19				3Q20				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical									
Inpatient	$ 8,420	$ 2,129,225	$ 1,089,969	$ 3,227,613	$ 204	$ 645,476	$ 962,537	$ 1,608,217	-50.2%
Outpatient	$ 12,752	$ 2,117,747	$ 388,426	$ 2,518,925	$ 30,037	$ 1,518,942	$ 483,857	$ 2,032,836	-19.3%
Total - Medical	$ 21,172	$ 4,246,971	$ 1,478,395	$ 5,746,538	$ 30,241	$ 2,164,418	$ 1,446,394	$ 3,641,053	-36.6%
Dental	$ 2,428	$ 301,319	$ 155,940	$ 459,688	$ 2,149	$ 234,681	$ 177,568	$ 414,399	-9.9%
Dental Exchange	$ -	$ -	$ 1,386,412	$ 1,386,412	$ -	$ -	$ 1,446,492	$ 1,446,492	4.3%
Total	**$ 23,600**	**$ 4,548,291**	**$ 3,020,747**	**$ 7,592,638**	**$ 32,391**	**$ 2,399,099**	**$ 3,070,454**	**$ 5,501,944**	**-27.5%**

Net Paid Claims - Per Participant per Month	3Q19				3Q20				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical	$ 588	$ 969	$ 638	$ 853	$ 840	$ 654	$ 617	$ 639	-25.0%
Dental	$ 34	$ 41	$ 42	$ 41	$ 30	$ 43	$ 47	$ 44	7.8%
Dental Exchange	$ -	$ -	$ 43	$ 43	$ -	$ -	$ 45	$ 45	3.9%

Paid Claims by Claim Type – Total

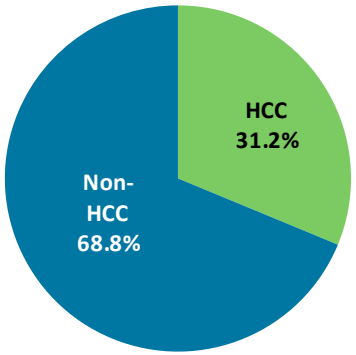
Net Paid Claims - Total Total Participants	3Q19				3Q20				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical									
Inpatient	$ 27,286,529	$ 8,339,161	$ 2,717,817	$ 38,343,507	$ 28,646,412	$ 11,568,236	$ 3,188,885	$ 43,403,533	13.2%
Outpatient	$ 42,325,416	$ 12,256,032	$ 1,905,781	$ 56,487,229	$ 49,895,110	$ 13,489,847	$ 1,905,415	$ 65,290,372	15.6%
Total - Medical	$ 69,611,944	$ 20,595,194	$ 4,623,599	$ 94,830,736	$ 78,541,522	$ 25,058,083	$ 5,094,300	$ 108,693,905	14.6%
Dental	$ 12,620,983	$ 1,803,221	$ 533,441	$ 14,957,645	$ 13,250,310	$ 1,769,042	$ 601,858	$ 15,621,209	4.4%
Dental Exchange	$ -	$ -	$ 3,556,016	$ 3,556,016	$ -	$ -	$ 3,814,708	$ 3,814,708	7.3%
Total	**$ 82,232,928**	**$ 22,398,415**	**$ 8,713,055**	**$ 113,344,397**	**$ 91,791,832**	**$ 26,827,125**	**$ 9,510,866**	**$ 128,129,822**	**13.0%**

Net Paid Claims - Per Participant per Month	3Q19				3Q20				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	
Medical	$ 396	$ 738	$ 592	$ 448	$ 441	$ 926	$ 651	$ 511	14.0%
Dental	$ 52	$ 48	$ 51	$ 52	$ 54	$ 49	$ 48	$ 53	2.5%
Dental Exchange	$ -	$ -	$ 46	$ 46	$ -	$ -	$ 48	$ 48	3.2%

Cost Distribution – Medical Claims

3Q19							3Q20					
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
126	0.3%	$29,879,772	31.5%	$930,047	3.0%	$100,000.01 Plus	121	0.3%	$33,962,230	31.2%	$790,791	2.3%
155	0.4%	$12,088,256	12.7%	$937,359	3.0%	$50,000.01-$100,000.00	179	0.4%	$13,580,650	12.5%	$1,088,988	3.1%
278	0.6%	$10,600,684	11.2%	$1,499,833	4.8%	$25,000.01-$50,000.00	386	0.9%	$14,437,844	13.3%	$2,049,744	5.8%
925	2.2%	$15,297,595	16.1%	$4,264,775	13.6%	$10,000.01-$25,000.00	1,037	2.4%	$17,232,031	15.9%	$4,688,759	13.3%
1,268	3.0%	$9,481,845	10.0%	$4,091,426	13.0%	$5,000.01-$10,000.00	1,371	3.2%	$10,279,425	9.5%	$4,485,520	12.8%
1,600	3.7%	$6,115,622	6.4%	$3,673,869	11.7%	$2,500.01-$5,000.00	1,856	4.3%	$7,019,835	6.5%	$4,320,982	12.3%
22,307	52.2%	$11,366,963	12.0%	$13,326,359	42.5%	$0.01-$2,500.00	22,760	53.1%	$12,181,891	11.2%	$14,870,180	42.3%
6,455	15.1%	$0	0.0%	$2,632,908	8.4%	$0.00	6,416	15.0%	$0	0.0%	$2,850,927	8.1%
9,635	22.5%	$0	0.0%	$0	0.0%	No Claims	8,723	20.4%	$0	0.0%	$0	0.0%
42,747	**100.0%**	**$94,830,736**	**100.0%**	**$31,356,576**	**100.0%**		**42,850**	**100.0%**	**$108,693,905**	**100.0%**	**$35,145,891**	**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	67	$8,760,410	25.8%
(CCS 16) Injury And Poisoning	75	$7,494,405	22.1%
(CCS 7) Diseases Of The Circulatory System	102	$5,495,803	16.2%
(CCS 15) Certain Conditions Originating In The Perinatal Period	13	$2,051,813	6.0%
(CCS 1) Infectious And Parasitic Diseases	61	$1,535,318	4.5%
(CCS 13) Diseases Of The Musculoskeletal System And Connective Tissue	79	$1,385,466	4.1%
(CCS 17) Symptoms; Signs; And Ill-Defined Conditions And Factors Influencing Health Status	130	$1,221,556	3.6%
(CCS 9) Diseases Of The Digestive System	77	$1,076,697	3.2%
(CCS 6) Diseases Of The Nervous System And Sense Organs	102	$1,035,094	3.0%
(CCS 5) Mental Illness	44	$1,014,329	3.0%
(CCS 8) Diseases Of The Respiratory System	100	$747,870	2.2%
(CCS 3) Endocrine; Nutritional; And Metabolic Diseases And Immunity Disorders	77	$705,339	2.1%
(CCS 10) Diseases Of The Genitourinary System	67	$618,020	1.8%
(CCS 18) Residual Codes; Unclassified; All E Codes [259. And 260.]	82	$291,765	0.9%
(CCS 12) Diseases Of The Skin And Subcutaneous Tissue	51	$201,628	0.6%
(CCS 4) Diseases Of The Blood And Blood-Forming Organs	45	$123,112	0.4%
(CCS 14) Congenital Anomalies	10	$119,855	0.4%
(CCS 11) Complications Of Pregnancy; Childbirth; And The Puerperium	5	$83,750	0.2%
Overall	**----**	**$33,962,230**	**100.0%**

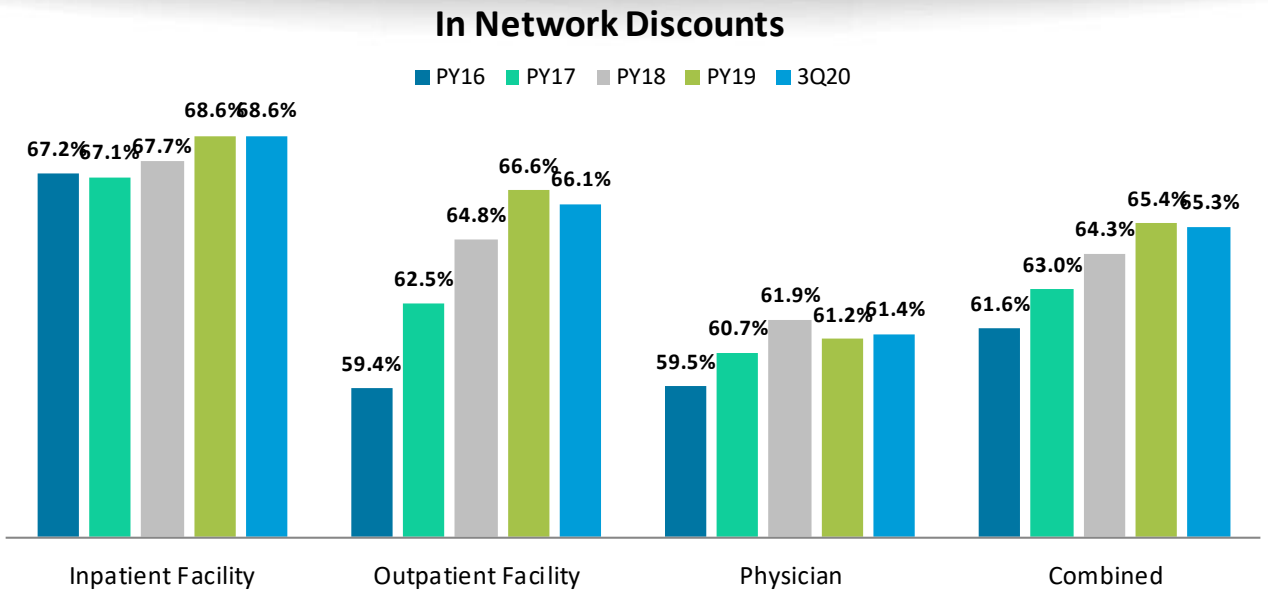
Utilization Summary (p. 1 of 2)

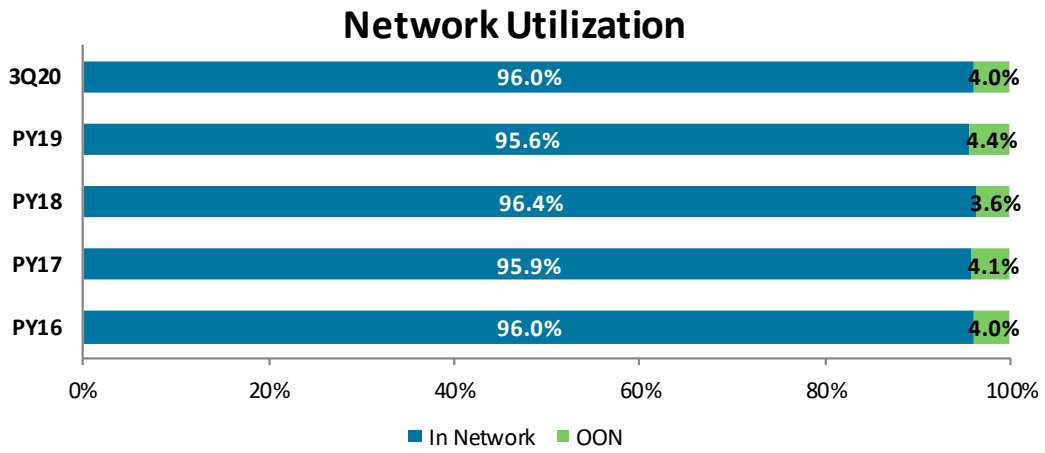
	Total				State Active				Non-State Active			
Summary	**3Q18**	**3Q19**	**3Q20**	**Variance to Prior Year**	**3Q18**	**3Q19**	**3Q20**	**Variance to Prior Year**	**3Q18**	**3Q19**	**3Q20**	**Variance to Prior Year**
Inpatient Facility												
# of Admits	1,620	1,667	1,798		1,235	1,294	1,420		0	1	0	
# of Bed Days	7,525	10,794	9,602		5,292	6,506	7,105		0	1	0	
Paid Per Admit	$18,185	$20,821	$21,368	2.6%	$16,829	$19,082	$17,375	-8.9%	$0	$4,922	$0	0.0%
Paid Per Day	$3,915	$3,216	$4,001	24.4%	$3,927	$3,795	$3,473	-8.5%	$0	$4,922	$0	0.0%
Admits Per 1,000	51	52	56	7.7%	45	47	51	9.6%	0	190	0	0.0%
Days Per 1,000	239	337	299	-11.2%	194	234	254	8.6%	0	190	0	0.0%
Avg LOS	4.6	6.5	5.3	-18.5%	4.3	5	5.0	0.0%	0	1	0	0.0%
Physician Office												
OV Utilization per Member	3.5	3.5	3.9	11.4%	3.3	3.2	3.6	12.5%	10.3	5.0	6.3	26.0%
Avg Paid per OV	$44	$43	$44	2.3%	$44	$43	$44	2.3%	$83	$88	$72	-18.2%
Avg OV Paid per Member	$155	$149	$171	14.8%	$143	$137	$160	16.8%	$860	$435	$451	3.7%
DX&L Utilization per Member	7.4	7.4	8.4	13.5%	6.8	6.9	7.9	14.5%	9.6	7.6	0	0.0%
Avg Paid per DX&L	$57	$62	$58	-6.5%	$55	$57	$55	-3.5%	$49	$61	$0	0.0%
Avg DX&L Paid per Member	$423	$461	$486	5.4%	$373	$389	$431	10.8%	$465	$463	$0	0.0%
Emergency Room												
# of Visits	5,268	5,180	5,442		4,363	4,211	4,460		3	2	2	
# of Admits	784	813	795		562	594	584		0	1	0	
Visits Per Member	0.17	0.16	0.17	5.8%	0.16	0.15	0.16	6.4%	0.56	0.38	0.38	0.0%
Visits Per 1,000	167	162	169	4.5%	160	151	160	5.7%	563	381	381	0.0%
Avg Paid per Visit	$1,834	$1,887	$2,179	15.5%	$1,808	$1,841	$2,188	18.9%	$1,027	$498	$1,803	0.0%
Admits Per Visit	0.15	0.16	0.15	-8.7%	0.13	0.14	0.13	-6.5%	0.00	0.50	0.00	0.0%
Urgent Care												
# of Visits	7,272	7,442	9,166		6,488	6,672	8,304		2	4	1	
Visits Per Member	0.23	0.23	0.29	24.0%	0.24	0.24	0.30	23.8%	0.38	0.76	0.19	0.0%
Visits Per 1,000	231	232	285	22.9%	238	240	297	23.8%	375	762	190	0.0%
Avg Paid per Visit	$38	$36	$47	29.7%	$35	$35	$46	30.1%	$140	$102	$170	0.0%
	Annualized	Annualized	Annualized		Annualized	Annualized	Annualized		Annualized	Annualized	Annualized	

Utilization Summary (p. 2 of 2)

	State Retirees				Non-State Retirees				
Summary	**3Q18**	**3Q19**	**3Q20**	**Variance to Prior Year**	**3Q18**	**3Q19**	**3Q20**	**Variance to Prior Year**	**HSB Peer Index**
Inpatient Facility									
# of Admits	277	284	299		108	88	79		
# of Bed Days	1,719	1,575	2,065		514	2,712	432		
Paid Per Admit	$22,172	$24,476	$40,300	64.7%	$23,468	$34,777	$21,500	-38.2%	$16,173
Paid Per Day	$3,573	$4,413	$5,835	32.2%	$4,931	$1,128	$3,932	248.6%	$3,708
Admits Per 1,000	79	79	82	4.0%	147	138	145	4.7%	61
Days Per 1,000	490	437	567	29.7%	701	4,267	794	-81.4%	264
Avg LOS	6.2	5.1	6.9	35.3%	4.8	30.8	5.5	-82.1%	4.3
Physician Office									
OV Utilization per Member	4.9	4.8	5.2	8.3%	6.1	6.4	7.2	12.5%	3.3
Avg Paid per OV	$47	$47	$46	-2.1%	$38	$38	$35	-7.9%	$50
Avg OV Paid per Member	$230	$224	$243	8.5%	$231	$240	$249	3.8%	$167
DX&L Utilization per Member	10.7	10.6	11.9	12.3%	13.9	13.5	13.7	1.5%	8.3
Avg Paid per DX&L	$68	$85	$73	-14.1%	$61	$79	$59	-25.3%	$67
Avg DX&L Paid per Member	$722	$905	$863	-4.6%	$840	$1,064	$806	-24.2%	$554
Emergency Room									
# of Visits	696	752	776		206	215	204		
# of Admits	169	160	160		53	58	51		
Visits Per Member	0.2	0.21	0.21	1.5%	0.28	0.34	0.38	10.3%	0.17
Visits Per 1,000	198	209	213	1.9%	281	338	375	11.0%	174
Avg Paid per Visit	$2,027	$2,147	$2,320	8.1%	$1,755	$1,891	$1,433	-24.2%	$1,684
Admits Per Visit	0.24	0.21	0.21	-1.8%	0.26	0.27	0.25	-7.4%	0.14
Urgent Care									
# of Visits	629	628	728		153	138	133		
Visits Per Member	0.18	0.17	0.20	17.6%	0.21	0.22	0.24	9.1%	0.24
Visits Per 1,000	179	174	200	14.9%	209	217	245	12.9%	242
Avg Paid per Visit	$64	$47	$63	33.2%	$49	$44	$37	-15.9%	$74
	Annualized	Annualized	Annualized		Annualized	Annualized	Annualized		

Provider Network Summary



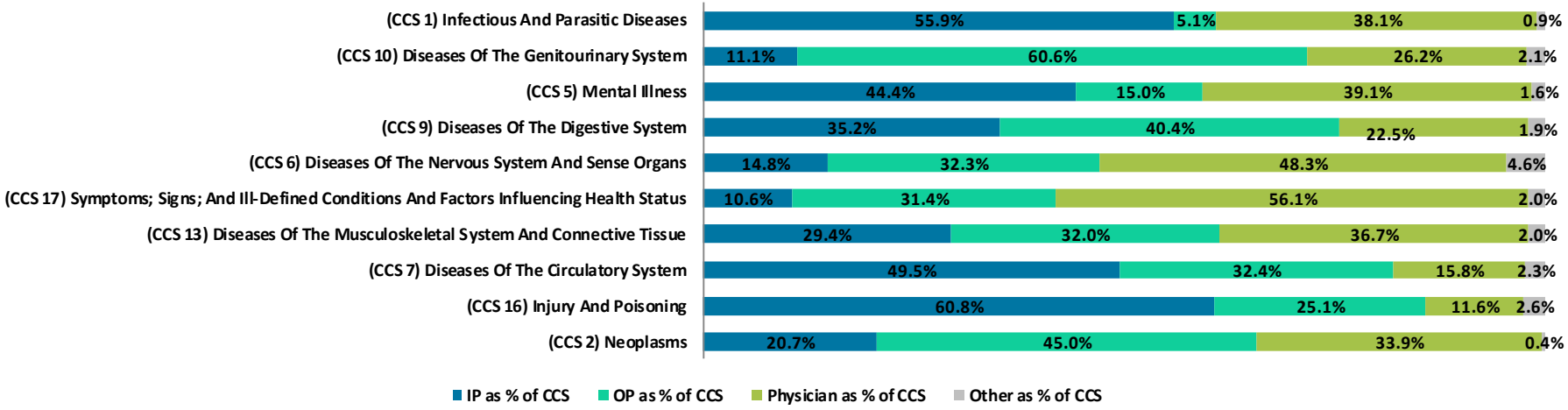


AHRQ* Clinical Classifications Summary

*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	$15,417,527	10.5%	$11,832,012	$2,825,983	$759,532	$6,405,298	$9,012,229
(CCS 16) Injury And Poisoning	$14,014,122	9.5%	$10,271,674	$1,742,380	$2,000,068	$4,288,492	$9,725,631
(CCS 7) Diseases Of The Circulatory System	$12,170,039	8.3%	$10,010,093	$1,874,915	$285,031	$5,372,872	$6,797,167
(CCS 13) Diseases Of The Musculoskeletal System And Connective Tissue	$10,454,524	7.1%	$6,850,261	$2,697,017	$907,247	$4,595,391	$5,859,133
(CCS 17) Symptoms; Signs; And Ill-Defined Conditions And Factors Influencing Healt	$9,763,673	6.6%	$6,104,025	$1,873,822	$1,785,826	$3,656,707	$6,106,966
(CCS 6) Diseases Of The Nervous System And Sense Organs	$6,782,082	4.6%	$4,102,140	$1,352,946	$1,326,996	$2,751,781	$4,030,301
(CCS 9) Diseases Of The Digestive System	$6,394,587	4.4%	$4,644,450	$989,451	$760,687	$2,949,399	$3,445,188
(CCS 5) Mental Illness	$4,983,940	3.4%	$2,461,170	$411,019	$2,111,750	$2,639,567	$2,344,373
(CCS 10) Diseases Of The Genitourinary System	$4,847,010	3.3%	$3,443,835	$927,121	$476,053	$1,893,199	$2,953,810
(CCS 1) Infectious And Parasitic Diseases	$4,693,650	3.2%	$2,563,395	$820,566	$1,309,690	$2,277,603	$2,416,047
(CCS 8) Diseases Of The Respiratory System	$4,327,346	2.9%	$2,400,500	$798,842	$1,128,004	$2,073,121	$2,254,225
(CCS 11) Complications Of Pregnancy; Childbirth; And The Puerperium	$3,771,128	2.6%	$2,643,576	$910,255	$217,297	$28,547	$3,742,581
(CCS 3) Endocrine; Nutritional; And Metabolic Diseases And Immunity Disorders	$3,563,567	2.4%	$2,296,122	$764,836	$502,608	$1,440,037	$2,123,530
(CCS 15) Certain Conditions Originating In The Perinatal Period	$3,480,299	2.4%	$2,461	$32,224	$3,445,614	$2,024,455	$1,455,844
(CCS 18) Residual Codes; Unclassified; All E Codes [259. And 260.]	$1,476,311	1.0%	$1,133,637	$246,424	$96,250	$734,787	$741,524
(CCS 12) Diseases Of The Skin And Subcutaneous Tissue	$1,034,936	0.7%	$697,153	$234,862	$102,920	$553,574	$481,362
(CCS 14) Congenital Anomalies	$843,823	0.6%	$204,263	$41,677	$597,883	$282,379	$561,444
(CCS 4) Diseases Of The Blood And Blood-Forming Organs	$675,340	0.5%	$414,358	$169,066	$91,916	$275,045	$400,295
Total	**$108,693,905**	**100.0%**	**$72,075,126**	**$18,713,408**	**$17,905,371**	**$44,242,255**	**$64,451,650**

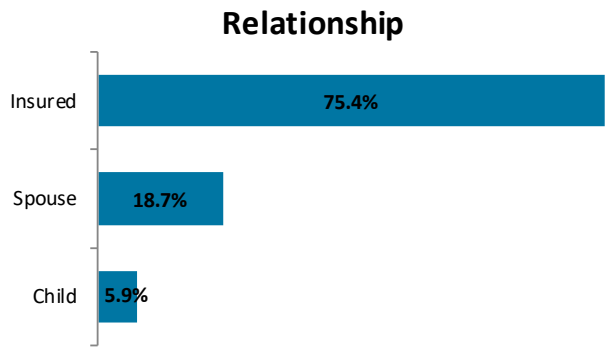
Top 10 Categories by Claim Type

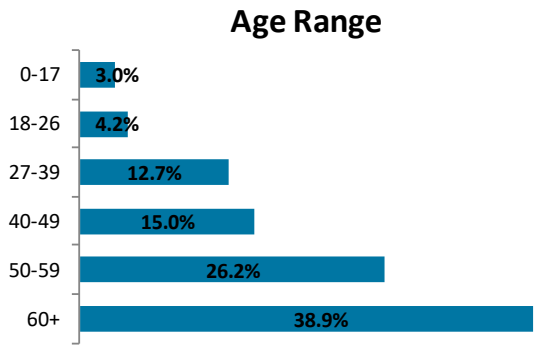


AHRQ Category – Neoplasms

Diagnosis Category	Patients	Claims	Total Paid	% Paid
Maintenance Chemotherapy; Radiotherapy [45.]	111	885	$3,697,687	24.0%
Cancer Of Breast [24.]	323	3,228	$2,110,583	13.7%
Cancer Of Lymphatic And Hematopoietic Tissue	106	1,548	$1,575,946	10.2%
Benign Neoplasms	2,437	4,843	$1,481,302	9.6%
Cancer; Other Primary	200	1,297	$1,445,736	9.4%
Secondary Malignancies [42.]	91	446	$951,058	6.2%
Cancer Of Skin	501	1,456	$885,265	5.7%
Other Gastrointestinal Cancer	45	703	$790,108	5.1%
Colorectal Cancer	82	968	$619,139	4.0%
Cancer Of Male Genital Organs	171	1,128	$538,512	3.5%
Cancer Of Bronchus; Lung [19.]	34	504	$415,553	2.7%
Cancer Of Uterus And Cervix	204	656	$295,433	1.9%
Neoplasms Of Unspecified Nature Or Uncertain Behavior [44.]	1,848	3,162	$242,584	1.6%
Cancer Of Ovary And Other Female Genital Organs	45	350	$147,459	1.0%
Cancer Of Urinary Organs	69	438	$130,696	0.8%
Malignant Neoplasm Without Specification Of Site [43.]	22	105	$90,465	0.6%
Overall	**----**	**----**	**$15,417,527**	**100.0%**

*Patient and claim counts are unique only within the category

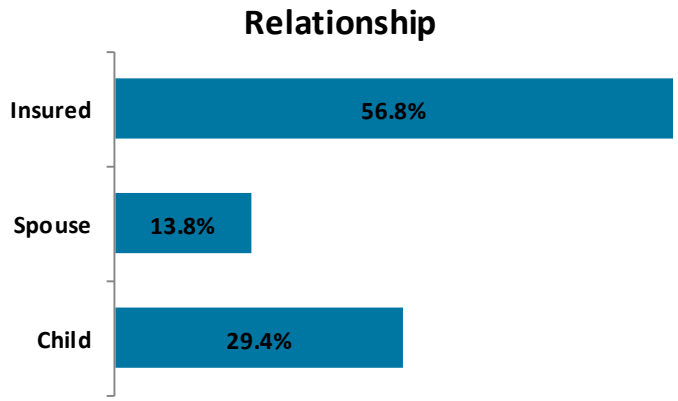


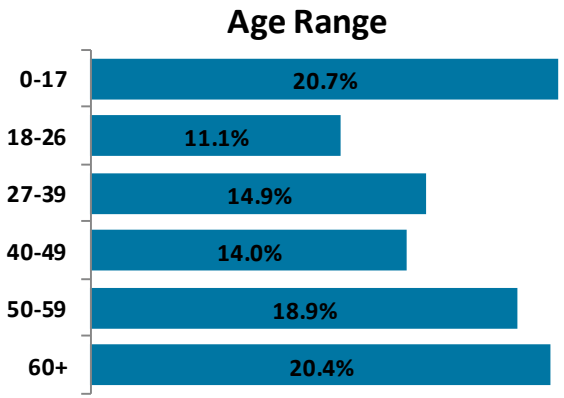


AHRQ Category – Injury & Poisoning

Diagnosis Category	Patients	Claims	Total Paid	% Paid
Burns [240.]	60	190	$4,822,187	34.4%
Complications	544	2,237	$2,889,119	20.6%
Fractures	823	5,296	$2,116,005	15.1%
Sprains And Strains [232.]	1,422	4,950	$907,142	6.5%
Joint Disorders And Dislocations; Trauma-Related [225.]	644	3,230	$797,917	5.7%
Other Injuries And Conditions Due To External Causes [244.]	1303	2,643	$545,099	3.9%
Crushing Injury Or Internal Injury [234.]	65	182	$522,383	3.7%
Open Wounds	708	1,965	$521,848	3.7%
Intracranial Injury [233.]	122	509	$413,664	3.0%
Superficial Injury; Contusion [239.]	764	1,451	$393,238	2.8%
Poisoning	86	171	$84,771	0.6%
Spinal Cord Injury [227.]	9	14	$751	0.0%
	----	----	$14,014,122	100.0%

*Patient and claim counts are unique only within the category

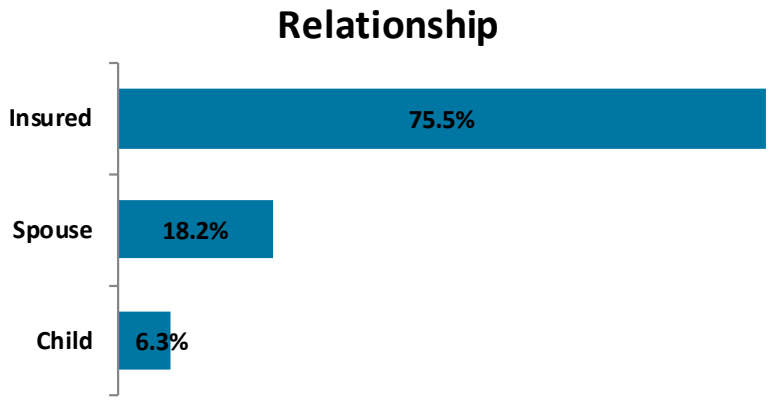


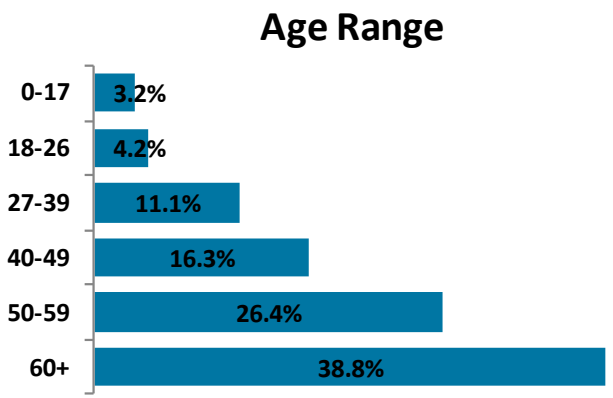


AHRQ Category – Diseases of the Circulatory System

Diagnosis Category	Patients	Claims	Total Paid	% Paid
Diseases Of The Heart	3,282	12,880	$7,970,794	65.5%
Hypertension	3,445	7,452	$1,377,932	11.3%
Cerebrovascular Disease	356	1,623	$1,377,801	11.3%
Diseases Of Veins And Lymphatics	640	1,921	$884,250	7.3%
Diseases Of Arteries; Arterioles; And Capillaries	1,065	1,904	$559,261	4.6%
Overall	**----**	**----**	**$12,170,039**	**100.0%**

