JOE LOMBARDO
Governor

STATE OF NEVADA
PUBLIC EMPLOYEES' BENEFITS PROGRAM
3427 Goni Rd, Suite 109| Carson City, Nevada 89706
Telephone 775-684-7000 | 702-486-3100 | 1-800-326-5496
www.pebp.state.nv.us

LAURA RICH
Executive Officer

JACK ROBB
Board Chair

MEETING NOTICE AND AGENDA

Name of Organization:	Public Employees' Benefits Program Board
Date and Time of Meeting:	May 25, 2023 9:00 a.m.
Place of Meeting:	This meeting will be available 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://www.youtube.com/watch?v=tQZ2TnTqtyo

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/84662256100

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: 846 6225 6100 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 3427 Goni Rd, Suite 109, Carson City NV 89706, or 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.. 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. (Radhika Kunnel, Deputy Attorney General) (Information/Discussion)

4. Consent Agenda (Jack Robb, 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 March 3, March 23, and April 21, 2023 PEBP Board Meetings
   - 4.2 Receipt of quarterly staff reports for the period ending December 31, 2022:
     - 4.2.1 Budget Report
     - 4.2.2 Utilization Report
   - 4.3 Receipt of quarterly vendor reports for the period ending December 31, 2022:
     - 4.3.1 UMR – Obesity Care Management
     - 4.3.2 UMR – Diabetes Care Management
     - 4.3.3 Sierra Healthcare Options – Utilization and Large Case Management
     - 4.3.4 UnitedHealthcare – Basic Life Insurance
     - 4.3.5 Willis Towers Watson's Individual Marketplace Enrollment and Performance Report
     - 4.3.6 Sierra Healthcare Options and UnitedHealthcare Plus Network
     - 4.3.7 HealthPlan of Nevada, Inc. – Southern Nevada HMO
     - 4.3.8 Doctor on Demand Engagement Report through March 2023

5. Discussion and possible action regarding the appointment of Celestena Glover as Interim Executive Officer of PEBP, using a statewide Manpower contract effective May 26, 2023, subject to the Governor's approval, per NRS 287.0424(1). (Jack Robb, Board Chair) (**For Possible Action**)

6. Discussion and possible action regarding the permanent appointment or recruitment of the PEBP Executive Officer (Jack Robb, Board Chair) (**For Possible Action**)

7. Discussion and possible action on Pharmacy Benefit Manager market check (Richard Ward, Segal) (**For Possible Action**)

8. Open Enrollment Update (Nik Proper, Operations Officer) (Information/Discussion)

9. Discussion and acceptance of Claim Technologies Incorporated audit findings for State of Nevada Public Employees' Benefits Program Plans for Express Scripts for plan years 2020 and 2022 for the periods of July 1, 2019 – June 30, 2020 and July 1, 2021 – June 20, 2022, respectively. (Nik Proper, Operations Officer) **(For Possible Action)**

10. Discussion and acceptance of Claim Technologies Incorporated audit findings for State of Nevada Public Employees' Benefits Program Plans administered by UMR Benefits for the period of October 1, 2022 – December 31, 2022. (Nik Proper, Operations Officer) **(For Possible Action)**

11. Presentation and possible action on the status and approval of new PEBP contracts, contract amendments and solicitations (Michelle Weyland, Administrative Services Officer) (**For Possible Action**)

    11.1 Contract Overview

    11.2 New Contracts

        11.2.1 Vivo Technologies

        11.2.2 National Diabetes Prevention Pilot Program

        11.2.3 Manpower

        11.2.4 Financial Auditor

    11.3 Contract Amendments

        11.3.1 Express Scripts

        11.3.2 UHC, Inc.

    11.4 Contract Solicitations

        11.4.1 Financial Auditor

    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 www.pebp.state.nv.us/meetings-events/board-/meetings (under the Board Meeting date referenced above). Contact Wendi Lunz at PEBP, 3427 Goni Rd, Suite 109, Carson City, NV 89706 (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 3427 Goni Rd, Suite 109, Carson City, NV 89706, 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, 3427 Goni Rd, Suite 109, Carson City, NV 89706 or on the PEBP website at www.pebp.state.nv.us. For additional information, contact Wendi Lunz at (775) 684-7020 or (800) 326-5496.
Notice of this meeting was posted on or before 9:00 a.m. on the third working day before the meeting on the PEBP website at www.pebp.state.nv.us, 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. (Radhika Kunnel, Deputy Attorney General) (Information/Discussion)

4.

4. Consent Agenda (Jack Robb, 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 March 3, March 23, and April 21, 2023 PEBP Board Meetings

   4.2 Receipt of quarterly staff reports for the period ending December 31, 2022:

   4.2.1 Budget Report

   4.2.2 Utilization Report

   4.3 Receipt of quarterly vendor reports for the period ending December 31, 2022:

   4.3.1 UMR – Obesity Care Management

   4.3.2 UMR – Diabetes Care Management

   4.3.3 Sierra Healthcare Options – Utilization and Large Case Management

   4.3.4 UnitedHealthcare – Basic Life Insurance

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

   4.3.6 Sierra Healthcare Options and UnitedHealthcare Plus Network

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

   4.3.8 Doctor on Demand Engagement Report through March 2023

4.1

4. Consent Agenda (Jack Robb, Board Chair) (**All Items for Possible Action**)

4.1 Approval of Action Minutes from the March 3, March 23, and April 21, 2023 PEBP Board Meetings.

STATE OF NEVADA
PUBLIC EMPLOYEES' BENEFITS PROGRAM
BOARD MEETING

Video/Telephonic Open Meeting
Carson City, NV

ACTION MINUTES (Subject to Board Approval)
March 3, 2023

MEMBERS PRESENT VIA TELECONFERENCE:	Mr. Jack Robb, Board Chair Mr. Jim Barnes, Vice Chair Ms. Linda Fox, Member Mr. Tom Verducci, Member Ms. Betsy Aiello, Member Ms. April Caughron, Member Ms. Michelle Kelley, Member Ms. Leslie Bittleston, Member Ms. Janell Woodward, Member Dr. Jennifer McClendon, Member
FOR THE BOARD:	Ms. Radhika Kunnel, Deputy Attorney General
FOR STAFF:	Ms. Laura Rich, Executive Officer Mr. Nik Proper, Operations Officer Ms. Cari Eaton, Chief Financial Officer Mr. Tim Lindley, Quality Control Officer Ms. Wendi Lunz, Executive Assistant
OTHER PRESENTERS:	Richard Ward - Segal Nancy Langeland - ESI

1. Open Meeting; Roll Call

    - Board Chair Robb opened the meeting at 9:01 a.m.

2. Public Comment
    - Kent Ervin – Nevada Faculty Alliance
    - Doug Unger – Nevada Faculty Alliance

3. Discussion and possible action regarding 2023 Legislative Bills that may impact the Public Employees' Benefits Program, including the following:
    - **Assembly Bills**
    - **Senate Bills**
    - **Bill Draft Requests**

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

BOARD ACTION ON ITEM 3

MOTION:	Motion for the PEBP Board to support BDR 57-161
BY:	Member Janell Woodward
SECOND:	Member Michelle Kelley
VOTE:	Unanimous; the motion carried

MOTION:	Motion for the PEBP Board oppose BDR 40-330
BY:	Member Tom Verducci
SECOND:	NONE
VOTE:	Motion dies; Board will remain neutral

MOTION:	Motion for the PEBP Board to support SB 119
BY:	Member Betsy Aiello
SECOND:	Member Leslie Bittleston
VOTE:	Unanimous; the motion carried

MOTION:	Motion for the PEBP Board to oppose SB 167
BY:	Member Linda Fox
SECOND:	NONE
VOTE:	Motion dies

MOTION:	Motion for the PEBP Board to remain neutral on SB 167
BY:	Member Betsy Aiello
SECOND:	Member April Caughron
VOTE:	Nine in favor, one opposed (Linda Fox); the motion carried

MOTION:	Motion for the PEBP Board to oppose SB 194
BY:	Member Linda Fox
SECOND:	NONE
VOTE:	Motion dies; Board will remain neutral

4. Public Comment
    - No public comment

5. Adjournment
    - Chair Robb adjourned the meeting at 10:23 a.m.

STATE OF NEVADA
PUBLIC EMPLOYEES' BENEFITS PROGRAM
BOARD MEETING

901 S. Stewart St.
Carson City, NV 89701
Video/Telephonic Open Meeting

ACTION MINUTES (Subject to Board Approval)
March 23, 2023

MEMBERS PRESENT VIA TELECONFERENCE:	Mr. Jack Robb, Board Chair Mr. Jim Barnes, Vice Chair Ms. Linda Fox, Member Mr. Tom Verducci, Member Ms. Betsy Aiello, Member Ms. April Caughron, Member Ms. Michelle Kelley, Member Ms. Leslie Bittleston, Member Ms. Janell Woodward, Member Dr. Jennifer McClendon, Member
FOR THE BOARD:	Ms. Radhika Kunnel, Deputy Attorney General
FOR STAFF:	Ms. Laura Rich, Executive Officer Mr. Nik Proper, Operations Officer Ms. Cari Eaton, Chief Financial Officer Mr. Tim Lindley, Quality Control Officer Ms. Wendi Lunz, Executive Assistant
OTHER PRESENTERS:	Brian Bowles – OPM Chris Syverson – NVBGH Michelle Suckow – CTI Rhonda Huckaby – UMR Jesse Stockwell – UMR Helmut Braun – UMR Darren Ashby – UMR Richard Ward – Segal Amy Cohen – Segal Jacy Jefferson

1. Open Meeting; Roll Call

    - Board Chair Robb opened the meeting at 8:30 a.m.

2. Public Comment
    - Terri Laird - RPEN
    - Ken Allen - AFCME
    - Larry Coffey – State Employee
    - Vanessa Delgada-Acosta

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

4. Consent Agenda (Jack Robb, 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 January 26, 2023 PEBP Board Meeting.

    4.2 Clifton Larson Allen Audited Financial Statements of Public Employees' Benefits Program Self-Insurance Trust Fund and the Retirees' Health & Welfare Benefits Fund for FY22.

BOARD ACTION ON ITEM 4
MOTION: Motion to approve the consent agenda.
BY: Member Linda Fox
SECOND: Member Leslie Bittleston
VOTE: Unanimous; the motion carried

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

****ITEM 12 TAKEN OUT OF ORDER**

12. Information and discussion regarding the Office of Project Management statewide ERP implementation and the integration of PEBP's enrollment and eligibility functionality. (Laura Rich, Executive Officer) (Information/Discussion)

6. Discussion and possible action on Diabetes Prevention/Diabetes Self-Management Education and Support pilot program (Laura Rich, Executive Officer) **(For Possible Action)**

BOARD ACTION ON ITEM 6
MOTION: Motion to participate in pilot program
BY: Member Linda Fox
SECOND: Member Michelle Kelley
VOTE: Unanimous; the motion carried

7. Discussion and possible action on recommended changes to Master Plan Documents for Plan Year 24 to include the removal of IUI benefit on the Low Deductible and EPO plans (July 1, 2023 – June 30, 2024) (Laura Rich, Executive Officer) (**For Possible Action**)

    7.1 Master Plan Document Recommended Changes

    7.2 HRA Summary Plan Description

BOARD ACTION ON ITEM 7
MOTION: Motion to approve the recommendation one through 11, but not 12 and keep IUI in the plan at this time.
BY: Member Michelle Kelley
SECOND: Member Janell Woodward
VOTE: Unanimous; the motion carried

8. Discussion and possible action on Executive Order 2023-003 (Laura Rich, Executive Officer) **(For Possible Action)**

BOARD ACTION ON ITEM 8
MOTION: Motion to approve Item Number 8 as recommended.
BY: Member Michelle Kelley
SECOND: Member Janell Woodward
VOTE: Unanimous; the motion carried

9. Discussion and acceptance of Claim Technologies Incorporated audit findings for State of Nevada Public Employees' Benefits Program Plans administered by UMR Benefits for the period July 1, 2022 – September 30, 2022. (Laura Rich, Executive Officer) **(For Possible Action)**

    9.1 UMR Remediation Plan

BOARD ACTION ON ITEM 9
MOTION: Motion that the Board support the report and the assessed penalties.
BY: Member Leslie Bittleston
SECOND: Member Linda Fox
VOTE: Unanimous; the motion carried

10. Presentation on PEBP claims experience and trend. (Richard Ward, Segal) (Information/Discussion)

11. Discussion and possible action to include approving Plan Year 24 (July 1, 2023 – June 30, 2024) rates for State and Non-State employees, retirees and their dependents for the Consumer Driven Health Plan (CDHP), Low Deductible (LD) Plan, Exclusive Provider Organization (EPO) Plan, and Health Maintenance Organization (HMO) Plan (Laura Rich, Executive Officer) **(For Possible Action)**

BOARD ACTION ON ITEM 11
MOTION: Motion to approve the rates as outlined and recommended by staff with the approval for technical adjustments as we go through the process.
BY: Member Michelle Kelley
SECOND: Member Linda Fox
VOTE: Unanimous; the motion carried

12. ****ITEM HEARD OUT OF ORDER – AFTER ITEM 5**

13. 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)**

- 13.1 Contract Overview
- 13.2 New Contracts
- 13.3 Contract Amendments
  - 13.3.1 Segal
- 13.4 Contract Solicitations
- 13.5 Status of Current Solicitations
  - 13.5.1 Enrollment and Eligibility System RFP

BOARD ACTION ON ITEM 13.3.1
MOTION: Motion to approve recommended by PEBP
BY: Member Leslie Bittleston
SECOND: Member Michelle Kelley
VOTE: Unanimous; the motion carried

BOARD ACTION ON ITEM 13.5.1
MOTION: Motion to cancel the Enrollment and Eligibility System RFP
BY: Member Linda Fox
SECOND: Member Leslie Bittleston
VOTE: Unanimous; the motion carried

14. Public Comment
    - No public comment

15. Adjournment
    - Chair Robb adjourned the meeting at 12:50 p.m.

STATE OF NEVADA
PUBLIC EMPLOYEES' BENEFITS PROGRAM
BOARD MEETING

Video/Telephonic Open Meeting
Carson City, NV

ACTION MINUTES (Subject to BoardApproval)
April 21, 2023

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

1. Open Meeting; Roll Call

    - Board Chair Robb opened the meeting at 1:00 p.m.

2. Public Comment
    - Kent Ervin – Nevada Faculty Alliance
    - Robin Reedy – National Alliance of Mental Illness
    - Barry Cole – Psychiatrist
    - Lea Case – Nevada Psychiatric Association
    - Kathleen Kruk – State Employee
    - Carter Bundy – AFSCME
    - Brady Easterling
3. PEBP Budget Closing Update (Laura Rich, Executive Officer) (For Discussion)

4. Discussion and possible action regarding 2023 Legislative Bills that may impact the Public Employees' Benefits Program, including the following:
    - **Assembly Bills**
    - **Senate Bills**
    - **Bill Draft Requests**

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

BOARD ACTION ON ITEM 3

MOTION:	Motion for the PEBP Board to oppose AB 85
BY:	Member Michelle Kelley
SECOND:	Member Tom Verducci
VOTE:	Unanimous; the motion carried

MOTION:	Motion for the PEBP Board support SB 167
BY:	Member Tom Verducci
SECOND:	Member Janell Woodward
VOTE:	Seven in favor, one opposed (Linda Fox); motion carried

MOTION:	Motion for the PEBP Board to support SB 431
BY:	Member Tom Verducci
SECOND:	Member Betsy Aiello
VOTE:	Unanimous; the motion carried

5. Public Comment
    - No public comment

6. Adjournment
    - Chair Robb adjourned the meeting at 2:16 p.m.

4.2

4. Consent Agenda (Jack Robb, Board Chair) (**All Items for Possible Action**)

    4.1 Approval of Action Minutes from the March 3, March 23, and April 21, 2023 PEBP Board Meetings.

    4.2 Receipt of quarterly staff reports for the period ending December 31, 2022

4.2.1

4. Consent Agenda (Jack Robb, Board Chair) (**All Items for Possible Action**)

4.2 Receipt of quarterly staff reports for the period ending December 31, 2022:

4.2.1 Budget Report

JOE LOMBARDO
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LAURA RICH
Executive Officer

JACK ROBB
Board Chair

AGENDA ITEM

[X] Action Item
[ ] Information Only

Date: May 25, 2023

Item Number: IV.II.I

Title: Chief Financial Officer Budget Report

Summary

This report addresses the Operational Budget as of December 31, 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 December 31, 2022, with comparisons to the same period in Fiscal Year 2022. 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 $167.6 million as of December 31, 2022, compared to $184.2 million as of December 31, 2021, or a decrease of 9.0%. Total expenses for the period have decreased by $4.5 million or 2.2% for the same period.

The budget status report shows Realized Funding Available (cash) at $119.7 million. This compares to $142.0 million for last year. The table below reflects the actual revenue and expenditures for the period.

Operational Budget 1338

	FISCAL YEAR 2023			FISCAL YEAR 2022		
	Actual as of 12/31/2022	Work Program	Percent	Actual as of 12/31/2021	Fiscal Year 2022 Close	Percent
Beginning Cash	148,854,786	148,854,786	100%	159,011,280	159,011,280	100%
Premium Income	152,267,289	390,499,657	39%	170,513,699	348,069,497	49%
All Other Income	15,344,269	22,371,771	69%	13,705,296	32,877,594	42%
Total Income	167,611,559	412,871,428	41%	184,218,995	380,947,090	48%
Personnel Services	1,005,160	2,935,386	34%	1,108,041	2,382,790	47%
Operating - Other than Personnel	1,554,378	3,084,395	50%	1,137,433	2,919,211	39%
Insurance Program Expenses	194,012,408	410,458,880	47%	198,839,647	385,500,378	52%
All Other Expenses	150,173	424,234	35%	153,356	301,205	51%
Total Expenses	196,722,119	416,902,895	47%	201,238,476	391,103,584	51%
Change in Cash	(29,110,561)	(4,031,467)		(17,019,481)	(10,156,494)	
REALIZED FUNDING AVAILABLE	119,744,225	144,823,319	83%	141,991,799	148,854,786	95%
Incurred But Not Reported Liability	(51,030,000)	(51,030,000)		(52,286,000)	(52,286,000)	
Catastrophic Reserve	(38,426,000)	(38,426,000)		(34,875,000)	(34,875,000)	
HRA Reserve	(22,800,889)	(22,800,889)		(25,056,050)	(25,056,050)	
NET REALIZED FUNDING AVAILABLE	7,487,336	32,566,430		29,774,749	36,637,736	

Current Budget Projections

The following table represents projections for FY 2023. The projection reflects total income to be less than budgeted by 2.8% ($546.1 million vs $561.7 million), total expenditures are projected to be less than budgeted by 1.3% ($411.3 million vs $416.9 million); total reserves are projected to be less than budgeted by 6.9% ($135.0 million vs $145.0 million).

State Subsidies are projected to be less than the budgeted amount by $18.6 million (6.3%), Non-State Subsidies are projected to be more than budgeted by $1.0 million (4.6%), and Premium Income is projected to be less than budgeted by $11.3 million (15.2%). This overall decrease in budgeted revenue is due in part to a planned 1-month employee premium holiday in October 2022 and due in large part to a reduction in State Subsidies and participant premiums 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:

- 1.90% fewer state actives,
- 1.23% more state non-Medicare retirees,
- 14.3% fewer non-state actives,
- 23.08% fewer non-state, non-Medicare retirees
- 5.38% more state Medicare retirees, and
- 2.82% fewer non-state Medicare retirees

Budgeted and Projected Income (Budget Account 1338)					
Description	**Budget**	**Actual 3/31/23**	**Projected**	**Difference**	
Carryforward	148,854,786	148,854,786	148,854,786	0	0.0%
State Subsidies	295,515,312	201,909,200	276,938,659	(18,576,653)	-6.3%
Non-State Subsidies	20,784,265	16,339,844	21,739,777	955,512	4.6%
Premium	74,200,080	45,865,523	62,939,639	(11,260,441)	-15.2%
COVID Funds	32,525	29,378	29,378	(3,147)	81.4%
Appropriations	6,009,449	6,009,449	6,009,449	0	-2.8%
All Other	16,329,797	22,459,502	29,616,011	13,286,214	81.4%
Total	561,726,214	441,467,682	546,127,700	(15,598,514)	-2.8%
Budgeted and Projected Expenses (Budget Account 1338)					
Description	**Budget**	**Actual 3/31/23**	**Projected**	**Difference**	
Operating	7,418,926	4,391,553	6,604,049	814,877	11.0%
State Insurance Costs	358,008,654	266,930,372	355,723,255	2,285,399	0.6%
Non-State Insurance Costs	11,952,082	6,776,441	9,554,565	2,397,517	20.1%
Medicare Retiree Insurance Costs	39,523,233	28,718,112	39,416,561	106,672	0.3%
Total Insurance Costs	409,483,969	302,424,925	404,694,382	4,789,587	1.2%
Total Expenses	416,902,895	306,816,477	411,298,431	5,604,464	1.3%
Restricted Reserves	112,256,889	112,256,889	111,943,147	313,742	0.3%
Differential Cash Available	32,566,430	22,394,316	22,886,122	9,680,308	29.7%
Total Reserves	144,823,319	134,651,205	134,829,269	9,994,050	6.9%
Total of Expenses and Reserves	561,726,214	441,467,682	546,127,700	15,598,514	2.8%

Expenses for Fiscal Year 2023 are projected to be $5.6 million (1.3%) less than budgeted when changes to reserves are excluded. Operating expenses are projected to be less than budgeted by $0.8 million (11.0%). Employee and Retiree insurances costs are projected to be less than budgeted by $4.8 million (1.3%) when taken in total (see table above for specific information).

Recommendations

None.

4.2.2

4. Consent Agenda (Jack Robb, Board Chair) (**All Items for Possible Action**)

    4.2 Receipt of quarterly staff reports for the period ending December 31, 2022:

        4.2.1 Budget Report

        4.2.2 Utilization Report

JOE LOMBARDO
Governor

STATE OF NEVADA
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LAURA RICH
Executive Officer

JACK ROBB
Board Chair

AGENDA ITEM

[X] Action Item
[ ] Information Only

Date: May 25, 2023

Item Number: IV.II.II

Title: Self-Funded CDHP, LDPPO, and EPO Plan Utilization Report for the period ending December 31, 2022

This report addresses medical, dental, prescription drug and HSA/HRA utilization for the PY 2023 period ending December 31, 2022. Included are:

- Executive Summary – provides a utilization overview.
- UMR Inc. CDHP Utilization Report – provides graphical supporting details for the information included in the Executive Summary.
- UMR Inc. LDPPO Utilization Report – provides graphical supporting details for the information included in the Executive Summary.
- UMR Inc. 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 Q2 Plan Year 2023 utilization data.

Executive Summary

CONSUMER DRIVEN HEALTH PLAN (CDHP)

The Consumer Driven Health Plan (CDHP) experience for Q2 of Plan Year 2023 compared to Q2 of Plan Year 2022 is summarized below.

- Population:
  - 13.7% decrease for primary participants
  - 17.1% decrease for primary participants plus dependents (members)
- Medical Cost:
  - 0.3% decrease for primary participants
  - 4.1% increase for primary participants plus dependents (members)
- High-Cost Claims:
  - There were 46 High-Cost Claimants accounting for 31.8% of the total plan paid for Q2 of Plan Year 2023
  - 18.3% decrease in High-Cost Claimants per 1,000 members
  - 38.5% increase in average cost of High-Cost Claimant paid
- Top three highest cost clinical classifications include:
  - Cancer ($2.7 million) – 22.2% of paid claims
  - Congenital/Chromosomal Anomalies ($1.5 million) – 12.2% of paid claims
  - Pregnancy-related Disorders ($1.03 million) – 8.5% of paid claims
- Emergency Room:
  - ER visits per 1,000 members decreased 5.3%
  - Average paid per ER visit increased 14.0%
- Urgent Care:
  - Urgent Care visits per 1,000 members remained the same at 0.0%
  - Average paid per Urgent Care visit decreased 38.1% (decrease from $63 to $39)
- Network Utilization:
  - 99.1% of claims are from In-Network providers
  - Q2 of Plan Year 2023 In-Network utilization increased 0.7% over PY 2022
  - Q2 of Plan Year 2023 In-Network discounts increased 1.6% over PY 2022

- Prescription Drug Utilization:
  - Overall:
    - Total Net Claims decreased 13.6%
    - Total Gross Claims Costs decreased 4.4% ($1.0 million)
    - Average Total Cost per Claim increased 10.6%
      - From $100.58 to $111.27
  - Member:
    - Total Member Cost decreased 11.4%
    - Average Participant Share per Claim increased 2.5%
    - Net Member PMPM increased 6.8%
      - From $28.21 to $30.14

- Plan
  - Total Plan Cost decreased 2.0%
  - Average Plan Share per Claim increased 13.4%
  - Net Plan PMPM increased 18.2%
    - From $82.83 to $97.90
  - Net Plan PMPM factoring rebates decreased 2.3%
    - From $64.39 to $62.93

LOW DEDUCTIBLE PPO PLAN (LDPPO)

The Low Deductible PPO Plan (LDPPO) experience for Q2 of Plan Year 2023 compared to Q2 of Plan Year 2022 is summarized below.

- Population:
  - 78.4% increase for primary participants
  - 70.7% increase for primary participants plus dependents (members)
- Medical Cost:
  - 18.6% decrease for primary participants
  - 14.8% decrease for primary participants plus dependents (members)
- High-Cost Claims:
  - There were 18 High-Cost Claimants accounting for 17.6% of the total plan paid for Q2 of Plan Year 2023
  - 54.3% decrease in High-Cost Claimants per 1,000 members
  - 11.9% decrease in average cost of High-Cost Claimant paid
- Top three highest cost clinical classifications include:
  - Cancer ($1.7 million) – 40.1% of paid claims
  - Endocrine/Metabolic Disorders ($0.7 million) – 17.1% of paid claims
  - Neurological Disorders ($0.4 million) – 10.3% of paid claims
- Emergency Room:
  - ER visits per 1,000 members increased 6.2%
  - Average paid per ER visit increased 36.0%
- Urgent Care:
  - Urgent Care visits per 1,000 members increased by 19.9%
  - Average paid per Urgent Care visit decreased 15.1% (decrease from $119 to $101)
- Network Utilization:
  - 99.3% of claims are from In-Network providers
  - Q2 of Plan Year 2023 In-Network utilization increased 0.7% over PY 2022
  - Q2 of Plan Year 2023 In-Network discounts increased 1.2% over PY 2022

- Prescription Drug Utilization:
  - Overall:
    - Total Net Claims increased 78.4%
    - Total Gross Claims Costs increased 110.5% ($6.2 million)
    - Average Total Cost per Claim increased 18.0%
      - From $100.30 to $118.37

- Member:
  - Total Member Cost increased 71.7%
  - Average Participant Share per Claim decreased 3.7%
  - Net Member PMPM decreased 1.8%
    - From $21.98 to $21.59
- Plan
  - Total Plan Cost increased 119.4%
  - Average Plan Share per Claim increased 23.0%
  - Net Plan PMPM increased 25.5%
    - From $95.94 to $120.36
  - Net Plan PMPM factoring rebates increased 8.4%
    - From $73.75 to $79.92

PEBP PREMIER PLAN (EPO)

The PEBP Premier Plan (EPO) experience for Q2 of Plan Year 2023 compared to Q2 of Plan Year 2022 is summarized below.

- Population:
  - 14.3% decrease for primary participants
  - 14.0% decrease for primary participants plus dependents (members)
- Medical Cost:
  - 8.8% increase for primary participants
  - 8.5% increase for primary participants plus dependents (members)
- High-Cost Claims:
  - There were 24 High-Cost Claimants accounting for 28.1% of the total plan paid for Q2 of Plan Year 2023
  - 7.3% increase in High-Cost Claimants per 1,000 members
  - 1.7% increase in average cost of High-Cost Claimant paid
- Top three highest cost clinical classifications include:
  - Cardiac Disorders ($1.01 million) – 19.5% of paid claims
  - Cancer ($1.0 million) – 19.5% of paid claims
  - Pregnancy-related Disorders ($0.9 million) – 18.4% of paid claims
- Emergency Room:
  - ER visits per 1,000 members decreased by 3.3%
  - Average paid per ER visit increased by 41.5%
- Urgent Care:
  - Urgent Care visits per 1,000 members decreased by 1.2%
  - Average paid per Urgent Care visit decreased 19.2%
- Network Utilization:
  - 97.2% of claims are from In-Network providers
  - In-Network utilization decreased 2.8%
  - In-Network discounts decreased 3.2%

- Prescription Drug Utilization:
  - Overall:
    - Total Net Claims decreased 10.5%
    - Total Gross Claims Costs increased 1.0% ($0.1 million)
    - Average Total Cost per Claim increased 12.9%
      - From $125.87to $142.12
  - Member:
    - Total Member Cost decreased 7.6%
    - Average Participant Share per Claim increased 3.3%
    - Net Member PMPM increased 7.6%
      - From $34.71 to $37.33
  - Plan
    - Total Plan Cost increased 2.7%
    - Average Plan Share per Claim increased 14.8%
    - Net Plan PMPM increased 19.6%
      - From $178.71 to $213.70
    - Net Plan PMPM factoring rebates decreased 1.7%
      - From $137.14 to $134.77

DENTAL PLAN

The Dental Plan experience for Q2 of Plan Year 2023 is summarized below.

- Dental Cost:
  - Total of $11,486,516 paid for Dental claims
    - Preventative claims account for 26.4% ($3.03 million)
    - Periodontal claims account for 6.2% ($0.7 million)
    - All other claims account for 67.4% ($7.7 million)

HEALTH REIMBURSEMENT ARRANGEMENT

The table below provides a list of CDHP HRA account balances as of December 31, 2022.

HRA Account Balances as of December 31, 2022			
$Range	**# Accounts**	**Total Account Balance**	**Average Per Account Balance**
0	697	0	0
$.01 - $500.00	2,304	583,891	253
$500.01 - $1,000	2,193	1,460,537	666
$1,000.01 - $1,500	737	896,301	1,216
$1,500.01 - $2,000	404	707,225	1,751
$2,000.01 - $2,500	321	718,938	2,240
$2,500.01 - $3,000	212	588,265	2,775
$3,000.01 - $3,500	208	676,959	3,255
$3,500.01 - $4,000	193	719,848	3,730
$4,000.01 - $4,500	138	586,781	4,252
$4,500.01 - $5,000	87	415,017	4,770
$5,000.01 +	**661**	**5,555,902**	**223,958**
Total	**8,155**	**$ 12,909,664**	**$ 1,583**

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 second quarter of Plan Year 2023. The CDHP total plan paid costs decreased 13.9% over the same time for Plan Year 2022. The LDPPO total plan paid costs decreased 30.4% over Q2 of Plan Year 2022. The EPO total plan paid costs decreased 6.8% over Q2 of Plan Year 2022. For HMO utilization and cost data please see the report provided in Appendix D.

Appendix A

Index of Tables
UMR Inc. – CDHP Utilization Review for PEBP
October 1, 2022 – December 31, 2022

DATASCOPE™

Nevada Public Employees' Benefits Program
HDHP Plan
July – December 2022 Incurred,
Paid through February 28, 2023

UMR℠

Overview

- Total Medical Spend for 2Q23 was $38,149,177 of which 76.6% was spent in the State Active population. When compared to 2Q22, this reflected a decrease of 13.9% in plan spend, with State Actives having a decrease of 14.4%.
  - When compared to 2Q21, 2Q23 decreased 30.0%, with State Actives having a decrease of 30.0%.
- On a PEPY basis (annualized), 2Q23 reflected a decrease of .3% when compared to 2Q22. The largest group, State Actives, had a slight increase of .3%.
  - When compared to 2Q21, 2Q23 decreased 1.2%, with State Actives increasing 1.9%.
- 93.9% of the Average Membership had paid Medical claims less than $2,500, with 33.3% of those having no claims paid at all during the reporting period.
- There were 46 high-cost Claimants (HCC's) over $100K, that accounted for 31.8% of the total spend. HCCs accounted for 29.2% of total spend during 2Q22, with 68 members hitting the $100K threshold. The largest diagnosis grouper was Cancer accounting for 22.2% of high-cost claimant dollars.
- IP Paid per Admit was $25,366 which is a decrease of 17.6% compared to 2Q22.
- ER Paid per Visit is $2,091, which is an increase of 14.0% compared to 2Q22.
- 99.1% of all Medical spend dollars were to In Network providers. The average In Network discount was 66.7%, which is an increase of 2.5% compared to the PY22 average discount of 65.1%.

Paid Claims by Age Group

Paid Claims by Age Group																
	2Q22						2Q23						% 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	$ 1,277,944	$ 801	$ 11,261	$ 7	$ 1,289,205	$ 808	$ 3,470,181	$ 3,343	$ 14,085	$ 14	$ 3,484,266	$ 3,357	170.3%	315.6%
1	$ 218,064	$ 140	$ 10,546	$ 7	$ 228,610	$ 147	$ 174,061	$ 134	$ 1,800	$ 1	$ 175,861	$ 136	-23.1%	-7.4%
2 - 4	$ 596,537	$ 106	$ 133,432	$ 24	$ 729,969	$ 130	$ 346,615	$ 90	$ 89,301	$ 23	$ 435,916	$ 113	-40.3%	-12.9%
5 - 9	$ 552,495	$ 50	$ 346,252	$ 31	$ 898,747	$ 81	$ 668,479	$ 79	$ 131,232	$ 15	$ 799,711	$ 94	-11.0%	16.8%
10 - 14	$ 1,372,587	$ 108	$ 214,797	$ 17	$ 1,587,384	$ 125	$ 720,821	$ 72	$ 155,167	$ 16	$ 875,988	$ 88	-44.8%	-29.8%
15 - 19	$ 1,501,518	$ 110	$ 362,227	$ 26	$ 1,863,745	$ 136	$ 2,396,355	$ 217	$ 384,782	$ 35	$ 2,781,137	$ 252	49.2%	85.3%
20 - 24	$ 1,332,931	$ 85	$ 472,228	$ 30	$ 1,805,159	$ 115	$ 1,472,721	$ 109	$ 501,925	$ 37	$ 1,974,646	$ 146	9.4%	26.6%
25 - 29	$ 2,121,688	$ 172	$ 423,653	$ 34	$ 2,545,341	$ 206	$ 1,435,151	$ 155	$ 510,509	$ 55	$ 1,945,660	$ 210	-23.6%	2.0%
30 - 34	$ 2,517,372	$ 173	$ 848,675	$ 58	$ 3,366,047	$ 232	$ 2,691,308	$ 236	$ 518,871	$ 46	$ 3,210,179	$ 282	-4.6%	21.6%
35 - 39	$ 3,030,234	$ 196	$ 723,282	$ 47	$ 3,753,516	$ 243	$ 1,285,040	$ 104	$ 834,785	$ 68	$ 2,119,825	$ 172	-43.5%	-29.3%
40 - 44	$ 2,877,343	$ 190	$ 971,764	$ 64	$ 3,849,107	$ 255	$ 1,965,468	$ 151	$ 1,023,455	$ 79	$ 2,988,923	$ 230	-22.3%	-9.7%
45 - 49	$ 3,136,604	$ 215	$ 1,309,218	$ 90	$ 4,445,822	$ 305	$ 2,175,094	$ 177	$ 1,154,443	$ 94	$ 3,329,537	$ 270	-25.1%	-11.3%
50 - 54	$ 4,526,244	$ 274	$ 1,978,561	$ 120	$ 6,504,805	$ 393	$ 4,020,905	$ 285	$ 1,881,357	$ 133	$ 5,902,262	$ 419	-9.3%	6.5%
55 - 59	$ 7,092,823	$ 397	$ 2,762,899	$ 155	$ 9,855,722	$ 552	$ 4,795,542	$ 308	$ 2,757,859	$ 177	$ 7,553,401	$ 486	-23.4%	-12.0%
60 - 64	$ 8,289,933	$ 396	$ 3,782,094	$ 181	$ 12,072,027	$ 577	$ 7,146,628	$ 389	$ 3,569,646	$ 194	$ 10,716,274	$ 583	-11.2%	1.0%
65+	$ 3,883,551	$ 301	$ 2,398,426	$ 186	$ 6,281,977	$ 487	$ 3,384,807	$ 279	$ 2,923,753	$ 241	$ 6,308,560	$ 520	0.4%	6.7%
Total	**$ 44,327,868**	**$ 219**	**$ 16,749,315**	**$ 83**	**$ 61,077,183**	**$ 302**	**$ 38,149,177**	**$ 228**	**$ 16,452,971**	**$ 98**	**$ 54,602,148**	**$ 326**	**-10.6%**	**7.8%**

Financial Summary (p. 1 of 2)

	Total				State Active				Non-State Active			
Summary	**2Q21**	**2Q22**	**2Q23**	**Variance to Prior Year**	**2Q21**	**2Q22**	**2Q23**	**Variance to Prior Year**	**2Q21**	**2Q22**	**2Q23**	**Variance to Prior Year**
Enrollment												
Avg # Employees	23,374	19,199	16,564	-13.7%	19,563	15,753	13,432	-14.7%	4	3	3	0.0%
Avg # Members	42,417	33,701	27,942	-17.1%	36,860	28,655	23,383	-18.4%	8	8	8	0.0%
Ratio	1.8	1.8	1.7	-4.0%	1.9	1.8	1.7	-4.4%	2.2	2.7	2.7	0.0%
Financial Summary												
Gross Cost	$76,401,647	$63,975,609	$54,222,932	-15.2%	$59,270,027	$49,236,488	$41,211,985	-16.3%	$6,447	$21,822	$29,248	34.0%
Client Paid	$54,485,410	$44,327,868	$38,149,177	-13.9%	$41,733,234	$34,143,038	$29,210,832	-14.4%	$2,531	$12,232	$19,651	60.7%
Employee Paid	$21,916,237	$19,647,740	$16,073,754	-18.2%	$17,536,793	$15,093,450	$12,001,153	-20.5%	$3,916	$9,589	$9,597	0.1%
Client Paid-PEPY	$4,662	$4,618	$4,606	-0.3%	$4,267	$4,335	$4,349	0.3%	$1,380	$8,155	$13,101	60.6%
Client Paid-PMPY	$2,569	$2,631	$2,731	3.8%	$2,264	$2,383	$2,498	4.8%	$633	$3,058	$4,913	60.7%
Client Paid-PEPM	$389	$385	$384	-0.3%	$356	$361	$362	0.3%	$115	$680	$1,092	60.6%
Client Paid-PMPM	$214	$219	$228	4.1%	$189	$199	$208	4.5%	$53	$255	$409	60.4%
High Cost Claimants (HCC's) > $100k												
# of HCC's	65	68	46	-32.4%	46	50	35	-30.0%	0	0	0	0.0%
HCC's / 1,000	1.5	2.0	1.7	-18.3%	1.3	1.7	1.5	-13.8%	0.0	0.0	0.0	0.0%
Avg HCC Paid	$216,173	$190,516	$263,874	38.5%	$200,836	$197,233	$271,047	37.4%	$0	$0	$0	0.0%
HCC's % of Plan Paid	25.8%	29.2%	31.8%	8.9%	22.1%	28.9%	32.5%	12.5%	0.0%	0.0%	0.0%	0.0%
Cost Distribution by Claim Type (PMPY)												
Facility Inpatient	$774	$924	$981	6.2%	$669	$816	$899	10.2%	$0	$0	$0	0.0%
Facility Outpatient	$797	$799	$851	6.5%	$658	$691	$767	11.0%	$366	$2,389	$2,937	22.9%
Physician	$946	$863	$899	4.2%	$895	$834	$832	-0.2%	$266	$646	$1,975	205.7%
Other	$52	$46	$0	-100.0%	$42	$42	$0	-100.0%	$1	$23	$0	0.0%
Total	$2,569	$2,631	$2,731	3.8%	$2,264	$2,383	$2,498	4.8%	$633	$3,058	$4,913	60.7%
	Annualized	Annualized	Annualized		Annualized	Annualized	Annualized		Annualized	Annualized	Annualized	

Financial Summary (p. 2 of 2)

	State Retirees				Non-State Retirees				
Summary	**2Q21**	**2Q22**	**2Q23**	**Variance to Prior Year**	**2Q21**	**2Q22**	**2Q23**	**Variance to Prior Year**	**Peer Index**
Enrollment									
Avg # Employees	3,264	2,996	2,749	-8.2%	543	448	379	-15.3%	
Avg # Members	4,911	4,508	4,105	-8.9%	638	531	447	-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	$14,171,257	$13,239,264	$10,973,139	-17.1%	$2,953,916	$1,478,034	$2,008,560	35.9%	
Client Paid	$10,442,899	$9,296,905	$7,549,558	-18.8%	$2,306,745	$875,694	$1,369,136	56.3%	
Employee Paid	$3,728,357	$3,942,360	$3,423,581	-13.2%	$647,171	$602,341	$639,424	6.2%	
Client Paid-PEPY	$6,399	$6,206	$5,492	-11.5%	$8,496	$3,912	$7,222	84.6%	$6,297
Client Paid-PMPY	$4,253	$4,125	$3,679	-10.8%	$7,227	$3,300	$6,133	85.8%	$3,879
Client Paid-PEPM	$533	$517	$458	-11.4%	$708	$326	$602	84.7%	$525
Client Paid-PMPM	$354	$344	$307	-10.8%	$602	$275	$511	85.8%	$323
High Cost Claimants (HCC's) > $100k									
# of HCC's	17	17	9	-47.1%	2	1	3	200.0%	
HCC's / 1,000	3.5	3.8	2.2	-41.9%	3.1	1.9	6.7	257.4%	
Avg HCC Paid	$229,644	$167,653	$216,838	29.3%	$454,420	$243,333	$233,344	-4.1%	
HCC's % of Plan Paid	37.4%	30.7%	25.8%	-16.0%	39.4%	27.8%	51.1%	83.8%	
Cost Distribution by Claim Type (PMPY)									
Facility Inpatient	$1,221	$1,603	$1,183	-26.2%	$3,435	$956	$3,405	256.2%	$1,149
Facility Outpatient	$1,710	$1,422	$1,264	-11.1%	$1,757	$1,289	$1,383	7.3%	$1,333
Physician	$1,206	$1,033	$1,231	19.2%	$1,903	$984	$1,344	36.6%	$1,301
Other	$116	$67	$0	-100.0%	$133	$72	$0	-100.0%	$96
Total	$4,253	$4,125	$3,679	-10.8%	$7,227	$3,300	$6,133	85.8%	$3,879
	Annualized	Annualized	Annualized		Annualized	Annualized	Annualized		

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

	Total				State Active				Non-State Active			
Summary	**PY21**	**PY22**	**2Q23**	**Variance to Prior Year**	**PY21**	**PY22**	**2Q23**	**Variance to Prior Year**	**PY21**	**PY22**	**2Q23**	**Variance to Prior Year**
Enrollment												
Avg # Employees	23,242	18,943	16,564	-12.6%	19,450	15,526	13,432	-13.5%	4	3	3	0.0%
Avg # Members	42,168	33,089	27,942	-15.6%	36,612	28,082	23,383	-16.7%	9	8	8	0.0%
Ratio	1.8	1.8	1.7	-3.4%	1.9	1.8	1.7	-3.9%	2.3	2.7	2.7	0.0%
Financial Summary												
Gross Cost	$167,612,161	$138,077,453	$54,222,932	-60.7%	$131,056,101	$106,593,460	$41,211,985	-61.3%	$45,142	$55,484	$29,248	-47.3%
Client Paid	$129,698,896	$104,706,277	$38,149,177	-63.6%	$100,360,791	$80,561,976	$29,210,832	-63.7%	$31,594	$38,304	$19,651	-48.7%
Employee Paid	$37,913,265	$33,371,175	$16,073,754	-51.8%	$30,695,310	$26,031,484	$12,001,153	-53.9%	$13,548	$17,181	$9,597	-44.1%
Client Paid-PEPY	$5,580	$5,527	$4,606	-16.7%	$5,160	$5,189	$4,349	-16.2%	$7,898	$12,768	$13,101	2.6%
Client Paid-PMPY	$3,076	$3,164	$2,731	-13.7%	$2,741	$2,869	$2,498	-12.9%	$3,510	$4,788	$4,913	2.6%
Client Paid-PEPM	$465	$461	$384	-16.7%	$430	$432	$362	-16.2%	$658	$1,064	$1,092	2.6%
Client Paid-PMPM	$256	$264	$228	-13.6%	$228	$239	$208	-13.0%	$293	$399	$409	2.5%
High Cost Claimants (HCC's) > $100k												
# of HCC's	173	160	46		124	115	35		0	0	0	
HCC's / 1,000	4.1	4.8	1.7		3.4	4.1	1.5		0.0	0.0	0.0	
Avg HCC Paid	$253,370	$251,190	$263,874	5.0%	$251,442	$262,921	$271,047	3.1%	$0	$0	$0	0.0%
HCC's % of Plan Paid	33.8%	38.4%	31.8%	-17.2%	31.1%	37.5%	32.5%	-13.3%	0.0%	0.0%	0.0%	0.0%
Cost Distribution by Claim Type (PMPY)												
Facility Inpatient	$893	$1,153	$981	-14.9%	$778	$1,028	$899	-12.5%	$0	$0	$0	0.0%
Facility Outpatient	$942	$939	$851	-9.4%	$794	$821	$767	-6.6%	$2,124	$3,554	$2,937	-17.4%
Physician	$1,176	$1,011	$899	-11.1%	$1,112	$964	$832	-13.7%	$1,339	$1,200	$1,975	64.6%
Other	$65	$62	$0	-100.0%	$56	$56	$0	-100.0%	$48	$34	$0	0.0%
Total	$3,076	$3,164	$2,731	-13.7%	$2,741	$2,869	$2,498	-12.9%	$3,510	$4,788	$4,913	2.6%
			Annualized				Annualized				Annualized	

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

	State Retirees				Non-State Retirees				
Summary	**PY21**	**PY22**	**2Q23**	**Variance to Prior Year**	**PY21**	**PY22**	**2Q23**	**Variance to Prior Year**	**Peer Index**
Enrollment									
Avg # Employees	3,269	2,981	2,749	-7.8%	519	433	379	-12.5%	
Avg # Members	4,936	4,486	4,105	-8.5%	611	514	447	-13.1%	
Ratio	1.5	1.5	1.5	-0.7%	1.2	1.2	1.2	0.0%	1.6
Financial Summary									
Gross Cost	$31,611,056	$27,879,066	$10,973,139	-60.6%	$4,899,862	$3,549,442	$2,008,560	-43.4%	
Client Paid	$25,416,793	$21,491,378	$7,549,558	-64.9%	$3,889,718	$2,614,619	$1,369,136	-47.6%	
Employee Paid	$6,194,263	$6,387,688	$3,423,581	-46.4%	$1,010,144	$934,823	$639,424	-31.6%	
Client Paid-PEPY	$7,774	$7,210	$5,492	-23.8%	$7,501	$6,033	$7,222	19.7%	$6,642
Client Paid-PMPY	$5,149	$4,791	$3,679	-23.2%	$6,362	$5,091	$6,133	20.5%	$4,116
Client Paid-PEPM	$648	$601	$458	-23.8%	$625	$503	$602	19.7%	$553
Client Paid-PMPM	$429	$399	$307	-23.1%	$530	$424	$511	20.5%	$343
High Cost Claimants (HCC's) > $100k									
# of HCC's	48	44	9		5	5	3		
HCC's / 1,000	9.7	9.8	2.2		8.2	9.7	6.7		
Avg HCC Paid	$234,370	$199,873	$216,838	8.5%	$280,896	$231,987	$233,344	0.6%	
HCC's % of Plan Paid	44.3%	40.9%	25.8%	-36.9%	36.1%	44.4%	51.1%	15.1%	
Cost Distribution by Claim Type (PMPY)									
Facility Inpatient	$1,515	$1,808	$1,183	-34.6%	$2,727	$2,262	$3,405	50.5%	$1,190
Facility Outpatient	$1,954	$1,612	$1,264	-21.6%	$1,599	$1,488	$1,383	-7.1%	$1,376
Physician	$1,555	$1,280	$1,231	-3.8%	$1,925	$1,227	$1,344	9.5%	$1,466
Other	$125	$91	$0	-100.0%	$110	$115	$0	-100.0%	$84
Total	$5,149	$4,791	$3,679	-23.2%	$6,362	$5,091	$6,133	20.5%	$4,116
			Annualized				Annualized		

Paid Claims by Claim Type – State Participants

Net Paid Claims - Total State Participants	2Q22				2Q23				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical									
Inpatient	$13,249,458.52	$3,414,145.78	$558,581.69	$ 17,222,186	$ 12,054,589	$ 201,931	$ 2,457,895	$ 14,714,415	-14.6%
Outpatient	$20,893,579.39	$4,706,894.68	$617,282.48	$ 26,217,757	$ 17,156,243	$ 582,669	$ 4,307,062	$ 22,045,975	-15.9%
Total - Medical	**$ 34,143,038**	**$ 8,121,040**	**$ 1,175,864**	**$ 43,439,943**	**$ 29,210,832**	**$ 784,601**	**$ 6,764,958**	**$ 36,760,390**	**-15.4%**

Net Paid Claims - Per Participant per Month	2Q22				2Q23				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical	$ 361	$ 572	$ 311	$ 386	$ 362	$ 60	$ 2,016	$ 379	-2.0%

Paid Claims by Claim Type – Non-State Participants

Net Paid Claims - Total Non-State Participants	2Q22				2Q23				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical									
Inpatient	$ 435	$ 22,515	$ 270,320	$ 293,270	$ -	$ 307,550	$ 528,292	$ 835,842	185.0%
Outpatient	$ 11,797	$ 192,910	$ 389,949	$ 594,656	$ 19,651	$ 297,967	$ 235,327	$ 552,945	-7.0%
Total - Medical	**$ 12,232**	**$ 215,424**	**$ 660,269**	**$ 887,926**	**$ 19,651**	**$ 605,517**	**$ 763,619**	**$ 1,388,787**	**56.4%**

Net Paid Claims - Per Participant per Month	2Q22				2Q23				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical	$ 680	$ 208	$ 400	$ 328	$ 1,092	$ 832	$ 494	$ 606	84.4%

Paid Claims by Claim Type – Total Participants

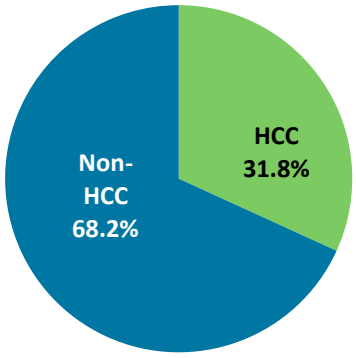
Net Paid Claims - Total Total Participants	2Q22				2Q23				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical									
Inpatient	$ 13,249,894	$ 3,436,660	$ 828,902	$ 17,515,456	$ 12,054,589	$ 509,481	$ 2,986,187	$ 15,550,258	-11.2%
Outpatient	$ 20,905,376	$ 4,899,804	$ 1,007,232	$ 26,812,413	$ 17,175,894	$ 880,636	$ 4,542,389	$ 22,598,920	-15.7%
Total - Medical	**$ 34,155,270**	**$ 8,336,465**	**$ 1,836,134**	**$ 44,327,868**	**$ 29,230,483**	**$ 1,390,117**	**$ 7,528,577**	**$ 38,149,177**	**-13.9%**

Net Paid Claims - Per Participant per Month	2Q22				2Q23				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	
Medical	$ 361	$ 547	$ 338	$ 385	$ 363	$ 100	$ 1,536	$ 384	-0.3%

Cost Distribution – Medical Claims

2Q22							2Q23					
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
65	0.2%	$12,955,097	29.2%	$476,522	2.4%	$100,000.01 Plus	44	0.2%	$12,138,215	31.8%	$255,290	1.6%
82	0.2%	$6,129,722	13.8%	$510,514	2.6%	$50,000.01-$100,000.00	62	0.2%	$4,801,280	12.6%	$340,002	2.1%
160	0.5%	$5,864,701	13.2%	$945,274	4.8%	$25,000.01-$50,000.00	140	0.5%	$5,076,275	13.3%	$846,964	5.3%
359	1.1%	$5,669,134	12.8%	$1,912,823	9.7%	$10,000.01-$25,000.00	343	1.2%	$5,474,220	14.3%	$1,710,395	10.6%
554	1.6%	$3,980,318	9.0%	$2,026,177	10.3%	$5,000.01-$10,000.00	446	1.6%	$3,208,248	8.4%	$1,644,691	10.2%
861	2.6%	$3,137,903	7.1%	$2,219,116	11.3%	$2,500.01-$5,000.00	662	2.4%	$2,431,970	6.4%	$1,710,878	10.6%
14,915	44.3%	$6,540,851	14.8%	$8,651,515	44.0%	$0.01-$2,500.00	10,973	39.3%	$5,018,970	13.2%	$7,076,094	44.0%
6,238	18.5%	$0	0.0%	$2,892,823	14.7%	$0.00	5,954	21.3%	$0	0.0%	$2,489,439	15.5%
10,468	31.1%	$50,142	0.1%	$12,976	0.1%	No Claims	9,319	33.3%	$0	0.0%	$0	0.0%
33,701	**100.0%**	**$44,327,868**	**100.0%**	**$19,647,740**	**100.0%**		**27,942**	**100.0%**	**$38,149,177**	**100.0%**	**$16,073,754**	**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	20	$2,691,510	22.2%
Congenital/Chromosomal Anomalies	5	$1,482,570	12.2%
Pregnancy-related Disorders	3	$1,034,465	8.5%
Infections	28	$977,123	8.0%
Cardiac Disorders	34	$946,830	7.8%
Spine-related Disorders	10	$842,634	6.9%
Neurological Disorders	22	$720,104	5.9%
Gastrointestinal Disorders	27	$648,613	5.3%
Mental Health	16	$537,313	4.4%
Endocrine/Metabolic Disorders	18	$509,697	4.2%
All Other		$1,747,357	14.4%
Overall	**----**	**$12,138,215**	**100.0%**

