STEVE SISOLAK
Governor

STATE OF NEVADA
PUBLIC EMPLOYEES' BENEFITS PROGRAM
901 S. Stewart Street, Suite 1001 | Carson City, Nevada 89701
Telephone 775-684-7000 | 702-486-3100 | 1-800-326-5496
www.pebp.state.nv.us

LAURA RICH
Executive Officer

LAURA FREED
Board Chair

MEETING NOTICE AND AGENDA

Name of Organization:	Public Employees' Benefits Program Board
Date and Time of Meeting:	September 29, 2022 9:00 a.m.
Place of Meeting:	This meeting will be conducted by means of a remote technology system pursuant to NRS 241.023 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/qXusIcHaXy0

To submit written public comment, please upload your document to the *Public Comment Upload Form* located under *Contact Us* on the PEBP website, *pebp.state.nv.us,* no later than 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/86162952737

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: 861 6295 2737 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 by uploading their document to the *Public Comment Upload Form* located under *Contact Us* on the PEBP website, *pebp.state.nv.us*, at least two business days prior to the meeting. Persons making public comment need to state and spell their name for the record at the beginning of their testimony.

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

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

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

   4.1 Approval of Action Minutes from the July 28, 2022 PEBP Board Meeting

   4.2 Receipt of quarterly staff reports for the period ending June 30, 2022:
   - 4.2.1 Budget Report
   - 4.2.2 Utilization Report

   4.3 Receipt of quarterly vendor reports for the period ending June 30, 2022:
   - 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 WTW'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 Engagement Report for August 2022

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

6. Informational report on claims payment accuracy and timeliness since the transition from HealthSCOPE Benefits to UMR. (UMR) (For Information Only)

7. Discussion and acceptance of Claim Technologies Incorporated audit findings for State of Nevada Public Employees' Benefits Program Plans for HealthSCOPE Benefits for period January 1, 2022 – March 31, 2022 (CTI) (**For Possible Action**)

8. Discussion and acceptance of Claim Technologies Incorporated audit findings for State of Nevada Public Employees' Benefits Program Plans for ExpressScripts for period July 1, 2020 – June 30, 2021 (CTI) (**For Possible Action**)

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

10. Discussion and possible direction from the Board to staff on potential program design changes for Plan Year 2024 (July 1, 2023 to June 30, 2024) for which the Board requests additional information and costs to be presented at the December 5, 2022 meeting. (Laura Rich, Executive Officer) (**For Possible Action)**

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

    11.1 Contract Overview

    11.2 New Contracts

    11.3 Contract Amendments

    11.4 Contract Solicitations

    11.5 Status of Current Solicitations

12. Public Comment

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

13. Adjournment

The supporting material to this agenda, also known as the Board Packet, is available, at no charge, on the PEBP website at 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 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 pebp.state.nv.us, at the office of the public body and to the public notice website for meetings at https://notice.nv.gov. In addition, the agenda was mailed to groups and individuals as requested.

1.

1. Open Meeting; Roll Call

2.

2. Public Comment

3.

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

4.

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

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

4.1 Approval of Action Minutes from the July 28, 2022 PEBP Board Meeting

4.2 Receipt of quarterly staff reports for the period ending June 30, 2022:

- 4.2.1 Budget Report
- 4.2.2 Utilization Report

4.3 Receipt of quarterly vendor reports for the period ending June 30, 2022:

- 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 for August 2022

4.1

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

4.1 Approval of Action Minutes from the July 28, 2022 PEBP Board Meeting.

STATE OF NEVADA
PUBLIC EMPLOYEES' BENEFITS PROGRAM
BOARD MEETING

Video/Telephonic Open Meeting
Carson City

ACTION MINUTES (Subject to Board Approval)
July 28, 2022

MEMBERS PRESENT VIA TELECONFERENCE:	Ms. Laura Freed, Board Chair Ms. Linda Fox, Vice Chair Mr. Tom Verducci, Member Ms. Betsy Aiello, Member Ms. Michelle Kelley Mr. Jim Barnes, Member Ms. Leslie Bittleston, Member Ms. Janell Woodward, Member Dr. Jennifer McClendon, Member
MEMBERS EXCUSED:	Ms. April Caughron, Member
FOR THE BOARD:	Ms. Radhika Kunnel, Deputy Attorney General
FOR STAFF:	Ms. Laura Rich, Executive Officer Mr. Nik Proper, Operations Officer Ms. Michelle Weyland, Administrative Services Officer Mr. Tim Lindley, Quality Control Officer Ms. Wendi Lunz, Executive Assistant

1. Open Meeting; Roll Call

    - Board Chair Freed opened the meeting at 9:02 a.m.

2. Public Comment

    - Terri Laird – RPEN
    - Kent Ervin – Nevada Faculty Alliance
    - Raven Sumner – UNLV Employee
    - Tess Opferman - AFSCME
    - Brooke Maylath
    - Tess Opferman - AFSCME
    - Larry Coffey - AFSCME

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

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

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

    4.1 Approval of Action Minutes from the May 26, 2022 PEBP Board Meeting

    4.2 Receipt of quarterly staff reports for the period ending March 31, 2022:
    - 4.2.1 Budget Report
    - 4.2.2 Utilization Report

    4.3 Receipt of quarterly vendor reports for the period ending March 31, 2022:
    - 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 for January 2022 through June 2022

4.4 Fiscal Year 2022 Other Post-Employment Benefits (OPEB) valuation prepared by Aon in conformance with the Governmental Accounting Standards Board (GASB) requirements.

4.5 Proposed PEBP Language Access Plan per NRS 232.0081

BOARD ACTION ON ITEM 4
MOTION: Motion to approve all the items and reports on the consent agenda with the exception of 4.2.1, 4.3.5 and 4.4.
BY: Member Leslie Bittleston
SECOND: Vice Chair Linda Fox
VOTE: Ayes - 8; the motion carried
Michelle Kelley - Abstained

BOARD ACTION ON ITEM 4.2.1, 4.3.5 and 4.4
MOTION: Motion to approve 4.2.1, 4.3.5 and 4.4.
BY: Member Jim Barnes
SECOND: Member Janelle Woodward
VOTE: Unanimous; the motion carried

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

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

6.1 Contract Overview

6.2 New Contracts

6.3 Contract Amendments

6.3.1 Claim Technologies, Inc.

6.4 Contract Solicitations

6.5 Status of Current Solicitations

BOARD ACTION ON ITEM 6.3.1
MOTION: Motion to approve staff's recommendation for Item 6.3.1.
BY: Member Leslie Bittleston
SECOND: Member Betsy Aiello
VOTE: Unanimous; the motion carried

7. Public Comment

    - Kent Ervin – Nevada Faculty Alliance

8. Adjournment

    - Board Chair Freed adjourned the meeting at 10:33 a.m.

4.2

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

    4.1 Approval of Action Minutes from the July 28, 2022 PEBP Board Meeting.

    4.2 Receipt of quarterly staff reports for the period ending June 30, 2022

4.2.1

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

4.2 Receipt of quarterly staff reports for the period ending June 30, 2022:

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: September 29, 2022

Item Number: IV.II.I

Title: Chief Financial Officer Budget Report

Summary

This report addresses the Operational Budget as of June 30, 2022 to include:

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

Budget Account 1338 – Operational Budget – Shown below is a summary of the operational budget account status as of June 30, 2022, 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 $363.5 million as of June 30, 2022, compared to $386.4 million as of June 30, 2021 or a decrease of 5.9%. Total expenses for the period have increased by $0.7 million or 0.2% for the same period.

The budget status report shows Realized Funding Available (cash) at $135.7 million. This compares to $154.8 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 6/30/2022	Work Program	Percent	Actual as of 6/30/2021	Fiscal Year 2021 Close	Percent
Beginning Cash	159,011,280	159,011,280	100%	154,541,329	154,541,329	100%
Premium Income	341,588,530	354,412,324	96%	366,550,801	368,807,766	99%
All Other Income	21,930,463	24,179,554	91%	19,835,354	24,098,398	82%
Total Income	363,518,993	378,591,878	96%	386,386,154	392,906,164	98%
Personnel Services	2,279,292	2,822,786	81%	2,311,337	2,413,496	96%
Operating - Other than Personnel	2,585,231	3,135,691	82%	2,169,759	2,340,118	93%
Insurance Program Expenses	381,671,622	389,943,547	98%	381,160,437	383,166,380	99%
All Other Expenses	286,022	1,199,300	24%	507,874	516,219	98%
Total Expenses	386,822,167	397,101,324	97%	386,149,407	388,436,213	99%
Change in Cash	(23,303,174)	(18,509,446)		236,748	4,469,951	
REALIZED FUNDING AVAILABLE	135,708,106	140,501,834	97%	154,778,077	159,011,280	97%
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	23,491,056	28,284,784		37,878,426	42,111,629	

Current Budget Projections

The following table represents projections for FY 2022. The projection reflects total income to be less than budgeted by 1.4% ($531.3 million vs $538.6 million), total expenditures are projected to be less than budgeted by 2.3% ($391.1 million vs $400.3 million); total reserves are projected to be less than budgeted by 4.6% ($140.2 million vs $147.0 million).

State Subsidies are projected to be less than the budgeted amount by $2.7 million (1.0%), Non-State Subsidies are projected to be more than budgeted by $3.3 million (16.3%), and Premium Income is projected to be less than budgeted by $8.0 million (11.6%). This overall decrease in budgeted revenue is due in part to a planned 1-month employee 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:

- 4.40% fewer state actives,
- 1.99% more state non-Medicare retirees,
- 2.38% fewer non-state actives,
- 20.35% fewer non-state, non-Medicare retirees
- 7.20% more state Medicare retirees, and
- 1.93% fewer non-state Medicare retirees

Budgeted and Projected Income (Budget Account 1338)					
Description	**Budget**	**Actual 6/30/22**	**Projected**	**Difference**	
Carryforward	159,011,280	159,011,280	159,011,280	0	0.0%
State Subsidies	266,543,926	258,832,572	263,885,832	(2,658,094)	-1.0%
Non-State Subsidies	20,042,853	22,961,216	23,317,959	3,275,106	16.3%
Premium	68,825,545	59,794,742	60,865,705	(7,959,840)	-11.6%
COVID Funds	10,507,308	8,557,308	10,507,308	0	0.0%
Appropriations	6,009,449	6,009,449	6,009,449	0	0.0%
Reversions	(8,667,000)	(8,667,000)	(8,667,000)	0	0.0%
All Other	16,329,797	16,030,706	16,360,837	31,040	0.2%
Total	538,603,158	522,530,274	531,291,370	(7,311,788)	-1.4%
Budgeted and Projected Expenses (Budget Account 1338)					
Description	**Budget**	**Actual 6/30/22**	**Projected**	**Difference**	
Operating	7,157,777	5,150,545	6,471,381	686,396	9.6%
State Insurance Costs	341,502,889	334,941,001	337,171,320	4,331,569	1.3%
Non-State Insurance Costs	11,507,187	7,955,555	8,333,545	3,173,642	27.6%
Medicare Retiree Insurance Costs	40,119,012	38,775,066	39,127,338	991,674	2.5%
Total Insurance Costs	393,129,088	381,671,622	384,632,203	8,496,885	2.2%
Total Expenses	400,286,865	386,822,167	391,103,584	9,183,281	2.3%
Restricted Reserves	112,217,050	112,217,050	109,961,889	2,255,161	2.0%
Differential Cash Available	34,766,243	23,491,057	30,225,897	4,540,346	13.1%
Total Reserves	146,983,293	135,708,107	140,187,786	6,795,507	4.6%
Total of Expenses and Reserves	547,270,158	522,530,274	531,291,370	15,978,788	2.9%

Expenses for Fiscal Year 2022 are projected to be $9.2 million (2.3%) less than budgeted when changes to reserves are excluded. Operating expenses are projected to be less than budgeted by $0.7 million (9.6%). Employee and Retiree insurances costs are projected to be less than budgeted by $8.5 million (2.2%) when taken in total (see table above for specific information).

Total reserves for the year ending June 30, 2022, are projected to be $140.2 million. Reserves include $52.3 million for Incurred but not Reported (IBNR) claims, $35.0 million for the Catastrophic Reserve to insure plan solvency, $22.8 million in HRA reserves, and a projected differential of cash available of $30.2 million.

Differential Cash Available for FY 2023

PEBP ended FY 2022 with $140.2 million of cash on hand to balance forward to FY 2023 (not including reversions). The FY 2023 budget was built with a balance forward amount of $117.9 million (not including reversions). PEBP will submit work programs to transfer the additional cash authority from FY 2022 to FY 2023 and make necessary adjustments to the required reserve category authority for FY 2023. Once all the adjustments are approved through the state budget process, PEBP is projecting a final differential cash available to begin FY 2023 of $33.1 million.

Recommendations

None.

4.2.2

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

    4.2 Receipt of quarterly staff reports for the period ending June 30, 2022:

        4.2.1 Budget Report

        4.2.2 Utilization Report

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LAURA RICH
Executive Officer

LAURA FREED
Board Chair

AGENDA ITEM

[X] Action Item
[ ] Information Only

Date: September 29, 2022

Item Number: IV.II.II

Title: Self-Funded CDHP, LDPPO, and EPO Plan Utilization Report for the period ending June 30, 2022

This report addresses medical, dental, prescription drug and HSA/HRA utilization for the PY 2022 period ending June 30, 2022. 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 Q4 Plan Year 2022 utilization data.

Executive Summary

CONSUMER DRIVEN HEALTH PLAN (CDHP)

The Consumer Driven Health Plan (CDHP) experience for Q4 of Plan Year 2022 compared to Q4 of Plan Year 2021 is summarized below.

- Population:
  - 18.3% decrease for primary participants
  - 21.3% decrease for primary participants plus dependents (members)
- Medical Cost:
  - 12.3% increase for primary participants
  - 16.5% increase for primary participants plus dependents (members)
- High-Cost Claims:
  - There were 198 High-Cost Claimants accounting for 39.5% of the total plan paid for Q4 of Plan Year 2022
  - 42.9% increase in High-Cost Claimants per 1,000 members
  - 2.2% decrease in average cost of High-Cost Claimant paid
- Top three highest cost clinical classifications include:
  - Cancer ($8.7 million) – 18.2% of paid claims
  - Pregnancy-related Disorders ($7.5 million) – 15.7% of paid claims
  - Infections ($6.2 million) – 13.0% of paid claims
- Emergency Room:
  - ER visits per 1,000 members increased 27.0%
  - Average paid per ER visit decreased 6.2%
- Urgent Care:
  - Urgent Care visits per 1,000 members increased by 29.7%
  - Average paid per Urgent Care visit decreased 9.1% (decrease from $77 to $70)
- Network Utilization:
  - 98.4% of claims are from In-Network providers
  - Q4 of Plan Year 2022 In-Network utilization increased 1.6% over PY 2021
  - Q4 of Plan Year 2022 In-Network discounts decreased 1.1% over PY 2021

- Prescription Drug Utilization:
  - Overall:
    - Total Net Claims decreased 17.1%
    - Total Gross Claims Costs decreased 12.5% ($6.7 million)
    - Average Total Cost per Claim increased 5.6%
      - From $102.38 to $108.12
  - Member:
    - Total Member Cost decreased 11.5%
    - Average Participant Share per Claim increased 6.8%
    - Net Member PMPM increased 12.6%
      - From $25.76 to $29.00
  - Plan
    - Total Plan Cost decreased 12.8%

        - Average Plan Share per Claim increased 5.2%
        - Net Plan PMPM increased 11.0%
            - From $80.67 to $89.53
        - Net Plan PMPM factoring rebates increased 4.9%
            - From $62.05 to $65.09

LOW DEDUCTIBLE PPO PLAN (LDPPO)

The Low Deductible PPO Plan (LDPPO) experience for Q4 of Plan Year 2022 is summarized below.

- Population:
    - 4,243 primary participants
    - 8,598 primary participants plus dependents (members)
- Medical Cost:
    - $585 PEPM for primary participants
    - $289 PMPM for primary participants plus dependents (members)
- High-Cost Claims:
    - There were 44 High-Cost Claimants accounting for 34.2% of the total plan paid for Q4 of Plan Year 2022
    - High-Cost Claimants per 1,000 members was 5.1
    - Average cost of High-Cost Claimant paid was $231,814
- Top three highest cost clinical classifications include:
    - Cancer ($2.4 million) – 23.5% of paid claims
    - Congenital / Chromosomal Anomalies ($1.1 million) – 10.9% of paid claims
    - Pregnancy-related Disorders ($0.8 million) – 8.3% of paid claims
- Emergency Room:
    - 122 ER visits per 1,000 members
    - Average paid per ER visit was $2,378
- Urgent Care:
    - 289 Urgent Care visits per 1,000 members
    - Average paid per Urgent Care visit was $120
- Network Utilization:
    - 98.7% of claims are from In-Network providers
    - Q4 of Plan Year 2022 In-Network discounts was 62.8%

- Prescription Drug Utilization:
    - Overall:
        - Total Net Claims through Q4 was 117,576
        - Total Gross Claims Costs was $12.7 million
        - Average Total Cost per Claim was $108.33
    - Member:
        - Total Member Cost through Q4 was $2.3 million
        - Average Participant Share per Claim was $19.94
        - Net Member PMPM was $22.90
    - Plan
        - Total Plan Cost through Q4 was $10.4 million
        - Average Plan Share per Claim was $88.38
        - Net Plan PMPM was $101.49
        - Net Plan PMPM factoring rebates was $91.16

PEBP PREMIER PLAN (EPO)

The PEBP Premier Plan (EPO) experience for Q4 of Plan Year 2022 compared to Q4 of Plan Year 2021 is summarized below.

- Population:
  - 13.2% decrease for primary participants
  - 12.1% decrease for primary participants plus dependents (members)
- Medical Cost:
  - 0.1% decrease for primary participants
  - 1.4% decrease for primary participants plus dependents (members)
- High-Cost Claims:
  - There were 59 High-Cost Claimants accounting for 31.5% of the total plan paid for Plan Year 2022
  - 10.0% increase in High-Cost Claimants per 1,000 members
  - 4.7% decrease in average cost of High-Cost Claimant paid
- Top three highest cost clinical classifications include:
  - Infections ($2.3 million) – 15.9 of paid claims
  - Pulmonary Disorders ($1.9 million) – 12.8% of paid claims
  - Cancer ($1.7 million) – 11.4% of paid claims
- Emergency Room:
  - ER visits per 1,000 members increased by 16.9%
  - Average paid per ER visit decreased by 19.8%
- Urgent Care:
  - Urgent Care visits per 1,000 members increased by 40.1%
  - Average paid per Urgent Care visit increased 1.3%
- Network Utilization:
  - 100% of claims are from In-Network providers
  - In-Network utilization increased 0.1%
  - In-Network discounts increased 6.3%
- Prescription Drug Utilization:
  - Overall:
    - Total Net Claims decreased 10.8%
    - Total Gross Claims Costs decreased 10.1% ($2.2 million)
    - Average Total Cost per Claim increased 0.8%
      - From $127.41 to $128.48
  - Member:
    - Total Member Cost decreased 8.3%
    - Average Participant Share per Claim increased 2.8%
    - Net Member PMPM increased 4.4%
      - From $35.96 to $37.53
  - Plan
    - Total Plan Cost decreased 10.4%
    - Average Plan Share per Claim increased 0.4%
    - Net Plan PMPM increased 2.0%
      - From $177.11 to $180.65
    - Net Plan PMPM factoring rebates increased 0.5%
      - From $136.47 to $137.14

DENTAL PLAN

The Dental Plan experience for Q4 of Plan Year 2022 is summarized below.

- Dental Cost:
  - Total Dental claims paid increased 0.82% (from $24.9 million for Q4 of PY21 to $25.1 million for Q4 of PY22)
    - Preventative claims account for 44.5% ($11.2 million)
    - Basic claims account for 28.7% ($7.2 million)
    - Major claims account for 19.5% ($4.9 million)
    - Periodontal claims account for 7.4% ($1.9 million)

HEALTH REIMBURSEMENT ARRANGEMENT

The table below provides a list of CDHP HRA account balances as of June 30, 2022.

HRA Account Balances as of June 30, 2022			
$Range	**# Accounts**	**Total Account Balance**	**Average Per Account Balance**
0	1,820	0	0
$.01 - $500.00	3,218	619,799	193
$500.01 - $1,000	1,383	943,284	682
$1,000.01 - $1,500	679	843,325	1,242
$1,500.01 - $2,000	436	758,767	1,740
$2,000.01 - $2,500	295	671,183	2,275
$2,500.01 - $3,000	279	760,319	2,725
$3,000.01 - $3,500	253	818,308	3,234
$3,500.01 - $4,000	165	613,126	3,716
$4,000.01 - $4,500	143	608,060	4,252
$4,500.01 - $5,000	91	436,996	4,802
$5,000.01 +	**679**	**5,679,805**	**224,103**
Total	**9,441**	**$ 12,752,972**	**$ 1,351**

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 fourth quarter of Plan Year 2022. The CDHP total plan paid costs decreased 8.4% over the same time for Plan Year 2021. The EPO total plan paid costs decreased 13.2% over Q4 of Plan Year 2021. For HMO utilization and cost data please see the report provided in Appendix D.

Appendix A

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HealthSCOPE – CDHP Utilization Review for PEBP
July 1, 2021 – June 30, 2022

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HSB DATASCOPE™

Nevada Public Employees' Benefits Program
HDHP Plan

July 2021 – June 2022

HealthSCOPE BENEFITS

Overview

- Total Medical Spend for PY22 was $121,061,784 of which 78.1% was spent in the State Active population. When compared to PY21, this reflected a decrease of 8.4% in plan spend, with State Actives having a decrease of 5.9%.
  - When compared to PY20, PY22 decreased 15.7%, with State Actives having a decrease of 10.9%.
- On a PEPY basis, PY22 reflected an increase of 12.2% when compared to PY21. The largest group, State Actives, increased 17.6%.
  - When compared to PY20, PY22 increased 4.7%, with State Actives increasing by 12.9%.
- 85.8% of the Average Membership had paid Medical claims less than $2,500, with 18.0% of those having no claims paid at all during the reporting period.
- There were 198 high-cost Claimants (HCC's) over $100K, that accounted for 39.5% of the total spend. HCCs accounted for 33.3% of total spend during PY21, with 178 members hitting the $100K threshold. The largest diagnosis grouper was Cancer accounting for 18.2% of high-cost claimant dollars.
- IP Paid per Admit was $29,540 which is an increase of 19.8% compared to PY21.
- ER Paid per Visit is $1,958, which is a decrease of 6.2% compared to PY21.
- 98.4% of all Medical spend dollars were to In Network providers. The average In Network discount was 64.8%, which is a decrease of 1.7% compared to the PY21 average discount of 65.9%.

Paid Claims by Age Group

Paid Claims by Age Group																
	PY21						PY20						% 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	$ 5,415,443	$ 1,347	$ 44,350	$ 11	$ 5,459,793	$ 1,358	$ 10,042,272	$ 3,472	$ 20,414	$ 7	$ 10,062,686	$ 3,479	84.3%	156.2%
1	$ 770,967	$ 167	$ 177,140	$ 38	$ 948,107	$ 206	$ 541,836	$ 174	$ 21,696	$ 7	$ 563,532	$ 181	-40.6%	-12.2%
2 - 4	$ 1,387,222	$ 88	$ 267,896	$ 17	$ 1,655,118	$ 106	$ 1,285,406	$ 120	$ 176,565	$ 16	$ 1,461,971	$ 136	-11.7%	28.8%
5 - 9	$ 1,823,563	$ 62	$ 458,414	$ 16	$ 2,281,977	$ 78	$ 1,249,888	$ 57	$ 508,750	$ 23	$ 1,758,638	$ 80	-22.9%	3.3%
10 - 14	$ 3,212,849	$ 95	$ 536,193	$ 16	$ 3,749,042	$ 110	$ 3,226,426	$ 129	$ 319,748	$ 13	$ 3,546,174	$ 142	-5.4%	28.3%
15 - 19	$ 3,321,789	$ 93	$ 786,785	$ 22	$ 4,108,574	$ 116	$ 4,138,279	$ 152	$ 536,105	$ 20	$ 4,674,384	$ 171	13.8%	48.2%
20 - 24	$ 4,525,090	$ 114	$ 1,209,865	$ 30	$ 5,734,955	$ 144	$ 3,905,935	$ 126	$ 678,949	$ 22	$ 4,584,884	$ 148	-20.1%	2.9%
25 - 29	$ 7,942,807	$ 254	$ 1,608,988	$ 51	$ 9,551,795	$ 305	$ 5,082,897	$ 211	$ 610,269	$ 25	$ 5,693,166	$ 236	-40.4%	-22.6%
30 - 34	$ 6,156,246	$ 167	$ 2,161,190	$ 59	$ 8,317,436	$ 225	$ 5,800,968	$ 204	$ 1,146,266	$ 40	$ 6,947,234	$ 245	-16.5%	8.7%
35 - 39	$ 6,948,179	$ 175	$ 3,053,399	$ 77	$ 10,001,578	$ 253	$ 6,505,080	$ 214	$ 1,015,029	$ 33	$ 7,520,109	$ 247	-24.8%	-2.2%
40 - 44	$ 6,891,321	$ 183	$ 2,597,142	$ 69	$ 9,488,463	$ 252	$ 7,569,551	$ 250	$ 1,427,267	$ 47	$ 8,996,818	$ 297	-5.2%	17.7%
45 - 49	$ 10,290,128	$ 273	$ 3,422,156	$ 91	$ 13,712,284	$ 364	$ 8,371,377	$ 289	$ 1,885,162	$ 65	$ 10,256,539	$ 354	-25.2%	-2.8%
50 - 54	$ 15,741,635	$ 390	$ 5,028,555	$ 125	$ 20,770,190	$ 515	$ 12,453,680	$ 379	$ 2,800,408	$ 85	$ 15,254,088	$ 464	-26.6%	-9.7%
55 - 59	$ 17,606,504	$ 401	$ 6,560,096	$ 149	$ 24,166,600	$ 550	$ 17,218,432	$ 487	$ 3,998,063	$ 113	$ 21,216,495	$ 600	-12.2%	9.0%
60 - 64	$ 24,591,770	$ 506	$ 8,019,921	$ 165	$ 32,611,691	$ 670	$ 20,994,317	$ 509	$ 5,565,183	$ 135	$ 26,559,500	$ 643	-18.6%	-4.0%
65+	$ 15,467,844	$ 541	$ 5,366,786	$ 188	$ 20,834,630	$ 728	$ 12,675,441	$ 490	$ 3,580,556	$ 138	$ 16,255,997	$ 629	-22.0%	-13.7%
Total	**$ 132,093,355**	**$ 260**	**$ 41,298,876**	**$ 81**	**$ 173,392,231**	**$ 342**	**$ 121,061,784**	**$ 303**	**$ 24,290,431**	**$ 61**	**$ 145,352,216**	**$ 364**	**-16.2%**	**6.5%**

Financial Summary (p. 1 of 2)

	Total				State Active				Non-State Active			
Summary	**PY20**	**PY21**	**PY22**	**Variance to Prior Year**	**PY20**	**PY21**	**PY22**	**Variance to Prior Year**	**PY20**	**PY21**	**PY22**	**Variance to Prior Year**
Enrollment												
Avg # Employees	23,673	23,322	19,051	-18.3%	19,809	19,529	15,628	-20.0%	4	4	3	-25.0%
Avg # Members	42,865	42,317	33,287	-21.3%	37,291	36,761	28,274	-23.1%	7	9	8	-11.1%
Ratio	1.8	1.8	1.8	-3.3%	1.9	1.9	1.8	-3.7%	1.8	2.3	2.7	18.7%
Financial Summary												
Gross Cost	$185,251,114	$169,798,016	$155,377,306	-8.5%	$139,774,757	$131,033,700	$121,460,006	-7.3%	$46,064	$40,353	$62,384	54.6%
Client Paid	$143,667,208	$132,093,355	$121,061,784	-8.4%	$106,095,205	$100,467,765	$94,525,005	-5.9%	$35,053	$26,699	$44,950	68.4%
Employee Paid	$41,583,906	$37,704,661	$34,315,522	-9.0%	$33,679,553	$30,565,935	$26,935,002	-11.9%	$11,011	$13,654	$17,434	27.7%
Client Paid-PEPY	$6,069	$5,664	$6,355	12.2%	$5,356	$5,144	$6,049	17.6%	$9,144	$6,675	$14,983	124.5%
Client Paid-PMPY	$3,352	$3,122	$3,637	16.5%	$2,845	$2,733	$3,343	22.3%	$5,130	$2,967	$5,619	89.4%
Client Paid-PEPM	$506	$472	$530	12.3%	$446	$429	$504	17.5%	$762	$556	$1,249	124.6%
Client Paid-PMPM	$279	$260	$303	16.5%	$237	$228	$279	22.4%	$427	$247	$468	89.5%
High Cost Claimants (HCC's) > $100k												
# of HCC's	206	178	198		151	128	152		0	0	0	
HCC's / 1,000	4.8	4.2	6.0		4.1	3.5	5.4		0.0	0.0	0.0	
Avg HCC Paid	$236,642	$246,763	$241,256	-2.2%	$206,591	$237,270	$246,809	4.0%	$0	$0	$0	0.0%
HCC's % of Plan Paid	33.9%	33.3%	39.5%	18.6%	29.4%	30.2%	39.7%	31.5%	0.0%	0.0%	0.0%	0.0%
Cost Distribution by Claim Type (PMPY)												
Facility Inpatient	$1,139	$893	$1,417	58.7%	$883	$750	$1,310	74.7%	$0	$14	$0	0.0%
Facility Outpatient	$1,040	$991	$1,059	6.9%	$880	$822	$928	12.9%	$2,087	$2,152	$3,664	70.3%
Physician	$1,093	$1,174	$1,084	-7.7%	$1,014	$1,105	$1,033	-6.5%	$2,777	$770	$1,902	147.0%
Other	$80	$64	$78	21.9%	$68	$56	$72	28.6%	$266	$30	$53	0.0%
Total	$3,352	$3,122	$3,637	16.5%	$2,845	$2,733	$3,343	22.3%	$5,130	$2,967	$5,619	89.4%

Financial Summary (p. 2 of 2)

	State Retirees				Non-State Retirees				
Summary	**PY20**	**PY21**	**PY22**	**Variance to Prior Year**	**PY20**	**PY21**	**PY22**	**Variance to Prior Year**	**HSB Peer Index**
Enrollment									
Avg # Employees	3,246	3,268	2,985	-8.7%	615	521	436	-16.3%	
Avg # Members	4,858	4,933	4,488	-9.0%	710	614	517	-15.9%	
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	$30,559,993	-7.5%	$6,079,723	$5,698,970	$3,294,923	-42.2%	
Client Paid	$32,691,908	$26,900,984	$24,143,064	-10.3%	$4,845,042	$4,697,908	$2,348,765	-50.0%	
Employee Paid	$6,658,661	$6,124,010	$6,416,929	4.8%	$1,234,681	$1,001,063	$946,157	-5.5%	
Client Paid-PEPY	$10,070	$8,231	$8,089	-1.7%	$7,882	$9,024	$5,392	-40.2%	$6,642
Client Paid-PMPY	$6,730	$5,454	$5,379	-1.4%	$6,821	$7,646	$4,545	-40.6%	$4,116
Client Paid-PEPM	$839	$686	$674	-1.7%	$657	$752	$449	-40.3%	$553
Client Paid-PMPM	$561	$454	$448	-1.3%	$568	$637	$379	-40.5%	$343
High Cost Claimants (HCC's) > $100k									
# of HCC's	60	44	51		8	9	4		
HCC's / 1,000	12.4	8.9	11.4		11.3	14.7	7.7		
Avg HCC Paid	$271,721	$261,318	$191,097	-26.9%	$156,233	$228,360	$126,929	-44.4%	
HCC's % of Plan Paid	49.9%	42.7%	40.4%	-5.4%	25.8%	43.7%	21.6%	-50.6%	
Cost Distribution by Claim Type (PMPY)									
Facility Inpatient	$2,853	$1,597	$2,075	29.9%	$2,835	$3,771	$1,567	-58.4%	$1,190
Facility Outpatient	$2,107	$2,154	$1,818	-15.6%	$2,143	$1,733	$1,569	-9.5%	$1,376
Physician	$1,600	$1,586	$1,374	-13.4%	$1,745	$2,022	$1,294	-36.0%	$1,466
Other	$170	$116	$112	-3.4%	$98	$120	$116	-3.3%	$84
Total	$6,730	$5,454	$5,379	-1.4%	$6,821	$7,646	$4,545	-40.6%	$4,116

Paid Claims by Claim Type – State Participants

Net Paid Claims - Total State Participants	PY21				PY22				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical									
Inpatient	$ 34,186,446	$ 5,917,760	$ 2,940,974	$ 43,045,180	$ 41,278,841	$ 8,426,715	$ 1,685,947	$ 51,391,504	19.4%
Outpatient	$ 66,281,319	$ 15,258,658	$ 2,783,591	$ 84,323,569	$ 53,246,164	$ 12,370,539	$ 1,659,862	$ 67,276,566	-20.2%
Total - Medical	**$ 100,467,765**	**$ 21,176,419**	**$ 5,724,565**	**$ 127,368,749**	**$ 94,525,005**	**$ 20,797,254**	**$ 3,345,810**	**$ 118,668,069**	**-6.8%**

Net Paid Claims - Per Participant per Month	PY21				PY22				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical	$ 437	$ 823	$ 887	$ 486	$ 504	$ 731	$ 455	$ 531	9.2%

Paid Claims by Claim Type – Non-State Participants

Net Paid Claims - Total Non-State Participants	PY21				PY22				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical									
Inpatient	$ 126	$ 1,556,727	$ 987,069	$ 2,543,922	$ 435	$ 601,615	$ 308,864	$ 910,915	-64.2%
Outpatient	$ 26,572	$ 1,476,264	$ 677,848	$ 2,180,684	$ 44,514	$ 910,426	$ 527,860	$ 1,482,800	-32.0%
Total - Medical					**$ 44,950**	**$ 1,512,042**	**$ 836,724**	**$ 2,393,715**	**#DIV/0!**

Net Paid Claims - Per Participant per Month	PY21				PY22				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical	$ 742	$ 1,478	$ 614	$ 984	$ 1,249	$ 766	$ 257	$ 455	-53.8%

Paid Claims by Claim Type – Total Participants

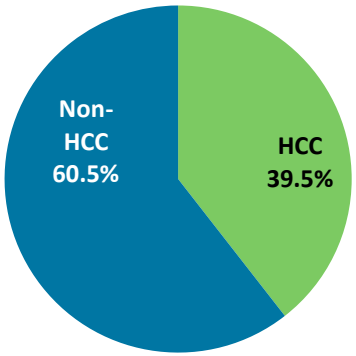
Net Paid Claims - Total Total Participants	PY21				PY22				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical									
Inpatient	$ 34,186,572	$ 7,474,487	$ 3,928,043	$ 45,589,102	$ 41,279,276	$ 9,028,330	$ 1,994,811	$ 52,302,418	14.7%
Outpatient	$ 66,307,891	$ 16,734,922	$ 3,461,439	$ 86,504,253	$ 53,290,678	$ 13,280,966	$ 2,187,722	$ 68,759,366	-20.5%
Total - Medical	**$ 100,494,463**	**$ 24,209,409**	**$ 7,389,483**	**$ 132,093,355**	**$ 94,569,955**	**$ 22,309,296**	**$ 4,182,533**	**$ 121,061,784**	**-8.4%**

Net Paid Claims - Per Participant per Month	PY21				PY22				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	
Medical	$ 437	$ 872	$ 806	$ 495	$ 504	$ 733	$ 395	$ 530	6.9%

Cost Distribution – Medical Claims

PY21							PY22					
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
152	0.4%	$43,883,781	33.2%	$1,073,302	2.8%	$100,000.01 Plus	152	0.5%	$47,171,219	39.0%	$1,228,731	3.6%
213	0.5%	$16,264,896	12.3%	$1,244,260	3.3%	$50,000.01-$100,000.00	189	0.6%	$15,301,169	12.6%	$1,294,994	3.8%
461	1.1%	$17,136,650	13.0%	$2,295,167	6.1%	$25,000.01-$50,000.00	317	1.0%	$12,646,070	10.4%	$1,880,808	5.5%
1,222	2.9%	$19,974,070	15.1%	$5,585,381	14.8%	$10,000.01-$25,000.00	917	2.8%	$16,218,322	13.4%	$4,768,289	13.9%
1,598	3.8%	$11,905,474	9.0%	$5,232,865	13.9%	$5,000.01-$10,000.00	1,365	4.1%	$10,747,869	8.9%	$4,703,618	13.7%
2,237	5.3%	$8,471,324	6.4%	$4,901,617	13.0%	$2,500.01-$5,000.00	1,857	5.6%	$7,190,135	5.9%	$4,432,106	12.9%
25,771	60.9%	$14,457,162	10.9%	$15,633,034	41.5%	$0.01-$2,500.00	18,708	56.2%	$11,786,999	9.7%	$13,928,915	40.6%
3,561	8.4%	$0	0.0%	$1,739,036	4.6%	$0.00	3,782	11.4%	$0	0.0%	$2,078,060	6.1%
7,102	16.8%	$0	0.0%	$0	0.0%	No Claims	6,001	18.0%	$0	0.0%	$0	0.0%
42,317	**100.0%**	**$132,093,355**	**100.0%**	**$37,704,661**	**100.0%**		**33,287**	**100.0%**	**$121,061,784**	**100.0%**	**$34,315,522**	**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	65	$8,679,983	18.2%
Pregnancy-related Disorders	12	$7,501,107	15.7%
Infections	100	$6,229,319	13.0%
Cardiac Disorders	131	$3,765,214	7.9%
Neurological Disorders	101	$2,450,401	5.1%
Gastrointestinal Disorders	105	$2,356,001	4.9%
Renal/Urologic Disorders	76	$2,354,425	4.9%
Trauma/Accidents	60	$1,838,343	3.8%
Mental Health	57	$1,830,423	3.8%
Endocrine/Metabolic Disorders	76	$1,544,981	3.2%
All Other		$9,218,424	19.3%
Overall	**----**	**$47,768,622**	**100.0%**

Utilization Summary (p. 1 of 2)

Inpatient data reflects facility charges and professional services.
DX&L = Diagnostics, X-Ray and Laboratory

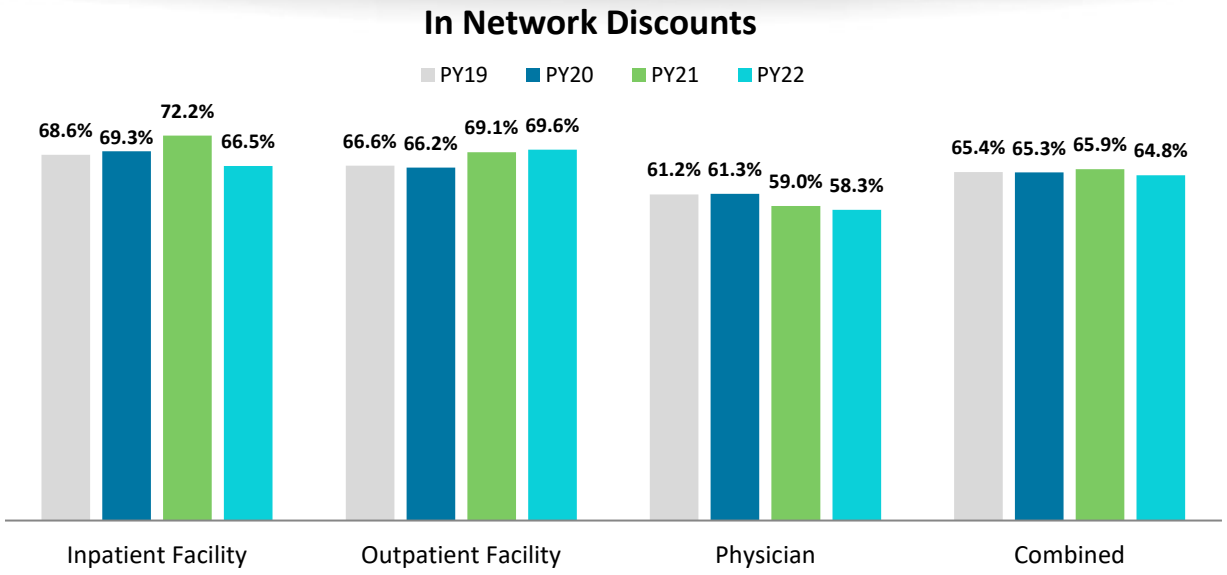
	Total				State Active				Non-State Active			
Summary	**PY20**	**PY21**	**PY22**	**Variance to Prior Year**	**PY20**	**PY21**	**PY22**	**Variance to Prior Year**	**PY20**	**PY21**	**PY22**	**Variance to Prior Year**
Inpatient Summary												
# of Admits	1,794	1,624	1,383		1,368	1,291	1,026		0	0	0	
# of Bed Days	10,484	9,984	8,716		7,803	7,887	6,405		0	0	0	
Paid Per Admit	$25,871	$24,652	$29,540	19.8%	$25,932	$23,488	$30,577	30.2%	$0	$0	$0	0.0%
Paid Per Day	$4,427	$4,010	$4,687	16.9%	$4,546	$3,845	$4,898	27.4%	$0	$0	$0	0.0%
Admits Per 1,000	42	38	42	10.5%	36	35	36	2.9%	0	0	0	0.0%
Days Per 1,000	243	236	262	11.0%	208	215	227	5.6%	0	0	0	0.0%
Avg LOS	5.8	6.1	6.3	3.3%	5.7	6.1	6.2	1.6%	0	0	0	0.0%
# of Admits From ER	913	861	781		639	643	521		0	0	0	
Physician Office												
OV Utilization per Member	3.9	3.9	3.9	0.0%	3.7	3.7	3.7	0.0%	10.7	3.7	3.9	5.4%
Avg Paid per OV	$78	$81	$83	2.5%	$77	$82	$84	2.4%	$117	$102	$95	-6.9%
Avg OV Paid per Member	$305	$316	$322	1.9%	$284	$302	$309	2.3%	$1,253	$374	$369	-1.3%
DX&L Utilization per Member	7.7	7.8	7.7	-1.3%	7.2	7.3	7.2	-1.4%	0	0	15.1	0.0%
Avg Paid per DX&L	$58	$56	$57	1.8%	$55	$53	$54	1.9%	$0	$0	$220	0.0%
Avg DX&L Paid per Member	$448	$438	$440	0.5%	$395	$387	$388	0.3%	$0	$0	$3,328	0.0%
Emergency Room												
# of Visits	6,106	4,867	4,872		5,099	4,146	4,054		2	2	6	
Visits Per Member	0.14	0.12	0.15	25.0%	0.14	0.11	0.14	27.3%	0.29	0.22	0.75	0.0%
Visits Per 1,000	142	115	146	27.0%	136	113	143	26.5%	293	222	750	0.0%
Avg Paid per Visit	$2,152	$2,088	$1,958	-6.2%	$2,152	$2,119	$1,996	-5.8%	$1,803	$8,337	$1,349	0.0%
Urgent Care												
# of Visits	12,124	8,962	9,145		10,976	8,007	8,103		2	4	5	
Visits Per Member	0.28	0.21	0.27	28.6%	0.29	0.22	0.29	31.8%	0.29	0.44	0.63	0.0%
Visits Per 1,000	281	212	275	29.7%	292	218	287	31.7%	286	444	625	0.0%
Avg Paid per Visit	$41	$77	$70	-9.1%	$40	$77	$70	-9.1%	$183	$99	$106	0.0%

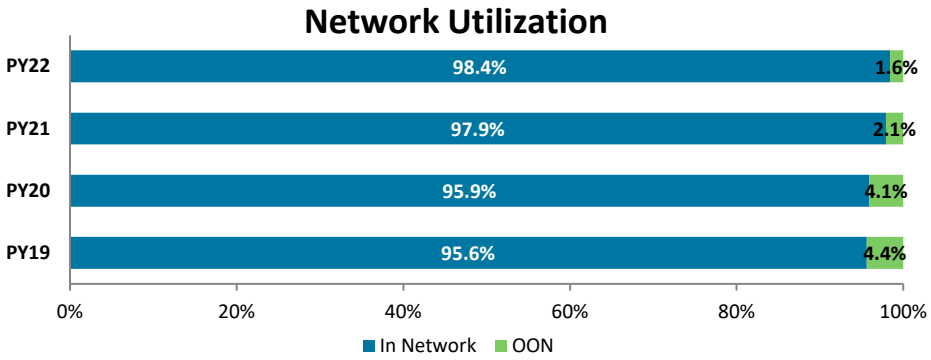
Utilization Summary (p. 2 of 2)

Inpatient data reflects facility charges and professional services.
DX&L = Diagnostics, X-Ray and Laboratory

	State Retirees				Non-State Retirees				
Summary	**PY20**	**PY21**	**PY22**	**Variance to Prior Year**	**PY20**	**PY21**	**PY22**	**Variance to Prior Year**	**HSB Peer Index**
Inpatient Summary									
# of Admits	320	274	306		106	59	51		
# of Bed Days	2,123	1,779	1,980		558	318	331		
Paid Per Admit	$28,174	$28,774	$26,671	-7.3%	$18,129	$30,974	$25,883	-16.4%	$18,822
Paid Per Day	$4,247	$4,432	$4,122	-7.0%	$3,444	$5,747	$3,988	-30.6%	$3,265
Admits Per 1,000	66	56	68	21.4%	150	96	99	3.1%	70
Days Per 1,000	438	361	441	22.2%	789	518	641	23.7%	402
Avg LOS	6.6	6.5	6.5	0.0%	5.3	5.4	6.5	20.4%	5.8
# of Admits From ER	199	178	224		75	40	36		
Physician Office									
OV Utilization per Member	5.3	5.0	5.1	2.0%	7.2	6.8	6.8	0.0%	5.4
Avg Paid per OV	$80	$82	$82	0.0%	$83	$59	$40	-32.2%	$96
Avg OV Paid per Member	$426	$411	$414	0.7%	$597	$403	$268	-33.5%	$515
DX&L Utilization per Member	10.9	10.6	10.3	-2.8%	13.2	12.5	10.3	-17.6%	11.0
Avg Paid per DX&L	$76	$73	$72	-1.4%	$53	$64	$60	-6.3%	$50
Avg DX&L Paid per Member	$824	$768	$742	-3.4%	$694	$803	$620	-22.8%	$543
Emergency Room									
# of Visits	817	627	713		188	92	99		
Visits Per Member	0.17	0.13	0.16	23.1%	0.27	0.15	0.19	26.7%	0.22
Visits Per 1,000	169	127	159	25.2%	266	150	192	28.0%	221
Avg Paid per Visit	$2,257	$1,874	$1,795	-4.2%	$1,713	$2,001	$1,630	-18.5%	$968
Urgent Care									
# of Visits	990	850	955		156	101	82		
Visits Per Member	0.20	0.17	0.21	23.5%	0.22	0.16	0.16	0.0%	0.35
Visits Per 1,000	204	172	213	23.8%	221	164	159	-3.0%	352
Avg Paid per Visit	$55	$79	$71	-10.1%	$37	$79	$39	-50.6%	$135

