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:	January 27, 2022 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/6HqGD0VijZk

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/86251248737 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: 862 5124 8737 then press #. When prompted for a Participant ID, please enter #.**

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

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

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

AGENDA

1. Open Meeting; Roll Call

2. Public Comment

   Public comment will be taken during this agenda item. No action may be taken on any matter raised under this item unless the matter is included on a future agenda as an item on which action may be taken. Public comments to the Board will be taken under advisement but will not be answered during the meeting. Comments may be limited to three minutes per person at the discretion of the chairperson. Additional three minute comment periods may be allowed on individual agenda items at the discretion of the chairperson. These additional comment periods shall be limited to comments relevant to the agenda item under consideration by the Board. The total time allotted to public comment may be limited to one hour at the discretion of the chairperson. 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 December 2, 2021 PEBP Board Meeting

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

   4.2.1 Budget Report

   4.2.2 Utilization Report

   4.3 Receipt of quarterly vendor reports for the period ending September 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 Insurance

   4.3.5 Willis Towers Watson's Individual Marketplace Enrollment and Performance Report

   4.3.6 AETNA Signature Administrators – PPO Network

   4.3.7 HealthPlan of Nevada, Inc. – Southern Nevada HMO

   4.3.8 Doctor on Demand

4.4 Acceptance of the annual PEBP Appeals and Complaints Summary for submission to the Nevada Division of Insurance.

4.5 Acceptance of Claim Technologies Incorporated audit findings for Health Reimbursement Arrangement administered by Via Benefits from Willis Towers Watson for the timeframe July 1, 2020 – June 30, 2021.

4.6 Clifton Larson Allen Audited Financial Statements for PEBP for FY21

5. Executive Officer Report (Laura Rich, Executive Officer) (Information/Discussion)
6. Enrollment and Eligibility System Implementation Update (Nik Proper, Operations Officer) (**For Possible Action**)
7. Presentation and possible action on the status and approval of new PEBP contracts, contract amendments and solicitations (Cari Eaton, Chief Financial Officer) (**For Possible Action**)
   - 7.1. Contract Overview
   - 7.2. New Contracts
     - 7.2.1. Selection of Pharmacy Benefit Manager between: Express Scripts (pursuant to Request for Proposal No. 95PEBP-S1711) and Northwest Drug Consortium (pursuant to NRS 333.475)
   - 7.3. Contract Amendments
     - 7.3.1. Express Scripts – Amendment #6
   - 7.4. Contract Solicitations
   - 7.5. Status of Current Solicitations
8. 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.
9. 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.

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- 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 Insurance
- 4.3.5 Willis Towers Watson's Individual Marketplace Enrollment and Performance Report
- 4.3.6 AETNA Signature Administrators – PPO Network
- 4.3.7 Health Plan of Nevada, Inc. – Southern Nevada HMO
- 4.3.8 Doctor on Demand Engagement Report through November 2021

4.1

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

4.1 Approval of Action Minutes from the September 30, 2021 PEBP Board Meeting.

STATE OF NEVADA
PUBLIC EMPLOYEES' BENEFITS PROGRAM
BOARD MEETING

The Legislative Building
401 South Carson Street, Room #4100
Carson City, NV 89701

ACTION MINUTES (Subject to Board Approval)
December 2, 2021

MEMBERS PRESENT VIA TELECONFERENCE:	Ms. Laura Freed, Board Chair Ms. Linda Fox, Vice Chair Ms. Michelle Kelley, Member Mr. Tom Verducci, Member Ms. Betsy Aiello, Member Ms. April Caughron, Member Mr. Jim Barnes, Member Ms. Leslie Bittleston, Member Dr. Jennifer McClendon, Member
FOR THE BOARD:	Ms. Michelle Briggs, Chief Deputy Attorney General
FOR STAFF:	Ms. Laura Rich, Executive Officer Mr. Nik Proper, Operations Officer Ms. Cari Eaton, Chief Financial Officer Mr. Tim Lindley, Quality Control Officer Ms. Wendi Lunz, Executive Assistant
OTHER PRESENTERS:	DuAne Young – Office of the Governor Mark Carlton - HPN Colleen Huber – Aon Tim Zettinger – Aon Meghan Hugus – Benefit Focus Scott Muir - LSI

1. Open Meeting; Roll Call

    - Board Chair Freed opened the meeting at 8:35 a.m.

2. Public Comment
    - Dr. Patricia Davin
    - Patricia Elliott
    - Brooke Maylath
    - Kent Ervin – Nevada Faculty Alliance
    - Priscilla Maloney – AFSCME
    - Doug Unger – Nevada Faculty Alliance
    - Terri Laird - RPEN
    - Stephanie Parker – State Employee
    - Logan Kennedy – Nevada Faculty Alliance
    - Rosalie Garcia
    - Janell Woodward – State Employee
    - Robert Borchardt – State Employee

3. PEBP Board disclosures for applicable Board meeting agenda items. (Michelle Briggs, Chief Deputy Attorney General) (Information/Discussion)

AGENDA ITEMS WERE HEARD IN THE FOLLOWING ORDER 1, 2, 3, 6, 7, 4, 5, 8, 9, 10

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 September 30, 2021 PEBP Board Meeting.

    4.2 PEBP American Rescue Plan Funds Request

BOARD ACTION ON ITEM 4
MOTION: Motion to approve Agenda Item 4.
BY: Member Leslie Bittleston
SECOND: Member April Caughron
VOTE: Unanimous; the motion carried

5. Executive Officer Report (Laura Rich, Executive Officer) (Information/Discussion)
6. Presentation and possible action regarding COVID-19 coverage including:
    6.1 Possible Restoration of Covid-19 Cost Sharing
    6.2 Surveillance Testing Coverage
    6.3 Possible Implementation of Covid-19 Premium Surcharges

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

BOARD ACTION ON ITEM 6.1
MOTION: Motion to reinstate cost sharing of the COVID related treatment and hospitalization for the CDHP effective March 1, 2022.
BY: Member Leslie Bittleston
SECOND: Vice Chair Linda Fox
VOTE: Unanimous; the motion carried

BOARD ACTION ON ITEM 6.2
MOTION: Motion to allow surveillance testing coverage only thorough PEBP sponsored vendors.
BY: Member Michelle Kelley
SECOND: Vice Chair Linda Fox
VOTE: Unanimous; the motion carried

BOARD ACTION ON ITEM 6.3 (COVID Surcharge for members)
MOTION: Motion to implement COVID surcharge effective July 1, 2022 effective in plan year 2023 for all unvaccinated members of PEBP of $55 a month per employee.
BY: Vice Chair Linda Fox
SECOND: Member Bittleston
VOTE: 7 aye/2 nay (Members Tom Verducci and Jim Barnes nays); Motion carried

BOARD ACTION ON ITEM 6.3 (COVID Surcharge for dependents)
MOTION: Motion to implement a 175 dollar a month COVID surcharge effective July 1, 2022 for unvaccinated spouses, domestic partners and dependents 18 and older with approval to PEBP staff to lower that surcharge if testing costs prove to be lower for the plan.
BY: Member Michelle Kelley
SECOND: Member April Caughron
VOTE: 7 aye/2 nay (Members Tom Verducci and Jim Barnes nays); Motion carried

7. Discussion and possible action on potential program design changes for Plan Year 2023 (July 1, 2022 to June 20, 2023). (Laura Rich, Executive Officer) (**For Possible Action**)

BOARD ACTION ON ITEM 7
MOTION: Motion to approve option three to use up $33,000,000 in differential cash over the next three plan years.
BY: Member Tom Verducci
SECOND: Member Michelle Kelley
VOTE: 4 aye/5 nay; Motion fails

BOARD ACTION ON ITEM 7
ALTERNATE MOTION: Motion to approve option two, using approximately $26,000,000 in differential cash from the original packet plan design, not the updated one.
BY: Vice Chair Linda Fox
SECOND: Member Leslie Bittleston
VOTE: 7 aye/2 nay; (Members Tom Verducci and Jim Barnes nays); Motion carried

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

        8.2.1 UMR, Inc.

12:20 p.m. – 2:03 p.m. MEETING CLOSED PURSUANT TO NRS 287.04.45(4) FOR BOARD TO DISCUSS NEW CONTRACT WITH UMR, INC.

BOARD ACTION ON ITEM 8.2.1
MOTION: Motion to approve the evaluation committee's recommendation to contract with UMR for third party administration and associated services beginning July 1, 2022.
BY: Member Michelle Kelley
SECOND: Member Leslie Bittleston
VOTE: Unanimous; the motion carried

        8.2.2 Webster Bank

BOARD ACTION ON ITEM 8.2.2
MOTION: Motion to approve the evaluation committee's recommendation to contract with HAS Bank for health savings accounts, health reimbursement accounts beginning July 1, 2022.
BY: Member Betsy Aiello
SECOND: Member April Caughron
VOTE: Unanimous; the motion carried

8.3 Contract Amendments

8.3.1 Aetna Signature Administrators no-cause termination

8.3.2 American Health Holdings, Inc. no-cause termination

BOARD ACTION ON ITEM 8.3.1 and 8.3.2
MOTION: Motion to approve PEBP staff to serve term notices on Aetna and AHH.
BY: Member April Caughron
SECOND: Vice Chair Linda Fox
VOTE: Unanimous; the motion carried

8.3.3 AON Consulting

8.3.4 LSI Consulting

BOARD ACTION ON ITEM 8.3.3 and 8.3.4
MOTION: Motion to approve PEBP staff recommendation for 8.3.3 and 8.3.4.
BY: Member Leslie Bittleston
SECOND: Member Betsy Aiello
VOTE: Unanimous; the motion carried

8.4 Contract Solicitations

8.4.1 Cancellation of Shopping Comparison Tool solicitation

BOARD ACTION ON ITEM 8.4.1
MOTION: Motion to approve PEBP staff to cancel the solicitation.
BY: Member Tom Verducci
SECOND: Member Michelle Kelley
VOTE: Unanimous; the motion carried

8.5 Status of Current Solicitations

9 Public Comment

- Janelle Woodward – State Employee

10 Adjournment

- Board Chair Freed adjourned the meeting at 2:18 p.m.

4.2

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

    4.1 Approval of Action Minutes from the September 30, 2021 PEBP Board Meeting.

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

4.2.1 Budget Report

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LAURA RICH
Executive Officer

LAURA FREED
Board Chair

AGENDA ITEM

[X] Action Item
[ ] Information Only

Date: January 27, 2022

Item Number: IV.II.I

Title: Chief Financial Officer Budget Report

Summary

This report addresses the Operational Budget as of September 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 September 30, 2021, with comparisons to the same period in Fiscal Year 2021. 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 $88.2 million as of September 30, 2021, compared to $77.6 million as of September 30, 2020, or an increase of 13.7%. Total expenses for the period have increased by $3.2 million or 3.2% for the same period.

The budget status report shows Realized Funding Available (cash) at $145.2 million. This compares to $133.3 million for last year. The table below reflects the actual revenue and expenditures for the period.

Operational Budget 1338

	FISCAL YEAR 2022			FISCAL YEAR 2021		
	Actual as of 9/30/2021	Work Program	Percent	Actual as of 9/30/2020	Fiscal Year 2021 Close	Percent
Beginning Cash	159,011,280	159,011,280	100%	154,541,329	154,541,329	100%
Premium Income	84,457,476	355,412,324	24%	74,097,153	368,687,811	20%
All Other Income	3,744,797	16,329,797	23%	3,466,083	19,835,354	17%
Total Income	88,202,273	371,742,121	24%	77,563,235	388,523,164	20%
Personnel Services	446,825	2,822,786	16%	456,897	2,413,496	19%
Operating - Other than Personnel	465,100	2,635,822	18%	437,631	2,285,529	19%
Insurance Program Expenses	100,977,790	374,702,990	27%	97,772,799	383,169,084	26%
All Other Expenses	85,350	331,125	26%	115,304	513,099	22%
Total Expenses	101,975,064	380,492,723	27%	98,782,631	388,381,209	25%
Change in Cash	(13,772,791)	(8,750,602)		(21,219,396)	141,955	
REALIZED FUNDING AVAILABLE	145,238,489	150,260,678	97%	133,321,933	154,683,284	86%
Incurred But Not Reported Liability	(52,286,000)	(52,286,000)		(51,514,000)	(51,514,000)	
Catastrophic Reserve	(34,875,000)	(34,875,000)		(34,835,000)	(34,835,000)	
HRA Reserve	(25,056,050)	(25,056,050)		(30,550,651)	(30,550,651)	
NET REALIZED FUNDING AVAILABLE	33,021,439	38,043,628		16,422,282	37,783,633	

Current Budget Projections

The following table represents projections for FY 2022. The projection reflects total income to be less than budgeted by 1.0% ($539.7 million vs $545.3 million), total expenditures are projected to be less than budgeted by 1.4% ($388.9 million vs $394.5 million); total reserves are projected to be more than budgeted by 0.0% ($150.8 million vs $150.8 million).

State Subsidies are projected to be more than the budgeted amount by $0.03 million (0.1%), Non-State Subsidies are projected to be more than budgeted by $2.7 million (13.6%), and Premium Income is projected to be less than budgeted by $7.5 million (10.9%). This overall decrease in budgeted revenue is due in part to a planned 1-month employer premium holiday in October 2021 and 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:

- 2.29% fewer state actives,
- 1.08% more state non-Medicare retirees,
- 0% no change in non-state actives,
- 7.29% fewer non-state, non-Medicare retirees
- 0.03% fewer state Medicare retirees, and
- 1.97% fewer non-state Medicare retirees

Budgeted and Projected Income (Budget Account 1338)					
Description	**Budget**	**Actual 9/30/21**	**Projected**	**Difference**	
Carryforward	159,011,280	159,011,280	159,011,280	0	0.0%
State Subsidies	266,543,926	62,157,887	266,794,976	251,050	0.1%
Non-State Subsidies	20,042,853	5,689,257	22,762,816	2,719,963	13.6%
Premium	68,825,545	16,610,331	61,341,730	(7,483,815)	-10.9%
COVID Funds	8,557,308	0	8,557,308	0	-7.0%
Appropriations	6,009,449	0	6,009,449	0	-1.0%
All Other	16,329,797	3,744,797	15,191,052	(1,138,745)	-7.0%
Total	545,320,158	247,213,553	539,668,612	(5,651,546)	-1.0%
Budgeted and Projected Expenses (Budget Account 1338)					
Description	**Budget**	**Actual 9/30/21**	**Projected**	**Difference**	
Operating	5,789,733	997,274	5,848,386	(58,653)	-1.0%
State Insurance Costs	340,421,064	90,168,888	335,406,164	5,014,900	1.5%
Non-State Insurance Costs	11,507,187	1,618,208	8,267,963	3,239,224	28.1%
Medicare Retiree Insurance Costs	36,829,785	9,190,693	39,377,491	(2,547,706)	-6.9%
Total Insurance Costs	388,758,036	100,977,790	383,051,619	5,706,417	1.5%
Total Expenses	394,547,769	101,975,064	388,900,005	5,647,764	1.4%
Restricted Reserves	112,217,050	112,217,050	112,636,055	(419,005)	-0.4%
Differential Cash Available	38,555,339	33,021,439	38,132,552	422,787	1.1%
Total Reserves	150,772,389	145,238,489	150,768,607	3,782	0.0%
Total of Expenses and Reserves	545,320,158	247,213,553	539,668,612	5,651,547	1.0%

Expenses for Fiscal Year 2022 are projected to be $5.6 million (1.4%) less than budgeted when changes to reserves are excluded. Operating expenses are projected to be less than budgeted by $0.01 million (1.0%). Employee and Retiree insurances costs are projected to be less than budgeted by $5.7 million (1.5%) when taken in total (see table above for specific information).

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 September 30, 2021:

        4.2.1 Budget Report

        4.2.2 Utilization Report

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Board Chair

AGENDA ITEM

[X] Action Item
[ ] Information Only

Date: January 27, 2022

Item Number: IV.II.II

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

This report addresses medical, dental, prescription drug and HSA/HRA utilization for the PY 2022 period ending September 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 LDPPO 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 D for Q1 Plan Year 2022 utilization data.

Executive Summary

CONSUMER DRIVEN HEALTH PLAN (CDHP)

The Consumer Driven Health Plan (CDHP) experience for Q1 of Plan Year 2022 compared to Q1 of Plan Year 2021 is summarized below.

- Population:
  - 16.9% decrease for primary participants
  - 19.6% decrease for primary participants plus dependents (members)
- Medical Cost:
  - 61.9% increase for primary participants
  - 67.0% increase for primary participants plus dependents (members)
- High-Cost Claims:
  - There were 45 High-Cost Claimants accounting for 29.8% of the total plan paid for Q1 of Plan Year 2022
  - 114.8% increase in High-Cost Claimants per 1,000 members
  - 32.2% increase in average cost of High-Cost Claimant paid
- Top three highest cost clinical classifications include:
  - Pregnancy-related Disorders ($3.6 million) – 31.9% of paid claims
  - Cancer ($1.7 million) – 15.0% of paid claims
  - Cardiac Disorders ($1.3 million) – 12.0% of paid claims
- Emergency Room:
  - ER visits per 1,000 members increased 42.0%
  - Average paid per ER visit decreased 10.7%
- Urgent Care:
  - Urgent Care visits per 1,000 members increased by 53.2%
  - Average paid per Urgent Care visit decreased 15.5% (decrease from $58 to $49)
- Network Utilization:
  - 99.1% of claims are from In-Network providers
  - Q1 of Plan Year 2022 In-Network utilization increased 1.2% over PY 2021
  - Q1 of Plan Year 2022 In-Network discounts decreased 1.2% over PY 2021

- Prescription Drug Utilization:
  - Overall:
    - Total Net Claims decreased 15.6%
    - Total Gross Claims Costs decreased 20.4% ($2.8 million)
    - Average Total Cost per Claim decreased 5.7%
      - From $105.55 to $99.54
  - Member:
    - Total Member Cost decreased 18.4%
    - Average Participant Share per Claim decreased 3.3%
    - Net Member PMPM increased 1.8%
      - From $30.47 to $31.03

- Plan
  - Total Plan Cost decreased 21.2%
  - Average Plan Share per Claim decreased 6.6%
  - Net Plan PMPM decreased 1.7%
    - From $76.18 to $74.90
  - Net Plan PMPM factoring rebates decreased 9.4%
    - From $56.97 to $51.63

LOW DEDUCTIBLE PPO PLAN (LDPPO)

The Low Deductible PPO Plan (LDPPO) experience for Q1 of Plan Year 2022 is summarized below.

- Population:
  - 3,638 primary participants
  - 7,618 primary participants plus dependents (members)
- Medical Cost:
  - $390 PEPM for primary participants
  - $186 PMPM for primary participants plus dependents (members)
- High-Cost Claims:
  - There were 11 High-Cost Claimants accounting for 20.7% of the total plan paid for Q1 of Plan Year 2022
  - High-Cost Claimants per 1,000 members was 1.4
  - Average cost of High-Cost Claimant paid was $80,052
- Top three highest cost clinical classifications include:
  - Cancer ($0.3 million) – 7.9% of paid claims
  - Pulmonary Disorders ($0.1 million) – 3.1% of paid claims
  - Cardiac Disorders ($0.1 million) – 3.0% of paid claims
- Emergency Room:
  - 109 ER visits per 1,000 members
  - Average paid per ER visit was $2,261
- Urgent Care:
  - 222 Urgent Care visits per 1,000 members
  - Average paid per Urgent Care visit was $116
- Network Utilization:
  - 99.2% of claims are from In-Network providers
  - Q1 of Plan Year 2022 In-Network discounts was 62.5%

- Prescription Drug Utilization:
  - Overall:
    - Total Net Claims for Q1 was 25,731
    - Total Gross Claims Costs was $2.6 million
    - Average Total Cost per Claim was $100.75
  - Member:
    - Total Member Cost for Q1 was $0.5 million
    - Average Participant Share per Claim was $20.43
    - Net Member PMPM was $23.13

- Plan
  - Total Plan Cost for Q1 was $2.1 million
  - Average Plan Share per Claim was $80.33
  - Net Plan PMPM was $90.97

PEBP PREMIER PLAN (EPO)

The PEBP Premier Plan (EPO) experience for Q1 of Plan Year 2022 compared to Q1 of Plan Year 2021 is summarized below.

- Population:
  - 12.1% decrease for primary participants
  - 11.1% decrease for primary participants plus dependents (members)
- Medical Cost:
  - 42.1% increase for primary participants
  - 40.5% increase for primary participants plus dependents (members)
- High-Cost Claims:
  - There were 14 High-Cost Claimants accounting for 28.1% of the total plan paid for Plan Year 2022
  - 74.0% increase in High-Cost Claimants per 1,000 members
  - 124.8% increase in average cost of High-Cost Claimant paid
- Top three highest cost clinical classifications include:
  - Pulmonary Disorders ($1.6 million) – 38.1% of paid claims
  - Cancer ($0.6 million) – 14.7% of paid claims
  - Congenital / Chromosomal Anomalies ($0.4 million) – 10.4% of paid claims
- Emergency Room:
  - ER visits per 1,000 members increased by 33.1%
  - Average paid per ER visit decreased by 23.9%
- Urgent Care:
  - Urgent Care visits per 1,000 members increased by 61.8%
  - Average paid per Urgent Care visit increased 11.6%
- Network Utilization:
  - 100% of claims are from In-Network providers
  - In-Network utilization increased 0.1%
  - In-Network discounts decreased 1.9%

- Prescription Drug Utilization:
  - Overall:
    - Total Net Claims decreased 12.0%
    - Total Gross Claims Costs decreased 5.5% ($0.3 million)
    - Average Total Cost per Claim increased 7.4%
      - From $123.29 to $132.41
  - Member:
    - Total Member Cost decreased 9.0%
    - Average Participant Share per Claim increased 3.5%
    - Net Member PMPM increased 2.5%
      - From $34.57 to $35.45

- Plan
  - Total Plan Cost decreased 4.8%
  - Average Plan Share per Claim increased 8.2%
  - Net Plan PMPM increased 7.2%
    - From $167.54 to $179.56
  - Net Plan PMPM factoring rebates increased 2.8%
    - From $128.81 to $132.47

DENTAL PLAN

The Dental Plan experience for Q1 of Plan Year 2022 is summarized below.

- Dental Cost:
  - Total of $6,875,834 paid for Dental claims
    - Preventative claims account for 42.5% ($3.0 million)
    - Basic claims account for 28.5% ($2.0 million)
    - Major claims account for 23.2% ($1.6 million)
    - Periodontal claims account for 5.9% ($0.4 million)

HEALTH REIMBURSEMENT ARRANGEMENT

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

HRA Account Balances as of September 30, 2021			
$Range	**# Accounts**	**Total Account Balance**	**Average Per Account Balance**
0	452	0	0
$.01 - $500.00	1,589	399,259	251
$500.01 - $1,000	2,248	1,508,114	671
$1,000.01 - $1,500	937	1,159,584	1,238
$1,500.01 - $2,000	616	1,066,687	1,732
$2,000.01 - $2,500	418	946,059	2,263
$2,500.01 - $3,000	338	924,588	2,735
$3,000.01 - $3,500	296	956,399	3,231
$3,500.01 - $4,000	195	728,814	3,738
$4,000.01 - $4,500	151	639,546	4,235
$4,500.01 - $5,000	118	561,485	4,758
$5,000.01 +	**776**	**6,361,871**	**223,822**
Total	**8,134**	**$ 15,252,407**	**$ 1,875**

CONCLUSION

The information in this report provides plan experience for the Consumer Driven Health Plan (CDHP), Low Deductible PPO Plan (LDPPO) and the PEBP Premier Plan (EPO) through the first quarter of Plan Year 2022. The CDHP total plan paid costs increased 34.5% over the same time for Plan Year 2021. The EPO total plan paid costs increased 24.8% over Q1 of Plan Year 2021. For HMO utilization and cost data please see the report provided in Appendix D.

Appendix A

Index of Tables
HealthSCOPE – CDHP Utilization Review for PEBP
July 1, 2021 – September 30, 2021

HSB DATASCOPE™

Nevada Public Employees' Benefits Program
HDHP Plan

July – September 2021

HealthSCOPE BENEFITS

Overview

- Total Medical Spend for 1Q22 was $37,411,602 of which 79.7% was spent in the State Active population. When compared to 1Q21, this reflected an increase of 34.5% in plan spend, with State Actives having a increase of 43.6%.
  - When compared to 1Q20, 1Q22 increased 11.04%, with State Actives having an increase of 28.0%.
- On a PEPY basis (annualized), 1Q22 reflected an increase of 62.0% when compared to 1Q21. The largest group, State Actives, increased 75.9%.
  - When compared to 1Q20, 1Q22 increased 34.6%, with State Actives increasing by 57.6%.
- 95.8% of the Average Membership had paid Medical claims less than $2,500, with 43.5% of those having no claims paid at all during the reporting period.
- There were 45 high-cost Claimants (HCC's) over $100K, that accounted for 29.8% of the total spend. HCCs accounted for 17.5% of total spend during 1Q21, with 26 members hitting the $100K threshold. The largest diagnosis grouper was Pregnancy-related Disorders accounting for 13.7% of high-cost claimant dollars.
- IP Paid per Admit was $19,894 which is a decrease of 31.2% compared to 1Q21.
- ER Paid per Visit is $1,700, which is a decrease of 9.7% compared to 1Q21.
- 99.1% of all Medical spend dollars were to In Network providers. The average In Network discount was 64.7%, which is a slight decrease of 1.8% compared to the PY21 average discount of 65.9%.

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

Paid Claims by Age Group										
	1Q21									
Age Range	Med Net Pay	Med PMPM	Rx Net Pay	Rx PMPM	Dental Net Pay	Dental PMPM	Net Pay	PMPM
<1	$ 1,080,593	$ 1,003	$ 793	$ 1	$ 4,323	$ 3	$ 1,085,709	$ 1,007
1	$ 197,607	$ 164	$ 35,200	$ 29	$ 14,982	$ 9	$ 247,789	$ 202
2 - 4	$ 327,957	$ 81	$ 111,736	$ 28	$ 102,409	$ 19	$ 542,102	$ 128
5 - 9	$ 420,452	$ 56	$ 67,769	$ 9	$ 331,101	$ 32	$ 819,322	$ 97
10 - 14	$ 543,849	$ 64	$ 101,849	$ 12	$ 359,102	$ 31	$ 1,004,800	$ 106
15 - 19	$ 699,507	$ 78	$ 157,419	$ 18	$ 450,025	$ 36	$ 1,306,952	$ 131
20 - 24	$ 1,215,352	$ 121	$ 294,446	$ 29	$ 281,160	$ 21	$ 1,790,958	$ 171
25 - 29	$ 1,611,528	$ 201	$ 345,132	$ 43	$ 257,375	$ 25	$ 2,214,035	$ 269
30 - 34	$ 1,317,372	$ 144	$ 525,273	$ 58	$ 328,874	$ 28	$ 2,171,520	$ 230
35 - 39	$ 1,527,645	$ 153	$ 987,609	$ 99	$ 373,973	$ 28	$ 2,889,227	$ 280
40 - 44	$ 1,418,558	$ 153	$ 522,574	$ 56	$ 343,866	$ 28	$ 2,284,998	$ 236
45 - 49	$ 1,782,677	$ 186	$ 816,086	$ 85	$ 397,638	$ 30	$ 2,996,401	$ 302
50 - 54	$ 3,555,545	$ 353	$ 1,093,621	$ 109	$ 428,987	$ 30	$ 5,078,153	$ 492
55 - 59	$ 3,253,538	$ 297	$ 1,411,874	$ 129	$ 520,748	$ 34	$ 5,186,160	$ 460
60 - 64	$ 5,890,686	$ 480	$ 1,760,456	$ 143	$ 680,896	$ 40	$ 8,332,038	$ 663
65+	$ 2,963,338	$ 420	$ 1,222,954	$ 173	$ 1,700,965	$ 42	$ 5,887,257	$ 635
Total	**$ 27,806,203**	**$ 218**	**$ 9,454,791**	**$ 74**	**$ 6,576,425**	**$ 32**	**$ 43,837,420**	**$ 324**

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

Paid Claims by Age Group									
	1Q22								% Change	
Age Range	Med Net Pay	Med PMPM	Rx Net Pay	Rx PMPM	Dental Net Pay	Dental PMPM	Net Pay	PMPM	Net Pay	PMPM
<1	$ 4,747,703	$ 5,734	$ 644	$ 1	$ 1,765	$ 1	$ 4,750,112	$ 5,736	337.5%	469.7%
1	$ 136,086	$ 167	$ 1,140	$ 1	$ 13,151	$ 8	$ 150,377	$ 176	-39.3%	-12.5%
2 - 4	$ 372,076	$ 128	$ 61,993	$ 21	$ 107,399	$ 21	$ 541,468	$ 170	-0.1%	33.3%
5 - 9	$ 338,030	$ 59	$ 156,013	$ 27	$ 340,333	$ 35	$ 834,376	$ 122	1.8%	25.0%
10 - 14	$ 1,078,022	$ 167	$ 119,626	$ 18	$ 351,851	$ 30	$ 1,549,499	$ 215	54.2%	103.2%
15 - 19	$ 1,130,397	$ 163	$ 151,863	$ 22	$ 427,142	$ 35	$ 1,709,402	$ 219	30.8%	67.2%
20 - 24	$ 1,229,824	$ 154	$ 267,397	$ 34	$ 255,617	$ 19	$ 1,752,838	$ 207	-2.1%	21.3%
25 - 29	$ 1,736,988	$ 272	$ 228,459	$ 36	$ 225,845	$ 24	$ 2,191,292	$ 332	-1.0%	23.4%
30 - 34	$ 1,289,355	$ 173	$ 341,247	$ 46	$ 303,359	$ 26	$ 1,933,961	$ 246	-10.9%	7.0%
35 - 39	$ 2,142,090	$ 273	$ 295,062	$ 38	$ 387,478	$ 30	$ 2,824,630	$ 341	-2.2%	21.6%
40 - 44	$ 2,420,389	$ 318	$ 464,554	$ 61	$ 373,237	$ 30	$ 3,258,180	$ 409	42.6%	72.8%
45 - 49	$ 2,162,980	$ 293	$ 654,760	$ 89	$ 394,622	$ 31	$ 3,212,362	$ 413	7.2%	37.0%
50 - 54	$ 3,508,050	$ 420	$ 935,191	$ 112	$ 513,809	$ 36	$ 4,957,050	$ 568	-2.4%	15.5%
55 - 59	$ 5,400,643	$ 598	$ 1,373,510	$ 152	$ 591,278	$ 39	$ 7,365,431	$ 789	42.0%	71.6%
60 - 64	$ 6,028,093	$ 570	$ 1,824,785	$ 173	$ 726,052	$ 44	$ 8,578,930	$ 786	3.0%	18.6%
65+	$ 3,690,876	$ 574	$ 1,158,447	$ 180	$ 1,862,895	$ 46	$ 6,712,218	$ 800	14.0%	25.9%
Total	**$ 37,411,602**	**$ 364**	**$ 8,034,690**	**$ 78**	**$ 6,875,835**	**$ 34**	**$ 52,322,125**	**$ 477**	**19.4%**	**47.3%**

Financial Summary (p. 1 of 2)

	Total				State Active				Non-State Active			
Summary	**1Q20**	**1Q21**	**1Q22**	**Variance to Prior Year**	**1Q20**	**1Q21**	**1Q22**	**Variance to Prior Year**	**1Q20**	**1Q21**	**1Q22**	**Variance to Prior Year**
Enrollment												
Avg # Employees	23,581	23,419	19,451	-16.9%	19,669	19,563	15,968	-18.4%	4	3	3	-9.9%
Avg # Members	42,753	42,580	34,222	-19.6%	37,138	36,973	29,132	-21.2%	7	7	8	14.3%
Ratio	1.8	1.8	1.8	-3.3%	1.9	1.9	1.8	-3.7%	1.8	2.1	2.7	27.1%
Financial Summary												
Gross Cost	$46,374,477	$38,766,628	$48,739,183	25.7%	$33,530,604	$29,572,105	$38,704,536	30.9%	$14,108	$2,580	$7,696	198.3%
Client Paid	$33,692,440	$27,806,203	$37,411,602	34.5%	$23,296,415	$20,763,800	$29,814,000	43.6%	$9,764	$1,404	$6,415	356.9%
Employee Paid	$12,682,036	$10,960,425	$11,327,580	3.3%	$10,234,189	$8,808,304	$8,890,537	0.9%	$4,344	$1,176	$1,281	8.9%
Client Paid-PEPY	$5,715	$4,749	$7,693	62.0%	$4,738	$4,246	$7,468	75.9%	$9,764	$1,684	$8,553	407.9%
Client Paid-PMPY	$3,152	$2,612	$4,373	67.4%	$2,509	$2,246	$4,094	82.3%	$5,579	$802	$3,208	300.0%
Client Paid-PEPM	$476	$396	$641	61.9%	$395	$354	$622	75.7%	$814	$140	$713	409.3%
Client Paid-PMPM	$263	$218	$364	67.0%	$209	$187	$341	82.4%	$465	$67	$267	298.5%
High Cost Claimants (HCC's) > $100k												
# of HCC's	29	26	45	73.1%	19	16	36	125.0%	0	0	0	0.0%
HCC's / 1,000	0.7	0.6	1.3	114.8%	0.5	0.4	1.2	188.4%	0.0	0.0	0.0	0.0%
Avg HCC Paid	$262,888	$187,205	$247,401	32.2%	$177,846	$146,448	$251,889	72.0%	$0	$0	$0	0.0%
HCC's % of Plan Paid	22.6%	17.5%	29.8%	70.3%	14.5%	11.3%	30.4%	169.0%	0.0%	0.0%	0.0%	0.0%
Cost Distribution by Claim Type (PMPY)												
Facility Inpatient	$1,123	$820	$1,750	113.4%	$745	$615	$1,693	175.3%	$0	$0	$0	0.0%
Facility Outpatient	$968	$855	$1,317	54.0%	$802	$768	$1,143	48.8%	$1,746	$146	$0	-100.0%
Physician	$985	$884	$1,217	37.7%	$898	$821	$1,177	43.4%	$3,490	$656	$3,129	377.0%
Other	$77	$53	$89	67.9%	$65	$42	$81	92.9%	$343	$0	$78	0.0%
Total	$3,152	$2,612	$4,373	67.4%	$2,509	$2,246	$4,094	82.3%	$5,579	$802	$3,208	300.0%
	Annualized	Annualized	Annualized		Annualized	Annualized	Annualized		Annualized	Annualized	Annualized	

Financial Summary (p. 2 of 2)

	State Retirees				Non-State Retirees				
Summary	**1Q20**	**1Q21**	**1Q22**	**Variance to Prior Year**	**1Q20**	**1Q21**	**1Q22**	**Variance to Prior Year**	**HSB Peer Index**
Enrollment									
Avg # Employees	3,250	3,295	3,024	-8.2%	658	558	456	-18.2%	
Avg # Members	4,852	4,944	4,540	-8.2%	757	656	542	-17.3%	
Ratio	1.5	1.5	1.5	0.0%	1.2	1.2	1.2	0.8%	1.6
Financial Summary									
Gross Cost	$11,245,697	$7,154,081	$9,096,199	27.1%	$1,584,068	$2,037,862	$930,751	-54.3%	
Client Paid	$9,169,894	$5,339,239	$6,997,820	31.1%	$1,216,367	$1,701,760	$593,368	-65.1%	
Employee Paid	$2,075,803	$1,814,842	$2,098,379	15.6%	$367,701	$336,102	$337,383	0.4%	
Client Paid-PEPY	$11,287	$6,482	$9,256	42.8%	$7,394	$12,206	$5,205	-57.4%	$6,297
Client Paid-PMPY	$7,560	$4,320	$6,166	42.7%	$6,430	$10,377	$4,376	-57.8%	$3,879
Client Paid-PEPM	$941	$540	$771	42.8%	$616	$1,017	$434	-57.3%	$525
Client Paid-PMPM	$630	$360	$514	42.8%	$536	$865	$365	-57.8%	$323
High Cost Claimants (HCC's) > $100k									
# of HCC's	9	8	12	50.0%	2	2	0	-100.0%	
HCC's / 1,000	1.9	1.6	2.7	63.6%	2.6	3.1	0.0	-100.0%	
Avg HCC Paid	$446,461	$217,549	$172,085	-20.9%	$113,262	$391,889	$0	-100.0%	
HCC's % of Plan Paid	43.8%	32.6%	31.5%	-3.4%	18.6%	46.1%	0.0%	-100.0%	
Cost Distribution by Claim Type (PMPY)									
Facility Inpatient	$3,722	$1,506	$2,164	43.7%	$3,007	$7,215	$1,398	-80.6%	$1,149
Facility Outpatient	$2,065	$1,442	$2,413	67.3%	$2,063	$1,365	$1,462	7.1%	$1,333
Physician	$1,609	$1,255	$1,437	14.5%	$1,265	$1,604	$1,470	-8.4%	$1,301
Other	$164	$117	$151	29.1%	$95	$192	$47	-75.5%	$96
Total	$7,560	$4,320	$6,166	42.7%	$6,430	$10,377	$4,376	-57.8%	$3,879
	Annualized	Annualized	Annualized		Annualized	Annualized	Annualized		

Financial Summary – Prior Year Comparison (p. 1 of 2)

	Total				State Active				Non-State Active			
Summary	**PY20**	**PY21**	**1Q22**	**Variance to Prior Year**	**PY20**	**PY21**	**1Q22**	**Variance to Prior Year**	**PY20**	**PY21**	**1Q22**	**Variance to Prior Year**
Enrollment												
Avg # Employees	23,673	23,322	19,451	-16.6%	19,809	19,529	15,968	-18.2%	4	4	3	-25.0%
Avg # Members	42,865	42,317	34,222	-19.1%	37,291	36,761	29,132	-20.8%	7	9	8	-11.1%
Ratio	1.8	1.8	1.8	-2.8%	1.9	1.9	1.8	-3.2%	1.8	2.3	2.7	18.7%
Financial Summary												
Gross Cost	$185,251,114	$169,798,016	$48,739,183	-71.3%	$139,774,757	$131,033,700	$38,704,536	-70.5%	$46,064	$40,353	$7,696	-80.9%
Client Paid	$143,667,208	$132,093,355	$37,411,602	-71.7%	$106,095,205	$100,467,765	$29,814,000	-70.3%	$35,053	$26,699	$6,415	-76.0%
Employee Paid	$41,583,906	$37,704,661	$11,327,580	-70.0%	$33,679,553	$30,565,935	$8,890,537	-70.9%	$11,011	$13,654	$1,281	-90.6%
Client Paid-PEPY	$6,069	$5,664	$7,693	35.8%	$5,356	$5,144	$7,468	45.2%	$9,144	$6,675	$8,553	28.1%
Client Paid-PMPY	$3,352	$3,122	$4,373	40.1%	$2,845	$2,733	$4,094	49.8%	$5,130	$2,967	$3,208	8.1%
Client Paid-PEPM	$506	$472	$641	35.8%	$446	$429	$622	45.0%	$762	$556	$713	28.2%
Client Paid-PMPM	$279	$260	$364	40.0%	$237	$228	$341	49.6%	$427	$247	$267	8.1%
High Cost Claimants (HCC's) > $100k												
# of HCC's	206	178	45		151	128	36		0	0	0	
HCC's / 1,000	4.8	4.2	1.3		4.1	3.5	1.2		0.0	0.0	0.0	
Avg HCC Paid	$236,642	$246,763	$247,401	0.3%	$206,591	$237,270	$251,889	6.2%	$0	$0	$0	0.0%
HCC's % of Plan Paid	33.9%	33.3%	29.8%	-10.5%	29.4%	30.2%	30.4%	0.7%	0.0%	0.0%	0.0%	0.0%
Cost Distribution by Claim Type (PMPY)												
Facility Inpatient	$1,139	$893	$1,750	96.0%	$883	$750	$1,693	125.7%	$0	$14	$0	0.0%
Facility Outpatient	$1,040	$991	$1,317	32.9%	$880	$822	$1,143	39.1%	$2,087	$2,152	$0	-100.0%
Physician	$1,093	$1,174	$1,217	3.7%	$1,014	$1,105	$1,177	6.5%	$2,777	$770	$3,129	306.4%
Other	$80	$64	$89	39.1%	$68	$56	$81	44.6%	$266	$30	$78	0.0%
Total	$3,352	$3,122	$4,373	40.1%	$2,845	$2,733	$4,094	49.8%	$5,130	$2,967	$3,208	8.1%
			Annualized				Annualized				Annualized	

Financial Summary – Prior Year Comparison (p. 2 of 2)

	State Retirees				Non-State Retirees				
Summary	**PY20**	**PY21**	**1Q22**	**Variance to Prior Year**	**PY20**	**PY21**	**1Q22**	**Variance to Prior Year**	**HSB Peer Index**
Enrollment									
Avg # Employees	3,246	3,268	3,024	-7.5%	615	521	456	-12.4%	
Avg # Members	4,858	4,933	4,540	-8.0%	710	614	542	-11.7%	
Ratio	1.5	1.5	1.5	-0.7%	1.2	1.2	1.2	0.8%	1.6
Financial Summary									
Gross Cost	$39,350,569	$33,024,994	$9,096,199	-72.5%	$6,079,723	$5,698,970	$930,751	-83.7%	
Client Paid	$32,691,908	$26,900,984	$6,997,820	-74.0%	$4,845,042	$4,697,908	$593,368	-87.4%	
Employee Paid	$6,658,661	$6,124,010	$2,098,379	-65.7%	$1,234,681	$1,001,063	$337,383	-66.3%	
Client Paid-PEPY	$10,070	$8,231	$9,256	12.5%	$7,882	$9,024	$5,205	-42.3%	$6,297
Client Paid-PMPY	$6,730	$5,454	$6,166	13.1%	$6,821	$7,646	$4,376	-42.8%	$3,879
Client Paid-PEPM	$839	$686	$771	12.4%	$657	$752	$434	-42.3%	$525
Client Paid-PMPM	$561	$454	$514	13.2%	$568	$637	$365	-42.7%	$323
High Cost Claimants (HCC's) > $100k									
# of HCC's	60	44	12		8	9	0		
HCC's / 1,000	12.4	8.9	2.7		11.3	14.7	0.0		
Avg HCC Paid	$271,721	$261,318	$172,085	-34.1%	$156,233	$228,360	$0	-100.0%	
HCC's % of Plan Paid	49.9%	42.7%	31.5%	-26.2%	25.8%	43.7%	0.0%	-100.0%	
Cost Distribution by Claim Type (PMPY)									
Facility Inpatient	$2,853	$1,597	$2,164	35.5%	$2,835	$3,771	$1,398	-62.9%	$1,149
Facility Outpatient	$2,107	$2,154	$2,413	12.0%	$2,143	$1,733	$1,462	-15.6%	$1,333
Physician	$1,600	$1,586	$1,437	-9.4%	$1,745	$2,022	$1,470	-27.3%	$1,301
Other	$170	$116	$151	30.2%	$98	$120	$47	-60.8%	$96
Total	$6,730	$5,454	$6,166	13.1%	$6,821	$7,646	$4,376	-42.8%	$3,879
			Annualized				Annualized		

Paid Claims by Claim Type – State Participants

Net Paid Claims - Total State Participants	1Q21				1Q22				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical									
Inpatient	$ 6,693,576	$ 1,239,353	$ 897,650	$ 8,830,580	$ 13,642,911	$ 2,165,278	$ 568,071	$ 16,376,260	85.4%
Outpatient	$ 14,070,224	$ 2,789,777	$ 412,459	$ 17,272,460	$ 16,171,088	$ 3,859,328	$ 405,143	$ 20,435,559	18.3%
Total - Medical	$ 20,763,800	$ 4,029,130	$ 1,310,109	$ 26,103,040	$ 29,814,000	$ 6,024,606	$ 973,214	$ 36,811,819	41.0%
Dental	$ 4,478,336	$ 517,283	$ 151,183	$ 5,146,801	$ 4,585,280	$ 580,702	$ 146,788	$ 5,312,770	3.2%
Dental Exchange	$ -	$ -	$ 825,777	$ 825,777	$ -	$ -	$ 944,022	$ 944,022	14.3%
Total	**$ 25,242,136**	**$ 4,546,413**	**$ 2,287,069**	**$ 32,075,619**	**$ 34,399,280**	**$ 6,605,308**	**$ 2,064,024**	**$ 43,068,612**	**34.3%**

Net Paid Claims - Per Participant per Month	1Q21				1Q22				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical	$ 354	$ 506	$ 681	$ 381	$ 622	$ 833	$ 531	$ 646	69.7%
Dental	$ 55	$ 51	$ 66	$ 55	$ 59	$ 56	$ 65	$ 58	6.1%
Dental Exchange	$ -	$ -	$ 50	$ 50	$ -	$ -	$ 56	$ 56	11.3%

