STEVE SISOLAK
Governor

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

LAURA RICH
Executive Officer

LAURA FREED
Board Chair

MEETING NOTICE AND AGENDA

Name of Organization:	Public Employees' Benefits Program Board
Date and Time of Meeting:	September 30, 2021 9:00 a.m.
Place of Meeting:	Pursuant to Assembly Bill 253 (2021), this meeting will be held virtually. Participation will be enabled by the use of remote technology using video- and tele-conference. Instructions for both options are below. This meeting can be viewed live over the Internet on the PEBP YouTube channel at https://youtu.be/QwrQlaCGY8I

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.

To listen to and view the PEBP Board Meeting please click on the YouTube Link located in "Place of Meeting" field above.

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

Option #1 **Join the webinar as an attendee https://us06web.zoom.us/j/86492266262 This link is only for those who want to make public comment. If you are just listening to the webinar, please use the YouTube Link located in the "Place of Meeting" field above.**

Option #2 **Dial: (669) 900-6833. When prompted to provide your Meeting ID, please enter: 864 9226 6262 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

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. (Michelle Briggs, Chief 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 July 29, 2021 PEBP Board Meeting

   4.2 Receipt of quarterly staff reports for the period ending June 30, 2021:

   4.2.1 Budget Report

   4.2.2 Utilization Report

   4.3 Receipt of quarterly vendor reports for the period ending June 30, 2021:

   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 Willis Towers Watson's Individual Marketplace Enrollment and Performance Report

   4.3.6 Hometown Health Providers and Sierra Healthcare Options – PPO Network

   4.3.7 Health Plan of Nevada, Inc. – Southern Nevada HMO

   4.3.8 Doctor on Demand Engagement Report through August 2021

5. Election of Board Vice-Chair pursuant to Nevada Administrative Code (NAC) 287.172. Eligible candidates are Linda Fox, Tom Verducci, Jennifer Krupp, April Caughron, Betsy Aiello, Michelle Kelley, Jim Barnes, Leslie Bittleston, and Jennifer McClendon. (Laura Freed, Board Chair) (**For Possible Action**)
6. Executive Officer Report (Laura Rich, Executive Officer) (Information/Discussion)
7. Presentation and possible action regarding COVID-19 coverage changes and potential Covid Surcharges (Laura Rich, Executive Officer) (**For Possible Action**)
8. Presentation and possible action on the status and approval of PEBP contracts, contract amendments and solicitations (Cari Eaton, Chief Financial Officer) **(For Possible Action)**
    - 8.1 Contract Overview
    - 8.2 New Contracts
    - 8.3 Contract Amendments
        - 8.3.1 LSI Consulting – Amendment #1
        - 8.3.2 Claim Technologies – Amendment #1
    - 8.4 Contract Solicitations
    - 8.5 Status of Current Solicitations
9. Discussion and possible direction from the Board to staff on potential program design changes for Plan Year 2023 (July 1, 2021 to June 30, 2022) for which the Board requests additional information and costs to be presented at the November 18, 2021 meeting. (Laura Rich, Executive Officer) (**For Possible Action**)
10. 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.
11. 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). Contact Wendi Lunz at PEBP, 901 S Stewart Street, Suite 1001, Carson City NV 89701 (775) 684-7020 or (800) 326-5496
An item raised during a report or public comment may be discussed but may not be deliberated or acted upon unless it is on the agenda as an action item.
All times are approximate. The Board reserves the right to take items in a different order or to combine two or more agenda items for consideration to accomplish business in the most efficient manner. The Board may remove an item from the agenda or delay discussion relating to an item on the agenda at any time.
We are pleased to make reasonable efforts to assist and accommodate persons with physical disabilities who wish to participate in the meeting. If special arrangements for the meeting are necessary, please notify the PEBP in writing, at 901 South Stewart Street, Suite 1001, Carson City, NV 89701, or call Wendi Lunz at (775) 684-7020 or (800) 326-5496, as soon as possible so that reasonable efforts can be made to accommodate the request.

Copies of both the PEBP Meeting Action Minutes and Meeting Transcripts, if such transcripts are prepared, are available for inspection, at no charge, at the PEBP Office, 901 South Stewart Street, Suite 1001, Carson City, Nevada, 89701 or on the PEBP website at 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. (Michelle Briggs, Chief 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.

4.1 Approval of Action Minutes from the July 29, 2021 PEBP Board Meeting

4.2 Receipt of quarterly staff reports for the period ending June 30, 2021:

- 4.2.1 Budget Report
- 4.2.2 Utilization Report

4.3 Receipt of quarterly vendor reports for the period ending June 30, 2021:

- 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 Willis Towers Watson's Individual Marketplace Enrollment and Performance Report
- 4.3.6 Hometown Health Providers and Sierra Healthcare Options – PPO Network
- 4.3.7 Health Plan of Nevada, Inc. – Southern Nevada HMO
- 4.3.8 Doctor on Demand Engagement Report through August 2021

4.1

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

4.1 Approval of Action Minutes from the July 29, 2021 PEBP Board Meeting.

STATE OF NEVADA
PUBLIC EMPLOYEES' BENEFITS PROGRAM
BOARD MEETING

Video/Telephonic Open Meeting
Carson City

ACTION MINUTES (Subject to Board Approval)
July 29, 2021

MEMBERS PRESENT VIA TELECONFERENCE:	Ms. Laura Freed, Board Chair Ms. Michelle Kelley, Member Mr. Tom Verducci, Member Ms. Jennifer Krupp, Member Ms. Betsy Aiello, Member Ms. April Caughron, Member Mr. Tim Lindley, Member
MEMBERS EXCUSED:	Ms. Linda Fox, Member
FOR THE BOARD:	Mr. Peter Keegan, Deputy Attorney General
FOR STAFF:	Ms. Laura Rich, Executive Officer Mr. Nik Proper, Operations Officer Ms. Cari Eaton, Chief Financial Officer Mr. Steven Martin, Chief Information Officer Ms. Nancy Spinelli, Quality Control Officer Ms. Wendi Lunz, Executive Assistant
OTHER PRESENTERS:	Ms. Stephanie Messier, AON Mr. Nathan Cassin, AON Mr. Andy Witte, AON Ms. Donna Sullivan, Chief Pharmacy Officer, WA Health Care Authority Mr. Robert Judge, Moda Health Mr. Trevor Douglas, Oregon Dept of Human Services Mr. William Hayes, Oregon Dept of Human Services Mr. Gideon Davis, State Purchasing Dr. Beth Slamowitz, Senior Policy Advisor on Pharmacy for DHHS Mr. Chris Garcia, Willis Towers Watson

1. Open Meeting; Roll Call

    - Board Chair Freed opened the meeting at 9:04 a.m.

2. Public Comment
    - Mr. Miller
    - Carter Bundy – AFSCME
    - Janelle Woodward – AFSCME
    - Terri Laird – RPEN
    - Priscilla Maloney - AFSCME

3. PEBP Board disclosures for applicable Board meeting agenda items. (Peter Keegan, 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 Minutes from the June 11, 2021 PEBP Board Meeting.

    4.2 Receipt of quarterly staff reports for the period ending March 31, 2021:

        4.2.1 Budget Report

        4.2.2 Utilization Report

    4.3 Receipt of quarterly vendor reports for the period ending March 31, 2021:

        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 Willis Towers Watson's Individual Marketplace Enrollment and Performance Report Q3 2021

        4.3.6 Hometown Health Providers and Sierra Healthcare Options – PPO Network

        4.3.7 HealthPlan of Nevada, Inc. – Southern Nevada HMO

        4.3.8 Doctor on Demand Engagement Report through March 2021

    4.4 Accept the Fiscal Year 2021 Other Post-Employment Benefits (OPEB) valuation prepared by Aon in conformance with the Governmental Accounting Standards Board (GASB) requirements.

BOARD ACTION ON ITEM 4

MOTION: Motion to approve everything under Agenda Item Four except for 4.3.5, 4.3.6 and 4.4
BY: Member Michelle Kelley
SECOND: Member Betsy Aiello
VOTE: Unanimous; the motion carried

BOARD ACTION ON ITEM 4.3.5, 4.3.6 and 4.4

MOTION: Motion to accept reports 4.3.5, 4.3.6 and accept the OPEB valuation under 4.4
BY: Member Betsy Aiello
SECOND: Member Tim Lindley
VOTE: Unanimous; the motion carried

5. Executive Officer Report, including discussion and possible action regarding budget approved by the legislature. (Laura Rich, Executive Officer) (Information/Discussion)
6. Presentation and possible action on the Northwest Prescription Drug Consortium (Laura Rich, Executive Officer) **(For Possible Action)**

BOARD ACTION ON ITEM 6 (Taken out of order before agenda item 4)

MOTION: Motion that the Board move forward with option three; PEBP releases a formal solicitation for a PBM. Once a winning bidder is selected, the Board can then choose to compare the winning bid against the Consortium option. If the Consortium is selected, the RFP is cancelled and PEBP will contract directly with the Consortium. If not, PEBP will move forward with negotiations with the winning bidder.
BY: Member Tom Verducci
SECOND: Member Tim Lindley
VOTE: Unanimous; the motion carried

7. Presentation and possible action on the status and approval of PEBP contracts, contract amendments and solicitations (Cari Eaton, Chief Financial Officer) **(For Possible Action)**
    - 7.1 Contract Overview
    - 7.2 New Contracts
    - 7.3 Contract Amendments
    - 7.4 Contract Solicitations
    - 7.5 Status of Current Solicitations

BOARD ACTION ON ITEM 7

MOTION: Motion to authorize PEBP Staff to complete a contract amendment with HealthScope for the national PPO service.
BY: Member Michelle Kelley
SECOND: Member April Caughron
VOTE: Unanimous; the motion carried

8. Discussion and possible action relating to PEBP's request for American Rescue Plan funding (Laura Rich, Executive Officer) (**For Possible Action**)

BOARD ACTION ON ITEM 8

MOTION: Motion for PEBP Staff to request ARP funding with prioritized to revert deductibles and out-of-pocket max to pre pandemic levels to the extent that it doesn't lead to unintended outcomes. In other words, letting the staff and the actuary make sure that it's equitable across all plan options and everybody benefits more or less equally. Then co-insurance. Then LTD. Then basic life. Then HSA payment of $700 to primary. *Addition to the motion* to give Executive Officer Rich the flexibility to prioritize the Board's intent and goals and the flexibility to make those changes.

BY: Member Tom Verducci

SECOND: Member Tim Lindley

VOTE: Unanimous; the motion carried

9. Public Comment
    - Terri Laird - RPEN
    - Carter Bundy – AFSCME
    - Janelle Woodward – AFSCME
10. Adjournment
    - Board Chair Freed adjourned the meeting at 1:23 p.m.

4.2

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

    4.1 Approval of Action Minutes from the July 29, 2021 PEBP Board Meeting.

    4.2 Receipt of quarterly staff reports for the period ending June 30, 2021

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 June 30, 2021:

4.2.1 Budget Report

STEVE SISOLAK
Governor

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

LAURA RICH
Executive Officer

LAURA FREED
Board Chair

AGENDA ITEM

[X] Action Item
[ ] Information Only

Date: September 30, 2021

Item Number: IV.II.I

Title: Chief Financial Officer Budget Report

Summary

This report addresses the Operational Budget as of June 30, 2021 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 June 30, 2021 with comparisons to the same period in Fiscal Year 2020. 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 $386.4 million as of June 30, 2021 compared to $370.1 million as of June 30, 2020 or a decrease of 4.4%. Total expenses for the period have decreased by $2.5 million or 0.6% for the same period.

The budget status report shows Realized Funding Available (cash) at $154.8 million. This compares to $132.0 million for last year. The table below reflects the actual revenue and expenditures for the period.

////

Operational Budget 1338

	FISCAL YEAR 2021			FISCAL YEAR 2020		
	Actual as of 6/30/2021	Work Program	Percent	Actual as of 6/30/2020	Fiscal Year 2020 Close	Percent
Beginning Cash	154,541,329	154,541,329	100%	150,276,433	150,276,433	100%
Premium Income	366,550,801	375,455,443	98%	353,826,673	378,746,198	93%
All Other Income	19,835,354	20,897,373	95%	16,243,687	17,070,199	95%
Total Income	386,386,154	396,352,816	97%	370,070,360	395,816,398	93%
Personnel Services	2,311,337	2,896,914	80%	2,504,369	2,603,314	96%
Operating - Other than Personnel	2,169,759	2,646,875	82%	2,026,253	2,073,172	98%
Insurance Program Expenses	381,160,437	418,380,481	91%	383,531,409	386,256,172	99%
All Other Expenses	507,874	647,864	78%	606,816	618,845	98%
Total Expenses	386,149,407	424,572,134	91%	388,668,846	391,551,503	99%
Change in Cash	236,748	(28,219,318)		(18,598,487)	4,264,895	
REALIZED FUNDING AVAILABLE	154,778,077	126,322,011	123%	131,677,946	154,541,328	85%
Incurred But Not Reported Liability	(51,514,000)	(51,514,000)		(58,790,000)	(58,790,000)	
Catastrophic Reserve	(34,835,000)	(34,835,000)		(24,201,541)	(24,201,541)	
HRA Reserve	(30,550,651)	(30,550,651)		(36,204,203)	(36,204,203)	
NET REALIZED FUNDING AVAILABLE	37,878,426	9,422,360		12,482,202	35,345,584	

Current Budget Projections

The following table represents projections for FY 2021. The projection reflects total income to be less than budgeted by 0.6% ($547.4 million vs $550.9 million), total expenditures are projected to be less than budgeted by 8.5% ($388.4 million vs $424.7 million); total reserves are projected to be more than budgeted by 22.0% ($159.0 million vs $130.4 million).

State Subsidies are projected to be less than the budgeted amount by $6.0 million (2.1%), Non-State Subsidies are projected to be less than budgeted by $4.7 million (16.3%), and Premium Income is projected to be more than budgeted by $4.0 million (5.8%). This overall decrease in budgeted revenue is due in part to a reduction in State Subsidies as a result of average enrollment as compared to budgeted enrollment and a change in the mix of plan tiers. The mix of participants is as follows:

- 3.74% fewer state actives,
- 0.72% fewer state non-Medicare retirees,
- 3.13% fewer non-state actives,
- 5.57% fewer non-state, non-Medicare retirees
- 4.50% fewer state Medicare retirees, and
- 7.15% fewer non-state Medicare retirees

Budgeted and Projected Income (Budget Account 1338)					
Description	**Budget**	**Actual 6/30/21**	**Projected**	**Difference**	
Carryforward	154,541,329	154,541,329	154,541,329	0	0.0%
State Subsidies	278,042,182	270,063,530	272,183,708	(5,858,474)	-2.1%
Non-State Subsidies	29,075,407	24,294,731	24,331,749	(4,743,658)	-16.3%
Premium	68,337,854	72,192,540	72,292,309	3,954,455	5.8%
All Other	20,897,373	19,835,354	24,098,398	3,201,025	15.3%
Total	550,894,145	540,927,483	547,447,493	(3,446,652)	-0.6%
Budgeted and Projected Expenses (Budget Account 1338)					
Description	**Budget**	**Actual 6/30/21**	**Projected**	**Difference**	
Operating	6,191,653	4,988,970	5,269,833	921,820	14.9%
State Employee Ins Cost	303,157,249	276,309,925	272,645,012	30,512,237	10.1%
State Retirees Ins Cost	57,514,279	53,810,064	57,348,279	166,000	0.3%
Non-State Employees Ins Cost	151,001	139,243	150,501	500	0.3%
Non-State Retirees Ins Cost	14,327,972	12,626,957	14,327,472	500	0.0%
State Medicare Ret Ins Cost	25,382,152	22,914,268	22,037,902	3,344,250	13.2%
Non-State Medicare Ret Ins Cost	17,991,547	15,359,981	16,657,214	1,334,333	7.4%
Total Insurance Costs	418,524,200	381,160,437	383,166,380	35,357,820	8.4%
Total Expenses	424,715,853	386,149,407	388,436,213	36,279,640	8.5%
Restricted Reserves	116,899,651	116,899,651	112,217,050	4,682,601	4.0%
Differential Cash Available	13,464,777	37,878,426	46,794,230	(33,329,453)	-247.5%
Total Reserves	130,364,428	154,778,077	159,011,280	(28,646,852)	-22.0%
Total of Expenses and Reserves	555,080,281	540,927,483	547,447,493	7,632,788	1.4%

Expenses for Fiscal Year 2021 are projected to be $36.3 million (8.5%) less than budgeted when changes to reserves are excluded. Operating expenses are projected to be less than budgeted by $0.9 million (14.9%). Employee and Retiree insurances costs are projected to be less than budgeted by $35.4 million (8.4%) when taken in total (see table above for specific information). The significant reduction in projected expenditures compared to the budget is substantially due to the claims suppression experienced due to COVID-19.

Total reserves for the year ending June 30, 2021 are projected to be $159 million. Reserves include $52.3 million for Incurred but not Reported (IBNR) claims, $35.0 million for the Catastrophic Reserve to insure plan solvency, $25.1 million in HRA reserves, and a projected differential of cash available of $47.0 million.

Differential Cash Available for FY 2022

PEBP ended FY 2021 with $159.0 million of cash on hand to balance forward to FY 2022. The FY 2022 budget was built with a balance forward amount of $126.1 million. PEBP will submit work programs to transfer the additional cash authority from FY 2021 to FY 2022 and make necessary adjustments to the required reserve and claims category authority for FY 2022. Once all the adjustments are approved through the state budget process, PEBP is projecting a final differential cash available for FY 2022 of $38.6 million.

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 June 30, 2021:

        4.2.1 Budget Report

        4.2.2 Utilization Report

STEVE SISOLAK
Governor

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

LAURA RICH
Executive Officer

LAURA FREED
Board Chair

AGENDA ITEM

[X] Action Item
[ ] Information Only

Date: September 30, 2021

Item Number: IV.II.II

Title: Self-Funded CDHP and EPO Plan Utilization Report for the period ending June 30, 2021

This report addresses medical, dental, prescription drug and HSA/HRA utilization for the PY 2021 period ending June 30, 2021. 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 Q4 Plan Year 2021 utilization data.

Executive Summary

CONSUMER DRIVEN HEALTH PLAN (CDHP)

The Consumer Driven Health Plan (CDHP) experience for Plan Year 2021 compared to Plan Year 2020 is summarized below.

- Population:
  - 1.5% decrease for primary participants
  - 1.3% decrease for primary participants plus dependents (members)
- Medical Cost:
  - 6.7% decrease for primary participants
  - 6.8% decrease for primary participants plus dependents (members)
- High Cost Claims:
  - There were 178 High Cost Claimants accounting for 33.3% of the total plan paid for Plan Year 2021
  - 12.5% decrease in High Cost Claimants per 1,000 members
  - 1.8% decrease in average cost of High Cost Claimant paid
- Top three highest cost clinical classifications include:
  - Cancer ($9.0 million) – 20.4% of paid claims
  - Cardiac Disorders ($4.3 million) – 9.7% of paid claims
  - Renal/Urologic Disorders ($4.0 million) – 9.1% of paid claims
- Emergency Room:
  - ER visits per 1,000 members decreased 18.8%
  - Average paid per ER visit decreased 3.0%
- Urgent Care:
  - Urgent Care visits per 1,000 members decreased by 24.6%
  - Average paid per Urgent Care visit increased 87.8% (increase from $41 to $77)
- Network Utilization:
  - 97.9% of claims are from In-Network providers
  - Plan Year 2021 In-Network utilization increased 2.0% over PY 2020
  - Plan Year 2021 In-Network discounts increased 0.6% over PY 2020
- Prescription Drug Utilization:
  - Overall:
    - Total Net Claims decreased 0.5%
    - Total Gross Claims Costs increased 5.4% ($2.7 million)
    - Average Total Cost per Claim increased 5.9%
      - From $96.24 to $101.90
  - Member:
    - Total Member Cost increased 0.8%
    - Average Participant Share per Claim increased 1.3%
    - Net Member PMPM increased 2.3%
      - From $25.06 to $25.62

- Plan
  - Total Plan Cost increased 6.9%
  - Average Plan Share per Claim increased 7.4%
  - Net Plan PMPM increased 8.5%
    - From $73.90 to $80.15
  - Net Plan PMPM factoring rebates increase 12.5%
    - From $54.69 to $61.53

PEBP PREMIER PLAN (EPO)

The PEBP Premier Plan (EPO) experience for Plan Year 2021 compared to the Plan Year 2020 is summarized below.

- Population:
  - 3.0% decrease for primary participants
  - 2.5% decrease for primary participants plus dependents (members)
- Medical Cost:
  - 8.3% increase for primary participants
  - 8.69% increase for primary participants plus dependents (members)
- High Cost Claims:
  - There were 61 High Cost Claimants accounting for 29.6% of the total plan paid for Plan Year 2021
  - 22.5% increase in High Cost Claimants per 1,000 members
  - 43.7% increase in average cost of High Cost Claimant paid
- Top three highest cost clinical classifications include:
  - Cancer ($3.1 million) – 20.0% of paid claims
  - Infections ($2.2 million) – 13.8% of paid claims
  - Hematological Disorders ($1.4 million) – 8.9% of paid claims
- Emergency Room:
  - ER visits per 1,000 members decreased by 20.7%
  - Average paid per ER visit decreased by 2.8%
- Urgent Care:
  - Urgent Care visits per 1,000 members decreased by 21.1%
  - Average paid per Urgent Care visit increased 9.4%
- Network Utilization:
  - 99.9% of claims are from In-Network providers
  - In-Network utilization increased 2.5%
  - In-Network discounts decreased 3.1%
- Prescription Drug Utilization:
  - Overall:
    - Total Net Claims decreased 1.0%
    - Total Gross Claims Costs increased 7.9% ($1.6 million)
    - Average Total Cost per Claim increased 9.0%
      - From $116.28 to $126.70

- Member:
  - Total Member Cost increased 38.0%
  - Average Participant Share per Claim increased 39.4%
  - Net Member PMPM increased 41.4%
    - From $25.26 to $35.73
- Plan
  - Total Plan Cost increased 3.3%
  - Average Plan Share per Claim increased 4.4%
  - Net Plan PMPM increased 5.9%
    - From $166.45 to $176.23
  - Net Plan PMPM factoring rebates increased 4.5%
    - From $129.79 to $135.59

DENTAL PLAN

The Dental Plan experience for Plan Year 2021 is summarized below.

- Dental Cost:
  - Total of $24,871,282 paid for Dental claims
    - Preventative claims account for 43.8% ($11.0 million)
    - Basic claims account for 29.7% ($7.4 million)
    - Major claims account for 19.4% ($4.8 million)
    - Periodontal claims account for 7.1% ($1.8 million)

HEALTH REIMBURSEMENT ARRANGEMENT

The table below provides a list of CDHP HRA account balances as of June 30, 2021.

HRA Account Balances as of June 30, 2021			
$Range	**# Accounts**	**Total Account Balance**	**Average Per Account Balance**
0	2,014	0	0
$.01 - $500.00	3,032	502,849	166
$500.01 - $1,000	1,672	1,211,924	725
$1,000.01 - $1,500	799	976,942	1,223
$1,500.01 - $2,000	611	1,073,792	1,757
$2,000.01 - $2,500	459	1,043,316	2,273
$2,500.01 - $3,000	328	895,910	2,731
$3,000.01 - $3,500	250	803,456	3,214
$3,500.01 - $4,000	158	589,583	3,732
$4,000.01 - $4,500	155	658,785	4,250
$4,500.01 - $5,000	106	503,219	4,747
$5,000.01 +	**774**	**6,227,707**	**224,066**
Total	**10,358**	**$ 14,487,483**	**$ 1,399**

CONCLUSION

The information in this report provides plan experience for the Consumer Driven Health Plan (CDHP) and the PEBP Premier Plan (EPO) through the fourth quarter of Plan Year 2021. The CDHP total plan paid costs decreased 8.3% over the same time for Plan Year 2020. The EPO total plan paid costs increased 2.3% over Plan Year 2020. 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, 2020 – June 30, 2021

HSB DATASCOPE™

Nevada Public Employees' Benefits Program
HDHP Plan

July 2020 – June 2021

HealthSCOPE BENEFITS

Overview

- Total Medical Spend for PY21 was $132,093,355 of which 76.1% was spent in the State Active population. When compared to PY20, this reflected a decrease of 8.1% in plan spend, with State Actives having a decrease of 5.3%.
  - When compared to PY19, PY21 was on track with total plan spend, with State Actives having a slight increase of 2.7%.
- On a PEPY basis, PY21 reflected a decrease of 6.7% when compared to PY20. The largest group, State Actives, decreased 4.0%.
  - When compared to PY19, PY21 was consistent, with State Actives increasing by 3.1%.
- 86.1% of the Average Membership had paid Medical claims less than $2,500, with 16.8% of those having no claims paid at all during the reporting period.
- There were 178 high-cost Claimants (HCC's) over $100K, that accounted for 33.3% of the total spend. HCCs accounted for 33.9% of total spend during PY20, with 206 members hitting the $100K threshold. The largest diagnosis grouper was Cancer accounting for 20.4% of high-cost claimant dollars.
- IP Paid per Admit was $24,652 which is a decrease of 4.7% compared to PY20.
- ER Paid per Visit is $2,088, which is a decrease of 3.0% compared to PY20.
- 97.9% of all Medical spend dollars were to In Network providers. The average In Network discount was 65.9%, which is on track with the PY20 average discount of 65.3%.

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

Paid Claims by Age Group								
	PY20							
Age Range	Med Net Pay	Med PMPM	Rx Net Pay	Rx PMPM	Dental Net Pay	Dental PMPM	Net Pay	PMPM
<1	$ 6,794,610	$1,627	$ 63,607	$15	$ 12,587	$2	$6,870,804	$1,644
1	$ 841,639	$180	$ 29,308	$6	$ 43,114	$6	$914,061	$193
2 - 4	$ 1,280,257	$80	$ 569,167	$36	$ 368,411	$17	$2,217,834	$132
5 - 9	$ 1,504,049	$49	$ 147,265	$5	$ 1,172,971	$28	$2,824,285	$82
10 - 14	$ 3,568,831	$104	$ 523,976	$15	$ 1,150,189	$24	$5,242,995	$144
15 - 19	$ 5,395,888	$149	$ 905,365	$25	$ 1,396,753	$28	$7,698,006	$202
20 - 24	$ 5,813,187	$142	$ 1,028,701	$25	$ 945,369	$17	$7,787,257	$184
25 - 29	$ 5,710,701	$171	$ 1,201,788	$36	$ 921,117	$22	$7,833,606	$230
30 - 34	$ 7,718,900	$214	$ 1,693,247	$47	$ 1,072,181	$23	$10,484,328	$283
35 - 39	$ 6,714,047	$168	$ 3,530,405	$88	$ 1,243,787	$24	$11,488,239	$280
40 - 44	$ 7,995,208	$219	$ 2,334,383	$64	$ 1,292,574	$26	$11,622,166	$309
45 - 49	$ 10,751,419	$277	$ 3,460,559	$89	$ 1,478,697	$27	$15,690,675	$393
50 - 54	$ 12,184,580	$300	$ 4,605,442	$113	$ 1,652,154	$29	$18,442,177	$442
55 - 59	$ 17,462,073	$392	$ 6,399,544	$144	$ 1,991,457	$32	$25,853,074	$568
60 - 64	$ 33,725,255	$675	$ 7,928,803	$159	$ 2,450,819	$35	$44,104,877	$868
65+	$ 16,206,562	$582	$ 5,055,571	$182	$ 5,869,624	$37	$27,131,757	$801
Total	**$143,667,208**	**$279**	**$39,477,131**	**$77**	**$23,061,804**	**$28**	**$206,206,141**	**$384**

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

Paid Claims by Age Group														
	PY21												% 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	$	5,415,443	$	1,347	$	44,350	$	11	$	10,773	$	2	$	5,470,566	$	1,360	-20.4%	-17.3%
1	$	770,967	$	167	$	177,140	$	38	$	51,343	$	8	$	999,450	$	214	9.3%	10.6%
2 - 4	$	1,387,222	$	88	$	267,896	$	17	$	392,172	$	18	$	2,047,290	$	124	-7.7%	-6.3%
5 - 9	$	1,823,563	$	62	$	458,414	$	16	$	1,266,649	$	32	$	3,548,626	$	109	25.6%	33.3%
10 - 14	$	3,212,849	$	95	$	536,193	$	16	$	1,303,875	$	28	$	5,052,917	$	138	-3.6%	-4.0%
15 - 19	$	3,321,789	$	93	$	786,785	$	22	$	1,558,916	$	31	$	5,667,490	$	147	-26.4%	-27.3%
20 - 24	$	4,525,090	$	114	$	1,209,865	$	30	$	994,512	$	18	$	6,729,467	$	162	-13.6%	-11.8%
25 - 29	$	7,942,807	$	254	$	1,608,988	$	51	$	943,068	$	23	$	10,494,863	$	329	34.0%	42.9%
30 - 34	$	6,156,246	$	167	$	2,161,190	$	59	$	1,240,433	$	26	$	9,557,869	$	251	-8.8%	-11.2%
35 - 39	$	6,948,179	$	175	$	3,053,399	$	77	$	1,411,095	$	27	$	11,412,673	$	280	-0.7%	-0.1%
40 - 44	$	6,891,321	$	183	$	2,597,142	$	69	$	1,413,716	$	28	$	10,902,179	$	280	-6.2%	-9.4%
45 - 49	$	10,290,128	$	273	$	3,422,156	$	91	$	1,513,069	$	29	$	15,225,353	$	393	-3.0%	-0.1%
50 - 54	$	15,741,635	$	390	$	5,028,555	$	125	$	1,762,122	$	31	$	22,532,312	$	545	22.2%	23.3%
55 - 59	$	17,606,504	$	401	$	6,560,096	$	149	$	2,050,892	$	34	$	26,217,492	$	584	1.4%	2.8%
60 - 64	$	24,591,770	$	506	$	8,019,921	$	165	$	2,536,102	$	37	$	35,147,793	$	708	-20.3%	-18.5%
65+	$	15,467,844	$	541	$	5,366,786	$	188	$	6,422,543	$	39	$	27,257,173	$	768	0.5%	-4.1%
Total	**$**	**132,093,355**	**$**	**260**	**$**	**41,298,876**	**$**	**81**	**$**	**24,871,282**	**$**	**30**	**$**	**198,263,513**	**$**	**372**	**-3.9%**	**-3.1%**

Financial Summary (p. 1 of 2)

	Total				State Active				Non-State Active			
Summary	**PY19**	**PY20**	**PY21**	**Variance to Prior Year**	**PY19**	**PY20**	**PY21**	**Variance to Prior Year**	**PY19**	**PY20**	**PY21**	**Variance to Prior Year**
Enrollment												
Avg # Employees	23,569	23,673	23,322	-1.5%	19,612	19,809	19,529	-1.4%	4	4	4	4.4%
Avg # Members	42,776	42,865	42,317	-1.3%	37,138	37,291	36,761	-1.4%	7	7	9	31.8%
Ratio	1.8	1.8	1.8	0.0%	1.9	1.9	1.9	0.0%	1.8	1.8	2.3	26.4%
Financial Summary												
Gross Cost	$172,993,213	$185,251,114	$169,798,016	-8.3%	$129,947,874	$139,774,757	$131,033,700	-6.3%	$105,325	$46,064	$40,353	-12.4%
Client Paid	$133,179,670	$143,667,208	$132,093,355	-8.1%	$97,851,639	$106,095,205	$100,467,765	-5.3%	$96,469	$35,053	$26,699	-23.8%
Employee Paid	$39,813,543	$41,583,906	$37,704,661	-9.3%	$32,096,235	$33,679,553	$30,565,935	-9.2%	$8,857	$11,011	$13,654	24.0%
Client Paid-PEPY	$5,651	$6,069	$5,664	-6.7%	$4,989	$5,356	$5,144	-4.0%	$24,117	$9,144	$6,675	-27.0%
Client Paid-PMPY	$3,113	$3,352	$3,122	-6.9%	$2,635	$2,845	$2,733	-3.9%	$13,781	$5,130	$2,967	-42.2%
Client Paid-PEPM	$471	$506	$472	-6.7%	$416	$446	$429	-3.8%	$2,010	$762	$556	-27.0%
Client Paid-PMPM	$259	$279	$260	-6.8%	$220	$237	$228	-3.8%	$1,148	$427	$247	-42.2%
High Cost Claimants (HCC's) > $100k												
# of HCC's	198	206	178		124	151	128		0	0	0	
HCC's / 1,000	4.6	4.8	4.2		3.3	4.1	3.5		0.0	0.0	0.0	
Avg HCC Paid	$219,374	$236,642	$246,763	4.3%	$218,720	$206,591	$237,270	14.9%	$0	$0	$0	0.0%
HCC's % of Plan Paid	32.6%	33.9%	33.3%	-1.8%	27.7%	29.4%	30.2%	2.7%	0.0%	0.0%	0.0%	0.0%
Cost Distribution by Claim Type (PMPY)												
Facility Inpatient	$1,071	$1,139	$893	-21.6%	$847	$883	$750	-15.1%	$3,087	$0	$14	0.0%
Facility Outpatient	$925	$1,040	$991	-4.7%	$782	$880	$822	-6.6%	$6,561	$2,087	$2,152	3.1%
Physician	$1,045	$1,093	$1,174	7.4%	$948	$1,014	$1,105	9.0%	$4,006	$2,777	$770	-72.3%
Other	$72	$80	$64	-20.0%	$58	$68	$56	-17.6%	$129	$266	$30	0.0%
Total	$3,113	$3,352	$3,122	-6.9%	$2,635	$2,845	$2,733	-3.9%	$13,781	$5,130	$2,967	-42.2%

Financial Summary (p. 2 of 2)

	State Retirees				Non-State Retirees				
Summary	**PY19**	**PY20**	**PY21**	**Variance to Prior Year**	**PY19**	**PY20**	**PY21**	**Variance to Prior Year**	**HSB Peer Index**
Enrollment									
Avg # Employees	3,224	3,246	3,268	0.7%	729	615	521	-15.3%	
Avg # Members	4,799	4,858	4,933	1.5%	832	710	614	-13.5%	
Ratio	1.5	1.5	1.5	0.7%	1.1	1.2	1.2	1.7%	1.6
Financial Summary									
Gross Cost	$34,175,219	$39,350,569	$33,024,994	-16.1%	$8,764,794	$6,079,723	$5,698,970	-6.3%	
Client Paid	$27,761,940	$32,691,908	$26,900,984	-17.7%	$7,469,622	$4,845,042	$4,697,908	-3.0%	
Employee Paid	$6,413,280	$6,658,661	$6,124,010	-8.0%	$1,295,172	$1,234,681	$1,001,063	-18.9%	
Client Paid-PEPY	$8,612	$10,070	$8,231	-18.3%	$10,246	$7,882	$9,024	14.5%	$6,297
Client Paid-PMPY	$5,785	$6,730	$5,454	-19.0%	$8,983	$6,821	$7,646	12.1%	$3,879
Client Paid-PEPM	$718	$839	$686	-18.2%	$854	$657	$752	14.5%	$525
Client Paid-PMPM	$482	$561	$454	-19.1%	$749	$568	$637	12.1%	$323
High Cost Claimants (HCC's) > $100k									
# of HCC's	58	60	44		16	8	9		
HCC's / 1,000	12.1	12.4	8.9		19.2	11.3	14.7		
Avg HCC Paid	$220,380	$271,721	$261,318	-3.8%	$220,793	$156,233	$228,360	46.2%	
HCC's % of Plan Paid	46.0%	49.9%	42.7%	-14.4%	47.3%	25.8%	43.7%	69.4%	
Cost Distribution by Claim Type (PMPY)									
Facility Inpatient	$2,155	$2,853	$1,597	-44.0%	$4,794	$2,835	$3,771	33.0%	$1,149
Facility Outpatient	$1,787	$2,107	$2,154	2.2%	$2,295	$2,143	$1,733	-19.1%	$1,333
Physician	$1,677	$1,600	$1,586	-0.9%	$1,732	$1,745	$2,022	15.9%	$1,301
Other	$166	$170	$116	-31.8%	$163	$98	$120	22.4%	$96
Total	$5,785	$6,730	$5,454	-19.0%	$8,983	$6,821	$7,646	12.1%	$3,879

Paid Claims by Claim Type – State Participants

Net Paid Claims - Total State Participants	PY20				PY21				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical									
Inpatient	$ 38,557,944	$ 12,386,833	$ 2,629,640	$ 53,574,416	$ 34,186,446	$ 5,917,760	$ 2,940,974	$ 43,045,180	-19.7%
Outpatient	$ 67,537,260	$ 15,689,986	$ 1,985,449	$ 85,212,696	$ 66,281,319	$ 15,258,658	$ 2,783,591	$ 84,323,569	-1.0%
Total - Medical	$ 106,095,205	$ 28,076,819	$ 4,615,089	$ 138,787,113	$ 100,467,765	$ 21,176,419	$ 5,724,565	$ 127,368,749	-8.2%
Dental	$ 15,744,257	$ 1,851,687	$ 494,735	$ 18,090,679	$ 17,004,298	$ 1,977,025	$ 520,098	$ 19,501,421	7.8%
Dental Exchange	$ -	$ -	$ 2,797,694	$ 2,797,694	$ -	$ -	$ 3,131,443	$ 3,131,443	11.9%
Total	**$ 121,839,461**	**$ 29,928,507**	**$ 7,907,519**	**$ 159,675,486**	**$ 117,472,063**	**$ 23,153,443**	**$ 9,376,107**	**$ 150,001,614**	**-6.1%**