Provider Network Summary





Diagnosis Grouper Summary

Diagnosis Grouper	Total Paid	% Paid	Insured	Spouse	Child	Male	Female	Unassigned
Pregnancy-related Disorders	$12,733,015	10.5%	$3,176,471	$937,097	$8,619,446	$7,289,635	$4,942,732	$500,648
Infections	$12,553,242	10.4%	$7,908,080	$3,645,083	$1,000,080	$6,764,332	$5,788,615	$295
COVID-19, Confirmed	$4,389,687	3.6%	$3,100,005	$1,071,094	$218,589	$2,243,349	$2,146,339	$0
Cancer	$12,513,757	10.3%	$10,463,881	$1,508,166	$541,710	$6,218,288	$6,295,469	$0
Health Status/Encounters	$9,129,347	7.5%	$5,428,246	$1,330,761	$2,370,340	$3,390,409	$5,727,243	$11,695
Gastrointestinal Disorders	$8,611,694	7.1%	$6,186,594	$1,525,378	$899,722	$4,196,566	$4,415,100	$28
Cardiac Disorders	$8,459,967	7.0%	$6,792,158	$1,571,293	$96,516	$5,369,998	$3,086,499	$3,469
Musculoskeletal Disorders	$7,759,598	6.4%	$5,731,890	$1,174,322	$853,386	$3,194,107	$4,541,646	$23,844
Neurological Disorders	$5,985,358	4.9%	$4,157,811	$1,092,644	$734,904	$1,817,770	$4,167,038	$550
Mental Health	$5,937,517	4.9%	$1,986,623	$462,774	$3,488,121	$2,214,856	$3,722,662	$0
Trauma/Accidents	$5,462,480	4.5%	$3,507,261	$585,396	$1,369,823	$2,762,792	$2,699,688	$0
Spine-related Disorders	$4,931,109	4.1%	$3,364,100	$1,110,891	$456,117	$1,674,825	$3,256,248	$36
Renal/Urologic Disorders	$4,543,708	3.8%	$2,927,229	$1,320,836	$295,643	$2,449,238	$2,094,219	$251
Eye/ENT Disorders	$3,361,824	2.8%	$2,351,156	$398,199	$612,468	$1,360,703	$2,000,600	$521
Endocrine/Metabolic Disorders	$2,958,614	2.4%	$2,389,031	$389,525	$180,057	$1,109,522	$1,848,662	$429
Pulmonary Disorders	$2,799,025	2.3%	$1,730,443	$434,090	$634,492	$1,299,871	$1,472,691	$26,462
Gynecological/Breast Disorders	$2,184,179	1.8%	$1,520,790	$422,851	$240,539	$58,508	$2,123,430	$2,241
Medical/Surgical Complications	$1,479,137	1.2%	$1,194,037	$220,181	$64,919	$777,986	$701,151	$0
Non-malignant Neoplasm	$1,456,490	1.2%	$974,461	$448,923	$33,106	$375,525	$1,080,965	$0
Dermatological Disorders	$1,392,014	1.1%	$875,626	$205,317	$311,071	$783,610	$608,405	$0
Congenital/Chromosomal Anomalies	$1,335,145	1.1%	$149,971	$5,046	$1,180,128	$849,697	$484,911	$537
Vascular Disorders	$1,188,147	1.0%	$995,372	$182,940	$9,835	$648,109	$540,038	$0
Miscellaneous	$1,118,927	0.9%	$611,141	$307,935	$199,852	$535,696	$563,949	$19,282
Diabetes	$1,084,360	0.9%	$693,065	$229,329	$161,966	$641,335	$443,025	$0
Hematological Disorders	$1,030,194	0.9%	$917,498	$58,806	$53,890	$340,303	$689,891	$0
Abnormal Lab/Radiology	$601,145	0.5%	$467,288	$120,076	$13,781	$234,303	$366,484	$357
Medication Related Conditions	$183,220	0.2%	$97,612	$41,283	$44,325	$77,903	$105,317	$0
Cholesterol Disorders	$116,441	0.1%	$92,749	$21,572	$2,120	$55,923	$60,519	$0
Allergic Reaction	$76,708	0.1%	$54,605	$6,142	$15,962	$30,128	$46,580	$0
Dental Conditions	$42,916	0.0%	$27,158	$1,578	$14,180	$16,762	$26,154	$0
External Hazard Exposure	$32,503	0.0%	$10,521	$13,836	$8,146	$18,950	$13,553	$0
Total	**$121,061,784**	**100.0%**	**$76,782,867**	**$19,772,270**	**$24,506,647**	**$56,557,652**	**$63,913,485**	**$590,647**

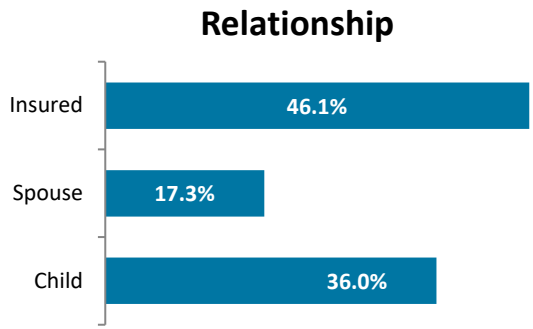
Mental Health Drilldown

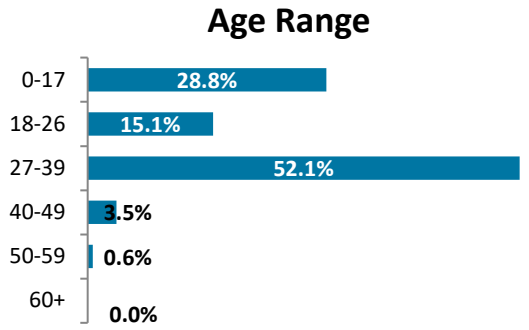
	PY19		PY20		PY21		PY22	
Grouper	Patients	Total Paid	Patients	Total Paid	Patients	Total Paid	Patients	Total Paid
Depression	1,438	$960,442	1,578	$1,202,510	1,622	$1,042,887	1,283	$1,216,572
Developmental Disorders	132	$376,873	155	$796,920	190	$1,169,559	152	$869,967
Alcohol Abuse/Dependence	127	$888,930	134	$689,963	129	$999,750	105	$844,866
Eating Disorders	46	$77,221	49	$159,855	50	$598,404	55	$624,485
Mental Health Conditions, Other	1,243	$504,177	1,341	$786,711	1,278	$792,762	1,079	$496,561
Substance Abuse/Dependence	115	$1,226,970	131	$1,029,390	138	$370,274	92	$482,356
Mood and Anxiety Disorders	1,646	$366,935	1,860	$484,244	1,957	$609,469	1,619	$480,089
Bipolar Disorder	343	$314,670	349	$379,745	319	$507,979	248	$297,995
Complications of Substance Abuse	85	$578,454	94	$713,276	74	$456,459	59	$288,895
Schizophrenia	26	$49,918	30	$46,596	26	$136,199	29	$103,628
Psychoses	47	$102,096	59	$71,859	52	$115,493	41	$85,700
Attention Deficit Disorder	428	$49,357	460	$60,539	493	$68,592	409	$60,653
Sleep Disorders	529	$48,331	568	$45,329	549	$70,710	410	$51,845
Personality Disorders	18	$13,066	24	$18,327	26	$17,095	24	$14,470
Sexually Related Disorders	53	$27,530	60	$20,133	67	$164,428	51	$13,115
Tobacco Use Disorder	172	$13,424	161	$6,997	124	$8,023	120	$6,321
Total		**$5,598,394**		**$6,512,394**		**$7,128,082**		**$5,937,517**

Diagnosis Grouper – Pregnancy-related Disorders

Diagnosis Sub-Grouper	Patients	Claims	Total Paid	% Paid
Perinatal Disorders	147	593	$2,944,874	23.1%
Liveborn Infants	239	423	$2,856,755	22.4%
Prematurity and Low Birth Weight	12	36	$2,569,424	20.2%
Labor and Delivery Related	321	833	$1,995,915	15.7%
Pregnancy Complications	438	1,760	$1,732,496	13.6%
Supervision of Pregnancy	524	2,343	$329,074	2.6%
Fetal Distress	13	53	$142,811	1.1%
Multiple Gestation Related	10	99	$87,041	0.7%
Abortion Related	49	126	$40,000	0.3%
Cesarean Delivery	23	24	$20,109	0.2%
Ectopic Pregnancy	6	19	$14,194	0.1%
Birth Injury	2	6	$323	0.0%
Overall	----	----	**$12,733,015**	**100.0%**

*Patient and claim counts are unique only within the category

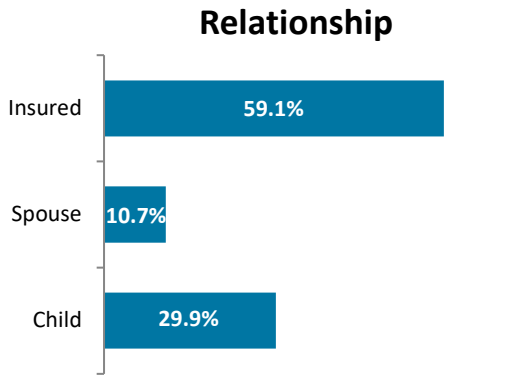


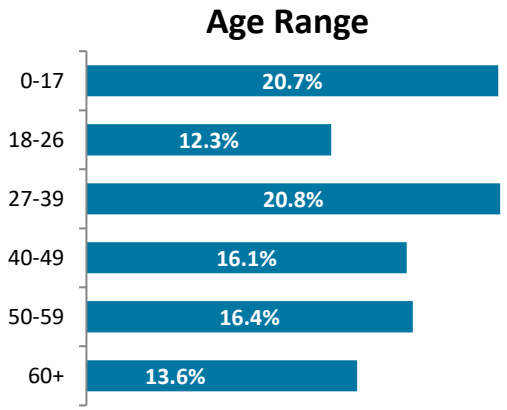


Diagnosis Grouper – Infections

Diagnosis Sub-Grouper	Patients	Claims	Total Paid	% Paid
Infectious Diseases	9,092	20,407	$6,070,093	48.4%
Septicemia	156	449	$5,912,718	47.1%
Osteomyelitis	27	453	$384,671	3.1%
Central Nervous System Infection	3	70	$93,774	0.7%
Influenza	149	166	$39,140	0.3%
Clostridium Difficile	6	8	$27,015	0.2%
HIV	41	183	$18,425	0.1%
Hepatitis B	21	71	$6,511	0.1%
Hepatitis C	9	18	$574	0.0%
Tuberculosis	5	8	$320	0.0%
Overall	**----**	**----**	**$12,553,242**	**100.0%**

*Patient and claim counts are unique only within the category

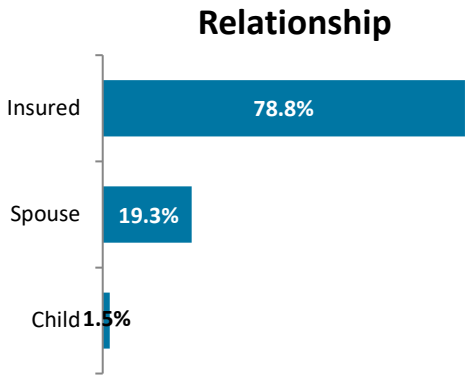


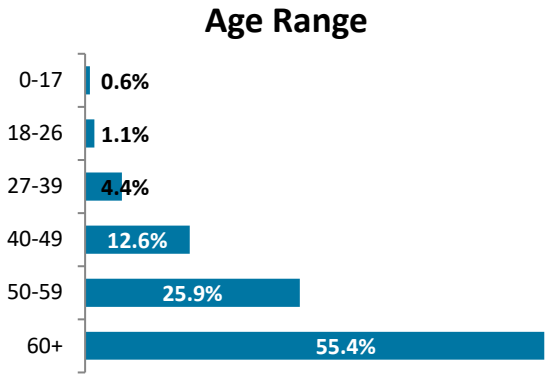


Diagnosis Grouper – Cancer

Diagnosis Sub-Grouper	Patients	Claims	Total Paid	% Paid
Cancer Therapies	124	809	$4,297,039	34.3%
Cancers, Other	466	2,132	$2,250,991	18.0%
Breast Cancer	233	2,007	$1,289,625	10.3%
Leukemias	35	724	$657,675	5.3%
Secondary Cancers	86	438	$645,985	5.2%
Prostate Cancer	125	736	$453,716	3.6%
Cervical/Uterine Cancer	59	389	$441,741	3.5%
Brain Cancer	15	214	$436,643	3.5%
Lung Cancer	28	258	$343,558	2.7%
Lymphomas	47	415	$325,135	2.6%
Colon Cancer	50	432	$313,345	2.5%
Melanoma	66	254	$279,950	2.2%
Thyroid Cancer	79	400	$222,662	1.8%
Ovarian Cancer	27	206	$186,267	1.5%
Pancreatic Cancer	10	90	$124,432	1.0%
Myeloma	9	170	$86,403	0.7%
Carcinoma in Situ	116	228	$77,396	0.6%
Kidney Cancer	21	84	$43,046	0.3%
Bladder Cancer	24	193	$38,147	0.3%
Overall	----	----	**$12,513,757**	**100.0%**

*Patient and claim counts are unique only within the category

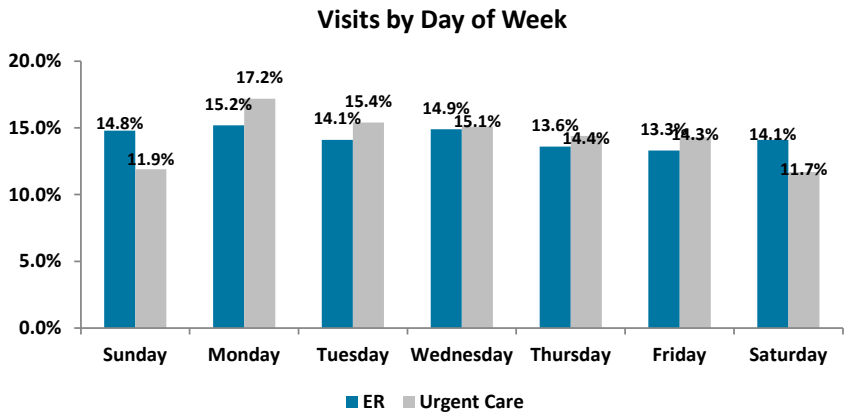


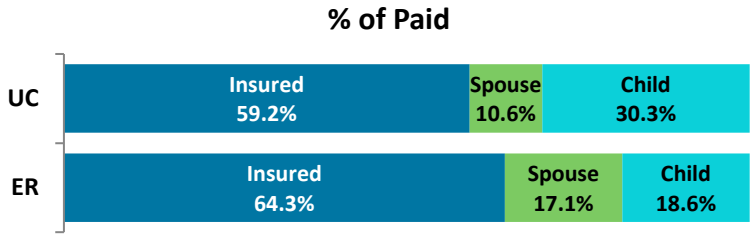


Emergency Room / Urgent Care Summary

	PY21		PY22		HSB Peer Index	
ER/Urgent Care	**ER**	**Urgent Care**	**ER**	**Urgent Care**	**ER**	**Urgent Care**
Number of Visits	4,867	8,962	4,872	9,145		
Visits Per Member	0.12	0.21	0.15	0.27	0.22	0.35
Visits/1000 Members	115	212	146	275	221	352
Avg Paid Per Visit	$2,088	$77	$1,958	$70	$968	$135
% with OV*	83.4%	79.9%	85.0%	80.7%		
% Avoidable	10.3%	24.7%	11.4%	31.9%		
Total Member Paid	**$4,910,210**	**$924,735**	**$4,782,423**	**$1,002,292**		
Total Plan Paid	**$10,161,696**	**$687,836**	**$9,539,584**	**$638,814**		

*looks back 12 months





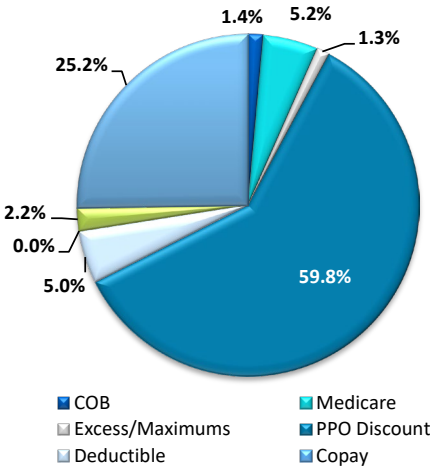
ER / UC Visits by Relationship						
Relationship	**ER**	**Per 1,000**	**Urgent Care**	**Per 1,000**	**Total**	**Per 1,000**
Insured	2,882	151	5,465	4,380	8,347	438
Spouse	688	167	926	863	1,614	392
Child	1,302	129	2,754	1,655	4,056	401
Total	**4,872**	**146**	**9,145**	**275**	**14,017**	**421**

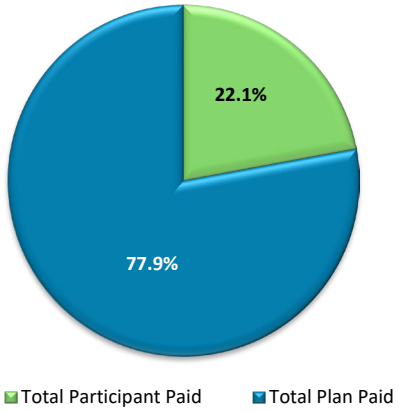
Hospital and physician urgent care centers are included in the data.
Paid amount includes facility and professional fees.

Savings Summary – Medical Claims

Description	Dollars	PPPM	% of Eligible
Eligible Charges	$478,518,195	$2,093	100.0%
COB	$6,728,087	$29	1.4%
Medicare	$24,736,286	$108	5.2%
Excess/Maximums	$6,012,028	$26	1.3%
PPO Discount	$286,718,248	$1,254	59.9%
Deductible	$23,815,517	$104	5.0%
Copay	$131,134	$1	0.0%
Coinsurance	$10,368,871	$45	2.2%
Total Participant Paid	**$34,315,522**	**$150**	**7.2%**
Total Plan Paid	**$121,061,784**	**$530**	**25.3%**

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





Paid Claims by Age Range – Dental

Dental Paid Claims by Age Group									
	PY20		PY21		PY22		% Change	
Age Range	Dental Plan Paid	Dental PMPM	Dental Plan Paid	Dental PMPM	Dental Plan Paid	Dental PMPM	Dental Plan Paid	Dental PMPM
<1	$ 12,587	$ 2	$ 10,773	$ 2	$ 10,558	$ 2	-2.0%	7.8%
1	$ 43,114	$ 6	$ 51,343	$ 8	$ 52,807	$ 9	2.9%	13.8%
2 - 4	$ 368,411	$ 17	$ 392,172	$ 18	$ 419,042	$ 21	6.9%	14.4%
5 - 9	$ 1,172,971	$ 28	$ 1,266,649	$ 32	$ 1,270,301	$ 33	0.3%	4.5%
10 - 14	$ 1,150,189	$ 24	$ 1,303,875	$ 28	$ 1,315,958	$ 29	0.9%	4.0%
15 - 19	$ 1,396,753	$ 28	$ 1,558,916	$ 31	$ 1,469,828	$ 29	-5.7%	-5.7%
20 - 24	$ 945,369	$ 17	$ 994,512	$ 18	$ 946,297	$ 18	-4.8%	-2.2%
25 - 29	$ 921,117	$ 22	$ 943,068	$ 23	$ 880,412	$ 23	-6.6%	-1.1%
30 - 34	$ 1,072,181	$ 23	$ 1,240,433	$ 26	$ 1,157,490	$ 26	-6.7%	-1.2%
35 - 39	$ 1,243,787	$ 24	$ 1,411,095	$ 27	$ 1,406,025	$ 28	-0.4%	2.6%
40 - 44	$ 1,292,574	$ 26	$ 1,413,716	$ 28	$ 1,428,908	$ 28	1.1%	0.5%
45 - 49	$ 1,478,697	$ 27	$ 1,513,069	$ 29	$ 1,476,709	$ 29	-2.4%	1.8%
50 - 54	$ 1,652,154	$ 29	$ 1,762,122	$ 31	$ 1,789,800	$ 31	1.6%	1.8%
55 - 59	$ 1,991,457	$ 32	$ 2,050,892	$ 34	$ 2,064,661	$ 35	0.7%	3.1%
60 - 64	$ 2,450,819	$ 35	$ 2,536,102	$ 37	$ 2,604,193	$ 40	2.7%	6.1%
65+	$ 5,869,624	$ 37	$ 6,422,543	$ 39	$ 6,781,407	$ 42	5.6%	5.2%
Total	**$ 23,061,804**	**$ 28**	**$ 24,871,282**	**$ 30**	**$ 25,074,396**	**$ 31**	**0.8%**	**3.2%**

Dental Paid Claims – State Participants

Dental Paid Claims - Total State Participants	PY21				PY22				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Dental	$ 17,004,298	$ 1,977,025	$ 520,098	$ 19,501,421	$ 16,670,025	$ 2,198,589	$ 518,166	$ 19,386,781	-0.6%
Dental Exchange	$ -	$ -	$ 3,131,443	$ 3,131,443	$ -	$ -	$ 3,432,124	$ 3,432,124	9.6%
Total	**$ 17,004,298**	**$ 1,977,025**	**$ 3,651,542**	**$ 22,632,865**	**$ 16,670,025**	**$ 2,198,589**	**$ 3,950,290**	**$ 22,818,904**	**9.0%**

Dental Paid Claims - Per Participant per Month	PY21				PY22				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Dental	$ 53	$ 49	$ 55	$ 52	$ 53	$ 53	$ 57	$ 53	1.6%
Dental Exchange	$ -	$ -	$ 47	$ 47	$ -	$ -	$ 50	$ 50	6.3%

Dental Paid Claims – Non-State Participants

Dental Paid Claims - Total Non-State Participants	PY21				PY22				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Dental	$ 5,294	$ 205,023	$ 223,935	$ 434,252	$ 7,960	$ 150,663	$ 229,869	$ 388,493	-10.5%
Dental Exchange	$ -	$ -	$ 1,804,165	$ 1,804,165	$ -	$ -	$ 1,866,999	$ 1,866,999	3.5%
Total	**$ 5,294**	**$ 205,023**	**$ 2,028,100**	**$ 2,238,417**	**$ 7,960**	**$ 150,663**	**$ 2,096,869**	**$ 2,255,492**	**0.8%**

Dental Paid Claims - Per Participant per Month	PY21				PY22				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Dental	$ 55	$ 42	$ 43	$ 42	$ 100	$ 45	$ 44	$ 45	6.2%
Dental Exchange	$ -	$ -	$ 43	$ 43	$ -	$ -	$ 45	$ 45	5.2%

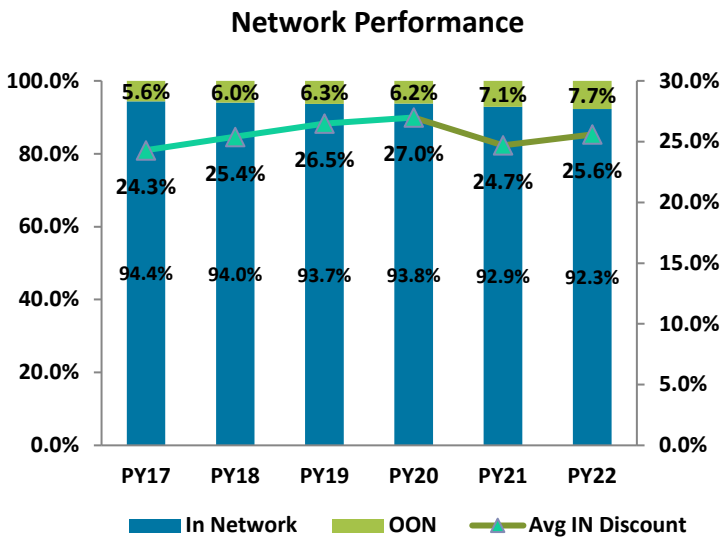
Dental Paid Claims – Total Participants

Dental Paid Claims - Total Total Participants														
	PY21					PY22					% Change			
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total		Actives	Pre-Medicare Retirees	Medicare Retirees	Total		Total			
Dental	$ 17,009,592	$ 2,182,048	$ 744,033	$ 19,935,673		$ 16,677,986	$ 2,349,252	$ 748,036	$ 19,775,274		-0.8%			
Dental Exchange	$ -	$ -	$ 4,935,609	$ 4,935,609		$ -	$ -	$ 5,299,123	$ 5,299,123		7.4%			
Total	**$ 17,009,592**	**$ 2,182,048**	**$ 5,679,642**	**$ 24,871,281**		**$ 16,677,986**	**$ 2,349,252**	**$ 6,047,159**	**$ 25,074,397**		**0.8%**			

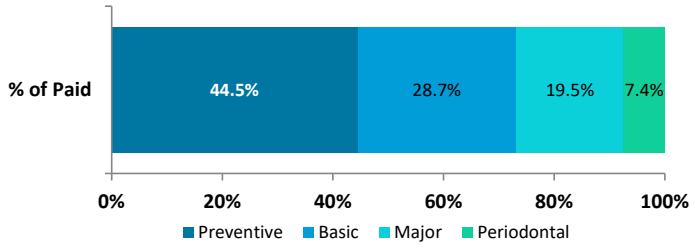
Dental Paid Claims - Per Participant per Month														
	PY21					PY22					% Change			
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total		Actives	Pre-Medicare Retirees	Medicare Retirees	Total					
Dental	$ 53	$ 49	$ 51	$ 52		$ 53	$ 52	$ 52	$ 53		1.7%			
Dental Exchange	$ -	$ -	$ 45	$ 45		$ -	$ -	$ 48	$ 48		6.0%			

Dental Claims Analysis

Cost Distribution								
Paid Claims Category	Avg # of Members	% of Members	# Claims	# of Claims	Total Paid	% of Paid	Total EE Paid	% of EE Paid
$1,000.01 Plus	7,245	10.9%	36,394	27.7%	$11,200,015	44.7%	$6,948,863	61.0%
$750.01-$1,000.00	2,880	4.3%	11,468	8.7%	$2,580,022	10.3%	$1,258,509	11.0%
$500.01-$750.00	5,414	8.1%	19,675	15.0%	$3,388,304	13.5%	$1,214,818	10.7%
$250.01-$500.00	15,855	23.8%	43,676	33.3%	$5,800,551	23.1%	$1,248,173	11.0%
$0.01-$250.00	11,833	17.8%	19,554	14.9%	$105,505	8.4%	$698,170	6.1%
$0.00	391	0.6%	478	0.4%	$0	0.0%	$29,336	0.3%
No Claims	22,937	34.5%	0	0.0%	$0	0.0%	$0	0.0%
Total	**66,555**	**100.0%**	**131,245**	**100.0%**	**$25,074,397**	**100.0%**	**$11,397,870**	**100.0%**



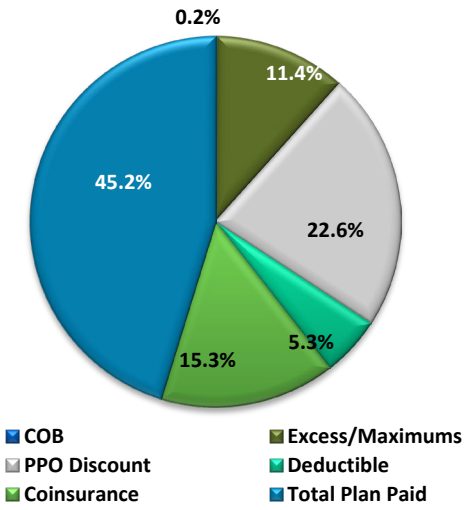
Claim Category	Total Paid	% of Paid
Preventive	$11,150,075	44.5%
Basic	$7,192,074	28.7%
Major	$4,877,601	19.5%
Periodontal	$1,854,646	7.4%
Total	**$25,074,397**	**100.0%**

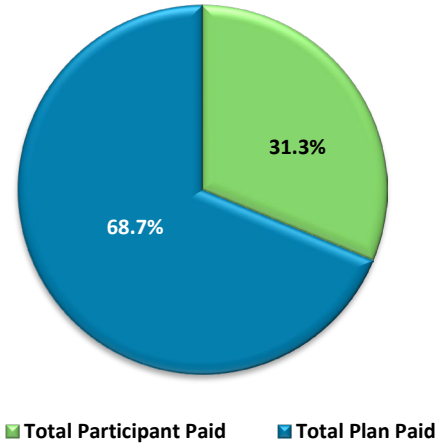


Savings Summary – Dental Claims

Description	Dollars	PPPM	% of Eligible
Eligible Charges	$55,263,175	$114	100.0%
COB	$95,780	$0	0.2%
Excess/Maximums	$6,344,579	$13	11.5%
PPO Discount	$12,501,966	$26	22.6%
Deductible	$2,916,147	$6	5.3%
Coinsurance	$8,481,723	$18	15.3%
Total Participant Paid	**$11,397,870**	**$24**	**20.6%**
Total Plan Paid	**$25,074,397**	**$52**	**45.4%**

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	1,104	1,071	33	96.2%
	<2 asthma related ER Visits in the last 6 months	1,104	1,102	2	99.8%
	No asthma related admit in last 12 months	1,104	1,104	0	100.0%
Chronic Obstructive Pulmonary Disease	No exacerbations in last 12 months	222	214	8	96.4%
	Members with COPD who had an annual spirometry test	222	34	188	15.3%
Congestive Heart Failure	No re-admit to hosp with Heart Failure diag w/in 30 days of HF inpatient stay discharge	9	9	0	100.0%
	No ER Visit for Heart Failure in last 90 days	223	218	5	97.8%
	Follow-up OV within 4 weeks of discharge from HF admission	9	8	1	88.9%
Diabetes	Annual office visit	1,697	1,608	89	94.8%
	Annual dilated eye exam	1,697	684	1,013	40.3%
	Annual foot exam	1,697	689	1,008	40.6%
	Annual HbA1c test done	1,697	1,353	344	79.7%
	Diabetes Annual lipid profile	1,697	1,257	440	74.1%
	Annual microalbumin urine screen	1,697	1,128	569	66.5%
Hyperlipidemia	Hyperlipidemia Annual lipid profile	4,264	3,316	948	77.8%
Hypertension	Annual lipid profile	4,559	3,013	1,546	66.1%
	Annual serum creatinine test	4,503	3,500	1,003	77.7%
Wellness	Well Child Visit - 15 months	237	227	10	95.8%
	Routine office visit in last 6 months	32,156	18,267	13,889	56.8%
	Age 45 to 75 years with colorectal cancer screening	12,787	3,141	9,646	24.6%
	Women age 25-65 with recommended cervical cancer screening	10,145	7,001	3,144	69.0%
	Males age greater than 49 with PSA test in last 24 months	4,971	2,358	2,613	47.4%
	Routine exam in last 24 months	32,155	26,632	5,523	82.8%
	Women age 40 to 75 with a screening mammogram last 24 months	8,292	4,731	3,561	57.1%

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	208	0.65%	6.25	$31,064
Asthma	1,242	3.86%	37.31	$21,094
Atrial Fibrillation	339	1.05%	10.18	$32,518
Blood Disorders	1,764	5.48%	52.99	$37,035
CAD	642	2.00%	19.29	$28,120
COPD	220	0.68%	6.61	$32,010
Cancer	1,193	3.71%	35.84	$28,071
Chronic Pain	655	2.04%	19.68	$31,165
Congestive Heart Failure	222	0.69%	6.67	$64,442
Demyelinating Diseases	75	0.23%	2.25	$73,118
Depression	1,889	5.87%	56.75	$22,676
Diabetes	1,870	5.81%	56.18	$22,590
ESRD	51	0.16%	1.53	$150,384
Eating Disorders	99	0.31%	2.97	$74,852
HIV/AIDS	41	0.13%	1.23	$54,919
Hyperlipidemia	4,520	14.05%	135.79	$13,018
Hypertension	4,594	14.28%	138.01	$16,024
Immune Disorders	87	0.27%	2.61	$88,490
Inflammatory Bowel Disease	104	0.32%	3.12	$62,155
Liver Diseases	579	1.80%	17.39	$28,892
Morbid Obesity	779	2.42%	23.40	$25,446
Osteoarthritis	1,106	3.44%	33.23	$20,497
Peripheral Vascular Disease	153	0.48%	4.60	$26,722
Rheumatoid Arthritis	148	0.46%	4.45	$36,625

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 June 30, 2022

Express Scripts

Membership Summary	4Q FY2022 CDHP	4Q FY2021 CDHP	Difference	% Change
			Membership Summary	
Member Count (Membership)	33,195	42,243	(9,048)	-21.4%
Utilizing Member Count (Patients)	26,324	30,203	(3,879)	-12.8%
Percent Utilizing (Utilization)	79.3%	71.5%	0.08	10.9%

Claim Summary			Claims Summary	
Net Claims (Total Rx's)	436,677	526,908	(90,231)	-17.1%
Claims per Elig Member per Month (Claims PMPM)	1.10	1.04	0.06	5.8%
Total Claims for Generic (Generic Rx)	373,579	452,874	(79,295.00)	-17.5%
Total Claims for Brand (Brand Rx)	63,098	74,034	(10,936.00)	-14.8%
Total Claims for Brand w/Gen Equiv (Multisource Brand Claims)	2,508	7,704	(5,196.00)	-67.4%
Total Non-Specialty Claims	430,924	520,293	(89,369.00)	-17.2%
Total Specialty Claims	5,753	6,615	(862.00)	-13.0%
Generic % of Total Claims (GFR)	**85.6%**	**85.9%**	(0.00)	-0.5%
Generic Effective Rate (GCR)	**99.3%**	**98.3%**	0.01	1.0%
Mail Order Claims	107,822	118,635	(10,813.00)	-9.1%
Mail Penetration Rate*	28.6%	25.5%	0.03	3.1%

Claims Cost Summary			Claims Cost Summary	
Total Prescription Cost (Total Gross Cost)	$47,215,556	$53,947,238	($6,731,682.00)	-12.5%
Total Generic Gross Cost	$6,238,057	$8,717,855	($2,479,798.00)	-28.4%
Total Brand Gross Cost	$40,977,499	$45,229,382	($4,251,883.00)	-9.4%
Total MSB Gross Cost	$1,091,780	$2,112,300	($1,020,520.00)	-48.3%
Total Ingredient Cost	$46,358,198	$53,305,122	($6,946,924.00)	-13.0%
Total Dispensing Fee	$832,495	$616,835	$215,660.00	35.0%
Total Other (e.g. tax)	$24,864	$25,280	($416.00)	-1.6%
Avg Total Cost per Claim (Gross Cost/Rx)	**$108.12**	**$102.38**	$5.74	5.6%
Avg Total Cost for Generic (Gross Cost/Generic Rx)	$16.70	$19.26	($2.56)	-13.3%
Avg Total Cost for Brand (Gross Cost/Brand Rx)	$649.43	$610.93	$38.50	6.3%
Avg Total Cost for MSB (MSB Gross Cost/MSB ARx)	$435.32	$274.18	$161.14	58.8%

Member Cost Summary			Member Cost Summary	
Total Member Cost	**$11,553,038**	**$13,056,418**	($1,503,380.00)	-11.5%
Total Copay	$9,106,595	$9,723,070	($616,475.00)	-6.3%
Total Deductible	$2,446,444	$3,333,348	($886,904.00)	-26.6%
Avg Copay per Claim (Copay/Rx)	$20.85	$18.45	$2.40	13.0%
Avg Participant Share per Claim (Copay+Deductible/RX)	**$26.46**	**$24.78**	**$1.68**	**6.8%**
Avg Copay for Generic (Copay/Generic Rx)	$7.98	$8.47	($0.49)	-5.8%
Avg Copay for Brand (Copay/Brand Rx)	$135.83	$124.54	$11.29	9.1%
Avg Copay for Brand w/ Generic Equiv (Copay/Multisource Rx)	$105.36	$70.91	$34.45	48.6%
Net PMPM (Participant Cost PMPM)	**$29.00**	**$25.76**	$3.25	12.6%
Copay % of Total Prescription Cost (Member Cost Share %)	24.5%	24.2%	0.3%	1.1%

Plan Cost Summary			Plan Cost Summary	
Total Plan Cost (Plan Cost)	**$35,662,517**	**$40,890,820**	**($5,228,303.00)**	**-12.8%**
Total Non-Specialty Cost (Non-Specialty Plan Cost)	$13,120,805	$15,910,692	($2,789,887.00)	-17.5%
Total Specialty Drug Cost (Specialty Plan Cost)	$22,541,712	$24,980,127	($2,438,415.00)	-9.8%
Avg Plan Cost per Claim (Plan Cost/Rx)	**$81.67**	**$77.61**	$4.06	5.2%
Avg Plan Cost for Generic (Plan Cost/Generic Rx)	$8.72	$10.78	($2.06)	-19.1%
Avg Plan Cost for Brand (Plan Cost/Brand Rx)	$513.59	$486.39	$27.20	5.6%
Avg Plan Cost for MSB (MSB Plan Cost/MSB ARx)	$329.97	$203.27	$126.70	62.3%
Net PMPM (Plan Cost PMPM)	**$89.53**	**$80.67**	**$8.86**	**11.0%**
PMPM for Specialty Only (Specialty PMPM)	$56.59	$49.28	$7.31	14.8%
PMPM without Specialty (Non-Specialty PMPM)	$32.94	$31.39	$4.02	17.3%
Specialty % of Plan Cost	63.2%	61.10%	$0.02	3.4%
Rebates Received (Q1-Q4 FY2022 actual)	$9,735,995	$9,438,730	$297,264.96	3.1%
Net PMPM (Plan Cost PMPM factoring Rebates)	**$65.09**	**$62.05**	**$3.04**	**4.9%**
PMPM for Specialty Only (Specialty PMPM)	$48.61	$41.83	$6.78	16.2%
PMPM without Specialty (Non-Specialty PMPM)	$19.20	$18.28	$0.92	5.0%

Appendix B

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July 1, 2021 – June 30, 2022

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HSB DATASCOPE™

Nevada Public Employees' Benefits Program
Low Deductible Plan

July 2021 – June 2022

HealthSCOPE BENEFITS

Overview

- Total Medical Spend for PY22 was $29,786,564 with a plan cost per employee per year (PEPY) of $7,020.
  - IP Cost per Admit is $34,334.
  - ER Cost per Visit is $2,378.
- Employees shared in 15.7% of the medical cost.
- Inpatient facility costs were 30.3% of the plan spend.
- 82.7% of the Average Membership had paid Medical claims less than $2,500, with 18.4% of those having no claims paid at all during the reporting period.
- 44 members exceeded the $100k high-cost threshold during the reporting period, which accounted for 34.2% of the plan spend. The highest diagnosis category was Cancer, accounting for 23.5% of the high-cost claimant dollars.
- Total spending with in-network providers was 98.7%. The average In Network discount was 62.8%.

Paid Claims by Age Group

Paid Claims by Age Group								
PY22								
Age Range	Med Net Pay	Med PMPM	Rx Net Pay	Rx PMPM	Net Pay	PMPM
<1	$ 2,626,168	$ 2,605	$ 2,239	$ 2	$ 2,628,407	$ 2,608
1	$ 182,708	$ 155	$ 4,588	$ 4	$ 187,296	$ 159
2 - 4	$ 376,272	$ 94	$ 35,053	$ 9	$ 411,325	$ 102
5 - 9	$ 466,822	$ 66	$ 91,184	$ 13	$ 558,006	$ 79
10 - 14	$ 821,187	$ 101	$ 130,109	$ 16	$ 951,296	$ 117
15 - 19	$ 1,161,721	$ 138	$ 238,552	$ 28	$ 1,400,273	$ 167
20 - 24	$ 1,134,163	$ 135	$ 179,677	$ 21	$ 1,313,840	$ 156
25 - 29	$ 1,212,154	$ 190	$ 268,118	$ 42	$ 1,480,272	$ 232
30 - 34	$ 1,692,680	$ 223	$ 462,622	$ 61	$ 2,155,302	$ 284
35 - 39	$ 2,896,229	$ 326	$ 454,526	$ 51	$ 3,350,755	$ 377
40 - 44	$ 2,933,647	$ 336	$ 647,615	$ 74	$ 3,581,262	$ 411
45 - 49	$ 2,409,689	$ 312	$ 498,904	$ 65	$ 2,908,593	$ 376
50 - 54	$ 2,274,847	$ 269	$ 815,851	$ 96	$ 3,090,698	$ 365
55 - 59	$ 3,757,782	$ 474	$ 747,975	$ 94	$ 4,505,757	$ 568
60 - 64	$ 3,743,991	$ 562	$ 1,323,895	$ 199	$ 5,067,886	$ 761
65+	$ 2,096,504	$ 828	$ 377,031	$ 149	$ 2,473,535	$ 977
Total	**$ 29,786,564**	**$ 289**	**$ 6,277,939**	**$ 61**	**$ 36,064,503**	**$ 350**

Financial Summary

	Total	State Active	Non-State Active	State Retirees	Non-State Retirees	
Summary	**PY22**	**PY22**	**PY22**	**PY22**	**PY22**	**HSB Peer Index**
Enrollment						
Avg # Employees	4,243	3,840	1	382	20	
Avg # Members	8,598	7,916	2	650	30	
Ratio	2.0	2.1	2.0	1.7	1.5	1.6
Financial Summary						
Gross Cost	$35,351,116	$30,739,217	$36,934	$4,307,527	$267,437	
Client Paid	$29,786,564	$25,809,414	$31,996	$3,726,092	$219,062	
Employee Paid	$5,564,551	$4,929,803	$4,938	$581,435	$48,375	
Client Paid-PEPY	$7,020	$6,722	$31,996	$9,750	$10,818	$6,642
Client Paid-PMPY	$3,464	$3,260	$15,998	$5,730	$7,242	$4,116
Client Paid-PEPM	$585	$560	$2,666	$812	$901	$553
Client Paid-PMPM	$289	$272	$1,333	$477	$603	$343
High Cost Claimants (HCC's) > $100k						
# of HCC's	44	36	0	8	1	
HCC's / 1,000	5.1	4.6	0.0	12.3	33.1	
Avg HCC Paid	$231,814	$238,573	$0	$187,543	$110,866	
HCC's % of Plan Paid	34.2%	33.3%	0.0%	40.3%	50.6%	
Cost Distribution by Claim Type (PMPY)						
Facility Inpatient	$1,051	$1,032	$424	$1,303	$717	$1,190
Facility Outpatient	$931	$835	$5,152	$1,961	$3,547	$1,376
Physician	$1,436	$1,350	$9,103	$2,388	$2,934	$1,466
Other	$46	$43	$1,319	$77	$43	$84
Total	$3,464	$3,260	$15,998	$5,730	$7,242	$4,116

Paid Claims by Claim Type – State Participants

Net Paid Claims - Total State Participants	PY22			
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total
Medical				
Inpatient	$ 9,392,633	$ 939,368	$ 2,950	$ 10,334,950
Outpatient	$ 16,416,782	$ 2,734,116	$ 49,658	$ 19,200,557
Total - Medical	**$ 25,809,414**	**$ 3,673,484**	**$ 52,608**	**$ 29,535,507**

Net Paid Claims - Per Participant per Month	PY22			
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total
Medical	$ 560	$ 858	$ 171	$ 583

Paid Claims by Claim Type – Non-State Participants

Net Paid Claims - Total Non-State Participants	PY22			
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total
Medical				
Inpatient	$ 1,051	$ 19,252	$ 5,276	$ 25,579
Outpatient	$ 30,944	$ 150,716	$ 43,819	$ 225,479
Total - Medical	**$ 31,996**	**$ 169,967**	**$ 49,095**	**$ 251,058**

Net Paid Claims - Per Participant per Month	PY22			
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total
Medical	$ 3,200	$ 1,307	$ 434	$ 992

Paid Claims by Claim Type – Total Participants

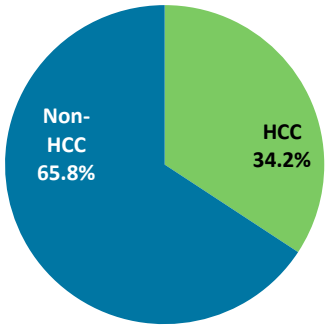
Net Paid Claims - Total Total Participants	PY22			
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total
Medical				
Inpatient	$ 9,393,684	$ 958,619	$ 8,225	$ 10,360,529
Outpatient	$ 16,447,726	$ 2,884,832	$ 93,477	$ 19,426,036
Total - Medical	**$ 25,841,410**	**$ 3,843,452**	**$ 101,703**	**$ 29,786,564**

Net Paid Claims - Per Participant per Month	PY22			
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total
Medical	$ 561	$ 872	$ 242	$ 585

Cost Distribution – Medical Claims

	PY22					
Paid Claims Category	Avg # of Members	% of Members	Total Paid	% of Paid	EE Paid	% EE Paid
$100,000.01 Plus	35	0.4%	$9,900,922	33.2%	$191,030	3.4%
$50,000.01-$100,000.00	40	0.5%	$2,906,551	9.8%	$215,648	3.9%
$25,000.01-$50,000.00	89	1.0%	$3,231,345	10.8%	$370,877	6.7%
$10,000.01-$25,000.00	264	3.1%	$4,203,521	14.1%	$888,235	16.0%
$5,000.01-$10,000.00	403	4.7%	$3,041,278	10.2%	$846,744	15.2%
$2,500.01-$5,000.00	657	7.6%	$2,468,014	8.3%	$946,264	17.0%
$0.01-$2,500.00	5,441	63.3%	$4,034,934	13.5%	$2,087,660	37.5%
$0.00	84	1.0%	$0	0.0%	$18,092	0.3%
No Claims	1,586	18.4%	$0	0.0%	$0	0.0%
	8,598	**100.0%**	**$29,786,564**	**100.0%**	**$5,564,551**	**100.0%**

Distribution of HCC Medical Claims Paid



HCC – High-Cost Claimant over $100K

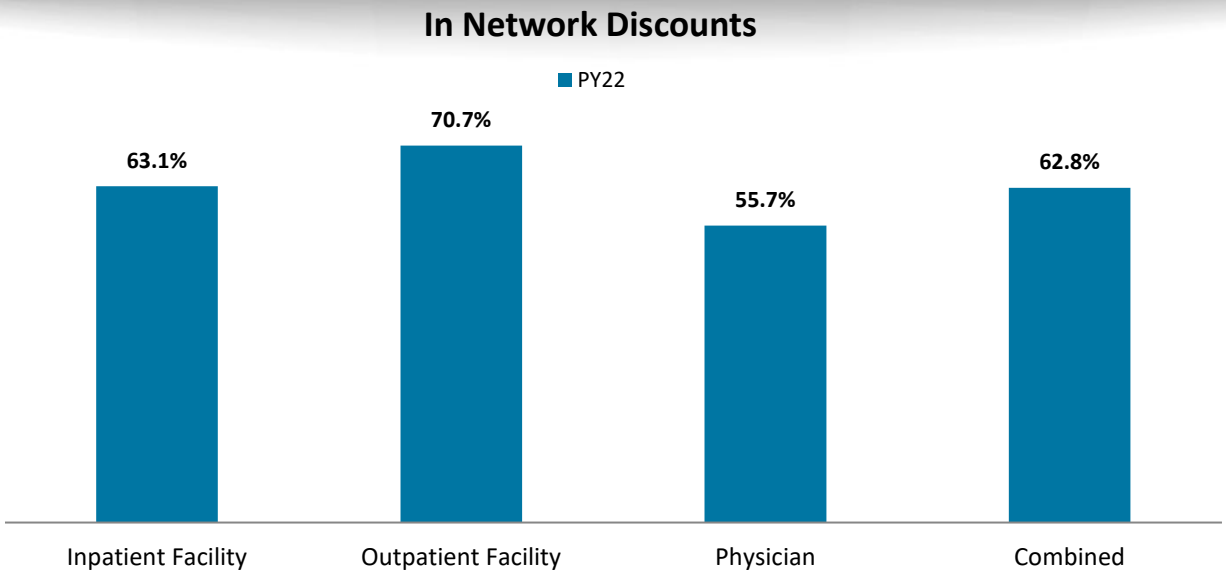
HCC's by Diagnosis Grouper			
Top 10 Diagnosis Groupers	Patients	Total Paid	% Paid
Cancer	17	$2,393,710	23.5%
Congenital/Chromosomal Anomalies	4	$1,115,421	10.9%
Pregnancy-related Disorders	2	$849,936	8.3%
Neurological Disorders	23	$835,350	8.2%
Vascular Disorders	10	$708,174	6.9%
Cardiac Disorders	27	$574,977	5.6%
Non-malignant Neoplasm	8	$482,380	4.7%
Endocrine/Metabolic Disorders	13	$448,167	4.4%
Mental Health	12	$409,622	4.0%
Pulmonary Disorders	23	$386,664	3.8%
All Other		$1,995,430	19.6%
Overall	**----**	**$10,199,832**	**100.0%**

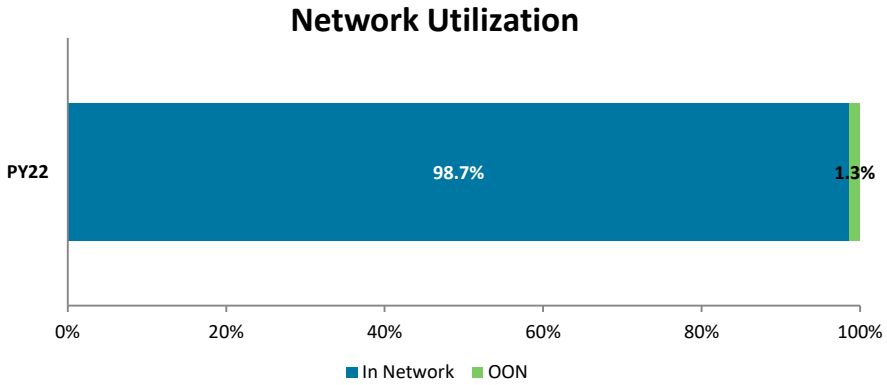
Utilization Summary

Inpatient data reflects facility charges and professional services.
DX&L = Diagnostics, X-Ray and Laboratory

	Total	State Active	Non-State Active	State Retirees	Non-State Retirees	
Summary	**PY22**	**PY22**	**PY22**	**PY22**	**PY22**	**HSB Peer Index**
Inpatient Facility						
# of Admits	295	254	1	33	7	
# of Bed Days	1,540	1,404	1	114	21	
Paid Per Admit	$34,334	$35,490	$2,303	$32,885	$3,777	$18,822
Paid Per Day	$6,577	$6,421	$2,303	$9,519	$1,259	$3,265
Admits Per 1,000	34	32	500	51	231	70
Days Per 1,000	179	177	500	175	694	402
Avg LOS	5.2	5.5	1	3.5	3.0	5.8
# Admits From ER	152	126	0	22	4	
Physician Office						
OV Utilization per Member	4.4	4.3	12.0	5.8	7.1	5.4
Avg Paid per OV	$125	$120	$315	$171	$100	$96
Avg OV Paid per Member	$547	$509	$3,777	$991	$708	$515
DX&L Utilization per Member	7.5	7.2	25.5	11.3	12.1	11.0
Avg Paid per DX&L	$51	$48	$99	$66	$80	$50
Avg DX&L Paid per Member	$379	$346	$2,513	$746	$968	$543
Emergency Room						
# of Visits	1,045	974	1	69	1	
Visits Per Member	0.12	0.12	0.5	0.11	0.03	0.22
Visits Per 1,000	122	123	500	106	33	221
Avg Paid per Visit	$2,378	$2,357	$5,209	$2,640	$1,827	$968
Urgent Care						
# of Visits	2,487	2,343	0	142	2	
Visits Per Member	0.29	0.30	0.00	0.22	0.07	0.35
Visits Per 1,000	289	296	0	218	66	352
Avg Paid per Visit	$120	$119	$0	$141	$70	$135