Paid Claims by Claim Type – Non-State Participants

Net Paid Claims - Total Non-State Participants	1Q21				1Q22				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical									
Inpatient	$ -	$ 360,962	$ 851,112	$ 1,212,075	$ -	$ 36,786	$ 173,483	$ 210,269	-82.7%
Outpatient	$ 1,404	$ 129,208	$ 360,477	$ 491,089	$ 6,415	$ 226,661	$ 156,437	$ 389,514	-20.7%
Total - Medical	$ 1,404	$ 490,171	$ 1,211,589	$ 1,703,164	$ 6,415	$ 263,448	$ 329,920	$ 599,783	-64.8%
Dental	$ 1,327	$ 64,084	$ 57,257	$ 122,667	$ 2,675	$ 47,615	$ 70,135	$ 120,425	-1.8%
Dental Exchange	$ -	$ -	$ 481,180	$ 481,180	-	-	$ 498,616	$ 498,616	3.6%
Total	**$ 2,730**	**$ 554,254**	**$ 1,750,026**	**$ 2,307,010**	**$ 9,090**	**$ 311,063**	**$ 898,671**	**$ 1,218,824**	**-47.2%**

Net Paid Claims - Per Participant per Month	1Q21				1Q22				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical	$ 140	$ 558	$ 1,526	$ 1,012	$ 713	$ 462	$ 413	$ 436	-57.0%
Dental	$ 60	$ 44	$ 46	$ 45	$ 134	$ 49	$ 54	$ 53	16.9%
Dental Exchange	$ -	$ -	$ 45	$ 45	$ -	$ -	$ 48	$ 48	5.8%

Paid Claims by Claim Type – Total

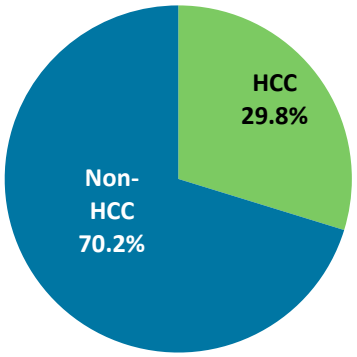
Net Paid Claims - Total Total Participants	1Q21				1Q22				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical									
Inpatient	$ 6,693,576	$ 1,600,316	$ 1,748,762	$ 10,042,654	$ 13,642,911	$ 2,202,064	$ 741,554	$ 16,586,530	65.2%
Outpatient	$ 14,071,628	$ 2,918,985	$ 772,936	$ 17,763,549	$ 16,177,503	$ 4,085,989	$ 561,581	$ 20,825,073	17.2%
Total - Medical	$ 20,765,204	$ 4,519,301	$ 2,521,698	$ 27,806,203	$ 29,820,415	$ 6,288,053	$ 1,303,134	$ 37,411,602	34.5%
Dental	$ 4,479,663	$ 581,367	$ 208,439	$ 5,269,468	$ 4,587,955	$ 628,317	$ 216,922	$ 5,433,195	3.1%
Dental Exchange	$ -	$ -	$ 1,306,957	$ 1,306,957	$ -	$ -	$ 1,442,638	$ 1,442,638	10.4%
Total	**$ 25,244,866**	**$ 5,100,667**	**$ 4,037,095**	**$ 34,382,629**	**$ 34,408,370**	**$ 6,916,371**	**$ 2,962,695**	**$ 44,287,436**	**28.8%**

Net Paid Claims - Per Participant per Month	1Q21				1Q22				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	
Medical	$ 354	$ 511	$ 928	$ 396	$ 622	$ 806	$ 495	$ 641	61.9%
Dental	$ 55	$ 50	$ 59	$ 55	$ 59	$ 55	$ 61	$ 58	6.4%
Dental Exchange	$ -	$ -	$ 48	$ 48	$ -	$ -	$ 53	$ 53	9.5%

Cost Distribution – Medical Claims

1Q21							1Q22					
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
21	0.0%	$4,842,321	17.4%	$99,429	0.9%	$100,000.01 Plus	31	0.1%	$10,882,754	29.1%	$147,569	1.3%
49	0.1%	$3,692,075	13.3%	$245,563	2.2%	$50,000.01-$100,000.00	57	0.2%	$5,195,553	13.9%	$298,041	2.6%
112	0.3%	$4,087,731	14.7%	$487,419	4.4%	$25,000.01-$50,000.00	98	0.3%	$4,512,780	12.1%	$483,165	4.3%
312	0.7%	$5,177,782	18.6%	$1,179,525	10.8%	$10,000.01-$25,000.00	296	0.9%	$5,605,906	15.0%	$1,156,990	10.2%
379	0.9%	$2,733,428	9.8%	$1,040,624	9.5%	$5,000.01-$10,000.00	369	1.1%	$3,132,843	8.4%	$1,072,900	9.5%
512	1.2%	$1,925,948	6.9%	$962,815	8.8%	$2,500.01-$5,000.00	581	1.7%	$2,396,085	6.4%	$1,219,917	10.8%
14,301	33.6%	$5,346,918	19.2%	$4,990,138	45.5%	$0.01-$2,500.00	12,424	36.3%	$5,685,681	15.2%	$5,053,637	44.6%
6,586	15.5%	$0	0.0%	$1,954,911	17.8%	$0.00	5,488	16.0%	$0	0.0%	$1,895,362	16.7%
20,309	47.7%	$0	0.0%	$0	0.0%	No Claims	14,877	43.5%	$0	0.0%	$0	0.0%
42,580	**100.0%**	**$27,806,203**	**100.0%**	**$10,960,425**	**100.0%**		**34,222**	**100.0%**	**$37,411,602**	**100.0%**	**$11,327,580**	**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**
Pregnancy-related Disorders	3	$3,555,145	31.9%
Cancer	18	$1,673,318	15.0%
Cardiac Disorders	20	$1,330,440	12.0%
Spine-related Disorders	6	$929,326	8.3%
Gastrointestinal Disorders	19	$602,971	5.4%
Infections	15	$565,254	5.1%
Hematological Disorders	10	$447,342	4.0%
Renal/Urologic Disorders	13	$336,864	3.0%
Trauma/Accidents	13	$255,256	2.3%
Congenital/Chromosomal Anomalies	3	$251,105	2.3%
All Other		$1,186,023	10.7%
Overall	**----**	**$11,133,044**	**100.0%**

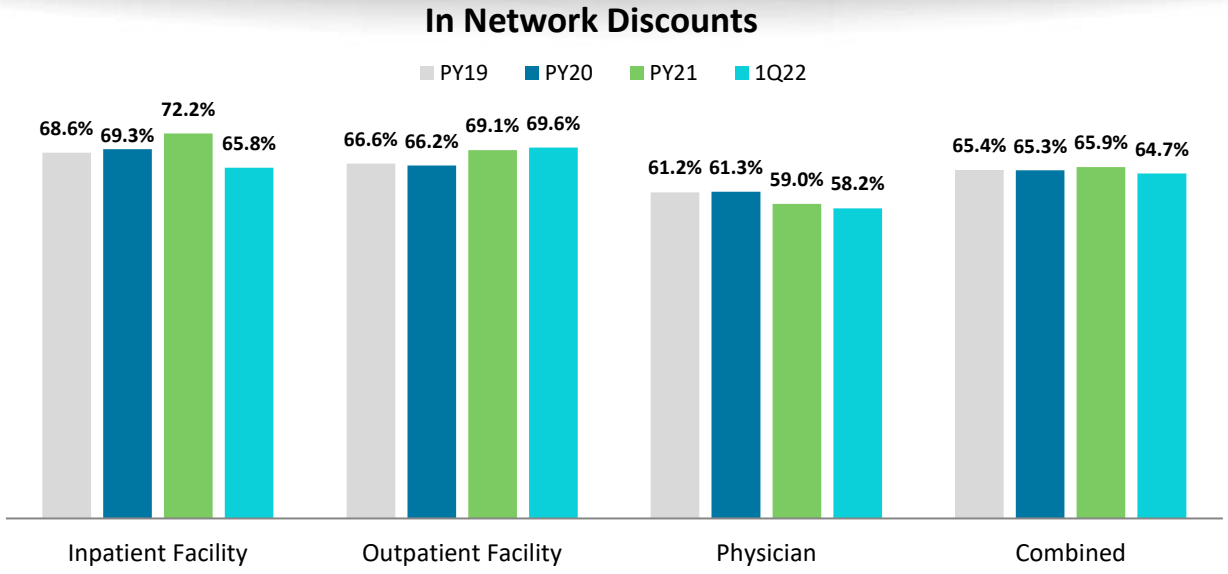
Utilization Summary (p. 1 of 2)

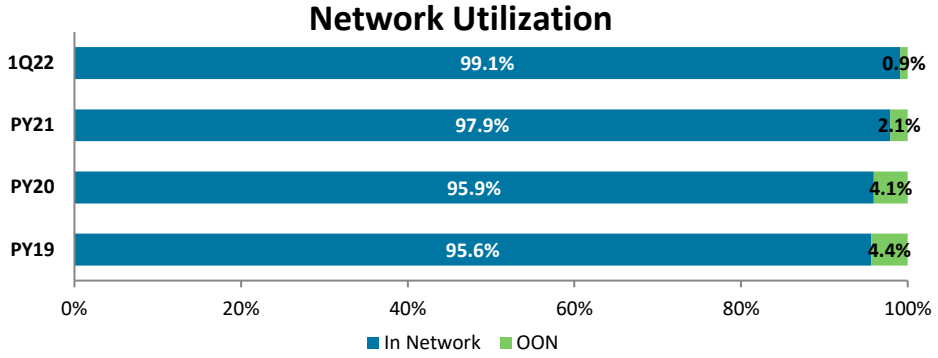
	Total				State Active				Non-State Active			
Summary	**1Q20**	**1Q21**	**1Q22**	**Variance to Prior Year**	**1Q20**	**1Q21**	**1Q22**	**Variance to Prior Year**	**1Q20**	**1Q21**	**1Q22**	**Variance to Prior Year**
Inpatient Summary												
# of Admits	497	384	368		387	314	277		0	0	0	
# of Bed Days	2,884	2,543	1,886		2,262	2,105	1,412		0	0	0	
Paid Per Admit	$25,415	$28,921	$19,894	-31.2%	$25,094	$24,849	$20,450	-17.7%	$0	$0	$0	0.0%
Paid Per Day	$4,380	$4,367	$3,882	-11.1%	$4,293	$3,707	$4,012	8.2%	$0	$0	$0	0.0%
Admits Per 1,000	46	36	43	19.4%	41	34	38	11.8%	0	0	0	0.0%
Days Per 1,000	267	238	220	-7.6%	241	227	194	-14.5%	0	0	0	0.0%
Avg LOS	5.8	6.6	5.1	-22.7%	5.8	6.7	5.1	-23.9%	0	0	0	0.0%
# Admits From ER	242	183	212		178	136	141		0	0	0	
Physician Office												
OV Utilization per Member	4.3	3.6	4.4	22.2%	4	3.4	4.1	20.6%	19.4	5.1	3.5	-31.4%
Avg Paid per OV	$65	$64	$79	23.4%	$65	$66	$81	22.7%	$95	$113	$55	-51.3%
Avg OV Paid per Member	$278	$231	$345	49.4%	$261	$226	$336	48.7%	$1,846	$579	$194	-66.5%
DX&L Utilization per Member	8.2	7.2	8.8	22.2%	7.7	6.8	8.3	22.1%	0	0	19	0.0%
Avg Paid per DX&L	$49	$53	$60	13.2%	$47	$47	$57	21.3%	$0	$0	$155	0.0%
Avg DX&L Paid per Member	$400	$381	$528	38.6%	$363	$318	$471	48.1%	$0	$0	$2,937	0.0%
Emergency Room												
# of Visits	1,634	1,216	1,296		1,343	1,049	1,076		1	0	0	
Visits Per Member	0.15	0.11	0.15	36.4%	0.14	0.11	0.15	36.4%	0.57	0.00	0.00	0.0%
Visits Per 1,000	151	114	151	32.5%	143	113	148	31.0%	571	0	0	0.0%
Avg Paid per Visit	$1,981	$1,882	$1,700	-9.7%	$1,961	$1,857	$1,743	-6.1%	$1,239	$0	$0	0.0%
Urgent Care												
# of Visits	3,029	2,082	2,535		2,752	1,887	2,267		1	0	0	
Visits Per Member	0.28	0.20	0.30	50.0%	0.29	0.20	0.31	55.0%	0.57	0.00	0.00	0.0%
Visits Per 1,000	281	195	296	51.8%	293	203	311	53.2%	571	0	0	0.0%
Avg Paid per Visit	$29	$54	$59	9.3%	$28	$54	$60	11.1%	$170	$0	$0	0.0%
	Annualized	Annualized	Annualized		Annualized	Annualized	Annualized		Annualized	Annualized	Annualized	

Utilization Summary (p. 2 of 2)

	State Retirees				Non-State Retirees				
Summary	**1Q20**	**1Q21**	**1Q22**	**Variance to Prior Year**	**1Q20**	**1Q21**	**1Q22**	**Variance to Prior Year**	**HSB Peer Index**
Inpatient Summary									
# of Admits	86	55	84		24	15	7		
# of Bed Days	506	361	428		116	77	46		
Paid Per Admit	$28,696	$44,268	$18,312	-58.6%	$18,836	$57,886	$16,866	-70.9%	$16,632
Paid Per Day	$4,877	$6,744	$3,594	-46.7%	$3,897	$11,277	$2,566	-77.2%	$3,217
Admits Per 1,000	71	45	74	64.4%	127	92	52	-43.5%	76
Days Per 1,000	418	294	377	28.2%	616	471	339	-28.0%	391
Avg LOS	5.9	6.6	5.1	-22.7%	4.8	5.1	6.6	29.4%	5.2
# Admits From ER	44	36	66		20	11	5		
Physician Office									
OV Utilization per Member	5.8	4.7	5.4	14.9%	7.5	6.3	7.5	19.0%	5.0
Avg Paid per OV	$67	$53	$76	43.4%	$51	$66	$30	-54.5%	$57
Avg OV Paid per Member	$388	$250	$415	66.0%	$384	$415	$226	-45.5%	$286
DX&L Utilization per Member	11.7	9.6	11.1	15.6%	13.8	10.2	11.7	14.7%	10.5
Avg Paid per DX&L	$56	$88	$78	-11.4%	$46	$45	$61	35.6%	$50
Avg DX&L Paid per Member	$655	$846	$868	2.6%	$639	$457	$712	55.8%	$522
Emergency Room									
# of Visits	237	146	192		53	21	28		
Visits Per Member	0.20	0.12	0.17	41.7%	0.28	0.13	0.21	61.5%	0.24
Visits Per 1,000	196	119	169	42.0%	281	128	207	61.7%	235
Avg Paid per Visit	$2,312	$1,749	$1,561	-10.7%	$1,015	$4,063	$1,015	-75.0%	$943
Urgent Care									
# of Visits	245	173	245		31	22	23		
Visits Per Member	0.20	0.14	0.22	57.1%	0.16	0.13	0.17	30.8%	0.3
Visits Per 1,000	202	141	216	53.2%	165	135	170	25.9%	300
Avg Paid per Visit	$36	$58	$49	-15.5%	$46	$29	$34	17.2%	$84
	Annualized	Annualized	Annualized		Annualized	Annualized	Annualized		

Provider Network Summary





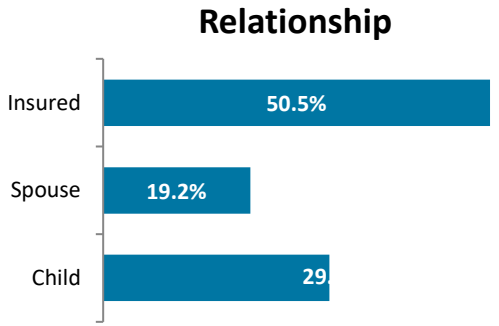
Diagnosis Grouper Summary

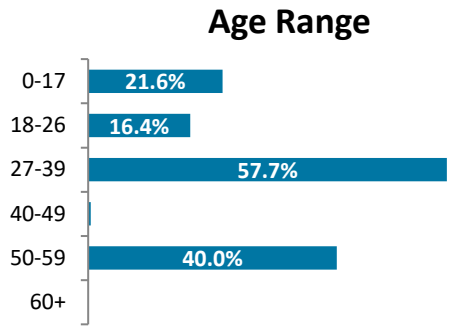
Diagnosis Grouper	Total Paid	% Paid	Insured	Spouse	Child	Male	Female
Pregnancy-related Disorders	$5,106,981	13.7%	$755,602	$281,028	$4,070,350	$3,790,671	$1,246,084
Cancer	$3,902,809	10.4%	$3,258,467	$417,459	$226,883	$1,793,291	$2,109,519
Cardiac Disorders	$3,072,159	8.2%	$2,304,697	$746,138	$21,324	$2,224,282	$845,018
Gastrointestinal Disorders	$2,905,640	7.8%	$2,119,857	$544,615	$241,168	$1,499,026	$1,406,614
Infections	$2,834,380	7.6%	$1,810,537	$723,690	$300,152	$1,311,580	$1,522,730
Health Status/Encounters	$2,776,068	7.4%	$1,576,176	$396,039	$803,853	$1,073,446	$1,701,191
Musculoskeletal Disorders	$2,211,157	5.9%	$1,591,713	$332,118	$287,325	$820,724	$1,388,822
Spine-related Disorders	$2,177,602	5.8%	$1,616,773	$376,342	$184,487	$494,182	$1,683,420
Mental Health	$1,604,144	4.3%	$617,811	$99,639	$886,694	$769,681	$834,463
Trauma/Accidents	$1,551,112	4.1%	$869,924	$259,228	$421,961	$690,535	$860,577
Neurological Disorders	$1,533,538	4.1%	$980,326	$255,409	$297,804	$593,200	$939,788
Renal/Urologic Disorders	$1,156,802	3.1%	$686,428	$367,440	$102,934	$749,465	$407,337
Eye/ENT Disorders	$882,513	2.4%	$647,641	$93,787	$141,085	$389,260	$493,254
Pulmonary Disorders	$722,875	1.9%	$440,683	$106,167	$176,025	$371,807	$351,068
Endocrine/Metabolic Disorders	$682,204	1.8%	$548,086	$105,459	$28,659	$227,773	$454,431
Gynecological/Breast Disorders	$677,434	1.8%	$430,777	$146,102	$100,555	$32,736	$644,619
Hematological Disorders	$643,054	1.7%	$605,865	$14,016	$23,172	$161,381	$481,672
Congenital/Chromosomal Anomalies	$512,363	1.4%	$51,691	$1,057	$459,615	$315,930	$196,433
Dermatological Disorders	$422,195	1.1%	$302,361	$31,674	$88,160	$291,879	$130,316
Non-malignant Neoplasm	$416,865	1.1%	$348,151	$55,804	$12,910	$131,451	$285,414
Medical/Surgical Complications	$408,383	1.1%	$321,604	$86,168	$611	$285,240	$123,142
Diabetes	$310,543	0.8%	$235,699	$46,211	$28,633	$171,027	$139,516
Vascular Disorders	$303,437	0.8%	$256,812	$45,892	$734	$57,809	$245,628
Miscellaneous	$295,103	0.8%	$179,122	$70,838	$45,143	$137,783	$157,320
Abnormal Lab/Radiology	$170,865	0.5%	$135,712	$27,471	$7,682	$77,993	$92,872
Medication Related Conditions	$54,753	0.1%	$31,856	$2,797	$20,099	$30,837	$23,916
Cholesterol Disorders	$26,753	0.1%	$21,218	$4,938	$597	$13,804	$12,949
External Hazard Exposure	$18,742	0.1%	$5,996	$7,314	$5,432	$11,101	$7,641
Dental Conditions	$18,437	0.0%	$15,857	$401	$2,179	$2,266	$16,171
Allergic Reaction	$12,693	0.0%	$5,734	$3,487	$3,472	$5,569	$7,124
Total	**$37,411,602**	**100.0%**	**$22,773,174**	**$5,648,729**	**$8,989,699**	**$18,525,727**	**$18,809,050**

Diagnosis Grouper – Pregnancy-related Disorders

Diagnosis Sub-Grouper	Patients	Claims	Total Paid	% Paid
Perinatal Disorders	58	172	$2,466,498	48.3%
Prematurity and Low Birth Weight	4	10	$1,052,593	20.6%
Pregnancy Complications	199	522	$494,795	9.7%
Labor and Delivery Related	95	197	$451,228	8.8%
Liveborn Infants	75	113	$434,545	8.5%
Fetal Distress	6	34	$95,988	1.9%
Supervision of Pregnancy	288	723	$90,550	1.8%
Abortion Related	13	32	$7,815	0.2%
Multiple Gestation Related	8	21	$6,763	0.1%
Ectopic Pregnancy	3	6	$4,235	0.1%
Cesarean Delivery	4	4	$1,970	0.0%
Birth Injury	0	0	$0	0.0%
Overall	**----**	**----**	**$5,106,981**	**100.0%**

*Patient and claim counts are unique only within the category

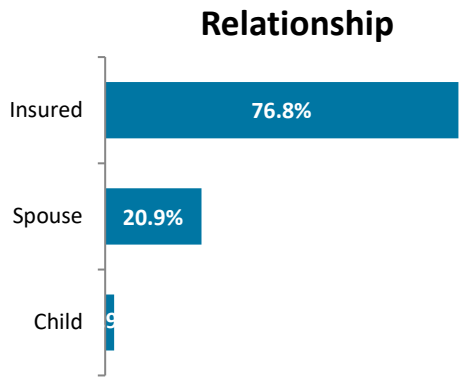


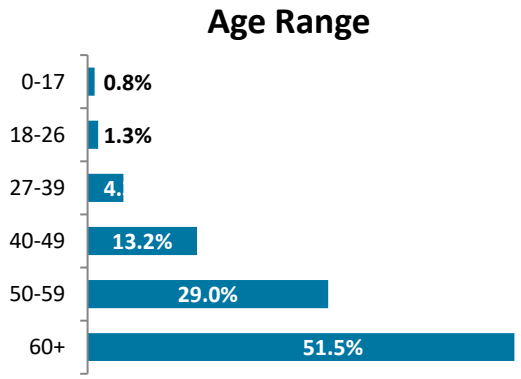


Diagnosis Grouper – Cancer

Diagnosis Sub-Grouper	Patients	Claims	Total Paid	% Paid
Cancer Therapies	79	372	$1,501,249	38.5%
Cancers, Other	190	524	$469,230	12.0%
Breast Cancer	153	690	$461,331	11.8%
Leukemias	24	205	$250,994	6.4%
Cervical/Uterine Cancer	37	124	$200,548	5.1%
Secondary Cancers	47	153	$175,878	4.5%
Colon Cancer	37	144	$133,573	3.4%
Brain Cancer	10	71	$122,616	3.1%
Lung Cancer	22	104	$112,252	2.9%
Ovarian Cancer	19	54	$89,173	2.3%
Prostate Cancer	71	205	$88,813	2.3%
Pancreatic Cancer	8	53	$82,868	2.1%
Lymphomas	32	162	$53,373	1.4%
Thyroid Cancer	46	124	$48,478	1.2%
Melanoma	33	88	$33,549	0.9%
Carcinoma in Situ	43	65	$23,408	0.6%
Kidney Cancer	10	30	$23,072	0.6%
Myeloma	8	49	$22,537	0.6%
Bladder Cancer	14	41	$9,867	0.3%
Overall	**----**	**----**	**$3,902,809**	**100.0%**

*Patient and claim counts are unique only within the category

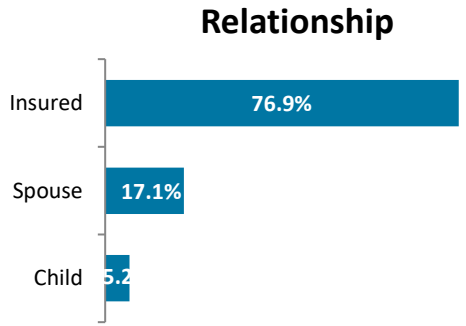


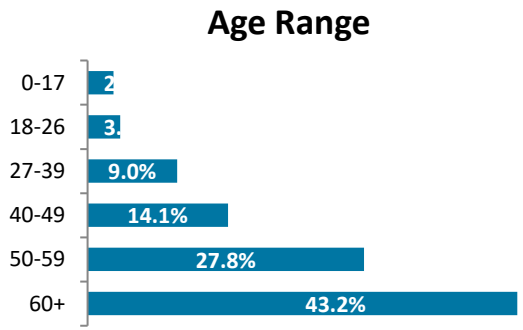


Diagnosis Grouper – Cardiac Disorders

Diagnosis Sub-Grouper	Patients	Claims	Total Paid	% Paid
Cardiac Conditions, Other	354	500	$729,468	23.7%
Atrial Fibrillation	120	340	$419,858	13.7%
Cardiac Arrhythmias	181	287	$389,989	12.7%
Chest Pain	514	995	$360,395	11.7%
Heart Valve Disorders	105	157	$354,778	11.5%
Myocardial Infarction	25	103	$237,411	7.7%
Coronary Artery Disease	201	334	$221,217	7.2%
Congestive Heart Failure	59	174	$178,753	5.8%
Hypertension	1,254	1,754	$95,571	3.1%
Cardiomyopathy	28	50	$30,118	1.0%
Pulmonary Embolism	25	66	$24,887	0.8%
Shock	7	22	$20,747	0.7%
Cardio-Respiratory Arrest	39	79	$7,083	0.2%
Ventricular Fibrillation	6	11	$1,884	0.1%
Overall	**----**	**----**	**$3,072,159**	**100.0%**

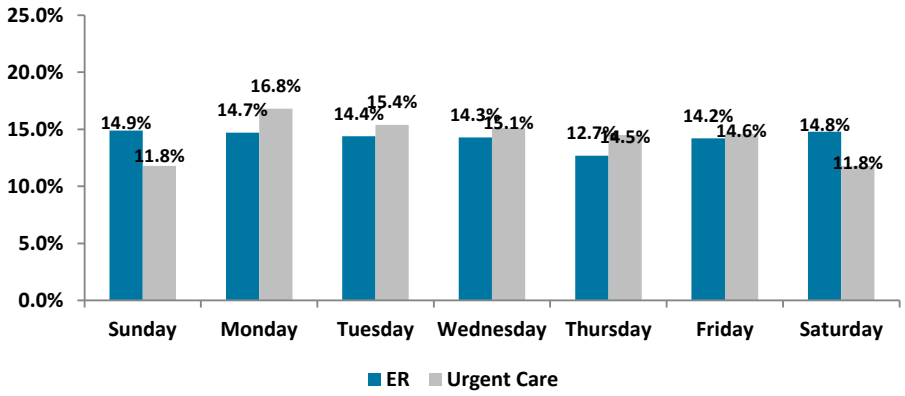
*Patient and claim counts are unique only within the category

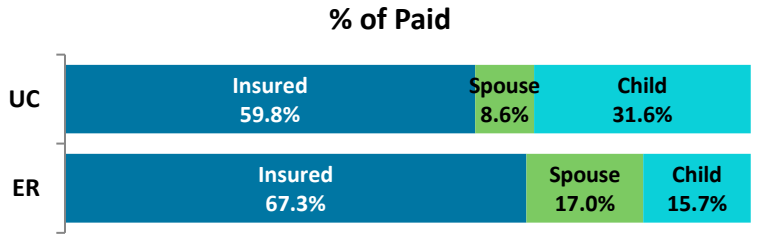




Emergency Room / Urgent Care Summary

	1Q21		1Q22		HSB Peer Index	
ER/Urgent Care	**ER**	**Urgent Care**	**ER**	**Urgent Care**	**ER**	**Urgent Care**
Number of Visits	1,216	2,082	1,296	2,535		
Visits Per Member	0.11	0.20	0.15	0.30	0.17	0.24
Visits/1000 Members	114	195	151	296	174	242
Avg Paid Per Visit	$1,882	$54	$1,700	$59	$1,684	$74
% with OV*	82.3%	79.0%	85.4%	82.5%		
% Avoidable	11.3%	24.9%	10.9%	27.6%		
Total Member Paid	**$1,492,021**	**$249,911**	**$1,386,977**	**$285,561**		
Total Plan Paid	**$2,288,406**	**$113,168**	**$2,203,298**	**$148,449**		
*looks back 12 months	Annualized	Annualized	Annualized	Annualized		



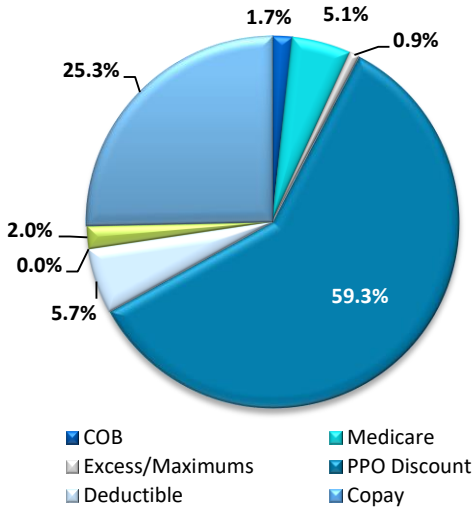


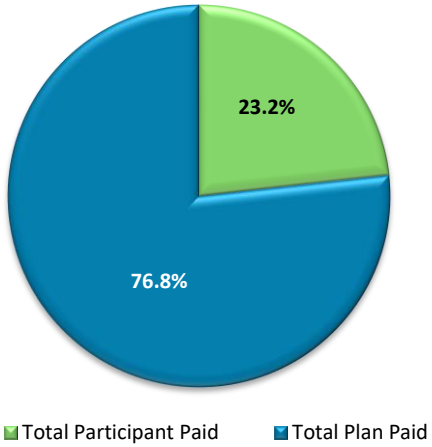
ER / UC Visits by Relationship						
Relationship	**ER**	**Per 1,000**	**Urgent Care**	**Per 1,000**	**Total**	**Per 1,000**
Insured	797	41	1,551	4,380	2,348	121
Spouse	189	44	746	863	935	218
Child	310	30	238	1,655	548	52
Total	**1,296**	**38**	**2,535**	**74**	**3,831**	**112**

Savings Summary – Medical Claims

Description	Dollars	PPPM	% of Eligible
Eligible Charges	$147,208,917	$2,523	100.0%
COB	$2,493,607	$43	1.7%
Medicare	$7,523,928	$129	5.1%
Excess/Maximums	$1,301,421	$22	0.9%
PPO Discount	$87,592,587	$1,501	59.5%
Deductible	$8,389,725	$144	5.7%
Copay	$46,323	$1	0.0%
Coinsurance	$2,891,532	$50	2.0%
Total Participant Paid	**$11,327,580**	**$194**	**7.7%**
Total Plan Paid	**$37,411,602**	**$641**	**25.4%**

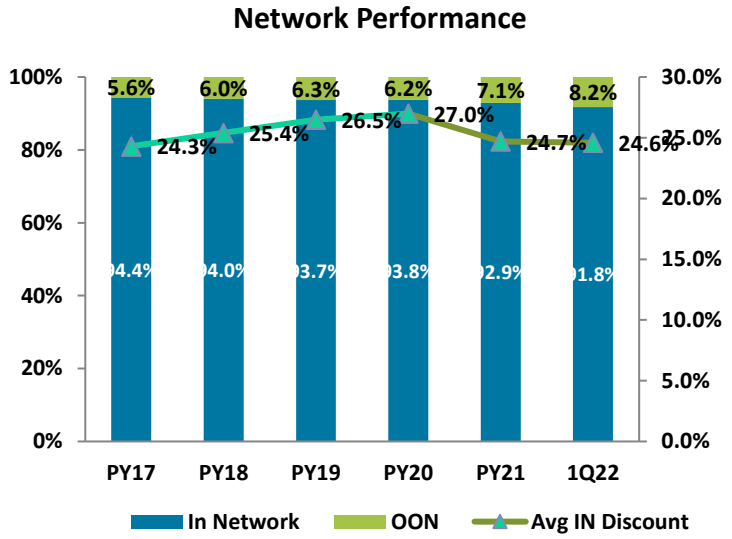
Total Participant Paid - PY21	**$135**
Total Plan Paid - PY21	**$472**



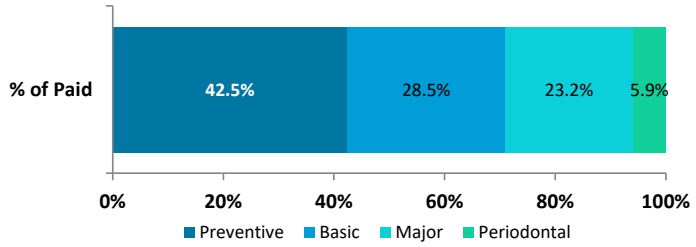


Dental Claims Analysis

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	1,485	2.0%	14,288	15.0%	$2,111,898	31.0%	$1,575,231	43.0%
$750.01-$1,000.00	725	1.0%	5,091	5.0%	$639,960	9.0%	$422,534	11.0%
$500.01-$750.00	1,275	2.0%	7,790	8.0%	$793,684	12.0%	$533,988	14.0%
$250.01-$500.00	2,233	3.0%	12,150	13.0%	$814,291	12.0%	$427,905	12.0%
$0.01-$250.00	18,952	28.0%	54,188	57.0%	$2,515,999	37.0%	$674,339	18.0%
$0.00	857	1.0%	1,291	1.0%	$0	0.0%	$68,008	2.0%
No Claims	41,280	62.0%	0	0.0%	$0	0.0%	$0	0.0%
Total	**66,807**	**100.0%**	**94,798**	**100.0%**	**$6,875,834**	**100.0%**	**$3,702,004**	**100.0%**



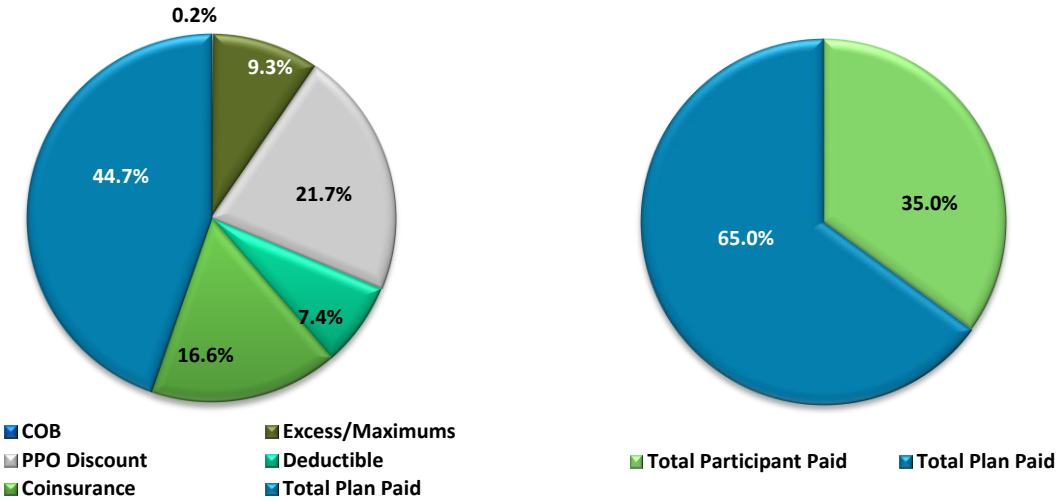
Claim Category	Total Paid	% of Paid
Preventive	$2,919,850	42.5%
Basic	$1,956,998	28.5%
Major	$1,592,245	23.2%
Periodontal	$406,741	5.9%
Total	**$6,875,834**	**100.0%**



Savings Summary – Dental Claims

Description	Dollars	PPPM	% of Eligible
Eligible Charges	$15,346,351	$127	100.0%
COB	$32,772	$0	0.2%
Excess/Maximums	$1,437,553	$12	9.4%
PPO Discount	$3,338,902	$28	21.8%
Deductible	$1,140,127	$9	7.4%
Coinsurance	$2,561,877	$21	16.7%
Total Participant Paid	**$3,702,004**	**$31**	**24.1%**
Total Plan Paid	**$6,875,834**	**$57**	**44.8%**

Total Participant Paid - PY21	**$23**
Total Plan Paid - PY21	**$51**



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	1,140	1,097	43	94.5%
	<2 asthma related ER Visits in the last 6 months	1,140	1,139	1	99.9%
	No asthma related admit in last 12 months	1,140	1,139	1	99.9%
Chronic Obstructive Pulmonary Disease	No exacerbations in last 12 months	239	233	6	97.5%
	Members with COPD who had an annual spirometry test	239	31	208	13.0%
Congestive Heart Failure	No re-admit to hosp with Heart Failure diag w/in 30 days of HF inpatient stay discharge	14	14	0	100.0%
	No ER Visit for Heart Failure in last 90 days	200	195	5	97.5%
	Follow-up OV within 4 weeks of discharge from HF admission	14	12	2	85.7%
Diabetes	Annual office visit	1,648	1,564	84	94.9%
	Annual dilated eye exam	1,648	709	939	43.0%
	Annual foot exam	1,648	671	977	40.7%
	Annual HbA1c test done	1,648	1,342	306	81.4%
	Diabetes Annual lipid profile	1,648	1,265	383	76.8%
	Annual microalbumin urine screen	1,648	1,133	515	68.8%
Hyperlipidemia	Hyperlipidemia Annual lipid profile	4,202	3,334	868	79.3%
Hypertension	Annual lipid profile	4,700	3,117	1,583	66.3%
	Annual serum creatinine test	4,616	3,634	982	78.7%
Wellness	Well Child Visit - 15 months	262	247	15	94.3%
	Routine office visit in last 6 months	33,965	20,078	13,887	59.1%
	Age 45 to 75 years with colorectal cancer screening	13,312	2,919	10,393	21.9%
	Women age 25-65 with recommended cervical cancer screening	10,686	7,423	3,263	69.5%
	Males age greater than 49 with PSA test in last 24 months	5,172	2,372	2,800	45.9%
	Routine exam in last 24 months	33,965	28,247	5,718	83.2%
	Women age 40 to 75 with a screening mammogram last 24 months	8,564	4,797	3,767	56.0%

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	193	0.57%	5.64	$15,318
Asthma	1,291	3.80%	37.72	$13,506
Atrial Fibrillation	316	0.93%	9.23	$39,654
Blood Disorders	1,705	5.02%	49.81	$26,701
CAD	665	1.96%	19.43	$23,195
COPD	237	0.70%	6.92	$24,004
Cancer	1,219	3.59%	35.61	$22,308
Chronic Pain	623	1.83%	18.20	$25,919
Congestive Heart Failure	199	0.59%	5.81	$53,486
Demyelinating Diseases	74	0.22%	2.16	$41,841
Depression	1,909	5.62%	55.77	$12,664
Diabetes	1,797	5.29%	52.50	$16,982
ESRD	46	0.14%	1.34	$103,861
Eating Disorders	105	0.31%	3.07	$24,846
HIV/AIDS	40	0.12%	1.17	$34,491
Hyperlipidemia	4,411	12.98%	128.86	$9,582
Hypertension	4,713	13.87%	137.69	$12,574
Immune Disorders	91	0.27%	2.66	$90,452
Inflammatory Bowel Disease	108	0.32%	3.16	$34,432
Liver Diseases	585	1.72%	17.09	$21,246
Morbid Obesity	793	2.33%	23.17	$16,556
Osteoarthritis	1,160	3.41%	33.89	$14,432
Peripheral Vascular Disease	170	0.50%	4.97	$20,453
Rheumatoid Arthritis	150	0.44%	4.38	$27,333

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 2022 - Quarter Ending September 30, 2021

Express Scripts

Membership Summary	1Q FY2022 CDHP	1Q FY2021 CDHP	Difference	% Change
			Membership Summary	
Member Count (Membership)	34,140	42,603	(8,463)	-19.9%
Utilizing Member Count (Patients)	17,136	19,835	(2,699)	-13.6%
Percent Utilizing (Utilization)	50.2%	46.6%	0.04	7.8%
Claim Summary			**Claims Summary**	
Net Claims (Total Rx's)	108,998	129,143	(20,145)	-15.6%
Claims per Elig Member per Month (Claims PMPM)	1.06	1.01	0.05	5.0%
Total Claims for Generic (Generic Rx)	93,554	111,213	(17,659.00)	-15.9%
Total Claims for Brand (Brand Rx)	15,444	17,930	(2,486.00)	-13.9%
Total Claims for Brand w/Gen Equiv (Multisource Brand Claims)	845	2,033	(1,188.00)	-58.4%
Total Non-Specialty Claims	107,692	127,547	(19,855.00)	-15.6%
Total Specialty Claims	1,306	1,596	(290.00)	-18.2%
Generic % of Total Claims (GFR)	**85.8%**	**86.1%**	(0.00)	-0.3%
Generic Effective Rate (GCR)	**99.1%**	**98.2%**	0.01	0.9%
Mail Order Claims	26,331	27,558	(1,227.00)	-4.5%
Mail Penetration Rate*	27.9%	24.1%	0.04	3.8%
Claims Cost Summary			**Claims Cost Summary**	
Total Prescription Cost (Total Gross Cost)	$10,849,379.00	$13,630,935.00	($2,781,556.00)	-20.4%
Total Generic Gross Cost	$1,592,374.00	$2,102,496.00	($510,122.00)	-24.3%
Total Brand Gross Cost	$9,257,005.00	$11,528,439.00	($2,271,434.00)	-19.7%
Total MSB Gross Cost	$296,105.00	$444,299.00	($148,194.00)	-33.4%
Total Ingredient Cost	$10,637,380.00	$13,521,315.00	($2,883,935.00)	-21.3%
Total Dispensing Fee	$207,843.00	$104,044.00	$103,799.00	99.8%
Total Other (e.g. tax)	$4,155.00	$5,576.00	($1,421.00)	-25.5%
Avg Total Cost per Claim (Gross Cost/Rx)	**$99.54**	**$105.55**	($6.01)	-5.7%
Avg Total Cost for Generic (Gross Cost/Generic Rx)	$17.02	$18.91	($1.89)	-10.0%
Avg Total Cost for Brand (Gross Cost/Brand Rx)	$599.39	$642.97	($43.58)	-6.8%
Avg Total Cost for MSB (MSB Gross Cost/MSB ARx)	$350.42	$218.54	$131.88	60.3%
Member Cost Summary			**Member Cost Summary**	
Total Member Cost	**$3,177,822.00**	**$3,894,908.00**	($717,086.00)	-18.4%
Total Copay	$2,012,504.00	$2,386,987.00	($374,483.00)	-15.7%
Total Deductible	$1,165,317.00	$1,507,921.00	($342,604.00)	-22.7%
Avg Copay per Claim (Copay/Rx)	$18.46	$18.48	($0.02)	-0.1%
Avg Participant Share per Claim (Copay+Deductible/RX)	**$29.15**	**$30.16**	**($1.00)**	**-3.3%**
Avg Copay for Generic (Copay/Generic Rx)	$10.37	$10.74	($0.37)	-3.4%
Avg Copay for Brand (Copay/Brand Rx)	$142.98	$150.61	($7.63)	-5.1%
Avg Copay for Brand w/ Generic Equiv (Copay/Multisource Rx)	$98.49	$80.93	$17.56	21.7%
Net PMPM (Participant Cost PMPM)	**$31.03**	**$30.47**	$0.55	1.8%
Copay % of Total Prescription Cost (Member Cost Share %)	29.3%	28.6%	0.7%	2.5%
Plan Cost Summary			**Plan Cost Summary**	
Total Plan Cost (Plan Cost)	**$7,671,557.00**	**$9,736,027.00**	**($2,064,470.00)**	**-21.2%**
Total Non-Specialty Cost (Non-Specialty Plan Cost)	$2,691,174.00	$3,136,301.00	($445,127.00)	-14.2%
Total Specialty Drug Cost (Specialty Plan Cost)	$4,980,383.00	$6,599,727.00	($1,619,344.00)	-24.5%
Avg Plan Cost per Claim (Plan Cost/Rx)	**$70.38**	**$75.39**	($5.01)	-6.6%
Avg Plan Cost for Generic (Plan Cost/Generic Rx)	$6.66	$8.16	($1.50)	-18.4%
Avg Plan Cost for Brand (Plan Cost/Brand Rx)	$456.42	$492.36	($35.94)	-7.3%
Avg Plan Cost for MSB (MSB Plan Cost/MSB ARx)	$251.93	$137.61	$114.32	83.1%
Net PMPM (Plan Cost PMPM)	**$74.90**	**$76.18**	**($1.27)**	**-1.7%**
PMPM for Specialty Only (Specialty PMPM)	$48.63	$51.64	($3.01)	-5.8%
PMPM without Specialty (Non-Specialty PMPM)	$26.28	$24.54	$4.02	17.3%
Specialty % of Plan Cost	64.9%	67.79%	($0.03)	-4.3%
Rebates Received (Q1 FY2022 actual)	$2,383,601.42	$2,454,526.22	($70,924.80)	-2.9%
Net PMPM (Plan Cost PMPM factoring Rebates)	**$51.63**	**$56.97**	**($5.34)**	**-9.4%**
PMPM for Specialty Only (Specialty PMPM)	$40.05	$44.22	($4.17)	-9.4%
PMPM without Specialty (Non-Specialty PMPM)	$14.78	$11.21	$3.57	31.8%

Appendix B

Index of Tables
HealthSCOPE – LDPPO Utilization Review for PEBP
July 1, 2021 – September 30, 2021

HSB DATASCOPE™

Nevada Public Employees' Benefits Program
Low Deductible Plan

July – September 2021

HealthSCOPE BENEFITS

Overview

- Total Medical Spend for 1Q22 was $4,252,059 with an annualized plan cost per employee per year (PEPY) of $4,675.
  - IP Cost per Admit is $20,778.
  - ER Cost per Visit is $2,261.
- Employees shared in 21.8% of the medical cost.
- Inpatient facility costs were 21.9% of the plan spend.
- 97.0% of the Average Membership had paid Medical claims less than $2,500, with 47.4% of those having no claims paid at all during the reporting period.
- 11 members exceeded the $100k high-cost threshold during the reporting period, which accounted for 20.7% of the plan spend. The highest diagnosis category was Cancer, accounting for 12.6% of the high-cost claimant dollars.
- Total spending with in-network providers was 99.2%. The average In Network discount was 62.5%.