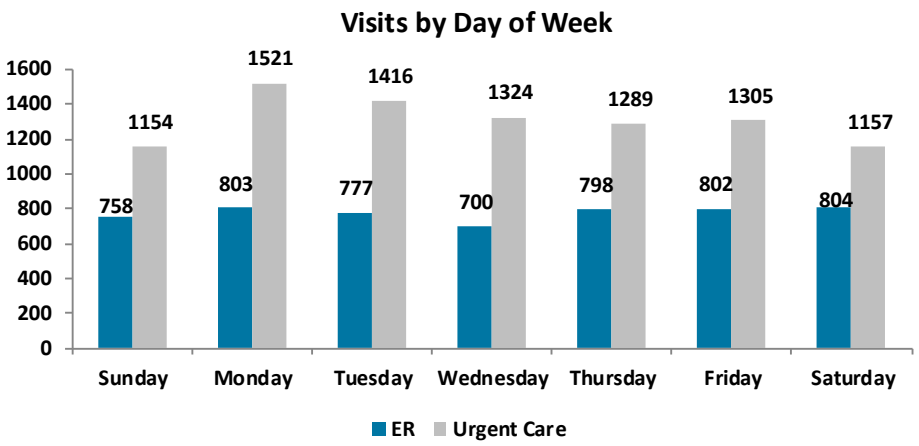
*Patient and claim counts are unique only within the category

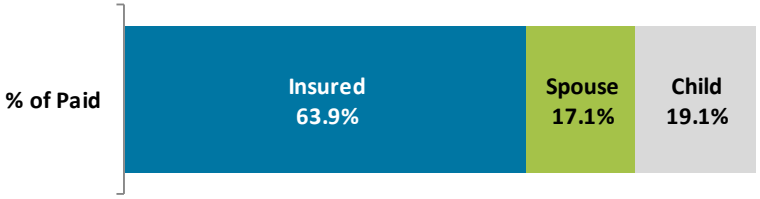




Emergency Room / Urgent Care Summary

	3Q19		3Q20		HSB Peer Index	
ER/Urgent Care	**ER**	**Urgent Care**	**ER**	**Urgent Care**	**ER**	**Urgent Care**
Number of Visits	5,179	7,442	5,442	9,166		
Number of Admits	813	----	795	----		
Visits Per Member	0.16	0.23	0.17	0.29	0.17	0.24
Visits/1000 Members	162	232	169	285	174	242
Avg Paid Per Visit	$1,886	$36	$2,179	$47	$1,684	$74
Admits per Visit	0.16	----	0.15	----	0.14	
% of Visits with HSB ER Dx	76.8%	----	76.9%	----		
% of Visits with a Physician OV*	77.5%	73.0%	77.6%	73.2%		
Total Plan Paid	**$9,767,091**	**$269,685**	**$11,856,611**	**$428,802**		
*looks back 12 months from ER visit	Annualized	Annualized	Annualized	Annualized		



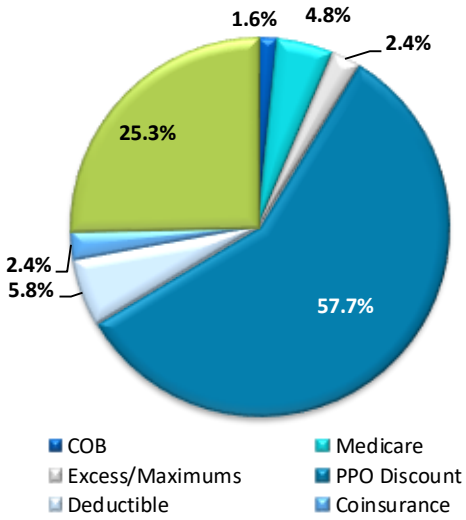


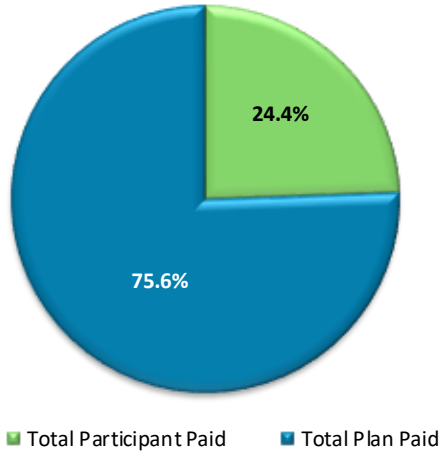
ER / UC Visits by Relationship						
Relationship	**ER**	**Per 1,000**	**Urgent Care**	**Per 1,000**	**Total**	**Per 1,000**
Insured	3,138	133	5,422	229	8,560	362
Spouse	855	154	1,016	183	1,871	338
Child	1,449	106	2,728	200	4,177	306
Total	**5,442**	**127**	**9,166**	**214**	**14,608**	**341**

Savings Summary – Medical Claims

Description	Dollars	PPPM	% of Eligible
Eligible Charges	$428,919,450	$2,015	100.0%
COB	$6,707,733	$32	1.6%
Medicare	$20,419,397	$96	4.8%
Excess/Maximums	$10,432,679	$49	2.4%
PPO Discount	$247,519,845	$1,163	57.7%
Deductible	$24,791,228	$116	5.8%
Coinsurance	$10,354,663	$49	2.4%
Total Participant Paid	**$35,145,891**	**$165**	**8.2%**
Total Plan Paid	**$108,693,905**	**$511**	**25.3%**

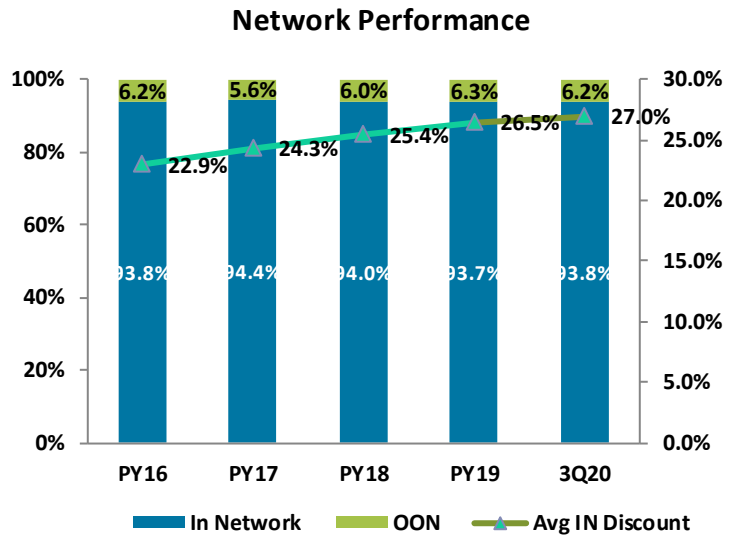
Total Participant Paid - PY19	**$141**
Total Plan Paid - PY19	**$471**



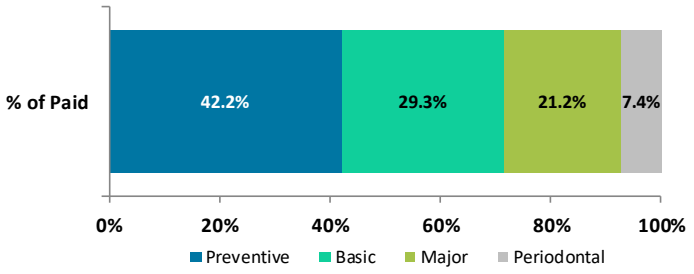


Dental Claims Analysis

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	5,106	7.4%	22,495	21.0%	$7,693,658	39.6%	$4,935,573	53.2%
$750.01-$1,000.00	2,214	3.2%	7,993	7.5%	$1,965,168	10.1%	$1,098,852	11.8%
$500.01-$750.00	3,763	5.5%	12,053	11.2%	$2,377,786	12.2%	$1,227,100	13.2%
$250.01-$500.00	12,201	17.8%	31,993	29.8%	$4,214,710	21.7%	$1,099,484	11.8%
$0.01-$250.00	20,814	30.3%	32,109	29.9%	$3,184,594	16.4%	$896,536	9.7%
$0.00	525	0.8%	620	0.6%	$0	0.0%	$26,510	0.3%
No Claims	24,057	35.0%	0	0.0%	$0	0.0%	$0	0.0%
Total	**68,680**	**100.0%**	**107,263**	**100.0%**	**$19,435,917**	**100.0%**	**$9,284,055**	**100.0%**



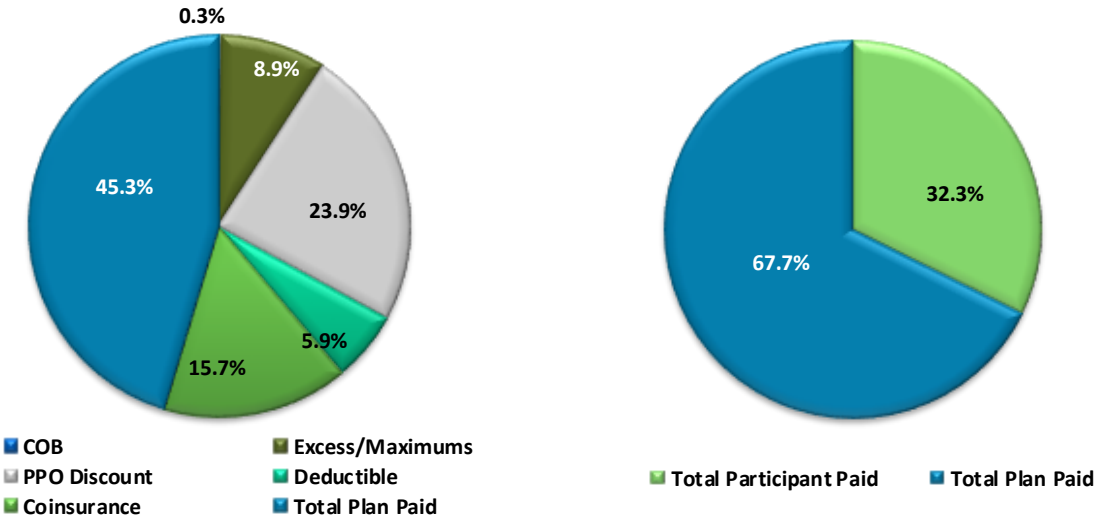
Claim Category	Total Paid	% of Paid
Preventive	$8,193,291	42.2%
Basic	$5,695,162	29.3%
Major	$4,115,737	21.2%
Periodontal	$1,431,727	7.4%
Total	**$19,435,917**	**100.0%**



Savings Summary – Dental Claims

Description	Dollars	PPPM	% of Eligible
Eligible Charges	$42,860,659	$69	100.0%
COB	$107,404	$0	0.3%
Excess/Maximums	$3,809,435	$6	8.9%
PPO Discount	$10,223,848	$17	23.9%
Deductible	$2,536,084	$4	5.9%
Coinsurance	$6,747,971	$11	15.7%
Total Participant Paid	**$9,284,055**	**$15**	**21.7%**
Total Plan Paid	**$19,435,917**	**$31**	**45.3%**

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



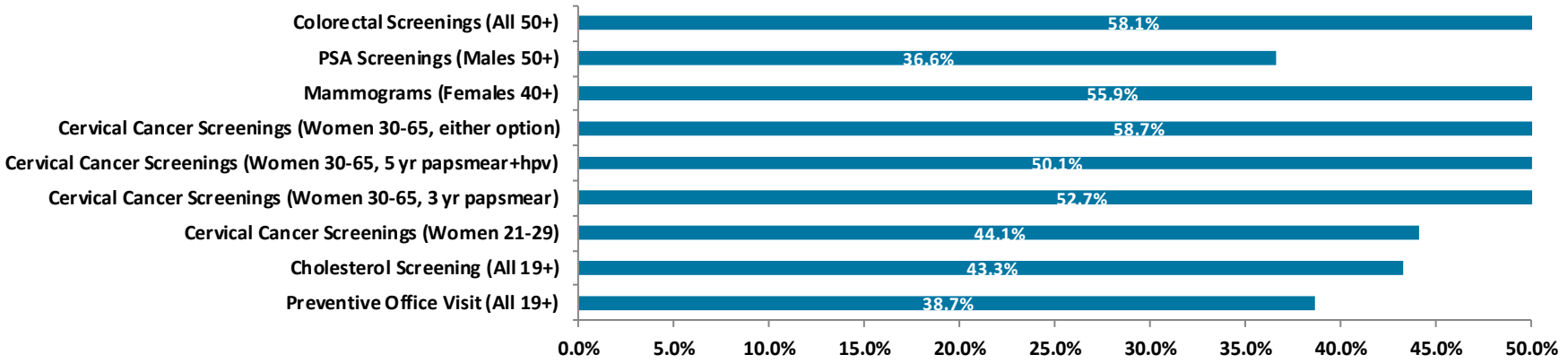
Preventive Services Compliance

*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+)	17,146	8,642	50.4%	15,036	3,804	25.3%	32,182	12,446	38.7%
Cholesterol Screening (All 19+)	17,146	8,059	47.0%	15,036	5,879	39.1%	32,182	13,938	43.3%
Cervical Cancer Screenings (Women 21-29)	2,716	1,198	44.1%	----	----	----	2,716	1,198	44.1%
Cervical Cancer Screenings (Women 30-65, 3 yr papsmear)	12,933	6,816	52.7%	----	----	----	12,933	6,816	52.7%
Cervical Cancer Screenings (Women 30-65, 5 yr papsmear+hpv)	12,933	6,479	50.1%	----	----	----	12,933	6,479	50.1%
Cervical Cancer Screenings (Women 30-65, either option)	12,933	7,592	58.7%	----	----	----	12,933	7,592	58.7%
Mammograms (Females 40+)	10,644	5,950	55.9%	----	----	----	10,644	5,950	55.9%
PSA Screenings (Males 50+)	----	----	----	6,371	2,332	36.6%	6,371	2,332	36.6%
Colorectal Screenings (All 50+)	7,380	4,443	60.2%	6,371	3,549	55.7%	13,751	7,991	58.1%

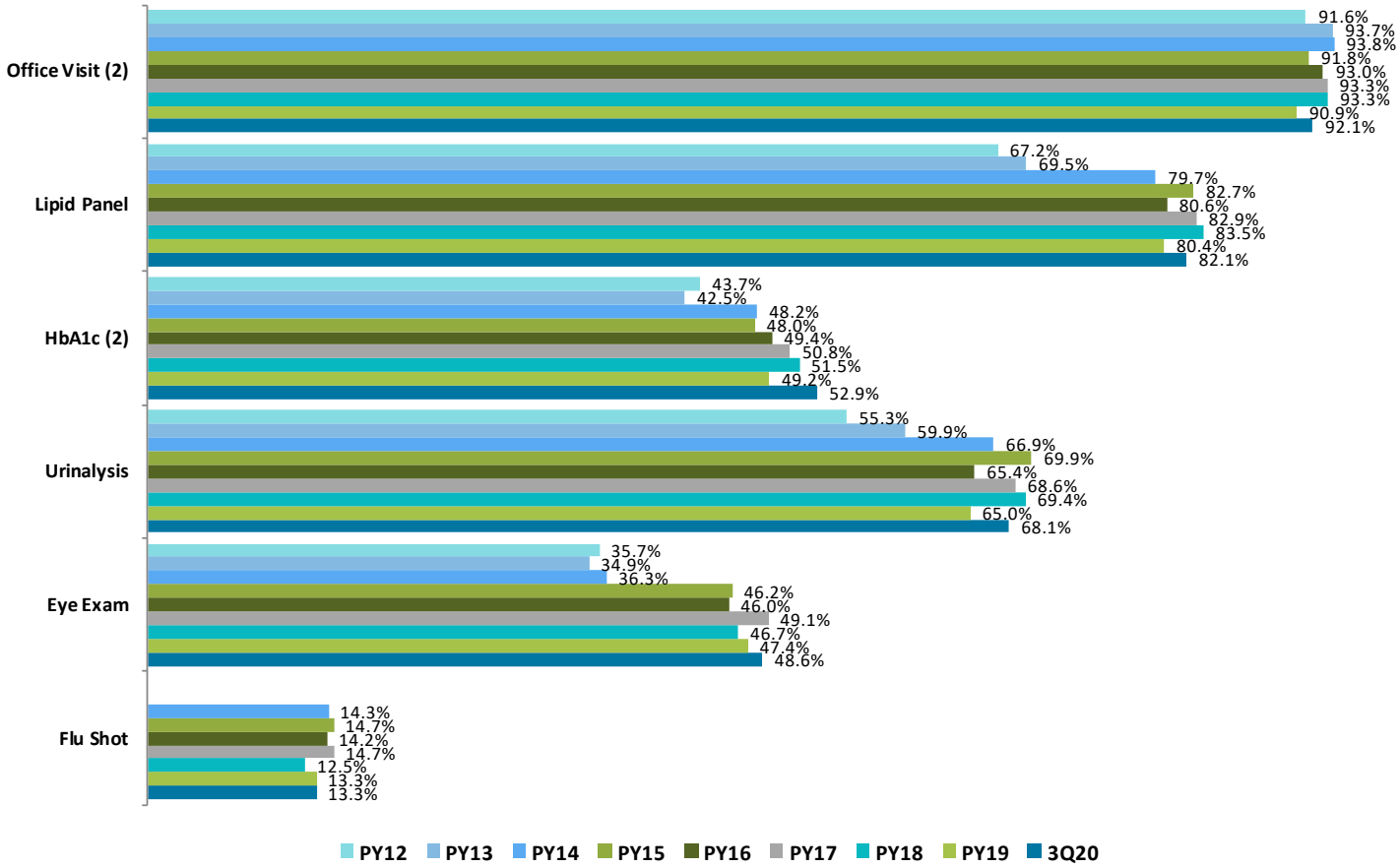
Overall Preventive Services Compliance Rates



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	PY12	PY13	PY14	PY15	PY16	PY17	PY18	PY19	3Q20
Members	1,651	1,643	1,555	1,676	1,693	1,704	1,747	1,838	1,919

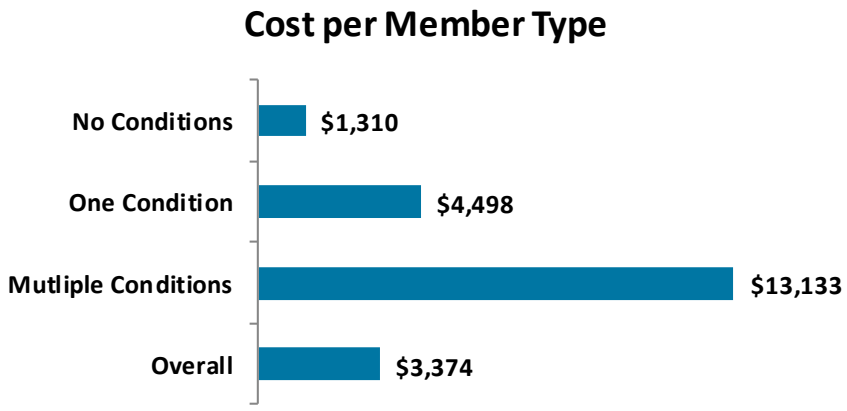


Chronic Conditions Summary

*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	1,223	1,146	29	37	$8,234,424	$6,733	99.3%	1 Office Visit
Cancer	1,396	1,318	33	59	$29,834,878	$21,372	----	----
Chronic Kidney Disease	348	324	8	60	$8,319,464	$23,907	----	----
Chronic Obstructive Pulmonary Disease (COPD)	287	268	7	59	$8,581,897	$29,902	96.9%	1 Office Visit
Congestive Heart Failure (CHF)	155	140	4	62	$13,802,312	$89,047	16.8%	1 Office Visit, 1 Lipid Profile, 1 Wellness Visit
Coronary Artery Disease (CAD)	667	630	16	63	$17,456,593	$26,172	26.2%	1 Office Visit, 1 Lipid Profile, 1 Wellness Visit
Depression	1,571	1,453	37	40	$17,491,602	$11,134	95.7%	1 Office Visit
Diabetes	1,919	1,796	45	56	$17,698,260	$9,223	23.0%	2 Office Visits, 1 Lipid Profile, 2 HbA1c's, 1 Urinalysis, 1 Eye Exam, 1 Flu Shot
Hyperlipidemia	3,467	3,311	81	54	$23,538,644	$6,789	43.4%	1 Office Visit, 1 Lipid Profile, 1 Wellness Visit
Hypertension	3,859	3,651	90	57	$39,394,184	$10,208	29.3%	1 Office Visit, 1 Lipid Profile, 1 Wellness Visit
Obesity	941	890	22	44	$6,085,297	$6,467	----	----

# of Conditions	Avg Members	Average Age	Relationship		
			Insured	Spouse	Child
No Conditions	28,815	31	46.9%	11.8%	41.3%
One Condition	8,896	46	70.1%	16.4%	13.5%
Multiple Conditions	5,068	55	78.4%	18.7%	2.9%
Overall	**42,778**	**36**	**54.6%**	**13.4%**	**32.0%**



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

Express Scripts

Membership Summary	3Q FY2020	3Q FY2019	Difference	% Change
			Membership Summary	
Member Count (Membership)	42,840	42,734	106	0.2%
Utilizing Member Count (Patients)	29,403	28,660	743	2.6%
Percent Utilizing (Utilization)	68.6%	67.1%	0.02	2.3%
Claim Summary			**Claims Summary**	
Net Claims (Total Rx's)	400,963	373,018	27,945	7.5%
Claims per Elig Member per Month (Claims PMPM)	1.04	0.97	0.07	7.2%
Total Claims for Generic (Generic Rx)	347,815	321,911	25,904.00	8.0%
Total Claims for Brand (Brand Rx)	53,148	51,107	2,041.00	4.0%
Total Claims for Brand w/Gen Equiv (Multisource Brand Claims)	6,089	5,948	141.00	2.4%
Total Non-Specialty Claims	396,299	368,641	27,658.00	7.5%
Total Specialty Claims	4,664	4,377	287.00	6.6%
Generic % of Total Claims (GFR)	**86.7%**	**86.3%**	0.00	0.5%
Generic Effective Rate (GCR)	**98.3%**	**98.2%**	0.00	0.1%
Mail Order Claims	70,684	48,106	22,578.00	46.9%
Mail Penetration Rate*	20.2%	14.8%	0.05	5.4%
Claims Cost Summary			**Claims Cost Summary**	
Total Prescription Cost (Total Gross Cost)	$37,241,356.00	$35,207,594.00	$2,033,762.00	5.8%
Total Generic Gross Cost	$6,146,701.00	$7,131,883.00	($985,182.00)	-13.8%
Total Brand Gross Cost	$31,094,655.00	$28,075,711.00	$3,018,944.00	10.8%
Total MSB Gross Cost	$1,250,878.00	$911,860.00	$339,018.00	37.2%
Total Ingredient Cost	$36,950,924.00	$34,916,192.00	$2,034,732.00	5.8%
Total Dispensing Fee	$275,882.00	$280,020.00	($4,138.00)	-1.5%
Total Other (e.g. tax)	$14,550.00	$11,382.00	$3,168.00	27.8%
Avg Total Cost per Claim (Gross Cost/Rx)	**$92.88**	**$94.39**	($1.51)	-1.6%
Avg Total Cost for Generic (Gross Cost/Generic Rx)	$17.67	$22.15	($4.48)	-20.2%
Avg Total Cost for Brand (Gross Cost/Brand Rx)	$585.06	$549.35	$35.71	6.5%
Avg Total Cost for MSB (MSB Gross Cost/MSB ARx)	$205.43	$153.31	$52.12	34.0%
Member Cost Summary			**Member Cost Summary**	
Total Member Cost	**$10,463,349.00**	**$7,938,326.00**	$2,525,023.00	31.8%
Total Copay	$5,278,052.00	$3,504,617.00	$1,773,435.00	50.6%
Total Deductible	$5,185,297.00	$4,433,709.00	$751,588.00	17.0%
Avg Copay per Claim (Copay/Rx)	$13.16	$9.40	$3.77	40.1%
Avg Participant Share per Claim (Copay+Deductible/RX)	**$26.10**	**$21.28**	**$4.81**	**22.6%**
Avg Copay for Generic (Copay/Generic Rx)	$9.15	$9.97	($0.82)	-8.2%
Avg Copay for Brand (Copay/Brand Rx)	$136.99	$92.53	$44.46	48.0%
Avg Copay for Brand w/ Generic Equiv (Copay/Multisource Rx)	$74.28	$70.74	$3.54	5.0%
Net PMPM (Participant Cost PMPM)	**$27.14**	**$20.64**	$6.50	31.5%
Copay % of Total Prescription Cost (Member Cost Share %)	28.1%	22.5%	5.5%	24.6%
Plan Cost Summary			**Plan Cost Summary**	
Total Plan Cost (Plan Cost)	**$26,778,006.00**	**$27,269,268.00**	**($491,262.00)**	**-1.8%**
Total Non-Specialty Cost (Non-Specialty Plan Cost)	$9,938,042.00	$11,030,325.00	($1,092,283.00)	-9.9%
Total Specialty Drug Cost (Specialty Plan Cost)	$16,839,964.00	$16,238,942.00	$601,022.00	3.7%
Avg Plan Cost per Claim (Plan Cost/Rx)	**$66.78**	**$73.10**	($6.32)	-8.6%
Avg Plan Cost for Generic (Plan Cost/Generic Rx)	$8.52	$12.19	($3.67)	-30.1%
Avg Plan Cost for Brand (Plan Cost/Brand Rx)	$448.06	$456.82	($8.76)	-1.9%
Avg Plan Cost for MSB (MSB Plan Cost/MSB ARx)	$131.15	$82.57	$48.58	58.8%
Net PMPM (Plan Cost PMPM)	**$69.45**	**$70.90**	**($1.45)**	**-2.0%**
PMPM for Specialty Only (Specialty PMPM)	$43.68	$42.22	$1.46	3.5%
PMPM without Specialty (Non-Specialty PMPM)	$25.78	$28.68	($2.90)	-10.1%
Rebates (Q1-Q3 FY2020 estimated)	$6,993,596.22	$6,067,574.80	$926,021.42	15.3%
Net PMPM (Plan Cost PMPM factoring Rebates)	**$51.25**	**$55.14**	**($3.88)**	**-7.0%**
PMPM for Specialty Only (Specialty PMPM)	$37.66	$37.63	$0.03	0.1%
PMPM without Specialty (Non-Specialty PMPM)	$13.59	$17.51	($3.92)	-22.4%

Appendix B

Index of Tables
HealthSCOPE – EPO Utilization Review for PEBP
July 1, 2019 – March 31, 2020

HSB DATASCOPE™

Nevada Public Employees' Benefits Program
EPO Plan

July 2019 – March 2020

HealthSCOPE BENEFITS

Overview

- Total Medical Spend for 3Q20 was $38,199,199 with an annualized plan cost per employee per year of $10,599. This is an increase of 21.2% when compared to PY19.
  - IP Cost per Admit is $13,055 which is 36.0% lower than PY19.
  - ER Cost per Visit is $2,609 which is on track with PY19.
- Employees shared in 9.6% of the medical cost.
- Inpatient facility costs were 19.0% of the plan spend.
- 72.7% of the Average Membership had paid Medical claims less than $2,500, with 10.6% of those having no claims paid at all during the reporting period.
- 35 members exceeded the $100k high cost threshold during the reporting period, which accounted for 16.5% of the plan spend. The highest diagnosis category was Neoplasms, accounting for 15.8% of the high cost claimant dollars.
- Total spending with in-network providers was 97.3%. The overall in-network discount was 57.9%.