Utilization Summary (p. 1 of 2)

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

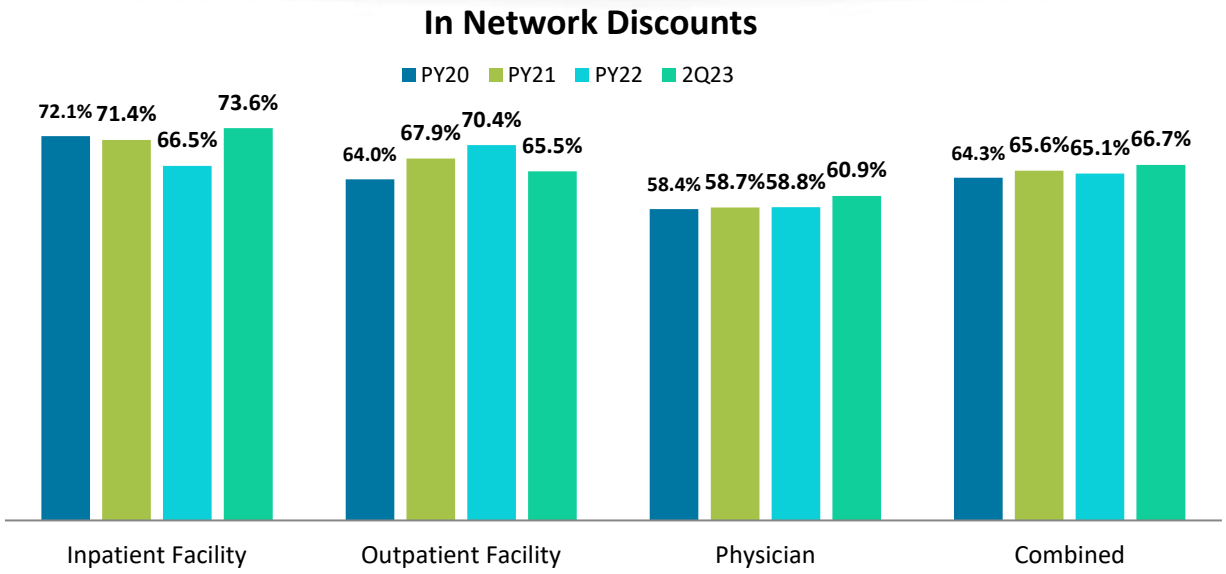
	Total				State Active				Non-State Active			
Summary	**2Q21**	**2Q22**	**2Q23**	**Variance to Prior Year**	**2Q21**	**2Q22**	**2Q23**	**Variance to Prior Year**	**2Q21**	**2Q22**	**2Q23**	**Variance to Prior Year**
Inpatient Summary												
# of Admits	845	699	525		688	513	379		0	0	0	
# of Bed Days	6,175	4,347	3,283		5,172	3,269	2,403		0	0	0	
Paid Per Admit	$37,523	$30,798	$25,366	-17.6%	$36,517	$31,757	$25,842	-18.6%	$0	$0	$0	0.0%
Paid Per Day	$5,135	$4,952	$4,056	-18.1%	$4,858	$4,984	$4,076	-18.2%	$0	$0	$0	0.0%
Admits Per 1,000	40	41	38	-7.3%	37	36	32	-11.1%	0	0	0	0.0%
Days Per 1,000	291	258	235	-8.9%	281	228	206	-9.6%	0	0	0	0.0%
Avg LOS	7.3	6.2	6.3	1.6%	7.5	6.4	6.3	-1.6%	0	0	0	0.0%
# Admits From ER	445	393	309		349	261	205		0	0	0	
Physician Office												
OV Utilization per Member	3.8	3.7	3.5	-5.4%	3.6	3.5	3.2	-8.6%	3.5	3.5	3.0	-14.3%
Avg Paid per OV	$66	$71	$71	0.0%	$67	$74	$69	-6.8%	$53	$48	$49	2.1%
Avg OV Paid per Member	$249	$262	$246	-6.1%	$241	$256	$222	-13.3%	$185	$166	$148	-10.8%
DX&L Utilization per Member	7.3	7.2	8.7	20.8%	6.9	6.8	7.9	16.2%	3.5	14.5	5	0.0%
Avg Paid per DX&L	$50	$45	$41	-8.9%	$47	$41	$40	-2.4%	$128	$41	$97	0.0%
Avg DX&L Paid per Member	$366	$322	$358	11.2%	$325	$282	$318	12.8%	$447	$594	$483	0.0%
Emergency Room												
# of Visits	2,462	2,520	1,985		2,104	2,102	1,587		0	3	3	
Visits Per Member	0.12	0.15	0.14	-6.7%	0.11	0.15	0.14	-6.7%	0	0.75	0.75	0.0%
Visits Per 1,000	116	150	142	-5.3%	114	147	136	-7.5%	0	750	750	0.0%
Avg Paid per Visit	$2,141	$1,835	$2,091	14.0%	$2,131	$1,847	$2,116	14.6%	$0	$1,489	$4,167	0.0%
Urgent Care												
# of Visits	4,895	4,606	3,821		4,406	4,072	3,389		0	2	2	
Visits Per Member	0.23	0.27	0.27	0.0%	0.24	0.28	0.29	3.6%	0.00	0.50	0.50	0.0%
Visits Per 1,000	231	273	273	0.0%	239	284	290	2.1%	0	500	500	0.0%
Avg Paid per Visit	$68	$63	$39	-38.1%	$67	$63	$39	-38.1%	$0	$102	$0	0.0%
	Annualized	Annualized	Annualized		Annualized	Annualized	Annualized		Annualized	Annualized	Annualized	

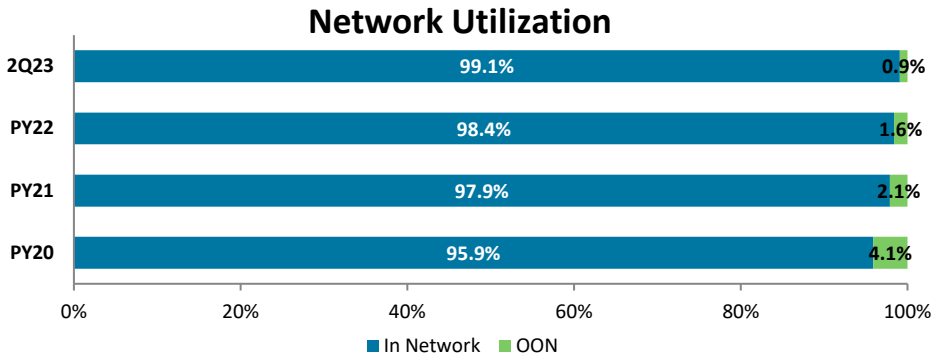
Utilization Summary (p. 2 of 2)

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

	State Retirees				Non-State Retirees				
Summary	**2Q21**	**2Q22**	**2Q23**	**Variance to Prior Year**	**2Q21**	**2Q22**	**2Q23**	**Variance to Prior Year**	**Peer Index**
Inpatient Summary									
# of Admits	128	166	113		29	20	33		
# of Bed Days	827	954	654		176	124	226		
Paid Per Admit	$40,813	$29,106	$23,741	-18.4%	$46,879	$20,260	$25,460	25.7%	$16,632
Paid Per Day	$6,317	$5,065	$4,102	-19.0%	$7,724	$3,268	$3,718	13.8%	$3,217
Admits Per 1,000	52	74	55	-25.7%	91	75	148	97.3%	76
Days Per 1,000	337	423	319	-24.6%	551	467	1,012	116.7%	391
Avg LOS	6.5	5.7	5.8	1.8%	6.1	6.2	6.8	9.7%	5.2
# Admits From ER	80	122	82		16	10	22		
Physician Office									
OV Utilization per Member	4.9	4.8	4.7	-2.1%	6.3	6.6	7.3	10.6%	5.0
Avg Paid per OV	$61	$64	$83	29.7%	$54	$26	$25	-3.8%	$57
Avg OV Paid per Member	$301	$308	$390	26.6%	$340	$173	$183	5.8%	$286
DX&L Utilization per Member	9.9	9.6	11.9	24.0%	11.7	9.7	18.9	94.8%	10.5
Avg Paid per DX&L	$62	$58	$46	-20.7%	$72	$47	$37	-21.3%	$50
Avg DX&L Paid per Member	$615	$560	$550	-1.8%	$835	$456	$700	53.5%	$522
Emergency Room									
# of Visits	315	358	336		43	57	59		
Visits Per Member	0.13	0.16	0.16	0.0%	0.13	0.21	0.26	23.8%	0.24
Visits Per 1,000	128	159	164	3.1%	135	215	264	22.8%	235
Avg Paid per Visit	$2,068	$1,795	$1,993	11.0%	$3,170	$1,677	$1,865	11.2%	$943
Urgent Care									
# of Visits	422	479	382		67	53	48		
Visits Per Member	0.17	0.21	0.19	-9.5%	0.21	0.20	0.22	10.0%	0.3
Visits Per 1,000	172	213	186	-12.7%	210	200	215	7.5%	300
Avg Paid per Visit	$72	$60	$40	-33.3%	$73	$39	$27	-30.8%	$84
	Annualized	Annualized	Annualized		Annualized	Annualized	Annualized		

Provider Network Summary





Diagnosis Grouper Summary

Diagnosis Grouper	Total Paid	% Paid	Insured	Spouse	Child	Male	Female
Cancer	$4,610,633	12.1%	$3,148,959	$779,106	$682,568	$2,495,533	$2,115,100
Health Status/Encounters	$3,353,732	8.8%	$1,998,347	$403,867	$951,518	$1,265,853	$2,087,879
Gastrointestinal Disorders	$2,922,487	7.7%	$1,742,664	$632,777	$547,046	$1,434,888	$1,487,599
Cardiac Disorders	$2,745,292	7.2%	$1,997,590	$693,362	$54,340	$1,169,778	$1,575,514
Pregnancy-related Disorders	$2,545,947	6.7%	$833,857	$282,401	$1,429,689	$802,167	$1,743,780
Infections	$2,075,907	5.4%	$1,389,984	$271,379	$414,544	$1,299,106	$776,801
Spine-related Disorders	$2,060,331	5.4%	$1,077,536	$216,080	$766,715	$466,967	$1,593,365
Neurological Disorders	$1,991,191	5.2%	$1,279,459	$366,834	$344,897	$833,183	$1,158,008
Trauma/Accidents	$1,844,771	4.8%	$1,225,049	$267,839	$351,883	$886,805	$957,966
Musculoskeletal Disorders	$1,792,954	4.7%	$1,382,147	$255,108	$155,698	$624,844	$1,168,111
Congenital/Chromosomal Anomalies	$1,656,219	4.3%	$43,202	$26,136	$1,586,882	$1,567,265	$88,954
Mental Health	$1,624,516	4.3%	$411,559	$178,575	$1,034,381	$467,940	$1,156,575
Pulmonary Disorders	$1,272,188	3.3%	$797,802	$107,377	$367,009	$694,160	$578,028
Renal/Urologic Disorders	$1,254,206	3.3%	$745,105	$307,657	$201,445	$795,238	$458,968
Endocrine/Metabolic Disorders	$1,131,011	3.0%	$696,387	$362,251	$72,374	$662,799	$468,212
Eye/ENT Disorders	$1,056,172	2.8%	$612,591	$184,653	$258,929	$501,401	$554,771
Medical/Surgical Complications	$883,846	2.3%	$717,706	$40,970	$125,171	$626,314	$257,533
Gynecological/Breast Disorders	$634,068	1.7%	$403,824	$173,395	$56,849	$5,877	$628,191
Hematological Disorders	$509,219	1.3%	$119,342	$326,793	$63,084	$372,726	$136,494
Diabetes	$449,980	1.2%	$377,237	$33,529	$39,214	$289,762	$160,218
Non-malignant Neoplasm	$446,507	1.2%	$374,518	$36,125	$35,864	$56,352	$390,155
Dermatological Disorders	$336,288	0.9%	$265,138	$28,263	$42,887	$184,258	$152,030
Vascular Disorders	$326,348	0.9%	$175,526	$142,930	$7,892	$87,313	$239,035
Miscellaneous	$285,282	0.7%	$177,880	$37,766	$69,636	$95,680	$189,603
Abnormal Lab/Radiology	$175,638	0.5%	$139,971	$29,565	$6,101	$70,232	$105,406
Dental Conditions	$51,120	0.1%	$2,225	$64	$48,831	$48,267	$2,853
Medication Related Conditions	$48,637	0.1%	$17,317	$11,788	$19,532	$23,938	$24,699
Cholesterol Disorders	$30,522	0.1%	$25,222	$4,465	$834	$15,246	$15,276
Allergic Reaction	$20,471	0.1%	$4,488	$7,010	$8,973	$3,246	$17,225
External Hazard Exposure	$13,469	0.0%	$11,866	$1,242	$361	$6,660	$6,810
Cause of Morbidity	$194	0.0%	$70	$0	$125	$70	$125
Social Determinants of Health	$29	0.0%	$29	$0	$0	$29	$0
Total	**$38,149,177**	**100.0%**	**$22,194,597**	**$6,209,306**	**$9,745,275**	**$17,853,893**	**$20,295,284**

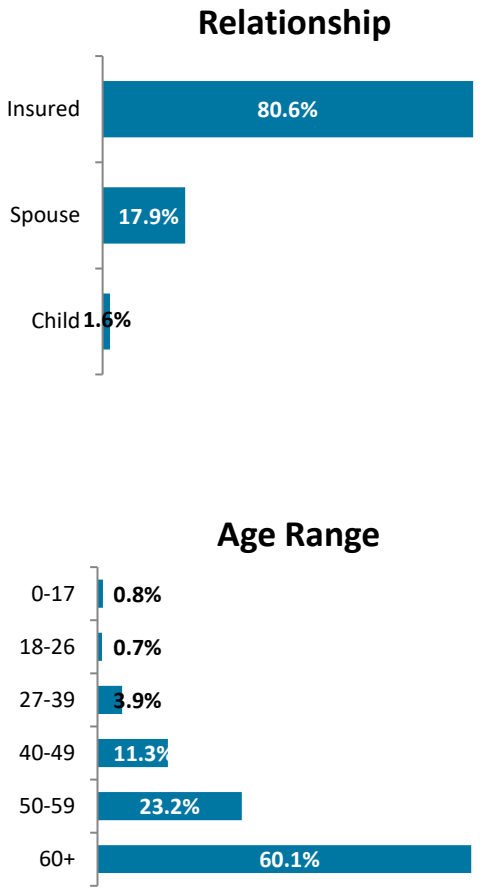
Mental Health Drilldown

	PY20		PY21		PY22		2Q23	
Grouper	Patients	Total Paid	Patients	Total Paid	Patients	Total Paid	Patients	Total Paid
Developmental Disorders	144	$790,389	179	$1,179,402	113	$719,871	76	$473,868
Depression	1,485	$1,137,444	1,597	$1,103,414	1,156	$1,279,244	601	$435,640
Mental Health Conditions, Other	1,222	$686,307	1,220	$771,034	911	$431,490	463	$160,654
Alcohol Abuse/Dependence	125	$868,472	136	$1,288,204	101	$873,612	72	$118,010
Psychoses	55	$78,740	54	$86,357	32	$70,201	14	$98,118
Mood and Anxiety Disorders	1,791	$437,001	1,920	$638,818	1,486	$406,189	771	$93,699
Complications of Substance Abuse	47	$257,582	42	$202,208	22	$89,081	15	$73,377
Bipolar Disorder	327	$340,422	315	$464,418	225	$197,224	138	$47,845
Schizophrenia	31	$43,420	26	$141,033	25	$110,357	12	$39,244
Substance Abuse/Dependence	121	$1,068,150	140	$213,345	86	$540,594	45	$36,997
Sexually Related Disorders	51	$24,993	68	$90,021	42	$11,305	35	$14,247
Eating Disorders	47	$74,872	55	$647,596	44	$596,928	22	$11,300
Attention Deficit Disorder	433	$58,455	482	$72,965	374	$57,319	239	$8,932
Sleep Disorders	526	$40,584	564	$76,491	371	$46,254	181	$8,270
Tobacco Use Disorder	149	$6,011	126	$8,010	106	$6,184	43	$3,926
Personality Disorders	19	$18,981	25	$16,690	19	$13,480	5	$388
Total		**$5,931,821**		**$7,000,007**		**$5,449,334**		**$1,624,516**

Diagnosis Grouper – Cancer

Diagnosis Sub-Grouper	Patients	Claims	Total Paid	% Paid
Cancer Therapies	57	268	$1,611,522	35.0%
Breast Cancer	140	945	$584,308	12.7%
Cancers, Other	76	590	$517,611	11.2%
Secondary Cancers	47	286	$507,597	11.0%
Lymphomas	31	314	$255,839	5.5%
Thyroid Cancer	38	173	$189,570	4.1%
Leukemias	27	338	$168,023	3.6%
Bladder Cancer	14	131	$126,845	2.8%
Prostate Cancer	72	338	$122,819	2.7%
Colon Cancer	29	229	$122,527	2.7%
Brain Cancer	8	118	$112,714	2.4%
Carcinoma in Situ	64	220	$96,263	2.1%
Cervical/Uterine Cancer	37	181	$49,082	1.1%
Lung Cancer	19	114	$42,728	0.9%
Non-Melanoma Skin Cancers	169	336	$34,764	0.8%
Ovarian Cancer	19	147	$26,639	0.6%
Myeloma	7	76	$17,253	0.4%
Kidney Cancer	14	46	$14,939	0.3%
Melanoma	28	70	$9,536	0.2%
Pancreatic Cancer	2	2	$52	0.0%
Overall	**----**	**----**	**$4,610,633**	**100.0%**

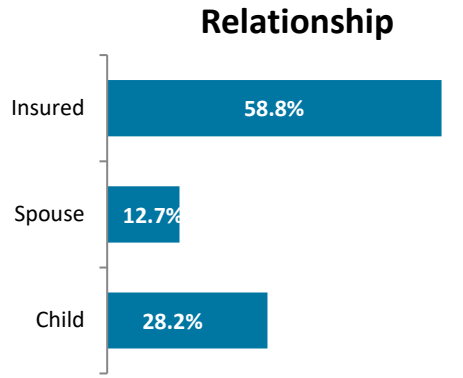
*Patient and claim counts are unique only within the category

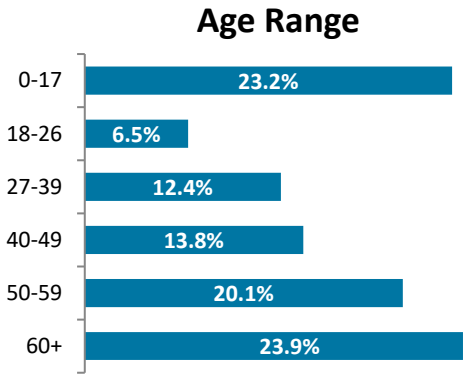


Diagnosis Grouper – Health Status/Encounters

Diagnosis Sub-Grouper	Patients	Claims	Total Paid	% Paid
Screenings	3,708	6,710	$1,173,190	35.0%
Exams	4,987	8,587	$823,293	24.5%
Prophylactic Measures	3,126	3,908	$599,939	17.9%
Encounters - Infants/Children	1,798	2,280	$341,652	10.2%
Prosthetics/Devices/Implants	273	927	$146,460	4.4%
Personal History of Condition	426	621	$90,654	2.7%
Aftercare	233	493	$62,323	1.9%
Encounter - Procedure	30	35	$51,706	1.5%
Family History of Condition	92	124	$36,975	1.1%
Encounter - Transplant Related	29	129	$13,994	0.4%
Lifestyle/Situational Issues	59	100	$4,646	0.1%
Counseling	110	168	$3,443	0.1%
Miscellaneous Examinations	12	19	$1,746	0.1%
Acquired Absence	28	35	$1,603	0.0%
Health Status, Other	55	80	$1,196	0.0%
Follow-Up Encounters	7	13	$858	0.0%
Blood Type	2	2	$53	0.0%
Donors	1	1	$0	0.0%
Overall	**----**	**----**	**$3,353,732**	**100.0%**

*Patient and claim counts are unique only within the category

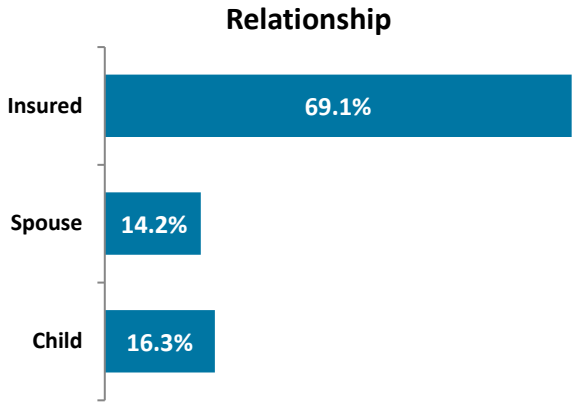


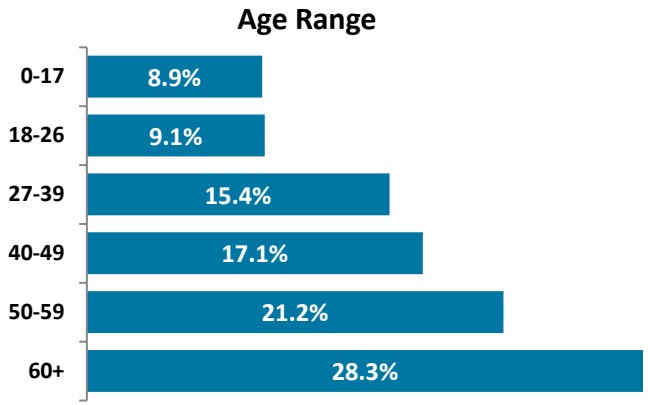


Diagnosis Grouper – Gastrointestinal Disorders

Diagnosis Sub-Grouper	Patients	Claims	Total Paid	% Paid
Hernias	111	341	$457,596	15.7%
Abdominal Disorders	916	1,932	$400,937	13.7%
Liver Diseases	178	310	$314,739	10.8%
Inflammatory Bowel Disease	57	227	$304,485	10.4%
GI Disorders, Other	432	925	$291,214	10.0%
Upper GI Disorders	443	937	$270,198	9.2%
GI Symptoms	549	1,094	$237,395	8.1%
Gallbladder and Biliary Disease	96	348	$229,731	7.9%
Appendicitis	24	129	$167,917	5.7%
Diverticulitis	87	169	$63,756	2.2%
Constipation	133	209	$54,869	1.9%
Ostomies	29	145	$51,119	1.7%
Pancreatic Disorders	20	63	$29,952	1.0%
Hemorrhoids	97	155	$19,098	0.7%
Hepatic Cirrhosis	20	69	$17,356	0.6%
Esophageal Varices	7	16	$9,696	0.3%
Peptic Ulcer/Related Disorders	25	31	$2,430	0.1%
	----	----	$2,922,487	100.0%

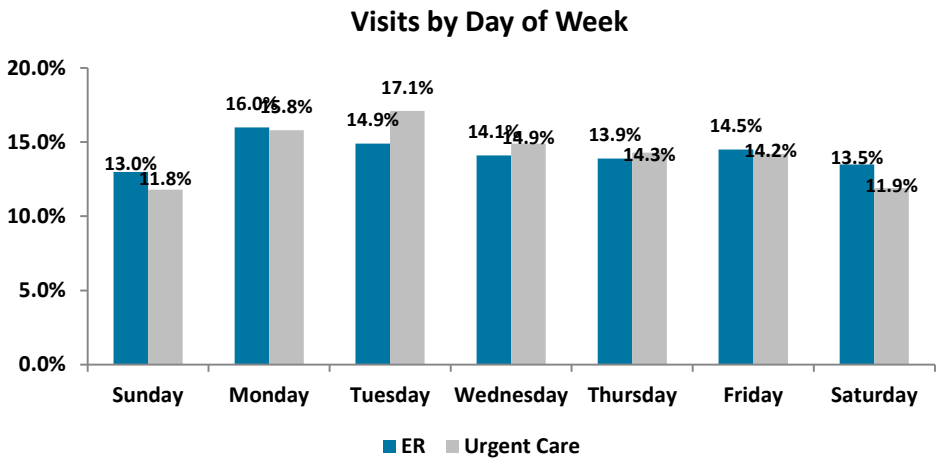
*Patient and claim counts are unique only within the category

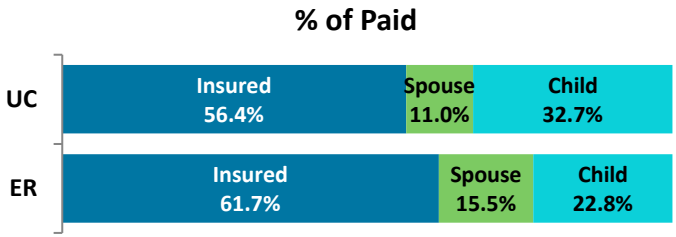




Emergency Room / Urgent Care Summary

	2Q22		2Q23		Peer Index	
ER/Urgent Care	**ER**	**Urgent Care**	**ER**	**Urgent Care**	**ER**	**Urgent Care**
Number of Visits	2,520	4,606	1,985	3,821		
Visits Per Member	0.15	0.27	0.14	0.27	0.22	0.35
Visits/1000 Members	150	273	142	273	221	352
Avg Paid Per Visit	$1,835	$63	$2,091	$39	$968	$135
% with OV*	84.2%	80.1%	80.2%	78.5%		
% Avoidable	13.5%	32.0%	15.1%	40.2%		
Total Member Paid	**$2,794,834**	**$507,083**	**$2,812,684**	**$522,853**		
Total Plan Paid	**$4,624,216**	**$287,916**	**$4,126,032**	**$149,367**		
*looks back 12 months	Annualized	Annualized	Annualized	Annualized		





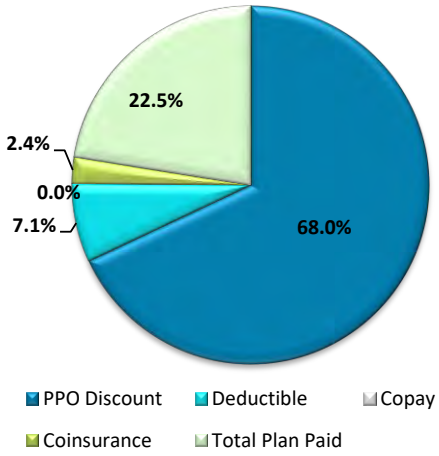
ER / UC Visits by Relationship						
Relationship	**ER**	**Per 1,000**	**Urgent Care**	**Per 1,000**	**Total**	**Per 1,000**
Insured	1,160	70	2,224	4,380	3,384	204
Spouse	265	79	386	863	651	195
Child	560	70	1,211	1,655	1,771	220
Total	**1,985**	**71**	**3,821**	**137**	**5,806**	**208**

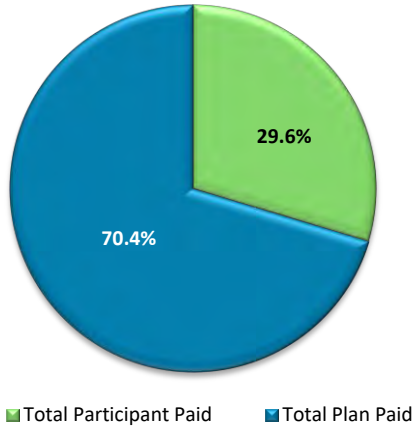
Hospital and physician urgent care centers are included in the data.
Paid amount includes facility and professional fees.

Savings Summary – Medical Claims

Description	Dollars	PPPM	% of Eligible
Eligible Charges	$178,811,725	$1,802	100.0%
PPO Discount	$115,416,119	$1,163	64.5%
Deductible	$11,996,076	$121	6.7%
Copay	$37,493	$0	0.0%
Coinsurance	$4,040,186	$41	2.3%
Total Participant Paid	**$16,073,754**	**$162**	**9.0%**
Total Plan Paid	**$38,149,177**	**$384**	**21.3%**

Total Participant Paid - PY22	**$147**
Total Plan Paid - PY22	**$461**





Paid Claims by Age Range – Dental

Dental Paid Claims by Age Group												
	2Q21		2Q22		2Q23		% Change	
Age Range	Dental Plan Paid	Dental PMPM	Dental Plan Paid	Dental PMPM	Dental Plan Paid	Dental PMPM	Dental Plan Paid	Dental PMPM
<1	$ 5,068	$ 2	$ 4,624	$ 2	$ 3,677	$ 1	-20.5%	-30.2%
1	$ 24,408	$ 7	$ 24,384	$ 8	$ 25,586	$ 9	4.9%	13.9%
2 - 4	$ 181,971	$ 17	$ 197,775	$ 19	$ 196,205	$ 21	-0.8%	8.3%
5 - 9	$ 595,727	$ 29	$ 615,077	$ 32	$ 544,872	$ 29	-11.4%	-8.3%
10 - 14	$ 653,228	$ 28	$ 632,173	$ 28	$ 597,828	$ 27	-5.4%	-2.0%
15 - 19	$ 816,303	$ 33	$ 758,700	$ 31	$ 711,743	$ 29	-6.2%	-7.0%
20 - 24	$ 490,797	$ 18	$ 461,202	$ 18	$ 442,530	$ 17	-4.0%	-5.9%
25 - 29	$ 491,651	$ 24	$ 434,828	$ 23	$ 372,460	$ 21	-14.3%	-8.6%
30 - 34	$ 603,798	$ 25	$ 568,428	$ 25	$ 477,840	$ 22	-15.9%	-11.8%
35 - 39	$ 704,019	$ 27	$ 714,163	$ 28	$ 600,599	$ 24	-15.9%	-12.8%
40 - 44	$ 683,674	$ 27	$ 694,624	$ 28	$ 659,885	$ 26	-5.0%	-6.9%
45 - 49	$ 750,892	$ 28	$ 726,434	$ 29	$ 661,311	$ 26	-9.0%	-8.7%
50 - 54	$ 859,163	$ 30	$ 919,786	$ 32	$ 833,773	$ 29	-9.4%	-9.1%
55 - 59	$ 1,036,572	$ 34	$ 1,035,663	$ 35	$ 957,492	$ 33	-7.5%	-6.4%
60 - 64	$ 1,280,570	$ 37	$ 1,313,464	$ 40	$ 1,162,161	$ 36	-11.5%	-9.1%
65+	$ 3,251,369	$ 40	$ 3,423,389	$ 42	$ 3,238,556	$ 40	-5.4%	-4.9%
Total	**$ 12,429,210**	**$30**	**$ 12,524,714**	**$ 31**	**$ 11,486,516**	**$ 29**	**-8.3%**	**-5.3%**

Dental Paid Claims – State Participants

Dental Paid Claims - Total State Participants	2Q22				2Q23				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Dental	$ 8,296,587	$ 1,078,805	$ 266,431	$ 9,641,823	$ 7,540,918	$ 1,042,467	$ 222,772	$ 8,806,158	-8.7%
Dental Exchange	$ -	$ -	$ 1,747,567	$ 1,747,567	$ -	$ -	$ 1,666,037	$ 1,666,037	-4.7%
Total	**$ 8,296,587**	**$ 1,078,805**	**$ 2,013,999**	**$ 11,389,391**	**$ 7,540,918**	**$ 1,042,467**	**$ 1,888,809**	**$ 10,472,194**	**-13.3%**

Dental Paid Claims - Per Participant per Month	2Q22				2Q23				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Dental	$ 53	$ 53	$ 57	$ 53	$ 48	$ 50	$ 52	$ 49	-8.4%
Dental Exchange	$ -	$ -	$ 51	$ 51	$ -	$ -	$ 48	$ 48	-6.3%

Dental Paid Claims – Non-State Participants

Dental Paid Claims - Total Non-State Participants	2Q22				2Q23				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Dental	$ 4,123	$ 79,390	$ 116,768	$ 200,281	$ 2,321	$ 45,795	$ 107,321	$ 155,437	-22.4%
Dental Exchange	$ -	$ -	$ 935,043	$ 935,043	$ -	$ -	$ 858,884	$ 858,884	-8.1%
Total	**$ 4,123**	**$ 79,390**	**$ 1,051,812**	**$ 1,135,324**	**$ 2,321**	**$ 45,795**	**$ 966,205**	**$ 1,014,321**	**-10.7%**

Dental Paid Claims - Per Participant per Month	2Q22				2Q23				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Dental	$ 55	$ 42	$ 43	$ 42	$ 64	$ 37	$ 43	$ 41	-2.8%
Dental Exchange	$ -	$ -	$ 43	$ 43	$ -	$ -	$ 42	$ 42	-1.1%

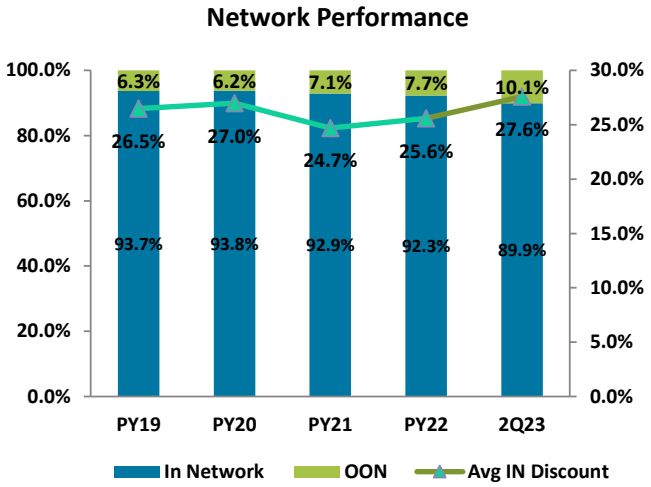
Dental Paid Claims – Total Participants

Dental Paid Claims - Total Total Participants	2Q22				2Q23				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Dental	$ 8,300,709	$ 1,158,195	$ 383,200	$ 9,842,104	$ 7,543,240	$ 1,088,262	$ 330,093	$ 8,961,594	-8.9%
Dental Exchange	$ -	$ -	$ 2,682,611	$ 2,682,611	$ -	$ -	$ 2,524,921	$ 2,524,921	-5.9%
Total	**$ 8,300,709**	**$ 1,158,195**	**$ 3,065,811**	**$ 12,524,715**	**$ 7,543,240**	**$ 1,088,262**	**$ 2,855,014**	**$ 11,486,516**	**-8.3%**

Dental Paid Claims - Per Participant per Month	2Q22				2Q23				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	
Dental	$ 53	$ 52	$ 52	$ 53	$ 48	$ 49	$ 49	$ 48	-8.4%
Dental Exchange	$ -	$ -	$ 49	$ 49	$ -	$ -	$ 46	$ 46	-6.1%

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	2,686	4.1%	8,981	15.1%	$3,883,796	33.8%	$2,484,324	43.3%
$750.01-$1,000.00	1,155	1.8%	3,265	5.5%	$1,009,373	8.8%	$648,582	11.3%
$500.01-$750.00	2,097	3.2%	5,417	9.1%	$1,305,763	11.4%	$805,391	14.1%
$250.01-$500.00	5,672	8.7%	12,286	20.7%	$1,953,913	17.0%	$744,905	13.0%
$0.01-$250.00	22,459	34.4%	28,804	48.5%	$3,333,671	29.0%	$980,872	17.1%
$0.00	614	0.9%	659	1.1%	$0	0.0%	$67,880	1.2%
No Claims	30,538	46.8%	0	0.0%	$0	0.0%	$0	0.0%
Total	**65,221**	**100.0%**	**59,412**	**100.0%**	**$11,486,516**	**100.0%**	**$5,731,955**	**100.0%**

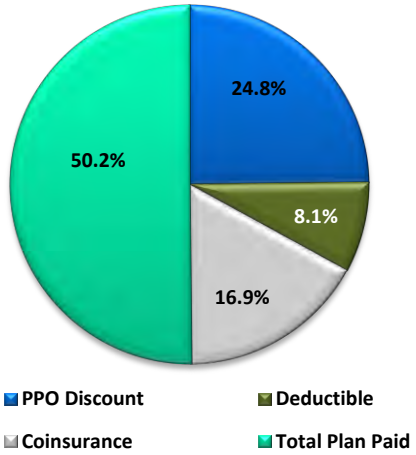


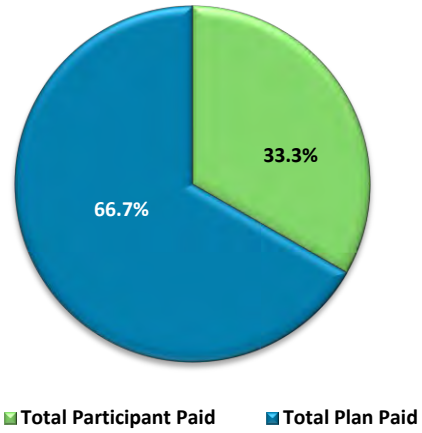
Dental Category	2Q22	2Q23	% of Paid	Variance to PY
PREVENTIVE SERVICES	$3,278,191	$3,031,641	26.4%	-7.5%
RESTORATIVE PROCEDURES	$3,075,145	$2,641,138	23.0%	-14.1%
DIAGNOSTIC PROCEDURES	$2,619,356	$2,630,286	22.9%	0.4%
PERIODONTICS	$817,527	$712,444	6.2%	-12.9%
ORAL AND MAXILLOFACIAL SURGERY	$705,807	$708,210	6.2%	0.3%
ENDODONICS	$617,174	$620,729	5.4%	0.6%
IMPLANT SERVICES	$671,287	$534,886	4.7%	-20.3%
ADJUNCTIVE GENERAL SERVICES	$394,365	$294,562	2.6%	-25.3%
PROSTHODONTICS	$239,465	$187,863	1.6%	-21.5%
PROSTHODONTICS - REMOVABLE	$105,413	$122,913	1.1%	16.6%
OTHER	$18	$1,845	0.0%	10023.8%
MAXILLOFACIAL PROSTHETICS	$452	$0	0.0%	-100.0%
ORTHODONTICS	$515	$0	0.0%	0.0%
Total	**$12,524,715**	**$11,486,516**	**100.0%**	**-8.3%**

Savings Summary – Dental Claims

Description	Dollars	PPPM	% of Eligible
Eligible Charges	$22,633,983	$94	100.0%
PPO Discount	$5,683,432	$24	25.1%
Deductible	$1,863,776	$8	8.2%
Coinsurance	$3,868,179	$16	17.1%
Total Participant Paid	**$5,731,955**	**$24**	**25.3%**
Total Plan Paid	**$11,486,516**	**$48**	**50.7%**

Total Participant Paid - PY22	**$23**
Total Plan Paid - PY22	**$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	982	941	41	96.2%
	<2 asthma related ER Visits in the last 6 months	982	980	2	99.8%
	No asthma related admit in last 12 months	982	981	1	99.9%
Chronic Obstructive Pulmonary Disease	No exacerbations in last 12 months	210	201	9	95.7%
	Members with COPD who had an annual spirometry test	210	36	174	17.1%
Congestive Heart Failure	No re-admit to hosp with Heart Failure diag w/in 30 days of HF inpatient stay discharge	6	6	0	100.0%
	No ER Visit for Heart Failure in last 90 days	192	189	3	98.4%
	Follow-up OV within 4 weeks of discharge from HF admission	6	5	1	83.3%
Diabetes	Annual office visit	933	889	44	95.3%
	Annual dilated eye exam	933	373	560	40.0%
	Annual foot exam	933	379	554	40.6%
	Annual HbA1c test done	933	768	165	82.3%
	Diabetes Annual lipid profile	933	694	239	74.4%
	Annual microalbumin urine screen	933	650	283	69.7%
Hyperlipidemia	Hyperlipidemia Annual lipid profile	3,910	3,075	835	78.6%
Hypertension	Annual lipid profile	4,064	2,695	1,369	66.3%
	Annual serum creatinine test	3,939	3,085	854	78.3%
Wellness	Well Child Visit - 15 months	206	199	7	96.6%
	Routine office visit in last 6 months (All Ages)	27,522	16,091	11,431	58.5%
	Colorectal cancer screening ages 45-75 within the appropriate time period	11,434	5,043	6,391	44.1%
	Women age 25-65 with recommended cervical cancer/HPV screening	8,602	5,829	2,773	67.8%
	Males age greater than 49 with PSA test in last 24 months	4,511	2,188	2,323	48.5%
	Routine exam in last 24 months (All Ages)	27,522	22,660	4,862	82.3%
	Women age 40 to 75 with a screening mammogram last 24 months	7,274	4,191	3,083	57.6%

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	183	0.66%	6.55	$12,790
Asthma	1,096	3.98%	39.22	$10,387
Atrial Fibrillation	304	1.10%	10.88	$24,267
Blood Disorders	1,561	5.67%	55.87	$22,642
CAD	590	2.14%	21.11	$16,233
COPD	208	0.76%	7.44	$19,040
Cancer	1,059	3.84%	37.90	$23,863
Chronic Pain	644	2.34%	23.05	$20,705
Congestive Heart Failure	194	0.70%	6.94	$43,175
Demyelinating Diseases	63	0.23%	2.25	$41,456
Depression	1,624	5.90%	58.12	$12,233
Diabetes	1,678	6.09%	60.05	$14,460
ESRD	40	0.15%	1.43	$57,425
Eating Disorders	84	0.30%	3.01	$25,318
HIV/AIDS	35	0.13%	1.25	$60,871
Hyperlipidemia	4,859	17.64%	173.89	$8,283
Hypertension	4,096	14.87%	146.59	$10,786
Immune Disorders	87	0.32%	3.11	$58,230
Inflammatory Bowel Disease	95	0.34%	3.40	$40,575
Liver Diseases	523	1.90%	18.72	$24,734
Morbid Obesity	719	2.61%	25.73	$15,824
Osteoarthritis	1,032	3.75%	36.93	$14,684
Peripheral Vascular Disease	161	0.58%	5.76	$14,043
Rheumatoid Arthritis	157	0.57%	5.62	$24,718

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 2023 - Through Quarter Ending December 31, 2022
Express Scripts

Membership Summary	1Q-2Q FY2023 CDHP	1Q-2Q FY2022 CDHP	Difference	% Change
			Membership Summary	
Member Count (Membership)	28,010	33,790	(5,780)	-17.1%
Utilizing Member Count (Patients)	18,037	22,823	(4,786)	-21.0%
Percent Utilizing (Utilization)	64.4%	67.5%	(0.03)	-4.7%

Claim Summary			Claims Summary	
Net Claims (Total Rx's)	193,380	223,830	(30,450)	-13.6%
Claims per Elig Member per Month (Claims PMPM)	1.15	1.10	0.05	4.5%
Total Claims for Generic (Generic Rx)	163,487	186,470	(22,983.00)	-12.3%
Total Claims for Brand (Brand Rx)	29,893	37,360	(7,467.00)	-20.0%
Total Claims for Brand w/Gen Equiv (Multisource Brand Claims)	769	1,628	(859.00)	-52.8%
Total Non-Specialty Claims	190,774	221,127	(30,353.00)	-13.7%
Total Specialty Claims	2,606	2,703	(97.00)	-3.6%
Generic % of Total Claims (GFR)	**84.5%**	**83.3%**	0.01	1.5%
Generic Effective Rate (GCR)	**99.5%**	**99.1%**	0.00	0.4%
Mail Order Claims	51,531	52,584	(1,053.00)	-2.0%
Mail Penetration Rate*	31.1%	28.0%	0.03	3.1%

Claims Cost Summary			Claims Cost Summary	
Total Prescription Cost (Total Gross Cost)	$21,518,275	$22,513,009	($994,734.00)	-4.4%
Total Generic Gross Cost	$2,494,885	$3,134,559	($639,674.00)	-20.4%
Total Brand Gross Cost	$19,023,390	$19,378,449	($355,059.00)	-1.8%
Total MSB Gross Cost	$441,855	$588,035	($146,180.00)	-24.9%
Total Ingredient Cost	$21,173,079	$21,903,908	($730,829.00)	-3.3%
Total Dispensing Fee	$323,875	$599,819	($275,944.00)	-46.0%
Total Other (e.g. tax)	$21,320	$9,282	$12,038.00	129.7%
Avg Total Cost per Claim (Gross Cost/Rx)	**$111.27**	**$100.58**	$10.69	10.6%
Avg Total Cost for Generic (Gross Cost/Generic Rx)	$15.26	$17.06	($1.80)	-10.6%
Avg Total Cost for Brand (Gross Cost/Brand Rx)	$636.38	$518.70	$117.68	22.7%
Avg Total Cost for MSB (MSB Gross Cost/MSB ARx)	$574.58	$361.20	$213.38	59.1%

Member Cost Summary			Member Cost Summary	
Total Member Cost	**$5,065,371**	**$5,719,476**	($654,105.00)	-11.4%
Total Copay	$3,685,708	$3,971,473	($285,765.00)	-7.2%
Total Deductible	$1,379,663	$1,748,003	($368,340.00)	-21.1%
Avg Copay per Claim (Copay/Rx)	$19.06	$17.74	$1.32	7.4%
Avg Participant Share per Claim (Copay+Deductible/RX)	**$26.19**	**$25.55**	**$0.64**	**2.5%**
Avg Copay for Generic (Copay/Generic Rx)	$7.64	$9.21	($1.57)	-17.0%
Avg Copay for Brand (Copay/Brand Rx)	$127.69	$107.14	$20.55	19.2%
Avg Copay for Brand w/ Generic Equiv (Copay/Multisource Rx)	$174.98	$95.58	$79.40	83.1%
Net PMPM (Participant Cost PMPM)	**$30.14**	**$28.21**	$1.93	6.8%
Copay % of Total Prescription Cost (Member Cost Share %)	23.5%	25.4%	-1.9%	-7.3%

Plan Cost Summary			Plan Cost Summary	
Total Plan Cost (Plan Cost)	**$16,452,903**	**$16,793,533**	**($340,630.00)**	**-2.0%**
Total Non-Specialty Cost (Non-Specialty Plan Cost)	$5,830,693	$5,961,007	($130,314.00)	-2.2%
Total Specialty Drug Cost (Specialty Plan Cost)	$10,622,210	$10,832,526	($210,316.00)	-1.9%
Avg Plan Cost per Claim (Plan Cost/Rx)	**$85.08**	**$75.03**	$10.05	13.4%
Avg Plan Cost for Generic (Plan Cost/Generic Rx)	$7.62	$7.60	$0.02	0.3%
Avg Plan Cost for Brand (Plan Cost/Brand Rx)	$508.69	$411.55	$97.14	23.6%
Avg Plan Cost for MSB (MSB Plan Cost/MSB ARx)	$399.60	$265.62	$133.98	50.4%
Net PMPM (Plan Cost PMPM)	**$97.90**	**$82.83**	**$15.07**	**18.2%**
PMPM without Specialty (Non-Specialty PMPM)	$34.69	$29.40	$4.02	17.3%
PMPM for Specialty Only (Specialty PMPM)	$63.20	$53.43	$9.77	18.3%
Specialty % of Plan Cost	64.6%	64.50%	$0.00	0.2%
Rebates Received (Q1-Q2 FY2023 actual)	$5,876,725	$3,738,137	$2,138,588.01	57.2%
Net PMPM (Plan Cost PMPM factoring Rebates)	**$62.93**	**$64.39**	**($1.46)**	**-2.3%**
PMPM without Specialty (Non-Specialty PMPM)	$14.27	$17.25	$0.92	5.0%
PMPM for Specialty Only (Specialty PMPM)	$48.87	$46.90	$1.97	4.2%

Appendix B

Index of Tables
UMR Inc. – LDPPO Utilization Review for PEBP
October 1, 2022 – December 31, 2022

DATASCOPE™

Nevada Public Employees' Benefits Program
Low Deductible Plan
July – December 2022 Incurred,
Paid through February 28, 2023

UMR℠

Overview

- Total Medical Spend for 2Q23 was $23,959,484 with an annualized plan cost per employee per year (PEPY) of $6,759. This is a decrease of 18.5% when compared to 2Q22.
  - IP Cost per Admit is $23,315 which is 36.3% lower than 2Q22.
  - ER Cost per Visit is $3,179 which is 36.0% higher than 2Q22.
- Employees shared in 14.6% of the medical cost.
- Inpatient facility costs were 19.9% of the plan spend.
- 90.2% of the Average Membership had paid Medical claims less than $2,500, with 27.0% of those having no claims paid at all during the reporting period.
- 18 members exceeded the $100k high-cost threshold during the reporting period, which accounted for 17.6% of the plan spend. The highest diagnosis category was Cancer, accounting for 40.1% of the high-cost claimant dollars.
- Total spending with in-network providers was 99.3%. The average In Network discount was 64.4%, which is 1.9% higher than the PY22 average discount of 63.2%.