Paid Claims by Age Group

Paid Claims by Age Group						
1Q22						
Age Range	Med Net Pay	Med PMPM	Rx Net Pay	Rx PMPM	Net Pay	PMPM
<1	$ 380,192	$ 1,837	$ 397	$ 2	$ 380,589	$ 1,839
1	$ 39,012	$ 130	$ 1,741	$ 6	$ 40,753	$ 136
2 - 4	$ 64,989	$ 71	$ 14,183	$ 16	$ 79,172	$ 87
5 - 9	$ 55,500	$ 35	$ 6,756	$ 4	$ 62,256	$ 39
10 - 14	$ 159,874	$ 83	$ 54,646	$ 28	$ 214,520	$ 111
15 - 19	$ 177,343	$ 96	$ 51,493	$ 28	$ 228,836	$ 123
20 - 24	$ 294,288	$ 159	$ 57,292	$ 31	$ 351,580	$ 190
25 - 29	$ 141,984	$ 118	$ 71,234	$ 59	$ 213,218	$ 177
30 - 34	$ 362,395	$ 222	$ 101,693	$ 62	$ 464,088	$ 284
35 - 39	$ 337,260	$ 171	$ 117,814	$ 60	$ 455,074	$ 231
40 - 44	$ 323,714	$ 167	$ 166,963	$ 86	$ 490,677	$ 253
45 - 49	$ 413,951	$ 238	$ 159,391	$ 92	$ 573,342	$ 330
50 - 54	$ 399,816	$ 215	$ 251,833	$ 135	$ 651,649	$ 350
55 - 59	$ 475,276	$ 263	$ 207,337	$ 115	$ 682,613	$ 377
60 - 64	$ 434,648	$ 292	$ 344,210	$ 231	$ 778,858	$ 523
65+	$ 191,818	$ 326	$ 111,870	$ 190	$ 303,688	$ 516
Total	**$ 4,252,059**	**$ 186**	**$ 1,718,853**	**$ 75**	**$ 5,970,913**	**$ 261**

Financial Summary

	Total	State Active	Non-State Active	State Retirees	Non-State Retirees	
Summary	**1Q22**	**1Q22**	**1Q22**	**1Q22**	**1Q22**	**HSB Peer Index**
Enrollment						
Avg # Employees	3,638	3,288	1	330	20	
Avg # Members	7,618	7,039	2	548	30	
Ratio	2.1	2.1	2.0	1.7	1.5	1.8
Financial Summary						
Gross Cost	$5,440,340	$4,899,002	$867	$528,554	$11,917	
Client Paid	$4,252,059	$3,842,723	$514	$402,691	$6,131	
Employee Paid	$1,188,280	$1,056,279	$353	$125,862	$5,786	
Client Paid-PEPY	$4,675	$4,675	$2,056	$4,886	$1,226	$6,209
Client Paid-PMPY	$2,233	$2,184	$1,028	$2,938	$817	$3,437
Client Paid-PEPM	$390	$390	$171	$407	$102	$517
Client Paid-PMPM	$186	$182	$86	$245	$68	$286
High Cost Claimants (HCC's) > $100k						
# of HCC's	11	10	0	1	0	
HCC's / 1,000	1.4	1.4	0.0	1.8	0.0	
Avg HCC Paid	$80,052	$84,525		$35,326		
HCC's % of Plan Paid	20.7%	22.0%	0.0%	8.8%	0.0%	
Cost Distribution by Claim Type (PMPY)						
Facility Inpatient	$488	$516	$0	$153	$0	$1,057
Facility Outpatient	$610	$567	$0	$1,188	$108	$1,145
Physician	$1,099	$1,068	$1,028	$1,513	$710	$1,122
Other	$36	$33	$0	$84	$0	$113
Total	$2,233	$2,184	$1,028	$2,938	$817	$3,437
	Annualized	Annualized	Annualized	Annualized	Annualized	

Paid Claims by Claim Type – State Participants

Net Paid Claims - Total State Participants	1Q22			
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total
Medical				
Inpatient	$ 1,270,916	$ 37,833	$ 1,622	$ 1,310,371
Outpatient	$ 2,571,807	$ 359,471	$ 3,765	$ 2,935,043
Total - Medical	**$ 3,842,723**	**$ 397,304**	**$ 5,387**	**$ 4,245,414**

Net Paid Claims - Per Participant per Month	1Q22			
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total
Medical	$ 389	$ 431	$ 79	$ 391

Paid Claims by Claim Type – Non-State Participants

Net Paid Claims - Total Non-State Participants	1Q22			
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total
Medical				
Inpatient	$ -	$ -	$ 39	$ 39
Outpatient	$ 514	$ 3,602	$ 2,491	$ 6,607
Total - Medical	**$ 514**	**$ 3,602**	**$ 2,529**	**$ 6,645**

Net Paid Claims - Per Participant per Month	1Q22			
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total
Medical	$ 514	$ 124	$ 2,530	$ 214

Paid Claims by Claim Type – Total

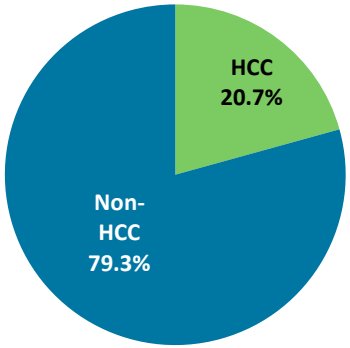
Net Paid Claims - Total Total Participants	1Q22			
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total
Medical				
Inpatient	$ 1,270,916	$ 37,833	$ 1,661	$ 1,310,410
Outpatient	$ 2,572,321	$ 363,072	$ 6,256	$ 2,941,650
Total - Medical	**$ 3,843,237**	**$ 400,906**	**$ 7,917**	**$ 4,252,059**

Net Paid Claims - Per Participant per Month	1Q22			
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total
Medical	$ 390	$ 422	$ 115	$ 390

Cost Distribution – Medical Claims

	1Q22					
Paid Claims Category	Avg # of Members	% of Members	Total Paid	% of Paid	EE Paid	% EE Paid
$100,000.01 Plus	4	0.1%	$562,057	13.2%	$19,902	1.7%
$50,000.01-$100,000.00	6	0.1%	$522,199	12.3%	$33,557	2.8%
$25,000.01-$50,000.00	16	0.2%	$543,156	12.8%	$53,003	4.5%
$10,000.01-$25,000.00	40	0.5%	$595,200	14.0%	$107,859	9.1%
$5,000.01-$10,000.00	62	0.8%	$410,010	9.6%	$104,682	8.8%
$2,500.01-$5,000.00	100	1.3%	$356,197	8.4%	$112,404	9.5%
$0.01-$2,500.00	3,568	46.8%	$1,263,239	29.7%	$729,146	61.3%
$0.00	213	2.8%	$0	0.0%	$27,727	2.3%
No Claims	3,611	47.4%	$0	0.0%	$0	0.0%
	7,618	**100.0%**	**$4,252,059**	**100.0%**	**$1,188,280**	**100.0%**

Distribution of HCC Medical Claims Paid



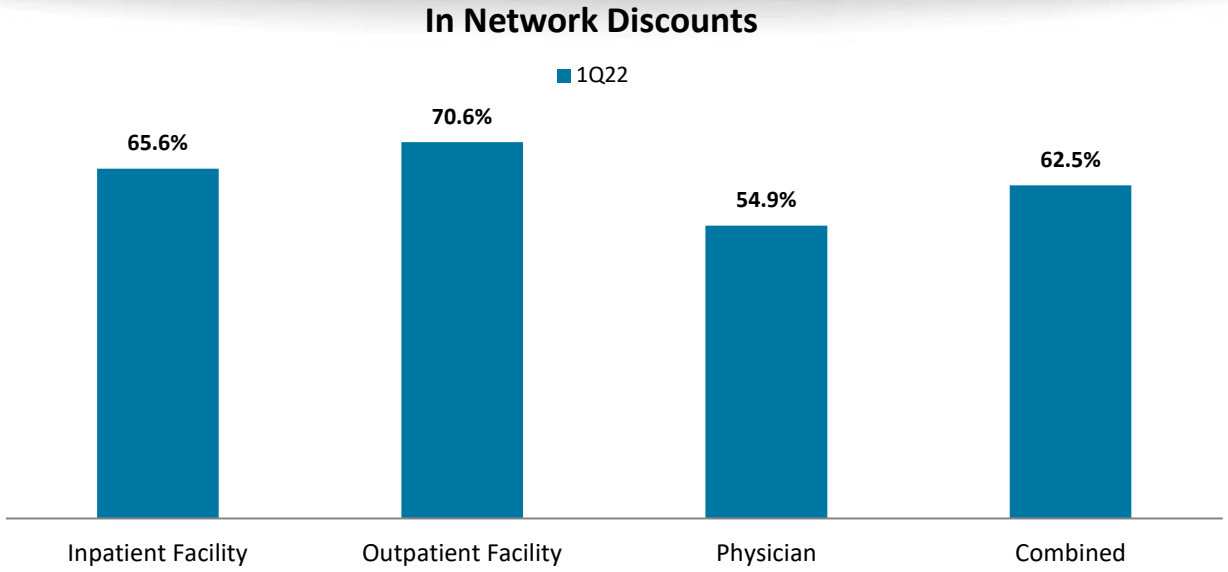
HCC – High-Cost Claimant over $100K

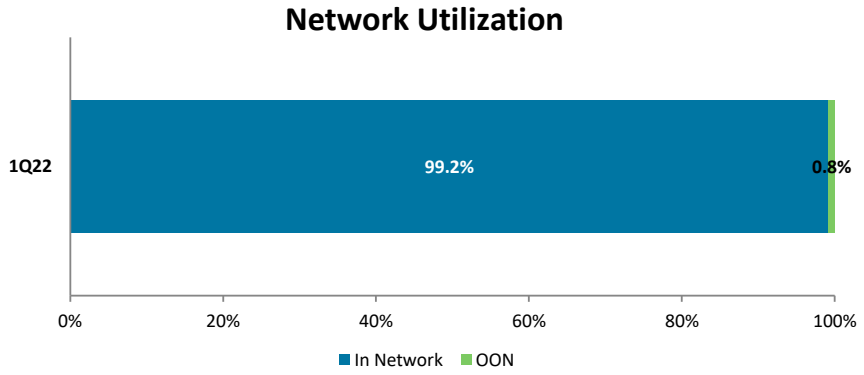
HCC's by Diagnosis Grouper			
Top 10 Diagnosis Groupers	Patients	Total Paid	% Paid
Cancer	5	$320,439	7.9%
Pulmonary Disorders	3	$125,942	3.1%
Cardiac Disorders	3	$123,154	3.0%
Mental Health	2	$77,892	1.9%
Trauma/Accidents	1	$76,720	1.9%
Congenital/Chromosomal Anomalies	2	$61,231	1.5%
Miscellaneous	3	$41,214	1.0%
Medical/Surgical Complications	1	$34,842	0.9%
Renal/Urologic Disorders	3	$3,212	0.1%
Pregnancy-related Disorders	2	$3,160	0.1%
All Other		$12,770	0.3%
Overall	**----**	**$880,576**	**21.6%**

Utilization Summary

	Total	State Active	Non-State Active	State Retirees	Non-State Retirees	
Summary	**1Q22**	**1Q22**	**1Q22**	**1Q22**	**1Q22**	**HSB Peer Index**
Inpatient Facility						
# of Admits	67	59	0	8	0	
# of Bed Days	375	346	0	29	0	
Paid Per Admit	$20,778	$20,506	$0	$22,780	$0	$16,173
Paid Per Day	$3,712	$3,497	$0	$6,284	$0	$3,708
Admits Per 1,000	35	34	0	58	0	61
Days Per 1,000	197	197	0	212	0	264
Avg LOS	5.6	5.9	0	3.6	0.0	4.3
# Admits From ER	36	30	0	6	0.0	
Physician Office						
OV Utilization per Member	3.5	3.4	2.0	4.7	4.9	3.3
Avg Paid per OV	$126	$125	$108	$134	$104	$50
Avg OV Paid per Member	$438	$423	$216	$632	$511	$167
DX&L Utilization per Member	6	5.8	0	9.4	0	8.3
Avg Paid per DX&L	$48	$47	$0	$59	$0	$67
Avg DX&L Paid per Member	$292	$273	$0	$558	$0	$554
Emergency Room						
# of Visits	207	194	0	13	0	
Visits Per Member	0.11	0.11	0	0.09	0	0.17
Visits Per 1,000	109	110	0	95	0	174
Avg Paid per Visit	$2,261	$2,223	$0	$2,825	$0	$1,684
Urgent Care						
# of Visits	423	396	0	27	0	
Visits Per Member	0.22	0.22	0.00	0.20	0.00	0.24
Visits Per 1,000	222	225	0	197	0	242
Avg Paid per Visit	$116	$114	$0	$139	$0	$74
	Annualized	Annualized	Annualized	Annualized	Annualized	

Provider Network Summary





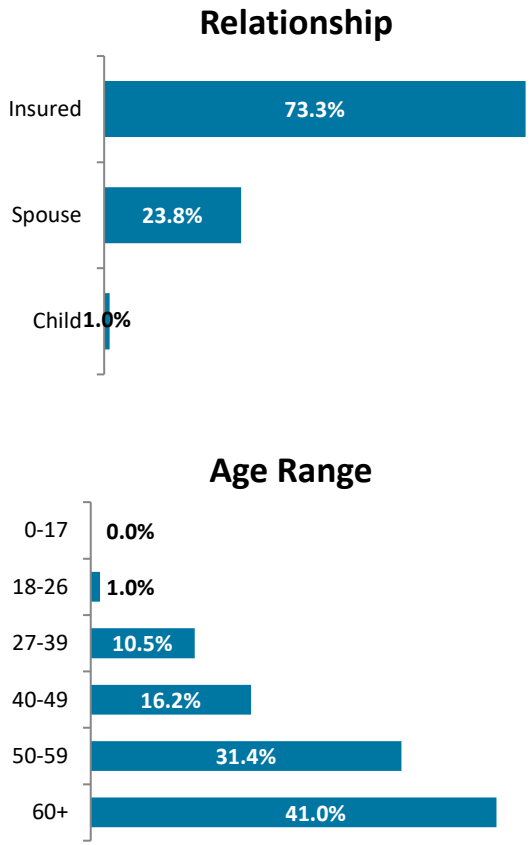
Diagnosis Grouper Summary

Diagnosis Grouper	Total Paid	% Paid	Insured	Spouse	Child	Male	Female
Cancer	$534,721	12.6%	$259,342	$274,500	$879	$195,675	$339,046
Health Status/Encounters	$406,471	9.6%	$198,297	$45,283	$162,890	$126,218	$280,253
Pregnancy-related Disorders	$384,409	9.0%	$215,449	$56,902	$112,058	$90,743	$293,666
Cardiac Disorders	$358,965	8.4%	$320,158	$32,996	$5,811	$286,405	$72,560
Gastrointestinal Disorders	$358,858	8.4%	$261,590	$74,424	$22,845	$94,506	$264,352
Mental Health	$259,103	6.1%	$63,831	$13,930	$181,342	$86,056	$173,047
Musculoskeletal Disorders	$228,030	5.4%	$141,023	$57,304	$29,703	$86,354	$141,676
Infections	$226,991	5.3%	$161,715	$19,034	$46,241	$62,531	$164,460
Pulmonary Disorders	$224,428	5.3%	$52,791	$16,969	$154,668	$154,238	$70,190
Eye/ENT Disorders	$216,647	5.1%	$101,609	$18,298	$96,741	$119,472	$97,175
Trauma/Accidents	$171,028	4.0%	$44,338	$6,250	$120,440	$50,890	$120,139
Gynecological/Breast Disorders	$136,812	3.2%	$96,274	$18,190	$22,349	$4,552	$132,260
Renal/Urologic Disorders	$118,085	2.8%	$85,869	$13,076	$19,140	$95,834	$22,251
Spine-related Disorders	$108,401	2.5%	$60,185	$20,099	$28,117	$17,606	$90,795
Neurological Disorders	$99,594	2.3%	$66,574	$18,842	$14,178	$25,953	$73,641
Miscellaneous	$81,731	1.9%	$25,491	$4,821	$51,420	$49,719	$32,013
Congenital/Chromosomal Anomalies	$71,972	1.7%	$759	$3,623	$67,590	$69,836	$2,136
Non-malignant Neoplasm	$52,095	1.2%	$43,287	$4,369	$4,438	$29,689	$22,405
Endocrine/Metabolic Disorders	$44,365	1.0%	$33,182	$9,786	$1,397	$11,083	$33,282
Medical/Surgical Complications	$39,560	0.9%	$2,129	$2,048	$35,383	$2,094	$37,465
Dermatological Disorders	$32,119	0.8%	$16,761	$7,130	$8,227	$9,775	$22,344
Diabetes	$23,459	0.6%	$12,519	$5,954	$4,985	$9,715	$13,743
Abnormal Lab/Radiology	$22,943	0.5%	$16,336	$5,377	$1,229	$7,847	$15,096
Hematological Disorders	$14,954	0.4%	$10,400	$2,336	$2,218	$2,451	$12,504
Vascular Disorders	$13,758	0.3%	$4,303	$5,155	$4,300	$5,589	$8,170
Cholesterol Disorders	$8,795	0.2%	$6,700	$1,792	$304	$4,087	$4,708
Dental Conditions	$4,565	0.1%	$129	$0	$4,436	$1,923	$2,642
External Hazard Exposure	$4,293	0.1%	$184	$0	$4,109	$3,928	$365
Medication Related Conditions	$4,128	0.1%	$874	$165	$3,089	$510	$3,619
Allergic Reaction	$779	0.0%	$517	$0	$261	$72	$707
Total	**$4,252,059**	**100.0%**	**$2,302,618**	**$738,655**	**$1,210,787**	**$1,705,350**	**$2,546,709**

Diagnosis Grouper – Cancer

Diagnosis Sub-Grouper	Patients	Claims	Total Paid	% Paid
Melanoma	7	30	$153,599	14.6%
Cancer Therapies	11	35	$147,237	14.0%
Brain Cancer	1	22	$78,919	7.5%
Cancers, Other	29	73	$54,228	5.2%
Thyroid Cancer	9	17	$29,403	2.8%
Breast Cancer	23	111	$18,147	1.7%
Secondary Cancers	8	31	$16,820	1.6%
Kidney Cancer	1	3	$12,085	1.1%
Carcinoma in Situ	10	36	$11,872	1.1%
Colon Cancer	4	22	$3,453	0.3%
Bladder Cancer	2	13	$2,625	0.2%
Lung Cancer	3	18	$2,570	0.2%
Prostate Cancer	8	22	$2,249	0.2%
Lymphomas	7	20	$870	0.1%
Leukemias	6	8	$561	0.1%
Cervical/Uterine Cancer	1	1	$83	0.0%
Overall	**----**	**----**	**$534,721**	**100.0%**

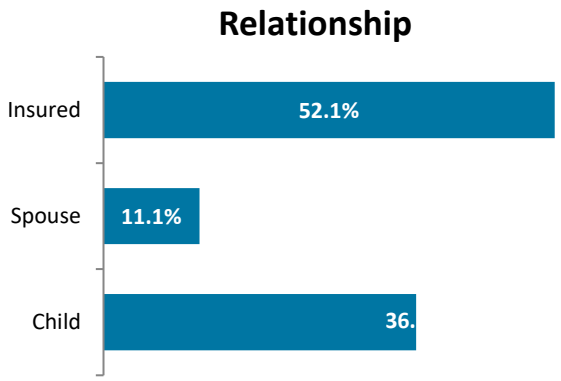
*Patient and claim counts are unique only within the category

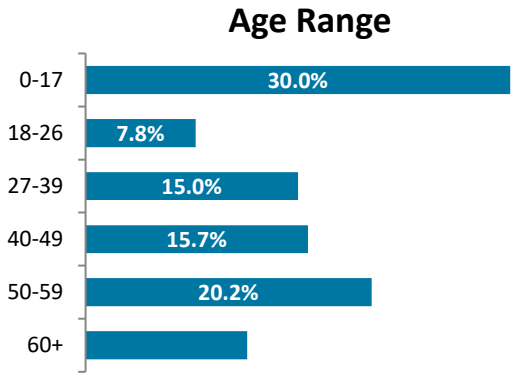


Diagnosis Grouper – Health Status/Encounters

Diagnosis Category	Patients	Claims	Total Paid	% Paid
Screenings	425	689	$112,174	27.0%
Exams	665	984	$100,011	24.7%
Prophylactic Measures	302	324	$99,233	16.0%
Encounters - Infants/Children	365	407	$67,975	7.3%
Aftercare	18	25	$8,413	5.6%
Prosthetics/Devices/Implants	24	54	$5,954	4.8%
Personal History of Condition	40	46	$5,170	4.6%
Counseling	25	32	$2,394	3.0%
Donors	1	2	$1,503	2.2%
History of Condition	16	18	$1,464	2.0%
Family History of Condition	11	11	$912	1.0%
Lifestyle/Situational Issues	15	15	$510	0.8%
Health Status, Other	7	7	$332	0.4%
Replacements	7	9	$254	0.2%
Encounter - Procedure	2	2	$173	0.1%
Miscellaneous Examinations	3	3	$0	0.1%
Follow-Up Encounters	0	0	$0	0.1%
Encounter - Transplant Related	0	0	$0	0.0%
Overall	**----**	**----**	**$406,471**	**100.0%**

*Patient and claim counts are unique only within the category

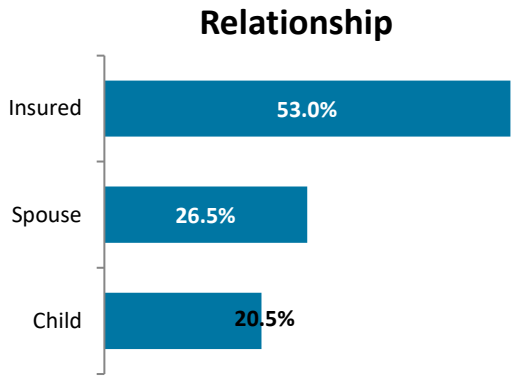


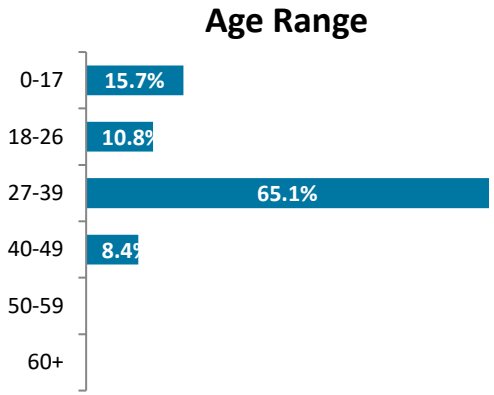


Diagnosis Grouper – Pregnancy-related Disorders

Diagnosis Sub-Grouper	Patients	Claims	Total Paid	% Paid
Pregnancy Complications	36	116	$174,719	45.5%
Labor and Delivery Related	13	44	$92,410	24.0%
Liveborn Infants	11	17	$92,093	24.0%
Supervision of Pregnancy	55	155	$11,495	3.0%
Abortion Related	5	10	$7,864	2.0%
Perinatal Disorders	7	12	$3,252	0.8%
Multiple Gestation Related	2	6	$2,563	0.7%
Cesarean Delivery	1	1	$12	0.0%
Overall	**----**	**----**	**$384,409**	**100.0%**

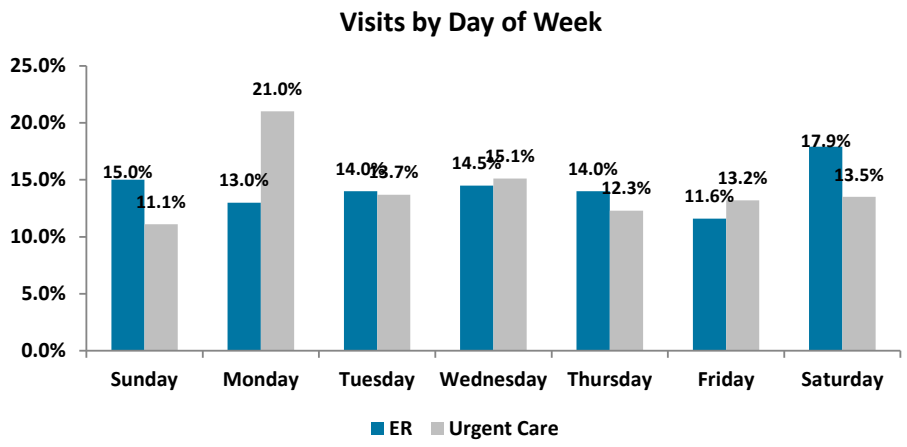
*Patient and claim counts are unique only within the category

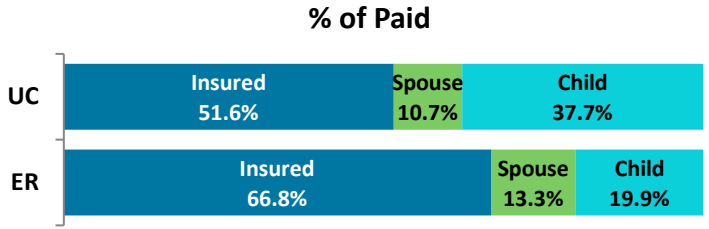




Emergency Room / Urgent Care Summary

	1Q22		HSB Peer Index	
ER/Urgent Care	**ER**	**Urgent Care**	**ER**	**Urgent Care**
Number of Visits	207	423		
Visits Per Member	0.11	0.22	0.17	0.24
Visits/1000 Members	109	222	174	242
Avg Paid Per Visit	$2,261	$116	$1,684	$74
% with OV*	79.7%	80.9%		
% Avoidable	9.2%	31.9%		
Total Member Paid	**$114,306**	**$27,988**		
Total Plan Paid	**$468,076**	**$49,083**		
*looks back 12 months from ER visit	Annualized	Annualized		

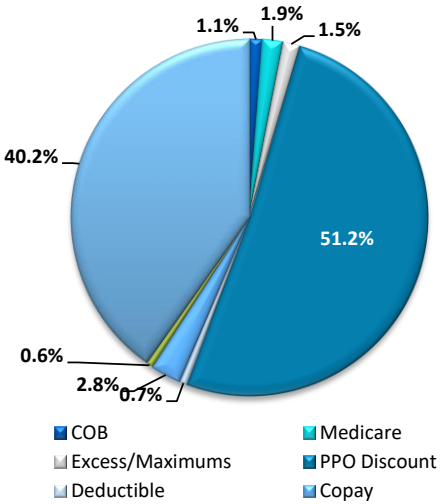


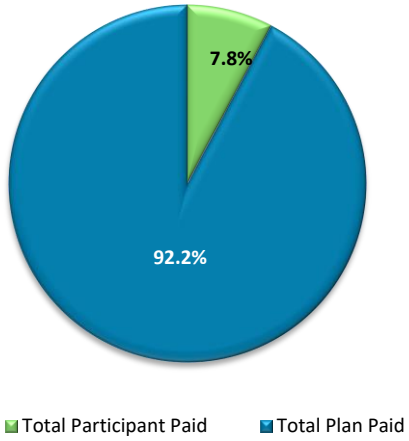


ER / UC Visits by Relationship						
Relationship	**ER**	**Per 1,000**	**Urgent Care**	**Per 1,000**	**Total**	**Per 1,000**
Insured	119	33	211	58	1,056	290
Spouse	26	24	51	47	202	185
Child	62	21	161	56	513	178
Total	**207**	**27**	**423**	**56**	**1,771**	**232**

Savings Summary – Medical Claims

Description	Dollars	PPPM	% of Eligible
Eligible Charges	$14,682,741	$1,177	100.0%
COB	$30,617	$2	0.2%
Medicare	$50,118	$4	0.3%
Excess/Maximums	$210,226	$17	1.4%
PPO Discount	$8,967,671	$719	61.1%
Deductible	$462,236	$37	3.1%
Copay	$474,742	$38	3.2%
Coinsurance	$251,302	$20	1.7%
Total Participant Paid	**$1,188,280**	**$95**	**8.1%**
Total Plan Paid	**$4,252,059**	**$390**	**29.0%**





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	291	288	3	99.0%
	<2 asthma related ER Visits in the last 6 months	291	291	0	100.0%
	No asthma related admit in last 12 months	291	290	1	99.7%
Chronic Obstructive Pulmonary Disease	No exacerbations in last 12 months	28	27	1	96.4%
	Members with COPD who had an annual spirometry test	28	0	28	0.0%
Congestive Heart Failure	No re-admit to hosp with Heart Failure diag w/in 30 days of HF inpatient stay discharge	1	1	0	100.0%
	No ER Visit for Heart Failure in last 90 days	30	29	1	96.7%
	Follow-up OV within 4 weeks of discharge from HF admission	1	1	0	100.0%
Diabetes	Annual office visit	351	343	8	97.7%
	Annual dilated eye exam	351	152	199	43.3%
	Annual foot exam	351	161	190	45.9%
	Annual HbA1c test done	351	299	52	85.2%
	Diabetes Annual lipid profile	351	269	82	76.6%
	Annual microalbumin urine screen	351	251	100	71.5%
Hyperlipidemia	Hyperlipidemia Annual lipid profile	861	725	136	84.2%
Hypertension	Annual lipid profile	792	585	207	73.9%
	Annual serum creatinine test	752	648	104	86.2%
Wellness	Well Child Visit - 15 months	83	72	11	86.7%
	Routine office visit in last 6 months	7,923	4,943	2,980	62.4%
	Age 45 to 75 years with colorectal cancer screening	2,546	659	1,887	25.9%
	Women age 25-65 with recommended cervical cancer screening	2,643	1,724	919	65.2%
	Males age greater than 49 with PSA test in last 24 months	822	367	455	44.6%
	Routine exam in last 24 months	7,923	6,286	1,637	79.3%
	Women age 40 to 75 with a screening mammogram last 24 months	1,870	1,086	784	58.1%

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	65	0.82%	8.53	$11,951
Asthma	319	4.03%	41.86	$8,325
Atrial Fibrillation	44	0.56%	5.77	$15,871
Blood Disorders	378	4.77%	49.60	$13,178
CAD	89	1.12%	11.68	$24,897
COPD	27	0.34%	3.54	$10,265
Cancer	238	3.00%	31.23	$15,658
Chronic Pain	125	1.58%	16.40	$11,957
Congestive Heart Failure	30	0.38%	3.94	$40,580
Demyelinating Diseases	19	0.24%	2.49	$28,986
Depression	541	6.83%	70.99	$5,715
Diabetes	371	4.68%	48.68	$12,078
ESRD	2	0.03%	0.26	$73,326
Eating Disorders	32	0.40%	4.20	$5,628
HIV/AIDS	4	0.05%	0.52	$23,463
Hyperlipidemia	878	11.08%	115.21	$7,487
Hypertension	796	10.04%	104.45	$9,275
Immune Disorders	32	0.40%	4.20	$12,518
Inflammatory Bowel Disease	38	0.48%	4.99	$16,134
Liver Diseases	114	1.44%	14.96	$8,878
Morbid Obesity	209	2.64%	27.42	$7,886
Osteoarthritis	185	2.33%	24.28	$12,299
Peripheral Vascular Disease	24	0.30%	3.15	$3,236
Rheumatoid Arthritis	36	0.45%	4.72	$20,140

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 2022 - Quarter Ending September 30, 2021

Express Scripts

Membership Summary	1Q FY2022 LDPPO		Difference	% Change
			Membership Summary	
Member Count (Membership)	7,574		7,574	#DIV/0!
Utilizing Member Count (Patients)	4,032		4,032	#DIV/0!
Percent Utilizing (Utilization)	53.2%	#DIV/0!	#DIV/0!	#DIV/0!

Claim Summary			Claims Summary	
Net Claims (Total Rx's)	25,731		25,731	#DIV/0!
Claims per Elig Member per Month (Claims PMPM)	1.13		1.13	#DIV/0!
Total Claims for Generic (Generic Rx)	21,517		21,517.00	#DIV/0!
Total Claims for Brand (Brand Rx)	4,214		4,214.00	#DIV/0!
Total Claims for Brand w/Gen Equiv (Multisource Brand Claims)	246		246.00	#DIV/0!
Total Non-Specialty Claims	25,416		25,416.00	#DIV/0!
Total Specialty Claims	315		315.00	#DIV/0!
Generic % of Total Claims (GFR)	**83.6%**	**#DIV/0!**	#DIV/0!	#DIV/0!
Generic Effective Rate (GCR)	**98.9%**	**#DIV/0!**	#DIV/0!	#DIV/0!
Mail Order Claims	6,665		6,665.00	#DIV/0!
Mail Penetration Rate*	30.0%		0.30	30.0%

Claims Cost Summary			Claims Cost Summary	
Total Prescription Cost (Total Gross Cost)	$2,592,508.00		$2,592,508.00	#DIV/0!
Total Generic Gross Cost	$509,338.00		$509,338.00	#DIV/0!
Total Brand Gross Cost	$2,083,170.00		$2,083,170.00	#DIV/0!
Total MSB Gross Cost	$90,744.00		$90,744.00	#DIV/0!
Total Ingredient Cost	$2,545,103.00		$2,545,103.00	#DIV/0!
Total Dispensing Fee	$45,356.00		$45,356.00	#DIV/0!
Total Other (e.g. tax)	$2,049.00		$2,049.00	#DIV/0!
Avg Total Cost per Claim (Gross Cost/Rx)	**$100.75**	**#DIV/0!**	#DIV/0!	#DIV/0!
Avg Total Cost for Generic (Gross Cost/Generic Rx)	$23.67		$23.67	#DIV/0!
Avg Total Cost for Brand (Gross Cost/Brand Rx)	$494.35		$494.35	#DIV/0!
Avg Total Cost for MSB (MSB Gross Cost/MSB ARx)	$368.88		$368.88	#DIV/0!

Member Cost Summary			Member Cost Summary	
Total Member Cost	**$525,588.00**		$525,588.00	#DIV/0!
Total Copay	$509,835.00	$0.00	$509,835.00	#DIV/0!
Total Deductible	$15,752.00	$0.00	$15,752.00	0.0%
Avg Copay per Claim (Copay/Rx)	$19.81	#DIV/0!	#DIV/0!	#DIV/0!
Avg Participant Share per Claim (Copay+Deductible/RX)	**$20.43**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**
Avg Copay for Generic (Copay/Generic Rx)	$7.79		$7.79	#DIV/0!
Avg Copay for Brand (Copay/Brand Rx)	$84.96		$84.96	#DIV/0!
Avg Copay for Brand w/ Generic Equiv (Copay/Multisource Rx)	$51.83		$51.83	#DIV/0!
Net PMPM (Participant Cost PMPM)	**$23.13**	**#DIV/0!**	#DIV/0!	#DIV/0!
Copay % of Total Prescription Cost (Member Cost Share %)	20.3%	#DIV/0!	#DIV/0!	#DIV/0!

Plan Cost Summary			Plan Cost Summary	
Total Plan Cost (Plan Cost)	**$2,066,920.00**		**$2,066,920.00**	**#DIV/0!**
Total Non-Specialty Cost (Non-Specialty Plan Cost)	$1,245,083.00		$1,245,083.00	#DIV/0!
Total Specialty Drug Cost (Specialty Plan Cost)	$821,837.00		$821,837.00	#DIV/0!
Avg Plan Cost per Claim (Plan Cost/Rx)	**$80.33**	**#DIV/0!**	#DIV/0!	#DIV/0!
Avg Plan Cost for Generic (Plan Cost/Generic Rx)	$15.88		$15.88	#DIV/0!
Avg Plan Cost for Brand (Plan Cost/Brand Rx)	$409.41		$409.41	#DIV/0!
Avg Plan Cost for MSB (MSB Plan Cost/MSB ARx)	$317.04		$317.04	#DIV/0!
Net PMPM (Plan Cost PMPM)	**$90.97**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**
PMPM for Specialty Only (Specialty PMPM)	$36.17		$36.17	#DIV/0!
PMPM without Specialty (Non-Specialty PMPM)	$54.80		$54.80	#DIV/0!
Rebates Received (Q1 FY2022 actual)			**$0.00**	**#DIV/0!**
Net PMPM (Plan Cost PMPM factoring Rebates)	**$90.97**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**
PMPM for Specialty Only (Specialty PMPM)			$0.00	#DIV/0!
PMPM without Specialty (Non-Specialty PMPM)			$0.00	#DIV/0!

Appendix C

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

HSB DATASCOPE™

Nevada Public Employees' Benefits Program
EPO Plan

July – September 2021

HealthSCOPE BENEFITS

Overview

- Total Medical Spend for 1Q22 was $14,534,272 with an annualized plan cost per employee per year (PEPY) of $13,979. This is an increase of 42.0% when compared to 1Q21.
  - IP Cost per Admit is $20,863 which is 34.5% lower than 1Q21.
  - ER Cost per Visit is $1,828 which is 23.9% lower than 1Q21.
- Employees shared in 9.2% of the medical cost.
- Inpatient facility costs were 31.8% of the plan spend.
- 91.7% of the Average Membership had paid Medical claims less than $2,500, with 29.9% of those having no claims paid at all during the reporting period.
- 14 members exceeded the $100k high-cost threshold during the reporting period, which accounted for 28.1% of the plan spend. The highest diagnosis category was Pulmonary Disorders, accounting for 13.1% of the high-cost claimant dollars.
- Total spending with in-network providers was 100.0%. The average In Network discount was 52.3%, which is 3.5% lower than the PY21 average discount of 54.2%.

Paid Claims by Age Group

Paid Claims by Age Group																
	1Q21						1Q22						% 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	$ 380,703	$1,295	$ 1,866	$6	$ 382,569	$1,301	$ 538,081	$ 2,638	$ 756	$ 4	$ 538,837	$ 2,641	40.8%	103.0%
1	$ 48,674	$156	$ 520	$2	$ 49,194	$158	$ 63,770	$ 262	$ 730	$ 3	$ 64,500	$ 265	31.1%	68.3%
2 - 4	$ 99,228	$119	$ 3,385	$4	$ 102,613	$123	$ 109,836	$ 138	$ 3,388	$ 4	$ 113,224	$ 142	10.3%	15.8%
5 - 9	$ 116,007	$76	$ 15,746	$10	$ 131,753	$86	$ 103,924	$ 80	$ 11,889	$ 9	$ 115,813	$ 90	-12.1%	4.0%
10 - 14	$ 234,320	$126	$ 50,397	$27	$ 284,717	$154	$ 680,492	$ 403	$ 55,438	$ 33	$ 735,930	$ 436	158.5%	183.7%
15 - 19	$ 467,329	$216	$ 92,183	$43	$ 559,512	$259	$ 498,845	$ 248	$ 107,312	$ 53	$ 606,157	$ 302	8.3%	16.6%
20 - 24	$ 453,790	$228	$ 220,279	$111	$ 674,069	$339	$ 386,484	$ 213	$ 115,000	$ 63	$ 501,484	$ 277	-25.6%	-18.5%
25 - 29	$ 313,772	$289	$ 213,693	$197	$ 527,465	$486	$ 393,921	$ 476	$ 323,994	$ 391	$ 717,915	$ 867	36.1%	78.5%
30 - 34	$ 869,527	$610	$ 172,291	$121	$ 1,041,818	$731	$ 727,925	$ 627	$ 111,355	$ 96	$ 839,280	$ 723	-19.4%	-1.1%
35 - 39	$ 907,005	$518	$ 208,290	$119	$ 1,115,295	$637	$ 815,349	$ 534	$ 172,241	$ 113	$ 987,590	$ 647	-11.5%	1.6%
40 - 44	$ 620,333	$364	$ 355,370	$209	$ 975,703	$573	$ 728,220	$ 460	$ 501,997	$ 317	$ 1,230,217	$ 777	26.1%	35.6%
45 - 49	$ 1,068,035	$531	$ 299,271	$149	$ 1,367,306	$679	$ 949,561	$ 536	$ 273,887	$ 154	$ 1,223,448	$ 690	-10.5%	1.6%
50 - 54	$ 1,254,437	$509	$ 634,820	$257	$ 1,889,257	$766	$ 2,909,164	$ 1,341	$ 568,823	$ 262	$ 3,477,987	$ 1,603	84.1%	109.3%
55 - 59	$ 1,434,014	$559	$ 704,947	$275	$ 2,138,961	$834	$ 1,862,695	$ 832	$ 518,200	$ 232	$ 2,380,895	$ 1,064	11.3%	27.6%
60 - 64	$ 2,519,978	$888	$ 1,009,228	$356	$ 3,529,206	$1,244	$ 2,228,511	$ 836	$ 935,248	$ 351	$ 3,163,759	$ 1,186	-10.4%	-4.6%
65+	$ 861,625	$711	$ 459,937	$379	$ 1,321,562	$1,090	$ 1,537,493	$ 1,338	$ 485,347	$ 422	$ 2,022,840	$ 1,761	53.1%	61.5%
Total	**$11,648,774**	**$447**	**$4,442,222**	**$171**	**$16,090,999**	**$618**	**$ 14,534,272**	**$ 628**	**$ 4,185,607**	**$ 181**	**$ 18,719,878**	**$ 809**	**16.3%**	**30.9%**

Financial Summary (p. 1 of 2)

	Total				State Active				Non-State Active			
Summary	**1Q20**	**1Q21**	**1Q22**	**Variance to Prior Year**	**1Q20**	**1Q21**	**1Q22**	**Variance to Prior Year**	**1Q20**	**1Q21**	**1Q22**	**Variance to Prior Year**
Enrollment												
Avg # Employees	4,837	4,733	4,159	-12.1%	4,078	4,016	3,495	-13.0%	4	4	3	-16.8%
Avg # Members	8,832	8,678	7,714	-11.1%	7,812	7,712	6,801	-11.8%	5	5	3	-33.4%
Ratio	1.8	1.8	1.9	1.1%	1.9	1.9	2.0	1.6%	1.3	1.3	1.0	-20.0%
Financial Summary												
Gross Cost	$12,759,081	$12,336,809	$16,002,424	29.7%	$10,932,583	$10,508,606	$13,495,816	28.4%	$5,288	$3,952	$1,581	-60.0%
Client Paid	$11,326,261	$11,648,774	$14,534,272	24.8%	$9,689,772	$9,926,728	$12,285,220	23.8%	$4,713	$3,222	$1,164	-63.9%
Employee Paid	$1,432,820	$688,035	$1,468,152	113.4%	$1,242,811	$581,878	$1,210,596	108.0%	$574	$730	$416	-43.0%
Client Paid-PEPY	$9,366	$9,845	$13,979	42.0%	$9,504	$9,886	$14,060	42.2%	$4,713	$3,222	$1,397	-56.6%
Client Paid-PMPY	$5,129	$5,370	$7,537	40.4%	$4,961	$5,149	$7,225	40.3%	$3,771	$2,578	$1,397	-45.8%
Client Paid-PEPM	$781	$820	$1,165	42.1%	$792	$824	$1,172	42.2%	$393	$269	$116	-56.9%
Client Paid-PMPM	$427	$447	$628	40.5%	$413	$429	$602	40.3%	$314	$215	$116	-46.0%
High Cost Claimants (HCC's) > $100k												
# of HCC's	4	9	14	55.6%	4	9	13	44.4%	0	0	0	0.0%
HCC's / 1,000	0.5	1.0	1.8	74.0%	0.5	1.2	1.9	63.2%	0.0	0.0	0.0	0.0%
Avg HCC Paid	$152,390	$161,344	$291,365	80.6%	$152,390	$154,128	$298,278	93.5%	$0	$0	$0	0.0%
HCC's % of Plan Paid	5.4%	12.5%	28.1%	124.8%	6.3%	14.0%	31.6%	125.7%	0.0%	0.0%	0.0%	0.0%
Cost Distribution by Claim Type (PMPY)												
Facility Inpatient	$849	$964	$2,396	148.5%	$782	$964	$2,313	139.9%	$0	$0	$0	0.0%
Facility Outpatient	$1,660	$1,755	$2,256	28.5%	$1,617	$1,662	$2,165	30.3%	$1,374	$223	$0	-100.0%
Physician	$2,454	$2,445	$2,700	10.4%	$2,412	$2,374	$2,577	8.6%	$2,349	$2,152	$1,338	-37.8%
Other	$167	$205	$185	-9.8%	$151	$149	$170	14.1%	$48	$203	$59	-70.9%
Total	$5,129	$5,370	$7,537	40.4%	$4,961	$5,149	$7,225	40.3%	$3,771	$2,578	$1,397	-45.8%
	Annualized	Annualized	Annualized		Annualized	Annualized	Annualized		Annualized	Annualized	Annualized	