Paid Claims by Age Group

Paid Claims by Age Group																				
	PY19						3Q20						% 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	$ 1,550,690	$ 1,538	$ 34,773	$ 34	$ 1,585,463	$ 1,573	-15.8%	-7.8%
1	$ 264,791	$ 245	$ 14,535	$ 13	$ 279,326	$ 259	$ 258,450	$ 312	$ 9,325	$ 11	$ 267,775	$ 323	-4.1%	25.0%
2 - 4	$ 372,210	$ 117	$ 14,845	$ 5	$ 387,055	$ 122	$ 417,928	$ 160	$ 17,226	$ 7	$ 435,154	$ 166	12.4%	36.5%
5 - 9	$ 502,906	$ 81	$ 95,811	$ 16	$ 598,717	$ 97	$ 577,460	$ 123	$ 101,893	$ 22	$ 679,353	$ 145	13.5%	49.8%
10 - 14	$ 1,277,258	$ 167	$ 244,065	$ 32	$ 1,521,323	$ 198	$ 1,140,369	$ 195	$ 197,376	$ 34	$ 1,337,745	$ 229	-12.1%	15.4%
15 - 19	$ 1,537,283	$ 186	$ 292,943	$ 35	$ 1,830,226	$ 222	$ 1,999,570	$ 310	$ 284,789	$ 44	$ 2,284,359	$ 354	24.8%	59.9%
20 - 24	$ 1,082,265	$ 156	$ 409,392	$ 59	$ 1,491,657	$ 215	$ 1,493,670	$ 270	$ 422,433	$ 76	$ 1,916,103	$ 346	28.5%	60.7%
25 - 29	$ 1,215,987	$ 295	$ 301,168	$ 73	$ 1,517,155	$ 369	$ 1,098,141	$ 325	$ 291,025	$ 86	$ 1,389,166	$ 412	-8.4%	11.7%
30 - 34	$ 2,784,920	$ 515	$ 341,212	$ 63	$ 3,126,132	$ 578	$ 1,900,017	$ 435	$ 281,313	$ 64	$ 2,181,330	$ 500	-30.2%	-13.5%
35 - 39	$ 2,361,827	$ 366	$ 734,028	$ 114	$ 3,095,855	$ 480	$ 2,790,735	$ 545	$ 644,074	$ 126	$ 3,434,809	$ 671	10.9%	39.9%
40 - 44	$ 2,437,647	$ 381	$ 784,468	$ 123	$ 3,222,115	$ 504	$ 2,234,457	$ 442	$ 1,076,982	$ 213	$ 3,311,439	$ 655	2.8%	30.0%
45 - 49	$ 2,770,287	$ 331	$ 1,525,758	$ 182	$ 4,296,045	$ 513	$ 3,281,830	$ 511	$ 1,142,389	$ 178	$ 4,424,219	$ 688	3.0%	34.2%
50 - 54	$ 5,152,391	$ 559	$ 2,107,261	$ 229	$ 7,259,652	$ 788	$ 4,114,440	$ 575	$ 1,809,508	$ 253	$ 5,923,948	$ 828	-18.4%	5.1%
55 - 59	$ 5,436,354	$ 503	$ 2,751,284	$ 254	$ 8,187,638	$ 757	$ 5,698,392	$ 708	$ 2,603,855	$ 324	$ 8,302,247	$ 1,032	1.4%	36.3%
60 - 64	$ 9,774,054	$ 815	$ 3,034,480	$ 253	$ 12,808,534	$ 1,067	$ 7,171,198	$ 803	$ 3,239,439	$ 363	$ 10,410,637	$ 1,166	-18.7%	9.2%
65+	$ 1,920,336	$ 395	$ 1,343,189	$ 276	$ 3,263,525	$ 672	$ 2,471,850	$ 678	$ 1,229,804	$ 337	$ 3,701,654	$ 1,016	13.4%	51.2%
Total	**$ 40,764,731**	**$ 400**	**$ 14,003,588**	**$ 137**	**$54,768,319**	**$ 537**	**$ 38,199,199**	**$ 483**	**$ 13,386,205**	**$ 169**	**$ 51,585,402**	**$ 652**	**-5.8%**	**21.5%**

Financial Summary (p. 1 of 2)

	Total			State Active			Non-State Active		
Summary	**PY19**	**3Q20**	**Variance to Prior Year**	**PY19**	**3Q20**	**Variance to Prior Year**	**PY19**	**3Q20**	**Variance to Prior Year**
Enrollment									
Avg # Employees	4,653	4,806	3.3%	3,878	4,060	4.7%	4	4	0.0%
Avg # Members	8,488	8,787	3.5%	7,445	7,777	4.5%	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	$42,277,795	-6.2%	$35,711,039	$35,353,224	-1.0%	$45,961	$50,833	10.6%
Client Paid	$40,764,731	$38,199,199	-6.3%	$32,097,283	$31,941,420	-0.5%	$40,931	$46,051	12.5%
Employee Paid	$4,329,941	$4,078,597	-5.8%	$3,613,757	$3,411,804	-5.6%	$5,030	$4,782	-4.9%
Client Paid-PEPY	$8,745	$10,599	21.2%	$8,277	$10,491	26.7%	$10,233	$15,350	50.0%
Client Paid-PMPY	$4,794	$5,796	20.9%	$4,311	$5,476	27.0%	$8,186	$12,280	50.0%
Client Paid-PEPM	$729	$883	21.1%	$690	$874	26.7%	$853	$1,279	49.9%
Client Paid-PMPM	$400	$483	20.8%	$359	$456	27.0%	$682	$1,023	50.0%
High Cost Claimants (HCC's) > $100k									
# of HCC's	39	35	-10.3%	27	28	3.7%	0	0	0.0%
HCC's / 1,000	4.6	4.0	-13.4%	3.6	3.6	-0.7%	0.0	0.0	0.0%
Avg HCC Paid	$274,612	$180,354	-34.3%	$246,453	$163,867	-33.5%	$0	$0	0.0%
HCC's % of Plan Paid	26.3%	16.5%	-37.3%	20.7%	14.4%	-30.4%	0.0%	0.0%	0.0%
Cost Distribution by Claim Type (PMPY)									
Facility Inpatient	$1,218	$1,099	-9.8%	$944	$1,001	6.0%	$3,360	$3,904	16.2%
Facility Outpatient	$1,506	$1,869	24.1%	$1,395	$1,761	26.2%	$1,369	$1,746	27.5%
Physician	$1,923	$2,630	36.8%	$1,844	$2,548	38.2%	$3,030	$6,426	112.1%
Other	$148	$198	33.8%	$127	$165	29.9%	$427	$204	-52.2%
Total	$4,794	$5,796	20.9%	$4,311	$5,476	27.0%	$8,186	$12,280	50.0%
		Annualized			Annualized			Annualized	

Financial Summary (p. 2 of 2)

	State Retirees			Non-State Retirees			
Summary	**PY19**	**3Q20**	**Variance to Prior Year**	**PY19**	**3Q20**	**Variance to Prior Year**	**HSB Peer Index**
Enrollment							
Avg # Employees	599	591	-1.3%	181	151	-16.4%	
Avg # Members	826	813	-1.5%	227	191	-15.6%	
Ratio	1.4	1.4	0.0%	1.3	1.3	0.8%	1.8
Financial Summary							
Gross Cost	$7,418,807	$6,105,347	-17.7%	$1,918,864	$768,391	-60.0%	
Client Paid	$6,863,148	$5,556,654	-19.0%	$1,763,370	$655,074	-62.9%	
Employee Paid	$555,659	$548,693	-1.3%	$155,495	$113,318	-27.1%	
Client Paid-PEPY	$11,461	$12,534	9.4%	$9,769	$5,789	-40.7%	$6,209
Client Paid-PMPY	$8,313	$9,109	9.6%	$7,777	$4,562	-41.3%	$3,437
Client Paid-PEPM	$955	$1,044	9.3%	$814	$482	-40.8%	$517
Client Paid-PMPM	$693	$759	9.5%	$648	$380	-41.4%	$286
High Cost Claimants (HCC's) > $100k							
# of HCC's	9	12	33.3%	3	0	0.0%	
HCC's / 1,000	10.9	14.8	35.3%	13.2	0.0	0.0%	
Avg HCC Paid	$339,256	$143,676	-57.6%	$334,114	$0	0.0%	
HCC's % of Plan Paid	44.5%	31.0%	-30.3%	56.8%	0.0%	0.0%	
Cost Distribution by Claim Type (PMPY)							
Facility Inpatient	$3,028	$2,120	-30.0%	$3,554	$647	-81.8%	$1,057
Facility Outpatient	$2,243	$3,056	36.2%	$2,477	$1,221	-50.7%	$1,145
Physician	$2,713	$3,432	26.5%	$1,587	$2,438	53.6%	$1,122
Other	$328	$502	53.0%	$158	$256	62.0%	$113
Total	$8,313	$9,109	9.6%	$7,777	$4,562	-41.3%	$3,437
		Annualized			Annualized		

Paid Claims by Claim Type – State Participants

Net Paid Claims - Total State Participants	PY19				3Q20				% 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	$ 7,701,769	$ 1,204,716	$ 377,971	$ 9,284,456	-19.4%
Outpatient	$ 23,335,008	$ 3,620,613	$ 482,422	$ 27,438,043	$ 24,239,651	$ 3,283,466	$ 690,501	$ 28,213,618	2.8%
Total - Medical	**$ 32,097,283**	**$ 6,219,999**	**$ 643,149**	**$ 38,960,431**	**$ 31,941,420**	**$ 4,488,182**	**$ 1,068,472**	**$ 37,498,074**	**-3.8%**

Net Paid Claims - Per Participant per Month	PY19				3Q20				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical	$ 690	$ 1,018	$ 596	$ 725	$ 874	$ 987	$ 1,382	$ 896	23.5%

Paid Claims by Claim Type – Non-State Participants

Net Paid Claims - Total Non-State Participants	PY19				3Q20				% 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	$ 42,373	$ 74,741	$ 139,612	-84.3%
Outpatient	$ 17,389	$ 754,444	$ 144,009	$ 915,842	$ 23,553	$ 451,178	$ 86,782	$ 561,513	-38.7%
Total - Medical	**$ 40,931**	**$ 1,609,283**	**$ 154,087**	**$ 1,804,301**	**$ 46,051**	**$ 493,551**	**$ 161,523**	**$ 701,124**	**-61.1%**

Net Paid Claims - Per Participant per Month	PY19				3Q20				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical	$ 853	$ 1,048	$ 242	$ 813	$ 1,279	$ 563	$ 336	$ 503	-38.1%

Paid Claims by Claim Type – Total

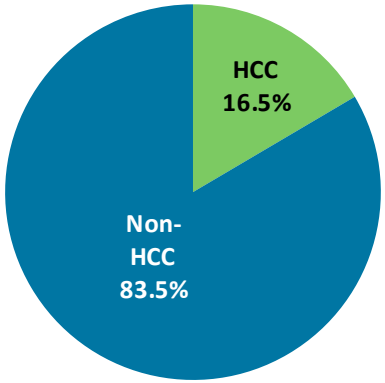
Net Paid Claims - Total Total Participants	PY19				3Q20				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical									
Inpatient	$ 8,785,816	$ 3,454,225	$ 170,805	$ 12,410,846	$ 7,724,267	$ 1,247,089	$ 452,712	$ 9,424,068	-24.1%
Outpatient	$ 23,352,397	$ 4,375,057	$ 626,431	$ 28,353,885	$ 24,263,204	$ 3,734,644	$ 777,283	$ 28,775,131	1.5%
Total - Medical	**$ 32,138,214**	**$ 7,829,282**	**$ 797,236**	**$ 40,764,731**	**$ 31,987,471**	**$ 4,981,733**	**$ 1,229,995**	**$ 38,199,199**	**-6.3%**

Net Paid Claims - Per Participant per Month	PY19				3Q20				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical	$ 690	$ 1,024	$ 465	$ 729	$ 875	$ 918	$ 981	$ 883	21.2%

Cost Distribution – Medical Claims

PY19							3Q20					
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	31	0.4%	$6,311,716	16.5%	$176,755	4.3%
63	0.7%	$4,489,989	11.0%	$285,075	6.6%	$50,000.01-$100,000.00	61	0.7%	$4,231,671	11.1%	$205,798	5.0%
148	1.7%	$5,378,700	13.2%	$370,909	8.6%	$25,000.01-$50,000.00	175	2.0%	$6,324,765	16.6%	$444,065	10.9%
489	5.7%	$7,901,863	19.4%	$770,638	17.8%	$10,000.01-$25,000.00	535	6.1%	$8,454,387	22.1%	$776,277	19.0%
592	7.0%	$4,367,753	10.7%	$713,266	16.5%	$5,000.01-$10,000.00	605	6.9%	$4,510,798	11.8%	$612,142	15.0%
935	11.0%	$3,470,368	8.5%	$766,356	17.7%	$2,500.01-$5,000.00	997	11.3%	$3,679,697	9.6%	$750,958	18.4%
5,310	62.5%	$4,495,610	11.0%	$1,195,579	27.6%	$0.01-$2,500.00	5,428	61.8%	$4,686,166	12.3%	$1,100,852	27.1%
16	0.2%	$0	0.0%	$4,162	0.1%	$0.00	24	0.3%	$0	0.0%	$11,750	0.3%
918	10.8%	$0	0.0%	$0	0.0%	No Claims	933	10.6%	$0	0.0%	$0	0.0%
8,503	**100.0%**	**$40,764,731**	**100.0%**	**$4,329,941**	**100.0%**		**8,787**	**100.0%**	**$38,199,199**	**100.0%**	**$4,078,597**	**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	15	$1,000,296	15.8%
(CCS 13) Diseases Of The Musculoskeletal System And Connective Tissue	20	$749,923	11.9%
(CCS 3) Endocrine; Nutritional; And Metabolic Diseases And Immunity Disorders	21	$719,753	11.4%
(CCS 4) Diseases Of The Blood And Blood-Forming Organs	10	$564,353	8.9%
(CCS 16) Injury And Poisoning	21	$546,027	8.7%
(CCS 15) Certain Conditions Originating In The Perinatal Period	2	$527,197	8.4%
(CCS 6) Diseases Of The Nervous System And Sense Organs	26	$440,960	7.0%
(CCS 10) Diseases Of The Genitourinary System	17	$369,963	5.9%
(CCS 8) Diseases Of The Respiratory System	28	$367,623	5.8%
(CCS 5) Mental Illness	16	$309,164	4.9%
(CCS 9) Diseases Of The Digestive System	19	$236,133	3.7%
(CCS 1) Infectious And Parasitic Diseases	16	$180,227	2.9%
(CCS 17) Symptoms; Signs; And Ill-Defined Conditions And Factors Influencing Health Status	31	$132,727	2.1%
(CCS 7) Diseases Of The Circulatory System	26	$118,161	1.9%
(CCS 18) Residual Codes; Unclassified; All E Codes [259. And 260.]	26	$25,037	0.4%
(CCS 14) Congenital Anomalies	4	$15,194	0.2%
(CCS 12) Diseases Of The Skin And Subcutaneous Tissue	11	$8,978	0.1%
Overall	**----**	**$6,311,716**	**100.0%**

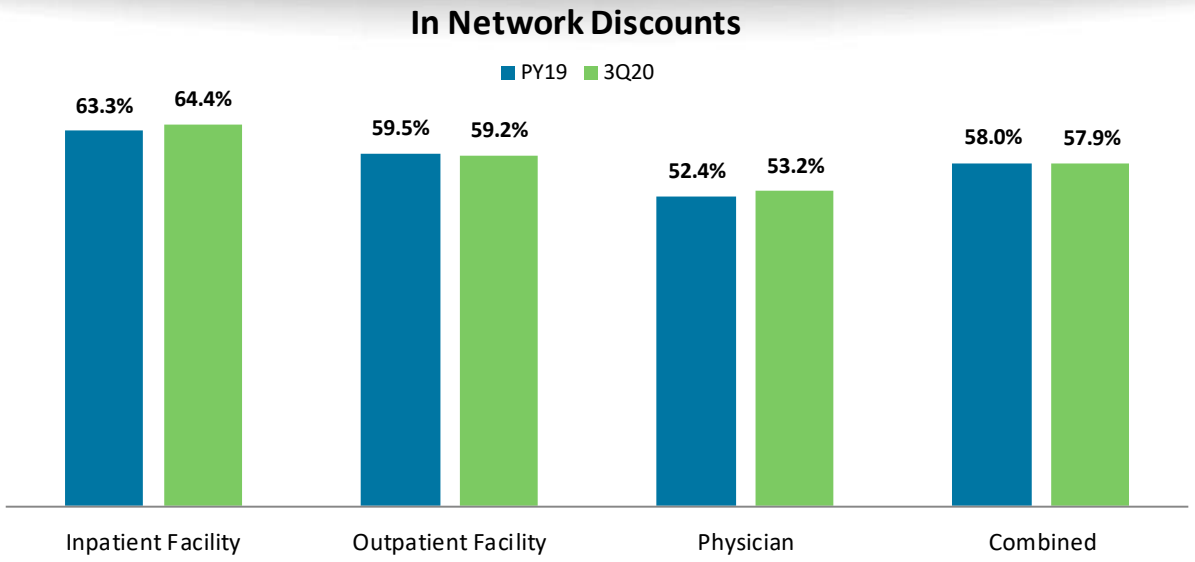
Utilization Summary (p. 1 of 2)

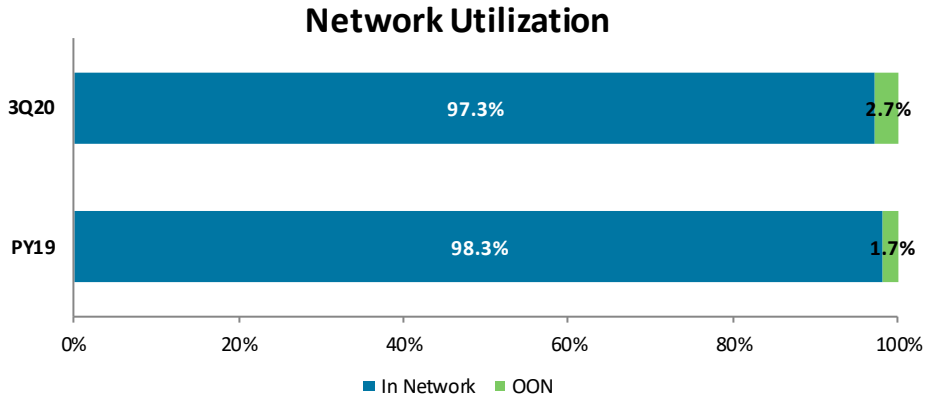
	Total			State Active			Non-State Active		
Summary	**PY19**	**3Q20**	**Variance to Prior Year**	**PY19**	**3Q20**	**Variance to Prior Year**	**PY19**	**3Q20**	**Variance to Prior Year**
Inpatient Facility									
# of Admits	507	557	9.9%	441	473	7.3%	1	1	0.0%
# of Bed Days	2,491	2,489	-0.1%	2,026	2,068	2.1%	2	2	0.0%
Paid Per Admit	$20,394	$13,055	-36.0%	$15,930	$12,455	-21.8%	$16,801	$14,640	-12.9%
Paid Per Day	$4,151	$2,922	-29.6%	$3,468	$2,849	-17.8%	$8,401	$7,320	-12.9%
Admits Per 1,000	60	85	41.7%	59	81	37.3%	200	267	33.5%
Days Per 1,000	293	378	29.0%	272	355	30.5%	400	533	33.3%
Avg LOS	4.9	4.5	-8.2%	4.6	4.4	-4.3%	2	2	0.0%
Physician Office									
OV Utilization per Member	4.4	5.5	25.0%	4.2	5.3	26.2%	5.6	8.8	57.1%
Avg Paid per OV	$94	$101	7.4%	$95	$103	8.4%	$105	$91	-13.3%
Avg OV Paid per Member	$410	$555	35.4%	$402	$545	35.6%	$587	$803	36.8%
DX&L Utilization per Member	8.9	11.2	25.8%	8.4	10.6	26.2%	14	17.6	25.7%
Avg Paid per DX&L	$78	$72	-7.7%	$75	$74	-1.3%	$106	$105	-0.9%
Avg DX&L Paid per Member	$690	$810	17.4%	$629	$784	24.6%	$1,491	$1,851	24.1%
Emergency Room									
# of Visits	1,453	1,507	3.7%	1,261	1,291	2.4%	0	2	0.0%
# of Admits	192	232	20.8%	154	175	13.6%	0	0	0.0%
Visits Per Member	0.17	0.23	34.5%	0.17	0.22	30.2%	0	0.53	0.0%
Visits Per 1,000	171	229	33.7%	169	221	31.0%	0	533	0.0%
Avg Paid per Visit	$2,608	$2,609	0.0%	$2,546	$2,698	6.0%	$0	$2,405	0.0%
Admits Per Visit	0.13	0.15	18.4%	0.12	0.14	13.0%	0.00	0.00	0.0%
Urgent Care									
# of Visits	2,450	2,538	3.6%	2,232	2,325	4.2%	0	0	0.0%
Visits Per Member	0.29	0.39	32.8%	0.30	0.40	32.9%	0.00	0.00	0.0%
Visits Per 1,000	288	385	33.7%	300	399	32.9%	0	0	0.0%
Avg Paid per Visit	$140	$156	11.4%	$140	$161	14.7%	$0	$0	0.0%
		Annualized			Annualized			Annualized	

Utilization Summary (p. 2 of 2)

	State Retirees			Non-State Retirees			
Summary	**PY19**	**3Q20**	**Variance to Prior Year**	**PY19**	**3Q20**	**Variance to Prior Year**	**HSB Peer Index**
Inpatient Facility							
# of Admits	52	73	40.4%	13	10	-23.1%	
# of Bed Days	361	328	-9.1%	102	91	-10.8%	
Paid Per Admit	$47,923	$17,438	-63.6%	$61,977	$9,286	-85.0%	$16,173
Paid Per Day	$6,903	$3,881	-43.8%	$7,899	$1,020	-87.1%	$3,708
Admits Per 1,000	63	120	90.5%	57	70	22.8%	61
Days Per 1,000	437	538	23.1%	450	634	40.9%	264
Avg LOS	6.9	4.5	-34.8%	7.8	9.1	16.7%	4.3
Physician Office							
OV Utilization per Member	5.6	7.4	32.1%	5.0	6.7	34.0%	3.3
Avg Paid per OV	$85	$90	5.9%	$86	$78	-9.3%	$50
Avg OV Paid per Member	$473	$665	40.6%	$431	$525	21.8%	$167
DX&L Utilization per Member	12.1	15.9	31.4%	12.2	15.7	28.7%	8.3
Avg Paid per DX&L	$88	$64	-27.3%	$104	$60	-42.3%	$67
Avg DX&L Paid per Member	$1,069	$1,020	-4.6%	$1,274	$933	-26.8%	$554
Emergency Room							
# of Visits	158	188	19.0%	94	26	-72.3%	
# of Admits	30	53	76.7%	8	4	-50.0%	
Visits Per Member	0.19	0.31	62.2%	0.41	0.18	-56.1%	0.17
Visits Per 1,000	191	308	61.4%	415	181	-56.4%	174
Avg Paid per Visit	$2,991	$2,171	-27.4%	$1,195	$1,376	15.1%	$1,684
Admits Per Visit	0.19	0.28	48.4%	0.09	0.15	66.7%	0.14
Urgent Care							
# of Visits	158	159	0.6%	60	54	-10.0%	
Visits Per Member	0.19	0.26	36.8%	0.26	0.38	46.2%	0.24
Visits Per 1,000	191	261	36.6%	265	376	41.9%	242
Avg Paid per Visit	$154	$161	4.5%	$96	$97	1.0%	$74
		Annualized			Annualized		

Provider Network Summary



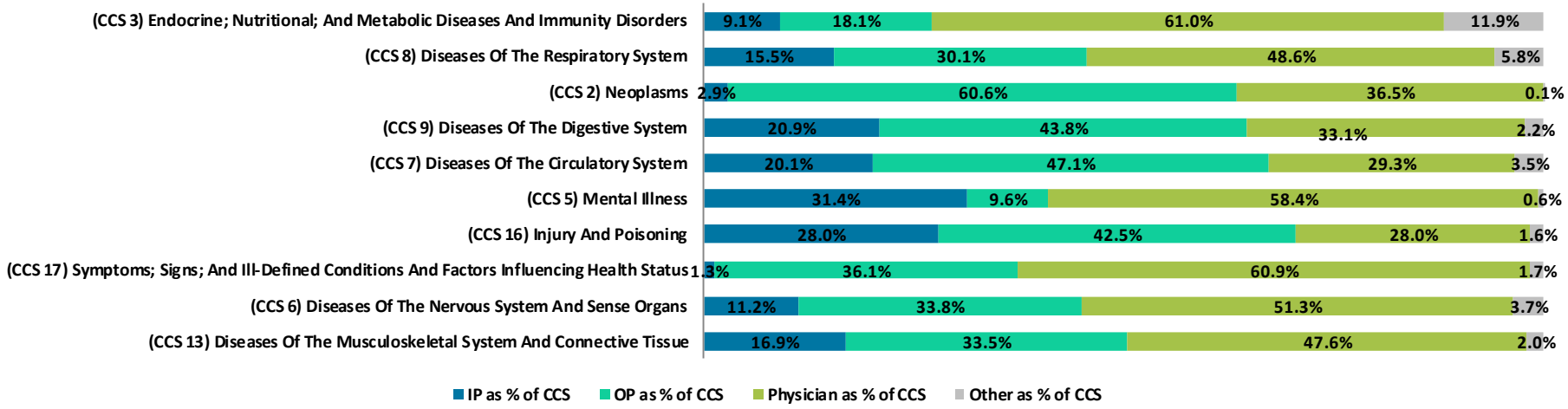


AHRQ* Clinical Classifications Summary

*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	$5,605,975	14.7%	$3,608,261	$1,556,795	$440,920	$2,581,906	$3,024,069
(CCS 6) Diseases Of The Nervous System And Sense Organs	$3,102,941	8.1%	$1,828,286	$637,186	$637,469	$1,283,126	$1,819,815
(CCS 17) Symptoms; Signs; And Ill-Defined Conditions And Factors Influencing Healt	$3,061,990	8.0%	$1,890,612	$456,170	$715,209	$1,028,561	$2,033,429
(CCS 16) Injury And Poisoning	$2,843,164	7.4%	$1,697,065	$406,327	$739,772	$1,507,924	$1,335,240
(CCS 5) Mental Illness	$2,837,468	7.4%	$1,547,792	$276,855	$1,012,821	$932,221	$1,905,247
(CCS 7) Diseases Of The Circulatory System	$2,712,409	7.1%	$2,051,462	$490,176	$170,771	$1,374,588	$1,337,822
(CCS 9) Diseases Of The Digestive System	$2,674,580	7.0%	$1,796,636	$399,323	$478,621	$1,127,480	$1,547,100
(CCS 2) Neoplasms	$2,519,993	6.6%	$1,965,269	$492,392	$62,333	$602,166	$1,917,827
(CCS 8) Diseases Of The Respiratory System	$2,331,401	6.1%	$1,455,075	$199,348	$676,978	$1,040,896	$1,290,505
(CCS 3) Endocrine; Nutritional; And Metabolic Diseases And Immunity Disorders	$2,319,193	6.1%	$1,784,087	$316,557	$218,548	$757,947	$1,561,246
(CCS 10) Diseases Of The Genitourinary System	$1,925,282	5.0%	$1,480,920	$266,116	$178,246	$657,573	$1,267,709
(CCS 11) Complications Of Pregnancy; Childbirth; And The Puerperium	$1,501,055	3.9%	$1,159,824	$231,067	$110,163	$24,367	$1,476,688
(CCS 1) Infectious And Parasitic Diseases	$1,275,457	3.3%	$657,995	$133,346	$484,117	$609,872	$665,585
(CCS 15) Certain Conditions Originating In The Perinatal Period	$1,064,218	2.8%	$9,750	$225	$1,054,243	$293,212	$771,006
(CCS 18) Residual Codes; Unclassified; All E Codes [259. And 260.]	$841,953	2.2%	$664,628	$110,067	$67,257	$357,114	$484,839
(CCS 4) Diseases Of The Blood And Blood-Forming Organs	$693,970	1.8%	$107,199	$571,116	$15,656	$22,886	$671,084
(CCS 12) Diseases Of The Skin And Subcutaneous Tissue	$598,748	1.6%	$378,397	$132,392	$87,960	$251,968	$346,781
(CCS 14) Congenital Anomalies	$289,401	0.8%	$11,406	$8,736	$269,258	$202,285	$87,116
Total	**$38,199,199**	**100.0%**	**$24,094,665**	**$6,684,192**	**$7,420,342**	**$14,656,091**	**$23,543,108**

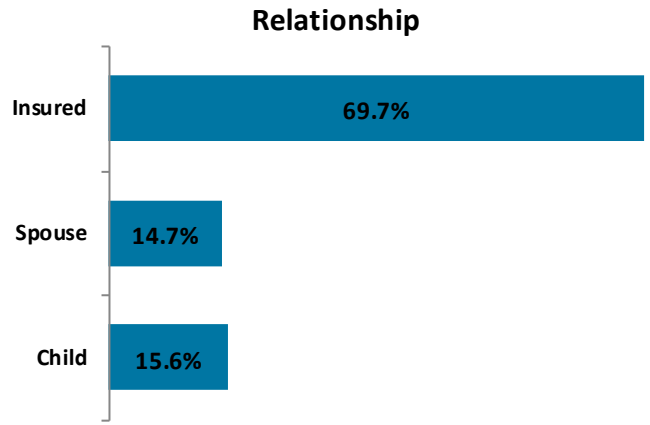
Top 10 Categories by Claim Type

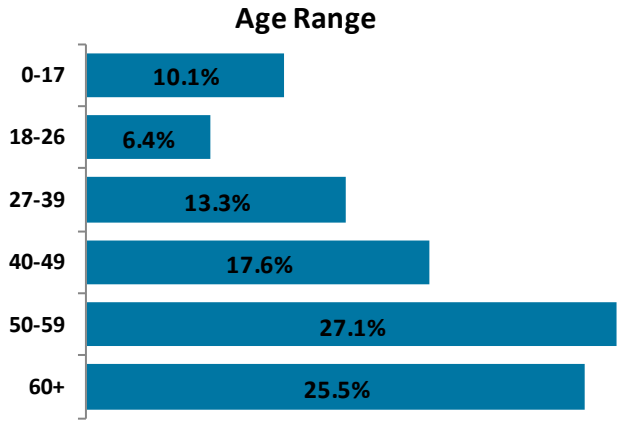


AHRQ Category – Diseases of the Musculoskeletal System & Connective Tissue

Diagnosis Category	Patients	Claims	Total Paid	% Paid
Spondylosis; Intervertebral Disc Disorders; Other Back Problems [205.]	1,220	8,464	$2,352,836	42.0%
Non-Traumatic Joint Disorders	1,366	7,272	$1,654,048	29.5%
Other Connective Tissue Disease [211.]	1,260	4,438	$860,201	15.3%
Acquired Deformities	210	612	$352,275	6.3%
Other Bone Disease And Musculoskeletal Deformities [212.]	455	1,934	$231,831	4.1%
Osteoporosis [206.]	60	127	$90,232	1.6%
Systemic Lupus Erythematosus And Connective Tissue Disorders [210.]	39	192	$57,235	1.0%
Infective Arthritis And Osteomyelitis (Except That Caused By Tb Or Std) [201.]	8	47	$4,810	0.1%
Pathological Fracture [207.]	5	6	$2,506	0.0%
	----	----	**$5,605,975**	**100.0%**

*Patient and claim counts are unique only within the category

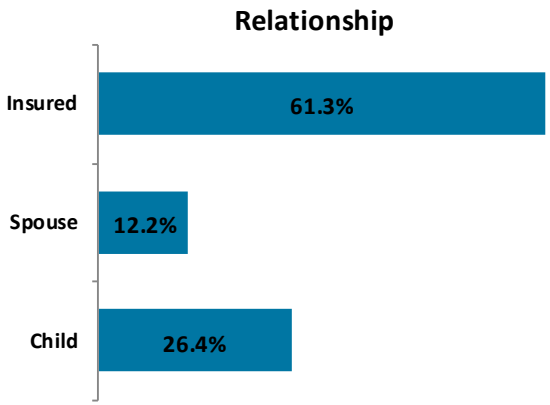


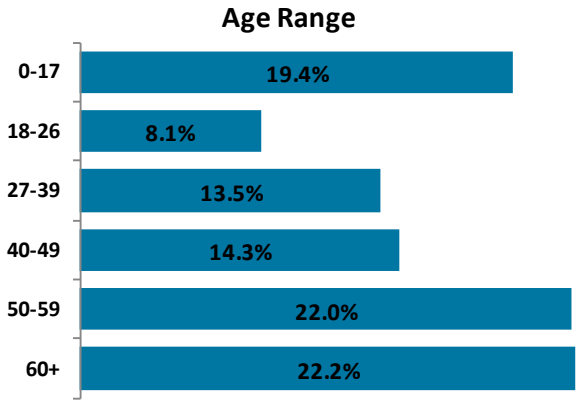


AHRQ Category – Diseases of the Nervous System & Sense Organs

Diagnosis Category	Patients	Claims	Total Paid	% Paid
Eye Disorders	2,735	5,121	$915,954	29.5%
Other Nervous System Disorders [95.]	577	2,016	$821,665	26.5%
Ear Conditions	761	1,504	$355,343	11.5%
Headache; Including Migraine [84.]	382	966	$311,984	10.1%
Epilepsy; Convulsions [83.]	88	387	$248,943	8.0%
Hereditary And Degenerative Nervous System Conditions	86	305	$209,741	6.8%
Paralysis [82.]	15	89	$134,606	4.3%
Central Nervous System Infection	4	13	$85,926	2.8%
Coma; Stupor; And Brain Damage [85.]	24	37	$18,779	0.6%
	----	----	$3,102,941	100.0%

*Patient and claim counts are unique only within the category

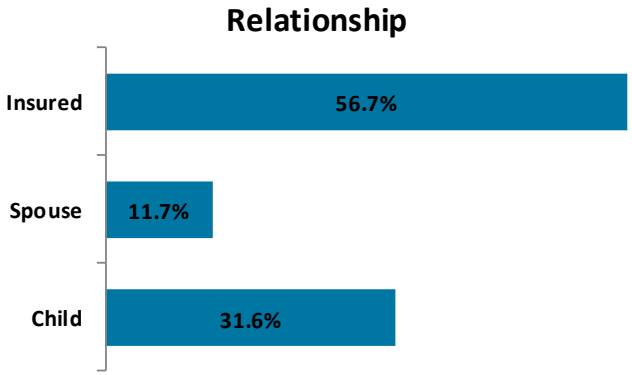


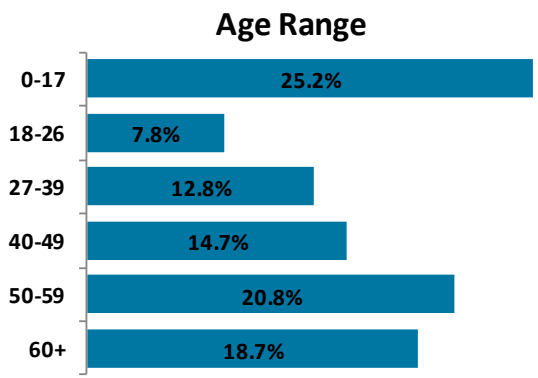


AHRQ Category – Symptoms, Signs; and Ill-defined Conditions & Factors Inf Health

Diagnosis Category	Patients	Claims	Total Paid	% Paid
Factors Influencing Health Care	5,087	13,134	$2,009,529	65.6%
Symptoms; Signs; And Ill-Defined Conditions	1,672	3,857	$1,052,462	34.4%
	----	----	**$3,061,990**	**100.0%**