Net Paid Claims - Per Participant per Month	PY20				PY21				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical	$ 446	$ 888	$ 630	$ 502	$ 437	$ 823	$ 887	$ 486	-3.0%
Dental	$ 48	$ 46	$ 54	$ 48	$ 53	$ 49	$ 55	$ 52	9.3%
Dental Exchange	$ -	$ -	$ 44	$ 44	$ -	$ -	$ 47	$ 47	7.4%

Paid Claims by Claim Type – Non-State Participants

Net Paid Claims - Total Non-State Participants	PY20				PY21				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical									
Inpatient	$ 204	$ 702,380	$ 1,444,526	$ 2,147,110	$ 126	$ 1,556,727	$ 987,069	$ 2,543,922	18.5%
Outpatient	$ 34,849	$ 2,057,080	$ 641,056	$ 2,732,985	$ 26,572	$ 1,476,264	$ 677,848	$ 2,180,684	-20.2%
Total - Medical	$ 35,053	$ 2,759,461	$ 2,085,582	$ 4,880,095	$ 26,699	$ 3,032,990	$ 1,664,917	$ 4,724,606	-3.2%
Dental	$ 2,486	$ 266,841	$ 203,135	$ 472,462	$ 5,294	$ 205,023	$ 223,935	$ 434,252	-8.1%
Dental Exchange	$ -	$ -	$ 1,700,969	$ 1,700,969			$ 1,804,165	$ 1,804,165	6.1%
Total	**$ 37,539**	**$ 3,026,301**	**$ 3,989,685**	**$ 7,053,525**	**$ 31,992**	**$ 3,238,014**	**$ 3,693,017**	**$ 6,963,023**	**-1.3%**

Net Paid Claims - Per Participant per Month	PY20				PY21				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical	$ 762	$ 649	$ 667	$ 658	$ 742	$ 1,478	$ 614	$ 984	49.7%
Dental	$ 26	$ 38	$ 40	$ 39	$ 55	$ 42	$ 43	$ 42	9.0%
Dental Exchange	$ -	$ -	$ 40	$ 40	$ -	$ -	$ 43	$ 43	8.4%

Paid Claims by Claim Type – Total

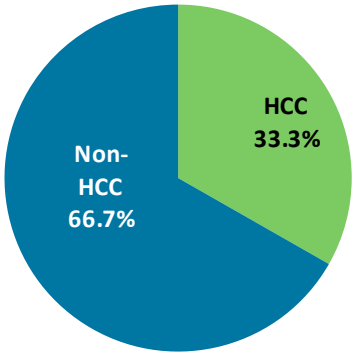
Net Paid Claims - Total Total Participants	PY20				PY21				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical									
Inpatient	$ 38,558,148	$ 13,089,213	$ 4,074,165	$ 55,721,526	$ 34,186,572	$ 7,474,487	$ 3,928,043	$ 45,589,102	-18.2%
Outpatient	$ 67,572,109	$ 17,747,067	$ 2,626,505	$ 87,945,681	$ 66,307,891	$ 16,734,922	$ 3,461,439	$ 86,504,253	-1.6%
Total - Medical	$ 106,130,257	$ 30,836,280	$ 6,700,671	$ 143,667,208	$ 100,494,463	$ 24,209,409	$ 7,389,483	$ 132,093,355	-8.1%
Dental	$ 15,746,743	$ 2,118,528	$ 697,870	$ 18,563,141	$ 17,009,592	$ 2,182,048	$ 744,033	$ 19,935,673	7.4%
Dental Exchange	$ -	$ -	$ 4,498,663	$ 4,498,663	$ -	$ -	$ 4,935,609	$ 4,935,609	9.7%
Total	**$ 121,877,000**	**$ 32,954,808**	**$ 11,897,203**	**$ 166,729,012**	**$ 117,504,055**	**$ 26,391,457**	**$ 13,069,124**	**$ 156,964,636**	**-5.9%**

Net Paid Claims - Per Participant per Month	PY20				PY21				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	
Medical	$ 446	$ 859	$ 641	$ 506	$ 437	$ 872	$ 806	$ 495	-2.1%
Dental	$ 48	$ 44	$ 49	$ 48	$ 53	$ 49	$ 51	$ 52	9.4%
Dental Exchange	$ -	$ -	$ 42	$ 42	$ -	$ -	$ 45	$ 45	7.9%

Cost Distribution – Medical Claims

PY20							PY21					
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
178	0.4%	$48,745,433	33.9%	$1,293,423	3.1%	$100,000.01 Plus	152	0.4%	$43,883,781	33.2%	$1,073,302	2.8%
245	0.6%	$18,722,982	13.0%	$1,451,386	3.5%	$50,000.01-$100,000.00	213	0.5%	$16,264,896	12.3%	$1,244,260	3.3%
489	1.1%	$18,430,502	12.8%	$2,576,800	6.2%	$25,000.01-$50,000.00	461	1.1%	$17,136,650	13.0%	$2,295,167	6.1%
1,345	3.1%	$22,375,812	15.6%	$6,136,143	14.8%	$10,000.01-$25,000.00	1,222	2.9%	$19,974,070	15.1%	$5,585,381	14.8%
1,773	4.1%	$13,273,550	9.2%	$5,814,853	14.0%	$5,000.01-$10,000.00	1,598	3.8%	$11,905,474	9.0%	$5,232,865	13.9%
2,258	5.3%	$8,604,868	6.0%	$5,148,488	12.4%	$2,500.01-$5,000.00	2,237	5.3%	$8,471,324	6.4%	$4,901,617	13.0%
23,252	54.2%	$13,514,062	9.4%	$16,399,035	39.5%	$0.01-$2,500.00	25,771	60.9%	$14,457,162	10.9%	$15,633,034	41.5%
5,748	13.4%	$0	0.0%	$2,763,779	6.6%	$0.00	3,561	8.4%	$0	0.0%	$1,739,036	4.6%
7,578	17.7%	$0	0.0%	$0	0.0%	No Claims	7,102	16.8%	$0	0.0%	$0	0.0%
42,865	**100.0%**	**$143,667,208**	**100.0%**	**$41,583,906**	**100.0%**		**42,317**	**100.0%**	**$132,093,355**	**100.0%**	**$37,704,661**	**100.0%**

Distribution of HCC Medical Claims Paid



HCC – High-Cost Claimant over $100K

HCC's by Diagnosis Grouper			
Top 10 Diagnosis Groupers	Patients	Total Paid	% Paid
Cancer	71	$8,959,329	20.4%
Cardiac Disorders	121	$4,277,273	9.7%
Renal/Urologic Disorders	84	$4,009,797	9.1%
Neurological Disorders	109	$3,529,208	8.0%
Gastrointestinal Disorders	108	$3,322,816	7.6%
Pregnancy-related Disorders	15	$2,695,592	6.1%
Infections	111	$2,534,036	5.8%
Spine-related Disorders	56	$2,346,919	5.3%
Medical/Surgical Complications	48	$2,328,428	5.3%
Mental Health	47	$2,104,755	4.8%
All Other		$7,815,677	17.8%
Overall	**----**	**$43,923,830**	**100.0%**

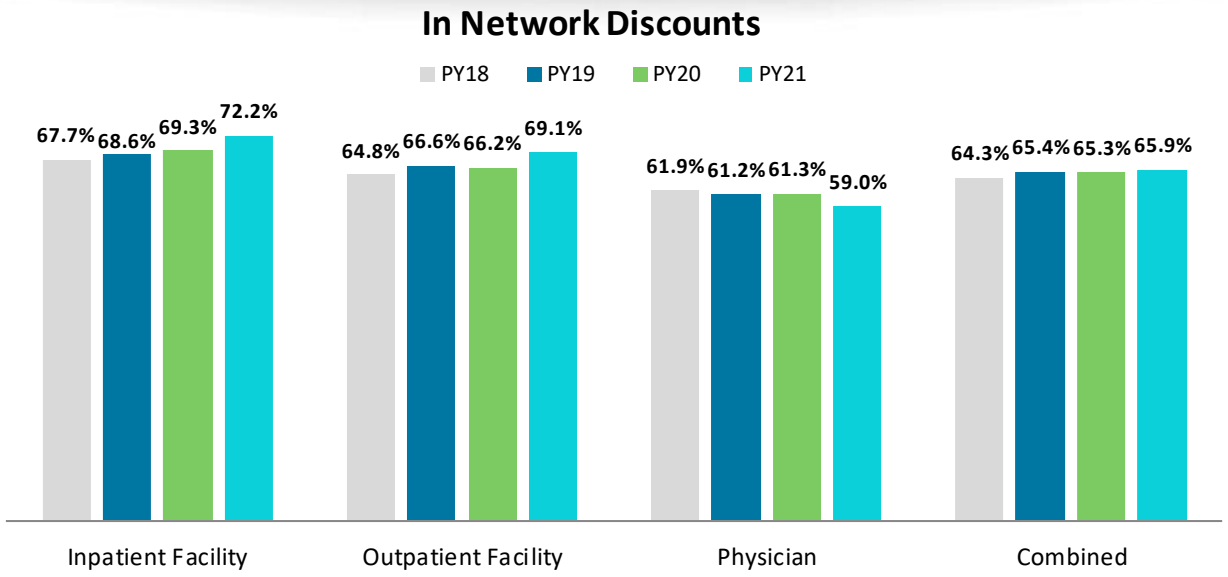
Utilization Summary (p. 1 of 2)

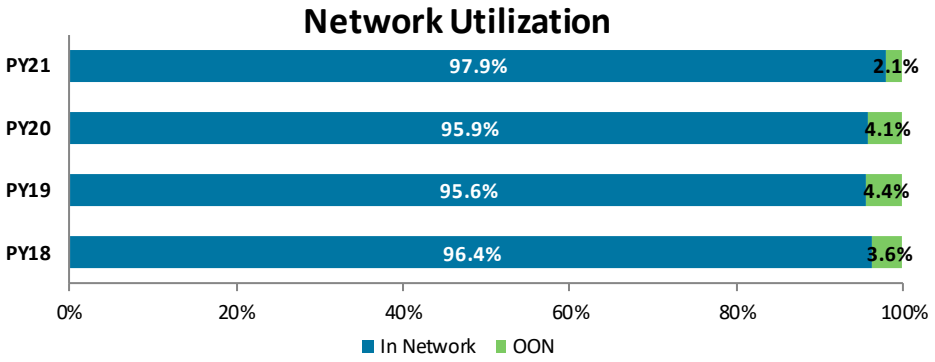
	Total				State Active				Non-State Active			
Summary	**PY19**	**PY20**	**PY21**	**Variance to Prior Year**	**PY19**	**PY20**	**PY21**	**Variance to Prior Year**	**PY19**	**PY20**	**PY21**	**Variance to Prior Year**
Inpatient Summary												
# of Admits	1,909	1,794	1,624		1,448	1,368	1,291		2	0	0	
# of Bed Days	11,963	10,484	9,984		8,556	7,803	7,887		9	0	0	
Paid Per Admit	$29,653	$25,871	$24,652	-4.7%	$25,308	$25,932	$23,488	-9.4%	$13,327	$0	$0	0.0%
Paid Per Day	$4,732	$4,427	$4,010	-9.4%	$4,283	$4,546	$3,845	-15.4%	$2,961	$0	$0	0.0%
Admits Per 1,000	44	42	38	-9.5%	39	36	35	-2.8%	286	0	0	0.0%
Days Per 1,000	277	243	236	-2.9%	228	208	215	3.4%	1,286	0	0	0.0%
Avg LOS	6.3	5.8	6.1	5.2%	5.9	5.7	6.1	7.0%	4.5	0	0	0.0%
# of Admits From ER	1,007	913	861		717	639	643		1	0	0	
Physician Office												
OV Utilization per Member	3.9	3.9	3.9	0.0%	3.6	3.7	3.7	0.0%	9.1	10.7	3.7	-65.4%
Avg Paid per OV	$75	$78	$81	3.8%	$74	$77	$82	6.5%	$99	$117	$102	-12.8%
Avg OV Paid per Member	$289	$305	$316	3.6%	$267	$284	$302	6.3%	$907	$1,253	$374	-70.2%
DX&L Utilization per Member	7.5	7.7	7.8	1.3%	6.9	7.2	7.3	1.4%	10.1	0	0	0.0%
Avg Paid per DX&L	$59	$58	$56	-3.4%	$54	$55	$53	-3.6%	$320	$0	$0	0.0%
Avg DX&L Paid per Member	$443	$448	$438	-2.2%	$375	$395	$387	-2.0%	$3,250	$0	$0	0.0%
Emergency Room												
# of Visits	6,125	6,106	4,867		5,131	5,099	4,146		1	2	2	
Visits Per Member	0.14	0.14	0.12	-14.3%	0.14	0.14	0.11	-21.4%	0.14	0.29	0.22	0.0%
Visits Per 1,000	142	142	115	-18.8%	137	136	113	-16.9%	143	293	222	0.0%
Avg Paid per Visit	$1,970	$2,152	$2,088	-3.0%	$1,933	$2,152	$2,119	-1.5%	$500	$1,803	$8,337	0.0%
Urgent Care												
# of Visits	12,048	12,124	8,962		10,108	10,976	8,007		6	2	4	
Visits Per Member	0.28	0.28	0.21	-25.0%	0.27	0.29	0.22	-24.1%	0.86	0.29	0.44	0.0%
Visits Per 1,000	279	281	212	-24.6%	269	292	218	-25.3%	857	286	444	0.0%
Avg Paid per Visit	$38	$41	$77	87.8%	$38	$40	$77	92.5%	$114	$183	$99	0.0%

Utilization Summary (p. 2 of 2)

	State Retirees				Non-State Retirees				
Summary	**PY19**	**PY20**	**PY21**	**Variance to Prior Year**	**PY19**	**PY20**	**PY21**	**Variance to Prior Year**	**HSB Peer Index**
Inpatient Summary									
# of Admits	355	320	274		104	106	59		
# of Bed Days	2,693	2,123	1,779		705	558	318		
Paid Per Admit	$47,845	$28,174	$28,774	2.1%	$28,356	$18,129	$30,974	70.9%	$16,632
Paid Per Day	$6,307	$4,247	$4,432	4.4%	$4,183	$3,444	$5,747	66.9%	$3,217
Admits Per 1,000	74	66	56	-15.2%	125	150	96	-36.0%	76
Days Per 1,000	563	438	361	-17.6%	849	789	518	-34.3%	391
Avg LOS	7.6	6.6	6.5	-1.5%	6.8	5.3	5.4	1.9%	5.2
# of Admits From ER	216	199	178		73	75	40		
Physician Office									
OV Utilization per Member	5.4	5.3	5.0	-5.7%	6.5	7.2	6.8	-5.6%	5.0
Avg Paid per OV	$84	$80	$82	2.5%	$51	$83	$59	-28.9%	$57
Avg OV Paid per Member	$450	$426	$411	-3.5%	$335	$597	$403	-32.5%	$286
DX&L Utilization per Member	10.9	10.9	10.6	-2.8%	13.5	13.2	12.5	-5.3%	10.5
Avg Paid per DX&L	$80	$76	$73	-3.9%	$73	$53	$64	20.8%	$50
Avg DX&L Paid per Member	$878	$824	$768	-6.8%	$980	$694	$803	15.7%	$522
Emergency Room									
# of Visits	794	817	627		199	188	92		
Visits Per Member	0.17	0.17	0.13	-23.5%	0.24	0.27	0.15	-44.4%	0.24
Visits Per 1,000	166	169	127	-24.9%	240	266	150	-43.6%	235
Avg Paid per Visit	$2,287	$2,257	$1,874	-17.0%	$1,681	$1,713	$2,001	16.8%	$943
Urgent Care									
# of Visits	965	990	850		173	156	101		
Visits Per Member	0.20	0.20	0.17	-15.0%	0.21	0.22	0.16	-27.3%	0.3
Visits Per 1,000	202	204	172	-15.7%	208	221	164	-25.8%	300
Avg Paid per Visit	$45	$55	$79	43.6%	$52	$37	$79	113.5%	$84

Provider Network Summary





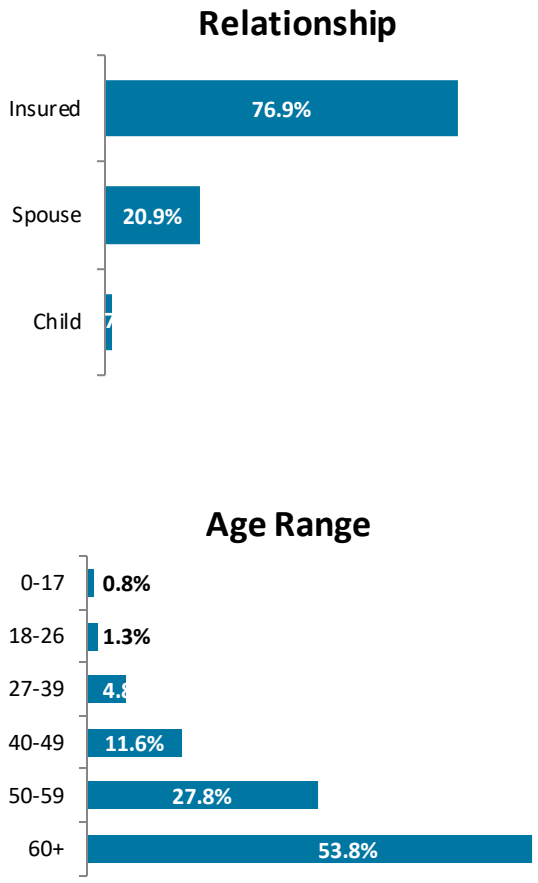
Diagnosis Grouper Summary

Diagnosis Grouper	Total Paid	% Paid	Insured	Spouse	Child	Male	Female
Cancer	$14,782,637	11.2%	$11,898,516	$2,658,021	$226,100	$5,506,485	$9,276,151
Health Status/Encounters	$11,155,547	8.4%	$6,527,340	$1,690,136	$2,938,071	$3,893,215	$7,256,557
Gastrointestinal Disorders	$10,858,263	8.2%	$7,355,682	$2,441,592	$1,060,989	$5,121,537	$5,736,423
Cardiac Disorders	$10,202,092	7.7%	$7,372,538	$2,596,904	$232,650	$6,825,856	$3,372,688
Musculoskeletal Disorders	$8,770,014	6.6%	$6,025,249	$1,929,571	$815,195	$3,137,841	$5,632,173
Neurological Disorders	$8,305,087	6.3%	$5,656,912	$1,629,911	$1,018,264	$2,898,793	$5,404,677
Infections	$8,275,124	6.3%	$5,700,608	$1,676,675	$897,841	$4,304,597	$3,969,939
Pregnancy-related Disorders	$8,065,949	6.1%	$2,945,761	$1,246,278	$3,873,910	$2,542,734	$5,353,316
Mental Health	$7,128,082	5.4%	$3,096,503	$727,872	$3,303,706	$3,217,275	$3,903,698
Renal/Urologic Disorders	$6,781,828	5.1%	$5,606,520	$874,565	$300,744	$4,709,492	$2,071,893
Spine-related Disorders	$6,510,300	4.9%	$4,760,780	$1,427,594	$321,926	$2,145,341	$4,364,959
Trauma/Accidents	$4,933,548	3.7%	$2,907,838	$994,785	$1,030,925	$2,608,828	$2,324,721
Eye/ENT Disorders	$4,182,231	3.2%	$2,672,501	$736,611	$773,119	$1,773,484	$2,408,748
Medical/Surgical Complications	$3,265,983	2.5%	$1,331,685	$1,459,833	$474,465	$1,102,066	$2,163,918
Pulmonary Disorders	$3,159,035	2.4%	$1,884,285	$494,818	$779,931	$1,598,448	$1,560,587
Gynecological/Breast Disorders	$2,833,801	2.1%	$1,961,085	$481,296	$391,421	$38,537	$2,795,264
Endocrine/Metabolic Disorders	$2,448,296	1.9%	$1,900,009	$349,392	$198,894	$987,136	$1,461,160
Non-malignant Neoplasm	$1,830,153	1.4%	$1,437,090	$242,556	$150,508	$709,276	$1,120,877
Diabetes	$1,576,715	1.2%	$949,553	$415,100	$212,062	$790,652	$786,063
Congenital/Chromosomal Anomalies	$1,548,228	1.2%	$169,988	$52,909	$1,325,331	$432,085	$942,066
Miscellaneous	$1,361,256	1.0%	$780,344	$303,658	$277,254	$630,320	$730,844
Dermatological Disorders	$1,088,658	0.8%	$699,875	$183,331	$205,452	$568,427	$520,231
Vascular Disorders	$1,041,635	0.8%	$678,176	$352,568	$10,892	$604,217	$437,418
Abnormal Lab/Radiology	$700,922	0.5%	$525,675	$126,595	$48,652	$279,455	$421,347
Hematological Disorders	$680,347	0.5%	$524,401	$95,484	$60,461	$282,144	$398,203
Medication Related Conditions	$201,055	0.2%	$98,323	$17,344	$85,388	$69,327	$131,727
Cholesterol Disorders	$158,873	0.1%	$122,310	$32,647	$3,917	$67,533	$91,340
Dental Conditions	$125,682	0.1%	$37,030	$13,323	$75,329	$69,705	$55,977
Allergic Reaction	$113,076	0.1%	$84,568	$10,293	$18,215	$72,263	$40,813
External Hazard Exposure	$8,939	0.0%	$2,494	$2,197	$4,249	$3,224	$5,715
Total	**$132,093,355**	**100.0%**	**$85,713,636**	**$25,263,858**	**$21,115,861**	**$56,990,291**	**$74,739,494**

Diagnosis Grouper – Cancer

Diagnosis Sub-Grouper	Patients	Claims	Total Paid	% Paid
Cancer Therapies	127	946	$3,918,077	26.5%
Breast Cancer	270	3,073	$2,305,600	15.6%
Cancers, Other	518	2,236	$1,857,713	12.6%
Secondary Cancers	94	546	$1,306,259	8.8%
Prostate Cancer	146	1,196	$856,821	5.8%
Brain Cancer	23	395	$839,053	5.7%
Cervical/Uterine Cancer	54	579	$511,582	3.5%
Lung Cancer	29	389	$505,791	3.4%
Bladder Cancer	25	409	$490,326	3.3%
Colon Cancer	58	613	$476,131	3.2%
Melanoma	71	390	$442,919	3.0%
Ovarian Cancer	31	321	$400,359	2.7%
Myeloma	17	274	$278,937	1.9%
Carcinoma in Situ	141	410	$167,889	1.1%
Lymphomas	59	544	$166,133	1.1%
Leukemias	45	465	$103,342	0.7%
Thyroid Cancer	91	411	$73,663	0.5%
Kidney Cancer	26	95	$44,404	0.3%
Pancreatic Cancer	11	81	$37,639	0.3%
Overall	----	----	**$14,782,637**	**100.0%**

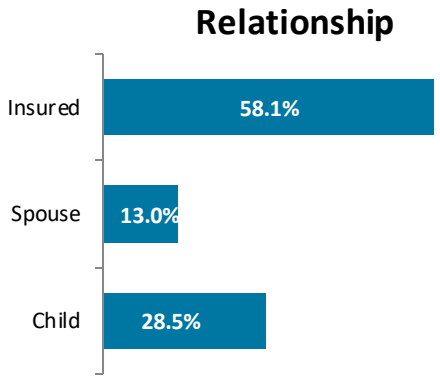
*Patient and claim counts are unique only within the category

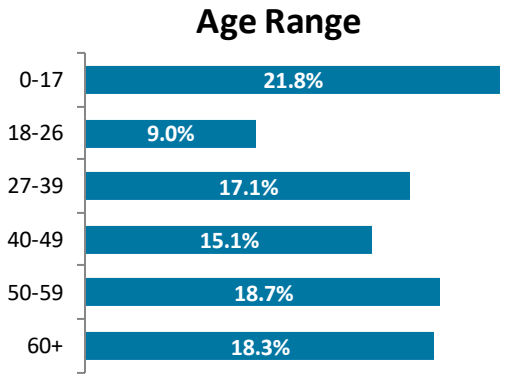


Diagnosis Grouper – Health Status / Encounters

Diagnosis Sub-Grouper	Patients	Claims	Total Paid	% Paid
Screenings	10,711	20,869	$3,262,433	29.2%
Exams	14,296	28,217	$2,785,940	25.0%
Prophylactic Measures	11,502	18,386	$1,938,499	17.4%
Encounters - Infants/Children	4,823	7,572	$1,080,849	9.7%
Prosthetics/Devices/Implants	560	1,469	$487,934	4.4%
Aftercare	533	989	$330,172	3.0%
History of Condition	316	563	$318,263	2.9%
Personal History of Condition	860	1,374	$298,499	2.7%
Encounter - Procedure	150	173	$174,591	1.6%
Follow-Up Encounters	43	183	$152,482	1.4%
Family History of Condition	254	359	$119,387	1.1%
Encounter - Transplant Related	53	465	$82,316	0.7%
Counseling	401	798	$49,934	0.4%
Lifestyle/Situational Issues	351	491	$28,903	0.3%
Replacements	94	351	$27,393	0.2%
Donors	9	12	$9,149	0.1%
Health Status, Other	153	199	$6,777	0.1%
Miscellaneous Examinations	60	99	$1,958	0.0%
Coronary Artery Disease	5	5	$68	0.0%
Overall	**----**	**----**	**$11,155,547**	**100.0%**

*Patient and claim counts are unique only within the category

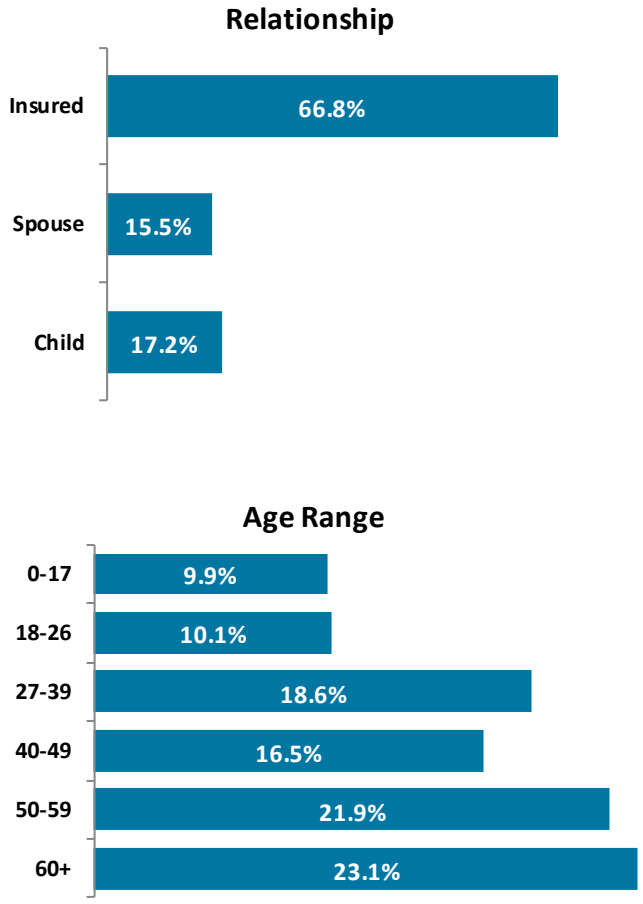




Diagnosis Grouper – Gastrointestinal Disorders

Diagnosis Sub-Grouper	Patients	Claims	Total Paid	% Paid
Hepatic Cirrhosis	56	217	$1,573,639	14.5%
Abdominal Disorders	2,646	6,327	$1,420,009	13.1%
GI Disorders, Other	1,658	3,708	$1,331,505	12.3%
Upper GI Disorders	1,347	3,092	$1,043,467	9.6%
Gallbladder and Biliary Disease	287	923	$960,801	8.8%
Appendicitis	63	322	$938,074	8.6%
Hernias	352	943	$927,082	8.5%
GI Symptoms	1,527	3,068	$735,308	6.8%
Inflammatory Bowel Disease	130	667	$669,480	6.2%
Ostomies	49	326	$336,386	3.1%
Pancreatic Disorders	60	291	$291,020	2.7%
Liver Diseases	426	787	$232,871	2.1%
Diverticulitis	100	231	$213,760	2.0%
Peptic Ulcer/Related Disorders	54	108	$95,148	0.9%
Hemorrhoids	261	466	$76,180	0.7%
Esophageal Varices	6	26	$13,535	0.1%
	----	----	$10,858,263	100.0%

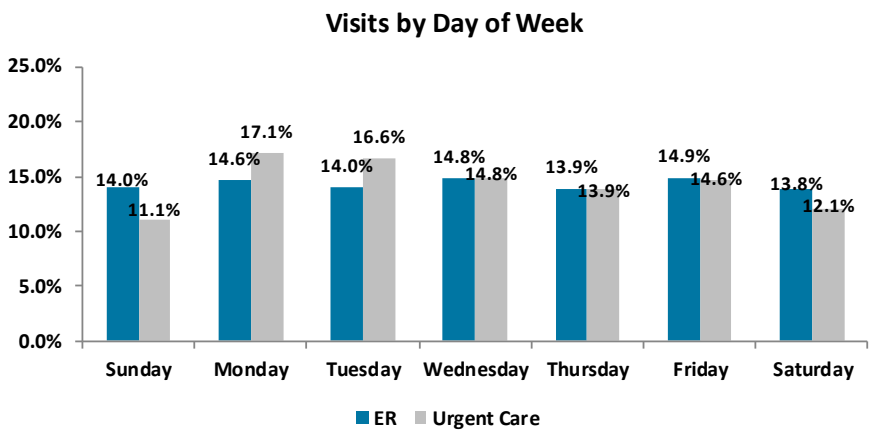
*Patient and claim counts are unique only within the category

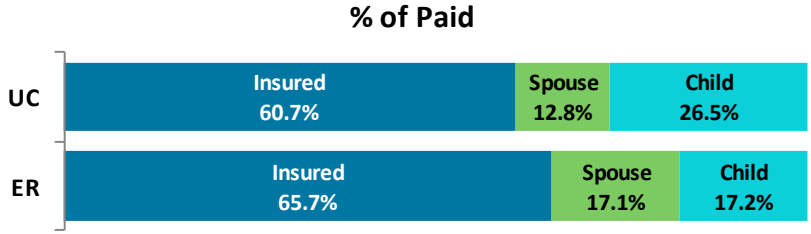


Emergency Room / Urgent Care Summary

	PY20		PY21		HSB Peer Index	
ER/Urgent Care	ER	Urgent Care	ER	Urgent Care	ER	Urgent Care
Number of Visits	6,106	12,124	4,867	8,962		
Visits Per Member	0.14	0.28	0.12	0.21	0.17	0.24
Visits/1000 Members	142	281	115	212	174	242
Avg Paid Per Visit	$2,152	$41	$2,088	$77	$1,684	$74
% with OV*	83.9%	79.8%	83.4%	79.9%		
% Avoidable	14.6%	38.7%	10.3%	24.7%		
Total Member Paid	**$6,390,217**	**$1,658,710**	**$4,910,210**	**$924,735**		
Total Plan Paid	**$13,142,270**	**$498,508**	**$10,161,696**	**$687,836**		

*looks back 12 months



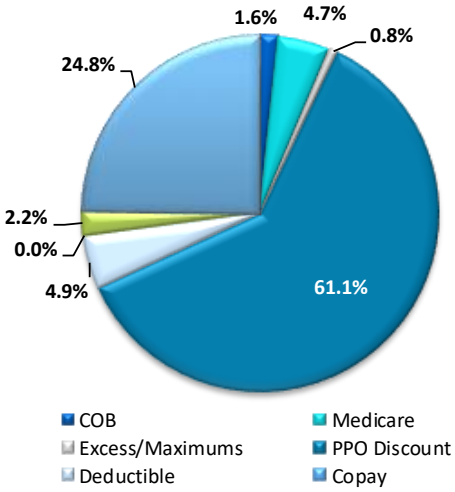


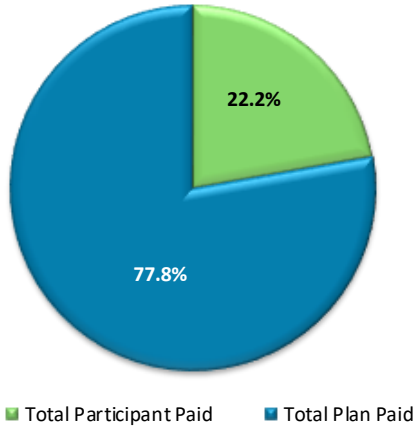
ER / UC Visits by Relationship						
Relationship	ER	Per 1,000	Urgent Care	Per 1,000	Total	Per 1,000
Insured	2,911	125	5,568	4,380	8,479	364
Spouse	786	144	1,083	863	1,869	341
Child	1,170	87	2,311	1,655	3,481	258
Total	**4,867**	**115**	**8,962**	**212**	**13,829**	**327**

Savings Summary – Medical Claims

Description	Dollars	PPPM	% of Eligible
Eligible Charges	$531,751,934	$1,900	100.0%
COB	$8,539,811	$31	1.6%
Medicare	$25,010,528	$89	4.7%
Excess/Maximums	$4,311,837	$15	0.8%
PPO Discount	$325,939,338	$1,165	61.3%
Deductible	$25,952,029	$93	4.9%
Copay	$208,775	$1	0.0%
Coinsurance	$11,543,857	$41	2.2%
Total Participant Paid	**$37,704,661**	**$135**	**7.1%**
Total Plan Paid	**$132,093,355**	**$472**	**24.8%**

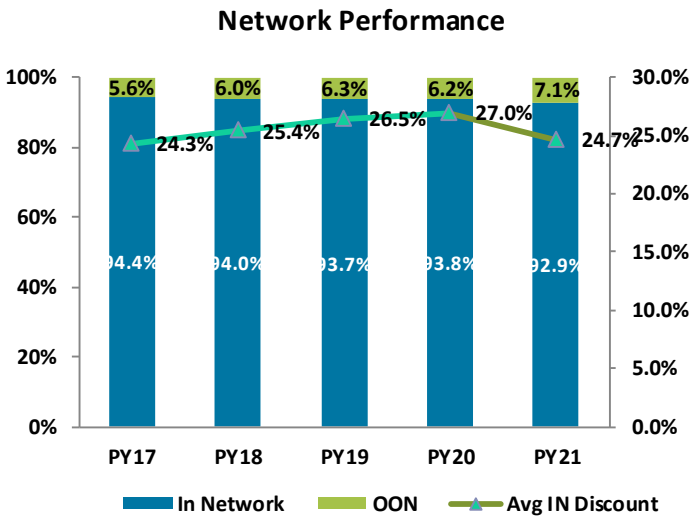
Total Participant Paid - PY20	**$146**
Total Plan Paid - PY20	**$506**



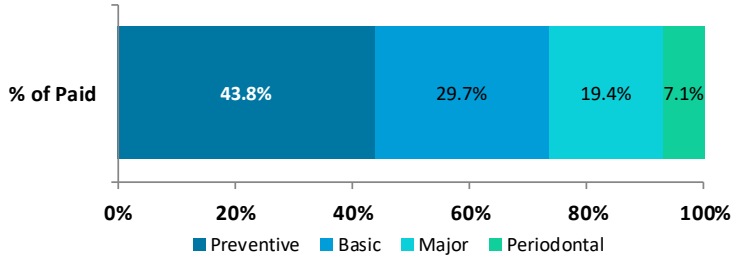


Dental Claims Analysis

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	7,312	10.7%	107,260	30.2%	$11,184,518	45.0%	$6,831,692	60.4%
$750.01-$1,000.00	2,955	4.3%	32,038	9.0%	$2,628,114	10.6%	$1,264,034	11.2%
$500.01-$750.00	5,338	7.8%	51,785	14.6%	$3,330,471	13.4%	$1,278,141	11.3%
$250.01-$500.00	15,561	22.8%	110,738	31.2%	$5,619,770	22.6%	$1,218,418	10.8%
$0.01-$250.00	12,334	18.1%	52,304	14.7%	$2,108,407	8.5%	$701,526	6.3%
$0.00	374	0.6%	874	0.3%	$0	0.0%	$18,868	0.2%
No Claims	24,231	35.6%	0	0.0%	$0	0.0%	$0	0.0%
Total	**68,106**	**100.0%**	**354,999**	**100.0%**	**$24,871,282**	**100.0%**	**$11,312,677**	**100.0%**



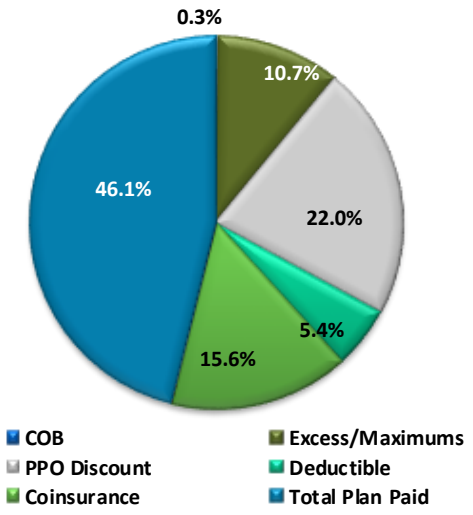
Claim Category	Total Paid	% of Paid
Preventive	$10,889,773	43.8%
Basic	$7,389,245	29.7%
Major	$4,814,922	19.4%
Periodontal	$1,777,341	7.1%
Total	**$24,871,282**	**100.0%**

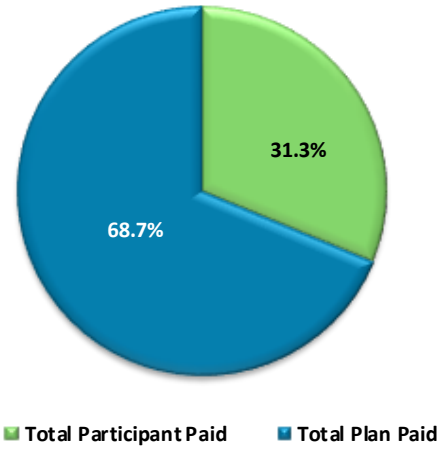


Savings Summary – Dental Claims

Description	Dollars	PPPM	% of Eligible
Eligible Charges	$53,762,663	$110	100.0%
COB	$143,864	$0	0.3%
Excess/Maximums	$5,742,999	$12	10.7%
PPO Discount	$11,852,163	$24	22.0%
Deductible	$2,909,831	$6	5.4%
Coinsurance	$8,402,847	$17	15.6%
Total Participant Paid	**$11,312,677**	**$23**	**21.0%**
Total Plan Paid	**$24,871,282**	**$51**	**46.3%**

Total Participant Paid - PY20	**$22**
Total Plan Paid - PY20	**$46**





Quality Metrics

Condition	Metric	#Members in Group	#Meeting Metric	#Not Meeting Metric	% Meeting Metric
Asthma	Asthma and a routine provider visit in the last 12 months	1,419	1,372	47	94.5%
	<2 asthma related ER Visits in the last 6 months	1,419	1,418	1	99.9%
	No asthma related admit in last 12 months	1,419	1,418	1	99.9%
Chronic Obstructive Pulmonary Disease	No exacerbations in last 12 months	281	274	7	97.5%
	Members with COPD who had an annual spirometry test	281	42	239	14.9%
Congestive Heart Failure	No re-admit to hosp with Heart Failure diag w/in 30 days of HF inpatient stay discharge	8	8	0	100.0%
	No ER Visit for Heart Failure in last 90 days	249	243	6	97.6%
	Follow-up OV within 4 weeks of discharge from HF admission	8	8	0	100.0%
Diabetes	Annual office visit	2,011	1,924	87	95.7%
	Annual dilated eye exam	2,011	896	1,115	44.6%
	Annual foot exam	2,011	849	1,162	42.2%
	Annual HbA1c test done	2,011	1,640	371	81.6%
	Diabetes Annual lipid profile	2,011	1,557	454	77.4%
	Annual microalbumin urine screen	2,011	1,400	611	69.6%
Hyperlipidemia	Hyperlipidemia Annual lipid profile	5,133	4,146	987	80.8%
Hypertension	Annual lipid profile	5,541	3,806	1,735	68.7%
	Annual serum creatinine test	5,417	4,331	1,086	80.0%
Wellness	Well Child Visit - 15 months	363	335	28	92.3%
	Routine office visit in last 6 months	41,783	24,518	17,265	58.7%
	Age 45 to 75 years with colorectal cancer screening	15,838	3,521	12,317	22.2%
	Women age 25-65 with recommended cervical cancer screening	13,217	9,309	3,908	70.4%
	Males age greater than 49 with PSA test in last 24 months	5,991	2,783	3,208	46.5%
	Routine exam in last 24 months	41,783	35,017	6,766	83.8%
	Women age 40 to 75 with a screening mammogram last 24 months	10,351	5,946	4,405	57.4%

All member counts represent members active at the end of the report period.
Quality Metrics are always calculated on an incurred basis.