Financial Summary (p. 2 of 2)

	State Retirees				Non-State Retirees				
Summary	**1Q20**	**1Q21**	**1Q22**	**Variance to Prior Year**	**1Q20**	**1Q21**	**1Q22**	**Variance to Prior Year**	**HSB Peer Index**
Enrollment									
Avg # Employees	596	582	566	-2.8%	159	131	95	-27.3%	
Avg # Members	815	793	784	-1.1%	201	168	125	-25.4%	
Ratio	1.4	1.4	1.4	2.2%	1.3	1.3	1.3	3.1%	1.6
Financial Summary									
Gross Cost	$1,599,330	$1,645,732	$2,084,416	26.7%	$221,881	$178,519	$420,611	135.6%	
Client Paid	$1,437,635	$1,559,274	$1,872,395	20.1%	$194,141	$159,551	$375,493	135.3%	
Employee Paid	$161,695	$86,459	$212,021	145.2%	$27,740	$18,968	$45,118	137.9%	
Client Paid-PEPY	$9,649	$10,717	$13,240	23.5%	$4,894	$4,884	$15,810	223.7%	$6,297
Client Paid-PMPY	$7,059	$7,865	$9,553	21.5%	$3,870	$3,806	$12,016	215.7%	$3,879
Client Paid-PEPM	$804	$893	$1,103	23.5%	$408	$407	$1,318	223.8%	$525
Client Paid-PMPM	$588	$655	$796	21.5%	$322	$317	$1,001	215.8%	$323
High Cost Claimants (HCC's) > $100k									
# of HCC's	0	1	0	0.0%	0	0	1	0.0%	
HCC's / 1,000	0.0	1.3	0.0	0.0%	0.0	0.0	8.0	0.0%	
Avg HCC Paid	$0	$64,942	$0	0.0%	$0	$0	$201,495	0.0%	
HCC's % of Plan Paid	0.0%	4.2%	0.0%	0.0%	0.0%	0.0%	53.7%	0.0%	
Cost Distribution by Claim Type (PMPY)									
Facility Inpatient	$1,491	$1,023	$2,295	124.3%	$904	$755	$7,615	908.6%	$1,149
Facility Outpatient	$2,232	$2,850	$3,175	11.4%	$1,024	$888	$1,515	70.6%	$1,333
Physician	$3,007	$3,328	$3,782	13.6%	$1,846	$1,559	$2,636	69.1%	$1,301
Other	$330	$665	$302	-54.6%	$97	$605	$249	-58.8%	$96
Total	$7,059	$7,865	$9,553	21.5%	$3,870	$3,806	$12,016	215.7%	$3,879
	Annualized	Annualized	Annualized		Annualized	Annualized	Annualized		

Financial Summary – Prior Year Comparison (p. 1 of 2)

	Total				State Active				Non-State Active			
Summary	**PY20**	**PY21**	**1Q22**	**Variance to Prior Year**	**PY20**	**PY21**	**1Q22**	**Variance to Prior Year**	**PY20**	**PY21**	**1Q22**	**Variance to Prior Year**
Enrollment												
Avg # Employees	4,794	4,650	4,159	-10.6%	4,054	3,949	3,495	-11.5%	4	4	3	-16.8%
Avg # Members	8,768	8,553	7,714	-9.8%	7,768	7,602	6,801	-10.5%	5	4	3	-23.1%
Ratio	1.8	1.8	1.9	0.5%	1.9	1.9	2.0	1.0%	1.3	1.1	1.0	-7.4%
Financial Summary												
Gross Cost	$55,523,229	$56,804,046	$16,002,424	-71.8%	$45,961,999	$44,805,657	$13,495,816	-69.9%	$70,916	$44,403	$1,581	-96.4%
Client Paid	$50,293,887	$53,113,944	$14,534,272	-72.6%	$41,579,805	$41,757,107	$12,285,220	-70.6%	$65,329	$41,594	$1,164	-97.2%
Employee Paid	$5,229,342	$3,690,102	$1,468,152	-60.2%	$4,382,194	$3,048,550	$1,210,596	-60.3%	$5,587	$2,808	$416	-85.2%
Client Paid-PEPY	$10,492	$11,422	$13,979	22.4%	$10,256	$10,575	$14,060	33.0%	$16,332	$10,399	$1,397	-86.6%
Client Paid-PMPY	$5,736	$6,210	$7,537	21.4%	$5,352	$5,493	$7,225	31.5%	$13,066	$9,599	$1,397	-85.4%
Client Paid-PEPM	$874	$952	$1,165	22.4%	$855	$881	$1,172	33.0%	$1,361	$867	$116	-86.6%
Client Paid-PMPM	$478	$518	$628	21.2%	$446	$458	$602	31.4%	$1,089	$800	$116	-85.5%
High Cost Claimants (HCC's) > $100k												
# of HCC's	51	61	14	-77.0%	40	49	13	-73.5%	0	0	0	0.0%
HCC's / 1,000	5.8	7.1	1.8	-74.6%	5.2	6.5	1.9	-70.4%	0.0	0.0	0.0	0.0%
Avg HCC Paid	$202,775	$257,989	$291,365	12.9%	$179,535	$212,968	$298,278	40.1%	$0	$0	$0	0.0%
HCC's % of Plan Paid	20.6%	29.6%	28.1%	-5.1%	17.3%	25.0%	31.6%	26.4%	0.0%	0.0%	0.0%	0.0%
Cost Distribution by Claim Type (PMPY)												
Facility Inpatient	$1,169	$1,457	$2,396	64.4%	$1,036	$1,091	$2,313	112.0%	$2,928	$0	$0	0.0%
Facility Outpatient	$1,832	$1,951	$2,256	15.6%	$1,693	$1,779	$2,165	21.7%	$4,817	$4,611	$0	-100.0%
Physician	$2,541	$2,608	$2,700	3.5%	$2,461	$2,464	$2,577	4.6%	$5,153	$4,469	$1,338	-70.1%
Other	$194	$194	$185	-4.6%	$163	$159	$170	6.9%	$168	$518	$59	-88.6%
Total	$5,736	$6,210	$7,537	21.4%	$5,352	$5,493	$7,225	31.5%	$13,066	$9,599	$1,397	-85.4%
			Annualized				Annualized				Annualized	

Financial Summary – Prior Year Comparison (p. 2 of 2)

	State Retirees				Non-State Retirees				
Summary	**PY20**	**PY21**	**1Q22**	**Variance to Prior Year**	**PY20**	**PY21**	**1Q22**	**Variance to Prior Year**	**HSB Peer Index**
Enrollment									
Avg # Employees	588	576	566	-1.7%	148	122	95	-22.3%	
Avg # Members	807	789	784	-0.6%	188	158	125	-20.8%	
Ratio	1.4	1.4	1.4	1.5%	1.3	1.3	1.3	2.3%	1.6
Financial Summary									
Gross Cost	$8,514,643	$7,966,596	$2,084,416	-73.8%	$975,672	$3,987,390	$420,611	-89.5%	
Client Paid	$7,803,114	$7,426,217	$1,872,395	-74.8%	$845,639	$3,889,026	$375,493	-90.3%	
Employee Paid	$711,529	$540,380	$212,021	-60.8%	$130,033	$98,364	$45,118	-54.1%	
Client Paid-PEPY	$13,272	$12,904	$13,240	2.6%	$5,730	$31,812	$15,810	-50.3%	$6,297
Client Paid-PMPY	$9,674	$9,413	$9,553	1.5%	$4,508	$24,653	$12,016	-51.3%	$3,879
Client Paid-PEPM	$1,106	$1,075	$1,103	2.6%	$477	$2,651	$1,318	-50.3%	$525
Client Paid-PMPM	$806	$784	$796	1.5%	$376	$2,054	$1,001	-51.3%	$323
High Cost Claimants (HCC's) > $100k									
# of HCC's	18	18	0	-100.0%	0	2	1	0.0%	
HCC's / 1,000	22.3	22.8	0.0	-100.0%	0.0	12.7	8.0	0.0%	
Avg HCC Paid	$175,561	$113,454	$0	-100.0%	$0	$1,629,851	$201,495	0.0%	
HCC's % of Plan Paid	40.5%	27.5%	0.0%	-100.0%	0.0%	83.8%	53.7%	0.0%	
Cost Distribution by Claim Type (PMPY)									
Facility Inpatient	$2,529	$1,454	$2,295	57.8%	$787	$19,176	$7,615	-60.3%	$1,149
Facility Outpatient	$3,276	$3,575	$3,175	-11.2%	$1,314	$2,010	$1,515	-24.6%	$1,333
Physician	$3,385	$3,897	$3,782	-3.0%	$2,165	$3,054	$2,636	-13.7%	$1,301
Other	$484	$487	$302	-38.0%	$242	$413	$249	-39.7%	$96
Total	$9,674	$9,413	$9,553	1.5%	$4,508	$24,653	$12,016	-51.3%	$3,879
			Annualized				Annualized		

Paid Claims by Claim Type – State Participants

Net Paid Claims - Total State Participants	1Q21				1Q22				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical									
Inpatient	$ 2,386,759	$ 235,184	$ 17,071	$ 2,639,014	$ 4,616,002	$ 433,340	$ 121,686	$ 5,171,028	95.9%
Outpatient	$ 7,539,969	$ 1,182,817	$ 124,201	$ 8,846,987	$ 7,669,218	$ 1,209,185	$ 108,184	$ 8,986,587	1.6%
Total - Medical	**$ 9,926,728**	**$ 1,418,001**	**$ 141,272**	**$ 11,486,001**	**$ 12,285,220**	**$ 1,642,525**	**$ 229,870**	**$ 14,157,615**	**23.3%**

Net Paid Claims - Per Participant per Month	1Q21				1Q22				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical	$ 824	$ 946	$ 572	$ 833	$ 1,170	$ 1,118	$ 1,008	$ 1,161	39.4%

Paid Claims by Claim Type – Non-State Participants

Net Paid Claims - Total Non-State Participants	1Q21				1Q22				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical									
Inpatient	$ -	$ 34,043	$ 360	$ 34,403	$ -	$ 236,598	$ 9,829	$ 246,428	616.3%
Outpatient	$ 3,222	$ 19,348	$ 105,799	$ 128,370	$ 1,164	$ 69,389	$ 59,676	$ 130,230	1.4%
Total - Medical	**$ 3,222**	**$ 53,392**	**$ 106,159**	**$ 162,773**	**$ 1,164**	**$ 305,988**	**$ 69,505**	**$ 376,657**	**131.4%**

Net Paid Claims - Per Participant per Month	1Q21				1Q22				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical	$ 269	$ 235	$ 643	$ 403	$ 116	$ 2,318	$ 454	$ 1,277	216.9%

Paid Claims by Claim Type – Total

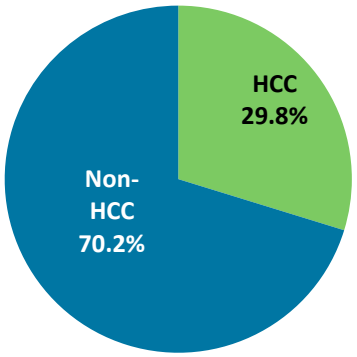
Net Paid Claims - Total Total Participants	1Q21				1Q22				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical									
Inpatient	$ 2,386,759	$ 269,227	$ 17,431	$ 2,673,418	$ 4,616,002	$ 669,939	$ 131,515	$ 5,417,456	102.6%
Outpatient	$ 7,543,191	$ 1,202,166	$ 230,000	$ 8,975,357	$ 7,670,382	$ 1,278,575	$ 167,859	$ 9,116,816	1.6%
Total - Medical	**$ 9,929,950**	**$ 1,471,393**	**$ 247,431**	**$ 11,648,774**	**$ 12,286,384**	**$ 1,948,513**	**$ 299,375**	**$ 14,534,272**	**24.8%**

Net Paid Claims - Per Participant per Month	1Q21				1Q22				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical	$ 823	$ 852	$ 601	$ 820	$ 1,169	$ 1,217	$ 786	$ 1,163	41.7%

Cost Distribution – Medical Claims

1Q21							1Q22					
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
7	0.1%	$1,452,092	12.5%	($58,624)	-8.5%	$100,000.01 Plus	9	0.1%	$4,007,516	27.6%	$23,365	1.6%
20	0.2%	$1,445,687	12.4%	$33,320	4.8%	$50,000.01-$100,000.00	18	0.2%	$1,389,429	9.6%	$53,387	3.6%
48	0.5%	$1,816,271	15.6%	$12,678	1.8%	$25,000.01-$50,000.00	46	0.6%	$1,786,692	12.3%	$78,886	5.4%
129	1.5%	$2,114,530	18.2%	$53,096	7.7%	$10,000.01-$25,000.00	138	1.8%	$2,404,546	16.5%	$186,109	12.7%
151	1.7%	$1,101,531	9.5%	$62,774	9.1%	$5,000.01-$10,000.00	151	2.0%	$1,213,812	8.4%	$165,369	11.3%
288	3.3%	$1,014,139	8.7%	$102,800	14.9%	$2,500.01-$5,000.00	280	3.6%	$1,038,193	7.1%	$201,207	13.7%
4,935	56.9%	$2,704,524	23.2%	$477,766	69.4%	$0.01-$2,500.00	4,657	60.4%	$2,694,085	18.5%	$750,762	51.2%
62	0.7%	$0	0.0%	$4,226	0.6%	$0.00	106	1.4%	$0	0.0%	$9,067	0.6%
3,039	35.0%	$0	0.0%	$0	0.0%	No Claims	2,308	29.9%	$0	0.0%	$0	0.0%
8,678	**100.0%**	**$11,648,774**	**100.0%**	**$688,035**	**100.0%**		**7,714**	**100.0%**	**$14,534,272**	**100.0%**	**$1,468,152**	**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**
Pulmonary Disorders	8	$1,556,111	38.1%
Cancer	6	$601,477	14.7%
Congenital/Chromosomal Anomalies	1	$422,617	10.4%
Endocrine/Metabolic Disorders	4	$380,695	9.3%
Medical/Surgical Complications	2	$300,206	7.4%
Pregnancy-related Disorders	1	$257,042	6.3%
Infections	5	$253,345	6.2%
Hematological Disorders	2	$166,709	4.1%
Miscellaneous	3	$68,934	1.7%
Health Status/Encounters	8	$45,353	1.1%
All Other		$26,619	0.7%
Overall	**----**	**$4,079,110**	**100.0%**

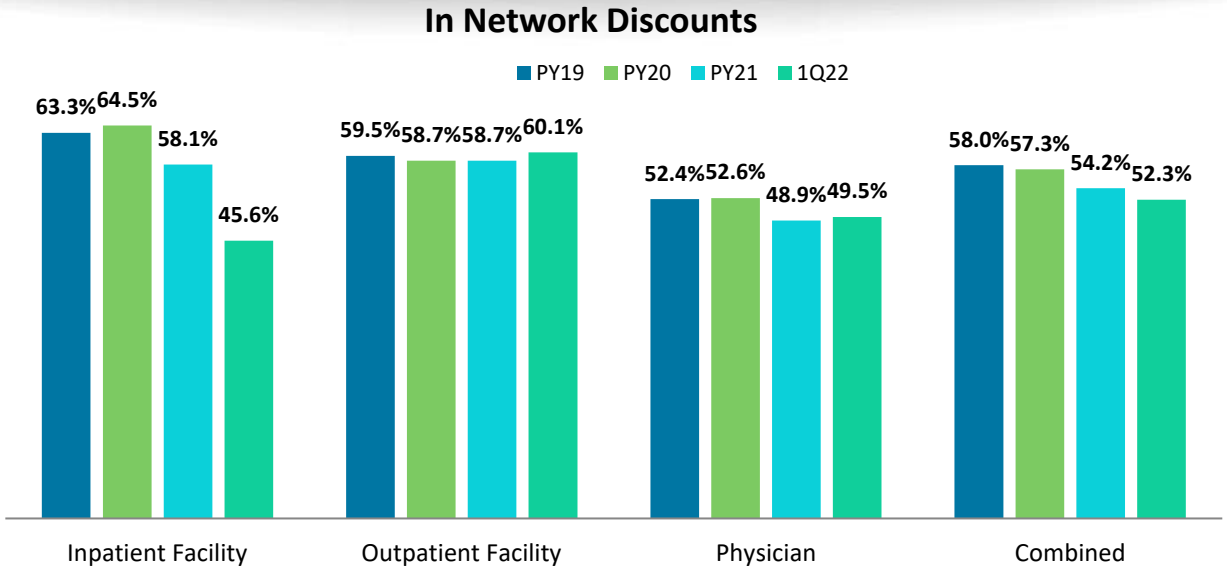
Utilization Summary (p. 1 of 2)

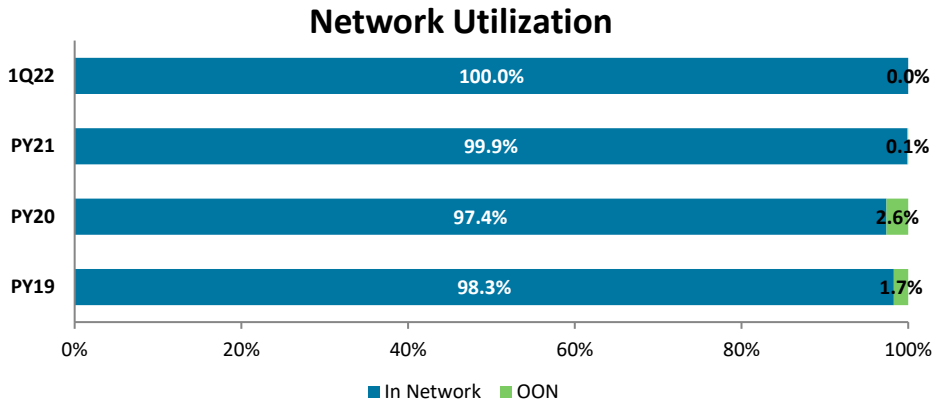
	Total				State Active				Non-State Active			
Summary	**1Q20**	**1Q21**	**1Q22**	**Variance to Prior Year**	**1Q20**	**1Q21**	**1Q22**	**Variance to Prior Year**	**1Q20**	**1Q21**	**1Q22**	**Variance to Prior Year**
Inpatient Summary												
# of Admits	142	111	113		117	96	98		1	0	0	
# of Bed Days	803	562	459		668	468	411		2	0	0	
Paid Per Admit	$27,194	$31,858	$20,863	-34.5%	$28,712	$24,356	$21,729	-10.8%	$22,498	$0	$0	0.0%
Paid Per Day	$4,809	$6,292	$5,136	-18.4%	$5,029	$4,996	$5,181	3.7%	$11,249	$0	$0	0.0%
Admits Per 1,000	64	51	59	15.7%	60	50	58	16.0%	800	0	0	0.0%
Days Per 1,000	363	259	238	-8.1%	341	242	242	0.0%	1,600	0	0	0.0%
Avg LOS	5.7	5.1	4.1	-19.6%	5.7	4.9	4.2	-14.3%	2.0	0.0	0.0	0.0%
# Admits From ER	67	48	54		52	38	45		0	0	0	
Physician Office												
OV Utilization per Member	6.1	5.6	6.1	8.9%	5.9	5.4	5.9	9.3%	6.4	8.8	8.4	-4.5%
Avg Paid per OV	$147	$152	$149	-2.0%	$152	$153	$150	-2.0%	$163	$91	$146	60.4%
Avg OV Paid per Member	$895	$857	$905	5.6%	$897	$827	$884	6.9%	$1,043	$797	$1,230	54.3%
DX&L Utilization per Member	10.9	9.7	11.2	15.5%	10.3	9.2	10.7	16.3%	18.4	3.2	0	-100.0%
Avg Paid per DX&L	$66	$69	$67	-2.9%	$68	$69	$68	-1.4%	$101	$94	$0	-100.0%
Avg DX&L Paid per Member	$728	$668	$748	12.0%	$704	$633	$728	15.0%	$1,865	$301	$0	-100.0%
Emergency Room												
# of Visits	462	334	395		410	299	343		0	0	0	
Visits Per Member	0.21	0.15	0.20	33.3%	0.21	0.15	0.20	33.3%	0.00	0.00	0.00	0.0%
Visits Per 1,000	209	154	205	33.1%	209	155	202	30.3%	0	0	0	0.0%
Avg Paid per Visit	$2,648	$2,401	$1,828	-23.9%	$2,690	$2,378	$1,806	-24.1%	$0	$0	$0	0.0%
Urgent Care												
# of Visits	744	523	753		673	459	688		0	0	0	
Visits Per Member	0.34	0.24	0.39	62.5%	0.34	0.24	0.40	66.7%	0.00	0.00	0.00	0.0%
Visits Per 1,000	336	241	390	61.8%	343	238	404	69.7%	0	0	0	0.0%
Avg Paid per Visit	$138	$138	$154	11.6%	$138	$140	$155	10.7%	$0	$0	$0	0.0%
	Annualized	Annualized	Annualized		Annualized	Annualized	Annualized		Annualized	Annualized	Annualized	

Utilization Summary (p. 2 of 2)

	State Retirees				Non-State Retirees				
Summary	**1Q20**	**1Q21**	**1Q22**	**Variance to Prior Year**	**1Q20**	**1Q21**	**1Q22**	**Variance to Prior Year**	**HSB Peer Index**
Inpatient Summary									
# of Admits	22	14	11		2	1	4		
# of Bed Days	128	56	39		5	38	9		
Paid Per Admit	$20,327	$22,967	$16,888	-26.5%	$16,275	$876,573	$10,583	-98.8%	$16,632
Paid Per Day	$3,494	$5,742	$4,763	-17.0%	$6,510	$23,068	$4,703	-79.6%	$3,217
Admits Per 1,000	109	71	56	-21.1%	40	24	128	433.3%	76
Days Per 1,000	635	285	199	-30.2%	100	918	288	-68.6%	391
Avg LOS	5.8	4	3.5	-12.5%	2.5	38.0	2.3	-93.9%	5.2
# Admits From ER	14	9	6		1	1	3		
Physician Office									
OV Utilization per Member	7.8	7.5	7.3	-2.7%	6.9	6.2	7.7	24.2%	5.0
Avg Paid per OV	$116	$159	$150	-5.7%	$107	$107	$109	1.9%	$57
Avg OV Paid per Member	$908	$1,192	$1,098	-7.9%	$744	$662	$844	27.5%	$286
DX&L Utilization per Member	15.6	13.7	14.7	7.3%	16	11.6	15.3	31.9%	10.5
Avg Paid per DX&L	$61	$75	$64	-14.7%	$48	$53	$41	-22.6%	$50
Avg DX&L Paid per Member	$946	$1,026	$937	-8.7%	$765	$620	$635	2.4%	$522
Emergency Room									
# of Visits	47	31	45		5	4	7		
Visits Per Member	0.23	0.16	0.23	43.8%	0.10	0.10	0.22	120.0%	0.24
Visits Per 1,000	233	158	230	45.6%	100	97	224	130.9%	235
Avg Paid per Visit	$2,422	$2,524	$2,129	-15.6%	$1,299	$3,172	$998	-68.5%	$943
Urgent Care									
# of Visits	56	52	55		15	12	10		
Visits Per Member	0.28	0.26	0.28	7.7%	0.30	0.29	0.32	10.3%	0.3
Visits Per 1,000	278	265	281	6.0%	300	290	320	10.3%	300
Avg Paid per Visit	$147	$131	$152	16.0%	$71	$115	$56	-51.3%	$84
	Annualized	Annualized	Annualized		Annualized	Annualized	Annualized		

Provider Network Summary





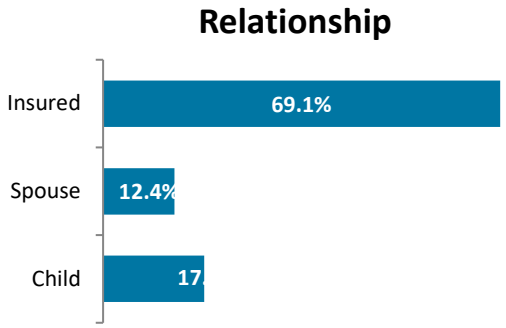
Diagnosis Grouper Summary

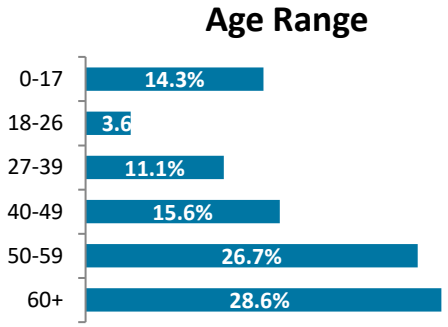
Diagnosis Grouper	Total Paid	% Paid	Insured	Spouse	Child	Male	Female
Pulmonary Disorders	$1,900,577	13.1%	$1,823,648	$36,948	$39,982	$1,719,681	$180,897
Cancer	$1,052,405	7.2%	$542,585	$509,078	$743	$658,440	$393,965
Gastrointestinal Disorders	$996,029	6.9%	$749,992	$168,176	$77,861	$333,370	$662,658
Musculoskeletal Disorders	$953,637	6.6%	$695,047	$134,749	$123,841	$415,279	$538,358
Pregnancy-related Disorders	$931,384	6.4%	$383,056	$74,007	$474,322	$136,266	$792,041
Health Status/Encounters	$864,969	6.0%	$522,717	$78,801	$263,452	$276,657	$588,046
Endocrine/Metabolic Disorders	$801,346	5.5%	$700,693	$83,424	$17,229	$206,705	$594,640
Cardiac Disorders	$768,203	5.3%	$627,995	$119,945	$20,263	$336,576	$431,627
Infections	$674,370	4.6%	$525,006	$19,442	$129,922	$359,722	$314,648
Neurological Disorders	$648,556	4.5%	$450,046	$50,863	$147,646	$145,379	$503,104
Spine-related Disorders	$582,271	4.0%	$427,641	$141,727	$12,904	$260,519	$321,752
Mental Health	$561,791	3.9%	$327,848	$48,202	$185,741	$168,727	$393,063
Eye/ENT Disorders	$531,391	3.7%	$299,705	$57,339	$174,347	$247,600	$283,791
Renal/Urologic Disorders	$519,366	3.6%	$384,578	$83,941	$50,847	$288,740	$230,565
Congenital/Chromosomal Anomalies	$467,556	3.2%	$21,764	$1,206	$444,585	$11,692	$455,864
Gynecological/Breast Disorders	$389,596	2.7%	$320,363	$20,843	$48,390	$7,342	$382,254
Medical/Surgical Complications	$369,447	2.5%	$344,805	$7,946	$16,695	$134,571	$234,876
Trauma/Accidents	$344,504	2.4%	$209,562	$28,315	$106,627	$197,414	$147,090
Hematological Disorders	$206,592	1.4%	$190,800	$14,851	$941	$178,814	$27,778
Miscellaneous	$179,099	1.2%	$139,966	$15,306	$23,827	$95,205	$83,894
Non-malignant Neoplasm	$149,057	1.0%	$125,793	$12,722	$10,542	$30,387	$118,670
Dermatological Disorders	$145,176	1.0%	$104,836	$14,712	$25,629	$45,948	$99,228
Diabetes	$144,497	1.0%	$120,136	$14,958	$9,402	$75,264	$69,233
Vascular Disorders	$121,445	0.8%	$120,302	$1,052	$91	$79,704	$41,741
Abnormal Lab/Radiology	$70,524	0.5%	$58,518	$6,545	$5,460	$19,900	$50,624
Medication Related Conditions	$54,498	0.4%	$21,815	$28,536	$4,148	$10,348	$44,150
Dental Conditions	$46,266	0.3%	$35,898	$1,691	$8,677	$5,361	$40,905
Cholesterol Disorders	$42,888	0.3%	$39,128	$3,302	$458	$9,445	$33,443
External Hazard Exposure	$11,641	0.1%	$3,636	$253	$7,751	$8,946	$2,695
Allergic Reaction	$5,192	0.0%	$2,147	$391	$2,654	$4,359	$833
Total	**$14,534,272**	**100.0%**	**$10,320,027**	**$1,779,273**	**$2,434,972**	**$6,468,359**	**$8,062,435**

Diagnosis Grouper – Pulmonary Disorders

Diagnosis Sub-Grouper	Patients	Claims	Total Paid	% Paid
Respiratory Failure	17	45	$1,594,808	83.9%
Lung Conditions, Other	48	80	$82,029	4.3%
Sleep Apnea	321	838	$74,916	3.9%
Respiratory Symptoms	267	396	$56,256	3.0%
Asthma	134	174	$32,713	1.7%
Pneumonia	22	37	$32,709	1.7%
COPD	35	94	$18,508	1.0%
Bronchitis	26	30	$7,749	0.4%
Aspiration Related	3	6	$890	0.0%
Cystic Fibrosis	0	0	$0	0.0%
Overall	**----**	**----**	**$1,900,577**	**100.0%**

*Patient and claim counts are unique only within the category

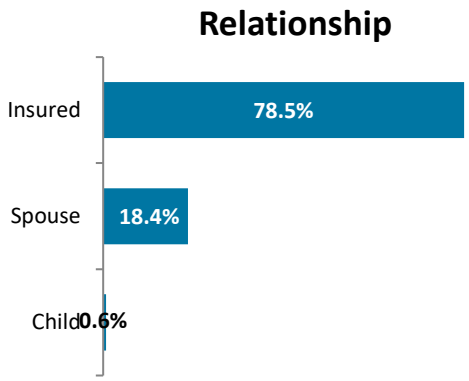


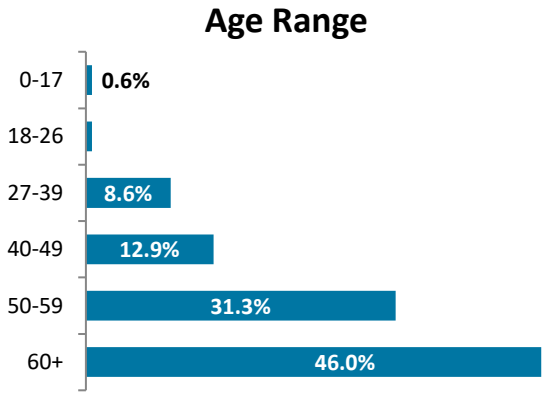


Diagnosis Grouper – Cancer

Diagnosis Sub-Grouper	Patients	Claims	Total Paid	% Paid
Cancer Therapies	11	57	$543,759	51.7%
Breast Cancer	26	109	$179,744	17.1%
Cancers, Other	55	136	$87,154	8.3%
Lung Cancer	5	71	$87,052	8.3%
Myeloma	3	15	$59,813	5.7%
Carcinoma in Situ	16	26	$26,733	2.5%
Bladder Cancer	2	4	$16,577	1.6%
Leukemias	11	30	$11,782	1.1%
Lymphomas	9	53	$11,171	1.1%
Secondary Cancers	5	18	$6,411	0.6%
Pancreatic Cancer	2	11	$5,531	0.5%
Melanoma	7	13	$5,302	0.5%
Colon Cancer	7	22	$5,151	0.5%
Prostate Cancer	11	18	$2,719	0.3%
Thyroid Cancer	10	20	$1,352	0.1%
Cervical/Uterine Cancer	2	2	$1,218	0.1%
Brain Cancer	2	3	$808	0.1%
Kidney Cancer	1	2	$127	0.0%
Ovarian Cancer	1	1	$0	0.0%
Overall	**----**	**----**	**$1,052,405**	**100.0%**

*Patient and claim counts are unique only within the category

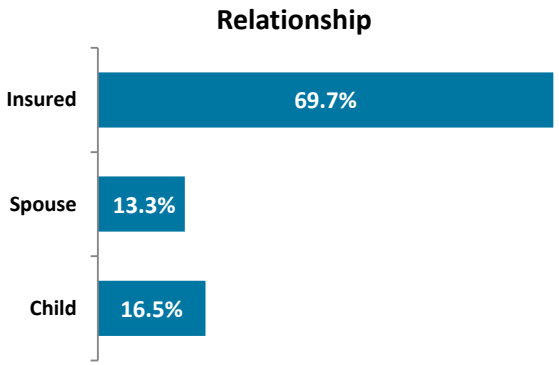


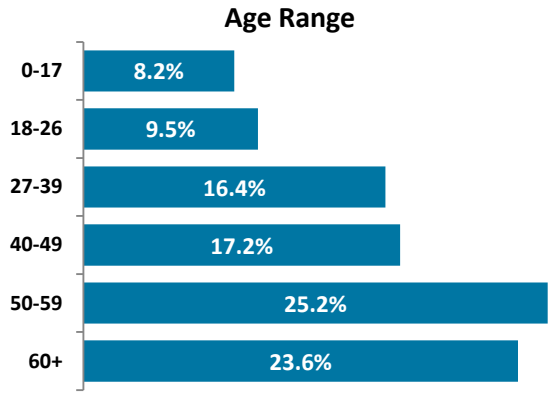


Diagnosis Grouper – Gastrointestinal Disorders

Diagnosis Sub-Grouper	Patients	Claims	Total Paid	% Paid
Abdominal Disorders	231	452	$180,632	18.1%
GI Symptoms	147	238	$142,047	14.3%
GI Disorders, Other	148	242	$129,930	13.0%
Upper GI Disorders	142	222	$120,170	12.1%
Diverticulitis	12	18	$90,702	9.1%
Gallbladder and Biliary Disease	24	77	$75,262	7.6%
Hernias	22	48	$63,232	6.3%
Pancreatic Disorders	13	32	$54,029	5.4%
Liver Diseases	46	74	$40,571	4.1%
Inflammatory Bowel Disease	20	36	$34,977	3.5%
Appendicitis	5	18	$34,765	3.5%
Peptic Ulcer/Related Disorders	4	5	$19,990	2.0%
Hemorrhoids	16	27	$6,986	0.7%
Hepatic Cirrhosis	4	21	$1,866	0.2%
Ostomies	5	5	$869	0.1%
	----	----	$996,029	100.0%

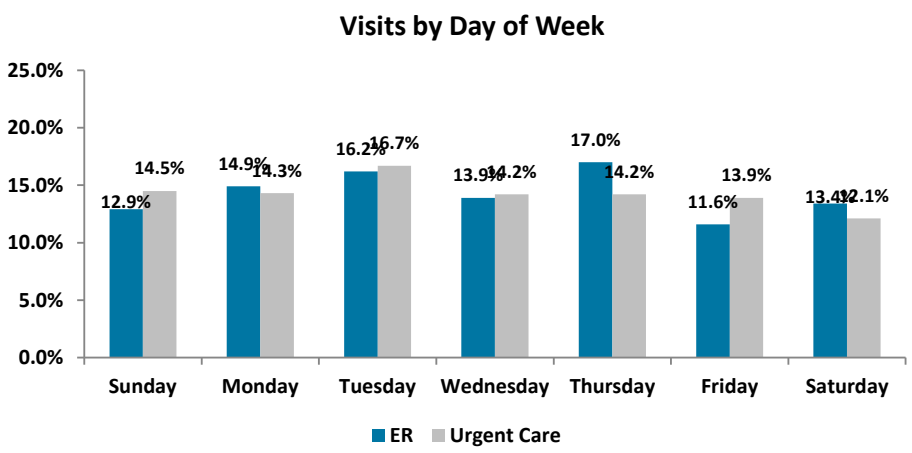
*Patient and claim counts are unique only within the category

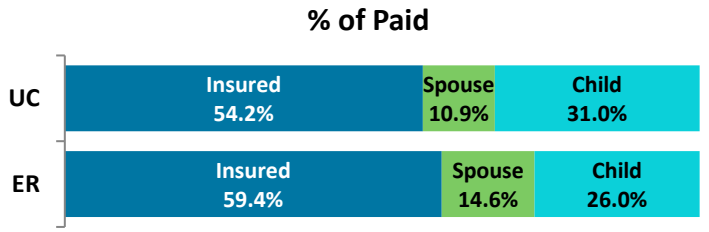




Emergency Room / Urgent Care Summary

	1Q21		1Q22		HSB Peer Index	
ER/Urgent Care	**ER**	**Urgent Care**	**ER**	**Urgent Care**	**ER**	**Urgent Care**
Number of Visits	334	523	395	753		
Visits Per Member	0.15	0.24	0.20	0.39	0.17	0.24
Visits/1000 Members	154	241	205	390	174	242
Avg Paid Per Visit	$2,401	$138	$1,828	$154	$1,684	$74
% with OV*	91.6%	89.5%	92.7%	88.2%		
% Avoidable	9.6%	30.2%	10.9%	33.7%		
Total Member Paid	**$134,185**	**$22,380**	**$192,377**	**$31,471**		
Total Plan Paid	**$801,876**	**$72,332**	**$722,171**	**$115,874**		
*looks back 12 months from ER visit	Annualized	Annualized	Annualized	Annualized		



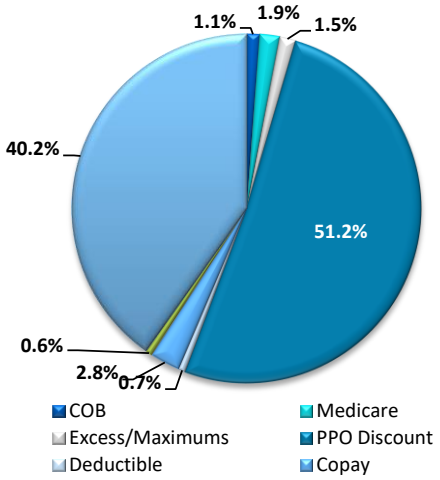


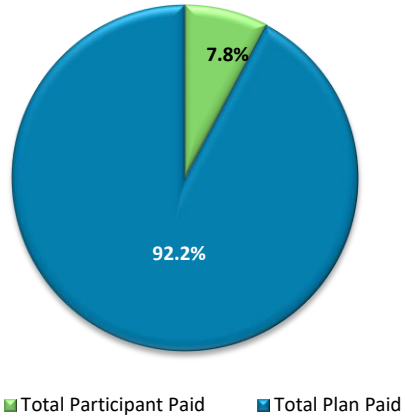
ER / UC Visits by Relationship						
Relationship	**ER**	**Per 1,000**	**Urgent Care**	**Per 1,000**	**Total**	**Per 1,000**
Insured	217	52	409	98	1,056	254
Spouse	49	58	76	91	202	241
Child	129	47	268	99	513	189
Total	**395**	**51**	**753**	**98**	**1,771**	**229**

Savings Summary – Medical Claims

Description	Dollars	PPPM	% of Eligible
Eligible Charges	$36,152,242	$2,898	100.0%
COB	$411,174	$33	1.1%
Medicare	$671,497	$54	1.9%
Excess/Maximums	$555,136	$44	1.5%
PPO Discount	$18,490,905	$1,482	51.1%
Deductible	$246,402	$20	0.7%
Copay	$999,064	$80	2.8%
Coinsurance	$222,686	$18	0.6%
Total Participant Paid	**$1,468,152**	**$118**	**4.1%**
Total Plan Paid	**$14,534,272**	**$1,165**	**40.2%**

Total Participant Paid - PY21	**$66**
Total Plan Paid - PY21	**$952**





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	511	501	10	98.0%
	<2 asthma related ER Visits in the last 6 months	511	510	1	99.8%
	No asthma related admit in last 12 months	511	510	1	99.8%
Chronic Obstructive Pulmonary Disease	No exacerbations in last 12 months	96	91	5	94.8%
	Members with COPD who had an annual spirometry test	96	14	82	14.6%
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	61	60	1	98.4%
	Follow-up OV within 4 weeks of discharge from HF admission	4	4	0	100.0%
Diabetes	Annual office visit	557	545	12	97.8%
	Annual dilated eye exam	557	288	269	51.7%
	Annual foot exam	557	231	326	41.5%
	Annual HbA1c test done	557	473	84	84.9%
	Diabetes Annual lipid profile	557	431	126	77.4%
	Annual microalbumin urine screen	557	395	162	70.9%
Hyperlipidemia	Hyperlipidemia Annual lipid profile	1,243	975	268	78.4%
Hypertension	Annual lipid profile	1,337	909	428	68.0%
	Annual serum creatinine test	1,309	1,065	244	81.4%
Wellness	Well Child Visit - 15 months	79	76	3	96.2%
	Routine office visit in last 6 months	7,667	5,684	1,983	74.1%
	Age 45 to 75 years with colorectal cancer screening	3,235	767	2,468	23.7%
	Women age 25-65 with recommended cervical cancer screening	2,468	1,853	615	75.1%
	Males age greater than 49 with PSA test in last 24 months	1,152	589	563	51.1%
	Routine exam in last 24 months	7,667	7,063	604	92.1%
	Women age 40 to 75 with a screening mammogram last 24 months	2,172	1,356	816	62.4%

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	114	1.49%	14.77	$18,235
Asthma	557	7.26%	72.17	$13,891
Atrial Fibrillation	87	1.13%	11.27	$33,439
Blood Disorders	472	6.16%	61.16	$40,956
CAD	168	2.19%	21.77	$22,650
COPD	95	1.24%	12.31	$54,505
Cancer	322	4.20%	41.72	$23,567
Chronic Pain	378	4.93%	48.98	$23,692
Congestive Heart Failure	61	0.80%	7.90	$144,774
Demyelinating Diseases	26	0.34%	3.37	$30,348
Depression	843	10.99%	109.23	$11,748
Diabetes	591	7.71%	76.57	$30,443
ESRD	9	0.12%	1.17	$79,686
Eating Disorders	35	0.46%	4.53	$69,409
HIV/AIDS	11	0.14%	1.43	$27,248
Hyperlipidemia	1,274	16.61%	165.07	$20,422
Hypertension	1,338	17.45%	173.36	$18,549
Immune Disorders	33	0.43%	4.28	$31,498
Inflammatory Bowel Disease	51	0.67%	6.61	$37,005
Liver Diseases	190	2.48%	24.62	$41,236
Morbid Obesity	340	4.43%	44.05	$21,532
Osteoarthritis	443	5.78%	57.40	$18,961
Peripheral Vascular Disease	44	0.57%	5.70	$27,850
Rheumatoid Arthritis	74	0.97%	9.59	$38,747

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 2022 - Quarter Ending September 30, 2021

Express Scripts

Membership Summary	1Q FY2022 EPO	1Q FY2021 EPO	Difference	% Change
			Membership Summary	
Member Count (Membership)	7,709	8,681	(972)	-11.2%
Utilizing Member Count (Patients)	4,878	5,102	(224)	-4.4%
Percent Utilizing (Utilization)	63.3%	58.8%	0	7.7%
Claim Summary			**Claims Summary**	
Net Claims (Total Rx's)	37,554	42,693	(5,139)	-12.0%
Claims per Elig Member per Month (Claims PMPM)	1.62	1.64	(0.02)	-1.2%
Total Claims for Generic (Generic Rx)	31,847	36,527	(4,680.00)	-12.8%
Total Claims for Brand (Brand Rx)	5,707	6,166	(459.00)	-7.4%
Total Claims for Brand w/Gen Equiv (Multisource Brand Claims)	322	670	(348.00)	-51.9%
Total Non-Specialty Claims	37,008	42,139	(5,131.00)	-12.2%
Total Specialty Claims	546	554	(8.00)	-1.4%
Generic % of Total Claims (GFR)	**84.8%**	**85.6%**	(0.01)	-0.9%
Generic Effective Rate (GCR)	**99.0%**	**98.2%**	0.01	0.8%
Mail Order Claims	7,156	4,806	2,350.00	48.9%
Mail Penetration Rate*	21.4%	12.3%	0.09	9.1%
Claims Cost Summary			**Claims Cost Summary**	
Total Prescription Cost (Total Gross Cost)	$4,972,394.00	$5,263,489.00	($291,095.00)	-5.5%
Total Generic Gross Cost	$735,056.00	$855,885.00	($120,829.00)	-14.1%
Total Brand Gross Cost	$4,237,339.00	$4,407,604.00	($170,265.00)	-3.9%
Total MSB Gross Cost	$69,608.00	$165,737.00	($96,129.00)	-58.0%
Total Ingredient Cost	$4,923,001.00	$5,239,679.00	($316,678.00)	-6.0%
Total Dispensing Fee	$47,801.00	$22,547.00	$25,254.00	112.0%
Total Other (e.g. tax)	$1,592.00	$1,263.00	$329.00	26.0%
Avg Total Cost per Claim (Gross Cost/Rx)	**$132.41**	**$123.29**	$9.12	7.4%
Avg Total Cost for Generic (Gross Cost/Generic Rx)	$23.08	$23.43	($0.35)	-1.5%
Avg Total Cost for Brand (Gross Cost/Brand Rx)	$742.48	$714.82	$27.66	3.9%
Avg Total Cost for MSB (MSB Gross Cost/MSB ARx)	$216.18	$247.37	($31.19)	-12.6%
Member Cost Summary			**Member Cost Summary**	
Total Member Cost	**$819,750.00**	**$900,349.00**	($80,599.00)	-9.0%
Total Copay	$810,949.00	$900,349.00	($89,400.00)	-9.9%
Total Deductible	$8,800.00	$0.00	$8,800.00	0.0%
Avg Copay per Claim (Copay/Rx)	$21.59	$21.09	$0.51	2.4%
Avg Participant Share per Claim (Copay+Deductible/RX)	**$21.83**	**$21.09**	**$0.74**	**3.5%**
Avg Copay for Generic (Copay/Generic Rx)	$7.68	$7.51	$0.17	2.3%
Avg Copay for Brand (Copay/Brand Rx)	$100.76	$101.55	($0.79)	-0.8%
Avg Copay for Brand w/ Generic Equiv (Copay/Multisource Rx)	$33.13	$32.96	$0.17	0.5%
Net PMPM (Participant Cost PMPM)	**$35.45**	**$34.57**	$0.87	2.5%
Copay % of Total Prescription Cost (Member Cost Share %)	16.5%	17.1%	-0.6%	-3.6%
Plan Cost Summary			**Plan Cost Summary**	
Total Plan Cost (Plan Cost)	**$4,152,645.00**	**$4,363,140.00**	**($210,495.00)**	**-4.8%**
Total Non-Specialty Cost (Non-Specialty Plan Cost)	$2,069,983.00	$2,199,457.00	($129,474.00)	-5.9%
Total Specialty Drug Cost (Specialty Plan Cost)	$2,082,661.00	$2,163,683.00	($81,022.00)	-3.7%
Avg Plan Cost per Claim (Plan Cost/Rx)	**$110.58**	**$102.20**	$8.38	8.2%
Avg Plan Cost for Generic (Plan Cost/Generic Rx)	$15.40	$15.93	($0.53)	-3.3%
Avg Plan Cost for Brand (Plan Cost/Brand Rx)	$641.72	$613.27	$28.45	4.6%
Avg Plan Cost for MSB (MSB Plan Cost/MSB ARx)	$183.05	$214.41	($31.36)	-14.6%
Net PMPM (Plan Cost PMPM)	**$179.56**	**$167.54**	**$12.02**	**7.2%**
PMPM for Specialty Only (Specialty PMPM)	$90.05	$83.08	$6.97	8.4%
PMPM without Specialty (Non-Specialty PMPM)	$89.51	$84.45	$5.06	6.0%
Rebates Received (Q1 FY2022 actual)	$1,088,920.45	$1,008,649.28	**$80,271.17**	**8.0%**
Net PMPM (Plan Cost PMPM factoring Rebates)	**$132.47**	**$128.81**	**$3.67**	**2.8%**
PMPM for Specialty Only (Specialty PMPM)	$75.38	$69.93	$5.45	7.8%
PMPM without Specialty (Non-Specialty PMPM)	$63.22	$57.91	$5.31	9.2%