*Patient and claim counts are unique only within the category

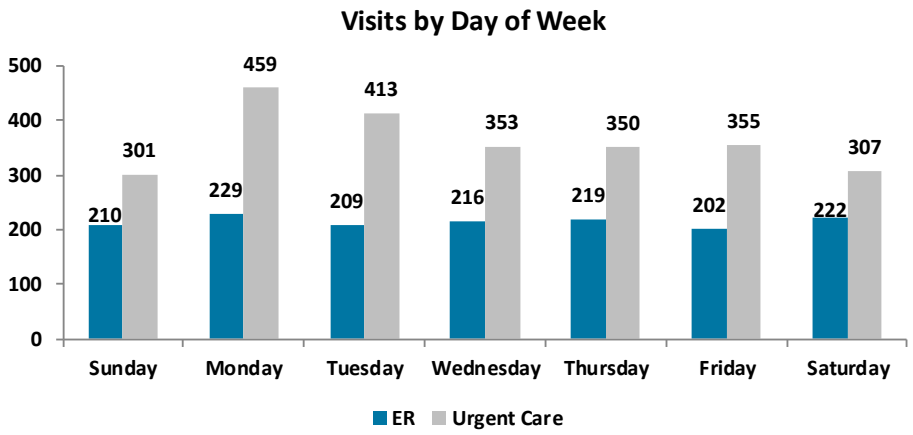


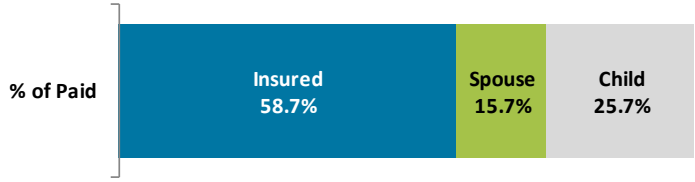


Emergency Room / Urgent Care Summary

	PY19		3Q20		HSB Peer Index	
ER/Urgent Care	**ER**	**Urgent Care**	**ER**	**Urgent Care**	**ER**	**Urgent Care**
Number of Visits	1,454	2,449	1,507	2,538		
Number of Admits	192	----	232	----		
Visits Per Member	0.17	0.29	0.23	0.39	0.17	0.24
Visits/1000 Members	171	288	229	385	174	242
Avg Paid Per Visit	$2,606	$139	$2,609	$156	$1,684	$74
Admits per Visit	0.13	----	0.15	----	0.14	
% of Visits with HSB ER Dx	79.4%	----	79.6%	----		
% of Visits with a Physician OV*	67.9%	67.3%	85.4%	82.5%		
Total Plan Paid	**$3,788,451**	**$341,606**	**$3,931,955**	**$395,897**		
			Annualized	Annualized		

*looks back 12 months from ER visit



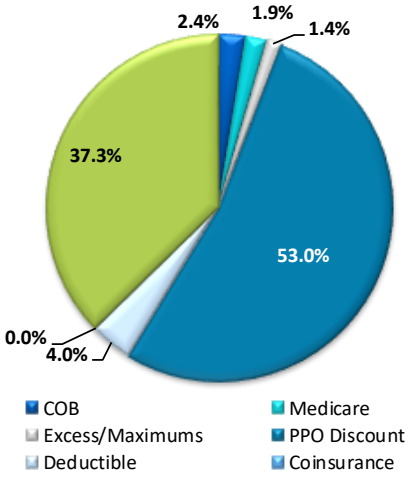


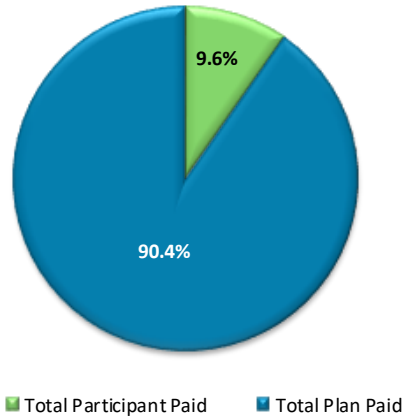
ER / UC Visits by Relationship						
Relationship	**ER**	**Per 1,000**	**Urgent Care**	**Per 1,000**	**Total**	**Per 1,000**
Insured	866	180	1,468	305	2,334	486
Spouse	190	198	242	252	432	450
Child	451	149	828	274	1,279	423
Total	**1,507**	**171**	**2,538**	**289**	**4,045**	**460**

Savings Summary – Medical Claims

Description	Dollars	PPPM	% of Eligible
Eligible Charges	$102,468,295	$2,369	100.0%
COB	$2,462,939	$57	2.4%
Medicare	$1,989,001	$46	1.9%
Excess/Maximums	$1,481,414	$34	1.4%
PPO Discount	$54,257,146	$1,254	53.0%
Deductible	$4,078,597	$94	4.0%
Coinsurance	$0	$0	0.0%
Total Participant Paid	**$4,078,597**	**$94**	**4.0%**
Total Plan Paid	**$38,199,199**	**$883**	**37.3%**

Total Participant Paid - PY19	**$77**
Total Plan Paid - PY19	**$729**



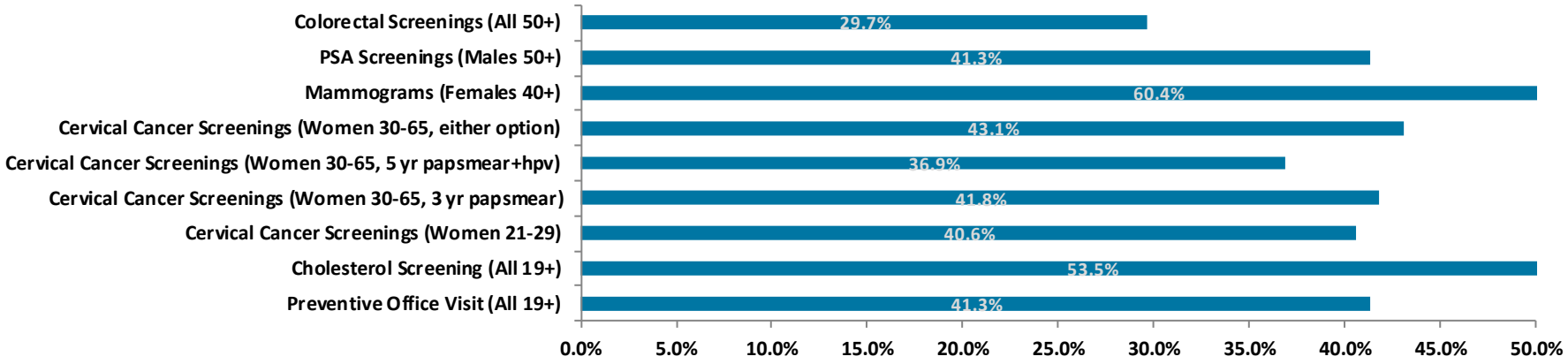


Preventive Services Compliance

*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+)	3,687	1,880	51.0%	2,735	774	28.3%	6,422	2,654	41.3%
Cholesterol Screening (All 19+)	3,687	2,032	55.1%	2,735	1,403	51.3%	6,422	3,435	53.5%
Cervical Cancer Screenings (Women 21-29)	458	186	40.6%	----	----	----	458	186	40.6%
Cervical Cancer Screenings (Women 30-65, 3 yr papsmear)	2,917	1,219	41.8%	----	----	----	2,917	1,219	41.8%
Cervical Cancer Screenings (Women 30-65, 5 yr papsmear+hpv)	2,917	1,076	36.9%	----	----	----	2,917	1,076	36.9%
Cervical Cancer Screenings (Women 30-65, either option)	2,917	1,257	43.1%	----	----	----	2,917	1,257	43.1%
Mammograms (Females 40+)	2,459	1,485	60.4%	----	----	----	2,459	1,485	60.4%
PSA Screenings (Males 50+)	----	----	----	1,355	560	41.3%	1,355	560	41.3%
Colorectal Screenings (All 50+)	1,757	568	32.3%	1,355	356	26.3%	3,112	924	29.7%

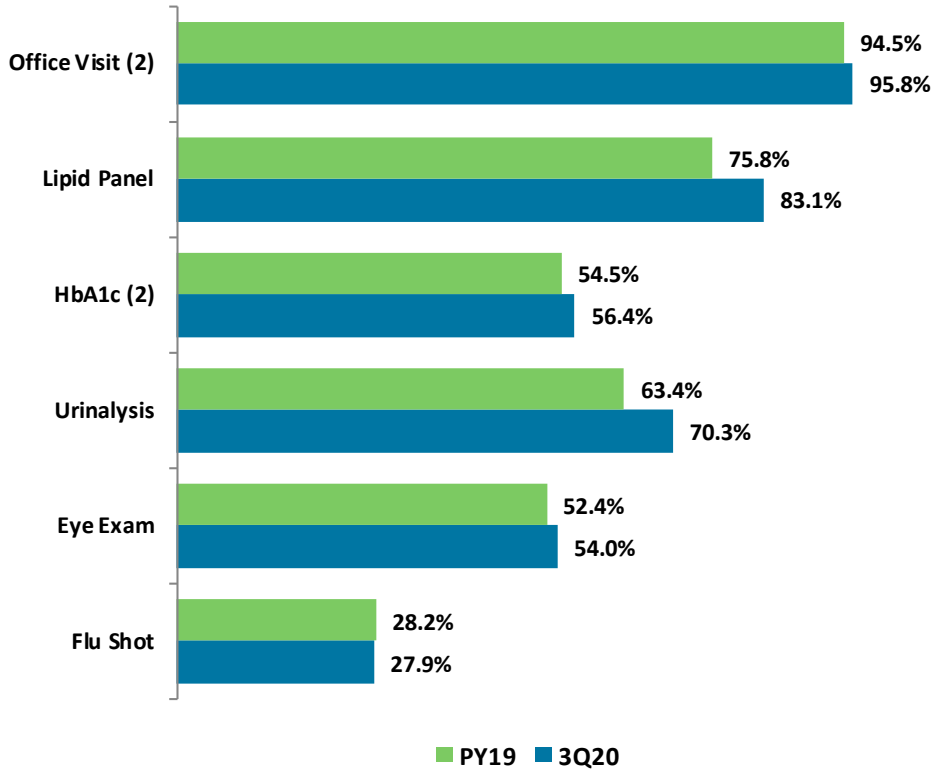
Overall Preventive Services Compliance Rates



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	3Q20
Members	525	569

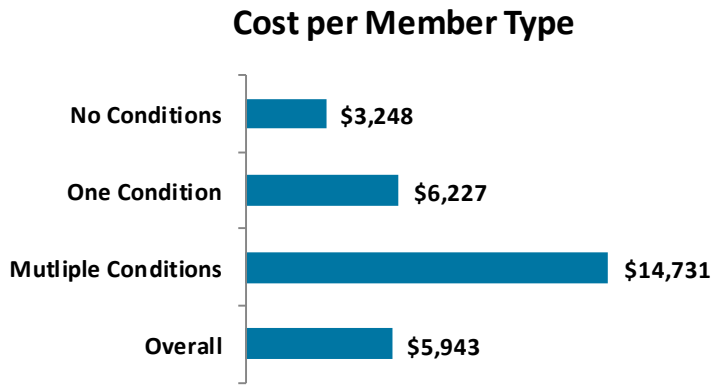


Chronic Conditions Summary

*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	424	404	48	39	$4,702,545	$11,091	99.8%	1 Office Visit
Cancer	315	298	36	58	$5,573,860	$17,695	----	----
Chronic Kidney Disease	79	73	9	56	$2,060,767	$26,086	----	----
Chronic Obstructive Pulmonary Disease (COPD)	97	94	11	60	$2,273,826	$23,442	99.0%	1 Office Visit
Congestive Heart Failure (CHF)	35	34	4	60	$1,502,987	$42,942	17.1%	1 Office Visit, 1 Lipid Profile, 1 Wellness Visit
Coronary Artery Disease (CAD)	143	133	16	61	$2,544,350	$17,793	19.6%	1 Office Visit, 1 Lipid Profile, 1 Wellness Visit
Depression	624	582	71	40	$6,361,177	$10,194	97.8%	1 Office Visit
Diabetes	569	533	65	55	$6,170,091	$10,844	26.9%	2 Office Visits, 1 Lipid Profile, 2 HbA1c's, 1 Urinalysis, 1 Eye Exam, 1 Flu Shot
Hyperlipidemia	774	737	88	55	$6,328,461	$8,176	36.6%	1 Office Visit, 1 Lipid Profile, 1 Wellness Visit
Hypertension	879	835	100	57	$10,113,056	$11,505	29.5%	1 Office Visit, 1 Lipid Profile, 1 Wellness Visit
Obesity	282	268	32	46	$2,709,500	$9,608	0.0%	----

# of Conditions	Avg Members	Average Age	Relationship		
			Insured	Spouse	Child
No Conditions	5,043	29	40.9%	9.4%	49.6%
One Condition	2,237	45	69.4%	13.9%	16.7%
Multiple Conditions	1,475	54	79.6%	16.9%	3.5%
Overall	**8,754**	**37**	**53.7%**	**11.7%**	**34.6%**



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

Express Scripts

Membership Summary	3Q FY2020 EPO	3Q FY2019 EPO	Difference	% Change
			Membership Summary	
Member Count (Membership)	8,790	8,487	303	3.6%
Utilizing Member Count (Patients)	7,102	6,702	400	6.0%
Percent Utilizing (Utilization)	80.8%	79.0%	0	2.3%
Claim Summary			**Claims Summary**	
Net Claims (Total Rx's)	132,010	122,941	9,069	7.4%
Claims per Elig Member per Month (Claims PMPM)	1.67	1.61	0.06	3.7%
Total Claims for Generic (Generic Rx)	113,798	106,631	7,167.00	6.7%
Total Claims for Brand (Brand Rx)	18,212	16,310	1,902.00	11.7%
Total Claims for Brand w/Gen Equiv (Multisource Brand Claims)	2,186	1,919	267.00	13.9%
Total Non-Specialty Claims	130,303	121,477	8,826.00	7.3%
Total Specialty Claims	1,707	1,464	243.00	16.6%
Generic % of Total Claims (GFR)	**86.2%**	**86.7%**	(0.01)	-0.6%
Generic Effective Rate (GCR)	**98.1%**	**98.2%**	(0.00)	-0.1%
Mail Order Claims	13,062	10,153	2,909.00	28.7%
Mail Penetration Rate*	11.0%	9.2%	0.02	1.8%
Claims Cost Summary			**Claims Cost Summary**	
Total Prescription Cost (Total Gross Cost)	$14,869,536.00	$12,142,972.00	$2,726,564.00	22.5%
Total Generic Gross Cost	$2,578,328.00	$2,865,317.00	($286,989.00)	-10.0%
Total Brand Gross Cost	$12,291,208.00	$9,277,655.00	$3,013,553.00	32.5%
Total MSB Gross Cost	$491,898.00	$292,112.00	$199,786.00	68.4%
Total Ingredient Cost	$14,802,478.00	$12,081,045.00	$2,721,433.00	22.5%
Total Dispensing Fee	$63,841.00	$60,311.00	$3,530.00	5.9%
Total Other (e.g. tax)	$3,217.00	$1,617.00	$1,600.00	98.9%
Avg Total Cost per Claim (Gross Cost/Rx)	**$112.64**	**$98.77**	$13.87	14.0%
Avg Total Cost for Generic (Gross Cost/Generic Rx)	$22.66	$26.87	($4.21)	-15.7%
Avg Total Cost for Brand (Gross Cost/Brand Rx)	$674.90	$568.83	$106.07	18.6%
Avg Total Cost for MSB (MSB Gross Cost/MSB ARx)	$225.02	$152.22	$72.80	47.8%
Member Cost Summary			**Member Cost Summary**	
Total Member Cost	**$2,139,968.00**	**$1,962,142.00**	$177,826.00	9.1%
Total Copay	$2,139,968.00	$1,962,142.00	$177,826.00	9.1%
Total Deductible	$0.00	$0.00	$0.00	0.0%
Avg Copay per Claim (Copay/Rx)	$16.21	$15.96	$0.25	1.6%
Avg Participant Share per Claim (Copay+Deductible/RX)	**$16.21**	**$15.96**	**$0.25**	**1.6%**
Avg Copay for Generic (Copay/Generic Rx)	$7.19	$6.35	$0.84	13.2%
Avg Copay for Brand (Copay/Brand Rx)	$72.56	$78.77	($6.21)	-7.9%
Avg Copay for Brand w/ Generic Equiv (Copay/Multisource Rx)	$28.78	$25.87	$2.91	11.2%
Net PMPM (Participant Cost PMPM)	**$27.05**	**$25.69**	$1.36	5.3%
Copay % of Total Prescription Cost (Member Cost Share %)	14.4%	16.2%	-1.8%	-10.9%
Plan Cost Summary			**Plan Cost Summary**	
Total Plan Cost (Plan Cost)	**$12,729,567.00**	**$10,180,831.00**	**$2,548,736.00**	**25.0%**
Total Non-Specialty Cost (Non-Specialty Plan Cost)	$5,987,437.00	$5,767,973.00	$219,464.00	3.8%
Total Specialty Drug Cost (Specialty Plan Cost)	$6,742,130.00	$4,412,858.00	$2,329,272.00	52.8%
Avg Plan Cost per Claim (Plan Cost/Rx)	**$96.43**	**$82.81**	$13.62	16.4%
Avg Plan Cost for Generic (Plan Cost/Generic Rx)	$15.46	$20.52	($5.06)	-24.7%
Avg Plan Cost for Brand (Plan Cost/Brand Rx)	$602.34	$490.07	$112.27	22.9%
Avg Plan Cost for MSB (MSB Plan Cost/MSB ARx)	$196.24	$126.35	$69.89	55.3%
Net PMPM (Plan Cost PMPM)	**$160.91**	**$133.29**	**$27.62**	**20.7%**
PMPM for Specialty Only (Specialty PMPM)	$85.22	$57.77	$27.45	47.5%
PMPM without Specialty (Non-Specialty PMPM)	$75.68	$75.51	$0.17	0.2%
Rebates (Q1-Q3 FY2020 estimated)	$3,032,477.97	$2,352,557.41	**$679,920.56**	**28.9%**
Net PMPM (Plan Cost PMPM factoring Rebates)	**$122.58**	**$101.94**	**$20.64**	**20.2%**
PMPM for Specialty Only (Specialty PMPM)	$73.07	$48.91	$24.16	49.4%
PMPM without Specialty (Non-Specialty PMPM)	$49.50	$53.03	($3.53)	-6.7%

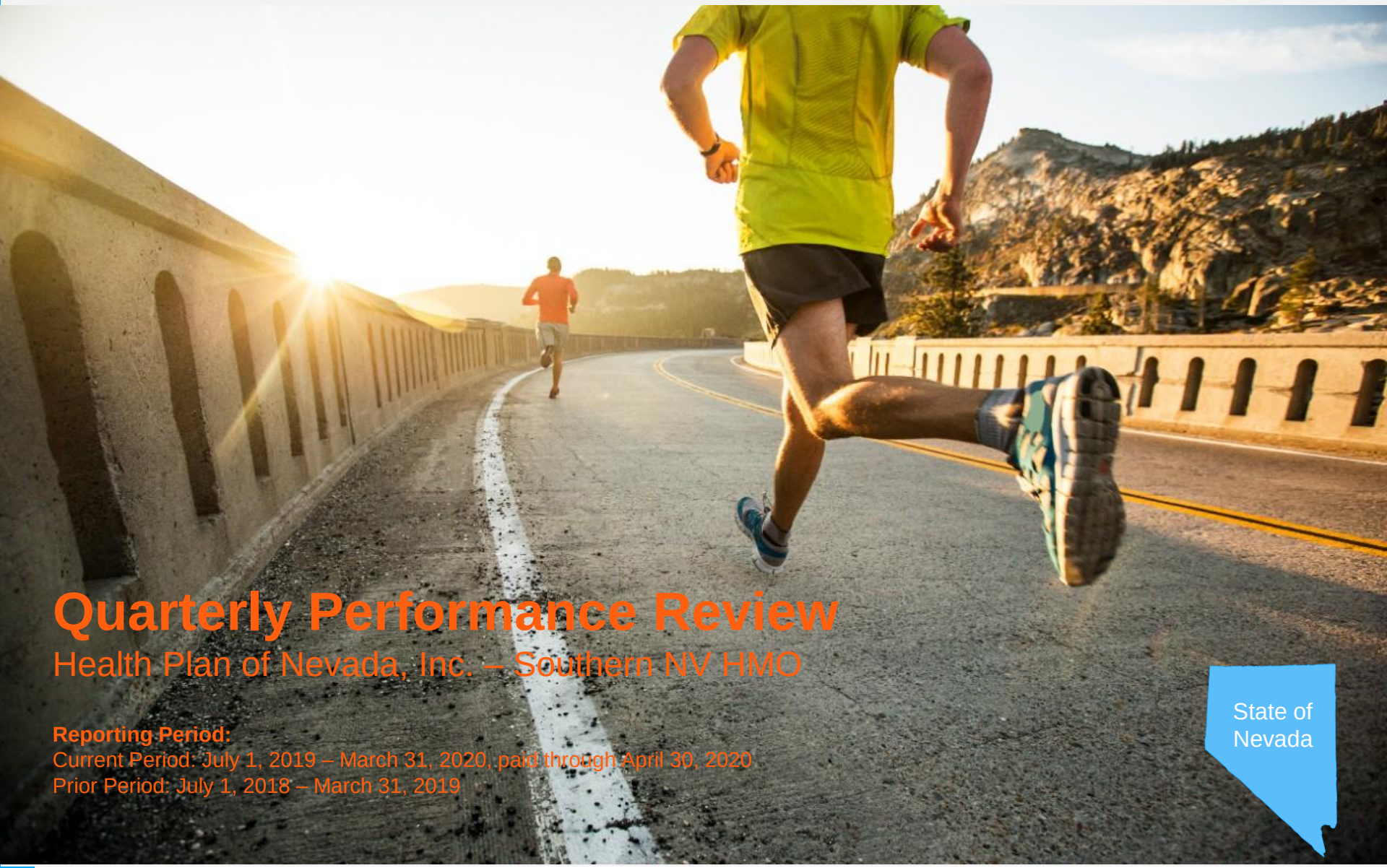
Appendix C

Index of Tables
Health Plan of Nevada –Utilization Review for PEBP
July 1, 2019 – March 31, 2020

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 – March 31, 2020, paid through April 30, 2020
Prior Period: July 1, 2018 – March 31, 2019

State of Nevada

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

- ✓ NowClinic and Walgreens now offering same-day medication delivery
- ✓ Added HCA hospitals and 17 Care Now Urgent Cares to the network
- ✓ Launched new HPN App
- ✓ 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

Includes Demographics And Financials

Demographic and Financial Overview

UnitedHealthcare

Demographics

Membership	Avg. Age	Famiy size	HHS Risk
Members: 6,865 Employees: 3,954	37.3	1.74	1.76
Prior: 6,704 3,888	Prior : 37.9 Norm: 35.3	Prior : 1.72 Norm: 1.74	Prior : 1.72 Norm: 1.42
2.4%	-1.6%	0.7%	2.3%

Medical and Rx Spend

16.0%

Medical PMPM
$325.23

Prior $280.41
Norm: $254.19

5.6%
90.0 ER Visits Per K

Prior: 85 ER Visits Per K
Norm: 71 ER Visits Per K

-2.4%
475 Urgent Care Visits Per K

Prior: 487 UC Visits Per K
Norm: 320 UC Visits Per K

12.3%

Overall PMPM
$446.98

Prior: $397.90
Norm: $334.99

4.8%
Specialty Rx
$61.07

Prior: $58.25
Norm: $35.78

2.3%
Avg. Scripts PMPY
18.0

Prior: 7.5
Norm: 9.2

3.6%

Rx PMPM
$121.75

Prior: $117.49
Norm: $80.75

Medical and Rx Plan Experience

What Happened

Highlights of Utilization

Utilization Metric	Prior	Current	Δ
Physician Office Visits			
Per Member Per Year	2.0	2.2	11.5%
Specialist Office Visits			
Per Member Per Year	4.9	5.5	12.2%
Emergency Room			
ER Visits	568	615	8.2%
ER Visits per K	84.7	89.5	5.6%
Urgent Care			
UC Visits	3,262	3,259	-0.1%
UC Visits per K	486.6	474.8	-2.4%
OutPatient Surgery			
Facility	25.4	29.7	17.2%
ASC	102.2	95.8	-6.2%
Inpatient Utilization			
Admissions Per K	5.00	5.4	8.0%
Bed Days Per K	20.6	26.8	30.1%
Average Length of Stay	4.2	4.9	16.7%
On Demand			
Now Clinic Visits	393	331	-15.8%
TAN Calls	568	571	0.5%
Convienent Care	493	515	4.5%

*Not representative of all Utilization

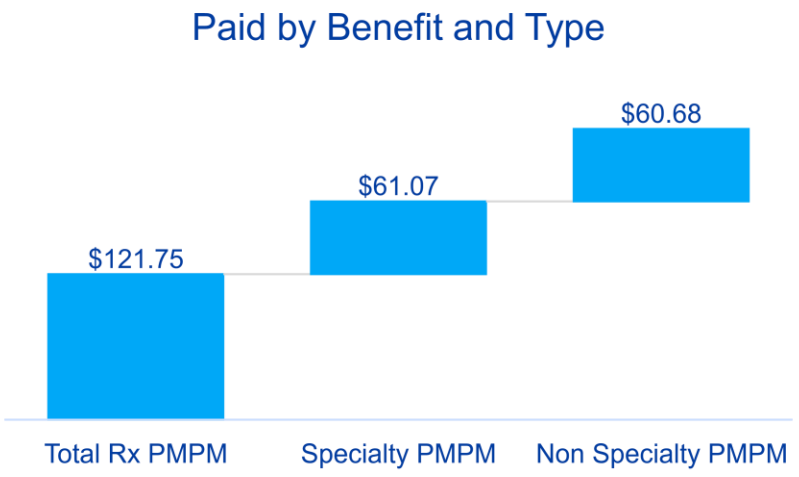
Highlights

- Increased PCP and Specialist visits on a PMPY basis
- ER utilization increased **5.6%**,
  - Average Net Paid / Visit decreased to **-1.1%**
- Urgent Care Utilization increased **-2.4%**
- Outpatient surgeries growing at facility settings
- Admits Per K decreased **8.0%** from prior period, but ALOS increased **16.7%** due to more complex stays
- Decreased utilization for Now Clinic and Convenient Care.
  - We will continue to see increases in these services as a result of COVID-19

Note: On Demand utilization is understated due to claims lag

Pharmacy Data

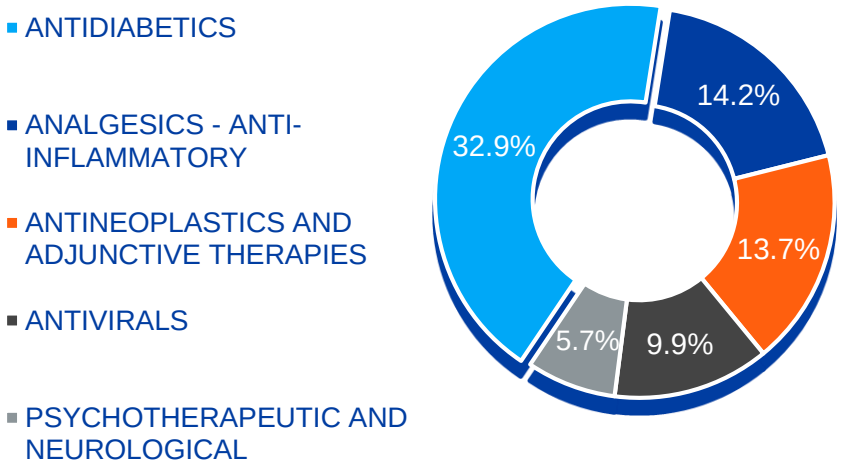
	Prior	Current	Δ	Peer	Δ
Enrolled Members	6,704	6,865	2.4%		
Average Prescriptions PMPY	17.6	18.0	2.3%	11.5	56.2%
Formulary Rate	93.2%	93.1%	-0.1%	91.8%	1.4%
Generic Use Rate	87.3%	87.1%	-0.3%	86.9%	0.2%
Generic Substitution Rate	97.4%	97.1%	-0.4%	96.5%	0.6%
Employee Cost Share PMPM	$19.43	$19.36	-0.3%	$13.42	44.3%
Avg Net Paid per Prescription	$80.28	$81.35	1.3%	$84.26	-3.5%
Net Paid PMPM	$117.49	$121.75	3.6%	$80.75	50.8%



Pharmacy PMPM trend is 3.6%

- Average net paid per script increased **1.3%**
- 83% of prescriptions were in Tier 1 and drove only **11.3%** of spend
- Tier 2 utilization increased **11.6%** and spend increased **25.3%**
- Increase in Humira utilization and spend from prior period.