Provider Network Summary





Diagnosis Grouper Summary

Diagnosis Grouper	Total Paid	% Paid	Insured	Spouse	Child	Male	Female	Unassigned
Cancer	$3,145,160	10.6%	$1,550,609	$1,504,806	$89,745	$1,214,034	$1,931,126	$0
Pregnancy-related Disorders	$2,546,310	8.5%	$873,419	$329,399	$1,343,492	$1,177,197	$1,364,018	$5,094
Health Status/Encounters	$2,454,035	8.2%	$1,308,240	$368,573	$777,223	$846,749	$1,598,376	$8,910
Gastrointestinal Disorders	$1,995,116	6.7%	$1,207,486	$497,753	$289,877	$672,555	$1,313,356	$9,205
Mental Health	$1,841,522	6.2%	$555,989	$163,289	$1,122,245	$623,131	$1,214,742	$3,649
Cardiac Disorders	$1,794,749	6.0%	$1,299,089	$441,024	$54,636	$1,121,478	$660,319	$12,952
Infections	$1,769,713	5.9%	$1,107,691	$454,002	$208,019	$605,225	$1,160,250	$4,237
COVID-19, Confirmed	$1,092,925	3.7%	$746,542	$300,752	$45,631	$375,909	$716,796	$221
Musculoskeletal Disorders	$1,702,909	5.7%	$1,051,359	$457,448	$194,103	$668,296	$1,027,358	$7,255
Neurological Disorders	$1,570,018	5.3%	$1,192,825	$205,413	$171,779	$300,128	$1,268,730	$1,160
Congenital/Chromosomal Anomalies	$1,196,473	4.0%	$322,986	$10,241	$863,246	$864,038	$331,552	$883
Eye/ENT Disorders	$1,162,056	3.9%	$594,797	$172,887	$394,373	$540,311	$618,150	$3,596
Trauma/Accidents	$1,143,827	3.8%	$674,542	$104,443	$364,842	$317,949	$817,298	$8,580
Pulmonary Disorders	$955,079	3.2%	$497,376	$143,023	$314,680	$522,670	$431,463	$946
Spine-related Disorders	$898,328	3.0%	$555,773	$162,938	$179,618	$273,496	$622,945	$1,888
Endocrine/Metabolic Disorders	$894,502	3.0%	$764,817	$113,345	$16,341	$119,193	$771,734	$3,575
Non-malignant Neoplasm	$844,965	2.8%	$380,321	$432,294	$32,351	$216,485	$623,961	$4,519
Renal/Urologic Disorders	$793,693	2.7%	$459,609	$253,528	$80,555	$496,048	$297,405	$239
Vascular Disorders	$778,122	2.6%	$238,673	$426,067	$113,382	$715,640	$62,406	$75
Gynecological/Breast Disorders	$746,029	2.5%	$512,926	$136,610	$96,492	$13,568	$730,373	$2,088
Miscellaneous	$289,867	1.0%	$137,260	$44,099	$108,508	$135,448	$154,419	$0
Medication Related Conditions	$287,080	1.0%	$253,619	$2,230	$31,232	$271,615	$15,465	$0
Dermatological Disorders	$250,475	0.8%	$151,161	$36,521	$62,793	$95,850	$153,573	$1,052
Diabetes	$183,733	0.6%	$103,158	$47,775	$32,800	$81,369	$102,037	$327
Medical/Surgical Complications	$174,317	0.6%	$79,035	$18,160	$77,122	$13,128	$161,152	$38
Abnormal Lab/Radiology	$150,009	0.5%	$106,481	$36,427	$7,102	$57,209	$92,500	$300
Hematological Disorders	$116,708	0.4%	$92,433	$16,325	$7,951	$19,822	$96,666	$220
Cholesterol Disorders	$64,686	0.2%	$50,636	$12,082	$1,968	$29,576	$34,881	$229
Allergic Reaction	$17,173	0.1%	$10,945	$911	$5,318	$3,012	$14,161	$0
Dental Conditions	$13,800	0.0%	$5,208	$1,586	$7,006	$4,657	$9,143	$0
External Hazard Exposure	$6,110	0.0%	$670	$0	$5,440	$4,578	$1,532	$0
Total	**$29,786,564**	**100.0%**	**$16,139,131**	**$6,593,196**	**$7,054,238**	**$12,024,456**	**$17,681,091**	**$81,018**

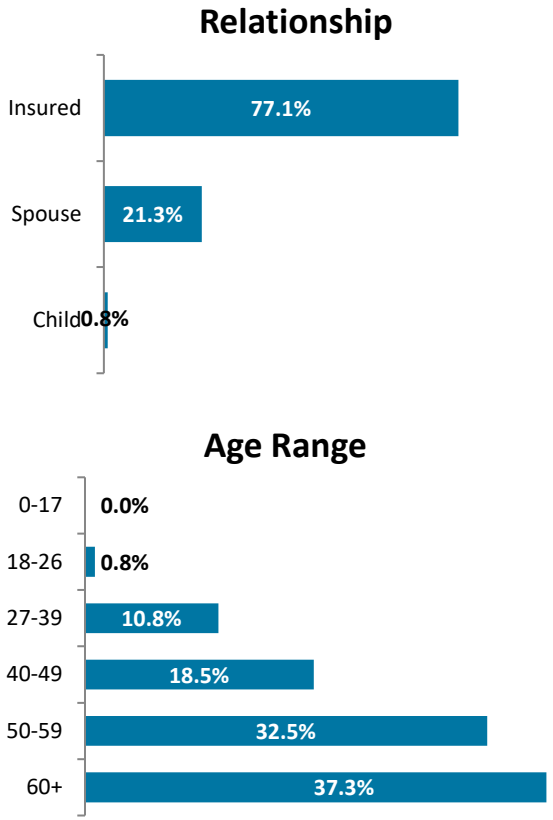
Mental Health Drilldown

Grouper	PY22 Patients	PY22 Total Paid
Depression	418	$479,963
Mental Health Conditions, Other	404	$324,862
Mood and Anxiety Disorders	571	$242,783
Developmental Disorders	54	$206,766
Bipolar Disorder	102	$201,868
Eating Disorders	21	$144,909
Attention Deficit Disorder	187	$73,187
Substance Abuse/Dependence	27	$60,269
Alcohol Abuse/Dependence	16	$37,724
Sleep Disorders	114	$22,656
Personality Disorders	14	$13,415
Psychoses	5	$10,635
Complications of Substance Abuse	7	$8,837
Sexually Related Disorders	24	$7,141
Tobacco Use Disorder	16	$4,469
Schizophrenia	2	$2,038
Total		**$1,841,522**

Diagnosis Grouper – Cancer

Diagnosis Sub-Grouper	Patients	Claims	Total Paid	% Paid
Cancer Therapies	27	228	$1,089,277	103.5%
Melanoma	17	112	$630,575	59.9%
Brain Cancer	2	61	$317,812	30.2%
Cancers, Other	80	376	$290,604	27.6%
Breast Cancer	53	496	$268,006	25.5%
Secondary Cancers	20	98	$178,494	17.0%
Prostate Cancer	19	123	$67,928	6.5%
Lung Cancer	7	119	$59,426	5.6%
Carcinoma in Situ	29	125	$51,860	4.9%
Thyroid Cancer	18	80	$41,799	4.0%
Bladder Cancer	3	92	$36,511	3.5%
Colon Cancer	5	118	$35,340	3.4%
Myeloma	2	51	$30,822	2.9%
Kidney Cancer	6	22	$14,042	1.3%
Cervical/Uterine Cancer	8	43	$13,889	1.3%
Leukemias	13	46	$6,685	0.6%
Lymphomas	15	57	$6,470	0.6%
Pancreatic Cancer	1	4	$3,839	0.4%
Ovarian Cancer	2	3	$1,779	0.2%
Overall	**----**	**----**	**$3,145,160**	**100.0%**

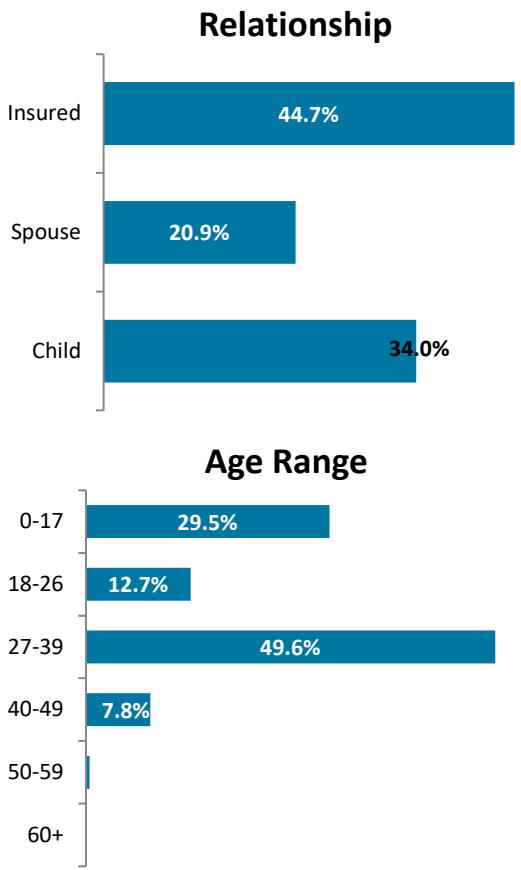
*Patient and claim counts are unique only within the category



Diagnosis Grouper – Pregnancy-related Disorders

Diagnosis Sub-Grouper	Patients	Claims	Total Paid	% Paid
Perinatal Disorders	44	126	$931,057	36.6%
Labor and Delivery Related	76	292	$642,990	25.3%
Pregnancy Complications	116	510	$507,681	19.9%
Liveborn Infants	68	120	$314,288	12.3%
Supervision of Pregnancy	142	785	$109,029	4.3%
Multiple Gestation Related	2	23	$21,470	0.8%
Abortion Related	15	33	$13,608	0.5%
Ectopic Pregnancy	2	11	$5,383	0.2%
Fetal Distress	2	2	$595	0.0%
Prematurity and Low Birth Weight	3	4	$196	0.0%
Cesarean Delivery	1	1	$12	0.0%
Overall	**----**	**----**	**$2,546,310**	**100.0%**

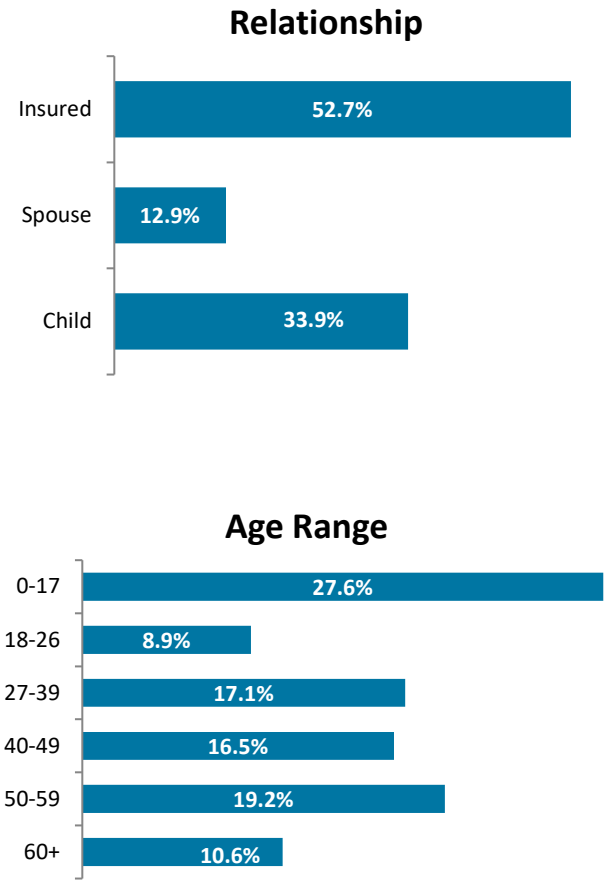
*Patient and claim counts are unique only within the category



Diagnosis Grouper – Health Status/Encounters

Diagnosis Category	Patients	Claims	Total Paid	% Paid
Screenings	2,023	3,992	$751,177	30.6%
Exams	2,846	5,428	$570,330	23.2%
Prophylactic Measures	1,688	2,362	$554,702	22.6%
Encounters - Infants/Children	1,176	1,768	$273,793	11.2%
Prosthetics/Devices/Implants	97	267	$79,092	3.2%
History of Condition	65	95	$65,328	2.7%
Personal History of Condition	195	304	$55,764	2.3%
Aftercare	94	159	$46,806	1.9%
Family History of Condition	55	81	$19,693	0.8%
Counseling	100	175	$12,190	0.5%
Lifestyle/Situational Issues	102	123	$7,898	0.3%
Follow-Up Encounters	7	17	$5,755	0.2%
Replacements	16	45	$3,734	0.2%
Donors	3	7	$3,138	0.1%
Encounter - Procedure	23	24	$2,529	0.1%
Health Status, Other	30	35	$1,464	0.1%
Encounter - Transplant Related	8	17	$462	0.0%
Miscellaneous Examinations	12	17	$180	0.0%
Overall	**----**	**----**	**$2,454,035**	**100.0%**

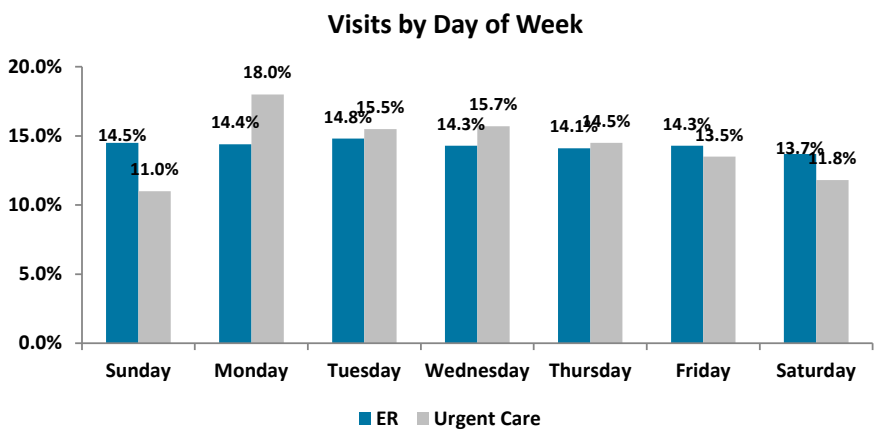
*Patient and claim counts are unique only within the category

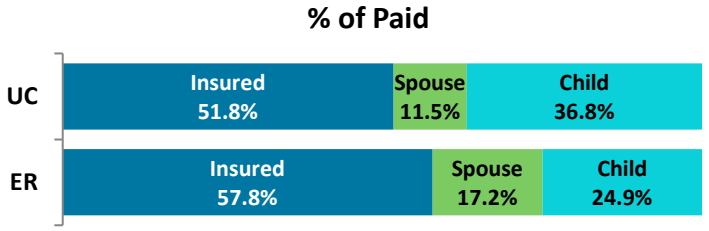


Emergency Room / Urgent Care Summary

	PY22		HSB Peer Index	
ER/Urgent Care	**ER**	**Urgent Care**	**ER**	**Urgent Care**
Number of Visits	1,045	2,487		
Visits Per Member	0.12	0.29	0.22	0.35
Visits/1000 Members	122	289	221	352
Avg Paid Per Visit	$2,378	$120	$968	$135
% with OV*	79.9%	77.3%		
% Avoidable	11.3%	34.7%		
Total Member Paid	**$609,967**	**$172,074**		
Total Plan Paid	**$2,484,656**	**$298,477**		

*looks back 12 months from ER visit



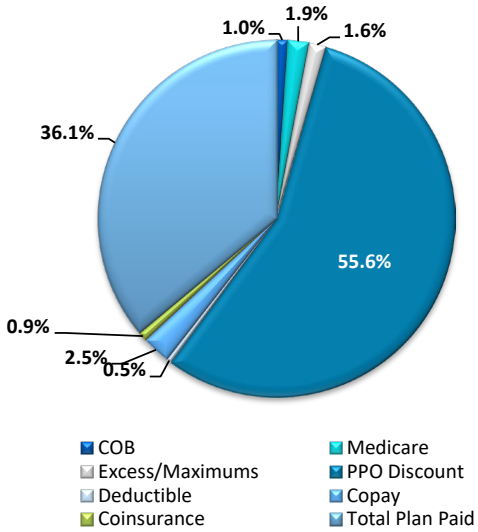


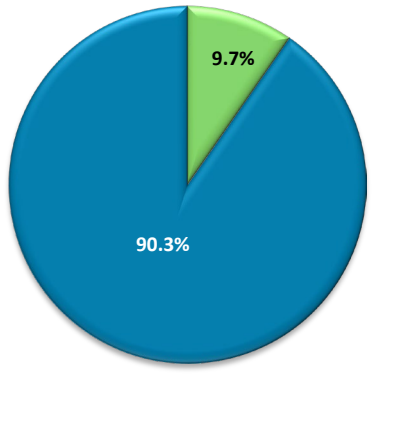
ER / UC Visits by Relationship						
Relationship	**ER**	**Per 1,000**	**Urgent Care**	**Per 1,000**	**Total**	**Per 1,000**
Insured	533	126	1,268	299	1,801	424
Spouse	150	126	293	246	443	371
Child	362	114	926	293	1,288	407
Total	**1,045**	**122**	**2,487**	**289**	**3,532**	**411**

Hospital and physician urgent care centers are included in the data.
Paid amount includes facility and professional fees.

Savings Summary – Medical Claims

Description	Dollars	PPPM	% of Eligible
Eligible Charges	$98,455,634	$2,031	100.0%
COB	$284,171	$6	0.3%
Medicare	$771,472	$16	0.8%
Excess/Maximums	$1,429,989	$30	1.5%
PPO Discount	$60,711,534	$1,253	61.7%
Deductible	$1,621,748	$33	1.6%
Copay	$2,513,797	$52	2.6%
Coinsurance	$1,429,006	$29	1.5%
Total Participant Paid	**$5,564,551**	**$115**	**5.7%**
Total Plan Paid	**$29,786,564**	**$585**	**30.3%**





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	349	340	9	97.4%
	<2 asthma related ER Visits in the last 6 months	349	349	0	100.0%
	No asthma related admit in last 12 months	349	348	1	99.7%
Chronic Obstructive Pulmonary Disease	No exacerbations in last 12 months	30	28	2	93.3%
	Members with COPD who had an annual spirometry test	30	4	26	13.3%
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	45	45	0	100.0%
	Follow-up OV within 4 weeks of discharge from HF admission	1	1	0	100.0%
Diabetes	Annual office visit	406	386	20	95.1%
	Annual dilated eye exam	406	164	242	40.4%
	Annual foot exam	406	161	245	39.7%
	Annual HbA1c test done	406	330	76	81.3%
	Diabetes Annual lipid profile	406	304	102	74.9%
	Annual microalbumin urine screen	406	276	130	68.0%
Hyperlipidemia	Hyperlipidemia Annual lipid profile	1,023	850	173	83.1%
Hypertension	Annual lipid profile	925	673	252	72.8%
	Annual serum creatinine test	779	665	114	85.4%
Wellness	Well Child Visit - 15 months	82	64	18	78.0%
	Routine office visit in last 6 months	9,566	5,717	3,849	59.8%
	Age 45 to 75 years with colorectal cancer screening	3,030	747	2,283	24.7%
	Women age 25-65 with recommended cervical cancer screening	3,270	1,909	1,361	58.4%
	Males age greater than 49 with PSA test in last 24 months	961	439	522	45.7%
	Routine exam in last 24 months	9,566	7,414	2,152	77.5%
	Women age 40 to 75 with a screening mammogram last 24 months	2,249	1,251	998	55.6%

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	82	0.86%	9.54	$30,741
Asthma	382	3.99%	44.43	$19,267
Atrial Fibrillation	61	0.64%	7.09	$48,756
Blood Disorders	450	4.70%	52.34	$36,173
CAD	108	1.13%	12.56	$52,788
COPD	29	0.30%	3.37	$65,377
Cancer	274	2.86%	31.87	$34,121
Chronic Pain	154	1.61%	17.91	$27,154
Congestive Heart Failure	45	0.47%	5.23	$86,247
Demyelinating Diseases	26	0.27%	3.02	$56,857
Depression	663	6.93%	77.11	$14,930
Diabetes	430	4.49%	50.01	$23,158
ESRD	5	0.05%	0.58	$786,381
Eating Disorders	43	0.45%	5.00	$41,633
HIV/AIDS	6	0.06%	0.70	$47,464
Hyperlipidemia	1,053	11.00%	122.47	$15,168
Hypertension	940	9.82%	109.33	$17,930
Immune Disorders	40	0.42%	4.65	$85,162
Inflammatory Bowel Disease	45	0.47%	5.23	$36,640
Liver Diseases	131	1.37%	15.24	$32,629
Morbid Obesity	255	2.66%	29.66	$13,458
Osteoarthritis	235	2.46%	27.33	$29,828
Peripheral Vascular Disease	33	0.34%	3.84	$15,066
Rheumatoid Arthritis	41	0.43%	4.77	$35,354

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 June 30, 2022

Express Scripts

Membership Summary	4Q FY2022 LDPPO		Difference	% Change
			Membership Summary	
Member Count (Membership)	8,533		8,533	#DIV/0!
Utilizing Member Count (Patients)	7,350		7,350	#DIV/0!
Percent Utilizing (Utilization)	86.1%	#DIV/0!	#DIV/0!	#DIV/0!

Claim Summary			Claims Summary	
Net Claims (Total Rx's)	117,576		117,576	#DIV/0!
Claims per Elig Member per Month (Claims PMPM)	1.15		1.15	#DIV/0!
Total Claims for Generic (Generic Rx)	99,041		99,041.00	#DIV/0!
Total Claims for Brand (Brand Rx)	18,535		18,535.00	#DIV/0!
Total Claims for Brand w/Gen Equiv (Multisource Brand Claims)	784		784.00	#DIV/0!
Total Non-Specialty Claims	116,059		116,059.00	#DIV/0!
Total Specialty Claims	1,517		1,517.00	#DIV/0!
Generic % of Total Claims (GFR)	**84.2%**	**#DIV/0!**	#DIV/0!	#DIV/0!
Generic Effective Rate (GCR)	**99.2%**	**#DIV/0!**	#DIV/0!	#DIV/0!
Mail Order Claims	32,171		32,171.00	#DIV/0!
Mail Penetration Rate*	31.8%		0.32	31.8%

Claims Cost Summary			Claims Cost Summary	
Total Prescription Cost (Total Gross Cost)	$12,736,832		$12,736,832.00	#DIV/0!
Total Generic Gross Cost	$2,354,762		$2,354,762.00	#DIV/0!
Total Brand Gross Cost	$10,382,069		$10,382,069.00	#DIV/0!
Total MSB Gross Cost	$286,304		$286,304.00	#DIV/0!
Total Ingredient Cost	$12,522,638		$12,522,638.00	#DIV/0!
Total Dispensing Fee	$204,413		$204,413.00	#DIV/0!
Total Other (e.g. tax)	$9,781		$9,781.00	#DIV/0!
Avg Total Cost per Claim (Gross Cost/Rx)	**$108.33**	**#DIV/0!**	#DIV/0!	#DIV/0!
Avg Total Cost for Generic (Gross Cost/Generic Rx)	$23.78		$23.78	#DIV/0!
Avg Total Cost for Brand (Gross Cost/Brand Rx)	$560.13		$560.13	#DIV/0!
Avg Total Cost for MSB (MSB Gross Cost/MSB ARx)	$365.18		$365.18	#DIV/0!

Member Cost Summary			Member Cost Summary	
Total Member Cost	**$2,344,912**		$2,344,912.00	#DIV/0!
Total Copay	$2,320,006	$0.00	$2,320,006.00	#DIV/0!
Total Deductible	$24,906	$0.00	$24,906.00	0.0%
Avg Copay per Claim (Copay/Rx)	$19.73	#DIV/0!	#DIV/0!	#DIV/0!
Avg Participant Share per Claim (Copay+Deductible/RX)	**$19.94**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**
Avg Copay for Generic (Copay/Generic Rx)	$7.23		$7.23	#DIV/0!
Avg Copay for Brand (Copay/Brand Rx)	$87.86		$87.86	#DIV/0!
Avg Copay for Brand w/ Generic Equiv (Copay/Multisource Rx)	$31.94		$31.94	#DIV/0!
Net PMPM (Participant Cost PMPM)	**$22.90**	**#DIV/0!**	#DIV/0!	#DIV/0!
Copay % of Total Prescription Cost (Member Cost Share %)	18.4%	#DIV/0!	#DIV/0!	#DIV/0!

Plan Cost Summary			Plan Cost Summary	
Total Plan Cost (Plan Cost)	**$10,391,920**		**$10,391,920.00**	**#DIV/0!**
Total Non-Specialty Cost (Non-Specialty Plan Cost)	$5,739,932		$5,739,932.00	#DIV/0!
Total Specialty Drug Cost (Specialty Plan Cost)	$4,651,987		$4,651,987.00	#DIV/0!
Avg Plan Cost per Claim (Plan Cost/Rx)	**$88.38**	**#DIV/0!**	#DIV/0!	#DIV/0!
Avg Plan Cost for Generic (Plan Cost/Generic Rx)	$16.54		$16.54	#DIV/0!
Avg Plan Cost for Brand (Plan Cost/Brand Rx)	$472.27		$472.27	#DIV/0!
Avg Plan Cost for MSB (MSB Plan Cost/MSB ARx)	$333.25		$333.25	#DIV/0!
Net PMPM (Plan Cost PMPM)	**$101.49**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**
PMPM for Specialty Only (Specialty PMPM)	$45.43		$45.43	#DIV/0!
PMPM without Specialty (Non-Specialty PMPM)	$56.06		$56.06	#DIV/0!
Rebates Received (Q1-Q4 FY2022 actual)	$1,057,775.76		**$1,057,775.76**	**#DIV/0!**
Net PMPM (Plan Cost PMPM factoring Rebates)	**$91.16**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**
PMPM for Specialty Only (Specialty PMPM)	$38.91		$38.91	#DIV/0!
PMPM without Specialty (Non-Specialty PMPM)	$37.93		$37.93	#DIV/0!

Appendix C

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HealthSCOPE – EPO Utilization Review for PEBP
July 1, 2021 – June 30, 2022

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HSB DATASCOPE™

Nevada Public Employees' Benefits Program
EPO Plan

July 2021 – June 2022

HealthSCOPE BENEFITS

Overview

- Total Medical Spend for PY22 was $46,097,383 with a plan cost per employee per year (PEPY) of $11,414. This is in line with PY21.
  - IP Cost per Admit is $31,480 which is 7.6% lower than PY21.
  - ER Cost per Visit is $1,966 which is 19.8% lower than PY21.
- Employees shared in 9.7% of the medical cost.
- Inpatient facility costs were 31.5% of the plan spend.
- 69.6% of the Average Membership had paid Medical claims less than $2,500, with 9.4% of those having no claims paid at all during the reporting period.
- 59 members exceeded the $100k high-cost threshold during the reporting period, which accounted for 31.5% of the plan spend. The highest diagnosis category was Infections, accounting for 15.9% of the high-cost claimant dollars.
- Total spending with in-network providers was 100.0%. The average In Network discount was 57.6%, which is 6.3% higher than the PY21 average discount of 54.2%.

Paid Claims by Age Group

Paid Claims by Age Group																
	PY21						PY22						% Change	
Age Range	Med Net Pay	Med PMPM	Rx Net Pay	Rx PMPM	Net Pay	PMPM	Med Net Pay	Med PMPM	Rx Net Pay	Rx PMPM	Net Pay	PMPM	Net Pay	PMPM
<1	$ 1,233,882	$1,168	$ 26,292	$25	$ 1,260,174	$1,193	$ 2,184,713	$ 2,494	$ 2,362	$ 3	$ 2,187,075	$ 2,497	73.6%	109.2%
1	$ 191,627	$158	$ 2,156	$2	$ 193,783	$160	$ 261,519	$ 307	$ 2,464	$ 3	$ 263,983	$ 310	36.2%	93.8%
2 - 4	$ 324,202	$96	$ 13,696	$4	$ 337,898	$100	$ 542,438	$ 179	$ 12,333	$ 4	$ 554,771	$ 183	64.2%	83.7%
5 - 9	$ 628,220	$105	$ 79,791	$13	$ 708,011	$118	$ 459,133	$ 93	$ 37,817	$ 8	$ 496,950	$ 101	-29.8%	-15.2%
10 - 14	$ 1,016,206	$138	$ 225,605	$31	$ 1,241,811	$169	$ 1,401,067	$ 213	$ 143,380	$ 22	$ 1,544,447	$ 235	24.4%	39.3%
15 - 19	$ 2,474,968	$293	$ 462,365	$55	$ 2,937,333	$347	$ 1,839,285	$ 231	$ 260,407	$ 33	$ 2,099,692	$ 264	-28.5%	-24.0%
20 - 24	$ 1,757,900	$221	$ 600,531	$75	$ 2,358,431	$296	$ 1,423,772	$ 199	$ 251,626	$ 35	$ 1,675,398	$ 234	-29.0%	-21.0%
25 - 29	$ 1,263,529	$300	$ 1,075,802	$255	$ 2,339,331	$555	$ 1,192,719	$ 372	$ 625,184	$ 195	$ 1,817,903	$ 567	-22.3%	2.2%
30 - 34	$ 3,536,048	$639	$ 841,315	$152	$ 4,377,363	$791	$ 1,836,569	$ 423	$ 302,727	$ 70	$ 2,139,296	$ 492	-51.1%	-37.8%
35 - 39	$ 3,394,187	$494	$ 833,528	$121	$ 4,227,715	$615	$ 3,282,867	$ 555	$ 493,062	$ 83	$ 3,775,929	$ 638	-10.7%	3.8%
40 - 44	$ 3,114,848	$450	$ 1,634,738	$236	$ 4,749,586	$686	$ 2,489,778	$ 408	$ 1,295,086	$ 212	$ 3,784,864	$ 620	-20.3%	-9.7%
45 - 49	$ 4,216,481	$546	$ 1,241,221	$161	$ 5,457,702	$707	$ 3,671,050	$ 535	$ 791,155	$ 115	$ 4,462,205	$ 650	-18.2%	-8.1%
50 - 54	$ 5,958,498	$609	$ 2,657,366	$271	$ 8,615,864	$880	$ 6,167,652	$ 721	$ 1,622,467	$ 190	$ 7,790,119	$ 910	-9.6%	3.5%
55 - 59	$ 9,635,953	$973	$ 2,534,338	$256	$ 12,170,291	$1,229	$ 7,620,175	$ 856	$ 1,572,356	$ 177	$ 9,192,531	$ 1,032	-24.5%	-16.0%
60 - 64	$ 10,301,328	$911	$ 4,072,301	$360	$ 14,373,629	$1,272	$ 7,911,671	$ 764	$ 2,671,081	$ 258	$ 10,582,752	$ 1,022	-26.4%	-19.6%
65+	$ 4,066,068	$826	$ 1,840,142	$374	$ 5,906,210	$1,200	$ 3,812,975	$ 827	$ 1,323,297	$ 287	$ 5,136,272	$ 1,115	-13.0%	-7.1%
Total	**$53,113,944**	**$518**	**$18,141,186**	**$177**	**$71,255,130**	**$694**	**$ 46,097,383**	**$ 511**	**$ 11,406,806**	**$ 126**	**$ 57,504,189**	**$ 637**	**-19.3%**	**-8.3%**

Financial Summary (p. 1 of 2)

	Total				State Active				Non-State Active			
Summary	**PY20**	**PY21**	**PY22**	**Variance to Prior Year**	**PY20**	**PY21**	**PY22**	**Variance to Prior Year**	**PY20**	**PY21**	**PY22**	**Variance to Prior Year**
Enrollment												
Avg # Employees	4,794	4,650	4,039	-13.2%	4,054	3,949	3,384	-14.3%	4	4	3	-29.3%
Avg # Members	8,768	8,553	7,522	-12.1%	7,768	7,602	6,607	-13.1%	5	4	3	-34.6%
Ratio	1.8	1.8	1.9	1.1%	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	$51,021,647	-10.2%	$45,961,999	$44,805,657	$43,258,358	-3.5%	$70,916	$44,403	$5,022	-88.7%
Client Paid	$50,293,887	$53,113,944	$46,097,383	-13.2%	$41,579,805	$41,757,107	$39,183,656	-6.2%	$65,329	$41,594	$3,851	-90.7%
Employee Paid	$5,229,342	$3,690,102	$4,924,264	33.4%	$4,382,194	$3,048,550	$4,074,703	33.7%	$5,587	$2,808	$1,172	-58.3%
Client Paid-PEPY	$10,492	$11,422	$11,414	-0.1%	$10,256	$10,575	$11,578	9.5%	$16,332	$10,399	$1,359	-86.9%
Client Paid-PMPY	$5,736	$6,210	$6,129	-1.3%	$5,352	$5,493	$5,931	8.0%	$13,066	$9,599	$1,359	-85.8%
Client Paid-PEPM	$874	$952	$951	-0.1%	$855	$881	$965	9.5%	$1,361	$867	$113	-87.0%
Client Paid-PMPM	$478	$518	$511	-1.4%	$446	$458	$494	7.9%	$1,089	$800	$113	-85.9%
High Cost Claimants (HCC's) > $100k												
# of HCC's	51	61	59	-3.3%	40	49	50	2.0%	0	0	0	0.0%
HCC's / 1,000	5.8	7.1	7.8	10.0%	5.2	6.5	7.6	17.4%	0.0	0.0	0.0	0.0%
Avg HCC Paid	$202,775	$257,989	$245,910	-4.7%	$179,535	$212,968	$258,338	21.3%	$0	$0	$0	0.0%
HCC's % of Plan Paid	20.6%	29.6%	31.5%	6.4%	17.3%	25.0%	33.0%	32.0%	0.0%	0.0%	0.0%	0.0%
Cost Distribution by Claim Type (PMPY)												
Facility Inpatient	$1,169	$1,457	$1,929	32.4%	$1,036	$1,091	$1,882	72.5%	$2,928	$0	$0	0.0%
Facility Outpatient	$1,832	$1,951	$1,691	-13.3%	$1,693	$1,779	$1,623	-8.8%	$4,817	$4,611	$27	-99.4%
Physician	$2,541	$2,608	$2,368	-9.2%	$2,461	$2,464	$2,295	-6.9%	$5,153	$4,469	$1,223	-72.6%
Other	$194	$194	$141	-27.3%	$163	$159	$131	-17.6%	$168	$518	$109	-79.0%
Total	$5,736	$6,210	$6,129	-1.3%	$5,352	$5,493	$5,931	8.0%	$13,066	$9,599	$1,359	-85.8%

Financial Summary (p. 2 of 2)

	State Retirees				Non-State Retirees				
Summary	**PY20**	**PY21**	**PY22**	**Variance to Prior Year**	**PY20**	**PY21**	**PY22**	**Variance to Prior Year**	**HSB Peer Index**
Enrollment									
Avg # Employees	588	576	567	-1.5%	148	122	85	-30.5%	
Avg # Members	807	789	799	1.2%	188	158	114	-28.0%	
Ratio	1.4	1.4	1.4	2.9%	1.3	1.3	1.3	3.9%	1.6
Financial Summary									
Gross Cost	$8,514,643	$7,966,596	$6,913,103	-13.2%	$975,672	$3,987,390	$845,163	-78.8%	
Client Paid	$7,803,114	$7,426,217	$6,189,006	-16.7%	$845,639	$3,889,026	$720,870	-81.5%	
Employee Paid	$711,529	$540,380	$724,097	34.0%	$130,033	$98,364	$124,293	26.4%	
Client Paid-PEPY	$13,272	$12,904	$10,923	-15.4%	$5,730	$31,812	$8,489	-73.3%	$6,642
Client Paid-PMPY	$9,674	$9,413	$7,748	-17.7%	$4,508	$24,653	$6,347	-74.3%	$4,116
Client Paid-PEPM	$1,106	$1,075	$910	-15.3%	$477	$2,651	$707	-73.3%	$553
Client Paid-PMPM	$806	$784	$646	-17.6%	$376	$2,054	$529	-74.2%	$343
High Cost Claimants (HCC's) > $100k									
# of HCC's	18	18	11	-38.9%	0	2	1	0.0%	
HCC's / 1,000	22.3	22.8	13.8	-39.7%	0.0	12.7	8.8	0.0%	
Avg HCC Paid	$175,561	$113,454	$125,820	10.9%	$0	$1,629,851	$207,778	0.0%	
HCC's % of Plan Paid	40.5%	27.5%	22.4%	-18.5%	0.0%	83.8%	28.8%	0.0%	
Cost Distribution by Claim Type (PMPY)									
Facility Inpatient	$2,529	$1,454	$2,180	49.9%	$787	$19,176	$2,921	-84.8%	$1,190
Facility Outpatient	$3,276	$3,575	$2,338	-34.6%	$1,314	$2,010	$1,129	-43.8%	$1,376
Physician	$3,385	$3,897	$3,014	-22.7%	$2,165	$3,054	$2,145	-29.8%	$1,466
Other	$484	$487	$217	-55.4%	$242	$413	$152	-63.2%	$84
Total	$9,674	$9,413	$7,748	-17.7%	$4,508	$24,653	$6,347	-74.3%	$4,116

Paid Claims by Claim Type – State Participants

Net Paid Claims - Total State Participants	PY21				PY22				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical									
Inpatient	$ 10,455,682	$ 1,271,089	$ 217,769	$ 11,944,540	$ 14,284,645	$ 1,772,609	$ 184,306	$ 16,241,560	36.0%
Outpatient	$ 31,301,425	$ 5,415,883	$ 521,476	$ 37,238,784	$ 24,899,011	$ 3,902,538	$ 329,553	$ 29,131,102	-21.8%
Total - Medical	**$ 41,757,107**	**$ 6,686,972**	**$ 739,245**	**$ 49,183,324**	**$ 39,183,656**	**$ 5,675,147**	**$ 513,859**	**$ 45,372,662**	**-7.7%**

Net Paid Claims - Per Participant per Month	PY21				PY22				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical	$ 881	$ 1,140	$ 716	$ 906	$ 965	$ 958	$ 589	$ 957	5.6%

Paid Claims by Claim Type – Non-State Participants

Net Paid Claims - Total Non-State Participants	PY21				PY22				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical									
Inpatient	$ 3,491	$ 3,089,255	$ 93,227	$ 3,185,973	$ -	$ 238,956	$ 106,276	$ 345,232	-89.2%
Outpatient	$ 38,104	$ 517,963	$ 188,580	$ 744,647	$ 3,851	$ 194,130	$ 181,509	$ 379,489	-49.0%
Total - Medical	**$ 41,594**	**$ 3,607,219**	**$ 281,807**	**$ 3,930,620**	**$ 3,851**	**$ 433,086**	**$ 287,785**	**$ 724,721**	**-81.6%**

Net Paid Claims - Per Participant per Month	PY21				PY22				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical	$ 867	$ 4,487	$ 427	$ 2,600	$ 113	$ 1,064	$ 470	$ 688	-73.5%

Paid Claims by Claim Type – Total

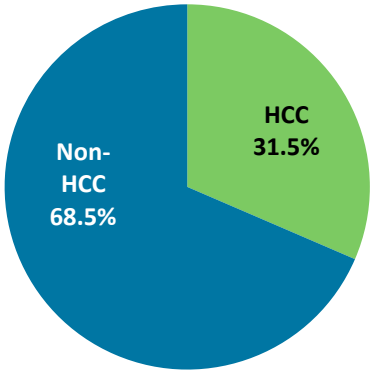
Net Paid Claims - Total Total Participants	PY21				PY22				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical									
Inpatient	$ 10,459,172	$ 4,360,344	$ 310,996	$ 15,130,513	$ 14,284,645	$ 2,011,565	$ 290,582	$ 16,586,792	9.6%
Outpatient	$ 31,339,529	$ 5,933,846	$ 710,056	$ 37,983,431	$ 24,902,862	$ 4,096,667	$ 511,062	$ 29,510,591	-22.3%
Total - Medical	**$ 41,798,702**	**$ 10,294,190**	**$ 1,021,052**	**$ 53,113,944**	**$ 39,187,506**	**$ 6,108,232**	**$ 801,644**	**$ 46,097,383**	**-13.2%**

Net Paid Claims - Per Participant per Month	PY21				PY22				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical	$ 881	$ 1,543	$ 603	$ 952	$ 964	$ 964	$ 540	$ 951	-0.1%

Cost Distribution – Medical Claims

PY21							PY22					
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
51	0.6%	$15,734,764	29.6%	$192,679	5.2%	$100,000.01 Plus	43	0.6%	$14,457,580	31.4%	$187,141	3.8%
81	0.9%	$6,153,855	11.6%	$221,750	6.0%	$50,000.01-$100,000.00	66	0.9%	$4,899,041	10.6%	$261,207	5.3%
206	2.4%	$7,631,477	14.4%	$414,155	11.2%	$25,000.01-$50,000.00	169	2.2%	$6,110,860	13.3%	$468,603	9.5%
580	6.8%	$9,746,549	18.4%	$754,991	20.5%	$10,000.01-$25,000.00	473	6.3%	$8,164,958	17.7%	$966,566	19.6%
701	8.2%	$5,228,065	9.8%	$678,130	18.4%	$5,000.01-$10,000.00	586	7.8%	$4,481,107	9.7%	$886,958	18.0%
1,043	12.2%	$3,911,413	7.4%	$617,094	16.7%	$2,500.01-$5,000.00	950	12.6%	$3,548,646	7.7%	$855,413	17.4%
5,060	59.2%	$4,707,244	8.9%	$810,948	22.0%	$0.01-$2,500.00	4,509	59.9%	$4,435,191	9.6%	$1,294,868	26.3%
14	0.2%	$0	0.0%	$354	0.0%	$0.00	23	0.3%	$0	0.0%	$3,508	0.1%
818	9.6%	$578	0.0%	$0	0.0%	No Claims	705	9.4%	$0	0.0%	$0	0.0%
8,553	**100.0%**	**$53,113,944**	**100.0%**	**$3,690,102**	**100.0%**		**7,522**	**100.0%**	**$46,097,383**	**100.0%**	**$4,924,264**	**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**
Infections	32	$2,309,621	15.9%
Pulmonary Disorders	40	$1,862,009	12.8%
Cancer	15	$1,660,370	11.4%
Endocrine/Metabolic Disorders	21	$1,491,873	10.3%
Pregnancy-related Disorders	4	$1,478,486	10.2%
Cardiac Disorders	35	$1,167,614	8.0%
Congenital/Chromosomal Anomalies	7	$811,685	5.6%
Hematological Disorders	14	$733,378	5.1%
Mental Health	14	$608,535	4.2%
Renal/Urologic Disorders	18	$369,465	2.5%
All Other		$2,015,643	13.9%
Overall	**----**	**$14,508,678**	**100.0%**

Utilization Summary (p. 1 of 2)

Inpatient data reflects facility charges and professional services.
DX&L = Diagnostics, X-Ray and Laboratory

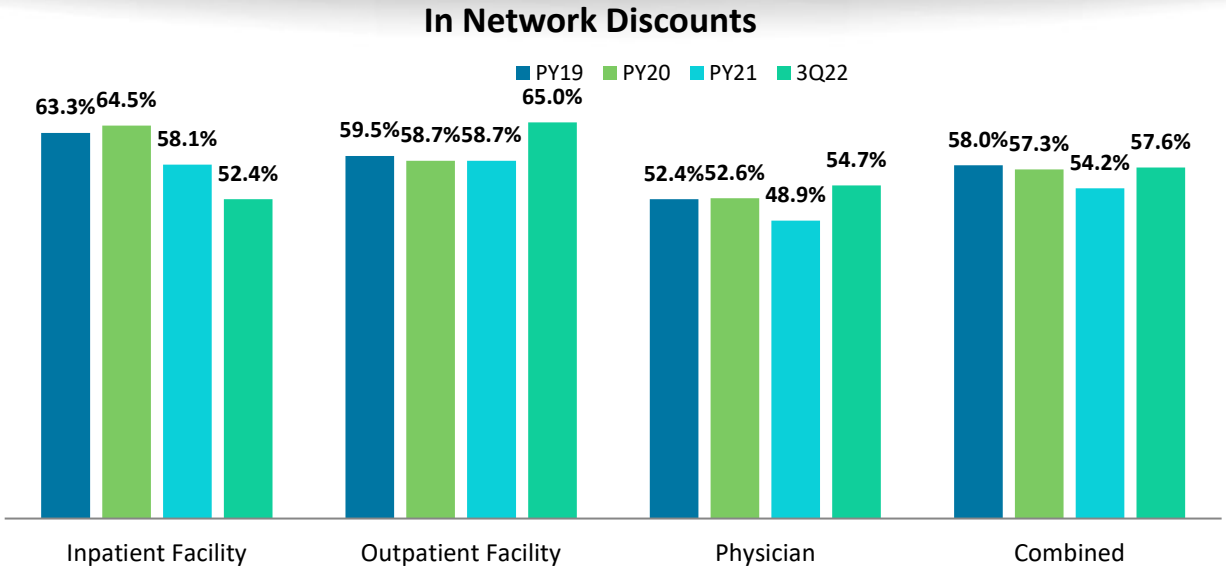
	Total				State Active				Non-State Active			
Summary	**PY20**	**PY21**	**PY22**	**Variance to Prior Year**	**PY20**	**PY21**	**PY22**	**Variance to Prior Year**	**PY20**	**PY21**	**PY22**	**Variance to Prior Year**
Inpatient Summary												
# of Admits	558	457	399		467	381	343		1	0	0	
# of Bed Days	2,969	2,940	2,208		2,379	2,188	1,889		2	0	0	
Paid Per Admit	$23,592	$34,055	$31,480	-7.6%	$22,998	$28,387	$32,508	14.5%	$22,498	$0	$0	0.0%
Paid Per Day	$4,434	$5,294	$5,689	7.5%	$4,514	$4,943	$5,903	19.4%	$11,249	$0	$0	0.0%
Admits Per 1,000	64	53	53	0.0%	60	50	52	4.0%	200	0	0	0.0%
Days Per 1,000	338	344	294	-14.5%	305	288	286	-0.7%	400	0	0	0.0%
Avg LOS	5.3	6.4	5.5	-14.1%	5.1	5.7	5.5	-3.5%	2.0	0.0	0.0	0.0%
# Admits From the ER	268	231	211		205	180	169	-6.1%	0	0	0	
Physician Office												
OV Utilization per Member	5.9	6.1	5.8	-4.9%	5.8	5.9	5.6	-5.1%	9.2	5.3	6.0	13.2%
Avg Paid per OV	$147	$151	$151	0.0%	$151	$152	$152	0.0%	$110	$136	$159	16.9%
Avg OV Paid per Member	$875	$913	$868	-4.9%	$868	$892	$848	-4.9%	$1,009	$720	$955	32.6%
DX&L Utilization per Member	10.2	10.3	10	-2.9%	9.6	9.7	9.5	-2.1%	17.6	16.8	0	-100.0%
Avg Paid per DX&L	$71	$70	$64	-8.6%	$72	$68	$65	-4.4%	$90	$58	$0	-100.0%
Avg DX&L Paid per Member	$723	$717	$642	-10.5%	$689	$665	$618	-7.1%	$1,582	$984	$0	-100.0%
Emergency Room												
# of Visits	1,706	1,319	1,354		1,501	1,156	1,163		2	2	0	
Visits Per Member	0.19	0.15	0.18	20.0%	0.19	0.15	0.18	20.0%	0.46	0.46	0.00	-100.0%
Visits Per 1,000	194	154	180	16.9%	193	152	176	15.8%	462	462	0	-100.0%
Avg Paid per Visit	$2,523	$2,452	$1,966	-19.8%	$2,557	$2,463	$1,939	-21.3%	$2,359	$10,325	$0	-100.0%
Urgent Care												
# of Visits	3,196	2,455	3,021		2,930	2,237	2,735		0	1	0	
Visits Per Member	0.36	0.29	0.40	37.9%	0.38	0.29	0.41	41.4%	0.00	0.23	0.00	0.0%
Visits Per 1,000	364	287	402	40.1%	376	294	414	40.8%	0	231	0	0.0%
Avg Paid per Visit	$139	$152	$154	1.3%	$140	$153	$156	2.0%	$0	$250	$0	0.0%