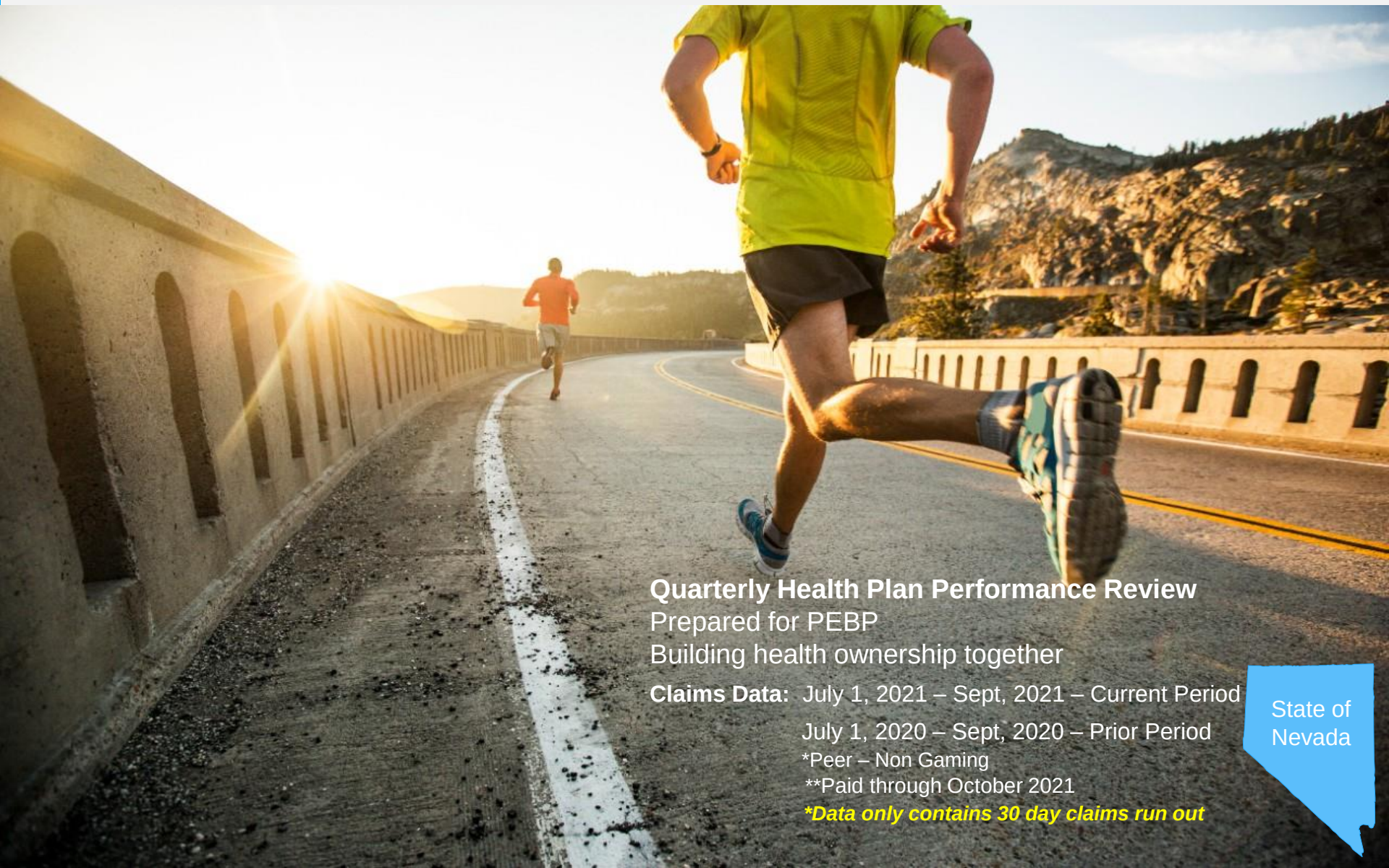
Appendix D

Index of Tables
Health Plan of Nevada –Utilization Review for PEBP
July 1, 2021 – September 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, 2021 – Sept, 2021 – Current Period
July 1, 2020 – Sept, 2020 – Prior Period
*Peer – Non Gaming
**Paid through October 2021
Data only contains 30 day claims run out

State of Nevada

Key Performance Indicators

Includes Demographics And Financials

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
- ✓ 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

Demographic and Financial Overview

UnitedHealthcare

Demographics

Membership	Age	Famiy size	Dependents <18	HHS Risk
Members: 6,747 Employees: 3,832 Prior: 6,830 3,935	37.1 Prior : 37.2 Norm: 35.1	1.76 Prior : 1.74 Norm: 1.81	22.9% Prior: 22.4 Norm: 21.9	1.53 Prior: 1.47 Norm: 1.34
-1.2%	-0.4%	1.4%	2.4%	4.4%

Medical and Rx Spend

42.3%

Medical PMPM
$457.26

Prior $321.35
Norm: $356.38

Utilization

Inpatient: ▼-36.7%
Outpatient: ▼ -21.5%
Professional:▼ - 7.3%

Spend

Inpatient: ▲ 46.0%
Outpatient: ▲ 40.2%
Professional: ▲36.5%

34.0%

Overall PMPM
$602.61

Prior: $449.76
Norm: $456.49

8.3%
Specialty Rx
$81.88

Prior: $75.58
Norm: $54.32

-2.3%
Avg. Scripts PMPY
17.0

Prior: 17.4
Norm: 11.7

13.2%
Rx PMPM
$145.35

Specialty Rx accounts for 56.3% of Rx Spend

Prior: $128.41
Norm: $100.11

Medical and Rx Plan Experience

What Happened

Highlights of Utilization

UnitedHealthcare®

Utilization Metric	Prior	Current	Δ
Physician Office Visits			
Per Member Per Year	1.9	1.6	-12.9%
Specialist Office Vists			
Per Member Per Year	10.7	9.2	-14.1%
Emergency Room			
ER Visits	205	136	-33.6%
ER Visits Per K	120.1	80.8	-32.7%
Urgent Care			
UC Visits	987.0	824.5	-16.5%
UC Visits Per K	578.1	488.9	-15.4%
OutPatient Surgery			
ASC	113.0	109.7	-3.0%
Facility	42.8	23.1	-45.9%
Inpatient Utilization			
Admissions Per K	62.5	47.9	-23.4%
Bed Days Per K	317.5	391.6	23.3%
Average Length of Stay	5.1	8.2	60.9%

Highlights

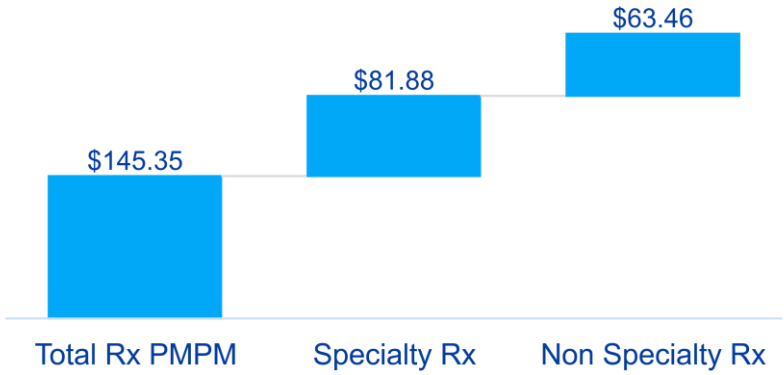
- PCP Visits decreased in the current period, down -12.9**%**
- Specialist Office visits dropped -14.1%
- ER utilization dropped **-32.7%**,
  - We saw a decrease in ER utilization throughout our book of business due to Covid
  - Average paid per visit increased 27.0%, due to more emergent cases
- Urgent Care Utilization decreased **-15.4%**
- Outpatient surgeries decreased at both ASC and OP Facility settings
- IP Admits decreased **-23.4%** from prior period
- Overall IP spend is up **46.0%**

- Average length of stay went from an average of 5.1 to 8.2 days per stay
- Average length of stay increased > 60%
- 6 Admits have greater than 20 day stays
- More complex admits (Cancer, Covid and respiratory diseases)

Pharmacy Data

	Prior	Current	Δ	Peer	Δ
Enrolled Members	6,830	6,747	-1.2%		
Average Prescriptions PMPY	17.4	17.0	-2.3%	11.7	45.8%
Formulary Rate	91.9%	89.6%	-2.6%	91.3%	-1.9%
Generic Use Rate	85.6%	83.9%	-1.9%	85.6%	-2.0%
Generic Substitution Rate	97.2%	98.3%	1.1%	96.6%	1.7%
Employee Cost Share PMPM	$22.40	$26.38	17.8%	$12.05	119.0%
Avg Net Paid per Prescription	$88.34	$102.36	15.9%	$94.75	8.0%
Net Paid PMPM	$128.41	$145.35	13.2%	$92.30	57.5%

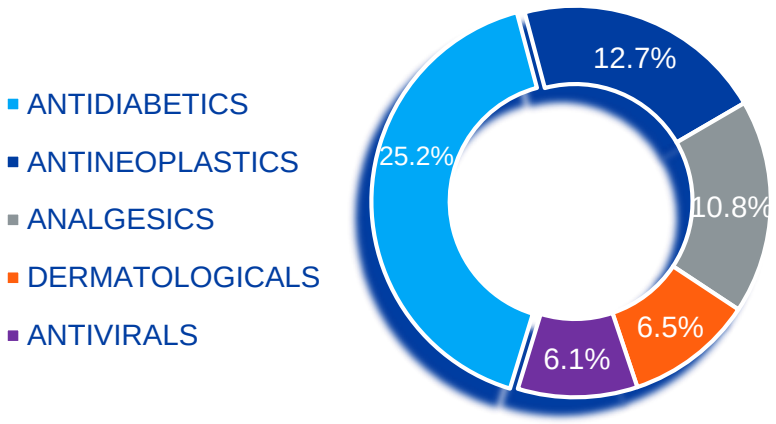
Paid By Benefit and Type



Pharmacy PMPM trend is up 13.2% ($16.94 PMPM)

- Average net paid per script increased **15.9%** (up $14.01 PMPM from prior period)
- Consistent with market trends; diabetic compliance is on the rise Antidiabetic Rx Spend increased **4.0%**
- Specialty Rx Spend increased **8.3%**
  Specialty Rx Drivers:
  *Humira (Analgesics, spend up **3.4%**)
  *Stelara (Dermatologic, spend up **196.1%**)
  *Aubagio(Psychotherapeutic, spend up **10.6%**)
- Avg. Prescriptions PMPY decreased -2.3%

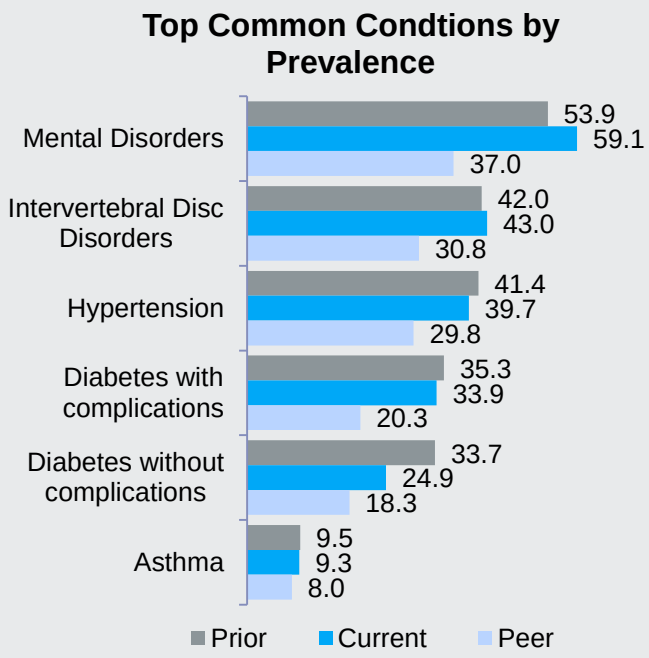
Top 5 Therapuetic Classes by Spend

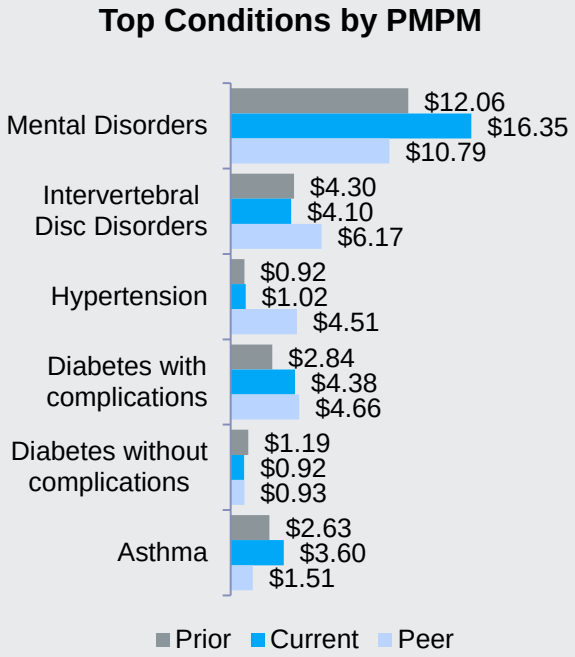


Condition Prevalence

Clinical Drivers

Clinical Conditions and Diagnosis





- Chronic illnesses continue to drive the top common conditions
- Mental Disorders, Intervertebral Disc Disorders and Hypertension are the most prevalent clinical conditions within this population for this period
- Mental Disorder prevalence increased 9.8% and had an increased in overall spend increased 35.5% (up,$4.28PMPM) from prior period
  - Alcohol related disorders increased 157.1%, up $1.38 PMPM YOY
  - Autism spend increased 109.4% (ABA therapy) up $5.45 PMPM from prior period

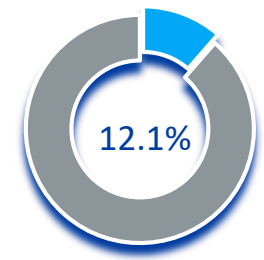
Chronic Condition Cost Drivers

UnitedHealthcare

89% Of Medical spend driven by members with these 4 Chronic Conditions. Average Engagement 97%

Asthma

6.7% of Members

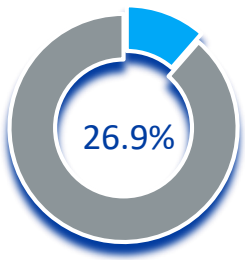


Average paid Per Claimant **$8,385**

Member Engagement **97.8%**

Cardio Hypertension

13.2% of Members

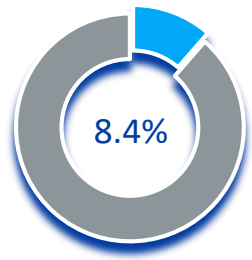


Average paid Per Claimant **$9,460**

Member Engagement **96.4%**

CAD

1.9% of Members

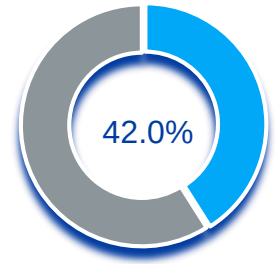


Average paid Per Claimant **$20,475**

Member Engagement **100.0%**

Diabetes

21.7% of Members



Average paid Per Claimant **$8,953**

Member Engagement **95.0%**

**Data obtained for this slide is for Eval period Oct-2020 thru Sep-2021*

Catastrophic Cases

High Cost Claimants

Catastrophic Cases Summary (>$50k)

UnitedHealthcare

3.8 Catastrophic Cases Per 1000

Prior: 1.9 ▲ 92.9%

27 Individuals (14 Prior Period)

.38% of the population

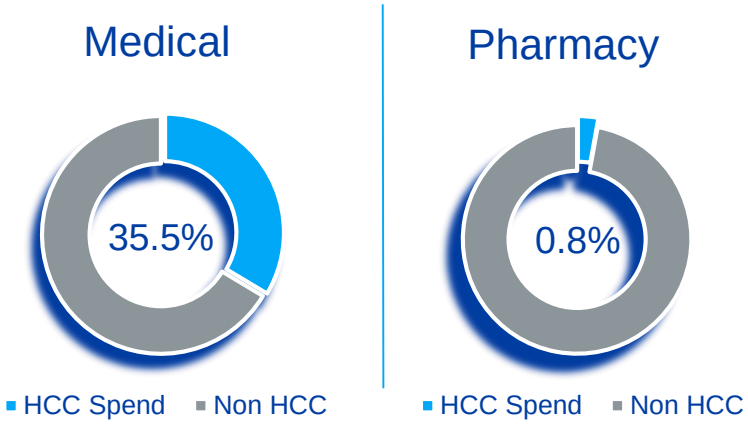
$122,620

Average Paid Per Case

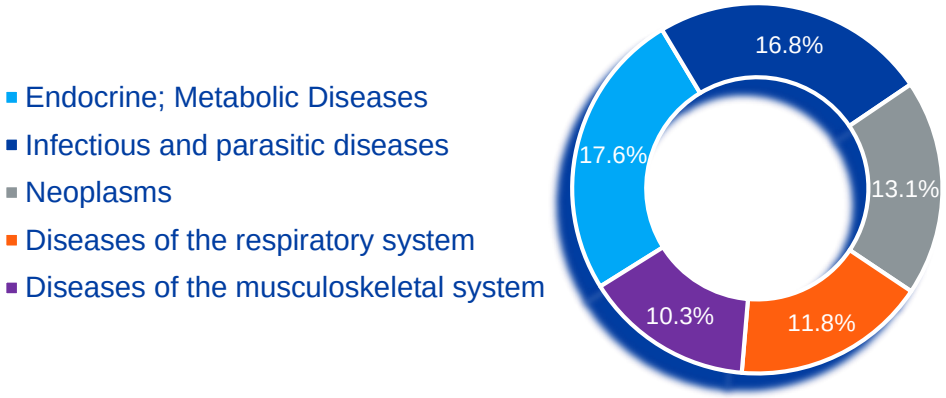
Prior: $87,310 ▲ **40.4%**

% of Total Med/Rx Spend as High Cost **27.1%**

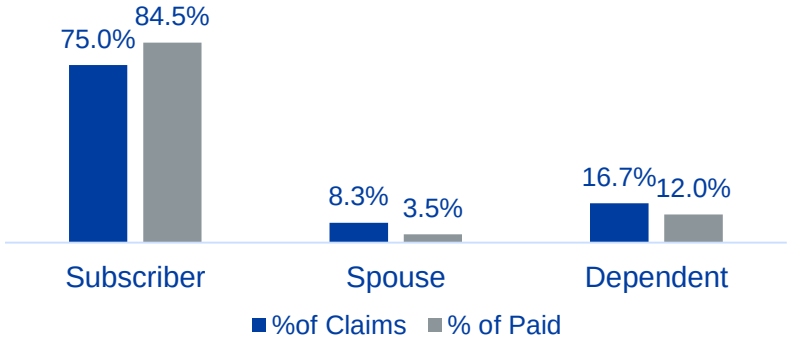
% Paid Attributed to Catastrophic Cases



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 September 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 Insurance

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

4.3.6 AETNA Signature Administrators – PPO Network

4.3.7 HealthPlan of Nevada, Inc. – Southern HMO

4.3.8 Doctor on Demand Engagement Reports through September 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 September 30, 2021:

        4.3.1 HealthSCOPE Benefits – Obesity Care Management

HSB DATASCOPE™

Obesity Care Management Report

Nevada Public Employees' Benefits Program

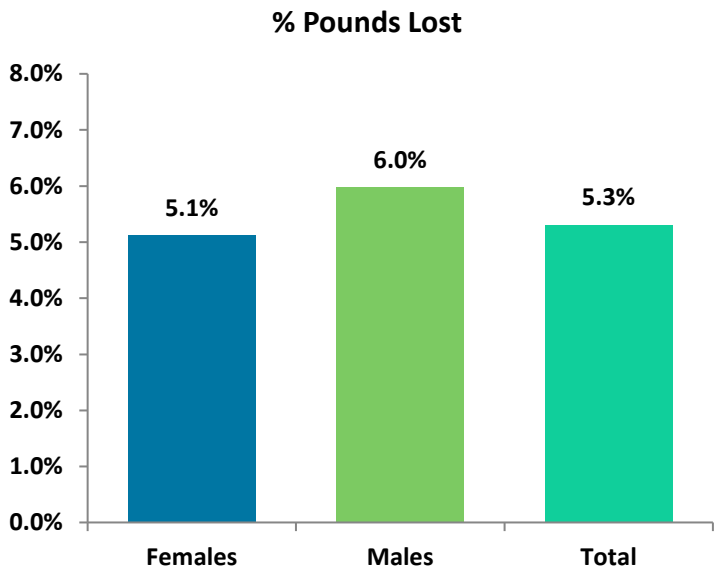
July – September 2021

HealthSCOPE BENEFITS

Obesity Care Management Overview

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

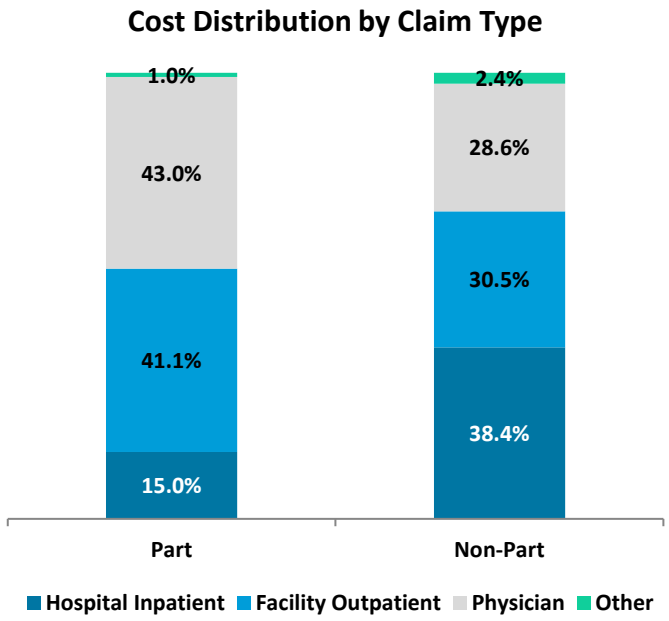
PEBP 1Q22			
Weight Management Summary	**Females**	**Males**	**Total**
# Mbrs Enrolled in Program	883	219	1,102
Average # Lbs. Lost	10.9	14.8	11.7
Total # Lbs. Lost	9,614.0	3,242.1	12,856.1
% Lbs. Lost	5.1%	6.0%	5.3%
Average Cost/ Member	$5,007	$5,123	$5,123



Obesity Care Management – Financial Summary

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

Summary	Participants	Non-Participants	Variance
Enrollment			
Avg # Employees	981	820	19.6%
Avg # Members	1,094	1,043	4.9%
Member/Employee Ratio	1.1	1.3	-11.8%
Financial Summary			
Gross Cost	$1,920,780	$5,241,200	
Client Paid	$1,446,665	$4,468,865	
Employee Paid	$474,115	$772,335	
Client Paid-PEPY	$5,901	$21,808	-72.9%
Client Paid-PMPY	$5,288	$17,133	-69.1%
Client Paid-PEPM	$492	$1,817	-72.9%
Client Paid-PMPM	$441	$1,428	-69.1%
High Cost Claimants (HCC's) > $100k			
# of HCC's	2	3	
HCC's / 1,000	1.8	2.9	0.0%
Avg HCC Paid	$118,844	$162,928	0.0%
HCC's % of Plan Paid	16.4%	10.9%	0.0%
Cost Distribution - PMPY			
Hospital Inpatient	$792	$6,579	-88.0%
Facility Outpatient	$2,172	$5,231	-58.5%
Physician	$2,273	$4,907	-53.7%
Other	$51	$416	-87.7%
Total	$5,288	$17,133	-69.1%
	Annualized	Annualized	



Obesity Care Management – Utilization Summary

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

Summary	Participants	Non-Participants	Variance
Inpatient Facility			
# of Admits	17	67	
# of Bed Days	46	295	
Paid Per Admit	$15,967	$27,259	-41.4%
Paid Per Day	$5,901	$6,191	-4.7%
Admits Per 1,000	62	257	-75.9%
Days Per 1,000	168	1131	-85.1%
Avg LOS	2.7	4.4	-38.6%
# of Admits From ER	8	42	-81.0%
Physician Office			
OV Utilization per Member	10.1	9.8	3.1%
Avg Paid per OV	$112	$108	3.7%
Avg OV Paid per Member	$1,131	$1,059	6.8%
DX&L Utilization per Member	17.3	24.2	-28.5%
Avg Paid per DX&L	$53	$82	-35.4%
Avg DX&L Paid per Member	$910	$1,979	-54.0%
Emergency Room			
# of Visits	69	109	
Visits Per Member	0.25	0.42	-40.5%
Visits Per 1,000	252	418	-39.7%
Avg Paid per Visit	$2,453	$2,275	7.8%
Urgent Care			
# of Visits	147	161	
Visits Per Member	0.54	0.62	-12.9%
Visits Per 1,000	537	617	-13.0%
Avg Paid per Visit	$77	$100	-23.0%
	Annualized	Annualized	

4.3.2

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

    4.3 Receipt of quarterly vendor reports for the period ending September 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

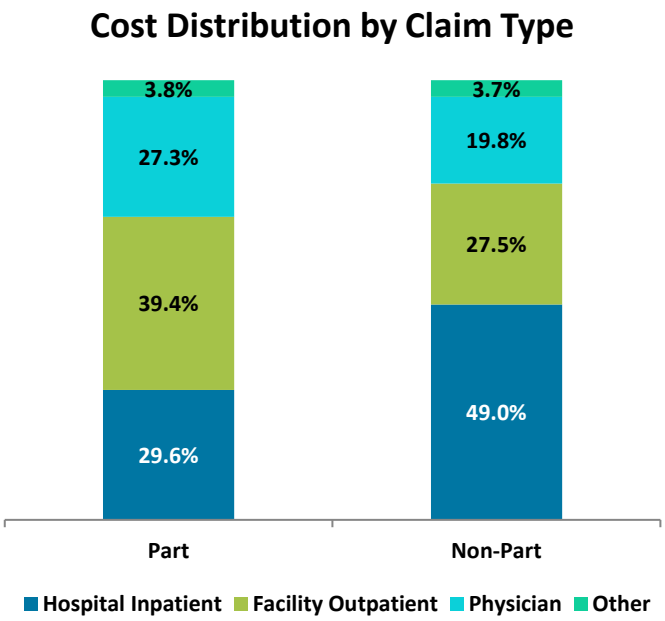
July – September 2021

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	323	1,882	-82.8%
Avg # Members	446	2,379	-81.2%
Member/Employee Ratio	1.4	1.3	9.5%
Financial Summary			
Gross Cost	$1,285,451	$10,319,463	
Client Paid	$973,107	$8,852,368	
Employee Paid	$312,343	$1,467,095	
Client Paid-PEPY	$12,038	$18,815	-36.0%
Client Paid-PMPY	$8,721	$14,884	-41.4%
Client Paid-PEPM	$1,003	$1,568	-36.0%
Client Paid-PMPM	$727	$1,240	-41.4%
High Cost Claimants (HCC's) > $100k			
# of HCC's	2	13	
HCC's / 1,000	4.4	5.5	0.0%
Avg HCC Paid	$119,402	$299,214	0.0%
HCC's % of Plan Paid	24.5%	43.9%	0.0%
Cost Distribution - PMPY			
Hospital Inpatient	$2,578	$7,292	-64.6%
Facility Outpatient	$3,432	$4,092	-16.1%
Physician	$2,382	$2,943	-19.1%
Other	$329	$558	-41.0%
Total	$8,721	$14,884	-41.4%
	Annualized	Annualized	



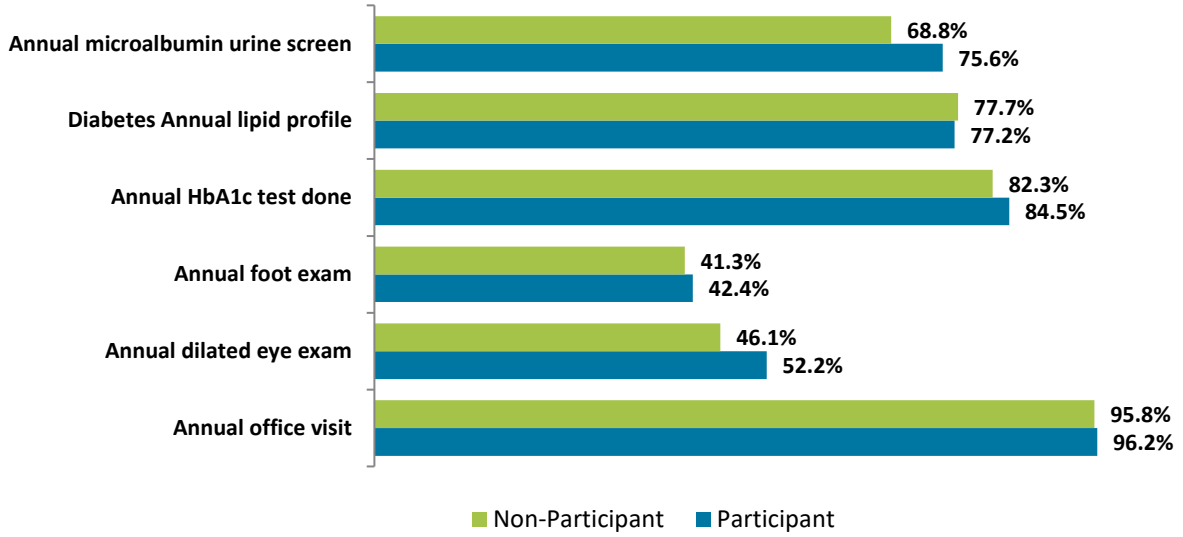
Diabetes Care Management – Utilization Summary

*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	12	95	
# of Bed Days	51	560	
Paid Per Admit	$17,897	$22,490	-20.4%
Paid Per Day	$4,211	$3,815	10.4%
Admits Per 1,000	108	160	-32.5%
Days Per 1,000	457	942	-51.5%
Avg LOS	4.3	5.9	-27.1%
# of Admits From ER	9	75	-88.0%
Physician Office			
OV Utilization per Member	7.9	8.6	-8.1%
Avg Paid per OV	$69	$87	-20.7%
Avg OV Paid per Member	$545	$750	-27.3%
DX&L Utilization per Member	16.3	22.2	-26.6%
Avg Paid per DX&L	$54	$79	-31.6%
Avg DX&L Paid per Member	$885	$1,753	-49.5%
Emergency Room			
# of Visits	15	183	
Visits Per Member	0.13	0.31	-58.1%
Visits Per 1,000	134	308	-56.5%
Avg Paid per Visit	$1,209	$2,472	-51.1%
Urgent Care			
# of Visits	36	238	
Visits Per Member	0.32	0.4	-20.0%
Visits Per 1,000	323	400	-19.3%
Avg Paid per Visit	$33	$95	-65.3%
	Annualized	Annualized	

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	316	304	12	96.2%	2,238	2,146	92	95.9%
	Annual dilated eye exam	316	165	151	52.2%	2,238	984	1,254	44.0%
	Annual foot exam	316	134	182	42.4%	2,238	929	1,309	41.5%
	Annual HbA1c test done	316	267	49	84.5%	2,238	1,845	393	82.4%
	Diabetes Annual lipid profile	316	244	72	77.2%	2,238	1,720	518	76.9%
	Annual microalbumin urine screen	316	239	77	75.6%	2,238	1,540	698	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 September 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

July 1, 2021 – September 30, 2021

AmericanHealth
American Health Holding Inc

Table of Contents

Executive Overview

AmericanHealth
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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 **October 31, 2021** and covers the reporting period of **July 1, 2021 – September 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 – 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

April 1, 2021 - June 30, 2021			
	Fees	Estimated Savings	ROI
Utilization Management	$193,047	$3,063,509	15.9 to 1
Case Management	$288,747	$1,553,012	5.4 to 1
Total	$481,794	$4,616,521	9.6 to 1

Utilization Management Breakout	
Inpatient Savings	$1,187,709
Outpatient Savings	$1,875,800

July 1, 2021 - September 30, 2021			
	Fees	Estimated Savings	ROI
Utilization Management	$188,253	$2,882,634	15.3 to 1
Case Management	$281,575	$1,978,459	7.0 to 1
Total	$469,828	$4,861,093	10.3 to 1

Utilization Management Breakout	
Inpatient Savings	$1,491,664
Outpatient Savings	$1,390,970

Utilization Management

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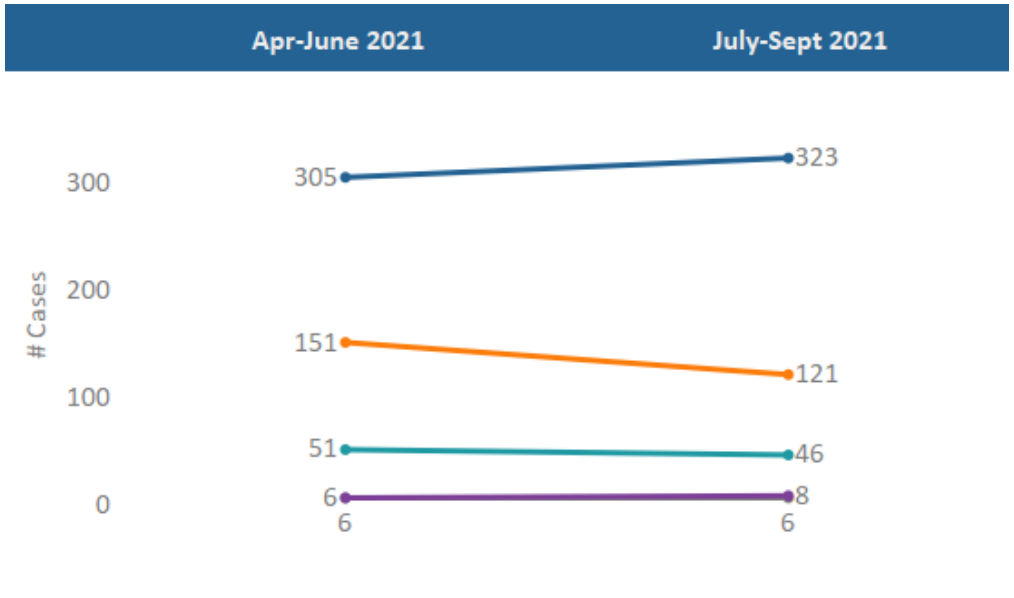
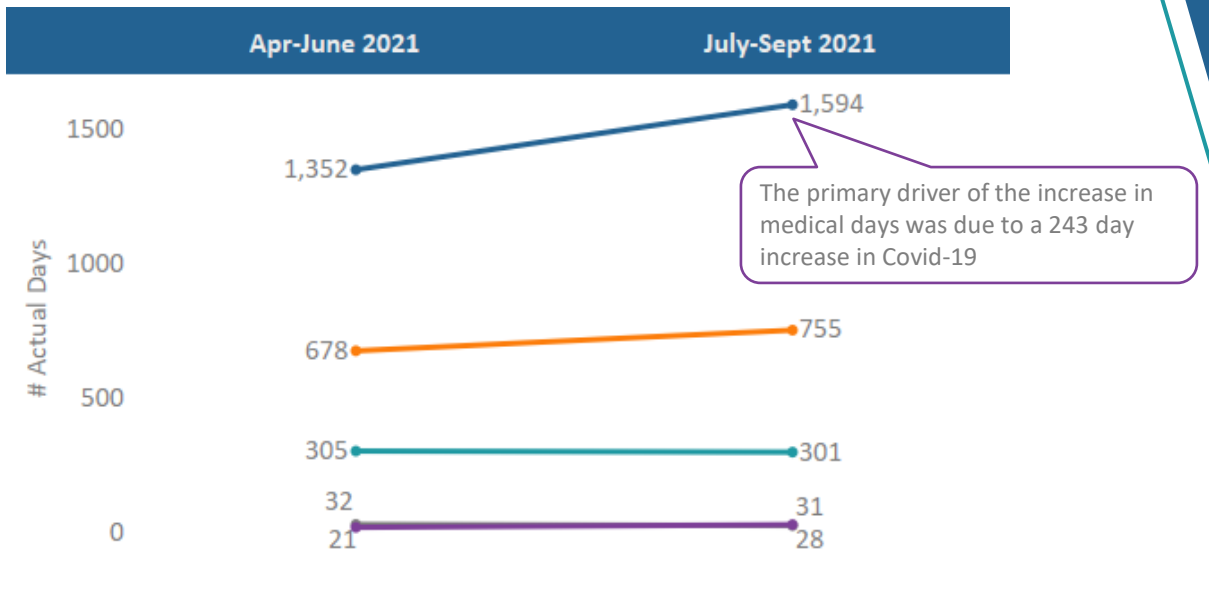
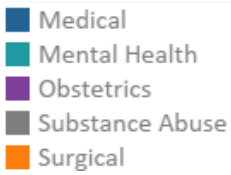
Acute Inpatient Activity Summary





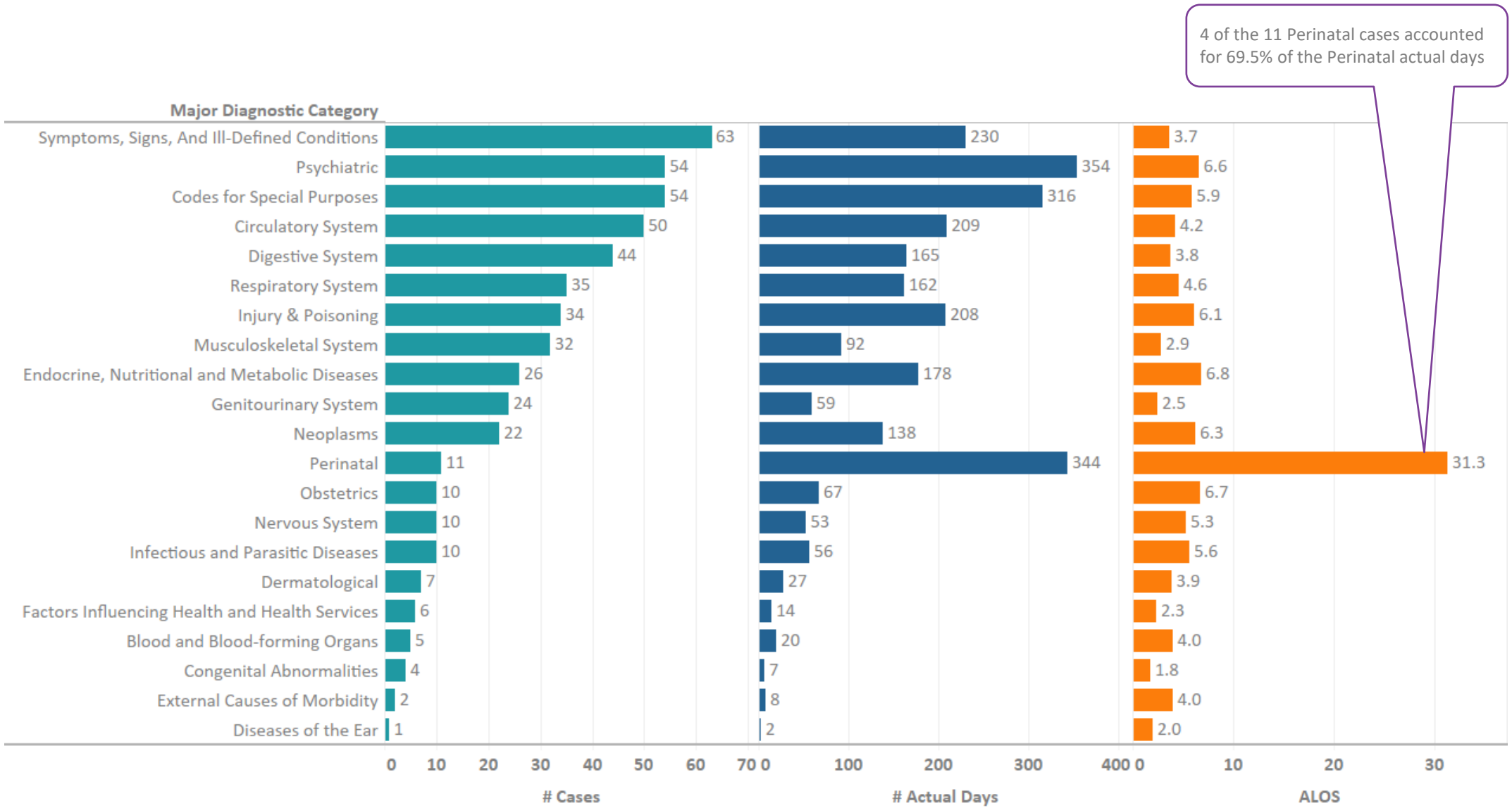


Utilization Review Process

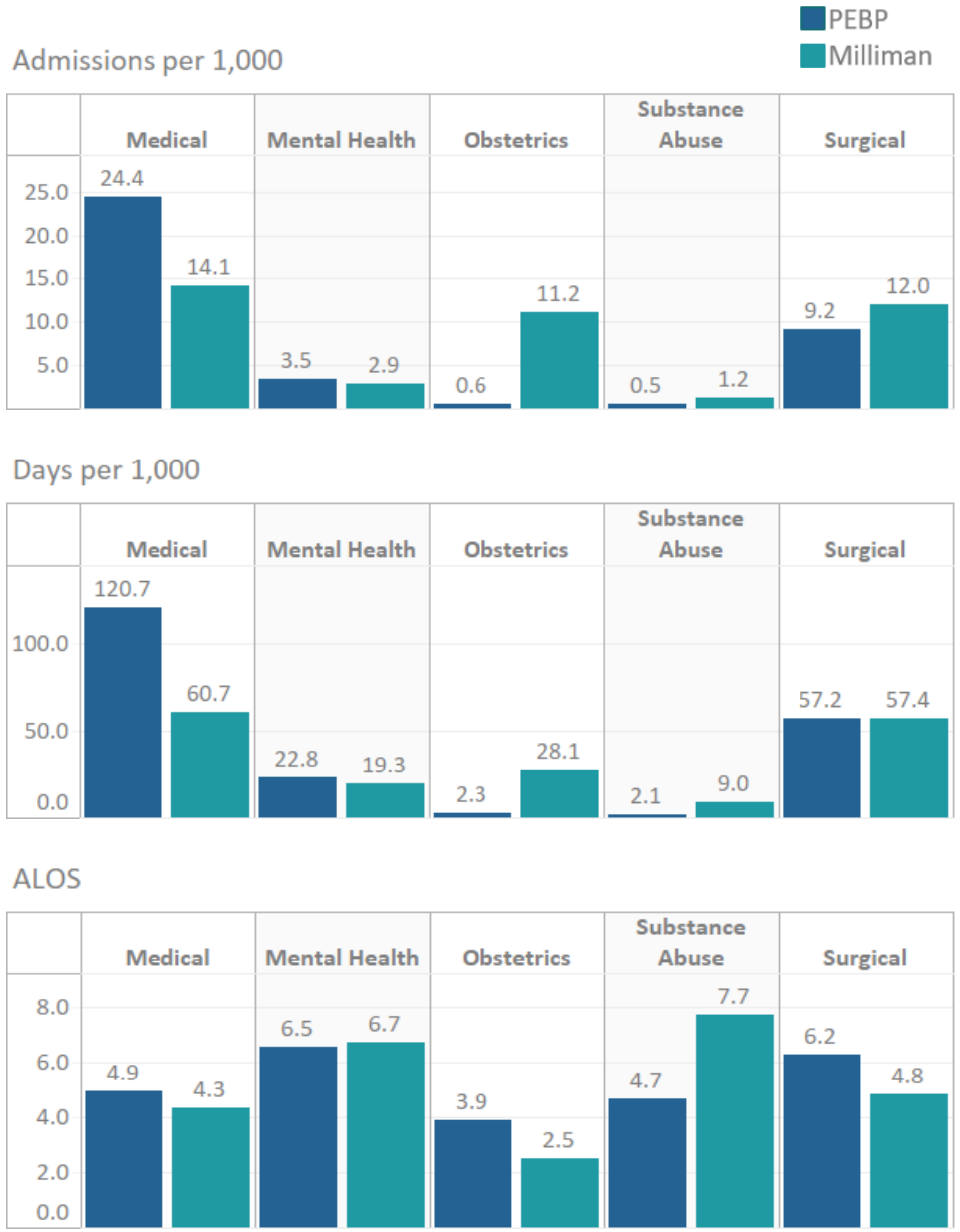
Days Saved: 181
Estimated Savings: $1,444,348