Top 5 Therapuetic Class by Spend



Catastrophic Cases

High Cost Claimants

Catastrophic Cases Summary (>$50k)

UnitedHealthcare

7.9 Catastrophic Cases Per 1000

Prior: 4.5 ▲ 77.0%

60 Individuals
.79% of the population

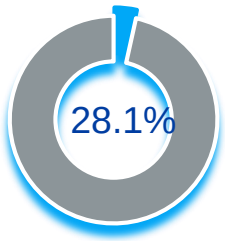
$100,367
Average Paid Per Case

Prior: $99,726 ▲ 0.6%

% of Spend as High Cost
21.8%

% Paid Attributed to Catastrophic Cases

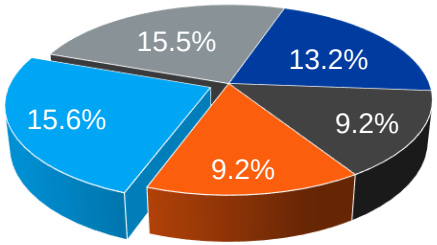
Medical



Pharmacy

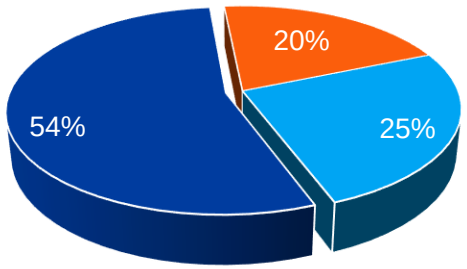
Top 5 AHRQ Chapter Description by Paid

- Diseases of the circulatory system
- Neoplasms
- Complications of pregnancy;
- Injury and poisoning
- Diseases of the blood



% of Claims by Relationship

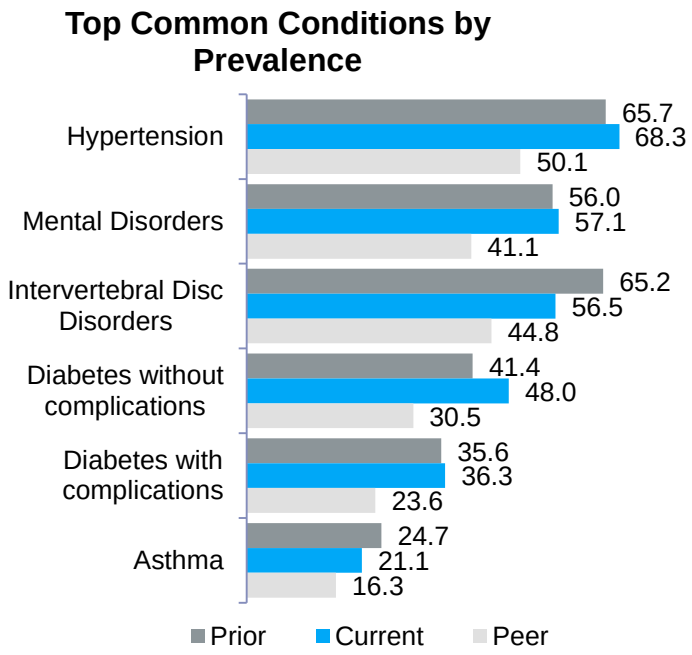
- Subscriber
- Spouse
- Dependent

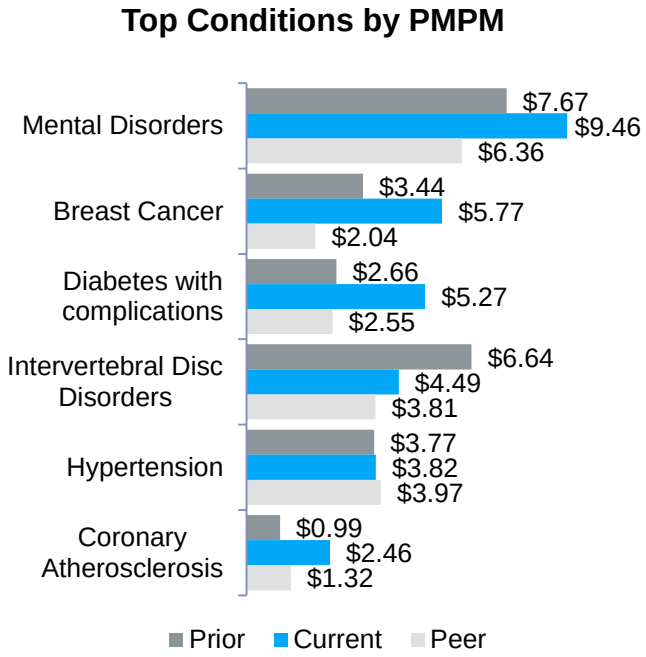


Condition Prevalence

Clinical Drivers

Clinical Conditions and Diagnosis



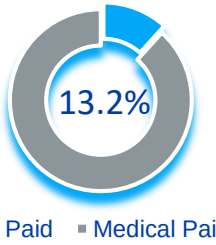
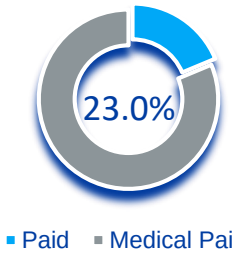
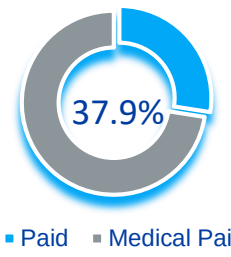
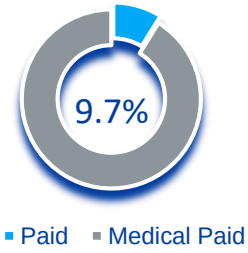


- Chronic illnesses are driving the top common conditions
- Hypertension, Mental Disorders, Intervertebral Disc Disorders and are the most prevalent clinical conditions within this population
- Spend for Diabetes both with and without complications increased (w/Complications increased 98.3%)
  - Approximately 9.2% of the population has a diabetes diagnosis

Chronic Condition Cost Drivers

UnitedHealthcare

84% Of total spend driven by members with these 4 Chronic Conditions

Asthma	Cardio Hypertension	Diabetes	Chronic Kidney
6.8% of Members	6.48% of Members	8.13% of Members	.74 % of Members
			
Average paid Per Claimant **$8,466**	Average paid Per Claimant **$15,458**	Average paid Per Claimant **$23,085**	Average paid Per Claimant **$56,794**
Member Engagement **95.7%**	Member Engagement **94.7%**	Member Engagement **95.0%**	Member Engagement **100%**

**Data obtained for this slide is for Eval period Jan-2019 thru Dec-2019*

4.3

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

    4.3 Receipt of quarterly vendor reports for the period ending March 31, 2020:

        4.3.1 HealthSCOPE Benefits – Obesity Care Management

        4.3.2 HealthSCOPE Benefits – Diabetes Care Management

        4.3.3 American Health Holdings – Utilization and Large Case Management

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

        4.3.5 Towers Watson's One Exchange – Medicare Exchange

        4.3.6 Hometown Health Providers and Sierra Healthcare Options – PPO Network

4.3.1

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

    4.3 Receipt of quarterly vendor reports for the period ending March 31, 2020:

        4.3.1 HealthSCOPE Benefits – Obesity Care Management

HSB DATASCOPE™

Obesity Care Management Report

Nevada Public Employees' Benefits Program

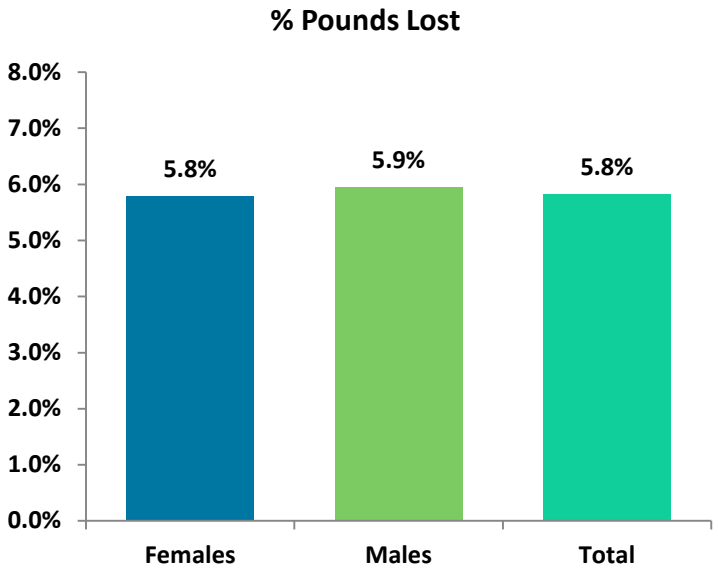
July 2019 – March 2020

HealthSCOPE BENEFITS

Obesity Care Management Overview

*Non-Participant is defined as a member who has been diagnosed with obesity in the past 12 months, but is not enrolled in the program

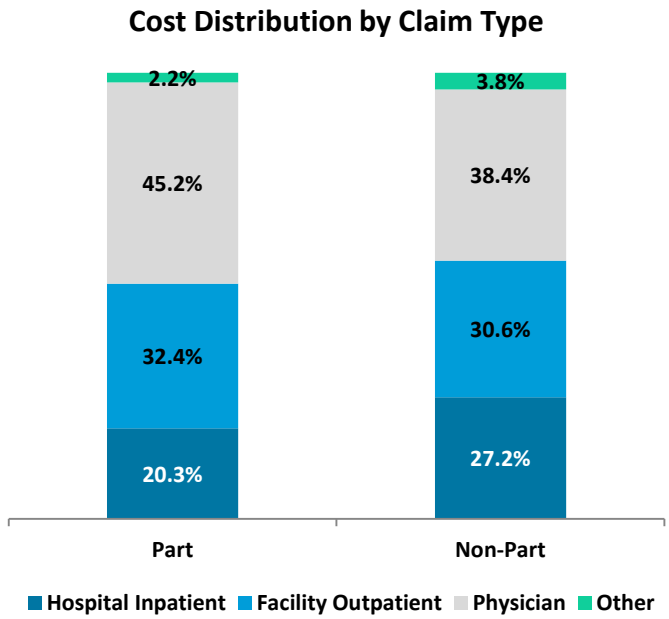
PEBP 3Q20			
Weight Management Summary	**Females**	**Males**	**Total**
# Mbrs Enrolled in Program	947	253	1,200
Average # Lbs. Lost	12.2	14.6	12.8
Total # Lbs. Lost	11,618.2	3,693.3	15,311.5
% Lbs. Lost	5.8%	5.9%	5.8%
Average Cost/ Member	$4,629	$4,616	$4,626



Obesity Care Management – Financial Summary

*Non-Participant is defined as a member who has been diagnosed with obesity in the past 12 months, but is not enrolled in the program

Summary	Participants	Non-Participants	Variance
Enrollment			
Avg # Employees	1,021	613	66.5%
Avg # Members	1,130	827	36.7%
Member/Employee Ratio	1.1	1.4	-17.8%
Financial Summary			
Gross Cost	$5,438,715	$6,177,460	
Client Paid	$4,110,218	$5,075,545	
Employee Paid	$1,328,496	$1,101,915	
Client Paid-PEPY	$5,366	$11,036	-51.4%
Client Paid-PMPY	$4,850	$8,184	-40.7%
Client Paid-PEPM	$447	$920	-51.4%
Client Paid-PMPM	$404	$682	-40.8%
High Cost Claimants (HCC's) > $100k			
# of HCC's	2	6	
HCC's / 1,000	1.8	7.3	0.0%
Avg HCC Paid	$178,251	$232,823	0.0%
HCC's % of Plan Paid	8.7%	27.5%	0.0%
Cost Distribution - PMPY			
Hospital Inpatient	$984	$2,228	-55.8%
Facility Outpatient	$1,571	$2,508	-37.4%
Physician	$2,190	$3,141	-30.3%
Other	$105	$307	-65.8%
Total	$4,850	$8,184	-40.7%
	Annualized	Annualized	



Obesity Care Management – Utilization Summary

*Non-Participant is defined as a member who has been diagnosed with obesity in the past 12 months, but is not enrolled in the program

Summary	Participants	Non-Participants	Variance
Inpatient Facility			
# of Admits	57	49	
# of Bed Days	189	355	
Paid Per Admit	$15,163	$27,979	-45.8%
Paid Per Day	$4,573	$3,862	18.4%
Admits Per 1,000	67	79	-15.2%
Days Per 1,000	223	572	-61.0%
Avg LOS	3.3	7.2	-54.2%
Physician Office			
OV Utilization per Member	9.9	8.9	11.2%
Avg Paid per OV	$74	$64	15.6%
Avg OV Paid per Member	$735	$575	27.8%
DX&L Utilization per Member	16.2	19.4	-16.5%
Avg Paid per DX&L	$48	$57	-15.8%
Avg DX&L Paid per Member	$779	$1,101	-29.2%
Emergency Room			
# of Visits	232	192	
# of Admits	29	19	
Visits Per Member	0.27	0.31	-12.9%
Visits Per 1,000	274	310	-11.6%
Avg Paid per Visit	$2,575	$2,641	-2.5%
Admits Per Visit	0.13	0.10	30.0%
Urgent Care			
# of Visits	466	352	
Visits Per Member	0.55	0.57	-3.5%
Visits Per 1,000	550	568	-3.2%
Avg Paid per Visit	$59	$108	-45.4%
	Annualized	Annualized	

4.3.2

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

    4.3 Receipt of quarterly vendor reports for the period ending March 31, 2020:

        4.3.1 HealthSCOPE Benefits – Obesity Care Management

        4.3.2 HealthSCOPE Benefits – Diabetes Care Management

HSB DATASCOPE™

Diabetes Care Management Report

Nevada Public Employees' Benefits Program

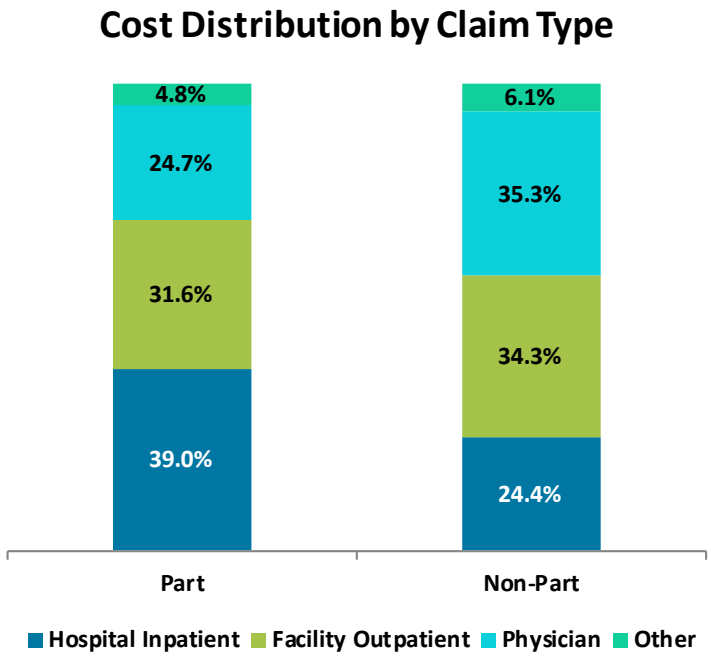
July 2019 – March 2020

HealthSCOPE BENEFITS

Diabetes Care Management – Financial Summary

*Non-Participant is defined as a member who has been diagnosed with diabetes in the past 12 months, but is not enrolled in the program
*Analysis based on active members

Summary	Participants	Non-Participants	Variance
Enrollment			
Avg # Employees	445	1,413	-68.5%
Avg # Members	620	1,794	-65.5%
Member/Employee Ratio	1.4	1.3	9.4%
Financial Summary			
Gross Cost	$4,576,713	$14,160,100	
Client Paid	$3,733,527	$11,672,668	
Employee Paid	$843,186	$2,487,432	
Client Paid-PEPY	$11,181	$11,013	1.5%
Client Paid-PMPY	$8,035	$8,675	-7.4%
Client Paid-PEPM	$932	$918	1.5%
Client Paid-PMPM	$670	$723	-7.3%
High Cost Claimants (HCC's) > $100k			
# of HCC's	7	17	
HCC's / 1,000	11.3	9.5	0.0%
Avg HCC Paid	$210,692	$152,767	0.0%
HCC's % of Plan Paid	39.5%	22.20%	0.0%
Cost Distribution - PMPY			
Hospital Inpatient	$3,130	$2,113	48.1%
Facility Outpatient	$2,537	$2,976	-14.8%
Physician	$1,984	$3,060	-35.2%
Other	$383	$526	-27.2%
Total	$8,035	$8,675	-7.4%
	Annualized	Annualized	



Diabetes Care Management – Utilization Summary

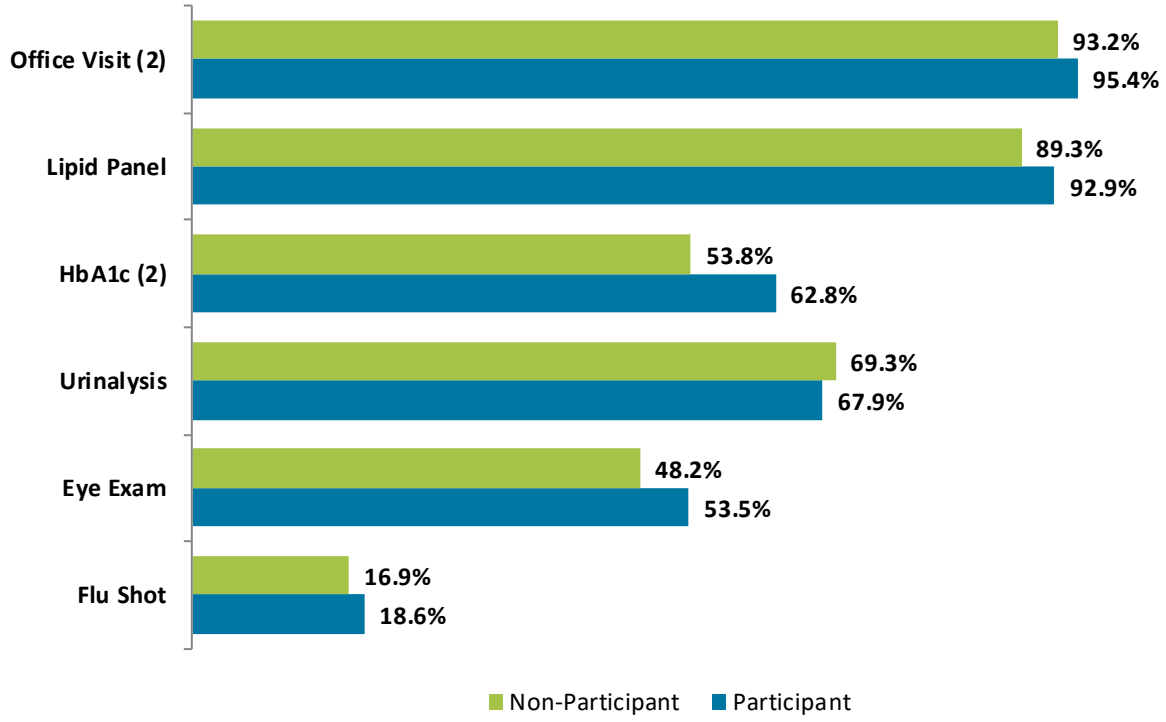
*Non-Participant is defined as a member who has been diagnosed with diabetes in the past 12 months, but is not enrolled in the program
*Analysis based on active members

Summary	Participants	Non-Participants	Variance
Inpatient Facility			
# of Admits	51	160	
# of Bed Days	304	713	
Paid Per Admit	$29,181	$17,257	69.1%
Paid Per Day	$4,895	$3,873	26.4%
Admits Per 1,000	110	119	-7.6%
Days Per 1,000	654	530	23.4%
Avg LOS	6	4.5	33.3%
Physician Office			
OV Utilization per Member	7.2	8.9	-19.1%
Avg Paid per OV	$61	$62	-1.6%
Avg OV Paid per Member	$441	$558	-21.0%
DX&L Utilization per Member	17.3	23.5	-26.4%
Avg Paid per DX&L	$49	$55	-10.9%
Avg DX&L Paid per Member	$839	$1,297	-35.3%
Emergency Room			
# of Visits	113	513	
# of Admits	29	105	
Visits Per Member	0.24	0.38	-36.8%
Visits Per 1,000	243	381	-36.2%
Avg Paid per Visit	$2,024	$2,666	-24.1%
Admits Per Visit	0.26	0.20	30.0%
Urgent Care			
# of Visits	123	534	
Visits Per Member	0.26	0.4	-35.0%
Visits Per 1,000	265	397	-33.2%
Avg Paid per Visit	$146	$122	19.7%
	Annualized	Annualized	

Diabetic Compliance

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

Diabetic Population		
Year	**Participant**	**Non-Participant**
Members	452	1,845



4.3.3

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

    4.3 Receipt of quarterly vendor reports for the period ending March 31, 2020:

        4.3.1 HealthSCOPE Benefits – Obesity Care Management

        4.3.2 HealthSCOPE Benefits – Diabetes Care Management

        4.3.3 American Health Holdings – Utilization and Large Case Management

AmericanHealth
American Health Holding Inc

Public Employees' Benefits Program – State of Nevada

Medical Management Review
January 1, 2020 – March 31, 2020

AHH Business Intelligence
Certified

Table of Contents

Return on Investment

The following tables summarize medical management savings and ROI for the Public Employees' Benefits Program.

July 1, 2019 - September 30, 2019			
	Fees	Estimated Savings	ROI
Utilization Management	$146,351	$1,485,049	10.1 to 1
Case Management	$294,385	$1,056,547	3.6 to 1
Total	$440,736	$2,541,596	5.8 to 1

Utilization Management Breakout	
Inpatient Savings:	$745,732
Outpatient Savings:	$739,317

October 1, 2019 - December 31, 2019			
	Fees	Estimated Savings	ROI
Utilization Management	$198,696	$881,052	4.4 to 1
Case Management	$297,195	$1,213,222	4.1 to 1
Total	$495,891	$2,094,274	4.2 to 1

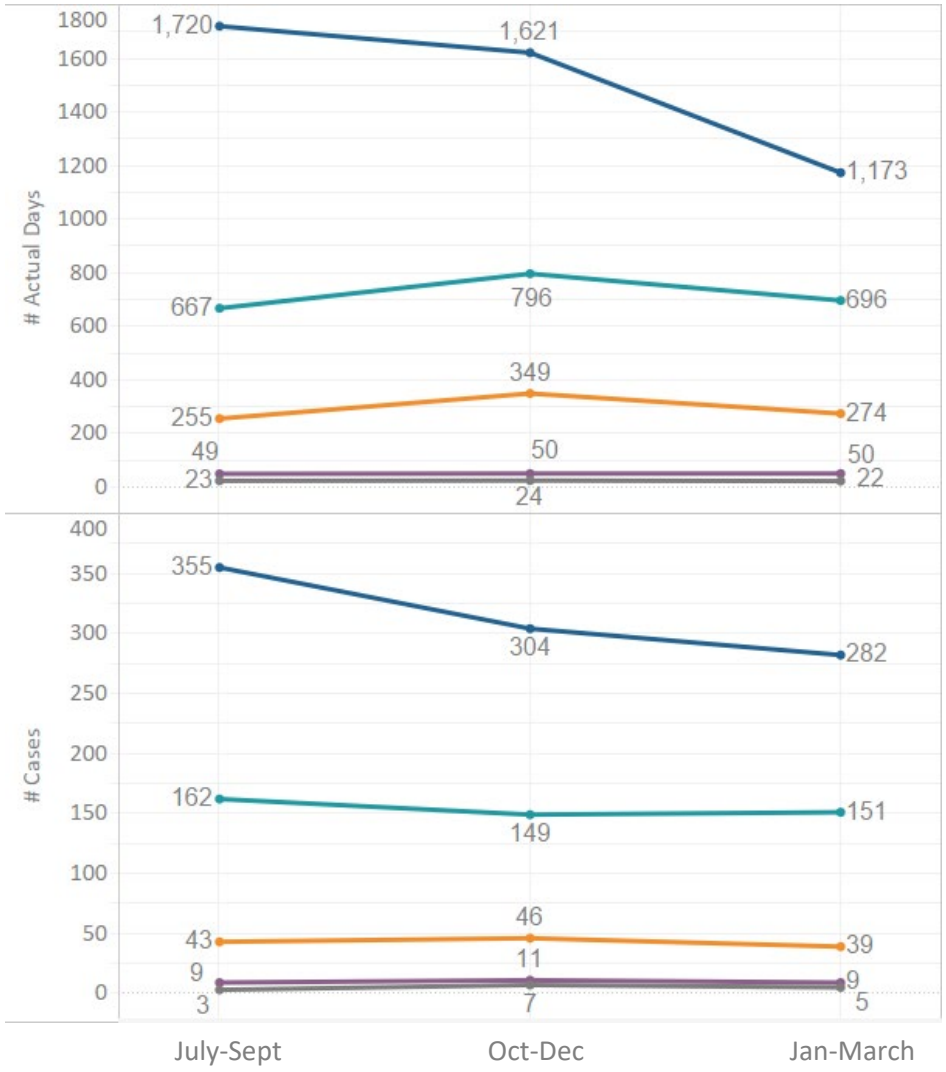
Utilization Management Breakout	
Inpatient Savings	$532,186
Outpatient Savings	$348,866

January 1, 2020 - March 31, 2020			
	Fees	Estimated Savings	ROI
Utilization Management	$197,917	$1,109,547	5.6 to 1
Case Management	$296,030	$573,832	1.9 to 1
Total	$493,947	$1,683,379	3.4 to 1

Utilization Management Breakout	
Inpatient Savings	$590,522
Outpatient Savings	$519,025

Utilization Management

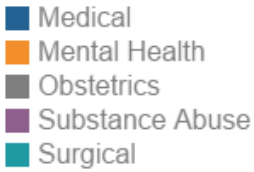
Acute Inpatient Activity Summary



January 1, 2020 - March 31, 2020

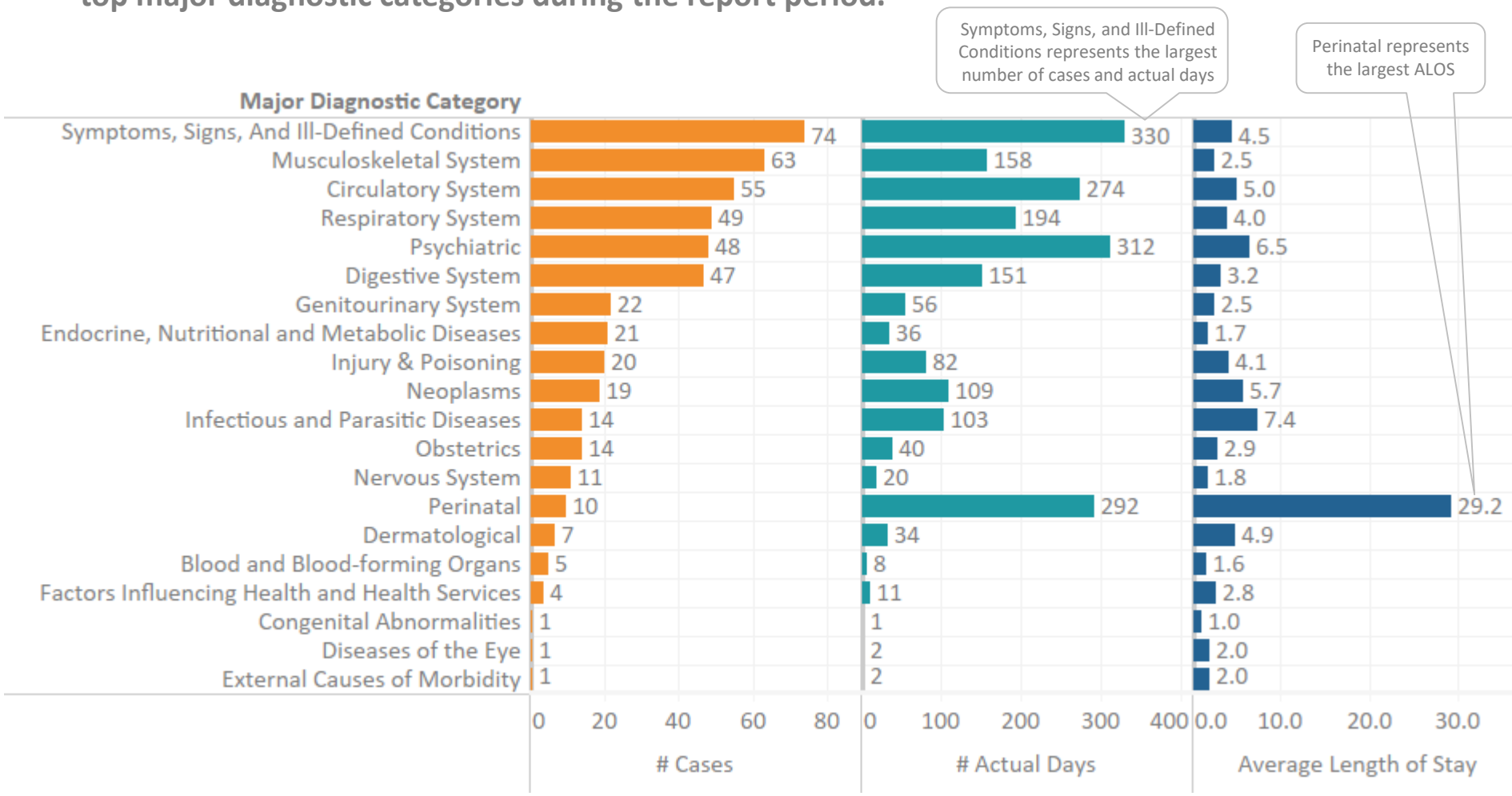
	# Cases	# Actual Days	# Requested Days	# Saved Days	Estimated Savings
Medical	282	1,173	1,185	36	$221,700
Surgical	151	696	707	27	$349,137
Mental Health	39	274	274	8	$11,093
Substance Abuse	9	50	50	4	$4,966
Obstetrics	5	22	22	0	$0
Grand Total	**486**	**2,215**	**2,238**	**75**	**$586,896**

As a result of the Utilization Review process, **75** unnecessary bed days were saved resulting in **$586,896** in estimated savings



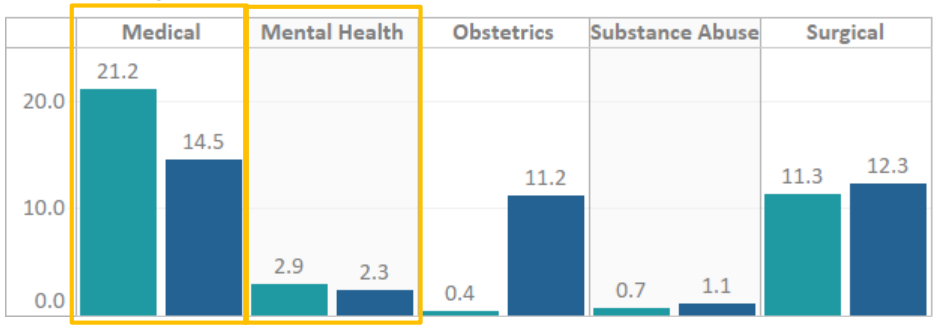
Acute Inpatient – Cases and Actual Days by Diagnostic Categories

The graph below presents the number of cases, actual days, and average length of stay of the top major diagnostic categories during the report period.