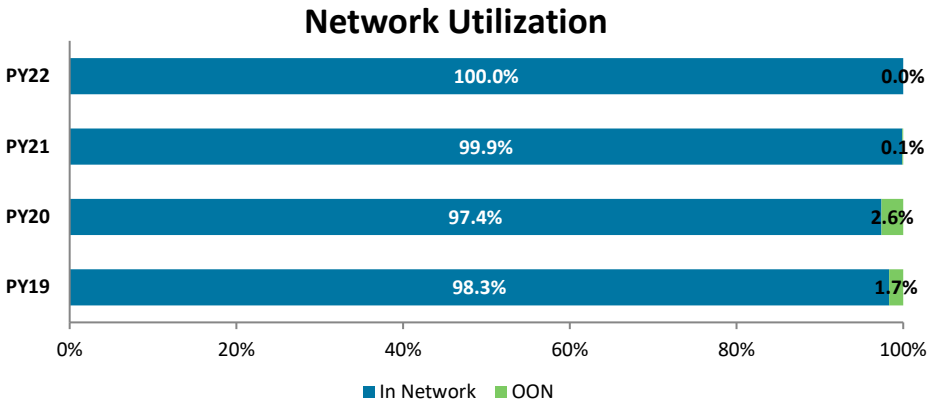
Utilization Summary (p. 2 of 2)

Inpatient data reflects facility charges and professional services.
DX&L = Diagnostics, X-Ray and Laboratory

	State Retirees				Non-State Retirees				
Summary	**PY20**	**PY21**	**PY22**	**Variance to Prior Year**	**PY20**	**PY21**	**PY22**	**Variance to Prior Year**	**HSB Peer Index**
Inpatient Summary									
# of Admits	78	68	46		12	8	10		
# of Bed Days	385	512	247		203	240	72		
Paid Per Admit	$28,333	$23,428	$27,614	17.9%	$15,995	$394,319	$13,993	-96.5%	$18,822
Paid Per Day	$5,740	$3,112	$5,143	65.3%	$946	$13,144	$1,944	-85.2%	$3,265
Admits Per 1,000	98	86	58	-32.6%	64	51	88	72.5%	70
Days Per 1,000	482	649	309	-52.4%	1,083	1,521	634	-58.3%	402
Avg LOS	4.9	7.5	5.4	-28.0%	16.9	30.0	7.2	-76.0%	5.8
# Admits From the ER	55	46	34	-26.1%	8	5	8		
Physician Office									
OV Utilization per Member	7.7	8.0	7.0	-12.5%	6.4	6.6	7.3	10.6%	5.4
Avg Paid per OV	$128	$140	$149	6.4%	$110	$136	$112	-17.6%	$96
Avg OV Paid per Member	$986	$1,119	$1,044	-6.7%	$704	$900	$822	-8.7%	$515
DX&L Utilization per Member	14.9	15	13.8	-8.0%	13.6	12.6	10.8	-14.3%	11.0
Avg Paid per DX&L	$66	$80	$63	-21.3%	$72	$64	$49	-23.4%	$50
Avg DX&L Paid per Member	$991	$1,195	$861	-27.9%	$982	$807	$528	-34.6%	$543
Emergency Room									
# of Visits	181	141	168		22	20	23		
Visits Per Member	0.23	0.18	0.21	16.7%	0.12	0.13	0.20	53.8%	0.22
Visits Per 1,000	227	179	210	17.3%	117	127	202	59.1%	221
Avg Paid per Visit	$2,317	$2,347	$2,298	-2.1%	$1,883	$1,741	$893	-48.7%	$968
Urgent Care									
# of Visits	209	185	250		57	32	36		
Visits Per Member	0.26	0.23	0.31	34.8%	0.30	0.20	0.32	60.0%	0.35
Visits Per 1,000	262	234	313	33.8%	304	203	317	56.2%	352
Avg Paid per Visit	$136	$141	$149	5.7%	$91	$115	$68	-40.9%	$135

Provider Network Summary





Diagnosis Grouper Summary

Diagnosis Grouper	Total Paid	% Paid	Insured	Spouse	Child	Male	Female	Unassigned
Infections	$4,043,941	8.8%	$3,165,394	$520,629	$357,919	$1,728,054	$2,315,880	$8
COVID-19, Confirmed	$2,134,030	4.6%	$1,938,688	$98,158	$97,184	$612,009	$1,522,022	$0
Pregnancy-related Disorders	$3,310,765	7.2%	$1,026,090	$335,292	$1,949,382	$544,452	$2,758,698	$7,615
Musculoskeletal Disorders	$3,161,060	6.9%	$2,257,516	$529,194	$374,351	$1,203,986	$1,955,992	$1,083
Cardiac Disorders	$3,113,126	6.8%	$2,643,209	$424,197	$45,721	$1,804,785	$1,307,391	$951
Health Status/Encounters	$3,079,760	6.7%	$1,818,294	$323,100	$938,366	$1,113,991	$1,959,180	$6,589
Cancer	$2,942,510	6.4%	$1,944,499	$822,609	$175,402	$1,648,231	$1,294,070	$209
Pulmonary Disorders	$2,883,155	6.3%	$2,470,326	$143,303	$269,525	$2,107,624	$775,416	$114
Gastrointestinal Disorders	$2,821,459	6.1%	$2,044,905	$374,211	$402,343	$1,063,910	$1,757,232	$316
Mental Health	$2,640,375	5.7%	$1,503,480	$174,217	$962,677	$1,016,648	$1,623,115	$611
Endocrine/Metabolic Disorders	$2,535,481	5.5%	$2,210,752	$245,910	$78,819	$761,496	$1,773,986	$0
Neurological Disorders	$1,970,159	4.3%	$1,396,123	$252,975	$321,061	$529,000	$1,440,745	$414
Eye/ENT Disorders	$1,853,610	4.0%	$1,059,262	$194,134	$600,214	$764,462	$1,087,261	$1,888
Spine-related Disorders	$1,795,078	3.9%	$1,262,756	$466,165	$66,157	$757,439	$1,037,639	$0
Renal/Urologic Disorders	$1,695,314	3.7%	$1,270,396	$240,383	$184,535	$814,516	$880,018	$780
Trauma/Accidents	$1,305,158	2.8%	$752,491	$233,543	$319,124	$667,154	$637,539	$466
Gynecological/Breast Disorders	$1,168,626	2.5%	$914,651	$95,996	$157,979	$18,246	$1,150,280	$100
Congenital/Chromosomal Anomalies	$1,028,027	2.2%	$478,331	$4,476	$545,220	$122,028	$905,999	$0
Hematological Disorders	$901,873	2.0%	$848,588	$40,798	$12,487	$773,957	$127,601	$315
Medical/Surgical Complications	$639,167	1.4%	$475,450	$60,684	$103,033	$268,815	$370,352	$0
Diabetes	$586,672	1.3%	$424,408	$83,077	$79,187	$361,088	$225,584	$0
Non-malignant Neoplasm	$549,740	1.2%	$421,770	$97,214	$30,756	$127,375	$421,862	$502
Dermatological Disorders	$530,051	1.1%	$322,263	$121,822	$85,966	$248,579	$281,168	$304
Miscellaneous	$497,074	1.1%	$368,395	$53,550	$75,128	$201,112	$295,605	$356
Vascular Disorders	$323,705	0.7%	$307,174	$13,441	$3,090	$231,703	$91,744	$259
Abnormal Lab/Radiology	$265,233	0.6%	$216,889	$36,610	$11,734	$88,219	$176,797	$216
Medication Related Conditions	$166,008	0.4%	$89,185	$34,751	$42,072	$47,530	$118,478	$0
Cholesterol Disorders	$150,045	0.3%	$134,764	$12,606	$2,674	$43,667	$106,378	$0
Dental Conditions	$79,799	0.2%	$49,694	$7,179	$22,927	$6,033	$73,766	$0
External Hazard Exposure	$38,727	0.1%	$6,768	$319	$31,640	$32,964	$5,763	$0
Allergic Reaction	$21,685	0.0%	$6,631	$765	$14,289	$9,341	$12,344	$0
Total	**$46,097,383**	**100.0%**	**$31,890,454**	**$5,943,151**	**$8,263,778**	**$19,106,404**	**$26,967,883**	**$23,096**

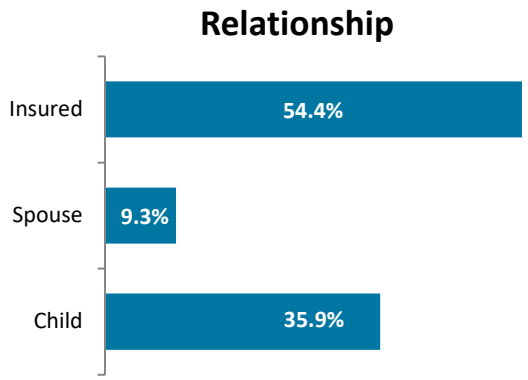
Mental Health Drilldown

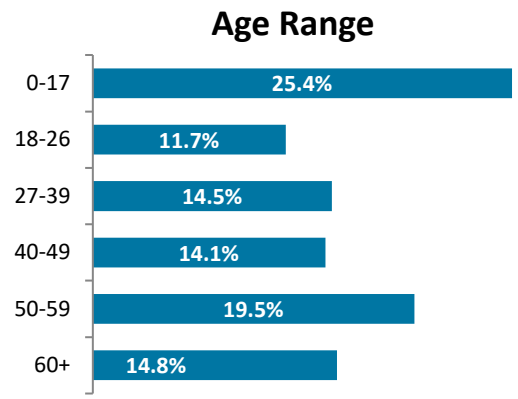
	PY19		PY20		PY21		PY22	
Grouper	Patients	Total Paid	Patients	Total Paid	Patients	Total Paid	Patients	Total Paid
Depression	532	$751,739	632	$1,048,452	655	$861,117	538	$690,232
Complications of Substance Abuse	26	$319,764	34	$325,820	30	$138,433	22	$421,274
Mental Health Conditions, Other	464	$493,299	595	$616,280	662	$938,742	386	$415,272
Mood and Anxiety Disorders	551	$333,099	694	$531,718	716	$636,220	461	$390,874
Bipolar Disorder	121	$202,469	151	$279,948	135	$252,449	80	$189,584
Eating Disorders	14	$268,532	17	$111,963	25	$376,295	20	$104,376
Developmental Disorders	53	$61,872	64	$149,263	64	$155,167	47	$92,072
Sexually Related Disorders	11	$3,408	20	$167,866	26	$81,490	16	$86,059
Attention Deficit Disorder	153	$58,480	187	$95,843	190	$94,546	133	$80,062
Alcohol Abuse/Dependence	33	$24,550	43	$162,989	39	$168,417	27	$75,291
Sleep Disorders	165	$29,028	186	$36,835	187	$38,393	90	$44,570
Personality Disorders	9	$10,876	10	$10,468	15	$18,725	15	$19,766
Substance Abuse/Dependence	40	$20,086	48	$107,498	54	$44,537	26	$14,330
Psychoses	7	$3,308	14	$18,805	8	$54,549	3	$10,457
Tobacco Use Disorder	49	$5,087	54	$5,349	42	$4,779	20	$4,216
Schizophrenia	9	$10,155	11	$16,662	10	$10,630	6	$1,940
Total		**$2,595,750**		**$3,685,761**		**$3,874,490**		**$2,640,375**

Diagnosis Grouper – Infections

Diagnosis Sub-Grouper	Patients	Claims	Total Paid	% Paid
Infectious Diseases	2,286	5,037	$2,674,333	66.1%
Septicemia	50	112	$1,324,220	32.7%
Influenza	62	68	$26,812	0.7%
Osteomyelitis	7	20	$8,084	0.2%
HIV	9	35	$5,394	0.1%
Central Nervous System Infection	1	4	$3,907	0.1%
Hepatitis B	4	10	$950	0.0%
Clostridium Difficile	2	2	$125	0.0%
Hepatitis C	2	2	$104	0.0%
Tuberculosis	2	2	$11	0.0%
Overall	**----**	**----**	**$4,043,941**	**100.0%**

*Patient and claim counts are unique only within the category

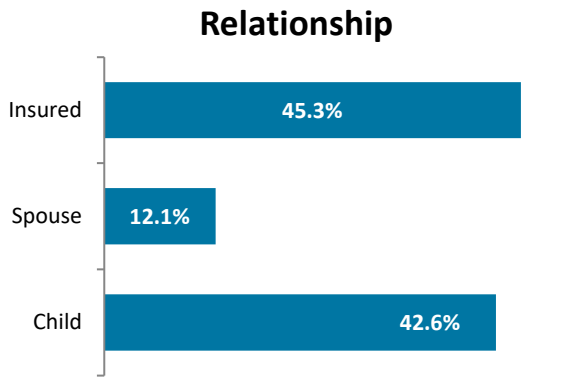


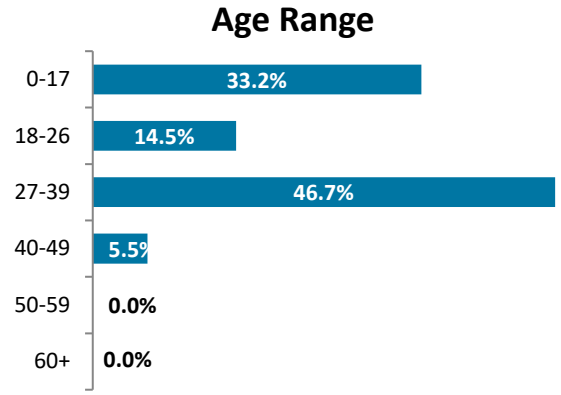


Diagnosis Grouper – Pregnancy-related Disorders

Diagnosis Sub-Grouper	Patients	Claims	Total Paid	% Paid
Liveborn Infants	91	179	$1,449,200	43.8%
Labor and Delivery Related	102	293	$849,790	25.7%
Pregnancy Complications	128	614	$497,005	15.0%
Fetal Distress	5	94	$243,298	7.3%
Supervision of Pregnancy	142	628	$135,321	4.1%
Perinatal Disorders	47	112	$68,214	2.1%
Abortion Related	11	29	$25,471	0.8%
Multiple Gestation Related	3	26	$17,202	0.5%
Ectopic Pregnancy	3	9	$12,732	0.4%
Cesarean Delivery	12	14	$8,443	0.3%
Prematurity and Low Birth Weight	7	12	$4,088	0.1%
Overall	**----**	**----**	**$3,310,765**	**100.0%**

*Patient and claim counts are unique only within the category

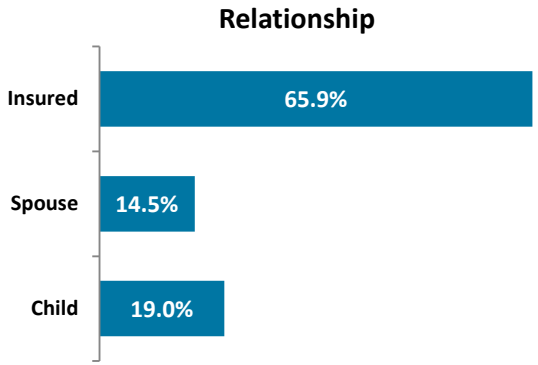


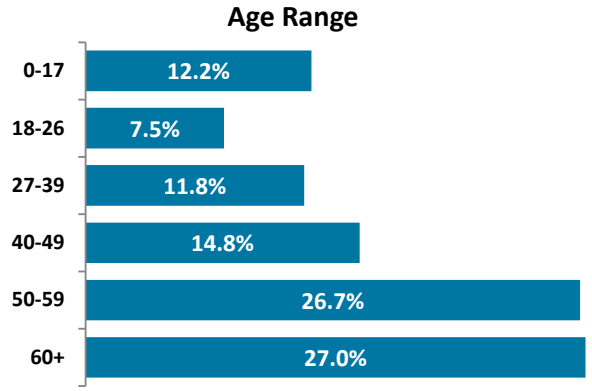


Diagnosis Grouper – Musculoskeletal Disorders

Diagnosis Sub-Grouper	Patients	Claims	Total Paid	% Paid
Musculoskeletal Disorders, Other	1,235	4,267	$946,223	29.9%
Osteoarthritis	388	1,084	$785,390	24.8%
Arthropathies, Other	1,097	4,162	$692,177	21.9%
Musculoskeletal, Aftercare	228	713	$183,826	5.8%
Foot Problems	77	168	$116,600	3.7%
Joint Disorders, Other	174	400	$115,941	3.7%
Limb Pain	504	1,080	$115,883	3.7%
Rheumatoid Arthritis	70	313	$112,056	3.5%
Joint Derangement	67	222	$67,204	2.1%
Connective Tissue Disorders	40	125	$11,955	0.4%
Musculoskeletal Deformities, Other	8	31	$5,649	0.2%
Infectious Arthropathies	2	2	$5,434	0.2%
Muscle Disorders	3	4	$1,953	0.1%
Aseptic Necrosis	1	2	$772	0.0%
	----	----	$3,161,060	100.0%

*Patient and claim counts are unique only within the category

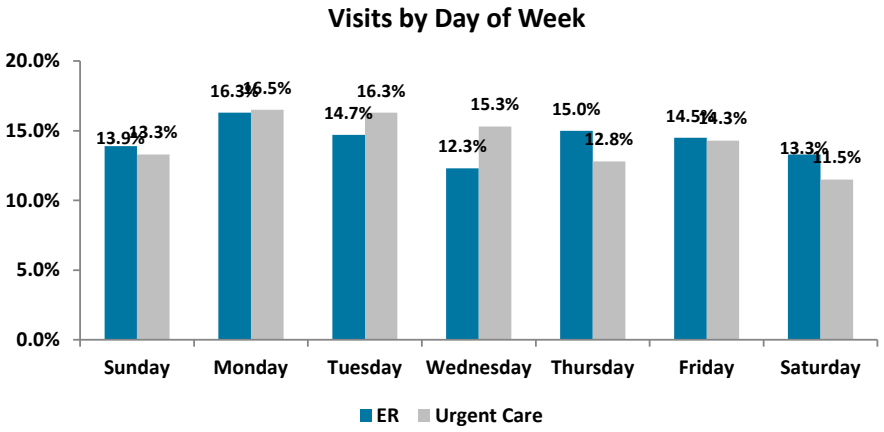


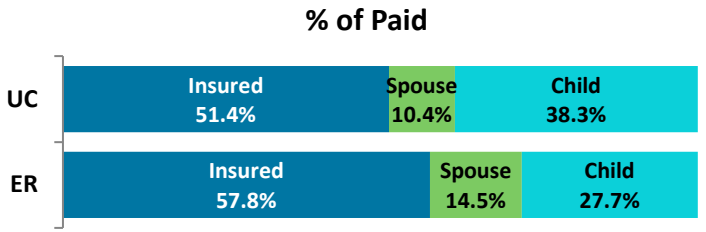


Emergency Room / Urgent Care Summary

	PY21		PY22		HSB Peer Index	
ER/Urgent Care	ER	Urgent Care	ER	Urgent Care	ER	Urgent Care
Number of Visits	1,319	2,455	1,354	3,021		
Visits Per Member	0.15	0.29	0.18	0.40	0.22	0.35
Visits/1000 Members	154	287	180	402	221	352
Avg Paid Per Visit	$2,452	$152	$1,966	$154	$968	$135
% with OV*	91.1%	87.1%	91.2%	89.3%		
% Avoidable	8.4%	30.6%	10.0%	34.5%		
Total Member Paid	**$517,708**	**$101,146**	**$717,538**	**$133,598**		
Total Plan Paid	**$3,234,079**	**$371,942**	**$2,662,184**	**$464,959**		

*looks back 12 months from ER visit





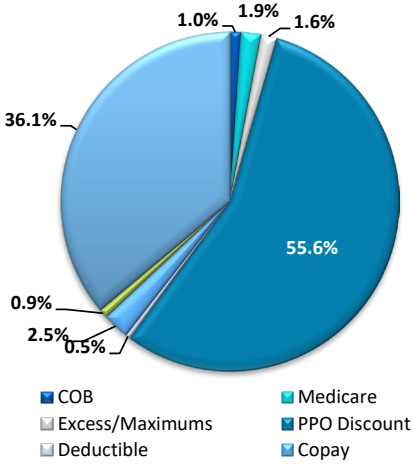
ER / UC Visits by Relationship						
Relationship	ER	Per 1,000	Urgent Care	Per 1,000	Total	Per 1,000
Insured	721	179	1,568	388	2,289	567
Spouse	170	208	314	384	484	592
Child	463	174	1,139	427	1,602	601
Total	**1,354**	**180**	**3,021**	**402**	**4,375**	**582**

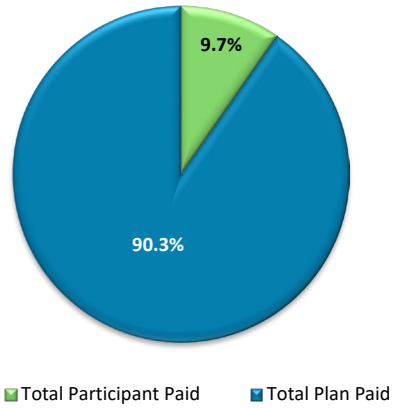
Hospital and physician urgent care centers are included in the data.
Paid amount includes facility and professional fees.

Savings Summary – Medical Claims

Description	Dollars	PPPM	% of Eligible
Eligible Charges	$127,585,718	$2,632	100.0%
COB	$1,263,657	$26	1.0%
Medicare	$2,422,313	$50	1.9%
Excess/Maximums	$1,989,046	$41	1.6%
PPO Discount	$71,098,124	$1,467	55.7%
Deductible	$590,603	$12	0.5%
Copay	$3,239,475	$67	2.5%
Coinsurance	$1,094,186	$23	0.9%
Total Participant Paid	**$4,924,264**	**$102**	**3.9%**
Total Plan Paid	**$46,097,383**	**$951**	**36.1%**

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	455	451	4	99.1%
	<2 asthma related ER Visits in the last 6 months	455	455	0	100.0%
	No asthma related admit in last 12 months	455	454	1	99.8%
Chronic Obstructive Pulmonary Disease	No exacerbations in last 12 months	84	82	2	97.6%
	Members with COPD who had an annual spirometry test	84	16	68	19.0%
Congestive Heart Failure	No re-admit to hosp with Heart Failure diag w/in 30 days of HF inpatient stay discharge	5	5	0	100.0%
	No ER Visit for Heart Failure in last 90 days	58	56	2	96.6%
	Follow-up OV within 4 weeks of discharge from HF admission	5	5	0	100.0%
Diabetes	Annual office visit	573	563	10	98.3%
	Annual dilated eye exam	573	259	314	45.2%
	Annual foot exam	573	240	333	41.9%
	Annual HbA1c test done	573	495	78	86.4%
	Diabetes Annual lipid profile	573	442	131	77.1%
	Annual microalbumin urine screen	573	403	170	70.3%
Hyperlipidemia	Hyperlipidemia Annual lipid profile	1,209	931	278	77.0%
Hypertension	Annual lipid profile	1,277	861	416	67.4%
	Annual serum creatinine test	1,244	1,012	232	81.4%
Wellness	Well Child Visit - 15 months	59	53	6	89.8%
	Routine office visit in last 6 months	7,309	5,215	2,094	71.4%
	Age 45 to 75 years with colorectal cancer screening	3,133	823	2,310	26.3%
	Women age 25-65 with recommended cervical cancer screening	2,364	1,774	590	75.0%
	Males age greater than 49 with PSA test in last 24 months	1,114	590	524	53.0%
	Routine exam in last 24 months	7,399	6,690	709	90.4%
	Women age 40 to 75 with a screening mammogram last 24 months	2,098	1,359	739	64.8%

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	115	1.57%	15.29	$23,966
Asthma	504	6.89%	67.01	$22,642
Atrial Fibrillation	83	1.14%	11.03	$43,258
Blood Disorders	472	6.46%	62.75	$45,739
CAD	160	2.19%	21.27	$29,726
COPD	83	1.14%	11.03	$47,534
Cancer	325	4.44%	43.21	$27,999
Chronic Pain	385	5.27%	51.19	$29,102
Congestive Heart Failure	58	0.79%	7.71	$68,198
Demyelinating Diseases	29	0.40%	3.86	$62,421
Depression	823	11.26%	109.42	$20,394
Diabetes	606	8.29%	80.57	$25,368
ESRD	11	0.15%	1.46	$86,268
Eating Disorders	32	0.44%	4.25	$34,434
HIV/AIDS	10	0.14%	1.33	$39,815
Hyperlipidemia	1,249	17.08%	166.05	$19,377
Hypertension	1,285	17.57%	170.84	$17,449
Immune Disorders	30	0.41%	3.99	$70,569
Inflammatory Bowel Disease	46	0.63%	6.12	$46,967
Liver Diseases	175	2.39%	23.27	$34,174
Morbid Obesity	322	4.40%	42.81	$24,557
Osteoarthritis	422	5.77%	56.10	$25,253
Peripheral Vascular Disease	42	0.57%	5.58	$25,194
Rheumatoid Arthritis	78	1.07%	10.37	$45,251

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 June 30, 2022

Express Scripts

Membership Summary	4Q FY2022 EPO	4Q FY2021 EPO	Difference	% Change
			Membership Summary	
Member Count (Membership)	7,514	8,556	(1,042)	-12.2%
Utilizing Member Count (Patients)	6,597	7,060	(463)	-6.6%
Percent Utilizing (Utilization)	87.8%	82.5%	0	6.4%
Claim Summary			**Claims Summary**	
Net Claims (Total Rx's)	153,114	171,692	(18,578)	-10.8%
Claims per Elig Member per Month (Claims PMPM)	1.70	1.67	0.03	1.8%
Total Claims for Generic (Generic Rx)	130,851	146,721	(15,870.00)	-10.8%
Total Claims for Brand (Brand Rx)	22,263	24,971	(2,708.00)	-10.8%
Total Claims for Brand w/Gen Equiv (Multisource Brand Claims)	972	2,685	(1,713.00)	-63.8%
Total Non-Specialty Claims	150,927	169,365	(18,438.00)	-10.9%
Total Specialty Claims	2,187	2,327	(140.00)	-6.0%
Generic % of Total Claims (GFR)	**85.5%**	**85.5%**	0.00	0.0%
Generic Effective Rate (GCR)	**99.3%**	**98.2%**	0.01	1.1%
Mail Order Claims	33,978	20,510	13,468.00	65.7%
Mail Penetration Rate*	24.7%	13.1%	0.12	11.6%
Claims Cost Summary			**Claims Cost Summary**	
Total Prescription Cost (Total Gross Cost)	$19,672,169	$21,875,973	($2,203,804.00)	-10.1%
Total Generic Gross Cost	$2,767,149	$3,402,603	($635,454.00)	-18.7%
Total Brand Gross Cost	$16,905,019	$18,473,370	($1,568,351.00)	-8.5%
Total MSB Gross Cost	$317,462	$586,844	($269,382.00)	-45.9%
Total Ingredient Cost	$19,485,625	$21,735,741	($2,250,116.00)	-10.4%
Total Dispensing Fee	$177,638	$134,123	$43,515.00	32.4%
Total Other (e.g. tax)	$8,905	$6,109	$2,796.00	45.8%
Avg Total Cost per Claim (Gross Cost/Rx)	**$128.48**	**$127.41**	$1.07	0.8%
Avg Total Cost for Generic (Gross Cost/Generic Rx)	$21.15	$23.19	($2.04)	-8.8%
Avg Total Cost for Brand (Gross Cost/Brand Rx)	$759.33	$739.79	$19.54	2.6%
Avg Total Cost for MSB (MSB Gross Cost/MSB ARx)	$326.61	$218.56	$108.05	49.4%
Member Cost Summary			**Member Cost Summary**	
Total Member Cost	**$3,383,761**	**$3,691,834**	($308,073.00)	-8.3%
Total Copay	$3,373,592	$3,691,834	($318,242.00)	-8.6%
Total Deductible	$10,169	$0	$10,169.00	0.0%
Avg Copay per Claim (Copay/Rx)	$22.03	$21.50	$0.53	2.5%
Avg Participant Share per Claim (Copay+Deductible/RX)	**$22.10**	**$21.50**	**$0.60**	**2.8%**
Avg Copay for Generic (Copay/Generic Rx)	$7.40	$7.33	$0.07	1.0%
Avg Copay for Brand (Copay/Brand Rx)	$108.48	$104.75	$3.73	3.6%
Avg Copay for Brand w/ Generic Equiv (Copay/Multisource Rx)	$38.29	$28.69	$9.60	33.5%
Net PMPM (Participant Cost PMPM)	**$37.53**	**$35.96**	$1.57	4.4%
Copay % of Total Prescription Cost (Member Cost Share %)	17.2%	16.9%	0.3%	1.9%
Plan Cost Summary			**Plan Cost Summary**	
Total Plan Cost (Plan Cost)	**$16,288,407**	**$18,184,139**	**($1,895,732.00)**	**-10.4%**
Total Non-Specialty Cost (Non-Specialty Plan Cost)	$8,237,063	$8,997,383	($760,320.00)	-8.5%
Total Specialty Drug Cost (Specialty Plan Cost)	$8,051,344	$9,186,756	($1,135,412.00)	-12.4%
Avg Plan Cost per Claim (Plan Cost/Rx)	**$106.38**	**$105.91**	$0.47	0.4%
Avg Plan Cost for Generic (Plan Cost/Generic Rx)	$13.74	$15.86	($2.12)	-13.4%
Avg Plan Cost for Brand (Plan Cost/Brand Rx)	$650.86	$635.04	$15.82	2.5%
Avg Plan Cost for MSB (MSB Plan Cost/MSB ARx)	$288.31	$189.88	$98.43	51.8%
Net PMPM (Plan Cost PMPM)	**$180.65**	**$177.11**	**$3.54**	**2.0%**
PMPM for Specialty Only (Specialty PMPM)	$89.29	$89.48	($0.19)	-0.2%
PMPM without Specialty (Non-Specialty PMPM)	$91.35	$87.63	$3.72	4.2%
Rebates Received (Q1-Q4 FY2022 actual)	$3,922,334.97	$4,172,313.36	**($249,978.39)**	**-6.0%**
Net PMPM (Plan Cost PMPM factoring Rebates)	**$137.14**	**$136.47**	**$0.67**	**0.5%**
PMPM for Specialty Only (Specialty PMPM)	$74.77	$75.78	($1.01)	-1.3%
PMPM without Specialty (Non-Specialty PMPM)	$59.59	$61.42	($1.83)	-3.0%

Appendix D

Index of Tables
Health Plan of Nevada –Utilization Review for PEBP
July 1, 2021 – June 30, 2022

KEY PERFORMANCE INDICATORS

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Utilization Highlights 6

Clinical Drivers 8

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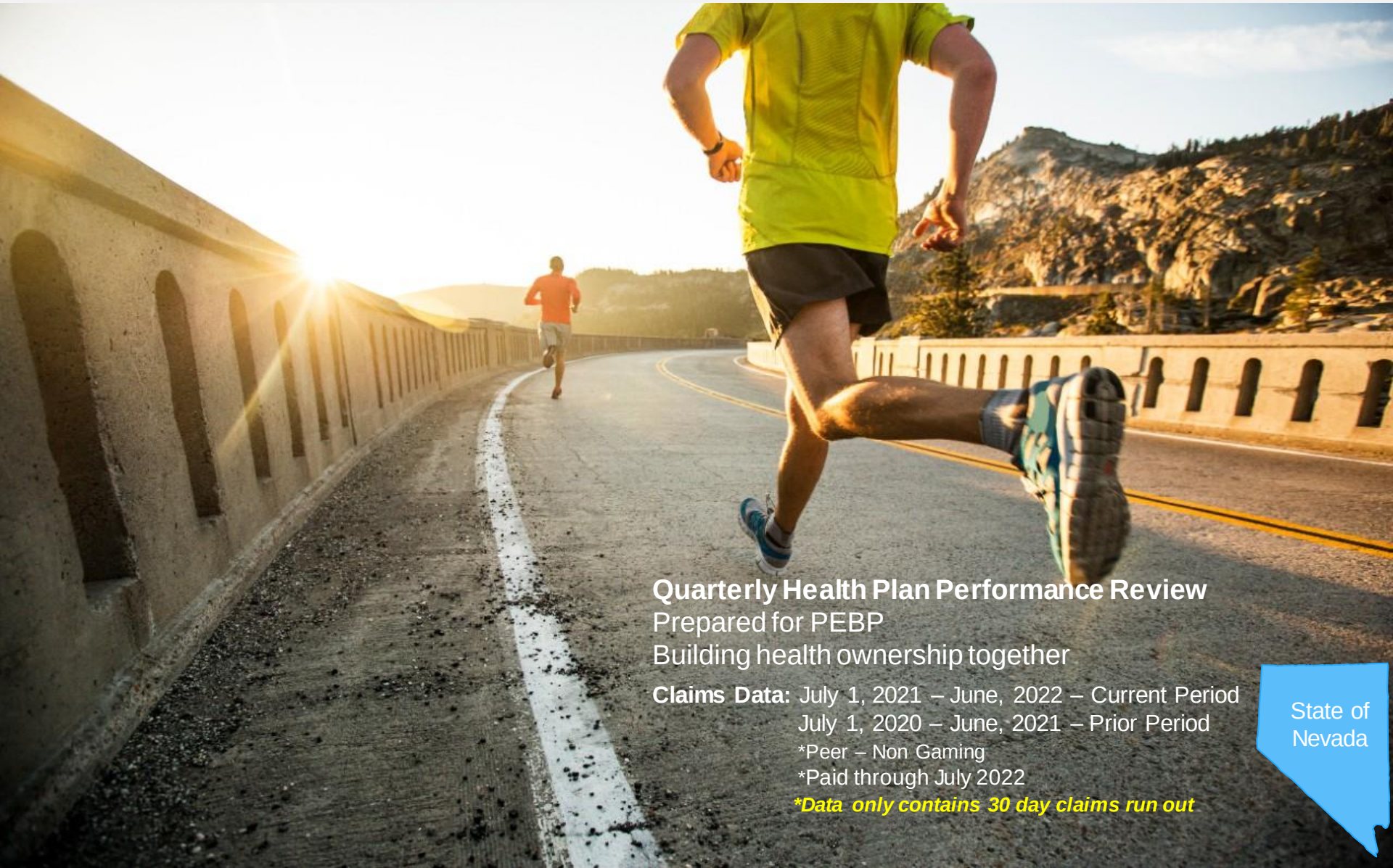
PRESCRIPTION DRUG COSTS

Prescription Drug Cost 7

Power Of Partnership.



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

Claims Data: July 1, 2021 – June, 2022 – Current Period
July 1, 2020 – June, 2021 – Prior Period
*Peer – Non Gaming
*Paid through July 2022
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	Avg. MemberAge	Famiy size	Dependents <18	HHS Risk
Members: 6,673 Employees: 3,781	37.1	1.76	22.9%	1.36
Prior: 6,779 3,891	Prior : 37.2 Norm: 35.3	Prior : 1.74 Norm 1.78	Prior: 22.5 Norm: 20.6	Prior: 1.33 Norm: 1.08
-1.6%	-0.2%	1.3 %	1.9%	2.3%

Medical and Rx Spend

35.4%

Medical PMPM
$484.60

Prior $358.03
Norm: $301.91

Utilization

Inpatient: ▼ -3.3%
Outpatient: ▼ -14.1%
Professional: ▼ -0.3%

Spend

Inpatient: ▲ 80.4%
Outpatient: ▲ 9.4%
Professional: ▲ 16.8%

27.8%

Overall PMPM
$634.02

Prior: $496.27
Norm: $399.85

10.9%
Specialty Rx
$64.60

Prior: $58.23
Norm: $52.54

-2.1%
Avg. Scripts PMPY
16.9

Prior: 17.2
Norm: 8.3

8.1%

Rx PMPM
$149.42

*Specialty Rx accounts for **43.2%** of Rx Spend*

Prior: $138.24
Norm: $97.93

Medical and Rx Plan Experience

What Happened

Highlights of Utilization

Key Metrics			
Utilization Metric	Prior	Current	Δ
Physician Office Vists PMPY	2.4	2.3	-4.2%
Specialist Office Vists PMPY	4.7	4.9	4.3%
ER Visits per K	77.0	80.5	4.5%
UC Visits per K	148.1	160.3	8.2%
On Demand	515.6	395.2	-23.3%
OutPatient Surgery			
ASC	126.6	125.3	-1.0%
Facility	41.6	37.0	-11.0%
Inpatient Utilization			
Admissions Per K	48.2	50.0	3.7%
Bed Days Per K	285.9	338.4	18.4%
Average Length of Stay	5.9	6.8	14.1%

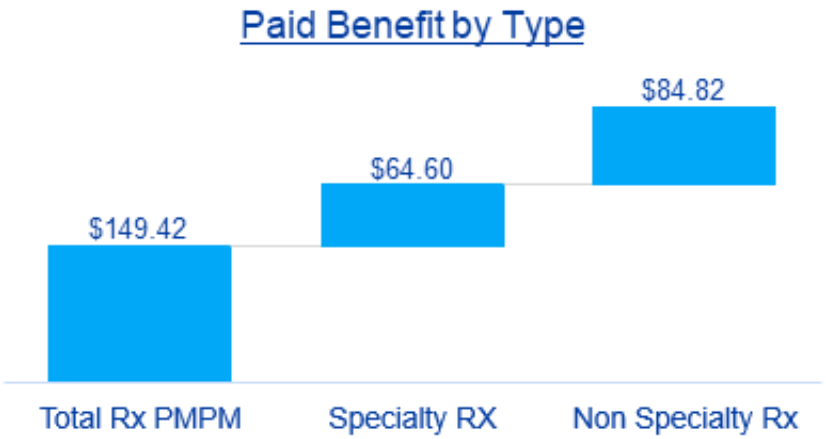
**Not representative of all Utilization*

Highlights

- PCP Visits decreased in the current period, down -4.2%
- Specialist Office visits increased 4.3%
- ER utilization increased 4.5% on a Per K basis
  - Average paid per visit decreased -15.5%, due to less emergent cases
- Urgent Care Utilization increased 8.2%
- Outpatient surgeries had decreases at both ASC and OP Facility settings
  - Procedures in ASC settings are more than double than those at OP setting
- On Demand utilization dropped -23.3%. Consistent with our book of business. More people heading to physician offices post pandemic.
- IP Admits increased 3.7% from the prior period
- Overall IP spend jumped 81.6%
  - Average length of stay increased 14.1%
  - 8 Admits greater than 40 days
  - 17 Admits with spend greater than $100k

Pharmacy Data

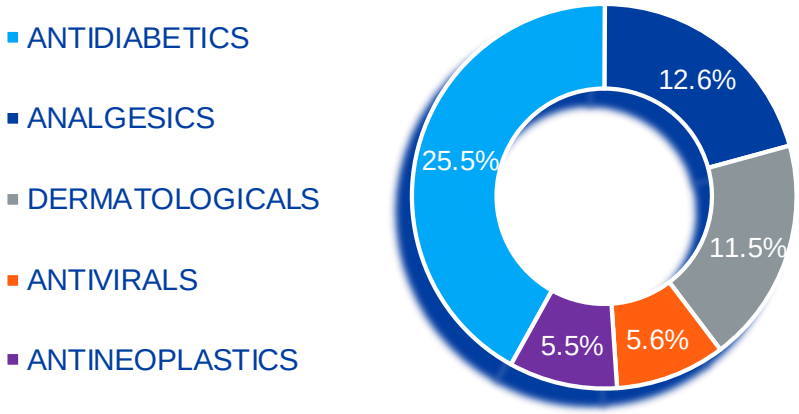
	Prior	Current	Δ	Peer	Δ
Enrolled Members	6,779	6,673	-1.6%		
Average Prescriptions PMPY	17.2	16.9	-2.1%	8.3	102.6%
Formulary Rate	91.6%	89.8%	-2.0%	86.9%	3.3%
Generic Use Rate	85.3%	83.7%	-1.9%	82.3%	1.7%
Generic Substitution Rate	97.4%	98.2%	0.8%	98.0%	0.2%
Employee Cost Share PMPM	$22.83	$27.91	22.2%	$10.74	159.7%
Avg Net Paid per Prescription	$96.36	$106.39	10.4%	$106.19	0.2%
Net Paid PMPM	$138.24	$149.42	8.1%	$73.62	103.0%



Pharmacy Spend is up 8.1% ($11.18 PMPM)

- Average net paid per script increased 10.4% (up $10.03 PMPM from prior period)
- Consistent with market trends; diabetic compliance is on the rise Antidiabetic Rx Spend increased 5.1% year over year
- Specialty Rx Spend increased 10.9% on a PMPM basis
  Specialty Rx Drivers:
  *Humira Pen (Analgesics, spend up 6.6%)
  *Jardiance (Antidiabetics, spend up 24.6%)
  *Ozempic (Antidiabetics, spend up 43.5%)
- Avg. Prescriptions PMPY decreased -2.1%

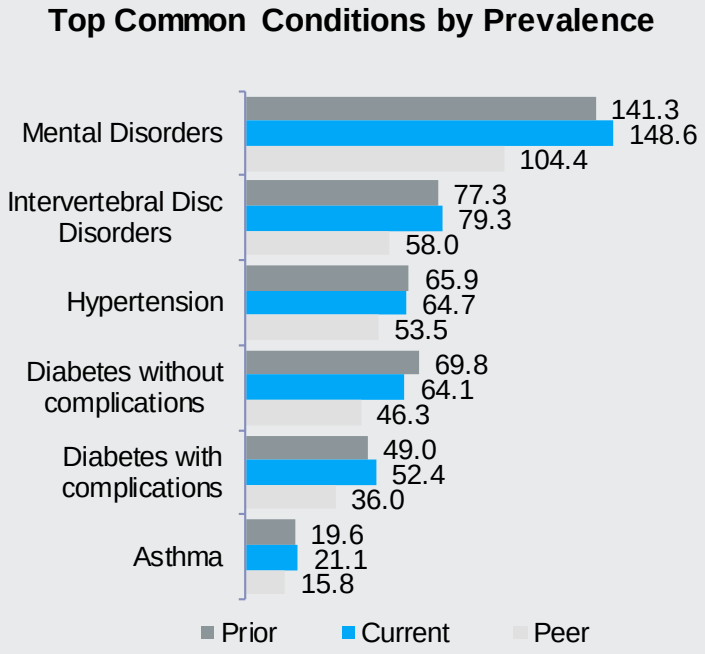
Top 5 Therapeutic Classes by Spend

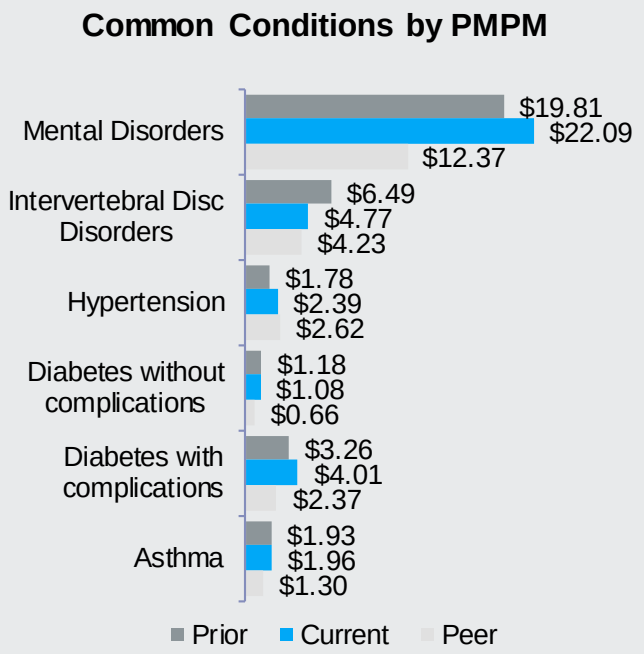


Condition Prevalence

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 5.2% and had an increased in overall spend increased 11.6% (up,$2.29PMPM) year over year
  - Spend on Mood disorders increased 64.2%, up $1.85 PMPM from prior period
  - Autism spend accounts for 37.7% of Mental Disorder spend. Autism/ABA Therapy spend down -12.1% in the current period

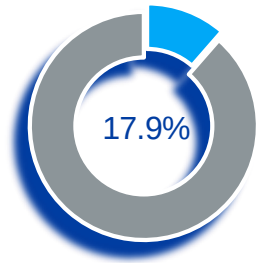
Chronic Condition Cost Drivers

UnitedHealthcare

87.9% Of Medical spend driven by members with these 4 Chronic Conditions. Average Engagement 96.7%

Asthma

8.1% of Members

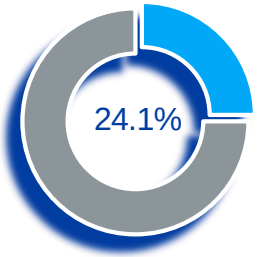


Average paid Per Claimant **$24,037**

Member Engagement **95.7%**

Cardio Hypertension

11.7% of Members

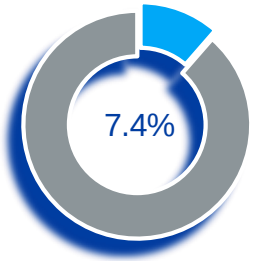


Average paid Per Claimant **$11,285**

Member Engagement **97.1%**

CAD

1.5% of Members

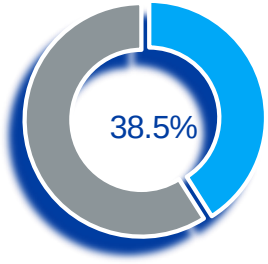


Average paid Per Claimant **$31,606**

Member Engagement **99.1%**

Diabetes

21.6% of Members



Average paid Per Claimant **$11,222**

Member Engagement **95.0%**

**Data obtained for this slide is for Eval period Aug-2021 thru July-2022*

Catastrophic Cases

High Cost Claimants

Catastrophic Cases Summary (>$50k)

UnitedHealthcare

13.08 Catastrophic Cases Per 1000

Prior: 10.14 ▲ 29.1%

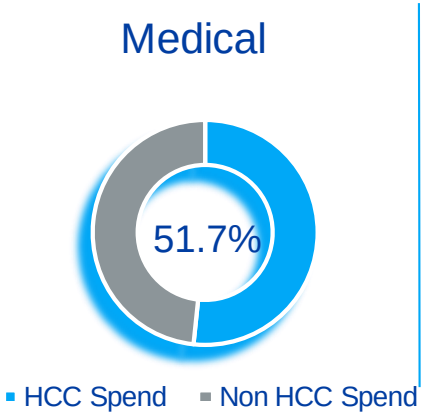
99 Individuals (76 Prior Period)
1.31% of the population

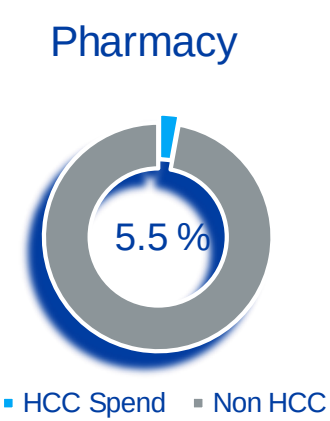
$209,127
Average Paid Per Case

Prior: $133,419 ▲ 22.8%

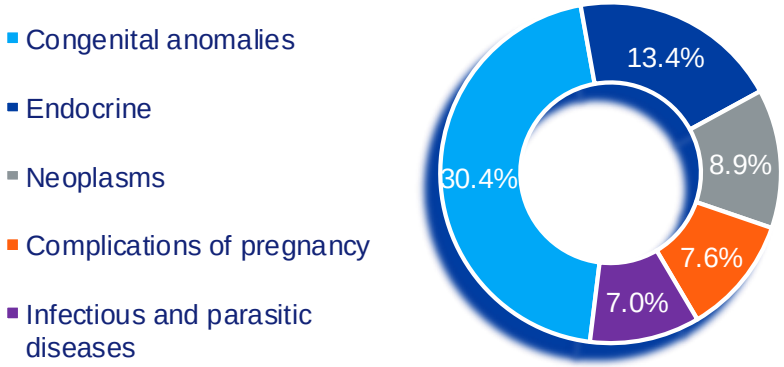
% of Total Med/Rx Spend as High Cost: **40.8%**