Chronic Conditions Prevalence

A member is identified as having a chronic condition if any one of the following three conditions is met within a 24 month service date period:

- **Two outpatient claims for the Dx on separate days of service**
- **One ER Visit with the Dx as primary**
- **One IP admission with the Dx as the admitting**

*For Diabetes only, one or more Rx claims can also be used to identify the condition.

Chronic Condition	# With Condition	% of Members	Members per 1000	PMPY
Affective Psychosis	250	0.60%	5.91	$9,642
Asthma	1,596	3.82%	37.72	$10,228
Atrial Fibrillation	376	0.90%	8.89	$45,275
Blood Disorders	2,123	5.08%	50.17	$24,877
CAD	804	1.92%	19.00	$23,033
COPD	280	0.67%	6.62	$29,224
Cancer	1,497	3.58%	35.38	$20,459
Chronic Pain	731	1.75%	17.27	$24,458
Congestive Heart Failure	248	0.59%	5.86	$49,750
Demyelinating Diseases	93	0.22%	2.20	$40,153
Depression	2,435	5.82%	57.54	$13,115
Diabetes	2,196	5.25%	51.89	$14,342
ESRD	54	0.13%	1.28	$138,539
Eating Disorders	129	0.31%	3.05	$27,848
HIV/AIDS	47	0.11%	1.11	$41,856
Hyperlipidemia	5,361	12.82%	126.69	$9,197
Hypertension	5,558	13.29%	131.34	$12,325
Immune Disorders	124	0.30%	2.93	$81,295
Inflammatory Bowel Disease	142	0.34%	3.36	$25,026
Liver Diseases	691	1.65%	16.33	$23,299
Morbid Obesity	976	2.33%	23.06	$14,301
Osteoarthritis	1,364	3.26%	32.23	$16,000
Peripheral Vascular Disease	208	0.50%	4.92	$25,813
Rheumatoid Arthritis	176	0.42%	4.16	$23,444

Data Includes Medical and Pharmacy
Based on 24 months incurred dates

Methodology

- Average member counts were weighted by the number of months each member had on the plan.
- Claims were pulled based upon the date paid.
- Claims were categorized based upon four groups:
  - Inpatient Facility
  - Outpatient Facility
  - Physician
  - Other (Other includes any medical reimbursements or durable medical equipment.)
- Inpatient analysis was done by identifying facility claims where a room and board charge was submitted and paid. Claims were then rolled up for the entire admission and categorized by the diagnosis code that held the highest paid amount. (Hospice and skilled nursing facility claims were excluded)
- Outpatient claims were flagged by an in-or-outpatient indicator being present on the claim that identified it as taking place at an outpatient facility.
- Physician claims were identified when the vendor type indicator was flagged as a professional charge.
  - These claims were in some cases segregated further to differentiate primary care physicians and specialists.
  - Office visits were identified by the presence of evaluation and management or consultation codes.
- Emergency room and urgent care episodes should be considered subcategories of physician and outpatient facility.
  - Emergency Room visits are identified by facility claims with a revenue code of 450-455, 457-459.
  - Urgent Care visits are identified by facility claims with a revenue code of 456 or physician claims with a place of service of “Urgent Care”.
  - Outpatient claims (including facility and physician) are then rolled up for the day of service and summarized as an ER/UC visit.
  - If a member has an emergency room visit on the same day as an urgent care visit, all claims are grouped into one episode and counted as an emergency room visit.
  - If a member was admitted into the hospital through the ER, the member will not show an ER visit. ER claims are bundled with the inpatient stay.

Public Employees' Benefits Program - RX Costs
PY 2021 - Quarter Ending June 30, 2021
Express Scripts

Membership Summary	4Q FY2021	4Q FY2020	Difference	% Change
			Membership Summary	
Member Count (Membership)	42,243	42,860	(617)	-1.4%
Utilizing Member Count (Patients)	30,005	30,900	(895)	-2.9%
Percent Utilizing (Utilization)	71.0%	72.1%	(0.01)	-1.5%

Claim Summary			Claims Summary	
Net Claims (Total Rx's)	526,191	528,797	(2,606)	-0.5%
Claims per Elig Member per Month (Claims PMPM)	1.04	1.03	0.01	1.0%
Total Claims for Generic (Generic Rx)	452,649	460,391	(7,742.00)	-1.7%
Total Claims for Brand (Brand Rx)	73,542	68,406	5,136.00	7.5%
Total Claims for Brand w/Gen Equiv (Multisource Brand Claims)	7,710	8,527	(817.00)	-9.6%
Total Non-Specialty Claims	519,654	522,551	(2,897.00)	-0.6%
Total Specialty Claims	6,537	6,246	291.00	4.7%
Generic % of Total Claims (GFR)	**86.0%**	**87.1%**	(0.01)	-1.2%
Generic Effective Rate (GCR)	**98.3%**	**98.2%**	0.00	0.1%
Mail Order Claims	118,349	98,221	20,128.00	20.5%
Mail Penetration Rate*	25.4%	21.0%	0.04	4.4%

Claims Cost Summary			Claims Cost Summary	
Total Prescription Cost (Total Gross Cost)	$53,616,255.00	$50,893,137.00	$2,723,118.00	5.4%
Total Generic Gross Cost	$8,699,910.00	$8,363,981.00	$335,929.00	4.0%
Total Brand Gross Cost	$44,916,345.00	$42,529,155.00	$2,387,190.00	5.6%
Total MSB Gross Cost	$2,113,836.00	$1,738,164.00	$375,672.00	21.6%
Total Ingredient Cost	$52,985,441.00	$50,551,936.00	$2,433,505.00	4.8%
Total Dispensing Fee	$605,635.00	$320,983.00	$284,652.00	88.7%
Total Other (e.g. tax)	$25,178.00	$20,217.00	$4,961.00	24.5%
Avg Total Cost per Claim (Gross Cost/Rx)	**$101.90**	**$96.24**	$5.65	5.9%
Avg Total Cost for Generic (Gross Cost/Generic Rx)	$19.22	$18.17	$1.05	5.8%
Avg Total Cost for Brand (Gross Cost/Brand Rx)	$610.76	$621.72	($10.96)	-1.8%
Avg Total Cost for MSB (MSB Gross Cost/MSB ARx)	$274.17	$203.84	$70.33	34.5%

Member Cost Summary			Member Cost Summary	
Total Member Cost	**$12,987,971.00**	**$12,887,094.00**	$100,877.00	0.8%
Total Copay	$9,666,995.00	$7,229,879.00	$2,437,116.00	33.7%
Total Deductible	$3,320,986.00	$5,657,215.00	($2,336,229.00)	-41.3%
Avg Copay per Claim (Copay/Rx)	$18.37	$13.67	$4.70	34.4%
Avg Participant Share per Claim (Copay+Deductible/RX)	**$24.68**	**$24.37**	**$0.31**	**1.3%**
Avg Copay for Generic (Copay/Generic Rx)	$8.47	$8.48	($0.01)	-0.1%
Avg Copay for Brand (Copay/Brand Rx)	$124.48	$131.29	($6.81)	-5.2%
Avg Copay for Brand w/ Generic Equiv (Copay/Multisource Rx)	$71.08	$65.93	$5.15	7.8%
Net PMPM (Participant Cost PMPM)	**$25.62**	**$25.06**	$0.56	2.3%
Copay % of Total Prescription Cost (Member Cost Share %)	24.2%	25.3%	-1.1%	-4.3%

Plan Cost Summary			Plan Cost Summary	
Total Plan Cost (Plan Cost)	**$40,628,274.00**	**$38,006,042.00**	**$2,622,232.00**	**6.9%**
Total Non-Specialty Cost (Non-Specialty Plan Cost)	$15,871,297.00	$14,212,154.00	$1,659,143.00	11.7%
Total Specialty Drug Cost (Specialty Plan Cost)	$24,756,977.00	$23,793,889.00	$963,088.00	4.0%
Avg Plan Cost per Claim (Plan Cost/Rx)	**$77.21**	**$71.87**	$5.34	7.4%
Avg Plan Cost for Generic (Plan Cost/Generic Rx)	$10.75	$9.68	$1.07	11.1%
Avg Plan Cost for Brand (Plan Cost/Brand Rx)	$486.25	$490.43	($4.18)	-0.9%
Avg Plan Cost for MSB (MSB Plan Cost/MSB ARx)	$203.09	$137.91	$65.18	47.3%
Net PMPM (Plan Cost PMPM)	**$80.15**	**$73.90**	**$6.25**	**8.5%**
PMPM for Specialty Only (Specialty PMPM)	$48.84	$46.26	$2.58	5.6%
PMPM without Specialty (Non-Specialty PMPM)	$31.31	$27.63	$4.02	17.3%
Specialty % of Plan Cost	60.9%	62.61%	($0.02)	-2.7%
Rebates (Q1-Q4 FY2021 actual)	$9,438,730.37	$9,876,814.94	($438,084.57)	-4.4%
Net PMPM (Plan Cost PMPM factoring Rebates)	**$61.53**	**$54.69**	**$6.84**	**12.5%**
PMPM for Specialty Only (Specialty PMPM)	$41.42	$40.11	$1.31	3.3%
PMPM without Specialty (Non-Specialty PMPM)	$18.30	$15.10	$3.20	21.2%

Appendix B

Index of Tables
HealthSCOPE – EPO Utilization Review for PEBP
July 1, 2020 – June 30, 2021

HSB DATASCOPE™

Nevada Public Employees' Benefits Program
EPO Plan

July 2020 – June 2021

HealthSCOPE BENEFITS

Overview

- Total Medical Spend for PY21 was $53,113,944 with a plan cost per employee per year of $11,422. This is an increase of 8.9% when compared to PY20.
  - IP Cost per Admit is $34,055 which is 44.3% higher than PY20.
  - ER Cost per Visit is $2,452 which is 2.8% lower than PY20.
- Employees shared in 6.5% of the medical cost.
- Inpatient facility costs were 20.4% of the plan spend.
- 69.0% of the Average Membership had paid Medical claims less than $2,500, with 9.6% of those having no claims paid at all during the reporting period.
- 61 members exceeded the $100k high-cost threshold during the reporting period, which accounted for 29.6% of the plan spend. The highest diagnosis category was Cancer, accounting for 20.0% of the high-cost claimant dollars.
- Total spending with in-network providers was 99.9%. The average In Network discount was 54.2%, which is 5.4% lower than the PY20 average discount of 57.3%.

Paid Claims by Age Group

Paid Claims by Age Group																		
	PY20						PY21						% 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	$ 2,065,664	$1,523	$ 43,610	$32	$ 2,109,274	$1,556	$ 1,233,882	$ 1,168	$ 26,292	$ 25	$ 1,260,174	$ 1,193	-40.3%	-23.3%
1	$ 322,038	$280	$ 10,151	$9	$ 332,189	$288	$ 191,627	$ 158	$ 2,156	$ 2	$ 193,783	$ 160	-41.7%	-44.5%
2 - 4	$ 499,290	$143	$ 21,093	$6	$ 520,383	$150	$ 324,202	$ 96	$ 13,696	$ 4	$ 337,898	$ 100	-35.1%	-33.4%
5 - 9	$ 671,109	$108	$ 118,472	$19	$ 789,581	$128	$ 628,220	$ 105	$ 79,791	$ 13	$ 708,011	$ 118	-10.3%	-7.4%
10 - 14	$ 1,496,169	$195	$ 261,037	$34	$ 1,757,206	$228	$ 1,016,206	$ 138	$ 225,605	$ 31	$ 1,241,811	$ 169	-29.3%	-26.1%
15 - 19	$ 2,508,550	$293	$ 365,029	$43	$ 2,873,579	$336	$ 2,474,968	$ 293	$ 462,365	$ 55	$ 2,937,333	$ 347	2.2%	3.3%
20 - 24	$ 1,896,090	$253	$ 649,773	$87	$ 2,545,863	$340	$ 1,757,900	$ 221	$ 600,531	$ 75	$ 2,358,431	$ 296	-7.4%	-12.9%
25 - 29	$ 1,399,255	$312	$ 448,440	$100	$ 1,847,695	$412	$ 1,263,529	$ 300	$ 1,075,802	$ 255	$ 2,339,331	$ 555	26.6%	34.8%
30 - 34	$ 2,810,656	$487	$ 384,069	$67	$ 3,194,725	$553	$ 3,536,048	$ 639	$ 841,315	$ 152	$ 4,377,363	$ 791	37.0%	43.1%
35 - 39	$ 3,816,160	$559	$ 872,086	$128	$ 4,688,246	$687	$ 3,394,187	$ 494	$ 833,528	$ 121	$ 4,227,715	$ 615	-9.8%	-10.5%
40 - 44	$ 3,025,413	$449	$ 1,471,349	$218	$ 4,496,762	$667	$ 3,114,848	$ 450	$ 1,634,738	$ 236	$ 4,749,586	$ 686	5.6%	2.8%
45 - 49	$ 4,355,742	$514	$ 1,557,551	$184	$ 5,913,293	$698	$ 4,216,481	$ 546	$ 1,241,221	$ 161	$ 5,457,702	$ 707	-7.7%	1.3%
50 - 54	$ 5,252,965	$547	$ 2,521,204	$263	$ 7,774,169	$810	$ 5,958,498	$ 609	$ 2,657,366	$ 271	$ 8,615,864	$ 880	10.8%	8.6%
55 - 59	$ 7,388,691	$691	$ 3,451,241	$323	$ 10,839,932	$1,014	$ 9,635,953	$ 973	$ 2,534,338	$ 256	$ 12,170,291	$ 1,229	12.3%	21.2%
60 - 64	$ 9,642,859	$815	$ 4,337,100	$367	$ 13,979,959	$1,182	$ 10,301,328	$ 911	$ 4,072,301	$ 360	$ 14,373,629	$ 1,272	2.8%	7.6%
65+	$ 3,143,235	$644	$ 1,712,534	$351	$ 4,855,769	$994	$ 4,066,068	$ 826	$ 1,840,142	$ 374	$ 5,906,210	$ 1,200	21.6%	20.8%
Total	**$50,293,887**	**$478**	**$18,224,739**	**$173**	**$68,518,625**	**$651**	**$ 53,113,944**	**$ 518**	**$ 18,141,186**	**$ 177**	**$ 71,255,131**	**$ 694**	**4.0%**	**6.7%**

Financial Summary (p. 1 of 2)

	Total				State Active				Non-State Active			
Summary	**PY19**	**PY20**	**PY21**	**Variance to Prior Year**	**PY19**	**PY20**	**PY21**	**Variance to Prior Year**	**PY19**	**PY20**	**PY21**	**Variance to Prior Year**
Enrollment												
Avg # Employees	4,653	4,794	4,650	-3.0%	3,878	4,054	3,949	-2.6%	4	4	4	0.0%
Avg # Members	8,488	8,768	8,553	-2.5%	7,445	7,768	7,602	-2.1%	5	5	4	-13.4%
Ratio	1.8	1.8	1.8	0.5%	1.9	1.9	1.9	0.5%	1.3	1.3	1.1	-13.6%
Financial Summary												
Gross Cost	$45,094,672	$55,523,229	$56,804,046	2.3%	$35,711,039	$45,961,999	$44,805,657	-2.5%	$45,961	$70,916	$44,403	-37.4%
Client Paid	$40,764,731	$50,293,887	$53,113,944	5.6%	$32,097,283	$41,579,805	$41,757,107	0.4%	$40,931	$65,329	$41,594	-36.3%
Employee Paid	$4,329,941	$5,229,342	$3,690,102	-29.4%	$3,613,757	$4,382,194	$3,048,550	-30.4%	$5,030	$5,587	$2,808	-49.7%
Client Paid-PEPY	$8,745	$10,492	$11,422	8.9%	$8,277	$10,256	$10,575	3.1%	$10,233	$16,332	$10,399	-36.3%
Client Paid-PMPY	$4,794	$5,736	$6,210	8.3%	$4,311	$5,352	$5,493	2.6%	$8,186	$13,066	$9,599	-26.5%
Client Paid-PEPM	$729	$874	$952	8.9%	$690	$855	$881	3.0%	$853	$1,361	$867	-36.3%
Client Paid-PMPM	$400	$478	$518	8.4%	$359	$446	$458	2.7%	$682	$1,089	$800	-26.5%
High Cost Claimants (HCC's) > $100k												
# of HCC's	39	51	61	19.6%	27	40	49	22.5%	0	0	0	0.0%
HCC's / 1,000	4.6	5.8	7.1	22.5%	3.6	5.2	6.5	25.2%	0.0	0.0	0.0	0.0%
Avg HCC Paid	$274,612	$202,775	$257,989	27.2%	$246,453	$179,535	$212,968	18.6%	$0	$0	$0	0.0%
HCC's % of Plan Paid	26.3%	20.6%	29.6%	43.7%	20.7%	17.3%	25.0%	44.5%	0.0%	0.0%	0.0%	0.0%
Cost Distribution by Claim Type (PMPY)												
Facility Inpatient	$1,218	$1,169	$1,457	24.6%	$944	$1,036	$1,091	5.3%	$3,360	$2,928	$0	-100.0%
Facility Outpatient	$1,506	$1,832	$1,951	6.5%	$1,395	$1,693	$1,779	5.1%	$1,369	$4,817	$4,611	-4.3%
Physician	$1,923	$2,541	$2,608	2.6%	$1,844	$2,461	$2,464	0.1%	$3,030	$5,153	$4,469	-13.3%
Other	$148	$194	$194	0.0%	$127	$163	$159	-2.5%	$427	$168	$518	208.3%
Total	$4,794	$5,736	$6,210	8.3%	$4,311	$5,352	$5,493	2.6%	$8,186	$13,066	$9,599	-26.5%

Financial Summary (p. 2 of 2)

	State Retirees				Non-State Retirees				
Summary	**PY19**	**PY20**	**PY21**	**Variance to Prior Year**	**PY19**	**PY20**	**PY21**	**Variance to Prior Year**	**HSB Peer Index**
Enrollment									
Avg # Employees	599	588	576	-2.1%	181	148	122	-17.2%	
Avg # Members	826	807	789	-2.2%	227	188	158	-15.9%	
Ratio	1.4	1.4	1.4	0.0%	1.3	1.3	1.3	1.6%	1.6
Financial Summary									
Gross Cost	$7,418,807	$8,514,643	$7,966,596	-6.4%	$1,918,864	$975,672	$3,987,390	308.7%	
Client Paid	$6,863,148	$7,803,114	$7,426,217	-4.8%	$1,763,370	$845,639	$3,889,026	359.9%	
Employee Paid	$555,659	$711,529	$540,380	-24.1%	$155,495	$130,033	$98,364	-24.4%	
Client Paid-PEPY	$11,461	$13,272	$12,904	-2.8%	$9,769	$5,730	$31,812	455.2%	$6,297
Client Paid-PMPY	$8,313	$9,674	$9,413	-2.7%	$7,777	$4,508	$24,653	446.9%	$3,879
Client Paid-PEPM	$955	$1,106	$1,075	-2.8%	$814	$477	$2,651	455.8%	$525
Client Paid-PMPM	$693	$806	$784	-2.7%	$648	$376	$2,054	446.3%	$323
High Cost Claimants (HCC's) > $100k									
# of HCC's	9	18	18	0.0%	3	0	2	0.0%	
HCC's / 1,000	10.9	22.3	22.8	2.2%	13.2	0.0	12.7	0.0%	
Avg HCC Paid	$339,256	$175,561	$113,454	-35.4%	$334,114	$0	$1,629,851	0.0%	
HCC's % of Plan Paid	44.5%	40.5%	27.5%	-32.1%	56.8%	0.0%	83.8%	0.0%	
Cost Distribution by Claim Type (PMPY)									
Facility Inpatient	$3,028	$2,529	$1,454	-42.5%	$3,554	$787	$19,176	2336.6%	$1,149
Facility Outpatient	$2,243	$3,276	$3,575	9.1%	$2,477	$1,314	$2,010	53.0%	$1,333
Physician	$2,713	$3,385	$3,897	15.1%	$1,587	$2,165	$3,054	41.1%	$1,301
Other	$328	$484	$487	0.6%	$158	$242	$413	70.7%	$96
Total	$8,313	$9,674	$9,413	-2.7%	$7,777	$4,508	$24,653	446.9%	$3,879

Paid Claims by Claim Type – State Participants

Net Paid Claims - Total State Participants	PY20				PY21				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical									
Inpatient	$ 10,464,957	$ 2,021,740	$ 396,512	$ 12,883,209	$ 10,455,682	$ 1,271,089	$ 217,769	$ 11,944,540	-7.3%
Outpatient	$ 31,114,848	$ 4,575,830	$ 809,032	$ 36,499,709	$ 31,301,425	$ 5,415,883	$ 521,476	$ 37,238,784	2.0%
Total - Medical	**$ 41,579,805**	**$ 6,597,569**	**$ 1,205,544**	**$ 49,382,919**	**$ 41,757,107**	**$ 6,686,972**	**$ 739,245**	**$ 49,183,324**	**-0.4%**

Net Paid Claims - Per Participant per Month	PY20				PY21				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical	$ 855	$ 1,092	$ 1,190	$ 887	$ 881	$ 1,140	$ 716	$ 906	2.2%

Paid Claims by Claim Type – Non-State Participants

Net Paid Claims - Total Non-State Participants	PY20				PY21				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical									
Inpatient	$ 22,498	$ 49,975	$ 123,810	$ 196,283	$ 3,491	$ 3,089,255	$ 93,227	$ 3,185,973	1523.2%
Outpatient	$ 42,831	$ 562,214	$ 109,640	$ 714,685	$ 38,104	$ 517,963	$ 188,580	$ 744,647	4.2%
Total - Medical	**$ 65,329**	**$ 612,189**	**$ 233,450**	**$ 910,968**	**$ 41,594**	**$ 3,607,219**	**$ 281,807**	**$ 3,930,620**	**331.5%**

Net Paid Claims - Per Participant per Month	PY20				PY21				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical	$ 1,361	$ 544	$ 362	$ 501	$ 867	$ 4,487	$ 427	$ 2,600	419.1%

Paid Claims by Claim Type – Total

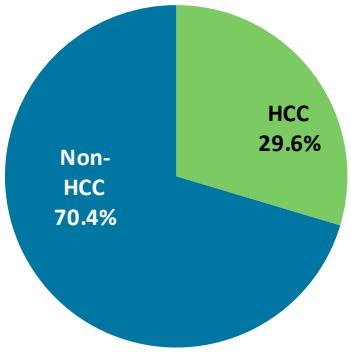
Net Paid Claims - Total Total Participants	PY20				PY21				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical									
Inpatient	$ 10,487,455	$ 2,071,715	$ 520,322	$ 13,079,492	$ 10,459,172	$ 4,360,344	$ 310,996	$ 15,130,513	15.7%
Outpatient	$ 31,157,679	$ 5,138,044	$ 918,672	$ 37,214,394	$ 31,339,529	$ 5,933,846	$ 710,056	$ 37,983,431	2.1%
Total - Medical	**$ 41,645,134**	**$ 7,209,759**	**$ 1,438,994**	**$ 50,293,887**	**$ 41,798,702**	**$ 10,294,190**	**$ 1,021,052**	**$ 53,113,944**	**5.6%**

Net Paid Claims - Per Participant per Month	PY20				PY21				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical	$ 855	$ 1,006	$ 868	$ 874	$ 881	$ 1,543	$ 603	$ 952	8.9%

Cost Distribution – Medical Claims

PY20							PY21					
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
44	0.5%	$10,340,819	20.6%	$390,985	7.5%	$100,000.01 Plus	51	0.6%	$15,734,764	29.6%	$192,679	5.2%
88	1.0%	$6,373,247	12.7%	$358,697	6.9%	$50,000.01-$100,000.00	81	0.9%	$6,153,855	11.6%	$221,750	6.0%
225	2.6%	$8,154,879	16.2%	$555,463	10.6%	$25,000.01-$50,000.00	206	2.4%	$7,631,477	14.4%	$414,155	11.2%
677	7.7%	$11,069,243	22.0%	$1,103,842	21.1%	$10,000.01-$25,000.00	580	6.8%	$9,746,549	18.4%	$754,991	20.5%
709	8.1%	$5,306,235	10.6%	$742,035	14.2%	$5,000.01-$10,000.00	701	8.2%	$5,228,065	9.8%	$678,130	18.4%
1,148	13.1%	$4,313,452	8.6%	$963,451	18.4%	$2,500.01-$5,000.00	1,043	12.2%	$3,911,413	7.4%	$617,094	16.7%
5,073	57.9%	$4,736,011	9.4%	$1,110,286	21.3%	$0.01-$2,500.00	5,060	59.2%	$4,707,244	8.9%	$810,948	22.0%
23	0.3%	$0	0.0%	$4,582	0.1%	$0.00	14	0.2%	$0	0.0%	$354	0.0%
780	8.9%	$0	0.0%	$0	0.0%	No Claims	818	9.6%	$578	0.0%	$0	0.0%
8,768	**100.0%**	**$50,293,887**	**100.0%**	**$5,229,342**	**100.0%**		**8,553**	**100.0%**	**$53,113,944**	**100.0%**	**$3,690,102**	**100.0%**

Distribution of HCC Medical Claims Paid



HCC – High-Cost Claimant over $100K

HCC's by Diagnosis Grouper			
Top 10 Diagnosis Groupers	Patients	Total Paid	% Paid
Cancer	21	$3,143,523	20.0%
Infections	35	$2,164,101	13.8%
Hematological Disorders	19	$1,396,015	8.9%
Renal/Urologic Disorders	21	$1,325,800	8.4%
Endocrine/Metabolic Disorders	27	$1,047,783	6.7%
Cardiac Disorders	39	$931,479	5.9%
Medical/Surgical Complications	18	$900,412	5.7%
Gastrointestinal Disorders	42	$820,513	5.2%
Trauma/Accidents	17	$514,630	3.3%
Pregnancy-related Disorders	5	$475,948	3.0%
All Other		$3,017,122	19.2%
Overall	**----**	**$15,737,327**	**100.0%**

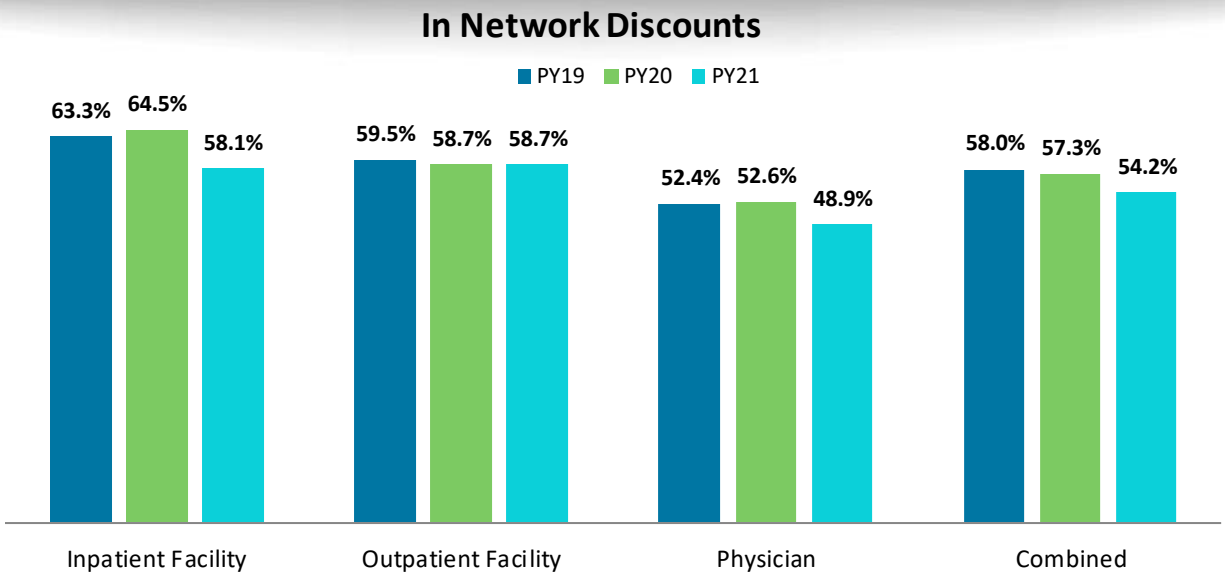
Utilization Summary (p. 1 of 2)

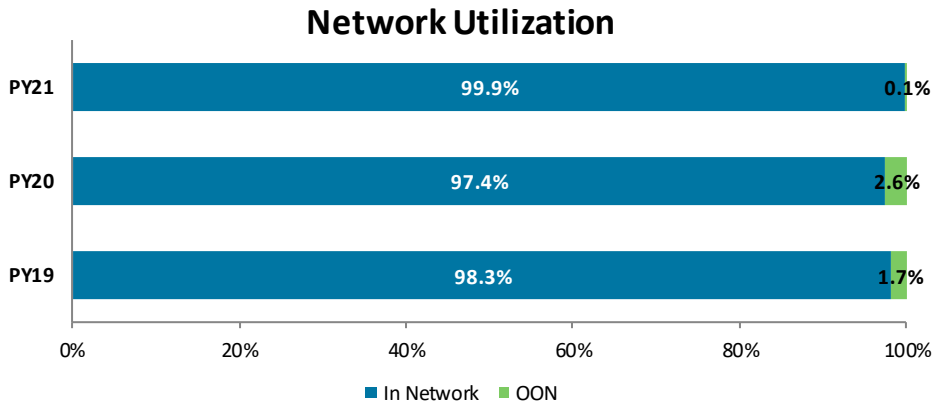
	Total				State Active				Non-State Active			
Summary	**PY19**	**PY20**	**PY21**	**Variance to Prior Year**	**PY19**	**PY20**	**PY21**	**Variance to Prior Year**	**PY19**	**PY20**	**PY21**	**Variance to Prior Year**
Inpatient Summary												
# of Admits	491	558	457		405	467	381		1	1	0	
# of Bed Days	2,966	2,969	2,940		2,370	2,379	2,188		2	2	0	
Paid Per Admit	$29,649	$23,592	$34,055	44.3%	$25,254	$22,998	$28,387	23.4%	$25,642	$22,498	$0	-100.0%
Paid Per Day	$4,908	$4,434	$5,294	19.4%	$4,316	$4,514	$4,943	9.5%	$12,821	$11,249	$0	-100.0%
Admits Per 1,000	58	64	53	-17.2%	54	60	50	-16.7%	200	200	0	-100.0%
Days Per 1,000	348	338	344	1.8%	317	305	288	-5.6%	400	400	0	-100.0%
Avg LOS	6.0	5.3	6.4	20.8%	5.9	5.1	5.7	11.8%	2.0	2.0	0.0	-100.0%
# Admits From the ER	227	268	231		170	205	180		0	0	0	
Physician Office												
OV Utilization per Member	5.2	5.9	6.1	3.4%	5.1	5.8	5.9	1.7%	6.0	9.2	5.3	-42.4%
Avg Paid per OV	$136	$147	$151	2.7%	$136	$151	$152	0.7%	$186	$110	$136	23.6%
Avg OV Paid per Member	$710	$875	$913	4.3%	$694	$868	$892	2.8%	$1,113	$1,009	$720	-28.6%
DX&L Utilization per Member	8.7	10.2	10.3	1.0%	8.3	9.6	9.7	1.0%	14	17.6	16.8	-4.5%
Avg Paid per DX&L	$73	$71	$70	-1.4%	$70	$72	$68	-5.6%	$106	$90	$58	-35.6%
Avg DX&L Paid per Member	$637	$723	$717	-0.8%	$577	$689	$665	-3.5%	$1,491	$1,582	$984	-37.8%
Emergency Room												
# of Visits	1,588	1,706	1,319		1,405	1,501	1,156		0	2	2	
Visits Per Member	0.19	0.19	0.15	-21.1%	0.19	0.19	0.15	-21.1%	0.00	0.40	0.46	15.0%
Visits Per 1,000	186	194	154	-20.7%	188	193	152	-21.2%	0	400	462	15.5%
Avg Paid per Visit	$2,494	$2,523	$2,452	-2.8%	$2,484	$2,557	$2,463	-3.7%	$0	$2,359	$10,325	337.7%
Urgent Care												
# of Visits	2,763	3,196	2,455		2,516	2,930	2,237		0	0	1	
Visits Per Member	0.32	0.36	0.29	-19.4%	0.34	0.38	0.29	-23.7%	0.00	0.00	0.23	0.0%
Visits Per 1,000	324	364	287	-21.1%	337	376	294	-21.8%	0	0	231	0.0%
Avg Paid per Visit	$114	$139	$152	9.4%	$116	$140	$153	9.3%	$0	$0	$250	0.0%

Utilization Summary (p. 2 of 2)

	State Retirees				Non-State Retirees				
Summary	**PY19**	**PY20**	**PY21**	**Variance to Prior Year**	**PY19**	**PY20**	**PY21**	**Variance to Prior Year**	**HSB Peer Index**
Inpatient Summary									
# of Admits	69	78	68		16	12	8		
# of Bed Days	480	385	512		114	203	240		
Paid Per Admit	$48,337	$28,333	$23,428	-17.3%	$60,553	$15,995	$394,319	2365.3%	$16,632
Paid Per Day	$6,948	$5,740	$3,112	-45.8%	$8,499	$946	$13,144	1289.4%	$3,217
Admits Per 1,000	85	98	86	-12.2%	71	64	51	-20.3%	76
Days Per 1,000	591	482	649	34.6%	503	1,083	1,521	40.4%	391
Avg LOS	7.0	4.9	7.5	53.1%	7.1	16.9	30.0	77.5%	5.2
# Admits From the ER	46	55	46		11	8	5		
Physician Office									
OV Utilization per Member	6.3	7.7	8.0	3.9%	5.3	6.4	6.6	3.1%	5.0
Avg Paid per OV	$138	$128	$140	9.4%	$124	$110	$136	23.6%	$57
Avg OV Paid per Member	$877	$986	$1,119	13.5%	$655	$704	$900	27.8%	$286
DX&L Utilization per Member	12.1	14.9	15	0.7%	12	13.6	12.6	-7.4%	10.5
Avg Paid per DX&L	$85	$66	$80	21.2%	$102	$72	$64	-11.1%	$50
Avg DX&L Paid per Member	$1,021	$991	$1,195	20.6%	$1,222	$982	$807	-17.8%	$522
Emergency Room									
# of Visits	150	181	141		33	22	20		
Visits Per Member	0.18	0.23	0.18	-21.7%	0.15	0.12	0.13	8.3%	0.24
Visits Per 1,000	185	227	179	-21.1%	146	117	127	8.5%	235
Avg Paid per Visit	$2,536	$2,317	$2,347	1.3%	$2,699	$1,883	$1,741	-7.5%	$943
Urgent Care									
# of Visits	186	209	185		61	57	32		
Visits Per Member	0.23	0.26	0.23	-11.5%	0.27	0.30	0.20	-33.3%	0.3
Visits Per 1,000	229	262	234	-10.7%	269	304	203	-33.2%	300
Avg Paid per Visit	$106	$136	$141	3.7%	$79	$91	$115	26.4%	$84