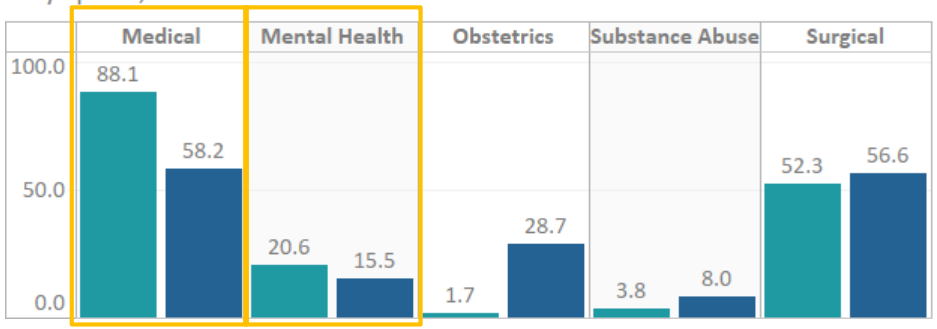
Acute Inpatient – Utilization Benchmarks

Admissions per 1,000



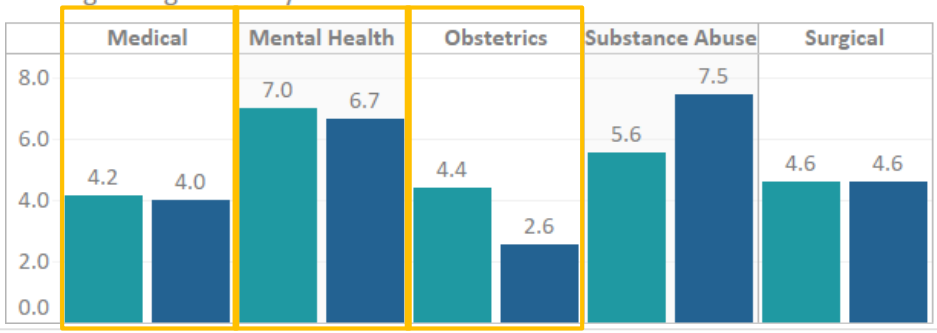
- Medical: Admissions were **46.2%** higher than Milliman benchmark. There were 282 admissions during the report period.
  - **2** members had **3** inpatient admissions
  - **20** members had **2** inpatient admissions
- Mental Health: Admissions were **26.1%** higher than Milliman benchmark. There were 39 admissions during the report period.
  - **3** members had **2** inpatient admissions

Days per 1,000



- Medical: Days were **51.4%** higher than Milliman benchmark.
  - **16** cases utilized **10** or more days each during the report period
- Mental Health: Days were **32.9%** higher than Milliman benchmark.
  - **3** cases utilized **16** or more days each during the report period

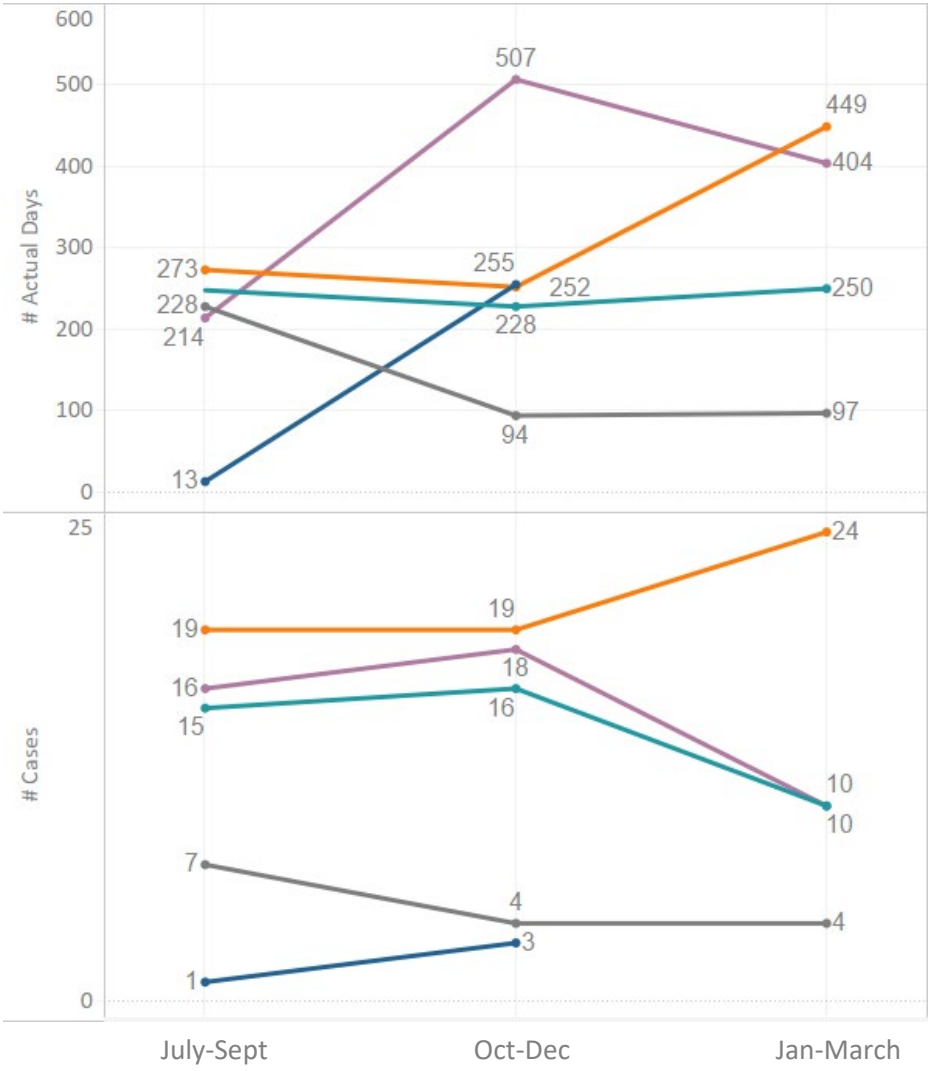
Average Length of Stay



- Medical: ALOS was **0.2** days higher than Milliman benchmark
  - **65** of the **282** medical cases were above the benchmark
  - Removal of **1** outlier case that consumed **114** days each resulted in an ALOS of 3.8
- Mental Health: ALOS was **0.3** days higher than Milliman benchmark
  - **13** of the **39** mental health cases were above the benchmark
  - Removal of **1** outlier case that consumed **41** days resulted in an ALOS of 6.1
- Obstetrics: ALOS was **1.8** days higher than Milliman benchmark
  - All **5** obstetrics cases were above the benchmark

Due to federal mandate regulations, not all Obstetrics cases require pre-certification; therefore, Obstetrics ALOS should be interpreted with caution.

Non-Acute Inpatient Activity Summary

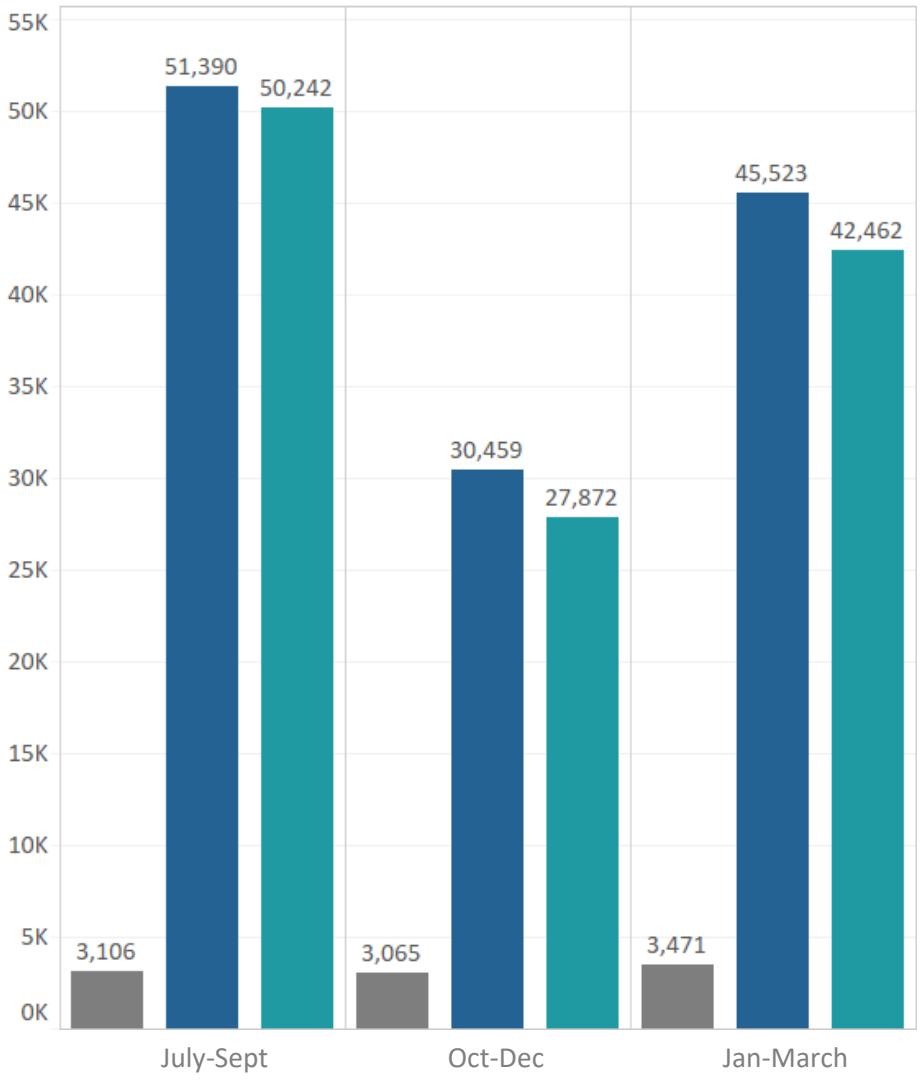


January 1, 2020 - March 31, 2020

	# Cases	# Actual Days	# Requested Days	# Saved Days	Estimated Savings
Residential Substance Abuse	24	449	458	1	$903
Skilled Nsg Facility	10	404	405	4	$2,723
Medical Rehab	10	250	250	0	$0
Long Term Acute	4	97	97	0	$0
Grand Total	**48**	**1,200**	**1,210**	**5**	**$3,626**

As a result of the Utilization Review process, **5** unnecessary bed days were saved resulting in **$3,626** in estimated savings

Outpatient –Summary



Diagnostic Test represents 48.9% of cases

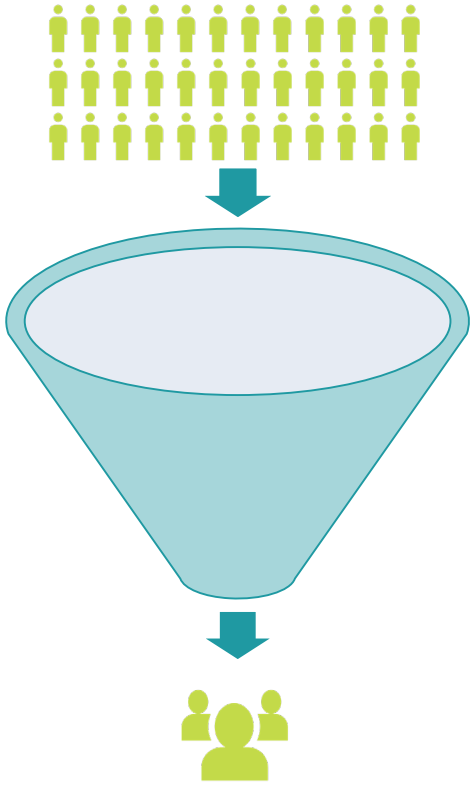
January 1, 2020 - March 31, 2020

Outpatient Setting	# Cases	# Units Requested	# Units Approved	# Units Saved	Outpatient Savings
Diagnostic Test	1,696	2,117	2,030	87	$126,727
Med Treatment	761	11,262	11,048	214	$305,480
Surgery	595	1,142	1,126	16	$25,804
DME	301	26,358	23,657	2,701	$55,844
Home Health	48	559	551	8	$1,190
Home Infusion	31	3,337	3,332	5	$0
MH/SA	30	439	425	14	$1,189
PT/OT/ST	6	111	95	16	$2,792
Home Enteral Feeding	2	137	137	0	$0
Hospice Home	1	61	61	0	$0
Grand Total	**3,471**	**45,523**	**42,462**	**3,061**	**$519,025**

There were **3,061** units saved resulting in **$519,025** in estimated savings

Case Management Referrals from Utilization Management

A critical function of Utilization Management is to identify members who are in need of more extensive Case Management services. One procedure that fulfills this function is the trigger of Utilization Management cases that meet specific requirements to Case Management.



- 534 inpatient cases were completed in Utilization Review
- 3,471 outpatient cases were completed in Utilization Review

- 324 inpatient cases (60.7%) automatically triggered to Case Management
- 793 outpatient cases (22.8%) automatically triggered to Case Management

- 182 inpatient cases (56.2%) were deemed appropriate for Case Management
- 46 outpatient cases (5.8%) were deemed appropriate for Case Management

Case Management

Case Management Summary

In the report period, our Case Managers performed interventions on behalf of the Public Employees' Benefits Program plan. Through their work with members, facilities and physicians, these Case Managers achieved over $500K in estimated savings. Savings are costs that potentially would have incurred to the plan, had we not intervened.

The following tables illustrate overall case activity and total savings achieved for the report period:

	Number of Cases		
Case Activity	Jul-Sept	Oct-Dec	Jan-March
Beginning Cases	92	186	165
Opened	231	134	166
Closes	137	155	148
Ending Open Cases	186	165	183

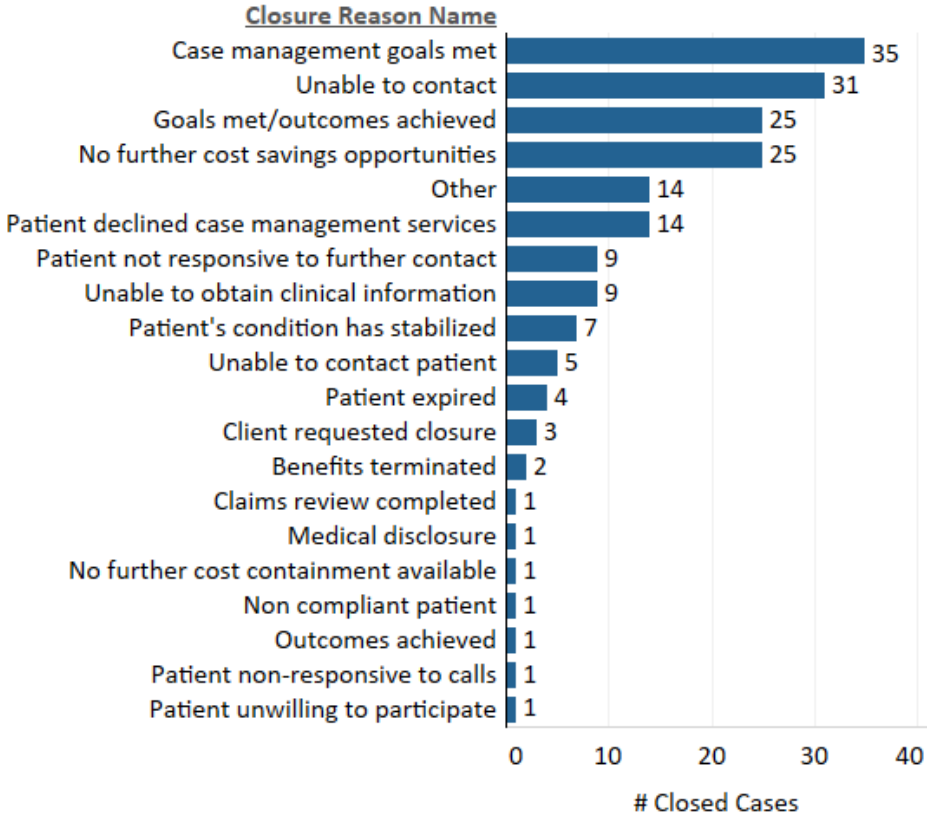
Total Case Management Savings for Jan-March
$537,832

Case Management Activity

The following tables summarize the number of open cases by case type and closed cases by closure reason during the report period.

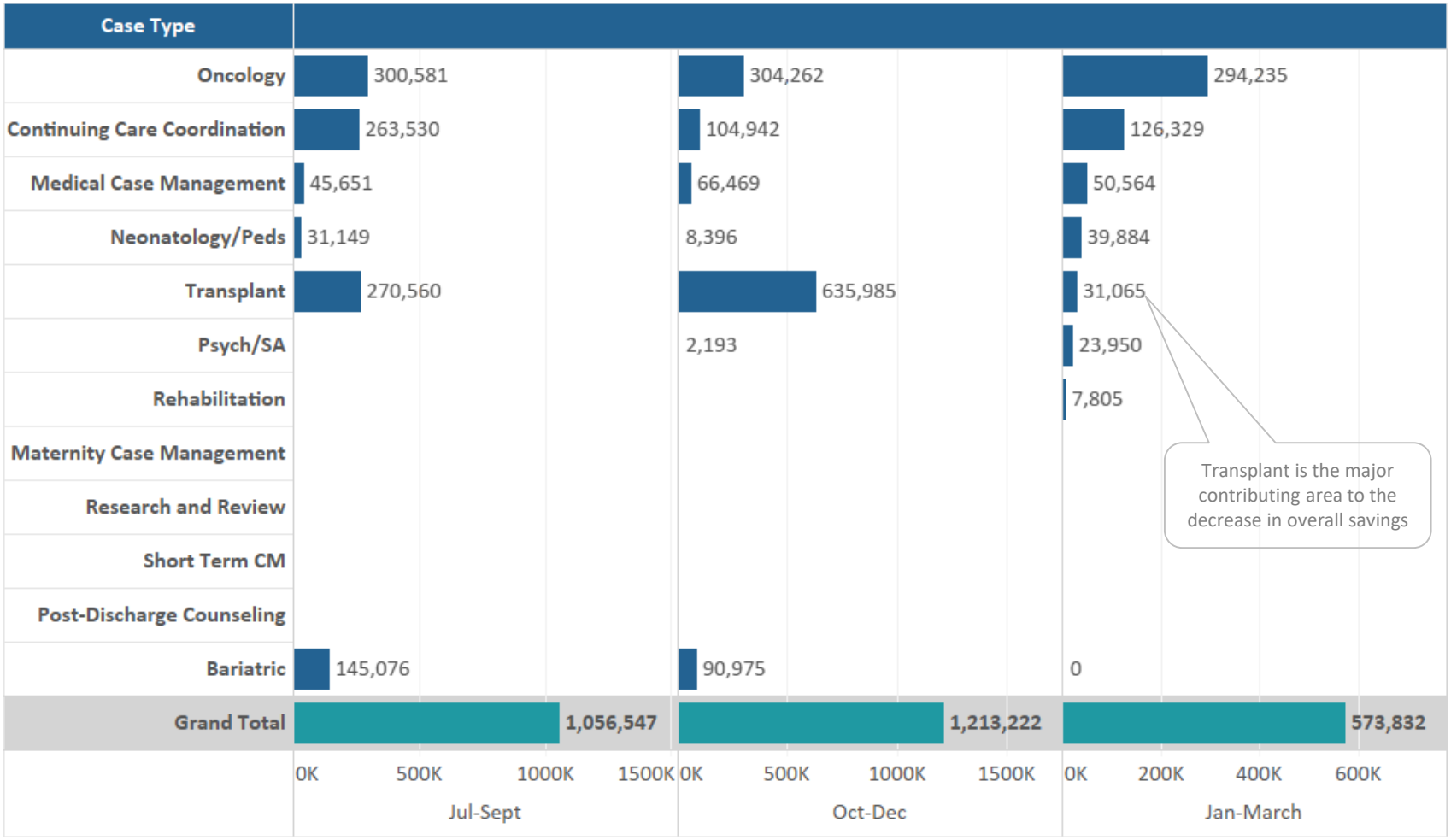
Open Cases by Case Type: Jan-March

Case Type	
Continuing Care Coordination	110
Short Term CM	80
Bariatric	51
Oncology	43
Medical Case Management	12
Psych/SA	12
Neonatology/Peds	10
Transplant	8
Maternity Case Management	2
Research and Review	1
Rehabilitation	2
Grand Total	**331**



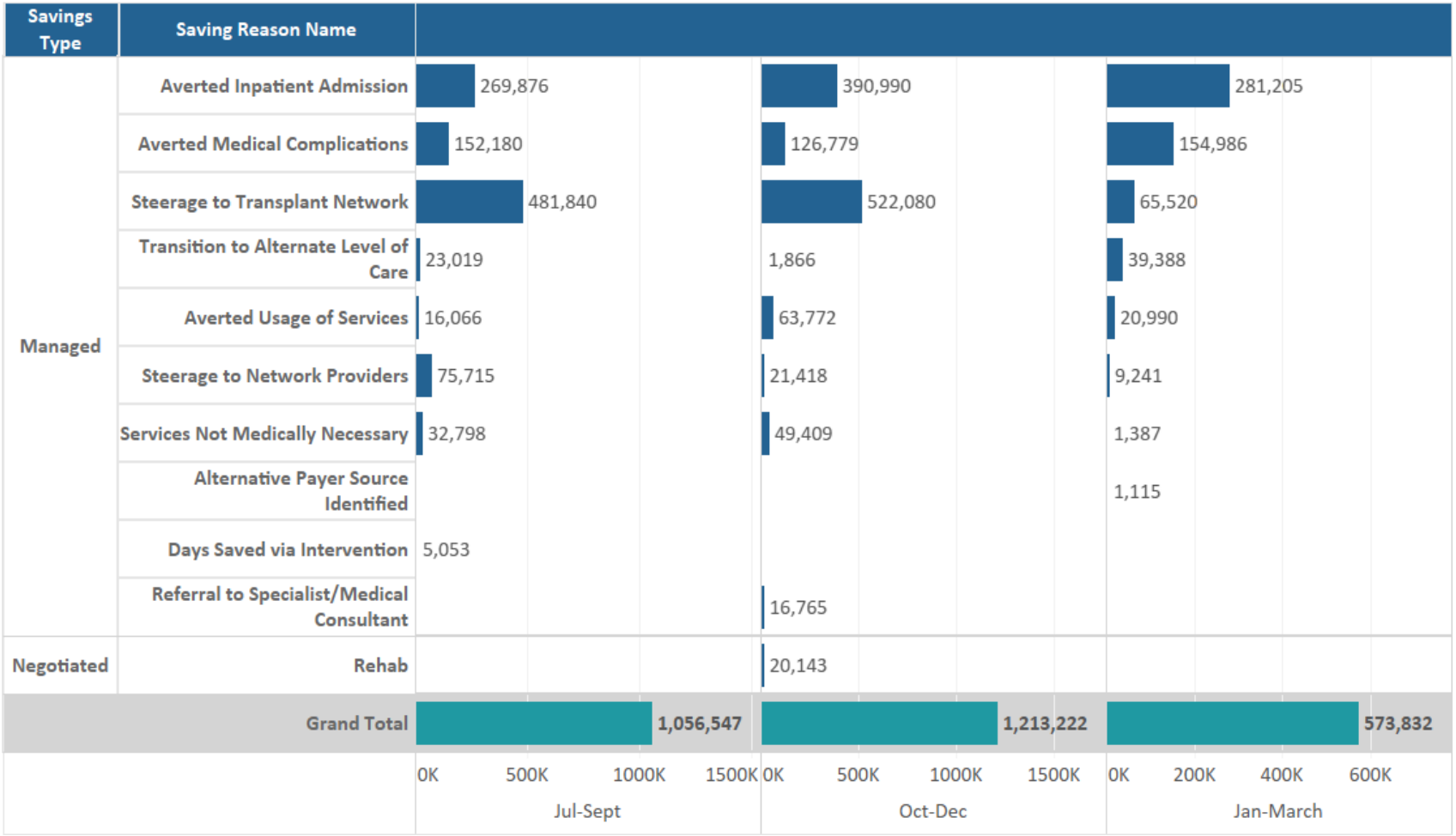
Savings by Case Type

The following graph presents savings by case type for the report period.



Case Management by Savings Reasons

The following graph presents savings by savings reason for the report period.



Post-Discharge Counseling

Participation Summary

The tables below presents the Public Employees' Benefits Program Post-Discharge Counseling participation rate compared to the AHH BOB rate.

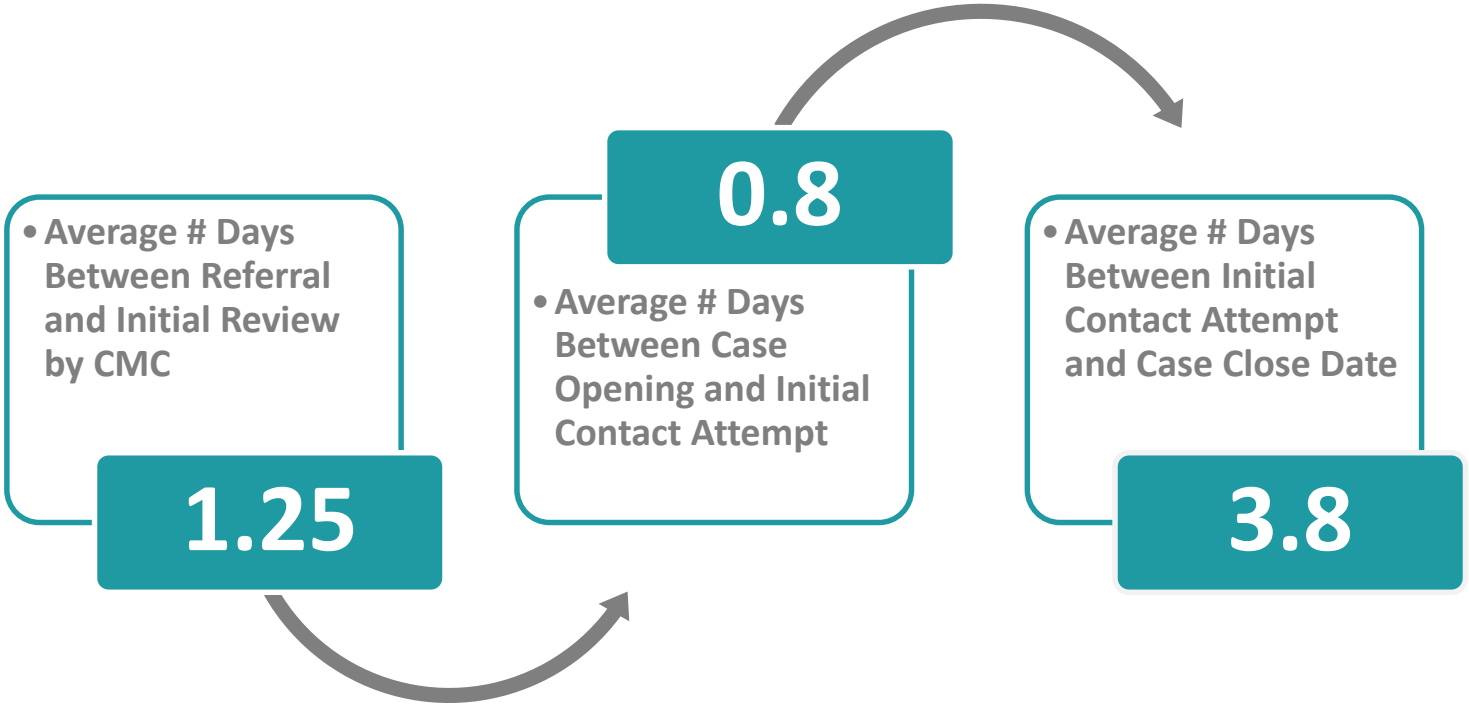
Program Metric	January 1, 2020 - March 31, 2020
# Cases Identified	313
# Participating Cases	29
% of Cases with Successful Outreach	**9.3%**

AHH BOB
AHH BOB Percent of Cases with Successful Outreach
48.8%

The participation rate for the 2019 report period was lower compared to the AHH BOB rate

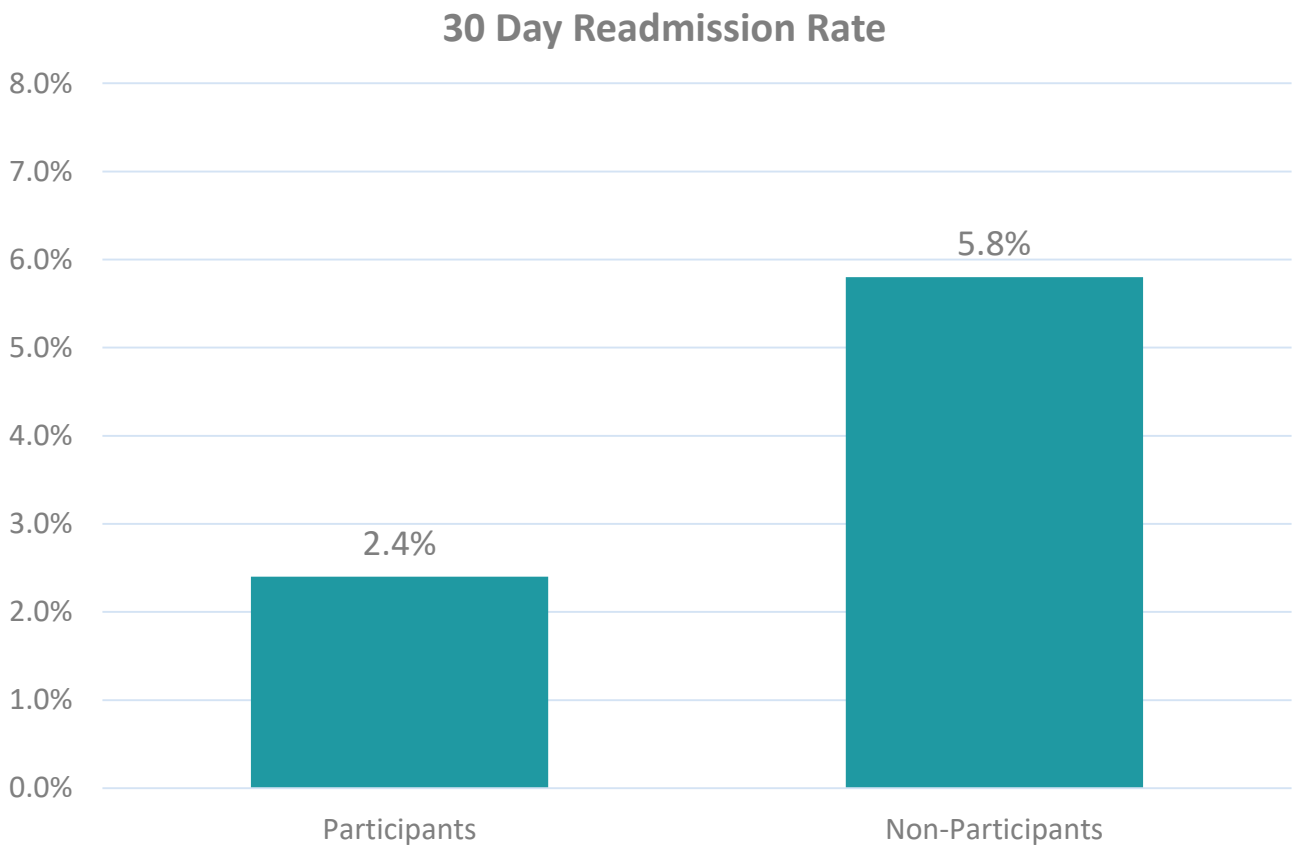
Average Turnaround Time

The table below presents a summary of the average turnaround times for the Post-Discharge Counseling program. Following a referral to the Post-Discharge Counseling program, the CMC will complete an initial review of the case and determine if the case is appropriate for the program. Once the case is reviewed and deemed appropriate, the case will be referred to a case manager who will review the case and subsequently make an initial contact attempt.