Paid Claims by Age Group

Paid Claims by Age Group																
	2Q22						2Q23						% Change	
Age Range	Med Net Pay	Med PMPM	Rx Net Pay	Rx PMPM	Net Pay	PMPM	Med Net Pay	Med PMPM	Rx Net Pay	Rx PMPM	Net Pay	PMPM	Net Pay	PMPM
<1	$ 2,309,271	$ 4,998	$ 1,306	$ 3	$ 2,310,577	$ 5,001	$ 952,206	$ 1,037	$ 12,813	$ 14	$ 965,019	$ 1,051	-58.2%	-79.0%
1	$ 93,751	$ 155	$ 3,150	$ 5	$ 96,901	$ 160	$ 200,437	$ 235	$ 4,730	$ 6	$ 205,167	$ 241	111.7%	50.6%
2 - 4	$ 217,849	$ 112	$ 31,015	$ 16	$ 248,864	$ 128	$ 519,289	$ 159	$ 24,713	$ 8	$ 544,002	$ 167	118.6%	30.0%
5 - 9	$ 178,334	$ 54	$ 40,388	$ 12	$ 218,722	$ 66	$ 461,813	$ 80	$ 291,974	$ 51	$ 753,787	$ 131	244.6%	97.2%
10 - 14	$ 444,900	$ 111	$ 104,294	$ 26	$ 549,194	$ 137	$ 840,770	$ 135	$ 164,248	$ 26	$ 1,005,018	$ 161	83.0%	17.7%
15 - 19	$ 554,002	$ 138	$ 168,892	$ 42	$ 722,894	$ 181	$ 1,017,142	$ 144	$ 252,305	$ 36	$ 1,269,447	$ 179	75.6%	-0.7%
20 - 24	$ 679,085	$ 171	$ 137,337	$ 35	$ 816,422	$ 206	$ 1,074,808	$ 160	$ 356,576	$ 53	$ 1,431,384	$ 213	75.3%	3.5%
25 - 29	$ 678,350	$ 237	$ 203,045	$ 71	$ 881,395	$ 308	$ 894,828	$ 168	$ 500,318	$ 94	$ 1,395,146	$ 262	58.3%	-14.8%
30 - 34	$ 854,172	$ 239	$ 306,656	$ 86	$ 1,160,828	$ 325	$ 1,698,193	$ 266	$ 468,856	$ 73	$ 2,167,049	$ 339	86.7%	4.4%
35 - 39	$ 1,556,544	$ 371	$ 337,103	$ 80	$ 1,893,647	$ 451	$ 1,949,915	$ 267	$ 718,780	$ 98	$ 2,668,695	$ 365	40.9%	-19.0%
40 - 44	$ 1,372,079	$ 333	$ 435,256	$ 106	$ 1,807,335	$ 438	$ 2,008,733	$ 286	$ 1,134,778	$ 162	$ 3,143,511	$ 448	73.9%	2.1%
45 - 49	$ 1,222,592	$ 330	$ 372,765	$ 101	$ 1,595,357	$ 430	$ 2,542,958	$ 401	$ 1,026,465	$ 162	$ 3,569,423	$ 563	123.7%	30.8%
50 - 54	$ 998,387	$ 247	$ 589,314	$ 146	$ 1,587,701	$ 392	$ 2,872,067	$ 423	$ 1,435,335	$ 211	$ 4,307,402	$ 634	171.3%	61.8%
55 - 59	$ 2,537,124	$ 671	$ 552,278	$ 146	$ 3,089,402	$ 817	$ 2,848,976	$ 468	$ 1,251,320	$ 205	$ 4,100,296	$ 673	32.7%	-17.6%
60 - 64	$ 1,928,053	$ 606	$ 1,000,909	$ 315	$ 2,928,962	$ 921	$ 3,233,417	$ 594	$ 1,923,145	$ 353	$ 5,156,562	$ 948	76.1%	2.9%
65+	$ 862,275	$ 708	$ 281,482	$ 231	$ 1,143,757	$ 939	$ 843,930	$ 412	$ 471,496	$ 230	$ 1,315,426	$ 643	15.0%	-31.5%
Total	**$ 16,486,768**	**$ 337**	**$ 4,565,189**	**$ 93**	**$21,051,957**	**$ 430**	**$ 23,959,484**	**$ 287**	**$ 10,037,853**	**$ 120**	**$ 33,997,337**	**$ 407**	**61.5%**	**-5.4%**

Financial Summary (p. 1 of 2)

	Total			State Active			Non-State Active		
Summary	**2Q22**	**2Q23**	**Variance to Prior Year**	**2Q22**	**2Q23**	**Variance to Prior Year**	**2Q22**	**2Q23**	**Variance to Prior Year**
Enrollment									
Avg # Employees	3,974	7,089	78.4%	3,595	6,434	79.0%	1	1	0.0%
Avg # Members	8,161	13,931	70.7%	7,531	12,824	70.3%	2	2	0.0%
Ratio	2.1	2.0	-3.9%	2.1	2.0	-5.2%	2.0	2.0	0.0%
Financial Summary									
Gross Cost	$19,582,093	$28,044,415	43.2%	$16,875,837	$24,386,794	44.5%	$20,089	$9,392	-53.2%
Client Paid	$16,486,768	$23,959,484	45.3%	$14,156,779	$20,789,498	46.9%	$16,221	$7,316	-54.9%
Employee Paid	$3,095,325	$4,084,930	32.0%	$2,719,057	$3,597,296	32.3%	$3,869	$2,077	-46.3%
Client Paid-PEPY	$8,298	$6,759	-18.5%	$7,876	$6,462	-18.0%	$32,442	$14,632	-54.9%
Client Paid-PMPY	$4,040	$3,440	-14.9%	$3,759	$3,242	-13.8%	$16,221	$7,316	-54.9%
Client Paid-PEPM	$692	$563	-18.6%	$656	$539	-17.8%	$2,703	$1,219	-54.9%
Client Paid-PMPM	$337	$287	-14.8%	$313	$270	-13.7%	$1,352	$610	-54.9%
High Cost Claimants (HCC's) > $100k									
# of HCC's	23	18	-21.7%	18	14	-22.2%	0	0	0.0%
HCC's / 1,000	2.8	1.3	-54.3%	2.4	1.1	-54.4%	0.0	0.0	0.0%
Avg HCC Paid	$265,379	$233,855	-11.9%	$283,321	$248,746	-12.2%	$0	$0	0.0%
HCC's % of Plan Paid	37.0%	17.6%	-52.4%	36.0%	16.8%	-53.3%	0.0%	0.0%	0.0%
Cost Distribution by Claim Type (PMPY)									
Facility Inpatient	$1,461	$683	-53.3%	$1,401	$619	-55.8%	$0	$0	0.0%
Facility Outpatient	$970	$1,194	23.1%	$861	$1,112	29.2%	$5,328	$491	0.0%
Physician	$1,557	$1,563	0.4%	$1,447	$1,512	4.5%	$10,893	$6,825	-37.3%
Other	$52	$0	-100.0%	$51	$0	-100.0%	$0	$0	0.0%
Total	$4,040	$3,440	-14.9%	$3,759	$3,242	-13.8%	$16,221	$7,316	-54.9%
	Annualized	Annualized		Annualized	Annualized		Annualized	Annualized	

Financial Summary (p. 2 of 2)

	State Retirees			Non-State Retirees			
Summary	**2Q22**	**2Q23**	**Variance to Prior Year**	**2Q22**	**2Q23**	**Variance to Prior Year**	**Peer Index**
Enrollment							
Avg # Employees	357	627	75.8%	21	27	26.7%	
Avg # Members	596	1,066	78.8%	32	39	20.7%	
Ratio	1.7	1.7	1.8%	1.5	1.5	-4.6%	1.6
Financial Summary							
Gross Cost	$2,523,590	$3,554,103	40.8%	$162,576	$94,126	-42.1%	
Client Paid	$2,184,001	$3,088,200	41.4%	$129,767	$74,470	-42.6%	
Employee Paid	$339,589	$465,903	37.2%	$32,809	$19,656	-40.1%	
Client Paid-PEPY	$12,241	$9,845	-19.6%	$12,261	$5,551	-54.7%	$6,642
Client Paid-PMPY	$7,329	$5,795	-20.9%	$8,068	$3,835	-52.5%	$4,116
Client Paid-PEPM	$1,020	$820	-19.6%	$1,022	$463	-54.7%	$553
Client Paid-PMPM	$611	$483	-20.9%	$672	$320	-52.4%	$343
High Cost Claimants (HCC's) > $100k							
# of HCC's	6	4	-33.3%	0	0	0.0%	
HCC's / 1,000	10.1	3.8	-62.8%	0.0	0.0	0.0%	
Avg HCC Paid	$167,323	$181,739	8.6%	$0	$0	0.0%	
HCC's % of Plan Paid	46.0%	23.5%	-48.9%	0.0%	0.0%	0.0%	
Cost Distribution by Claim Type (PMPY)							
Facility Inpatient	$2,281	$1,469	-35.6%	$552	$324	-41.3%	$1,190
Facility Outpatient	$2,141	$2,179	1.8%	$4,599	$1,368	-70.3%	$1,376
Physician	$2,842	$2,147	-24.5%	$2,852	$2,143	-24.9%	$1,466
Other	$65	$0	-100.0%	$65	$0	-100.0%	$84
Total	$7,329	$5,795	-20.9%	$8,068	$3,835	-52.5%	$4,116
	Annualized	Annualized		Annualized	Annualized		

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

	Total			State Active			Non-State Active		
Summary	**PY22**	**2Q23**	**Variance to Prior Year**	**PY22**	**2Q23**	**Variance to Prior Year**	**PY22**	**2Q23**	**Variance to Prior Year**
Enrollment									
Avg # Employees	4,336	7,089	63.5%	3,926	6,434	63.9%	1	1	0.0%
Avg # Members	8,762	13,931	59.0%	8,071	12,824	58.9%	2	2	0.0%
Ratio	2.0	2.0	-2.5%	2.1	2.0	-3.4%	2.0	2.0	0.0%
Financial Summary									
Gross Cost	$40,570,436	$28,044,415	-30.9%	$35,366,785	$24,386,794	-31.0%	$38,494	$9,392	-75.6%
Client Paid	$34,446,692	$23,959,484	-30.4%	$29,933,591	$20,789,498	-30.5%	$33,556	$7,316	-78.2%
Employee Paid	$6,123,744	$4,084,930	-33.3%	$5,433,194	$3,597,296	-33.8%	$4,938	$2,077	-57.9%
Client Paid-PEPY	$7,944	$6,759	-14.9%	$7,624	$6,462	-15.2%	$33,556	$14,632	-56.4%
Client Paid-PMPY	$3,931	$3,440	-12.5%	$3,709	$3,242	-12.6%	$16,778	$7,316	-56.4%
Client Paid-PEPM	$662	$563	-15.0%	$635	$539	-15.1%	$2,796	$1,219	-56.4%
Client Paid-PMPM	$328	$287	-12.5%	$309	$270	-12.6%	$1,398	$610	-56.4%
High Cost Claimants (HCC's) > $100k									
# of HCC's	41	18	-56.1%	33	14	-57.6%	0	0	0.0%
HCC's / 1,000	4.7	1.3	-72.4%	4.1	1.1	-73.3%	0.0	0.0	0.0%
Avg HCC Paid	$286,071	$233,855	-18.3%	$305,172	$248,746	-18.5%	$0	$0	0.0%
HCC's % of Plan Paid	34.0%	17.6%	-48.2%	33.6%	16.8%	-50.0%	0.0%	0.0%	0.0%
Cost Distribution by Claim Type (PMPY)									
Facility Inpatient	$1,269	$683	-46.2%	$1,257	$619	-50.8%	$424	$0	-100.0%
Facility Outpatient	$1,043	$1,194	14.5%	$933	$1,112	19.2%	$5,152	$491	-90.5%
Physician	$1,567	$1,563	-0.3%	$1,468	$1,512	3.0%	$9,883	$6,825	-30.9%
Other	$53	$0	-100.0%	$50	$0	-100.0%	$1,319	$0	-100.0%
Total	$3,931	$3,440	-12.5%	$3,709	$3,242	-12.6%	$16,778	$7,316	-56.4%
		Annualized			Annualized			Annualized	

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

	State Retirees			Non-State Retirees			
Summary	**PY22**	**2Q23**	**Variance to Prior Year**	**PY22**	**2Q23**	**Variance to Prior Year**	**Peer Index**
Enrollment							
Avg # Employees	388	627	61.8%	21	27	26.3%	
Avg # Members	657	1,066	62.2%	32	39	20.4%	
Ratio	1.7	1.7	0.6%	1.5	1.5	-4.6%	1.6
Financial Summary							
Gross Cost	$4,886,927	$3,554,103	-27.3%	$278,229	$94,126	-66.2%	
Client Paid	$4,252,910	$3,088,200	-27.4%	$226,635	$74,470	-67.1%	
Employee Paid	$634,017	$465,903	-26.5%	$51,594	$19,656	-61.9%	
Client Paid-PEPY	$10,968	$9,845	-10.2%	$10,665	$5,551	-48.0%	$6,642
Client Paid-PMPY	$6,473	$5,795	-10.5%	$7,027	$3,835	-45.4%	$4,116
Client Paid-PEPM	$914	$820	-10.3%	$889	$463	-47.9%	$553
Client Paid-PMPM	$539	$483	-10.4%	$586	$320	-45.4%	$343
High Cost Claimants (HCC's) > $100k							
# of HCC's	8	4	-50.0%	1	0	-100.0%	
HCC's / 1,000	12.2	3.8	-69.2%	31.0	0.0	-100.0%	
Avg HCC Paid	$193,399	$181,739	-6.0%	$111,053	$0	-100.0%	
HCC's % of Plan Paid	36.4%	23.5%	-35.4%	49.0%	0.0%	-100.0%	
Cost Distribution by Claim Type (PMPY)							
Facility Inpatient	$1,452	$1,469	1.2%	$675	$324	-52.0%	$1,190
Facility Outpatient	$2,262	$2,179	-3.7%	$3,333	$1,368	-59.0%	$1,376
Physician	$2,676	$2,147	-19.8%	$2,969	$2,143	-27.8%	$1,466
Other	$83	$0	-100.0%	$50	$0	-100.0%	$84
Total	$6,473	$5,795	-10.5%	$7,027	$3,835	-45.4%	$4,116
		Annualized			Annualized		

Paid Claims by Claim Type – State Participants

Net Paid Claims - Total State Participants	2Q22				2Q23				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical									
Inpatient	$6,020,449.91	$718,877.11	$1,882.65	$ 6,741,210	$ 4,809,745	$ 4,304	$ 874,647	$ 5,688,696	-15.6%
Outpatient	$8,136,329.46	$1,440,040.70	$23,200.70	$ 9,599,571	$ 15,979,754	$ 50,099	$ 2,159,150	$ 18,189,003	89.5%
Total - Medical	**$ 14,156,779**	**$ 2,158,918**	**$ 25,083**	**$ 16,340,781**	**$ 20,789,498**	**$ 54,403**	**$ 3,033,797**	**$ 23,877,699**	**46.1%**

Net Paid Claims - Per Participant per Month	2Q22				2Q23				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical	$ 656	$ 1,091	$ 154	$ 689	$ 539	$ 15	$ 12,855	$ 564	-18.2%

Paid Claims by Claim Type – Non-State Participants

Net Paid Claims - Total Non-State Participants	2Q22				2Q23				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical									
Inpatient	$ -	$ 4,782	$ 6,547	$ 11,329	$ -	$ 6,740	$ 564	$ 7,304	-35.5%
Outpatient	$ 16,221	$ 31,706	$ 86,731	$ 134,658	$ 7,316	$ 47,465	$ 19,700	$ 74,481	-44.7%
Total - Medical	**$ 16,221**	**$ 36,488**	**$ 93,279**	**$ 145,988**	**$ 7,316**	**$ 54,205**	**$ 20,265**	**$ 81,786**	**-44.0%**

Net Paid Claims - Per Participant per Month	2Q22				2Q23				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical	$ 4,056	$ 521	$ 1,636	$ 1,114	$ 1,219	$ 630	$ 270	$ 490	-56.1%

Paid Claims by Claim Type – Total Participants

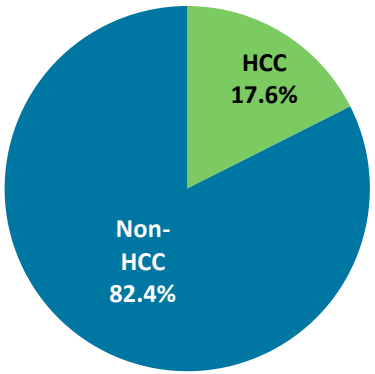
Net Paid Claims - Total Total Participants	2Q22				2Q23				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical									
Inpatient	$ 6,020,450	$ 723,659	$ 8,430	$ 6,752,539	$ 4,809,745	$ 11,044	$ 875,211	$ 5,696,000	-15.6%
Outpatient	$ 8,152,550	$ 1,471,747	$ 109,932	$ 9,734,229	$ 15,987,070	$ 97,564	$ 2,178,850	$ 18,263,484	87.6%
Total - Medical	**$ 14,173,000**	**$ 2,195,406**	**$ 118,362**	**$ 16,486,768**	**$ 20,796,814**	**$ 108,608**	**$ 3,054,062**	**$ 23,959,484**	**45.3%**

Net Paid Claims - Per Participant per Month	2Q22				2Q23				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical	$ 657	$ 1,072	$ 538	$ 692	$ 539	$ 30	$ 9,820	$ 563	-18.5%

Cost Distribution – Medical Claims

2Q22							2Q23					
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
22	0.3%	$6,103,717	37.0%	$102,621	3.3%	$100,000.01 Plus	17	0.1%	$4,209,398	17.6%	$72,124	1.8%
21	0.3%	$1,468,741	8.9%	$90,455	2.9%	$50,000.01-$100,000.00	41	0.3%	$3,128,054	13.1%	$174,984	4.3%
39	0.5%	$1,450,384	8.8%	$140,078	4.5%	$25,000.01-$50,000.00	67	0.5%	$2,366,111	9.9%	$246,522	6.0%
125	1.5%	$1,979,591	12.0%	$391,303	12.6%	$10,000.01-$25,000.00	269	1.9%	$4,293,330	17.9%	$710,874	17.4%
207	2.5%	$1,508,625	9.2%	$395,618	12.8%	$5,000.01-$10,000.00	356	2.6%	$2,549,174	10.6%	$571,665	14.0%
313	3.8%	$1,162,097	7.0%	$432,717	14.0%	$2,500.01-$5,000.00	624	4.5%	$2,315,355	9.7%	$636,009	15.6%
4,992	61.2%	$2,810,917	17.0%	$1,521,800	49.2%	$0.01-$2,500.00	8,683	62.3%	$5,098,063	21.3%	$1,667,131	40.8%
130	1.6%	$0	0.0%	$20,021	0.6%	$0.00	121	0.9%	$0	0.0%	$5,623	0.1%
2,312	28.3%	$2,696	0.0%	$712	0.0%	No Claims	3,754	27.0%	$0	0.0%	$0	0.0%
8,161	**100.0%**	**$16,486,768**	**100.0%**	**$3,095,325**	**100.0%**		**13,931**	**100.0%**	**$23,959,484**	**100.0%**	**$4,084,930**	**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	10	$1,689,626	40.1%
Endocrine/Metabolic Disorders	6	$719,159	17.1%
Neurological Disorders	7	$433,385	10.3%
Medical/Surgical Complications	7	$312,929	7.4%
Spine-related Disorders	2	$189,918	4.5%
Gastrointestinal Disorders	8	$188,312	4.5%
Congenital/Chromosomal Anomalies	3	$131,527	3.1%
Infections	9	$126,083	3.0%
Renal/Urologic Disorders	4	$120,589	2.9%
Cardiac Disorders	8	$96,953	2.3%
All Other		$200,916	4.8%
Overall	**----**	**$4,209,398**	**100.0%**

Utilization Summary (p. 1 of 2)

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

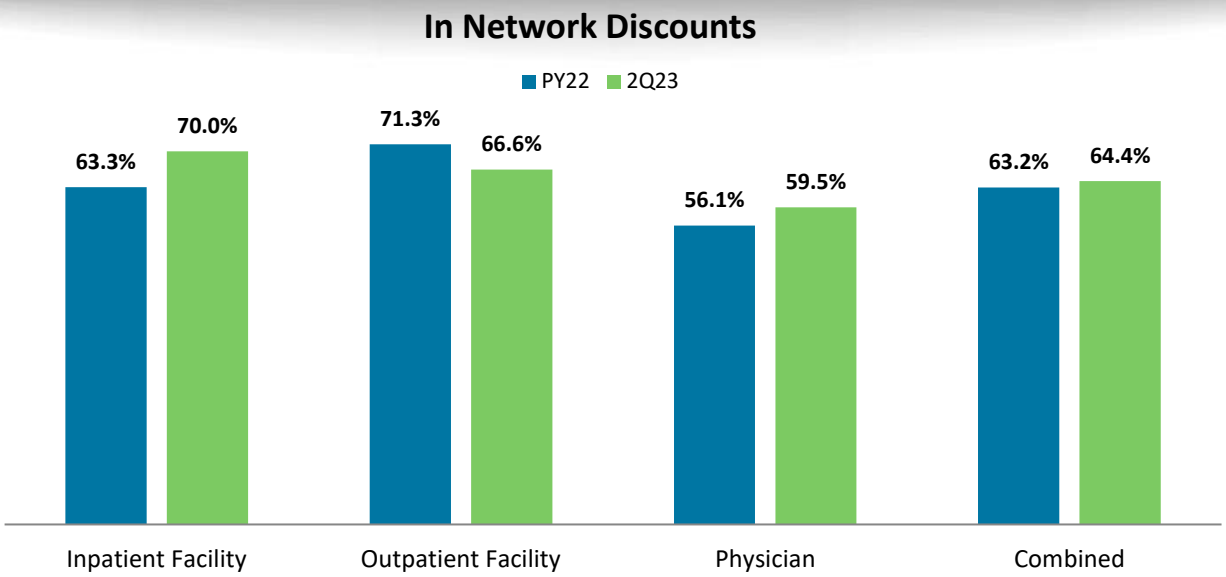
	Total			State Active			Non-State Active		
Summary	**2Q22**	**2Q23**	**Variance to Prior Year**	**2Q22**	**2Q23**	**Variance to Prior Year**	**2Q22**	**2Q23**	**Variance to Prior Year**
Inpatient Facility									
# of Admits	157	239		132	215		0	0	
# of Bed Days	779	1,039		694	940		0	0	
Paid Per Admit	$36,610	$23,315	-36.3%	$36,703	$21,956	-40.2%	$0	$0	0.0%
Paid Per Day	$7,378	$5,363	-27.3%	$6,981	$5,022	-28.1%	$0	$0	0.0%
Admits Per 1,000	38	34	-10.5%	35	34	-2.9%	0	0	0.0%
Days Per 1,000	191	149	-22.0%	184	147	-20.1%	0	0	0.0%
Avg LOS	5	4.3	-14.0%	5.3	4.4	-17.0%	0	0	0.0%
# Admits From ER	79	111		63	97		0	0	
Physician Office									
OV Utilization per Member	4.6	4.5	-2.2%	4.5	4.4	-2.2%	11.0	12.0	9.1%
Avg Paid per OV	$133	$116	-12.8%	$124	$115	-7.3%	$228	$340	49.1%
Avg OV Paid per Member	$616	$525	-14.8%	$560	$508	-9.3%	$2,513	$4,076	62.2%
DX&L Utilization per Member	8.1	9.5	17.3%	7.7	9.1	18.2%	33	30	-9.1%
Avg Paid per DX&L	$48	$59	22.9%	$45	$58	28.9%	$111	$63	-43.2%
Avg DX&L Paid per Member	$387	$562	45.2%	$345	$523	51.6%	$3,658	$1,876	-48.7%
Emergency Room									
# of Visits	532	958		496	878		0	0	
Visits Per Member	0.13	0.14	7.7%	0.13	0.14	7.7%	0	0	0.0%
Visits Per 1,000	130	138	6.2%	132	137	3.8%	0	0	0.0%
Avg Paid per Visit	$2,338	$3,179	36.0%	$2,302	$3,204	39.2%	$0	$0	0.0%
Urgent Care									
# of Visits	1,270	2,596		1,188	2,465		0	1	
Visits Per Member	0.31	0.37	19.4%	0.32	0.38	18.8%	0.00	1.00	0.0%
Visits Per 1,000	311	373	19.9%	315	384	21.9%	0	1,000	0.0%
Avg Paid per Visit	$119	$101	-15.1%	$118	$101	-14.4%	$0	$170	0.0%
	Annualized	Annualized		Annualized	Annualized		Annualized	Annualized	

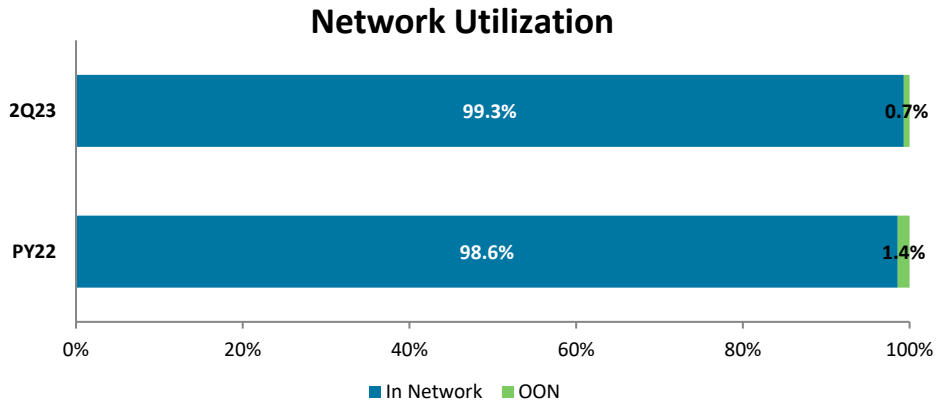
Utilization Summary (p. 2 of 2)

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

	State Retirees			Non-State Retirees			
Summary	**2Q22**	**2Q23**	**Variance to Prior Year**	**2Q22**	**2Q23**	**Variance to Prior Year**	**Peer Index**
Inpatient Facility							
# of Admits	20	23		5	1		
# of Bed Days	71	96		14	3		
Paid Per Admit	$43,865	$36,656	-16.4%	$5,130	$8,577	67.2%	$18,822
Paid Per Day	$12,356	$8,782	-28.9%	$1,832	$2,859	56.1%	$3,265
Admits Per 1,000	67	43	-35.8%	311	52	-83.3%	70
Days Per 1,000	238	180	-24.4%	870	155	-82.2%	402
Avg LOS	3.6	4.2	16.7%	2.8	3.0	7.1%	5.8
# Admits From ER	14	14		2	0		
Physician Office							
OV Utilization per Member	6.3	6.1	-3.2%	6.2	7.5	21.0%	5.4
Avg Paid per OV	$209	$118	-43.5%	$108	$83	-23.1%	$96
Avg OV Paid per Member	$1,318	$719	-45.4%	$671	$625	-6.9%	$515
DX&L Utilization per Member	13	14.2	9.2%	14.4	17	18.1%	11.0
Avg Paid per DX&L	$67	$72	7.5%	$77	$45	-41.6%	$50
Avg DX&L Paid per Member	$875	$1,018	16.3%	$1,107	$763	-31.1%	$543
Emergency Room							
# of Visits	35	77		1	3		
Visits Per Member	0.12	0.14	16.7%	0.06	0.15	0.0%	0.22
Visits Per 1,000	117	144	23.1%	62	155	0.0%	221
Avg Paid per Visit	$2,860	$2,961	3.5%	$1,827	$1,260	0.0%	$968
Urgent Care							
# of Visits	80	129		2	1		
Visits Per Member	0.27	0.24	-11.1%	0.12	0.05	0.0%	0.35
Visits Per 1,000	268	242	-9.7%	124	52	0.0%	352
Avg Paid per Visit	$146	$101	-30.8%	$70	$52	0.0%	$135
	Annualized	Annualized		Annualized	Annualized		

Provider Network Summary





Diagnosis Grouper Summary

Diagnosis Grouper	Total Paid	% Paid	Insured	Spouse	Child	Male	Female
Cancer	$2,909,945	12.1%	$1,565,239	$1,031,901	$312,804	$982,445	$1,927,500
Gastrointestinal Disorders	$2,125,866	8.9%	$1,495,710	$322,493	$307,663	$689,766	$1,436,099
Health Status/Encounters	$2,065,926	8.6%	$1,086,216	$253,796	$725,913	$739,816	$1,326,110
Pregnancy-related Disorders	$1,549,936	6.5%	$838,362	$245,091	$466,483	$285,887	$1,264,049
Neurological Disorders	$1,501,800	6.3%	$914,819	$179,375	$407,606	$478,656	$1,023,145
Cardiac Disorders	$1,433,501	6.0%	$1,010,739	$304,449	$118,313	$775,719	$657,782
Endocrine/Metabolic Disorders	$1,229,533	5.1%	$614,495	$530,151	$84,887	$138,630	$1,090,903
Mental Health	$1,201,630	5.0%	$501,076	$126,498	$574,057	$400,530	$801,100
Musculoskeletal Disorders	$1,143,673	4.8%	$792,394	$171,149	$180,130	$368,227	$775,447
Trauma/Accidents	$1,140,907	4.8%	$601,022	$184,729	$355,156	$650,992	$489,916
Eye/ENT Disorders	$1,128,639	4.7%	$585,791	$153,760	$389,088	$414,897	$713,742
Infections	$872,996	3.6%	$448,815	$125,403	$298,777	$472,007	$400,989
Spine-related Disorders	$844,404	3.5%	$461,344	$283,634	$99,426	$534,741	$309,663
Gynecological/Breast Disorders	$772,422	3.2%	$563,687	$112,659	$96,076	$21,849	$750,573
Renal/Urologic Disorders	$699,093	2.9%	$374,325	$114,884	$209,884	$244,997	$454,096
Pulmonary Disorders	$648,883	2.7%	$316,201	$69,541	$263,141	$347,655	$301,228
Non-malignant Neoplasm	$562,445	2.3%	$379,659	$159,077	$23,709	$127,487	$434,958
Medical/Surgical Complications	$511,538	2.1%	$397,777	$5,660	$108,101	$444,801	$66,737
Dermatological Disorders	$290,256	1.2%	$165,421	$43,873	$80,962	$126,166	$164,089
Miscellaneous	$262,318	1.1%	$156,732	$37,680	$67,906	$97,511	$164,807
Diabetes	$236,844	1.0%	$131,640	$90,021	$15,184	$146,665	$90,180
Congenital/Chromosomal Anomalies	$204,420	0.9%	$17,434	$136,122	$50,865	$158,414	$46,006
Abnormal Lab/Radiology	$190,719	0.8%	$123,849	$52,941	$13,929	$63,109	$127,610
Hematological Disorders	$143,741	0.6%	$86,718	$30,607	$26,416	$92,081	$51,660
Medication Related Conditions	$106,433	0.4%	$51,690	$4,336	$50,406	$54,555	$51,877
Vascular Disorders	$82,410	0.3%	$53,589	$23,139	$5,682	$32,587	$49,823
Cholesterol Disorders	$60,845	0.3%	$47,480	$11,088	$2,276	$32,174	$28,671
Allergic Reaction	$18,021	0.1%	$5,510	$169	$12,342	$7,675	$10,346
External Hazard Exposure	$13,187	0.1%	$9,058	$0	$4,129	$4,741	$8,446
Dental Conditions	$6,583	0.0%	$1,324	$196	$5,063	$2,849	$3,734
Social Determinants of Health	$545	0.0%	$435	$110	$0	$435	$110
Cause of Morbidity	$26	0.0%	$26	$0	$0	$0	$26
Total	**$23,959,484**	**100.0%**	**$13,798,578**	**$4,804,533**	**$5,356,374**	**$8,938,064**	**$15,021,420**

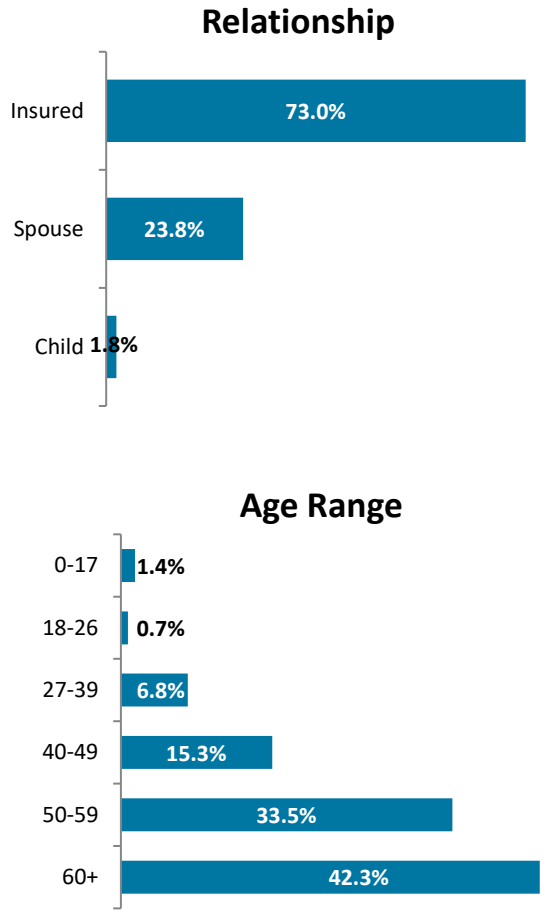
Mental Health Drilldown

Grouper	PY22 Patients	PY22 Total Paid	2Q23 Patients	2Q23 Total Paid
Depression	453	$568,975	518	$302,978
Mood and Anxiety Disorders	613	$271,735	638	$279,854
Mental Health Conditions, Other	431	$351,519	465	$209,018
Alcohol Abuse/Dependence	20	$75,926	34	$103,461
Developmental Disorders	59	$215,640	65	$71,548
Bipolar Disorder	107	$247,201	131	$60,713
Attention Deficit Disorder	199	$80,894	265	$52,176
Schizophrenia	4	$2,259	9	$32,392
Sleep Disorders	124	$26,517	122	$29,023
Eating Disorders	24	$147,776	24	$15,755
Sexually Related Disorders	28	$8,553	36	$14,976
Substance Abuse/Dependence	29	$68,285	27	$11,362
Psychoses	6	$10,965	8	$9,942
Personality Disorders	14	$15,495	12	$6,166
Tobacco Use Disorder	16	$4,458	27	$1,641
Complications of Substance Abuse	6	$27,466	4	$627
Total		**$2,123,665**		**$1,201,630**

Diagnosis Grouper – Cancer

Diagnosis Sub-Grouper	Patients	Claims	Total Paid	% Paid
Cancer Therapies	20	101	$1,577,785	90.4%
Breast Cancer	66	497	$461,682	26.4%
Non-Melanoma Skin Cancers	50	160	$183,375	10.5%
Cancers, Other	42	232	$162,922	9.3%
Brain Cancer	3	102	$127,579	7.3%
Prostate Cancer	23	127	$107,130	6.1%
Secondary Cancers	17	103	$61,335	3.5%
Thyroid Cancer	22	86	$53,237	3.0%
Lymphomas	14	113	$52,817	3.0%
Colon Cancer	6	53	$31,346	1.8%
Carcinoma in Situ	26	52	$26,407	1.5%
Myeloma	2	56	$18,351	1.1%
Leukemias	7	48	$14,609	0.8%
Lung Cancer	10	79	$13,368	0.8%
Melanoma	15	31	$10,404	0.6%
Cervical/Uterine Cancer	12	24	$4,660	0.3%
Kidney Cancer	8	19	$2,068	0.1%
Ovarian Cancer	2	6	$479	0.0%
Pancreatic Cancer	1	2	$389	0.0%
Overall	**----**	**----**	**$2,909,945**	**100.0%**

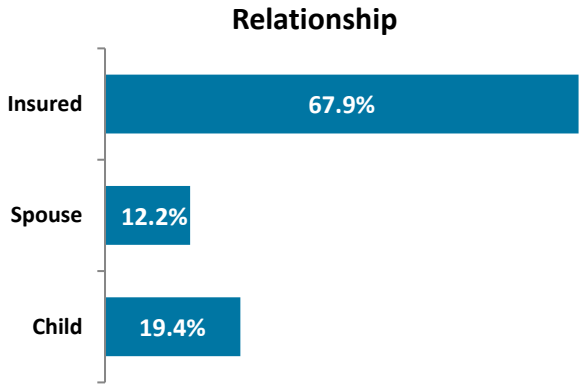
*Patient and claim counts are unique only within the category

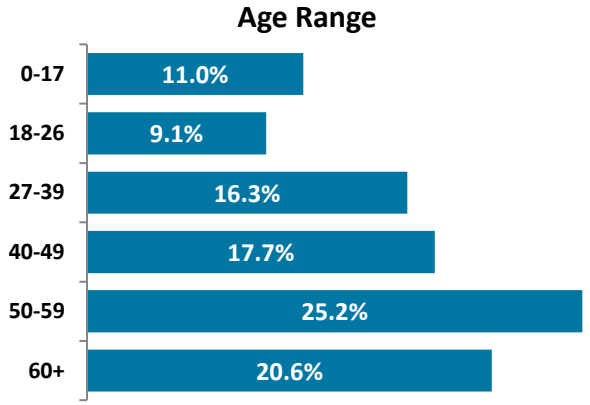


Diagnosis Grouper – Gastrointestinal Orders

Diagnosis Sub-Grouper	Patients	Claims	Total Paid	% Paid
GI Disorders, Other	272	611	$473,001	75.8%
Abdominal Disorders	513	1,093	$413,995	66.3%
Gallbladder and Biliary Disease	53	234	$225,708	36.2%
Hernias	64	175	$224,642	36.0%
Upper GI Disorders	283	541	$168,219	27.0%
Appendicitis	9	48	$130,587	20.9%
GI Symptoms	327	602	$119,394	19.1%
Diverticulitis	44	98	$101,408	16.2%
Inflammatory Bowel Disease	45	147	$82,171	13.2%
Pancreatic Disorders	12	48	$61,920	9.9%
Constipation	92	165	$51,804	8.3%
Liver Diseases	94	161	$27,207	4.4%
Ostomies	8	40	$16,898	2.7%
Hemorrhoids	60	101	$14,445	2.3%
Peptic Ulcer/Related Disorders	12	19	$11,300	1.8%
Esophageal Varices	2	3	$1,935	0.3%
Hepatic Cirrhosis	10	13	$1,232	0.2%
	----	----	$2,125,866	340.6%

*Patient and claim counts are unique only within the category

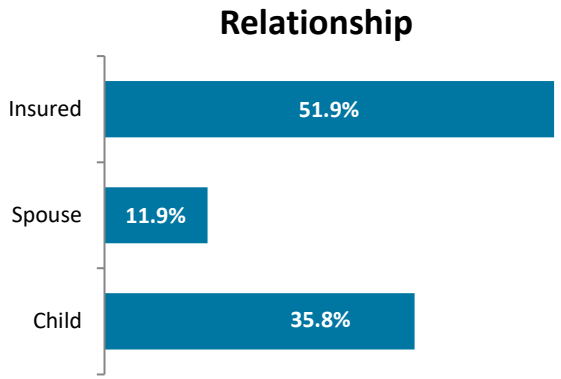


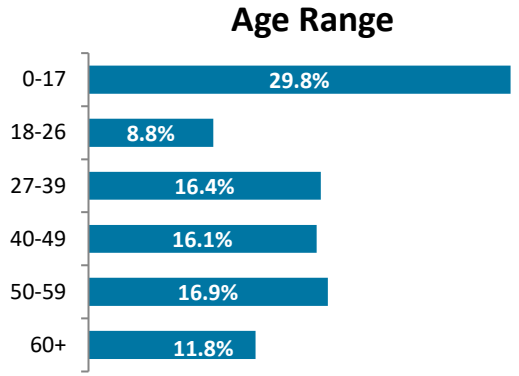


Diagnosis Grouper – Health Status/Encounters

Diagnosis Category	Patients	Claims	Total Paid	% Paid
Screenings	2,083	3,780	$606,136	29.3%
Exams	2,768	4,692	$515,633	25.0%
Prophylactic Measures	2,063	2,602	$450,436	21.8%
Encounters - Infants/Children	1,350	1,782	$266,611	12.9%
Personal History of Condition	250	443	$98,816	4.8%
Prosthetics/Devices/Implants	102	283	$50,685	2.5%
Aftercare	108	202	$30,952	1.5%
Family History of Condition	62	79	$17,585	0.9%
Encounter - Transplant Related	9	38	$13,960	0.7%
Counseling	54	84	$3,667	0.2%
Encounter - Procedure	30	37	$3,295	0.2%
Donors	1	1	$2,589	0.1%
Lifestyle/Situational Issues	35	59	$2,482	0.1%
Follow-Up Encounters	2	5	$1,477	0.1%
Miscellaneous Examinations	16	31	$833	0.0%
Acquired Absence	7	8	$390	0.0%
Health Status, Other	19	24	$378	0.0%
Overall	**----**	**----**	**$2,065,926**	**313.1%**

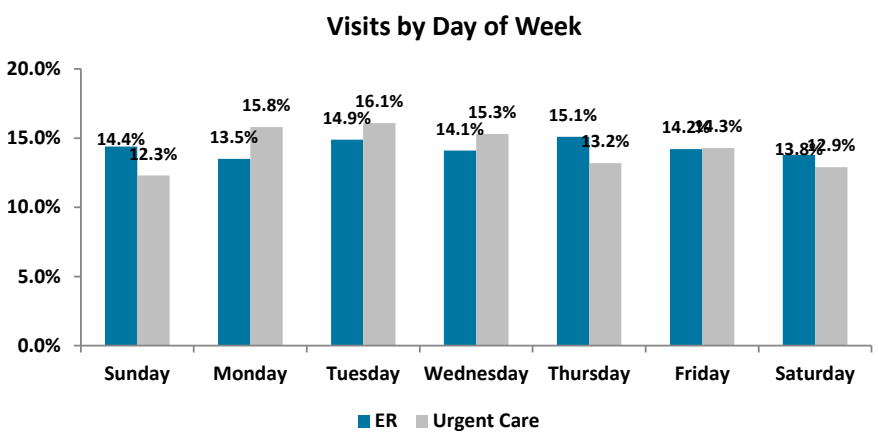
*Patient and claim counts are unique only within the category

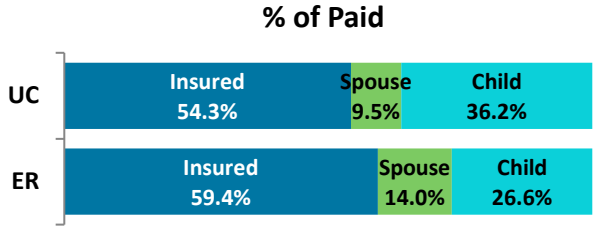




Emergency Room / Urgent Care Summary

	2Q22		2Q23		Peer Index	
ER/Urgent Care	**ER**	**Urgent Care**	**ER**	**Urgent Care**	**ER**	**Urgent Care**
Number of Visits	532	1,270	958	2,596		
Visits Per Member	0.13	0.31	0.14	0.37	0.22	0.35
Visits/1000 Members	130	311	138	373	221	352
Avg Paid Per Visit	$2,338	$119	$3,179	$101	$968	$135
% with OV*	80.4%	77.6%	78.9%	75.5%		
% Avoidable	12.4%	34.0%	14.3%	41.4%		
Total Member Paid	**$304,525**	**$83,973**	**$665,547**	**$189,724**		
Total Plan Paid	**$1,243,955**	**$151,485**	**$3,045,918**	**$262,539**		
*looks back 12 months from ER visit	Annualized	Annualized	Annualized	Annualized		





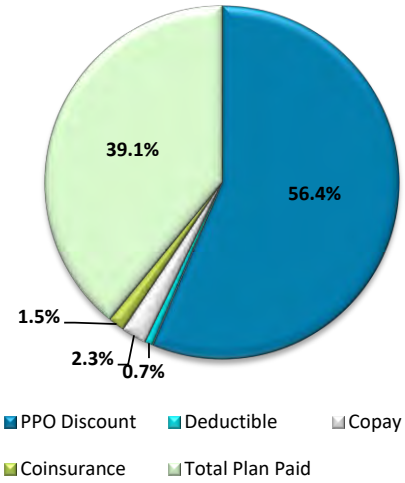
ER / UC Visits by Relationship						
Relationship	**ER**	**Per 1,000**	**Urgent Care**	**Per 1,000**	**Total**	**Per 1,000**
Insured	497	70	1,407	198	1,904	269
Spouse	126	69	253	139	379	209
Child	335	67	936	186	1,271	253
Total	**958**	**69**	**2,596**	**186**	**3,554**	**255**

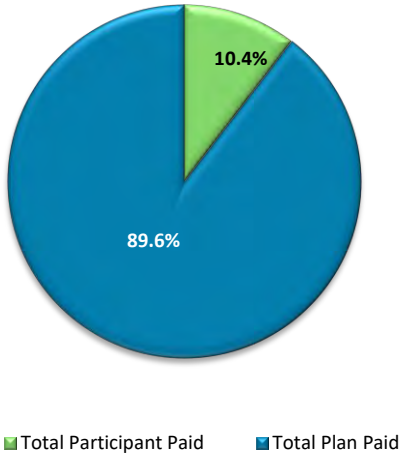
Hospital and physician urgent care centers are included in the data.
Paid amount includes facility and professional fees.

Savings Summary – Medical Claims

Description	Dollars	PPPM	% of Eligible
Eligible Charges	$80,520,989	$3,818	100.0%
PPO Discount	$51,410,587	$2,438	63.8%
Deductible	$0	$0	0.0%
Copay	$2,190,670	$104	2.7%
Coinsurance	$1,894,260	$90	2.4%
Total Participant Paid	**$4,084,930**	**$194**	**5.1%**
Total Plan Paid	**$23,959,484**	**$563**	**29.8%**

Total Participant Paid - PY22	**$136**
Total Plan Paid - PY22	**$539**





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	578	571	7	98.8%
	<2 asthma related ER Visits in the last 6 months	578	577	1	99.8%
	No asthma related admit in last 12 months	578	578	0	100.0%
Chronic Obstructive Pulmonary Disease	No exacerbations in last 12 months	60	57	3	95.0%
	Members with COPD who had an annual spirometry test	60	10	50	16.7%
Congestive Heart Failure	No re-admit to hosp with Heart Failure diag w/in 30 days of HF inpatient stay discharge	3	3	0	100.0%
	No ER Visit for Heart Failure in last 90 days	58	57	1	98.3%
	Follow-up OV within 4 weeks of discharge from HF admission	3	2	1	66.7%
Diabetes	Annual office visit	436	418	18	95.9%
	Annual dilated eye exam	436	161	275	36.9%
	Annual foot exam	436	181	255	41.5%
	Annual HbA1c test done	436	377	59	86.5%
	Diabetes Annual lipid profile	436	342	94	78.4%
	Annual microalbumin urine screen	436	320	116	73.4%
Hyperlipidemia	Hyperlipidemia Annual lipid profile	1,658	1,375	283	82.9%
Hypertension	Annual lipid profile	1,527	1,128	399	73.9%
	Annual serum creatinine test	1,334	1,140	194	85.5%
Wellness	Well Child Visit - 15 months	113	100	13	88.5%
	Routine office visit in last 6 months (All Ages)	14,323	9,235	5,088	64.5%
	Colorectal cancer screening ages 45-75 within the appropriate time period	4,506	1,877	2,629	41.7%
	Women age 25-65 with recommended cervical cancer/HPV screening	4,758	2,890	1,868	60.7%
	Males age greater than 49 with PSA test in last 24 months	1,412	669	743	47.4%
	Routine exam in last 24 months (All Ages)	14,323	11,643	2,680	81.3%
	Women age 40 to 75 with a screening mammogram last 24 months	3,348	1,922	1,426	57.4%

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

Chronic Conditions Prevalence

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

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

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

Chronic Condition	# With Condition	% of Members	Members per 1000	PMPY
Affective Psychosis	131	0.91%	9.40	$9,810
Asthma	623	4.35%	44.72	$11,506
Atrial Fibrillation	89	0.62%	6.39	$31,700
Blood Disorders	666	4.65%	47.81	$21,761
CAD	179	1.25%	12.85	$22,480
COPD	57	0.40%	4.09	$33,664
Cancer	389	2.71%	27.92	$28,714
Chronic Pain	287	2.00%	20.60	$16,792
Congestive Heart Failure	58	0.40%	4.16	$39,773
Demyelinating Diseases	42	0.29%	3.01	$51,703
Depression	1,065	7.43%	76.45	$9,236
Diabetes	700	4.88%	50.25	$15,548
ESRD	9	0.06%	0.65	$83,702
Eating Disorders	72	0.50%	5.17	$9,714
HIV/AIDS	9	0.06%	0.65	$28,178
Hyperlipidemia	2,009	14.02%	144.21	$11,546
Hypertension	1,535	10.71%	110.19	$14,306
Immune Disorders	62	0.43%	4.45	$54,646
Inflammatory Bowel Disease	63	0.44%	4.52	$21,383
Liver Diseases	236	1.65%	16.94	$20,899
Morbid Obesity	398	2.78%	28.57	$14,787
Osteoarthritis	400	2.79%	28.71	$13,790
Peripheral Vascular Disease	38	0.27%	2.73	$13,245
Rheumatoid Arthritis	78	0.54%	5.60	$27,824

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 2023 - Through Quarter Ending December 31, 2022

Express Scripts

Membership Summary	1Q-2Q FY2023 LDPPO	1Q-2Q FY2022 LDPPO	Difference	% Change
			Membership Summary	
Member Count (Membership)	13,900	7,947	5,953	74.9%
Utilizing Member Count (Patients)	9,685	5,804	3,881	66.9%
Percent Utilizing (Utilization)	69.7%	73.0%	(0)	-4.6%

Claim Summary			Claims Summary	
Net Claims (Total Rx's)	100,013	56,061	43,952	78.4%
Claims per Elig Member per Month (Claims PMPM)	1.20	1.18	0.02	1.7%
Total Claims for Generic (Generic Rx)	83,074	45,647	37,427.00	82.0%
Total Claims for Brand (Brand Rx)	16,939	10,414	6,525.00	62.7%
Total Claims for Brand w/Gen Equiv (Multisource Brand Claims)	506	472	34.00	7.2%
Total Non-Specialty Claims	98,690	55,410	43,280.00	78.1%
Total Specialty Claims	1,323	651	672.00	103.2%
Generic % of Total Claims (GFR)	**83.1%**	**81.4%**	0.02	2.0%
Generic Effective Rate (GCR)	**99.4%**	**99.0%**	0.00	0.4%
Mail Order Claims	29,609	14,370	15,239.00	106.0%
Mail Penetration Rate*	34.8%	30.7%	0.04	4.1%

Claims Cost Summary			Claims Cost Summary	
Total Prescription Cost (Total Gross Cost)	$11,838,596	$5,622,737	$6,215,859.00	110.5%
Total Generic Gross Cost	$1,641,190	$1,070,845	$570,345.00	53.3%
Total Brand Gross Cost	$10,197,406	$4,551,891	$5,645,515.00	124.0%
Total MSB Gross Cost	$221,796	$153,809	$67,987.00	44.2%
Total Ingredient Cost	$11,663,636	$5,475,128	$6,188,508.00	113.0%
Total Dispensing Fee	$158,542	$143,783	$14,759.00	10.3%
Total Other (e.g. tax)	$16,417	$3,826	$12,591.00	329.1%
Avg Total Cost per Claim (Gross Cost/Rx)	**$118.37**	**$100.30**	$18.07	18.0%
Avg Total Cost for Generic (Gross Cost/Generic Rx)	$19.76	$23.46	($3.70)	-15.8%
Avg Total Cost for Brand (Gross Cost/Brand Rx)	$602.01	$437.09	$164.92	37.7%
Avg Total Cost for MSB (MSB Gross Cost/MSB ARx)	$438.33	$325.87	$112.46	34.5%

Member Cost Summary			Member Cost Summary	
Total Member Cost	**$1,800,382**	**$1,048,272**	$752,110.00	71.7%
Total Copay	$1,800,382	$1,048,272	$752,110.00	71.7%
Total Deductible	$0	$0	$0.00	0.0%
Avg Copay per Claim (Copay/Rx)	$18.00	$18.70	($0.70)	-3.7%
Avg Participant Share per Claim (Copay+Deductible/RX)	**$18.00**	**$18.70**	**($0.70)**	**-3.7%**
Avg Copay for Generic (Copay/Generic Rx)	$6.60	$7.52	($0.92)	-12.2%
Avg Copay for Brand (Copay/Brand Rx)	$73.90	$67.69	$6.21	9.2%
Avg Copay for Brand w/ Generic Equiv (Copay/Multisource Rx)	$14.93	$43.17	($28.24)	-65.4%
Net PMPM (Participant Cost PMPM)	**$21.59**	**$21.98**	($0.40)	-1.8%
Copay % of Total Prescription Cost (Member Cost Share %)	15.2%	18.6%	-3.4%	-18.4%

Plan Cost Summary			Plan Cost Summary	
Total Plan Cost (Plan Cost)	**$10,038,214**	**$4,574,465**	**$5,463,749.00**	**119.4%**
Total Non-Specialty Cost (Non-Specialty Plan Cost)	$4,997,512	$2,624,883	$2,372,629.00	90.4%
Total Specialty Drug Cost (Specialty Plan Cost)	$5,040,702	$1,949,582	$3,091,120.00	158.6%
Avg Plan Cost per Claim (Plan Cost/Rx)	**$100.37**	**$81.60**	$18.77	23.0%
Avg Plan Cost for Generic (Plan Cost/Generic Rx)	$13.15	$15.94	($2.79)	-17.5%
Avg Plan Cost for Brand (Plan Cost/Brand Rx)	$528.10	$369.41	$158.69	43.0%
Avg Plan Cost for MSB (MSB Plan Cost/MSB ARx)	$423.41	$282.70	$140.71	49.8%
Net PMPM (Plan Cost PMPM)	**$120.36**	**$95.94**	**$24.43**	**25.5%**
PMPM without Specialty (Non-Specialty PMPM)	$59.92	$55.05	$4.87	8.8%
PMPM for Specialty Only (Specialty PMPM)	$60.44	$40.89	$19.55	47.8%
Rebates Received (Q1-Q2 FY2023 actual)	$3,373,251	$1,057,776	$2,315,474.84	218.9%
Net PMPM (Plan Cost PMPM factoring Rebates)	**$79.92**	**$73.75**	**$6.16**	**8.4%**
PMPM without Specialty (Non-Specialty PMPM)	$34.67	$38.01	$0.92	5.0%
PMPM for Specialty Only (Specialty PMPM)	$44.75	$35.49	$9.26	26.1%

Appendix C

Index of Tables
UMR Inc. – EPO Utilization Review for PEBP
October 1, 2022 – December 31, 2022

DATASCOPE™

Nevada Public Employees' Benefits Program
EPO Plan
July – December 2022 Incurred,
Paid through February 28, 2023

UMR℠

Overview

- Total Medical Spend for 2Q23 was $18,443,519 with an annualized plan cost per employee per year (PEPY) of $10,495. This is an increase of 8.7% when compared to 2Q22.
  - IP Cost per Admit is $38,964 which is 5.7% higher than 2Q22.
  - ER Cost per Visit is $2,818 which is 41.5% higher than 2Q22.
- Employees shared in 10.4% of the medical cost.
- Inpatient facility costs were 30.7% of the plan spend.
- 86.2% of the Average Membership had paid Medical claims less than $2,500, with 19.6% of those having no claims paid at all during the reporting period.
- 24 members exceeded the $100k high-cost threshold during the reporting period, which accounted for 28.1% of the plan spend. The highest diagnosis category was Cardiac Disorders, accounting for 19.5% of the high-cost claimant dollars.
- Total spending with in-network providers was 97.2%. The average In Network discount was 56.7%, which is 5.3% lower than the PY22 average discount of 59.9%.