Provider Network Summary





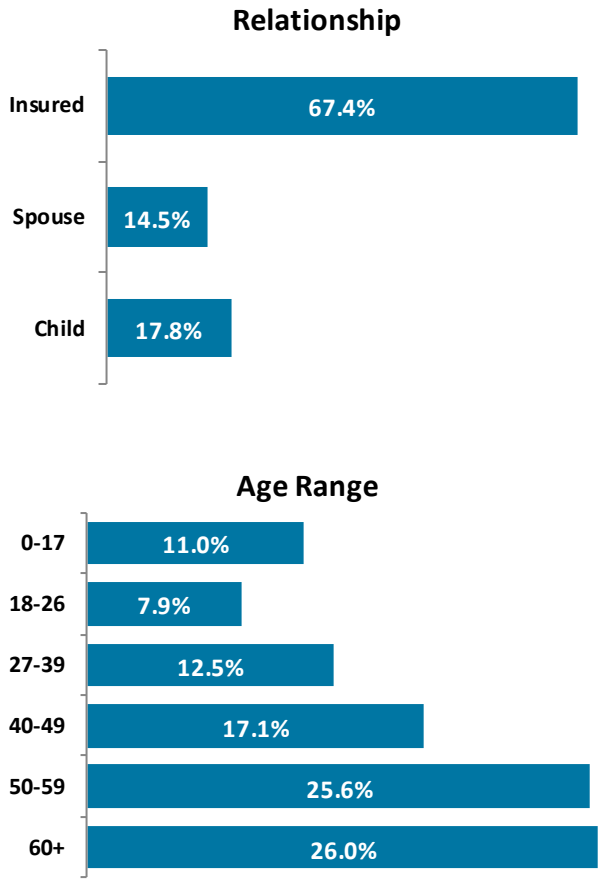
Diagnosis Grouper Summary

Diagnosis Grouper	Total Paid	% Paid	Insured	Spouse	Child	Male	Female
Musculoskeletal Disorders	$4,270,863	8.0%	$3,002,954	$883,426	$384,482	$1,814,460	$2,456,403
Cancer	$4,161,749	7.8%	$3,135,341	$1,006,446	$19,962	$1,566,135	$2,595,615
Mental Health	$3,874,490	7.3%	$1,760,069	$389,979	$1,724,441	$1,214,965	$2,659,524
Infections	$3,791,844	7.1%	$2,965,717	$609,192	$216,934	$991,052	$2,800,791
Gastrointestinal Disorders	$3,648,978	6.9%	$2,641,557	$540,022	$467,399	$1,774,483	$1,874,496
Spine-related Disorders	$3,269,932	6.2%	$2,612,429	$603,108	$54,395	$1,111,770	$2,158,162
Cardiac Disorders	$3,225,098	6.1%	$2,191,609	$927,210	$106,279	$1,656,759	$1,567,994
Health Status/Encounters	$3,135,266	5.9%	$1,822,182	$353,825	$959,259	$1,074,554	$2,058,504
Eye/ENT Disorders	$2,394,375	4.5%	$1,657,838	$225,233	$511,304	$1,095,661	$1,298,613
Pregnancy-related Disorders	$2,344,791	4.4%	$1,117,633	$250,195	$976,963	$162,196	$2,174,464
Renal/Urologic Disorders	$2,334,479	4.4%	$1,765,162	$201,483	$367,835	$1,131,177	$1,203,302
Endocrine/Metabolic Disorders	$2,172,530	4.1%	$1,727,469	$253,731	$191,330	$582,621	$1,589,909
Neurological Disorders	$2,076,896	3.9%	$1,370,365	$439,491	$267,040	$764,766	$1,312,130
Trauma/Accidents	$1,964,968	3.7%	$1,179,836	$348,886	$436,245	$792,390	$1,172,577
Pulmonary Disorders	$1,671,455	3.1%	$1,330,015	$247,927	$93,513	$937,244	$734,028
Hematological Disorders	$1,563,936	2.9%	$1,009,110	$534,591	$20,235	$898,564	$665,372
Gynecological/Breast Disorders	$1,255,611	2.4%	$924,426	$174,552	$156,634	$32,197	$1,223,415
Medical/Surgical Complications	$1,190,526	2.2%	$1,025,104	$111,372	$54,050	$302,953	$887,573
Non-malignant Neoplasm	$1,034,959	1.9%	$801,563	$201,048	$32,349	$448,580	$586,379
Diabetes	$766,100	1.4%	$527,658	$168,771	$69,670	$410,666	$355,434
Vascular Disorders	$712,329	1.3%	$584,882	$120,994	$6,453	$401,310	$311,020
Dermatological Disorders	$697,858	1.3%	$430,742	$126,856	$140,259	$296,384	$401,473
Miscellaneous	$488,244	0.9%	$283,918	$103,352	$100,975	$238,957	$249,287
Abnormal Lab/Radiology	$332,982	0.6%	$268,689	$52,890	$11,403	$119,795	$213,186
Congenital/Chromosomal Anomalies	$323,399	0.6%	$25,631	$20,999	$276,769	$245,688	$76,837
Cholesterol Disorders	$172,335	0.3%	$144,921	$23,572	$3,842	$57,983	$114,353
Medication Related Conditions	$98,721	0.2%	$62,083	$18,217	$18,421	$30,622	$68,099
Dental Conditions	$92,508	0.2%	$63,357	$7,211	$21,939	$67,221	$25,287
Allergic Reaction	$39,669	0.1%	$25,197	$3,034	$11,438	$12,046	$27,623
External Hazard Exposure	$7,054	0.0%	$3,259	$31	$3,764	$3,136	$3,918
Total	**$53,113,944**	**100.0%**	**$36,460,717**	**$8,947,645**	**$7,705,582**	**$20,236,335**	**$32,865,767**

Diagnosis Grouper – Musculoskeletal Disorders

Diagnosis Sub-Grouper	Patients	Claims	Total Paid	% Paid
Musculoskeletal Disorders, Other	1,404	4,802	$1,209,398	28.3%
Osteoarthritis	433	1,210	$987,993	23.1%
Arthropathies, Other	1,193	4,612	$902,570	21.1%
Musculoskeletal, Aftercare	277	797	$196,228	4.6%
Muscle Disorders	6	30	$184,118	4.3%
Joint Disorders, Other	228	925	$170,246	4.0%
Foot Problems	82	175	$148,870	3.5%
Limb Pain	544	1,233	$127,723	3.0%
Infectious Arthropathies	3	34	$115,234	2.7%
Rheumatoid Arthritis	78	310	$112,163	2.6%
Joint Derangement	68	174	$81,911	1.9%
Connective Tissue Disorders	44	161	$27,395	0.6%
Musculoskeletal Deformities, Other	14	22	$6,295	0.1%
Aseptic Necrosis	1	1	$719	0.0%
	----	----	$4,270,863	100.0%

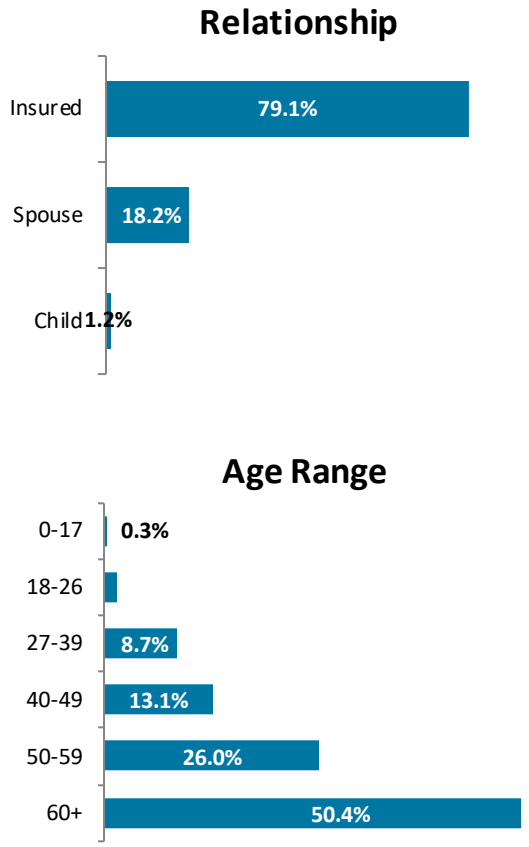
*Patient and claim counts are unique only within the category



Diagnosis Grouper – Cancer

Diagnosis Sub-Grouper	Patients	Claims	Total Paid	% Paid
Breast Cancer	47	493	$1,116,720	26.8%
Cancers, Other	148	497	$872,697	21.0%
Leukemias	13	255	$560,880	13.5%
Cancer Therapies	15	91	$435,748	10.5%
Lung Cancer	6	99	$219,022	5.3%
Prostate Cancer	25	181	$167,736	4.0%
Secondary Cancers	11	30	$151,623	3.6%
Colon Cancer	10	139	$145,229	3.5%
Cervical/Uterine Cancer	7	41	$130,656	3.1%
Brain Cancer	2	38	$128,673	3.1%
Carcinoma in Situ	46	118	$84,826	2.0%
Lymphomas	13	76	$60,720	1.5%
Myeloma	5	34	$51,570	1.2%
Thyroid Cancer	19	67	$13,376	0.3%
Melanoma	18	49	$12,301	0.3%
Bladder Cancer	1	10	$5,703	0.1%
Kidney Cancer	5	15	$3,146	0.1%
Ovarian Cancer	2	4	$910	0.0%
Pancreatic Cancer	1	3	$213	0.0%
Overall	**----**	**----**	**$4,161,749**	**100.0%**

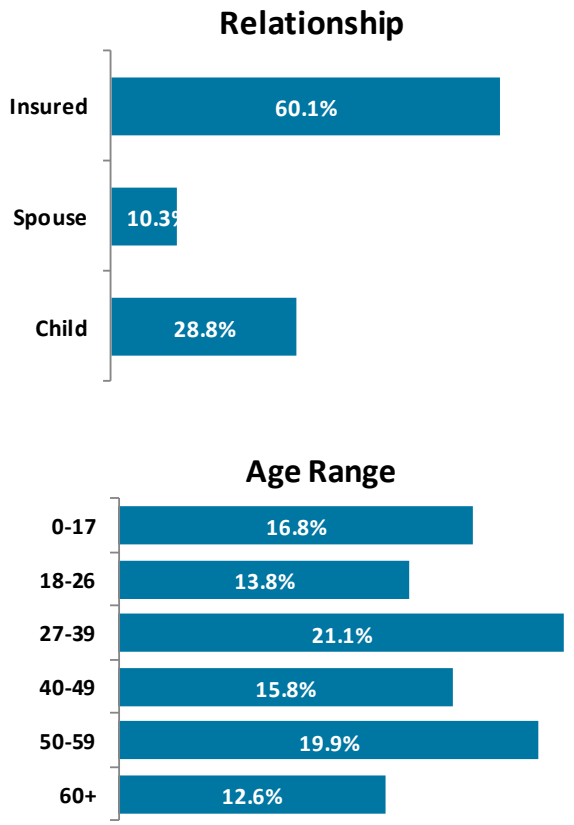
*Patient and claim counts are unique only within the category



Diagnosis Grouper – Mental Health

Diagnosis Category	Patients	Claims	Total Paid	% Paid
Mental Health Conditions, Other	662	5,002	$938,742	24.2%
Depression	655	4,019	$861,117	22.2%
Mood and Anxiety Disorders	716	3,684	$636,220	16.4%
Eating Disorders	25	249	$376,295	9.7%
Bipolar Disorder	135	949	$252,449	6.5%
Alcohol Abuse/Dependence	39	240	$168,417	4.3%
Developmental Disorders	64	1,078	$155,167	4.0%
Complications of Substance Abuse	30	135	$138,433	3.6%
Attention Deficit Disorder	190	639	$94,546	2.4%
Sexually Related Disorders	26	103	$81,490	2.1%
Psychoses	8	59	$54,549	1.4%
Substance Abuse/Dependence	54	172	$44,537	1.1%
Sleep Disorders	187	305	$38,393	1.0%
Personality Disorders	15	121	$18,725	0.5%
Schizophrenia	10	48	$10,630	0.3%
Tobacco Use Disorder	42	46	$4,779	0.1%
	----	----	$3,874,490	100.0%

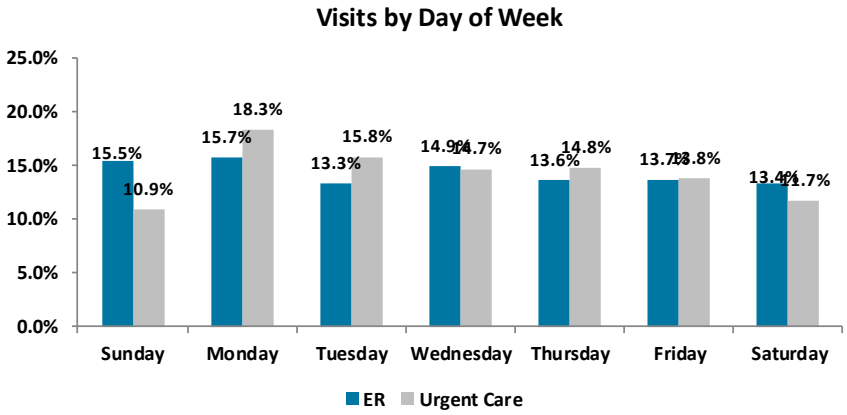
*Patient and claim counts are unique only within the category

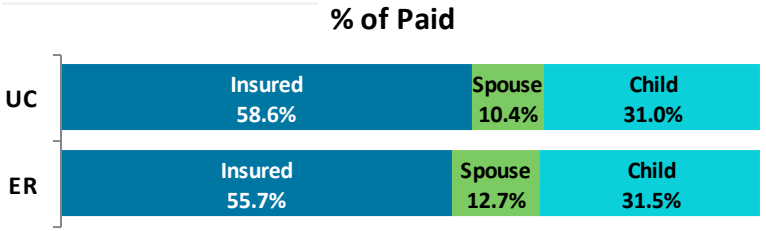


Emergency Room / Urgent Care Summary

	PY20		PY21		HSB Peer Index	
ER/Urgent Care	**ER**	**Urgent Care**	**ER**	**Urgent Care**	**ER**	**Urgent Care**
Number of Visits	1,706	3,196	1,319	2,455		
Visits Per Member	0.19	0.36	0.15	0.29	0.17	0.24
Visits/1000 Members	194	364	154	287	174	242
Avg Paid Per Visit	$2,523	$139	$2,452	$152	$1,684	$74
% with OV*	89.4%	87.3%	91.1%	87.1%		
% Avoidable	12.8%	41.3%	8.4%	30.6%		
Total Member Paid	**$689,949**	**$153,368**	**$517,708**	**$101,146**		
Total Plan Paid	**$4,304,209**	**$445,115**	**$3,234,079**	**$371,942**		

*looks back 12 months from ER visit



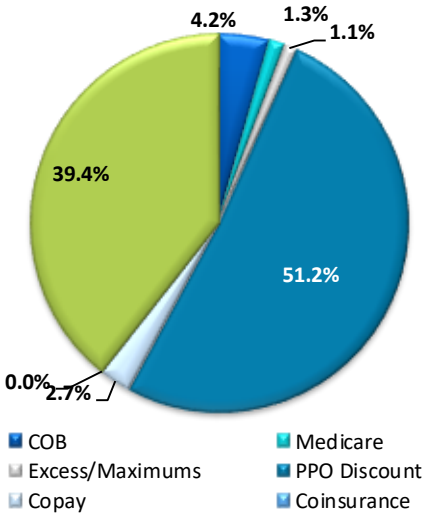


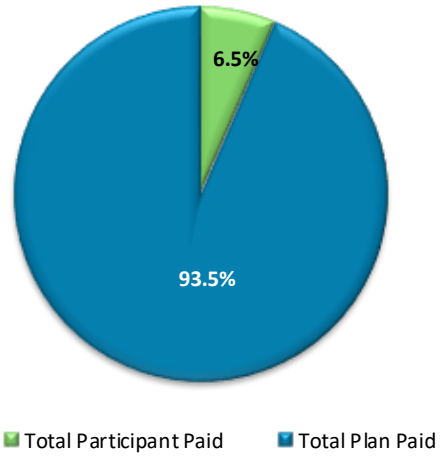
ER / UC Visits by Relationship						
Relationship	**ER**	**Per 1,000**	**Urgent Care**	**Per 1,000**	**Total**	**Per 1,000**
Insured	735	158	1,438	309	1,056	227
Spouse	168	182	255	277	202	219
Child	416	140	762	256	513	172
Total	**1,319**	**154**	**2,455**	**287**	**1,771**	**207**

Savings Summary – Medical Claims

Description	Dollars	PPPM	% of Eligible
Eligible Charges	$130,149,063	$2,332	100.0%
COB	$5,723,875	$103	4.4%
Medicare	$1,807,928	$32	1.4%
Excess/Maximums	$1,484,422	$27	1.1%
PPO Discount	$69,117,566	$1,239	53.1%
Copay	$3,690,102	$66	2.8%
Coinsurance	$0	$0	0.0%
Total Participant Paid	**$3,690,102**	**$66**	**2.8%**
Total Plan Paid	**$53,113,944**	**$952**	**40.8%**

Total Participant Paid - PY20	**$91**
Total Plan Paid - PY20	**$874**





Quality Metrics

Condition	Metric	#Members in Group	#Meeting Metric	#Not Meeting Metric	% Meeting Metric
Asthma	Asthma and a routine provider visit in the last 12 months	564	554	22	98.2%
	<2 asthma related ER Visits in the last 6 months	564	563	1	99.8%
	No asthma related admit in last 12 months	564	564	0	100.0%
Chronic Obstructive Pulmonary Disease	No exacerbations in last 12 months	97	92	5	94.8%
	Members with COPD who had an annual spirometry test	97	16	81	16.5%
Congestive Heart Failure	No re-admit to hosp with Heart Failure diag w/in 30 days of HF inpatient stay discharge	3	3	0	100.0%
	No ER Visit for Heart Failure in last 90 days	62	59	3	95.2%
	Follow-up OV within 4 weeks of discharge from HF admission	3	3	0	100.0%
Diabetes	Annual office visit	600	588	12	98.0%
	Annual dilated eye exam	600	326	274	54.3%
	Annual foot exam	600	234	366	39.0%
	Annual HbA1c test done	600	512	88	85.3%
	Diabetes Annual lipid profile	600	471	129	78.5%
	Annual microalbumin urine screen	600	411	189	68.5%
Hyperlipidemia	Hyperlipidemia Annual lipid profile	1,328	1,084	244	81.6%
Hypertension	Annual lipid profile	1,427	1,011	416	70.8%
	Annual serum creatinine test	1,389	1,148	241	82.6%
Wellness	Well Child Visit - 15 months	97	94	3	96.9%
	Routine office visit in last 6 months	8,412	5,997	2,415	71.3%
	Age 45 to 75 years with colorectal cancer screening	3,484	815	2,669	23.4%
	Women age 25-65 with recommended cervical cancer screening	2,770	2,042	728	73.7%
	Males age greater than 49 with PSA test in last 24 months	1,240	638	602	51.5%
	Routine exam in last 24 months	8,412	7,707	705	91.6%
	Women age 40 to 75 with a screening mammogram last 24 months	2,352	1,459	893	62.0%

All member counts represent members active at the end of the report period.
Quality Metrics are always calculated on an incurred basis.

Chronic Conditions Prevalence

A member is identified as having a chronic condition if any one of the following three conditions is met within a 24 month service date period:

- **Two outpatient claims for the Dx on separate days of service**
- **One ER Visit with the Dx as primary**
- **One IP admission with the Dx as the admitting**

*For Diabetes only, one or more Rx claims can also be used to identify the condition.

Chronic Condition	# With Condition	% of Members	Members per 1000	PMPY
Affective Psychosis	122	1.45%	14.26	$11,666
Asthma	608	7.23%	71.09	$13,725
Atrial Fibrillation	93	1.11%	10.87	$43,577
Blood Disorders	536	6.37%	62.67	$23,306
CAD	180	2.14%	21.05	$26,868
COPD	96	1.14%	11.22	$42,772
Cancer	346	4.11%	40.45	$21,875
Chronic Pain	420	4.99%	49.11	$22,784
Congestive Heart Failure	62	0.74%	7.25	$49,979
Demyelinating Diseases	30	0.36%	3.51	$42,151
Depression	903	10.73%	105.58	$11,896
Diabetes	631	7.50%	73.78	$20,522
ESRD	9	0.11%	1.05	$118,889
Eating Disorders	39	0.46%	4.56	$26,897
HIV/AIDS	10	0.12%	1.17	$35,823
Hyperlipidemia	1,355	16.11%	158.43	$14,436
Hypertension	1,429	16.99%	167.08	$15,188
Immune Disorders	40	0.48%	4.68	$46,884
Inflammatory Bowel Disease	60	0.71%	7.02	$25,700
Liver Diseases	204	2.43%	23.85	$31,246
Morbid Obesity	358	4.26%	41.86	$20,451
Osteoarthritis	470	5.59%	54.95	$19,018
Peripheral Vascular Disease	51	0.61%	5.96	$21,367
Rheumatoid Arthritis	75	0.89%	8.77	$29,925

Data Includes Medical and Pharmacy
Based on 24 months incurred dates

Methodology

- Average member counts were weighted by the number of months each member had on the plan.
- Claims were pulled based upon the date paid.
- Claims were categorized based upon four groups:
  - Inpatient Facility
  - Outpatient Facility
  - Physician
  - Other (Other includes any medical reimbursements or durable medical equipment.)
- Inpatient analysis was done by identifying facility claims where a room and board charge was submitted and paid. Claims were then rolled up for the entire admission and categorized by the diagnosis code that held the highest paid amount. (Hospice and skilled nursing facility claims were excluded)
- Outpatient claims were flagged by an in-or-outpatient indicator being present on the claim that identified it as taking place at an outpatient facility.
- Physician claims were identified when the vendor type indicator was flagged as a professional charge.
  - These claims were in some cases segregated further to differentiate primary care physicians and specialists.
  - Office visits were identified by the presence of evaluation and management or consultation codes.
- Emergency room and urgent care episodes should be considered subcategories of physician and outpatient facility.
  - Emergency Room visits are identified by facility claims with a revenue code of 450-455, 457-459.
  - Urgent Care visits are identified by facility claims with a revenue code of 456 or physician claims with a place of service of “Urgent Care”.
  - Outpatient claims (including facility and physician) are then rolled up for the day of service and summarized as an ER/UC visit.
  - If a member has an emergency room visit on the same day as an urgent care visit, all claims are grouped into one episode and counted as an emergency room visit.
  - If a member was admitted into the hospital through the ER, the member will not show an ER visit. ER claims are bundled with the inpatient stay.

Public Employees' Benefits Program - RX Costs
PY 2021 - Quarter Ending June 30, 2021

Express Scripts

Membership Summary	4Q FY2021 EPO	4Q FY2020 EPO	Difference	% Change
			Membership Summary	
Member Count (Membership)	8,556	8,770	(214)	-2.4%
Utilizing Member Count (Patients)	7,044	7,335	(291)	-4.0%
Percent Utilizing (Utilization)	82.3%	83.6%	(0)	-1.6%
Claim Summary			**Claims Summary**	
Net Claims (Total Rx's)	171,756	173,517	(1,761)	-1.0%
Claims per Elig Member per Month (Claims PMPM)	1.67	1.65	0.02	1.2%
Total Claims for Generic (Generic Rx)	146,903	149,918	(3,015.00)	-2.0%
Total Claims for Brand (Brand Rx)	24,856	23,599	1,257.00	5.3%
Total Claims for Brand w/Gen Equiv (Multisource Brand Claims)	2,695	3,052	(357.00)	-11.7%
Total Non-Specialty Claims	169,452	171,230	(1,778.00)	-1.0%
Total Specialty Claims	2,304	2,287	17.00	0.7%
Generic % of Total Claims (GFR)	**85.5%**	**86.4%**	(0.01)	-1.0%
Generic Effective Rate (GCR)	**98.2%**	**98.0%**	0.00	0.2%
Mail Order Claims	20,437	17,728	2,709.00	15.3%
Mail Penetration Rate*	13.0%	11.3%	0.02	1.7%
Claims Cost Summary			**Claims Cost Summary**	
Total Prescription Cost (Total Gross Cost)	$21,762,219.00	$20,175,804.00	$1,586,415.00	7.9%
Total Generic Gross Cost	$3,406,043.00	$3,356,274.00	$49,769.00	1.5%
Total Brand Gross Cost	$18,356,176.00	$16,819,530.00	$1,536,646.00	9.1%
Total MSB Gross Cost	$587,595.00	$676,195.00	($88,600.00)	-13.1%
Total Ingredient Cost	$21,625,162.00	$20,096,878.00	$1,528,284.00	7.6%
Total Dispensing Fee	$130,937.00	$74,310.00	$56,627.00	76.2%
Total Other (e.g. tax)	$6,120.00	$4,616.00	$1,504.00	32.6%
Avg Total Cost per Claim (Gross Cost/Rx)	**$126.70**	**$116.28**	$10.43	9.0%
Avg Total Cost for Generic (Gross Cost/Generic Rx)	$23.19	$22.39	$0.80	3.6%
Avg Total Cost for Brand (Gross Cost/Brand Rx)	$738.59	$712.72	$25.87	3.6%
Avg Total Cost for MSB (MSB Gross Cost/MSB ARx)	$218.03	$221.56	($3.53)	-1.6%
Member Cost Summary			**Member Cost Summary**	
Total Member Cost	**$3,668,366.00**	**$2,658,712.00**	$1,009,654.00	38.0%
Total Copay	$3,668,366.00	$2,658,712.00	$1,009,654.00	38.0%
Total Deductible	$0.00	$0.00	$0.00	0.0%
Avg Copay per Claim (Copay/Rx)	$21.36	$15.32	$6.04	39.4%
Avg Participant Share per Claim (Copay+Deductible/RX)	**$21.36**	**$15.32**	**$6.04**	**39.4%**
Avg Copay for Generic (Copay/Generic Rx)	$7.34	$7.07	$0.27	3.8%
Avg Copay for Brand (Copay/Brand Rx)	$104.24	$67.74	$36.50	53.9%
Avg Copay for Brand w/ Generic Equiv (Copay/Multisource Rx)	$28.71	$27.49	$1.22	4.4%
Net PMPM (Participant Cost PMPM)	**$35.73**	**$25.26**	$10.47	41.4%
Copay % of Total Prescription Cost (Member Cost Share %)	16.9%	13.2%	3.7%	27.9%
Plan Cost Summary			**Plan Cost Summary**	
Total Plan Cost (Plan Cost)	**$18,093,584.00**	**$17,517,092.00**	**$576,492.00**	**3.3%**
Total Non-Specialty Cost (Non-Specialty Plan Cost)	$8,995,143.00	$8,049,655.00	$945,488.00	11.7%
Total Specialty Drug Cost (Specialty Plan Cost)	$9,098,710.00	$9,467,437.00	($368,727.00)	-3.9%
Avg Plan Cost per Claim (Plan Cost/Rx)	**$105.34**	**$100.95**	$4.39	4.4%
Avg Plan Cost for Generic (Plan Cost/Generic Rx)	$15.85	$15.32	$0.53	3.5%
Avg Plan Cost for Brand (Plan Cost/Brand Rx)	$634.35	$644.99	($10.64)	-1.6%
Avg Plan Cost for MSB (MSB Plan Cost/MSB ARx)	$189.32	$194.07	($4.75)	-2.4%
Net PMPM (Plan Cost PMPM)	**$176.23**	**$166.45**	**$9.78**	**5.9%**
PMPM for Specialty Only (Specialty PMPM)	$88.62	$89.96	($1.34)	-1.5%
PMPM without Specialty (Non-Specialty PMPM)	$87.61	$76.49	$11.12	14.5%
Rebates (Q1-Q4 FY2021 actual)	$4,172,313.36	$3,858,361.77	**$313,951.59**	**8.1%**
Net PMPM (Plan Cost PMPM factoring Rebates)	**$135.59**	**$129.79**	**$5.80**	**4.5%**
PMPM for Specialty Only (Specialty PMPM)	$75.07	$77.32	($2.25)	-2.9%
PMPM without Specialty (Non-Specialty PMPM)	$61.60	$50.24	$11.36	22.6%

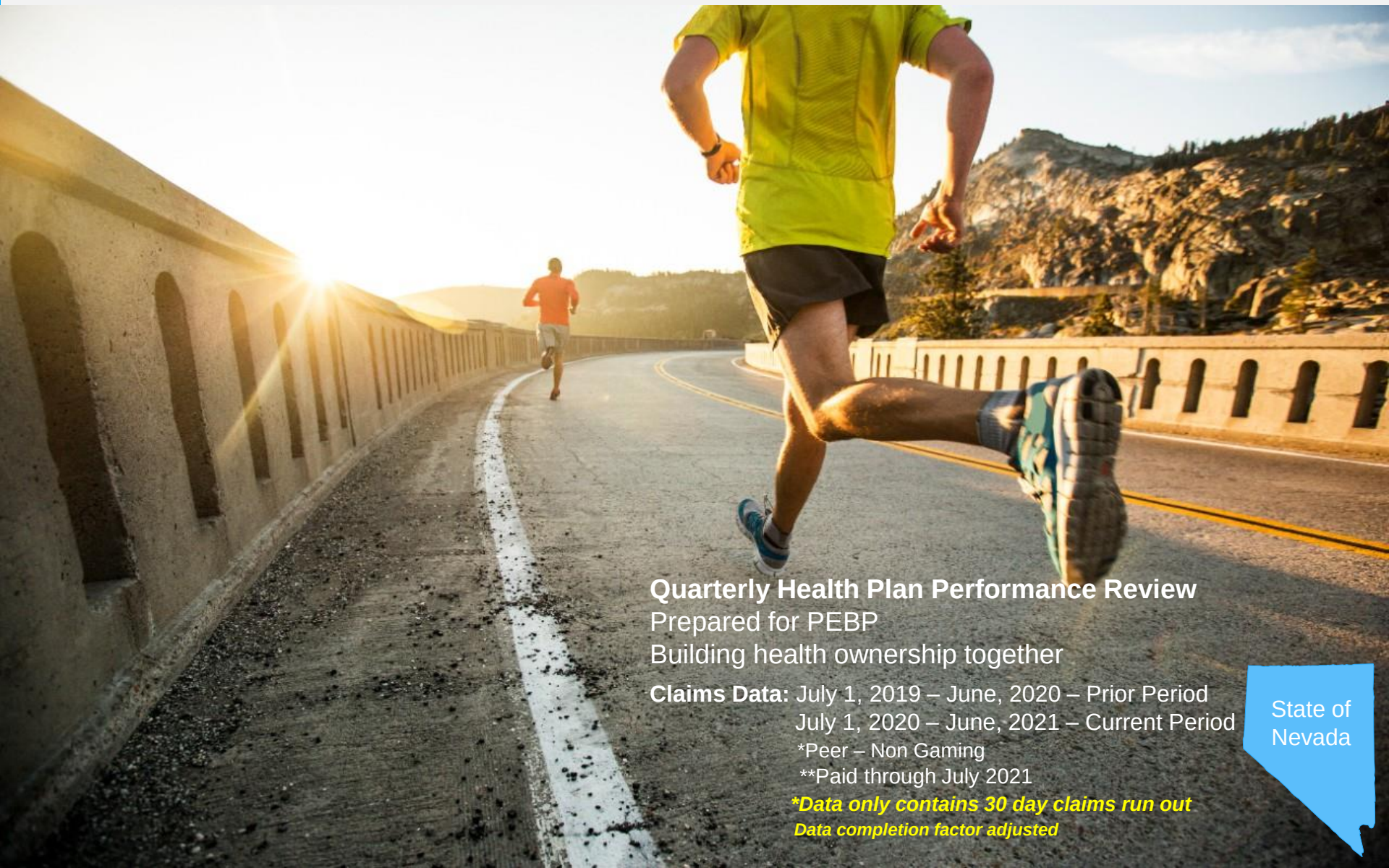
Appendix C

Index of Tables
Health Plan of Nevada –Utilization Review for PEBP
July 1, 2020 – June 30, 2021

KEY PERFORMANCE INDICATORS

PRESCRIPTION DRUG COSTS

Power Of Partnership.