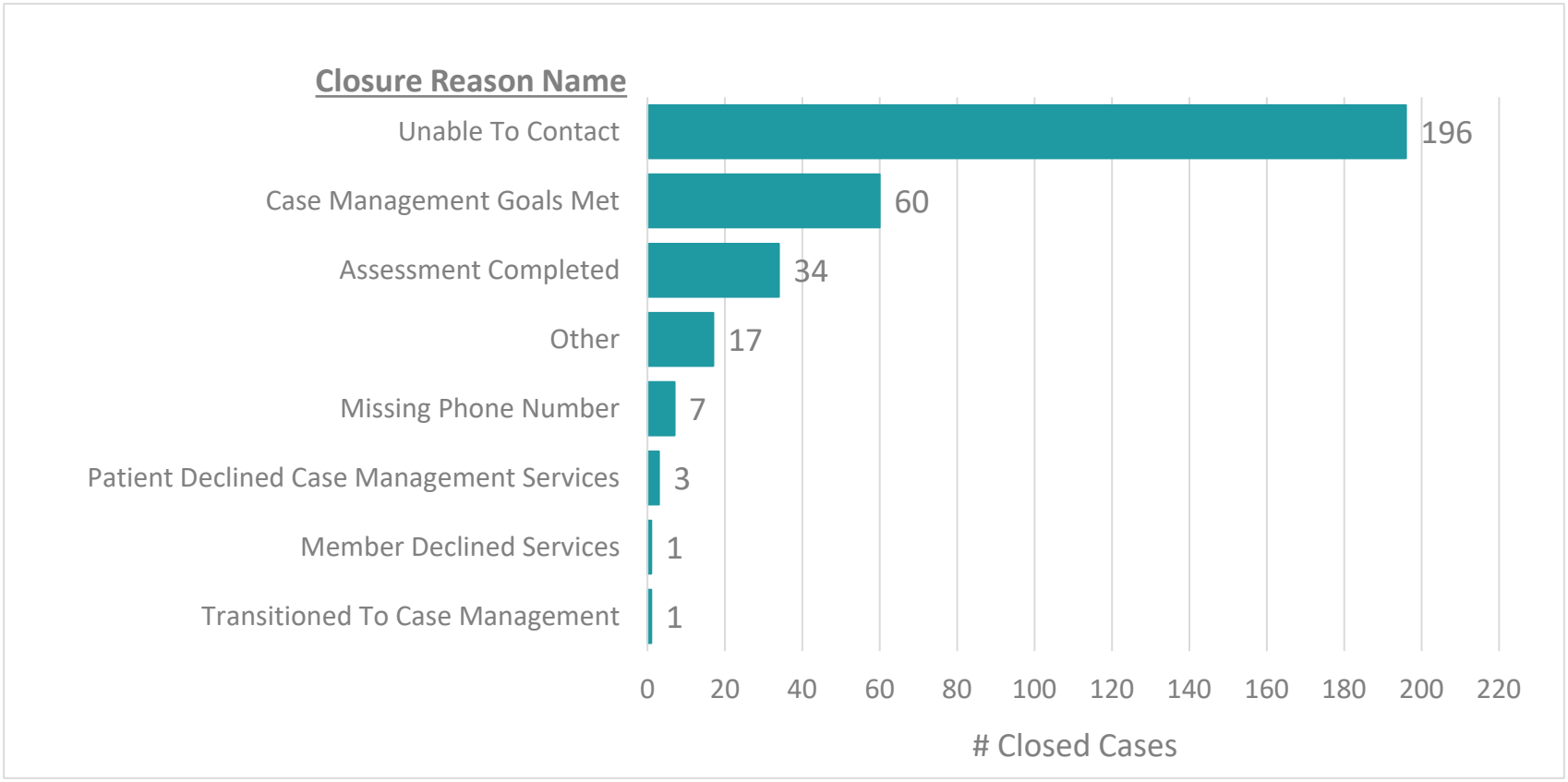
30 Day Readmission Rate

The 30-day readmission rate for participants in this program was below the rate for non-participation, illustrating the effectiveness of the Post-Discharge program.



Case Closure Reason

Post-Discharge Counseling cases are closed for a variety of reasons and a case may have more than one closure reason. The following graph presents the number of closed cases by closure reason during the report period.



Utilization Analysis

Observations

- Medical attributed to 58.0% of acute inpatient cases and 53.0% of actual days
- Medical and Mental Health was higher than the Milliman benchmark for acute inpatient admissions, days, and ALOS
- Residential Substance Abuse days increased 78.2% from 2nd Plan QTR to 3rd Plan QTR
- Diagnostic Test represented 48.9% of all outpatient cases and accounted for 24.4% of savings
- Continuing Care Coordination make up 33.2% of CM case types

Insights

- Symptoms, Signs, and Ill-Defined Conditions represented 18.5% of acute inpatient Medical cases and 21.6% of Medical actual days
- 5 cases attributed 24.2% of total Medical days and 3 cases that attributed to 27.0% of total Mental Health days
- One case that consumed 123 days was the primary contributor to the increase in Residential Substance Abuse days
- Symptoms, Sign, and Ill-Defined Conditions represented approximately 22.2% of Diagnostic Test outpatient cases, units requested, and units approved
- 52 of the 110 open CM Continuing Care Coordination cases fall into the Neoplasms major diagnostic category

Contacts

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4.3.4

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

    4.3 Receipt of quarterly vendor reports for the period ending March 31, 2020:

        4.3.1 HealthSCOPE Benefits – Obesity Care Management

        4.3.2 HealthSCOPE Benefits – Diabetes Care Management

        4.3.3 American Health Holdings – Utilization and Large Case Management

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

The Standard

Quarterly Report: Basic Life Insurance and Long Term Disability:
Quarter Ending
March 31, 2020

Report Table of Contents

Basic Life Insurance & Long Term Disability Executive Summary

Most Recent Five Plan Years: July 01, 2015 to March 31, 2020

This is the third quarter report for the 2019-20 plan year, providing information for the period beginning July 1, 2015 and ending March 31, 2020.

Basic Life

At this point of the current plan year, Basic Life incidence (page 4) is up down-over-year for active members and for retirees. At this time last year, the overall incidence rate was 4.2 claims/1,000 lives; this year, it has decreased slightly to 4.0. From a loss ratio perspective (page 5), the loss ratio for active members is up from 23% last year to 26% this year. For retirees, the loss ratio is down, from 311% to 242%. Historically, the highest claim activity for PEBP is in the 3rd quarter of the plan year, and so far, the overall claim incidence is slightly down. We will see how the final 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 continue to 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. At this time last year, there were 4 LTD claims for the 2018-19 plan year. For the 2019-20 plan year thus far, we have had 11 claims incurred (almost 3 times compared to the same time period last year). The 2018-19 total plan year resulted in 15 total claims, so we will see what effect the final quarter results end up.

LTD loss ratios (page 8) are reported on a cash basis, without regard for the incurred date. The loss ratio for the 2019-20 plan year is 115%, which is significantly higher than the loss ratio for this period last year of 18% and the entire 2018-19 plan year of 42%. The 115% loss ratio is drastically higher than each of the last 4 plan years as well.

PEBP's LTD incidence for Circulatory and Cancer claims is higher than our block. Cancer liability is also 3 times higher than our public block. PEBP continues to have significantly better liability results for Musculoskeletal claims when compared to our block, by almost 50%

Basic Life Insurance Claims by Plan Year and Participant Type

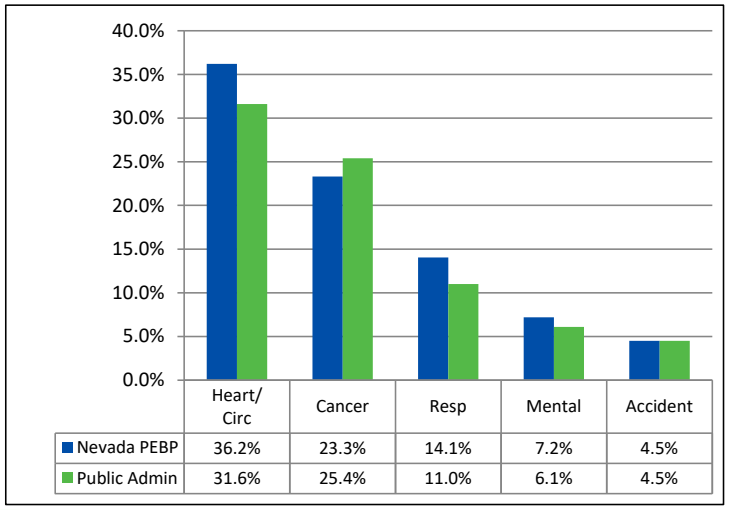
Most Recent Five Plan Years: July 01, 2015 to March 31, 2020

	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	25	0.9
Retirees	271	18.4	321	21.6	294	19.4	273	17.4	145	9.2
Totals	**312**	**8.4**	**372**	**9.5**	**335**	**8.4**	**320**	**7.8**	**170**	**4.0**

Basic Life Insurance Claims by Diagnostic Category

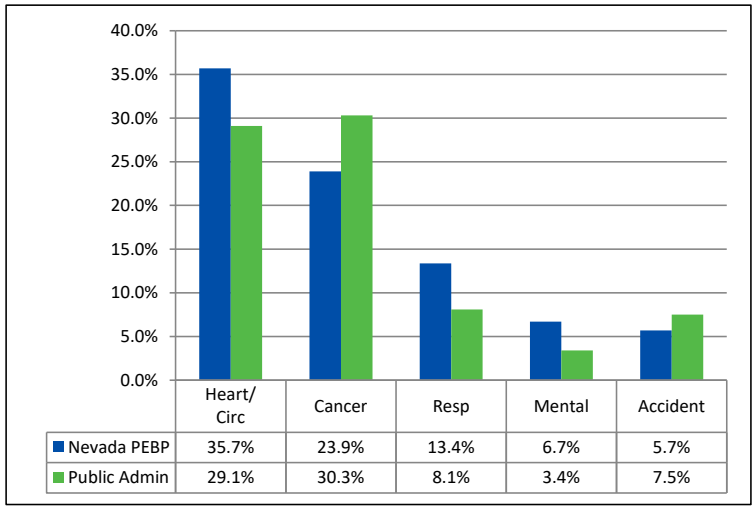
Public Admin benchmark is from SIC book of business for most recent 5 calendar years

Top Five Diagnostic Categories by Incidence



	Heart/ Circ	Cancer	Resp	Mental	Accident
Nevada PEBP	36.2%	23.3%	14.1%	7.2%	4.5%
Public Admin	31.6%	25.4%	11.0%	6.1%	4.5%

Top Five Diagnostic Categories by Liability

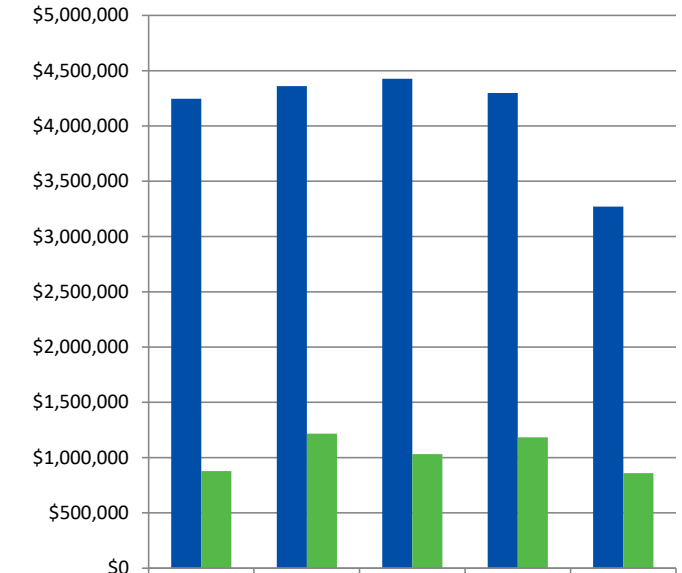


	Heart/ Circ	Cancer	Resp	Mental	Accident
Nevada PEBP	35.7%	23.9%	13.4%	6.7%	5.7%
Public Admin	29.1%	30.3%	8.1%	3.4%	7.5%

Basic Life Insurance Earned Premiums & Liability by Participant Type

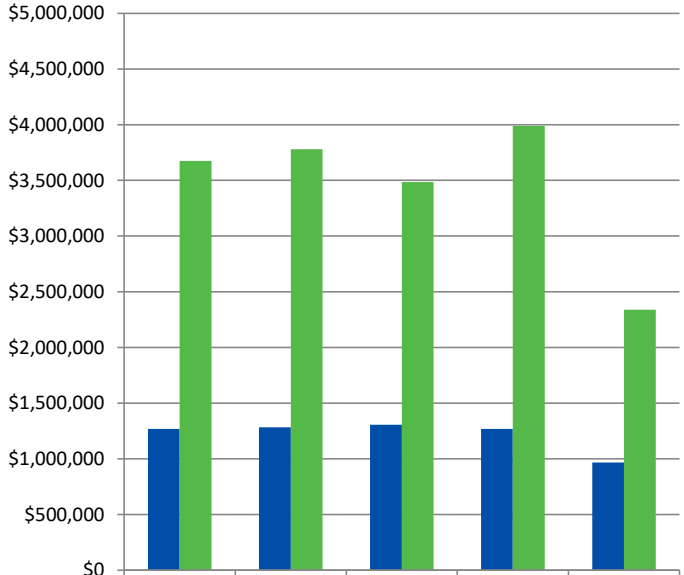
Most Recent Five Plan Years: July 01, 2015 to March 31, 2020

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	$3,270,194
Claim Liability	$877,477	$1,217,375	$1,031,986	$1,184,218	$858,999
Loss Ratio	0.21	0.28	0.23	0.28	0.26

Retired Participants

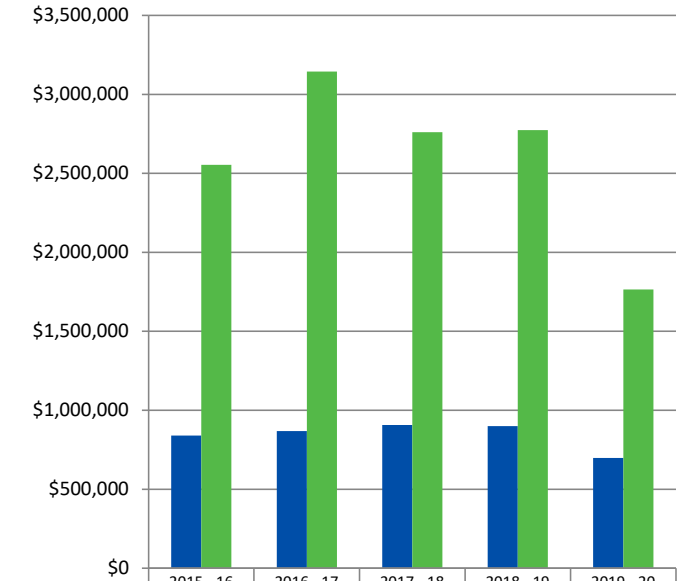


	2015 - 16	2016 - 17	2017 - 18	2018 - 19	2019 - 20
Earned Premium	$1,268,470	$1,282,457	$1,306,604	$1,267,917	$967,155
Claim Liability	$3,674,745	$3,779,175	$3,485,155	$3,989,557	$2,339,053
Loss Ratio	2.90	2.95	2.67	3.15	2.42

Basic Life Retiree Insurance Earned Premiums & Liability by Participant Type

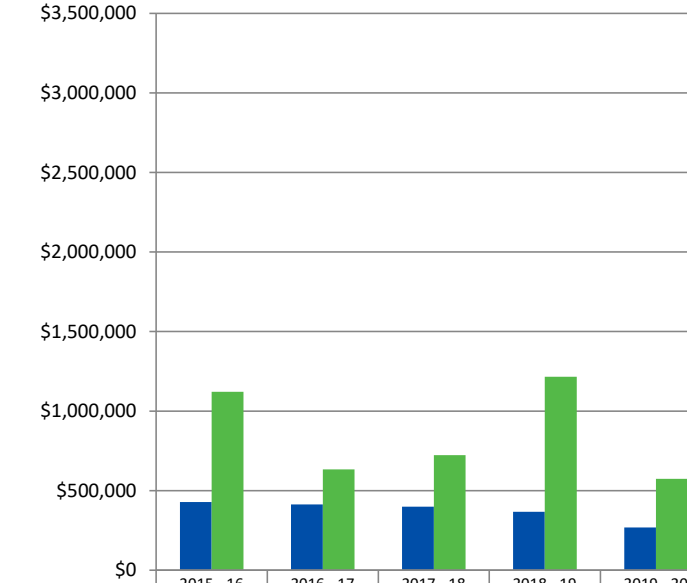
Most Recent Five Plan Years: July 01, 2015 to March 31, 2020

State Retired Participants



	2015 - 16	2016 - 17	2017 - 18	2018 - 19	2019 - 20
Earned Premium	$839,732	$868,775	$907,326	$900,218	$698,167
Claim Liability	$2,553,682	$3,145,175	$2,761,244	$2,774,315	$1,764,465
Loss Ratio	3.04	3.62	3.04	3.08	2.53

Non-State Retired Participants



	2015 - 16	2016 - 17	2017 - 18	2018 - 19	2019 - 20
Earned Premium	$428,738	$413,682	$399,278	$367,699	$268,988
Claim Liability	$1,121,063	$634,000	$723,911	$1,215,242	$574,588
Loss Ratio	2.61	1.53	1.81	3.30	2.14

Long Term Disability Claims by Plan Year

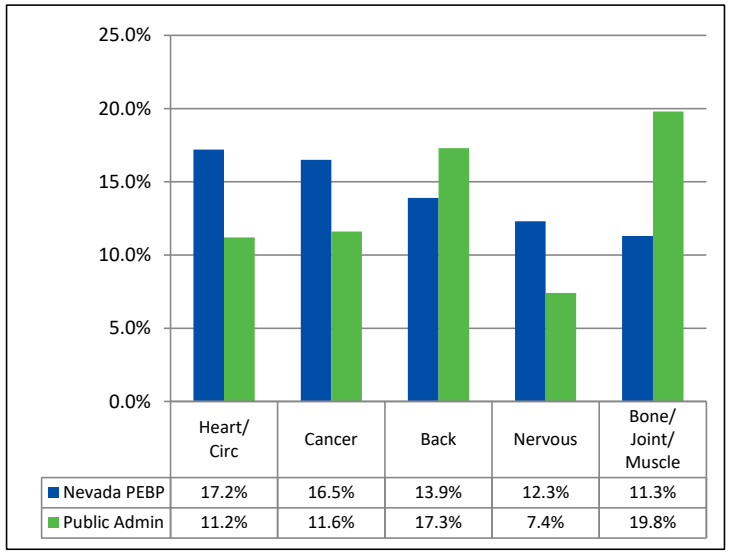
Most Recent Five Plan Years: July 01, 2015 to March 31, 2020

	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	29	1.2	36	1.4	29	1.1	24	0.9	11	0.4

Long Term Disability Claims by Diagnostic Category

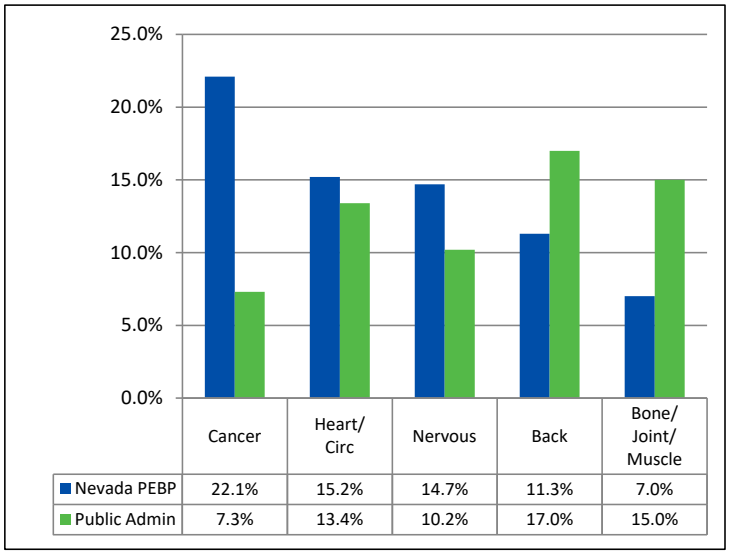
Public Admin benchmark is from SIC book of business for most recent 5 calendar years

Top Five Diagnostic Categories by Incidence



	Heart/ Circ	Cancer	Back	Nervous	Bone/ Joint/ Muscle
Nevada PEBP	17.2%	16.5%	13.9%	12.3%	11.3%
Public Admin	11.2%	11.6%	17.3%	7.4%	19.8%

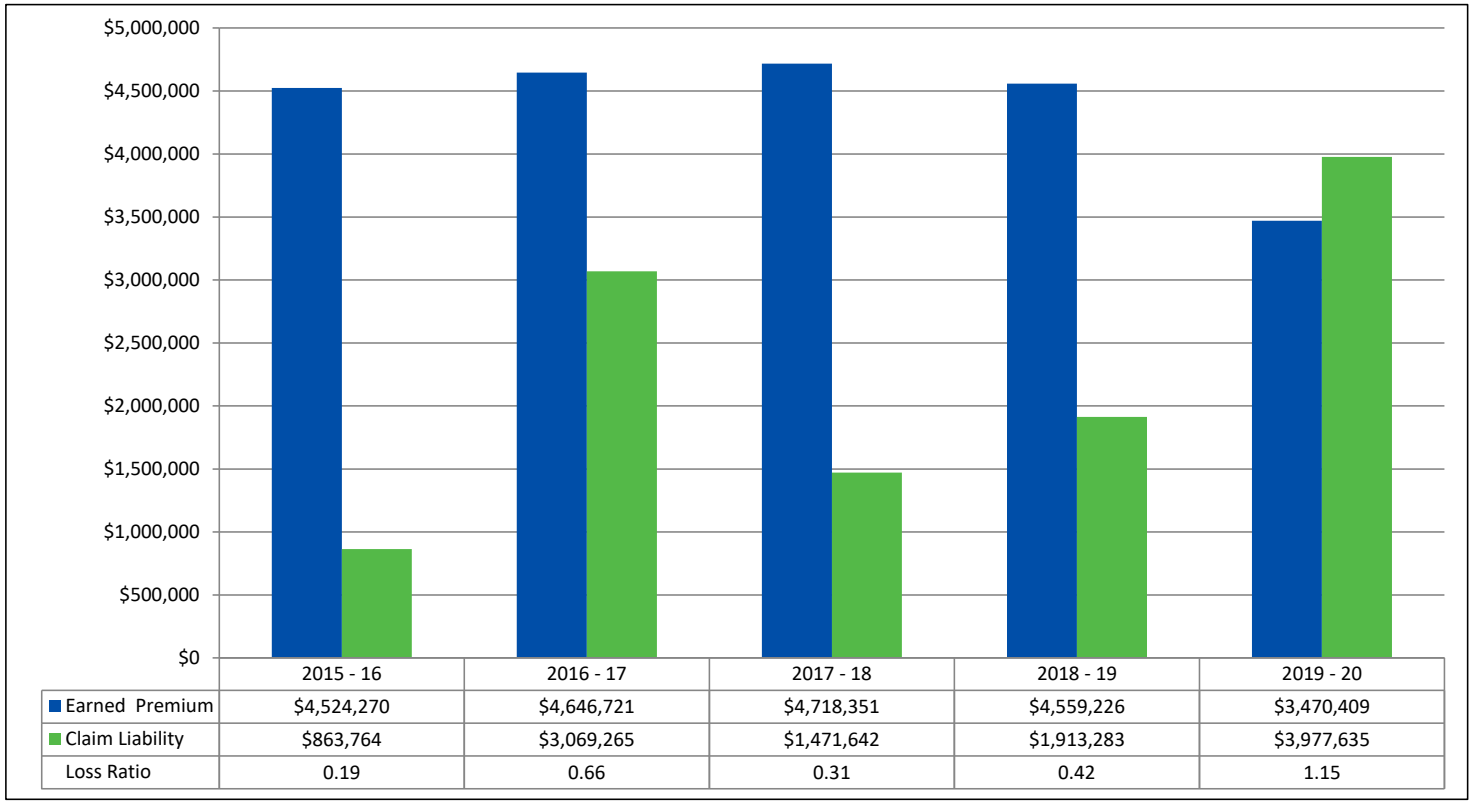
Top Five Diagnostic Categories by Liability



	Cancer	Heart/ Circ	Nervous	Back	Bone/ Joint/ Muscle
Nevada PEBP	22.1%	15.2%	14.7%	11.3%	7.0%
Public Admin	7.3%	13.4%	10.2%	17.0%	15.0%

Long Term Disability Earned Premiums & Liability

Most Recent Five Plan Years: July 01, 2015 to March 31, 2020



	2015 - 16	2016 - 17	2017 - 18	2018 - 19	2019 - 20
Earned Premium	$4,524,270	$4,646,721	$4,718,351	$4,559,226	$3,470,409
Claim Liability	$863,764	$3,069,265	$1,471,642	$1,913,283	$3,977,635
Loss Ratio	0.19	0.66	0.31	0.42	1.15

Claim Appeals

Quarterly Update for Plan Year to Date July 01, 2019 to March 31, 2020

	In Process	Decision Upheld	Decision Overturned	Total
Claim Appeals				
Life Insurance Claims	0	0	0	0
Long-Term Disability Claims	0	1	1	2
Short-Term Disability Claims	0	0	0	0
Total Appeals	**0**	**1**	**1**	**2**

4.3.5

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

    4.3 Receipt of quarterly vendor reports for the period ending March 31, 2020:

        4.3.1 HealthSCOPE Benefits – Obesity Care Management

        4.3.2 HealthSCOPE Benefits – Diabetes Care Management

        4.3.3 American Health Holdings – Utilization and Large Case Management

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

        4.3.5 Towers Watson's One Exchange – Medicare Exchange

Nevada Public Employees Benefit Program

Quarterly Update – 3rd Quarter Plan Year 2020

Willis Towers Watson's Individual Marketplace

May 1, 2020

The Public Employees Benefit Program Executive Dashboard

Quarterly Update – 3rd Quarter Plan Year 2020

Executive Summary

Plan Enrollment:

- At the end of Q3 2020, PEBP's total enrollment into Medicare policies through Willis Towers Watson's Individual Marketplace increased to 12,749. Since inception, 103 carriers have been selected by PEBP's retirees with current enrollment in 1,381 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 6,259 and 2,165 enrollees respectively. The average monthly premium cost for MS plans remained consistent at $149.
- The percentage of Medicare Advantage (MA or MAPD) plans selected remained consistent at 20%. Top MA carriers include Hometown Health Plan with 1,161 individual plan selections and Humana with 400 individual plan selections. The average monthly premium cost to PEBP participants is $23.

Customer Satisfaction:

- In Q3 2020, PEBP participant satisfaction with Enrollment Calls had an average satisfaction score result of 4.6 out of 5.0 based on 66 surveys returned.
- For Q3 2020, the average satisfaction score for Service Calls was 4.2 out of 5.0 based on 378 surveys returned.
- The combined average satisfaction score for Enrollment Calls and Service Calls was 4.2 out of 5.0 for Q3 2020.
- For Funding Calls, PEBP customer satisfaction was 4.2 out of 5.0. This was a an increase when compared to Q2 2020. There were 24 survey responses in Q3.

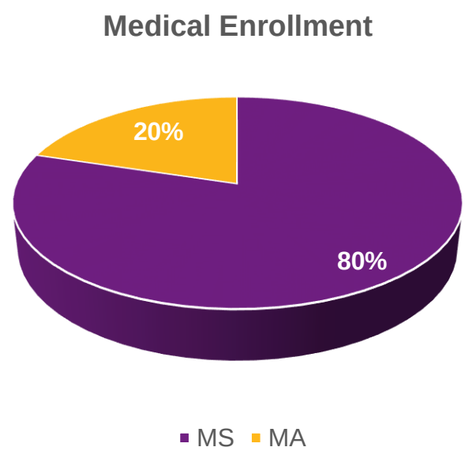
Health Reimbursement Arrangement:

- At the end of Q3 2020 there were 12,576 Health Reimbursement Arrangement (HRA) accounts for PEBP participants.
- There were 87,193 claims submitted against the HRA for reimbursement in Q3, with 78.8% being submitted via Auto-Reimbursement, meaning that participants did not have to manually submit 68,673 claims for Premium Reimbursement.
- The total reimbursement amount processed for Q3 was $7,7793,327.

Summary of Retiree Decisions and Costs

Retiree Plan Selection Through 03/31/2019		Previous Qtr
Total enrolled through individual marketplace	12,749	12,952
Number of carriers**	103	102
Number of plans**	1,381	1,402

Plan Type Selection Through 03/31/2019		Previous Qtr
Medicare Advantage (MA, MAPD)	2,585	2,554
Medicare Supplement (MS)	10,167	10,428



"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	10,167	$147
Medicare Advantage (MA,MAPD)	2,585	$0 / $24
Part D drug coverage	7,557	$25
Dental coverage	1,147	$37
Vision coverage	1,964	$13

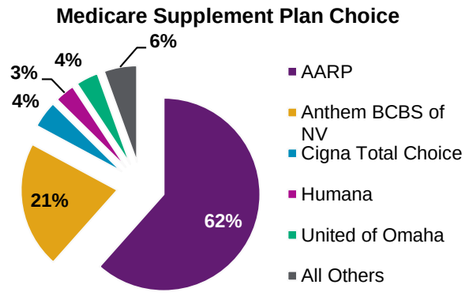
** Reflects total carriers and plans that PEBP participants have enrolled in nationwide, since inception.