Paid Claims by Age Group

Paid Claims by Age Group																
	2Q22						2Q23						% 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	$ 1,502,921	$ 3,479	$ 1,695	$ 4	$ 1,504,616	$3,483	$ 1,303,974	$ 3,150	$ 482	$ 1	$ 1,304,456	$ 3,151	-13.3%	-9.5%
1	$ 149,079	$ 319	$ 1,283	$ 3	$ 150,362	$321	$ 117,093	$ 331	$ 444	$ 1	$ 117,537	$ 332	-21.8%	3.3%
2 - 4	$ 239,999	$ 155	$ 8,097	$ 5	$ 248,096	$160	$ 278,943	$ 221	$ 7,836	$ 6	$ 286,779	$ 228	15.6%	42.0%
5 - 9	$ 198,942	$ 79	$ 28,481	$ 11	$ 227,423	$90	$ 182,513	$ 85	$ 43,015	$ 20	$ 225,528	$ 105	-0.8%	16.9%
10 - 14	$ 373,457	$ 113	$ 107,627	$ 32	$ 481,084	$145	$ 373,107	$ 132	$ 70,752	$ 25	$ 443,859	$ 157	-7.7%	8.6%
15 - 19	$ 825,587	$ 208	$ 168,246	$ 42	$ 993,833	$250	$ 586,215	$ 171	$ 272,470	$ 79	$ 858,685	$ 250	-13.6%	0.0%
20 - 24	$ 510,327	$ 143	$ 166,295	$ 47	$ 676,622	$190	$ 683,903	$ 216	$ 116,004	$ 37	$ 799,907	$ 253	18.2%	33.5%
25 - 29	$ 579,795	$ 349	$ 369,444	$ 222	$ 949,239	$571	$ 376,254	$ 277	$ 147,145	$ 109	$ 523,399	$ 386	-44.9%	-32.4%
30 - 34	$ 883,737	$ 397	$ 231,492	$ 104	$ 1,115,229	$501	$ 772,250	$ 425	$ 821,679	$ 452	$ 1,593,929	$ 877	42.9%	75.0%
35 - 39	$ 1,564,613	$ 515	$ 332,717	$ 110	$ 1,897,330	$625	$ 1,365,816	$ 555	$ 444,333	$ 181	$ 1,810,149	$ 736	-4.6%	17.7%
40 - 44	$ 1,239,803	$ 400	$ 927,601	$ 299	$ 2,167,404	$699	$ 1,455,516	$ 559	$ 754,980	$ 290	$ 2,210,496	$ 849	2.0%	21.5%
45 - 49	$ 1,399,285	$ 402	$ 559,975	$ 161	$ 1,959,260	$563	$ 1,094,520	$ 372	$ 599,433	$ 203	$ 1,693,953	$ 575	-13.5%	2.1%
50 - 54	$ 2,044,705	$ 479	$ 1,177,620	$ 276	$ 3,222,325	$754	$ 2,136,084	$ 537	$ 1,040,649	$ 262	$ 3,176,733	$ 799	-1.4%	5.9%
55 - 59	$ 3,314,803	$ 742	$ 1,114,582	$ 249	$ 4,429,385	$991	$ 2,652,993	$ 678	$ 1,330,969	$ 340	$ 3,983,962	$ 1,018	-10.1%	2.8%
60 - 64	$ 3,385,013	$ 644	$ 2,011,815	$ 383	$ 5,396,828	$1,027	$ 3,767,595	$ 839	$ 1,894,677	$ 422	$ 5,662,272	$ 1,262	4.9%	22.9%
65+	$ 1,572,791	$ 686	$ 972,422	$ 424	$ 2,545,213	$1,110	$ 1,296,743	$ 616	$ 864,926	$ 411	$ 2,161,669	$ 1,026	-15.1%	-7.6%
Total	**$ 19,784,855**	**$ 433**	**$ 8,179,390**	**$ 179**	**$27,964,245**	**$613**	**$ 18,443,519**	**$ 470**	**$ 8,409,793**	**$ 214**	**$ 26,853,312**	**$ 684**	**-4.0%**	**11.6%**

Financial Summary (p. 1 of 2)

	Total				State Active				Non-State Active			
Summary	**2Q21**	**2Q22**	**2Q23**	**Variance to Prior Year**	**2Q21**	**2Q22**	**2Q23**	**Variance to Prior Year**	**2Q21**	**2Q22**	**2Q23**	**Variance to Prior Year**
Enrollment												
Avg # Employees	4,679	4,100	3,515	-14.3%	3,977	3,440	2,932	-14.8%	4	3	2	-36.9%
Avg # Members	8,593	7,607	6,541	-14.0%	7,640	6,692	5,703	-14.8%	5	3	2	-36.9%
Ratio	1.8	1.9	1.9	0.0%	1.9	2.0	1.9	-0.5%	1.2	1.0	1.0	0.0%
Financial Summary												
Gross Cost	$26,486,851	$22,421,549	$20,580,358	-8.2%	$20,782,214	$19,253,441	$17,206,132	-10.6%	$34,259	$3,180	$1,987	-37.5%
Client Paid	$24,689,442	$19,784,855	$18,443,519	-6.8%	$19,286,436	$17,081,090	$15,460,924	-9.5%	$32,155	$2,330	$1,551	-33.4%
Employee Paid	$1,797,409	$2,636,694	$2,136,839	-19.0%	$1,495,778	$2,172,351	$1,745,208	-19.7%	$2,103	$850	$436	-48.7%
Client Paid-PEPY	$10,553	$9,652	$10,495	8.7%	$9,699	$9,930	$10,546	6.2%	$16,078	$1,471	$1,551	5.4%
Client Paid-PMPY	$5,747	$5,202	$5,640	8.4%	$5,049	$5,105	$5,422	6.2%	$13,781	$1,471	$1,551	5.4%
Client Paid-PEPM	$879	$804	$875	8.8%	$808	$828	$879	6.2%	$1,340	$123	$129	4.9%
Client Paid-PMPM	$479	$433	$470	8.5%	$421	$425	$452	6.4%	$1,148	$123	$129	4.9%
High Cost Claimants (HCC's) > $100k												
# of HCC's	28	26	24	-7.7%	20	23	20	-13.0%	0	0	0	0.0%
HCC's / 1,000	3.3	3.4	3.7	7.3%	2.6	3.4	3.5	2.0%	0.0	0.0	0.0	0.0%
Avg HCC Paid	$228,769	$211,967	$215,676	1.7%	$198,593	$224,122	$215,064	-4.0%	$0	$0	$0	0.0%
HCC's % of Plan Paid	25.9%	27.9%	28.1%	0.7%	20.6%	30.2%	27.8%	-7.9%	0.0%	0.0%	0.0%	0.0%
Cost Distribution by Claim Type (PMPY)												
Facility Inpatient	$1,212	$1,511	$1,734	14.8%	$868	$1,500	$1,682	12.1%	$0	$0	$0	0.0%
Facility Outpatient	$1,846	$1,294	$1,882	45.4%	$1,663	$1,261	$1,784	41.5%	$8,332	$49	$242	0.0%
Physician	$2,504	$2,291	$2,024	-11.7%	$2,371	$2,247	$1,957	-12.9%	$4,648	$1,314	$1,309	-0.4%
Other	$184	$106	$0	-100.0%	$147	$97	$0	-100.0%	$801	$108	$0	-100.0%
Total	$5,747	$5,202	$5,640	8.4%	$5,049	$5,105	$5,422	6.2%	$13,781	$1,471	$1,551	5.4%
	Annualized	Annualized	Annualized		Annualized	Annualized	Annualized		Annualized	Annualized	Annualized	

Financial Summary (p. 2 of 2)

	State Retirees				Non-State Retirees				
Summary	**2Q21**	**2Q22**	**2Q23**	**Variance to Prior Year**	**2Q21**	**2Q22**	**2Q23**	**Variance to Prior Year**	**Peer Index**
Enrollment									
Avg # Employees	570	565	515	-8.9%	128	91	66	-28.0%	
Avg # Members	784	791	743	-6.0%	164	121	93	-23.2%	
Ratio	1.4	1.4	1.4	2.9%	1.3	1.3	1.4	6.8%	1.6
Financial Summary									
Gross Cost	$3,947,123	$2,777,883	$3,166,544	14.0%	$1,723,255	$387,046	$205,696	-46.9%	
Client Paid	$3,692,480	$2,394,965	$2,829,500	18.1%	$1,678,371	$306,470	$151,543	-50.6%	
Employee Paid	$254,643	$382,918	$337,043	-12.0%	$44,884	$80,576	$54,153	-32.8%	
Client Paid-PEPY	$12,952	$8,475	$10,988	29.7%	$26,225	$6,723	$4,616	-31.3%	$6,297
Client Paid-PMPY	$9,420	$6,059	$7,615	25.7%	$20,468	$5,059	$3,259	-35.6%	$3,879
Client Paid-PEPM	$1,079	$706	$916	29.7%	$2,185	$560	$385	-31.3%	$525
Client Paid-PMPM	$785	$505	$635	25.7%	$1,706	$422	$272	-35.5%	$323
High Cost Claimants (HCC's) > $100k									
# of HCC's	7	4	4	0.0%	1	0	0	0.0%	
HCC's / 1,000	8.9	5.1	5.4	0.0%	6.1	0.0	0.0	0.0%	
Avg HCC Paid	$150,209	$89,083	$218,734	0.0%	$1,382,203	$0	$0	0.0%	
HCC's % of Plan Paid	28.5%	14.9%	30.9%	0.0%	82.4%	0.0%	0.0%	0.0%	
Cost Distribution by Claim Type (PMPY)									
Facility Inpatient	$1,551	$1,536	$2,313	50.6%	$15,626	$2,008	$310	-84.6%	$1,149
Facility Outpatient	$3,616	$1,618	$2,717	67.9%	$1,743	$1,064	$1,256	18.0%	$1,333
Physician	$3,768	$2,735	$2,585	-5.5%	$2,628	$1,811	$1,692	-6.6%	$1,301
Other	$485	$171	$0	-100.0%	$470	$176	$0	-100.0%	$96
Total	$9,420	$6,059	$7,615	25.7%	$20,468	$5,059	$3,259	-35.6%	$3,879
	Annualized	Annualized	Annualized		Annualized	Annualized	Annualized		

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

	Total				State Active				Non-State Active			
Summary	**PY21**	**PY22**	**2Q23**	**Variance to Prior Year**	**PY21**	**PY22**	**2Q23**	**Variance to Prior Year**	**PY21**	**PY22**	**2Q23**	**Variance to Prior Year**
Enrollment												
Avg # Employees	4,635	4,021	3,515	-12.6%	3,934	3,370	2,932	-13.0%	4	3	2	-29.3%
Avg # Members	8,519	7,491	6,541	-12.7%	7,566	6,579	5,703	-13.3%	4	3	2	-29.3%
Ratio	1.8	1.9	1.9	0.0%	1.9	2.0	1.9	-0.5%	1.1	1.0	1.0	0.0%
Financial Summary												
Gross Cost	$57,531,667	$44,187,042	$20,580,358	-53.4%	$45,628,807	$37,820,607	$17,206,132	-54.5%	$41,511	$4,744	$1,987	-58.1%
Client Paid	$53,783,772	$39,320,787	$18,443,519	-53.1%	$42,531,149	$33,797,612	$15,460,924	-54.3%	$39,013	$3,622	$1,551	-57.2%
Employee Paid	$3,747,895	$4,866,255	$2,136,839	-56.1%	$3,097,659	$4,022,996	$1,745,208	-56.6%	$2,498	$1,122	$436	-61.1%
Client Paid-PEPY	$11,605	$9,779	$10,495	7.3%	$10,811	$10,030	$10,546	5.1%	$9,753	$1,278	$1,551	21.4%
Client Paid-PMPY	$6,314	$5,249	$5,640	7.4%	$5,621	$5,137	$5,422	5.5%	$9,003	$1,278	$1,551	21.4%
Client Paid-PEPM	$967	$815	$875	7.4%	$901	$836	$879	5.1%	$813	$107	$129	20.6%
Client Paid-PMPM	$526	$437	$470	7.6%	$468	$428	$452	5.6%	$750	$107	$129	20.6%
High Cost Claimants (HCC's) > $100k												
# of HCC's	58	46	24	-47.8%	43	40	20	-50.0%	0	0	0	0.0%
HCC's / 1,000	6.8	6.1	3.7	-40.2%	5.7	6.1	3.5	-42.3%	0.0	0.0	0.0	0.0%
Avg HCC Paid	$290,301	$237,083	$215,676	-9.0%	$270,803	$246,357	$215,064	-12.7%	$0	$0	$0	0.0%
HCC's % of Plan Paid	31.3%	27.7%	28.1%	1.4%	27.4%	29.2%	27.8%	-4.8%	0.0%	0.0%	0.0%	0.0%
Cost Distribution by Claim Type (PMPY)												
Facility Inpatient	$1,531	$1,432	$1,734	21.1%	$1,194	$1,437	$1,682	17.0%	$0	$0	$0	0.0%
Facility Outpatient	$1,988	$1,442	$1,882	30.5%	$1,813	$1,382	$1,784	29.1%	$4,568	$27	$242	796.3%
Physician	$2,609	$2,259	$2,024	-10.4%	$2,458	$2,209	$1,957	-11.4%	$3,917	$1,142	$1,309	14.6%
Other	$185	$116	$0	-100.0%	$156	$109	$0	-100.0%	$518	$109	$0	-100.0%
Total	$6,314	$5,249	$5,640	7.4%	$5,621	$5,137	$5,422	5.5%	$9,003	$1,278	$1,551	21.4%
			Annualized				Annualized				Annualized	

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

	State Retirees				Non-State Retirees				
Summary	**PY21**	**PY22**	**2Q23**	**Variance to Prior Year**	**PY21**	**PY22**	**2Q23**	**Variance to Prior Year**	**Peer Index**
Enrollment									
Avg # Employees	574	564	515	-8.6%	122	85	66	-22.7%	
Avg # Members	791	796	743	-6.6%	158	114	93	-18.1%	
Ratio	1.4	1.4	1.4	2.1%	1.3	1.3	1.4	6.0%	1.6
Financial Summary									
Gross Cost	$8,174,556	$5,794,991	$3,166,544	-45.4%	$3,686,792	$566,699	$205,696	-63.7%	
Client Paid	$7,625,090	$5,071,309	$2,829,500	-44.2%	$3,588,520	$448,244	$151,543	-66.2%	
Employee Paid	$549,466	$723,682	$337,043	-53.4%	$98,272	$118,455	$54,153	-54.3%	
Client Paid-PEPY	$13,276	$8,998	$10,988	22.1%	$29,354	$5,279	$4,616	-12.6%	$6,642
Client Paid-PMPY	$9,643	$6,373	$7,615	19.5%	$22,748	$3,946	$3,259	-17.4%	$4,116
Client Paid-PEPM	$1,106	$750	$916	22.1%	$2,446	$440	$385	-12.5%	$553
Client Paid-PMPM	$804	$531	$635	19.6%	$1,896	$329	$272	-17.3%	$343
High Cost Claimants (HCC's) > $100k									
# of HCC's	15	8	4	-50.0%	2	0	0	0.0%	
HCC's / 1,000	19.0	10.1	5.4	-46.5%	12.7	0.0	0.0	0.0%	
Avg HCC Paid	$144,889	$131,446	$218,734	66.4%	$1,509,798	$0	$0	0.0%	
HCC's % of Plan Paid	28.5%	20.7%	30.9%	49.3%	84.1%	0.0%	0.0%	0.0%	
Cost Distribution by Claim Type (PMPY)									
Facility Inpatient	$1,565	$1,443	$2,313	60.3%	$17,532	$1,101	$310	-71.8%	$1,190
Facility Outpatient	$3,680	$2,015	$2,717	34.8%	$1,836	$940	$1,256	33.6%	$1,376
Physician	$3,977	$2,742	$2,585	-5.7%	$2,993	$1,800	$1,692	-6.0%	$1,466
Other	$420	$174	$0	-100.0%	$388	$106	$0	-100.0%	$84
Total	$9,643	$6,373	$7,615	19.5%	$22,748	$3,946	$3,259	-17.4%	$4,116
			Annualized				Annualized		

Paid Claims by Claim Type – State Participants

Net Paid Claims - Total State Participants	2Q22				2Q23				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical									
Inpatient	$6,075,273.72	$684,985.07	$4,114.77	$ 6,764,374	$ 5,586,527	$ 463,550	$ 518,318	$ 6,568,395	-2.9%
Outpatient	$11,005,816.58	$1,593,657.21	$112,207.95	$ 12,711,682	$ 9,874,397	$ 159,110	$ 1,688,522	$ 11,722,029	-7.8%
Total - Medical	**$ 17,081,090**	**$ 2,278,642**	**$ 116,323**	**$ 19,476,055**	**$ 15,460,924**	**$ 622,660**	**$ 2,206,840**	**$ 18,290,424**	**-6.1%**

Net Paid Claims - Per Participant per Month	2Q22				2Q23				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical	$ 828	$ 779	$ 249	$ 810	$ 879	$ 233	$ 5,305	$ 884	9.1%

Paid Claims by Claim Type – Non-State Participants

Net Paid Claims - Total Non-State Participants	2Q22				2Q23				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical									
Inpatient	$ -	$ 91,549	$ 35,605	$ 127,154	$ -	$ 14,081	$ 2,403	$ 16,484	-87.0%
Outpatient	$ 2,330	$ 86,274	$ 93,042	$ 181,645	$ 1,551	$ 55,496	$ 79,563	$ 136,610	-24.8%
Total - Medical	**$ 2,330**	**$ 177,823**	**$ 128,647**	**$ 308,800**	**$ 1,551**	**$ 69,577**	**$ 81,966**	**$ 153,094**	**-50.4%**

Net Paid Claims - Per Participant per Month	2Q22				2Q23				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical	$ 123	$ 770	$ 407	$ 546	$ 129	$ 689	$ 280	$ 377	-30.9%

Paid Claims by Claim Type – Total

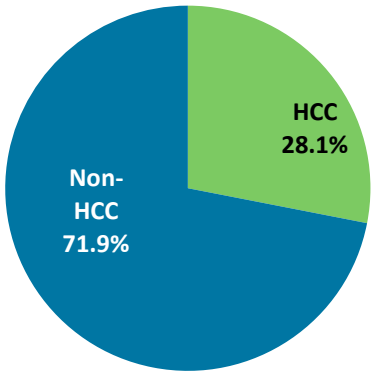
Net Paid Claims - Total Total Participants	2Q22				2Q23				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical									
Inpatient	$ 6,075,274	$ 776,534	$ 39,720	$ 6,891,528	$ 5,586,527	$ 477,631	$ 520,722	$ 6,584,880	-4.4%
Outpatient	$ 11,008,146	$ 1,679,931	$ 205,250	$ 12,893,327	$ 9,875,948	$ 214,606	$ 1,768,085	$ 11,858,639	-8.0%
Total - Medical	**$ 17,083,420**	**$ 2,456,465**	**$ 244,970**	**$ 19,784,855**	**$ 15,462,475**	**$ 692,237**	**$ 2,288,807**	**$ 18,443,519**	**-6.8%**

Net Paid Claims - Per Participant per Month	2Q22				2Q23				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical	$ 827	$ 779	$ 313	$ 804	$ 878	$ 249	$ 3,228	$ 875	8.7%

Cost Distribution – Medical Claims

2Q22							2Q23					
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
25	0.3%	$5,511,145	27.9%	$77,586	2.9%	$100,000.01 Plus	22	0.3%	$5,176,214	28.1%	$68,514	3.2%
22	0.3%	$1,533,155	7.7%	$83,271	3.2%	$50,000.01-$100,000.00	21	0.3%	$1,396,775	7.6%	$66,125	3.1%
66	0.9%	$2,426,263	12.3%	$144,978	5.5%	$25,000.01-$50,000.00	79	1.2%	$2,702,541	14.7%	$167,270	7.8%
187	2.5%	$3,039,152	15.4%	$347,574	13.2%	$10,000.01-$25,000.00	211	3.2%	$3,507,644	19.0%	$375,402	17.6%
273	3.6%	$1,971,791	10.0%	$381,232	14.5%	$5,000.01-$10,000.00	211	3.2%	$1,524,074	8.3%	$270,107	12.6%
516	6.8%	$1,816,112	9.2%	$458,247	17.4%	$2,500.01-$5,000.00	364	5.6%	$1,317,297	7.1%	$305,730	14.3%
5,016	65.9%	$3,485,015	17.6%	$1,139,057	43.2%	$0.01-$2,500.00	4,232	64.7%	$2,818,973	15.3%	$881,235	41.2%
58	0.8%	$0	0.0%	$4,461	0.2%	$0.00	122	1.9%	$0	0.0%	$2,455	0.1%
1,444	19.0%	$2,223	0.0%	$290	0.0%	No Claims	1,279	19.6%	$0	0.0%	$0	0.0%
7,607	**100.0%**	**$19,784,855**	**100.0%**	**$2,636,694**	**100.0%**		**6,541**	**100.0%**	**$18,443,519**	**100.0%**	**$2,136,839**	**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**
Cardiac Disorders	17	$1,011,313	19.5%
Cancer	5	$1,008,433	19.5%
Pregnancy-related Disorders	2	$953,996	18.4%
Infections	11	$828,594	16.0%
Medical/Surgical Complications	6	$300,714	5.8%
Neurological Disorders	8	$273,721	5.3%
Hematological Disorders	9	$246,816	4.8%
Spine-related Disorders	5	$244,280	4.7%
Diabetes	5	$89,913	1.7%
Health Status/Encounters	19	$73,894	1.4%
All Other		$144,540	2.8%
Overall	**----**	**$5,176,214**	**100.0%**

Utilization Summary (p. 1 of 2)

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

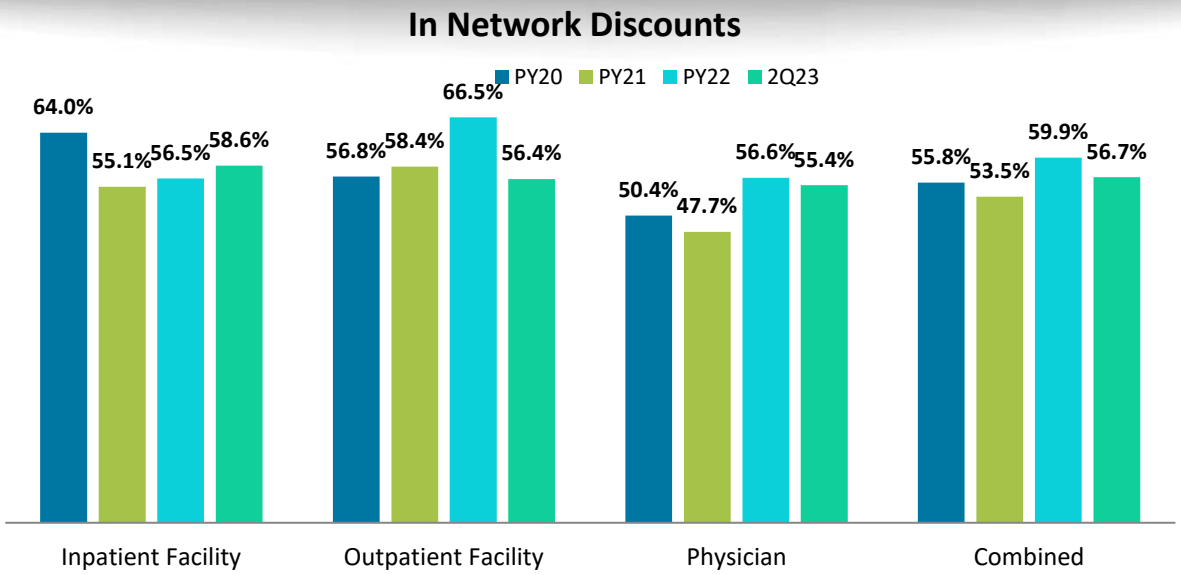
	Total				State Active				Non-State Active			
Summary	**2Q21**	**2Q22**	**2Q23**	**Variance to Prior Year**	**2Q21**	**2Q22**	**2Q23**	**Variance to Prior Year**	**2Q21**	**2Q22**	**2Q23**	**Variance to Prior Year**
Inpatient Summary												
# of Admits	240	225	172		199	192	143		0	0	0	
# of Bed Days	1,640	1,311	926		1,122	1,093	763		0	0	0	
Paid Per Admit	$38,855	$36,860	$38,964	5.7%	$25,933	$37,853	$37,904	0.1%	$0	$0	$0	0.0%
Paid Per Day	$5,686	$6,326	$7,237	14.4%	$4,600	$6,649	$7,104	6.8%	$0	$0	$0	0.0%
Admits Per 1,000	56	59	53	-10.2%	52	57	50	-12.3%	0	0	0	0.0%
Days Per 1,000	382	345	283	-18.0%	294	327	268	-18.0%	0	0	0	0.0%
Avg LOS	6.8	5.8	5.4	-6.9%	5.6	5.7	5.3	-7.0%	0.0	0.0	0.0	0.0%
# Admits From ER	114	116	78		85	94	63		0	0	0	
Physician Office												
OV Utilization per Member	6.0	5.6	5.1	-8.9%	5.8	5.4	4.9	-9.3%	5.1	6.3	7.0	11.1%
Avg Paid per OV	$145	$155	$150	-3.2%	$146	$155	$157	1.3%	$138	$164	$112	-31.7%
Avg OV Paid per Member	$865	$866	$768	-11.3%	$844	$836	$775	-7.3%	$709	$1,039	$786	-24.4%
DX&L Utilization per Member	9.8	9.6	10.5	9.4%	9.3	9.1	10	9.9%	21	3.8	32	742.1%
Avg Paid per DX&L	$69	$54	$69	27.8%	$68	$56	$72	28.6%	$59	$33	$12	-63.6%
Avg DX&L Paid per Member	$677	$521	$729	39.9%	$631	$513	$723	40.9%	$1,233	$126	$396	214.3%
Emergency Room												
# of Visits	639	696	579		566	595	496		2	0	0	
Visits Per Member	0.15	0.18	0.18	0.0%	0.15	0.18	0.17	-5.6%	0.86	0.00	0.00	0.0%
Visits Per 1,000	149	183	177	-3.3%	148	178	174	-2.2%	857	0	0	0.0%
Avg Paid per Visit	$2,633	$1,992	$2,818	41.5%	$2,559	$1,982	$2,837	43.1%	$5,449	$0	$0	0.0%
Urgent Care												
# of Visits	1,254	1,530	1,297		1,141	1,387	1,157		0	0	0	
Visits Per Member	0.29	0.40	0.40	0.0%	0.30	0.41	0.41	0.0%	0.00	0.00	0.00	0.0%
Visits Per 1,000	292	402	397	-1.2%	299	415	406	-2.2%	0	0	0	0.0%
Avg Paid per Visit	$149	$156	$126	-19.2%	$150	$158	$127	-19.6%	$0	$0	$0	0.0%
	Annualized	Annualized	Annualized		Annualized	Annualized	Annualized		Annualized	Annualized	Annualized	

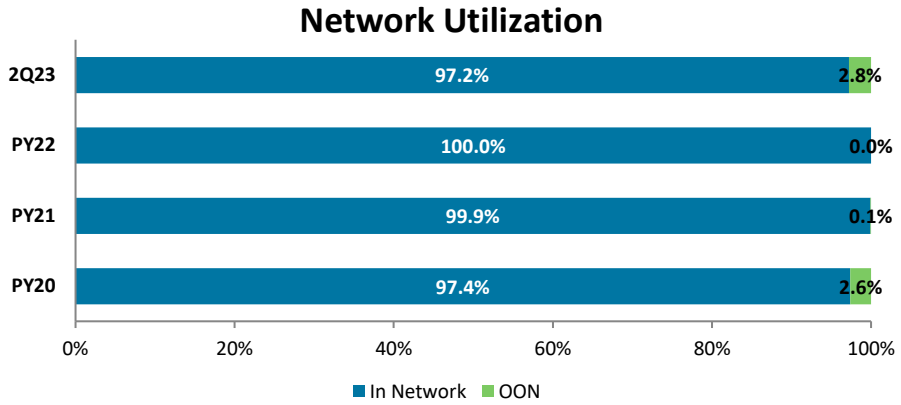
Utilization Summary (p. 2 of 2)

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

	State Retirees				Non-State Retirees				
Summary	**2Q21**	**2Q22**	**2Q23**	**Variance to Prior Year**	**2Q21**	**2Q22**	**2Q23**	**Variance to Prior Year**	**Peer Index**
Inpatient Summary									
# of Admits	36	25	27		5	8	2		
# of Bed Days	382	153	156		136	65	7		
Paid Per Admit	$37,010	$35,722	$46,841	31.1%	$566,443	$16,574	$8,442	-49.1%	$16,632
Paid Per Day	$3,488	$5,837	$8,107	38.9%	$20,825	$2,040	$2,412	18.2%	$3,217
Admits Per 1,000	92	63	73	15.9%	61	132	43	-67.4%	76
Days Per 1,000	974	387	420	8.5%	1,659	1,073	151	-85.9%	391
Avg LOS	10.6	6.1	5.8	-4.9%	27.2	8.1	3.5	-56.8%	5.2
# Admits From ER	26	17	14		3	5	1		
Physician Office									
OV Utilization per Member	7.8	6.9	6.2	-10.1%	6.8	7.0	6.3	-10.0%	5.0
Avg Paid per OV	$137	$163	$122	-25.2%	$127	$117	$65	-44.4%	$57
Avg OV Paid per Member	$1,074	$1,123	$755	-32.8%	$866	$817	$410	-49.8%	$286
DX&L Utilization per Member	13.9	13.2	14.5	9.8%	11.4	11.5	12.6	9.6%	10.5
Avg Paid per DX&L	$80	$44	$55	25.0%	$64	$47	$41	-12.8%	$50
Avg DX&L Paid per Member	$1,118	$583	$802	37.6%	$729	$538	$514	-4.5%	$522
Emergency Room									
# of Visits	60	84	72		11	17	11		
Visits Per Member	0.15	0.21	0.19	-9.5%	0.13	0.28	0.24	-14.3%	0.24
Visits Per 1,000	153	213	194	-8.9%	134	281	237	-15.7%	235
Avg Paid per Visit	$3,442	$2,301	$2,967	28.9%	$1,480	$817	$983	20.3%	$943
Urgent Care									
# of Visits	95	122	125		18	21	15		
Visits Per Member	0.24	0.31	0.34	9.7%	0.22	0.35	0.32	-8.6%	0.3
Visits Per 1,000	242	309	336	8.7%	220	347	323	-6.9%	300
Avg Paid per Visit	$140	$151	$123	-18.5%	$143	$62	$57	-8.1%	$84
	Annualized	Annualized	Annualized		Annualized	Annualized	Annualized		

Provider Network Summary





Diagnosis Grouper Summary

Diagnosis Grouper	Total Paid	% Paid	Insured	Spouse	Child	Male	Female
Cardiac Disorders	$2,010,746	10.9%	$1,702,431	$196,757	$111,558	$1,206,431	$804,315
Pregnancy-related Disorders	$1,837,239	10.0%	$519,565	$156,609	$1,161,065	$368,551	$1,468,687
Cancer	$1,745,743	9.5%	$1,308,977	$199,433	$237,333	$508,102	$1,237,642
Infections	$1,365,658	7.4%	$931,750	$292,308	$141,600	$680,656	$685,001
Health Status/Encounters	$1,251,354	6.8%	$726,424	$123,475	$401,456	$532,426	$718,928
Gastrointestinal Disorders	$1,163,911	6.3%	$877,838	$124,464	$161,609	$513,988	$649,923
Musculoskeletal Disorders	$1,068,988	5.8%	$777,414	$236,088	$55,486	$433,658	$635,330
Neurological Disorders	$916,974	5.0%	$546,157	$260,650	$110,167	$274,992	$641,982
Eye/ENT Disorders	$888,767	4.8%	$483,246	$96,386	$309,136	$349,329	$539,438
Spine-related Disorders	$855,838	4.6%	$667,933	$142,852	$45,053	$279,990	$575,847
Pulmonary Disorders	$584,213	3.2%	$350,336	$64,905	$168,972	$200,610	$383,603
Mental Health	$576,225	3.1%	$242,835	$36,486	$296,904	$176,818	$399,408
Trauma/Accidents	$556,377	3.0%	$338,446	$77,614	$140,318	$243,322	$313,056
Endocrine/Metabolic Disorders	$547,776	3.0%	$480,236	$31,482	$36,058	$174,795	$372,981
Gynecological/Breast Disorders	$454,572	2.5%	$361,920	$50,046	$42,606	$5,023	$449,549
Medical/Surgical Complications	$390,004	2.1%	$86,750	$298,472	$4,783	$7,589	$382,415
Diabetes	$342,879	1.9%	$291,454	$37,728	$13,697	$273,085	$69,794
Renal/Urologic Disorders	$304,200	1.6%	$219,210	$37,639	$47,351	$143,352	$160,848
Hematological Disorders	$296,844	1.6%	$289,960	$2,854	$4,030	$258,407	$38,437
Non-malignant Neoplasm	$270,905	1.5%	$175,511	$85,845	$9,549	$84,363	$186,542
Dermatological Disorders	$216,967	1.2%	$141,899	$39,889	$35,179	$102,817	$114,150
Miscellaneous	$197,795	1.1%	$111,842	$23,278	$62,676	$91,099	$106,696
Vascular Disorders	$188,627	1.0%	$89,775	$96,312	$2,540	$129,275	$59,352
Abnormal Lab/Radiology	$143,197	0.8%	$107,990	$21,610	$13,598	$58,635	$84,562
Congenital/Chromosomal Anomalies	$136,638	0.7%	$13,722	$22,416	$100,501	$71,820	$64,819
Cholesterol Disorders	$55,457	0.3%	$49,591	$4,441	$1,425	$16,945	$38,512
Medication Related Conditions	$31,559	0.2%	$18,034	$8,178	$5,347	$12,559	$19,000
Allergic Reaction	$29,605	0.2%	$6,958	$90	$22,558	$19,094	$10,512
Dental Conditions	$11,155	0.1%	$5,766	$459	$4,930	$7,428	$3,726
External Hazard Exposure	$3,304	0.0%	$1,649	$326	$1,329	$1,015	$2,289
Cause of Morbidity	$0	0.0%	$0	$0	$0	$0	$0
Social Determinants of Health	$0	0.0%	$0	$0	$0	$0	$0
Total	**$18,443,519**	**100.0%**	**$11,925,617**	**$2,769,091**	**$3,748,810**	**$7,226,176**	**$11,217,343**

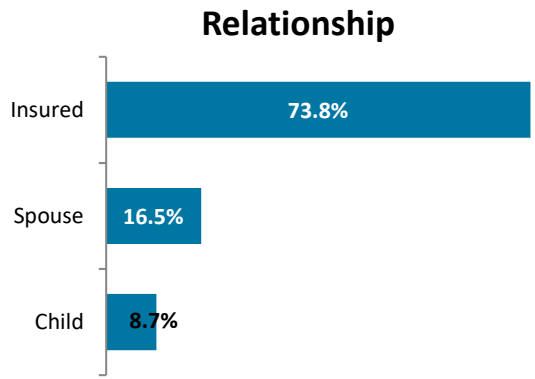
Mental Health Drilldown

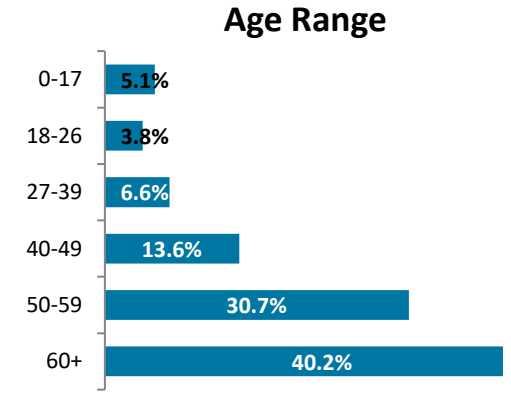
	PY20		PY21		PY22		2Q23	
Grouper	Patients	Total Paid	Patients	Total Paid	Patients	Total Paid	Patients	Total Paid
Depression	598	$910,160	625	$833,183	505	$720,907	316	$174,436
Mood and Anxiety Disorders	665	$513,247	711	$655,375	636	$361,898	378	$122,192
Mental Health Conditions, Other	572	$599,986	609	$876,606	458	$367,897	261	$113,357
Alcohol Abuse/Dependence	47	$243,386	43	$163,692	37	$110,736	18	$55,001
Attention Deficit Disorder	178	$84,996	180	$98,736	179	$76,754	139	$23,237
Eating Disorders	16	$86,923	24	$370,761	23	$51,995	12	$21,474
Bipolar Disorder	149	$206,258	127	$261,349	107	$171,696	74	$19,519
Substance Abuse/Dependence	45	$74,263	57	$45,039	39	$14,853	28	$13,637
Sleep Disorders	180	$35,203	187	$38,478	148	$43,716	72	$11,719
Developmental Disorders	50	$123,894	65	$155,300	58	$89,043	33	$11,003
Complications of Substance Abuse	21	$116,313	14	$63,661	8	$12,407	3	$3,167
Personality Disorders	10	$10,154	14	$20,064	17	$47,043	8	$2,631
Sexually Related Disorders	16	$5,705	27	$81,154	27	$85,457	16	$2,017
Schizophrenia	10	$9,300	9	$10,631	6	$2,286	8	$1,133
Tobacco Use Disorder	45	$3,028	38	$4,775	36	$4,114	17	$1,098
Psychoses	10	$6,353	7	$55,219	6	$9,762	4	$605
Total		**$3,029,167**		**$3,734,023**		**$2,170,566**		**$576,225**

Diagnosis Grouper – Cardiac Disorders

Diagnosis Sub-Grouper	Patients	Claims	Total Paid	% Paid
Heart Valve Disorders	39	104	$429,804	21.4%
Atrial Fibrillation	46	155	$278,081	13.8%
Myocardial Infarction	8	48	$266,096	13.2%
Cardiac Arrhythmias	105	197	$208,661	10.4%
Coronary Artery Disease	67	155	$194,712	9.7%
Chest Pain	141	316	$181,683	9.0%
Hypertension	407	681	$131,568	6.5%
Congestive Heart Failure	24	64	$127,590	6.3%
Pulmonary Embolism	13	51	$83,878	4.2%
Cardio-Respiratory Arrest	11	30	$57,582	2.9%
Cardiac Conditions, Other	85	167	$39,546	2.0%
Cardiomyopathy	8	25	$7,333	0.4%
Shock	4	5	$4,048	0.2%
Ventricular Fibrillation	1	2	$166	0.0%
Overall	**----**	**----**	**$2,010,746**	**100.0%**

*Patient and claim counts are unique only within the category

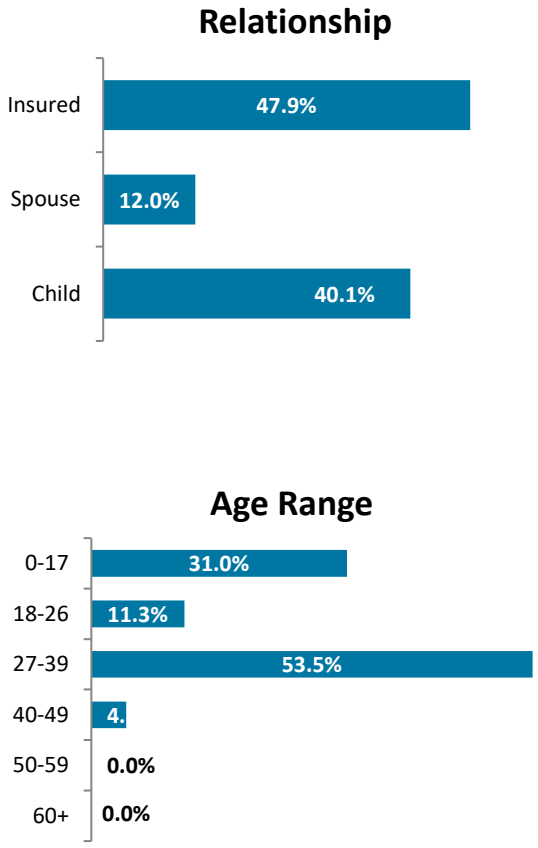




Diagnosis Grouper – Pregnancy-related Disorders

Diagnosis Sub-Grouper	Patients	Claims	Total Paid	% Paid
Perinatal Disorders	19	125	$582,151	31.7%
Liveborn Infants	45	114	$391,565	21.3%
Labor and Delivery Related	47	124	$336,249	18.3%
Pregnancy Complications	71	358	$333,681	18.2%
Fetal Distress	3	139	$109,350	6.0%
Supervision of Pregnancy	80	346	$68,637	3.7%
Abortion Related	8	18	$7,530	0.4%
Cesarean Delivery	6	8	$5,931	0.3%
Birth Injury	1	1	$1,973	0.1%
Prematurity and Low Birth Weight	1	1	$171	0.0%
Overall	**----**	**----**	**$1,837,239**	**100.0%**

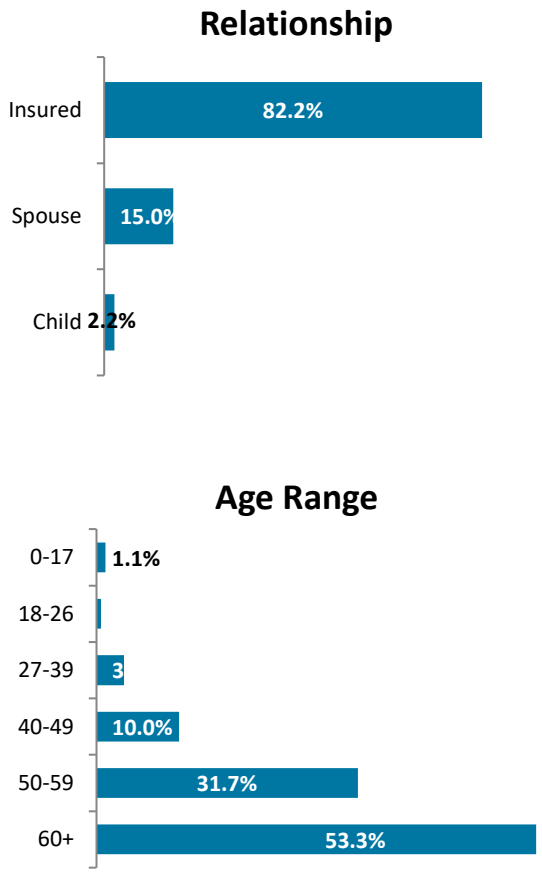
*Patient and claim counts are unique only within the category



Diagnosis Grouper – Cancer

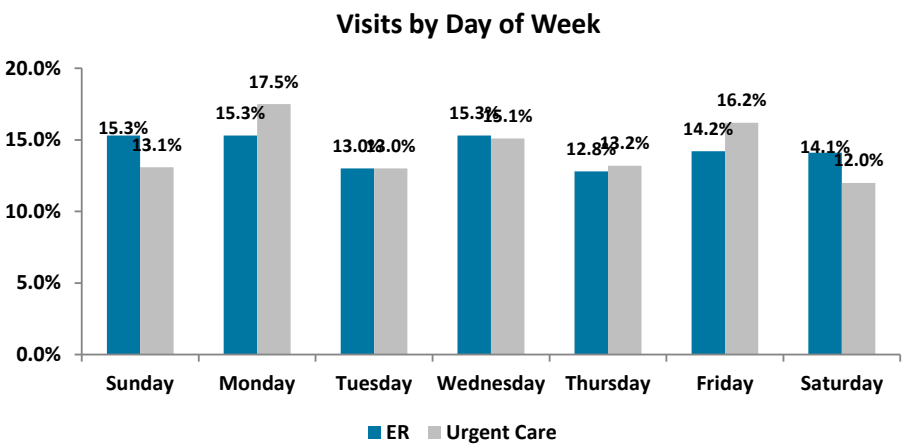
Diagnosis Sub-Grouper	Patients	Claims	Total Paid	% Paid
Cancer Therapies	11	35	$381,016	21.8%
Breast Cancer	33	276	$330,594	18.9%
Melanoma	7	46	$286,567	16.4%
Secondary Cancers	8	68	$212,051	12.1%
Brain Cancer	2	31	$207,900	11.9%
Carcinoma in Situ	21	67	$84,270	4.8%
Colon Cancer	5	73	$50,266	2.9%
Cancers, Other	16	69	$32,027	1.8%
Non-Melanoma Skin Cancers	54	110	$26,859	1.5%
Cervical/Uterine Cancer	6	20	$25,538	1.5%
Leukemias	6	53	$23,819	1.4%
Lung Cancer	3	30	$18,788	1.1%
Prostate Cancer	17	63	$18,458	1.1%
Lymphomas	9	47	$15,924	0.9%
Thyroid Cancer	10	21	$12,296	0.7%
Kidney Cancer	4	11	$9,728	0.6%
Ovarian Cancer	4	16	$9,012	0.5%
Bladder Cancer	1	1	$285	0.0%
Pancreatic Cancer	1	1	$273	0.0%
Myeloma	1	1	$70	0.0%
Overall	**----**	**----**	**$1,745,743**	**100.0%**

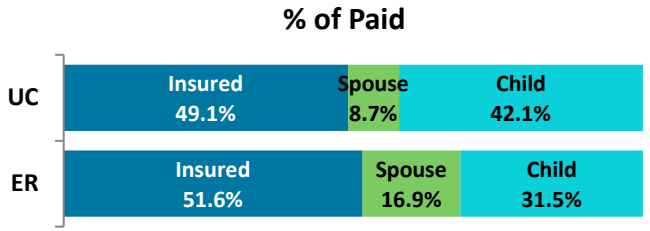
*Patient and claim counts are unique only within the category



Emergency Room / Urgent Care Summary

	2Q22		2Q23		Peer Index	
ER/Urgent Care	**ER**	**Urgent Care**	**ER**	**Urgent Care**	**ER**	**Urgent Care**
Number of Visits	696	1,530	579	1,297		
Visits Per Member	0.18	0.40	0.18	0.40	0.22	0.35
Visits/1000 Members	183	402	177	397	221	352
Avg Paid Per Visit	$1,992	$156	$2,818	$126	$968	$135
% with OV*	91.7%	89.2%	91.3%	87.7%		
% Avoidable	12.4%	34.5%	15.3%	38.4%		
Total Member Paid	**$387,339**	**$65,777**	**$323,841**	**$60,981**		
Total Plan Paid	**$1,386,184**	**$238,791**	**$1,629,881**	**$163,516**		
*looks back 12 months from ER visit	Annualized	Annualized	Annualized	Annualized		





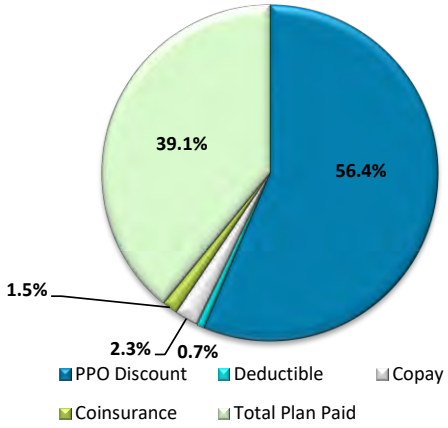
ER / UC Visits by Relationship						
Relationship	**ER**	**Per 1,000**	**Urgent Care**	**Per 1,000**	**Total**	**Per 1,000**
Insured	282	80	650	185	932	265
Spouse	76	109	118	170	194	279
Child	221	95	529	227	750	322
Total	**579**	**89**	**1,297**	**198**	**1,876**	**287**

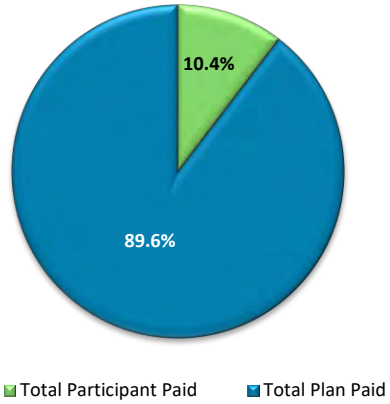
Hospital and physician urgent care centers are included in the data.
Paid amount includes facility and professional fees.