Quarterly Health Plan Performance Review
Prepared for PEBP
Building health ownership together

Claims Data: July 1, 2019 – June, 2020 – Prior Period
July 1, 2020 – June, 2021 – Current Period
*Peer – Non Gaming
**Paid through July 2021
Data only contains 30 day claims run out
Data completion factor adjusted

State of Nevada

39 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
- ✓ 55,000 sq ft state-of-the-art cancer center
- ✓ Saturday appointments with primary care

Enhancements Made for Your Members

- ✓ Provided COVID-19 testing and vaccinations at multiple locations throughout the Las Vegas area, including drive through locations.
- ✓ Introduced the **Tummy2Toddler pregnancy support app** helping mothers stay healthy during every step of pregnancy and early childhood.
- ✓ NowClinic and Walgreens now offering same-day medication delivery
- ✓ Added HCA hospitals and 17 Care Now Urgent Cares to the network
- ✓ Real Appeal weight loss program
- ✓ Dispatch Health to provide at home urgent visits

Key Performance Indicators

Includes Demographics And Financials

Demographic and Financial Overview

UnitedHealthcare

Demographics

Membership	Avg. Member Age	Famiy size	Dependents <18	HHS Risk
Members: 6,780 Employees: 3,891 Prior: 6,844 3,947	37.2 Prior : 37.2 Norm: 36.2	1.74 Prior : 1.74 Norm: 1.76	22.5% Prior: 22.4 Norm: 20.3	1.44 Prior: 1.32 0.99
-1.3%	-0.1%	0.3%	0.3%	9.1%

Medical and Rx Spend

18.8%

Medical PMPM
$353.17

Prior $297.40
Norm: $286.24

Utilization

Inpatient: ▼-3.9%
Outpatient: ▲.4%
Professional: ▲8.7%

Spend

Inpatient: ▲37.0%
Outpatient: ▲9.6%
Professional: ▲13.0%

17.2%

Overall PMPM
$491.35

Prior: $419.12
Norm: $377.90

1.5%
Specialty Rx
$58.62

Prior: $50.55
Norm: $45.32

-3.6%
Avg. Scripts PMPY
17.2

Prior: 17.8
Norm: 11.3

13.5%
Rx PMPM
$138.17

Specialty Rx accounts for 42.2% of Rx Spend

Prior: $121.73
Norm: $91.64

Medical and Rx Plan Experience

What Happened

Highlights of Utilization

Utilization Metric	Prior	Current	Δ
Physician Office Visits			
Per Member Per Year	2.3	2.6	10.6%
Specialist Office Vists			
Per Member Per Year	4.5	4.6	3.0%
Emergency Room			
ER Visits	756	662	-12.5%
ER Visits Per K	110.0	97.6	-11.3%
Urgent Care			
UC Visits	3,874.8	3,555.7	-8.2%
UC Visits Per K	563.9	524.5	-7.0%
OutPatient Surgery			
ASC	117.6	90.1	-23.4%
Facility	38.0	37.9	-0.2%
Inpatient Utilization			
Admissions Per K	60.3	60.6	0.6%
Bed Days Per K	272.9	340.7	24.9%
Average Length of Stay	4.5	5.6	24.2%

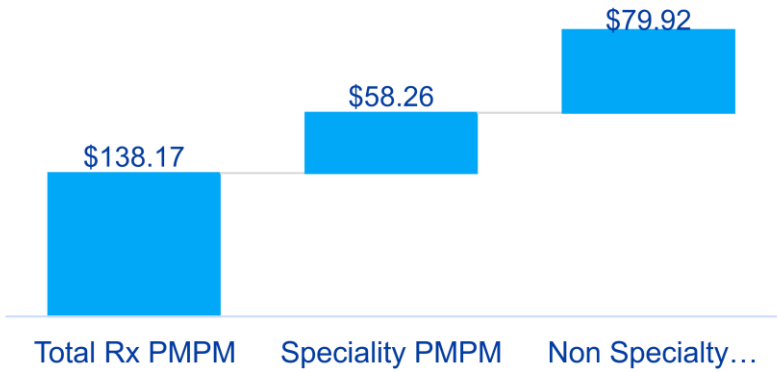
Highlights

- PCP Visits increased in the current period, up **10.6%**
- ER utilization dropped **-11.3%**,
  - We saw a decrease in ER utilization throughout our book of business due to Covid
  - Average paid per visit increased **14.9%,** due to more emergent cases
- Urgent Care Utilization decreased **-7.0%**
- Outpatient surgeries decreased at ASC settings while utilization at OP Surgery Facilities remained flat YOY
- IP Admits remained relatively flat, but IP spend increased 29.1%.
  - 19 Admits had a length of stay greater than 20 days
    - 2 Admits greater than 40 days

Pharmacy Data

	Prior	Current	Δ	Peer	Δ
Enrolled Members	6,872	6,780	-1.3%		
Average Prescriptions PMPY	17.8	17.2	-3.6%	11.3	52.6%
Formulary Rate	93.6%	91.6%	-2.1%	89.9%	1.9%
Generic Use Rate	87.2%	85.3%	-2.2%	84.8%	0.6%
Generic Substitution Rate	97.1%	97.4%	0.2%	97.1%	0.3%
Employee Cost Share PMPM	$19.62	$22.81	16.2%	$13.64	67.2%
Avg Net Paid per Prescription	$81.97	$96.49	17.7%	$97.65	-1.2%
Net Paid PMPM	$121.73	$138.17	13.5%	$91.64	50.8%

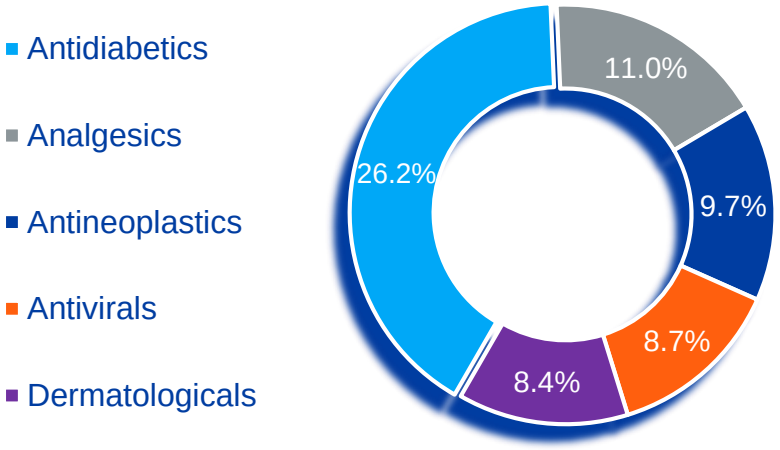
Rx Paid by Benefit and Type



Pharmacy PMPM trend is up 13.5% ($16.44 PMPM)

- Average net paid per script increased **17.7%** (up $14.52 PMPM from prior period)
- Consistent with market trends; diabetic compliance on the rise Antidiabetic Rx Spend increased **10.5%**
- Specialty Rx Spend increased **1.5%**
  Specialty Rx Drivers:
  *Humira (Analgesics, spend up **21.4%**)
  *Stelara (Dermatologic, spend up **96.3%**)
  *Aubagio(Psychotherapeutic, spend up **7.2%**)
- Avg. Prescriptions PMPY more than 50% higher than Peer

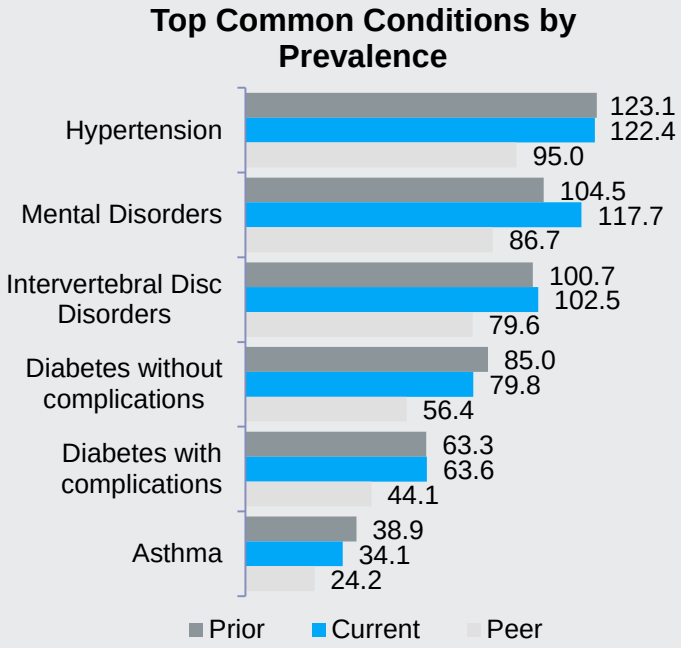
Top 5 Therapeutic Classes by Spend

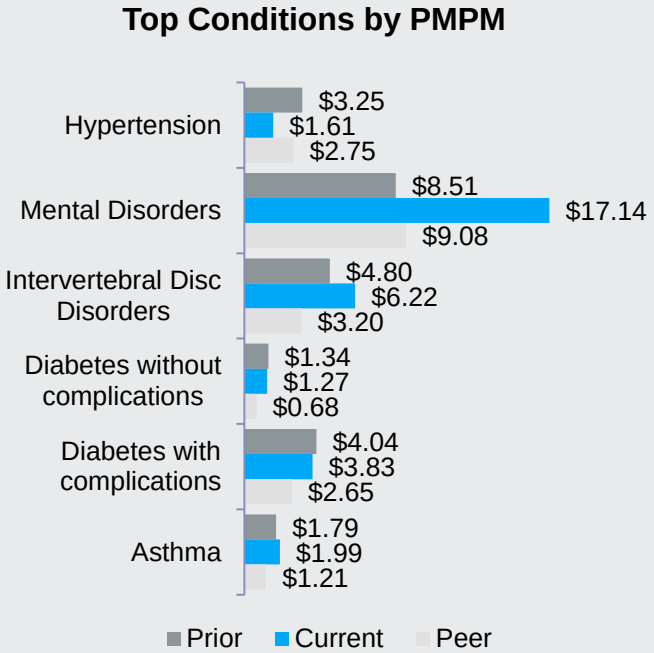


Condition Prevalence

Clinical Drivers

Clinical Conditions and Diagnosis





- Chronic illnesses continue to drive the top common conditions
- Hypertension, Mental Disorders, Intervertebral Disc Disorders and are the most prevalent clinical conditions within this population
- Mental Disorder prevalence increased 12.7%, but had a big jump in spend >100% (up $8.63 PMPM year over year
  - Alcohol related disorders increased 241.3%, up $1.64 PMPM YOY
  - Autism spend increased 141.4% (ABA therapy) up $5.80 PMPM from prior period

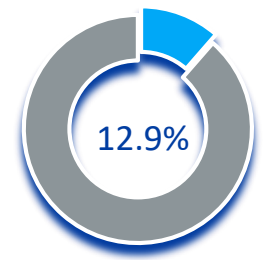
Chronic Condition Cost Drivers

UnitedHealthcare

76% of Medical spend driven by members with these 4 Chronic Conditions and an overall avg. 95% PCP Engagement

Asthma

6.3% of Members

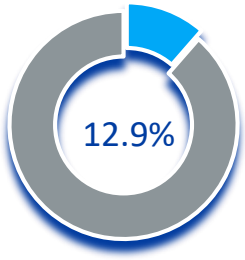


Average paid Per Claimant **$9,256**

Member Engagement **96.9%**

Cardio Hypertension

5.7% of Members



Average paid Per Claimant **$10,252**

Member Engagement **95.8%**

CAD

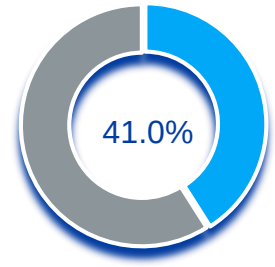
1.9% of Members

Average paid Per Claimant **$21,209**

Member Engagement **100.0%**

Diabetes

20.4% of Members



Average paid Per Claimant **$8,961**

Member Engagement **95.9%**

**Data obtained for this slide is for Eval period Aug-2020 thru Jul-2021*

Catastrophic Cases

High Cost Claimants

Catastrophic Cases Summary (>$50k)

UnitedHealthcare

10.8 Catastrophic Cases Per 1000

Prior: 8.3 ▲ 29.8%

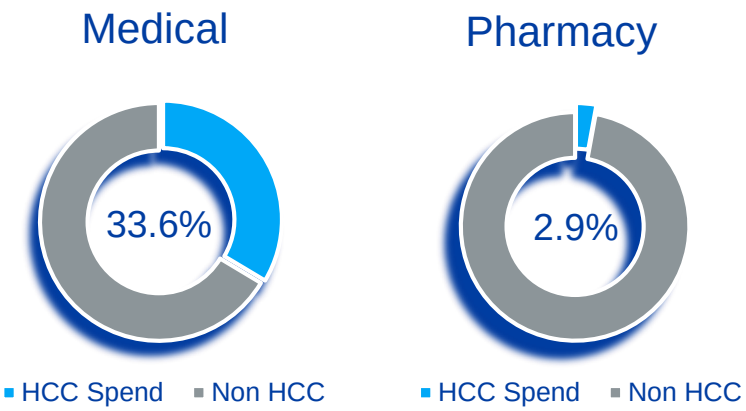
81 Individuals (65 Prior Period)
1.08% of the population

$123,114
Average Paid Per Case

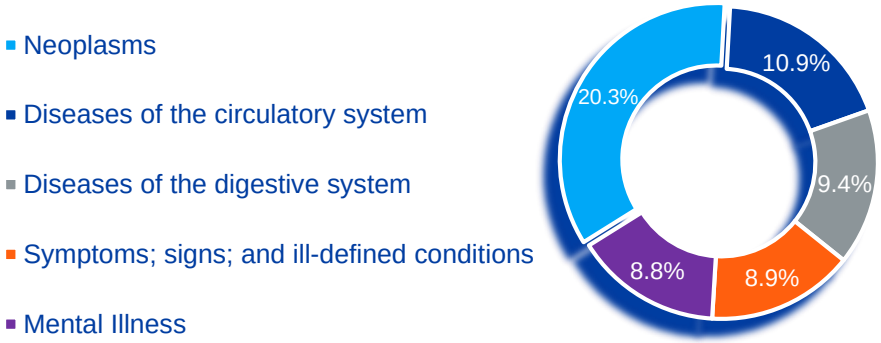
Prior: $105,093 ▲ 17.1%

% of Total Med/Rx Spend as High Cost 24.9%

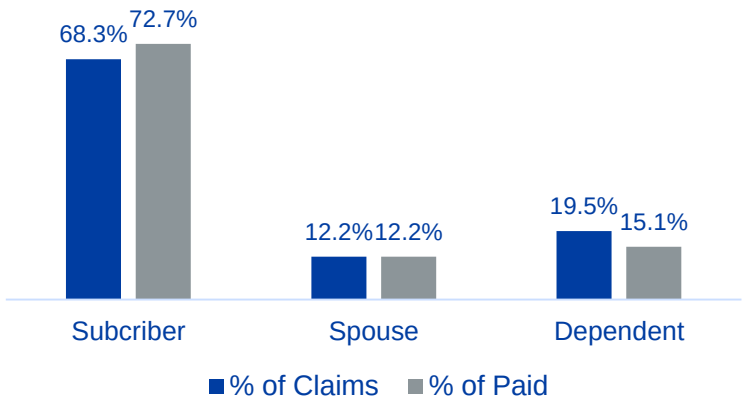
% Paid Attributed to Catastrophic Cases



Top 5 AHRQ Chapter Description by Paid



Claims and Spend by Relationship



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 June 30, 2021:

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 Willis Towers Watson's Individual Marketplace Enrollment & Performance Report

4.3.6 Hometown Health Providers and Sierra Healthcare Options – PPO Network

4.3.7 HealthPlan of Nevada, Inc. – Southern HMO

4.3.8 Doctor on Demand Engagement Reports through July 2021

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 June 30, 2021:

        4.3.1 HealthSCOPE Benefits – Obesity Care Management

HSB DATASCOPE™

Obesity Care Management Report

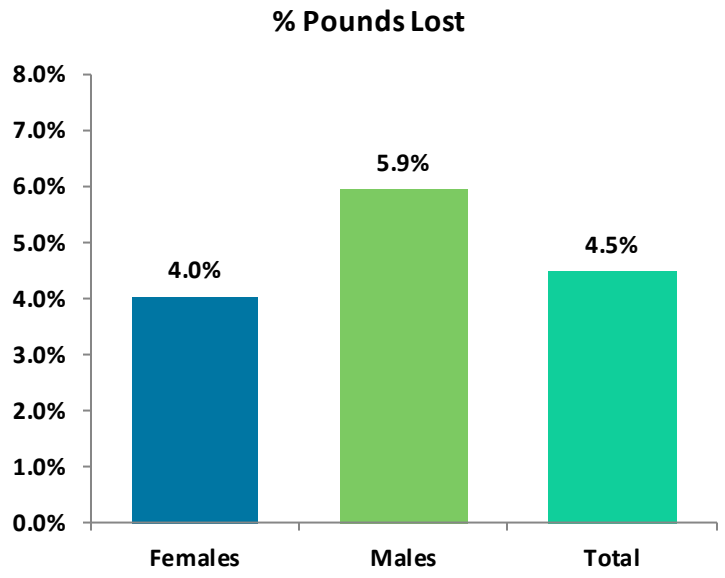
Nevada Public Employees' Benefits Program

July 2020 – June 2021

HealthSCOPE BENEFITS

Obesity Care Management Overview

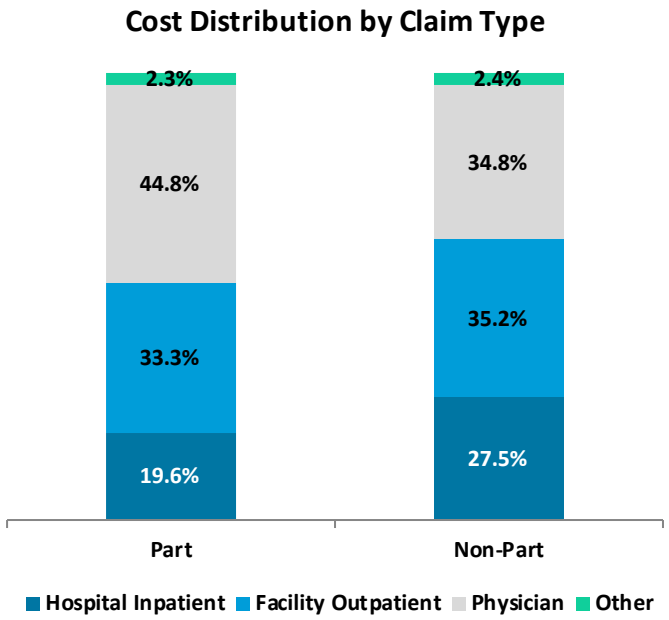
PEBP PY21			
Weight Management Summary	**Females**	**Males**	**Total**
# Mbrs Enrolled in Program	969	257	1,226
Average # Lbs. Lost	9.3	15.4	10.6
Total # Lbs. Lost	9,026.3	3,959.0	12,985.3
% Lbs. Lost	4.0%	5.9%	4.5%
Average Cost/ Member	$4,909	$5,784	$5,092



*Non-participant is defined as a member with morbid obesity chronic condition flag, but is not enrolled in the Obesity Care Management Program

Obesity Care Management – Financial Summary

Summary	Participants	Non-Participants	Variance
Enrollment			
Avg # Employees	1,053	793	32.9%
Avg # Members	1,181	1,020	15.9%
Member/Employee Ratio	1.1	1.3	-13.2%
Financial Summary			
Gross Cost	$7,821,130	$16,330,660	
Client Paid	$6,245,605	$14,538,865	
Employee Paid	$1,575,526	$1,791,795	
Client Paid-PEPY	$5,931	$18,346	-67.7%
Client Paid-PMPY	$5,287	$14,257	-62.9%
Client Paid-PEPM	$494	$1,529	-67.7%
Client Paid-PMPM	$441	$1,188	-62.9%
High Cost Claimants (HCC's) > $100k			
# of HCC's	5	24	
HCC's / 1,000	4.2	23.5	0.0%
Avg HCC Paid	$237,647	$227,123	0.0%
HCC's % of Plan Paid	19.0%	37.5%	0.0%
Cost Distribution - PMPY			
Hospital Inpatient	$1,037	$3,926	-73.6%
Facility Outpatient	$1,759	$5,018	-64.9%
Physician	$2,366	$4,966	-52.4%
Other	$124	$347	-64.3%
Total	$5,287	$14,257	-62.9%



*Non-participant is defined as a member with morbid obesity chronic condition flag, but is not enrolled in the Obesity Care Management Program

Obesity Care Management – Utilization Summary

Summary	Participants	Non-Participants	Variance
Inpatient Facility			
# of Admits	80	195	
# of Bed Days	542	971	
Paid Per Admit	$17,256	$22,661	-23.9%
Paid Per Day	$2,547	$4,551	-44.0%
Admits Per 1,000	68	191	-64.4%
Days Per 1,000	459	952	-51.8%
Avg LOS	6.8	5	36.0%
# of Admits From ER	38	127	-70.1%
Physician Office			
OV Utilization per Member	10.1	9.0	12.2%
Avg Paid per OV	$98	$126	-22.2%
Avg OV Paid per Member	$983	$1,133	-13.2%
DX&L Utilization per Member	16.3	21.9	-25.6%
Avg Paid per DX&L	$48	$85	-43.5%
Avg DX&L Paid per Member	$785	$1,858	-57.8%
Emergency Room			
# of Visits	238	322	
Visits Per Member	0.2	0.32	-37.5%
Visits Per 1,000	201	316	-36.4%
Avg Paid per Visit	$2,322	$2,758	-15.8%
Urgent Care			
# of Visits	461	460	
Visits Per Member	0.39	0.45	-13.3%
Visits Per 1,000	390	451	-13.5%
Avg Paid per Visit	$85	$113	-24.8%

*Non-participant is defined as a member with morbid obesity chronic condition flag, but is not enrolled in the Obesity Care Management Program

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 June 30, 2021:

        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

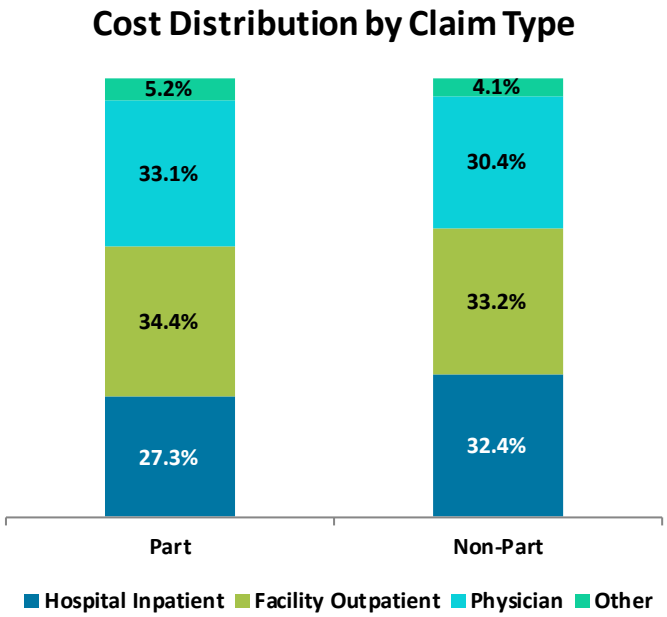
July 2020 – June 2021

HealthSCOPE BENEFITS

Diabetes Care Management – Financial Summary

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

Summary	Participants	Non-Participants	Variance
Enrollment			
Avg # Employees	405	1,827	-77.8%
Avg # Members	572	2,321	-75.4%
Member/Employee Ratio	1.4	1.3	11.0%
Financial Summary			
Gross Cost	$4,922,301	$28,650,833	
Client Paid	$4,054,453	$25,085,078	
Employee Paid	$867,848	$3,565,754	
Client Paid-PEPY	$10,007	$13,731	-27.1%
Client Paid-PMPY	$7,088	$10,807	-34.4%
Client Paid-PEPM	$834	$1,144	-27.1%
Client Paid-PMPM	$591	$901	-34.4%
High Cost Claimants (HCC's) > $100k			
# of HCC's	5	45	
HCC's / 1,000	8.7	19.4	0.0%
Avg HCC Paid	$285,985	$241,351	0.0%
HCC's % of Plan Paid	35.3%	43.3%	0.0%
Cost Distribution - PMPY			
Hospital Inpatient	$1,933	$3,497	-44.7%
Facility Outpatient	$2,437	$3,589	-32.1%
Physician	$2,348	$3,281	-28.4%
Other	$371	$440	-15.7%
Total	$7,088	$10,807	-34.4%



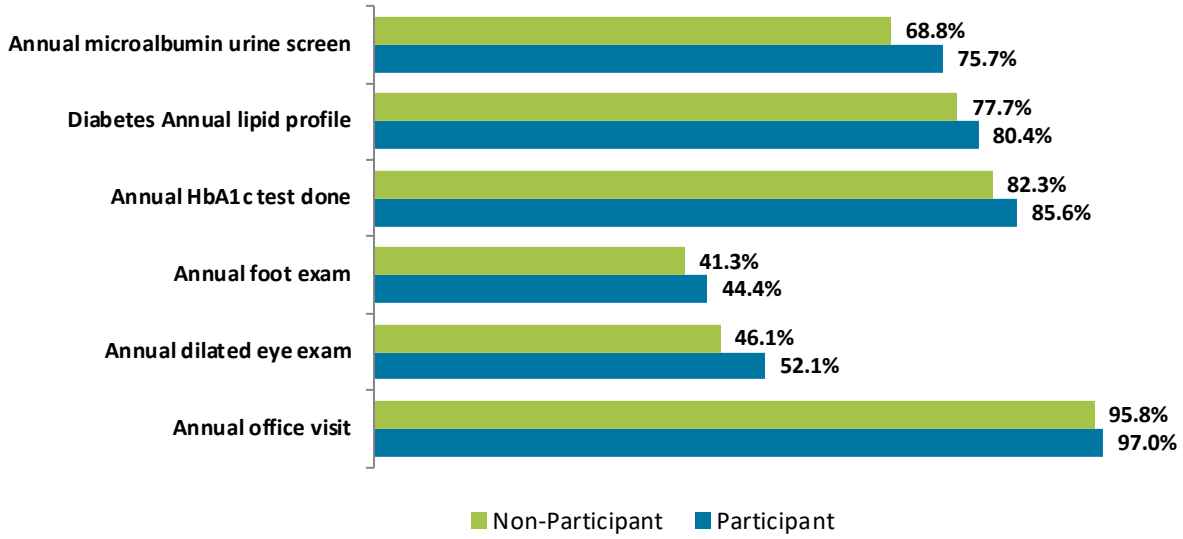
Diabetes Care Management – Utilization Summary

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

Summary	Participants	Non-Participants	Variance
Inpatient Facility			
# of Admits	36	319	
# of Bed Days	245	2,274	
Paid Per Admit	$38,231	$34,497	10.8%
Paid Per Day	$5,618	$4,839	16.1%
Admits Per 1,000	63	137	-54.0%
Days Per 1,000	428	980	-56.3%
Avg LOS	6.8	7.1	-4.2%
# of Admits From ER	26	220	-88.2%
Physician Office			
OV Utilization per Member	7.2	8.1	-11.1%
Avg Paid per OV	$81	$94	-13.8%
Avg OV Paid per Member	$584	$761	-23.3%
DX&L Utilization per Member	16.2	21.8	-25.7%
Avg Paid per DX&L	$48	$62	-22.6%
Avg DX&L Paid per Member	$783	$1,347	-41.9%
Emergency Room			
# of Visits	85	559	
Visits Per Member	0.15	0.24	-37.5%
Visits Per 1,000	149	241	-38.2%
Avg Paid per Visit	$2,516	$2,688	-6.4%
Urgent Care			
# of Visits	119	741	
Visits Per Member	0.21	0.32	-34.4%
Visits Per 1,000	208	319	-34.8%
Avg Paid per Visit	$83	$115	-27.8%

Quality Metrics

		Participant				Non-Participant			
Condition	Metric	#Members in Group	#Meeting Metric	#Not Meeting Metric	% Meeting Metric	#Members in Group	#Meeting Metric	#Not Meeting Metric	% Meeting Metric
Diabetes	Annual office visit	403	391	12	97.0%	2,119	2,031	88	95.8%
	Annual dilated eye exam	403	210	193	52.1%	2,119	976	1,143	46.1%
	Annual foot exam	403	179	224	44.4%	2,119	876	1,243	41.3%
	Annual HbA1c test done	403	345	58	85.6%	2,119	1,744	375	82.3%
	Diabetes Annual lipid profile	403	324	79	80.4%	2,119	1,646	473	77.7%
	Annual microalbumin urine screen	403	305	98	75.7%	2,119	1,458	661	68.8%



All member counts represent members active at the end of the report period.
Quality Metrics are always calculated on an incurred basis.

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 June 30, 2021:

        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

Public Employees Benefit Program – State of Nevada

Medical Management Review

April 1, 2021 – June 30, 2021

AmericanHealth
American Health Holding Inc

Table of Contents

Executive Overview

AmericanHealth
American Health Holding Inc

Overview

This presentation contains information for **Public Employees Benefit Program** and provides an overview of **Utilization Management, Case Management,** and **Post-Discharge Counseling**.

All data included is as of **July 31, 2021** and covers the reporting period of **April 1, 2021 – June 30, 2021**; all tables and graphs reflect the reporting period unless expressly noted. When requested, prior period comparison details are provided and indicated on the associated graphs or charts.

Return on Investment – Year Over Year Comparison

- Summary of medical management savings and ROI
  - Utilization Management savings are achieved through medical necessity reviews of inpatient bed days and outpatient services
  - Case Management savings are estimated costs that would have been incurred to the plan, had we not intervened

January 1, 2021 - March 31, 2021			
	Fees	Estimated Savings	ROI
Utilization Management	$192,119	$3,122,374	16.3 to 1
Case Management	$287,357	$964,120	3.4 to 1
Total	$479,476	$4,086,494	8.5 to 1

Utilization Management Breakout	
Inpatient Savings	$1,556,054
Outpatient Savings	$1,566,320

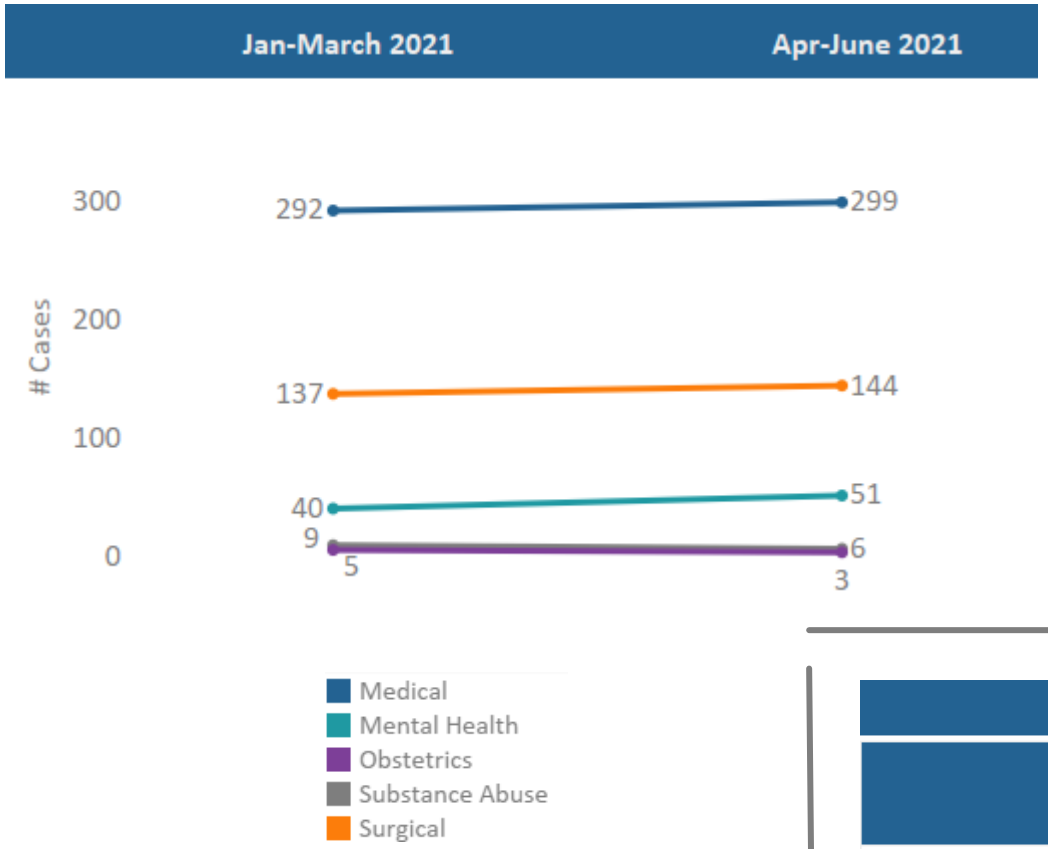
April 1, 2021 - June 30, 2021			
	Fees	Estimated Savings	ROI
Utilization Management	$193,047	$3,292,054	17.1 to 1
Case Management	$288,747	$1,568,177	5.4 to 1
Total	$481,794	$4,860,231	10.1 to 1

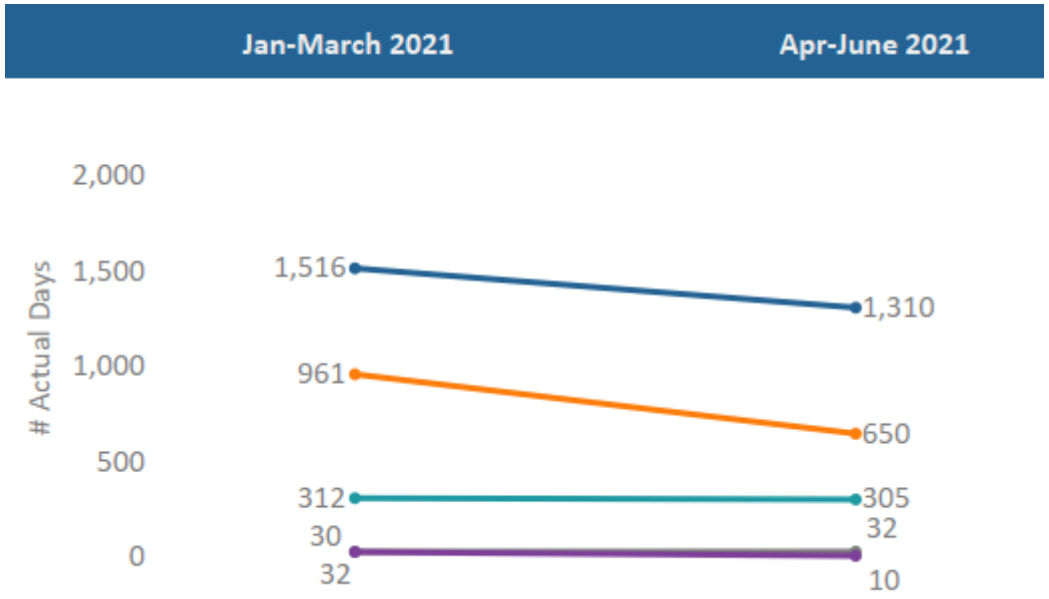
Utilization Management Breakout	
Inpatient Savings	$1,407,609
Outpatient Savings	$1,884,445

Utilization Management

AmericanHealth
American Health Holding Inc

Acute Inpatient Activity Summary



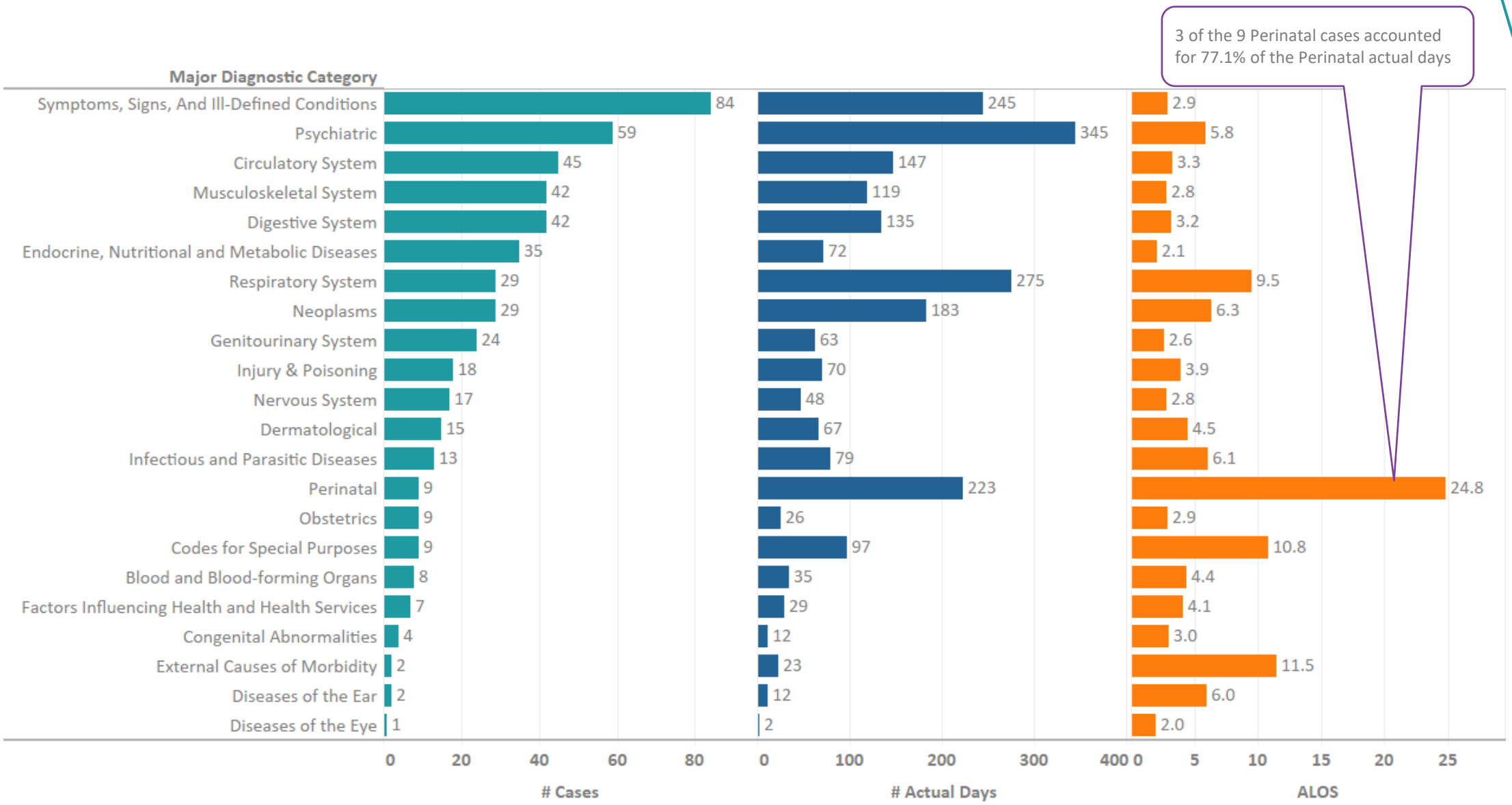


Utilization Review Process

Days Saved: 187
Estimated Savings: $1,360,701

April 1, 2021 - June 30, 2021						
	Cases	Actual Days	Requested Days	Approved Days	Saved Days	Estimated Savings
Medical	299	1,310	1,324	1,201	124	$817,656
Surgical	144	650	655	620	35	$501,795
Mental Health	51	305	311	293	18	$28,530
Substance Abuse	6	32	32	22	10	$12,720
Obstetrics	3	10	10	10	0	$0
Grand Total	**503**	**2,307**	**2,332**	**2,146**	**187**	**$1,360,701**

Acute Inpatient – Case and Actual Days by Diagnostic Categories



Acute Inpatient Activity – Utilization Benchmarks

Admissions per 1,000

- During the report period, medical and mental health acute inpatient admissions were above the Milliman benchmarks
  - **26** medical members had **2 or more** inpatient admissions
  - **6** mental health members had **2 or more** inpatient admissions

Days per 1,000

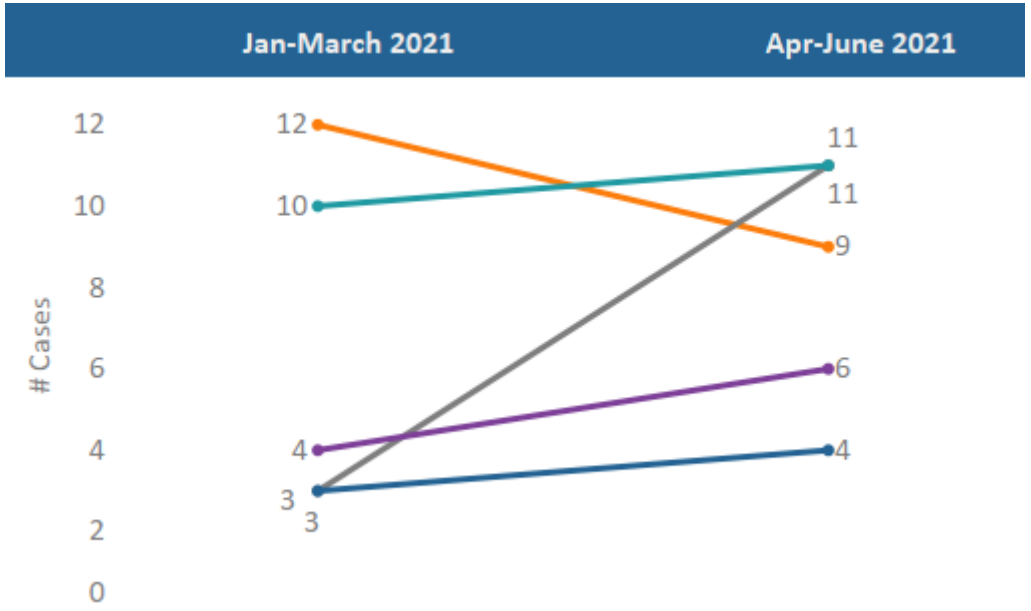
- During the report period, medical and mental health acute inpatient days per 1,000 were above the Milliman benchmarks
  - **26** medical cases utilized **10 or more** days during the report period
  - **3** mental health cases utilized **17 or more** days during the report period