July 1, 2021 - September 30, 2021						
	Cases	Actual Days	Requested Days	Approved Days	Saved Days	Estimated Savings
Medical	323	1,594	1,617	1,499	118	$778,092
Surgical	121	755	669	625	44	$630,828
Mental Health	46	301	309	301	8	$12,680
Obstetrics	8	31	31	29	2	$11,300
Substance Abuse	6	28	28	19	9	$11,448
Grand Total	**504**	**2,709**	**2,654**	**2,473**	**181**	**$1,444,348**

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
  - **29** medical members had **2 or more** inpatient admissions
  - **1** mental health member had **7** inpatient admissions

Days per 1,000

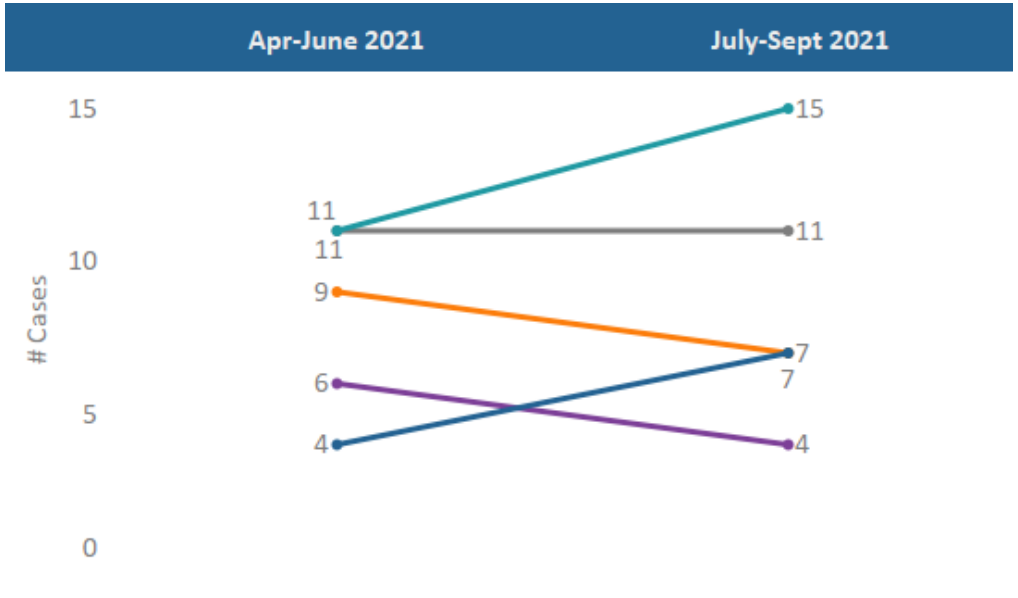
- During the report period, medical and mental health acute inpatient days per 1,000 were above the Milliman benchmarks
  - **44** medical cases utilized **9 or more** days during the report period
  - **1** mental health case utilized **23** days during the report period

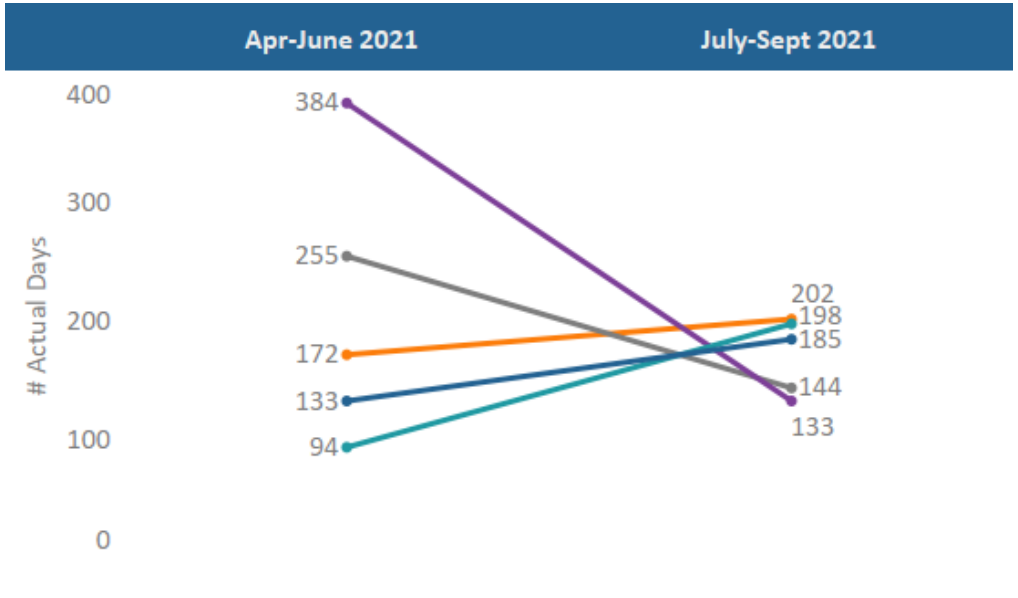
Average Length of Stay

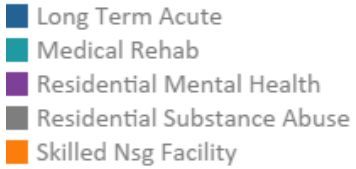
- During the report period, medical, obstetrics, and surgical ALOS were above the Milliman benchmark
  - **105 of the 323** medical cases were above the benchmark during the report period
  - **6 of the 8** obstetrics cases were above the benchmark during the report period
  - **34 of the 121** surgical cases were above the benchmark during the report period

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





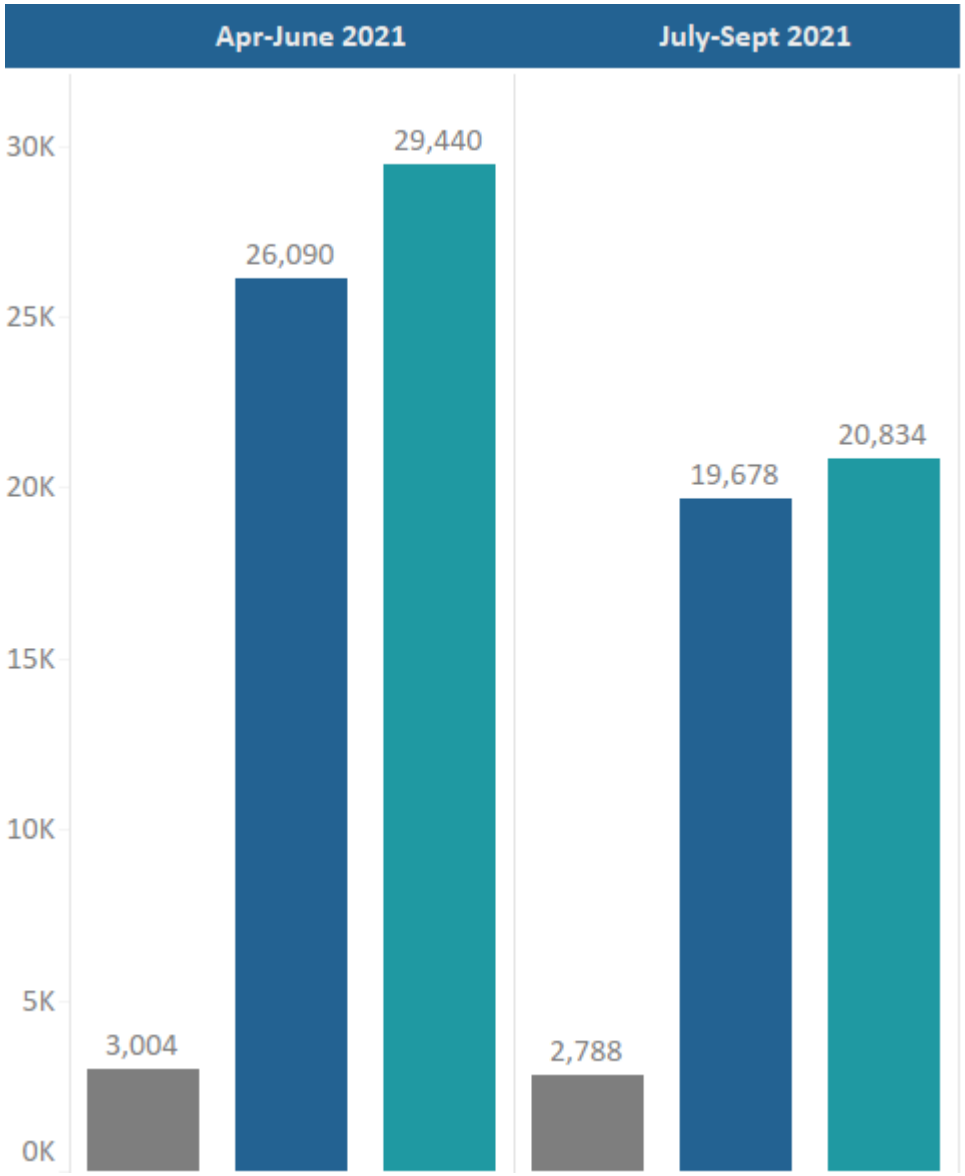


Utilization Review Process

Days Saved: 29
Estimated Savings: $47,316

April 1, 2021 - June 30, 2021						
	Cases	Actual Days	Requested Days	Approved Days	Saved Days	Estimated Savings
Medical Rehab	15	198	198	198	0	$0
Residential Substance Abuse	11	144	144	143	1	$1,008
Skilled Nsg Facility	7	202	202	194	8	$5,336
Long Term Acute	7	185	192	184	8	$32,176
Residential Mental Health	4	133	133	121	12	$8,796
Grand Total	**44**	**862**	**869**	**840**	**29**	**$47,316**

Outpatient Activity Summary



July 1, 2021 - September 30, 2021					
Outpatient Setting	# Cases	# Units Requested	# Units Approved	# Units Saved	Outpatient Savings
Diagnostic Test	1,721	2,127	1,939	188	$258,432
Surgery	600	1,059	995	64	$74,542
Med Treatment	207	4,818	4,648	170	$986,573
DME	146	7,360	6,783	577	$27,198
Home Health	57	878	764	114	$23,704
MH/SA	29	445	444	1	$408
Home Infusion	20	1,983	1,983	0	$0
PT/OT/ST	3	84	84	0	$0
Home Private Duty	2	1,602	1,560	42	$20,114
Home Enteral Feeding	2	456	456	0	$0
Hospice Home	1	22	22	0	$0
Grand Total	**2,788**	**20,834**	**19,678**	**1,156**	**$1,390,970**

2 cases accounted for 59.4% of the Med Treatment savings

Utilization Review Process

Units Saved: 1,156
Estimated Savings: $1,390,970

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
July-Sept 2021	548	358	65.3%	251	70.1%

Outpatient Referrals					
	# Cases	# Cases Referred to CM	% Cases Referred to CM	# Referrals Accepted in CM	% Referrals Accepted in CM
July-Sept 2021	2,788	672	24.1%	22	3.3%

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

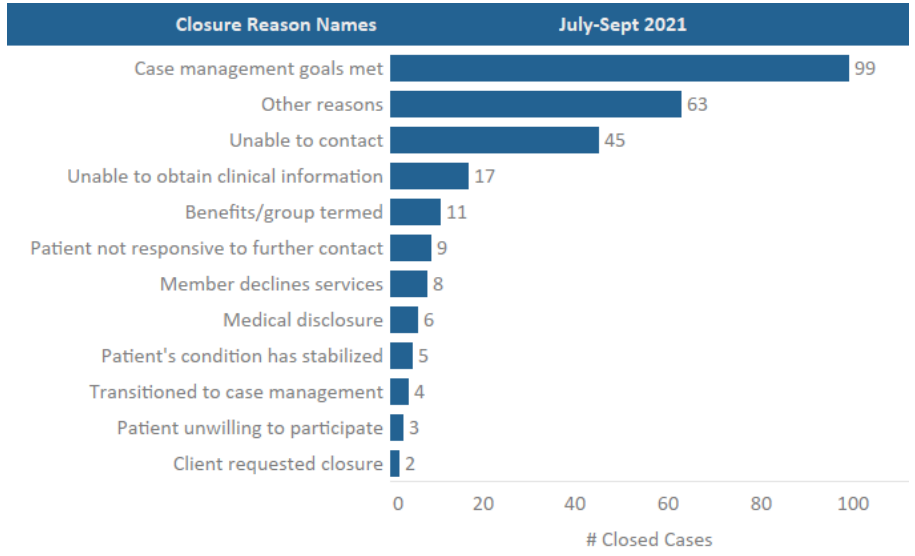
$1,978,459

Average Savings per Case = $4,517

Based on 438 cases in an open state between 7/1/2021 – 9/30/2021

Number of Cases

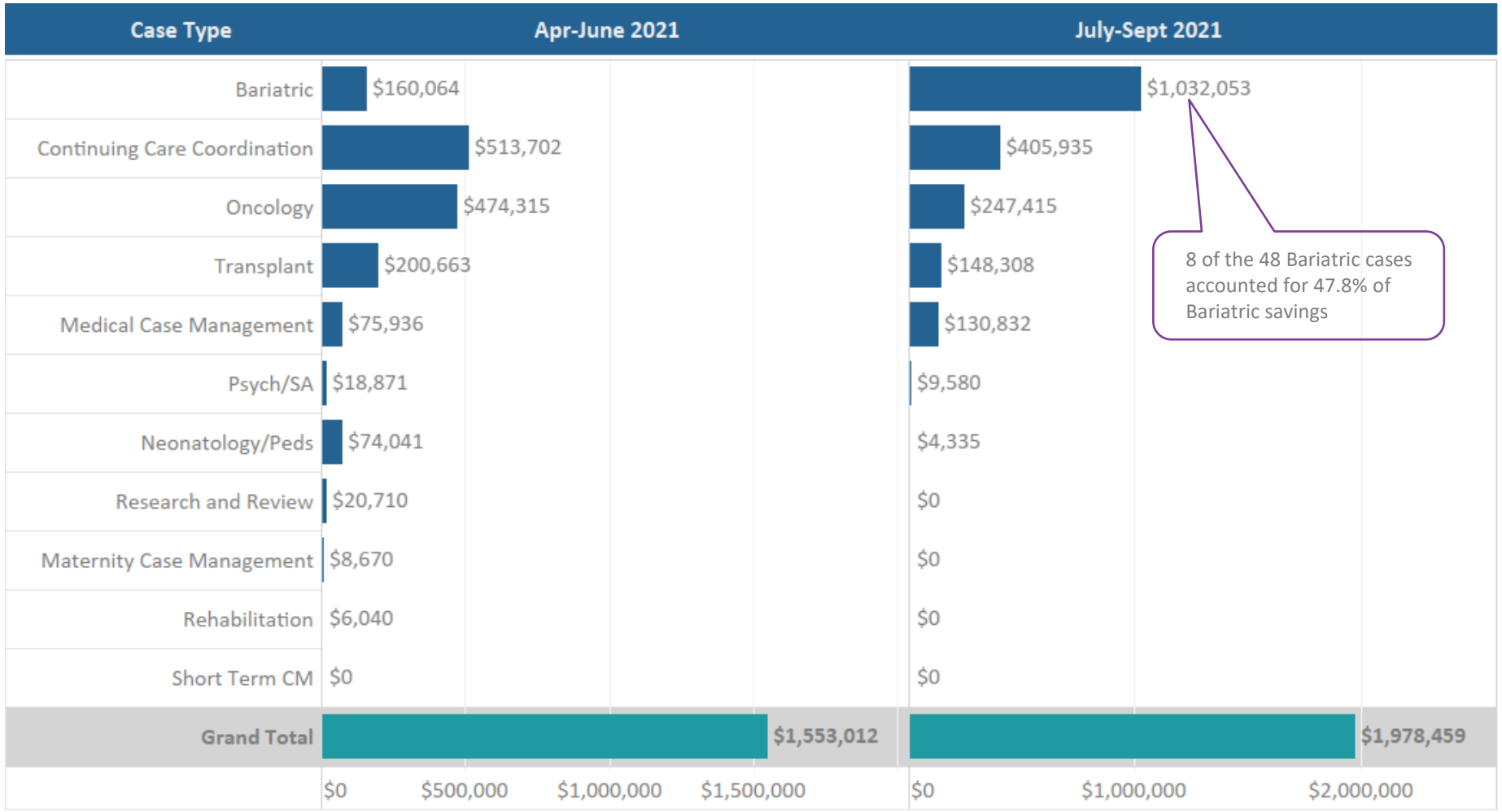
Case Activity	Apr-June 2021	July-Sept 2021
# Beginning Cases	197	191
# Opened Cases	214	247
# Closed Cases	220	252
# Ending Cases	191	186



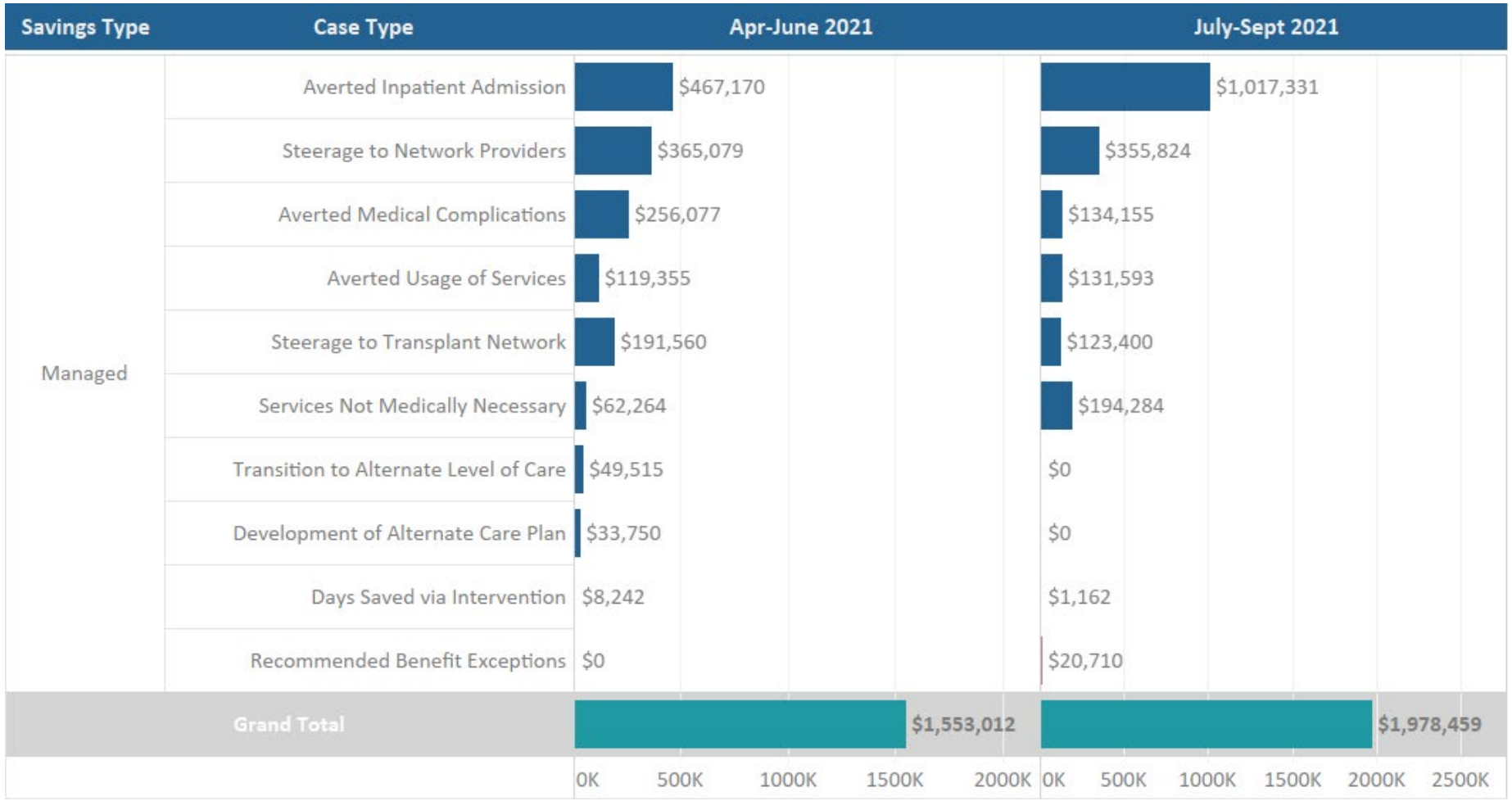
Case Type	July-Sept 2021
Short Term CM	152
Continuing Care Coordination	94
Oncology	53
Bariatric	48
Advocacy	39
Medical Case Management	19
Psych/SA	10
Neonatology/Peds	10
Transplant	8
Maternity Case Management	2
Rehabilitation	1
Research and Review	1
Grand Total	**438**

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

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.

412*
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.

10
Participants

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

1
Participants

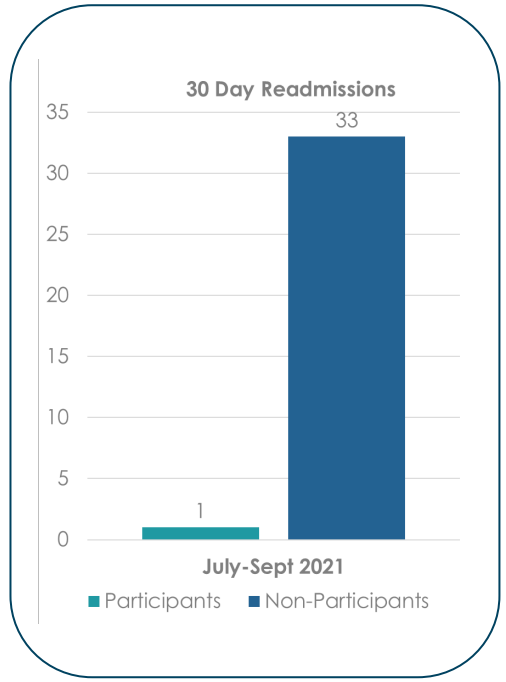
# of participating members with readmissions

402
Non-Participants

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

33
Non-Participants

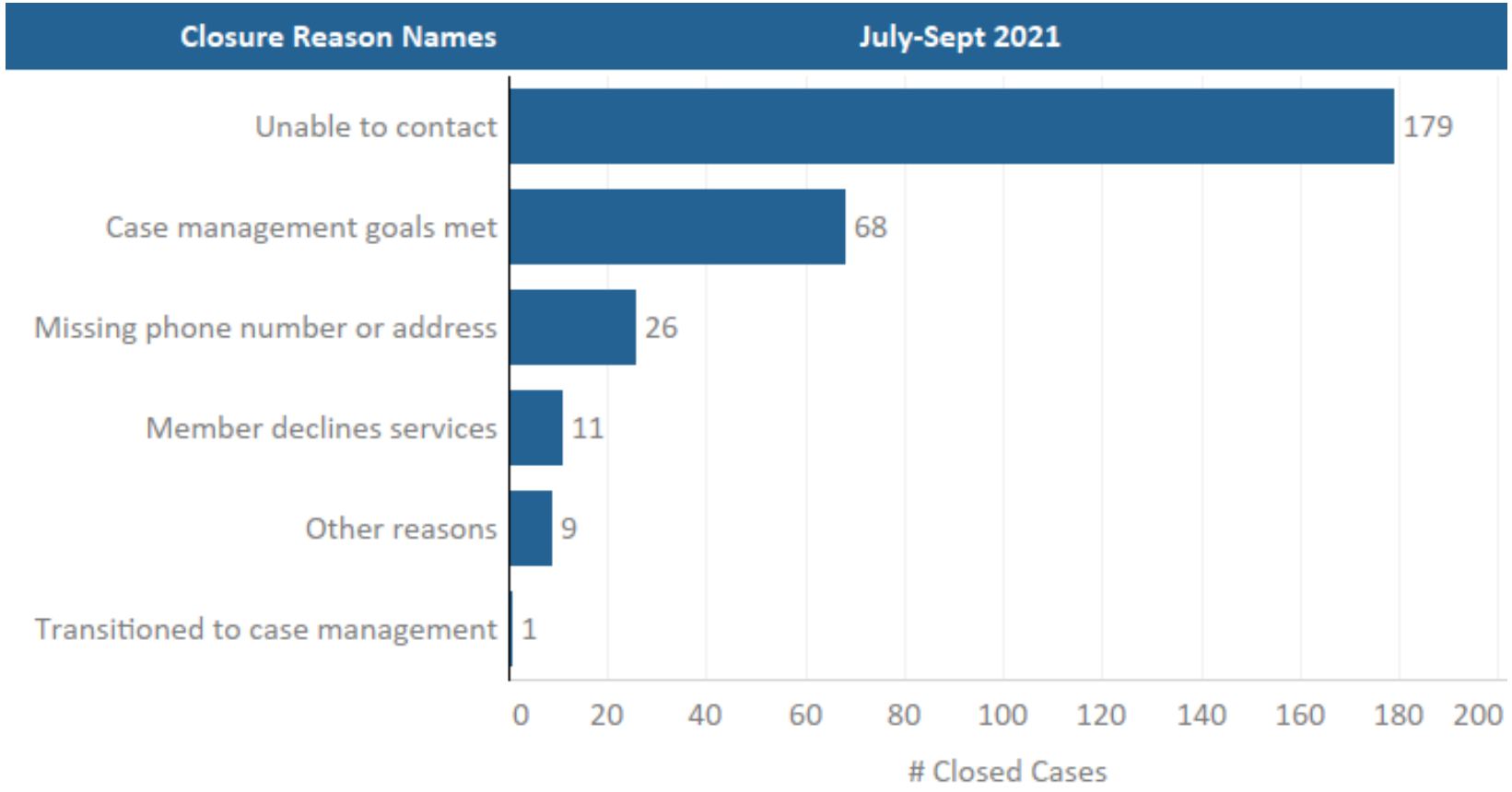
# of non-participating members with readmissions



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.



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 September 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 Insurance

The Standard

Quarterly Report: Basic Life Insurance:
Quarter Ending
September 30, 2021

Report Table of Contents

Basic Life Insurance Executive Summary

Most Recent Five Plan Years: July 01, 2017 to September 30, 2021

This is the initial report for the 2021-22 plan year, providing information for the most recent 5-year plan period, beginning July 1, 2017 and ending September 30, 2021.

Basic Life

Because this is the first report for the plan year, there's not much to report on an incidence basis for Basic Life. Incidence (page 4) is reported on an incurred rather than paid basis. There were 6 employee claims incurred during the first quarter, along with 11 retiree claims. For the recently completed 2020-21 plan year, the overall Basic Life incidence was up, 9.2 claims per 1,000 insureds compared to a most recent for five-year average of 8.76. Incidence for both employees and retirees contributed to those results with active employees at 2.5 claims and retirees at 20.6 claims per 1,000, compared to five-year averages of 1.92 and 19.68, respectively.

For the first quarter, the Basic Life loss ratio for active employees (page 5) was 6%. For the 2020-21 plan year, the loss ratio for active employees was 33%, a slight increase from the prior year which was 27%. Retirees resulted in a 404% loss ratio for the most recent quarter, compared to a 345% loss ratio for the 2020-21 plan year. Overall, the most recent quarter's combined Basic Life loss ratio was 101%, compared to most recent 2020-21 plan year loss ratio of 105%.

Basic Life Insurance Claims by Plan Year and Participant Type

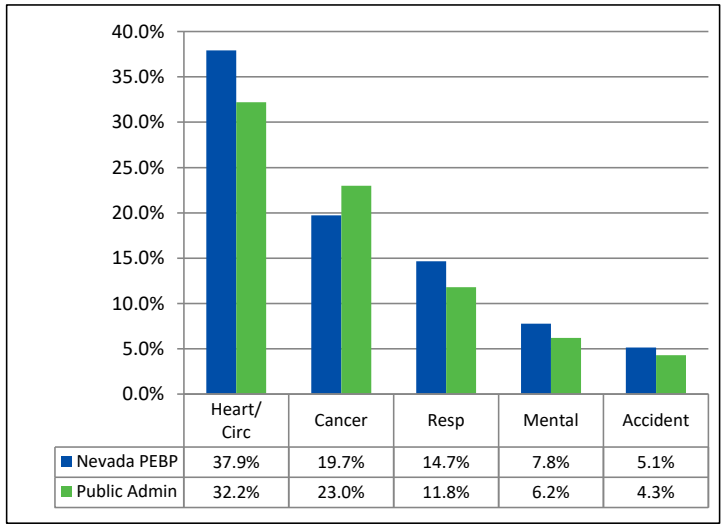
Most Recent Five Plan Years: July 01, 2017 to September 30, 2021

	From Jul-17 Through Jun-18		From Jul-18 Through Jun-19		From Jul-19 Through Jun-20		From Jul-20 Through Jun-21		From Jul-21 Through Jun-22	
Participant Type	**Count**	**Inc./ 1000**	**Count**	**Inc./ 1000**	**Count**	**Inc./ 1000**	**Count**	**Inc./ 1000**	**Count**	**Inc./ 1000**
Actives	41	1.6	47	1.8	47	1.7	66	2.5	6	0.2
Retirees	295	19.5	279	17.8	298	18.9	328	20.6	11	0.7
Totals	**336**	**8.6**	**326**	**8.1**	**345**	**8.4**	**394**	**9.2**	**17**	**0.4**

Basic Life Insurance Claims by Diagnostic Category

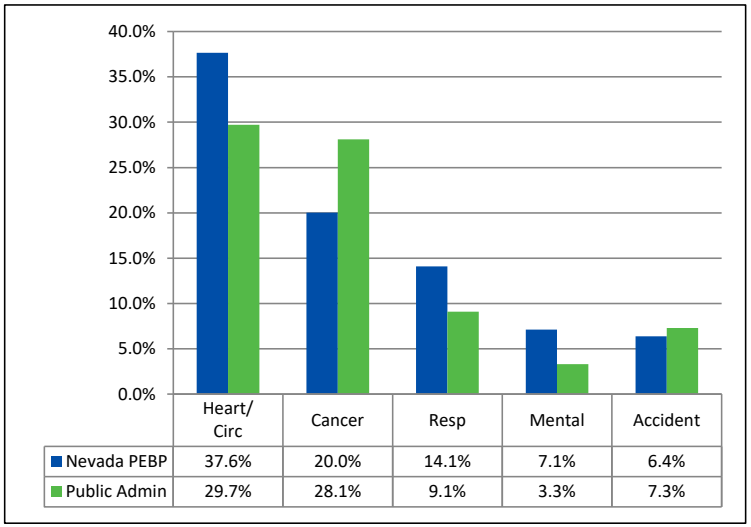
Public Admin benchmark is from SIC book of business for most recent 5 calendar years

Top Five Diagnostic Categories by Incidence



	Heart/ Circ	Cancer	Resp	Mental	Accident
Nevada PEBP	37.9%	19.7%	14.7%	7.8%	5.1%
Public Admin	32.2%	23.0%	11.8%	6.2%	4.3%

Top Five Diagnostic Categories by Liability

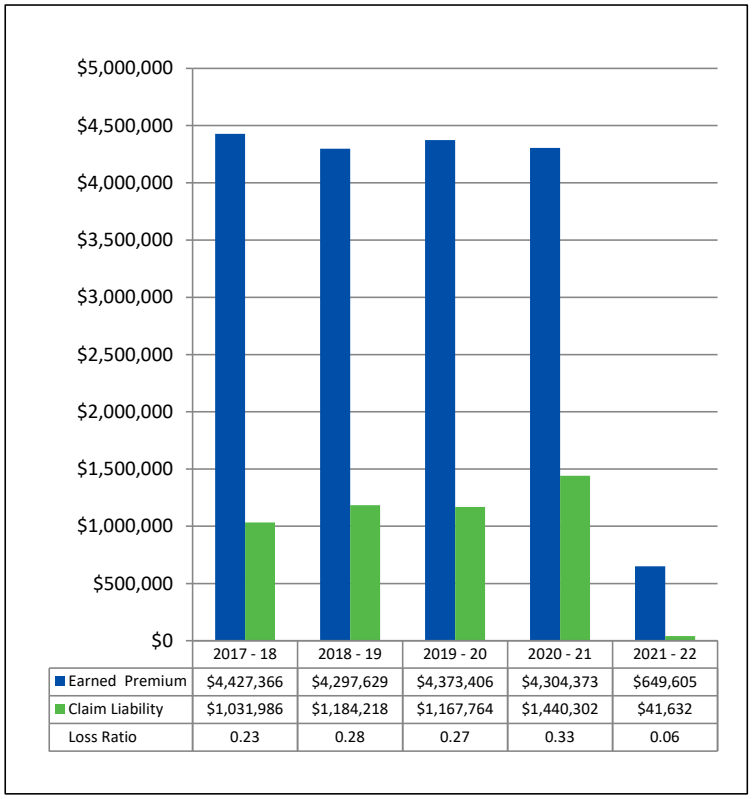


	Heart/ Circ	Cancer	Resp	Mental	Accident
Nevada PEBP	37.6%	20.0%	14.1%	7.1%	6.4%
Public Admin	29.7%	28.1%	9.1%	3.3%	7.3%

Basic Life Insurance Earned Premiums & Liability by Participant Type

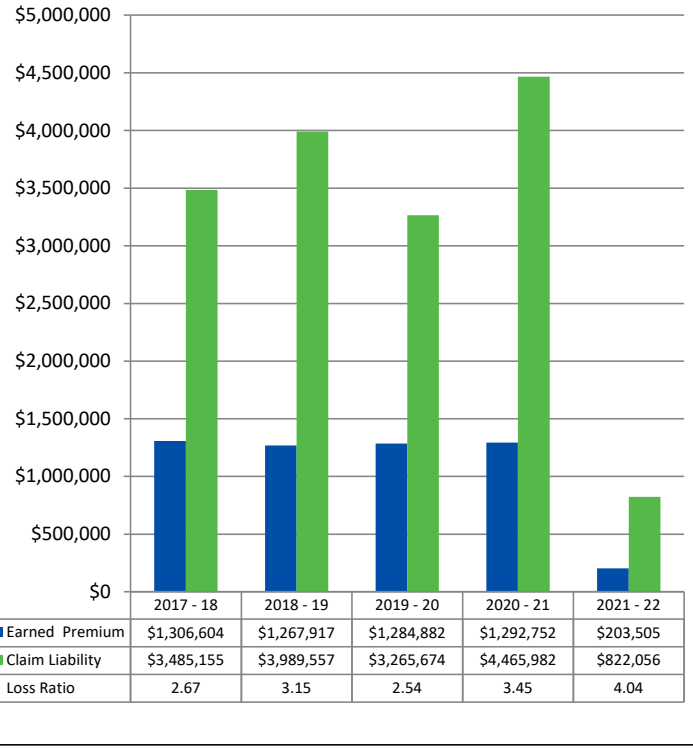
Most Recent Five Plan Years: July 01, 2017 to September 30, 2021

Active Participants



	2017 - 18	2018 - 19	2019 - 20	2020 - 21	2021 - 22
Earned Premium	$4,427,366	$4,297,629	$4,373,406	$4,304,373	$649,605
Claim Liability	$1,031,986	$1,184,218	$1,167,764	$1,440,302	$41,632
Loss Ratio	0.23	0.28	0.27	0.33	0.06

Retired Participants

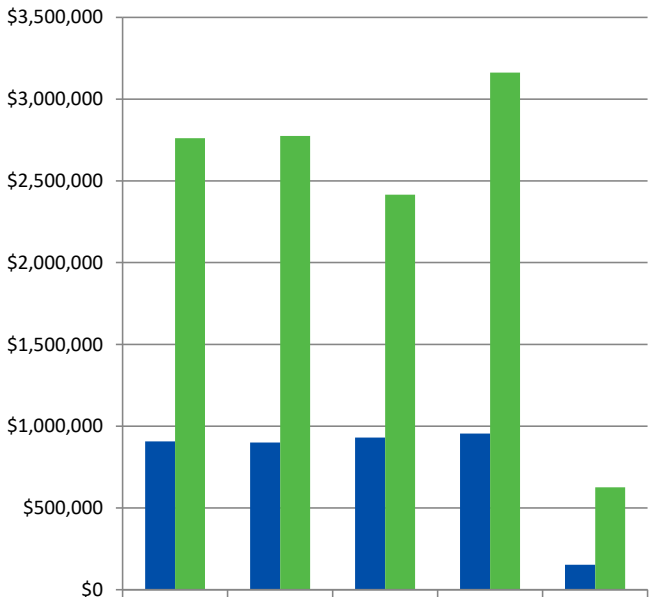


	2017 - 18	2018 - 19	2019 - 20	2020 - 21	2021 - 22
Earned Premium	$1,306,604	$1,267,917	$1,284,882	$1,292,752	$203,505
Claim Liability	$3,485,155	$3,989,557	$3,265,674	$4,465,982	$822,056
Loss Ratio	2.67	3.15	2.54	3.45	4.04

Basic Life Retiree Insurance Earned Premiums & Liability by Participant Type

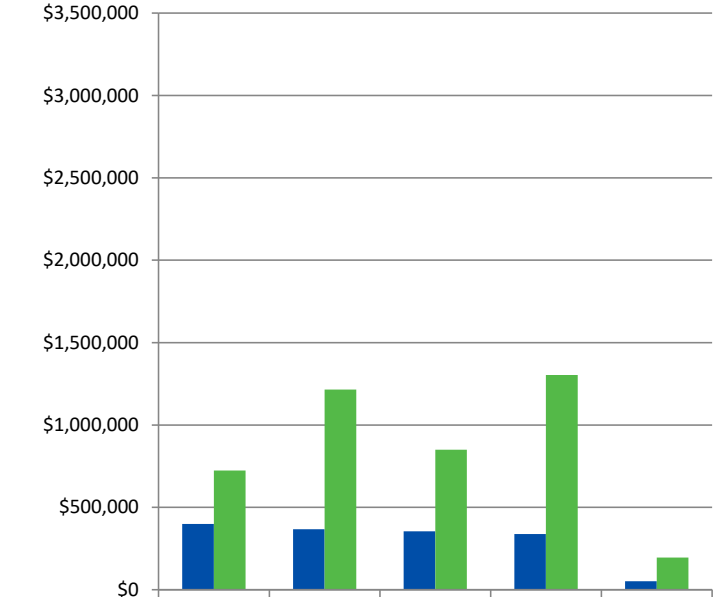
Most Recent Five Plan Years: July 01, 2017 to September 30, 2021

State Retired Participants



	2017 - 18	2018 - 19	2019 - 20	2020 - 21	2021 - 22
Earned Premium	$907,326	$900,218	$930,348	$954,967	$152,417
Claim Liability	$2,761,244	$2,774,315	$2,415,621	$3,162,080	$626,482
Loss Ratio	3.04	3.08	2.60	3.31	4.11

Non-State Retired Participants



	2017 - 18	2018 - 19	2019 - 20	2020 - 21	2021 - 22
Earned Premium	$399,278	$367,699	$354,534	$337,785	$51,088
Claim Liability	$723,911	$1,215,242	$850,053	$1,303,902	$195,574
Loss Ratio	1.81	3.30	2.40	3.86	3.83

Claim Appeals

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

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

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 September 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 Insurance

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

Nevada Public Employees Benefit Program

Quarterly Update – 1st Quarter Plan Year 2022

Willis Towers Watson's Individual Marketplace

October 26, 2021

The Public Employees Benefit Program Executive Dashboard

Quarterly Update – 1st Quarter Plan Year 2022

Executive Summary

Plan Enrollment:

- At the end of Q1 2022, PEBP's total enrollment into Medicare policies through Willis Towers Watson's Individual Marketplace increased to 12,023. Since inception, 111 carriers have been selected by PEBP's retirees with current enrollment in 1,569 different plans.
- Medicare Supplement (MS) plan selection remained consistent at 85% of the total population with the majority of participants selecting AARP and Anthem BCBS of Nevada as their insurer; each carrier holds plans for 6,323 and 2,196 enrollees respectively. The average monthly premium cost for MS plans remained consistent at $146.
- The percentage of Medicare Advantage (MA or MAPD) plans selected remained consistent at 15%. Top MA carriers include Hometown Health Plan with 707 individual plan selections and Aetna with 445 individual plan selections. The average monthly premium cost to PEBP participants decreased to $14 compared to the prior quarter.

Customer Satisfaction:

- In Q1 2022, PEBP participant satisfaction with Enrollment Calls had an average satisfaction score result of 4.7 out of 5.0 based on 22 surveys returned.
- For Q1 2022, the average satisfaction score for Service Calls was 4.5 out of 5.0 based on 317 surveys returned.
- The combined average satisfaction score for Enrollment Calls and Service Calls was 4.5 out of 5.0 for Q1 2022.

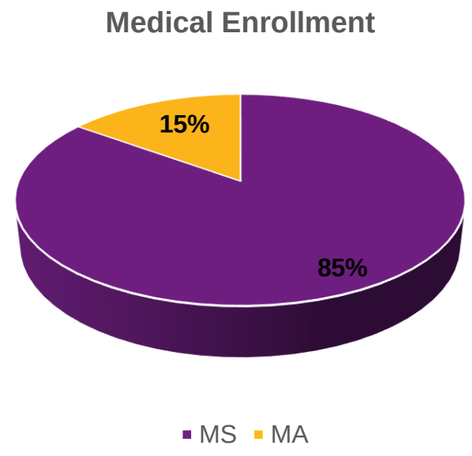
Health Reimbursement Arrangement:

- At the end of Q1 2022 there were 13,462 Health Reimbursement Arrangement (HRA) accounts for PEBP participants.
- There were 83,085 claims processed in Q1, with 96% being submitted via Auto-Reimbursement, meaning that participants did not have to manually submit 79,685 claims for Premium Reimbursement.
- The total reimbursement amount processed for Q1 was $8,124,833.