Savings Summary – Medical Claims

Description	Dollars	PPPM	% of Eligible
Eligible Charges	$48,372,235	$2,294	100.0%
PPO Discount	$26,636,046	$1,263	55.1%
Deductible	$353,593	$17	0.7%
Copay	$1,083,172	$51	2.2%
Coinsurance	$700,074	$33	1.4%
Total Participant Paid	**$2,136,839**	**$101**	**4.4%**
Total Plan Paid	**$18,443,519**	**$875**	**38.1%**

Total Participant Paid - PY22	**$101**
Total Plan Paid - PY22	**$815**





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	393	391	2	99.5%
	<2 asthma related ER Visits in the last 6 months	393	393	0	100.0%
	No asthma related admit in last 12 months	393	393	0	100.0%
Chronic Obstructive Pulmonary Disease	No exacerbations in last 12 months	75	74	1	98.7%
	Members with COPD who had an annual spirometry test	75	8	67	10.7%
Congestive Heart Failure	No re-admit to hosp with Heart Failure diag w/in 30 days of HF inpatient stay discharge	0	0	0	0.0%
	No ER Visit for Heart Failure in last 90 days	51	51	0	100.0%
	Follow-up OV within 4 weeks of discharge from HF admission	0	0	0	0.0%
Diabetes	Annual office visit	345	338	7	98.0%
	Annual dilated eye exam	345	171	174	49.6%
	Annual foot exam	345	136	209	39.4%
	Annual HbA1c test done	345	301	44	87.2%
	Diabetes Annual lipid profile	345	269	76	78.0%
	Annual microalbumin urine screen	345	266	79	77.1%
Hyperlipidemia	Hyperlipidemia Annual lipid profile	1,092	858	234	78.6%
Hypertension	Annual lipid profile	1,168	816	352	69.9%
	Annual serum creatinine test	1,134	933	201	82.3%
Wellness	Well Child Visit - 15 months	58	55	3	94.8%
	Routine office visit in last 6 months (All Ages)	6,446	4,732	1,714	73.4%
	Colorectal cancer screening ages 45-75 within the appropriate time period	2,795	1,299	1,496	46.5%
	Women age 25-65 with recommended cervical cancer/HPV screening	2,019	1,495	524	74.0%
	Males age greater than 49 with PSA test in last 24 months	1,037	565	472	54.5%
	Routine exam in last 24 months (All Ages)	6,446	5,922	524	91.9%
	Women age 40 to 75 with a screening mammogram last 24 months	1,820	1,171	649	64.3%

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	101	1.57%	15.44	$21,832
Asthma	439	6.81%	67.12	$15,914
Atrial Fibrillation	74	1.15%	11.31	$28,125
Blood Disorders	431	6.69%	65.89	$38,153
CAD	146	2.26%	22.32	$34,829
COPD	74	1.15%	11.31	$22,533
Cancer	294	4.56%	44.95	$31,689
Chronic Pain	376	5.83%	57.49	$20,219
Congestive Heart Failure	50	0.78%	7.64	$49,854
Demyelinating Diseases	25	0.39%	3.82	$37,062
Depression	742	11.51%	113.44	$13,932
Diabetes	543	8.42%	83.02	$22,620
ESRD	8	0.12%	1.22	$45,926
Eating Disorders	31	0.48%	4.74	$9,384
HIV/AIDS	11	0.17%	1.68	$36,646
Hyperlipidemia	1,371	21.27%	209.61	$15,889
Hypertension	1,177	18.26%	179.95	$17,260
Immune Disorders	45	0.70%	6.88	$46,807
Inflammatory Bowel Disease	38	0.59%	5.81	$37,850
Liver Diseases	152	2.36%	23.24	$17,456
Morbid Obesity	307	4.76%	46.94	$21,660
Osteoarthritis	361	5.60%	55.19	$21,743
Peripheral Vascular Disease	41	0.64%	6.27	$16,644
Rheumatoid Arthritis	73	1.13%	11.16	$43,916

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 2023 - Through Quarter Ending December 31, 2022
Express Scripts

Membership Summary	1Q-2Q FY2023 EPO	1Q-2Q FY2022 EPO	Difference	% Change
			Membership Summary	
Member Count (Membership)	6,559	7,635	(1,076)	-14.1%
Utilizing Member Count (Patients)	4,944	5,892	(948)	-16.1%
Percent Utilizing (Utilization)	75.4%	77.2%	(0)	-2.3%

Claim Summary			Claims Summary	
Net Claims (Total Rx's)	69,510	77,672	(8,162)	-10.5%
Claims per Elig Member per Month (Claims PMPM)	1.77	1.70	0.07	4.1%
Total Claims for Generic (Generic Rx)	58,771	65,067	(6,296.00)	-9.7%
Total Claims for Brand (Brand Rx)	10,739	12,605	(1,866.00)	-14.8%
Total Claims for Brand w/Gen Equiv (Multisource Brand Claims)	326	650	(324.00)	-49.8%
Total Non-Specialty Claims	68,402	76,573	(8,171.00)	-10.7%
Total Specialty Claims	1,108	1,099	9.00	0.8%
Generic % of Total Claims (GFR)	**84.6%**	**83.8%**	0.01	0.9%
Generic Effective Rate (GCR)	**99.4%**	**99.0%**	0.00	0.4%
Mail Order Claims	18,173	15,491	2,682.00	17.3%
Mail Penetration Rate*	29.3%	22.6%	0.07	6.7%

Claims Cost Summary			Claims Cost Summary	
Total Prescription Cost (Total Gross Cost)	$9,878,987	$9,776,796	$102,191.00	1.0%
Total Generic Gross Cost	$1,102,017	$1,443,044	($341,027.00)	-23.6%
Total Brand Gross Cost	$8,776,970	$8,333,752	$443,218.00	5.3%
Total MSB Gross Cost	$207,200	$147,078	$60,122.00	40.9%
Total Ingredient Cost	$9,794,585	$9,644,809	$149,776.00	1.6%
Total Dispensing Fee	$75,843	$128,548	($52,705.00)	-41.0%
Total Other (e.g. tax)	$8,559	$3,439	$5,120.00	148.9%
Avg Total Cost per Claim (Gross Cost/Rx)	**$142.12**	**$125.87**	$16.25	12.9%
Avg Total Cost for Generic (Gross Cost/Generic Rx)	$18.75	$22.18	($3.43)	-15.5%
Avg Total Cost for Brand (Gross Cost/Brand Rx)	$817.30	$661.15	$156.15	23.6%
Avg Total Cost for MSB (MSB Gross Cost/MSB ARx)	$635.58	$226.27	$409.31	180.9%

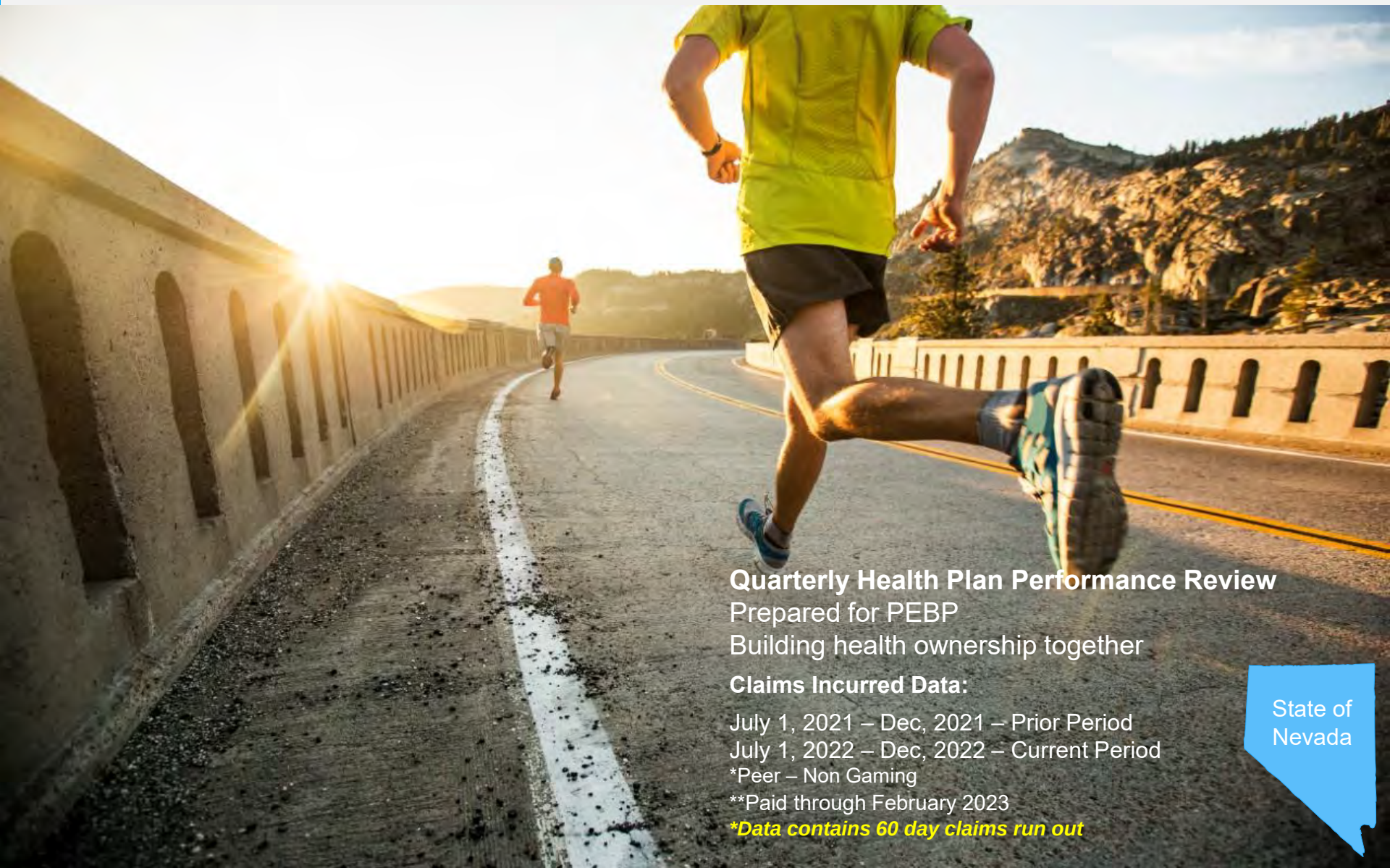
Member Cost Summary			Member Cost Summary	
Total Member Cost	**$1,469,205**	**$1,589,882**	($120,677.00)	-7.6%
Total Copay	$1,466,995	$1,580,115	($113,120.00)	-7.2%
Total Deductible	$2,210	$9,768	($7,558.00)	0.0%
Avg Copay per Claim (Copay/Rx)	$21.10	$20.34	$0.76	3.7%
Avg Participant Share per Claim (Copay+Deductible/RX)	**$21.14**	**$20.47**	**$0.67**	**3.3%**
Avg Copay for Generic (Copay/Generic Rx)	$6.79	$7.65	($0.86)	-11.2%
Avg Copay for Brand (Copay/Brand Rx)	$99.66	$86.63	$13.03	15.0%
Avg Copay for Brand w/ Generic Equiv (Copay/Multisource Rx)	$75.43	$32.34	$43.09	133.2%
Net PMPM (Participant Cost PMPM)	**$37.33**	**$34.71**	$2.63	7.6%
Copay % of Total Prescription Cost (Member Cost Share %)	14.9%	16.3%	-1.4%	-8.5%

Plan Cost Summary			Plan Cost Summary	
Total Plan Cost (Plan Cost)	**$8,409,782**	**$8,186,914**	**$222,868.00**	**2.7%**
Total Non-Specialty Cost (Non-Specialty Plan Cost)	$3,759,704	$4,101,928	($342,224.00)	-8.3%
Total Specialty Drug Cost (Specialty Plan Cost)	$4,650,079	$4,084,986	$565,093.00	13.8%
Avg Plan Cost per Claim (Plan Cost/Rx)	**$120.99**	**$105.40**	$15.58	14.8%
Avg Plan Cost for Generic (Plan Cost/Generic Rx)	$11.96	$14.53	($2.57)	-17.7%
Avg Plan Cost for Brand (Plan Cost/Brand Rx)	$717.64	$574.52	$143.12	24.9%
Avg Plan Cost for MSB (MSB Plan Cost/MSB ARx)	$560.15	$193.94	$366.21	188.8%
Net PMPM (Plan Cost PMPM)	**$213.70**	**$178.71**	**$34.98**	**19.6%**
PMPM without Specialty (Non-Specialty PMPM)	$95.54	$89.54	$6.00	6.7%
PMPM for Specialty Only (Specialty PMPM)	$118.16	$89.17	$28.99	32.5%
Rebates Received (Q1 FY2023 actual)	$3,106,125	$1,904,485	$1,201,639.56	63.1%
Net PMPM (Plan Cost PMPM factoring Rebates)	**$134.77**	**$137.14**	**($2.37)**	**-1.7%**
PMPM without Specialty (Non-Specialty PMPM)	$53.53	$59.85	$0.92	5.0%
PMPM for Specialty Only (Specialty PMPM)	$88.90	$76.58	$12.32	16.1%

Appendix D

Index of Tables
Health Plan of Nevada –Utilization Review for PEBP
October 1, 2022 – December 31, 2022

Power Of Partnership.



Quarterly Health Plan Performance Review

Prepared for PEBP

Building health ownership together

Claims Incurred Data:

July 1, 2021 – Dec, 2021 – Prior Period
July 1, 2022 – Dec, 2022 – Current Period
*Peer – Non Gaming
**Paid through February 2023
Data contains 60 day claims run out

State of Nevada

Executive Summary

Spend and Utilization

Executive Summary Utilization & Spend

UnitedHealthcare

Population

- -2.0% decrease for employees
- -1.7% decrease for members

Medical Rx Paid PMPM

- -33.3% decrease in overall medical paid
- -1.5% decrease in non Catastrophic spend
- 2.6% increase in Catastrophic spend

High Cost Claimants

- 36 High Cost Claimants accounted for 29.3% of medical spend
- -21.7% decrease in HCC from prior period
- Avg. Paid per claimant decreased -54.6%

Emergency Room

- ER Visits Per 1,000 members increased 9.3%
- Avg. paid per ER Visit increased 15.1%

Urgent Care

- Urgent Care visits per 1,000 members decreased by -20.6%
- Avg. paid per Urgent care visit increased 6.2%

Rx Drivers

- Rx Net Paid PMPM increased 13.9%
- Specialty Spend increased 41.0%
- Specialty Rx driving 52.4% of total Rx Spend

Overall Medical / Rx

- Total Medical/Rx decreased -23.5% on PMPM basis

Executive Summary Utilization & Spend

UnitedHealthcare®

Claims Paid by Age Group														
	Through December 2021 Q1 and Q2						Through December 2022 Q1 and Q2						Change	
Age Band	Medical Net Paid	Medical PMPM	Rx Net Paid	Rx PMPM	Med/Rx Net Paid	Med/Rx PMPM	Medical Net Paid	Medical PMPM	Rx Net Paid	Rx PMPM	Med/Rx Net Paid	Med/Rx PMPM	Med/Rx Net Paid	Med/Rx Net PMPM
<1	$6,964,278	$21,737	$1,161	$4	$6,965,439	$21,740	$253,386	$720	$1,086	$3	$254,472	$723	-96.3%	-14.8%
01	$84,586	$183	$2,517	$5	$87,103	$189	$222,493	$701	$2,631	$8	$225,124	$709	282.3%	51.9%
02-04	$318,908	$266	$6,960	$6	$325,869	$272	$356,170	$298	$8,538	$7	$364,707	$305	12.0%	23.0%
05-09	$371,876	$153	$34,199	$14	$406,075	$167	$497,123	$222	$33,003	$15	$530,126	$236	44.7%	4.4%
10-14	$1,374,158	$466	$131,134	$44	$1,505,292	$510	$507,272	$182	$184,547	$66	$691,819	$248	-60.9%	48.9%
15-19	$865,770	$280	$148,091	$48	$1,013,861	$328	$653,434	$204	$106,742	$33	$760,176	$237	-27.4%	-30.7%
20-24	$616,996	$205	$199,291	$66	$816,287	$271	$411,105	$144	$106,283	$37	$517,389	$182	-29.6%	-43.6%
25-29	$520,749	$284	$167,317	$91	$688,066	$375	$670,999	$355	$189,175	$100	$860,174	$455	25.1%	9.7%
30-34	$584,499	$262	$416,881	$187	$1,001,380	$450	$840,948	$381	$256,434	$116	$1,097,382	$497	45.0%	-38.0%
35-39	$1,327,284	$482	$301,591	$109	$1,628,875	$591	$899,310	$346	$531,983	$205	$1,431,293	$551	-28.2%	87.0%
40-44	$1,005,079	$344	$338,199	$116	$1,343,278	$460	$947,639	$341	$415,297	$149	$1,362,936	$491	-0.9%	29.0%
45-49	$832,002	$253	$413,026	$125	$1,245,028	$378	$1,224,074	$355	$508,773	$148	$1,732,847	$503	40.7%	17.8%
50-54	$2,346,478	$613	$1,146,954	$299	$3,493,432	$912	$1,850,906	$483	$1,213,698	$317	$3,064,605	$799	-21.2%	5.7%
55-59	$1,914,870	$501	$1,003,819	$262	$2,918,689	$763	$1,733,694	$467	$1,136,564	$306	$2,870,258	$773	-6.7%	16.7%
60-64	$1,852,871	$497	$885,709	$238	$2,738,580	$735	$1,888,335	$526	$1,136,218	$316	$3,024,553	$842	5.8%	33.1%
65+	$1,340,467	$533	$701,698	$279	$2,042,165	$813	$1,626,923	$633	$755,719	$294	$2,382,642	$927	18.6%	5.3%
Total	$22,320,873	$553	$5,898,545	$146	$28,219,418	$699	$14,583,811	$368	$6,586,692	$166	$21,170,503	$535	-25.0%	-23.5%

Financial Summary

Financial and Demographic												
	Total				State Active				Retiree (State/Non-State)			
Summary	Thru 2Q20	Thru 2Q21	Thru 2Q22	▲	Thru 2Q20	Thru 2Q21	Thru 2Q22	▲	Thru 2Q20	Thru 2Q21	Thru 2Q22	▲
Avg. # Employees	3,918	3,815	3,750	-1.7%	3,424	3,342	3,312	-0.9%	494	472	439	-7.1%
Avg. # Members	6,816	6,730	6,597	-2.0%	6,183	6,112	6,005	-1.8%	634	618	592	-4.1%
Ratio	1.7	1.8	1.8	-0.3%	1.8	1.8	1.8	-0.8%	1.3	1.3	1.4	3.2%
Financial												
Medical Paid	$14,578,321	$22,366,163	$14,570,566	-34.9%	$12,908,385	$19,787,795	$12,961,296	-34.5%	$1,670,307	$2,578,368	$1,609,270	-37.6%
Member Paid	$947,046	$1,401,195	$979,192	-30.1%	$548,967	$1,057,289	$766,937	-27.5%	$398,079	$343,906	$212,255	-38.3%
Net Paid PEPY	$7,442	$11,702	$7,777	-33.5%	$7,540	$11,834	$7,832	-33.8%	$6,758	$10,767	$7,359	-31.7%
Net Paid PMPY	$4,277	$6,633	$4,421	-33.3%	$4,176	$6,471	$4,320	-33.3%	$5,270	$8,232	$5,450	-33.8%
Net Paid PEPM	$620	$975	$648	-33.5%	$628	$986	$653	-33.8%	$563	$897	$613	-31.7%
Net Paid PMPM	$356	$554	$368	-33.5%	$348	$539	$360	-33.3%	$439	$686	$454	-33.8%
High Cost Claimants												
# of HCC's > $50k	31	46	36	-21.7%	24	36	32	-11.1%	7	10	4	-60.0%
Avg. paid per claimant	$134,412	$261,295	$118,743	-54.6%	$151,276	$299,331	$116,221	-61.2%	$76,592	$124,366	$138,918	11.7%
HCC % of Spend	28.5%	53.6%	29.3%	-45.3%	28.1%	54.4%	28.7%	-47.3%	31.4%	47.5%	34.4%	-27.6%
Spend by Location (PMPY)												
Inpatient	$1,462	$3,408	$1,257	-63.1%	$1,418	$3,647	$1,345	-63.1%	$1,896	$3,660	$2,036	-44.4%
Outpatient	$1,042	$1,141	$1,192	4.4%	$1,026	$971	$1,141	17.5%	$1,195	$1,629	$1,236	-24.1%
Professional	$1,774	$2,097	$1,969	-6.1%	$1,732	$1,332	$1,375	3.2%	$2,179	$3,055	$2,160	-29.3%
Total	$4,277	$6,646	$4,417	-33.5%	$4,176	$6,475	$4,317	-33.3%	$5,270	$8,344	$5,432	-34.9%

Paid Claims by Claim Type

UnitedHealthcare

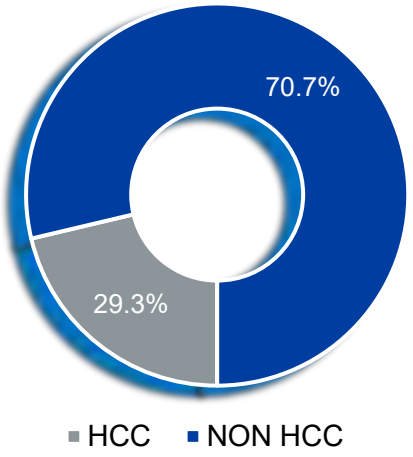
Net Paid Claims - Total									
Total Participants									
	Thru 2Q21				Thru 2Q22				▲
	Actives	Pre-Medicare	Medicare	Total	Actives	Pre-Medicare	Medicare	Total	
Medical									
InPatient	$10,582,813	$275,414	$611,296	$11,469,523	$3,206,599	$100,642	$837,802	$4,145,043	-63.9%
OutPatient	$9,945,374	$221,839	$729,427	$10,896,641	$9,216,166	$408,719	$800,638	$10,425,523	-4.3%
Total - Medical	$20,528,187	$497,253	$1,340,723	$22,366,163	$12,422,765	$509,361	$1,638,441	$14,570,566	-34.9%

Net Paid Claims - Total									
Total Participants									
	Thru 2Q21				Thru 2Q22				▲
	Actives	Pre-Medicare	Medicare	Total	Actives	Pre-Medicare	Medicare	Total	
Medical PMPM	$554	$600	$1,618	$554	$343	$682	$637	$368	-33.5%

Cost Distribution – Medical Claims > $50K

Thru 2Q21							Thru 2Q22					
# of Members	% of Population	Total Paid	% of Paid	Subscriber Paid	% of Subscribers paid	Paid Claims	# of Members	% of Population	Total Paid	% of Paid	Subscriber Paid	% of Subscribers paid
11	0.2%	$8,424,261	37.7%	$1,038,241	12.3%	> $100k	8	0.1%	$1,344,474	9.2%	$971,593	72.3%
18	0.3%	$1,476,668	6.6%	$1,071,368	72.6%	$50k- $100k	14	0.2%	$1,325,776	9.1%	$1,062,094	80.1%
41	0.6%	$1,800,609	8.1%	$1,471,734	81.7%	$25k - $50k	39	0.6%	$1,441,751	9.9%	$1,113,084	77.2%
143	2.1%	$2,722,483	12.2%	$2,055,078	75.5%	$10k - $25k	141	2.1%	$2,645,108	18.2%	$1,837,691	69.5%
208	3.1%	$1,715,638	7.7%	$1,080,408	63.0%	$5k - $10k	223	3.4%	$1,852,983	12.7%	$1,268,169	68.4%

% Paid Attributed to Catastrophic Cases



HCC > $50k - AHRQ Chapter Conditions - Thru 2Q22			
Top 5 AHRQ Category conditions	# of Patients	Total Paid	% of Med Paid
Neoplasms	7	$778,851	5.3%
Endocrine; nutritional; and metabolic diseases	3	$544,858	3.7%
Diseases of the digestive system	5	$482,143	3.3%
Injury and poisoning	2	$457,944	3.1%
Infectious and parasitic diseases	3	$388,294	2.7%

Utilization Summary

UnitedHealthcare

Utilization Summary	Total			State Active			Retiree State/Non-State		
	Thru 2Q21	Thru 2Q22	▲	Thru 2Q21	Thru 2Q22	▲	Thru 2Q21	Thru 2Q22	▲
Inpatient									
# of Admits	226	188	-16.8%	176	168	-4.3%	50	20	-60.4%
# of Bedays	1,752	1,064	-39.3%	1,352	936	-30.8%	400	128	-67.9%
Avg. Paid per Admit	$50,488	$22,286	-55.9%	$58,465	$21,202	-63.7%	$22,561	$31,472	39.5%
Avg. Paid per Day	$6,511	$3,938	-39.5%	$7,600	$3,810	-49.9%	$2,831	$4,872	72.1%
Admits Per K	67.1	57.0	-15.1%	57.5	56.0	-2.6%	162.4	67.0	-58.7%
Days Per K	520.6	322.6	-38.0%	442.4	311.7	-29.5%	1,294.6	433.0	-66.6%
ALOS	7.8	5.7	-27.0%	7.7	5.6	-27.7%	5.5	5.9	7.3%
Admits from ER	119	83	-30.3%	88	73	-17.0%	31	10	-67.7%
Physician Office Visits									
Per Member Per Year	2.7	2.2	-17.0%	2.6	2.2	-16.8%	3.2	2.6	-18.7%
Paid Per Visit	$136	$153	13.1%	$141	$159	13.0%	$95	$107	12.7%
Net Paid PMPM	$30	$29	-6.1%	$31	$29	-6.0%	$25	$23	-8.4%
Emergency Room									
# of Visits	363	389	7.2%	331	360	8.8%	32	29	-9.4%
Visits Per K	107.9	117.9	9.3%	108.3	119.9	10.7%	103.6	97.9	-5.5%
Avg Paid Per Visit	$2,459	$2,831	15.1%	$2,489	$2,891	16.1%	$2,151	$2,085	-3.0%
Urgent Care									
# of Visits	2,518	1,960	-22.2%	2,259	1,777	-21.3%	259	183	-29.3%
Visits Per K	748.3	594.2	-20.6%	739.2	591.9	-19.9%	838.2	617.7	-26.3%
Avg Paid Per Visit	$115	$122	6.2%	$86	$92	6.1%	$87	$76	-13.1%

**Not Representative of all utilization*

**Data based on medical spend only*

Diagnosis Grouper Summary – Top 25

UnitedHealthcare®

Top 25 AHRQ Category	Total Paid	% Paid	Insured	Spouse	Dependent	Male	Female	Unassigned
Septicemia (except in labor)	$556,753	4.8%	$503,357	$50,230	$3,166	$227,300	$329,453	$0
Thyroid disorders	$534,195	4.7%	$478,293	$49,832	$6,070	$1,057	$533,138	$0
Non-Hodgkin`s lymphoma	$323,569	2.8%	$301,220	$22,350		$27,499	$296,070	$0
Complication of device; implant or graft	$285,455	2.5%	$137,626	$88,874	$58,954	$168,596	$116,859	$0
Disorders usually diagnosed in infancy childhood or adol	$277,633	2.4%			$277,633	$226,382	$51,251	$0
Complications of surgical procedures or medical care	$249,712	2.2%	$248,187	$1,412	$114	$208,817	$40,895	$0
Acute and unspecified renal failure	$234,660	2.0%	$230,049	$4,565	$46	$231,888	$2,772	$0
Other nutritional; endocrine; and metabolic disorders	$211,180	1.8%	$156,688	$52,580	$1,912	$34,137	$177,043	$0
Cancer of breast	$205,111	1.8%	$193,061	$12,050			$205,111	$0
Spondylosis; intervertebral disc disorders; other back prc	$204,070	1.8%	$166,321	$35,329	$2,421	$65,388	$138,682	$0
Maintenance chemotherapy; radiotherapy	$200,775	1.7%	$185,838	$14,937		$61,884	$138,891	$0
Mood disorders	$190,781	1.7%	$62,299	$14,548	$113,934	$85,360	$105,421	$0
Polyhydramnios and other problems of amniotic cavity	$165,876	1.4%	$155,716	$10,160	$0		$165,876	$0
Osteoarthritis	$165,836	1.4%	$137,731	$28,105		$50,002	$115,835	$0
Abdominal pain	$163,377	1.4%	$126,874	$12,320	$24,184	$48,173	$115,204	$0
Other nervous system disorders	$162,980	1.4%	$30,818	$124,571	$7,590	$13,955	$149,025	$0
Other screening for suspected conditions (not mental dis	$158,370	1.4%	$127,986	$26,612	$3,771	$50,328	$108,042	$0
Diabetes mellitus with complications	$155,477	1.4%	$99,109	$26,155	$30,213	$109,633	$45,844	$0
Other gastrointestinal disorders	$152,213	1.3%	$132,467	$7,208	$12,538	$13,416	$138,797	$0
Cancer of prostate	$148,299	1.3%	$66,963	$81,336		$148,299		$0
Aortic; peripheral; and visceral artery aneurysms	$146,383	1.3%	$16,329	$130,055		$18,208	$128,176	$0
Acute bronchitis	$141,428	1.2%	$10,025	$191	$131,211	$44,177	$97,251	$0
Liveborn	$134,613	1.2%			$134,613	$112,521	$22,091	$0
Cardiac dysrhythmias	$134,266	1.2%	$99,838	$34,133	$295	$82,162	$52,103	$0
Medical examination/evaluation	$131,562	1.1%	$27,265	$8,546	$95,751	$55,135	$76,428	$0

**Not Representative of all utilization*

**Data based on medical spend only*

Mental Health Drilldown

UnitedHealthcare

Top 10 Mental Health				
AHRQ Category Description	Thru 2Q21		Thru 2Q22	
	Patients	Total Paid	Patients	Total Paid
Disorders usually diagnosed in infancy childhood	39	$316,108	29	$277,633
Mood disorders	388	$208,659	358	$190,781
Anxiety disorders	339	$66,775	302	$112,486
Substance-related disorders	26	$20,909	20	$33,371
Adjustment disorders	130	$27,330	97	$27,635
Attention-deficit conduct disorders	96	$10,854	110	$21,697
Suicide and intentional self-inflicted injury	11	$25,157	9	$18,529
Schizophrenia and other psychotic disorders	13	$8,342	7	$17,856
Miscellaneous mental health disorders	39	$56,878	33	$14,922
Alcohol-related disorders	18	$60,090	9	$14,841

**Not Representative of all utilization*

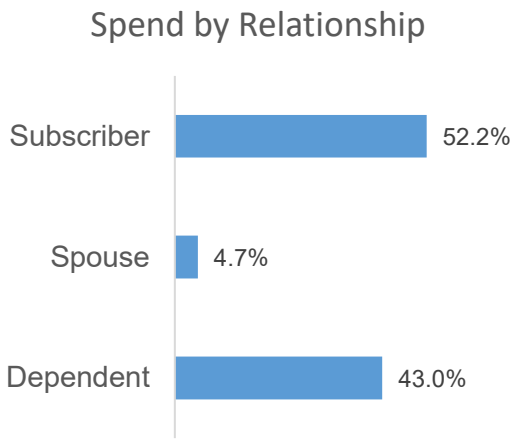
**Data based on medical spend only*

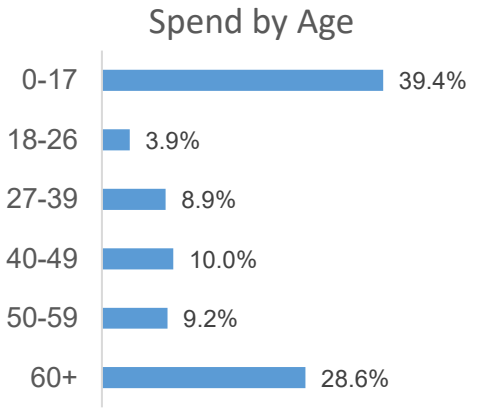
Respiratory Disorders

Respiratory Disorders				
AHRQ Category Description	Patients	Claims	Total Paid	% Paid
Acute bronchitis	95	127	$141,428	21.3%
Other upper respiratory infections	622	839	$98,236	14.8%
Other lower respiratory disease	319	571	$94,511	14.2%
Asthma	165	295	$72,128	10.9%
Other upper respiratory disease	277	756	$71,128	10.7%
Pneumonia	25	66	$64,987	9.8%
Chronic obstructive pulmonary disease	64	140	$46,568	7.0%
Influenza	49	54	$25,953	3.9%
Respiratory failure; insufficiency; arrest (adult)	16	47	$21,144	3.2%
Acute and chronic tonsillitis	32	62	$20,255	3.1%

Not Representative of all utilization

Data based on medical spend only



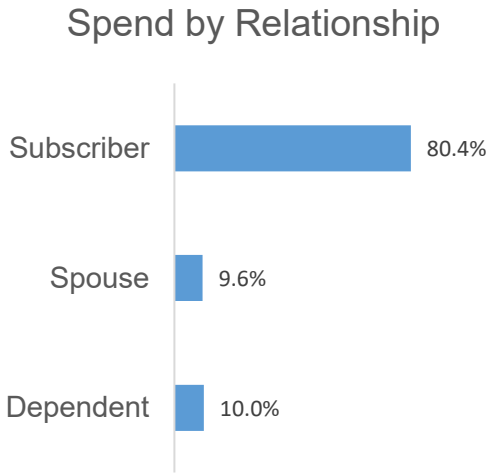


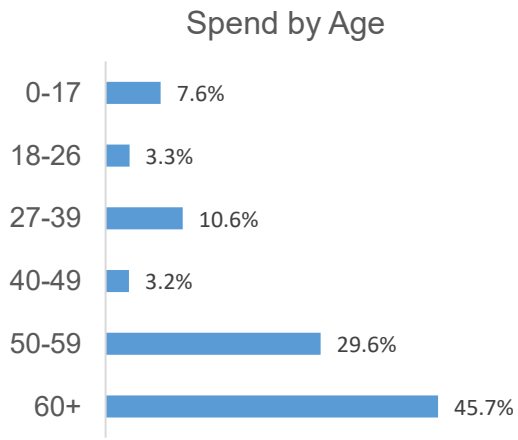
Infections

Infectious and Parasitic Diseases				
AHRQ Description	Patients	Claims	Total Paid	% Paid
Septicemia (except in labor)	16	47	$556,753	72.6%
Immunizations and screening for infectious disease	843	1,287	$101,930	13.3%
Viral infection	344	501	$96,374	12.6%
HIV infection	17	49	$5,748	0.7%
Mycoses	71	102	$2,151	0.3%
Hepatitis	13	41	$2,011	0.3%
Bacterial infection; unspecified site	7	11	$1,104	0.1%
Other infections; including parasitic	7	13	$640	0.1%
Tuberculosis	4	11	$0	0.0%
Sexually transmitted infections (not HIV or hepatitis)	8	11	$0	0.0%

**Not Representative of all utilization*

**Data based on medical spend only*





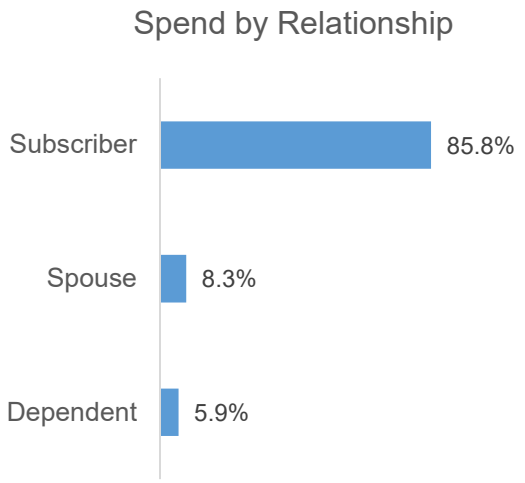
Pregnancy Related Disorders

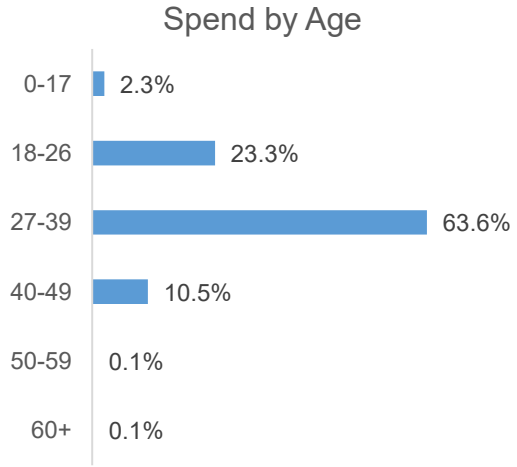
UnitedHealthcare®

Top 10 Complications of Pregnancy				
AHRQ Description	Patients	Claims	Total Paid	% Paid
Polyhydramnios and other problems of amniotic cavity	8	19	$165,876	22.6%
Complications of birth; puerperium affecting management	21	37	$129,773	17.7%
Other pregnancy and delivery including normal	65	260	$73,108	10.0%
Other complications of pregnancy	49	198	$68,388	9.3%
Previous C-section	5	18	$56,360	7.7%
Umbilical cord complication	6	11	$42,671	5.8%
Prolonged pregnancy	5	6	$42,110	5.7%
Contraceptive and procreative management	125	250	$38,077	5.2%
OB-related trauma to perineum and vulva	4	4	$28,599	3.9%
Diabetes or abnormal glucose tolerance complicating pregnancy	11	44	$27,369	3.7%

**Not Representative of all utilization*

**Data based on medical spend only*





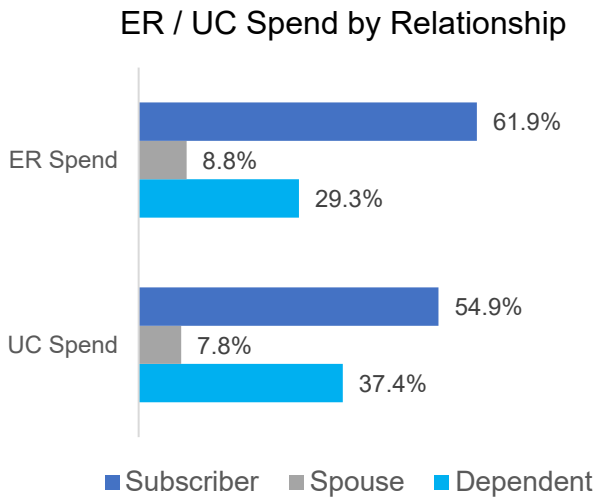
Emergency Room and Urgent Care

	Thru 2Q21		Thru 2Q22		Peer	
Metric	ER	Urgent Care	ER	Urgent Care	ER	Urgent Care
# of Visits	363	2,518	389	1,960		
Visits Per Member	0.05	0.48	0.06	0.54	0.08	0.14
Visits Per K	107.9	748.3	117.9	594.2	89.6	385.3
Avg. Paid Per Visit	$2,459	$112	$2,831	$121	$2,607	$118

**Not Representative of all utilization*

**Data based on medical spend only*

Emergency Room and Urgent Care Visits by Relationships - Thru 2Q22				
Relationship	ER Visits	ER Per K	UC Visits	UC Per K
Member	202	61.2	1,219	369.6
Spouse	35	10.6	157	47.6
Dependent	152	46.1	584	177.0
Total	389	117.9	1,960	594.2



Clinical Conditions by Medical Spend

UnitedHealthcare®

Top 15 Common Condition	# of Members	% of Members	Members Per K	PMPM
Mental Disorders	542	4.1%	41.1	$13.33
Intervertebral Disc Disorders	458	3.5%	34.7	$5.16
Diabetes with complications	310	2.3%	23.5	$3.93
Prostate Cancer	55	0.4%	4.2	$5.18
Breast Cancer	424	3.2%	32.1	$3.23
Acute Myocardial Infarction	62	0.5%	4.7	$1.30
Asthma	6	0.0%	0.5	$1.47
COPD	76	0.6%	5.8	$1.99
Diabetes without complications	28	0.2%	2.1	$0.23
Coronary Atherosclerosis	164	1.2%	12.4	$1.82
Chronic Renal Failure	5	0.0%	0.4	$0.05
Hypertension	64	0.5%	4.9	$1.18
Congestive Heart Failure (CHF)	326	2.5%	24.7	$1.18
Colon Cancer	24	0.2%	1.8	$3.75
Cervical Cancer	17	0.1%	1.3	$0.02

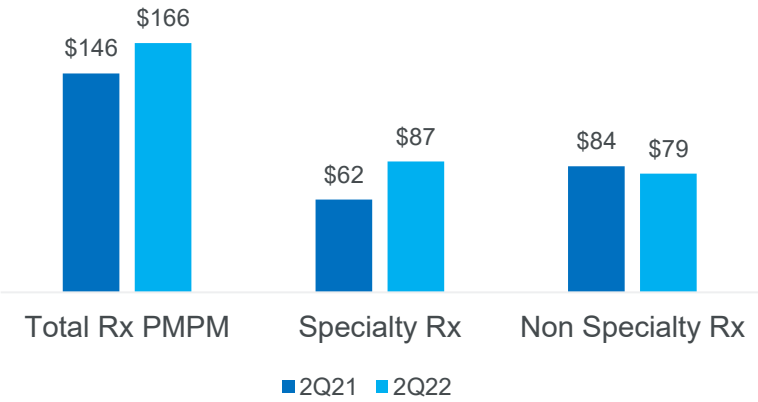
**Not Representative of all utilization*

**Data based on medical spend only*

Pharmacy Drivers

	Thru 2Q21	Thru 2Q22	Δ
Enrolled Members	6,730	6,597	-2.0%
Average Prescriptions PMPY	17.3	16.7	-3.4%
Formulary Rate	87.6%	89.7%	2.4%
Generic Use Rate	81.8%	83.8%	2.6%
Generic Substitution Rate	98.2%	98.3%	0.1%
Avg Net Paid per Prescription	$101	$119	17.9%
Net Paid PMPM	$146	$166	13.9%

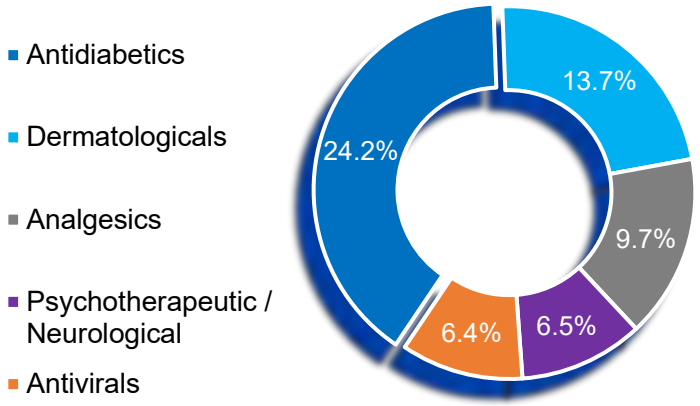
Total Rx Spend by Benefit and Type



Pharmacy Performance

- Rx spend increased of **13.9%**, ($20.33 pmpm) from prior period
- Avg. paid per Script increased **17.9%** ($18.11 pmpm) year over year
- Specialty Rx Spend driving **52.4%** of Rx Spend
- Specialty Rx spend increased **23.8%** from prior period
  Specialty Rx Drivers:
  Jardiance (Antidiabetic) Spend up **14.3%**
  Ozempic (Antidiabetic) Spend up **12.2%**
-

Top 5 Therapeutic Classes by Spend



4.3

4. Consent Agenda (Jack Robb, Board Chair) (**All Items for Possible Action**)

4.3 Receipt of quarterly vendor reports for the period ending December 31, 2022:

4.3.1 UMR – Obesity Care Management

4.3.2 UMR – Diabetes Care Management

4.3.3 Sierra Healthcare Options – Utilization and Large Case Management

4.3.4 UnitedHealthcare – Basic Life Insurance

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

4.3.6 Sierra Healthcare Options and UnitedHealthcare Plus Network

4.3.7 HealthPlan of Nevada, Inc. – Southern HMO

4.3.8 Doctor on Demand Engagement Report through March 2023

4.3.1

4. Consent Agenda (Jack Robb, Board Chair) (**All Items for Possible Action**)

    4.3 Receipt of quarterly vendor reports for the period ending December 31, 2022:

        4.3.1 UMR – Obesity Care Management

DATASCOPE™

Obesity Care Management Report

Nevada Public Employees' Benefits Program

July 2022 – December 2022 Incurred,

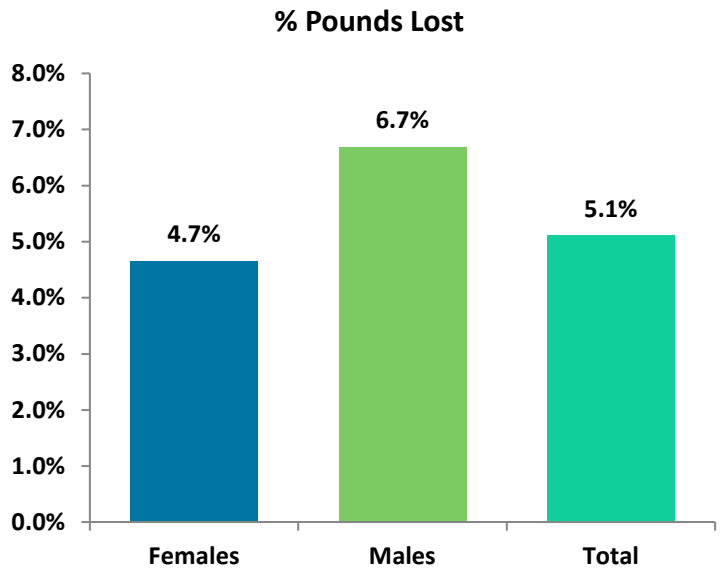
Paid through February 28, 2023

UMR℠

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

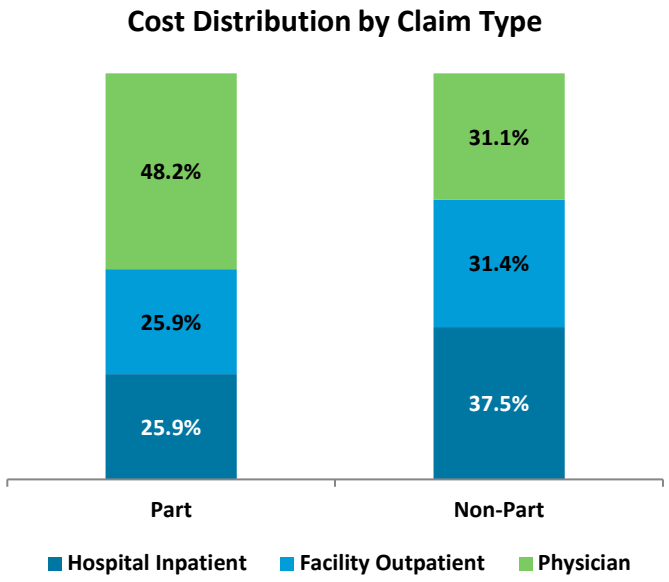
PEBP 2Q23			
Weight Management Summary	**Females**	**Males**	**Total**
# Mbrs Enrolled in Program	235	58	293
Average # Lbs. Lost	14.3	14.8	14.4
Total # Lbs. Lost	3,357.8	856.5	4,214.3
% Lbs. Lost	4.7%	6.7%	5.1%
Average Cost/ Member	$3,465	$3,014	$3,376



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	260	1,087	-76.1%
Avg # Members	291	1,328	-78.1%
Member/Employee Ratio	1.1	1.2	-8.2%
Financial Summary			
Gross Cost	$728,163	$9,713,905	
Client Paid	$551,738	$8,227,255	
Employee Paid	$176,424	$1,486,650	
Client Paid-PEPY	$4,252	$15,133	-71.9%
Client Paid-PMPY	$3,794	$12,395	-69.4%
Client Paid-PEPM	$354	$1,261	-71.9%
Client Paid-PMPM	$316	$1,033	-69.4%
High Cost Claimants (HCC's) > $100k			
# of HCC's	0	15	
HCC's / 1,000	0.0	11.3	0.0%
Avg HCC Paid	$0	$188,815	0.0%
HCC's % of Plan Paid	0.0%	34.4%	0.0%
Cost Distribution - PMPY			
Hospital Inpatient	$590	$5,070	-88.4%
Facility Outpatient	$964	$4,050	-76.2%
Physician	$2,240	$3,275	-31.6%
Total	$3,794	$12,395	-69.4%
	Annualized	Annualized	



Obesity Care Management – Utilization Summary

Summary	Participants	Non-Participants	Variance
Inpatient Facility			
# of Admits	4	105	
# of Bed Days	13	623	
Paid Per Admit	$14,719	$32,448	-54.6%
Paid Per Day	$4,529	$5,469	-17.2%
Admits Per 1,000	28	158	-82.3%
Days Per 1,000	89	939	-90.5%
Avg LOS	3.3	5.9	-44.1%
# of Admits From ER	3	57	-94.7%
Physician Office			
OV Utilization per Member	14.8	9.0	64.4%
Avg Paid per OV	$94	$94	0.0%
Avg OV Paid per Member	$1,398	$839	66.6%
DX&L Utilization per Member	20.1	22.8	-11.8%
Avg Paid per DX&L	$25	$65	-61.5%
Avg DX&L Paid per Member	$505	$1,473	-65.7%
Emergency Room			
# of Visits	32	235	
Visits Per Member	0.22	0.35	-37.1%
Visits Per 1,000	220	354	-37.9%
Avg Paid per Visit	$1,894	$3,454	-45.2%
Urgent Care			
# of Visits	74	320	
Visits Per Member	0.51	0.48	6.3%
Visits Per 1,000	509	482	5.6%
Avg Paid per Visit	$76	$96	-20.8%
	Annualized	Annualized	

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

4.3.2

4. Consent Agenda (Jack Robb, Board Chair) (**All Items for Possible Action**)

    4.3 Receipt of quarterly vendor reports for the period ending December 31, 2022:

        4.3.1 UMR – Obesity Care Management

        4.3.2 UMR– Diabetes Care Management

DATASCOPE™

Diabetes Care Management Report

Nevada Public Employees' Benefits Program

July 2022 – December 2022 Incurred,

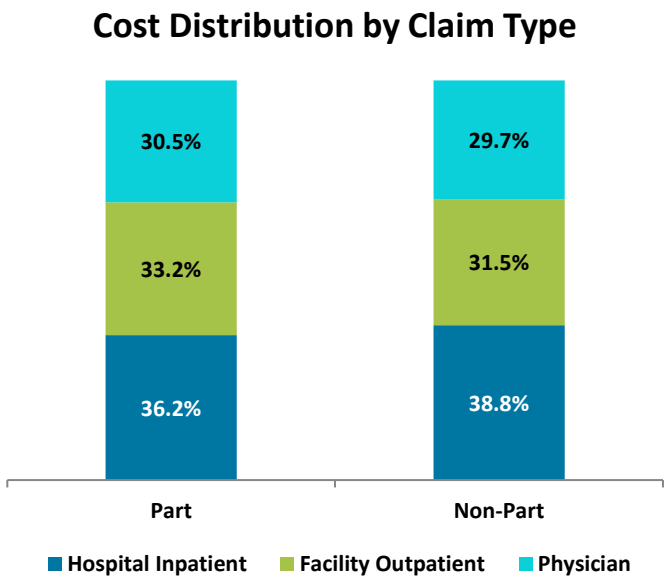
Paid through February 28, 2023

UMR℠

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	238	2,080	-88.5%
Avg # Members	326	2,620	-87.5%
Member/Employee Ratio	1.4	1.3	8.7%
Financial Summary			
Gross Cost	$1,193,140	$14,797,728	
Client Paid	$767,129	$12,332,977	
Employee Paid	$426,011	$2,464,751	
Client Paid-PEPY	$6,437	$11,859	-45.7%
Client Paid-PMPY	$4,702	$9,414	-50.1%
Client Paid-PEPM	$536	$988	-45.7%
Client Paid-PMPM	$392	$785	-50.1%
High Cost Claimants (HCC's) > $100k			
# of HCC's	1	21	
HCC's / 1,000	3.1	8.0	0.0%
Avg HCC Paid	$221,580	$220,251	0.6%
HCC's % of Plan Paid	28.9%	37.5%	0.0%
Cost Distribution - PMPY			
Hospital Inpatient	$1,704	$3,648	-53.3%
Facility Outpatient	$1,562	$2,968	-47.4%
Physician	$1,435	$2,799	-48.7%
Total	$4,702	$9,414	-50.1%
	Annualized	Annualized	



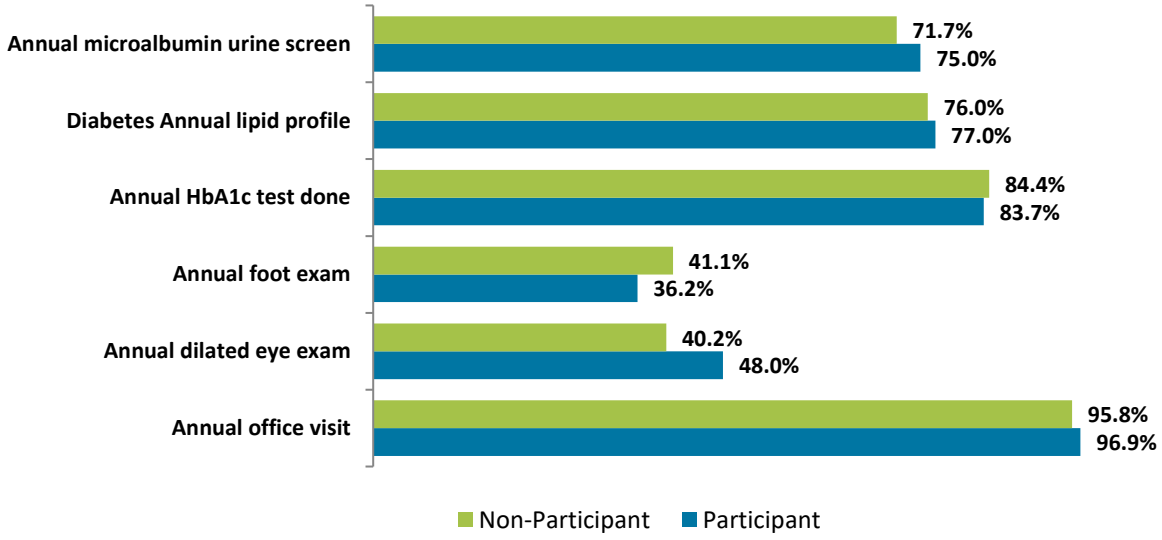
Diabetes Care Management – Utilization Summary

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

Summary	Participants	Non-Participants	Variance
Inpatient Facility			
# of Admits	16	160	
# of Bed Days	108	948	
Paid Per Admit	$19,146	$32,350	-40.8%
Paid Per Day	$2,836	$5,460	-48.1%
Admits Per 1,000	98	122	-19.7%
Days Per 1,000	662	724	-8.6%
Avg LOS	6.8	5.9	15.3%
# of Admits From ER	15	98	-84.7%
Physician Office			
OV Utilization per Member	7.1	7.6	-6.6%
Avg Paid per OV	$54	$97	-44.3%
Avg OV Paid per Member	$386	$739	-47.8%
DX&L Utilization per Member	20.9	23.9	-12.6%
Avg Paid per DX&L	$22	$60	-63.3%
Avg DX&L Paid per Member	$469	$1,433	-67.3%
Emergency Room			
# of Visits	29	335	
Visits Per Member	0.18	0.26	-30.8%
Visits Per 1,000	178	256	-30.5%
Avg Paid per Visit	$1,491	$3,309	-54.9%
Urgent Care			
# of Visits	45	511	
Visits Per Member	0.28	0.39	-28.2%
Visits Per 1,000	276	390	-29.2%
Avg Paid per Visit	$75	$83	-9.6%
	Annualized	Annualized	

Quality Metrics

		Participant				Non-Participant			
Condition	Metric	#Members in Group	#Meeting Metric	#Not Meeting Metric	% Meeting Metric	#Members in Group	#Meeting Metric	#Not Meeting Metric	% Meeting Metric
Diabetes	Annual office visit	196	190	6	96.9%	1,514	1,450	64	95.8%
	Annual dilated eye exam	196	94	102	48.0%	1,514	608	906	40.2%
	Annual foot exam	196	71	125	36.2%	1,514	622	892	41.1%
	Annual HbA1c test done	196	164	32	83.7%	1,514	1,278	236	84.4%
	Diabetes Annual lipid profile	196	151	45	77.0%	1,514	1,151	363	76.0%
	Annual microalbumin urine screen	196	147	49	75.0%	1,514	1,086	428	71.7%



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 (Jack Robb, Board Chair) (**All Items for Possible Action**)

    4.3 Receipt of quarterly vendor reports for the period ending December 31, 2022:

        4.3.1 UMR – Obesity Care Management

        4.3.2 UMR – Diabetes Care Management

        4.3.3 Sierra Healthcare Options – Utilization and Large Case Management

SHO-PUBLIC EMPLOYEES BENEFIT PROGRAM

2022 Performance Review

SIERRA HEALTH-CARE OPTIONS, INC.

Excutive Summary

Metrics	Oct-22	Nov-22	Dec-22	Average
Enrollment	49,084	49,116	48,946	**49,048**

	Inpatient All - LTACH, AIR, SNF, and OOA				
Month	**Oct-22**	**Nov-22**	**Dec-22**	**Total**	**Average**
Total Discharges	151	140	163	**454**	**151**
Total Discharges LOS	682	775	515	**1,972**	**657**
Average LOS	4.5	5.5	3.2	**4.3**	**4.4**

Out of Area, Hopital Rehabilitation and Skilled Nursing are excluded from this calculation.