% Paid Attributed to Catastrophic Cases

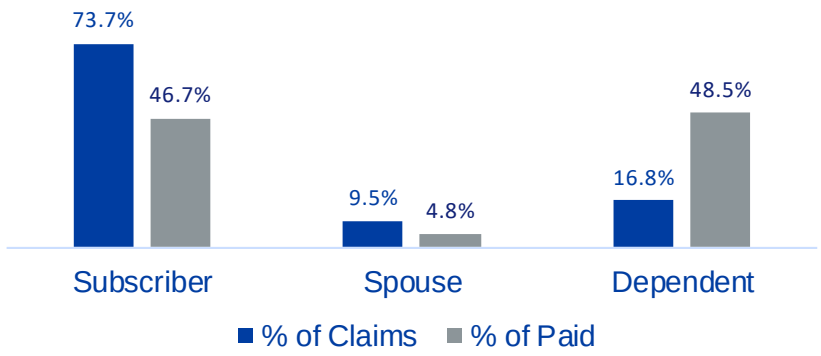




Top 5 AHRQ Chapter Description by Paid



Claims and Spend by Relationship



4.3

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

4.3 Receipt of quarterly vendor reports for the period ending June 30, 2022:

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 Report for August 2022

4.3.1

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

    4.3 Receipt of quarterly vendor reports for the period ending June 30, 2022:

        4.3.1 HealthSCOPE Benefits – Obesity Care Management

HSB DATASCOPE™

Obesity Care Management Report

Nevada Public Employees' Benefits Program

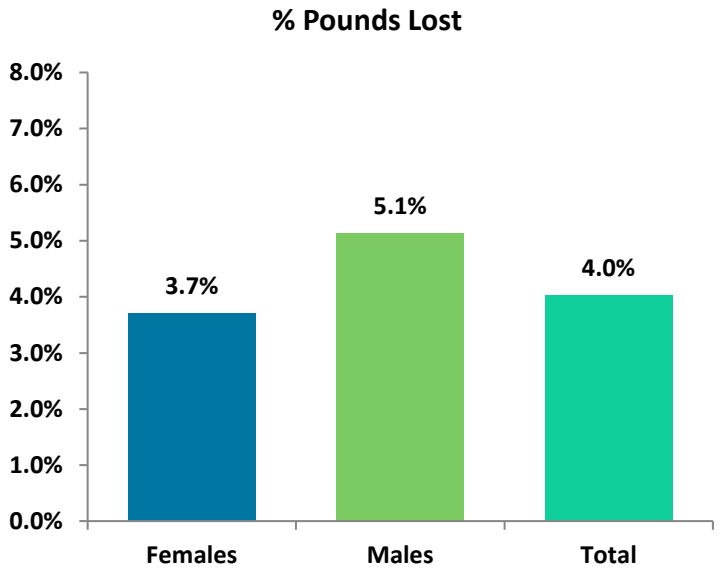
July 2021 - June 2022

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

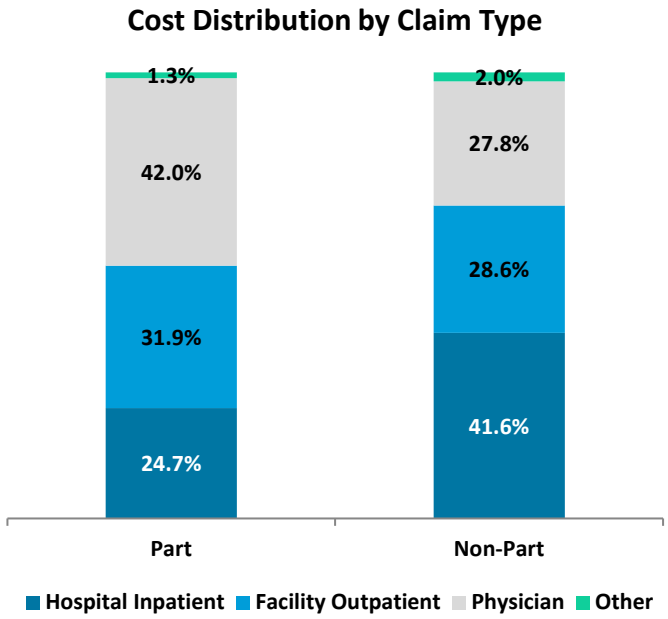
PEBP PY22			
Weight Management Summary	**Females**	**Males**	**Total**
# Mbrs Enrolled in Program	873	216	1,089
Average # Lbs. Lost	10.6	14.7	11.4
Total # Lbs. Lost	9,278.6	3,171.0	12,449.6
% Lbs. Lost	3.7%	5.1%	4.0%
Average Cost/ Member	$6,118	$6,804	$6,254



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	1,004	830	21.0%
Avg # Members	1,116	1,063	5.0%
Member/Employee Ratio	1.1	1.3	-13.3%
Financial Summary			
Gross Cost	$7,465,920	$19,130,630	
Client Paid	$5,970,378	$16,849,309	
Employee Paid	$1,495,542	$2,281,321	
Client Paid-PEPY	$5,947	$20,302	-70.7%
Client Paid-PMPY	$5,349	$15,849	-66.3%
Client Paid-PEPM	$496	$1,692	-70.7%
Client Paid-PMPM	$446	$1,321	-66.2%
High Cost Claimants (HCC's) > $100k			
# of HCC's	5	29	
HCC's / 1,000	4.5	27.3	0.0%
Avg HCC Paid	$314,308	$244,373	0.0%
HCC's % of Plan Paid	26.3%	42.1%	0.0%
Cost Distribution - PMPY			
Hospital Inpatient	$1,323	$6,588	-79.9%
Facility Outpatient	$1,709	$4,530	-62.3%
Physician	$2,246	$4,411	-49.1%
Other	$71	$321	-77.9%
Total	$5,349	$15,849	-66.3%



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	50	203	
# of Bed Days	282	1244	
Paid Per Admit	$37,752	$34,574	9.2%
Paid Per Day	$6,694	$5,642	18.6%
Admits Per 1,000	45	191	-76.4%
Days Per 1,000	253	1170	-78.4%
Avg LOS	5.6	6.1	-8.2%
# of Admits From ER	24	121	-80.2%
Physician Office			
OV Utilization per Member	9.7	9.4	3.2%
Avg Paid per OV	$113	$115	-1.7%
Avg OV Paid per Member	$1,101	$1,076	2.3%
DX&L Utilization per Member	15.6	21.5	-27.4%
Avg Paid per DX&L	$42	$81	-48.1%
Avg DX&L Paid per Member	$664	$1,730	-61.6%
Emergency Room			
# of Visits	232	394	
Visits Per Member	0.21	0.37	-43.2%
Visits Per 1,000	208	371	-43.9%
Avg Paid per Visit	$2,319	$2,533	-8.4%
Urgent Care			
# of Visits	494	623	
Visits Per Member	0.44	0.59	-25.4%
Visits Per 1,000	443	586	-24.4%
Avg Paid per Visit	$96	$125	-23.2%

4.3.2

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

    4.3 Receipt of quarterly vendor reports for the period ending June 30, 2022:

        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

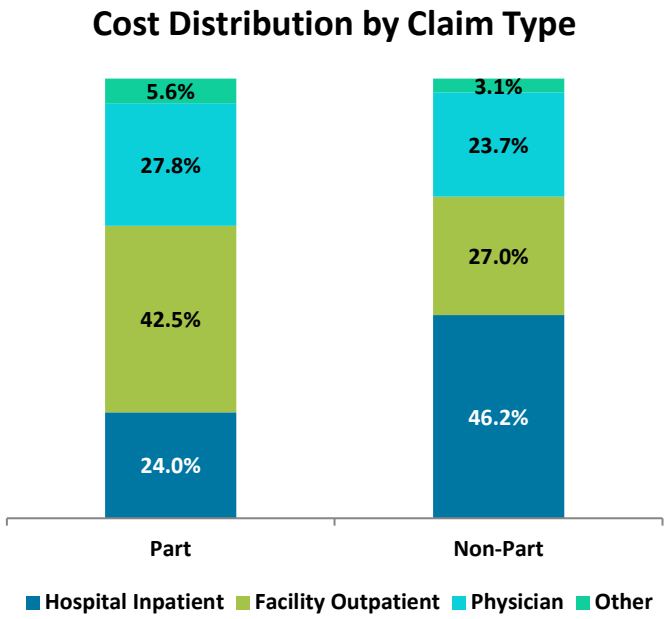
July 2021 – June 2022

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	301	1,976	-84.8%
Avg # Members	417	2,493	-83.3%
Member/Employee Ratio	1.4	1.3	10.3%
Financial Summary			
Gross Cost	$3,868,404	$34,801,464	
Client Paid	$3,118,243	$30,401,911	
Employee Paid	$750,160	$4,399,554	
Client Paid-PEPY	$10,351	$15,389	-32.7%
Client Paid-PMPY	$7,470	$12,193	-38.7%
Client Paid-PEPM	$863	$1,282	-32.7%
Client Paid-PMPM	$623	$1,016	-38.7%
High Cost Claimants (HCC's) > $100k			
# of HCC's	7	53	
HCC's / 1,000	16.8	21.3	0.0%
Avg HCC Paid	$187,600	$306,250	0.0%
HCC's % of Plan Paid	42.1%	53.4%	0.0%
Cost Distribution - PMPY			
Hospital Inpatient	$1,796	$5,630	-68.1%
Facility Outpatient	$3,176	$3,289	-3.4%
Physician	$2,078	$2,891	-28.1%
Other	$421	$383	9.9%
Total	$7,470	$12,193	-38.7%



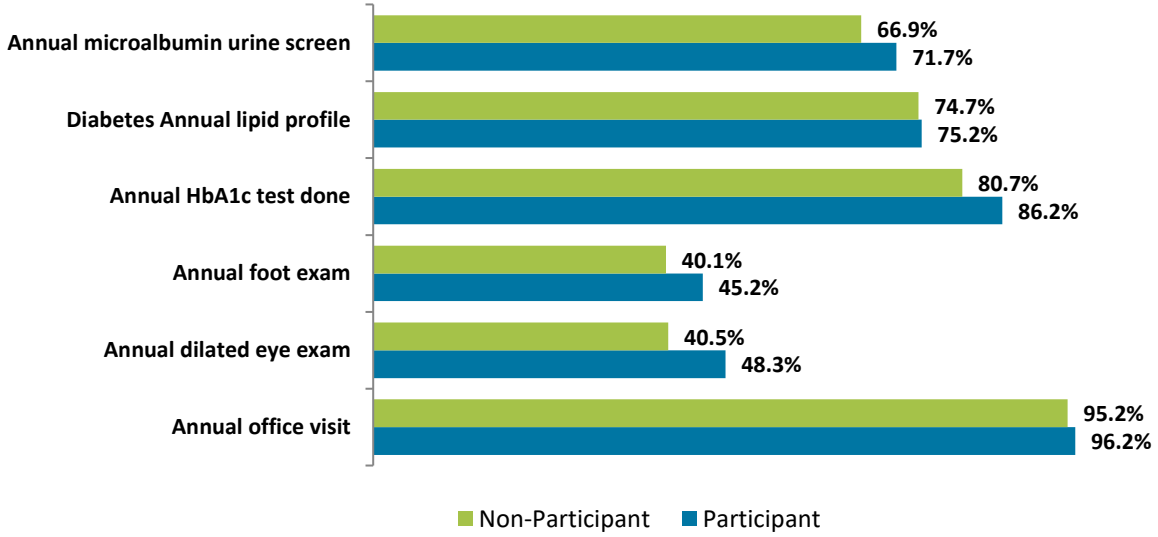
Diabetes Care Management – Utilization Summary

*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	39	323	
# of Bed Days	198	2,176	
Paid Per Admit	$19,705	$41,278	-52.3%
Paid Per Day	$3,881	$6,127	-36.7%
Admits Per 1,000	93	130	-28.5%
Days Per 1,000	474	873	-45.7%
Avg LOS	5.1	6.7	-23.9%
# of Admits From ER	19	177	-89.3%
Physician Office			
OV Utilization per Member	7.4	8.0	-7.5%
Avg Paid per OV	$83	$110	-24.5%
Avg OV Paid per Member	$619	$879	-29.6%
DX&L Utilization per Member	16.6	20.6	-19.4%
Avg Paid per DX&L	$55	$62	-11.3%
Avg DX&L Paid per Member	$908	$1,272	-28.6%
Emergency Room			
# of Visits	83	665	
Visits Per Member	0.20	0.27	-25.9%
Visits Per 1,000	199	267	-25.5%
Avg Paid per Visit	$1,991	$2,792	-28.7%
Urgent Care			
# of Visits	112	920	
Visits Per Member	0.27	0.37	-27.0%
Visits Per 1,000	268	369	-27.4%
Avg Paid per Visit	$71	$114	-37.7%

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	290	279	11	96.2%	2,383	2,268	115	95.2%
	Annual dilated eye exam	290	140	150	48.3%	2,383	964	1,419	40.5%
	Annual foot exam	290	131	159	45.2%	2,383	956	1,427	40.1%
	Annual HbA1c test done	290	250	40	86.2%	2,383	1,924	459	80.7%
	Diabetes Annual lipid profile	290	218	72	75.2%	2,383	1,781	602	74.7%
	Annual microalbumin urine screen	290	208	82	71.7%	2,383	1,594	789	66.9%



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

4.3.3

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

    4.3 Receipt of quarterly vendor reports for the period ending June 30, 2022:

        4.3.1 HealthSCOPE Benefits – Obesity Care Management

        4.3.2 HealthSCOPE Benefits – Diabetes Care Management

        4.3.3 American Health Holdings – Utilization and Large Case Management

Public Employees Benefit Program – State of Nevada

Medical Management Review

April 1, 2022 – June 30, 2022

AmericanHealth
American Health Holding Inc

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- Return on Investment

Medical Management Summary

- Utilization Management
- Case Management
- Post-Discharge Counseling

Executive Overview

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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 **July 31, 2022** and covers the reporting period of **April 1, 2022 – June 30, 2022**; 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

January 1, 2022 - March 31, 2022			
	Fees	Estimated Savings	ROI
Utilization Management	$189,215	$3,006,181	15.9 to 1
Case Management	$283,014	$2,421,710	8.6 to 1
Total	$472,229	$5,427,891	11.5 to 1

Utilization Management Breakout	
Inpatient Savings	$1,237,064
Outpatient Savings	$1,769,117

April 1, 2022 - June 30, 2022			
	Fees	Estimated Savings	ROI
Utilization Management	$189,063	$2,586,560	13.7 to 1
Case Management	$283,101	$1,243,213	4.4 to 1
Total	$472,164	$3,829,773	8.1 to 1

Utilization Management Breakout	
Inpatient Savings	$1,463,383
Outpatient Savings	$1,123,177

Utilization Management

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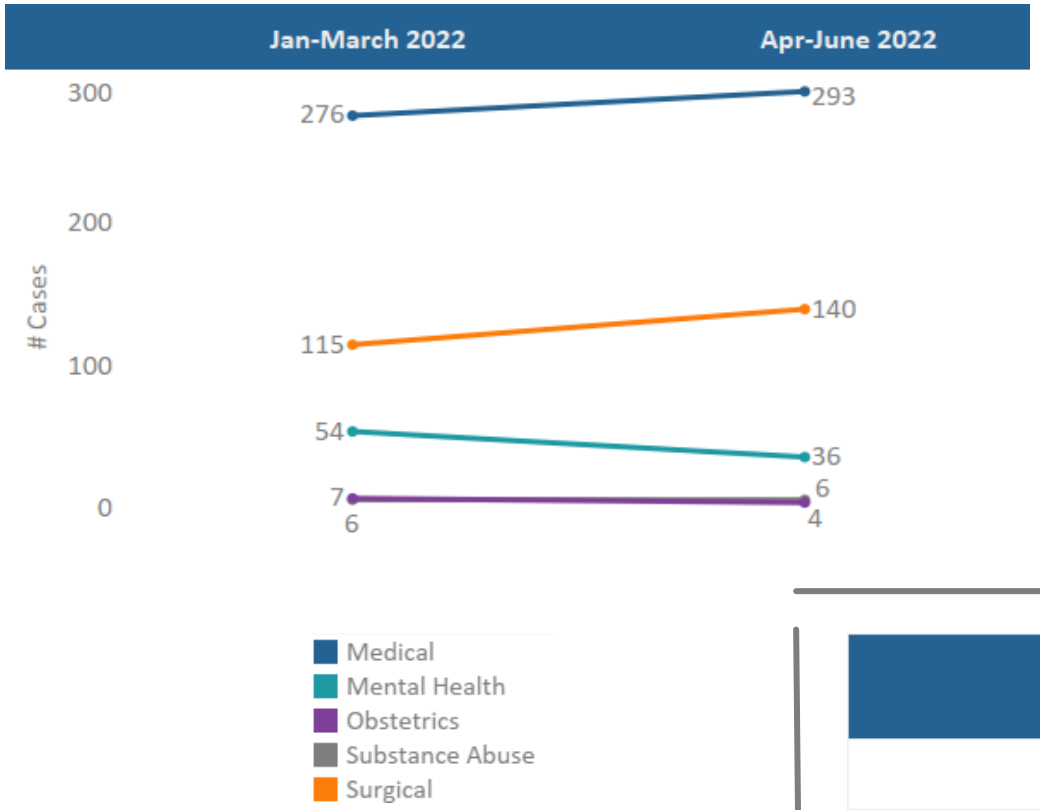
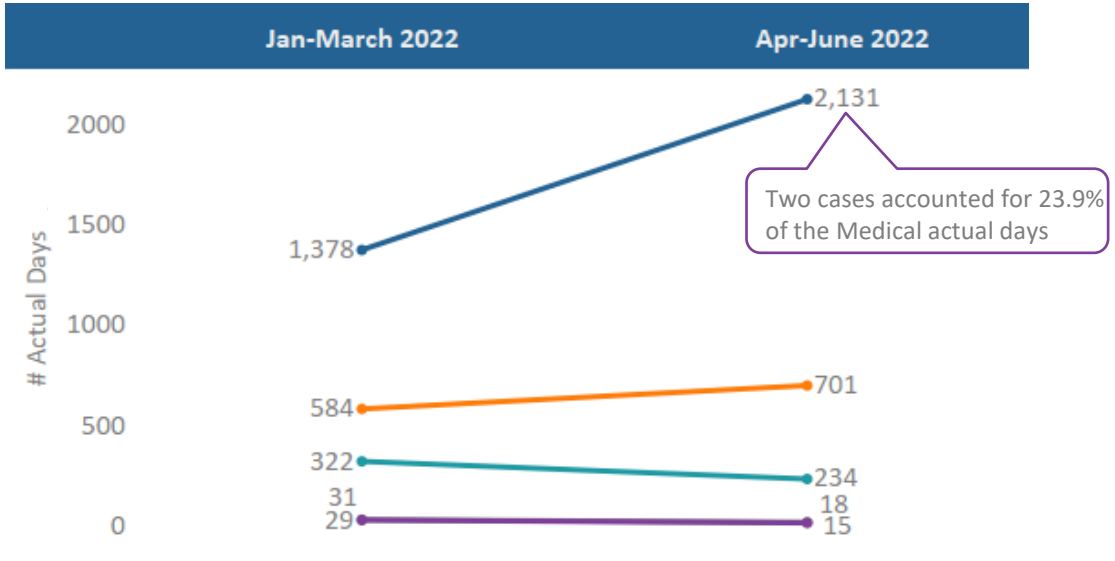
Acute Inpatient Activity Summary



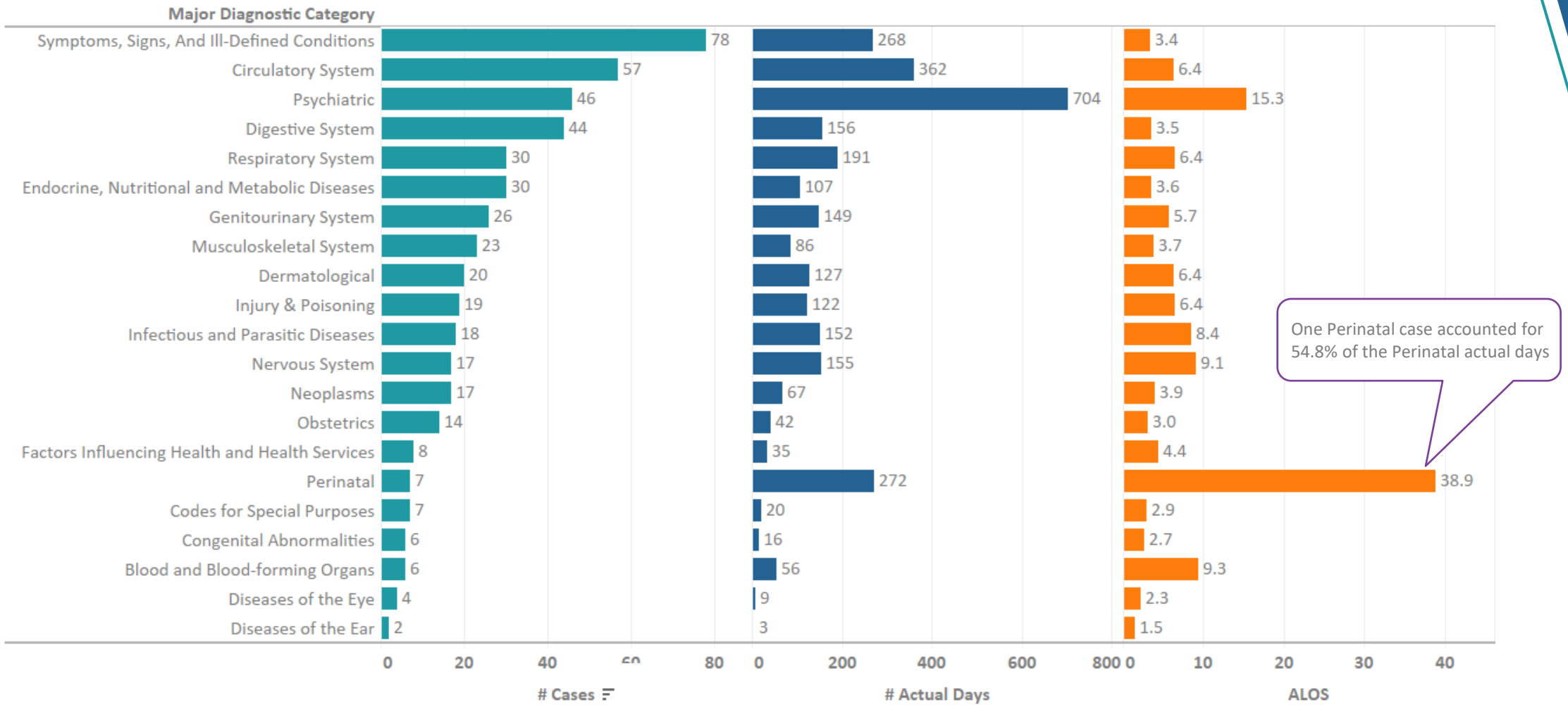


Utilization Review Process

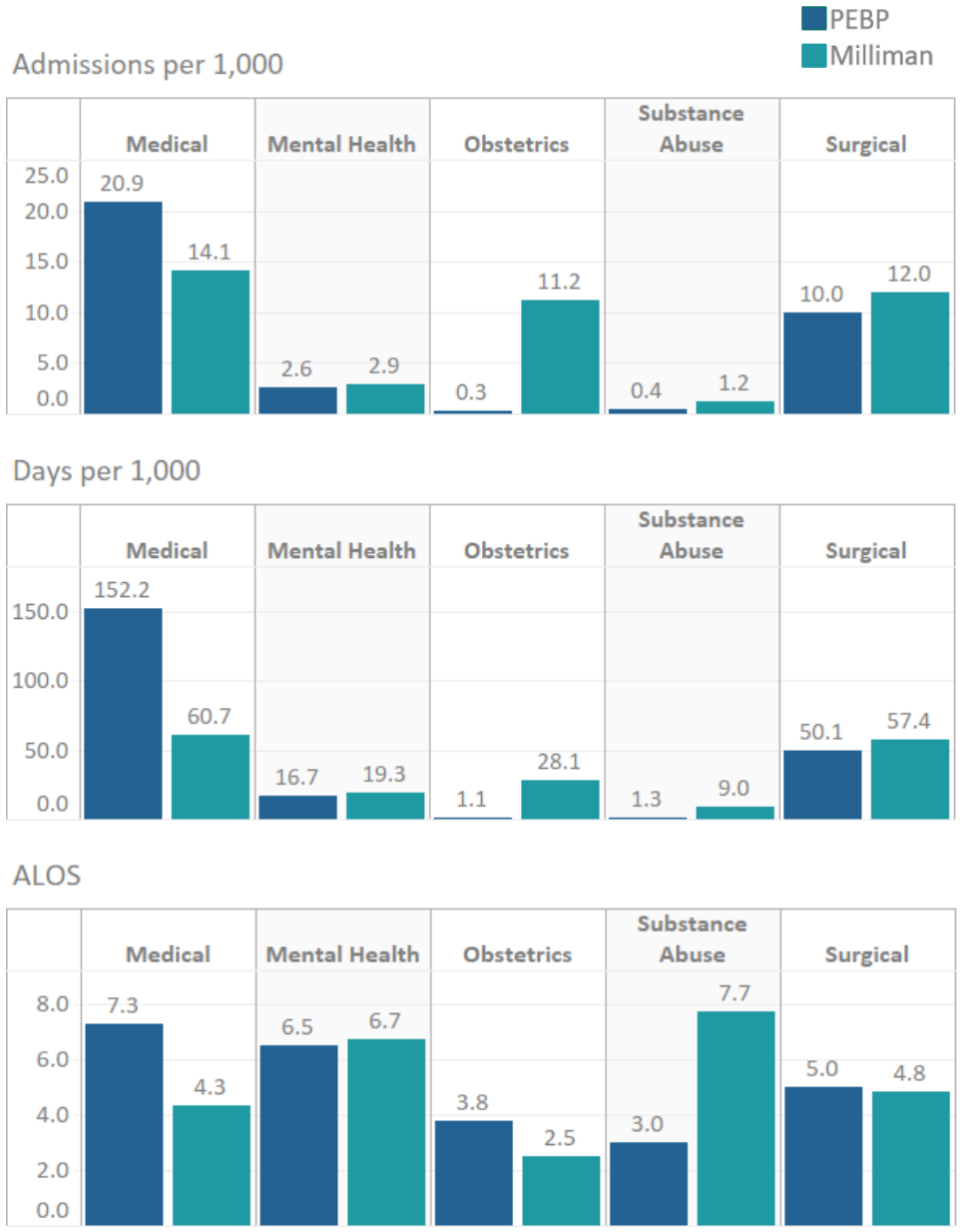
Days Saved: 170
Estimated Savings: $1,405,675

	Cases	Actual Days	Requested Days	Approved Days	Saved Days	Estimated Savings
Medical	293	2,131	2,145	2,048	97	$639,618
Surgical	140	701	704	653	51	$731,187
Mental Health	36	234	236	214	22	$34,870
Substance Abuse	6	18	18	18	0	$0
Obstetrics	4	15	15	15	0	$0
Grand Total	**479**	**3,099**	**3,118**	**2,948**	**170**	**$1,405,675**

Acute Inpatient – Case and Actual Days by Diagnostic Categories



Acute Inpatient Activity – Utilization Benchmarks



Admissions per 1,000

- During the report period, medical acute inpatient admissions were above the Milliman benchmarks
  - **Medical: 34** members had **2 or more** inpatient admissions

Days per 1,000

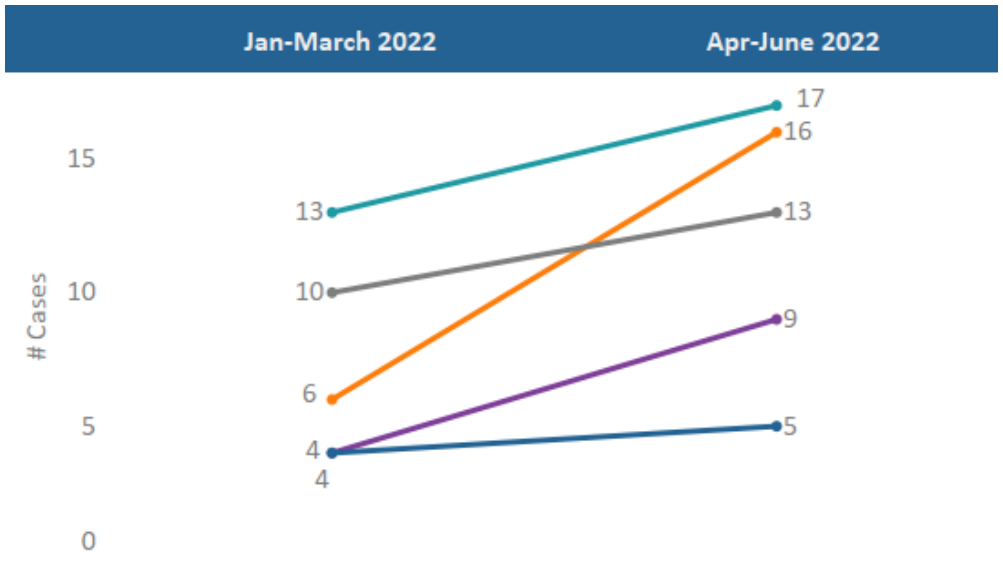
- During the report period, medical acute inpatient days per 1,000 were above the Milliman benchmarks
  - **Medical: 29** cases utilized **15 or more** days during the report period

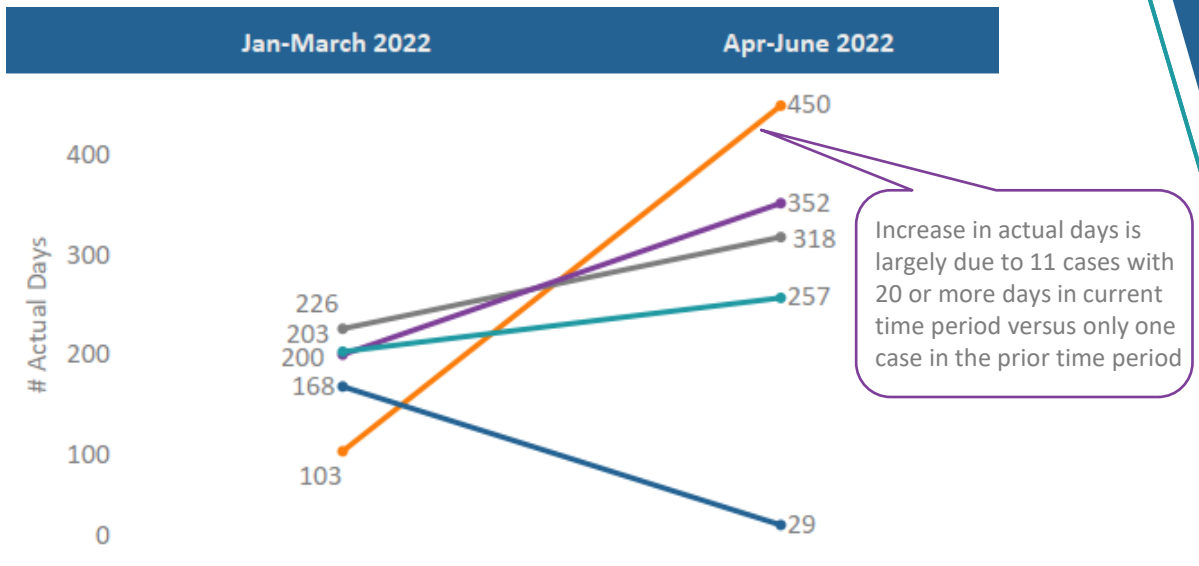
Average Length of Stay

- During the report period, medical, obstetrics, and surgical ALOS were above the Milliman benchmark
  - **Medical: 98 of the 293** cases were above the benchmark during the report period
  - **Obstetrics: 4 of the 4** cases were above the benchmark during the report period
  - **Surgical: 39 of the 140** 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





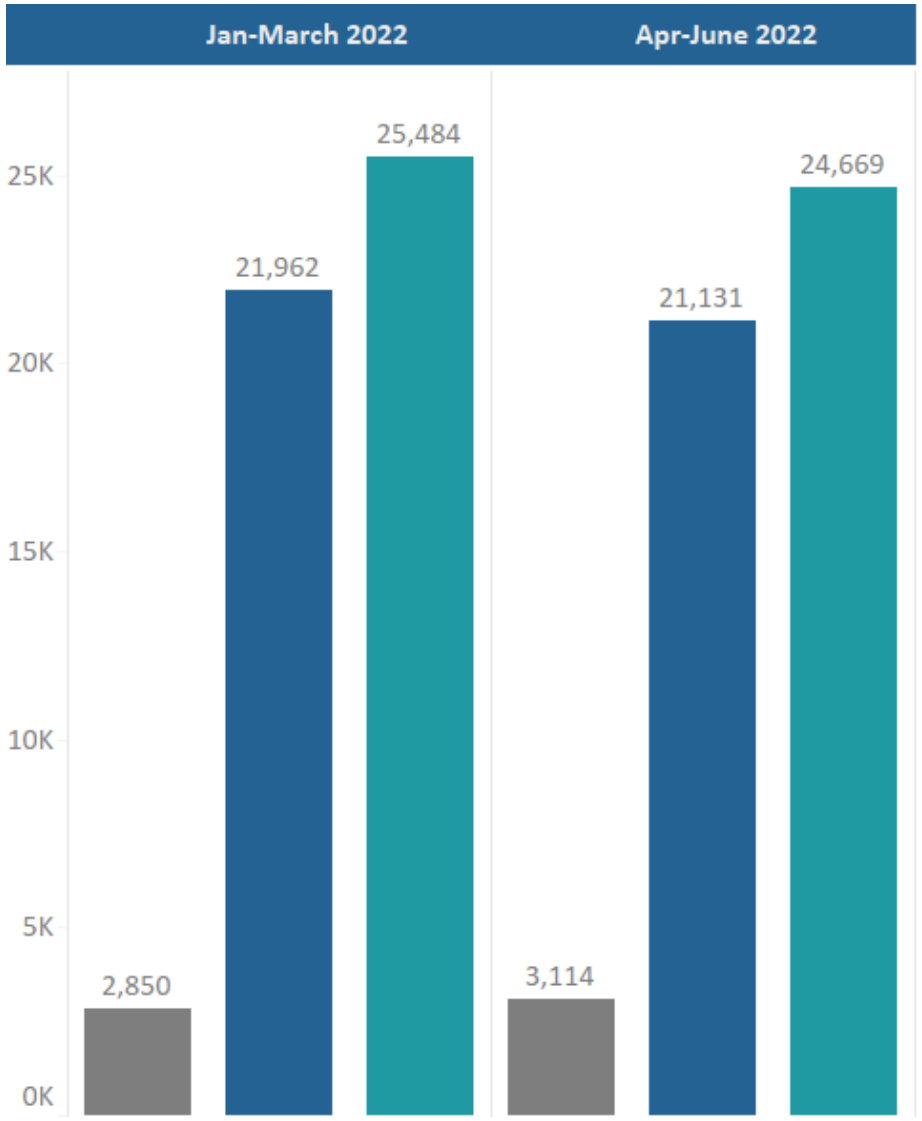
Long Term Acute
Medical Rehab
Residential Mental Health
Residential Substance Abuse
Skilled Nsg Facility

Utilization Review Process

Days Saved: 58
Estimated Savings: $57,708

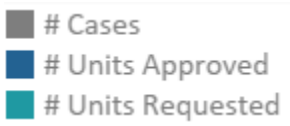
	Cases	Actual Days	Requested Days	Approved Days	Saved Days	Estimated Savings
Medical Rehab	17	257	257	253	4	$10,712
Skilled Nsg Facility	16	450	450	421	29	$19,343
Residential Substance Abuse	13	318	318	308	10	$10,080
Residential Mental Health	9	352	360	347	13	$9,529
Long Term Acute	5	29	29	27	2	$8,044
Grand Total	**60**	**1,406**	**1,414**	**1,356**	**58**	**$57,708**

Outpatient Activity Summary



Outpatient Setting	# Cases	# Units Requested	# Units Approved	# Units Saved	Outpatient Savings
Diagnostic Test	1,800	2,342	2,056	286	$339,970
Surgery	782	1,464	1,420	44	$89,714
Med Treatment	231	3,198	2,647	551	$591,588
DME	186	13,931	11,426	2,505	$53,087
Home Health	46	632	573	59	$12,093
Home Infusion	24	906	874	32	$0
MH/SA	33	562	550	12	$30,304
PT/OT/ST	10	265	216	49	$6,421
Home Private Duty	1	1,280	1,280	0	$0
Hospice Home	1	89	89	0	$0
Grand Total	**3,114**	**24,669**	**21,131**	**3,538**	**$1,123,177**

3 cases accounted for 60.0% of the Med Treatment savings



Utilization Review Process

Units Saved: 3,538
Estimated Savings: $1,123,177

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
539	349	64.7%	203	58.2%

Outpatient Referrals				
# Cases	# Cases Referred to CM	% Cases Referred to CM	# Referrals Accepted in CM	% Referrals Accepted in CM
3,114	759	24.4%	8	1.1%

Case Management

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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

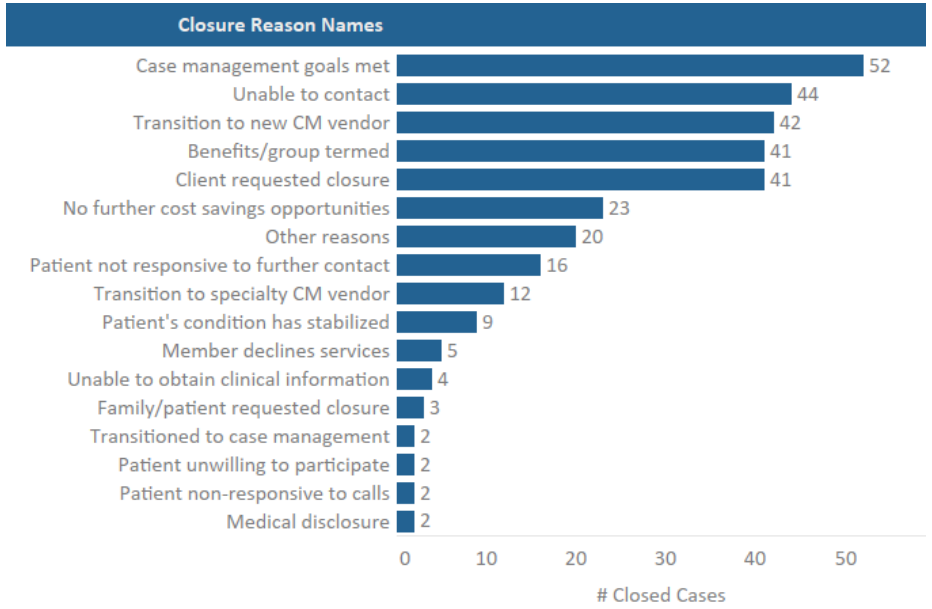
$1,243,213

Average Savings per Case = $4,521

Based on 275 cases in an open state between 4/1/2022 – 6/30/2022

Number of Cases

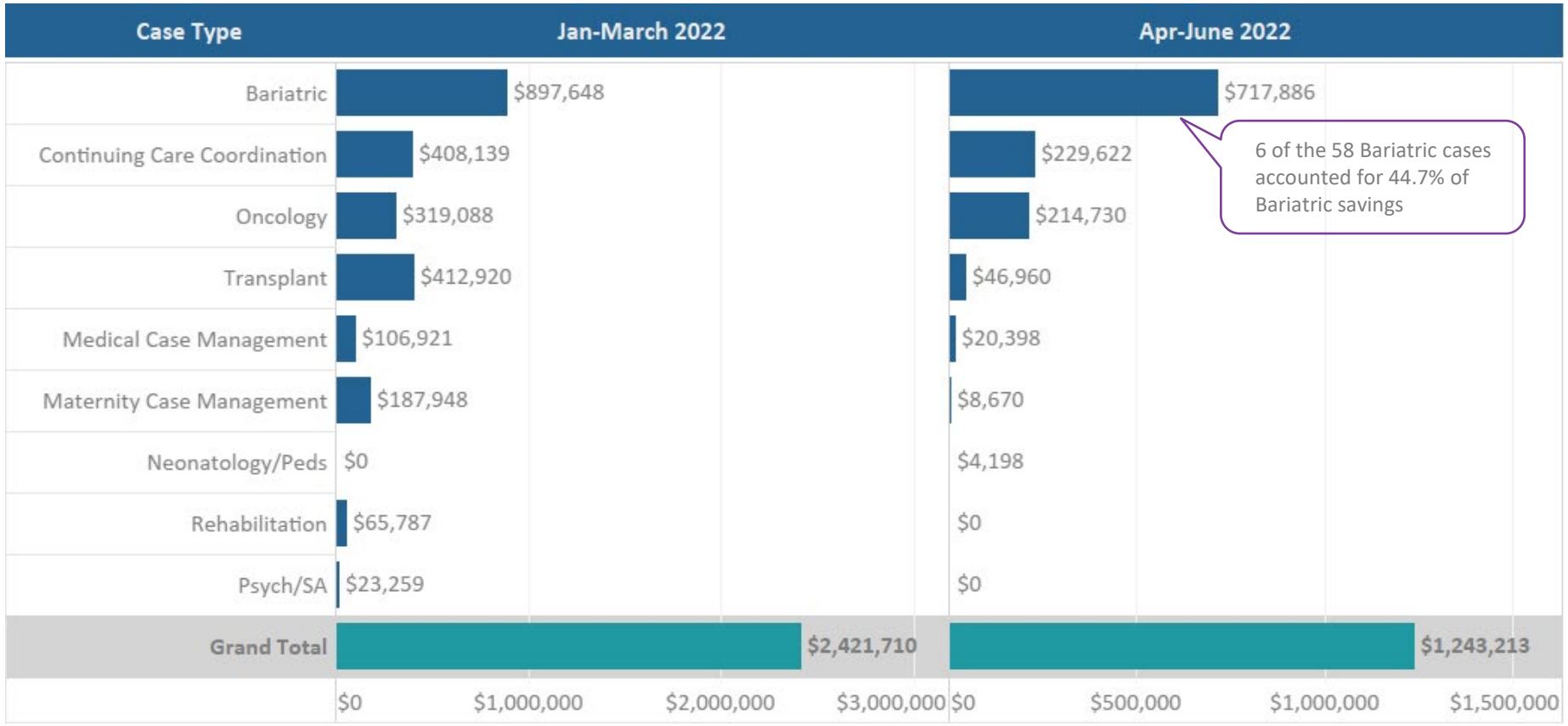
Case Activity	Jan-March 2022	Apr-June 2022
# Beginning Cases	177	187
# Opened Cases	134	88
# Closed Cases	124	275
# Ending Cases	187	0



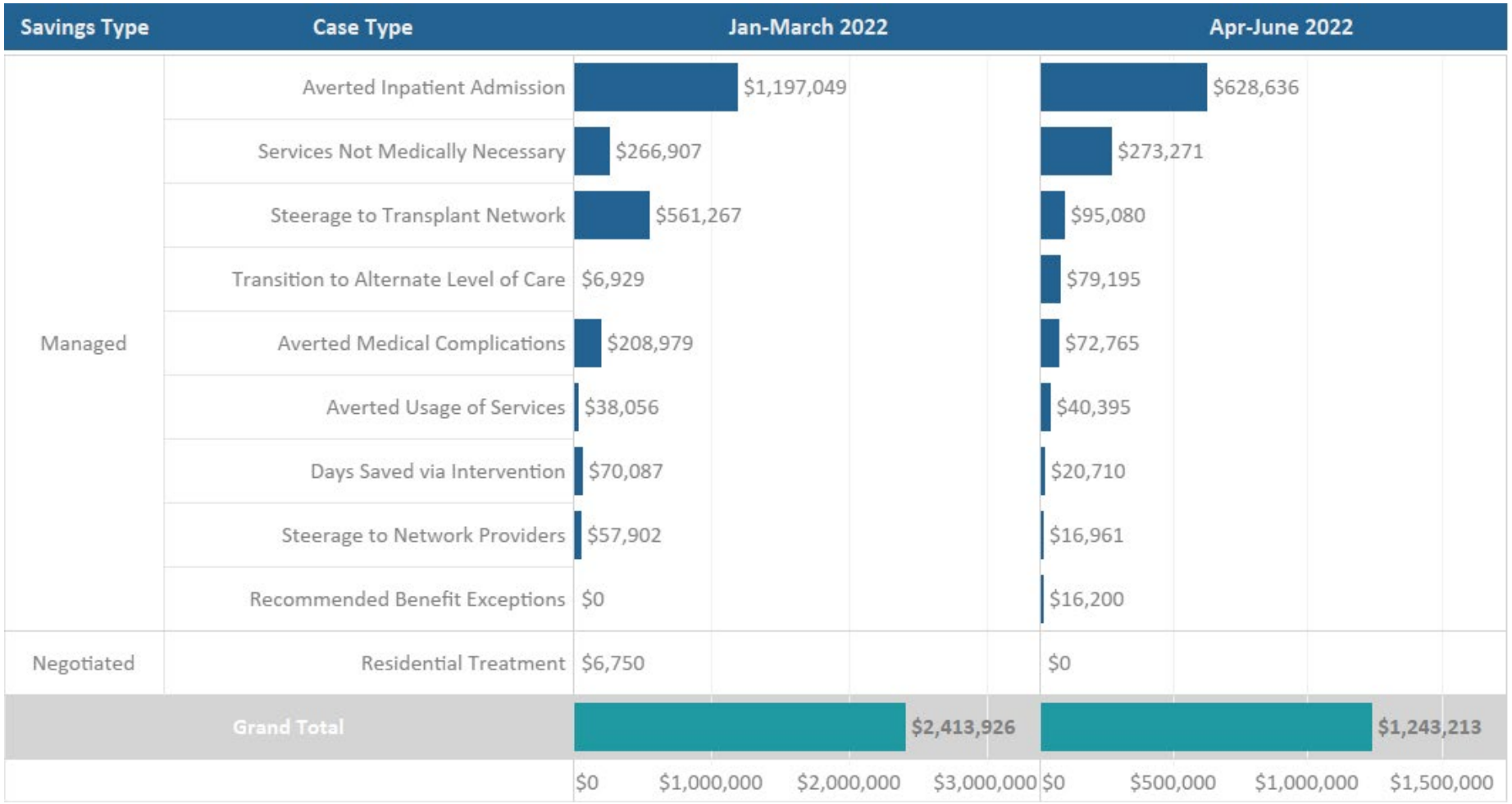
Case Type	
Continuing Care Coordination	99
Bariatric	58
Oncology	43
Short Term CM	26
Transplant	12
Medical Case Management	11
Psych/SA	10
Neonatology/Peds	5
Research and Review	3
Maternity Case Management	3
Advocacy	3
Air Evacuation	2
Grand Total	**275**

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

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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.

373*
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.