The Public Employees Benefit Program Executive Dashboard

Quarterly Update – 3rd Quarter Plan Year 2020

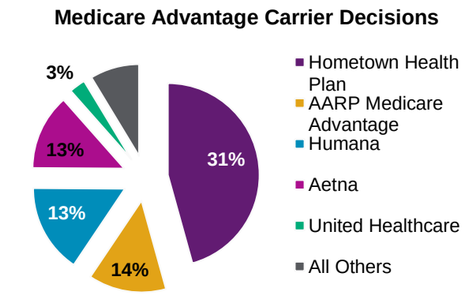
Summary of Retiree Carrier Choice

Top Medicare Supplement Plans	Total
AARP	6,259
Anthem BCBS of NV	2,165
Cigna Total Choice	459
Humana	340
United of Omaha	381



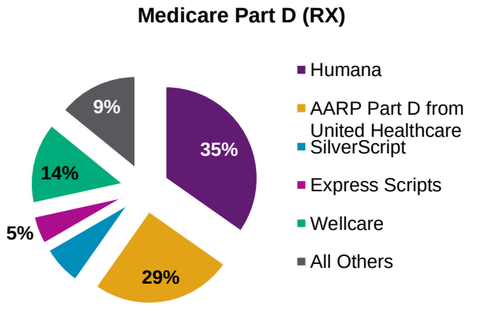
Cost Data For MS Plans	Cost
Minimum	$22
Average	$149
Median	$143
Maximum	$459

Top Medicare Advantage Plans	Total
AARP Medicare Advantage	361
Aetna	355
Hometown Health Plan	1,161
Humana	400
United Healthcare	69



Cost Data For MA Plans	Cost
Minimum	$0
Average	$23
Median	$0
Maximum	$205

Top Medicare Part D (RX)	Total
AARP Medicare Advantage	2,143
Express Scripts Medicare	435
Humana	2,840
SilverScript	575
WellCare	1,237



Cost Data For Part D (RX)	Cost
Minimum	$10
Average	$25
Median	$20
Maximum	$130

The Public Employees Benefit Program Executive Dashboard

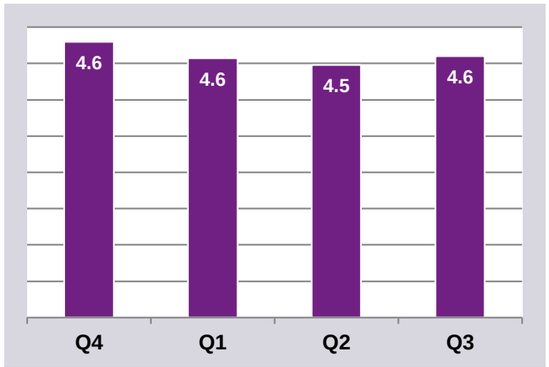
Quarterly Update – 3rd Quarter Plan Year 2020

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

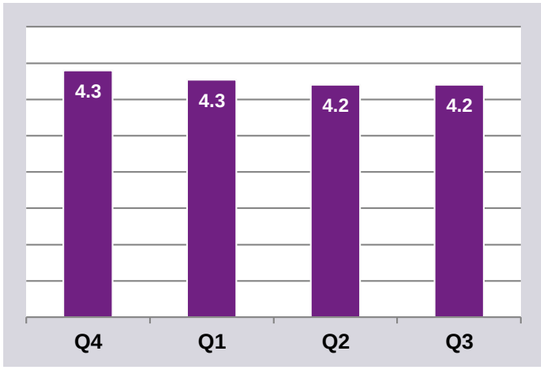
Q3 Enrollment Satisfaction

CSAT score	Count	%
5	49	74%
4	10	15%
3	4	6%
2	0	0%
1	3	5%
	66	**100%**



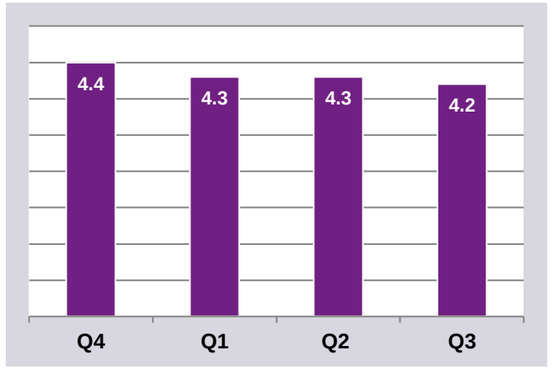
Q3 Service Satisfaction

CSAT score	Count	%
5	234	62%
4	56	15%
3	43	11%
2	14	4%
1	31	8%
	378	**100%**



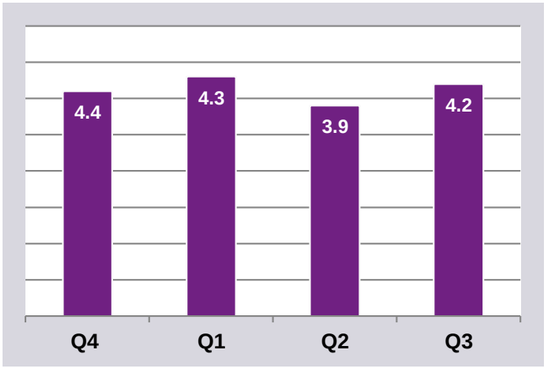
Q3 Enrollment & Service Combined

CSAT score	Count	%
5	283	64%
4	66	15%
3	47	11%
2	14	3%
1	34	8%
	444	**100%**



Q3 HRA Satisfaction

CSAT score	Count	%
5	14	58%
4	4	17%
3	4	17%
2	1	4%
1	1	4%
	24	**100%**

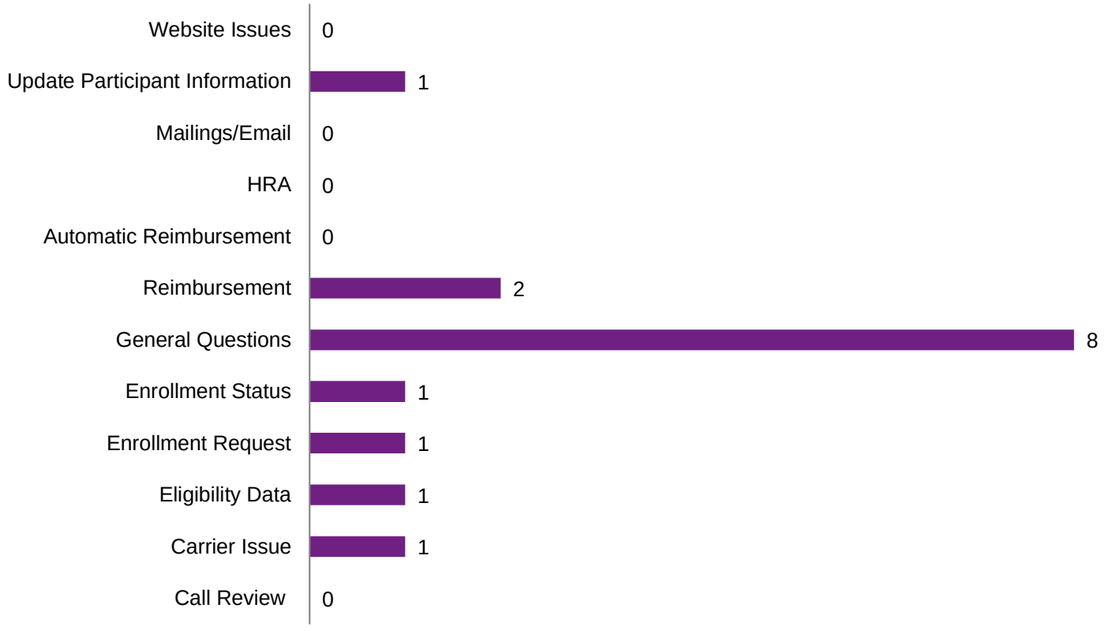


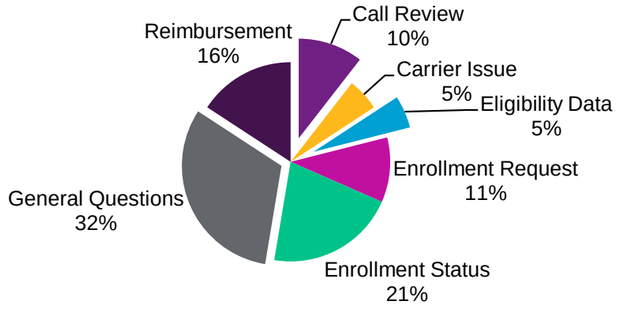
The Public Employees Benefit Program Executive Dashboard

Quarterly Update – 3rd 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 Q3-PY20 is 15 and are associated with the following categories:





Health Reimbursement Account (HRA)

Claim Activity for the Qtr.	Total
HRA accounts	12,576
Number of claims paid	45,016
Accounts with no balance	6,657
Claims paid amount	$7,793,327

Claims By Source	Total
A/R file	68,673
Mail	14,698
Web	3,822

Call Category	Total
General / Instructional	1,513
Denial Reason Explanation	97
Available Balance	75
Date EFT / Mail Issued	65
Dedicated / Designated Call Transfer	61

The Public Employees Benefit Program Executive Dashboard

Quarterly Update – 3rd Quarter Plan Year 2020

Performance Guarantees*

Category	Commitment	Outcome	PG MET
Claims Turnaround Time	≤ 2 days	0.54 Days	Yes
Claim Financial Accuracy	≥ 98%	99.12%	Yes
Claim Processing Financial Accuracy	≥ 98%	98.69%	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.	2 Minutes 8 Seconds	No
Benefits Administration Customer Service Abandonment Rate	≤ 5%	4.71%	Yes
Customer Satisfaction	≥ 80%	89%	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 – 3rd Quarter Plan Year 2020

Operations Report

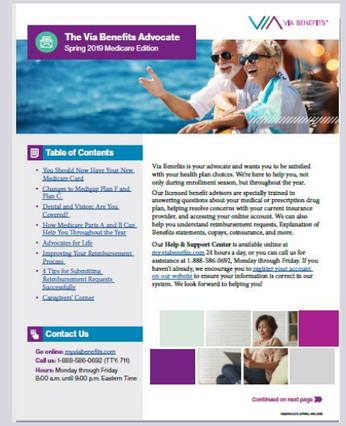
Funding Platform Change:

The conversion from PayFlex to Willis Towers Watson's Funding Administration Platform was completed on April 3. Claims that were held during the black out period from March 18 to April 2 started to be processed on April 3 and reimbursements for those claims started to be released at the end of the following week. A new mobile app will be available for participants to use to submit claims directly through their mobile devices.

Communications:

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

- 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.



CARES Act:

On March 27, the Coronavirus Aid, Relief and Economic Security (CARES) Act was signed into law. The CARES Act is a part of the $2 trillion stimulus package aimed at providing additional relief during the coronavirus pandemic.

The CARES Act includes important provisions for users of Health Reimbursement Arrangements (HRAs), specifically:

- Over-the-counter (OTC) drugs and medications not prescribed by a physician can now be reimbursed pre-tax.
- Menstrual care products are also now considered eligible expenses.
- The changes to eligible expenses are retroactively effective January 1, 2020.

Nevada PEBP's HRA is now being administered consistent with these changes to approve all OTC medications. High level information will be provided to participants in our Spring Newsletter, referenced above.

The Public Employees Benefit Program Executive Dashboard

Quarterly Update – 3rd 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	49s	1,988	29s	21m 38s	300
April	22s	2,866	18	18m 02s	262
May					
June					
July					
August					
September					
October					
November					
December					

The Public Employees Benefit Program Executive Dashboard

Quarterly Update – 3rd 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 – 3rd 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

4.3.6

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

    4.3 Receipt of quarterly vendor reports for the period ending March 31, 2020:

        4.3.1 HealthSCOPE Benefits – Obesity Care Management

        4.3.2 HealthSCOPE Benefits – Diabetes Care Management

        4.3.3 American Health Holdings – Utilization and Large Case Management

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

        4.3.5 Towers Watson's One Exchange – Medicare Exchange

        4.3.6 Hometown Health Providers and Sierra Healthcare Options – PPO Network

Hometown Health Providers & Sierra Healthcare Options

Q3 PlanYear2020

Jan 1st, 2020 – March 31, 2020

Hometown Health

SIERRA HEALTH-CARE OPTIONS, INC.

Nevada PUBLIC EMPLOYEES' BENEFITS PROGRAM

PEBP

Health Matters.

July 23, 2020

Service Performance Standard(Metric)	Guarantee Measurement	Actual	Pass/Fail
I. EDI claims repricing	**95%**- Turnaround time frame for repricing of medical claims within 3 business days of receipt from PEBP's TPA	89%	Fail
	97%- Accuracy of claims repriced by the PPO Network must be accurate and must not cause a claim adjustment by PEBP'sTPA	98.2%	Pass
II. A.Hometown Health Provider DataChanges*	**100%**- Data changes must be provided to PEBP'sTPA within 30 calendar days following the effective date of the change	100%	Pass
	100%- Provider fee schedule revisions must be provided to PEBP'sTPA within 30 calendar days following the effective date of the change	100%	Pass
II. B.Sierra Healthcare Options(SHO) Provider DataChanges*	**100%**- Data changes must be provided to PEBP'sTPA within 30 calendar days following the effective date of the change	100%	Pass
	100%- Provider fee schedule revisions must be provided to PEBP'sTPA within 30 calendar following the effective date of the change	100%	Pass
	(100% of the ACT'sare rounted to the State of Nevada within 30 days of notification of the add, change or term. Please note: the effective date of add, change or term can be greater than 30 days based on the date SHO receives the notifaction or signed document from the provider)		
III. Data Reporting	A. Standard reports must be delivered within 10days of end of reporting period or event as determined by PEBP. B. Special reports requested by PEBP and/or PEBP's Consultant/Actuary must be delivered within 10 days of agreed response date. .	100% 100%	Pass Pass
IV. Subcontractor disclosure	**100%**- of all subcontractors utilized by vendor are disclosed prior to any work being done on behalf of PEBP. Business Associate Agreements completed by all subcontractors.	100%	Pass
V. Website	**100%**- Network website must be updated within 30 calendar days as provider information changes take effect	100%	Pass

4.3.7

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

4.3 Receipt of quarterly vendor reports for the period ending March 31, 2020:

4.3.1 HealthSCOPE Benefits – Obesity Care Management

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4.3.5 Towers Watson's One Exchange – Medicare Exchange

4.3.6 Hometown Health Providers and Sierra Healthcare Options – PPO Network

4.3.7 HealthPlan of Nevada, Inc. – Southern Nevada HMO

Health Plan of Nevada

Quarterly
Update for
January - March 2020

HEALTH PLAN OF NEVADA
A UnitedHealthcare Company

Nevada PUBLIC EMPLOYEES' BENEFITS PROGRAM
PEBP
Health Matters.

March 15th, 2020

Health Plan of Nevada HMO

Performance Standards and Guarantees- Self Reported

Quarterly Report for January - March 2020

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	2.19 days	Pass
	Membership materials (electronic)- Available within 10 working days of date of eligibility input	6.75 days	Pass
III. Customer Service-Telephone	Speed to queue and answer by live voice- Within 60 seconds	152 sec	Fail
	5% or less - Telephone abandonment rate	14%	Fail
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 312	Pass

5.

5. Election of Board Vice-Chair pursuant to Nevada Administrative Code (NAC) 287.172. Eligible candidates are Don Bailey, Sr., Linda Fox, Tom Verducci, Marsha Urban, Jennifer Krupp, David Smith and Jet Mitchell (Laura Freed, Board Chair) **(For Possible Action)**

6.

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

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

☐ Action Item

☒ Information Only

Date: July 23, 2020

Item Number: VI

Title: Executive Officer Report

SUMMARY

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

REPORT

PLAN YEAR 21 ENROLLMENT

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

PEBP Primary Member Enrollment Report

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

COVID-19 UPDATE

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

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

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

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

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

Illustrative – to aid in discussion

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

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

Proprietary for PEBP Board and Staff use only

7

AON Empower Results®

COVID-19 Coverage

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

SOLICITATIONS UPDATE

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

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

CONCLUSION

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

APPROVED REGULATION OF THE

COMMISSIONER OF INSURANCE

LCB File No. R054-20

Filed July 2, 2020

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

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

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

Legislative Counsel's Digest:

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

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

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

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

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

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

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

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

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

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

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

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

4. As used in this section:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

4. As used in this section:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

4. As used in this section:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

4. As used in this section:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

4. As used in this section:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

4. As used in this section:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

4. As used in this section:

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

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

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

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

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

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

Sec. 8. This regulation:

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

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

7.

7. Discussion and Possible action of Legislative Counsel Bureau Audit Report and Corrective Action Plan (Laura Rich, Executive Officer) (**For Possible Action**)

8.

8. Presentation on results of Request for Information (RFI) for Actuarial Review Services and Benefits Management System (Laura Rich, Executive Officer) (Information/Discussion)

STEVE SISOLAK
Governor

LAURA FREED
Board Chair

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Expires 04/01/2021

LAURA RICH
Executive Officer

AGENDA ITEM

☐ Action Item
☒ Information Only

Date: July 23, 2020

Item Number: VIII

Title: Results of Request For Information (RFI)

BACKGROUND

At the January 23, 2020 PEBP Board meeting, the Board approved further analysis on a variety of possible enhancement requests, including an independent actuarial review and a possible eligibility enrollment system replacement. Request For Information (RFI) were posted for both services and PEBP received responses from multiple vendors.

REPORT

ACTUARIAL REVIEW

The request for Actuarial Review services was one of the budget enhancement requests received from the advocate groups. The intent of the review is to provide independent verification of the actuarial services provided by Aon to PEBP. In order to have a better understanding of the cost for this type of service, and to include it as a budget enhancement, PEBP solicited an RFI and received responses from Wakely Consulting Group, Diamond Consulting Group and The Segal Group.

Although the cost proposals provided by each of the vendors varied somewhat in scope and are only high-level estimates based on the level of detail and services PEBP would choose to utilize, the proposals came in very similarly priced overall, at approximately $100,000.

ELIGIBILITY AND ENROLLMENT SYSTEM

In January, staff proposed an RFI for an eligibility and enrollment system as a necessary step should the Board should choose to cancel Morneau Shepell's two-year amendment. At the May 28th Board meeting, the Board did vote to cancel the amendment and directed staff to proceed with a competitive solicitation. Staff has since developed a Request For Proposal (RFP) and the

solicitation is currently underway. Because of the active status of this solicitation, only the following high-level updates for the corresponding RFI are being presented:

- 8 responses were received
- The complex nature of PEBP's eligibility and enrollment system and PEBP plan rules present a significant degree of difficulty for vendors to be able to accurately price a system absent a discovery phase and much more detail than can be provided in an RFI. As expected, vendors presented cost solutions that varied significantly from one to another. Some presented higher PMPM fees with no up-front implementation costs and others presented the inverse as well as variations of the two.

CONCLUSION

Unfortunately, the pandemic has changed the economic landscape of the state since the PEBP Board was presented with possible program enhancements in January. Although no formal guidance on Fiscal Year 22/23 has been provided to date, PEBP does not anticipate any enhancements being incorporated into the agencies FY22/23 budget.

9.

9. Discussion and Possible action of plan design changes to be considered for Fiscal Year 2022/2023 agency request budget submission (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: July 23, 2020

Item Number: IX

Title: Plan Design Changes for Fiscal Year 2022/2023

BACKGROUND

Each Biennium, state agencies must build and submit an agency budget request to the Governor's Finance Office by the end of August. The budget request undergoes review and often, numerous modifications before it eventually becomes part of the Governor's proposed budget presented in January prior to the start of the legislative session.

Under normal conditions, agencies receive a set of instructions and general directives in the spring prior to the August budget submission deadline. With a relatively stable economic outlook, this past spring agencies were advised to submit budgets that aligned with the Governor's goal of a family and child centered government. Unfortunately, the COVID-19 pandemic has drastically changed the situation and the state is now expected to be faced significant budget shortfalls for FY 22/23.

The special session which took place earlier this month, focused solely on resolving the more immediate FY 21 budget shortfalls. Meanwhile, until updated economic indicators become available, state agencies have moved forward with FY 22/23 budget building and it is only safe to assume that more budget cuts will be necessary.

REPORT

WHAT IS PROMPTING THE CHANGES

Recognizing that any further budget cuts under the current plan design will have significant impacts on members, either in the form of reduced benefits, increased out-of-pocket expenses, increased premiums or a combination of all of those, PEBP has taken this opportunity to revamp the program by introducing modifications and additions to the current plan design.

PEBP staff, 4 board members, PEBP's actuary and many other partners met in May for a 2-day strategic planning session to discuss options that would enable the program to reduce costs, retain benefits and improve member satisfaction. PEBP also reached out to advocacy groups to provide written input and feedback on what changes they would like to see, noting that "nothing was off the table".

Although PEBP has not been provided specific targets for PY 22/23, the expectation based on the current economic climate is that the program will be asked to make additional reductions, so the team collectively strategized to develop program policy and plan changes that are able to absorb the impact of budget reductions more easily, while also being mindful of economic impact on PEBP participants.

VARIABLES

There are many variables that will significantly affect projections and in turn, likely impact PEBP's budget:

Contracts
PEBP has 5 contracts up for renewal, some of them having a very significant impact on the overall budget. A change in the medical and/or dental network contracts will impact claims costs, while changes to the Benefits Management system and HMO contracts will affect administrative costs. Actuarial projections will not incorporate any of these possible changes as the contracts will not be approved until early 2021.

COVID-19
To date PEBP has paid approximately $500,000 in COVID-19 related claims, however these claims costs have been incurred during a period when the state was largely shut down. Since restrictions were relaxed and businesses were allowed to reopen, the COVID-19 cases have spiked dramatically. We cannot predict if this will lead to a sharp increase in related cases or, as some have predicted, if there will be a resurgence in the fall.

Trend
The pandemic will almost undoubtedly have a bearing on trend. Medical carriers are currently anticipating a 0.5%-1.0% increase on 2021 trends for claims that were suppressed in 2020 and will return in 2020. Those claim trends do not yet include any additional increase in costs due to potential future infection waves, future treatment regimens, long-term health impacts of those who have contracted COVID, the cost and availability of a future vaccine, etc. Collectively the unknowns of this pandemic will certainly increase the volatility on claim projections.

State Economic Conditions
The vast majority of the member premium is subsidized by the state through the employer contribution, which is approved at each legislative session. Historically, the employer contribution has been approximately 91-96% of the total premium cost for active employees,

however, given the current budget shortfalls, it is unclear what percentage the state will be able to contribute toward premiums in FY 22/23.

PLAN DESIGN CHANGES

Presented in the table below are the concepts behind the proposed plan changes that are to be included in the FY 22/23 agency budget request submission. Although a preliminary plan benefit design is shown, the deductibles, copays and coinsurance displayed are based on very immature data and will very likely change when the Board is presented with updated information at the November Board meeting where final PY22 plan design decisions will be approved. It is important to recognize that the proposed plan design shown in the table below is meant to illustrate what the plan design benefit might look like once factors such as updated trend are taken into consideration.

PEBP identified several goals during the plan design process. First, we wanted to improve the plan options so that members had more appropriate plan selections that met their needs. The idea of a low deductible plan has been consistently requested by members and advocacy groups, so PEBP introduced a middle tier option that more closely fulfills this request. The second goal was to modify the plan designs to make them simpler for the average member to use and comprehend. Introducing copays and reducing/eliminating the complex rules that have been built on the CDHP will allow members to have a better understanding of their benefits.

The third goal was to reduce PEBP costs. Since PEBP has not yet been given a target for FY 22/23, PEBP anticipates submitting two budget requests – one assuming a 5% reduction, the other assuming a 10% reduction. This will give the Governor's Finance Office (GFO) two options when deciding what should eventually be included in the Governor's recommended budget provided updated economic indicators that better determine the states' fiscal position in FY 22/23 are available.

Proposed Plan Design Changes

	Modified CDHP			New Low Ded PPO w/ copay			EPO/HMO		
	Current	**~5%**	**~10%**	**Current**	**~5%**	**10%**	**Current**	**~5%**	**~10%**
Deductible (Individual w/in Family)	$1,500/$3,000 ($2,800)	$2,000/$4,000 ($2,000)	$2,500/$5,000 ($2,500)		$1,000/$2,000 ($1,000)	$1,250/$2,500 ($1,250)	$0	$500/$1,000 ($500)	$600/$1,200 ($600)
OOP Max (Individual w/in Family)	$3,900/$7,800 ($6,850)	$5,000/$10,000 ($5,000)	$5,500/$11,000 ($5,500)		$5,000/$10,000 ($5,000)	$5,500/$11,000 ($5,500)	$7,150/$14,300 ($7,150)	$5,000/$10,000 ($5,000)	$5,500/$11,000 ($5,500)
Coinsurance	20%	20%	25%		20%	20%	N/A	15%	20%
Primary Care Visit	20% after ded.	20% after ded.	25% after ded.		$30	$30	$20	$20	$20
Specialist Visit	20% after ded.	20% after ded.	25% after ded.		$50	$50	$40	$40	$40
ER visit	20% after ded.	20% after ded.	25% after ded.		$750	$1,200	$500	$750	$800
UC Visit	20% after ded.	20% after ded.	25% after ded.		$80	$120	$30	$50	$80
Inpatient Hospital	20% after ded.	20% after ded.	25% after ded.		$750	ded/coins	$500	$750	$800
Outpatient Surgery	20% after ded.	20% after ded.	25% after ded.		$500	ded/coins	$350	$350	ded/coins
RX									
Generic	20% after ded.	20% after ded.	25% after ded.		$10	$10	$10	$10	$10
Formulary	20% after ded.	20% after ded.	25% after ded.		$40	$40	$40	$40	$40
Non-formulary	20% after ded.	20% after ded.	25% after ded.		$75	$80	$75	$75	$80
Specialty	20% after ded.	20% after ded.	25% after ded.		20% after ded.	25% after ded.	20%	20% after ded.	25% after ded.
HSA employer contribution	$700 + $200/dep	$500	N/A		N/A	N/A	N/A	N/A	N/A
AV	87.3%	80.4%	76.6%		83.0%	80.7%	92.0%	87.2%	85.1%
Premium	Least expensive premium			Middle option premium			Most expensive premium		

In addition to the above plan design changes, PEBP is also proposing a dental buy up plan. This will allow members to purchase a richer dental benefit for an additional premium.

CONCLUSION

PEBP must submit an agency request budget by the end of August. The Board must decide whether PEBP's agency request budget should incorporate the options introduced above or submit a budget using PEBP's current plan design structure.

PEBP Recommendation: PEBP recommends the Board approve incorporating the new plan design concepts identified in this report, to include the modification of the existing CHDP and HMO/EPO plans, the addition of a mid-level low deductible copay plan, and the addition of a dental buy up plan. These plan options not only reduce the program costs but increase member

choice and allow for greater flexibility when faced with the very realistic possibility of budget reductions.

10.

10. Discussion and Possible action of recommended policy changes to be considered for Plan Year 2022 (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: July 23, 2020

Item Number: X

Title: Recommended Policy Changes

REPORT

In addition to new plan design strategies, PEBP's May strategic planning also centered around possible policy changes. Historically, PEBP has employed numerous calculations and processes that are outside of the norm or that do not follow more standard actuarial practices. As the program has evolved, the need to reconsider these has grown in order to provide greater stability, transparency and a more streamlined path forward.

BOARD POLICIES

Underwriting Self-Funded Plans as One Risk Pool

In a self-funded plan, a claim is PEBP's responsibility regardless of which plan the member has selected. Pricing plans based on their actuarial values (the overall average percentage of healthcare costs paid by the plan) eliminates plan "death spirals" – a situation that occurs when a less healthy population, or overly large risk pools, move to or away from a specific plan. Currently, PEBP underwrites plans separately which impacts overall experience as high cost members move from one plan to another. Underwriting plans as one single risk pool eliminates this potential issue. For example, if an EPO member who is a on $3M/year specialty medication moves to the CDHP and then back again, the member takes the experience with them from year to year, but ultimately it remains PEBP's responsibility to pay those claims regardless. By underwriting all self-funded claims experience together, that one member's claims will not adversely impact one plan's renewal over the others. Instead, the high cost claims are lumped in with a broader risk pool and neutralized. As PEBP considers moving to three plan designs, pricing each plan according the Actuarial Values becomes even more important. Under this scenario, PEBP would continue to maintain the required State and Non-State risk pools.

Contribution Strategy

When the CDHP was originally introduced, the intent was to price the HMO and CDHP plans so that the total out of pocket expenses (premiums and copays) were equivalent. Over the past decade, this pricing differential was not maintained as the HMO rates have been set based on claims experience by fully insured carriers. This has ultimately resulted in significantly higher HMO/EPO single coverage costs when compared to the CDHP. Part of this disparity could be solved by the recommendation to underwrite plans made above, however contributions strategies play a significant role as well.

PEBP recommends applying a single contribution strategy (flat dollar amount) that is consistent across all the plans. Under this new strategy, PEBP's budget projections become more stable as projections are no longer dependent on participant plan selections. It eliminates this variable and focuses solely on the tier level selections.

HSA/HRA Funding by Dependent Count

Although PEBP may not be in fortunate enough position to provide HSA/HRA contributions in PY22, the program may want to reconsider a more streamlined approach to its funding strategies regarding dependents. The current process of funding based on the number of dependents (up to 3) creates unknown variables that ultimately have an affect on budget projections. The recommendation going forward is to establish dependent funding based on one of the following:

1. Tier (Employee only, E+Spouse, E+Children, E+Family)
2. Single amount for employee only coverage and another for any dependent coverage tier
3. Single amount per employee regardless of tier

Streamlining Tier Factors

Today, PEBP receives claims estimates from Aon that are tiered based on medical and pharmacy experience for state participants, non-state participants and a separate claims experience for dental. Aon provides rates based on the experience and tier per plan, and PEBP then adds on what is referred to as the "administrative load". Some of these administrative costs are flat amounts by tier and others, such as HSA/HRA funding, vary by tier. This results in final total rates that differ from the initial actuarial rates developed by Aon. PEBP recommends the program follow a more traditional actuarial underwriting process by:

- Using a per participant per month factor for claims
- Adding on administrative fees on a per participant per month basis
- Use one tier for all plans, products, state and non-state
- Keeping this factor static for the two-year budget cycle (at a minimum)

Definition and Use of Excess Reserves

The intent of the above recommendations is to reduce the probability of the program generating excess reserves the program has experienced in the past. Providing a more actuarially sound

program will reduce some of the volatility in PEBP's budget projections, however significant changes in the program (such as the addition/elimination of a plan) may introduce unknown variables that will ultimately affect projections and possibly never fully eliminate the existence of excess reserves. It is PEBP's recommendation that excess reserves be:

1. Defined:
   Excess reserves have historically varied dramatically throughout the plan year and are heavily affected by claims experience, lag and projections.
   a. PEBP recommends excess reserves be referred to as "excess cash".
   b. PEBP recommends identifying a point in time where excess cash is reported. Reporting excess cash in September after the end of the fiscal year provides the most sound and consistent figures and allows PEBP to report on actuals versus projections.
2. Use:
   PEBP recommends the board adopt a policy regarding how the program uses excess cash. Since excess cash is not a constant, PEBP does not believe excess cash is suitable to use for any on-going costs of the program.

OPERATIONAL CHANGES

Although the below change does not require Board approval, it is important to highlight as it will be reflected in budget reports made available to the PEBP Board and public.

Rx Rebates

PEBP receives a substantial amount of pharmacy rebates every year. In FY 20, PEBP is projected to receive approximately $13M in Rx rebates. It is typical to see rebates directly offset the cost of pharmacy claims (since that is how they are generated), however currently PEBP uses it to offset administrative costs. Moving forward, beginning in FY22, PEBP will be working with the Governor's Finance Office to ensure these rebates are moved into the claims category to more provide a more accurate reflection of the underwriting of claims calculations.

PEBP Recommendations:

1. ***Underwrite all self-funded plans into one risk pool while continuing to maintain the required state and non-state risk pools***
2. ***Apply a single contribution strategy consistent across all plans***
3. ***Establish HSA/HRA funding strategy***
4. ***Streamlining tiers by following a more traditional actuarial underwriting process by:***
   a. ***Using a per participant per month factor for claims***
   b. ***Adding on administrative fees on a per participant per month basis***
   c. ***Use one tier for all plans, products, state and non-state***
   d. ***Keeping this factor static for the two-year budget cycle (at a minimum)***
5. ***Definition and use of excess reserves***

11.

11. Public Comment

12.

12. Adjournment