	Inpatient Hospital Acute Only				
Month	**Oct-22**	**Nov-22**	**Dec-22**	**Total**	**Average**
Total Discharges	93	88	118	**299**	**100**
Total Discharges LOS	395	392	416	**1,203**	**401**
Average LOS	4.2	4.5	3.5	**4.0**	**4.1**

		Beddays by Facility Type			
Metrics					
Facility Type	**Oct-22**	**Nov-22**	**Dec-22**	**Total**	**Average**
Hospital	395	392	501	**1,288**	**429**
Hospital Rehabilitation	0	0	6	**6**	**2**
Skilled Nursing	4	18	0	**22**	**7**
Out of Area	346	472	388	**1,206**	**402**

		Admits by Facility Type			
Metrics					
Facility Type	**Oct-22**	**Nov-22**	**Dec-22**	**Total**	**Average**
Hospital	89	91	113	**293**	**98**
Hospital Rehabilitation	0	0	1	**1**	**0**
Skilled Nursing	1	1	0	**2**	**1**
Out of Area	54	69	44	**167**	**56**

		Readmits by Facility Type			
Metrics					
Facility Type	**Oct-22**	**Nov-22**	**Dec-22**	**Total**	**Average**
Hospital	10	2	0	**12**	**4**
Hospital Rehabilitation	0	0	0	**0**	**0**
Skilled Nursing	0	0	0	**0**	**0**
Out of Area	1	0	0	**1**	**0**

		Average Length of Stay by Facility			
Facility Type	**Metrics**				
	Facility Name	**Oct-22**	**Nov-22**	**Dec-22**	**Total**
Hospital	CENTENNIAL HILLS HOSPITAL MEDICAL CENTER	4.6	3.3	4.0	**4.0**
	DESERT SPRINGS HOSPITAL MEDICAL CENTER	0.0	4.0	4.7	**2.9**
	HENDERSON HOSPITAL	4.0	2.5	2.0	**2.8**
	LAS VEGAS VAMC	1.0	0.0	0.0	**0.3**
	MIKE O CALLAGHAN FEDERAL HOSPITAL	1.0	11.0	0.0	**4.0**
	MOUNTAIN VIEW HOSPITAL	4.6	6.4	3.5	**4.8**
	NORTH VISTA HOSPITAL	1.0	0.0	1.5	**0.8**
	RENOWN REGIONAL MEDICAL CENTER	4.3	4.4	4.2	**4.3**
	SOUTHERN HILLS HOSPITAL	1.4	3.5	1.0	**2.0**
	SPRING VALLEY HOSPITAL	2.3	7.3	5.8	**5.1**
	ST ROSE DOMINICAN HOSPITAL SAN MARTIN CAMPUS	1.0	4.0	2.5	**2.5**
	ST ROSE DOMINICAN HOSPITAL SIENA CAMPUS	2.7	4.5	2.0	**3.1**
	SUMMERLIN HOSPITAL MEDICAL CTR	8.0	3.9	2.7	**4.9**
	SUNRISE HOSPITAL	2.3	4.8	1.5	**2.9**
	UNIVERSITY MEDICAL CENTER SO NV	6.5	0.0	3.0	**3.2**
	VALLEY HOSPITAL MEDICAL CTR	0.0	2.7	8.0	**3.6**
	Total	**4.2**	**4.5**	**3.5**	**4.1**
Hospital Rehabilitation	ENCOMPASS HEALTH HOSPITAL OF DESERT CANYON	0.0	0.0	0.0	**0.0**
	ENCOMPASS HEALTH HOSPITAL OF HENDERSON	0.0	0.0	6.0	**2.0**
	ENCOMPASS HEALTH REHAB OF LAS VEGAS	0.0	0.0	0.0	**0.0**
	Total	**0.0**	**0.0**	**6.0**	**2.0**
Skilled Nursing	HARMON HOSPITAL	0.0	0.0	0.0	**0.0**
	SANDSTONE SPRING VALLEY LLC	2.0	18.0	0.0	**6.7**
	TRELLIS CENTENNIAL	0.0	0.0	0.0	**0.0**
	Total	**2.0**	**18.0**	**0.0**	**6.7**
Out of Area	Out of Area	5.1	7.2	2.1	**4.8**
	Total	**5.1**	**7.2**	**2.1**	**4.8**

Beddays by Facility

Facility Type	Metrics	Oct-22	Nov-22	Dec-22	Total	Average
	Facility Name					
Hospital	CENTENNIAL HILLS HOSPITAL MEDICAL CENTER	37	10	36	**83**	**28**
	DESERT SPRINGS HOSPITAL MEDICAL CENTER	7	4	14	**25**	**8**
	HENDERSON HOSPITAL	20	5	8	**33**	**11**
	LAS VEGAS VAMC	1	0	0	**1**	**0**
	MIKE O CALLAGHAN FEDERAL HOSPITAL	1	11	0	**12**	**4**
	MOUNTAIN VIEW HOSPITAL	32	51	72	**155**	**52**
	NORTH VISTA HOSPITAL	1	1	3	**5**	**2**
	RENOWN REGIONAL MEDICAL CENTER	146	186	224	**556**	**185**
	SOUTHERN HILLS HOSPITAL	7	14	2	**23**	**8**
	SPRING VALLEY HOSPITAL	9	22	23	**54**	**18**
	ST ROSE DOMINICAN HOSPITAL SAN MARTIN CAMPUS	2	16	15	**33**	**11**
	ST ROSE DOMINICAN HOSPITAL SIENA CAMPUS	24	9	22	**55**	**18**
	SUMMERLIN HOSPITAL MEDICAL CTR	88	31	27	**146**	**49**
	SUNRISE HOSPITAL	7	24	44	**75**	**25**
	UNIVERSITY MEDICAL CENTER SO NV	13	0	3	**16**	**5**
	VALLEY HOSPITAL MEDICAL CTR	0	8	8	**16**	**5**
	Total	**395**	**392**	**501**	**1,288**	**429**
Hospital Rehabilitation	ENCOMPASS HEALTH HOSPITAL OF DESERT CANYON	0	0	0	**0**	**0**
	ENCOMPASS HEALTH HOSPITAL OF HENDERSON	0	0	6	**6**	**2**
	ENCOMPASS HEALTH REHAB OF LAS VEGAS	0	0	0	**0**	**0**
	Total	**0**	**0**	**6**	**6**	**2**
Skilled Nursing	HARMON HOSPITAL	0	0	0	**0**	**0**
	SANDSTONE SPRING VALLEY LLC	4	18	0	**22**	**7**
	TRELLIS CENTENNIAL	0	0	0	**0**	**0**
	Total	**4**	**18**	**0**	**22**	**7**
Out of Area	Out of Area	346	472	388	**1,206**	**402**
	Total	**346**	**472**	**388**	**1,206**	**402**

Admits by Facility

Facility Type	Metrics	Oct-22	Nov-22	Dec-22	Total	Average
	Facility Name					
Hospital	CENTENNIAL HILLS HOSPITAL MEDICAL CENTER	7	3	9	**19**	**6**
	DESERT SPRINGS HOSPITAL MEDICAL CENTER	1	1	2	**4**	**1**
	HENDERSON HOSPITAL	5	2	4	**11**	**4**
	LAS VEGAS VAMC	1	0	0	**1**	**0**
	MIKE O CALLAGHAN FEDERAL HOSPITAL	1	1	0	**2**	**1**
	MOUNTAIN VIEW HOSPITAL	8	9	14	**31**	**10**
	NORTH VISTA HOSPITAL	1	1	1	**3**	**1**
	RENOWN REGIONAL MEDICAL CENTER	30	42	50	**122**	**41**
	SOUTHERN HILLS HOSPITAL	4	5	1	**10**	**3**
	SPRING VALLEY HOSPITAL	4	3	3	**10**	**3**
	ST ROSE DOMINICAN HOSPITAL SAN MARTIN CAMPUS	1	5	4	**10**	**3**
	ST ROSE DOMINICAN HOSPITAL SIENA CAMPUS	8	4	9	**21**	**7**
	SUMMERLIN HOSPITAL MEDICAL CTR	11	7	8	**26**	**9**
	SUNRISE HOSPITAL	3	5	5	**13**	**4**
	UNIVERSITY MEDICAL CENTER SO NV	4	0	1	**5**	**2**
	VALLEY HOSPITAL MEDICAL CTR	0	3	2	**5**	**2**
	Total	**89**	**91**	**113**	**293**	**98**
Hospital Rehabilitation	ENCOMPASS HEALTH HOSPITAL OF DESERT CANYON	0	0	0	**0**	**0**
	ENCOMPASS HEALTH HOSPITAL OF HENDERSON	0	0	1	**1**	**0**
	ENCOMPASS HEALTH REHAB OF LAS VEGAS	0	0	0	**0**	**0**
	Total	**0**	**0**	**1**	**1**	**0**
Skilled Nursing	HARMON HOSPITAL	0	0	0	**0**	**0**
	SANDSTONE SPRING VALLEY LLC	1	1	0	**2**	**1**
	TRELLIS CENTENNIAL	0	0	0	**0**	**0**
	Total	**1**	**1**	**0**	**2**	**1**
Out of Area	Out of Area	54	69	44	**167**	**56**
	Total	**54**	**69**	**44**	**167**	**56**

Readmits by Facility

Facility Type	Metrics	Readmits				
	Facility Name	**Oct-22**	**Nov-22**	**Dec-22**	**Total**	**Average**
Hospital	CENTENNIAL HILLS HOSPITAL MEDICAL CENTER	0	0	0	**0**	**0**
	DESERT SPRINGS HOSPITAL MEDICAL CENTER	1	0	0	**2**	**0**
	HENDERSON HOSPITAL	0	0	0	**1**	**0**
	LAS VEGAS VAMC	0	0	0	**0**	**0**
	MIKE O CALLAGHAN FEDERAL HOSPITAL	0	0	0	**0**	**0**
	MOUNTAIN VIEW HOSPITAL	0	1	0	**1**	**0**
	NORTH VISTA HOSPITAL	0	0	0	**0**	**0**
	RENOWN REGIONAL MEDICAL CENTER	5	1	0	**17**	**3**
	SOUTHERN HILLS HOSPITAL	0	0	0	**1**	**0**
	SPRING VALLEY HOSPITAL	0	0	0	**1**	**0**
	ST ROSE DOMINICAN HOSPITAL SAN MARTIN CAMPUS	0	0	0	**0**	**0**
	ST ROSE DOMINICAN HOSPITAL SIENA CAMPUS	0	0	0	**0**	**0**
	SUMMERLIN HOSPITAL MEDICAL CTR	4	0	0	**19**	**3**
	SUNRISE HOSPITAL	0	0	0	**1**	**0**

	UNIVERSITY MEDICAL CENTER SO NV	0	0	0	**0**	**0**
	VALLEY HOSPITAL MEDICAL CTR	0	0	0	**1**	**0**
	Total	**10**	**2**	**0**	**44**	**0**
Out of Area	Out of Area	1	0	0	**14**	**2**
	Total	**1**	**0**	**0**	**14**	**0**

		Readmits by Facility				
Facility Type	**Metrics**	**Readmit Rate**				
	Facility Name	**Oct-22**	**Nov-22**	**Dec-22**	**Total**	**Average**
Hospital	CENTENNIAL HILLS HOSPITAL MEDICAL CENTER	0.0%	0.0%	0.0%	**0.0%**	**0.0%**
	DESERT SPRINGS HOSPITAL MEDICAL CENTER	100.0%	0.0%	0.0%	**28.6%**	**28.6%**
	HENDERSON HOSPITAL	0.0%	0.0%	0.0%	**4.2%**	**4.2%**
	LAS VEGAS VAMC	0.0%	0.0%	0.0%	**0.0%**	**0.0%**
	MIKE O CALLAGHAN FEDERAL HOSPITAL	0.0%	0.0%	0.0%	**0.0%**	**0.0%**
	MOUNTAIN VIEW HOSPITAL	0.0%	11.1%	0.0%	**2.3%**	**2.3%**
	NORTH VISTA HOSPITAL	0.0%	0.0%	0.0%	**0.0%**	**0.0%**
	RENOWN REGIONAL MEDICAL CENTER	16.7%	2.4%	0.0%	**7.1%**	**7.1%**
	SOUTHERN HILLS HOSPITAL	0.0%	0.0%	0.0%	**4.3%**	**4.3%**
	SPRING VALLEY HOSPITAL	0.0%	0.0%	0.0%	**4.5%**	**4.5%**
	ST ROSE DOMINICAN HOSPITAL SAN MARTIN CAMPUS	0.0%	0.0%	0.0%	**0.0%**	**0.0%**
	ST ROSE DOMINICAN HOSPITAL SIENA CAMPUS	0.0%	0.0%	0.0%	**0.0%**	**0.0%**
	SUMMERLIN HOSPITAL MEDICAL CTR	36.4%	0.0%	0.0%	**35.2%**	**35.2%**
	SUNRISE HOSPITAL	0.0%	0.0%	0.0%	**5.0%**	**5.0%**
	UNIVERSITY MEDICAL CENTER SO NV	0.0%	0.0%	0.0%	**0.0%**	**0.0%**
	VALLEY HOSPITAL MEDICAL CTR	0.0%	0.0%	0.0%	**11.1%**	**11.1%**
	Total	**11.2%**	**2.2%**	**0.0%**	**7.7%**	**0.0%**
Out of Area	Out of Area	1.9%	0.0%	0.0%	**4.2%**	**4.2%**
	Total	**1.9%**	**0.0%**	**0.0%**	**4.2%**	**0.0%**

SHO-PUBLIC EMPLOYEES BENEFIT PROGRAM

2022 Performance Review

SIERRA HEALTH-CARE OPTIONS, INC.

Utilization Summary

Outpatient Case Management

Month	Oct-22	Nov-22	Dec-22	YTD	Average
New Cases	175	137	236	**548**	**183**
Accepted	117	88	169	**374**	**125**
Acceptance Rate	66.9%	64.2%	71.6%	**68.2%**	**67.6%**
Average Duration (closed only)	15.5	10.0	4.1	**9.2**	**9.9**

Inpatient Case Management

Month	Oct-22	Nov-22	Dec-22	YTD	Average
Open End of Month	21	43	12	**76**	**25**
Cases opened in the month	144	161	158	**463**	**154**
Cases closed in the month	151	140	163	**454**	**151**
Denied Days	5	5	13	**23**	**7.7**
Average LOS	4.5	5.5	3.2	**4.4**	**4.4**
NICU Open at End of Month	1	0	0	**1**	**0**
NICU Cases opened in the month	4	0	4	**8**	**3**
NICU Cases closed in the month	4	0	3	**7**	**2**
NICU Average Legth of Stay	12.8	0.0	0.7	**6.7**	**4.5**

Authorizations

Month	Oct-22	Nov-22	Dec-22	YTD	Average
Total services reviewed	3,058	2,862	2,525	**8,445**	**2,815**
Services Approved	2,849	2,773	2,461	**8,083**	**2,694**
Approval Rate	93.2%	96.9%	97.5%	**95.7%**	**95.8%**
Services Denied	209	89	64	**362**	**121**
Denied Charges	$85,501	$98,105	$11,398	**$195,004**	**$65,001**
Denial Rate	6.8%	3.1%	2.5%	**4.5%**	**4.2%**

Denial Reason

Metrics			Denied		
Denial Reason	**Oct-22**	**Nov-22**	**Dec-22**	**YTD**	**Average**
Non-covered service(s)	0	3	0	**3**	**1**
Not medically necessary	209	86	64	**359**	**120**
None	5	5	13	**23**	**8**

Turn Around Time

Month	Oct-22	Nov-22	Dec-22	YTD	Average
2 or fewer days	673	575	527	**1,775**	**592**
2 or fewer Pct	65.3%	60.7%	62.4%	**62.8%**	**62.8%**
5 or fewer days	724	620	568	**1,912**	**637**
5 or fewer Pct	70.3%	65.4%	67.2%	**67.6%**	**67.6%**
15 or fewer Days	1,015	939	836	**2,790**	**930**
15 or fewer Pct	98.5%	99.1%	98.9%	**98.8%**	**98.8%**
Over 15 days	15	9	9	**33**	**11**
Over 15 days Pct	1.5%	0.9%	1.1%	**1.2%**	**1.2%**

Turn around time is the number of days between the case open date and case close date.

Stat

Month	Oct-22	Nov-22	Dec-22	YTD	Average
Stat Request	780	639	695	**2,114**	**705**

Appeals

Month	Oct-22	Nov-22	Dec-22	YTD	Average
Appeals 1st Level	1	1	5	**7.0**	**2.3**
Appeals 2nd Level	0	0	0	**0.0**	**0.0**
Appeals 3rd Level	0	0	0	**0.0**	**0.0**
Appeals Overturned	0	0	1	**1.0**	**0.3**
Appeals Upheld	2	0	5	**7.0**	**2.3**

Reviews

Month	Oct-22	Nov-22	Dec-22	YTD	Average

Retros	0	3	0	**3**	**1**

Telephone Advise Nurse

Metrics

Outcome description	Oct-22	Nov-22	Dec-22	YTD	Average
ER	0	0	1	**1**	**0**
Other	0	0	9	**9**	**3**
PCP	0	0	1	**1**	**0**
Self-Care/Home Care	0	0	1	**1**	**0**
Urgent Care	1	0	3	**4**	**1**

SHO-PUBLIC EMPLOYEES BENEFIT PROGRAM

2022 Performance Review

SIERRA HEALTH-CARE OPTIONS, INC.

Bedday Summary

Acute Only

*NOTE: Per K formula: Actual number / membership * 12,000*

Month	Oct-22	Nov-22	Dec-22	YTD
Membership	49,084	49,116	48,946	**147,145**
Beddays per K	160.6	187.4	208.6	**185.6**
Admits per K	34.0	37.4	38.0	**36.5**
Average LOS	4.1	5.2	3.2	**4.2**
Readmits per K	2.7	0.5	0.0	**1.1**
Readmit Rate	7.9%	1.3%	0.0%	**3.1%**

SHO

Month	Oct-22	Nov-22	Dec-22	YTD
Beddays per K	183.3	162.9	174.3	**173.5**
Admits per K	36.6	37.1	37.5	**37.0**
Average LOS	4.6	4.4	3.5	**4.1**
Readmits per K	2.0	1.0	0.0	**1.0**
Readmit Rate	5.4%	2.6%	0.0%	**2.7%**

SHL PPO

Month	Oct-22	Nov-22	Dec-22	YTD
Beddays per K	133.7	128.9	84.4	**115.7**
Admits per K	40.1	34.5	24.6	**33.1**
Average LOS	4.3	3.7	5.7	**4.6**
Reamits per K	3.0	0.9	0.6	**1.5**
Readmit Rate	7.4%	2.7%	2.3%	**4.1%**

This report includes: Place of service 21 Acute only with a status of "to be discharged" or discharged.

4.3.4

4. Consent Agenda (Jack Robb, Board Chair) (**All Items for Possible Action**)

    4.3 Receipt of quarterly vendor reports for the period ending December 31, 2022:

        4.3.1 UMR – Obesity Care Management

        4.3.2 UMR – Diabetes Care Management

        4.3.3 Sierra Healthcare Options – Utilization and Large Case Management

        4.3.4 UnitedHealthcare – Basic Life Insurance

370074 State of Nevada Public Employees' Benefits Program

Life Performance Guarantees

Service	Metric	Measurement	How Measured	Fee at Risk	Results Details (Q2)	Guarantee Achieved?
Client Implementation	Enrollment materials	Enrollment materials completed/shipped within agreed upon timeframe	Implementation Tracking	.3% of premium	N/A	Yes
	Draft certificate issued	30 days from receipt of set up information	Implementation Tracking	.3% of premium	N/A	Yes
	System Readiness	Systems ready for claims/customer service within the following days from receipt of complete set up information: · 45 days list billed groups (excludes EDI) · 30 days for self billed groups	Implementation Tracking	.3% of premium	N/A	Yes
Claim Processing	Life Claims - Timeliness of claim payment	97% of claims processed within 10 days of receipt of complete information	Claim Turn Around Reports	.3% of premium	97.0%	Yes
	Complete Life Claim – Decision	97% of claims approved and payment issues, or claims denied and letter mailed in five business days following receipt of all information necessary to make a claim decision.	Quarterly claim decision report	.3% of premium	100.0%	Yes
	Life Claims - Accuracy of claim payment	98% of claims processed accurately	Internal Claims Audit	.3% of premium	99.0%	Yes
Employer Reporting	Accurate reporting provided 45 days after the end of the quarter	Claim reporting sent out to employer	Reporting Send Date	.3% of premium		
Claim Customer Service *	Average speed of answer	80% in less than 30 seconds	Call Center Statistics	.3% of premium	95.0%	Yes
	Abandonment Rate	<5% abandonment rate	Call Center Statistics	.3% of premium	1.1%	Yes
Account Management	Client Satisfaction	UHCSB performs satisfactory ongoing, day-to-day account management in the opinion of the client's HR and/or benefits staff.	Based on average score of 5 out of 10 on the standard client loyalty survey.	.3% of premium		
			Total at Risk	**The lesser of 3% or $50,000**		

4.3.5

4. Consent Agenda (Jack Robb, Board Chair) (**All Items for Possible Action**)

    4.3 Receipt of quarterly vendor reports for the period ending December 31, 2022:

        4.3.1 UMR – Obesity Care Management

        4.3.2 UMR – Diabetes Care Management

        4.3.3 Sierra Healthcare Options – Utilization and Large Case Management

        4.3.4 UnitedHealthcare – Basic Life Insurance

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

Public Employees Benefit Program

Quarterly Update –2nd Quarter Plan Year 2023

WTW's Individual Marketplace

February 14, 2023

The Public Employees Benefit Program Executive Dashboard

Quarterly Update – 2nd Quarter Plan Year 2023

Executive Summary

Plan Enrollment:

- At the end of FY Q2 2023, PEBP's total enrollment into Medicare policies through WTW's Individual Marketplace decreased to 11,339. Since inception, 118 carriers have been selected by PEBP's retirees with current enrollment in 1,869 different plans.
- Medicare Supplement (MS) plan selection remained consistent at 87% of the total population with the majority of participants selecting AARP and Anthem BCBS of Nevada as their insurer; each carrier holds plans for 6,245 and 1,917 enrollees respectively. The average monthly premium cost for MS plans remained consistent at $146.
- The percentage of Medicare Advantage (MA or MAPD) plans selected remained consistent at 13%. Top MA carriers include Aetna with 584 individual plan selections and Humana with 268 individual plan selections. The average monthly premium cost to PEBP participants remained consistent at $11.

Customer Satisfaction:

- In Q2 2023, PEBP participant satisfaction with Enrollment Calls had an average satisfaction score result of 4.6 out of 5.0 based on 39 surveys returned.
- For Q2 2023, the average satisfaction score for Service Calls was 4.3 out of 5.0 based on 325 surveys returned.
- The combined average satisfaction score for Enrollment Calls and Service Calls was 4.3 out of 5.0 for Q2 2023.

Health Reimbursement Arrangement:

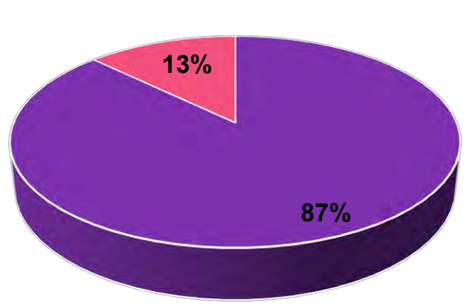
- At the end of Q2 2023 there were 13,796 Health Reimbursement Arrangement (HRA) accounts for PEBP participants.
- There were 84,168 claims processed in Q2, with 95% being submitted via Auto-Reimbursement, meaning that participants did not have to manually submit 80,198 claims for Premium Reimbursement.
- The total reimbursement amount processed for Q2 was $8,250,715.

Summary of Retiree Decisions and Costs

Retiree Plan Selection Through 12/31/2022		Previous Qtr.
Total enrolled through individual marketplace	11,339	11,523
Number of carriers**	118	115
Number of plans**	1,869	1,767

Plan Type Selection Through 12/31/2022		Previous Qtr.
Medicare Advantage (MA, MAPD)	1,451	1,506
Medicare Supplement (MS)	9,918	10,023

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	9,918	$146
Medicare Advantage (MA,MAPD)	1,451	$0 / $11
Part D drug coverage	6,684	$23
Dental coverage	1,084	$38
Vision coverage	2,044	$11

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

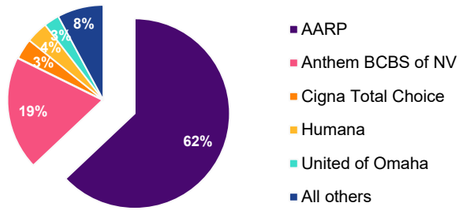
The Public Employees Benefit Program Executive Dashboard

Quarterly Update – 2nd Quarter Plan Year 2023

Summary of Retiree Carrier Choice

Top Medicare Supplement Plans	Total
AARP	6,245
Anthem BCBS of NV	1,917
Cigna Total Choice	346
Humana	368
United of Omaha	261

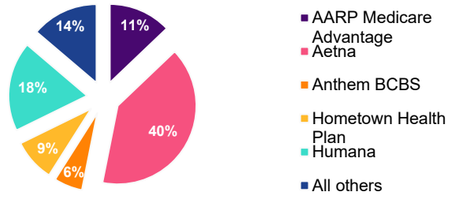
Medicare Supplement Carrier Choice



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

Top Medicare Advantage Plans	Total
AARP Medicare Advantage	187
Aetna	584
Anthem BCBS	85
Hometown Health Plan	127
Humana	268

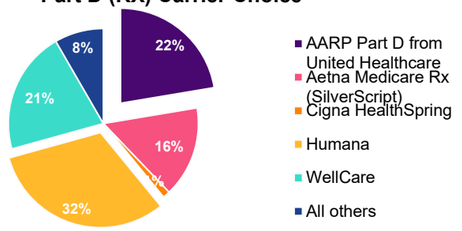
Medicare Advantage Carrier Choice



Cost Data For MA Plans	Cost
Minimum	$0
Average	$11
Median	$0
Maximum	$194

Top Medicare Part D (RX)	Total
AARP Part D from United Healthcare	1,594
Aetna Medicare Rx (SilverScript)	1,104
Cigna HealthSpring	87
Humana	2,254
WellCare	1,494

Part D (RX) Carrier Choice



Cost Data For Part D (RX)	Cost
Minimum	$4
Average	$23
Median	$16
Maximum	$118

The Public Employees Benefit Program Executive Dashboard

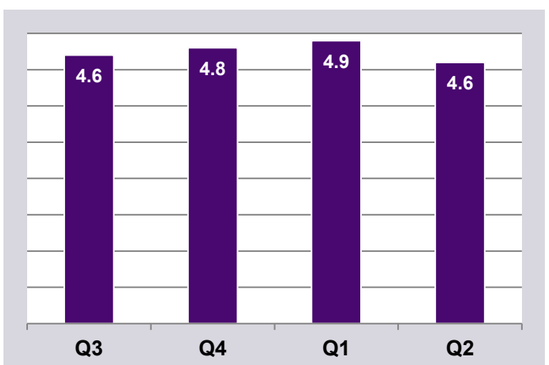
Quarterly Update – 2nd Quarter Plan Year 2023

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

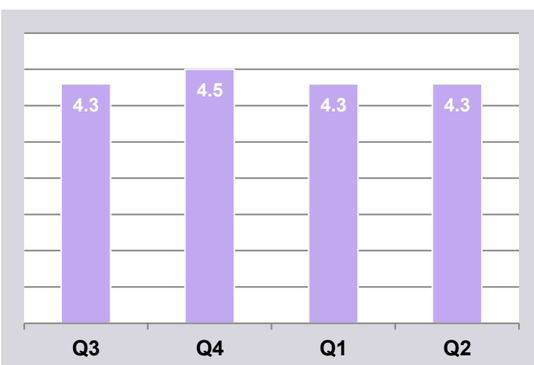
Q2 Enrollment Satisfaction

CSAT score	Count	%
5	28	72%
4	9	23%
3	0	0%
2	2	5%
1	0	0%
	39	



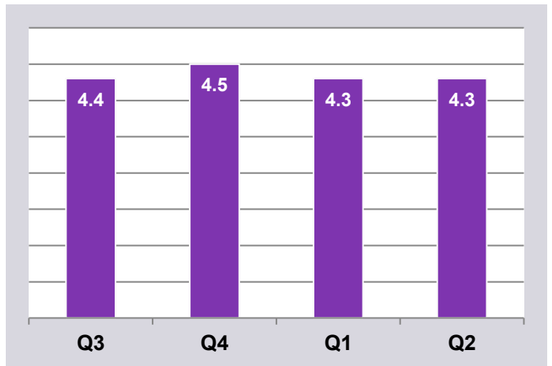
Q2 Service Satisfaction

CSAT score	Count	%
5	205	63%
4	58	18%
3	28	9%
2	10	3%
1	24	7%
	325	



Q2 Enrollment & Service Combined

CSAT score	Count	%
5	233	64%
4	67	18%
3	28	8%
2	12	3%
1	24	7%
	364	

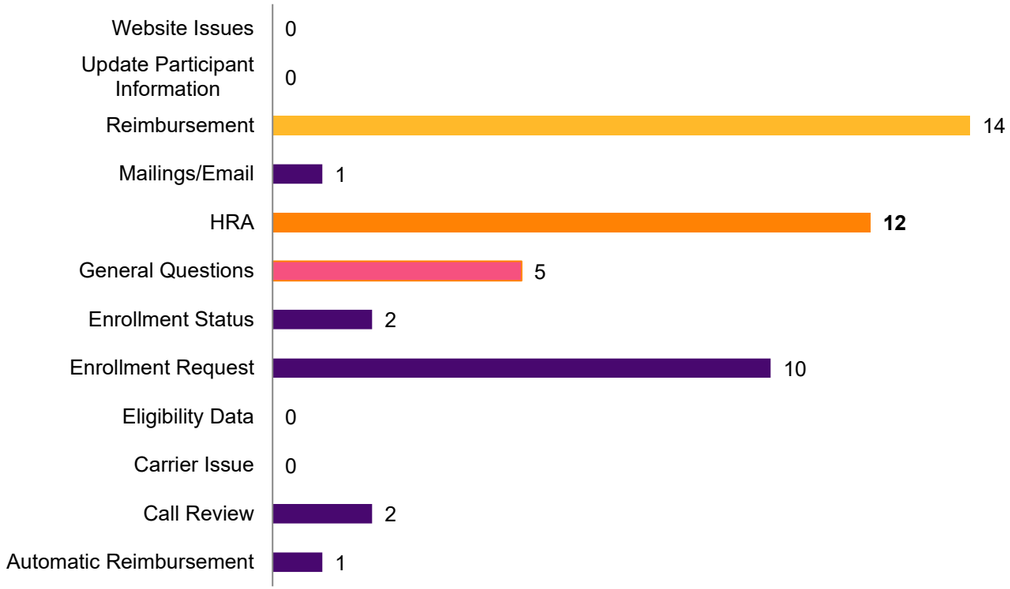


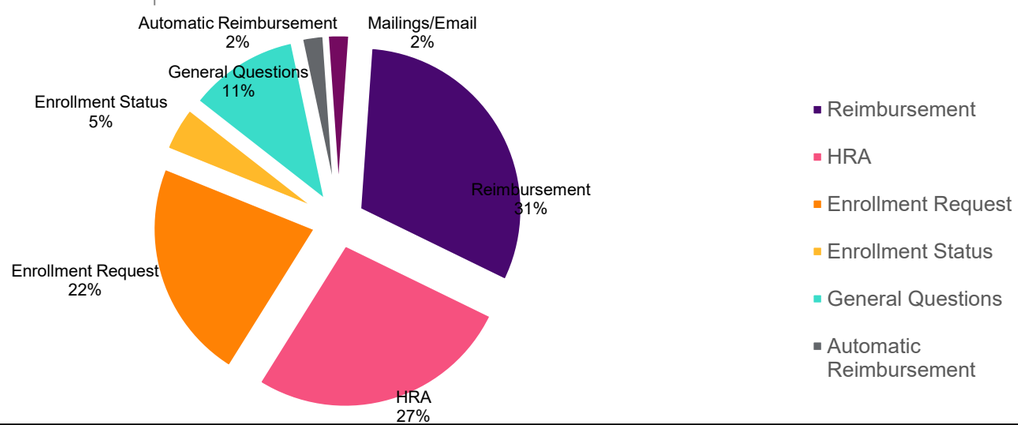
The Public Employees Benefit Program Executive Dashboard

Quarterly Update – 2nd Quarter Plan Year 2023

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 Q2-PY23 is 47 and are associated with the following categories:





Health Reimbursement Account (HRA)

Claim Activity for the Qtr.	Total
HRA accounts	13,796
Number of payments	49,968
Accounts with no balance	7,934
Claims paid amount	$8,250,715.68

Claims By Source	Total
A/R file	80,198
Mail	1,413
Web	1,692
Mobile App	865

The Public Employees Benefit Program Executive Dashboard

Quarterly Update – 2nd Quarter Plan Year 2023

Performance Guarantees*

Category	Commitment	Outcome	PG MET
Claims Turnaround Time	≤ 2 days	0.36 Days	Yes
Claim Financial Accuracy	≥ 98%	99.31%	Yes
Reports	≤ 15 business days	Met	Yes
HRA Web Services	≥ 99%	100%	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.	1 Minute 42 Seconds	Yes
Benefits Administration Customer Service Abandonment Rate Annual	≤ 5%	4.97%	Yes
Customer Satisfaction	≥ 80%	90.11%	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 – 2nd Quarter Plan Year 2023

Operations Report

Medicare Open Enrollment Plan Changes for 2023

The Medicare Open Enrollment Season for 2023 occurred from October 15, 2022 – December 7, 2022. The below chart captures information on the number of participants that made changes in their existing Medicare Medical or Prescription Drug Plan. There was a significant decrease in the number of participants who changed their Prescription Drug Plan, however the number of change for this year (548) is actually more consistent with the number of changes we see year to year. All other changes for the new plan year are consistent with prior years.

Original Plan	New Plan	1/1/2023 Changes	1/1/2022 Changes
Medicare Supplement	Medicare Supplement	37	39
Medicare Supplement	Medicare Advantage	89	72
Medicare Advantage	Medicare Advantage	1,487	1,411
Medicare Advantage	Medicare Supplement	9	8
Prescription Drug Plan	Prescription Drug Plan	548	1,732

HRA Available Balance Cap of $8,000:

Effective May 31, 2023, we will process the annual $8,000 HRA Available Balance Cap reduction on accounts with a balance of more then $8,000. Nevada PEBP is planning on sending communications related to this Cap to participants with balances of $7,000 or greater as they are expected to be the ones who will potentially be impacted by the Cap this year. The goal of the communication is to remind participants to submit claims against their balance to reduce it below the $8,000 threshold so they do not lose any of their HRA balance. Once funds are removed because they are over the $8,000 cap, they cannot be added back.

The Public Employees Benefit Program Executive Dashboard

Quarterly Update – 2nd Quarter Plan Year 2023

Operations Report

Spring Retiree Meetings:

Historically, WTW and Nevada PEBP hold three days of retiree meetings in the Spring focusing on participants ageing into Medicare as well as those already enrolled but who may need help with their HRA. The meetings typically would occur in Las Vegas, Reno, and Carson City with 2 presentations per day. However, due to the 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 March 27 and 28. 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
March 27 - 9:30 am PT	Pre-Medicare/Ageing into Medicare
March 27 – 12:00 pm PT	HRA/Medicare Open Enrollment
March 28 – 11:30 am PT	HRA/Medicare Open Enrollment
March 28 - 2:00 pm PT	Pre-Medicare/Ageing into Medicare

Communications:

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

- Spring 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 for the spring will mail out in mid-February and will be staggered over 2 weeks.


Balance Reminder

Via Benefits
PO Box 12345
City Name, PA 87890-1234
Electronic Service Requested

John Sample
1234 Street Name
Any Town, OH 12345
United States

GROUP NAME, LLC

Account Balance Breakdown

Account	Plan Year	Available Balance
HRA	2018	$140.00
HRA	2019	$220.00
HRA	2020	$1,280.00
Total Available Balance: $1,660.00		

We're here to assist you

Sincerely,
Via Benefits

Get Informed Faster

4.3.6

4. Consent Agenda (Jack Robb, Board Chair) (**All Items for Possible Action**)

    4.3 Receipt of quarterly vendor reports for the period ending December 31, 2022:

        4.3.1 UMR – Obesity Care Management

        4.3.2 UMR – Diabetes Care Management

        4.3.3 Sierra Healthcare Options – Utilization and Large Case Management

        4.3.4 UnitedHealthcare – Basic Life Insurance

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

        4.3.6 Sierra Healthcare Options and UnitedHealthcare Plus Network

Network Repricing Quality - UMR		
PEBP PG Target	97%	
Q1 Results	99.9%	
Q2 Results	98.9%	
Q3 Results		
Q4 Results		

Network Repricing Turnaround Time - UMR		
PEBP PG Target	Returned 97% in 3 Days	Returned 99% in 5 days
Q1 Results	96%	99%
Q2 Results	90%	98%
Q3 Results		
Q4 Results		

Network Provider Directory Disputes - UMR		
PEBP PG Target	Total Directory Disputes	TAT - Within 10 Business Days
Q1 Results	0	N/A
Q2 Results	0	N/A
Q3 Results		
Q4 Results		

4.3.7

4. Consent Agenda (Jack Robb, Board Chair) (**All Items for Possible Action**)

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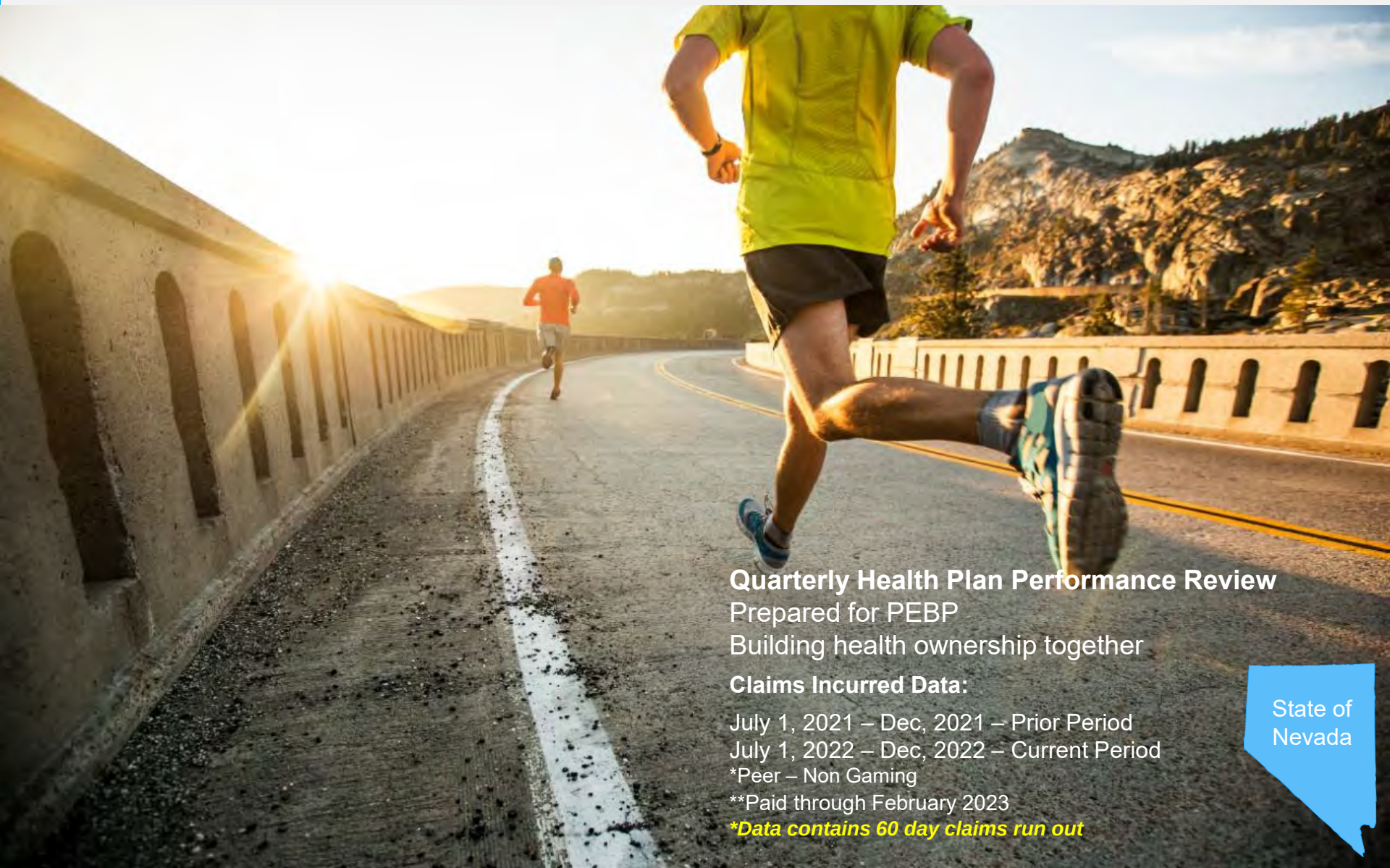
4.3.6 Sierra Healthcare Options and UnitedHealthcare Plus Network

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 Incurred Data:

July 1, 2021 – Dec, 2021 – Prior Period
July 1, 2022 – Dec, 2022 – Current Period
*Peer – Non Gaming
**Paid through February 2023
Data contains 60 day claims run out

State of Nevada

Executive Summary

Spend and Utilization

Executive Summary Utilization & Spend

UnitedHealthcare

Population

- -2.0% decrease for employees
- -1.7% decrease for members

Medical Rx Paid PMPM

- -33.3% decrease in overall medical paid
- -1.5% decrease in non Catastrophic spend
- 2.6% increase in Catastrophic spend

High Cost Claimants

- 36 High Cost Claimants accounted for 29.3% of medical spend
- -21.7% decrease in HCC from prior period
- Avg. Paid per claimant decreased -54.6%

Emergency Room

- ER Visits Per 1,000 members increased 9.3%
- Avg. paid per ER Visit increased 15.1%

Urgent Care

- Urgent Care visits per 1,000 members decreased by -20.6%
- Avg. paid per Urgent care visit increased 6.2%

Rx Drivers

- Rx Net Paid PMPM increased 13.9%
- Specialty Spend increased 41.0%
- Specialty Rx driving 52.4% of total Rx Spend

Overall Medical / Rx

- Total Medical/Rx decreased -23.5% on PMPM basis

Executive Summary Utilization & Spend

UnitedHealthcare®

Claims Paid by Age Group														
	Through December 2021 Q1 and Q2						Through December 2022 Q1 and Q2						Change	
Age Band	Medical Net Paid	Medical PMPM	Rx Net Paid	Rx PMPM	Med/Rx Net Paid	Med/Rx PMPM	Medical Net Paid	Medical PMPM	Rx Net Paid	Rx PMPM	Med/Rx Net Paid	Med/Rx PMPM	Med/Rx Net Paid	Med/Rx Net PMPM
<1	$6,964,278	$21,737	$1,161	$4	$6,965,439	$21,740	$253,386	$720	$1,086	$3	$254,472	$723	-96.3%	-14.8%
01	$84,586	$183	$2,517	$5	$87,103	$189	$222,493	$701	$2,631	$8	$225,124	$709	282.3%	51.9%
02-04	$318,908	$266	$6,960	$6	$325,869	$272	$356,170	$298	$8,538	$7	$364,707	$305	12.0%	23.0%
05-09	$371,876	$153	$34,199	$14	$406,075	$167	$497,123	$222	$33,003	$15	$530,126	$236	44.7%	4.4%
10-14	$1,374,158	$466	$131,134	$44	$1,505,292	$510	$507,272	$182	$184,547	$66	$691,819	$248	-60.9%	48.9%
15-19	$865,770	$280	$148,091	$48	$1,013,861	$328	$653,434	$204	$106,742	$33	$760,176	$237	-27.4%	-30.7%
20-24	$616,996	$205	$199,291	$66	$816,287	$271	$411,105	$144	$106,283	$37	$517,389	$182	-29.6%	-43.6%
25-29	$520,749	$284	$167,317	$91	$688,066	$375	$670,999	$355	$189,175	$100	$860,174	$455	25.1%	9.7%
30-34	$584,499	$262	$416,881	$187	$1,001,380	$450	$840,948	$381	$256,434	$116	$1,097,382	$497	45.0%	-38.0%
35-39	$1,327,284	$482	$301,591	$109	$1,628,875	$591	$899,310	$346	$531,983	$205	$1,431,293	$551	-28.2%	87.0%
40-44	$1,005,079	$344	$338,199	$116	$1,343,278	$460	$947,639	$341	$415,297	$149	$1,362,936	$491	-0.9%	29.0%
45-49	$832,002	$253	$413,026	$125	$1,245,028	$378	$1,224,074	$355	$508,773	$148	$1,732,847	$503	40.7%	17.8%
50-54	$2,346,478	$613	$1,146,954	$299	$3,493,432	$912	$1,850,906	$483	$1,213,698	$317	$3,064,605	$799	-21.2%	5.7%
55-59	$1,914,870	$501	$1,003,819	$262	$2,918,689	$763	$1,733,694	$467	$1,136,564	$306	$2,870,258	$773	-6.7%	16.7%
60-64	$1,852,871	$497	$885,709	$238	$2,738,580	$735	$1,888,335	$526	$1,136,218	$316	$3,024,553	$842	5.8%	33.1%
65+	$1,340,467	$533	$701,698	$279	$2,042,165	$813	$1,626,923	$633	$755,719	$294	$2,382,642	$927	18.6%	5.3%
Total	$22,320,873	$553	$5,898,545	$146	$28,219,418	$699	$14,583,811	$368	$6,586,692	$166	$21,170,503	$535	-25.0%	-23.5%

Financial Summary

Financial and Demographic												
	Total				State Active				Retiree (State/Non-State)			
Summary	Thru 2Q20	Thru 2Q21	Thru 2Q22	▲	Thru 2Q20	Thru 2Q21	Thru 2Q22	▲	Thru 2Q20	Thru 2Q21	Thru 2Q22	▲
Avg. # Employees	3,918	3,815	3,750	-1.7%	3,424	3,342	3,312	-0.9%	494	472	439	-7.1%
Avg. # Members	6,816	6,730	6,597	-2.0%	6,183	6,112	6,005	-1.8%	634	618	592	-4.1%
Ratio	1.7	1.8	1.8	-0.3%	1.8	1.8	1.8	-0.8%	1.3	1.3	1.4	3.2%
Financial												
Medical Paid	$14,578,321	$22,366,163	$14,570,566	-34.9%	$12,908,385	$19,787,795	$12,961,296	-34.5%	$1,670,307	$2,578,368	$1,609,270	-37.6%
Member Paid	$947,046	$1,401,195	$979,192	-30.1%	$548,967	$1,057,289	$766,937	-27.5%	$398,079	$343,906	$212,255	-38.3%
Net Paid PEPY	$7,442	$11,702	$7,777	-33.5%	$7,540	$11,834	$7,832	-33.8%	$6,758	$10,767	$7,359	-31.7%
Net Paid PMPY	$4,277	$6,633	$4,421	-33.3%	$4,176	$6,471	$4,320	-33.3%	$5,270	$8,232	$5,450	-33.8%
Net Paid PEPM	$620	$975	$648	-33.5%	$628	$986	$653	-33.8%	$563	$897	$613	-31.7%
Net Paid PMPM	$356	$554	$368	-33.5%	$348	$539	$360	-33.3%	$439	$686	$454	-33.8%
High Cost Claimants												
# of HCC's > $50k	31	46	36	-21.7%	24	36	32	-11.1%	7	10	4	-60.0%
Avg. paid per claimant	$134,412	$261,295	$118,743	-54.6%	$151,276	$299,331	$116,221	-61.2%	$76,592	$124,366	$138,918	11.7%
HCC % of Spend	28.5%	53.6%	29.3%	-45.3%	28.1%	54.4%	28.7%	-47.3%	31.4%	47.5%	34.4%	-27.6%
Spend by Location (PMPY)												
Inpatient	$1,462	$3,408	$1,257	-63.1%	$1,418	$3,647	$1,345	-63.1%	$1,896	$3,660	$2,036	-44.4%
Outpatient	$1,042	$1,141	$1,192	4.4%	$1,026	$971	$1,141	17.5%	$1,195	$1,629	$1,236	-24.1%
Professional	$1,774	$2,097	$1,969	-6.1%	$1,732	$1,332	$1,375	3.2%	$2,179	$3,055	$2,160	-29.3%
Total	$4,277	$6,646	$4,417	-33.5%	$4,176	$6,475	$4,317	-33.3%	$5,270	$8,344	$5,432	-34.9%

Paid Claims by Claim Type

UnitedHealthcare

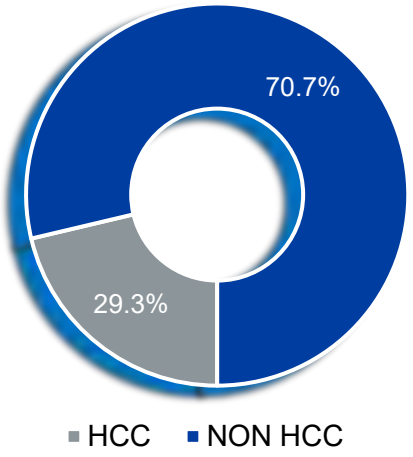
Net Paid Claims - Total									
Total Participants									
	Thru 2Q21				Thru 2Q22				▲
	Actives	Pre-Medicare	Medicare	Total	Actives	Pre-Medicare	Medicare	Total	
Medical									
InPatient	$10,582,813	$275,414	$611,296	$11,469,523	$3,206,599	$100,642	$837,802	$4,145,043	-63.9%
OutPatient	$9,945,374	$221,839	$729,427	$10,896,641	$9,216,166	$408,719	$800,638	$10,425,523	-4.3%
Total - Medical	$20,528,187	$497,253	$1,340,723	$22,366,163	$12,422,765	$509,361	$1,638,441	$14,570,566	-34.9%

Net Paid Claims - Total									
Total Participants									
	Thru 2Q21				Thru 2Q22				▲
	Actives	Pre-Medicare	Medicare	Total	Actives	Pre-Medicare	Medicare	Total	
Medical PMPM	$554	$600	$1,618	$554	$343	$682	$637	$368	-33.5%

Cost Distribution – Medical Claims > $50K

Thru 2Q21							Thru 2Q22					
# of Members	% of Population	Total Paid	% of Paid	Subscriber Paid	% of Subscribers paid	Paid Claims	# of Members	% of Population	Total Paid	% of Paid	Subscriber Paid	% of Subscribers paid
11	0.2%	$8,424,261	37.7%	$1,038,241	12.3%	> $100k	8	0.1%	$1,344,474	9.2%	$971,593	72.3%
18	0.3%	$1,476,668	6.6%	$1,071,368	72.6%	$50k- $100k	14	0.2%	$1,325,776	9.1%	$1,062,094	80.1%
41	0.6%	$1,800,609	8.1%	$1,471,734	81.7%	$25k - $50k	39	0.6%	$1,441,751	9.9%	$1,113,084	77.2%
143	2.1%	$2,722,483	12.2%	$2,055,078	75.5%	$10k - $25k	141	2.1%	$2,645,108	18.2%	$1,837,691	69.5%
208	3.1%	$1,715,638	7.7%	$1,080,408	63.0%	$5k - $10k	223	3.4%	$1,852,983	12.7%	$1,268,169	68.4%

% Paid Attributed to Catastrophic Cases



HCC > $50k - AHRQ Chapter Conditions - Thru 2Q22			
Top 5 AHRQ Category conditions	# of Patients	Total Paid	% of Med Paid
Neoplasms	7	$778,851	5.3%
Endocrine; nutritional; and metabolic diseases	3	$544,858	3.7%
Diseases of the digestive system	5	$482,143	3.3%
Injury and poisoning	2	$457,944	3.1%
Infectious and parasitic diseases	3	$388,294	2.7%

Utilization Summary

UnitedHealthcare

Utilization Summary	Total			State Active			Retiree State/Non-State		
	Thru 2Q21	Thru 2Q22	▲	Thru 2Q21	Thru 2Q22	▲	Thru 2Q21	Thru 2Q22	▲
Inpatient									
# of Admits	226	188	-16.8%	176	168	-4.3%	50	20	-60.4%
# of Bedays	1,752	1,064	-39.3%	1,352	936	-30.8%	400	128	-67.9%
Avg. Paid per Admit	$50,488	$22,286	-55.9%	$58,465	$21,202	-63.7%	$22,561	$31,472	39.5%
Avg. Paid per Day	$6,511	$3,938	-39.5%	$7,600	$3,810	-49.9%	$2,831	$4,872	72.1%
Admits Per K	67.1	57.0	-15.1%	57.5	56.0	-2.6%	162.4	67.0	-58.7%
Days Per K	520.6	322.6	-38.0%	442.4	311.7	-29.5%	1,294.6	433.0	-66.6%
ALOS	7.8	5.7	-27.0%	7.7	5.6	-27.7%	5.5	5.9	7.3%
Admits from ER	119	83	-30.3%	88	73	-17.0%	31	10	-67.7%
Physician Office Visits									
Per Member Per Year	2.7	2.2	-17.0%	2.6	2.2	-16.8%	3.2	2.6	-18.7%
Paid Per Visit	$136	$153	13.1%	$141	$159	13.0%	$95	$107	12.7%
Net Paid PMPM	$30	$29	-6.1%	$31	$29	-6.0%	$25	$23	-8.4%
Emergency Room									
# of Visits	363	389	7.2%	331	360	8.8%	32	29	-9.4%
Visits Per K	107.9	117.9	9.3%	108.3	119.9	10.7%	103.6	97.9	-5.5%
Avg Paid Per Visit	$2,459	$2,831	15.1%	$2,489	$2,891	16.1%	$2,151	$2,085	-3.0%
Urgent Care									
# of Visits	2,518	1,960	-22.2%	2,259	1,777	-21.3%	259	183	-29.3%
Visits Per K	748.3	594.2	-20.6%	739.2	591.9	-19.9%	838.2	617.7	-26.3%
Avg Paid Per Visit	$115	$122	6.2%	$86	$92	6.1%	$87	$76	-13.1%