16
Participants

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

2
Participants

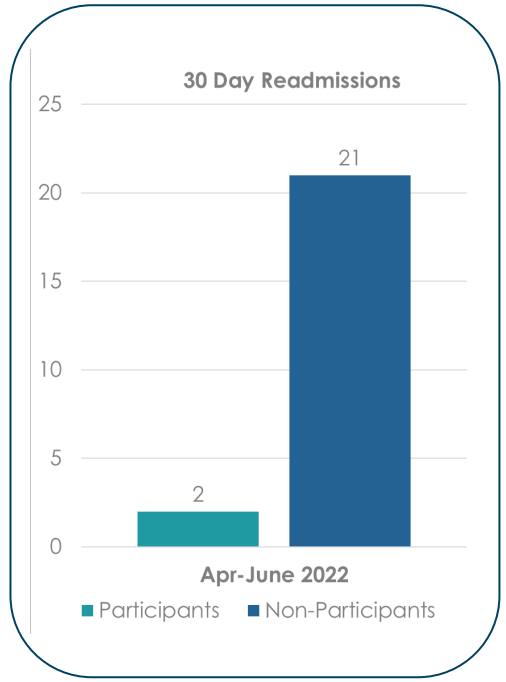
# of participating members with readmissions

357
Non-Participants

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

21
Non-Participants

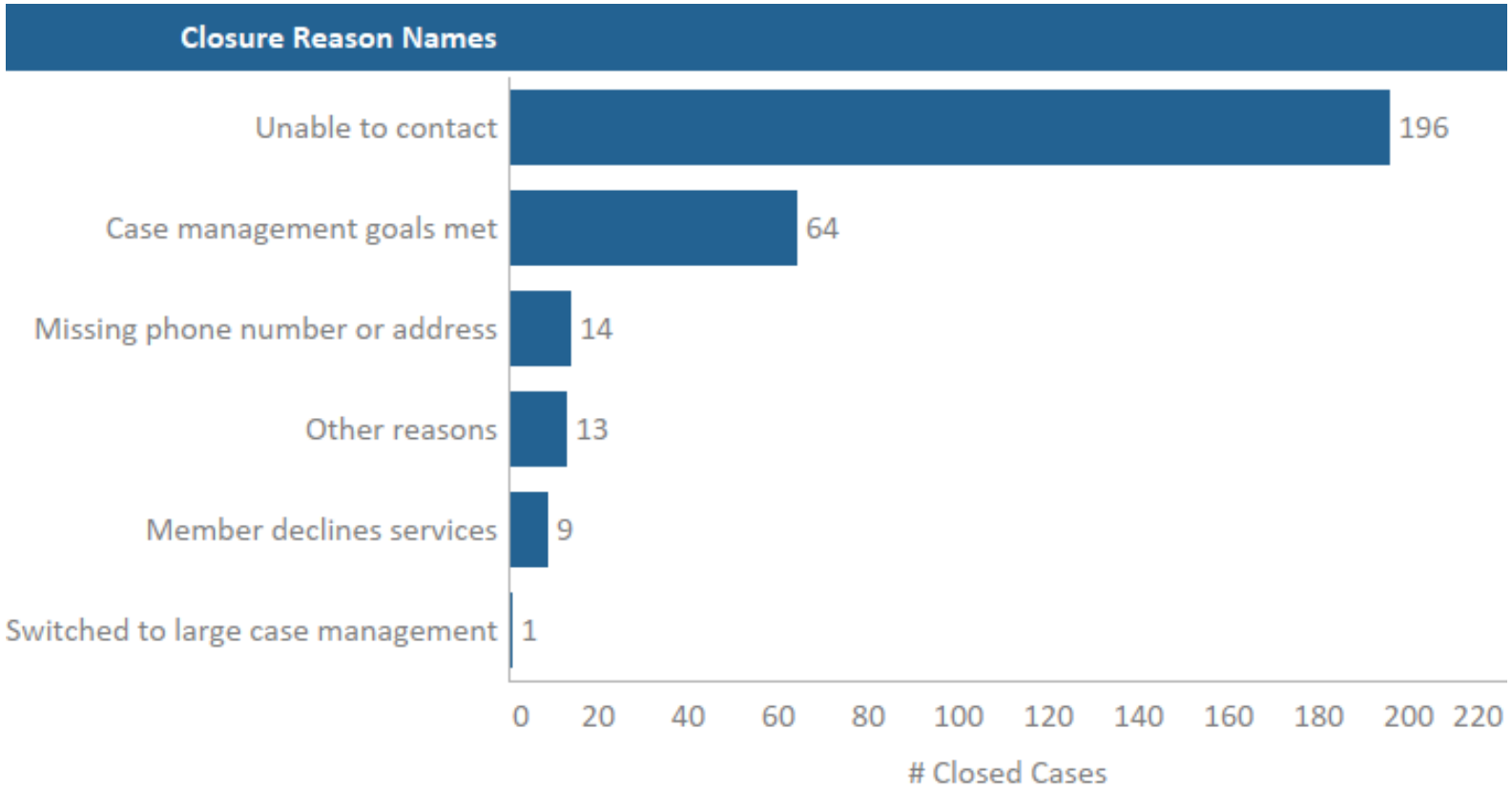
# of non-participating members with readmissions



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

Post-Discharge Counseling – Case Closure Reason

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



Performance Measures

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

Performance Measures

Service Performance Standard	Guarantee	Method of Measurement	Actual	Pass/Fail
VII. Customer Satisfaction Survey	90% or greater	Survey 100% of CM post-encounters within 7 days of closing the CM case; vendor may use hard copy surveys mailed via first class mail with return envelope to the member; or, vendor may use an electronic survey method. The survey responses will be reported semi-annually to PEBP no later than 30 calendar days following the end of the 2nd and 4th quarters of each plan year. Report shall include the prior semi-annual report findings for comparison purposes.	100%	Pass
VIII. Hospital Discharge Planning	95%	CM will contact or attempt to contact 95% of patients discharged from any facility within 3 business days of notification of discharge with clinical coaching and discharge planning assistance.	100%	Pass
IX. Large Case Management	95%	CM will identify and initiate case management for chronic disease, high dollar claims, and ER usage.	100%	Pass
X. Utilization Management for medical necessity and Center of Excellence usage	98%	UM review to determine medical necessity in accordance with the MPDs. Services to be performed at a Center of Excellence to be managed through the Case Management process.	100%	Pass
XI. Return On Investment (ROI) Guarantee	2:1 Savings to Fees for UM 3:1 Savings to Fees for CM	UM Pass/Fail CM Pass/Fail	UM ROI 7.6 to 1 CM ROI 3.3 to 1	Pass
XII. Disclosure of subcontractors and unauthorized transfer of PEBP data.	100%	A. All subcontractors who have access to PHI or PII data and physical locations where PEBP PHI or PII data is maintained and/or stored must be identified in this contract. Any changes to those subcontractors or physical locations where PEBP data is stored must be communicated to PEBP at least 60 days prior to implementation of services by the subcontractor. Implementation will not be in effect until PEBP has provided written authorization. B. All PEBP PHI or PII data will be stored, processed and maintained solely on currently designated servers and storage devices identified in this contract. Any changes to those designated systems during the life of this agreement shall be reported to PEBP at least 60 days prior to the changes being implemented. Implementation will not be in effect until PEBP has provided written authorization.	100%	Pass

4.3.4

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

    4.3 Receipt of quarterly vendor reports for the period ending June 30, 2022:

        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
June 30, 2022

Report Table of Contents

Basic Life Insurance & Long Term Disability Executive Summary	Page 3
Basic Life Insurance Claims by Plan Year and Participant Type	Page 4
Basic Life Insurance Claims by Diagnostic Category	Page 4
Basic Life Insurance Earned Premiums & Liability by Participant Type	Page 5
Basic Life Retiree Insurance Earned Premiums & Liability by Participant Type	Page 6
Claim Appeals	Page 7

Basic Life Insurance Executive Summary

Most Recent Five Plan Years: July 01, 2017 to June 30, 2022

This is the final report for the 2021-22 plan year, providing updated information for the period beginning July 1, 2017 and ending June 30, 2022.

Basic Life

In total, Basic Life claim incidence and loss ratios decreased in the 2021-22 plan year compared to the prior plan year. Incidence (page 4) was down for actives (1.3 compared to 2.6/1,000) and retirees (7.5 compared to 21.8/1,000). Claims are still being processed for the end of the plan year, so these figures will likely increase. The loss ratios (page 5) for actives and retirees both trended down, with the active loss ratio at 16% compared to 33% last year and retiree loss ratio at 297% compared to 345%. The overall loss ratio for Basic Life increased for this period, 82% compared to 106% last year. The Basic Life plan suffered a loss of $68,940 for the plan year compared to a negative $1,518,963 last year, so the experience has trended positively compared to the prior plan year.

When looking at the retiree liability for the plan year, the incidence has decreased from 347 claims/$1,000 for the prior plan year to 123 claims for this plan year. This figure will change as we continue to process claims for the end of the plan year. The loss ratio increased for the retiree plan overall, applying to both the state and non-state retirees: loss ratios decreased this plan year compared to the prior plan year, 290% compared to 331% for state retirees and 316% compared to 386% for non-state retirees (page 6).

Basic Life Insurance Claims by Plan Year and Participant Type

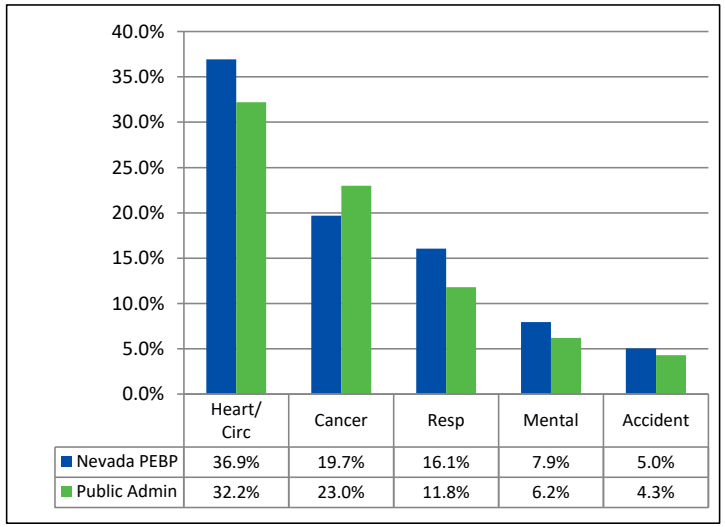
Most Recent Five Plan Years: July 01, 2017 to June 30, 2022

	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	67	2.6	34	1.3
Retirees	295	19.5	279	17.8	298	18.9	347	21.8	123	7.5
Totals	**336**	**8.6**	**326**	**8.1**	**345**	**8.4**	**414**	**9.7**	**157**	**3.7**

Basic Life Insurance Claims by Diagnostic Category

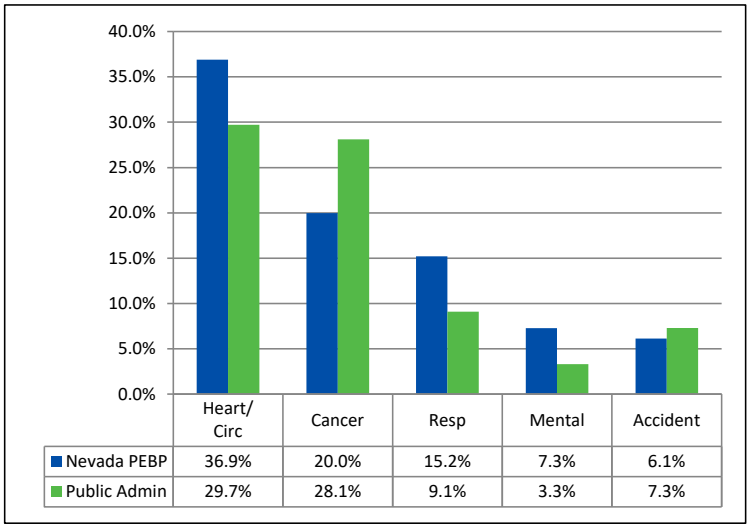
Public Admin benchmark is from SIC book of business for most recent 5 calendar years

Top Five Diagnostic Categories by Incidence



	Heart/ Circ	Cancer	Resp	Mental	Accident
Nevada PEBP	36.9%	19.7%	16.1%	7.9%	5.0%
Public Admin	32.2%	23.0%	11.8%	6.2%	4.3%

Top Five Diagnostic Categories by Liability

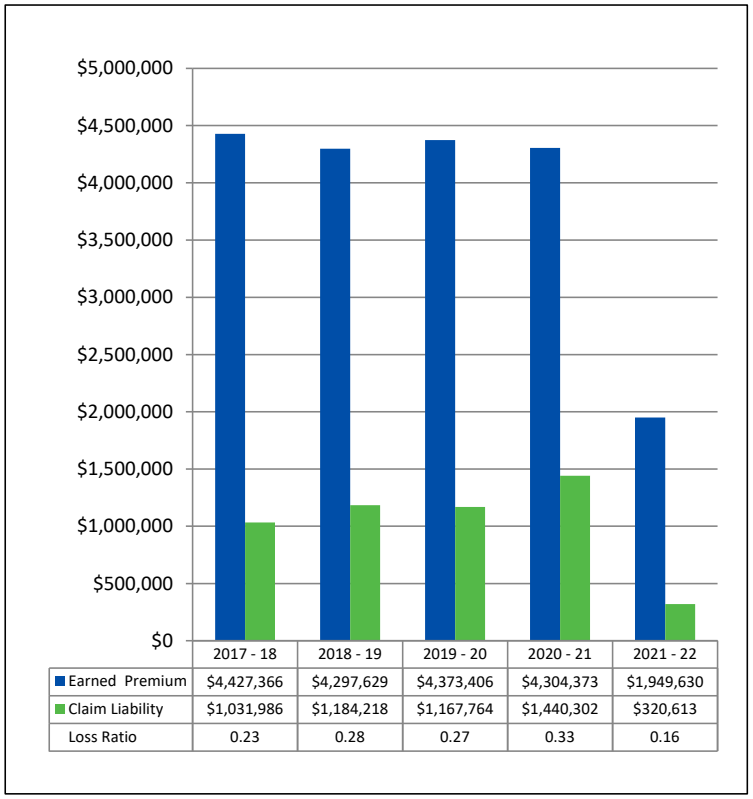


	Heart/ Circ	Cancer	Resp	Mental	Accident
Nevada PEBP	36.9%	20.0%	15.2%	7.3%	6.1%
Public Admin	29.7%	28.1%	9.1%	3.3%	7.3%

Basic Life Insurance Earned Premiums & Liability by Participant Type

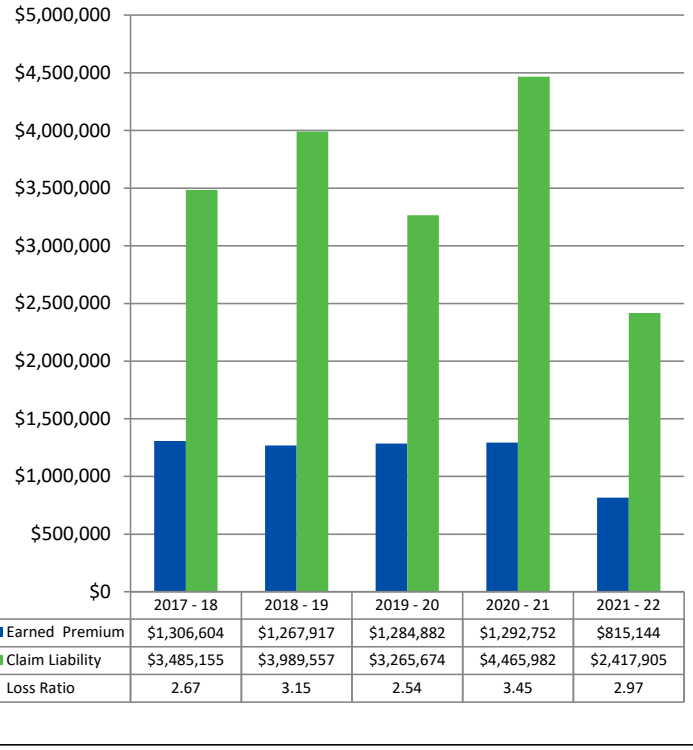
Most Recent Five Plan Years: July 01, 2017 to June 30, 2022

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	$1,949,630
Claim Liability	$1,031,986	$1,184,218	$1,167,764	$1,440,302	$320,613
Loss Ratio	0.23	0.28	0.27	0.33	0.16

Retired Participants

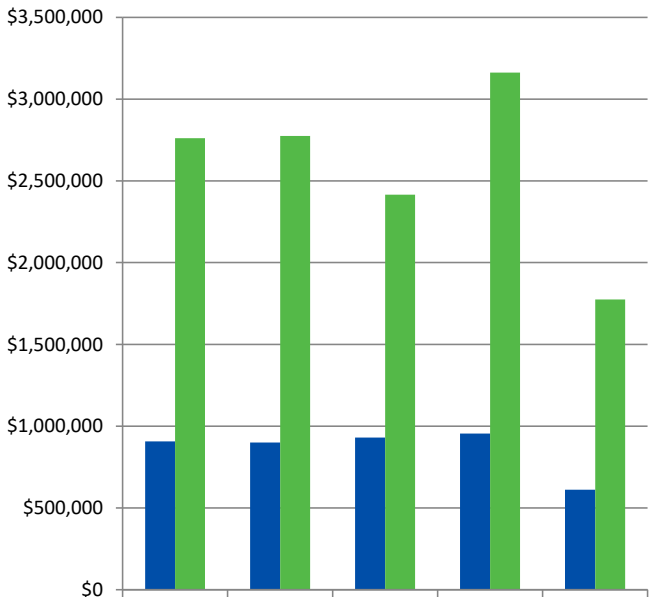


	2017 - 18	2018 - 19	2019 - 20	2020 - 21	2021 - 22
Earned Premium	$1,306,604	$1,267,917	$1,284,882	$1,292,752	$815,144
Claim Liability	$3,485,155	$3,989,557	$3,265,674	$4,465,982	$2,417,905
Loss Ratio	2.67	3.15	2.54	3.45	2.97

Basic Life Retiree Insurance Earned Premiums & Liability by Participant Type

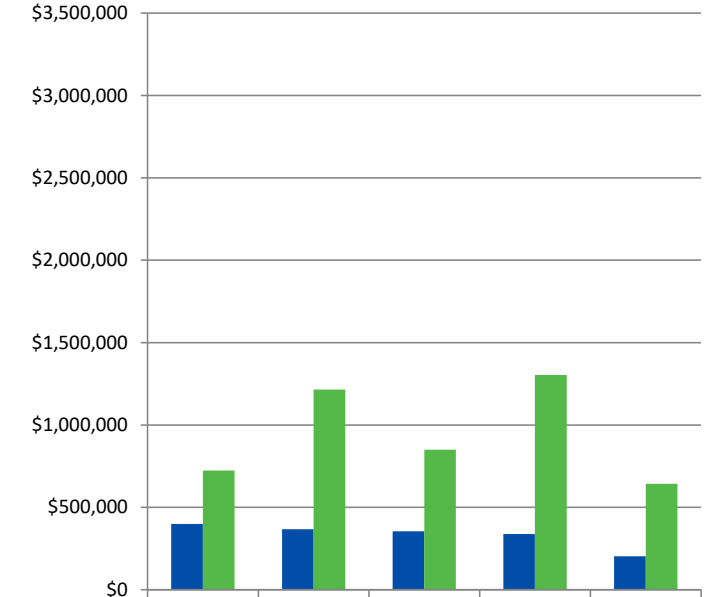
Most Recent Five Plan Years: July 01, 2017 to June 30, 2022

State Retired Participants



	2017 - 18	2018 - 19	2019 - 20	2020 - 21	2021 - 22
Earned Premium	$907,326	$900,218	$930,348	$954,967	$611,745
Claim Liability	$2,761,244	$2,774,315	$2,415,621	$3,162,080	$1,775,012
Loss Ratio	3.04	3.08	2.60	3.31	2.90

Non-State Retired Participants



	2017 - 18	2018 - 19	2019 - 20	2020 - 21	2021 - 22
Earned Premium	$399,278	$367,699	$354,534	$337,785	$203,399
Claim Liability	$723,911	$1,215,242	$850,053	$1,303,902	$642,893
Loss Ratio	1.81	3.30	2.40	3.86	3.16

Claim Appeals

Quarterly Update for Plan Year to Date July 01, 2021 to June 30, 2022

	In Process	Decision Upheld	Decision Overturned	Total
Claim Appeals				
Life Insurance Claims	0	0	0	**0**
Short-Term Disability Claims	0	2	0	**2**
Long-Term Disability Claims	0	4	1	**5**
Total Appeals	**0**	**6**	**1**	**7**

4.3.5

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

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        4.3.1 HealthSCOPE Benefits – Obesity Care Management

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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

Public Employees Benefit Program

April 26, 2022

Quarterly Update –4th Quarter Plan Year 2022

WTW's Individual Marketplace

The Public Employees Benefit Program Executive Dashboard

Quarterly Update – 4th Quarter Plan Year 2022

Executive Summary

Plan Enrollment:

- At the end of FY Q4 2022, PEBP's total enrollment into Medicare policies through WTW's Individual Marketplace increased to 11,421. Since inception, 114 carriers have been selected by PEBP's retirees with current enrollment in 1,749 different plans.
- Medicare Supplement (MS) plan selection decreased to 88% of the total population with the majority of participants selecting AARP and Anthem BCBS of Nevada as their insurer; each carrier holds plans for 6,273 and 2,019 enrollees respectively. The average monthly premium cost for MS plans remained consistent at $146.
- The percentage of Medicare Advantage (MA or MAPD) plans selected increased to 12%. Top MA carriers include Aetna with 531 individual plan selections and AARP with 293 individual plan selections. The average monthly premium cost to PEBP participants remained consistent at $12.

Customer Satisfaction:

- In Q4 2022, PEBP participant satisfaction with Enrollment Calls had an average satisfaction score result of 4.8 out of 5.0 based on 50 surveys returned.
- For Q4 2022, the average satisfaction score for Service Calls was 4.5 out of 5.0 based on 388 surveys returned.
- The combined average satisfaction score for Enrollment Calls and Service Calls was 4.5 out of 5.0 for Q4 2022.

Health Reimbursement Arrangement:

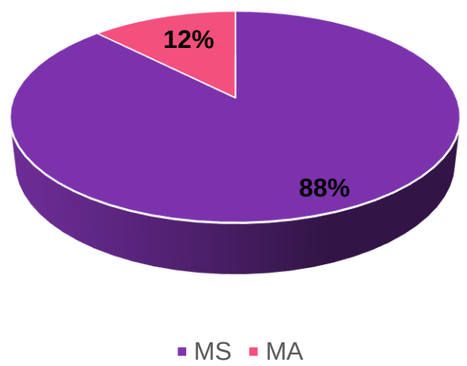
- At the end of Q4 2022 there were 13,465 Health Reimbursement Arrangement (HRA) accounts for PEBP participants.
- There were 125,703 claims processed in Q4, with 87% being submitted via Auto-Reimbursement, meaning that participants did not have to manually submit 108,780 claims for Premium Reimbursement.
- The total reimbursement amount processed for Q4 was $4,700,703.

Summary of Retiree Decisions and Costs

Retiree Plan Selection Through 06/30/2022		Previous Qtr.
Total enrolled through individual marketplace	11,421	11,283
Number of carriers**	114	114
Number of plans**	1,749	1,717

Plan Type Selection Through 06/30/2022		Previous Qtr.
Medicare Advantage (MA, MAPD)	1,419	1,320
Medicare Supplement (MS)	10,007	9,968

Medical Enrollment



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

Plan Type	Number Enrolled	Average Premium
Medicare Supplement	10,007	$146
Medicare Advantage (MA,MAPD)	1,419	$0 / $12
Part D drug coverage	6,670	$23
Dental coverage	1,068	$38
Vision coverage	2,032	$11

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

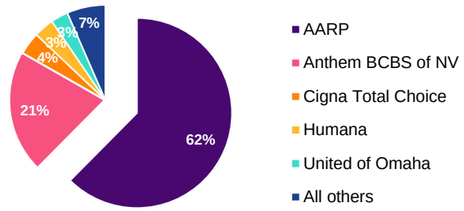
The Public Employees Benefit Program Executive Dashboard

Quarterly Update – 4th Quarter Plan Year 2022

Summary of Retiree Carrier Choice

Top Medicare Supplement Plans	Total
AARP	6,273
Anthem BCBS of NV	2,019
Cigna Total Choice	370
Humana	364
United of Omaha	283

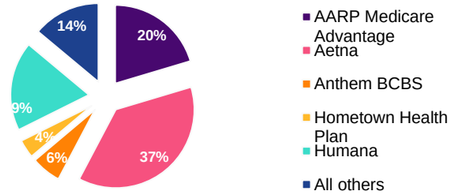
Medicare Supplement Carrier Choice



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

Top Medicare Advantage Plans	Total
AARP Medicare Advantage	293
Aetna	531
Anthem BCBS	84
Hometown Health Plan	78
Humana	244

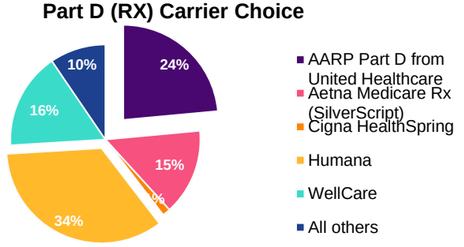
Medicare Advantage Carrier Choice



Cost Data For MA Plans	Cost
Minimum	$0
Average	$12
Median	$0
Maximum	$194

Top Medicare Part D (RX)	Total
AARP Part D from United Healthcare	1,655
Aetna Medicare Rx (SilverScript)	1,092
Cigna HealthSpring	95
Humana	2,419
WellCare	1,227

Part D (RX) Carrier Choice



Cost Data For Part D (RX)	Cost
Minimum	$6
Average	$23
Median	$16
Maximum	$127

The Public Employees Benefit Program Executive Dashboard

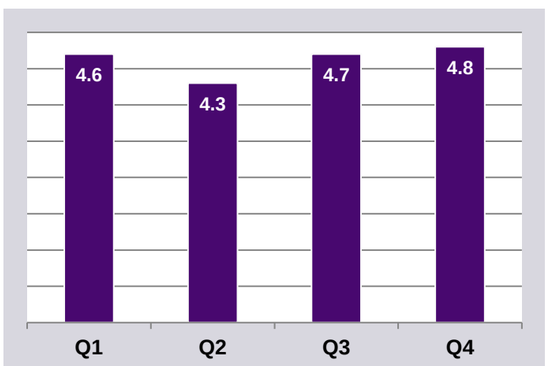
Quarterly Update – 4th Quarter Plan Year 2022

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

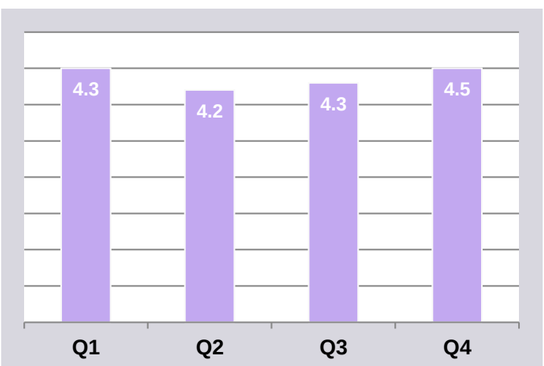
Q4 Enrollment Satisfaction

CSAT score	Count	%
5	44	88%
4	3	6%
3	2	4%
2	1	2%
1	0	0%
	50	**100%**



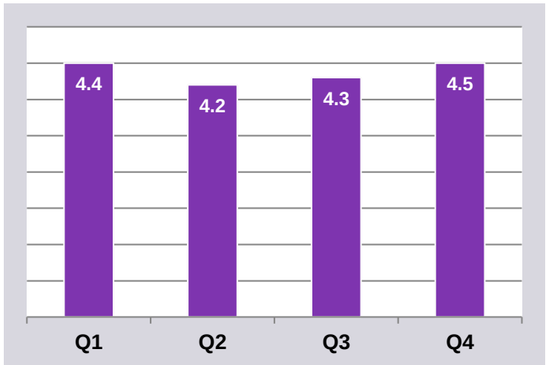
Q4 Service Satisfaction

CSAT score	Count	%
5	276	71%
4	53	14%
3	34	9%
2	7	2%
1	18	5%
	388	**100%**



Q4 Enrollment & Service Combined

CSAT score	Count	%
5	320	73%
4	56	13%
3	36	8%
2	8	2%
1	18	4%
	438	**100%**

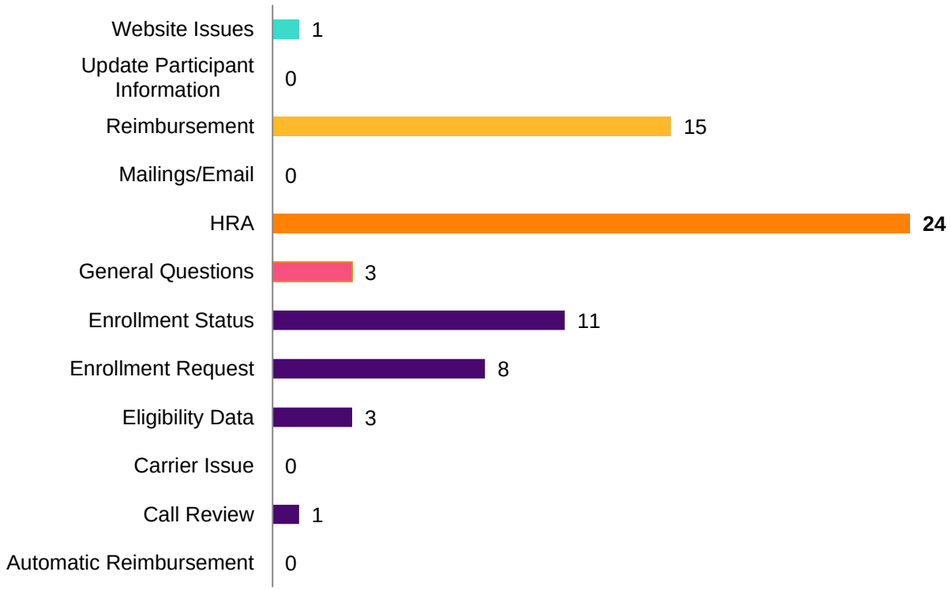


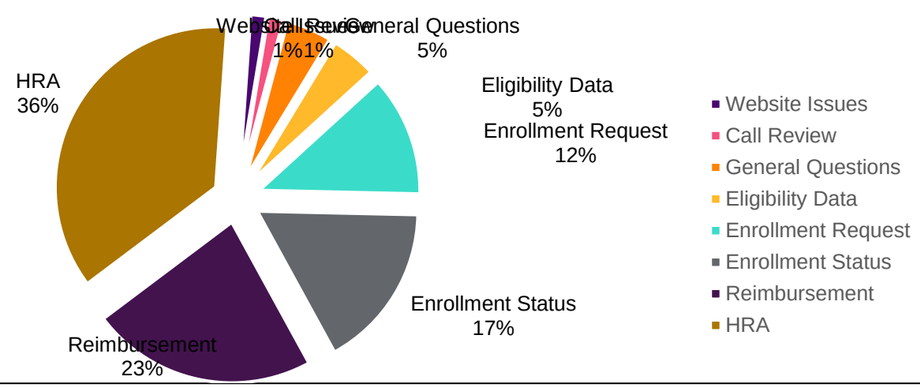
The Public Employees Benefit Program Executive Dashboard

Quarterly Update – 4th Quarter Plan Year 2022

Customer Service – Issues Log Resolution

Each quarter a certain number of participant inquiries are received by both PEBP and WTW that require escalation to Individual Marketplace Issues Log. Items on the Issues Log are carefully evaluated and continuously monitored by seasoned WTW staff until resolution is reached. The total number of inquiries reviewed during Q4-PY22 is 66 and are associated with the following categories:





Health Reimbursement Account (HRA)

Claim Activity for the Qtr.	Total
HRA accounts	13,465
Number of payments	29,875
Accounts with no balance	7,573
Claims paid amount	$4,700,703.

Claims By Source	Total
A/R file	108,780
Mail	8,030
Web	7,084
Mobile App	1,809

The Public Employees Benefit Program Executive Dashboard

Quarterly Update – 4th Quarter Plan Year 2022

Performance Guarantees*

Category	Commitment	Outcome	PG MET
Claims Turnaround Time	≤ 2 days	0.14 Days	Yes
Claim Financial Accuracy	≥ 98%	99.37%	Yes
Claim Processing Payment Precision	≥ 98%	Results not Reported on Benefits Accounts	Yes
Reports	≤ 15 business days	Met	Yes
HRA Web Services	≥ 99%	99.95%	Yes
Benefits Administration Customer Service Avg. Speed to Answer	≤ 2 min. in Q1 ≤ 90 sec in Q4 and Q4 ≤ 5 minutes in Q4 Note - Quarters listed are based on calendar year.	18 Seconds	Yes
Benefits Administration Customer Service Abandonment Rate Annual	≤ 5%	Annual	N/A
Customer Satisfaction	≥ 80%	94.06%	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 – 4th Quarter Plan Year 2022

Operations Report

Fall Retiree Meetings:

Historically, WTW and Nevada PEBP hold three days of retiree meetings in the fall focusing on participants ageing into Medicare as well as those already enrolled but who may need help with their HRA or have questions about Medicare Open Enrollment for the coming year. The meetings typically would occur in Las Vegas, Reno, and Carson City with 2 presentations per day. However, due to pandemic, we are still not able to have the live in person meetings. Instead, we will be holding two days of virtual meetings with two meetings per day. The virtual meetings will be held on October 19 and 20. Links for participants to register for the meetings are available on the main page of our Nevada PEBP specific Website at https://my.viabenefits.com/PEBP

Meeting Date/Time	Meeting Type
October 19 - 9:30 am PT	Pre-Medicare/Ageing into Medicare
October 19 – 12:00 pm PT	HRA/Medicare Open Enrollment
October 20 – 11:30 am PT	Pre-Medicare/Ageing into Medicare
October 20 - 2:00 pm PT	HRA/Medicare Open Enrollment

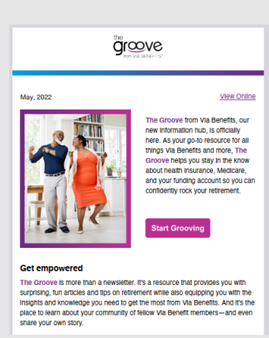
Communications:

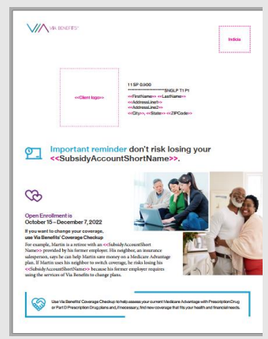
Below is information on communications that were mailed or will be coming up.

- Fall “The Groove” Newsletter
  - Our newsletter, which has been re-branded as “The Groove”, is a communication that will sent via mail and email this fall in mid/late September. The intent of this communication is to educate participants on Medicare and the upcoming Medicare Open Enrollment Period that will be from October 15 – December 7.

- HRA Qualification Reminder Notification
  - This is a new communication for the fall designed to remind retirees that have a funding qualification requirement to contact Via Benefits during OEP if they want to change plans, so they do not negatively impact their HRA qualification. This communication will be mailed in mid/late September.

- Fall Balance Reminder
  - This communication is mailed to participants who have not had any payment activity in their HRA in the prior 90 days. It is designed to remind them of their HRA balance so they can take action and submit new claims for reimbursement from their account. The Balance Reminder is scheduled to be mailed in mid/late September.





4.3.6

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

    4.3 Receipt of quarterly vendor reports for the period ending June 30, 2022:

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        4.3.2 HealthSCOPE Benefits – Diabetes Care Management

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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 AETNA Signature Administrators – PPO Network

ASA Performance Guarantee Summary

HealthSCOPE-State of Nevada

	Frequency	Standard	April	May	June	Q2
Reporting by Aetna						
Repricing Accuracy	Quarterly	97%		-----		100%
Timely Claims Repricing within 3 Days	Quarterly	97%		-----		100%
Timely Claims Repricing within 5 Days	Quarterly	99%		-----		100%

4.3.7

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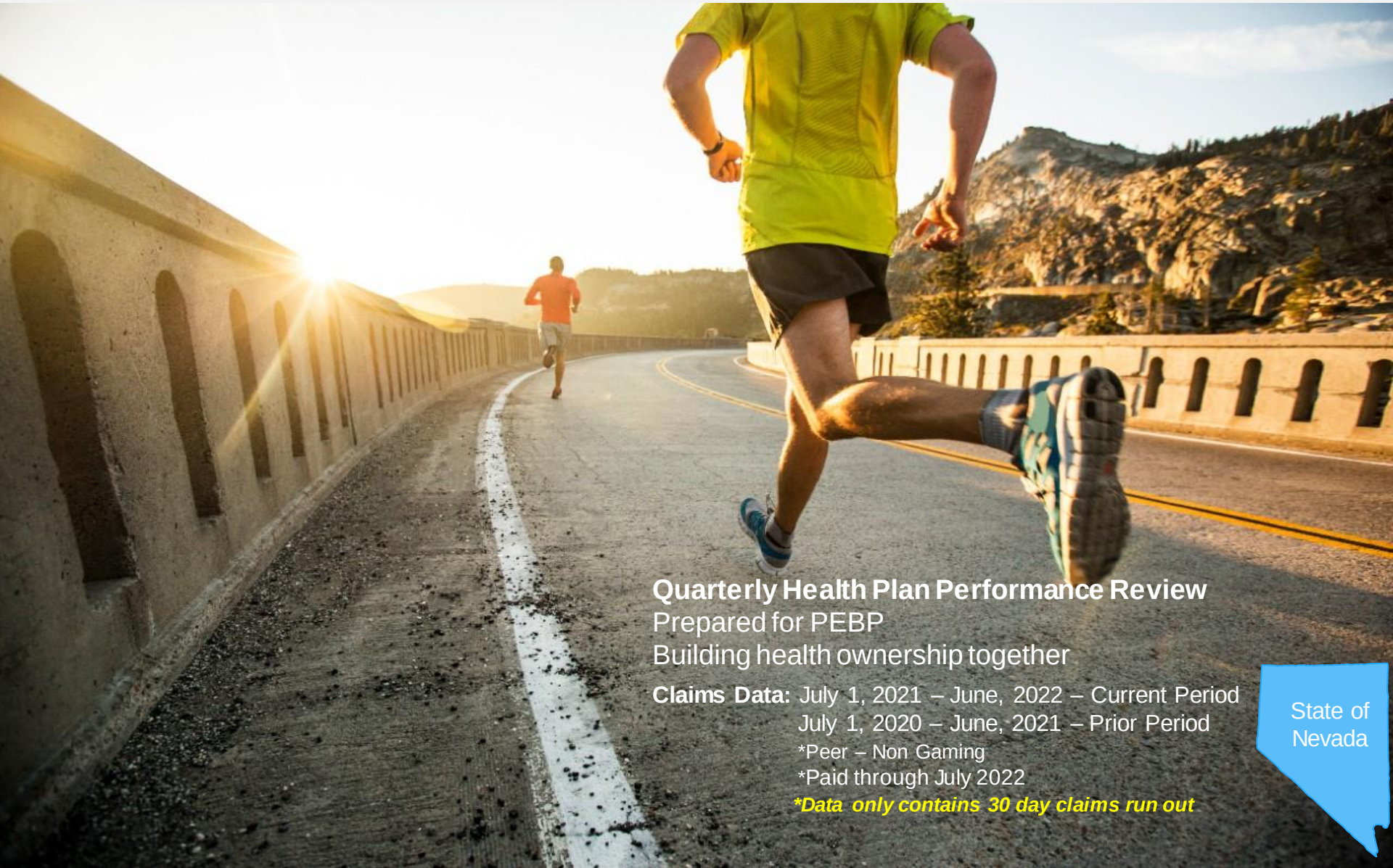
        4.3.4 The Standard Insurance – Basic Life Insurance

        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

Power Of Partnership.



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

Claims Data: July 1, 2021 – June, 2022 – Current Period
July 1, 2020 – June, 2021 – Prior Period
*Peer – Non Gaming
*Paid through July 2022
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	Avg. MemberAge	Famiy size	Dependents <18	HHS Risk
Members: 6,673 Employees: 3,781	37.1	1.76	22.9%	1.36
Prior: 6,779 3,891	Prior : 37.2 Norm: 35.3	Prior : 1.74 Norm 1.78	Prior: 22.5 Norm: 20.6	Prior: 1.33 Norm: 1.08
-1.6%	-0.2%	1.3 %	1.9%	2.3%

Medical and Rx Spend

35.4%

Medical PMPM
$484.60

Prior $358.03
Norm: $301.91

Utilization

Inpatient: ▼ -3.3%
Outpatient: ▼ -14.1%
Professional: ▼ -0.3%

Spend

Inpatient: ▲ 80.4%
Outpatient: ▲ 9.4%
Professional: ▲ 16.8%

27.8%

Overall PMPM
$634.02

Prior: $496.27
Norm: $399.85

10.9%
Specialty Rx
$64.60

Prior: $58.23
Norm: $52.54

-2.1%
Avg. Scripts PMPY
16.9

Prior: 17.2
Norm: 8.3

8.1%

Rx PMPM
$149.42

*Specialty Rx accounts for **43.2%** of Rx Spend*

Prior: $138.24
Norm: $97.93

Medical and Rx Plan Experience

What Happened

Highlights of Utilization

Key Metrics			
Utilization Metric	Prior	Current	Δ
Physician Office Vists PMPY	2.4	2.3	-4.2%
Specialist Office Vists PMPY	4.7	4.9	4.3%
ER Visits per K	77.0	80.5	4.5%
UC Visits per K	148.1	160.3	8.2%
On Demand	515.6	395.2	-23.3%
OutPatient Surgery			
ASC	126.6	125.3	-1.0%
Facility	41.6	37.0	-11.0%
Inpatient Utilization			
Admissions Per K	48.2	50.0	3.7%
Bed Days Per K	285.9	338.4	18.4%
Average Length of Stay	5.9	6.8	14.1%

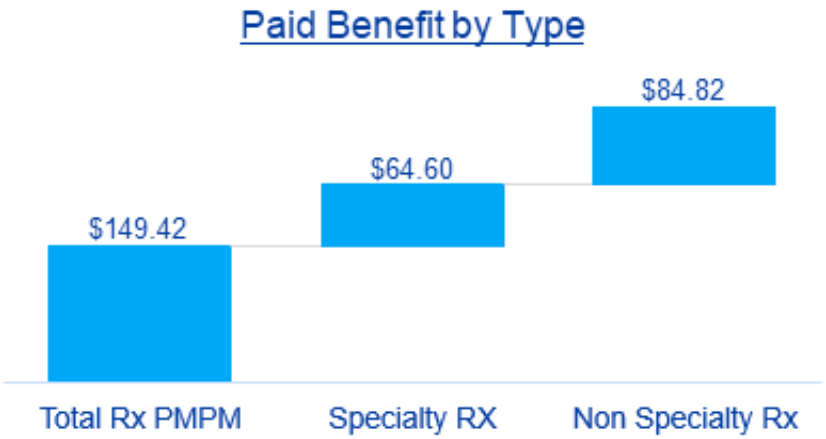
**Not representative of all Utilization*

Highlights

- PCP Visits decreased in the current period, down -4.2%
- Specialist Office visits increased 4.3%
- ER utilization increased 4.5% on a Per K basis
  - Average paid per visit decreased -15.5%, due to less emergent cases
- Urgent Care Utilization increased 8.2%
- Outpatient surgeries had decreases at both ASC and OP Facility settings
  - Procedures in ASC settings are more than double than those at OP setting
- On Demand utilization dropped -23.3%. Consistent with our book of business. More people heading to physician offices post pandemic.
- IP Admits increased 3.7% from the prior period
- Overall IP spend jumped 81.6%
  - Average length of stay increased 14.1%
  - 8 Admits greater than 40 days
  - 17 Admits with spend greater than $100k

Pharmacy Data

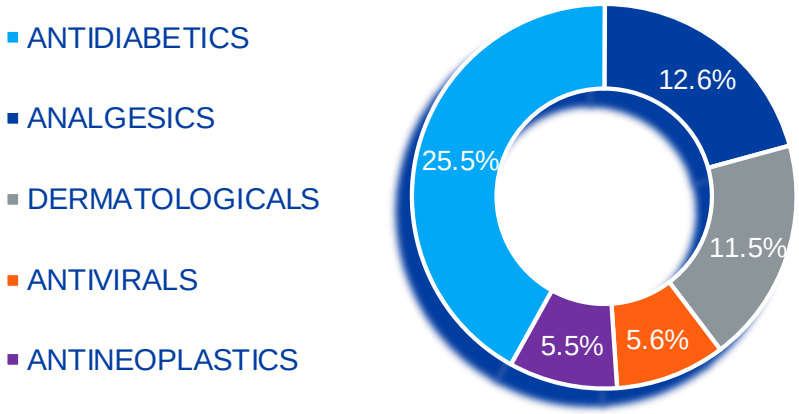
	Prior	Current	Δ	Peer	Δ
Enrolled Members	6,779	6,673	-1.6%		
Average Prescriptions PMPY	17.2	16.9	-2.1%	8.3	102.6%
Formulary Rate	91.6%	89.8%	-2.0%	86.9%	3.3%
Generic Use Rate	85.3%	83.7%	-1.9%	82.3%	1.7%
Generic Substitution Rate	97.4%	98.2%	0.8%	98.0%	0.2%
Employee Cost Share PMPM	$22.83	$27.91	22.2%	$10.74	159.7%
Avg Net Paid per Prescription	$96.36	$106.39	10.4%	$106.19	0.2%
Net Paid PMPM	$138.24	$149.42	8.1%	$73.62	103.0%



Pharmacy Spend is up 8.1% ($11.18 PMPM)

- Average net paid per script increased 10.4% (up $10.03 PMPM from prior period)
- Consistent with market trends; diabetic compliance is on the rise Antidiabetic Rx Spend increased 5.1% year over year
- Specialty Rx Spend increased 10.9% on a PMPM basis
  Specialty Rx Drivers:
  *Humira Pen (Analgesics, spend up 6.6%)
  *Jardiance (Antidiabetics, spend up 24.6%)
  *Ozempic (Antidiabetics, spend up 43.5%)
- Avg. Prescriptions PMPY decreased -2.1%

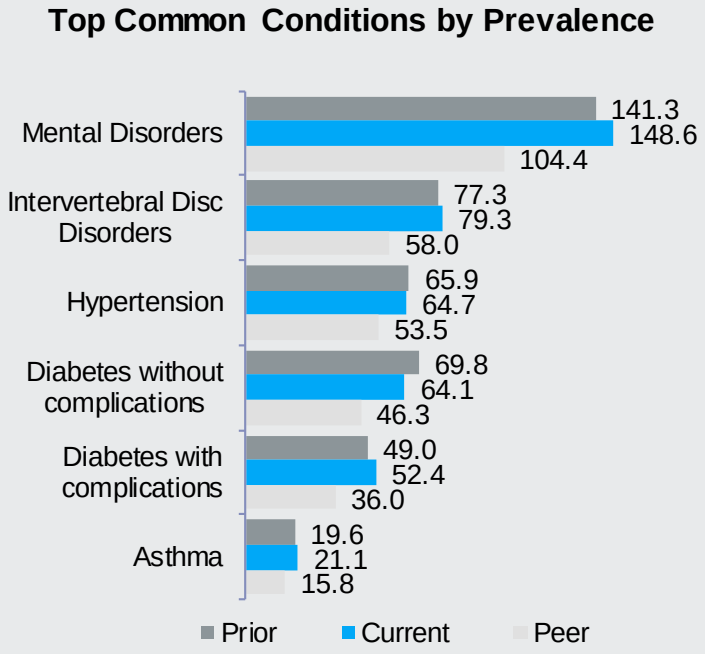
Top 5 Therapeutic Classes by Spend

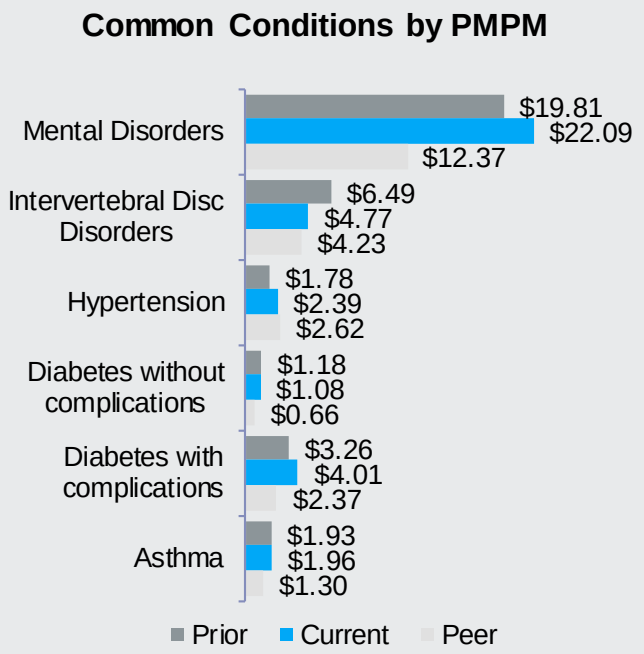


Condition Prevalence

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 5.2% and had an increased in overall spend increased 11.6% (up,$2.29PMPM) year over year
  - Spend on Mood disorders increased 64.2%, up $1.85 PMPM from prior period
  - Autism spend accounts for 37.7% of Mental Disorder spend. Autism/ABA Therapy spend down -12.1% in the current period

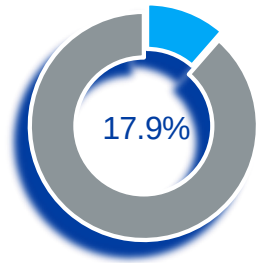
Chronic Condition Cost Drivers

UnitedHealthcare

87.9% Of Medical spend driven by members with these 4 Chronic Conditions. Average Engagement 96.7%

Asthma

8.1% of Members

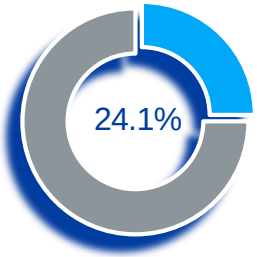


Average paid Per Claimant **$24,037**

Member Engagement **95.7%**

Cardio Hypertension

11.7% of Members

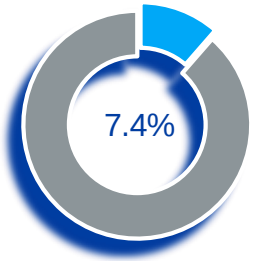


Average paid Per Claimant **$11,285**

Member Engagement **97.1%**

CAD

1.5% of Members

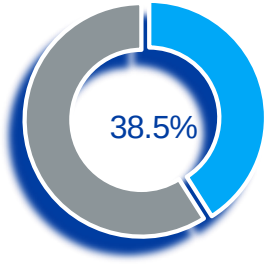


Average paid Per Claimant **$31,606**

Member Engagement **99.1%**

Diabetes

21.6% of Members



Average paid Per Claimant **$11,222**

Member Engagement **95.0%**

**Data obtained for this slide is for Eval period Aug-2021 thru July-2022*

Catastrophic Cases

High Cost Claimants

Catastrophic Cases Summary (>$50k)

UnitedHealthcare

13.08 Catastrophic Cases Per 1000

Prior: 10.14 ▲ 29.1%

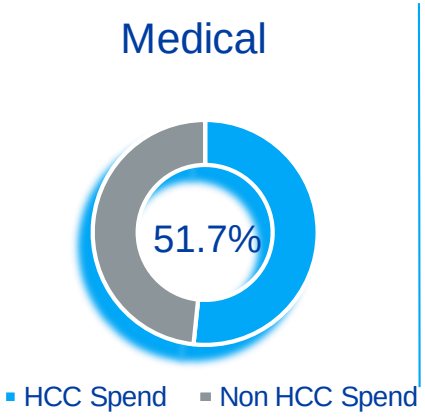
99 Individuals (76 Prior Period)
1.31% of the population

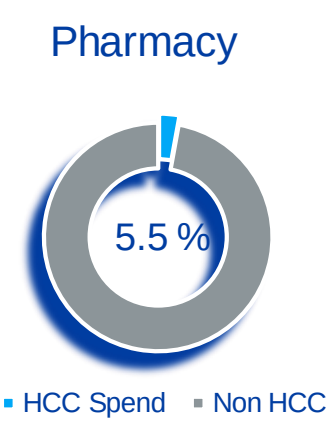
$209,127
Average Paid Per Case

Prior: $133,419 ▲ 22.8%

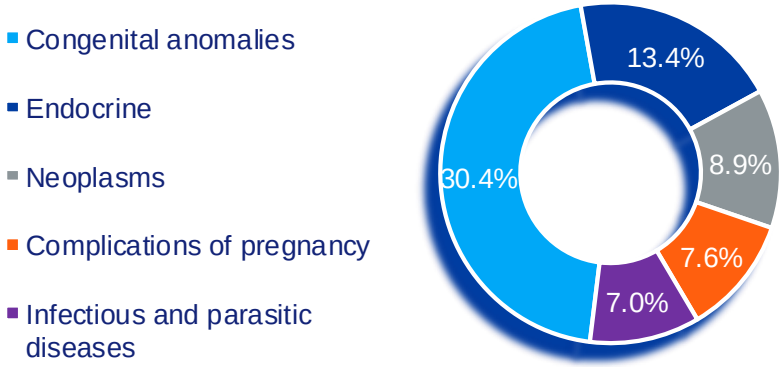
% of Total Med/Rx Spend as High Cost: **40.8%**

% Paid Attributed to Catastrophic Cases

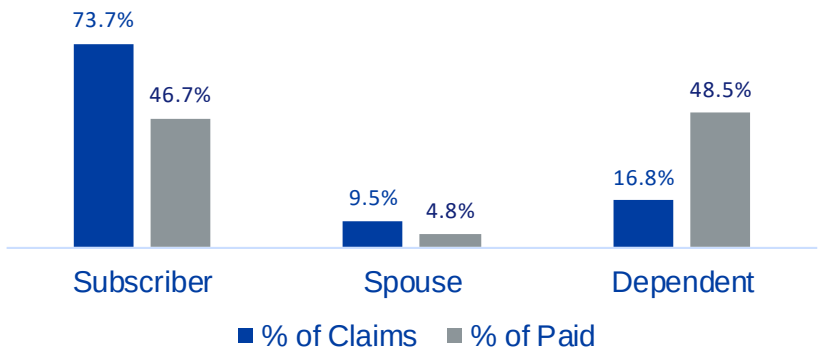




Top 5 AHRQ Chapter Description by Paid



Claims and Spend by Relationship



4.3.8

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

4.3 Receipt of quarterly vendor reports for the period ending June 30, 2022:

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 Hometown Health Providers and Sierra Healthcare Options – PPO Network

4.3.7 HealthPlan of Nevada, Inc. – Southern Nevada HMO

4.3.8 Doctor on Demand Engagement Report for August 2022

State of Nevada
2022-08 Engagement Report

dr. on demand by Included Health

Engagement Summary

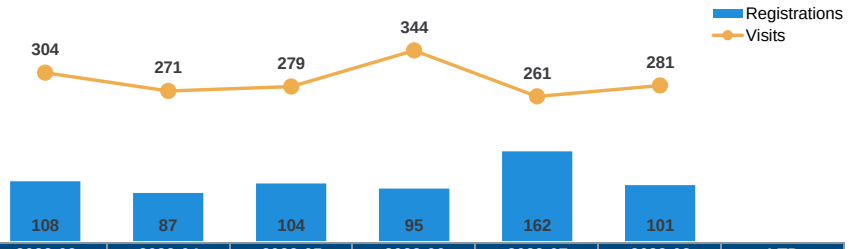
	As % Of Total Population: 0		
Engagement Metric	**2022-08**	**YTD Annualized**	**LTD**
% Registered	-	-	-
% Unique Engagement (Visitors / Lives)	-	-	-
% Overall Engagement (Visits / Lives)	-	-	-

Year To Date Activity

Registration Summary	YTD
# Registered	881

Visit Summary	YTD
# Unique Visitors	1,312
# Visits	2,274

Monthly Activity Last Six Months



Registration Summary	Prior	2022-03	2022-04	2022-05	2022-06	2022-07	2022-08	LTD
# Registered	10,359	108	87	104	95	162	101	11,016

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	2022-03	2022-04	2022-05	2022-06	2022-07	2022-08	LTD
# Unique Visitors		4,457	256	221	235	275	209	232	4,921
# Visits		11,840	304	271	279	344	261	281	13,580
Visit Frequency	% 1 Visit	51.1%	87.1%	83.3%	86.8%	80.7%	80.9%	83.6%	50.0%
	% 2 Visits	18.9%	9.4%	12.2%	10.2%	15.6%	14.8%	12.9%	18.8%
	% 3+ Visits	30.0%	3.5%	4.5%	3.0%	3.6%	4.3%	3.4%	31.2%

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.