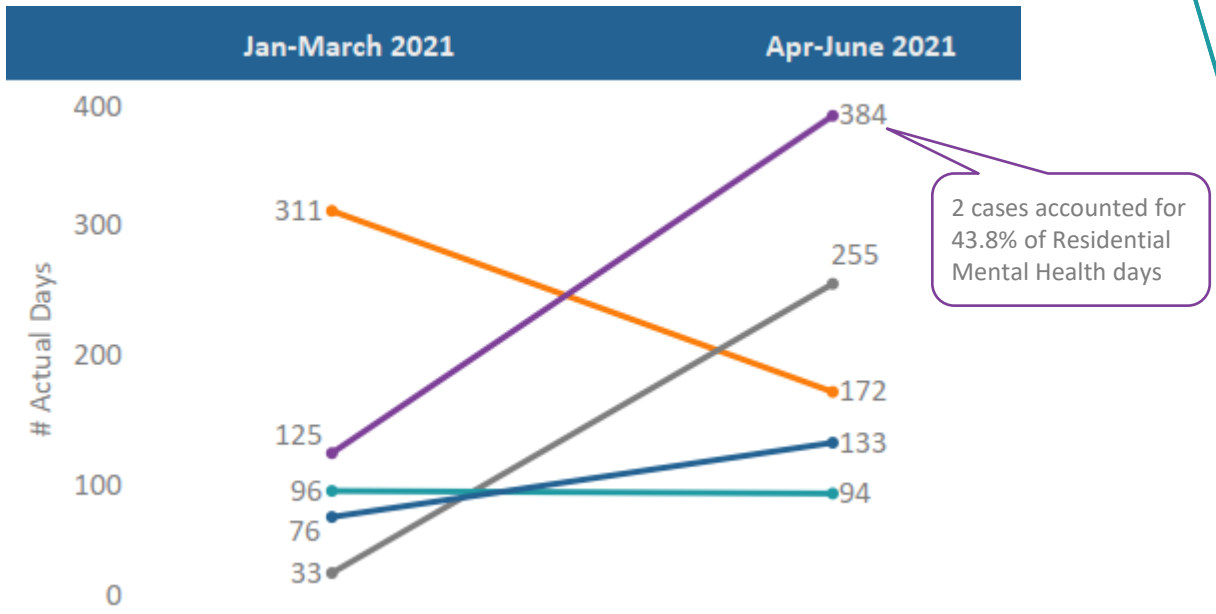
Average Length of Stay

- During the report period, all categories were at or lower than the Milliman 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



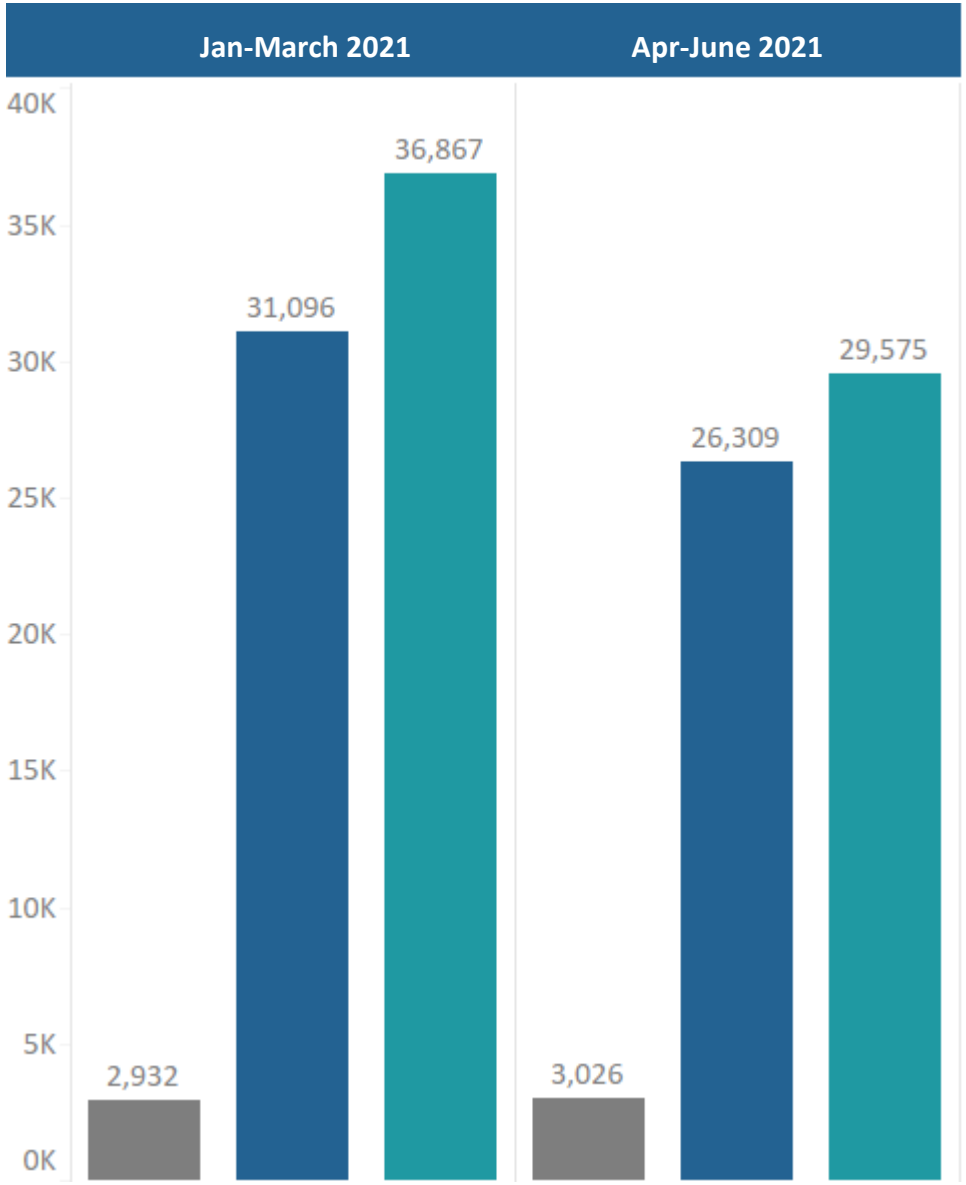


Utilization Review Process

Days Saved: 34
Estimated Savings: $46,908

April 1, 2021 - June 30, 2021						
	Cases	Actual Days	Requested Days	Approved Days	Saved Days	Estimated Savings
Medical Rehab	11	94	108	101	7	$18,746
Residential Substance Abuse	11	255	258	251	7	$7,056
Skilled Nsg Facility	9	172	173	171	2	$1,334
Residential Mental Health	6	384	384	368	16	$11,728
Long Term Acute	4	133	133	131	2	$8,044
Grand Total	**41**	**1,038**	**1,056**	**1,022**	**34**	**$46,908**

Outpatient Activity Summary



April 1, 2021 - June 30, 2021					
Outpatient Setting	# Cases	# Units Requested	# Units Approved	# Units Saved	Outpatient Savings
Diagnostic Test	1,777	2,304	2,105	199	$185,691
Surgery	684	1,192	1,161	31	$83,751
Med Treatment	217	6,414	5,795	619	$1,557,234
DME	212	16,718	14,421	2,297	$37,011
Home Health	54	840	773	67	$13,821
MH/SA	45	712	695	17	$6,937
Home Infusion	22	862	826	36	$0
PT/OT/ST	12	291	291	0	$0
Home Enteral Feeding	2	181	181	0	$0
Hospice Home	1	61	61	0	$0
Grand Total	**3,026**	**29,575**	**26,309**	**3,266**	**$1,884,445**

3 cases accounted for 70.2% of the Med Treatment savings

Utilization Review Process

Units Saved: 3,266
Estimated Savings: $1,884,445

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.

Inpatient Referrals					
	# Cases	# Cases Referred to CM	% Cases Referred to CM	# Referrals Accepted in CM	% Referrals Accepted in CM
Apr-June 2021	544	331	60.8%	245	74.0%

Outpatient Referrals					
	# Cases	# Cases Referred to CM	% Cases Referred to CM	# Referrals Accepted in CM	% Referrals Accepted in CM
Apr-June 2021	3,026	728	24.1%	18	2.5%

Case Management

AmericanHealth
American Health Holding Inc

Case Management Summary

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

Total Case Management Savings

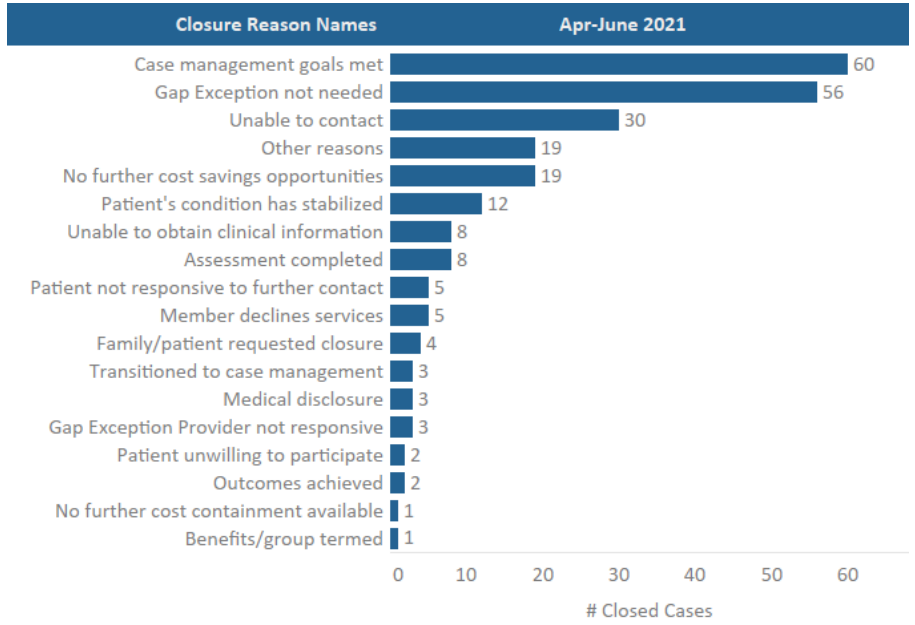
$1,568,177

Average Savings per Case = $3,853

Based on 407 cases in an open state between 4/1/2021 – 6/30/2021

Number of Cases

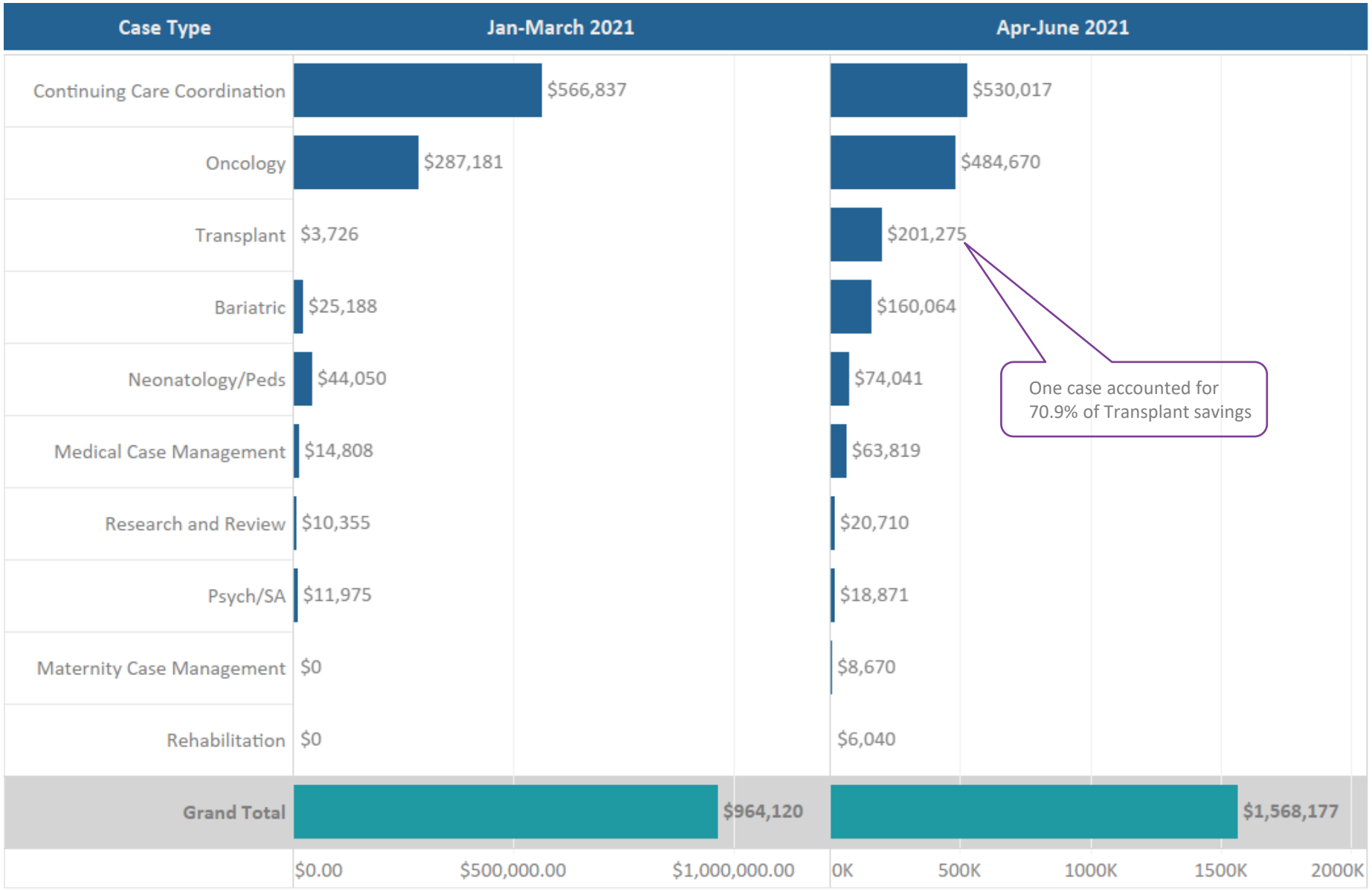
Case Activity	Jan-March 2021	Apr-June 2021
# Beginning Cases	200	194
# Opened Cases	210	213
# Closed Cases	216	220
# Ending Cases	194	187



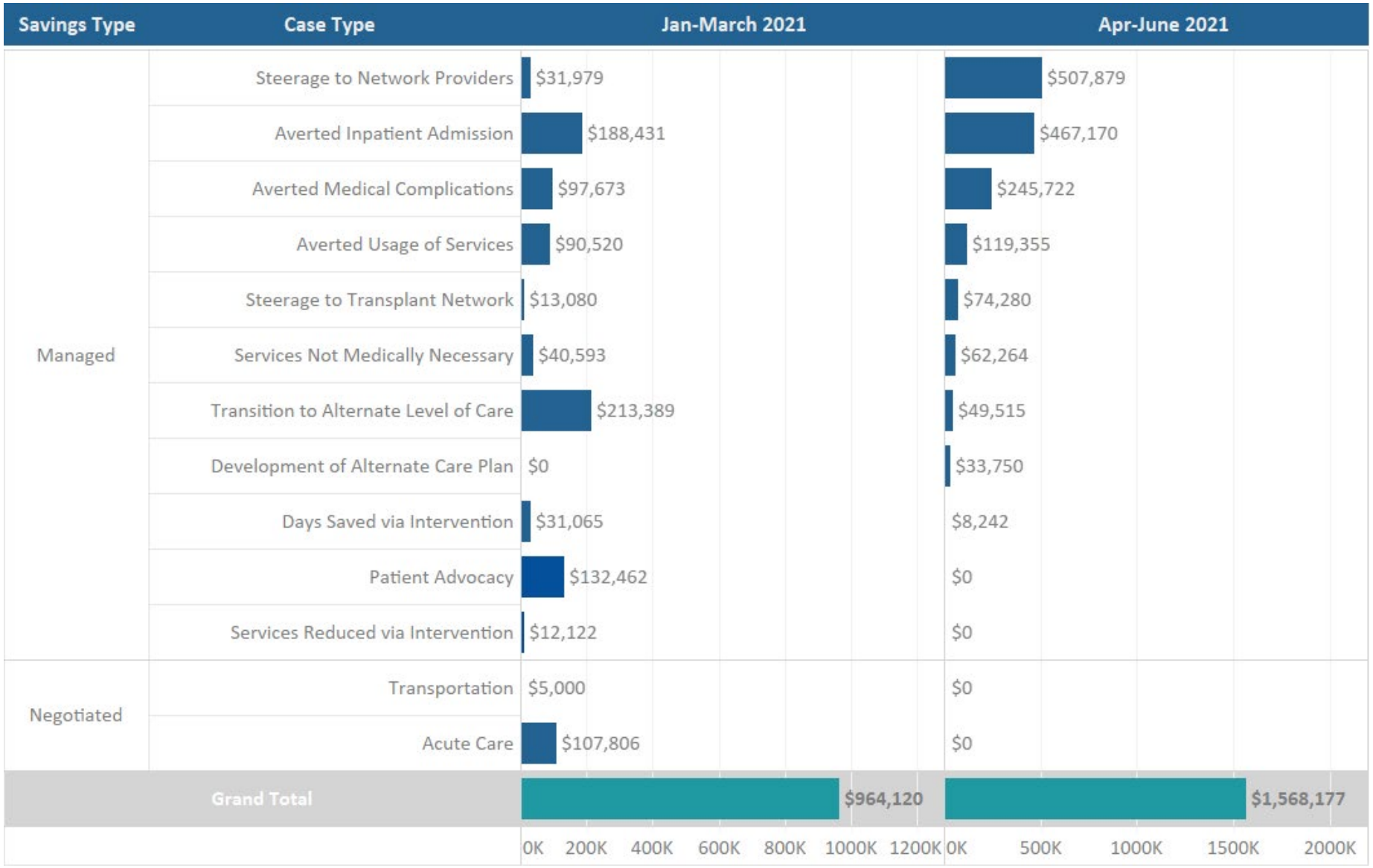
Total number of closure reasons may be greater than the number of cases as cases may have more than one closure reason.

Case Type	Apr-June 2021
Short Term CM	137
Continuing Care Coordination	106
Bariatric	55
Oncology	45
Medical Case Management	17
Neonatology/Peds	12
Psych/SA	11
Advocacy	8
Transplant	8
Maternity Case Management	2
Rehabilitation	1
Research and Review	1
Grand Total	**407**

Case Management – Savings by Case Type



Case Management – Savings by Source



Post-Discharge Counseling

AmericanHealth
American Health Holding Inc

Post-Discharge Counseling Summary

The diagram below illustrates the total number of candidates for readmission within the reporting period identified for Post-Discharge Counseling, regardless of whether the member participated in a counseling call and whether the member experienced readmission within 30 days after discharge.

379*
Candidates

Members with Potential for readmission during the report period

*Due to a 30-day requirement to identify a readmission, the referral and call participant populations may differ from the readmission candidate population.

26
Participants

Members with potential for readmission during the report period participated in a program call

2 or 7.7%
Participants

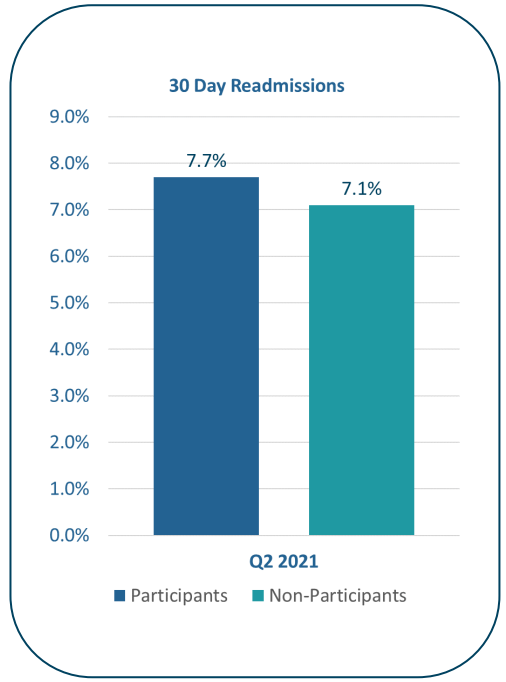
# of participating members with readmissions

353
Non-Participants

Members with potential for readmission during the report period did not participate in a program call

25 or 7.1%
Non-Participants

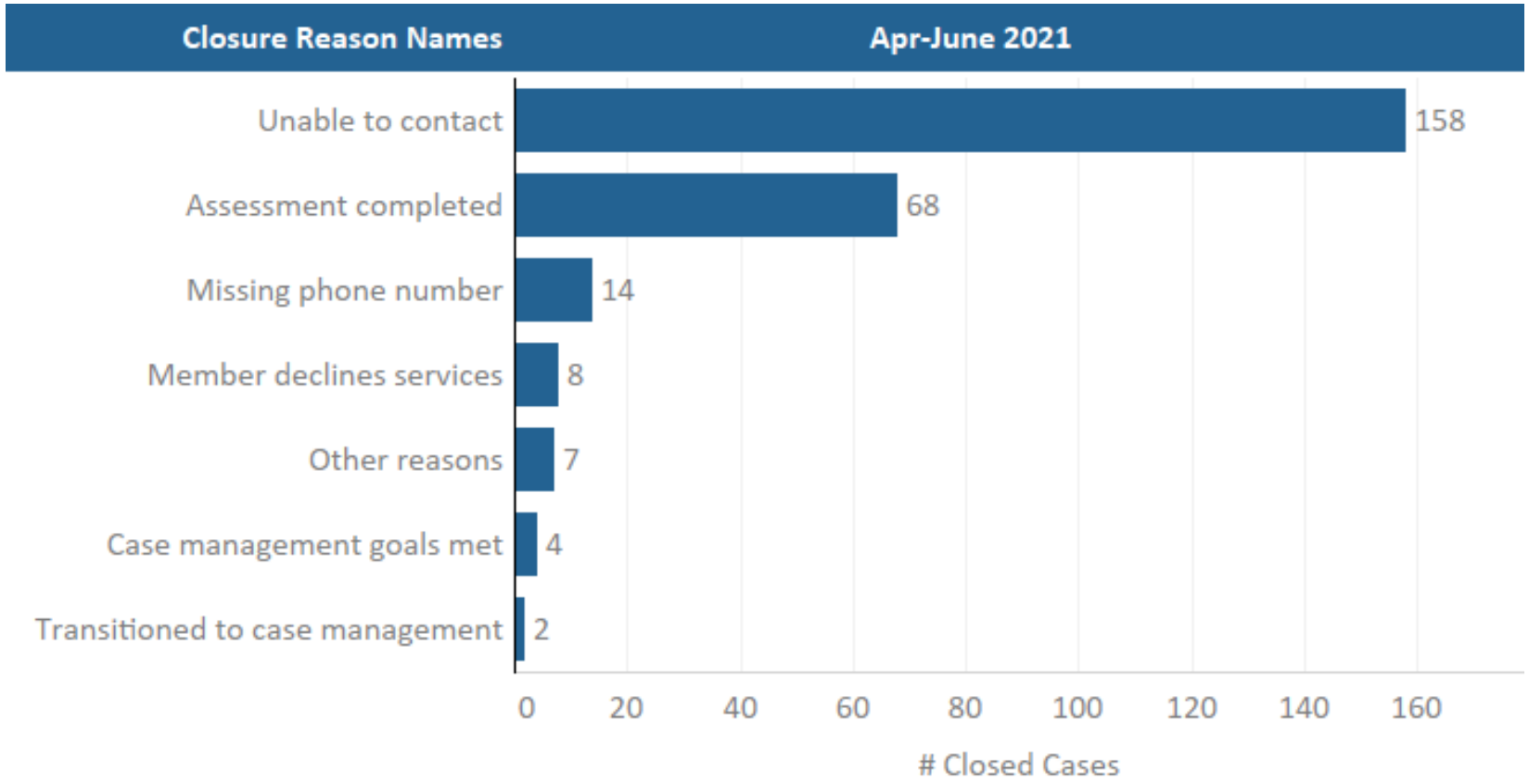
# of non-participating members with readmissions



Due to the small number of participants, any conclusions regarding outcomes must be interpreted with caution.

Post-Discharge Counseling – 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.



Performance Measures

Service Performance Standard	Guarantee	Method of Measurement	Actual	Pass/Fail
I. Quarterly and annual management reports	10 calendar days	Number of days after the end of the quarter that quarterly and annual reports are provided to PEBP and/or PEBP's actuary.	100%	Pass
II. Notification of potential high expense cases. High expense case is defined as a single claim or treatment plan expected to exceed $100,000.00	98%	Designated PEBP staff will be notified within 5 business days of the UM/CM vendors initial notification of the requested service	100%	Pass
III. Pre-certification information shall be provided to PEBP's third party administrator	98%	Precertification requests from healthcare providers shall be completed in accordance with URAC/NCQA standards and turn-around timeframes, or more efficient timeframe as proposed in questions 2.8.11; completed Pre-certifications shall be communicated to PEBP's Third Party Administrator using an approved method e.g. electronically, within 5 business days of UM completing Precertification determination.	100%	Pass
IV. Concurrent hospital review	98%	Concurrent hospital reviews shall be completed in accordance with URAC/NCQA standards; completed reviews shall be communicated to the provider using an approved method e.g. electronically within 2 business days of determination decision.	99%	Pass
V. Retrospective hospital review	98%	Retrospective reviews must be completed in accordance with URAC/NCQA standards; completed reviews shall be communicated using an approved method e.g. electronically within 5 business days of determination decision.	100%	Pass
VI. Implementation, initial transition from current UM/CM vendor and future transition to incoming UM/CM vendor during and after the termination of this contract.	98%	Tasks: Percent of tasks complete on time pursuant to the implementation or transition plan in the RFP response or as mutually agreed to by vendor and PEBP. Problem Resolution: Percent of problems document within 2 business days and resolved within 10 business days or later if agreed to by PEBP.	100%	Pass

Performance Measures

Service Performance Standard	Guarantee	Method of Measurement	Actual	Pass/Fail
VII. Customer Satisfaction Survey	90% or greater	Survey 100% of CM post-encounters within 7 days of closing the CM case; vendor may use hard copy surveys mailed via first class mail with return envelope to the member; or, vendor may use an electronic survey method. The survey responses will be reported semi-annually to PEBP no later than 30 calendar days following the end of the 2nd and 4th quarters of each plan year. Report shall include the prior semi-annual report findings for comparison purposes.	100%	Pass
VIII. Hospital Discharge Planning	95%	CM will contact or attempt to contact 95% of patients discharged from any facility within 3 business days of notification of discharge with clinical coaching and discharge planning assistance.	100%	Pass
IX. Large Case Management	95%	CM will identify and initiate case management for chronic disease, high dollar claims, and ER usage.	100%	Pass
X. Utilization Management for medical necessity and Center of Excellence usage	98%	UM review to determine medical necessity in accordance with the MPDs. Services to be performed at a Center of Excellence to be managed through the Case Management process.	100%	Pass
XI. Return On Investment (ROI) Guarantee	2:1 Savings to Fees for UM 3:1 Savings to Fees for CM	UM Pass/Fail CM Pass/Fail	UM ROI 13.0 to 1 CM ROI 3.5 to 1	Pass
XII. Disclosure of subcontractors and unauthorized transfer of PEBP data.	100%	A. All subcontractors who have access to PHI or PII data and physical locations where PEBP PHI or PII data is maintained and/or stored must be identified in this contract. Any changes to those subcontractors or physical locations where PEBP data is stored must be communicated to PEBP at least 60 days prior to implementation of services by the subcontractor. Implementation will not be in effect until PEBP has provided written authorization. B. All PEBP PHI or PII data will be stored, processed and maintained solely on currently designated servers and storage devices identified in this contract. Any changes to those designated systems during the life of this agreement shall be reported to PEBP at least 60 days prior to the changes being implemented. Implementation will not be in effect until PEBP has provided written authorization.	100%	Pass

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 June 30, 2021:

        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
June 30, 2021

Report Table of Contents

Basic Life Insurance & Long Term Disability Executive Summary

Most Recent Five Plan Years: July 01, 2016 to June 30, 2021

This is the final report for the 2020-21 plan year, providing updated information for the period beginning July 1, 2016 and ending June 30, 2021.

Basic Life

In total, Basic Life claim incidence and loss ratios decreased slightly in the 2020-21 plan year compared to the prior plan year. Incidence (page 4) was up for actives (2.0 compared to 1.7/1,000) and down for retirees (16.7 compared to 18.9/1,000). The loss ratios (page 5) for actives and retirees both trended up, with the active loss ratio up slightly at 33% compared to 27% last year and retiree loss ratio up more significantly at 345% compared to 254%. The overall loss ratio for Basic Life increased for this period, 106% compared to 78% last year. The Basic Life plan suffered a large loss of $1,518,963 for the plan year compared to a negative $22,600 last year, so the experience has deteriorated compared to the prior plan year.

When looking at the retiree liability for the plan year, the incidence has decreased from 298 claims/$1,000 for the prior plan year to 267 claims for this plan year. The loss ratio increased for the retiree plan overall, applying to both the state and non-state retirees: loss ratios increased this plan year compared to the prior plan year, 331% compared to 260% for state retirees and 386% compared to 240% for non-state retirees (page 6).

Long Term Disability

LTD claim incidence (page 7) is reported on an incurred basis; claims are charged to the plan year in which the disability began. While we do not have complete information, it appears the 2020-21 plan year may result in a large decrease in incidence, 12 claims for this plan year versus 27 for the prior plan year based on the most recent claim data.

LTD loss ratios (page 8) are reported on a cash basis, without regard for incurred date. The loss ratio for the 2020-21 plan year (35%) was down over the 2019-20 plan year (96%). The claim liability also decreased significantly for the period, representing 35% of the prior year's liability.

For the 2020-21 plan year, LTD claims and expenses were less than premiums by $1.6 million, decreasing the all year's deficit to $3.2 million.

Basic Life Insurance Claims by Plan Year and Participant Type

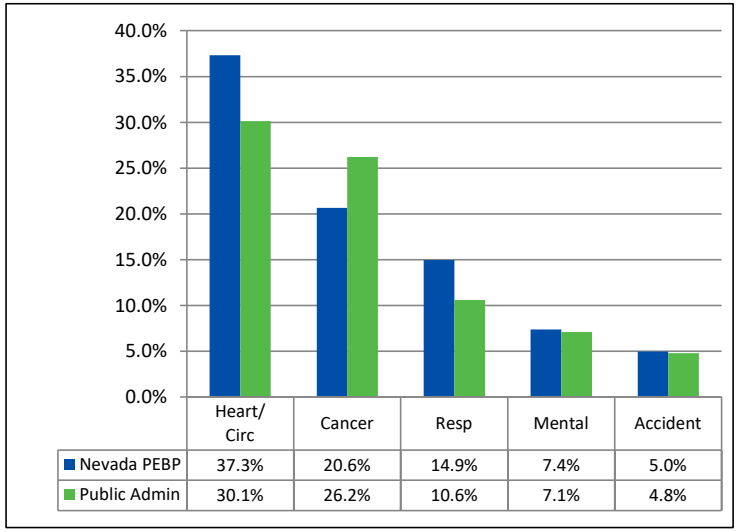
Most Recent Five Plan Years: July 01, 2016 to June 30, 2021

	From Jul-16 Through Jun-17		From Jul-17 Through Jun-18		From Jul-18 Through Jun-19		From Jul-19 Through Jun-20		From Jul-20 Through Jun-21	
Participant Type	**Count**	**Inc./ 1000**	**Count**	**Inc./ 1000**	**Count**	**Inc./ 1000**	**Count**	**Inc./ 1000**	**Count**	**Inc./ 1000**
Actives	51	2.0	41	1.6	47	1.8	47	1.7	52	2.0
Retirees	325	21.8	295	19.5	279	17.8	298	18.9	267	16.7
Totals	**376**	**9.6**	**336**	**8.4**	**326**	**7.9**	**345**	**8.0**	**319**	**7.6**

Basic Life Insurance Claims by Diagnostic Category

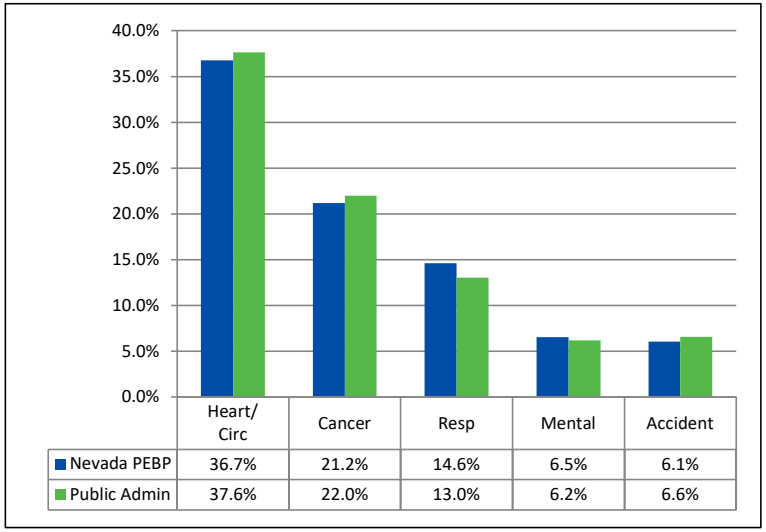
Public Admin benchmark is from SIC book of business for most recent 5 calendar years

Top Five Diagnostic Categories by Incidence



	Heart/ Circ	Cancer	Resp	Mental	Accident
Nevada PEBP	37.3%	20.6%	14.9%	7.4%	5.0%
Public Admin	30.1%	26.2%	10.6%	7.1%	4.8%

Top Five Diagnostic Categories by Liability

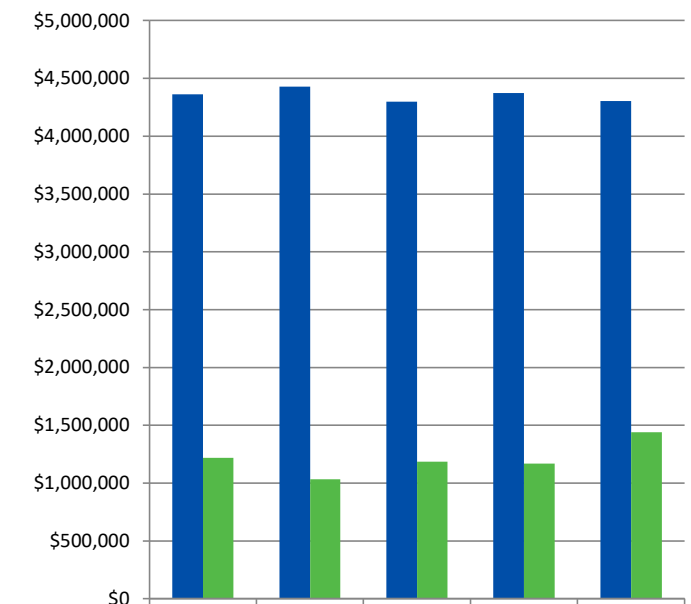


	Heart/ Circ	Cancer	Resp	Mental	Accident
Nevada PEBP	36.7%	21.2%	14.6%	6.5%	6.1%
Public Admin	37.6%	22.0%	13.0%	6.2%	6.6%

Basic Life Insurance Earned Premiums & Liability by Participant Type

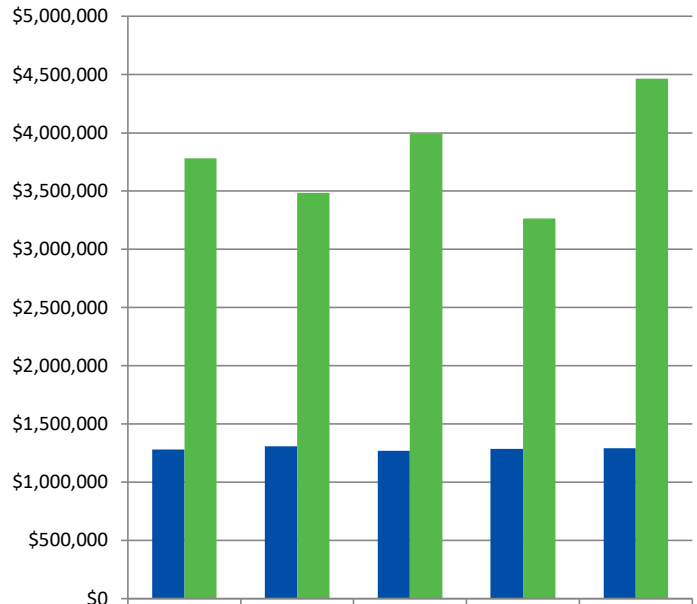
Most Recent Five Plan Years: July 01, 2016 to June 30, 2021

Active Participants



	2016 - 17	2017 - 18	2018 - 19	2019 - 20	2020 - 21
Earned Premium	$4,360,152	$4,427,366	$4,297,629	$4,373,406	$4,304,373
Claim Liability	$1,217,375	$1,031,986	$1,184,218	$1,167,764	$1,440,302
Loss Ratio	0.28	0.23	0.28	0.27	0.33

Retired Participants

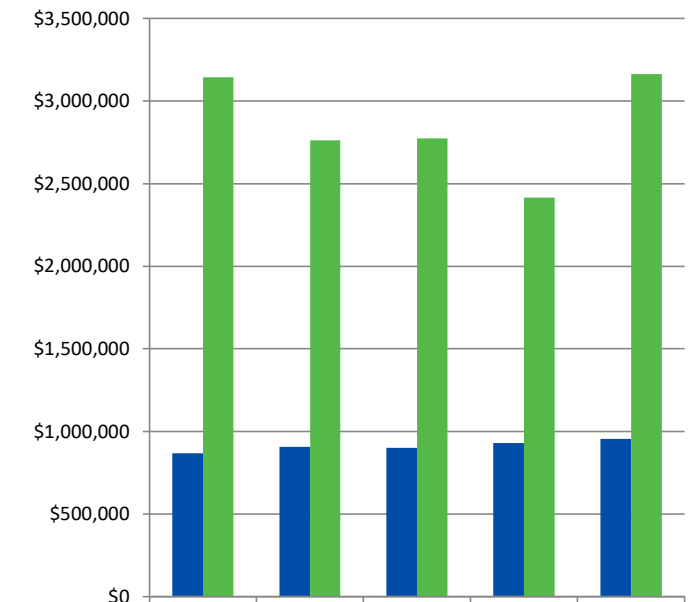


	2016 - 17	2017 - 18	2018 - 19	2019 - 20	2020 - 21
Earned Premium	$1,282,457	$1,306,604	$1,267,917	$1,284,882	$1,292,752
Claim Liability	$3,779,175	$3,485,155	$3,989,557	$3,265,674	$4,465,982
Loss Ratio	2.95	2.67	3.15	2.54	3.45