**Not Representative of all utilization*

**Data based on medical spend only*

Diagnosis Grouper Summary – Top 25

UnitedHealthcare®

Top 25 AHRQ Category	Total Paid	% Paid	Insured	Spouse	Dependent	Male	Female	Unassigned
Septicemia (except in labor)	$556,753	4.8%	$503,357	$50,230	$3,166	$227,300	$329,453	$0
Thyroid disorders	$534,195	4.7%	$478,293	$49,832	$6,070	$1,057	$533,138	$0
Non-Hodgkin`s lymphoma	$323,569	2.8%	$301,220	$22,350		$27,499	$296,070	$0
Complication of device; implant or graft	$285,455	2.5%	$137,626	$88,874	$58,954	$168,596	$116,859	$0
Disorders usually diagnosed in infancy childhood or adol	$277,633	2.4%			$277,633	$226,382	$51,251	$0
Complications of surgical procedures or medical care	$249,712	2.2%	$248,187	$1,412	$114	$208,817	$40,895	$0
Acute and unspecified renal failure	$234,660	2.0%	$230,049	$4,565	$46	$231,888	$2,772	$0
Other nutritional; endocrine; and metabolic disorders	$211,180	1.8%	$156,688	$52,580	$1,912	$34,137	$177,043	$0
Cancer of breast	$205,111	1.8%	$193,061	$12,050			$205,111	$0
Spondylosis; intervertebral disc disorders; other back prc	$204,070	1.8%	$166,321	$35,329	$2,421	$65,388	$138,682	$0
Maintenance chemotherapy; radiotherapy	$200,775	1.7%	$185,838	$14,937		$61,884	$138,891	$0
Mood disorders	$190,781	1.7%	$62,299	$14,548	$113,934	$85,360	$105,421	$0
Polyhydramnios and other problems of amniotic cavity	$165,876	1.4%	$155,716	$10,160	$0		$165,876	$0
Osteoarthritis	$165,836	1.4%	$137,731	$28,105		$50,002	$115,835	$0
Abdominal pain	$163,377	1.4%	$126,874	$12,320	$24,184	$48,173	$115,204	$0
Other nervous system disorders	$162,980	1.4%	$30,818	$124,571	$7,590	$13,955	$149,025	$0
Other screening for suspected conditions (not mental dis	$158,370	1.4%	$127,986	$26,612	$3,771	$50,328	$108,042	$0
Diabetes mellitus with complications	$155,477	1.4%	$99,109	$26,155	$30,213	$109,633	$45,844	$0
Other gastrointestinal disorders	$152,213	1.3%	$132,467	$7,208	$12,538	$13,416	$138,797	$0
Cancer of prostate	$148,299	1.3%	$66,963	$81,336		$148,299		$0
Aortic; peripheral; and visceral artery aneurysms	$146,383	1.3%	$16,329	$130,055		$18,208	$128,176	$0
Acute bronchitis	$141,428	1.2%	$10,025	$191	$131,211	$44,177	$97,251	$0
Liveborn	$134,613	1.2%			$134,613	$112,521	$22,091	$0
Cardiac dysrhythmias	$134,266	1.2%	$99,838	$34,133	$295	$82,162	$52,103	$0
Medical examination/evaluation	$131,562	1.1%	$27,265	$8,546	$95,751	$55,135	$76,428	$0

**Not Representative of all utilization*

**Data based on medical spend only*

Mental Health Drilldown

UnitedHealthcare

Top 10 Mental Health				
AHRQ Category Description	Thru 2Q21		Thru 2Q22	
	Patients	Total Paid	Patients	Total Paid
Disorders usually diagnosed in infancy childhood	39	$316,108	29	$277,633
Mood disorders	388	$208,659	358	$190,781
Anxiety disorders	339	$66,775	302	$112,486
Substance-related disorders	26	$20,909	20	$33,371
Adjustment disorders	130	$27,330	97	$27,635
Attention-deficit conduct disorders	96	$10,854	110	$21,697
Suicide and intentional self-inflicted injury	11	$25,157	9	$18,529
Schizophrenia and other psychotic disorders	13	$8,342	7	$17,856
Miscellaneous mental health disorders	39	$56,878	33	$14,922
Alcohol-related disorders	18	$60,090	9	$14,841

**Not Representative of all utilization*

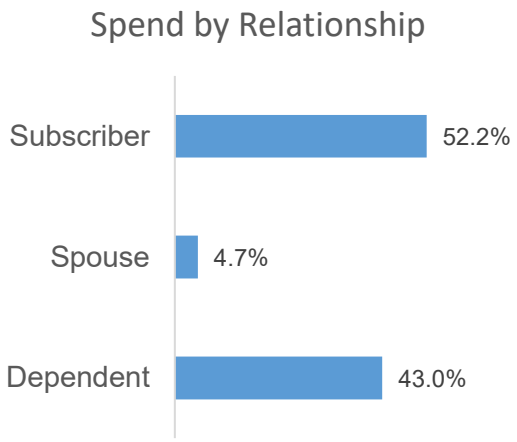
**Data based on medical spend only*

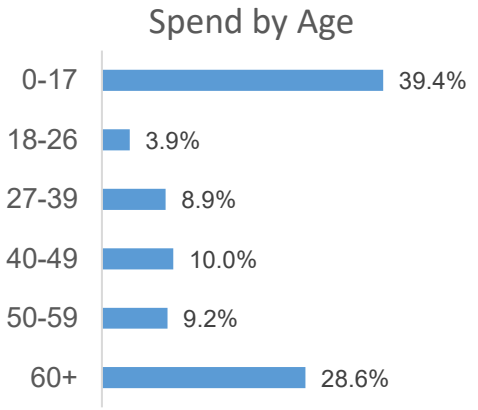
Respiratory Disorders

Respiratory Disorders				
AHRQ Category Description	Patients	Claims	Total Paid	% Paid
Acute bronchitis	95	127	$141,428	21.3%
Other upper respiratory infections	622	839	$98,236	14.8%
Other lower respiratory disease	319	571	$94,511	14.2%
Asthma	165	295	$72,128	10.9%
Other upper respiratory disease	277	756	$71,128	10.7%
Pneumonia	25	66	$64,987	9.8%
Chronic obstructive pulmonary disease	64	140	$46,568	7.0%
Influenza	49	54	$25,953	3.9%
Respiratory failure; insufficiency; arrest (adult)	16	47	$21,144	3.2%
Acute and chronic tonsillitis	32	62	$20,255	3.1%

Not Representative of all utilization

Data based on medical spend only



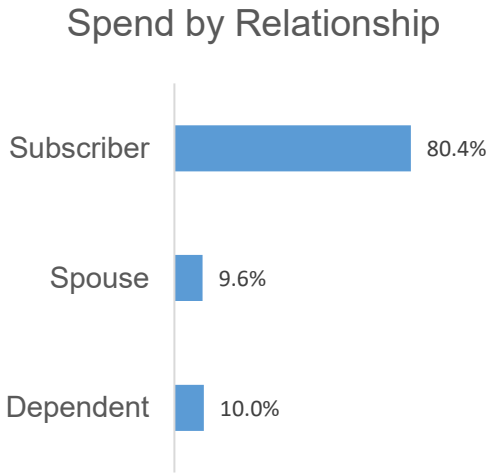


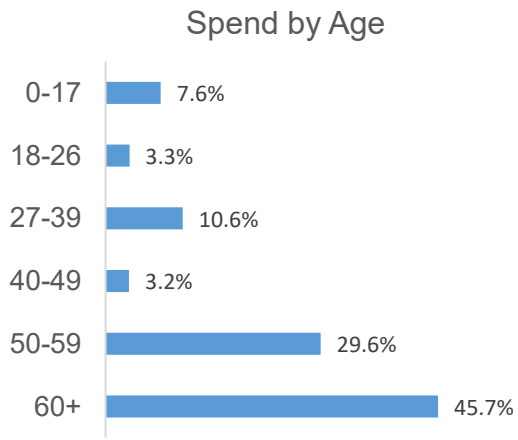
Infections

Infectious and Parasitic Diseases				
AHRQ Description	Patients	Claims	Total Paid	% Paid
Septicemia (except in labor)	16	47	$556,753	72.6%
Immunizations and screening for infectious disease	843	1,287	$101,930	13.3%
Viral infection	344	501	$96,374	12.6%
HIV infection	17	49	$5,748	0.7%
Mycoses	71	102	$2,151	0.3%
Hepatitis	13	41	$2,011	0.3%
Bacterial infection; unspecified site	7	11	$1,104	0.1%
Other infections; including parasitic	7	13	$640	0.1%
Tuberculosis	4	11	$0	0.0%
Sexually transmitted infections (not HIV or hepatitis)	8	11	$0	0.0%

**Not Representative of all utilization*

**Data based on medical spend only*





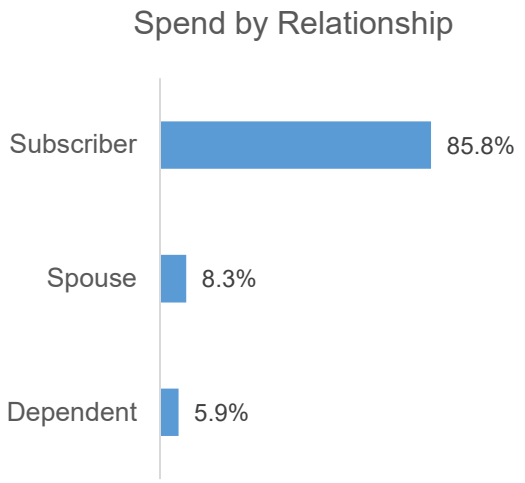
Pregnancy Related Disorders

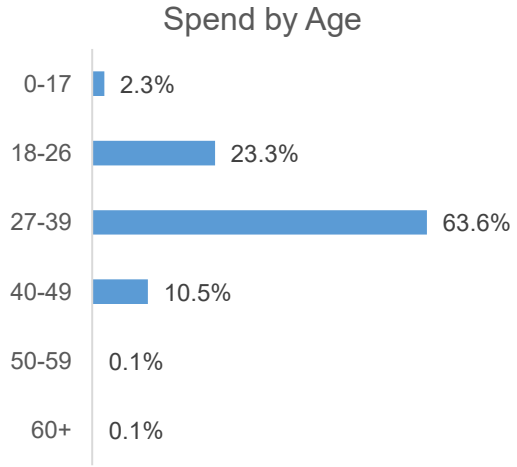
UnitedHealthcare®

Top 10 Complications of Pregnancy				
AHRQ Description	Patients	Claims	Total Paid	% Paid
Polyhydramnios and other problems of amniotic cavity	8	19	$165,876	22.6%
Complications of birth; puerperium affecting management	21	37	$129,773	17.7%
Other pregnancy and delivery including normal	65	260	$73,108	10.0%
Other complications of pregnancy	49	198	$68,388	9.3%
Previous C-section	5	18	$56,360	7.7%
Umbilical cord complication	6	11	$42,671	5.8%
Prolonged pregnancy	5	6	$42,110	5.7%
Contraceptive and procreative management	125	250	$38,077	5.2%
OB-related trauma to perineum and vulva	4	4	$28,599	3.9%
Diabetes or abnormal glucose tolerance complicating pregnancy	11	44	$27,369	3.7%

**Not Representative of all utilization*

**Data based on medical spend only*





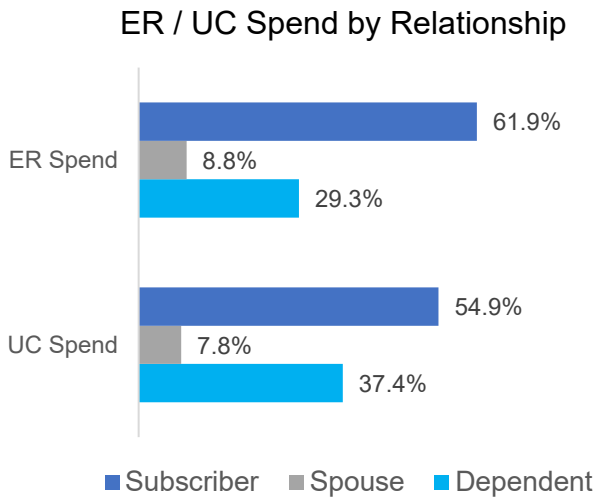
Emergency Room and Urgent Care

	Thru 2Q21		Thru 2Q22		Peer	
Metric	ER	Urgent Care	ER	Urgent Care	ER	Urgent Care
# of Visits	363	2,518	389	1,960		
Visits Per Member	0.05	0.48	0.06	0.54	0.08	0.14
Visits Per K	107.9	748.3	117.9	594.2	89.6	385.3
Avg. Paid Per Visit	$2,459	$112	$2,831	$121	$2,607	$118

**Not Representative of all utilization*

**Data based on medical spend only*

Emergency Room and Urgent Care Visits by Relationships - Thru 2Q22				
Relationship	ER Visits	ER Per K	UC Visits	UC Per K
Member	202	61.2	1,219	369.6
Spouse	35	10.6	157	47.6
Dependent	152	46.1	584	177.0
Total	389	117.9	1,960	594.2



Clinical Conditions by Medical Spend

UnitedHealthcare®

Top 15 Common Condition	# of Members	% of Members	Members Per K	PMPM
Mental Disorders	542	4.1%	41.1	$13.33
Intervertebral Disc Disorders	458	3.5%	34.7	$5.16
Diabetes with complications	310	2.3%	23.5	$3.93
Prostate Cancer	55	0.4%	4.2	$5.18
Breast Cancer	424	3.2%	32.1	$3.23
Acute Myocardial Infarction	62	0.5%	4.7	$1.30
Asthma	6	0.0%	0.5	$1.47
COPD	76	0.6%	5.8	$1.99
Diabetes without complications	28	0.2%	2.1	$0.23
Coronary Atherosclerosis	164	1.2%	12.4	$1.82
Chronic Renal Failure	5	0.0%	0.4	$0.05
Hypertension	64	0.5%	4.9	$1.18
Congestive Heart Failure (CHF)	326	2.5%	24.7	$1.18
Colon Cancer	24	0.2%	1.8	$3.75
Cervical Cancer	17	0.1%	1.3	$0.02

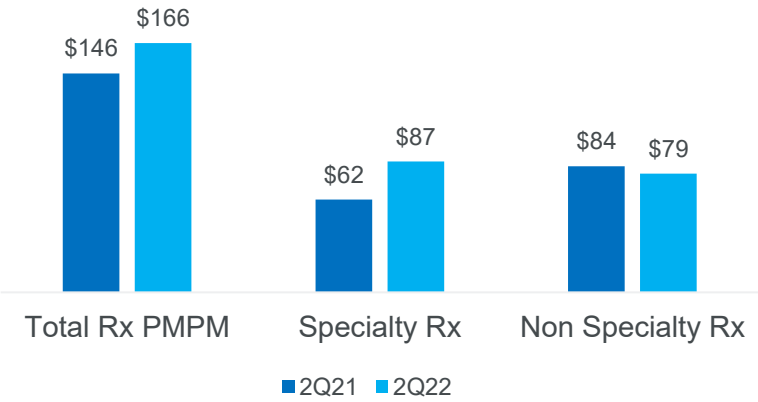
**Not Representative of all utilization*

**Data based on medical spend only*

Pharmacy Drivers

	Thru 2Q21	Thru 2Q22	Δ
Enrolled Members	6,730	6,597	-2.0%
Average Prescriptions PMPY	17.3	16.7	-3.4%
Formulary Rate	87.6%	89.7%	2.4%
Generic Use Rate	81.8%	83.8%	2.6%
Generic Substitution Rate	98.2%	98.3%	0.1%
Avg Net Paid per Prescription	$101	$119	17.9%
Net Paid PMPM	$146	$166	13.9%

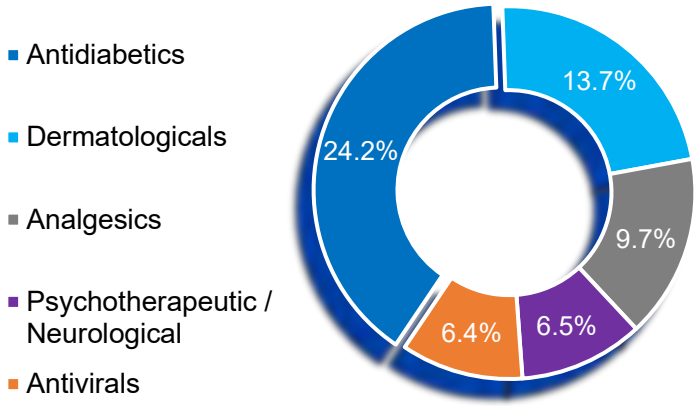
Total Rx Spend by Benefit and Type



Pharmacy Performance

- Rx spend increased of **13.9%**, ($20.33 pmpm) from prior period
- Avg. paid per Script increased **17.9%** ($18.11 pmpm) year over year
- Specialty Rx Spend driving **52.4%** of Rx Spend
- Specialty Rx spend increased **23.8%** from prior period
  Specialty Rx Drivers:
  Jardiance (Antidiabetic) Spend up **14.3%**
  Ozempic (Antidiabetic) Spend up **12.2%**
-

Top 5 Therapeutic Classes by Spend



4.3.8

4. Consent Agenda (Jack Robb, Board Chair) (**All Items for Possible Action**)

4.3 Receipt of quarterly vendor reports for the period ending December 31, 2022:

4.3.1 UMR – Obesity Care Management

4.3.2 UMR – Diabetes Care Management

4.3.3 Sierra Healthcare Options – Utilization and Large Case Management

4.3.4 UnitedHealthcare – Basic Life Insurance

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

4.3.6 Sierra Healthcare Options and UnitedHealthcare Plus

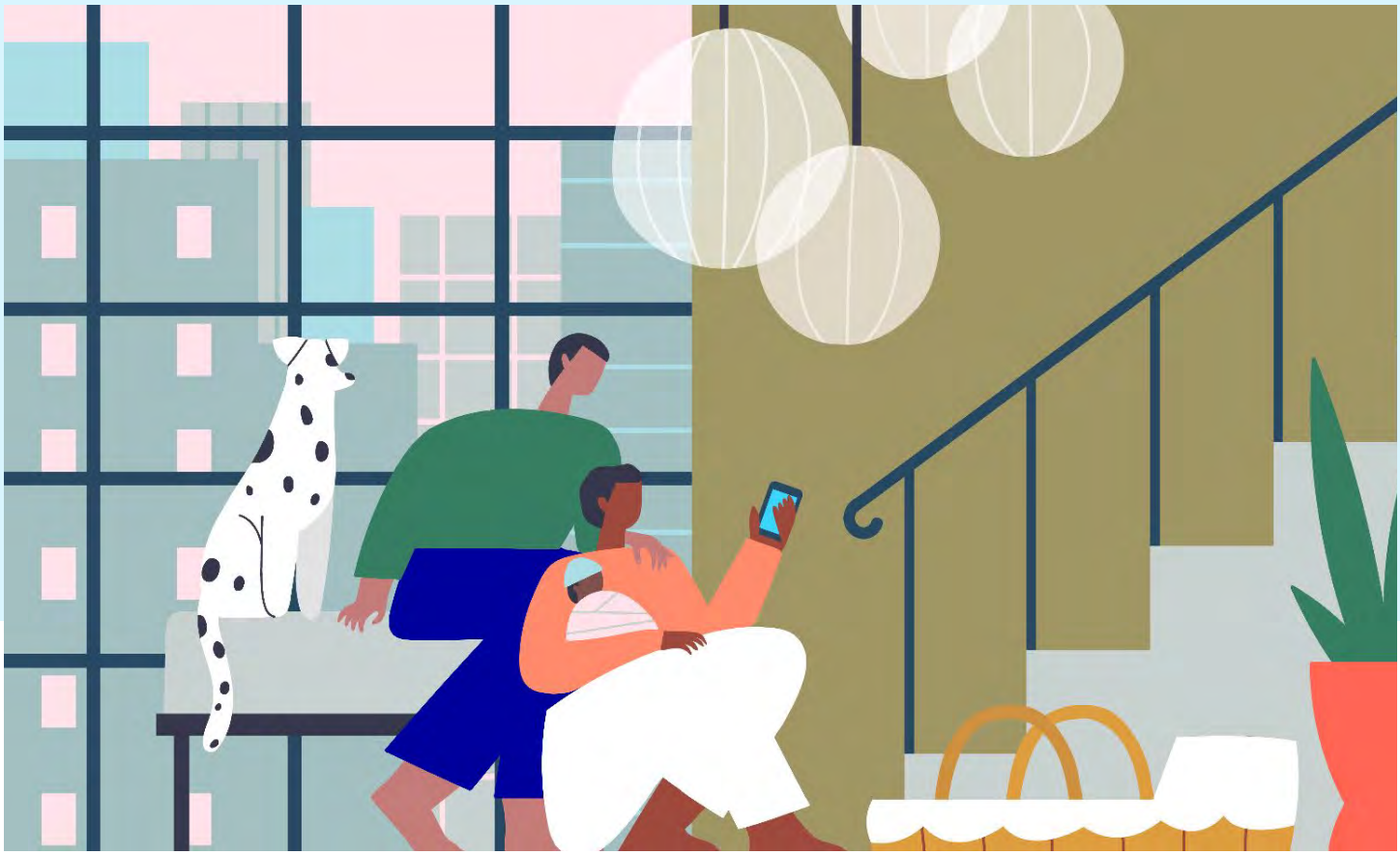
4.3.7 HealthPlan of Nevada, Inc. – Southern Nevada HMO

4.3.8 Doctor on Demand Engagement Report through March 2023

Virtual Care Engagement Monthly Report

UMR – STATE OF NEVADA

Reporting Period: 2023-01-01 to 2023-02-01

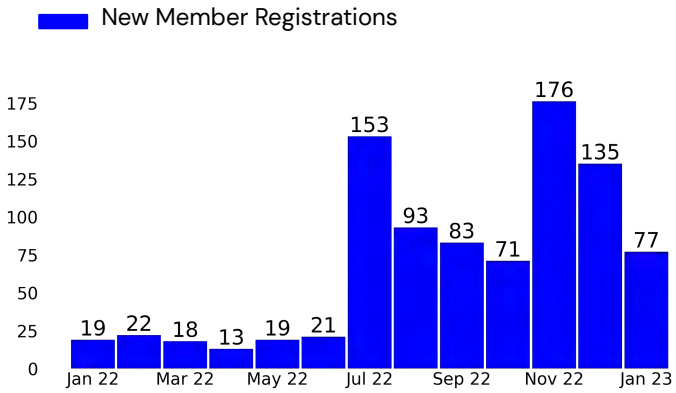


Member Engagement

77	228	282
Registrations This Month	Unique Visitors This Month	Total Visits This month

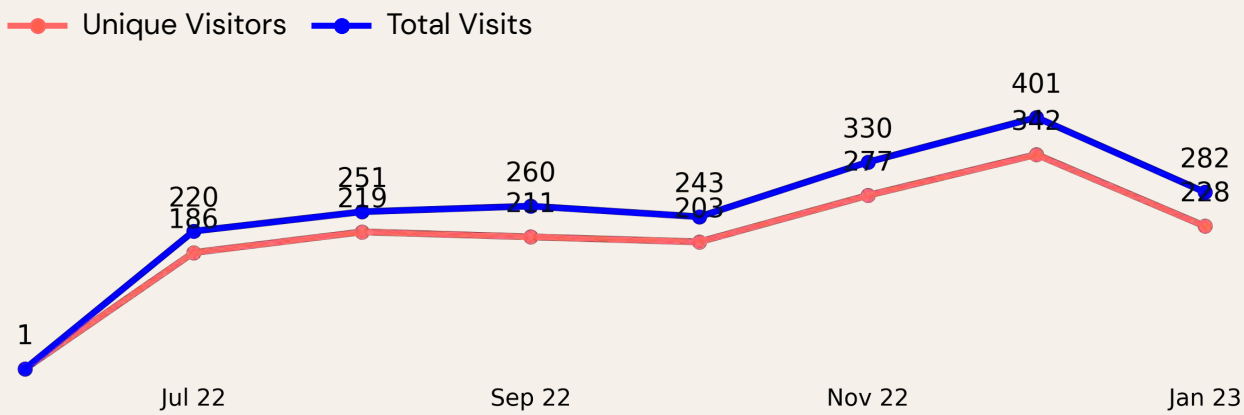
This section highlights how many members have engaged with our services, as measured by registrations and visits. Registration is a leading indicator of program health, as it opens the door to continuous engagement with members and supporting them when clinical needs arise. Monitoring monthly engagement is key to program success; changes in engagement can result from marketing initiatives or seasonality (e.g. cold and flu).

New Registrations (Last 12 Months)



Total Covered Lives	1,811 Registrations Since Launch	Registration Rate Since Launch
Employee Covered Lives	77 Registrations Year to Date	Registration Rate Year to Date

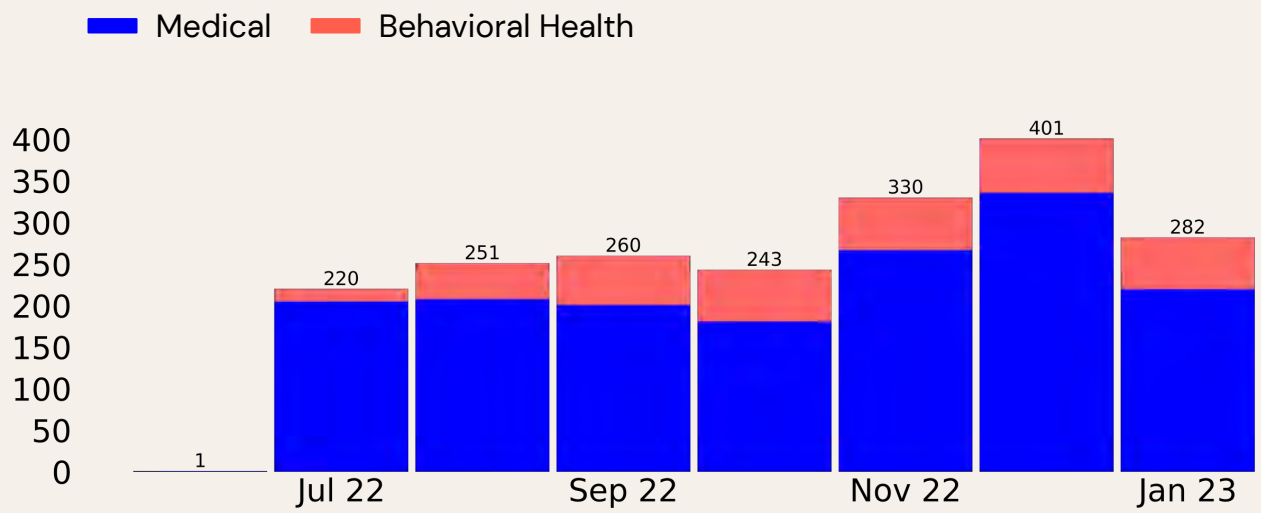
Visits Last 12 Months



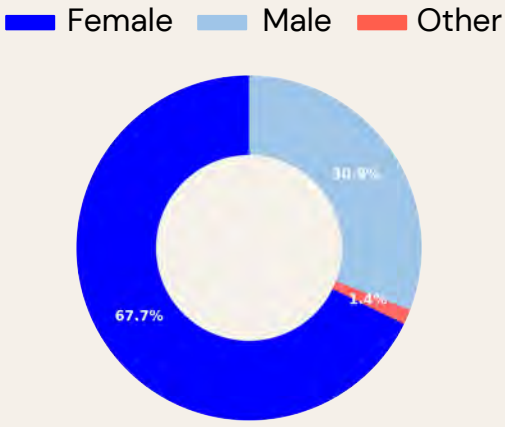
1,988 Visits Since Launch	1,210 Unique Visitors Since Launch	1.6 Average Visits Per Visitor Since Launch	Engagement Rate Since Launch (Visitors/Lives)
282 Visits Year to Date	228 Unique visitors year to date	1.2 Average Visits Per Visitor Year to Date	Engagement Rate Year to Date (Visitors/Lives)

Member Engagement

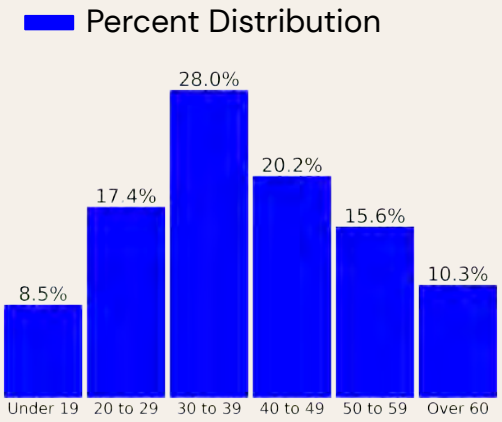
Medical & Behavioral Health Visits (Rolling 12 Months)



Visits by Reported Gender Year to Date



Visits by Age Year to Date



Most Popular Day for Visits Year to Date

Monday

Most Popular Time for Visits Year to Date

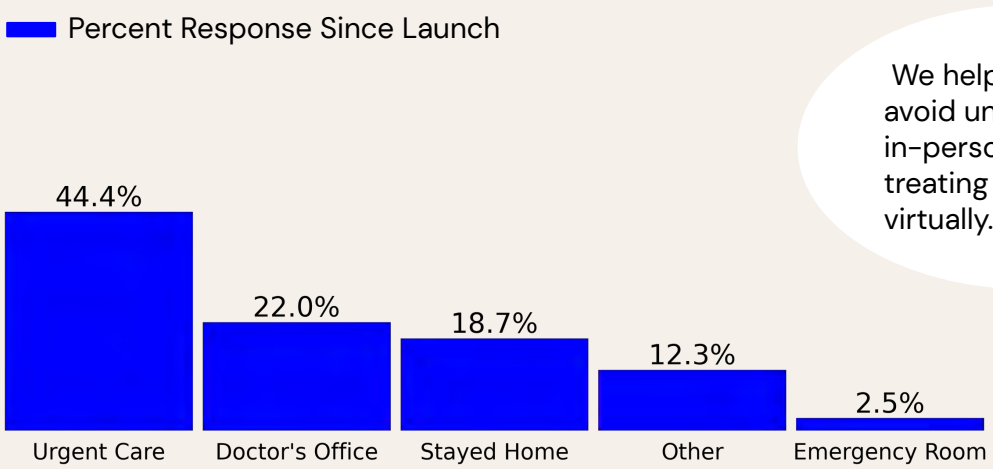
10AM – Noon

*Most popular day and time metrics are adjusted to time zone local where the visit was initiated

Member Access

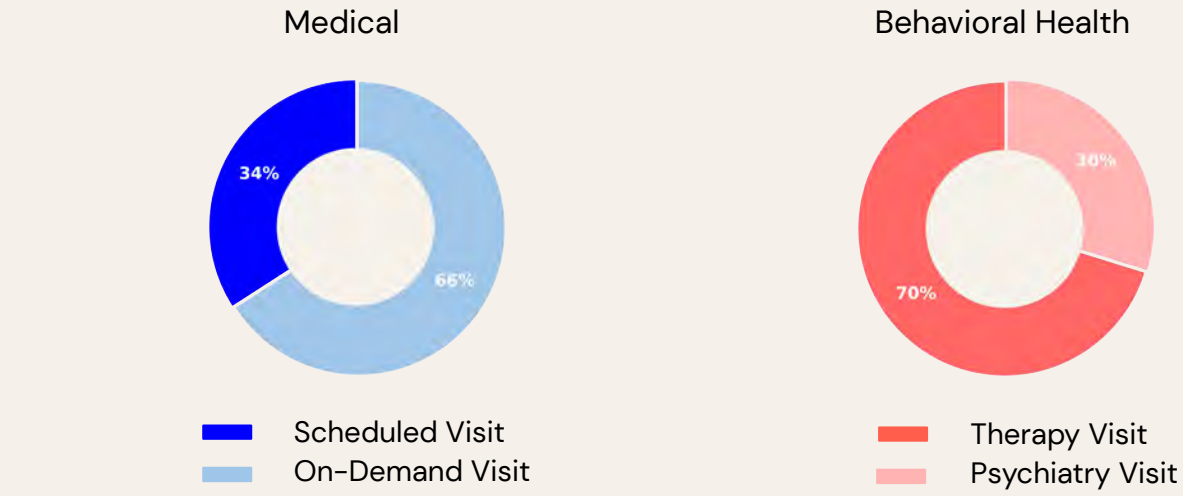
This section highlights our impact on increasing members' access to appropriate medical and behavioral health care, and their satisfaction with our services. We improve access to care by seeing members after hours (when brick & mortar providers are closed) and by making it easier to visit with a provider during business hours.

Without Included Health, where would you have gone?



We help members avoid unnecessary in-person visits by treating their needs virtually.

Member Demand by Visit Type Since Launch



Member Experience Metrics	This Month	Since Launch
Average Member Rating	5.0 / 5	5.0 / 5
Average Wait Time for On-Demand Medical Appointments	8.5 min	23.9 min

Member Clinical Needs

This section highlights the range of clinical conditions that we are treating through virtual care services. The program addresses a comprehensive range of both physical and behavioral health needs, and chronic and acute conditions. Examining the top needs of your population can inform more targeted clinical interventions and programs.

Member Reported Symptoms

Top 10 Symptoms

Symptom	Visits This Month	Visits Since Launch
Congestion / sinus p..	86	655
Cough	70	578
Fatigue / weakness	53	491
Headache	49	451
Sore throat	54	431
Difficulty sleeping	54	375
Nasal discharge	51	335
Fever	29	258
Difficulty / pain sw..	25	227
Sputum / productive ..	29	220

Member Conditions

Top 10 Diagnoses

ICD-10 Diagnoses	Visits This Month	Visits Since Launch
Other upper respiratory infect..	62	417
Anxiety disorders	49	275
Mood disorders	35	201
Urinary tract infections	20	166
COVID-19	10	136
Administrative/social admission	11	109
Cough, unspecified	12	101
Other upper respiratory disease	13	88
Acute bronchitis	13	78
Inflammation; infection of eye..	10	75

Clinical Service Delivery

Our clinical team can provide a wide range of clinical services to help address members' needs. Our team has a focus on prescribing and labs to ensure our efficacy meets or exceeds that of in-person care through connections with pharmacy benefits and top lab networks

Prescriptions and Testing Summary

333	72.0%	28	3.8%
Prescriptions This Month	of visits resulted in a prescription order	Lab Orders This Month	of visits resulted in a lab order

Top Prescriptions and Testing Orders

Top Prescriptions	Count This Month	Count Since Launch
benzonatate	27	212
prednisone	26	166
albuterol	16	114
amoxicillin/potassiu..	16	106
nitrofurantoin monoh..	14	102
ipratropium nasal	14	92
fluticasone nasal	18	74
methylprednisolone	8	68
nirmatrelvir/ritonavir	7	61
amoxicillin	9	57

Top Labs	Count This Month	Count Since Launch
Comprehensive Metabo..	3	24
CBC+diff	1	22
TSH with Reflex to F..	1	16
Urinalysis, Complete..	1	16
Lipid Panel	2	14
Chlamydia/GC, Urine	2	12
Urine Culture, Routine	1	11
Hemoglobin A1c	2	11
Vitamin D	1	10
Thyroid Stimulating ..	1	8

For any questions regarding the reporting, please feel free to reach out to your respective client success lead. Thank you.

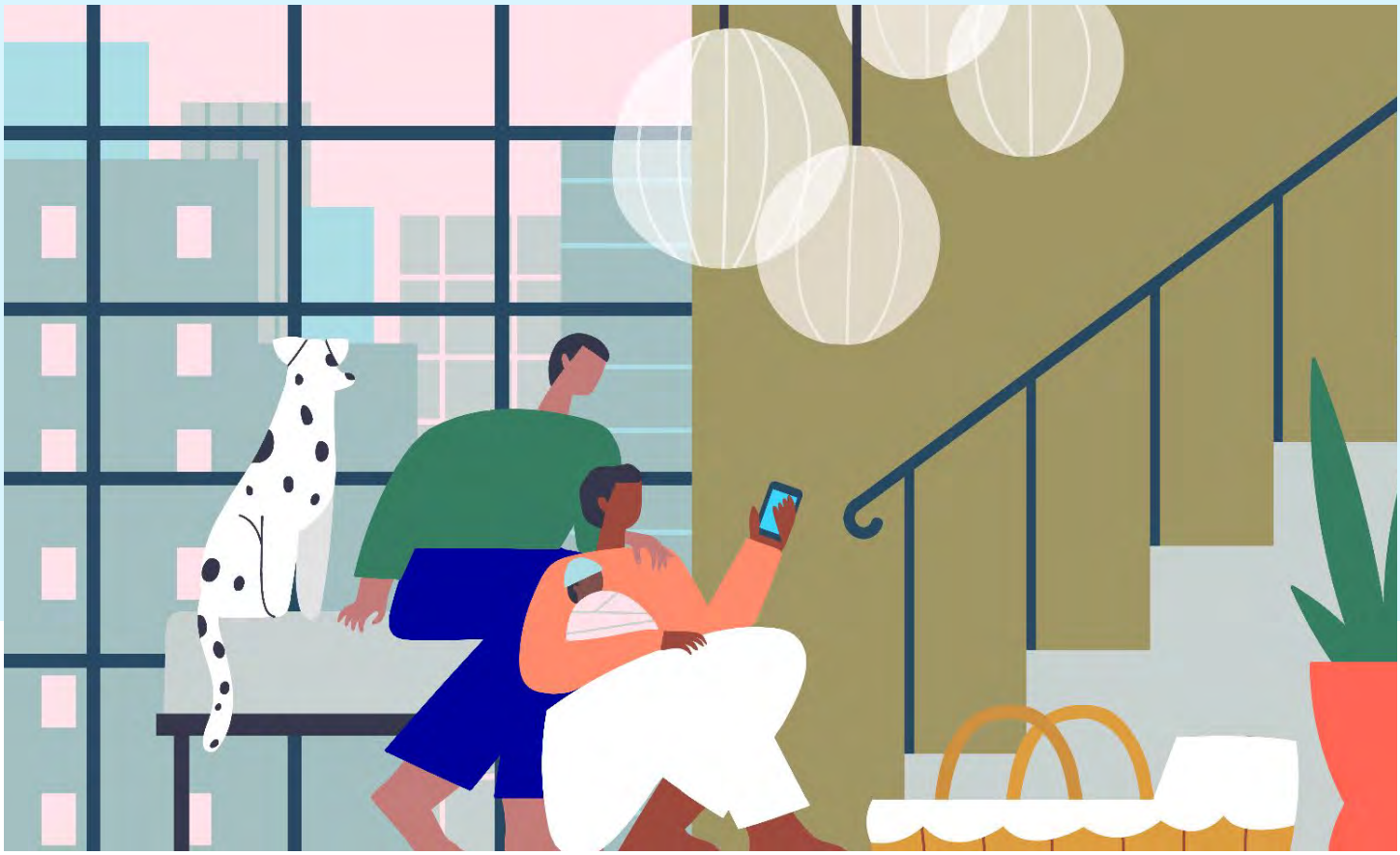
Data Dictionary

Metric	Definition
Behavioral Health Visit	Behavioral Health visits refer to scheduled appointments with our multidisciplinary team of therapists, psychologists, and psychiatrists. Our integrated Behavioral Health solution delivers highly-accessible, virtual-first therapy and psychiatry to members to address every member need from subclinical to clinical. Therapy visits are 25 or 50 minutes in length depending on the patient's needs. Initial Psychiatry visits are 45 minutes in length and all follow up psychiatry visits are 15 minutes in length.
Covered Lives	Total count of member lives (employees and dependents) eligible for Included Health services.
Employee Lives	Total count of employee lives eligible for Included Health services.
Engagement Rate	Total number of unique visitors as a percentage of eligible lives.
Medical Visit	Medical visits refer to on-demand and/or scheduled encounters with our multidisciplinary team of clinicians. **Urgent Care:** Our Everyday & Urgent Care solution offers accessible video-first care for acute needs. Our multidisciplinary team of employed clinicians provide 24/7 care on demand or by appointment to improve access to care and deliver a better care experience. Providers are cross-trained in behavioral health, primary dermatology, and geriatric medicine, to treat a wide range of everyday & urgent care and behavioral health needs including cold, flu, UTIs, sinus infections, along with anxiety and depression **Virtual Primary Care -** With Primary Care, we provide 24/7 care across the full continuum of member needs, including physical - acute, preventive and chronic - and behavioral for engaged members.
ICD-10 Code and Description	Describes the top international classification of diseases for diagnoses, symptoms, and procedures recorded by our clinicians as a result of the visit.
Member Rating	Average visitor rating of 1-5 stars submitted upon visit completion.
Patient Reported Symptoms	Describes the top symptoms selected by the patient during visit intake. A patient may select more than one symptom per visit.
Registration	A member is considered "registered" when they accept the Included Health TOS, either in a digital session or phone call. Registration rate is the total number of individuals registered as a percentage of eligible lives.
Reported Age and Gender	Describes the patient's age and gender category as provided by the member's insurance carrier or reported by the patient. Note, these demographics describe the patient, not the visitor.
Visit	A visit describes a member's encounter with an Included Health provider. Visits can be classified as: Medical or Behavioral (Therapy, Psychiatry)
Visitors	A member that initiates a visit with Included Health. Unique visitor counts is determined by the member that initiates the visit, not the patient seen by the provider. For example: A patient that initiates a visit for herself and a separate visit for her child is counted as one unique visitor.

Virtual Care Engagement Monthly Report

UMR – STATE OF NEVADA

Reporting Period: 2023-02-01 to 2023-03-01

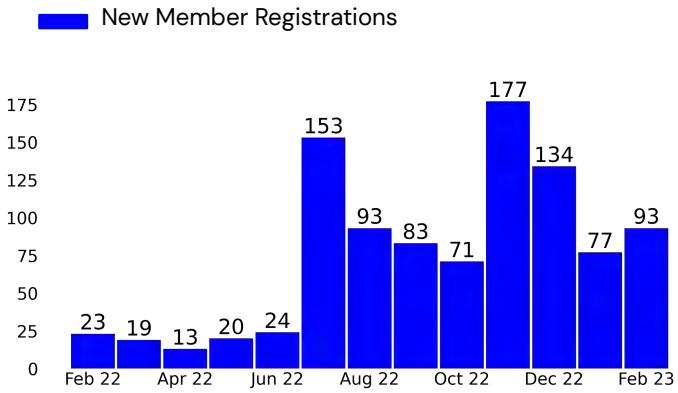


Member Engagement

93	244	299
Registrations This Month	Unique Visitors This Month	Total Visits This month

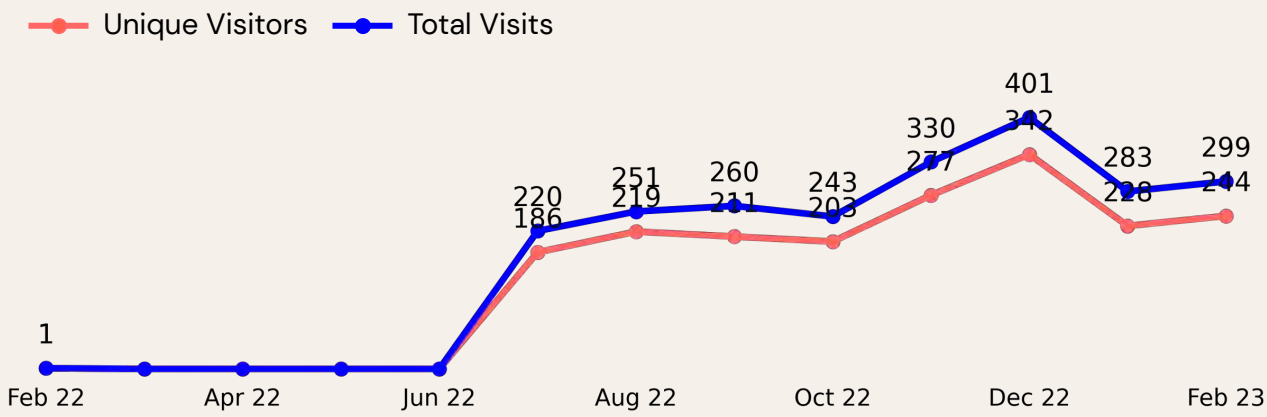
This section highlights how many members have engaged with our services, as measured by registrations and visits. Registration is a leading indicator of program health, as it opens the door to continuous engagement with members and supporting them when clinical needs arise. Monitoring monthly engagement is key to program success; changes in engagement can result from marketing initiatives or seasonality (e.g. cold and flu).

New Registrations (Last 12 Months)



Total Covered Lives	**1,957** Registrations Since Launch	Registration Rate Since Launch
Employee Covered Lives	**170** Registrations Year to Date	Registration Rate Year to Date

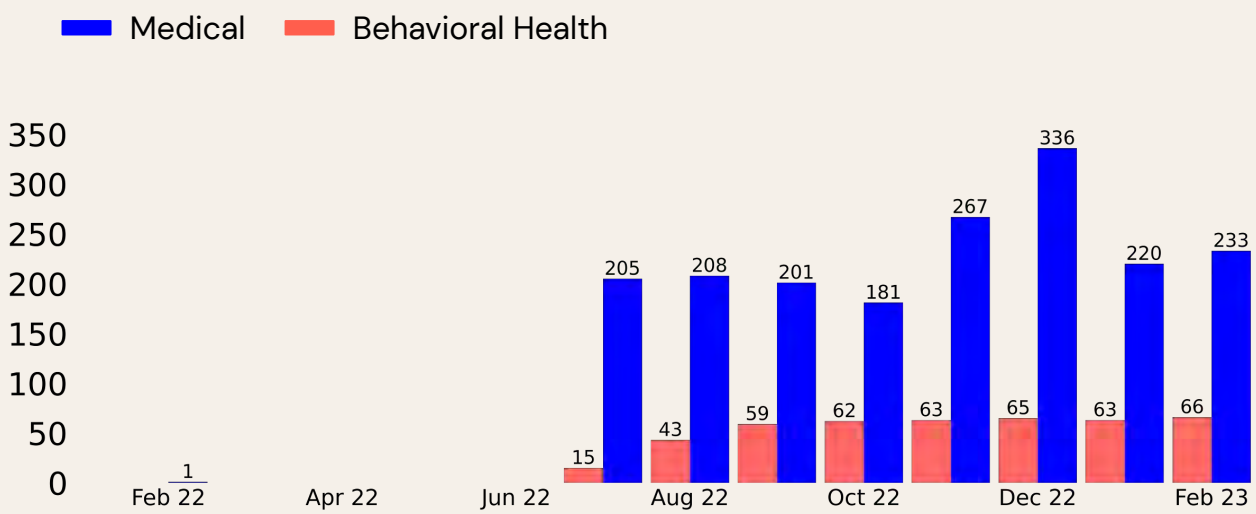
Visits Last 12 Months



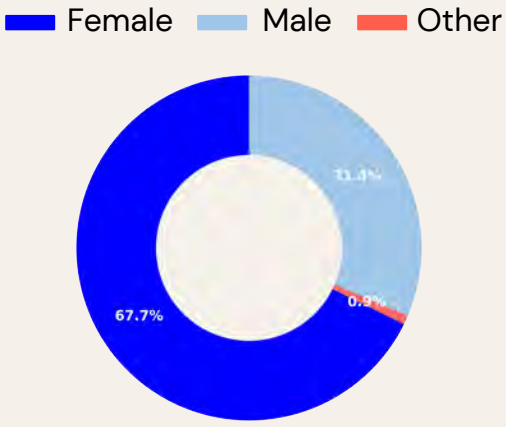
2,288 Visits Since Launch	**1,340** Unique Visitors Since Launch	**1.7** Average Visits Per Visitor Since Launch	Engagement Rate Since Launch (Visitors/Lives)	
582 Visits Year to Date	**426** Unique Visitors Year to Date	**1.4** Average Visits Per Visitor Year to Date	Engagement Rate Year to Date (Visitors/Lives)	

Member Engagement

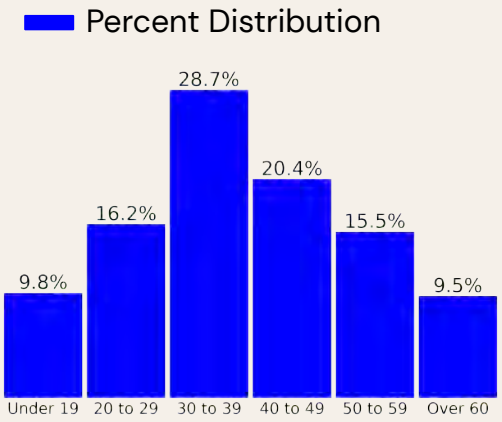
Medical & Behavioral Health Visits (Rolling 12 Months)



Visits by Reported Gender Year to Date



Visits by Age Year to Date



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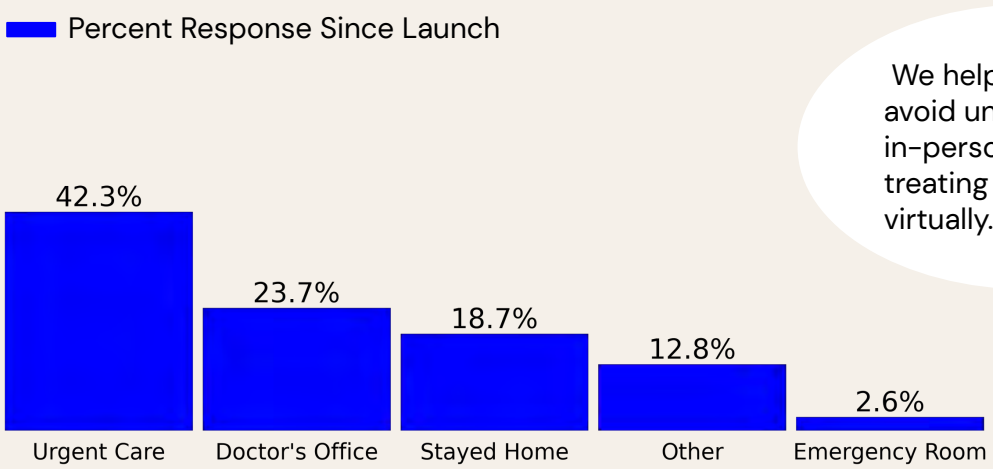

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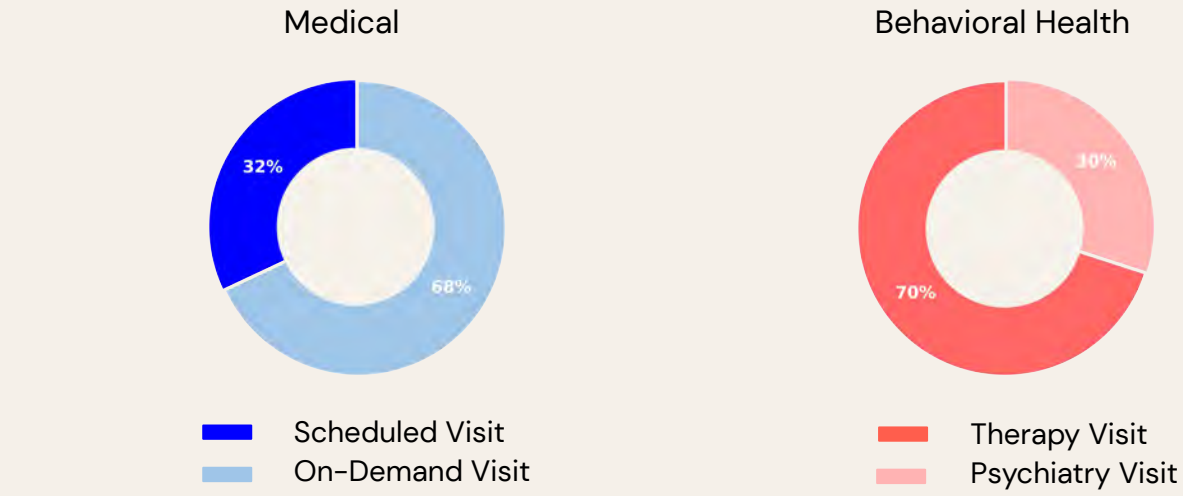
Member Demand by Visit Type Since Launch



Member Experience Metrics	This Month	Since Launch
Average Member Rating	4.9 / 5	5.0 / 5
Average Wait Time for On-Demand Medical Appointments	7.1 min	21.3 min

Member Clinical Needs

This section highlights the range of clinical conditions that we are treating through virtual care services. The program addresses a comprehensive range of both physical and behavioral health needs, and chronic and acute conditions. Examining the top needs of your population can inform more targeted clinical interventions and programs.

Member Reported Symptoms

Top 10 Symptoms

Symptom	Visits This Month	Visits Since Launch
Congestion / sinus p..	103	758
Cough	90	668
Fatigue / weakness	73	564
Headache	68	519
Sore throat	76	507
Difficulty sleeping	67	442
Nasal discharge	64	399
Fever	41	299
Difficulty / pain sw..	40	267
Sputum / productive ..	31	251

Member Conditions

Top 10 Diagnoses

ICD-10 Diagnoses	Visits This Month	Visits Since Launch
Other upper respiratory infect..	80	497
Anxiety disorders	53	329
Mood disorders	33	234
Urinary tract infections	22	188
COVID-19	25	161
Administrative/social admission	12	121
Cough, unspecified	9	110
Inflammation; infection of eye..	23	98
Other upper respiratory disease	6	94
Acute bronchitis	12	90

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albuterol	16	130
amoxicillin/potassiu..	9	115
nitrofurantoin monoh..	11	113
ipratropium nasal	13	105
fluticasone nasal	11	85
methylprednisolone	11	79
nirmatrelvir/ritonavir	14	75
amoxicillin	14	71

Top Labs	Count This Month	Count Since Launch
Comprehensive Metabo..	3	27
CBC+diff	3	25
TSH with Reflex to F..	4	20
Lipid Panel	4	18
Urinalysis, Complete..	2	18
Hemoglobin A1c	4	15
Urine Culture, Routine	2	13
Chlamydia/GC, Urine	1	13
Vitamin D	2	12
HIV-1/2 Ag/Ab, 4th G..	1	8

For any questions regarding the reporting, please feel free to reach out to your respective client success lead. Thank you.