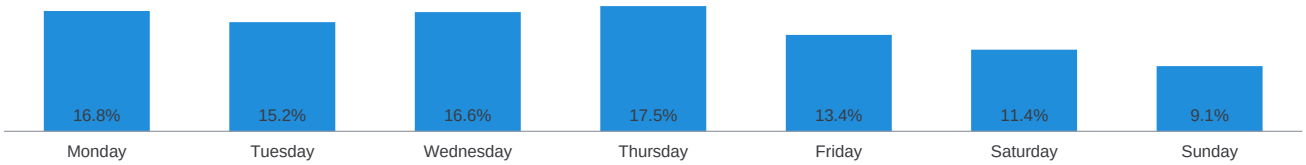
Visit Type Summary		Prior	2022-03	2022-04	2022-05	2022-06	2022-07	2022-08	LTD
Medical		9,405	244	218	225	295	220	220	10,827
Mental Health	Therapy	1,301	36	35	36	26	24	43	1,501
	Psychiatry	1,134	24	18	18	23	17	18	1,252

Benefit Summary	Prior	2022-03	2022-04	2022-05	2022-06	2022-07	2022-08	LTD
# Visits With Benefit Applied	11,537	299	265	265	335	243	262	13,206
# Visits Without Benefit Applied	303	5	6	14	9	18	19	374

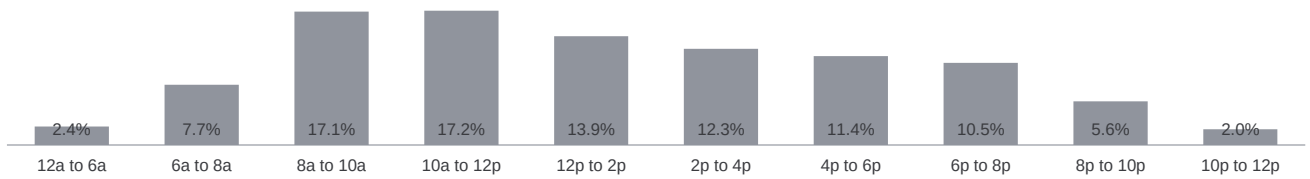
Note: Benefit not applied on visits by ineligible members, visits by members not properly associated to organization / insurance, or on visits where a discount has been applied

Six Month Trends: Visit Time And Demographics

Day Of Week



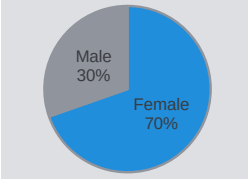
Hour Of Day



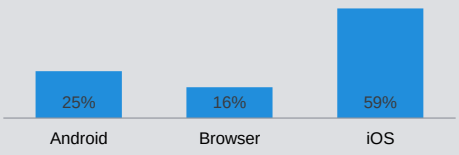
Patient Age

0 to 17 (Custodial)	9%
18 to 29	17%
30 to 49	51%
50 and over	23%

Patient Gender



Visitor App Type



State of Nevada
2022-08 Engagement Report

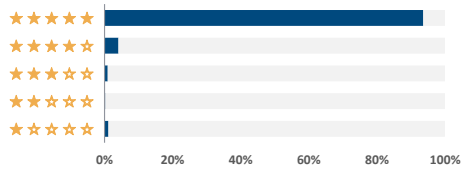
dr. on demand by Included Health

Historical Visit Experience

9,538 Visit Ratings (1-5 Stars):

Average: **4.9**

Stars:



Avg Connection Time (On Demand Visits Only): **12.5 Minutes**

Historical Post Visit Survey Results

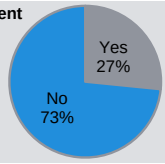
Without Doctor On Demand, where would you have gone to get this issue treated?

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

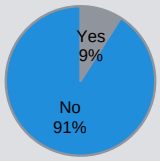
Response	# Responses	% Responses
Emergency Room	186	4%
Urgent Care	2,432	48%
Doctor's Office	1,343	27%
Stayed Home	763	15%
Other	318	6%

Six Month Trends: Visit Initiation

Initiated By Appointment (Medical Visits Only)

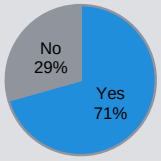


Initiated By Custodian

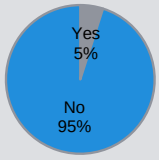


Six Month Trends: Visit Result

Resulted In Rx



Resulted In Lab Order



Historical Top 15 Symptoms

Symptom	# Symptoms	% of All Sym
General Symptoms: Fatigue / weakness	2,873	6%
Head / Neck: Headache	2,827	6%
Chest: Cough	2,796	6%
Head / Neck: Sore throat	2,526	5%
Head / Neck: Congestion / sinus problem	2,440	5%
General Symptoms: Difficulty sleeping	2,395	5%
Head / Neck: Nasal discharge	1,980	4%
General Symptoms: Fever	1,492	3%
General Symptoms: Loss of appetite	1,302	3%
Genitourinary: Discomfort / burning with urination	1,291	3%
Genitourinary: Frequent urination	1,271	3%
Head / Neck: Congestion/sinus problem	989	2%
Head / Neck: Ear pain	962	2%
Head / Neck: Difficulty / pain swallowing	916	2%
Skin: Skin rashes / bumps	849	2%

Historical Top 15 ICD10 Codes

ICD10 Code And Description	# ICD10s	% of All ICD10
N390 - Urinary tract infection, site not specified	1,219	7%
J0190 - Acute sinusitis, unspecified	811	5%
J069 - Acute upper respiratory infection, unspecified	737	4%
F411 - Generalized anxiety disorder	525	3%
J029 - Acute pharyngitis, unspecified	500	3%
Z760 - Encounter for issue of repeat prescription	418	3%
F419 - Anxiety disorder, unspecified	371	2%
R05 - Cough	337	2%
J209 - Acute bronchitis, unspecified	329	2%
U071 - COVID-19	321	2%
F4323 - Adjustment disorder with mixed anxiety and depressed mo	314	2%
J0180 - Other acute sinusitis	255	2%
F331 - Major depressive disorder, recurrent, moderate	238	1%
F339 - Major depressive disorder, recurrent, unspecified	204	1%
R059 - Cough, unspecified	204	1%

Historical Top 15 Rx

Rx Name	# Rx	% of All Rx
benzonatate	932	7%
predniSONE	876	6%
nitrofurantoin	813	6%
amoxicillin-clavulanate	787	6%
albuterol	763	6%
fluticasone nasal	352	3%
fluconazole	350	3%
sulfamethoxazole-trimethoprim	331	2%
azithromycin	297	2%
amoxicillin	290	2%
FLUoxetine	269	2%
methylPREDNISolone	260	2%
doxycycline	259	2%
ipratropium nasal	248	2%
sertraline	246	2%

Historical Top 15 Lab Orders

Lab Name	# Lab Orders	% of All Orders
Comprehensive Metabolic Panel	148	9%
TSH with Reflex to Free T4	139	9%
Urinalysis, Complete with Reflex	116	7%
CBC+diff	115	7%
Lipid Panel	105	7%
Urine Culture, Routine	97	6%
Hemoglobin A1c	95	6%
Vitamin D	70	4%
Chlamydia/GC, Urine	54	3%
Urinalysis, Complete	51	3%
B12/Folate	38	2%
Basic Metabolic Panel	34	2%
Stool O&P	28	2%
Stool Culture	27	2%
RPR w/ Reflex	25	2%

5.

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

6.

6. Informational report on claims payment accuracy and the timeliness since the transition from HealthSCOPE Benefits to UMR. (UMR) (For Information Only)

7.

7. Discussion and acceptance of Claim Technologies Incorporated audit findings for State of Nevada Public Employees' Benefits Program Plans for HealthSCOPE Benefits for period January 1, 2022 - March 31, 2022 (CTI) (**For Possible Action**)

Draft as of June 14, 2022

Comprehensive Claim Administration Audit

QUARTERLY FINDINGS REPORT

State of Nevada Public Employee Benefit Program Plans

Administered by HealthScope Benefits

Audit Period: January 1, 2022 through March 31, 2022
Audit Number 1.FY22.Q3

Presented to

State of Nevada Public Employee Benefit Program

June 14, 2022

CLAIM TECHNOLOGIES INCORPORATED

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EXECUTIVE SUMMARY

This ***Quarterly Findings Report*** is a compilation of the detailed information, findings, and conclusions drawn from Claim Technologies Incorporated's (CTI's) audit of HealthScope Benefits' (HealthScope) administration of the State of Nevada Public Employee Benefit Program's (PEBP) medical, dental, and health reimbursement arrangement (HRA) plan.

Scope

CTI performed an audit of HealthScope's administration of the PEBP's medical, dental and HRA for the period of January 1, 2022 through March 31, 2022 (quarter 3 (Q3) for Fiscal Year (FY) 2022). The population of claims and amount paid during the audit period reported by HealthSCOPE Benefits:

Medical and Dental	
Total Paid Amount	$53,704,711
Total Number of Claims Paid/Denied/Adjusted	188,118
Health Reimbursement Arrangement (HRA)	
Total Paid Amount	$880,745
Total Number of Claims Paid/Denied/Adjusted	9,828

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

- Operational Review – Performance Guarantees Only
- 100% Electronic Screening with Targeted Samples
- Random Sample Audit
- Data Analytics

Auditor's Opinion

Based on these findings, and in our opinion:

1. HealthSCOPE met its Financial Accuracy measurement in Q3 FY2022 and no penalty is owed.
2. HealthSCOPE should:
    - Review the 100% Electronic Screening with Targeted Sample results and focus on the most material findings in Duplicate Payments, Spinal Region Upcoding, and Timely Filing Payments.
    - Review the Random Sample Audit results and review the system error and how to prevent similar system errors going forward.

Summary of HealthSCOPE's Guarantee Measurements

Based on CTI's Random Sample Audit results, HealthSCOPE met both claims processing measurements for the PEBP in Q3 FY2022.

Quarterly Guarantee	Measure	Met/Not Met	Penalty
Financial Accuracy	99%	Met – 99.89%	None.
Payment Accuracy	98%	Met – 99.50%	None.

AUDIT OBJECTIVES

This report contains CTI's findings from our audit of HealthScope Benefits' (HealthScope) administration of the State of Nevada Public Employee Benefit Program (PEBP) plans. We provide this report to PEBP, the plan sponsor, and HealthScope, the claim administrator. A copy of HealthScope's response to these findings can be found in the Appendix of this report.

CTI conducted the audit according to accepted standards and procedures for claim audits in the health insurance industry. We based our audit findings on the data and information provided by PEBP and HealthScope. The validity of our findings relies on the accuracy and completeness of that information. We planned and performed the audit to obtain reasonable assurance claims were adjudicated according to the terms of the contract between HealthScope and PEBP.

CTI specializes in the audit and control of health plan claim administration. Accordingly, the statements we make relate narrowly and specifically to the overall effectiveness of policies, procedures, and systems HealthScope used to pay PEBP's claims during the audit period. While performing the audit, CTI complied with all confidentiality, non-disclosure, and conflict of interest requirements and did not receive anything of value or any benefit of any kind other than agreed upon audit fees.

The objectives of CTI's audit of HealthScope's claim administration were to determine whether:

- HealthScope followed the terms of its contract with PEBP;
- HealthScope paid claims according to the provisions of the plan documents and if those provisions were clear and consistent; and
- members were eligible and covered by PEBP's plans at the time a service paid by HealthScope was incurred.

OPERATIONAL REVIEW PERFORMANCE GUARANTEES

Performance Guarantees

As part of CTI's quarterly audit of PEBP, we reviewed the Performance Guarantees included in its contract with HealthSCOPE. The results for Q3 FY2022 follow.

Metric	Guarantee Measurement	Actual	Met/ Not Met
Financial Accuracy	99% or greater of the dollars paid for the audited medical/dental claims to be paid accurately.	99.89%	Met
Payment Accuracy	98% or greater of medical/dental claims audited are paid accurately.	99.50%	Met
Claim Processing Turnaround	99% of all medical/dental claims are to be processed within 30 days	99.94%	Met
Customer Service	• Telephone Response Time less than 30 seconds for inbound calls. • Telephone Abandonment Rate less than 3% First call Resolution greater or equal to 95%	6 Seconds Less than .01% 97.97%	Met Met Met
Data Reporting	• 100% of standard reports within 10 business days • Annual/Regulatory Documents within 10 business days of the Plan Year	No exceptions noted NA – Annual Report	Met NA
Disclosure of Subcontractors	• Report access of PEBP data within 30 calendar days • Removal of PEBP member PHI within 3 business days after knowledge	No exceptions noted No exceptions noted	Met Met

100% ELECTRONIC SCREENING WITH TARGETED SAMPLE ANALYSIS

Objective

CTI's Electronic Screening and Analysis System (ESAS) software identified and quantified potential claim administration payment errors. PEBP and HealthScope should discuss any verified under- or overpayments to determine the appropriate actions to correct the errors.

Scope

CTI electronically screened 100% of the service lines processed by HealthScope during the audit period for both medical and dental claims. The accuracy and completeness of HealthScope's data directly impacted the screening categories we completed and the integrity of our findings. We screened the following high-level ESAS categories to identify potential amounts at risk:

- Duplicate payments to providers and/or employees
- Plan exclusions and limitations
- Multiple surgical procedures

Methodology

We used ESAS to analyze claim payment accuracy as well as any opportunities for system and process improvement. Using the data file provided by HealthScope, we readjudicated each line on every claim the plan paid or denied during the audit period against the plan's benefits. Our Technical Lead Auditor tested a targeted sample of claims to provide insight into HealthScope's claim administration as well as operational policies and procedures. We followed these procedures to complete our ESAS process:

- ***Electronic Screening Parameters Set*** – We used your plan document provisions to set the parameters in ESAS.
- ***Data Conversion*** – We converted and validated your claim data, reconciled it against control totals, and checked it for reasonableness.
- ***Electronic Screening*** – We systematically screened 100% of the service lines processed and flagged claims not administered according to plan parameters.
- ***Auditor Analysis*** – If claims within an ESAS screening category represented a material amount, our auditors analyzed the findings to confirm results were valid. Note than using ESAS could lead to false positives if there was incomplete claim data. CTI auditors made every effort to identify and remove false positives.
- ***Targeted Sample Analysis*** – From the categories identified with material amounts at risk, we selected the best examples of potential under- or overpayments to test. As cases were not randomly selected, we cannot extrapolate results. We selected 50 cases and sent your administrator a questionnaire for each. Targeted samples verified if the claim data supported our finding and if our understanding of plan provisions matched HealthScope's administration.
- ***Audit of Administrator Response and Documentation*** – We reviewed the responses and redacted the responses to eliminate personal health information. Based on the responses and further analysis of the findings, we removed false positives identified from the potential amounts at risk.

Findings

We are confident in the accuracy of our ESAS results. It should be noted that the dollar amounts associated with the results represent potential payment errors and process improvement opportunities. We would have to perform additional testing to substantiate the findings that could then provide the basis for remedial action planning or reimbursement.

Categories for Process Improvement

The following detail report shows, by category, the number of line items or claimants with process improvement opportunities remaining after our analysis and removal of verified false positives. A CTI auditor reviewed the responses and supporting documentation. The administrator responses are copied directly from HealthScope's reply to audit findings.

Process Improvement Summary Report				
Client: PEBP **Screening Period:** Q3 FY2022				
Category	**Number of Service Codes**	**Number of Members**	**Billed Charge**	**Allowed***
Fraud, Waste and Abuse				
Spinal Region Upcoding – Number of spinal regions treated does not match number of spinal regions billed and allowed.	977	361	$66,983	$35,663

**Allowed equals total paid by plan and member combined.*

Electronic screening of all service lines processed revealed the potential for incorrectly paid claims. Analysis confirmed the opportunity for process improvement and further testing is recommended. For each potential error, we sent an ESAS Questionnaire (QID) to HealthScope for written response. After review of the response and additional information provided, CTI confirmed the potential for process improvement. Note that all recommendations for HealthSCOPE process improvements will also be included in the Q4 FY2021 report.

Manually adjudicated claims were processed by an individual claim processor. Auto-adjudicated claims were paid by the system with no manual intervention.

Fraud, Waste, and Abuse Detail Report					
QID	**Category**	**Over Paid**	**HealthScope Response**	**CTI Conclusion**	**Manual or System**
35	Spinal Region Upcoding	$83.99	Disagree.	Procedural deficiency and overpayment remain. The description for CPT codes for chiropractic care includes the number of regions of spine or extraspinal regions treated and should be supported by the diagnosis. The provider billed five or more spinal regions treated; however, the diagnosis billed supported treatment of only two spinal regions. These procedures are spinal region driven and should be billed with appropriate diagnosis codes to support billing.	☒ M ☐ S
36		$56.76			☒ M ☐ S

Categories for Potential Amount at Risk

The following report shows, by category, the number of line items or claims and the total potential amount at risk remaining at the conclusion of our analysis, targeted samples, and removal of verified false positives. Following the report is a detailed explanation of our results with findings for all screening categories where, in our opinion, process improvement, recovery or savings opportunities exist. The administrator responses are copied directly from HealthScope's reply to audit findings.

Categories for Potential Amount at Risk				
Client: PEBP **Screening Period:** Q3 FY2022				
Category	**Number of Service Codes**	**Number of Members**	**Billed Charge**	**Allowed***
Duplicate Payments				
Providers and/or Employees	168	41	$102,937	$41,082
Timely Filing				
Paid after timely filing limit	803	231	$2,054,152	$736,947

**Allowed equals total paid by plan and member combined.*

Electronic screening of all service lines processed revealed the potential for incorrectly paid claims. Analysis confirmed the opportunity for process improvement and further testing is recommended.

Duplicate Payments Detail Report				
QID	**Over Paid**	**HealthScope Response**	**CTI Conclusion**	**Manual or System**
30	$1,197.68	Agree. NEV.XXXX4785 is a duplicate claim. The edit was overridden by analyst in error.	Procedural deficiency and overpayment remain.	☒ M ☐ S
Timely Filing Detail Report				
QID	**Over Paid**	**HealthScope Response**	**CTI Conclusion**	**Manual or System**
12	$1,197.68	Disagree. Original claim NEV.XXXX6319 was received within the timely filing limit. The original claim was denied for Medicare EOB and itemized bill. The claim was split and NEV.XXXX8031 was reconsidered and paid according to the plan benefits.	Procedural deficiency and overpayment remain. Claim was processed 21 months after the date of service.	☒ M ☐ S
13	$21,157.31	Disagree. Original claim NEV.XXXX1429 was received within the timely filing limit. The provider submitted a correct claim that was received on 10/23/2021 and denied for itemization. The provider submitted the requested information within the timeframe and paid under NEV.XXX6334.	Procedural deficiency and overpayment remain. Claim was processed 16 months after the date of service.	☒ M ☐ S

There were also errors found under the dental benefit plan for services paid. CTI's review indicated three Dental Surgical Procedures paid for a total of $2,168.50 including:

- one Repair of maxillofacial and/or soft hard tissue defect;
- one Graft, bone; nasal, maxillary, or malar areas and
- one Sinus augmentation with Bone or Bone substitutes via a lateral open approach.

Additionally, there were Invalid Procedure Codes paid for a total of $1,463.68 including one each of Bone graft in conjunction with Periradicular surgery; Biologic material to aid in soft and osseous tissue; Surgical repair on root resorption; Intraorifice barrier; Splint-intra-coronal; Buccal/Labial Frenectomy and Lingual frenectomy.

In CTI's experience the PEBP's dental plan document is vague and/or silent on a number of dental services. We recommend that the language be updated to indicate specifically which services are covered and which are excluded. This will eliminate the option for medical necessity which means any claim currently submitted is being paid.

RANDOM SAMPLE AUDIT

Objectives

The objectives of our Random Sample Audit were to determine if medical and dental claims were paid according to plan specifications and the administrative agreement, to measure and benchmark process quality, and to prioritize areas of administrative deficiency for further review and remediation.

Scope

CTI's statistically valid Random Sample Audit included a stratified random sample of 200 paid or denied claims. HealthScope's performance was measured using the following key performance indicators:

- Financial Accuracy
- Accurate Payment
- Accurate Processing

We also measured claim turnaround time, a commonly relied upon performance measure.

In addition, CTI sampled 50 health reimbursement arrangement (HRA) claims to ensure payment and processing accuracy.

Methodology

Our Random Sample Audit ensures a high degree of consistency in methodology and is based upon the principles of statistical process control with a management philosophy of continuous quality improvement. Our auditors reviewed each sample claim selected to ensure it conformed to plan specifications, agreements, and negotiated discounts. We recorded our findings in our proprietary audit system.

When applicable, we cited claim payment and processing errors identified by comparing the way a selected claim was paid and the information HealthScope had available at the time the transaction was processed**. It is important to note that even if the sampled claim was subsequently corrected prior to CTI's audit, we have still cited the error so you can discuss how to reduce errors and re-work in the future with your administrator.**

CTI communicated with HealthScope in writing about any errors or observations using system-generated response forms. We sent HealthScope a preliminary report for its review and written response. We considered HealthScope's written response, as found in the Appendix, when producing our final reports. Note that the administrator responses have been copied directly from HealthScope's reply.

Financial Accuracy

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 claims sampled and reviewed revealed $123.72 in underpayments and no overpayments, for an absolute value variance of $123.72.

The weighted Financial Accuracy rate was 99.89%.

Financial Accuracy Detail Report						
Error Description	**Audit No.**	**Under Paid**	**HealthScope Response**	**CTI Conclusion**	**Manual or System**	
Coinsurance Error	1127	$123.72	Agree. Claim should not have assessed a $123.72 coinsurance. There would be a $123.72 underpayment on this claim.	Procedural error and underpayment remain. Coinsurance amount should have not been assessed.	☐ M ☒ S	
Subtotal	**1**					
TOTALS	**1**	**VARIANCE $123.72**			**M: 0**	**S: 1**

Accurate Payment

CTI defines Accurate Payment as the number of claims paid correctly compared to the total number of claims paid for the audit sample.

The audit sample revealed 1 incorrectly paid claims and 199 correctly paid claims. Note CTI only uses adequately documented claims for this calculation.

Total Claims	Incorrectly Paid Claims		Frequency
	Underpaid Claims	Overpaid Claims	
200	1	0	99.50%

Accurate Processing

CTI defines Accurate Processing as the number of claims processed without errors compared to the total number of claims processed in the audit sample.

Correctly Processed Claims	Incorrectly Processed Claims		Frequency
	System	Manual	
199	1	0	99.50%

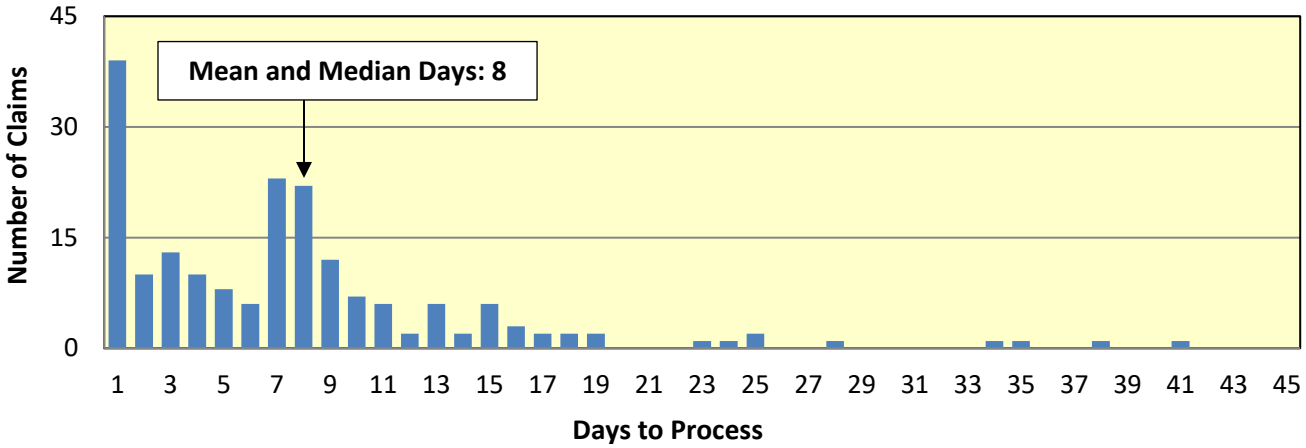
Accurate Processing Detail Report				
Error Description	**Audit No.**	**HealthScope Response**	**CTI Conclusion**	**Manual or System**
Managed Care				
Coinsurance Error	1127	Agree. Claim should not have assessed a coinsurance. There would be an underpayment on this claim.	Procedural error remains. Coinsurance should have not been assessed.	☐ M ☒ S

Claim Turnaround

CTI defines Claim Turnaround as the number of calendar days required to process a claim – from the date the claim was received by the administrator to the date a payment, denial, or additional information request was processed – expressed as both the Median and Mean for the audit sample.

Claim administrators commonly measure claim turnaround time in mean days. Median days, however, is a more meaningful measure for administrators to focus on when analyzing claim turnaround because it prevents one or just a few claims with extended turnaround time from distorting the true performance picture.

Median and Mean Claim Turnaround



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
HealthSCOPE is denying any claim with a diagnosis code of T86.19 (Sepsis) pending completion of an accident report. This is delaying payment of members claims.	1055

Health Reimbursement Arrangement (HRA) Findings

CTI also reviewed 50 HRA claims as part of our random sample. We communicated with HealthScope in writing about any errors or observations found using response forms. In addition, we sent HealthScope a preliminary report for its review and written response. We considered HealthScope's written response, as found in the Appendix, when producing our final reports.

Our audit revealed no procedures or situations that may have caused an error on the sampled claim.

DATA ANALYTICS

Medical Findings

This component of our audit used your electronic claim data to identify improvement opportunities and potential recoveries. The informational categories we analyzed include:

- Network Provider Utilization and Discount Savings;
- Sanctioned Provider Identification;
- Patient Protection and Affordable Care Act (PPACA) Preventive Services Payment Compliance;
- National Correct Coding Initiative (NCCI) Editing Compliance; and
- Global Surgery Prohibited Fee Period Analysis.

The following pages provide the scope and report for each data analytic to enable more-informed decisions about ways PEBP can maximize benefit plan administration and performance.

Network Provider Utilization and Discount Savings

The Network Provider Utilization and Discount Savings report provides an evaluation of provider network discounts obtained during the audit period. Since discounts can be calculated differently by administrators, carriers, and benefit consultants, we believe calculating discounts in the same manner for all our clients will allow for more meaningful comparisons to be made.

Scope

CTI compared submitted charges to allowable charges for all claims paid during the audit period. The review was divided into three subsets:

- In-network
- Out-of-network
- Secondary networks

Each of these subsets was further delineated into four subgroups:

- Ancillary services – such as durable medical equipment
- Non-facility services – such as an office visit
- Facility inpatient – such as services received at a hospital
- Facility outpatient – such as services received at a surgical center

Report

The following report relied on the data and data fields provided by your administrator. We made no assumptions when requested data fields were not provided.

Paid Dates 1/1/2022 through 3/31/2022				
Proprietary and Confidential Information. Do not reproduce without express permission of Claim Technologies Inc.				
Total of All Claims				
Claim Type	**Allowed Amount**	**Provider Discount**		**Paid**
Ancillary	$2,689,116	$4,635,036	63.3%	$2,365,069
Non-Facility	$24,558,190	$27,363,997	52.7%	$17,184,442
Facility Inpatient	$16,456,761	$30,380,988	64.9%	$15,756,474
Facility Outpatient	$15,263,591	$33,833,190	68.9%	$12,293,734
Total	**$58,967,657**	**$96,213,211**	**62.0%**	**$47,599,719**
In-Network				
Claim Type	**Allowed Amount**	**Provider Discount**		**Paid**
Ancillary	$2,574,564	$4,635,036	64.3%	$2,301,741
Non-Facility	$23,621,021	$27,355,839	53.7%	$16,862,951
Facility Inpatient	$16,261,466	$30,109,697	64.9%	$15,627,014
Facility Outpatient	$14,960,964	$33,312,429	69.0%	$12,072,300
Total In-Network	**$57,418,014**	**$95,413,001**	**62.4%**	**$46,864,006**
% of Eligible Charge -	97.4%	% Claim Frequency -	84.7%	
Out of Network				
Claim Type	**Allowed Amount**	**Provider Discount**		**Paid**
Ancillary	$114,552	$0	0.0%	$63,328
Non-Facility	$937,169	$8,158	0.9%	$321,490
Facility Inpatient	$195,295	$271,291	58.1%	$129,460
Facility Outpatient	$302,627	$520,761	63.2%	$221,434
Total Out of Network	**$1,549,643**	**$800,210**	**34.1%**	**$735,713**
% of Eligible Charge -	2.6%	% Claim Frequency -	15.3%	

**Paid claim totals exclude claims from members aged 65 and older.*

PEBP's members had utilization of network or secondary network medical providers at 97.40% of all allowed charges and 84.70% of all claims.

Sanctioned Provider Identification

The Sanctioned Provider Identification report identifies services rendered by providers on the Office of Inspector General's (OIG) List of Excluded Individuals/Entities (LEIE). OIG's LEIE provides information to the healthcare industry, patients, and the public about individuals and entities currently excluded from participation in Medicare, Medicaid, and all other federal health care programs.

Scope

We received and converted an electronic data file of all claims processed during the audit period. The claims screened included all medical (not including prescription drug) and dental claims paid or denied during the audit period. Through electronic screening, we identified all claims in the audit universe that were non-facility claims, i.e., claims submitted by providers of service other than hospitals, nursing, or skilled care facilities, or durable medical equipment suppliers. These claims predominantly include physician and other medical professional claims.

Report

We screened 100% of non-facility claims against OIG's LEIE and identified the following providers as sanctioned. Our screening indicated the following providers received payment from the administrator during the audit period.

NPI	Exclusion Date	Reinstatement Date	Exclusion Type	Provider Name	Claim Count	Total Charged	Total Allowed	Total Paid
1104912278	20191219	N/A	1128a4	JAMES SHELBY	2	$332	$332	$197
1548342025	20130820	N/A	1128b14	7 DAY DENTAL	2	$924	$898	$453
				Totals	**4**	**$1,256**	**$1,230**	**$649**

According to the OIG, James Shelby was excluded on December 19, 2019 with for a felony-controlled substance conviction. 7 Day Dental has been excluded for default on a health education loan or scholarship.

PPACA Preventive Services Coverage Compliance

The Preventive Services Coverage Compliance report confirms that the administrator processed preventive services as required by PPACA and as regulated by the Department of Health and Human Services (HHS). The federal PPACA mandate for all health plans (unless grandfathered) requires that certain preventive services, if performed by a network provider, must be covered at 100% without copayment, coinsurance, or deductible. Our review analyzed in-network preventive care services to determine if your administrator paid services in compliance with PPACA guidelines.

Scope

Our review included all in-network services we believe should be categorized as preventive and paid at 100%. The guidance provided by HHS for the definition of preventive services is somewhat vague, leaving it up to individual health plans to define their own system edits. In addition to the U.S. Preventive Services Task Force recommendations, CTI researched best practices of major health plan administrators to develop a compliance review we believe reflects the industry's most comprehensive overview of procedures to be paid at 100%.

Our review did not include services:

- performed by an out-of-network provider;
- adjusted or paid more than once (duplicate payments) during the audit period; or
- for which PPACA requirements suggest a frequency limitation such as one per year.

Our data analytics parameters relied upon the published recommendations from the sources HHS used to create the list of preventive services for which it has mandated coverage.

Reports

We analyzed the payments to determine if they were compliant. Types of services for which we identified non-compliance (if any) are listed first and the percentage of allowed charge paid is in the last column. To demonstrate full compliance with PPACA's requirements, the last column of this report should show 100% of services performed by network providers were paid and that no deductible, coinsurance, or copayment was applied.

Because services may be denied for reasons other than exclusion or limitation of non-covered services (e.g., a service could be denied because the patient was ineligible at the time it was performed), less than 100% of the preventive services may be paid.

The preventive services compliance review shows the frequency of claims paid at less than required benefit levels (i.e., claims reduced payment due to the application of deductibles, coinsurance, and/or copayments). We electronically screened 78 categories of preventive services that match the preventive care services specified by HHS including immunizations, women's health, tobacco use counseling, cholesterol and cancer screenings, and wellness examinations. This review either confirms compliance with PPACA or highlights areas for improvement.

CTI's analysis also found that 94.73% of the procedure codes identified as preventive services were paid by HealthScope at 100% when provided in-network. A detailed list of the other 5.27% is available upon request.

The following reports provide an outline for discussion between PEBP and HealthScope.

Preventive Care Services Compliance Review Paid at Less than 100%

PEBP - HealthSCOPE

Audit Period 1/1/2022 - 3/31/2022

Plans: All

Filters: Exclude - out of network, adjustments, edits with frequency limits, claimants 65 or older

		Claim Lines Submitted	Denied	Applied Deductible		Applied Copay		Applied Coinsurance		Paid @100%		
Edit Guideline	Preventive Service Benefit	#	#	#	Amount	#	Amount	#	Amount	#	Amount	%
USPSTF-A	Hemoglobinopathies or sickle cell screening 0-90 days	1	0	1	$11	0	$0	0	$0	0	$0	.00%
USPSTF-B	Pre-Diabetes/Type 2 Diabetes	1	0	1	$184	0	$0	0	$0	0	$0	.00%
USPSTF-B	Breast cancer chemoprevention counseling- >17	12	0	5	$394	2	$100	4	$83	1	$251	8.33%
HHS	Breastfeeding support and counseling - women	28	0	10	$3,049	7	$340	6	$238	5	$358	17.86%
USPSTF-A,B	Rh incompatibility screening - pregnant women	85	22	15	$655	8	$467	25	$270	14	$337	22.22%
USPSTF-A	HIV screening - pregnant women	12	0	7	$409	0	$0	2	$10	3	$104	25.00%
USPSTF-B	BRCA screening counseling - women	28	3	5	$1,054	8	$340	2	$300	10	$8,767	40.00%
HHS	Gestational Diabetes Mellitus screening - women	128	0	27	$241	0	$0	32	$49	69	$801	53.91%
USPSTF-A	Hepatitis B screening - women	24	0	6	$63	0	$0	4	$7	14	$138	58.33%
USPSTF-B	Depression screening - >18	87	1	23	$392	3	$40	8	$25	52	$858	60.47%
USPSTF-A	HIV screening - >14	146	1	44	$1,014	0	$0	12	$99	89	$2,171	61.38%
USPSTF-B	Hepatitis C Virus (HCV) Screening	173	4	45	$772	0	$0	18	$96	106	$1,625	62.72%
USPSTF-A	Urinary tract infection screening - pregnant women	109	3	23	$710	5	$135	11	$93	67	$1,818	63.21%
USPSTF-B	Healthy diet counseling	237	0	27	$2,572	7	$242	50	$1,593	153	$24,133	64.56%
USPSTF-A	Syphillis screening	55	1	13	$47	0	$0	5	$4	36	$132	66.67%
USPSTF-B	Depression screening - 12-18	27	0	5	$30	0	$0	4	$6	18	$130	66.67%
USPSTF-A	Syphilis screening - pregnant women	131	0	27	$140	0	$0	14	$10	90	$460	68.70%
USPSTF-A,B	Chlamydia infection screening - women	259	1	54	$3,018	1	$82	24	$247	179	$7,880	69.38%
USPSTF-B	Gonorrhea screening - female	248	1	47	$2,589	1	$82	22	$193	177	$7,852	71.66%
USPSTF-B	Tobacco use counseling - >18	22	2	1	$9	0	$0	4	$20	15	$278	75.00%
USPSTF-A	Phenylketonuria (PKU) screening 0-90 days	8	0	2	$8	0	$0	0	$0	6	$159	75.00%
USPSTF-A,B	Cholesterol abnormalities screening - women >19	672	1	99	$1,252	0	$0	31	$94	541	$6,521	80.63%
USPSTF-B	Alcohol misuse - screening and counseling	26	0	4	$74	0	$0	1	$4	21	$388	80.77%
USPSTF-A	Cholesterol abnormalities screening - men 35-75	517	1	76	$941	0	$0	20	$90	420	$4,663	81.40%
Bright Futures	Lead screening - <21	14	0	2	$21	0	$0	0	$0	12	$146	85.71%
ACIP	Immunizations - Hepatitis A >18	15	0	1	$127	0	$0	1	$24	13	$1,305	86.67%
Bright Futures	Dyslipidemia screening - 2-20	32	0	3	$28	0	$0	0	$0	29	$356	90.63%
Bright Futures	Hearing Screening 0-21 yrs	149	11	4	$120	0	$0	8	$45	126	$2,713	91.30%
Bright Futures	Tuberculin testing - <21	12	0	1	$6	0	$0	0	$0	11	$128	91.67%
ACIP	Immunizations - Influenza Age >18	373	6	8	$245	0	$0	16	$122	343	$11,344	93.46%
ACIP	Immunizations - Pneumococcal >18	32	0	1	$110	0	$0	1	$25	30	$4,940	93.75%
Bright Futures	Iron Supplement - <21	84	0	3	$7	0	$0	0	$0	81	$221	96.43%
USPSTF-A	Colorectal cancer screening - 45-75	611	2	12	$1,252	5	$435	3	$36	589	$262,157	96.72%
ACIP	Immunizations - Herpes Zoster >59	177	1	2	$171	0	$0	3	$170	171	$62,599	97.16%
HHS	Contraceptive methods - women	375	0	4	$216	0	$0	2	$31	368	$134,749	98.13%
ACIP	Immunization Administration - >18	1,179	41	8	$586	0	$0	13	$250	1,117	$41,569	98.15%
USPSTF-A	Cervical Cancer Screening (Pap) - women	1,095	2	13	$464	1	$71	6	$81	1,073	$35,258	98.17%
USPSTF-B	Breast cancer mammography screening - >39	3,492	3	25	$1,863	3	$120	16	$344	3,445	$332,572	98.74%
HHS	Cervical Cancer Screening (HPV DNA) - women >29	669	1	6	$464	0	$0	2	$12	660	$26,122	98.80%
HHS	Wellness Examinations - >18	700	2	3	$103	1	$30	3	$27	691	$109,026	99.00%
Bright Futures	Developmental Autism screening - <3	189	0	1	$11	0	$0	0	$0	188	$2,906	99.47%
HHS	Wellness Examinations - women	2,262	8	5	$339	2	$55	3	$445	2,244	$373,760	99.56%
HRSA/HHS	Wellness Examinations - <19	1,847	3	2	$83	2	$55	0	$0	1,840	$237,749	99.78%
ACIP	Immunizations - DTP <19	486	2	1	$36	0	$0	0	$0	483	$51,637	99.79%

PPACA Preventive Services Coverage Compliance Detail Report

QID	Error Description	Under Paid	HealthScope Response	CTI Conclusion	Manual or System
7	Coinsurance Applied	$2,911.33	Agree. Claim should have been paid as preventive.	Procedural deficiency and underpayment remain. HealthSCOPE applied a deductible/ coinsurance to a preventive service.	☒ M ☐ S
8	Deductible Applied				

Preventive Care Services Compliance Review Paid at 100%												
PEBP - HealthSCOPE												
Audit Period 1/1/2022 - 3/31/2022												
Plans: All												
Filters: Exclude - out of network, adjustments, edits with frequency limits, claimants 65 or older												
		Claim Lines Submitted	Denied	Applied Deductible		Applied Copay		Applied Coinsurance		Paid @100%		
Edit Guideline	Preventive Service Benefit	#	#	#	Amount	#	Amount	#	Amount	#	Amount	%
ACIP	Immunization Administration - <19	2,174	19	0	$0	0	$0	0	$0	2,155	$82,096	100.00%
ACIP	Immunizations - Influenza <19	459	0	0	$0	0	$0	0	$0	459	$13,168	100.00%
FDA/CDC	Immunizations - Covid19	397	0	0	$0	0	$0	0	$0	397	$17,524	100.00%
ACIP	Immunizations - Rotavirus <19	205	0	0	$0	0	$0	0	$0	205	$31,834	100.00%
ACIP	Immunizations - Human papillomavirus	198	0	0	$0	0	$0	0	$0	198	$75,763	100.00%
ACIP	Immunizations - Hepatitis A <19	193	0	0	$0	0	$0	0	$0	193	$10,730	100.00%
ACIP	Immunizations - Meningococcal <19	147	0	0	$0	0	$0	0	$0	147	$31,732	100.00%
ACIP	Immunizations - Meningococcal >18	117	1	0	$0	0	$0	0	$0	116	$30,384	100.00%
USPSTF-B	Vision screening - 3- 5	110	3	0	$0	0	$0	0	$0	107	$996	100.00%
ACIP	Immunizations - Measles, Mumps, Rubella <19	93	0	0	$0	0	$0	0	$0	93	$39,442	100.00%
ACIP	Immunizations - Hepatitis B <19	91	0	0	$0	0	$0	0	$0	91	$5,119	100.00%
ACIP	Immunizations - Varicella <19	69	0	0	$0	0	$0	0	$0	69	$12,752	100.00%
ACIP	Immunizations - Inactivated Poliovirus <19	34	0	0	$0	0	$0	0	$0	34	$1,896	100.00%
ACIP	Immunizations - Hepatitis B >18	26	2	0	$0	0	$0	0	$0	24	$1,834	100.00%
ACIP	Immunizations - Varicella >18	10	0	0	$0	0	$0	0	$0	10	$1,501	100.00%

NCCI Editing Compliance

While there are no universally accepted correct coding guidelines among private insurers and administrators, the Centers for Medicare & Medicaid Services (CMS), the nation's largest payer for health care, took the initiative to provide valuable guidance for medical benefit plans. Implementation of NCCI mandated several initiatives to prevent improperly billed claims from being paid under Medicare and Medicaid.

Scope

The two NCCI initiatives that can offer the greatest return benefit to self-funded employee benefit plans are the Procedure-to-Procedure (PTP) Edits and Medically Unlikely Edits (MUEs).

Our claim system code editing analysis identified services submitted to the plan and paid by HealthScope that Medicare and Medicaid would have denied. **Since HealthScope paid the billed charges, the payments represent a potential savings opportunity to PEBP.**

It is difficult to establish the extent to which administrators and carriers use NCCI edits; however, CTI recommends these reports be discussed with your administrator to determine the extent to which they incorporate CMS edits. Using these edits typically reduces claim expense and furthers efforts toward achieving standardized code-editing systems for all payers.

PTP Edits Reports

PTP Edits compare procedure codes from multiple claim lines on the same day to identify when procedures submitted on the same claim cannot be billed together. Our reports are grouped by outpatient hospital services and non-facility claims using CMS' quarterly updated data. If your administrator is not currently using these CMS edits, CTI's reports will help you evaluate the savings you would have realized had the PTP Edits been in place.