Basic Life Retiree Insurance Earned Premiums & Liability by Participant Type

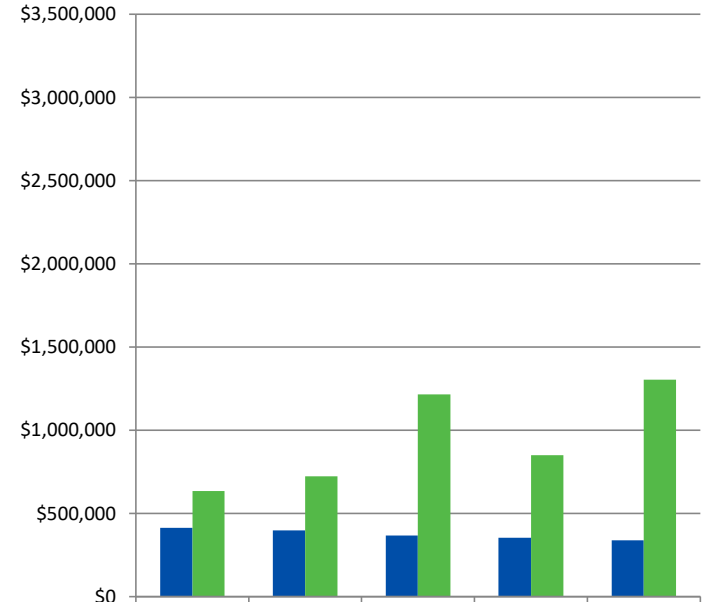
Most Recent Five Plan Years: July 01, 2016 to June 30, 2021

State Retired Participants



	2016 - 17	2017 - 18	2018 - 19	2019 - 20	2020 - 21
Earned Premium	$868,775	$907,326	$900,218	$930,348	$954,967
Claim Liability	$3,145,175	$2,761,244	$2,774,315	$2,415,621	$3,162,080
Loss Ratio	3.62	3.04	3.08	2.60	3.31

Non-State Retired Participants



	2016 - 17	2017 - 18	2018 - 19	2019 - 20	2020 - 21
Earned Premium	$413,682	$399,278	$367,699	$354,534	$337,785
Claim Liability	$634,000	$723,911	$1,215,242	$850,053	$1,303,902
Loss Ratio	1.53	1.81	3.30	2.40	3.86

Long Term Disability Claims by Plan Year

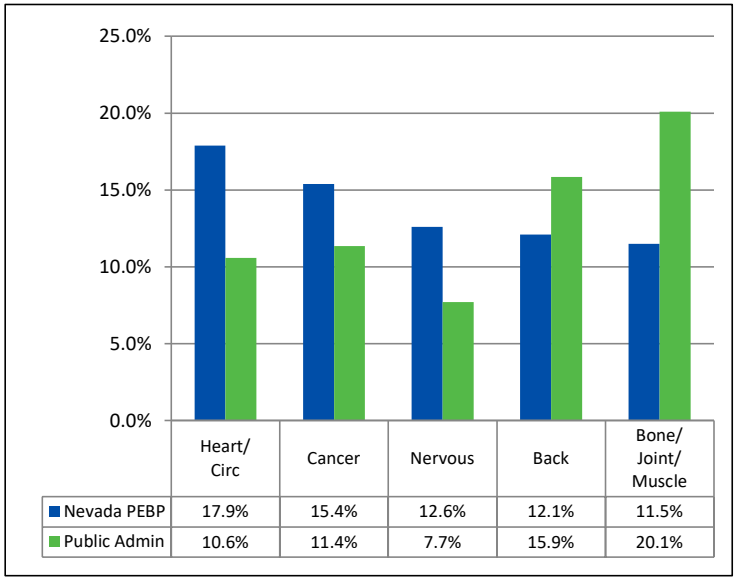
Most Recent Five Plan Years: July 01, 2016 to June 30, 2021

	From Jul-16 Through Jun-17		From Jul-17 Through Jun-18		From Jul-18 Through Jun-19		From Jul-19 Through Jun-20		From Jul-20 Through Jun-21	
	Count	Inc./ 1000	Count	Inc./ 1000	Count	Inc./ 1000	Count	Inc./ 1000	Count	Inc./ 1000
LTD Claims	36	1.4	29	1.1	26	1.0	27	1.0	12	0.5

Long Term Disability Claims by Diagnostic Category

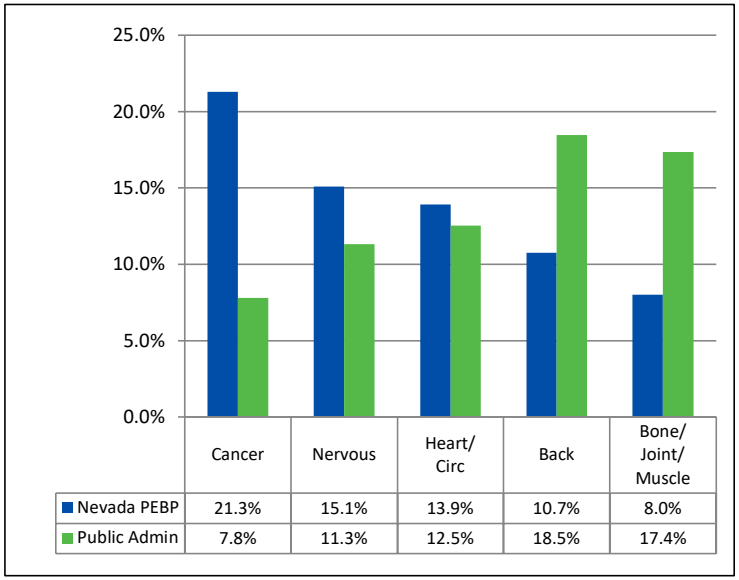
Public Admin benchmark is from SIC book of business for most recent 5 calendar years

Top Five Diagnostic Categories by Incidence



	Heart/ Circ	Cancer	Nervous	Back	Bone/ Joint/ Muscle
Nevada PEBP	17.9%	15.4%	12.6%	12.1%	11.5%
Public Admin	10.6%	11.4%	7.7%	15.9%	20.1%

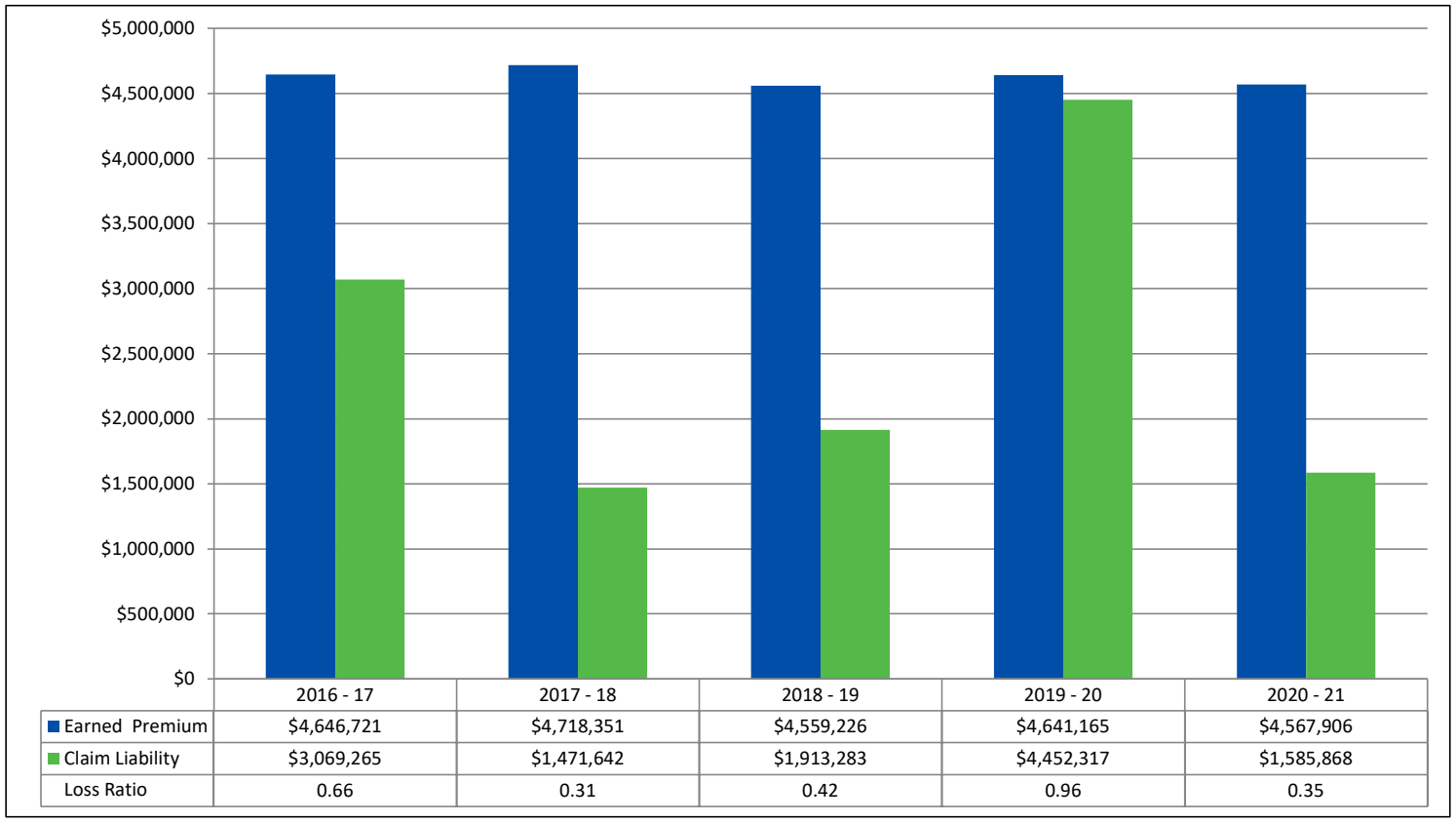
Top Five Diagnostic Categories by Liability



	Cancer	Nervous	Heart/ Circ	Back	Bone/ Joint/ Muscle
Nevada PEBP	21.3%	15.1%	13.9%	10.7%	8.0%
Public Admin	7.8%	11.3%	12.5%	18.5%	17.4%

Long Term Disability Earned Premiums & Liability

Most Recent Five Plan Years: July 01, 2016 to June 30, 2021



	2016 - 17	2017 - 18	2018 - 19	2019 - 20	2020 - 21
Earned Premium	$4,646,721	$4,718,351	$4,559,226	$4,641,165	$4,567,906
Claim Liability	$3,069,265	$1,471,642	$1,913,283	$4,452,317	$1,585,868
Loss Ratio	0.66	0.31	0.42	0.96	0.35

Claim Appeals

Quarterly Update for Plan Year to Date July 01, 2020 to June 30, 2021

	In Process	Decision Upheld	Decision Overturned	Total
Claim Appeals				
Life Insurance Claims	0	0	0	0
Long-Term Disability Claims	0	3	2	5
Short-Term Disability Claims	0	0	0	0
Total Appeals	**0**	**3**	**2**	**5**

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 June 30, 2021:

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 Willis Towers Watson's Individual Marketplace Enrollment & Performance Report

Nevada Public Employees Benefit Program

Quarterly Update – 4th Quarter Plan Year 2021

Willis Towers Watson's Individual Marketplace

July 29, 2021

The Public Employees Benefit Program Executive Dashboard

Quarterly Update – 4th Quarter Plan Year 2021

Executive Summary

Plan Enrollment:

- At the end of Q4 2021, PEBP's total enrollment into Medicare policies through Willis Towers Watson's Individual Marketplace decreased to 11,881. Since inception, 110 carriers have been selected by PEBP's retirees with current enrollment in 1,543 different plans.
- Medicare Supplement (MS) plan selection remained consistent at 86% of the total population with the majority of participants selecting AARP and Anthem BCBS of Nevada as their insurer; each carrier holds plans for 6,319 and 2,182 enrollees respectively. The average monthly premium cost for MS plans remained consistent at $147.
- The percentage of Medicare Advantage (MA or MAPD) plans selected remained consistent at 14%. Top MA carriers include Hometown Health Plan with 686 individual plan selections and Aetna with 421 individual plan selections. The average monthly premium cost to PEBP participants decreased to $15 compared to the prior quarter.

Customer Satisfaction:

- In Q4 2021, PEBP participant satisfaction with Enrollment Calls had an average satisfaction score result of 4.9 out of 5.0 based on 30 surveys returned.
- For Q4 2021, the average satisfaction score for Service Calls was 4.5 out of 5.0 based on 356 surveys returned.
- The combined average satisfaction score for Enrollment Calls and Service Calls was 4.5 out of 5.0 for Q4 2021.

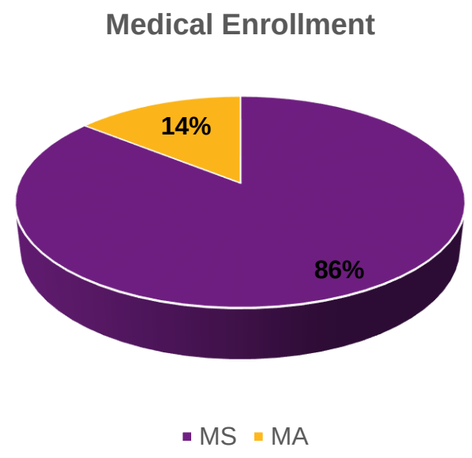
Health Reimbursement Arrangement:

- At the end of Q4 2021 there were 13,231 Health Reimbursement Arrangement (HRA) accounts for PEBP participants.
- There were 82,697 claims processed in Q4, with 95% being submitted via Auto-Reimbursement, meaning that participants did not have to manually submit 78,756 claims for Premium Reimbursement.
- The total reimbursement amount processed for Q4 was $8,324,498.

Summary of Retiree Decisions and Costs

Retiree Plan Selection Through 6/30/2021		Previous Qtr.
Total enrolled through individual marketplace	11,881	11,882
Number of carriers**	110	110
Number of plans**	1,543	1,557

Plan Type Selection Through 6/30/2021		Previous Qtr.
Medicare Advantage (MA, MAPD)	1,698	1,688
Medicare Supplement (MS)	10,191	10,236



"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	10,191	$147
Medicare Advantage (MA,MAPD)	1,698	$0 / $15
Part D drug coverage	7,486	$24
Dental coverage	1,093	$37
Vision coverage	2,044	$14

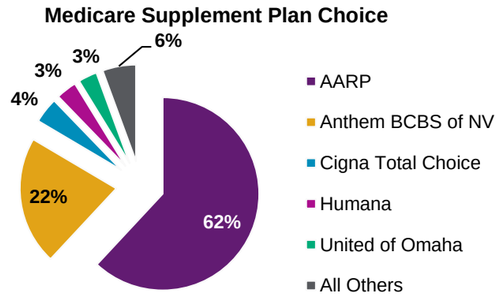
** Reflects total carriers and plans that PEBP participants have enrolled in nationwide, since inception.

The Public Employees Benefit Program Executive Dashboard

Quarterly Update – 4th Quarter Plan Year 2021

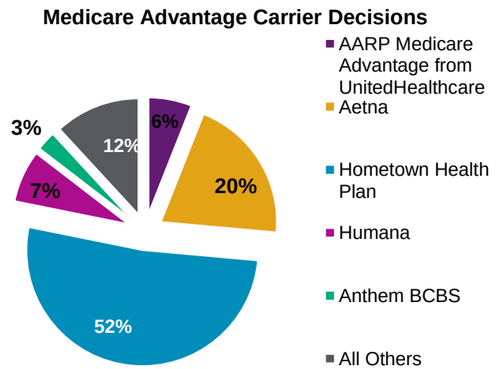
Summary of Retiree Carrier Choice

Top Medicare Supplement Plans	Total
AARP	6,319
Anthem BCBS of NV	2,182
Cigna Total Choice	426
Humana	351
United of Omaha	312



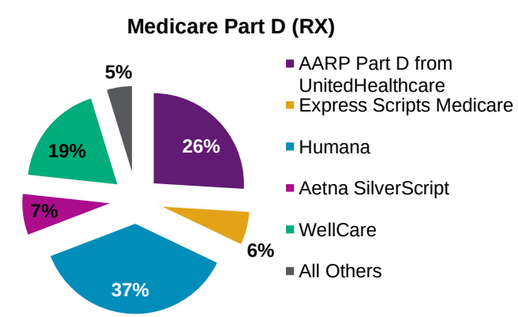
Cost Data For MS Plans	Cost
Minimum	$22
Average	$147
Median	$141
Maximum	$481

Top Medicare Advantage Plans	Total
AARP Medicare Advantage	179
Aetna	421
Hometown Health Plan	686
Humana	181
Anthem BCBS	63



Cost Data For MA Plans	Cost
Minimum	$0
Average	$15
Median	$0
Maximum	$194

Top Medicare Part D (RX)	Total
AARP Part D from United Healthcare	1,775
Aetna Medicare Rx (SilverScript)	809
Express Scripts Medicare	513
Humana	2,554
WellCare	1,446



Cost Data For Part D (RX)	Cost
Minimum	$6
Average	$24
Median	$18
Maximum	$130

The Public Employees Benefit Program Executive Dashboard

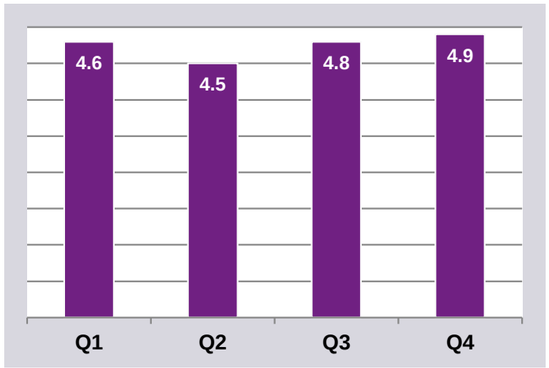
Quarterly Update – 4th Quarter Plan Year 2021

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

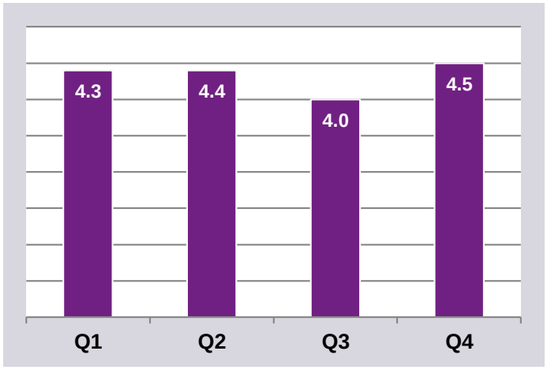
Q4 Enrollment Satisfaction

CSAT score	Count	%
5	26	87%
4	4	13%
3	0	0%
2	0	0%
1	0	0%
	30	**100%**



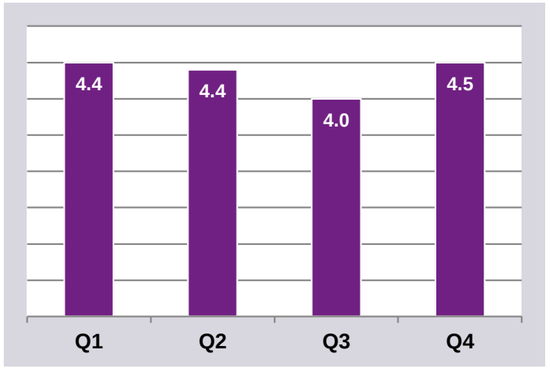
Q4 Service Satisfaction

CSAT score	Count	%
5	258	71%
4	63	17%
3	24	7%
2	9	2%
1	11	3%
	365	**100%**



Q4 Enrollment & Service Combined

CSAT score	Count	%
5	284	72%
4	67	17%
3	24	6%
2	9	2%
1	11	3%
	395	**100%**

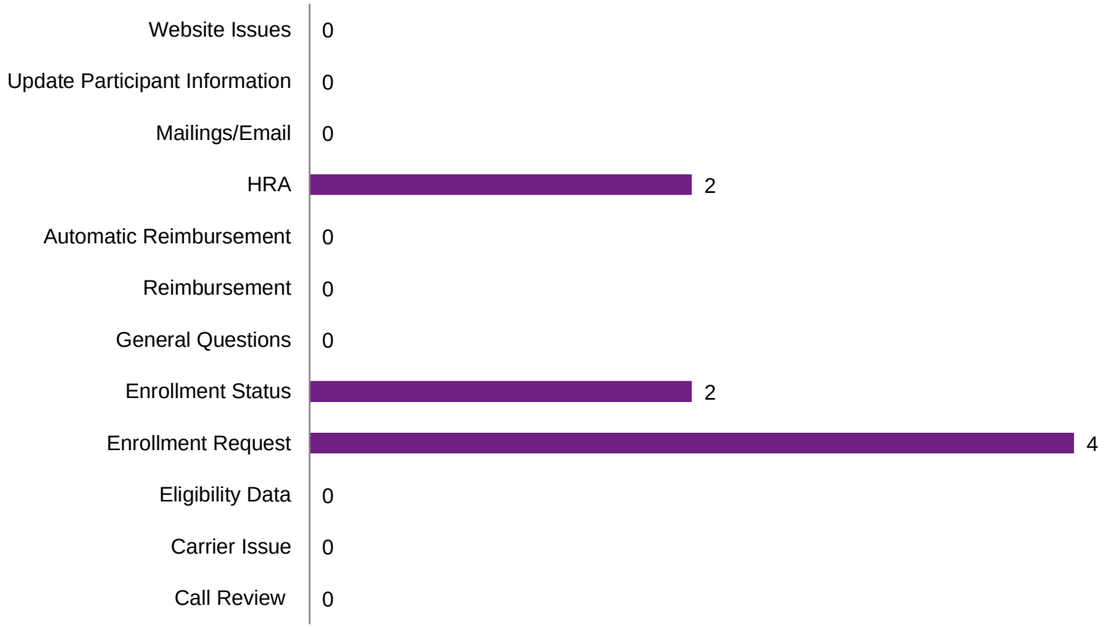


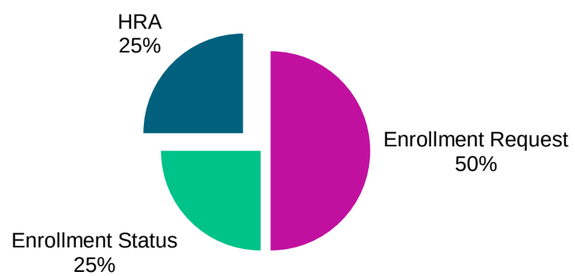
The Public Employees Benefit Program Executive Dashboard

Quarterly Update – 4th Quarter Plan Year 2021

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 Q4-PY21 is 8 and are associated with the following categories:





Health Reimbursement Account (HRA)

Claim Activity for the Qtr.	Total
HRA accounts	13,231
Number of payments	52,956
Accounts with no balance	7,233
Claims paid amount	$8,324,498

Claims By Source	Total 82,697
A/R file	78,756
Mail	1,722
Web	1,737
Mobile App	482

The Public Employees Benefit Program Executive Dashboard

Quarterly Update – 4th Quarter Plan Year 2021

Performance Guarantees*

Category	Commitment	Outcome	PG MET
Claims Turnaround Time	≤ 2 days	0.36 Days	Yes
Claim Financial Accuracy	≥ 98%	98.87%	Yes
Claim Processing Payment Precision	≥ 98%	Results not Reported on Benefits Accounts	Yes
Reports	≤ 15 business days	Met	Yes
HRA Web Services	≥ 99%	99.92%	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.	9 Seconds	Yes
Benefits Administration Customer Service Abandonment Rate Annual	≤ 5%	Annual	N/A
Customer Satisfaction	≥ 80%	94.94%	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

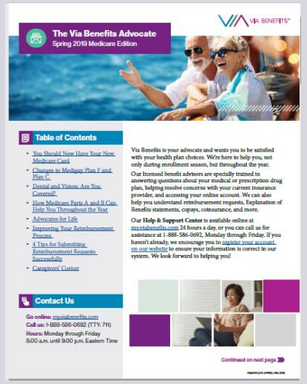
Quarterly Update – 3rd Quarter Plan Year 2021

Operations Report

Communications:

Below is information on communications that were mailed or will be coming up.

- Fall Balance Reminder
  - This communication is sent to participants via mail if they have a balance in their Health Reimbursement Arrangement (HRA) and haven't had any claims payment activity in the prior 90 days. The fall balance reminder is generally sent in in September.
- Fall Newsletter
  - This communication is sent participants via email or mail and is designed to educate participants on different areas like Medicare, HRA, Direct Deposit, and Auto-Reimbursement functionality. It will also focus on the upcoming Medicare Enrollment season that will be from October 15 – December 7. This newsletter typically is sent from mid-September – mid-October.



New $8,000 HRA Available Balance Cap:

Effective May 31, 2021, Nevada PEBP implemented an $8,000 HRA Available Balance Cap. The implementation of this new cap saw balance adjustment for 1,110 retiree accounts processed to reduce the balance to $8,000. These adjustments reduced the HRA Balance liability for Nevada PEBP.

The new $8,000 HRA Available Balance Cap process will be an annual process going forward.

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 June 30, 2021:

        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 Willis Towers Watson's Individual Marketplace Enrollment & Performance Report

        4.3.6 Hometown Health Providers and Sierra Healthcare Options – PPO Network

Hometown Health Providers & Sierra Healthcare Options

Q4 PlanYear2021

April 1st, 2021 – June 30, 2021

Hometown Health

SIERRA HEALTH-CARE OPTIONS, INC.

Nevada PUBLIC EMPLOYEES' BENEFITS PROGRAM

PEBP

Health Matters.

Sept 23, 2021

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	97%	Pass
	97%- Accuracy of claims repriced by the PPO Network must be accurate and must not cause a claim adjustment by PEBP'sTPA	98%	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 June 30, 2021:

        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 Willis Towers Watson's Individual Marketplace Enrollment & Performance Report

        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

Annual
Update for
July 1, 2020 – June 30, 2021

HEALTH PLAN OF NEVADA
A UnitedHealthcare Company

Nevada PUBLIC EMPLOYEES' BENEFITS PROGRAM
PEBP
Health Matters.

August 13th, 2021

Health Plan of Nevada HMO

Performance Standards and Guarantees- Self Reported

Annual Report for July 2020 – June 2021

Service Performance Standard (Metric)	Guarantee Measurement	Actual	Pass/Fail
I. Claims Processing	**97%** - Claims Financial Accuracy	100.00%	Pass
	95% - Claims Procedural Accuracy	100.00%	Pass
	95% in 30 working days - Clean claims turnaround for unaffiliated providers	98.51%	Pass
II. Participant Correspondence	ID Card Turnaround- Mailed within 10 working days of date of eligibility input	3.12 days	Pass
	Membership materials (electronic)- Available within 10 working days of date of eligibility input	6.21 days	Pass
III. Customer Service- Telephone	Speed to queue and answer by live voice- Within 60 seconds	13 sec	Pass
	5% or less - Telephone abandonment rate	1.50%	Pass
IV. Other Customer Service	**98%** - Resolved resolution within 30 days of receipt of written correspondence (i.e. complaint or appeal)	100.00%	Pass
	Notification to member regarding PCP disenrollment - within 30 working days	100%	Pass
	Primary Care Physician /Member Ratio - 1 to 2450	1 to 257.5	Pass

4.3.8

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

4.3 Receipt of quarterly vendor reports for the period ending June 30, 2021:

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 Willis Towers Watson's Individual Marketplace Enrollment & Performance Report

4.3.6 Hometown Health Providers and Sierra Healthcare Options – PPO Network

4.3.7 HealthPlan of Nevada, Inc. – Southern Nevada HMO

4.3.8 Doctor on Demand Engagement Reports through August 2021

NVPEB

HealthSCOPE Benefits

2021-08 Engagement Report

dr. on demand

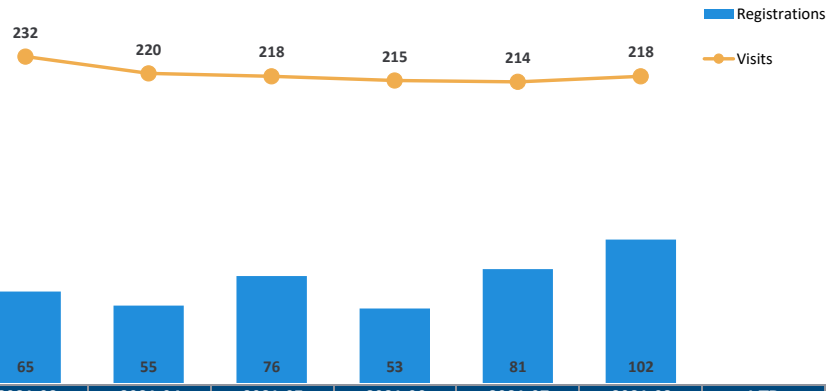
Note: Only Doctor On Demand visits with an associated claim submission to the Payer are included in the Engagement Report -- any free, discounted, uncovered, or other non-claim visits are not included. This is true of all metrics, trends, and aggregations.

Year To Date Activity

Registration Summary	YTD
# Registered	591

Visit Summary	YTD
# Unique Visitors	1,032
# Visits	1,786

Monthly Activity



Registration Summary	Prior	2021-03	2021-04	2021-05	2021-06	2021-07	2021-08	LTD
# Registered	9,125	65	55	76	53	81	102	9,557

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

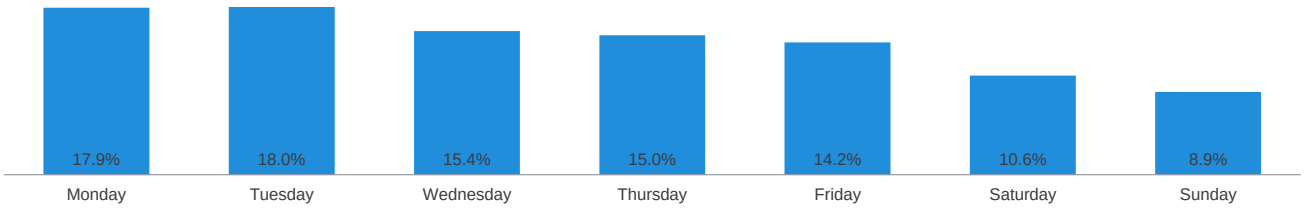
Visit Summary		Prior	2021-03	2021-04	2021-05	2021-06	2021-07	2021-08	LTD
# Unique Visitors		3,655	195	185	194	187	187	189	3,993
# Visits		8,143	232	220	218	215	214	218	9,460
Visit Frequency	% 1 Visit	57.0%	86.2%	84.9%	88.1%	88.8%	87.7%	86.8%	54.5%
	% 2 Visits	18.6%	9.7%	11.9%	11.3%	7.5%	10.2%	11.6%	19.1%
	% 3 Visits Or More	24.4%	4.1%	3.2%	0.5%	3.7%	2.1%	1.6%	26.4%

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

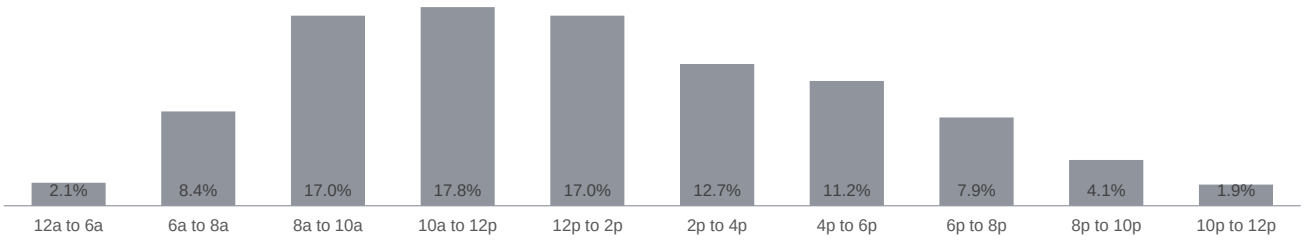
Visit Type Summary		Prior	2021-03	2021-04	2021-05	2021-06	2021-07	2021-08	LTD
Medical		6,719	168	158	164	165	168	180	7,722
Mental Health	Therapy	763	36	33	20	27	26	19	924
	Psychiatry	661	28	29	34	23	20	19	814

Six Month Trends: Visit Time And Demographics

Day Of Week



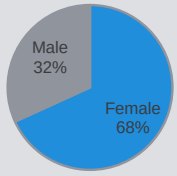
Hour Of Day



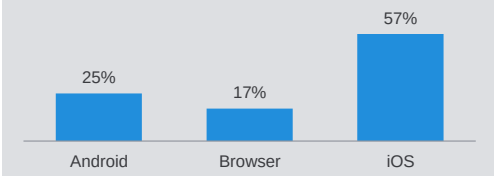
Patient Age

0 to 17 (Custodial)	6%
18 to 29	19%
30 to 49	50%
50 and over	24%

Patient Gender



Visitor App Type



NVPEB

HealthSCOPE Benefits

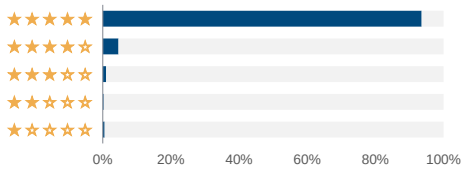
2021-08 Engagement Report

Historical Visit Experience

7,057 Visit Ratings (1-5 Stars):

Average: **4.9**

Stars:



Avg Connection Time (On Demand Visits Only): **9.0 Minutes**

Historical Post Visit Survey Results

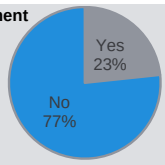
Without Doctor On Demand, where would you have gone to get this issue treated?

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

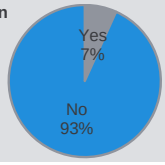
Response	# Responses	% Responses
Emergency Room	121	3%
Urgent Care	1,866	50%
Doctor's Office	1,041	28%
Stayed Home	523	14%
Other	178	5%

Six Month Trends: Visit Initiation

Initiated By Appointment
(Medical Visits Only)

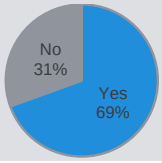


Initiated By Custodian

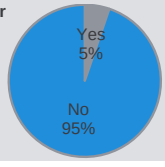


Six Month Trends: Visit Result

Resulted In Rx



Resulted In Lab Order



Historical Top 15 Symptoms

Symptom	# Symptoms	% of All Sym
General Symptoms: Fatigue / weakness	2,072	5.9%
Head / Neck: Headache	2,068	5.9%
Chest: Cough	1,977	5.6%
Head / Neck: Sore throat	1,822	5.2%
General Symptoms: Difficulty sleeping	1,724	4.9%
Head / Neck: Nasal discharge	1,462	4.2%
Head / Neck: Congestion / sinus problem	1,393	4.0%
General Symptoms: Fever	1,103	3.1%
Head / Neck: Congestion/sinus problem	1,002	2.9%
General Symptoms: Loss of appetite	971	2.8%
Genitourinary: Discomfort / burning with urination	956	2.7%
Genitourinary: Frequent urination	942	2.7%
Chest: Shortness of breath	615	1.8%
Head / Neck: Ear pain	603	1.7%
Skin: Skin rashes / bumps	599	1.7%

Historical Top 15 ICD10 Codes

ICD10 Code And Description	# ICD10s	% of All ICD10
N39.0 - Urinary tract infection, site not specified	911	7.4%
J01.90 - Acute sinusitis, unspecified	577	4.7%
J06.9 - Acute upper respiratory infection, unspecified	562	4.5%
F41.1 - Generalized anxiety disorder	372	3.0%
J02.9 - Acute pharyngitis, unspecified	355	2.9%
Z76.0 - Encounter for issue of repeat prescription	314	2.5%
R05 - Cough	313	2.5%
F43.23 - Adjustment disorder with mixed anxiety and depressed mo	253	2.0%
J20.9 - Acute bronchitis, unspecified	237	1.9%
F41.9 - Anxiety disorder, unspecified	215	1.7%
J01.80 - Other acute sinusitis	174	1.4%
F33.1 - Major depressive disorder, recurrent, moderate	158	1.3%
Z63.0 - Problems in relationship with spouse or partner	150	1.2%
F33.9 - Major depressive disorder, recurrent, unspecified	134	1.1%
F34.1 - Dysthymic disorder	131	1.1%

Historical Top 15 Rx

Rx	# Visits	% of All Rx
nitrofurantoin	661	6.7%
amoxicillin-clavulanate	629	6.4%
predniSONE	623	6.3%
benzonatate	620	6.3%
albuterol	577	5.8%
fluticasone nasal	268	2.7%
sulfamethoxazole-trimethoprim	264	2.7%
fluconazole	258	2.6%
methylPREDNISolone	230	2.3%
amoxicillin	226	2.3%
azithromycin	222	2.2%
FLUoxetine	212	2.1%
doxycycline	203	2.1%
sertraline	195	2.0%
escitalopram	189	1.9%

Historical Top 15 Lab Orders

Lab Name	# Lab Orders	% of All Orders
TSH with Reflex to Free T4	107	9.9%
Comprehensive Metabolic Panel	99	9.2%
CBC+diff	81	7.5%
Urinalysis, Complete with Reflex	80	7.4%
Lipid Panel	71	6.6%
Urine Culture, Routine	68	6.3%
Hemoglobin A1c	61	5.7%
Vitamin D	50	4.6%
Urinalysis, Complete	38	3.5%
Chlamydia/GC, Urine	35	3.3%
B12/Folate	30	2.8%
Basic Metabolic Panel	24	2.2%
RPR w/ Reflex	16	1.5%
T. Vaginalis, Urine FEMALE	14	1.3%
T. Vaginalis, Urine MALE	13	1.2%

5.