Summary of Retiree Decisions and Costs

Retiree Plan Selection Through 9/30/2021		Previous Qtr.
Total enrolled through individual marketplace	12,023	11,881
Number of carriers**	111	110
Number of plans**	1,569	1,543

Plan Type Selection Through 9/30/2021		Previous Qtr.
Medicare Advantage (MA, MAPD)	1,805	1,698
Medicare Supplement (MS)	10,226	10,191



"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	10,226	$146
Medicare Advantage (MA,MAPD)	1,805	$0 / $14
Part D drug coverage	7,518	$24
Dental coverage	1,075	$37
Vision coverage	2,040	$11

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

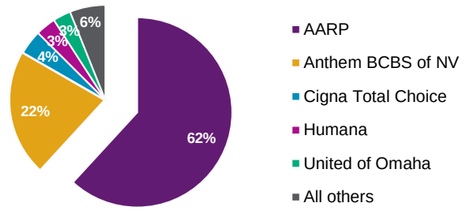
The Public Employees Benefit Program Executive Dashboard

Quarterly Update – 1st Quarter Plan Year 2022

Summary of Retiree Carrier Choice

Top Medicare Supplement Plans	Total
AARP	6,323
Anthem BCBS of NV	2,196
Cigna Total Choice	425
Humana	351
United of Omaha	311

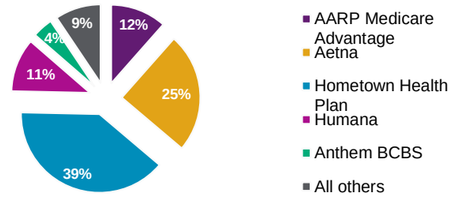
Medicare Supplement Carrier Choice



Cost Data For MS Plans	Cost
Minimum	$22
Average	$146
Median	$140
Maximum	$481

Top Medicare Advantage Plans	Total
AARP Medicare Advantage	208
Aetna	445
Hometown Health Plan	707
Humana	199
Anthem BCBS	76

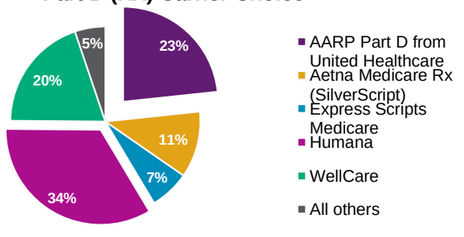
Medicare Advantage Carrier Choice



Cost Data For MA Plans	Cost
Minimum	$0
Average	$14
Median	$0
Maximum	$194

Top Medicare Part D (RX)	Total
AARP Part D from United Healthcare	1,753
Aetna Medicare Rx (SilverScript)	851
Express Scripts Medicare	510
Humana	2,535
WellCare	1,479

Part D (RX) Carrier Choice



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

The Public Employees Benefit Program Executive Dashboard

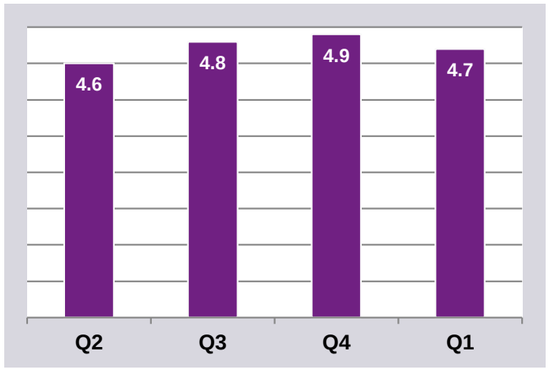
Quarterly Update – 1st Quarter Plan Year 2022

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

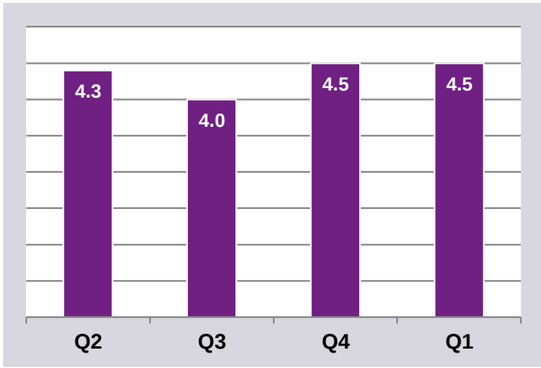
Q1 Enrollment Satisfaction

CSAT score	Count	%
5	16	73%
4	5	23%
3	1	5%
2	0	0%
1	0	0%
	22	**100%**



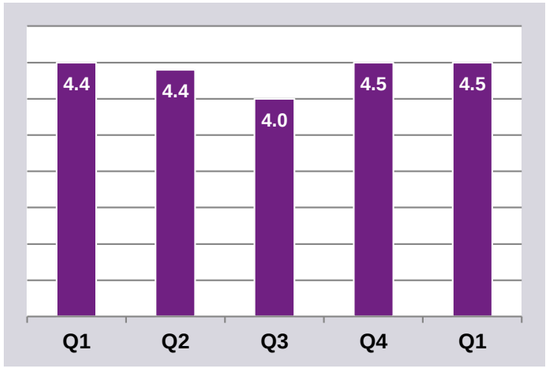
Q1 Service Satisfaction

CSAT score	Count	%
5	227	72%
4	46	15%
3	26	8%
2	5	2%
1	13	4%
	317	**100%**



Q1 Enrollment & Service Combined

CSAT score	Count	%
5	243	72%
4	51	15%
3	27	8%
2	5	1%
1	13	4%
	339	**100%**

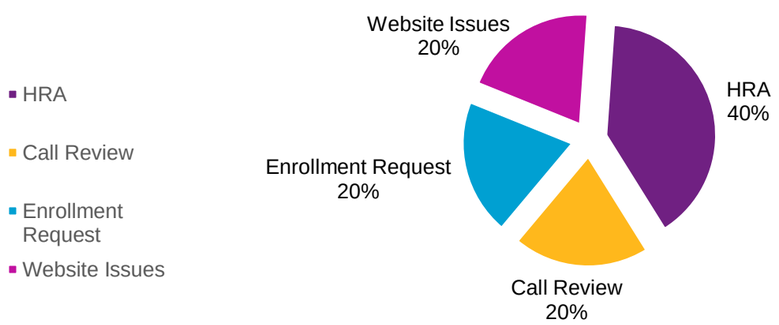


The Public Employees Benefit Program Executive Dashboard

Quarterly Update – 1st Quarter Plan Year 2022

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 Q1-PY22 is 5 and are associated with the following categories:



Health Reimbursement Account (HRA)

Claim Activity for the Qtr.	Total
HRA accounts	13,462
Number of payments	53,588
Accounts with no balance	7,315
Claims paid amount	$8,124,833

Claims By Source	Total 83,085
A/R file	79,685
Mail	1,435
Web	1,525
Mobile App	440

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

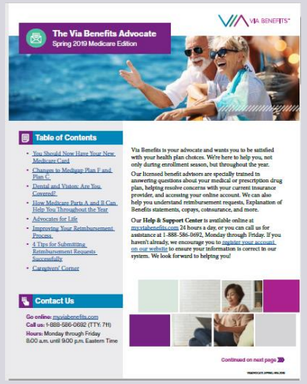
Quarterly Update – 3rd Quarter Plan Year 2021

Operations Report

Communications:

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

- Fall Balance Reminder
  - This communication was 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 was sent in September.
- Fall Newsletter
  - This communication was sent to 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 is from October 15 – December 7. This newsletter was sent from mid-September – mid-October.



2022 Medicare Open Enrollment Period (OEP):

Medicare Open Enrollment began on October 15 and runs though December 7. Retirees looking to make changes to their Medicare Advantage or Rx plans are encourages to utilized the Website to help minimize wait times to our call center during the busiest time of year. Participants can utilize our Shop and Compare tool to review plan options and prices for 95% of the plans on Via Benefits by going to https://my.viabenefits.com/PEBP.

Fall Retiree Meetings:

We held two days of virtual retiree meetings on October 19 and 20. Each day had two meetings with the first focusing on participants ageing into Medicare and the second focusing on those that are already Medicare eligible with discussions about the 2022 Medicare Open Enrollment period and how to utilize the HRA. Below is information related to the number of attendees per meeting. Recordings of the presentations from October 20 have been posted to the Via Benefits website for PEBP at https://my.viabenefits.com/PEBP.

Date – Meeting Type	Attendees
10/19 – Ageing Into Medicare Focused	176
10/19 – OEP and HRA focused	61
10/20 – Ageing Into Medicare Focused	106
10/20 – OEP and HRA focused	49

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 September 30, 2021:

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4.3.3 American Health Holdings – Utilization and Large Case Management

4.3.4 The Standard Insurance – Basic Life Insurance

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

4.3.6 AETNA Signature Administrators – PPO Network

ASA Performance Guarantee Summary

PEBP CYQ3 2021

	Frequency	Standard	CYQ3
Reporting by Aetna			
Repricing Accuracy	Quarterly	97%	
Timely EDI Claims Repricing within 3 Days	Quarterly	97%	99%
Timely EDI Claims Repricing within 5 Days	Quarterly	99%	100%

4.3.7

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        4.3.4 The Standard Insurance – Basic Life 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**)

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4.3.2 HealthSCOPE Benefits – Diabetes Care Management

4.3.3 American Health Holdings – Utilization and Large Case Management

4.3.4 The Standard Insurance – Basic Life 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 November 2021

State of Nevada
2021-11 Engagement Report

dr. on demand by Included Health

Engagement Summary

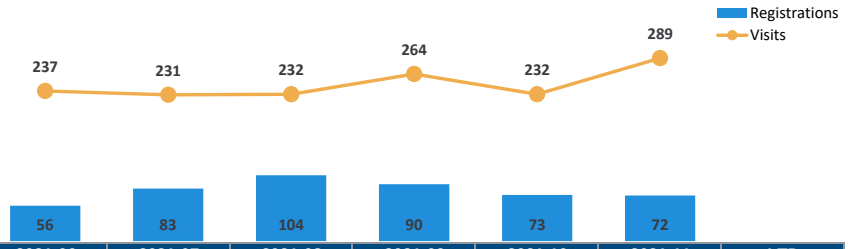
	As % Of Total Population: 0		
Engagement Metric	**2021-11**	**YTD Annualized**	**LTD**
% Registered	-	-	-
% Unique Engagement (Visitors / Lives)	-	-	-
% Overall Engagement (Visits / Lives)	-	-	-

Year To Date Activity

Registration Summary	YTD
# Registered	840

Visit Summary	YTD
# Unique Visitors	1,398
# Visits	2,718

Monthly Activity Last Six Months



Registration Summary	Prior	2021-06	2021-07	2021-08	2021-09	2021-10	2021-11	LTD
# Registered	9,550	56	83	104	90	73	72	10,028

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

Visit Summary		Prior	2021-06	2021-07	2021-08	2021-09	2021-10	2021-11	LTD
# Unique Visitors		3,865	198	197	196	196	187	231	4,239
# Visits		9,575	237	231	232	264	232	289	11,060
Visit Frequency	% 1 Visit	53.1%	86.4%	85.3%	84.2%	78.1%	84.0%	83.1%	51.4%
	% 2 Visits	19.1%	8.6%	12.7%	14.3%	13.8%	10.2%	10.8%	19.0%
	% 3+ Visits	27.8%	5.1%	2.0%	1.5%	8.2%	5.9%	6.1%	29.6%

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.

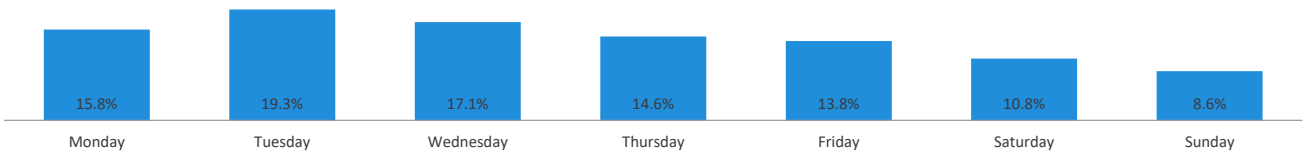
Visit Type Summary		Prior	2021-06	2021-07	2021-08	2021-09	2021-10	2021-11	LTD
Medical		7,617	174	182	190	190	179	246	8,778
Mental Health	Therapy	1,011	32	27	22	49	36	29	1,206
	Psychiatry	947	31	22	20	25	17	14	1,076

Benefit Summary	Prior	2021-06	2021-07	2021-08	2021-09	2021-10	2021-11	LTD
# Visits With Benefit Applied	9,327	230	225	228	260	227	283	10,780
# Visits Without Benefit Applied	248	7	6	4	4	5	6	280

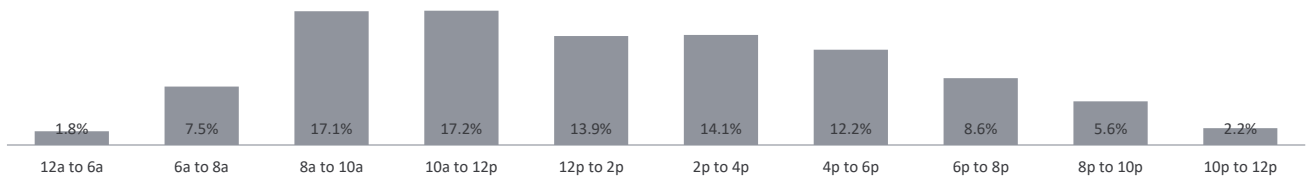
Note: Benefit not applied on visits by ineligible members, visits by members not properly associated to organization / insurance, or on visits where a discount has been applied

Six Month Trends: Visit Time And Demographics

Day Of Week



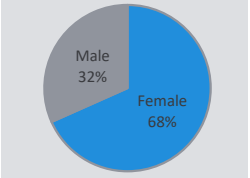
Hour Of Day



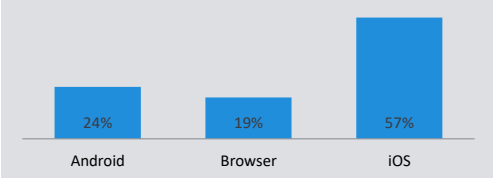
Patient Age

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

Patient Gender



Visitor App Type



State of Nevada
2021-11 Engagement Report

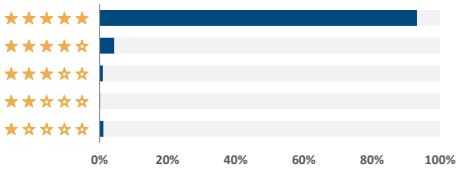
dr. on demand by Included Health

Historical Visit Experience

7,830 Visit Ratings (1-5 Stars):

Average: **4.9**

Stars:



Avg Connection Time (On Demand Visits Only): **9.4 Minutes**

Historical Post Visit Survey Results

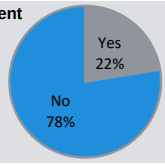
Without Doctor On Demand, where would you have gone to get this issue treated?

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

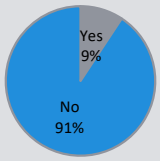
Response	# Responses	% Responses
Emergency Room	154	4%
Urgent Care	2,088	49%
Doctor's Office	1,160	27%
Stayed Home	608	14%
Other	230	5%

Six Month Trends: Visit Initiation

Initiated By Appointment (Medical Visits Only)

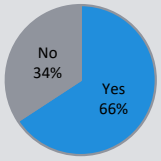


Initiated By Custodian

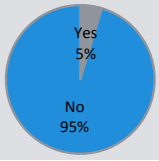


Six Month Trends: Visit Result

Resulted In Rx



Resulted In Lab Order



Historical Top 15 Symptoms

Symptom	# Symptoms	% of All Sym
General Symptoms: Fatigue / weakness	2,326	6%
Head / Neck: Headache	2,281	6%
Chest: Cough	2,218	6%
Head / Neck: Sore throat	2,019	5%
General Symptoms: Difficulty sleeping	1,951	5%
Head / Neck: Congestion / sinus problem	1,677	4%
Head / Neck: Nasal discharge	1,586	4%
General Symptoms: Fever	1,201	3%
General Symptoms: Loss of appetite	1,088	3%
Genitourinary: Discomfort / burning with urination	1,070	3%
Genitourinary: Frequent urination	1,052	3%
Head / Neck: Congestion/sinus problem	989	3%
Head / Neck: Ear pain	712	2%
Skin: Skin rashes / bumps	693	2%
Chest: Shortness of breath	690	2%

Historical Top 15 ICD10 Codes

ICD10 Code And Description	# ICD10s	% of All ICD10
N390 - Urinary tract infection, site not specified	1,006	8%
J0190 - Acute sinusitis, unspecified	658	5%
J069 - Acute upper respiratory infection, unspecified	604	5%
F411 - Generalized anxiety disorder	413	3%
J029 - Acute pharyngitis, unspecified	387	3%
Z760 - Encounter for issue of repeat prescription	339	3%
R05 - Cough	337	3%
F4323 - Adjustment disorder with mixed anxiety and depressed mo	270	2%
J209 - Acute bronchitis, unspecified	264	2%
F419 - Anxiety disorder, unspecified	260	2%
J0180 - Other acute sinusitis	201	2%
F331 - Major depressive disorder, recurrent, moderate	189	1%
F339 - Major depressive disorder, recurrent, unspecified	169	1%
Z630 - Problems in relationship with spouse or partner	152	1%
F341 - Dysthymic disorder	144	1%

Historical Top 15 Rx

Rx Name	# Rx	% of All Rx
nitrofurantoin	722	7%
predniSONE	699	6%
benzonatate	678	6%
amoxicillin-clavulanate	664	6%
albuterol	639	6%
fluconazole	288	3%
fluticasone nasal	280	3%
sulfamethoxazole-trimethoprim	276	3%
FLUoxetine	247	2%
azithromycin	242	2%
methylPREDNISolone	239	2%
amoxicillin	231	2%
doxycycline	223	2%
sertraline	214	2%
escitalopram	209	2%

Historical Top 15 Lab Orders

Lab Name	# Lab Orders	% of All Orders
TSH with Reflex to Free T4	115	9%
Comprehensive Metabolic Panel	112	9%
Urinalysis, Complete with Reflex	91	7%
CBC+diff	88	7%
Lipid Panel	80	7%
Urine Culture, Routine	77	6%
Hemoglobin A1c	73	6%
Vitamin D	57	5%
Chlamydia/GC, Urine	42	3%
Urinalysis, Complete	42	3%
B12/Folate	31	3%
Basic Metabolic Panel	26	2%
RPR w/ Reflex	21	2%
Stool O&P	19	2%
Stool Culture	18	2%

4.4

4.4 Acceptance of the annual PEBP Appeals and Complaints Summary for submission to the Nevada Division of Insurance.

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 FREED
Board Chair

LAURA RICH
Executive Officer

January 27, 2022

Richard Whitley, MS
Director of DHHS
Office of Consumer Health Assistance
555 E. Washington Avenue, Suite 4800
Las Vegas, NV 89101

Re: Public Employees' Benefits Program (PEBP) Appeals and Complaints Summary Report Calendar Year 2021

Dear Mr. Whitley:

In accordance with NRS 695G.310, PEBP presents to the Office of Consumer Health Assistance its annual Appeals and Complaints Summary Report for Calendar Year 2021. As required by NRS, the name of the employee(s) responsible for appeals and descriptions of notification procedures and explanation of rights are listed below, followed by a narrative summary of the attached appeals and complaints log. A graph showing the number of appeals and complaints received in Calendar Years 2013 through 2021 has been included for historical comparison.

Per NRS 695G.200, the name and title of the employee authorized for resolving complaints:

Tim Lindley, Quality Control Officer, PEBP
Gina Reynolds, Quality Control Analyst, PEBP

NRS 695G.200, a description of the system for resolving appeals and to notify an insured of the decision regarding their appeal:

PEBP is contracted with HealthSCOPE Benefits (HSB) located in Little Rock, Arkansas, to provide third-party administration services for the Consumer Driven Health Plan (CDHP), Low Deductible PPO (LD), and the Exclusive Provider Organization (EPO). As PEBP's claims administrator, HSB receives claims from physicians, dentists, laboratories, and other providers. HSB reviews the claims and processes them in accordance with provisions located in the applicable plan year PEBP Master Plan Document. Included at the bottom of every explanation of benefits (EOB) notice sent by HSB to participants is a statement that reads:

"If you have any questions about this explanation of benefits, please call Customer Service at the toll-free number on your ID card or send a written request to the following address:

HealthSCOPE Benefits
Attn: Claim Inquiry,
PO Box 2860
Little Rock, AR 72203.

You may also contact us to request free of charge a copy of any rules, guidelines, protocols, or the scientific or clinical basis used in making the decision on the processing of your claim.

If you are not satisfied with this decision, either you or your authorized representative can start the appeal process by sending a written request to:

My Health Plan
c/o HealthSCOPE Benefits, Inc.,
PO Box 2860
Little Rock, AR 72203

Or as otherwise set out in your benefit plan blook within 180 days of receipt of this explanation of benefits (unless a longer term is permitted by your plan). Please note that if you choose to designate an authorized representative, you must make this designation to us in writing.

Please follow the steps below to make sure that your appeal is processed in a timely manner.

- Send a copy of this explanation of benefits along with any relevant additional information (e.g., benefit documents, medical records) that helps to determine if your claim is covered under the plan. Contact Customer Service if you need help or have further questions.
- Be sure to include: 1) Your name, 2) Account number from the front of this form, 3) ID number from the front of this form, 4) Name of the patient and relationship, and 5) "Attention: Appeals Unit" on all supporting documents.
- Contact Customer Service at the number on the front of this form to request access to and copies of all documents, records, and other information about your claim, free of charge. You have the right to billing and diagnosis codes as well.
- If your situation is urgent, you may request an expedited appeal which will generally be conducted within 72 hours. If you believe that your situation is urgent, follow the instructions above for filing an internal appeal and call Customer Service to request a simultaneous external review if permitted by your plan.
- You will be notified of the decision in a timely manner, as described in your plan materials.

This is the first step available to every participant in the three-level claims appeal process afforded by the PEBP CDHP, LD, or EPO plan. All participants have the right to file a Level 1 Appeal for adverse benefit determinations. The written request for appeal is mailed to the HealthSCOPE Benefits address listed on the EOB. HealthSCOPE's decision on the Level 1 Appeal is mailed to the PEBP participant in writing. If HealthSCOPE approves the appeal, they reprocess the related claim(s). If HealthSCOPE Benefits denies the Level 1 Appeal, the denial letter to the participant includes instructions on how to proceed to a Level 2 Appeal, if the participant deems necessary. Level 2 Appeals are adjudicated by PEBP, and decisions on approval or denial are sent to participants in writing. If the Level 2 Appeal is denied, the denial letter to the participant may include instructions on how to proceed to an External Review. External Reviews are managed by the Nevada Office of Consumer Health Assistance (OCHA).

The claim appeal process that PEBP describes in its Master Plan Document is in compliance with the requirements established by the Patient Protection and Affordable Care Act of 2010 (PPACA) and the Nevada Insurance Statutes in NRS 695G. Forms for completing the various levels of review are available by logging in to the E-PEBP Portal at www.pebp.state.nv.us or by calling the PEBP office.

Summary Narrative

The PEBP Quality Control Appeals and Complaints Summary Report lists 10 external reviews, 36 appeals and 63 complaints received in Calendar Year 2021, categorized by vendor or program, then by type. This compares to 10 external reviews, 16 appeals and 72 complaints received in 2020.

When compared to 2020, the 2021 Appeals and Complaints have increased overall. The number of external reviews remained the same, a decrease in complaints; however, there was an increase in appeals. The increase in appeals can be attributed to reviews of Out-of-Network claims, reviews of medical necessity, and experimental and investigatory medical procedures / equipment. Willis Towers Watson's VIA Benefits experienced a minor decrease in complaints with 11 in 2021 compared to 16 in 2020, with most complaints relating to customer service during Medicare Open Enrollment. This was attributed to staff shortages caused by COVID and other employment hurdles experience nationwide. Express Scripts (ESI) experienced no change in complaints with 18 in 2021 compared to 18 in 2020. The majority of ESI complaints centered on price of prescriptions and deductible questions. With a new network starting mid-year, AETNA experienced 7 complaints centered on members unable to find In-Network Providers. Corestream, who has been administering the voluntary benefits for PEBP members beginning in July of 2019 has been effective in assisting PEBP participants and only incurred 1 formal complaints for their second full calendar year. The percentage of complaints for PEBP, Healthscope Benefits, the statewide PPO network, Diversified Dental, Health Plan of Nevada, and Standard Insurance experienced a significant drop in 2021, from 33 overall complaints in 2020 down to 21 for 2021.

Sincerely,

Tim Lindley

Quality Control Officer
Public Employees' Benefits Program
775-684-7000
tlindley@peb.nv.gov

STEVE SISOLAK
Governor

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LAURA FREED
Board Chair

LAURA RICH
Executive Officer

January 27, 2022

Barbara Richardson, Insurance Commissioner
Nevada Division of Insurance
1818 E. College Parkway, Suite 103
Carson City, NV 89706

Re: Public Employees' Benefits Program (PEBP) Appeals and Complaints Summary Report for Calendar Year 2021.

Dear Commissioner Richardson:

In accordance with NAC 287.750, PEBP presents to the Nevada Division of Insurance its annual Appeals and Complaints Summary Report for Calendar Year 2021. As required by code, the name of the employee(s) responsible for appeals and descriptions of notification procedures and explanation of rights are listed below, followed by a narrative summary of the attached appeals and complaints log. A graph showing the number of appeals and complaints received in Calendar Years 2013 through 2021 has been included for historical comparison.

NAC 287.750(1)(a), "name and title of the employee responsible for the system for resolving complaints":

> Tim Lindley, Quality Control Officer, PEBP
> Gina Reynolds, Quality Control Analyst, PEBP

NAC 287.750(1)(b), a "description of the procedure used to notify an insured of the decision regarding his or her complaint":

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Sincerely,

Tim Lindley
Quality Control Officer
Public Employees' Benefits Program
775-684-7000
tlindley@peb.nv.gov

2nd Level Appeals - Medical/Dental

	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	YTD Total	% of Total
EPO-Medical Claim Denial				1	1		1	2		2		2	9	25.0%
LD-Medical Claim Denial												1	1	2.8%
CDHP-Medical Claim Denial	1		5		1	1	2	1	3	1	3	3	21	58.3%
Dental Claim Denial													0	0.0%
VIA HRA Appeals	1			1	1	2							5	13.9%
Total	2	0	5	2	3	3	3	3	3	3	3	6	36	33.0%

2nd Level Appeals - Medical/Dental Summary

Complaint Categories	Description
EPO-Medical Claim Denial	Level 2 Appeals related to the denial of medical benefits to EPO members. Examples include use of Out-of-Network facilities.
LD-Medical Claim Denial	Level 2 Appeals related to the denial of medical benefits to LD members. Examples include a review of medical necessity.
CDHP-Medical Claim Denial	Level 2 Appeals related to the denial of medical benefits to CDHP members. Examples include the use of Out-of-Network services and balance billing.
Dental Claim Denial	No dental claim appeals were received.
VIA HRA Appeals	Appeals related to member requests for reconsideration of HRA reimbursement.

External Review Appeals

	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	YTD Total	% of Total
CDHP Overturned					2								2	20.0%
CDHP Upheld		1				1				1			3	30.0%
LD Overturned													0	0.0%
LD Upheld													0	0.0%
EPO Overturned		1			1								2	20.0%
EPO Upheld													0	0.0%
Dental Overturned													0	0.0%
Dental Upheld													0	0.0%
AHH Overturned							2				1		3	30.0%
AHH Upheld													0	0.0%
Total	0	2	0	0	3	1	2	0	0	1	1	0	10	9.2%

External Review Appeals Summary

Complaint Categories	Description
CDHP Overturned	External Review of HSB CDHP Medical Claim Denial determination overturned. Examples include review medical necessity.
CDHP Upheld	External Review of HSB CDHP Medical Claim Denial determination upheld. Examples include review of experimental treatments.
LD Overturned	No External Reviews were received.
LD Upheld	No External Reviews were received.
EPO Overturned	External Review of HSB EPO Medical Claim Denial determination overturned. Examples include review of medical necessity.
EPO Upheld	No External Reviews were received.
Dental Overturned	No External Reviews were received.
Dental Upheld	No External Reviews were received.
AHH Overturned	External Review of American Health Holding coverage determination. Overturned for medically necessity.
AHH Upheld	No External Reviews were received.

Complaints- HealthSCOPE Benefits

	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	YTD Total	% of Total
HSB-CDHP/LD Customer Service						1							1	16.7%
HSB-EPO Customer Service				1					1	1			3	50.0%
HSB-CDHP/LD Medical Claim Denial							1		1				2	33.3%
HSB-EPO Medical Claim Denial													0	0.0%
HSB-CDHP/LD Plan Design													0	0.0%
HSB-EPO Plan Design													0	0.0%
HSB-Provider Access Network													0	0.0%
HSB-Dental Claim Denial													0	0.0%
HSB-Dental Customer Service													0	0.0%
HSB-CDHP HSA/HRA/FSA													0	0.0%
Total	0	0	0	1	0	1	1	0	2	1	0	0	6	5.5%

Complaints- HealthSCOPE Benefits Summary

Complaint Categories	Description
HSB-EPO/CDHP/LD Customer Service	Complaints related to HSB customer service for EPO and CDHP members.
HSB-EPO/CDHP/LD Medical Claim Denial	Complaints related to HSB medical claim denials for EPO and CDHP members. Examples include provider billing OON on labwork previously covered, OON facilities, and medical claim denial.
HSB-EPO/CDHP/LD Plan Design	Complaints related to HSB Plan Design. No examples available.
HSB-EPO/CDHP/LD Provider Access Network	Complaint related to HSB Provider Access Network. No examples available.
HSB-Dental Claim Denial	Complaints related to HSB Dental Claim Denial. No examples available.
HSB-Dental Customer Service	Complaints related to HSB Dental Customer Service. No examples available.
HSB-CDHP HSA/HRA/FSA	Complaints related t HSB-CDHP HSA/HRS/FSA. No examples available.

Complaints - Healthcare Bluebook

	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	YTD Total	% of Total
HCBB													0	0.0%
Total	0	0	0	0	0	0	0	0	0	0	0	0	0	0.0%

Complaints - Healthcare Bluebook Summary

Complaint Categories	Description
HCBB	None

Complaints - Hometown Health UM/CM

	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	YTD Total	% of Total
HTH-Customer Service													0	0.0%
HTH-UM/Pre-Cert													0	0.0%
Total	0	0	0	0	0	0	0	0	0	0	0	0	0	0.0%

Complaints - Hometown Health UM/CM Summary

Complaint Categories	Description
HTH-Customer Service	Complaints related to Hometown Health customer service. Examples not available.
HTH-UM/Pre-Cert	Complaints related to Hometown Health UM/Pre-Cert. Examples not available.

Complaints - Health Plan of Nevada HMO

	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	YTD Total	% of Total
HPN-Customer Service													0	0.0%
HPN-Plan Design													0	0.0%
HPN-Prescriptions													0	0.0%
HPN-Network Providers													0	0.0%
Total	0	0	0	0	0	0	0	0	0	0	0	0	0	0.0%

Complaints - Health Plan of Nevada HMO Summary

Complaint Categories	Description
HPN-Customer Service	Complaints relating to HPN customer service. Examples not available.
HPN-Plan Design	Complaints relating to HPN Plan Design. Examples not available.
HPN-Prescriptions	Complaints relating to HPN Prescriptions. Examples not available.
HPN-Network Providers	Complaints relating to HPN contracted network providers. Examples not available.

Complaints - Diversified Dental

	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	YTD Total	% of Total
DD-Customer Service													0	0.0%
DD-Network Providers													0	0.0%
DD-Plan Design													0	0.0%
Total	0	0	0	0	0	0	0	0	0	0	0	0	0	0.0%

Complaints - Diversified Dental Summary

Complaint Categories	Description
DD-Customer Service	Complaints relating to DD customer service. Examples not available.
DD-Network Providers	Complaints relating to specific DD providers. Examples include billing issues and quality of care.
DD-Plan Design	Complaints relating to DD Plan requirements. Examples not available.

Complaints - Express Scripts

	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	YTD Total	% of Total
ESI-Plan Design				1									1	5.6%
ESI-Customer Service	2	1			1								4	22.2%
ESI-CDHP RX Prior Auth	1			1									2	11.1%
ESI-EPO RX Prior Auth							1						1	5.6%
ESI-CDHP RX Price	1	1	1		1		1	1	1				7	38.9%
ESI-EPO RX Price													0	0.0%
ESI-LD PPO RX Price							1	2					3	
ESI- LD PPO Price														
Total	4	2	1	2	2	0	3	3	1	0	0	0	18	16.5%

Complaints - Express Scripts Summary

Complaint Categories	Description
ESI-EPO/CDHP Plan Design	ESI Plan Design complaints relate to complaints pertaining directly to Plan requirements such as Medicare primary payer guidelines value programs and billing processes.
ESI-Customer Service	Complaints that arise when members are unable to achieve a resolution through contact with ESI customer service directly. Examples include unauthorized charges, copay assistance issues, confusion on Plan rules, and delivery of temperature controlled medication.
ESI-EPO/CDHP Prior Authorization	Complaints that occur due to expiration of prior authorizations causing a delay or denial of refill. In all cases the prior authorization expires, and the member is unable to achieve a resolution through ESI customer service. The issues usually arise due to difficulty reaching providers to obtain the necessary information to approve the medication as well as members having difficulty understand the requirements / process.
ESI-EPO/CDHP RX Price	Complaints relating to the cost of a medication directly. Examples include issues with copay assistance, accumulators billing for specialty medication.

Complaints - Aetna Network

	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	YTD Total	% of Total
Aetna-Customer Service													0	0.0%
Aetna-Network Providers					2			1	2	2			7	100.0%
Total					2			1	2	2			7	6.4%

Complaints - Aetna Network Summary

Complaint Categories	Description
Aetna-Customer Service	Complaints relating to Aetna customer service. Examples not available.
Aetna-Network Providers	Complaints relating to Aetna customer service. Examples include difficulty find Home Health Care Providers in rural areas.

Complaints - PEBP

	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	YTD Total	% of Total
PEBP-Customer Service													0	0.0%
PEBP-Plan Design		1	1		2	1		3	1			1	10	100.0%
PEBP-Eligibility													0	0.0%
Total	0	1	1	0	2	1	0	3	1	0	0	1	10	9.2%

Complaints - PEBP Summary

Complaint Categories	Description
PEBP-Customer Service	Complaints relating to PEBP customer service. Examples not available.
PEBP-Plan Design	Complaints relating to PEBP Plan Design. Examples include Medicare primary plan rules, subrogation requests and network changes.
PEBP-Eligibility	Complaints relating to PEBP eligibility. Examples not available.

Complaints - SHO/HTH EPO/PPO Network

	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	YTD Total	% of Total
HTH-Network Providers		3		1				1					5	100.0%
SHO -Network Providers													0	0.0%
Total	0	3	0	1	0	0	0	1	0	0	0	0	5	4.6%

Complaints - SHO/HTH EPO/PPO Network Summary

Complaint Categories	Description
HTH-Network Providers	Complaints relating to specific providers within the HTH network. Examples include difficulty obtaining DME supplies.
SHO -Network Providers	Complaints relating to specific providers within the SHO network. Examples include customer service issues.

Complaints - Standard Insurance

	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	YTD Total	% of Total
STD-Customer Service													0	0.0%
STD- Plan Design													0	0.0%
Total	0	0	0	0	0	0	0	0	0	0	0	0	0	0.0%

Complaints - Standard Insurance Summary

Complaint Categories	Description
STD-Customer Service	Complaints relating to Standard customer service. Examples not available.
STD- Plan Design	Complaints relating to Standard Plan design. Examples not available.

Complaints - TW/VIA Benefits

	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	YTD Total	% of Total
VIA-Carrier Issues													0	0.0%
VIA-Customer Service								1	1		7		9	81.8%
VIA-Disenroll/Over-pmt			1										1	9.1%
VIA-Enrollment													0	0.0%
VIA-HRA Funding	1												1	9.1%
Total	1	0	1	0	0	0	0	1	1	0	7	0	11	10.1%

Complaints - TW/VIA Benefits Summary

Complaint Categories	Description
VIA-Carrier Issues	Complaints relating to Via carrier issues. Examples not available.
VIA-Customer Service	Complaints relating to Via customer service. Examples include response time, reimbursement issues and website changes.
VIA-Disenroll/Over-pmt	Complaints relating to Via Disenrollment and Overpayments. Examples include members disenrolling from a plan through Via Benefits resulting the loss of HRA funding and all PEBP Benefits.
VIA-Enrollment	Complaints relating to Via Enrollment. Examples not available.
VIA-HRA Funding	Complaints relating to Via HRA funding. Examples include denials due to failure to provide necessary documentation.

Complaints - American Health Holding UM/CM

	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	YTD Total	% of Total
AHH-Customer Service						3							3	60.0%
AHH-UM/Pre-Cert							1					1	2	40.0%
Total	0	0	0	0	0	3	1	0	0	0	0	1	5	4.6%

Complaints - American Health Holding UM/CM Summary

Complaint Categories	Description
AHH-Customer Service	Complaints relating to AHH customer service. Examples not available.
AHH-UM/Pre-Cert	Complaints relating directly to medical management provided by AHH.

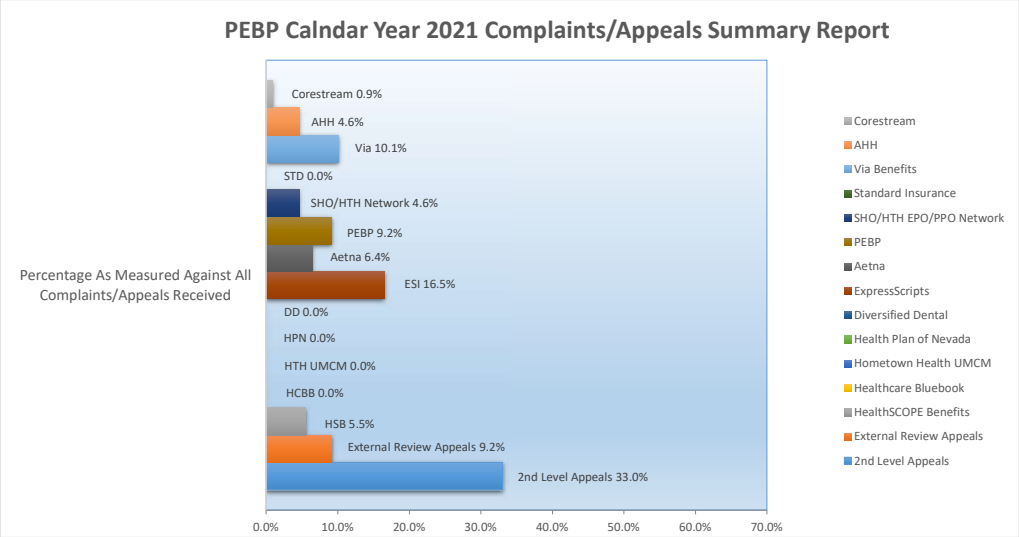
Complaints - Corestream

	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	YTD Total	% of Total
Corestream-Customer Service													0	0.0%
Corestream-Portal Administration													0	0.0%
Corestream-Voluntary Products					1								1	100.0%
Total	0	0	0	0	1	0	0	0	0	0	0	0	1	0.9%

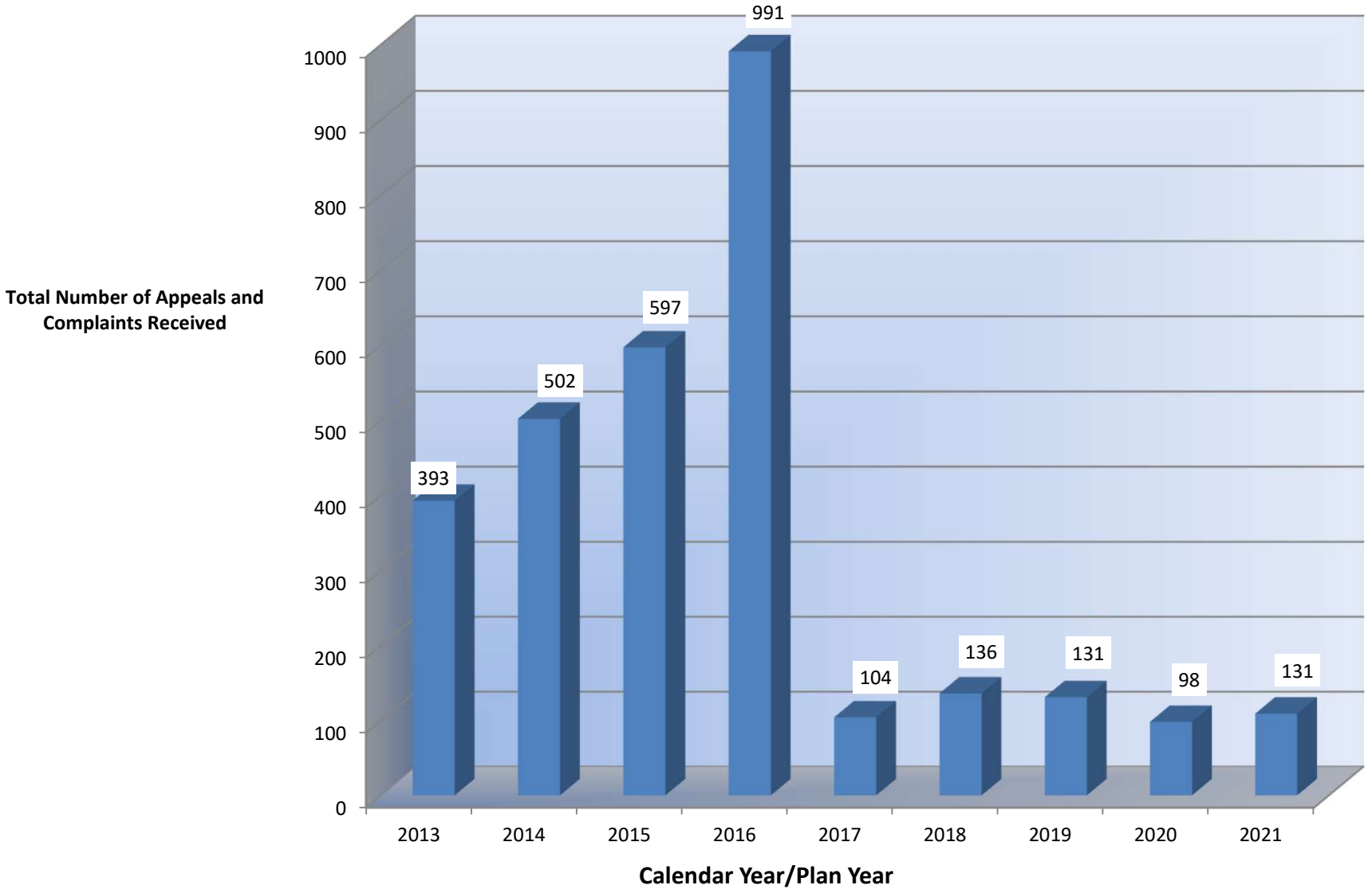
Complaints - Corestream Summary

Complaint Categories	Description
Corestream-Billing Issue	Complaint related to a bill for service not received.

Appeals & Complaints Totals	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	YTD Total
	7	8	8	6	12	9	10	12	10	7	11	8	109



PEBP Complaints and Appeals History Comparison 2013 - 2021



4.5

4.5 Acceptance of Claim Technologies Incorporated audit findings for Health Reimbursement Arrangement administered by Via Benefits from Willis Towers Watson for the timeframe July 1, 2020 – June 30, 2021

Claim Administration Audit

HEALTH REIMBURSEMENT ARRANGEMENT

State of Nevada Public Employees' Benefits Program Health Reimbursement Arrangement Plan
Administered by Via Benefits from Willis Towers Watson

Audit Period: July 1, 2020 through June 30, 2021
Plan Year 2021

Presented to

State of Nevada Public Employees' Benefits Program

November 19, 2021
Revised as of December 17, 2021

CLAIM TECHNOLOGIES INCORPORATED

TABLE OF CONTENTS

EXECUTIVE SUMMARY

This Comprehensive Audit Report is a compilation of the detailed information, findings, and conclusions drawn from Claim Technologies Incorporated's (CTI's) audit of Via Benefits from Willis Towers Watson's (Via Benefits) administration of the State of Nevada Public Employees' Benefits Program (PEBP) Medicare Exchange Health Reimbursement Arrangement (HRA) plan.

Scope

CTI performed an audit of Via Benefits' administration of the PEBP HRA for the period of July 1, 2020 through June 30, 2021 (plan year 2021). The population of claims and amount paid during the audit period was taken from the paid claim file provided by Via Benefits.

Total Paid Amount	$22,779,809.76
Total Number of Claims Paid/Denied/Adjusted	257,365

The audit included the following components which are described in more detail in the following pages.

- Operational Review
- Random Sample Audit
- Eligibility Verification

Auditor's Opinion

Based on these findings, and in our opinion:

1. Via Benefits provided good service to PEBP's members by exceeding its performance guarantee for all four quarters for the Customer Satisfaction Quarter Review goal. Via Benefits exceeded the goal by more than 11% each quarter during plan year 2021.
2. Via Benefits should:
    - Track the reasons for overpayments to understand why overpayments occur and prevent them going forward.
    - Coordinate with LifeWorks to update eligibility information in a timelier manner to prevent negative account balances going forward.
    - Provide examiners with additional coaching on the processing errors identified during the audit.

Summary of Via Benefits Guarantee Measurements

Based on CTI's Random Sample Audit results, Via Benefits met two of its three claims processing measurements for the PEBP.

Metric	Met/Not Met	Penalty
Claim Processing Turnaround Time Annual Review	Met	NA
Claim Processing Payment Precision Annual Review	Not Met	$10,000
Claim Financial Payment Precision Annual Review	Met	NA

In addition, CTI validated that Via Benefits missed the following measurements:

- Customer Service Abandonment Rate – $7,500 penalty waived at 03/25/21 PEBP Board Meeting.
- Customer Speed to Answer Q2 PY 2021 – $2,000 penalty waived at 03/25/21 PEBP Board Meeting.
- Customer Speed to Answer Q3 PY 2021 – $2,000 penalty paid by check on 06/01/21.

OPERATIONAL REVIEW

Objectives

CTI's Operational Review evaluates Via Benefits' claims system, staffing, and procedures related to administration including enrollment, customer service, and overpayment recovery. We also used the Operational Review to verify compliance with contract terms and in support of our Random Sample Audit activities.