Procedure to Procedure Edits								
PEBP - HealthSCOPE								
Based on Paid Dates 1/1/2022 through 3/31/2022								
Outpatient Hospital Services (facility claims with codes not designated inpatient)								
Primary		**Secondary**			**Primary Description**	**Secondary Description**	**Line**	**Amount CMS**
Code	**Mod**	**Code**	**Mod**	**Mod Use**			**Count**	**Would Deny**
74177	TC	96374		YES	CT ABD & PELV W/CONTRAST	THER/PROPH/DIAG INJ IV PUSH	7	$4,662
					Standards of medical / surgical practice			
63081		22551		YES	Remove vert body dcmprn crvl	NECK SPINE FUSE&REMOV BEL C2	1	$3,855
					More extensive procedure			
51702		96361		YES	INSERT TEMP BLADDER CATH	HYDRATE IV INFUSION ADD-ON	1	$3,045
					Misuse of column two code with column one code			
70496	TC	70450	TC	YES	CT ANGIOGRAPHY HEAD	CT HEAD/BRAIN W/O DYE	5	$2,352
					Misuse of column two code with column one code			
51702		96366		YES	INSERT TEMP BLADDER CATH	THER/PROPH/DIAG IV INF ADDON	1	$2,290
					Misuse of column two code with column one code			
96372		99218		YES	THER/PROPH/DIAG INJ SC/IM	INITIAL OBSERVATION CARE	2	$2,257
					Standards of medical / surgical practice			
96374		96372		YES	THER/PROPH/DIAG INJ IV PUSH	THER/PROPH/DIAG INJ SC/IM	7	$1,943
					CPT Manual or CMS manual coding instructions			
81450		88374		YES	Targeted genomic sequence analysis panel, hema	Morphometric analysis, in situ hybridizatic	1	$1,828
					Misuse of column two code with column one code			
93653		99157		YES	Ep & ablate supravent arrhyt	MOD SED OTHER PHYS/QHP EACH ADDL 15 M	1	$1,757
					HCPCS/CPT procedure code definition			
92526	GN	97110	GP	YES	ORAL FUNCTION THERAPY	THERAPEUTIC EXERCISES	7	$1,756
					Misuse of column two code with column one code			
						Top 10 TOTAL	**33**	**$25,743**
						GRAND TOTAL	**347**	**$63,951**

Non-Facility (non-facility claims with CPT codes:00100 - 99999)								
Primary		**Secondary**			**Primary Description**	**Secondary Description**	**Line**	**Amount CMS**
Code	**Mod**	**Code**	**Mod**	**Mod Use**			**Count**	**Would Deny**
63052		61783		YES		SCAN PROC SPINAL	1	$495
					Misuse of column two code with column one code			
90471		99204		YES	IMMUNIZATION ADMIN	Office/outpatient visit for E&M of new patie	1	$351
					CPT Manual or CMS manual coding instructions			
63047		69990		NO	Remove spine lamina 1 lmbr	MICROSURGERY ADD-ON	1	$342
					Misuse of column two code with column one code			
29824		29822		YES	SHOULDER ARTHROSCOPY/SURGERY	debridement, limited, 1 or 2 discrete structu	1	$281
					More extensive procedure			
90471		99396		YES	IMMUNIZATION ADMIN	PREV VISIT EST AGE 40-64	2	$270
					CPT Manual or CMS manual coding instructions			
00752	AA	95955	59,26	NO	ANESTH REPAIR OF HERNIA	EEG DURING SURGERY	1	$215
					Standard preparation / monitoring services for anesthesia			
00790	AA,P3	95955	59,26	NO	ANESTH SURG UPPER ABDOMEN	EEG DURING SURGERY	1	$215
					Standard preparation / monitoring services for anesthesia			
90471		99384		YES	IMMUNIZATION ADMIN	PREV VISIT NEW AGE 12-17	2	$211
					CPT Manual or CMS manual coding instructions			
90460		99392		YES	IM ADMIN 1ST/ONLY COMPONENT	PREV VISIT EST AGE 1-4	2	$210
					CPT Manual or CMS manual coding instructions			
90471		99385		YES	IMMUNIZATION ADMIN	PREV VISIT NEW AGE 18-39	2	$204
					CPT Manual or CMS manual coding instructions			
						Top 10 TOTAL	**14**	**$2,795**
						GRAND TOTAL	**82**	**$5,787**

MUE Reports

An MUE is an edit that tests claim lines for the same beneficiary, procedure code, date of service, and billing provider against a maximum allowable number of service units. The MUE rule for a given code is the maximum number of service units a provider should report for a single day of service. MUE errors could be caused by incorrect coding, inappropriate services performed, or fraud. MUEs do not require Medicare contractors to perform a manual review or suspend claims; rather, claim lines are denied and must be correctly resubmitted by providers, typically with a lesser payment amount.

CTI's MUE analyses are grouped into three separate reports:

- Outpatient hospital
- Non-facility
- Ancillary

NCCI MUE Edits				
PEBP - HealthSCOPE				
Based on Paid Dates 1/1/2022 through 3/31/2022				
Outpatient Hospital Services (facility claims with codes not designated inpatient)				
Procedure Code	**Service Unit Limit**	**Procedure Description**	**Line Count Exceeding Limit**	**Amount CMS Would Deny**
93580	1	TRANSCATH CLOSURE OF ASD	1	$21,063
		Rationale: Anatomic Consideration		
A9588	10	FLUCICLOVINE F-18	1	$11,922
		Rationale: Prescribing Information		
88342	4	IMMUNOHISTOCHEMISTRY	3	$8,385
		Rationale: Clinical: Data		
C1889	2	IMPLANT/INSERT DEVICE, NOC	1	$8,299
		Rationale: Clinical: CMS Workgroup		
36215	2	PLACE CATHETER IN ARTERY	1	$7,219
		Rationale: Clinical: Data		
75705	20	ARTERY X-RAYS SPINE	1	$5,950
		Rationale: Clinical: Data		
99218	1	INITIAL OBSERVATION CARE	11	$5,712
		Rationale: Code Descriptor / CPT Instruction		
36245	3	INS CATH ABD/L-EXT ART 1ST	1	$3,944
		Rationale: Clinical: Data		
36226	1	Place cath vertebral art	1	$2,872
		Rationale: CMS Policy		
97799	1	PHYSICAL MEDICINE PROCEDURE	4	$2,774
		Rationale: Clinical: CMS Workgroup		
		Top 10 TOTAL	**25**	**$78,141**
		GRAND TOTAL	**142**	**$118,293**

Non-Facility (non-facility claims with CPT codes:00100 - 99999)				
Procedure Code	**Service Unit Limit**	**Procedure Description**	**Line Count Exceeding Limit**	**Amount CMS Would Deny**
15879	1	Suction lipectomy lwr extrem	2	$18,750
		Rationale: CMS Policy		
19350	1	BREAST RECONSTRUCTION	1	$16,980
		Rationale: CMS Policy		
J9355	105	INJ TRASTUZUMAB EXCL BIOSIMI	1	$14,096
		Rationale: CMS Policy		
19380	1	Revision of reconstructed breast(eg,significant removal o	1	$7,778
		Rationale: CMS Policy		
77295	1	SET RADIATION THERAPY FIELD	1	$7,572
		Rationale: Nature of Service/Procedure		
97155	24	ADAPT BHV TX PRTCL MODIFICAJ PHYS/QHP EA 15 MIN	7	$4,567
		Rationale: Clinical: Society Comment		
J0475	8	BACLOFEN 10 MG INJECTION	2	$2,467
		Rationale: Prescribing Information		
88307	8	TISSUE EXAM BY PATHOLOGIST	2	$2,449
		Rationale: Clinical: Data		
95165	30	ANTIGEN THERAPY SERVICES	2	$2,419
		Rationale: Clinical: Data		
88374	5	Morphometric analysis, in situ hybridization (quantitativ	4	$1,812
		Rationale: Clinical: Data		
		Top 10 TOTAL	**23**	**$78,890**
		GRAND TOTAL	**127**	**$97,992**

Ancillary (All other claims not flagged Inpatient, Outpatient Hospital, or non-facility)				
Procedure Code	**Service Unit Limit**	**Procedure Description**	**Line Count Exceeding Limit**	**Amount CMS Would Deny**
E0465	2	Home ventilator, any type, used with invasive interface, (e	1	$3,600
		Rationale: Nature of Equipment		
A4253	1	BLOOD GLUCOSE/REAGENT STRIPS	11	$875
		Rationale: Nature of Equipment		
V2520	2	CONTACT LENS HYDROPHILIC	8	$865
		Rationale: Anatomic Consideration		
E0630	1	PATIENT LIFT HYDRAULIC	4	$684
		Rationale: Nature of Equipment		
K0001	1	STANDARD WHEELCHAIR	6	$672
		Rationale: Nature of Equipment		
A7520	1	TRACH/LARYN TUBE NON-CUFFED	4	$475
		Rationale: Published Contractor Policy		
V2521	2	CNTCT LENS HYDROPHILIC TORIC	4	$440
		Rationale: Anatomic Consideration		
E0651	1	PNEUM COMPRESSOR SEGMENTAL	3	$411
		Rationale: Nature of Equipment		
E0443	1	PORTABLE 02 CONTENTS, GAS	8	$255
		Rationale: Code Descriptor / CPT Instruction		
E0260	1	HOSP BED SEMI-ELECTR W/ MATT	1	$239
		Rationale: Nature of Equipment		
		Top 10 TOTAL	**50**	**$8,516**
		GRAND TOTAL	**73**	**$9,809**

Medically Unlikely Edit Detail Report					
QID	**Error Description**	**Over Paid**	**HealthScope Response**	**CTI Conclusion**	**Manual or System**
1	Ancillary	$3,600.00	Agree. The edit was overridden by an analyst in error.	Procedural deficiency and underpayment remain as agreed.	☒ M ☐ S

Global Surgery Prohibited Fee Period Analysis

CMS created the definition of global surgical package to make payments for services provided by a surgeon before, during, and after procedures. The objective of CTI's Global Surgery Prohibited Fee Period Analysis is to compare paid surgical claims to Medicare's payment guidelines and identify instances of unbundling and improper use of evaluation and management (E/M) coding.

Scope

The scope of the Global Surgery Prohibited Fee Period Analysis is surgery charges provided in any setting, including inpatient hospital, outpatient hospital, ambulatory surgical center (ASC), and physician's office. Claims for surgeon visits in intensive care or critical care units are also included in the global surgical package. Our analysis encompasses the three types of procedures with global surgical packages: simple, minor, and major. Each type has specific global periods:

- Simple – One day
- Minor – Ten days
- Major – Ninety days

CMS allows providers to bill for an E/M service after surgery if the patient's condition required a significant, separately identifiable E/M service beyond the usual pre-operative and post-operative care.

When this occurs, the provider can add a modifier 24, 25, or 57 to the E/M service procedure code but must submit supporting documentation with the claim.

Report

The following report provides a summary of:

- top 10 providers with and without E/M charges during prohibited periods and associated charges;
- analysis of same providers' surgeries with modifier 24, 25, or 57 when Medicare would have required supporting documentation before payment; and
- analysis of the same providers' surgeries without modifier 24, 25, or 57 when Medicare would have denied payment.

Payment of unbundled, post-surgical E/M services during the global fee period increases the cost of a claim. While there are no universally accepted guidelines for global surgery fee periods with 24, 25, or 57 modifiers, some states and groups mandate providers accept assignment of benefits on those claims. This mitigates the financial impact of unbundling and improper coding. When we discuss our findings, we will help you identify strategies to monitor and eliminate unbundling within your plan.

PEBP - HealthSCOPE									
Audit Period 1/1/2022 - 3/31/2022									
	Surgeries with 'CMS Defined' Prohibited Global Fee Periods					Evaluation and Management Services using Same ID as Surgeon and Within Prohibited Global Fee Period			
	Surgeries without E/M Procedures during Prohibited Global Fee		Surgery with E/M Charge during Prohibited Global Fee Periods			E/M Procedure Codes with Modifier 24, 25, or 57		E/M Procedure Codes without Modifier 24, 25, or 57	
Provider Id	Count	Allowed Charge	Count	% Surgeries with E/M Charges during Prohibited Global Fee Periods	Allowed Charge	Total Count; 0,10 & 90 days	Allowed Charge	Total Count; 0,10 & 90 days	Allowed Charge
742851819	0	$0	1	100.0%	$26	0	$0	1	$196
680405220	64	$23,477	1	1.5%	$429	0	$0	1	$155
273905550	0	$0	2	100.0%	$3,414	0	$0	1	$151
263632448	34	$12,239	8	19.0%	$3,176	7	$1,334	1	$148
364105559	8	$1,662	2	20.0%	$719	1	$69	2	$138
880103557	336	$223,742	58	14.7%	$11,193	55	$6,534	1	$127
270028866	200	$86,259	25	11.1%	$2,994	24	$2,064	1	$106
880115812	4	$5,990	10	71.4%	$4,179	8	$767	1	$103
880133501	308	$123,207	21	6.4%	$4,202	21	$2,734	1	$102
853177121	0	$0	1	100.0%	$1,775	0	$0	1	$95
Top 10	**954**	**$476,577**	**129**	**11.9%**	**$32,107**	**116**	**$13,503**	**11**	**$1,320**
Overall Total	**4,650**	**$1,463,711**	**409**	**8.1%**	**$83,403**	**382**	**$43,872**	**12**	**$1,362**

CONCLUSION

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

APPENDIX – ADMINISTRATOR RESPONSE TO DRAFT REPORT

Your administrator's response to the draft report follows.

27 Corporate Hill Drive
Little Rock, AR 72205

June 13, 2022

Claim Technologies Incorporated
100 Court Avenue Suite 306
Des Moines, IA 50309

Dear Ms. Nisius,

Thank you for the opportunity to work with CTI on our mutual client State of Nevada Public Employees' Benefit Program.

Appendix – Administrator's Response to Draft Report for State of Nevada Public Employees' Benefit Program.

HealthSCOPE Benefits has reviewed Audit Number 1.FY22.Q3 draft report and would like to add the response to the conclusions within the audit report.

PERFORMANCE GUARANTEES:

HealthSCOPE Benefits has provided the information to CTI regarding the FY.22.Q3 reporting requirements.

TARGETED SAMPLE ANALYSIS:

Fraud, Waste, and Abuse Detail Report:

QID 35 – HSB does not agree with CTI conclusion. The claim was considered according to the plan benefits.

QID 36 - HSB does not agree with CTI conclusion. The claim was considered according to the plan benefits.

Duplicate Payment Detail Report:

QID 30- HSB does agree with CTI conclusion. The duplicate edit was overridden by the analyst in error.

Timely Filing Detail Report:

QID 12 – HSB does not agree with CTI conclusion. The original claim was received within the timely filing limits and denied for Medicare EOB and itemized bill. Once the additional information was received the claim was reconsidered. No overpayment on file.

QID 13 – HSB does not agree with CTI conclusion. The original claim was received within the timely filing limits and considered under the plan. The provider submitted a corrected claim on 10/23/21 and denied for itemized bill due to the additional charges received. Once the requested information was received the claim was reconsidered with the corrected charges. No overpayment on file.

Durable Medical Precertification Detail Report:

QID 38 – HSB does not agree with CTI conclusion regarding the precertification on file. Authorization on file # 6127890 for services rendered.

RANDOM SAMPLE AUDIT:

Financial Accuracy Detail Report:

Audit No. 1127 – HSB does agree with CTI conclusion. The claim should not have assessed a $123.72 coinsurance. There would be a $123.72 underpayment.

Accurate Processing Detail Report:

Audit No. 1127 – HSB does agree with CTI conclusion. The claim should not have assessed a $123.72 coinsurance. There would be a $123.72 underpayment.

Observation:

Audit Number 1055 – The claim was investigated based on ICD 10 T86.19 as listed on the possible subrogation list in our policy and procedures.

PPACA Preventive Services Coverage Compliance Detail Report:

QID 7 – HSB does agree with CTI conclusion. The claim should have paid as preventive.

QID 8 – QID 8 is the same claim and same member as identified in QID 7 listed above.

Medically Unlikely Edit Detail Report:

QID 1 - HSB does agree with CTI Conclusion. The analyst overrode the edit for the units billed on this claim.

Thank you,

Jennifer Spencer, Associate Director of Quality Assurance
HealthSCOPE Benefits, Inc

CLAIM TECHNOLOGIES INCORPORATED

100 Court Avenue – Suite 306 • Des Moines, IA 50309

(515) 244-7322 • claimtechnologies.com

8.

8. Discussion and acceptance of Claim Technologies Incorporated audit findings for State of Nevada Public Employees' Benefits Program Plans for ExpressScripts for period July 1, 2020 – June 30, 2021 (CTI) (**For Possible Action**)

Prescription Benefit Management Audit

SPECIFIC FINDINGS REPORT

State of Nevada Public Employee Benefit Program Plans

Administered by Express Scripts

Audit Period: July 1, 2020 – June 30, 2021
Audit Number 3.FY21

Presented to

State of Nevada Public Employee Benefit Program

Revised July 18, 2022

Prepared by

PillarRx Consulting

Subcontractor to

CLAIM TECHNOLOGIES INCORPORATED

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EXECUTIVE SUMMARY

This ***Specific Findings Report*** contains detailed information, findings, and conclusions that the PillarRx Consulting, LLC's (PillarRx) audit team has drawn from our Prescription Benefit Management Audit of Express Scripts' (ESI's) administration of State of Nevada Public Employee Benefit Program's (PEBP's) pharmacy plan.

Scope

PillarRx performed an audit of ESI's administration of the PEBP's pharmacy plan for the period of July 1, 2020 through June 30, 2021 (FY2021). The population of claims and amount paid during the audit period reported by HealthSCOPE Benefits:

Pharmacy	
Number of Prescriptions Paid	455,444
Net Plan Paid	$58,997,529

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

1. Pricing and Fees Audit
2. Reconciliation of Pricing Guarantees
3. Benefit Payment Accuracy Review
4. Rebate Review
5. Performance Guarantee Review

Auditor's Findings

PillarRx has the following opinion/recommendations based on the FY2021 audit of ESI:

1. Financial Accuracy is defined by the discount and dispensing fee in the PBM contract, versus actual PBM performance. ESI met the financial accuracy performance standard listed in the contact for retail and did not meet it for mail order. When aggregate however, ESI's overall performance did not meet PEBP's contractual financial accuracy guarantee. PillarRx's agrees with ESI calculated under-performance amount of $125,443.43. The penalty was paid to PEBP on November 12, 2021.
2. Processing accuracy is measured comparing the intended plan benefit as listed in the summary Plan Description (SPD) with the claim processed by the PBM. ESI's overall performance in both Retail and Mail order met PEBP's contractual processing accuracy guarantee.

Summary of HealthSCOPE's Guarantee Measurements

Performance Standard	Description of Standard	PBM Performance/Penalty	Met/Not Met
Financial Accuracy Overview	99% of all claims paid with NO errors unless subject to intervention.	This guarantee includes five categories. Two of the five categories were not met for a net underperformance of $125,443.43. Refer to page 11 for additional detail.	Not Met
Processing Accuracy Overview	99% of all claims paid with NO errors unless subject to intervention.	100% of all claims paid with no errors.	Met

AUDIT OBJECTIVES

This ***Specific Findings Report*** contains detailed information, findings, and conclusions that the PillarRx audit team has drawn from their Audit of ESI's administration of the PEBP's pharmacy plan. This report is provided to the PEBP, the plan sponsor, and ESI the pharmacy benefit manager (PBM).

The findings in this report are based on data and information ESI and the PEBP provided to PillarRx and the report's validity relies upon the accuracy and completeness of that information.

The audit was planned and performed to obtain a reasonable assurance that prescription drug claims were adjudicated according to the terms of the contract between ESI and the PEBP as well as Client approved benefit descriptions (summary plan descriptions, plan documents or other communications).

PillarRx is a firm specializing in audit and control of pharmacy benefit plan administration. The statements made by PillarRx in this report relate narrowly and specifically to the overall efficacy of ESI's policies, processes, and systems relative to the PEBP's paid claims during the audit period. While performing the audit, PillarRx complied with all confidentiality, non-disclosure, and conflict of interest requirements and did not receive anything of value or any benefit of any kind other than agreed upon audit fees.

Audit Objectives

The objectives of the PillarRx audit of ESI's pharmacy benefit management were to:

- verify that claims were processed in accordance with the pricing terms specified in the contract;
- verify that claims adjudicated according to plan provisions;
- review minimum rebate guarantees and verified payment was made; and
- validate that ESI is meeting contractually approved Performance Guarantees.

PRICING AND FEES AUDIT

Pricing and Fees Audit Objective

The Pricing and Fees Audit verified that claims were processed in compliance with the discounts and fees specified in ESI's contract with the PEBP.

Pricing and Fees Audit Scope

After verification of the electronic claim data provided by ESI, PillarRx systematically repriced 100% of prescription drug claims paid during the audit period to determine that:

- Discounts were applied correctly based on the lesser of MAC, Average Wholesale Price (AWP), and Usual and Customary (U&C); and
- Pharmacy dispensing and administrative fees were applied correctly.

Pricing and Fees Audit Methodology

Contract Document Review

PillarRx requested and received from the PEBP and ESI all contracts, amendments, formulary drug lists, and reconciliation documents.

Claim Validation

We mapped and validated the raw claim data provided by ESI to our standard layout. Raw claim data represented the successive pharmacy claim transactions that included both paid and reversed claims and was critical to our understanding of ESI's processing and adjudication rules. Once mapped, the data was reconciled against control totals and put through a rigorous process referred to at PillarRx as data forensics – or the verification of claim data by assessing appropriate patterns and relationships. The data forensics included comparing the mapped data to the following benchmarks:

- Prior authorizations
- Rejections
- Reversals
- National Provider Identifier (NPI)
- National Drug Code (NDC)

To complete the claim validation, we conducted a conference call with ESI to verify that:

- Pharmacy benefit claims data provided for this audit was complete and accurate;
- Claims were loaded correctly into the PillarRx system; and
- Claim counts and total paid claim amounts were accurate.

Pricing and Fees Analysis

The analysis of pricing and fees included electronic comparison of the pharmacy reimbursements for all brand, generic and specialty drugs, or products.

The allowance for brand drugs compared the contracted guaranteed reimbursement rate to the ingredient cost. For this audit of ESI, the ingredient cost allowance was determined using the Blue Book AWP from the MediSpan Drug Database or the pharmacy's U&C listed on the claim for the date each prescription was dispensed.

PillarRx also verified electronically that dispensing fees for each drug type, distribution channel and service fees (e.g., compound drug service fees) were paid in accordance with ESI's contract.

Pricing and Fees Audit Findings

Pricing Findings

ESI applied all adjudication methods for determining the correct allowance for prescriptions drugs by type and distribution method during the audit period.

Dispensing Fee Findings

The dispensing fee was the amount contractually agreed upon by the PEBP and ESI as the amount to be paid by the plan to the pharmacy for dispensing a prescription.

As shown in the following table, the dispensing fee analysis identified fees were in alignment based on the contract for FY2021.

***Note:** In the following chart, a **negative** variance indicates a higher than contracted dispensing fee collected. A **positive** variance indicates a lower than contracted dispensing fee collected.*

Dispensing Fees (7/1/2020 – 6/30/2021)					
Component Description*	**Contracted Dispensing Fee**	**Number of Claims**	**Total Actual Dispensing Fee**	**Total Contracted Dispensing Fee**	**Total Overage/ (Shortfall)**
Retail Brand (1-83DS) STD	$0.60	7,664	$3,000.17	$4,598.40	$1,598.23
Retail Brand (84-90 DS) STD	$0.10	1,038	$161.00	$103.80	($57.20)
Mail Brand	$0.00	8,354	$0.00	$0.00	$0.00
Mail Generic	$0.00	36,703	$0.00	$0.00	$0.00
Retail Generic (1-83 DS) STD	$0.60	48,428	$27,704.25	$29,056.80	$1,352.55
Retail Generic (84-90 DS) (STD)	$0.10	22,173	$2,153.49	$2,217.30	$63.81
Retail Brand (1-83 DS)	$0.60	16,757	$6,448.85	$10,054.20	$3,605.35
Retail Brand (84-90 DS)	$0.00	4,049	$0.00	$0.00	$0.00
Retail Generic (1-83 DS)	$0.60	210,804	$130,438.48	$126,482.40	($3,956.08)
Retail Generic (84-90 DS Fee)	$0.00	29,844	$0.00	$0.00	$0.00
	TOTAL	**385,814**	**$169,906.24**	**$172,512.90**	**$2,606.66**

** Compound, Over the Counter, Retail Usual and Customary, Vaccines, Subscriber, and Coordination of Benefits claims were excluded from all contract guarantees, PillarRx reviewed claims for reasonableness and found no outliers.*

RECONCILIATION OF PRICING GUARANTEES

Reconciliation of Pricing Guarantees Objective

The Reconciliation of Pricing Guarantees determined if the discount savings and other price controls with guaranteed performance levels in ESI's contract with the PEBP were met, and if not met, that accurate credit or payment was made to the PEBP within the timeframe specified in the contract.

Reconciliation of Pricing Guarantees Scope

Using the terms of the PEBP's contract with ESI, we accumulated all prescription claims by type and distribution method for the period specified in the contract and balanced the total discount savings against the specified minimum discount guarantees. Similarly, all other performance guarantees were mapped against the actual prescription claims as adjudicated during the prescribed contract periods for performance guarantees. This reconciliation included the following contractual guarantees:

- AWP discounts applied for all drugs against third party pricing sources;
- MAC allowance for generic;
- Specialty drug allowance; and
- Dispensing fees.

Reconciliation of Pricing Guarantees Methodology

PillarRx used its proprietary AccuCAST® system to electronically compile total discount savings by silo (drug type and distribution method) and compare them to the contract guarantees in the ESI contract. If ESI's performance fell short of any of the guarantees, we validated that ESI recognized the shortfall and credited or paid the difference to the PEBP on a timely basis.

Reconciliation of Pricing Guarantees Findings

The following tables demonstrate our findings relative to pricing guarantees.

Key	Over Performance *> Greater Than Contracted Rates*	Acceptable Performance *— Same as Contracted Rates*	Under-Performance *< Less Than Contracted Rates*

FY2021							
Component Description*	**Number of Claims**	**Contracted Discount Rate**	**Actual Discount Rate**	**Contracted Claim Ingredient Cost**	**Actual Claim Ingredient Cost**	**Variance Total Overage/ (Shortfall)**	
Retail Brand (1-83 DS) STD	7,664	18.75%	18.43%	$3,716,566.80	$3,731,426.39	($14,859.59)	<
Retail Brand (84-90 DS) STD	1,038	22.75%	22.37%	$1,119,391.84	$1,124,894.19	($5,502.35)	<
Retail Generic STD	70,601	83.75%	83.53%	$2,292,521.16	$2,324,194.44	($31,673.28)	<
Retail Brand (1-83 DS) STD	16,757	18.75%	18.91%	$6,680,854.82	$6,667,528.32	$13,326.50	>
Retail Brand (84-90 DS	4,049	24.50%	24.58%	$3,926,570.94	$3,922,446.85	$4,124.09	>
Retail Generic (1-83 DS)	210,804	83.75%	84.39%	$3,569,655.06	$3,429,147.56	$140,507.50	>
Retail Generic (84-90 DS)	29,844	87.25%	86.80%	$1,207,788.79	$1,250,595.74	($42,806.95)	<
Mail Brand	8,354	24.50%	24.82%	$6,169,984.33	$6,143,959.14	$26,025.19	>
Mail Generic	36,703	87.25%	86.05%	$1,620,870.74	$1,772,927.47	($152,056.73)	<
ESI Specialty	4,292	19.75%	20.02%	$19,081,960.25	$19,082,560.28	($600.03)	<
			TOTAL	**$49,386,164.73**	**$49,449,680.38**	**($63,515.65)**	**<**

**Compound, Over the Counter, Retail Usual and Customary, Vaccines, Subscriber, and Coordination of Benefits claims were excluded from all contract guarantees, PillarRx reviewed claims for reasonableness and found no outliers.*

In summary, when aggregating the pricing guarantee discounts with the dispensing fee outcome, ESI's calculated a reconciliation of $125,443.43. This was paid out to PEBP on November 12, 2021. See chart below for breakout.

	PillarRx Combined Discounts and Dispensing Fee Guarantees	ESI Combined Discounts and Dispensing Fee Guarantee Reconciliation
Discounts	($63,515.65)	($125,975.44)
Dispensing Fees	$2,606.66	$532.01
FY2021	($60,908.99)	($125,443.43)

No further action is necessary.

BENEFIT PAYMENT ACCURACY REVIEW

Benefit Payment Accuracy Review Objective

The objective of the Benefit Payment Accuracy Review was to verify correct adjudication of plan design provisions and quantify potential opportunities for recovery and/or cost savings.

Benefit Payment Accuracy Review Scope

PillarRx created an exact model of the benefit plan parameters of State of Nevada's pharmacy plan in AccuCAST and systematically re-adjudicated 100% of paid prescription drug claim. Benefit plan parameters analyzed included, but were not limited to:

- Age and gender
- Copay/coinsurance
- Day supply maximums
- Excluded drugs
- Prior authorizations
- Quantity limits
- Refill limits
- Zero balance claims

Exceptions that were identified, but could not be explained by PillarRx's benefit analysts, were provided to ESI for explanation. When adequate documentation was provided to support exceptions were adjudicated correctly, AccuCAST was reset to represent the revised plan parameters and the claims were electronically re-adjudicated again to ensure consistency.

Benefit Payment Accuracy Review Methodology

After receiving the plan documentation from the PEBP and ESI including, copayment and coverage rules, and summary plan descriptions and/or plan documents, PillarRx programmed the PEBP's plan design in AccuCAST. Each claim was then readjudicated and exceptions were identified. The exceptions were aggregated by category and our benefit analysts reviewed each category. Exceptions that could not be explained were submitted to ESI for review.

Benefit Payment Accuracy Review Findings

Copayments

Copayments represented the dollar amount required to be paid by the member when a prescription drug was purchased. Our observations and conclusions relative to copayment application are shown in the following chart.

Copayment Analysis FY2021				
Total Claims	**Copays Per Plan**	**Copays Collected**	**Variance**	**Variance Percent**
456,519	$17,149,047	$17,149,047	0	0.00%

PillarRx submitted 99 commercial claims based on 24 different scenarios to ESI that represented potential exceptions to the copayment requirements for FY2021. ESI's response provided adequate explanation and documentation for each category of exception which allowed PillarRx to conclude copayments were applied correctly.

PillarRx agrees with ESI's responses and confirmed that copays were accurately administered in accordance with plan documents. No further action is required.

Drug Exclusions/Prior Authorizations
Exclusions specify the drugs and products that a plan would not cover unless there was a Prior Authorization (PA) on file. Based on documentation provided by ESI, PillarRx created excluded drug and PA drug listings and re-adjudicated the claims for these non-covered and prior authorized medications.

The claim data and documentation provided by ESI allowed PillarRx to confirm that drug exclusions and prior authorizations were administered correctly. No further action is required.

Administration of Age Rules
Age rules specify that a participant must be within a specific age group for a specific medication to be covered. PillarRx noted no issues related to age rules.

Administration of Quantity Limits
Quantity limits are included in plans to ensure safety and appropriate utilization. PillarRx noted that based on the language in the drug coverage documents provided by ESI, claims were adjudicated within plan parameters. No further action is required

PERFORMANCE GUARANTEE REVIEW

Performance Standard	Description of Standard	PBM Performance/Penalty	Met/ Not Met
Financial and Processing Accuracy			
Retail Claim Financial Accuracy	99% of all claims paid with NO errors	100% – ESI reported an over performance of $110,879.21 for Retail Financial Accuracy including $110,347.20 for discounts and $532.20 for dispensing fees.	Met
Retail Processing Accuracy		100% – PillarRx noted no errors for Retail Processing Accuracy.	Met
Mail Order Claim Financial Accuracy	99% of all claims paid with NO errors unless subject to intervention.	95.92% – ESI reported an under performance of $301.262.59 for the Mail Order Financial Accuracy including $301,262.59 for discounts and $0 for dispensing fees.	Not Met
Mail Order Claim Processing Accuracy		100% PillarRx noted no errors for Mail Order Processing Accuracy.	Met
Specialty Claim Financial Accuracy	99% of all claims paid with NO errors unless subject to intervention.	100% – ESI reported an over performance of $64,939.95 for the Specialty Financial Accuracy. (This includes $64,939.95 for discounts. Dispensing fee accuracy was not included in the guarantee.)	Met
Specialty Claim Processing Accuracy		100% – PillarRx noted no errors for Specialty Claim Processing Accuracy.	Met
Rebate Amounts	PEBP shall receive 100% of rebate dollars due to PEBP for PEBP utilization for retail drugs, mail order drugs and specialty drugs.	100% – ESI reported and paid a rebate amount of $14,602,035 which is above the PillarRx calculated amount of $14,590,240.	Met
Rebate Remittance Time to PEBP	100% of rebate dollars received by the PBM or pharmacy network or specialty drug vendor shall be remitted to PEBP within 90 calendar days after the last calendar day of the quarter in which such rebates were received.	0% – All four quarterly rebate payments for FY21 were remitted after the required 90-day timeframe.	Not Met
Claim Processing Turnaround			
Mail Order Claims Processing Time, Normal	95% of prescriptions shipped within 2 business days of receiving prescription (as measured from date order received at the PBM to date order shipped), excluding prescriptions requiring intervention.	0.6 business days	Met
Mail Order Claims, Processing Time, Intervention	95% of prescriptions shipped within 5 business days of receiving prescription (as measured from date order received at the PBM to date order shipped), for prescriptions requiring intervention.	0.9 business days	Met
Telephone Services			
Customer Service Telephone Response Time	Average time to answer all calls should be 30 seconds or less.	7.9 seconds	Met
Telephone Abandonment Rate	3% or less calls abandoned.	0.7%	Met

REBATE REVIEW

Rebate Audit Objective

The Rebate Review provides confirmation that ESI has reimbursed the PEBP the minimum amount per brand claim as outlined in the PBM contract.

Rebate Review Scope

PillarRx's Rebate Review assessed whether the minimum per claim rebates listed within the PEBP's contract with ESI were met. The review assessed whether there were any differences between the rebates contractually agreed upon between the PEBP and ESI and the rebate amounts that were actually paid to the PEBP.

Rebate Review Methodology

PillarRx identified all brand claims per distribution channel and calculated the minimum rebate amount owed to the PEBP based on its contract terms with ESI. These amounts were then reconciled against the rebate reports provided by ESI.

Rebate Review Findings

PillarRx has found that differences can occur in the rebate amounts billed to manufacturers by a PBM and the rebate amount calculated by PillarRx for an individual health plan. The primary reason for this difference lies in the common practice by PBMs of submitting rebate-eligible claims to a manufacturer for the PBM's book of business rather than for each plan sponsor individually.

This typically works to the advantage of the plans, as the amount of rebates paid by the manufacturer will be based on a larger pool of claims. The PBM then pays rebates to each plan sponsor separately based on the plan's claims.

Rebate Calculations FY2021		
Component Description	**Number of Claims**	**Total Minimum Contract Rebate**
Brand 1-83 DS	22,693	$3,969,525.00
Brand 84-90 DS	5,912	$2,924,955.00
Specialty Accredo	4,463	$5,036,410.00
Specialty	730	$219,000.00
Mail Brand	4,930	$2,440,350.00
Total	**38,728**	**$14,590,240.00**

PillarRx's Rebate Review shows, based on the minimum rebates stipulated within the contract between PEBP and ESI, that ESI met and exceeded the minimum rebates owed by $11,795.00. ESI paid out a total of $14,602,035.00 in rebates to the PEBP. No additional monies are owed to the PEBP for rebates.

Rebate Payments		
Allocation Period	**Payment Date**	**Total Amount**
FY20 Q1: 7/1/20-9/30/20	January 27, 2021	$3,213,684.85
FY20 Q2: 10/1/20-12/31/20	April 29, 2021	$3,428,956.69
FY20 Q3: 1/1/21-3/31/21	July 28, 2021	$3,472,521.87
FY20 Q4: 4/1/21-6/30/21	October 28, 2021	$4,543,186.83

RECOMMENDATIONS

PillarRx has the following recommendations for PEBP.

1. PEBP should consider removing offsetting from its Financial Accuracy Guarantees. For example, if ESI overperforms in any of the five categories it can currently be used to offset an underperformance in another category. Using this audit as an example, PEBP would have received $412,632 in penalties had offsetting not been allowed.

2. PEBP should consider updating its performance guarantees around Financial Accuracy to calculate the results based on the financial numbers and not claim counts. Financial guarantees are summarized by component (Retail Brand, Retail Generic, Mail Brand, Mail Generic, Specialty) and not on a claim level.

APPENDIX – PBM RESPONSE TO DRAFT REPORT

Mat Voelker

Quality Review & Audit Lead Analyst

Client Audit

7/15/2022

Nevada Public Employees Benefit Program

Financial Guarantee Audit

ESI has completed the research for the findings discovered in this audit and is available to discuss plan benefit set-up directly with the client should any questions remain. ESI accepts the findings that have been presented on the final audit report created by Pillar Rx at the conclusion of the audit.

CLAIM TECHNOLOGIES INCORPORATED

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9.

9. 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: September 29, 2022

Item Number: IX

Title: Executive Officer Report

REPORT

STAFFING AND OPERATIONS

PEBP is pleased to announce that our vacancy rate has improved from 32% to 20%. PEBP has successfully onboarded new employees to fill four of the eleven vacancies, but it will be several months before many of them are fully trained.

Lower call center call volume has resulted in improved call center wait times, but email response times continue to be longer than normal. PEBP has temporarily reinstated one-day-a-week walk-ins by appointment in order to accommodate members who wish to meet with PEBP staff in person, however if call volumes increase (such as during Medicare Open Enrollment), walk-ins may have to be suspended.

BUDGET UPDATE

State agencies, including PEBP, were required to submit agency request budgets by August 31. At the request of the Board, PEBP submitted a second budget which included the reinstatement of all benefits to pre-pandemic levels. Agencies begin presenting their respective budgets to the Governor's Finance Office (GFO) during the September/October months. This allows GFO staff to ask questions in preparation for how the agency requests will eventually become a part of the Governor's Recommended Budget, which is released in mid-January.

82ND (2023) LEGISLATIVE SESSION

The 82nd Legislative Session is scheduled to begin on February 6, 2023. PEBP has already begun tracking Bill Draft Requests (BDR) as they get posted. To date, 90 of the 446 posted BDR's have been identified as bills impacting healthcare or issues that may have an impact on the agency in general.

As detailed bill language is released, the list of BDR's PEBP is tracking will start to dwindle; however, PEBP anticipates a large volume of healthcare related bills and expects to be very busy this upcoming legislative session. As we have done previously, monthly Board meetings will be scheduled between February and May 2023 to provide the Board an opportunity to discuss and weigh in on proposed legislation.

OFFICE RELOCATION

Throughout the last several years there have been conversations about the possibility of PEBP moving out of the Bryan Building to provide needed space for the Department of Conservation and Natural Resources (DCNR). Recently, the Division of Emergency Management (DEM) indicated their need to expand their current space in order to meet federal requirements and standards. DEM's expansion will require the Division of Forestry (NDF), which is a division of DCNR, to move. Since it makes sense to house NDF in the Bryan Building, PEBP (with the support of the Governor's Office) has agreed to locate to a new space.

Although PEBP has identified a new office location in Carson City that will accommodate the agency needs, the timing of the move is highly contingent on necessary IT equipment which, unfortunately, is on backorder. The goal is to move before legislative session begins in February 2023, however if that is determined to not be possible, the move will likely be delayed until after July 2023 to avoid any disruptions to activities relating to session and open enrollment.

10.

10. Discussion and possible direction from the Board to staff on potential program design changes for Plan Year 2024 (July 1, 2023 to June 30, 2024) for which the Board requests additional information and costs to be presented at the December 5, 2022 meeting. (Laura Rich, Executive Officer) (**For Possible Action**)

STEVE SISOLAK
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LAURA RICH
Executive Officer

LAURA FREED
Board Chair

AGENDA ITEM

[X] Action Item
[ ] Information Only

Date: September 29, 2022

Item Number: X

Title: Plan Year 2024 Initiatives Report

BACKGROUND

FUNDING

PEBP's final FY24/25 budget will remain unknown until it is approved by the legislature in the spring of 2023. The budget submitted by PEBP (per Governor's Office directives), was built to fund the program at current benefit levels for the biennium. The second budget, at the direction of the Board, was built to fund the program at pre-pandemic levels. Since PEBP is already using excess cash to restore many of the benefits cut as a result of the pandemic, the bulk of the additional costs of the alternate budget submission come from the restoration of life insurance and long-term disability insurance.

As shown in the table below, PEBP is starting off the current fiscal year with a beginning differential cash balance of approximately $33M. After factoring in all the funding that has already been earmarked, PEBP is left with a projected balance of approximately $9.5M in excess cash that can be allocated toward new benefits, incentives, or other enhancements.

Beginning cash differential for FY23	**33,107,848**
Medicare HRA ($11 to $13)	**(3,300,000)**
Plan Design Spendown PY23	*$8,667,000 already allocated in budget*
Premium BuyDown	**(3,000,000)**
Plan Design Spendown PY24 - Projected	**(8,667,000)**
Plan Design Spendown PY25 - Projected	**(8,667,000)**
Projected Available Cash Differential for FY23	**9,473,848**

Not all benefit enhancements will require the use of funds though. While most benefit enhancements come with a cost, it is important to note that many may be cost neutral or even result in an overall net savings. For example, the implementation of a chronic disease or weight loss program may result in the overall reduction in claims or a reduced increase in claims. However, the return on investment (ROI) is at times difficult to prove and if missed, could require PEBP to dip into catastrophic reserves to make up the budgetary differences.

HOW DOES PEBP COMPARE?

State agencies, including PEBP, continue to be plagued by staffing shortages. It has been argued that the state is not competitive in employee compensation and benefits when compared to the private sector and other public employers in Nevada. As a result, staff felt it was important to understand how PEBP benefits compare as we begin discussions on how best to enhance the plan for the upcoming plan year(s).

PEBP chose several large public employers throughout the state and compared the most important fundamentals of plan design. While an apples-to-apples comparison is almost impossible, the table in attachment A provides a simple illustration of the benefits provided by PEBP in comparison to other Nevada public employers:

SEE *ATTACHMENT A*

REPORT

PROPOSED PY24 INITIATIVES

Earlier this year, PEBP staff, several board members and vendors met in a day-long strategic planning session. Each partner provided valuable input on plan performance and possible solutions that may be beneficial to plan performance.

Program	Description	Justification
Real Appeal	Virtual weight loss program. No PMPM admin fees. Paid through claims.	Obesity is associated with most chronic conditions including diabetes, hypertension and heart disease. Launching an option that assists with weight loss and weight management may help reduce costs in other areas.
Hinge Health	Virtual musculoskeletal clinic and therapy program to address chronic knee, back, neck, hip and shoulder pain. PMPM cost.	Musculoskeletal related claims account for approximately 6% of plan costs. The provider shortage in Nevada creates barriers to accessing care. This option may not only provide greater access, but also help reduce overall MSK related claims costs.
Cancer Concierge	Focus is on assisting the member navigate a critical and stressful situation. These programs assist patients by making medical appointments, coordinating care among multiple providers, providing health coaching and mental wellbeing counseling, assisting with billing and claims submissions and generally easing a difficult situation so the patient can focus on his/her own care and wellbeing PMPM Cost	Cancer is the number one cost driver in the plan. Patients diagnosed with cancer often have complicated medical situations and complex billing scenarios.
Medical Travel	These programs provide access to a national network of specialists for planned, generally high-cost, surgical procedures. These networks are built on value-based contracts, where providers have generally agreed to provide care on a bundled-service basis and result in lower costs and improved outcomes PMPM Cost	PEBP has already implemented versions of this (e.g. hip and knee surgeries) as a way to reduce costs. This option expands medical travel into other areas using a vendor.
Premium credits	Utilize differential cash to provide premium credits	Premium credits provide immediate financial impacts to members.
Doctor on Demand	Explore incentivization of DoD utilization for behavioral health services.	There is a drastic shortage of behavioral health providers in Nevada, especially in the north and in the rurals.

Elimination of EPO plan	The EPO was developed to replace the fully insured HMO plan previously offered by Hometown Health and is intended to mirror the fully insured HMO plan offered by HPN in the South.	The mix of regional constraints of the plan and access issues in the north create additional barriers for members and administrative burdens on staff. With the introduction of the LD plan, the EPO may no longer be necessary.

STAFF RECOMMENDATION:
PEBP recommends the Board approve the research of some or all of the above proposed PY24 program initiatives, as well as any others not listed in this report.

Attachment A

	PEBP			Washoe County			Clark County	City of Sparks	City of Las Vegas - 2019 DATA			Clark Cnty School Dist Licensed		Lyon County School District			Carson City School District		
	CHDP	LD	HMO/EPO	HDHP	PPO	HMO		PPO	HPN-HMO	VPS-PPO	PPO Plus	Signature	Advantage	HDHP	Base	Buy Up	HDHP	Freedom	HMO
Monthly Premium																			
Employee	$47	$68	$161	$0	$0	$0		$0	$0	$0	$0	$39	$24	$0	$0	$0	$0	$0	$0
E+Spouse	$251	$293	$479	$267	$469	$410		$189	*$213*	*$273*	*$338*	$268	$248	$586	$609	$807	$547	$874	$848
E+Children	$123	$153	$280	$225	$387	$328		$170	*$196*	*$250*	*$308*	$766	$525	$478	$497	$675	$413	$646	$628
E+Family	$328	$378	$598	$453	$819	$763	Clark County	$365	*$471*	*$602*	*$745*	$951	$535	$1,168	$1,215	$1,511	$961	$1,519	$1,476
Deductible (ind)	$1,500	$0	$100	$2,600	$375	$0	does make	$200	*$0*	*$2,000*	*$500*	$500	$1,500	$4,000	$3,500	$2,000	$3,000	$1,000	$0
(fam)	$3,000	$0	$200	$2,950	$750	$0	employee	$400	*$0*	*$4,000*	*$1,000*	$1,500	$3,000	$8,000	$7,000	$4,000	$6,000	$3,000	$0
OOPM (ind)	$4,000	$4,000	$5,000	$5,250	$3,450	$3,500	benefits	$1,000	*$6,000*	*$6,250*	*$3,000*	$7,500	$7,000	$4,000	$6,600	$5,000	$3,000	$4,000	$5,000
(fam)	$8,000	$8,000	$10,000	$6,350	$6,900	$7,000	publicly	$2,000	*$12,000*	*$12,500*	*$6,000*	$15,000	$14,000	$8,000	$13,200	$10,000	$6,000	$8,000	$10,000
Member Coinsurance	20%	20%	0%	20%	20%	0%	available.	20%		*30%*	*20%*	20%	20%	0%	20%	20%	0%	20%	20%
ER Visit	20%	$750	$600	20%	20%+$75	$250		20%	*$150*	*$350+30%*	*$150*	$300 - After Ded.	20%	$0- After Ded.	$350	$350	$0- After Ded.	$500	$500
UC Visit	20%	$80	$50	20%	20%	$40		20%	*$15*	*$45*	*$50*	$30	20%	$0- After Ded.	$50	$50	$0- After Ded.	$50	$50
HSA Contribution	$600	N/A	N/A	$2,000	N/A	N/A		N/A	N/A	N/A	N/A	N/A	$500/$1000	N/A	N/A	N/A	$3,000	N/A	N/A
Retiree subsidy	Premium subsidy for employee and family tiers + YOS subsidy			No premium subsidy, YOS subsidy for employee only				Depends on CB agreement. Sick leave converted to subsidy until depleted.	No subsidy. Retiree pays full cost of premiums.			No premium subsidy. YOS Subsidy for employee only.		No subsidy. Retiree pays full cost of premiums.			No subsidy. Retiree pays full cost of premiums		

PEBP staff has attempted to gather the data based on publicly available information; however, this could be outdated or incomplete.
Health care in Southern NV (Las Vegas) is significantly less expensive than other areas of the state, thus plans that provide coverage exclusively in Southern Nevada will be less costly.
Health care in the rurals and northern areas of NV is significantly more expensive than in Southern NV, thus plans that provide coverage exclusively in the North or rurals will be more costly.
PEBP provides coverage to employees/retirees throughout the state as well as nationally/globally.

11.

11. 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**)

    11.1 Contract Overview
    11.2 New Contracts
    11.3 Contract Amendments
    11.4 Contract Solicitations
    11.5 Status of Current Solicitations

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Governor

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LAURA RICH
Executive Officer

LAURA FREED
Board Chair

AGENDA ITEM

[X] Action Item
[ ] Information Only

Date: September 29, 2022

Item Number: XI

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

11.1 Contracts Overview

Below is a listing of the active PEBP contracts as of August 30, 2022.

PEBP Active Contracts Summary							
Vendor	Service	Contract #	Effective Date	Termination Date	Contract Max	Current Expenditures	Amount Remaining
CliftonLarsonAllen	Financial Auditor	24088	5/1/2021	12/31/2024	$ 212,485.00	$ 50,710.00	$ 161,775.00
Health Plan of Nevada Inc	Southern Nevada HMO	23802	7/1/2021	6/30/2025	$ 192,093,848.00	$ 50,641,770.07	$ 141,452,077.93
Diversified Dental Services Inc.	Dental PPO	23810	7/1/2021	6/30/2026	$ 1,601,613.00	$ 382,898.56	$ 1,218,714.44
Lifeworks	Benefits Management System	25935	5/10/2022	12/31/2026	$ 6,145,600.00	$ 1,234,081.30	$ 4,911,518.70
Express Scripts, Inc.	Pharmacy Benefit Manager	25582	5/10/2022	6/30/2026	$ 332,109,496.00	$ 14,443,080.88	$ 317,666,415.12
United Healtcare Insurance	Group Basic Life Insurance	25607	7/1/2022	6/30/2026	$ 12,824,248.00	$ -	$ 12,824,248.00
Brown & Brown of Massachusetts	Health Plan Auditor	24030	4/13/2021	6/30/2027	$ 1,581,662.00	$ 161,196.00	$ 1,420,466.00
Segal Company, Inc.	Consulting Services	25557	7/1/2022	6/30/2027	$ 3,990,000.00	$ 128,755.00	$ 3,861,245.00
UMR, Inc.	TPA and Other Services	25155	7/1/2022	6/30/2028	$ 65,413,106.00	$ -	$ 65,413,106.00

Recommendation

No action necessary

11.2 New Contracts

PEBP does not currently have any new contracts for ratification.

11.3 Contract Amendment Ratifications

PEBP does not currently have any contract amendments for ratification.

11.4 Contract Solicitation Ratifications

PEBP does not currently have any contract solicitations for ratification.

11.5 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
Eligibility and Enrollment System	TBD			

12.

12. Public Comment

13.

13. Adjournment