5. Election of Board Vice-Chair pursuant to Nevada Administrative Code (NAC) 287.172. Eligible candidates are Linda Fox, Tom Verducci, Jennifer Krupp, April Caughron, Betsy Aiello, Michelle Kelley, Jim Barnes, Leslie Bittleston and Jennifer McClendon. (Laura Freed, Board Chair) (**For Possible Action**)

6.

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

STEVE SISOLAK
Governor

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

LAURA RICH
Executive Officer

LAURA FREED
Board Chair

AGENDA ITEM

☐ Action Item
☒ Information Only

Date: September 30, 2021

Item Number: VI

Title: Executive Officer Report

SUMMARY

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

REPORT

ARPA FUNDING UPDATE

PEBP submitted its request for American Rescue Plan funds through the "Every Nevadan Recovery Framework" link per the Board approved direction at the July 2021 Board meeting. The State Treasurer's Office has hosted many meetings throughout the state as part of its listening tour and it is expected that funding decisions will be made in the coming months. PEBP has made both the Governor's Office and Treasurer's Office aware of PEBP's unique timing requirements relating to benefit design planning.

PEBP was also given instruction by the Governor's Finance Office that the request for additional CARES Act funding must also be requested in the same manner, therefore PEBP submitted an additional request to cover COVID-19 costs incurred by the plan to date. However, most recently, PEBP and GFO staff have had follow up discussions and PEBP has received new guidance requesting PEBP to submit a work program for $5M in reimbursements, which has been placed on the October IFC agenda.

STAFFING UPDATES

Many PEBP members at one point have interacted with PEBP's long time staff member, Quality Control Officer Nancy Spinelli. Nancy has worked at PEBP for over two decades in almost every role at PEBP. Most recently she has led Quality Control where she was responsible for researching and handling member complaints and issues. Retirees have also come to know her well as she has attended events and assisted retirees with their PEBP and Medicare questions. Nancy announced last month that she would finally be retiring and her last day would be September 10th. She will most definitely be missed, and it will certainly be a significant gap in the PEBP executive team.

I am happy to announce that a new Quality Control Officer has been appointed. Former Board Member, Tim Lindley, was appointed on September 20th. His experience on the board and his auditing background will prove to be very helpful in his new role.

Another major staffing change has occurred for our vendor partner, Aon. Many Board members, and those who follow the PEBP Board meetings, have become familiar with PEBP's lead actuary, Stephanie Messier. Stephanie recently left her position at Aon and as a result, we will see new Aon representatives take on her role.

PLAN UPDATES

Since 2010, PEBP's Master Plan Documents have required members to receive their routine lab services through independent labs, such as Quest and LabCorp. This is due to the relative high fees charged by hospital-based labs that can be triple or more the cost for the same service as free-standing facilities. Before July 1, PEBP did not enforce this plan rule because the relationship between the Hometown Health Network and Renown maintained fees similar to those fees charged by independent labs. After switching to the new Aetna network contracted rates for Renown labs is now billed at hospital lab rates, which would increase plan costs dramatically if the plan requirement is not enforced.

It is important to emphasize Renown labs are in-network through Aetna and members can still utilize Renown labs for hospital pre-admission or outpatient surgery. To add to this, the Master Plan Document allows for exceptions to this rule should no independent lab options be available within a 50 mile radius.

This can be confusing for members since the provider directory displays Renown labs as an in-network provider. Realizing this, PEBP has released several notices to members. PEBP has also coordinated with HealthSCOPE Benefits to allow a one-time exception and an education opportunity to ensure members who were not aware of the enforcement are not subject to denied claims.

PEBP is also in discussions with Renown and Aetna to identify possible solutions that increase access while continuing to keep costs low for the program. In the meantime, Renown has indicated

they are unable to operationally apply PEBP's plan rules to a subset of PEBP patients seen under the Aetna contract and can only apply an all or nothing approach by employer. Renown has opted to not service members routine laboratory testing at Renown labs in their effort to ensure PEBP members are not unknowingly responsible for higher out-of-pocket cost for routine lab claims. In addition, members requiring lab draws during an infusion procedure may also be affected since Renown states that it must apply the all in or all out coverage.

Laboratory Outpatient Services

Outpatient lab services are covered when medically necessary, when ordered by a physician or health care practitioner, and when services are performed in accordance with the Laboratory Outpatient Services benefit described in this section.

Free-standing, non-hospital-based laboratory facility: The Plan covers outpatient routine and preventive lab services performed at free-standing, non-hospital-based lab facilities. Although there may be other in-network free-standing, non-hospital-based lab facilities, the Plan's preferred facilities include Lab Corp and Quest. Routine and preventive lab services include:

- Medically necessary routine labs when ordered by a physician as part of comprehensive medical care.
- Preventive laboratory services such as but not limited to basic metabolic panel, lipid, or general health panel. Refer to the *Preventive Care/Wellness Services* for information regarding benefits for screening tests and preventive lab testing.

Outpatient hospital-based lab facilities and hospital-based lab draw stations: The Plan covers outpatient lab services for pre-admission testing when performed 7 days prior to a scheduled hospital admission or outpatient surgery. The testing must be related to the sickness or injury for which admission or surgery is planned.

If a free-standing, non-hospital-based outpatient laboratory facility is not available within 50 miles of your residence, you may use a hospital-based laboratory facility or hospital-based draw station.

BOARD MEMBER TRAINING

Historically, the Attorney General's Office and the Commission on Ethics have provided the PEBP Board with the required Open Meeting Law and Ethics trainings during PEBP Board meetings. To make the best use of the public and Board members' time, PEBP staff will instead be providing Board members with training material, as well as information on how to attend annual trainings hosted by the State outside of the Board meetings. Board members will be responsible for completing the required training.

COVID AND FLU SHOT CLINICS

Every year PEBP hosts a series of flu shot clinics for members in Carson City and Las Vegas. This year, we will also include the COVID vaccine. Although the flu vaccine was not yet available, PEBP hosted its first vaccine clinic in the Bryan building on August 23rd to respond to the State's newly implemented testing requirements for unvaccinated employees. Three additional flu shot and COVID vaccine clinics are scheduled in September and October in both Carson City and Las Vegas.

7.

7. Presentation and possible action regarding COVID-19 coverage changes and potential Covid Surcharges (Laura Rich, Executive Officer) (**For Possible Action**)

STEVE SISOLAK
Governor

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

LAURA RICH
Executive Officer

LAURA FREED
Board Chair

AGENDA ITEM

[X] Action Item
[ ] Information Only

Date: September 30, 2021

Item Number: VII

Title: COVID-19 Update, Coverage Options and Potential COVID Surcharge for Unvaccinated Members

SUMMARY

This report will provide the Board, participants, public, and other stakeholders information on PEBP COVID-19 claims experience and discuss potential coverage and premium options.

BACKGROUND

On March 5, 2020, Governor Sisolak issued an Emergency Regulation requiring all fully-insured health plans regulated by the Division of Insurance (DOI) to cover all COVID-19 testingrelated costs. Because PEBP is a self-insured program and is therefore not regulated by the DOI, several coverage options were brought to the Board at the March 31, 2020 meeting. The Board ultimately voted on and approved the following option:

- Option 2: Effective March 5 through July 3, 2020, cover all testing and associated office visit at 100% of the plan's maximum allowable charge regardless of network participation status with no cost sharing to the member. Cover formulary medications for the treatment of COVID-19 with no cost sharing and non-formulary medications without prior authorization when supply shortages exist.

The elimination of cost sharing for COVID-19 testing was later strengthened on a federal level and the Board opted to extend the no cost-sharing requirement for associated office visits and treatments indefinitely.

REPORT

PEBP COVID-19 CLAIMS EXPERIENCE

The chart below provides an illustration of the COVID diagnosis among members in PEBP's self-insured plans (not including Medicare Exchange or HMO members).

COVID-19 Diagnosis	# of Members	# with ER	*% with ER*	# with Inpatient	*% with Inpatient*	# with ICU	# with Ventilator
Confirmed	2,252	335	14.9%	226	10.0%	34	13
Probable*	35	2	5.7%	2	5.7%	1	0
Possible*	273	39	14.3%	200	73.3%	32	6

- 18 PEBP members have passed away as a result of a COVID-19 diagnosis
- Since the beginning of the pandemic, the plan has paid $13,240,650 in COVID related costs, including claims for testing, treatment and vaccinations.
- The plan has paid approximately $5,046,389 in (medical) claims costs since April 2021, when the vaccine became available to Nevadans 16 years of age and older.

Examples:

Case 1: 61-year-old female admitted on 8/14/20 to Summerlin Hospital for shortness of breath and fever. Member was diagnosed with COVID-19 and admitted to ICU. Member passed away on 9/26/20. COVID related services plan paid amount **$197,185.90**

Case 2: 70-year-old male admitted to Carson Tahoe Regional Medical Center for worsening respiratory distress. Member was diagnosed with COVID-19 and admitted to ICU. Member passed away on 4/19/21. COVID related services plan paid amount **$179,411.12**

Case 3: 28-year-old male with no significant prior medical history. He presented to the emergency department at Sunrise Hospital on July 18, 2021 with complaints of shortness of breath, cough, nausea, and fever. He tested positive for COVID-19 and was unvaccinated. He tried to manage his symptoms as outpatient but they worsened. He also noticed occasional blood in his phlegm. He was started on intravenous medications and antibiotics. He required intubation and mechanical ventilation on July 30, 2021 due to hypoxic respiratory failure. it was determined that he needed extracorporeal membrane oxygenation (ECMO). However, there were no ECMO beds available in Nevada. A referral was made to UCLA Health Hospital in California where an ECMO bed was available for him. He was transferred to Ronald Reagan UCLA Medical Center on August 4, 2021 by air ambulance. The member passed away on August 16, 2021. COVID related services: **~$1M in billed charges**

COST-SHARING COVERAGE

As the vaccine has become widely available to adults, insurers have reverted toward applying normal cost-sharing rules for COVID-19 claims (excluding testing, which continues to be required to be covered at 100%). For PEBP, this change would result in COVID related hospitalization and treatment being again subject to deductibles, coinsurance and copays, versus the 100% coverage that is in place today.

COVID SURCHARGES

On August 25, 2021, Delta announced that it would be implementing a $200 surcharge on health insurance premiums to all unvaccinated employees, citing the surcharge as a way to recover the costs of insuring employees who get hospitalized for COVID. The company, who like PEBP is self-insured, has paid on average of approximately $50,000 for COVID hospitalizations. Two weeks after the announcement, 20% of their previously unvaccinated employees had been vaccinated. https://www.natlawreview.com/article/imposing-group-health-plan-monthly-surcharges-unvaccinated

After receiving initial support from the Governor's Office, PEBP conducted some preliminary research in this area. Although there appears to be a lack of clear guidance and various potential challenges, there may be opportunities to mimic a solution similar to Delta's COVID surcharge for implementation at PEBP either mid-year or at the beginning of the upcoming plan year. Staff will work in conjunction with Governor's Office and other state agencies to develop options to present at the November Board meeting, should the Board express interest in the possible implementation of COVID surcharges to unvaccinated members.

Recommendation:

1. ***Remove 100% coverage benefit for COVID related treatment and hospitalization and apply existing plan rules to COVID related treatment and hospitalization claims moving forward.***
2. ***Permit PEBP staff to conduct further research on COVID surcharges and provide an update and potential options at the November Board meeting.***

8.

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

    8.1 Contract Overview

    8.2 New Contracts

    8.3 Contract Amendments

        8.3.1 LSI Consulting – Amendment #1

        8.3.2 Claim Technologies – Amendment #1

    8.4 Contract Solicitations

    8.5 Status of Current Solicitations

STEVE SISOLAK
Governor

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

LAURA RICH
Executive Officer

LAURA FREED
Board Chair

AGENDA ITEM

[X] Action Item
[ ] Information Only

Date: September 30, 2021

Item Number: VIII

Title: Contract Status Report

Summary

This report addresses the status of PEBP contracts to include:

1. Contract Overview
2. New Contracts for approval
3. Contract Amendments for approval
4. Contract Solicitations for approval
5. Status of Current Solicitations

8.1 Contracts Overview

Below is a listing of the active PEBP contracts as of June 30, 2021.

PEBP Active Contracts Summary							
Vendor	**Service**	**Contract #**	**Effective Date**	**Termination Date**	**Contract Max**	**Current Expenditures**	**Amount Remaining**
HealthScope Benefits	TPA	11825	2/8/2011	6/30/2022	$ 62,600,000	$ 57,208,041	$ 5,391,959
Health Claim Auditors Inc.	Health Plan Auditor	12614	10/11/2011	9/30/2022	$ 2,827,910	$ 1,535,497	$ 1,292,413
HealthScope Benefits	National PPO	13330	7/1/2012	6/30/2022	$ 15,455,000	$ 11,202,909	$ 4,252,091
The Standard	Group Basic Life Insurance	14276	7/1/2013	6/30/2022	$ 80,587,091	$ 76,307,632	$ 4,279,459
HealthScope Benefits	Voluntary Flexible Spending Account	14465	7/1/2013	6/30/2022	$ 125,000	$ -	$ 125,000
Diversified Dental Services Inc.	Dental Contract	14563	7/9/2013	6/30/2021	$ 3,081,984	$ 2,533,604	$ 548,380
HealthScope Benefits	Dental Claims	14574	7/9/2013	6/30/2022	$ 6,100,000	$ 5,050,894	$ 1,049,106
Hometown Health Providers	In-state PPO Network	15510	7/1/2014	6/30/2022	$ 9,955,139	$ 8,535,716	$ 1,419,423
Standard Insurance Company	Voluntary Life Insurance	15503	7/1/2014	6/30/2023	$ 22,500,000	$ -	$ 22,500,000
Morneau Shepell LTD	Benefits Management System	15941	1/1/2015	12/31/2023	$ 8,623,789	$ 6,007,334	$ 2,616,455
Extend Health, Inc	Medicare Exchange	16468	7/1/2015	6/30/2025	$ 1,546,000	$ 1,233,742	$ 312,258
KPS3	Website Redesign	17226	11/1/2015	6/30/2021	$ 80,775	$ 69,783	$ 10,992
Casey,Neilon & Associates	Financial Auditor	17424	3/8/2016	12/31/2021	$ 236,500	$ 225,052	$ 11,448
Express Scripts, Inc.	Pharmacy Benefit Manager	17551	4/12/2016	6/30/2022	$291,134,666	$ 236,057,102	$ 55,077,564
AON Consulting	Consulting Services	17596	7/1/2016	6/30/2022	$ 3,601,585	$ 2,841,240	$ 760,345
Health Plan of Nevada Inc	Southern Nevada HMO	18362	7/1/2017	6/30/2021	$231,000,000	$ 149,562,738	$ 81,437,262
American Health Holdings	PPO Utilization Management Case Management	21376	7/1/2019	6/30/2023	$ 8,000,000	$ 3,869,465	$ 4,130,535
Labyrinth Solutions, Inc.	Benefits Management System	23678	12/8/2020	6/30/2027	$ 6,849,000	$ -	$ 6,849,000
Aetna	PPO Network	23846	7/1/2021	6/30/2026	$ 7,127,250	$ -	$ 7,127,250
Health Plan of Nevada Inc	HMO Provider	23802	7/1/2021	6/30/2025	$192,093,848	$ -	$192,093,848
Diversified Dental Services Inc.	Dental Provider	23810	7/1/2021	6/30/2026	$ 1,601,613	$ -	$ 1,601,613
Claim Technologies	Health Plan Auditor	24030	4/13/2021	6/30/2027	$ 1,407,656	$ -	$ 1,407,656
CliftonLarsonAllen	Financial Auditor	24088	5/15/2021	12/31/2024	$ 212,485	$ -	$ 212,485

Recommendation

No action necessary

8.2 New Contracts

PEBP does not currently have any new contracts for ratification.

8.3 Contract Amendment Ratifications

The following active PEBP contracts require amendments:

8.3.1 LSI CONSULTING

PEBP contracted with LSI Consulting for Eligibility and Enrollment System services which became effective December 8, 2020, resulting from RFP 95PEBP-S1244.

This contract amendment is required to amend the fee schedule to begin services and payments in December 2021 (instead of January 2022); to add payment for COBRA management; and to add additional work order authority for current and future change orders. This amendment increases the contract maximum by $1,354,25 to $8,203,257.

Recommendation

PEBP recommends the Board authorize staff to complete a contract amendment between PEBP and LSI Consulting for Enrollment and Eligibility services in contract #23678 to update the fee schedule and increase the contract maximum.

8.3.2 CLAIM TECHNOLOGIES INC.

PEBP contracted with Claim Technologies, Inc. for health plan auditing services which began July 1, 2021, resulting from RFP 95PEBP-S1388.

This is the first amendment to the original contract to update the Fee Schedule to include an additional TPA audit for Q2 PY2021 and add authority for various focus audits. This amendment will increase the contract maximum to $1,551,662 from $1,407,656.

Recommendation

PEBP recommends the Board authorize staff to complete a contract amendment between PEBP and Claim Technologies Inc. for Health Claim Auditing services in contract #24030 to update the fee schedule and increase the contract maximum.

8.4 Contract Solicitation Ratifications

PEBP does not currently have any contract solicitations for ratification.

8.5 Status of Current Solicitations

The chart below provides information on the status of PEBP's in-progress solicitations:

Service	Anticipated/Actual RFP release date	Anticipated/ Actual NOI	Winning Vendor	Anticipated Board Approval
Medical TPA	04/26/2021	08/11/2021	UMR, Inc.	Nov 2021
Dental TPA	04/26/2021	08/11/2021		Nov 2021
Medical National Network	04/26/2021	08/11/2021		Nov 2021
Medical Statewide Network option	04/26/2021	08/11/2021		Nov 2021
HSA HRA Admin	07/02/2021	09/16/2021	Webster Bank / HSA Bank	Nov 2021
2nd Opinion	07/28/2021	10/15/2021	TBD	Jan 2022
Telemedicine	08/04/2021	11/05/2021	TBD	Jan 2022
Transparency	08/08/2021	12/01/2021	TBD	Jan 2022
Pharmacy	09/02/2021	12/05/2021	TBD	Jan 2022
Actuary	09/12/2021	11/17/2021	TBD	Jan 2022
Life Insurance	09/27/2021	12/01/2021	TBD	Jan 2022

Recommendation

No action necessary

9.

9. Discussion and possible direction from the Board to staff on potential program design changes for Plan Year 2023 (July 1, 2021 to June 30, 2022) for which the Board requests additional information and costs to be presented at the November 18, 2021 meeting.
(Laura Rich, Executive Officer) (**For Possible Action**)

STEVE SISOLAK
Governor

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

LAURA RICH
Executive Officer

LAURA FREED
Board Chair

AGENDA ITEM

[X] Action Item
[ ] Information Only

Date: September 30, 2021

Item Number: IX

Title: Potential Plan Design Changes for PY23

SUMMARY

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

BACKGROUND

Generally, preparation for the upcoming plan year begins before the prior plan year has even ended. In past years, PEBP has kicked off benefit design planning by holding strategic planning sessions where staff, Board members and partners come together to identify areas of opportunity and cost saving solutions for the plan. Ideas are then typically presented to the Board in September which in turn provides staff a roadmap for the November plan design meeting.

The volatility brought on by the pandemic, coupled with the volume of contracts which have already been or will be implemented has greatly impacted PEBP's ability to conduct thorough analysis and review of any innovative solutions that could benefit the program. With major contracts such as the Third Part Administrator (TPA) and the Pharmacy Benefit Manager (PBM) out to bid, it is impossible to review potential solutions and determine cost savings without knowing which vendor will be awarded the contract or the terms of the contract. Additionally, on July 1, PEBP transitioned to the Aetna network. Since claims costs make up the majority of the PEBP budget, PEBP may see a significant budgetary impact, and with only two months of data and other pandemic related variables, it is difficult to confidently make recommendations using supporting data. Lastly, members have already experienced significant change with the various transitions that have occurred this plan year, and there is even more change on the

horizon with the implementation of a new enrollment system, new TPA technology, and potentially other new vendors and systems as these solicitations get awarded. It is staff's opinion that it may be in the best interest of members, staff, and the program to let the dust settle before any more significant changes are implemented.

REPORT

AON REPORT

See Attachment A

RECOMMENDATIONS

Considering the projected surplus and the recent benefit cuts, staff recommends the Board consider spending down a portion of these funds conservatively to ensure any benefits that are restored can continue to remain funded in the next biennium assuming no drastic changes to PEBP's budget in the next biennium. By using the surplus in a phased approach, it provides the safety net that is necessary for the long-term funding and sustainability of restored benefits. It also leaves the plan open to allocate any potential Rescue Plan funding in a similar manner should this become a reality.

It is important to note that statutorily, PEBP will ultimately require legislative approval of the use of these funds by the Interim Finance Committee (IFC). Once the Board has approved the plan benefit design in November, it will need to be submitted as an IFC agenda item.

Recommendation 1 options:

1. ***Develop plan design enhancements using $4M to allocate toward funding the restored benefits through PY25.***
2. ***Develop plan design enhancements using $6M to allocate toward funding the restored benefits through PY24***
3. ***Develop plan design enhancement using a different methodology approved by the Board***

Recommendation 2 options:

1. ***Based on previous Board guidance discussed at the July 22 Board meeting, staff shall use the above funding to determine plan design restorations/enhancements, prioritizing deductibles, out-of-pocket maximums, and copays.***
2. ***Staff to provide alternative benefit restoration options such as restoration of life insurance, LTD, etc.***
3. ***Staff to provide a combination of all of the above.***

Nevada Public Employee Benefits Plan Briefing: Presentation to the Board

September 30, 2021 PEBP Board Meeting

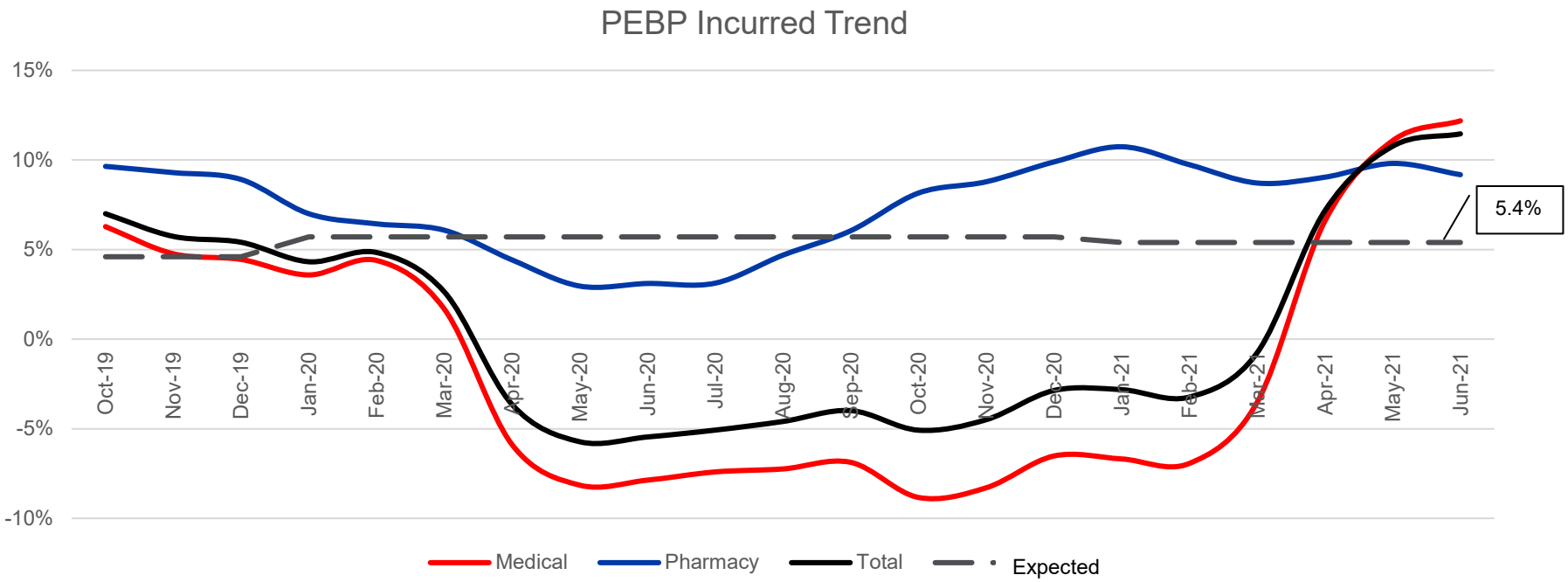
Prepared by Aon
Health Solutions

Empower Results®

Agenda

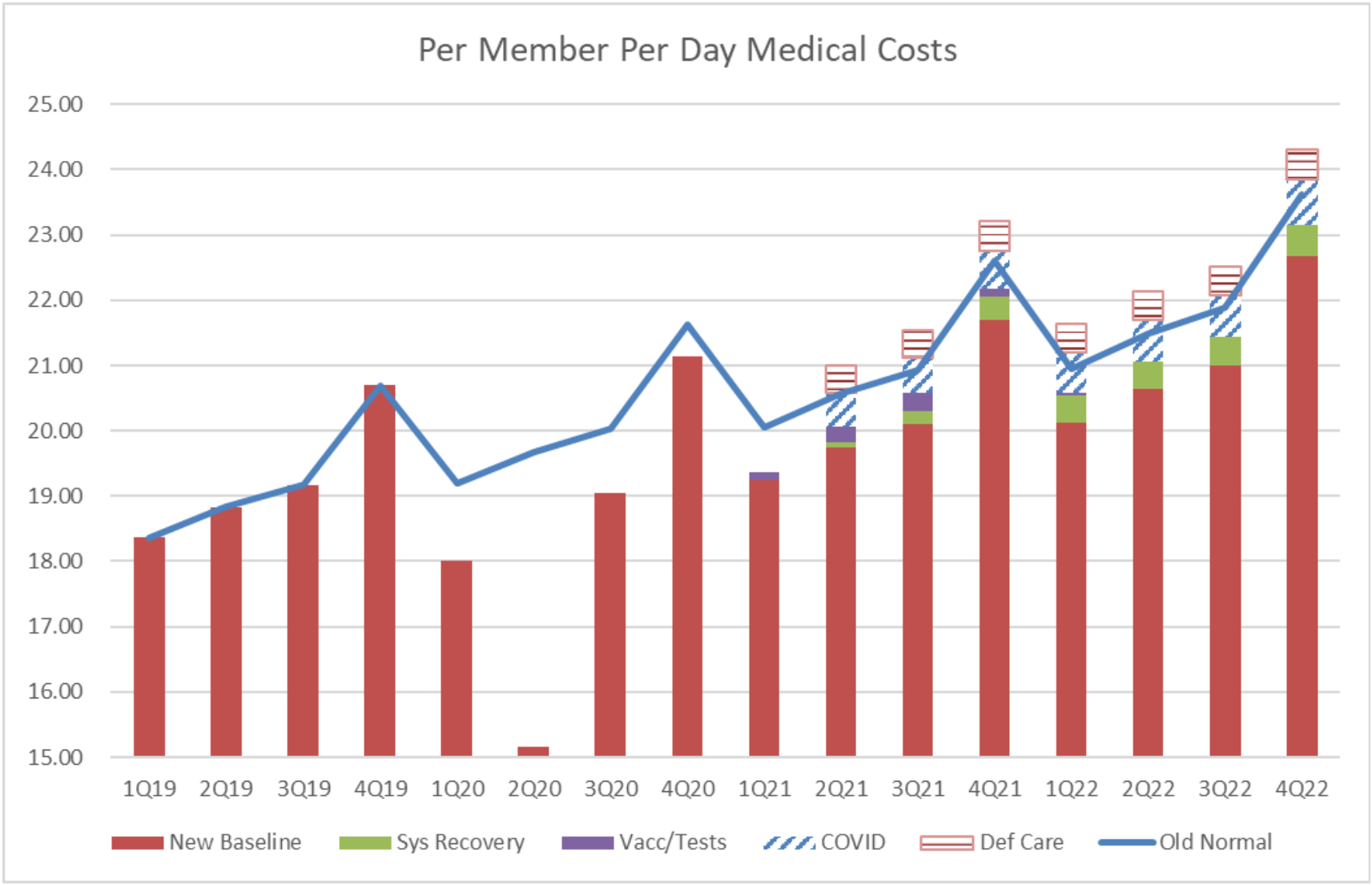
- PEBP Incurred Paid Claims Trend
- National Impact of Covid-19
- Historical Differential Cash Available
- Levers to Return Differential

PEBP Incurred Claims Trend on a Rolling 12 Month Basis



- Medical trend dropped significantly in March 2020 and has been rebounding beginning February/March 2021 and most recently at 12% in June 2021
- Pharmacy trend has been more consistent during 2020, but is trending higher than expected at 9% thru June 2021
- Expected FY21 medical/Rx trend was 5.4%

How Will the System Recover Towards Pre-COVID-19 Equilibrium? (National Experience)



COVID Impact 2021 and 2022 Claims Projection

- In addition to the 5.4% projected healthcare trend for PEBP, the figures below are the estimated supplementary impact of COVID-19 on a **national level**
- Medical-only expectations, based on currently available information
- Expectations will continue to be revised as new data and experience emerges

Medical Only

2021 Projection

System Capacity: -5% to -3% Impact

COVID-19 Impacts: +1 to + 4% Impact

- Vaccines and testing (1%–2% increase)
- COVID-19 direct costs in excess of suppressed claims (0%–1% increase)
- Deferred care return and increased severity in excess of suppressed claims (0%–1% increase)

Combined
-4% to +1% Impact

2022 Projection

System Capacity: -5% to -3% Impact

COVID-19 Impacts: 1% to +5% Impact

- Vaccines and testing (1%–2% increase)
- COVID-19 direct costs (0%–1% increase)
- Deferred care return and increased severity (0%–2% increase)

Combined
-4% to + 2% Impact

COVID-19: 2021 and 2022 Projected Market Impacts

The effects of COVID-19 are expected to continue in 2021 and 2022, with some factors inflating costs and other factors suppressing costs.

Rebound Claims

Rebound claims that were suppressed in 2020 and 2021 due to lockdowns and general deferred utilization may rebound in 2022.

Conditions

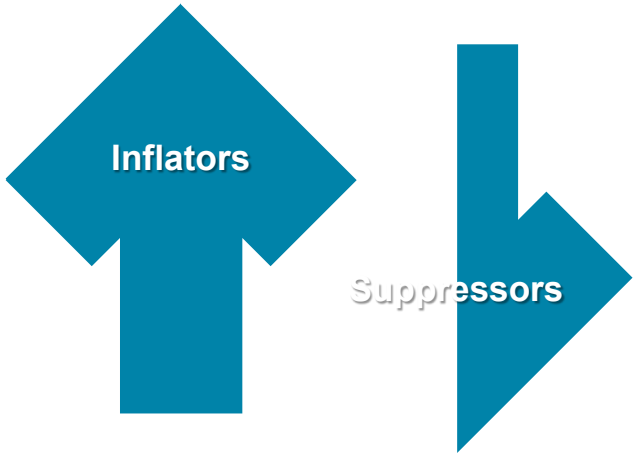
Members that neglected care may have unmanaged chronic conditions which can result in an increase in severity. Also, off season waves of other diseases may contribute additional costs.

Direct Costs

There will be a cost for ongoing testing and vaccinations (including boosters for variants and reduced immunity over time). Additionally, ongoing direct COVID-19 acute and chronic "long hauler" claims will result in additional costs.

Health System and Economic Conditions

Continued provider consolidation may increase market leverage and drive higher costs. Stimulus and economic recovery may cause utilization spike.



Avoided Claims

Claims suppressed during additional waves in 2021 may not return

Continued Precautions

Continued social distancing and mask-wearing may reduce the spread of other diseases (like the flu) and also impact the likelihood of members seeking care

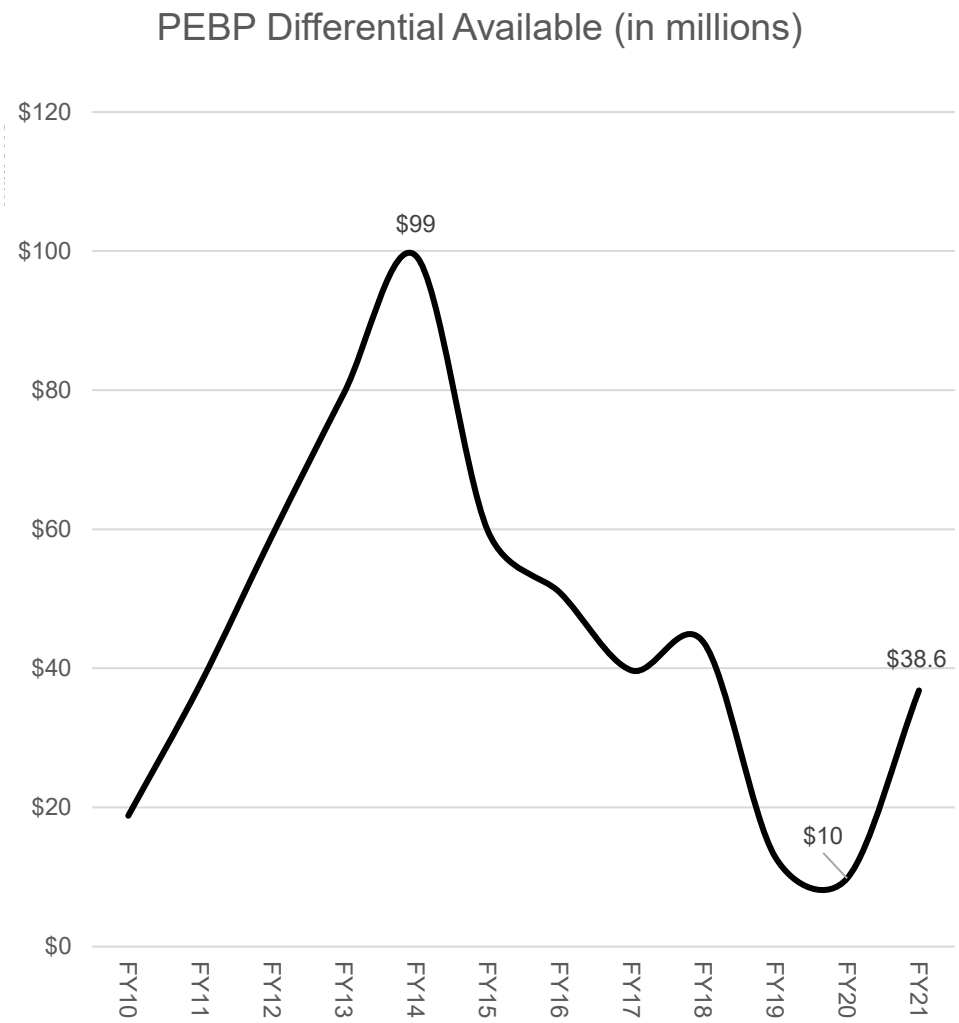
Virtual Care

Increased member utilization of virtual care options could reduce overall professional category spend

Health System Capacity

Reduced staffing levels may limit the return of deferred care until capacity levels return to normal

Historical Differential Cash Available



Historically, PEBP has spent down differential cash available over a longer duration, reducing year-over-year impacts to members

- Beginning FY22, the differential cash available is $38.6M with $9.1M planned to be spent in FY22.

Considerations for other adjustments

- Expected COVID rebound of 4%, or $12M, due to claims suppression
- Vendor contracts as of July 1, 2021 have limited experience with new pricing
- New vendor contracts will be effective July 1, 2022 which will be dependent on board's actions in coming months. This may impact claims volatility and reserve levels.

Breakdown of Differential Cash Available

	In Millions	Comments
FY 2021	$38.6	
Allocated FY2022 Projections	-$9.1	Buy-down subsidies and Medicare HRA
FY2022 Projected Balance	$29.5	
FY2023 Medicare Subsidy	-$5.2	Funded via excess per legislature
COVID rebound of 4%	-$12	This assumes recent trends of 12% will moderate to closer to 5.4% budget trend
Projected Differential Cash Available	**$12.3**	
Allocated over 3 Years	**~$4 million**	To be spent in FY23, FY24, and FY25
Allocated over 2 Years	**~$6 million**	To be spent in FY23 and FY24

Allocating any differential cash available over 2-3 years will allow PEBP to maintain any benefit enhancements for that time period regardless of budget status.

Levers to Return Surplus

Premium Credits/Holidays

Pros

- Everyone receives a return of premium; including non-utilizers contributing to the excess surplus
- Those that use the plan efficiency and likely generate more of the surplus will benefit from lower contributions
- Contributions are typically the most important cost share element for employee perception since it is an immediate impact
- Timing of implementation is flexible (e.g. does not have to be in place at the beginning of the plan year)

Cons

- Retains current out of pocket cost sharing

Plan Design Enrichment

Pros

- Those that use the Plan most receive the benefit

Cons

- Those that use the plan most are not generating the surplus
- Employees that do not have medical claims are still paying premiums and gaining little extra value
- If benefits become richer, may need to increase in the future due to healthcare inflation. This could cause member noise and confusion

Impact

- The members will realize savings in deductibles, copays before coinsurance and out-of-pocket maximums

10.

10. Public Comment

11.

11. Adjournment