Scope

The scope of our review included:

1. Claim administrator information
    - Insurance and bonding
    - Conflicts of interest
    - Performance standards
    - Business continuity planning
    - System software
    - Offsite claim administration
2. Claim funding:
    - Claim funding mechanism
    - Check processing and security
3. Claim adjudication, customer service, and eligibility maintenance procedures:
    - Contributions and rollovers
    - Claim processing
    - Customer service call and inquiry handling
    - Overpayment and adjustments
    - System security
4. Privacy and security compliance

Methodology

CTI used an Operational Review Questionnaire to gather information from Via Benefits. We reviewed Via Benefits' responses and any supporting documentation supplied to gain an understanding of the procedures, staffing, and systems used to administer the PEBP's HRA plan. This allowed us to conduct the audit more effectively.

Findings

In our review of we observed the following:

- Via Benefits provided the following insurance coverage information:

Coverage	Amount
Errors and Omissions	$5,000,000 Aggregate Limit
Crime	$1,000,000
Cyber Liability	$5,000,000

- Willis Towers Watson indicated it had been audited by KPMG LLP, for compliance with the standards of the American Institute of Certified Public Accountants through the issuance of a Service Organization Controls (SOC) 1 Report. Exceptions were noted and a copy of the report has been provided to PEBP.
- Compliance with Performance Guarantees

Metric	Guarantee Measurement	Actual	Met/ Not Met
Claim Processing Turnaround Time Annual Review	Processing will average two business days. Additionally, 98% of claims will be processed within five business days.	1.18 days 100% processed within five business days	Met Met
Claim Processing Payment Precision Annual Review	Processing average precision will be at least 98% or better.	97.00%	Not Met
Claim Financial Payment Precision Annual Review	Financial Accuracy will be 98% or better.	98.53%	Met
Reports Annual Review	Reports provided within 15 days.	Reports available on first day of every month	Met
HRA Web Services Annual Review	99% availability of web services for benefit information and HRA information exclusive of scheduled maintenance.	99.92%	Met
Customer Service Abandon Rate Annual Review	The percentage of incoming calls abandoned by participants be 5% or less.	9%	Not Met
Customer Service Speed to Answer Quarter Review	Incoming telephone calls answered in less than or equal to: Ninety seconds in Q1 PY 2021 Five minutes in Q2 PY 2021 Two minutes in Q3 PY 2021 Ninety seconds in Q4 PY 2021	Q1 PY 2021 – 0:37 Q2 PY 2021 – 8:49 Q3 PY 2021 – 2:28 Q4 PY 2021 – 0:10	Met – Q1 PY 2021 Not Met – Q2 PY 2021 Not Met – Q3 PY 2021 Met – Q4 PY 2021
Customer Satisfaction Quarter Review	At least 80% of participants surveyed will be satisfied with services.	Q1 PY 2021 – 93.38% Q2 PY 2021 – 91.93% Q3 PY 2021 – 92.95% Q4 PY 2021 – 94.94%	Met
Disclosure of Subcontractors Per Violation	Additional subcontractors shall not be engaged, unless at least 60 days prior to the engagement is given.	Individual Marketplace Subcontractor list dated April 15, 2021	Met
Unauthorized Transfer of Data Per Violation	All data will be stored, processed, and maintained on designated servers. Any changes must have 60 days notification.	No changes reported	Met

- For the second quarter of plan year 2021, Via Benefits missed its Customer Service Speed to Answer performance guarantee and reported the PEPB waived the $2,000 penalty at its March 25, 2021, Board meeting.
- For the third quarter of plan year 2021, Via Benefits missed its Customer Service Speed to Answer performance guarantee. Via Benefits issued a check for $2,000 to PEBP on June 10, 2021.

- For the Customer Service Abandon Rate Annual Review missed performance guarantee, PEPB waived the $7,500 penalty at its March 25, 2021, Board meeting.
- Via Benefits reported using the Acclaim system, an in-house application that was developed for claim adjudication and payment purposes. The Acclaim system has been used for 20 years.
- The business continuity plan provided by Via Benefits included two approaches to data protection, 1) continuous off-site replication to a second, geographically distant location and 2) the use of daily backups of files and databases.
- Via Benefits indicated no claim processing functions are outsourced.
- All reimbursements are paid directly from PEBP's bank account; there is a custom process developed for HRA reimbursements to be paid directly to the participant.
- Via Benefits reported the preferred method of refunds is for it to be forwarded directly to PEBP. Via Benefits receives a log of all repayments and adjusts records as needed.
- Via Benefits reported stale checks are voided after 18 months. The amount of the check will be credited back to the individual's HRA account.
- Via Benefits indicated PEBP provided the allocation amount that participants were eligible for. Effective May 31, 2021, however, PEBP implemented an $8,000 cap on the available balance.
- Via Benefits provided an overpayment report for plan year 2021, that showed:
    - Overpayment Total: $57,714.39
    - Recovered Total: $41,210.68
    - Unrecovered Total: $16,503.71
- Via Benefits did not provide the reason for overpayments on the report; however, it did indicate lost eligibility was the biggest reason for recovering medical expenses.
- Via Benefits reported 146 members with a negative account balance totaling $67,561.82.
- Customer service operations were available via phone Monday through Friday from 5:00 AM to 6:00 PM PST.
- The member online portal allows claims submission, help tickets, participant balances, and direct deposit information.
- Via Benefits communicated with account holders via mail or email. It provided newsletters twice a year, a one-time enrollment guide mailing when a participant aged into Medicare, and one-time HRA welcome packet mailing upon initial qualification.
- Via Benefits reported it used secure system passwords and system authorization, as well as separation of duties. It also limited access to eligibility maintenance and claim adjudication.
- Via Benefits' internal system control document provided a thorough overview including detail on data entry logic, duplicate logic, and overpayment logic as examples.
- Web-based security and compliance training was provided by Via Benefits annually.
- Via Benefits reported that there were no privacy or security breaches identified during the audit period.

RANDOM SAMPLE AUDIT

Objective

The objective of the Random Sample Audit was to identify any administrative process deficiencies in PEBP's health reimbursement arrangement claims.

Scope

The scope of our Random Sample Audit for the PEBP included a review of a random sample of HRA claims paid by Via Benefits during the period of July 1, 2020 through June 30, 2021. The random sample included 200. Performance was measured for the following key performance categories:

- Financial Accuracy
- Payment Accuracy
- Claim Turnaround Time

Methodology

The Random Sample Audit was conducted remotely at CTI's Des Moines, Iowa office. Each claim was reviewed by a CTI auditor to determine if it was paid or processed correctly based on member eligibility or plan provisions as defined in the plan documents or amendments.

CTI cited errors when a sampled claim was determined to have been paid or processed incorrectly. Payment errors were observed based on how the selected claim was paid and the information Via Benefits had at the time the transaction was processed.

Findings

CTI defines financial accuracy as the total correct claim payments made compared to the total dollars of correct claim payments that should have been made for the audit sample. The sampled claims were selected from the PEBP HRA claims. Note: procedural accuracy includes both financial and procedural errors. A summary of each finding follows the chart below.

Performance Measure	Claims Sampled		Sampled Claims with Errors		Results
	Claims	Dollars Paid	Claims	Dollars Paid	
Financial Accuracy	200	$17,145.03	2	$252.50	98.53%
Procedural Accuracy	200		6		97.00%
Claim Turnaround Time	Guarantee – 98% of claims reimbursed within 5 business days				100%

Audit Number	CTI's Observation	Via Benefits Response	CTI's Conclusion
Financial Errors			
1016	Not processed: Date of service (DOS) 06/11/20 $91.15 and $1.33. DOS 07/16/20 $38.43 (entered as $37.40). Underpayment: $93.51	Agree.	Error and $27.50 underpayment remain. Charges were overlooked and date of service was entered incorrectly.
1110	Claim paid without description of service. Claim was adjusted to pay monthly premium of $45.00	Agree.	Error and $225.00 overpayment remain. Paid incorrect premium amount.

Audit Number	CTI's Observation	Via Benefits Response	CTI's Conclusion
	(total bi-annual premium of $270.00). Overpayment of $225.00.		
2	**Financial Errors**		
Procedural Errors			
1051	Rollout was done for another plan year which delayed the payment for two months.	Agree.	Procedural error remains. Payment delayed for 60 days due to rollout.
1082	$57.80 Income-Related Monthly Adjustment Amount (IRMAA) and $144.40 for Part B Premium should have been paid in separate payments and were processed as one. Also, the premium for September should have been paid and not held for monthly release.	Agree.	Procedural error remains. Payment should be split in two transactions for duplicate purposes. Monthly payment should have been held and paid upon receipt.
1134	Incorrect date of service. The requested amount was for the quarterly premium and the examiner entered the full amount under October 2020.	Agree.	Procedural error remains. Incorrect date of service was used to process claim.
1162	The examiner selected the incorrect coverage type. Benefit selected was for Medicare Part B premium and should have been for pharmacy. This claim was adjusted to apply the correct coverage type.	Agree.	Procedural error remains. Payment allowed under the incorrect benefit type.
4	**Procedural Errors**		
6	**TOTAL ERRORS**		

Additional Observations

During the Random Sample Audit, our auditor observed the following procedures or situations that may not have caused an error on the sampled claim but may impact future claims or overall quality of service.

Observation	Audit Number
A portion of the documents submitted for this out-of-sample claim were not processed resulting in an underpayment of $66.00.	1016
Payment on this out-of-sample claim should be for date of service 04/22/21 but it was processed as 04/23/21.	1035
An incorrect date of service was used on this out-of-sample claim. Payment was made on the account with a negative balance resulting in a $69.00 overpayment.	1042
This out-of-sample claim was incorrectly denied which resulted in a $5,678.11 underpayment.	1081
Monthly premium came through with a different amount on the data file. Best practice would be for Via Benefits to have a check and balance procedure in place.	1090
This out-of-sample claim was incorrectly denied which resulted in a $3,670.18 underpayment.	1120
One payment in full was requested on this premium but a reoccurring monthly payment was set up in the claim system. Overpaid $1,663.50.	1055

ELIGIBILITY VERIFICATION

Our electronic comparison of dates of service to PEBP's eligibility file revealed some services were paid during the audit period for potentially ineligible claimants. At this time, potentially overpaid amounts have been flagged into one of the following categories:

Description	Line Count	Claimant Count	Paid Amount
Not on File	729	67	$134,686.89
Incurred After Benefit End Date	766	241	$125,258.02
Incurred Prior to Benefit Begin Date	706	144	$121,431.35
TOTALS	**2,201**	**452**	**$381,376.26**

**CTI notes that 1.67% of PEBP's total medical spend processed by Via Benefits was identified as paid for members who may not have been eligible for coverage. These results are higher than the less than 1% CTI generally reports.*

In our experience, there are occasionally eligibility data issues that affect screening quality and reliability. CTI has provided LifeWorks with detail reports listing individuals with flagged claims to validate eligibility data provided for this screening was correct and did not generate false positives.

RECOMMENDATIONS

Based on the findings of our annual audit of Via Benefits, CTI recommends the following:

1. The overpayment report provided by Via Benefits' should specify the reason for overpayments. If the reasons are not currently captured and tracked, CTI recommends doing so. Tracking the reason for overpayments will allow both the PEBP and Via Benefits to understand why overpayments occur and help determine the steps necessary to prevent them going forward.
2. Via Benefits and LifeWorks need to work together to determine how to best update eligibility in a timely manner. Via Benefits reported 146 members with a negative account balance for a total of $67,561.82.
3. Via Benefits should coach examiners on the claim processing errors identified during the audit:
    - Overlooked charges in claim file
    - Incorrect amount entered
    - Incorrect date of service entered
    - Allowed payment under incorrect benefit type
4. Via Benefits should develop a process to track claim turnaround time.
5. Performance Guarantee Metrics included in PEBP's contract with Via Benefits should be measurable to allow for outside validation of the metric being met.
6. PEBP should verify that missed performance goals have been credited back to the plan.

CONCLUSION

We consider it a privilege to have worked for, and with, your staff and administrator. Thank you for choosing CTI.

APPENDIX – ADMINISTRATOR RESPONSE TO DRAFT REPORT

Your administrator's response to the draft report follows.

Willis Towers Watson

November 17, 2021

To whom it may concern:

Below is the Wills Towers Watson response to the Audit of the State of Nevada Public Employees' Benefits Program Health Reimbursement Arrangement for the period of July 2020-June 2021:

- Claim Technologies Incorporated noted that of the 200 claims reviewed there were two financial errors. **WTW agrees to these findings**.
- Claim Technologies Incorporated noted that of the 200 claims reviewed there were six procedural errors. **WTW agrees to these findings.**
- WTW questioned the sampling methodology as 75% of the claims were manual claims and 25% were pass thru claims. Considering the number of participants that have enrolled in automatic reimbursement, we would expect to see a higher number of pass thru claims represented in the sample. **Claim Technologies confirmed that the sample was selected randomly and this was just a coincidence**.
- WTW suggests that future audits be conducted in person at our Tampa, FL location.

We appreciate the partnership with Claim Technologies Incorporated and look forward to working with them in the future.

Sincerely,

Cara Smouse

Cara Smouse, MBA
Senior Associate

cc: Phillip Massey
Brian Caldwell

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4.6

4.6 Clifton Larson Allen Audited Financial Statements for PEBP for FY21

5.

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

STEVE SISOLAK
Governor

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LAURA RICH
Executive Officer

LAURA FREED
Board Chair

AGENDA ITEM

☐ Action Item
☒ Information Only

Date: January 27, 2022

Item Number: V

Title: Executive Officer Report

SUMMARY

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

REPORT

COVID-19 UPDATE

Emergency Declaration:

On January 14, the Department of Health and Human Services extended the national public health emergency. As a result, the end date for the cost share waiver and other COVID-19 benefit options has been extended to April 15, 2022. The following benefits are affected by this extension:

- Cost sharing for COVID-19 testing and test-related visits
- Cost share for COVID-19 vaccine administration.

OSHA Mandate:

OSHA's Emergency Temporary Standard, which imposes testing requirement on large employers, was blocked by the Supreme Court on January 13th; however, this decision does not affect the Governor's policy mandating weekly testing of unvaccinated state employees.

Insurer Mandate:

On January 10th, the Departments of Health and Human Services (HHS), Labor, and Treasury released guidance outlining new policy requiring insurers and group health plans to cover and reimburse covered members for up to eight at-home COVID tests per 30-day period. The requirement began on January 15th and goes through the end of the public health emergency.

Under this policy, insurers are incentivized to negotiate with in-network pharmacies to ensure members can purchase tests at zero cost and avoid the burdensome process of paying for tests up front and having to submit receipts for reimbursement. Members will also be able to submit receipts and be reimbursed up to $12/each test purchased through other pharmacies where automatic payment arrangements are not in place. With such short notice, most insurers (including PEBP) are unable to have an automated process in place by the effective date, so members will initially have to utilize the manual reimbursement option. As of the date this report was written, the following process has been established and communicated to PEBP members:

- CDHP/LD/EPO: Tests will be reimbursed through a manual reimbursement request performed by our Pharmacy Benefit Manager, Express Scripts (ESI). Members will need to mail/fax the ESI claim form along with a pharmacy receipt.
    - ESI is in the process of establishing the technology necessary to ensure members can purchase OTC tests at no up-front costs through partnering pharmacies and/or through mail order. This is expected to be available within the next 30 days.

- HMO (HPN): Members can purchase OTC tests at any Walmart Pharmacy with no up-front costs. Members who purchase tests at other pharmacy can submit receipts through the online member center to receive a reimbursement.

The impact of this mandate is yet to be determined and will be largely dependent on COVID infection rates, consumer behavior, as well as COVID policies. If the infection rates continue to remain high, it is likely the demand for tests will also increase. On one hand, eight OTC tests will cost the plan approximately the same as one PCR test. It is unlikely members will seek a PCR test if rapid tests are widely available. Additionally, the Biden Administration recently announced an online option so Americans can order up to four free tests per household, which could also presumably reduce the number of PCR tests members are seeking. Given these factors, PEBP can theorize the plan will likely not experience increases in testing related costs because the OTC cost will replace the previous more expensive PCR testing.

On the other hand, many PCR tests performed today have never been billed to the plan. Numerous testing providers are receiving state or federal funding to perform COVID testing, therefore insurance information is not collected from members and insurers are not being billed. PEBP has no way of knowing how many members have received COVID tests through these sources, but it can be presumed the percentage is significant. In this case, PEBP would very likely experience higher testing costs because OTC tests would now be replacing testing costs PEBP previously did

not absorb. Moreover, there is the concern members may stockpile OTC tests regardless of need. The combination of all these factors has the potential to drive up plan costs considerably.

Testing roll-out:

PEBP, through its HealthSCOPE Benefits contract, is partnering with Quest Diagnostics to oversee the distribution of tests and facilitate access to those unvaccinated state employees who are subject to the state weekly testing requirement as well as those employees who become symptomatic or with confirmed exposures.

PEBP has reached out to all department directors for information and to-date, PEBP has received requests for over 20,000 individual tests to be shipped to state agencies across the state. Additionally, there are over 300 tests to be mailed to individuals.

As of the date of this report, PEBP is awaiting the finalization of the contract between HealthSCOPE Benefits and Quest. Tests are expected to ship within 3 weeks of the final signed contract.

Surcharges:

With the focus on testing roll-out and implementation of the new enrollment system, there are no substantial updates to provide on the implementation of surcharges at this time, however, below are some high-level updates on next steps:

- Discussions regarding the implementation of this functionality with BenefitFocus have already begun. Although PEBP has been granted access to state vaccination data, this functionality remains a priority.
- PEBP has begun initial discussions with the Governor's Office regarding the religious/medical exemption process.
- PEBP will continue working with Aon to monitor COVID costs to ensure surcharge amounts approved at the December 2, 2021 meeting remain valid.

STAFFING

PEBP has not been immune to staffing issues caused by national labor shortages and COVID. PEBP currently has 8 of 34 positions vacant and getting the open positions filled has been challenging. The first obstacle is related to the Division of Human Resource Management (DHRM) new recruitment system and the longer processing times associated with the new system. Once a candidate list is finally received, many of the best candidates are either no longer interested or have already accepted another position elsewhere. In some cases, PEBP has had to repost positions and/or consider an underfill option.

Furthermore, COVID infections and exposure have led to absenteeism. This has the most significant impact on our member services unit (call center), because, while already understaffed, these positions are unable to work remotely if they believe they have been exposed or are having symptoms.

With the additional volume of work happening at PEBP as well as the numerous upcoming changes, it is important that PEBP is fully staffed and trained to ensure the agency can be successful moving forward. It is an understatement to say that the PEBP staff have been giving it 100% despite the intense challenges the agency is faced with.

Legislative Committee Meetings:

On February 8th, PEBP is scheduled to present to the Interim Retirement and Benefits Committee (IRBC). Per NRS 287.0425, PEBP is required to present a series of reports regarding the program's previous fiscal year performance and operations. Similar to last years' presentation, PEBP has also elected to provide the committee with information on all major PEBP Board decisions and other information the committee members may find useful as legislators prepare for the 2023 legislative session.

PEBP is also on the agenda for the February 9th meeting of the Interim Finance Committee. PEBP has submitted a work program authorizing the use of $8.7M in excess reserves to fund the PY 23 plan design to restore deductibles and out-of-pocket maximums beginning July 1, 2022. Although this was approved by the Board in December, the legislature must ultimately authorize the use of reserves to fund benefits.

6.

6. Enrollment and Eligibility System Implementation Update (Nik Proper, Operations Officer) (**For Possible Action**)

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AGENDA ITEM

[X] Action Item
[ ] Information Only

Date: January 27, 2022

Item Number: VI

Title: Enrollment and Eligibility System

SUMMARY

This report will provide the Board, participants, public, and other stakeholders information on the roll out of PEBP's new enrollment and eligibility system.

REPORT

ENROLLMENT AND ELIGIBILITY SYSTEM UPDATE

PEBP's new enrollment and eligibility system, Benefitplace managed by Benefitfocus, went live on 1/3/22. PEBP's contract is with LSI, but the bulk of the sub-contracted work is performed by Benefitfocus. As with all implementation and system changes there will be successes, challenges, and issues needing to be worked out after going live.

Go-Live Successes:

- Benefitplace member portal worked successfully on day one. Members have been able to log in successfully with no issues.
- The Voluntary Benefits Special Enrollment Period elections were processed correctly.
- Correct health coverages and elections for most members.
- Due to demographic file integrations with the States' two biggest pay centers, Central Payroll and NSHE, employees making demographic changes and HR representatives entering employee statuses of those pay centers now only make the changes in their respective systems. This should increase efficiency and reduce administrative errors.

Go-Live Challenges:

- Member Data Discrepancies
  Data integrity and reconciliations are part of system changes and with this system go-live there have been data discrepancies on some members' accounts. This includes a small number of members entirely missing in the system, status/coverage discrepancies, incorrect HSA contributions, and incorrect subsidies applied on some retiree accounts. The full number of impacted members is unknown currently as staff are unable to identify. Instead, staff is tracking these incidents as members self-report issues. Staff are doing their best to attempt to reconcile these accounts and resolve issues immediately, including performing urgent updates direct with vendors so services can be accessed, but without access to prior historical information PEBP must rely on Benefitfocus to investigate and resolve the bulk of the issues. Benefitfocus is auditing and reconciling data from PEBP's previous vendor to correct these issues. The integration of demographic files with Central Payroll and NSHE should improve many of these discrepancies shortly, but the downstream effects on the accounting and billing side will continue until all issues are resolved.
  Impact: Volume unknown as staff is only made aware when members contact PEBP, but reported cases are around 100.
  Mitigation: Benefitfocus is auditing and reconciling accounts from data received from the previous vendor Lifeworks, vendor data, and demographic file data.

- Demographic File Feeds
  This implementation focused heavily on creating demographic file feeds with Central Payroll and NSHE. This idea was that agencies know what statuses their employees are supposed to be in, and while we hope in the long run this will be a benefit to all parties involved, as of now this also has contributed to some the above members discrepancies. The new system does not enable staff to manually make certain changes on accounts since data on the demographic files overrides all manual changes.
  Impact: Contributing to account discrepancies, volume is unknown but reported cases are low.
  Mitigation: Benefitfocus is working on what can be done to limit certain fields from being overridden when receiving these files.

- Accounting and Billing
  Currently PEBP staff and members do not have access to the billing platform to view or make payments. January 2022 invoices were unable to be produced causing PEBP to ask direct billed members and groups to send payments based off December 2021 invoices which potentially misses newly direct billed members. PEBP uses enrollment reports to pay vendors, make tax payments, project budget revenue and expenditures, and build budgets. Without accurate and timely enrollment reports those functions are affected. Premiums and deductions will be inaccurate on some members' accounts due to the data discrepancies, but the number of impacted members is unknown at this time. Not all PEBP premiums are an even number, so deductions for many Central Payroll and NSHE

employees are going to be off by one cent due to Benefitfocus having to round to the nearest cent because of their functionality to only be able to split deductions 50-50.
Impact: These issues are going to cause heavy reconciliation efforts with frustration on staff, members, and agencies.
Mitigation: Benefitfocus is working with their team to address this on adjustment files, and possibly having to change development for 7/1/22 reverting all deductions being taken out in one lump sum.

- Benefitplace Functionality for Staff
  Benefitplace serves as the member portal and the Admin/Staff portal. It is not a true CRM system as it currently lacks some user-friendly functionality for call center staff Basic functionality such as creating notes on a member's account, responding to messages, and processing eligibility events all now take longer to accomplish in this system.
  Impact: Internal operational processes and procedures taking longer which means new coverage, terminations and coverage changes will take longer to take effect. This delay impacts member coverage and workload on PEBP's vendor partners
  Mitigation: There may be future development or process changes that can address some of these issues, but most will remain due to the functionality of the system.

Possible Other Downstream Effects:

- 7/1/22 Smart 21 Integration go-live
  These current issues may cause a delay in testing and configuring files in preparation for 7/1/22.
  Mitigation: LSI has been in communication with OPM.

- Covid Surcharge Implementation
  With the delays and issues mentioned, this could cause a delay in appropriately implementing the covid surcharge on unvaccinated member accounts.
  Mitigation: PEBP will be working diligently to address this in upcoming implementation meetings.

The Enrollment and Eligibility contract with LSI includes performance guarantees related to implementation. As a result of the missing functionality and large data discrepancies that have and will continue to have a direct impact on member accounts and staff's ability to perform the mission of the agency, PEBP is considering the assessment of penalties. The maximum penalty in this case would be $10,000 for each of the two performance guarantees.

PEBP has discussed the various concerns and issues with leadership at LSI Consulting and as a result LSI has offered to propose the following alternative solutions:

Employee Benefits Administration & Management Solution [SOLUTION] Project Initiative

Invenio-LSI/BenefitFocus - Current Status of PEBP SOLUTION Project Initiative

EXECUTIVE SUMMARY – As of January 21st, 2022

HIGH LEVEL
Project Status - Program Management Viewpoint and Perspective:

Overall:

- SOLUTION has been transitioned into LIVE Production Status for (2) of the (3) major components
  - ✓ Voluntary Benefits (December 1st, 2021)
  - ✓ Main SOLUTION (January 3rd, 2022)
- The remaining SOLUTION Component (Billing {both Direct and Consolidated}) is targeted for Go-Live by February 14th, 2022.
- Members (State Employee, NSHE, & PERS) within and currently having access to the SOLUTION:
  - ✓ 46,115
- Current Challenges noted from GO-LIVE:
  - ! Data Validation and Synchronization from previous State Solution Supplier.
  - ! Billing Platform not yet fully validated and ready for final review and testing.
  - ! Responsiveness and Quality of Data + Support from previous State SOLUTION Supplier
  - ! Integrations with State Existing Payroll and HR Demographic Solutions, as well as potentially, NSHE associated Systems.
  - ! Training and Enablement.
  - ! Change Management & Communications.

RISKS

- Some Members effected by Data Quality and Validation – indicating no coverage
- No current Billing Visibility for PEBP to issue Group Invoices (Consolidated Billing)
- Potential for State's Health Services Vendor Service disruptions, based on Billing Platform not yet in Production

- New Hires, Transfers and Retirees occurring during SOLUTION transition (old legacy State Solution → to new Invenio-LSI/BenefitFocus SOLUTION) may not show up

Expected Go-Live Challenges:

- Data Quality and Consistency with Legacy Solution
- Data Integration Maturity and Optimization
- Maturing and Optimizing Eligibility Logic
- Overall Change Management Optimization
- Single-Sign On/ First Time User Access

Unexpected Go-Live Challenges:

- Lack of integration flexibility of State's existing Payroll Platform
- Poor Responsiveness and Quality from State's Existing Solution Provider
- Amount of Data Quality and Synchronization issues
- Having to Pivot to developing the required Payroll System Interface/Integration as a result of the SMART21 Payroll Platform Go-Live being extended to July 1st, 2022.
- Billing Platform Logic and Formatting Configuration to meet State requirements
- Lack of time availability to do more training and enablement for PEBP Operations and Support Teams

Invenio-LSI/BenefitFocus – Identified Challenges [Looking Back – What could we have been done differently]

- Dealing with Project Resource impacts based on the COVID-19 Pandemic.
- Implementation – Done Remotely, should have been more of a blend of On-Site/Remote to better interact with PEBP Team
- Needed to perform significantly more due diligence around State Billing Requirements during Requirements Phase of the Implementation, given State Subsidy Logic and Requirements
- Increased Data Quality and Validation inspection of State's Previous Suppliers Base Data which was imported.
- More Training and Enablement sessions for the PEBP Operations and Support Team

Invenio-LSI/BenefitFocus – Corrective Actions / Proactive Partnership based Support to PEBP [What's in place since Go-Live {1-3-2022}]

- Invenio-LSI/BenefitFocus – Daily 1-hour Review/Resolution Meeting with PEBP
  - Operational Issue Tickets

- Invenio-LSI/BenefitFocus – Daily 1-hour Review/Resolution Meeting with PEBP {new as of 1/25/2022}
  - Project Go-Live Related Issues

- BenefitFocus – Dedicated Team focused on Data Quality and Validation Issues
  - Daily Triage Team
  - Ability to help correct missing or bad Member Data with Health Providers

- BenefitFocus – Dedicated Team focused on Billing Solution
  - Final Configuration and Testing to facilitate Review & Approval by PEBP

- BenefitFocus – Dedicated Team focused on Identified Daily Operation Challenges and Submitted Resolution Request Tickets.
  - Hyper-Care Support
  - Daily Triage Team – until we conclude initial Operational Maturity and Stability period / Post Go-Live

- Invenio-LSI and BenefitFocus – Full Visibility and Support from Executive Leadership
  - To resolve identified issues and challenges

- Invenio-LSI – Coordination with SMART21 and State Legacy Payroll Teams
  - To resolve identified issues and challenges

Invenio-LSI – Proposed Partnership based Service Credits for Implementation Tasked missed as well as Go-Live Challenges

- Pursuant to the Contract executed with PEBP for the SOLUTION – the following SLA and Service Credits were defined:

Service Performance Standard	Guarantee	Method of Measurement	Penalty
I. Implementation: initial transition from incumbent vendor to incoming vendor	98%	A. Tasks Percent of tasks complete on time pursuant to the implementation plan or as mutually agreed to by Vendor and PEBP.	A. Contractor will pay PEBP five percent (5%) of the associated professional services project fee, not to exceed ten thousand ($10,000) for any project that is not *Fully Operational* within ten(10) business days of the target date established by the associated *Final Implementation Schedule*
		B. Go Live Vendor agrees that implementation will be complete by the mutually agreed to Go Live date. The Performance Guarantee set forth in this section is subject to PEBP's performance of its obligations, provided that we shall only be excused from this Performance Guarantee if PEBP or its vendors' nonperformance contributed to our failure to meet the Performance Guarantee.	B. Contractor will pay PEBP five percent (5%) of the associated professional services project fee, not to exceed ten thousand ($10,000) for any project that is not *Fully Operational* within ten(10) business days of the target date established by the associated *Final Implementation Schedule*

- To fully acknowledge responsibilities for outstanding Implementation areas not yet fully completed (Direct and Consolidated Billing) as well as identified Operational Challenges (since Go-Live on 1/3/2022) – Invenio LSI and BenefitFocus are proposing the following Service Credits to PEBP:
  - Full relief of the scheduled (per Contract) December-2021 SOLUTION Subscription Service and Support Fees
    - Credit to PEBP → $87,618.50
  - To demonstrate the sensitivity and appreciation for the impacts these delays and challenges are having on PEBP and its Members- in good-faith, and as good partners to PEBP – with our proposed Service Credit to PEBP, we have far exceeded the mutually agreed to Contractual Service Performance Standards Penalties.
  - Both Invenio-LSI and BenefitFocus firmly believe that with the remediation and resolution plans in place- all outstanding Implementation and Operational Challenges should be fully addressed by the end of February-2022, during the Post Go-Live Maturity and Stabilization period.

- **Some Members effected by Data Quality and Validation – indicating no coverage**

Invenio-LSI/BenefitFocus Resolution Plan	Current Status (as of 1-21-22)
▪ Manually Inspect all Member Data Files	▪ BenefitFocus Dedicated Team has worked through a majority of the Inspection. Full Completion and Validation targeted for Completion by end of week (1-28-22) between what we received from State's previous SOLUTION supplier and State Health Provider (HSB)
▪ For any Member found and validated missing from current SOLUTION – BenefitFocus dedicated team will correct with: ▪ State Health Provider(s) to ensure no disruption in coverage ▪ Correct source of error so that data validation and continuity is established.	▪ This process began on Go-Live ▪ Another full review and audit was conducted on 1/17/2022
▪ Adjust and Optimize MEMBER Data and Integrations with State Health Providers to ensure 100% Accuracy	▪ Once BenefitFocus Dedicated Team Manually Inspects all Member Data and confirms source of mismatch and/or missing data from State's Previous SOLUTION Supplier – this Adjustment and Optimization process will be executed and completed. Target date – by 2/4/2022
▪ Invenio-LSI/BenefitFocus and PEBP meeting daily as well have established an escalation process – should Members identify and communicate issues/challenges with the Benefits coverages	▪ (3) of these situations were escalated last week (week of January 17th, 2022) via Governor's office → (2) of the (3) were immediate triaged and addressed. The remaining case is still under review.

- **Billing Platform not yet fully validated and ready for final review and testing.**

Invenio-LSI/BenefitFocus Resolution Plan	Current Status (as of 1-21-22)
▪ A new dedicated BenefitFocus Team has been put in place to accelerate the final configuration and unit testing in order to demonstrate functionality of the Group – Consolidated Billing for PEBP	▪ Working through validation of all Subsidy related logic & data ▪ Planned Demonstration and Review Session with State's Invoice Data & Format – Scheduled for 2/2/2022 ▪ Upon PEBP's confirmation – Transition to Go-Live Plan will commence during week of February 7th, 2022 ▪ Planned (current) Go-Live for Consolidated (Full Roll-Up Invoice to PEBP) – Target Billing → 2-14-2022 ○ This will support PEBP Payment of Group Invoices by the 25th of the Month ▪ Contingency – In the interim, utilize December-2021 Invoice as baseline and reconcile variances between this and Full Production Group Billing ▪ Dedicated BenefitFocus Team will assist PEBP with any coordination and workaround with State Health Service Suppliers until Group Consolidate Billing is in Full Production ▪ Invenio-LSI/BenefitFocus will provide daily updates to PEBP Leadership on status of this resolution/remediation plan.
▪ In the interim – the BenefitFocus Team is providing required reporting to PEBP for visibility in order to work with STATE Heath Services Vendors	▪ We have executed this process for Risk Mitigation and Triage with PEBP ▪ We have provided initial reporting to PEBP for Review (1-21-2022)
▪ For Voluntary Benefits – BenefitFocus has assigned a dedicated team to work through all related challenges and is fully responsible to ensure no coverage disruption, as the Direct Billing Functionality is fully reviewed, validated and in Production	▪ Full Review of "to-date" Voluntary Benefits invoicing and coordination with Benefits Providers – on-going by BenefitFocus

- **Responsiveness and Quality of Data and Support from previous State SOLUTION Supplier**

Invenio-LSI/BenefitFocus Resolution Plan	Current Status (as of 1-21-22)
▪ We have reached a point of "diminishing" returns and value to try to get what we need from the State's previous Supplier	▪ BenefitFocus Dedicated is now fully inspecting and validating ALL of the data sent over from the State's previous Supplier for alignment, accuracy and quality. ▪ Completion of this inspection and validation – expected by 2/4/2022

- **Integrations with State Existing Payroll and HR Demographic Solutions, as well as potentially, NSHE associated Systems.**

Invenio-LSI/BenefitFocus Resolution Plan	Current Status (as of 1-21-22)
▪ We have identified a CORE Resolution Team consisting of PEBP, State Payroll, SMART21 and BenefitFocus Integration specialist to determine how to address or develop workarounds for currently identified CORE HR Demographic and Existing State Payroll Integration challenges	▪ Meeting scheduled – 1-24-2022
▪ We have reached out to NSHE to validate the HR Demographic Information from their System is consistent on what is required to complete eligibility calculations and associated Payroll Deductions	▪ Awaiting NSHE Feedback – Week of 1/24/22

- **Training and Enablement.**

Invenio-LSI/BenefitFocus Resolution Plan	Current Status (as of 1-21-22)
▪ We have listened to, and captured initial Operational Feedback from PEBP since Go-Live (1-3-2022) ▪ Based on this Operational Feedback, Invenio-LSI and BenefitFocus are working on an expanded set of additional training sessions for the PEBP Team ▪ We intend to work with the PEBP Leadership team to ensure that we have captured the key SOLUTION areas which need more Training and Knowledge Transfer	▪ These Sessions will be scheduled after the two critical issues [Data Validation and Synchronization from previous State Solution Supplier & Billing Platform not yet fully validated and ready for final review and testing.] are resolved ▪ In the meantime – during the "ever-day" 1-hour Operational Mtgs with the PEBP team – the BenefitFocus Support Team is addressing specific Operational Questions as well as providing Knowledge Transfer

- **Change Management & Communications**

Invenio-LSI/BenefitFocus Resolution Plan	Current Status (as of 1-21-22)
▪ We have identified Change Management and Communications areas which may be helpful to PEBP with its Members, as PEBP fully transitions over to a new SOLUTION ▪ With any Transition of this nature – the amount of Change and focus on User Adoption and Communications is key towards ensuring a successful experience for PEBP Members.	▪ We are planning to meet with PEBP to go over some ideas and proposed Change Management & Communications enhancements.

Recommendation:
Assess appropriate performance penalties and require LSI submit an on-going performance improvement plan to the Board through July 2022 or until all identified issues have been resolved.

7.

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

- 7.1 Contract Overview
- 7.2 New Contracts
  - 7.2.1 Selection of Pharmacy Benefit Manager Between: Express Scripts (pursuant to Request for Proposal No. 95PEBP-S1711) and Northwest Drug Consortium (pursuant to NRS 333.475)
- 7.3 Contract Amendments
  - 7.3.1 Express Scripts – Amendment #6
- 7.4 Contract Solicitations
- 7.5 Status of Current Solicitations

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AGENDA ITEM

[X] Action Item
[ ] Information Only

Date: January 27, 2022

Item Number: VII

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

7.1 Contracts Overview

Below is a listing of the active PEBP contracts as of December 31, 2021.

PEBP Active Contracts Summary

Vendor	Service	Contract #	Effective Date	Termination Date	Contract Max	Current Expenditures	Amount Remaining
Morneau Shepell LTD	Benefits Management System	15941	1/1/2015	12/31/2021	$ 8,623,789.00	$ 6,452,631.63	$ 2,171,157.37
AON Consulting	Consulting Services	17596	7/1/2016	6/30/2022	$ 3,651,585.00	$ 3,214,998.21	$ 436,586.79
HealthScope Benefits	Dental Claims	14574	7/9/2013	6/30/2022	$ 6,100,000.00	$ 5,427,521.94	$ 672,478.06
The Standard	Group Basic Life Insurance	14276	7/1/2013	6/30/2022	$ 80,587,091.00	$ 78,015,590.67	$ 2,571,500.33
Hometown Health Providers	In-state PPO Network	15510	7/1/2014	6/30/2022	$ 9,955,139.00	$ 8,564,330.59	$ 1,390,808.41
HealthScope Benefits	National PPO	13330	7/1/2012	6/30/2022	$ 15,455,000.00	$ 12,300,101.21	$ 3,154,898.79
HealthScope Benefits	TPA	11825	2/8/2011	6/30/2022	$ 62,600,000.00	$ -	$ 62,600,000.00
HealthScope Benefits	Voluntary Flexible Spending Account	14465	7/1/2013	6/30/2022	$ 125,000.00	$ -	$ 125,000.00
Express Scripts, Inc.	Pharmacy Benefit Manager	17551	4/12/2016	6/30/2022	$291,134,666.00	$263,689,850.95	$ 27,444,815.05
American Health Holdings	PPO Utilization Management Case Management	21376	7/1/2019	6/30/2023	$ 8,000,000.00	$ 4,969,177.52	$ 3,030,822.48
Standard Insurance Company	Voluntary Life Insurance	15503	7/1/2014	6/30/2023	$ 80,587,091.00	$ 78,015,590.67	$ 2,571,500.33
CliftonLarsonAllen	Financial Auditor	24088	5/15/2021	12/31/2024	$ 212,485.00	$ 10,500.00	$ 201,985.00
Extend Health, Inc	Medicare Exchange	16468	7/1/2015	6/30/2025	$ 1,546,000.00	$ 1,233,741.92	$ 312,258.08
Health Plan of Nevada Inc	Southern Nevada HMO	23802	7/1/2021	6/30/2025	$192,093,848.00	$ 20,114,160.44	$171,979,687.56
Diversified Dental Services Inc.	Dental Contract	23810	7/1/2021	6/30/2026	$ 1,601,613.00	$ 178,517.76	$ 1,423,095.24
Aetna	PPO Network	23846	7/1/2021	6/30/2026	$ 7,127,250.00	$ 767,290.75	$ 6,359,959.25
Labyrinth Solutions, Inc.	Benefits Management System	23678	12/8/2020	6/30/2027	$ 7,328,667.00	$ -	$ 7,328,667.00
Claim Technologies	Health Plan Auditor	24030	4/13/2021	6/30/2027	$ 1,551,662.00	$ -	$ 1,551,662.00

Recommendation

No action necessary

7.2 New Contracts

On July 29, 2021, the PEBP Board approved staff to release a solicitation for a Pharmacy Benefit Manager (PBM) while also concurrently negotiating with the Northwest Drug Consortium. Additionally, the decision of the Board requested staff to bring the results of the winning proposal from the solicitation to a future Board meeting where the negotiated PBM proposal would be compared against the Northwest Drug Consortium option and awarded at the decision of the Board.

7.2.1 EXPRESS SCRIPTS INC.

On September 1, 2021, the Public Employees' Benefits Program released Request for Proposal (RFP) 95PEBP-S1711 for Pharmacy Benefit Manager (PBM) Services. The following were some items important to PEBP in the consideration of the award of this contract:

- Simultaneously to releasing this RFP, PEBP is evaluating the possibility of joining the Northwest Prescription Drug Consortium (https://www.oregon.gov/oha/HPA/DSI-Pharmacy/Pages/Northwest-Prescription-Drug-Consortium.aspx) to meet the States' pharmacy needs. The State reserves the right to cancel this solicitation and contract with the Northwest Prescription Drug Consortium pursuant to NRS 333.475 if determined to be in the best interest of the State.

- The Public Employees' Benefits Program (PEBP) is interested in partnering with a Pharmacy Benefit Manager (PBM) vendor who will work with PEBP and other PEBP vendors to assure the continued success of its self-funded program. The objective of this RFP is to acquire a PBM servicer that will be a strategic partner in providing the Services included in the scope of work identified in this RFP while being able to accommodate the current and possible future plan designs approved by the PEBP Board.

Vendor responses were scored based on the following criteria.

- Minimum Qualifications and Critical Items
- Technical
- Customer Service
- Financial (includes Fees, Credits, Performance Guarantees, and Network Discounts)
- Best and Final Offers

On October 1, 2021, PEBP received six (6) proposals in response to RFP 95PEBP-S1711. The evaluation period began on October 28, 2021 and ended on December 6, 2021. The eight-member evaluation committee included two PEBP Board members and other subject matter experts. Express Scripts Inc. received the highest score by the evaluation committee and PEBP has successfully negotiated a contract. Some of the highest scoring areas by the evaluators were:

- Vendor Experience
- Cost
- Network Access/Management

Express Scripts, Inc. is the current incumbent PBM so the transition is expected to be overall less disruptive to both members and staff and will require minimal implementation.

The effective date of the contract is anticipated to be April 12, 2021 (upon BOE approval) through June 30, 2026. Services and fees are expected to begin on June 1, 2022.

Recommendation

Approve a vendor to provide pharmacy services beginning July 1, 2022.

7.2.2 NORTHWEST PRESCRIPTION DRUG CONSORTIUM

Pursuant to NRS 333.475, PEBP is provided the option to enter into a contract with a governmental state entity that has used an open and competitive method similar to Nevada's procurement practices. On July 29, 2021, the PEBP Board approved staff to release a solicitation for a Pharmacy Benefit Manager (PBM) while concurrently negotiating with the Northwest Drug Consortium. Additionally, the decision of the Board requested staff to bring the results of the winning proposal from the solicitation to a future Board meeting where the negotiated PBM proposal would be compared against the Northwest Drug Consortium option and awarded at the decision of the Board.

Recommendation

Approve a vendor to provide pharmacy services beginning July 1, 2022.

7.3 Contract Amendment Ratifications

Below are the contract amendment ratification requests.

7.3.1 EXPRESS SCRIPTS INC.

PEBP contracted with Express Scripts Inc. for Pharmacy Benefit Management services which became effective April 12, 2016 and has a termination date of June 30, 2022. This amendment increases the contract maximum from $291,134,666 to $302,920,638. This increase adds additional authority to pay claims through the remainder of the contract and to add authority to implement the optional Medicaid Subrogation program service.

The Medicaid Subrogation program is required pursuant to the State statutes implementing provisions of the Federal Deficit Reduction Act of 2005 pertaining to Medicaid third-party liability, which are now codified in Section 1902(a)(25)(I) of the Social Security Act, 42 USC 1396a(a)(25)(I), third-party insurers and their pharmacy benefit managers are required to furnish State Medicaid departments (or their contracted agents) with enrollment and eligibility information sufficient to enable Medicaid to

identify instances in which an individual is covered both by Medicaid and by private insurance, and where an insurer may therefore have third-party liability for a Medicaid claim.

Recommendation

PEBP recommends the Board authorize staff to amend the contract between PEBP and Express Scripts Inc. for Pharmacy Benefit Manager services in contract #17551 to add the Medicaid Subrogation Program, update the fee schedule, and increase the contract maximum.

7.4 Contract Solicitation Ratifications

PEBP does not currently have any contract solicitations for ratification.

7.5 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
Actuary	10/18/2021	11/17/2021	Segal	March 2022
Life Insurance	10/14/2021	12/01/2021	UMR, Inc.	March 2022

Recommendation

No action necessary

8.

8. Public Comment

9.

9. Adjournment