Data Dictionary

Metric	Definition
Behavioral Health Visit	Behavioral Health visits refer to scheduled appointments with our multidisciplinary team of therapists, psychologists, and psychiatrists. Our integrated Behavioral Health solution delivers highly-accessible, virtual-first therapy and psychiatry to members to address every member need from subclinical to clinical. Therapy visits are 25 or 50 minutes in length depending on the patient's needs. Initial Psychiatry visits are 45 minutes in length and all follow up psychiatry visits are 15 minutes in length.
Covered Lives	Total count of member lives (employees and dependents) eligible for Included Health services.
Employee Lives	Total count of employee lives eligible for Included Health services.
Engagement Rate	Total number of unique visitors as a percentage of eligible lives.
Medical Visit	Medical visits refer to on-demand and/or scheduled encounters with our multidisciplinary team of clinicians. **Urgent Care:** Our Everyday & Urgent Care solution offers accessible video-first care for acute needs. Our multidisciplinary team of employed clinicians provide 24/7 care on demand or by appointment to improve access to care and deliver a better care experience. Providers are cross-trained in behavioral health, primary dermatology, and geriatric medicine, to treat a wide range of everyday & urgent care and behavioral health needs including cold, flu, UTIs, sinus infections, along with anxiety and depression **Virtual Primary Care -** With Primary Care, we provide 24/7 care across the full continuum of member needs, including physical - acute, preventive and chronic - and behavioral for engaged members.
ICD-10 Code and Description	Describes the top international classification of diseases for diagnoses, symptoms, and procedures recorded by our clinicians as a result of the visit.
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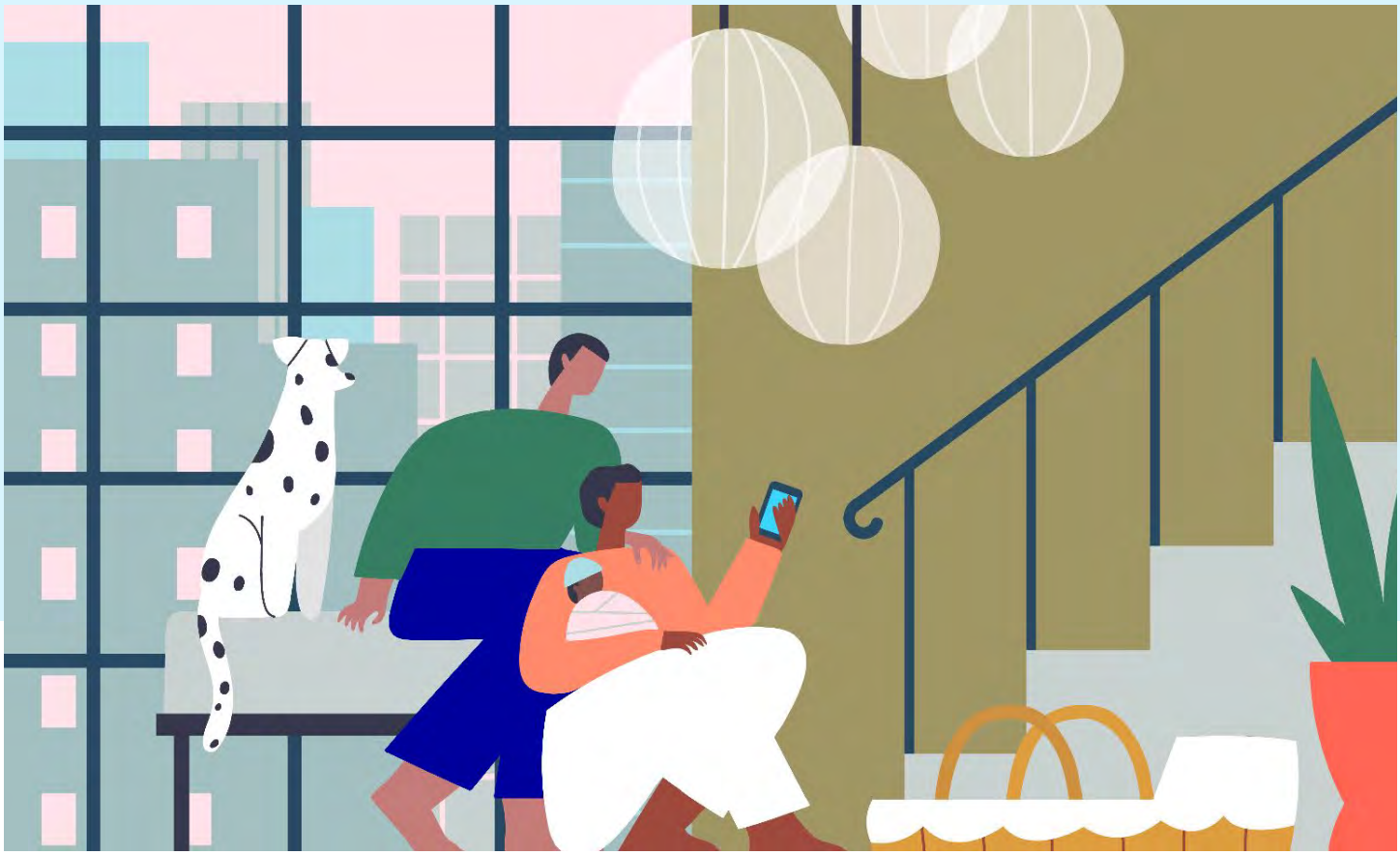
Visitors	A member that initiates a visit with Included Health. Unique visitor counts is determined by the member that initiates the visit, not the patient seen by the provider. For example: A patient that initiates a visit for herself and a separate visit for her child is counted as one unique visitor.

Virtual Care Engagement Monthly Report

UMR – STATE OF NEVADA

Reporting Period: 2023-03-01 to 2023-04-01

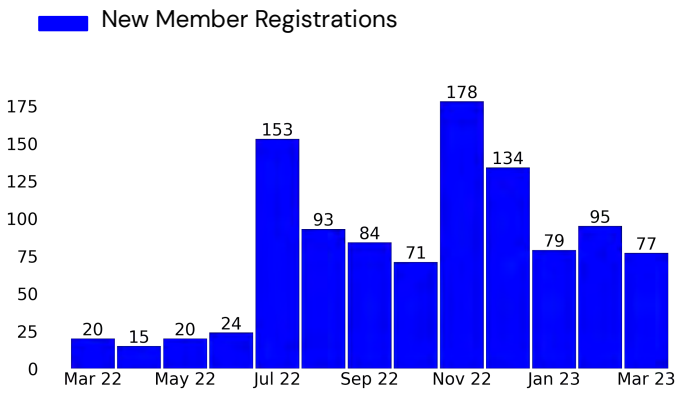


Member Engagement

77	279	326
Registrations This Month	Unique Visitors This Month	Total Visits This month

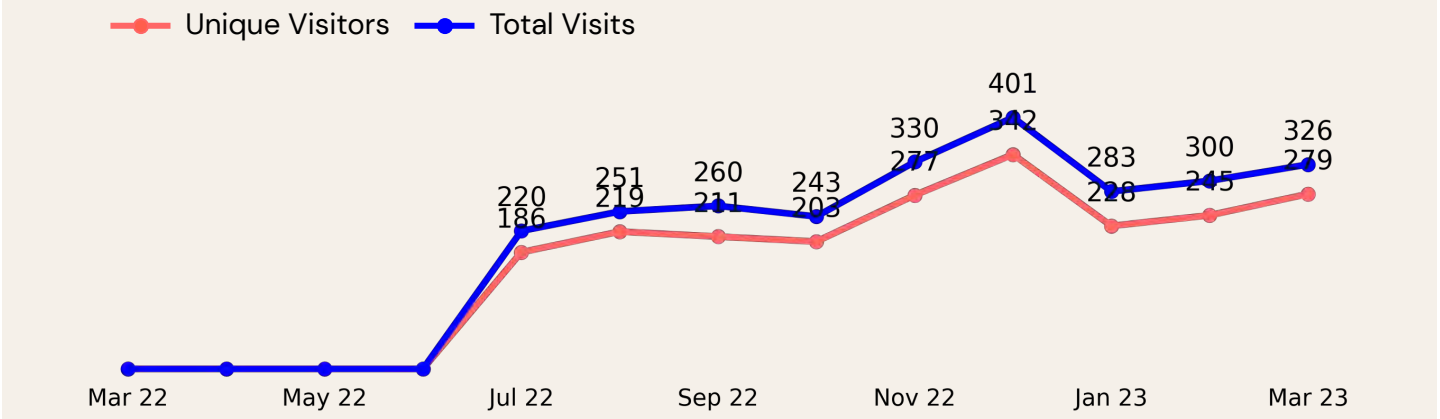
This section highlights how many members have engaged with our services, as measured by registrations and visits. Registration is a leading indicator of program health, as it opens the door to continuous engagement with members and supporting them when clinical needs arise. Monitoring monthly engagement is key to program success; changes in engagement can result from marketing initiatives or seasonality (e.g. cold and flu).

New Registrations (Last 12 Months)



Total Covered Lives	**2,106** Registrations Since Launch	Registration Rate Since Launch
Employee Covered Lives	**251** Registrations Year to Date	Registration Rate Year to Date

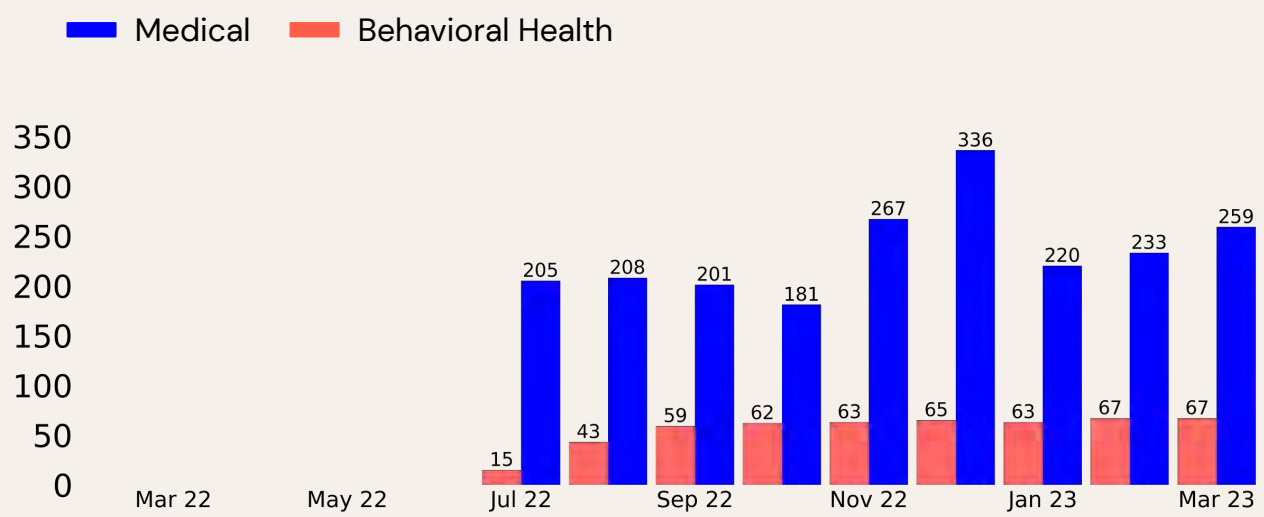
Visits Last 12 Months



2,615 Visits Since Launch	**1,483** Unique Visitors Since Launch	**1.8** Average Visits Per Visitor Since Launch	Engagement Rate Since Launch (Visitors/Lives)	
909 Visits Year to Date	**639** Unique Visitors Year to Date	**1.4** Average Visits Per Visitor Year to Date	Engagement Rate Year to Date (Visitors/Lives)	

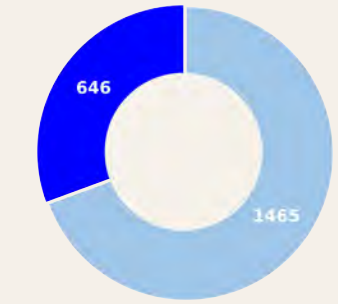
Member Engagement

Medical & Behavioral Health Visits (Rolling 12 Months)



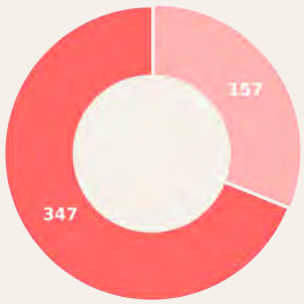
Member Demand by Visit Type Lifetime to Date

Medical



Scheduled Visit
On-Demand Visit

Behavioral Health



Therapy Visit
Psychiatry Visit

Most Popular Day for Visits Year to Date

Monday

Most Popular Time for Visits Year to Date

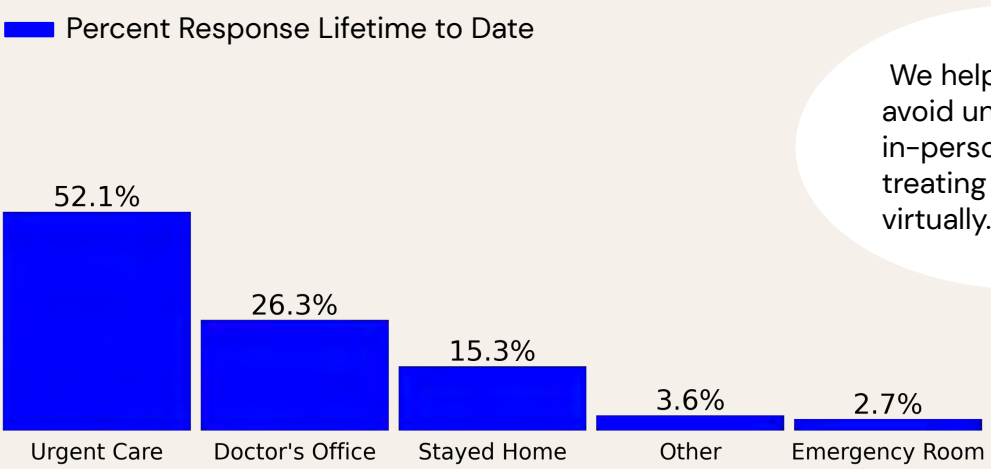
10AM – Noon

*Most popular day and time metrics are adjusted to time zone local where the visit was initiated

Member Access

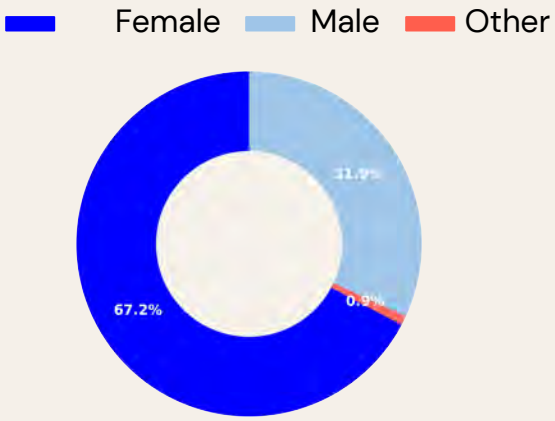
This section highlights our impact on increasing members' access to appropriate medical and behavioral health care, and their satisfaction with our services. We improve access to care by seeing members after hours (when brick & mortar providers are closed) and by making it easier to visit with a provider during business hours.

Without Included Health, where would you have gone?

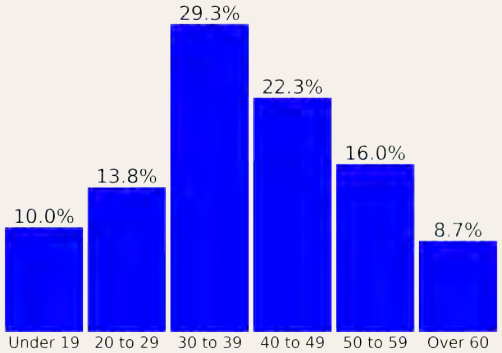


We help members avoid unnecessary in-person visits by treating their needs virtually.

Visits by Reported Gender Year to Date



Visits by Age Year to Date



Member Experience Metrics	This Month	Lifetime to Date
Average Member Rating	4.96 / 5	4.96 / 5
Average Wait Time for On-Demand Medical Appointments	7.29 min	19.36 min

Member Clinical Needs

This section highlights the range of clinical conditions that we are treating through virtual care services. The program addresses a comprehensive range of both physical and behavioral health needs, and chronic and acute conditions. Examining the top needs of your population can inform more targeted clinical interventions and programs.

Member Reported Symptoms

Top 10 Symptoms

Symptom	Visits This Month	Visits Lifetime to Date
Congestion / sinus p..	104	862
Cough	83	751
Fatigue / weakness	65	629
Headache	80	599
Sore throat	70	577
Difficulty sleeping	53	495
Nasal discharge	53	452
Fever	33	332
Difficulty / pain sw..	38	305
Sputum / productive ..	35	286

Member Conditions

Top 10 Diagnoses

ICD-10 Diagnoses	Visits This Month	Visits Lifetime to Date
Other upper respiratory infect..	87	584
Anxiety disorders	45	374
Mood disorders	31	265
Urinary tract infections	29	217
COVID-19	16	177
Administrative/social admission	20	141
Cough, unspecified	14	124
Inflammation; infection of eye..	18	116
Other upper respiratory disease	11	105
Acute bronchitis	10	100

Clinical Service Delivery

Our clinical team can provide a wide range of clinical services to help address members' needs. Our team has a focus on prescribing and labs to ensure our efficacy meets or exceeds that of in-person care through connections with pharmacy benefits and top lab networks

Prescriptions and Testing Summary

364	70.9%	34	3.6%
Prescriptions This Month	of visits resulted in a prescription order	Lab Orders This Month	of visits resulted in a lab order

Top Prescriptions and Testing Orders

Top Prescriptions	Count This Month	Count Lifetime to Date
benzonatate	30	274
prednisone	22	206
albuterol	13	143
amoxicillin/potassiu..	21	136
nitrofurantoin monoh..	15	128
ipratropium nasal	18	123
fluticasone nasal	12	97
nirmatrelvir/ritonavir	12	87
methylprednisolone	7	86
amoxicillin	13	84

Top Labs	Count This Month	Count Lifetime to Date
Comprehensive Metabo..	4	31
CBC+diff	4	29
TSH with Reflex to F..	3	23
Lipid Panel	4	22
Urinalysis, Complete..	3	21
Hemoglobin A1c	3	18
Urine Culture, Routine	4	17
Chlamydia/GC, Urine	1	14
Vitamin D	1	13
HIV-1/2 Ag/Ab, 4th G..	1	9

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5.

5. Discussion and possible action regarding the appointment of Celestena Glover as Interim Executive Officer of PEBP, using a statewide Manpower contract effective May 26, 2023, subject to the Governor's approval, per NRS 287.0424(1). (Jack Robb, Board Chair) (**For Possible Action**)

6.

6. Discussion and possible action regarding the permanent appointment or recruitment of the PEBP Executive Officer (Jack Robb, Board Chair) (**For Possible Action**)

7.

7. Discussion and possible action on Pharmacy Benefit Manager market check (Richard Ward, Segal) (**For Possible Action**)

8.

8. Open Enrollment Update (Nik Proper, Operations Officer) (Information/Discussion)

JOE LOMBARDO
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

JACK ROBB
Board Chair

AGENDA ITEM

☐ Action Item
☒ Information Only

Date: May 25, 2023

Item Number: VIII

Title: Open Enrollment Report

SUMMARY

This report provides the PEBP Board and members of the public with information regarding PEBP operations.

REPORT

Open Enrollment

Open Enrollment (OE) began on May 1st and will continue through May 31st. OE events were queued successfully with no major issues being reported as of the date this report was written.

PEBP's OE meetings were performed virtually again this year and we are pleased to announce that the accessibility of the virtual webinars resulted in a high participation of 1,603 total attendees, which is 345 more compared to last year.

Webinar Attendees	2022	2023
PEBP Plans	1,203	1,534
Medicare Exchange	55	69

As of May 18th, 2,830 open enrollment events have been completed with 1,457 in progress. Each year PEBP receives a migration report highlighting member movement and activity between plans. The chart below illustrates member enrollment changes that have taken place through May 18th.

Plan Enrollment as of 5/18/23 - Total Lives Covered

Plan	PY2023 Enrollment	PY2024 Enrollment
CDHP	26875	26039
LD-PPO	14911	15997
EPO	6221	6079
HMO	6246	6249
Dental Only	10440	10402
Declined	2496	2544

Plan Year 24 HSA/HRA funding

Beginning in Plan Year 2024, all plans will be receiving HSA or HRA funding in a combination from the base employer contribution for the CDHP plan only, an additional one-time PEBP board approved contribution for all plans, and a one-time Legislature appropriated contribution for all plans. Due to the State budget bill not being officially signed, we have taken precautions and operationally made it where come the first week of July that the base employer contribution and the one-time PEBP Board approved contributions will be funded into members' accounts. The Legislature appropriated contribution will be funded separately sometime later in July or early August depending on the status of the State budget bill.

9.

9. Discussion and acceptance of Claim Technologies Incorporated audit findings for State of Nevada Public Employees' Benefits Program Plans for Express Scripts for plan years 2020 and 2022 for the periods of July 1, 2019 – June 30, 2020 and July 1, 2021 – June 20, 2022, respectively. (Nik Proper, Operations Officer) **(For Possible Action)**

JOE LOMBARDO
Governor

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LAURA RICH
Executive Officer

JACK ROBB
Board Chair

Date: May 25, 2023

Item Number: IX

Title: Express Scripts Performance Guarantees Summary for Plan Year 2020 and 2022

SUMMARY

This report provides the PEBP Board and members of the public with supplemental information regarding CTI's audit of PEBP's Pharmacy Benefit Manager, Express Scripts (ESI), and the performance guarantees that were not part of the audit results. The information illustrates the additional penalties for self-reported, unmet performance guarantees not specifically audited for plan year 2020 and 2022. These are broken down by years and performance guarantee categories.

REPORT

2020

When implementing the new auditor contract with Claim Technologies, the audit for plan year 2020 was omitted. The audit authority for plan year 2020 was captured in a contract adjustment approved by the board on May 26, 2022.

Of the performance guarantees, the Member Satisfaction Survey was reported to be "Not Met" and incurred a penalty in the amount of $17,556.00.

2022

Of the performance guarantees, the Member Satisfaction Survey was reported to be "Not Met" and incurred a penalty in the amount of $78,559.54.

CONCLUSION

These penalties are automatically assessed by PEBP independently of the audit determinations.

DRAFT 05/12/2023

Prescription Benefit Management Audit

ANNUAL FINDINGS REPORT

State of Nevada Public Employee Benefit Program Plans

Administered by Express Scripts

Audit Period: July 1, 2019 – June 30, 2020
Audit Number 2. FY2020

Presented to

State of Nevada Public Employee Benefit Program

Prepared by

PillarRx Consulting

Subcontractor to

CLAIM TECHNOLOGIES INCORPORATED

TABLE OF CONTENTS

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 for the Fiscal Year (FY) July 1, 2019, through June 30, 2020. The population of claims and amount paid during the audit period reported by ESI:

Pharmacy	
Number of Prescriptions Paid	480,714
Net Plan Paid	$55,600,607.89

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

- Pricing and Fees Audit
- Reconciliation of Pricing Guarantees
- Benefit Payment Accuracy Review
- Rebate Review
- Performance Guarantee Review

Auditor's Findings

PillarRx has the following opinion/recommendations based on the FY2020 audit of ESI:

1. Financial Accuracy is defined by the discount and dispensing fee in the PBM contract, versus actual PBM performance. ESI's overall performance in both Retail and Mail order met PEBP's contractual financial accuracy guarantee.
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 ESI's Guarantee Measurements

Annual Metric	Guarantee	Met/Not Met	Penalty	Calculated Penalty
Retail				
Claim Financial Accuracy	99% of all claims paid with NO errors.	Met – 100%	0%	$0
Processing Accuracy		Met – 100%	0%	$0
Mail Order				
Claim Financial Accuracy	99% of all claims paid with NO errors unless subject to intervention.	Met – 100%	$0	$0
Claim Processing Accuracy		Met – 100%	0%	$0
		Total Penalty		$0

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 PEBP's pharmacy plan. This report is provided to PEBP, the plan sponsor, and ESI the pharmacy benefit manager (PBM).

The findings in this report are based on data and information ESI and 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 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 PEBP's paid claims during the audit period. While performing the audit, PillarRx complied with applicable 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 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;
- 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 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 PEBP and ESI each contract, amendment, formulary drug list, and reconciliation document required to conduct the audit.

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 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. ESI utilizes MediSpan as well as First Data Bank for generic or brand drug classification.

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 applicable 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 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 not in alignment based on the contract for FY2020.

***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 (7/1/2019 – 6/30/2020)					
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	9,556	$3,657.87	$5,733.60	$2,075.73
Retail Brand (84-90 DS) STD	$0.10	1,796	$486.57	$179.60	($306.97)
Mail Brand	$0.00	4,628	$0.00	$0.00	$0.00
Mail Generic	$0.00	32,341	$0.00	$0.00	$0.00
Retail Generic (1-83 DS) STD	$0.60	55,811	$34,625.52	$33,486.60	($1,138.92)
Retail Generic (84-90 DS)	$0.10	21,759	$2,920.02	$2,175.90	($744.12)
Retail Brand (1-83 DS)	$0.60	22,501	$8,809.50	$13,500.60	$4,691.10
Retail Brand (84-90 DS)	$0.00	3,403	$24.59	$0.00	($24.59)
Retail Generic (1-83 DS)	$0.60	221,476	$149,050.39	$132,885.60	($16,164.79)
Retail Generic (84-90 DS Fee)	$0.00	33,590	$839.77	$0.00	($839.77)
TOTAL		**406,861**	**$200,414.23**	**$187,961.90**	**($12,452.33)**

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

In conclusion, ESI overcharged PEBP for dispensing fees in the amount of $12,452.33. This amount has been included in the total pricing and fees reconciliation.

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 PEBP were met, and if those performance levels were not met, that accurate credit or payment was made to PEBP within the timeframe specified in the contract.

Reconciliation of Pricing Guarantees Scope

Using the terms of PEBP's contract with ESI, we accumulated 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, 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 each drug 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 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*	Underperformance *< Less Than Contracted Rates*

FY2020								
Component Description*	Number of Claims	Contracted Discount Rate	Actual Discount Rate	Difference (Contracted vs Actual)	Contracted Claim Ingredient Cost	Actual Claim Ingredient Cost	Variance Total Overage/ (Shortfall)	
Retail Brand (1-83 DS) STD	9,556	18.50%	19.16%	- 0.66%	$3,767,256.48	$3,736,583.88	$30,672.60	>
Retail Brand (84-90 DS) STD	1,797	22.50%	22.01%	+ 0.49%	$1,673,447.95	$1,683,934.32	($10,486.37)	<
Retail Generic STD	77,570	83.25%	82.59%	+ 0.66%	$2,379,744.55	$2,473,403.37	($93,658.82)	<
Retail Brand (1-83 DS) STD	22,553	18.50%	26.23%	-7.73%	$6,604,703.23	$5,978,509.44	$626,193.79	>
Retail Brand (84-90 DS)	3,403	24.50%	25.97%	- 1.47%	$2,904,360.20	$2,847,996.32	$56,363.88	>
Retail Generic (1-83 DS)	221,490	83.75%	84.01%	0.26%	$3,610,605.59	$3,552,109.85	$58,495.74	>
Retail Generic (84-90 DS)	33,591	87.00%	87.89%	-0.89%	$1,236,317.28	$1,151,747.25	$84,570.03	>
Mail Brand	4,628	24.50%	24.50%	0.00%	$4,392,592.36	$4,392,591.04	$1.32	>
Mail Generic	32,342	87.00%	83.38%	+ 3.62%	$1,369,577.25	$1,751,471.19	($381,893.94)	<
ESI Specialty	4,149	19.25%	19.49%	- 0.24%	$17,769,209.09	$17,716,712.90	$52,496.19	>
			TOTAL	**- 5.96%**	**$45,707,813.98**	**$45,285,059.56**	**$422,754.42**	**>**

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

The aggregate total for each standard is calculated separately (retail, mail, and specialty) and then combined to determine the total over or underperformance**.**

In summary, when aggregating the pricing guarantee discounts with the dispensing fee outcome, ESI's calculated a reconciliation of $320.41. See chart below for breakout.

	PillarRx s and Dispensing Fee Guarantees	ESI Combined Discounts and Dispensing Fee Guarantee Reconciliation
Discounts	$422,745.42	$851,870.44
Dispensing Fees	($12,452.33)	($320.41)
FY2020	$410,293.09	($320.41)

PillarRx found an underperformance in retail generic STD, mail generic and retail brand STD channels totaling $486,039.14, this means less than the contracted rate. However, this amount was offset by overperformances in the other channels (mail brand, ESI Specialty, etc) which resulted in an adjusted overperformance amount of $422,745.42. This is considered plan savings because the contract allows for offsetting.

PillarRx also found an underperformance of dispensing fees in the amount of $12,452.33 which resulted in an aggregate total overperformance or plan savings of $410,293.09.

No additional money is owed to PEBP due to underperformance, this was recognized throughout the year as claims were processed.

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 PEBP'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

Identified exceptions that could not be explained were provided to ESI for an 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 PEBP and ESI including member cost share, 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

Member Cost Share

Cost share indicates the dollar amount required to be paid by the member when a prescription drug is purchased. A PillarRx cost share audit compares the plan design received from ESI to the plan design received from PEBP. Benefit plan design rules are created to ensure members' claims have been properly adjudicated at the pharmacy.

Cost share (copay, deductible, or coinsurance) represented the dollar amount required to be paid by the member when a prescription drug was purchased. Our observations and conclusions relative to cost share application are shown in the following chart.

Member Cost Share (7/1/2019 – 6/30/2020)	
Total Claims	**Cost Share Collected**
480,714	$15,630,782.08

PillarRx submitted 94 commercial claims based on eight different scenarios to ESI that represented potential exceptions to the member cost share requirements for FY2020. ESI's response provided adequate explanation and documentation for each category of exception for each scenario except for one which allowed PillarRx to conclude copayments may not have been applied correctly.

Scenario	ESI Response
Diabetes Care Management Medications	
Applying $0 Cost Share.	Claim is correct. ESI notes these adjustments were part of a pricing issue found and corrected in 2020. Members were not impacted, and the adjustments were applied to make the plan whole.

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				
I.B	Retail Claim Financial Accuracy	99% of all claims paid with NO errors	100% – PillarRx noted no additional financial accuracy errors, other than the ESI self-reported underperformance amount of $320.	Met
	Retail Processing Accuracy		100%	Met
I.C	Mail Order Claim Financial Accuracy	99% of all claims paid with NO errors unless subject to intervention.	100%	Met
	Mail Order Claim Processing Accuracy		100%	Met
I.F	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%	Met
I.G	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.	100%	Met
Claim Processing Turnaround				
I.D	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.	1.1 business days	Met
I.D	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.	0.7 business days	Met
Telephone Services				
II.A	Customer Service Response Time	Average time to answer all calls should be 30 seconds or less.	8.3 seconds	Met
II.B	Abandonment Rate	3% or less calls abandoned.	0.7%	Met
Member Satisfaction				
II.D	Member Satisfaction Survey	One random sample member survey completed annually on PEBP specific basis or PEBP specific responses to a book of business survey.	Target – 90% or greater ESI Score – 83% ESI did not meet the target for member satisfaction and has provided proof of payment to PEBP in the amount of $17,556 (0.25% of admin fees). Credit was made on 3/9/21.	Not Met

REBATE REVIEW

Rebate Audit Objective

The Rebate Review provides confirmation that ESI has reimbursed 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 PEBP and ESI and the rebate amounts that were actually paid to the PEBP.

Rebate Review Methodology

PillarRx identified each brand claim per distribution channel and calculated the minimum rebate amount owed to 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 FY2020		
Component Description	**Number of Claims**	**Total Minimum Contract Rebate**
Brand 1 - 83 DS	33,522	$3,100,785.00
Brand 84 - 90 DS	5,566	$1,765,813.50
Specialty Accredo	4,564	$3,468,640.00
Specialty	1,238	$3,468,640.00
Mail Brand	6,770	$2,147,782.50
TOTAL	**51,660**	**$13,951,661.00**

PillarRx's Rebate Review shows, based on the minimum rebates stipulated within the contract between PEBP and ESI, that ESI exceeded the minimum rebates owed.

ESI Rebate Payments FY 2020		
Allocation Period	**Payment Date**	**Total Amount**
FY19 Q1: 7/1/19 - 9/30/19	October 30,2019	$3,967,614.07
FY19 Q2: 10/1/19 - 12/31/19	January 30, 2020	$143,695.07
	February 21, 2020	$3,236,500.95
FY19 Q3: 1/1/20 - 3/31/20	April 28, 2020	$3,303,286.62
FY19 Q4: 4/1/20 - 6/30/20	July 28,2020	$3,463,175.60
	TOTAL	**$14,114,272.31**

ESI paid out total rebates of $14,114,272.21 to PEBP. No additional monies are owed to PEBP.

CONCLUSION

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

APPENDIX – PBM RESPONSE TO DRAFT REPORT

EXPRESS SCRIPTS®

April 5, 2023

Shaidikia DeVaughn
PillarRx Consulting
shaidikia.devaughn@pillarrx.com

RE: State of Nevada FY 2020 - DRAFT Report- Additional Information Needed

Dear Shaidikia DeVaughn:

Please find enclosed ESI's responses to the pharmacy audit report received on 2/10/2023, and additional questions received on 3/22/2023, from the audit that was performed on behalf of Nevada Public Employees Benefit Program for the audit period 7/1/2019 - 6/30/2020. ESI has provided responses as well as excerpts from the PillarRx report to provide context.

If you have any questions after reviewing the enclosed information, please let me know.

Sincerely,

Tony Nowacki
Client Audit Advisor
AMNowacki@express-scripts.com

Confidential Information

This document contains proprietary information and/or data of ESI Holding Company and its subsidiaries and affiliates (hereinafter referred to as "ESI Holding Company"). Recipient, by accepting this document, agrees that it will not duplicate, use, or disclose-in whole or in part-this document, or the information contained therein, or any part thereof to others for any other purpose except as specifically authorized in writing by ESI Holding Company. EXEMPT FROM PUBLIC DISCLOSURE: Information contained herein is confidential information of ESI Holding Company and is exempt from public disclosure under 5 U.S.C. §552 (b). Do not disclose outside of the recipient organization of the United States Government.

RECONCILIATION OF PRICING GUARANTEES

Reconciliation of Pricing Guarantees Findings

In summary, when aggregating the pricing guarantee discounts with the dispensing fee outcome, ESI's calculated a reconciliation of $320.41. See chart below for breakout.

PillarRx found an underperformance in both the retail generic and mail generic channels totaling $77,594.48. PillarRx also found an underperformance, or over collection of dispensing fees in the amount of $12,454.03 resulting in a total underperformance of $90,048.51 which is due to PEBP.

	PillarRx Combined Discounts and Dispensing Fee Guarantees	ESI Combined Discounts and Dispensing Fee Guarantee Reconciliation
Discounts	($77,594.48)	$851,870.44
Dispensing Fees	($12,454.03)	($320.41)
FY2020	($90,048.51)	($320.41)

ESI Response (3/2/23)

ESI maintains that the pricing guarantee was reconciled in accordance with the PBM Agreement, resulting in a shortfall amount of $320.41. ESI provided responses to the issues submitted by PillarRx during the sample phase of the audit, aside from two open issues. Regarding guarantee key 138652, ESI notes all of the claims in question were included in the guarantee appropriately, resulting in the totals reported by ESI in the Settlement Report. Regarding the OTC samples, ESI is finalizing the review to confirm whether these products were OTCs at the time of adjudication and should have been excluded. If determined that these were OTC products, ESI will re-reconcile the guarantee to exclude these claims.

Post Draft Question #1

Due to the recommendations from Pillar on the Pricing & Guarantees, will ESI re-reconcile? Or will additional payment be issued.

ESI Response (4/5/23)

ESI maintains that the pricing guarantee was reconciled in accordance with the PBM Agreement, resulting in a shortfall amount of $320.41 and will not be re-reconciled.

Post Draft Questions #2

Additionally, when will the research be completed the OTC claims?

ESI Response (4/5/23)
ESI has confirmed the OTC claims in question were not considered to be OTC at the time of adjudication and were appropriately included in the guarantee.

	PillarRx Combined Discounts and Dispensing Fee Guarantees	ESI Combined Discounts and Dispensing Fee Guarantee Reconciliation
Discounts	$422,755.41	$851,870.44
Dispensing Fees	($12,452.33)	($320.41)
FY2020	$410,303.08	($320.41)

BENEFIT PAYMENT ACCURACY REVIEW

Benefit Payment Accuracy Review Findings

Scenario - Diabetes Care Management Medications- Applying a $0 Cost Share.

ESI Response- Claim is correct. ESI notes the claim in question is an adjustment. Please note impact related to this issue would have been discussed and shared with the client at the time the adjustment was completed. The ESI Account Team is available to further discuss this issue directly with the client should they wish to do so.

PillarRx recommends PEBP follow up with ESI on the adjudication of Diabetes Care Management Medications to ensure that copays are being applied correctly.

ESI Response (3/2/23)
ESI will review the scenario directly with the client should they wish to do so.

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	98.92%- ESI reported an over performance in the Retail standard, however, PillarRx reported an over performance for Retail Financial Accuracy of $262,844 and an under performance (over charge) of $12,454,03 in dispensing fees.	Not 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.	93.37% – ESI reported an under performance in the Mail standard of $381,206, and PillarRx reported an under performance of $381,885 and $0 for dispensing fees	Not Met
Mail Order Claim Processing Accuracy		100% - PillarRx noted no errors for Mail Order Processing Accuracy.	Met
Member Satisfaction			
Member Satisfaction Survey	One random sample member survey completed annually on PEBP specific basis or PEBP specific responses to a book of business survey.	Target- 90% or greater ESI Score- 83%	Not Met

ESI Response (3/2/23)
ESI notes that our reporting indicates that the Claim Adjudication Accuracy and Claim Financial Accuracy metrics were met. The shortfalls noted under PBM Performance in the grid above relate to pricing guarantees which are reconciled separately and addressed in the pricing guarantees section of this report. Additional reporting has been provided to address the rebate sections of this grid. ESI does

agree that the member satisfaction survey metric was missed, with a penalty of $17,556 which was credited to the 3/9/21 claims invoice.

Post Draft Question #1
A complete breakdown of how the Member Satisfaction payment was calculated as well as a check number to confirm payment has been made.

ESI Response (4/5/23)
The penalty is calculated as 0.25% of Admin fees for the year, per percentage point the metric was missed by. For the audit period, the total admin fees (with the credit line for prior penalties removed) was $991,770.22. The metric was failed by 7 percent, so the total penalty is ($991,770.22 * 0.25%) * 7 = $17,355.98. Additionally it was found that the prior penalty payment was off by $200, so the total payment was $17,556. The payment was submitted 3/9/21 and was made through an invoice credit on 3/15/21, and not paid by a check. Support has been provided alongside these responses.

REBATE REVIEW

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 FY2020		
Component Description	**Number of Claims**	**Total Minimum Contract Rebate**
Brand 1-83 DS	33,522	$3,100,785.00
Brand 84-90 DS	5,566	$1,765,813.50
Specialty Accredo	4,564	$3,468,640.00
Specialty	1,238	$3,468,640.00
Mail Brand	6,770	$2,147,782.50
Total	**51,660**	**$13,951,661.00**

Pending Review- Rebate Invoices needed from PBM for review.

Rebate Payments		
Allocation Period	**Payment Date**	**Total Amount**
FY19 Q1: 7/1/19-9/30/19		
FY19 Q2: 10/1/19-12/31/19		
FY19 Q3: 1/1/20-3/31/20		
FY19 Q4: 4/1/20-6/30/20		

ESI Response (3/2/23)

ESI's reconciliation shows that total rebates owed for the period of 7/1/19 – 6/30/20 was $13,604,854.82 based on the collected rebates, which exceeded the calculated per Rx amount of $12,543,838.96. The payment for these rebates were included in the payments noted below. If there are discrepancies on which claims were included in the guarantee, ESI requests that PillarRx provide discrepant claims for review.

Rebate Payments		
Allocation Period	**Payment Date**	**Total Amount**
FY19 Q1: 7/1/19-9/30/19	10/30/2019	$3,967,614.07
FY19 Q2: 10/1/19-12/31/19	1/30/2020	$143,695.07
	2/21/2020	$3,236,500.95
FY19 Q3: 1/1/20-3/31/20	4/28/2020	$3,303,286.62
FY19 Q4: 4/1/20-6/30/20	7/28/2020	$3,463,175.50

Express Scripts has completed the research for the findings presented above. The Account Team will work directly with Nevada PEBP and is available to discuss plan benefit set-up directly with Nevada PEBP should any questions remain.

DRAFT 05/11/2023

Prescription Benefit Management Audit

ANNUAL FINDINGS REPORT

State of Nevada Public Employee Benefit Program Plans

Administered by Express Scripts

Audit Period: July 1, 2021 – June 30, 2022
Audit Number 2. FY2022

Presented to

State of Nevada Public Employee Benefit Program

Prepared by

PillarRx Consulting

Subcontractor to

CLAIM TECHNOLOGIES INCORPORATED

TABLE OF CONTENTS

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 PEBP's pharmacy plan for the Fiscal Year (FY) July 1, 2021, through June 30, 2022 (FY2022). The population of claims and amount paid during the audit period reported by ESI:

Pharmacy	
Number of Prescriptions Paid	463,998
Net Plan Paid	$61,712,280.96

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

- Pricing and Fees Audit
- Reconciliation of Pricing Guarantees
- Benefit Payment Accuracy Review
- Rebate Review
- Performance Guarantee Review

Auditor's Findings

PillarRx has the following opinion/recommendations based on the FY2022 audit of ESI:

1. Mail Order Claim Financial Accuracy improved in this audit period.
2. The Member Satisfaction Survey results continued to miss the minimum performance guarantee and a penalty is owed as indicated below.

Summary of ESI's Guarantee Measurements

Annual Metric	Guarantee	Met/Not Met	Penalty	Calculated Penalty
Retail				
Claim Financial Accuracy	99% of all claims paid with NO errors.	Met – 100%	0%	$0
Processing Accuracy		Met – 99.82%	0%	$0
Mail Order				
Claim Financial Accuracy	99% of all claims paid with NO errors unless subject to intervention.	Met – 100%	0%	$0
Claim Processing Accuracy		Met – 100%	0%	$0
Member Satisfaction Survey	Customer Satisfaction: One random sample member survey will be completed on annually on a PEBP specific basis, or PEBP specific responses to a book of business survey. Express Scripts guarantees a participant satisfaction rate of 90% or greater.	Not Met – 80%	0.25% of annual admin fees for every percent or fraction thereof below 90%	$78,559.54
		Total Penalty	(0.25%*$3,142,381.69)*10	$78,559.54

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 PEBP's pharmacy plan. This report is provided to PEBP, the plan sponsor, and ESI the pharmacy benefit manager (PBM).

The findings in this report are based on data and information ESI and 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 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 PEBP's paid claims during the audit period. While performing the audit, PillarRx complied with 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 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;
- 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 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 PEBP and ESI each contract, 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 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. ESI utilizes MediSpan as well as First Data Bank for generic or brand drug classification.

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 applicable 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 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 not in alignment based on the contract for FY2022.

***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 (7/1/2021 – 6/30/2022)					
Component Description*	**Contracted Dispensing Fee**	**Number of Claims**	**Total Actual Dispensing Fee**	**Total Contracted Dispensing Fee**	**Total Overage/ (Shortfall)**
Retail Brand (1-83DS)	$0.55	15,020	$9,155.54	$8,261.00	($894.54)
Retail Brand (84-90 DS)	$0.00	5,512	$50.35	$0.00	($50.35)
Retail Generic (1-83 DS)	$0.55	258,432	$104,137.74	$142,137.60	$37,999.86
Retail Generic (84-90 DS Fee)	$0.00	46,986	$958.59	$0.00	($958.59)
Mail Brand	$0.00	6,497	$0.00	$0.00	$0.00
Mail Generic	$0.00	51,014	$0.00	$0.00	$0.00
TOTAL		**383,461**	**$114,302.22**	**$150,398.60**	**$36,096.38**

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

ESI overperformed in this category. No further action is required.

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 PEBP were met, and if and if those performance levels were not met, that accurate credit or payment was made to PEBP within the timeframe specified in the contract.

Reconciliation of Pricing Guarantees Scope

Using the terms of PEBP's contract with ESI, we accumulated 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, 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 each drug 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 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*	Underperformance *< Less Than Contracted Rates*

Discounts FY2022								
Component Description*	Number of Claims	Contracted Discount Rate	Actual Discount Rate	Difference in Rate (Contracted vs Actual)	Contracted Claim Ingredient Cost	Actual Claim Ingredient Cost	Variance Total Overage/(Shortfall)	
Retail Brand (1-83 DS) STD	15,020	19.50%	21.08%	+1.58%	$7,795,728.81	$7,642,597.37	$153,131.44	>
Retail Brand (84-90 DS) STD	5,512	24.75%	24.75%	0.00%	$7,232,075.71	$7,156,702.28	$75,373.43	>
Retail Generic (1-83 DS)	258,432	84.50%	84.15%	-0.35%	$4,303,917.22	$4,401,167.80	($97,250.58)	<
Retail Generic (84-90 DS)	46,986	87.75%	86.95%	-0.80%	$1,968,732.90	$2,097,145.34	($128,412.44)	<
Mail Brand	6,497	24.50%	24.50%	0.00%	$7,916,783.51	$7,943,086.28	($26,302.77)	<
Mail Generic	51,014	88.08%	88.09%	+ 0.01%	$2,082,842.80	$2,024,299.40	$58,543.10	>
ESI Specialty	4,260	21.50%	19.59%	- 1.91%	$21,176,101.55	$21,692,261.77	($516,160.22)	<
			TOTAL	**+ 1.47%**	**$52,476,182.50**	**$52,957,260.24**	**($481,078.05)**	**<**

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

The aggregate total for each standard is calculated separately (retail, mail, and specialty) and then combined to determine the total over or underperformance**.**

In summary, when aggregating the pricing guarantee discounts with the dispensing fee outcome, ESI's calculated a reconciliation of ($495,962.06). See chart below for breakout.

	PillarRx Combined Discounts and Dispensing Fee Guarantees	ESI Combined Discounts and Dispensing Fee Guarantee Reconciliation
Discounts	($481,078.05)	($495,962.06)
Dispensing Fees	$36,096.38	$39,940.07
FY2022	($481,078.05)	($495,962.06)

The calculated shortfall of $495,962.06 was paid to PEBP on 11/15/22.

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 PEBP'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

Identified exceptions that could not be explained were provided to ESI for an 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 PEBP and ESI including member cost share, accumulators, 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

Cost share indicates the dollar amount required to be paid by the member when a prescription drug is purchased. A PillarRx cost share audit compares the plan design received from ESI to the plan design received from PEBP. Benefit plan design rules are created to ensure members' claims have been properly adjudicated at the pharmacy.

Cost share (copay, deductible, or coinsurance) represented the dollar amount required to be paid by the member when a prescription drug was purchased. Our observations and conclusions relative to cost share application are shown in the following chart.

Member Cost Share (7/1/2021 – 6/30/2022)	
Total Claims	**Cost Share Collected**
463,998	$17,291,807.78

PillarRx submitted 130 claims based on 12 different scenarios to ESI that represented potential exceptions to the member cost share requirements for FY2022. ESI's response provided adequate explanation and documentation for each category of exception for each scenario. No further action is required.

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				
I.B	Retail Claim Financial Accuracy Retail Processing Accuracy	99% of all claims paid with NO errors.	100% 99.82%	Met Met
I.C	Mail Order Claim Financial Accuracy Mail Order Claim Processing Accuracy	99% of all claims paid with NO errors unless subject to intervention.	100% 100%	Met Met
I.F	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%	Met
I.G	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.	100%	Met
Claim Processing Turnaround				
I.D	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.	0.7 business days	Met
I.D	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.	1.0 business days	Met
	Telephone Services			
II.A	Customer Service Response Time	Average time to answer all calls should be 30 seconds or less.	8.3 seconds	Met
II.B	Abandonment Rate	3% or less calls abandoned.	0.7%	Met
	Member Satisfaction			
II.D	Member Satisfaction Survey	One random sample member survey completed annually on PEBP specific basis or PEBP specific responses to a book of business survey.	Target – 90% or greater ESI Score – 80% ESI did not meet the target for member satisfaction. A penalty is due in the amount of $78,559.54 (0.25% of admin fees for each percentage below target) Admin Fees for FY 2022 = $3,142,381.69.	Not Met

REBATE REVIEW

Rebate Audit Objective

The Rebate Review provides confirmation that ESI has reimbursed 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 PEBP's contract with ESI were met. The review assessed whether there were any differences between the rebates contractually agreed upon between PEBP and ESI and the rebate amounts that were actually paid to PEBP.

Rebate Review Methodology

PillarRx identified each brand claim per distribution channel and calculated the minimum rebate amount owed to 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 FY2022		
Component Description	**Number of Claims**	**Total Minimum Contract Rebate**
Brand 1-83 DS	14,346	$2,797,470.00
Brand 84-90 DS	5,244	$3,067,740.00
Specialty Accredo	3,274	$4,501,750.00
Specialty	897	$22,425.00
Mail Brand	5,834	$3,412,890.00
TOTAL	**29,595**	**$13,802,890.00**

PillarRx's Rebate Review shows, based on the minimum rebates stipulated within the contract between PEBP and ESI, that ESI exceeded the minimum rebates owed.

ESI Rebate Payments FY 2022		
Allocation Period	**Payment Date**	**Total Amount**
FY22 Q1: 7/1/21-9/30/21	10/28/2021	$4,543,186.83
FY22 Q2: 10/1/21-12/31/21	1/28/2022	$3,266,255.84
FY22 Q3: 1/1/22-3/31/22	4/28/2022	$3,434,141.52
FY22 Q4: 4/1/22-6/30/22	8/28/2022	$8,396,429.01
	TOTAL	**$19,640,013.20**

ESI paid out total rebates of $19,640,013.20 to PEBP. No additional monies are owed to PEBP.

RECOMMENDATION

PillarRx has the following opinion/recommendations based on the FY2022 audit of ESI:

ESI did not meet the member satisfaction survey target for FY2022, therefore, a payment for the penalty is due to PEBP in the amount of $78,559.54. ESI indicated this penalty will be remitted to PEBP post-audit.

APPENDIX – PBM RESPONSE TO DRAFT REPORT

EXPRESS SCRIPTS®

May 9, 2023

Shaidikia DeVaughn
PillarRx Consulting
shaidikia.devaughn@pillarrx.com

RE: State of Nevada Specific Findings DRAFT Report FY 2022

Dear Shaidikia DeVaughn:

Please find enclosed ESI's responses to the pharmacy audit report received on 4/24/2023 that was performed on behalf of Nevada Public Employees Benefit Program for the audit period 7/1/2021 - 6/30/2022. ESI has provided responses as well as excerpts from the PillarRx report to provide context.

If you have any questions after reviewing the enclosed information, please let me know.

Sincerely,

Marcia Corredor
Client Audit Senior Advisor

Confidential Information

RECONCILIATION OF PRICING GUARANTEES

Reconciliation of Pricing Guarantees Findings

The following tables demonstrate our findings relative to pricing guarantees.

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

Discounts FY2022								
Component Description*	Number of Claims	Contracted Discount Rate	Actual Discount Rate	Difference in Rate (Contracted vs Actual)	Contracted Claim Ingredient Cost	Actual Claim Ingredient Cost	Variance Total Overage/ (Shortfall)	
Retail Brand (1-83 DS) STD	15,020	19.50%	21.08%	+1.58%	$7,795,728.81	$7,642,597.37	$153,131.44	>
Retail Brand (84-90 DS) STD	5,512	24.75%	24.75%	0.00%	$7,232,075.71	$7,156,702.28	$75,373.43	>
Retail Generic (1-83 DS)	258,432	84.50%	84.15%	-0.35%	$4,303,917.22	$4,401,167.80	($97,250.58)	<
Retail Generic (84-90 DS)	46,986	87.75%	86.95%	-0.80%	$1,968,732.90	$2,097,145.34	($128,412.44)	<
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Mail Generic	51,014	88.08%	88.09%	+ 0.01%	$2,082,842.80	$2,024,299.40	$58,543.10	>
ESI Specialty	4,260	21.50%	19.59%	- 1.91%	$21,176,101.55	$21,692,261.77	($516,160.22)	<
			TOTAL	**+ 1.47%**	**$52,476,182.50**	**$52,957,260.24**	**($481,078.05)**	**<**

**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.*

The aggregate total for each standard is calculated separately (retail, mail, and specialty) and then combined to determine the total over or underperformance.

In summary, when aggregating the pricing guarantee discounts with the dispensing fee outcome, ESI's calculated a reconciliation of ($495,962.06). See chart below for breakout.

	PillarRx Combined Discounts and Dispensing Fee Guarantees	ESI Combined Discounts and Dispensing Fee Guarantee Reconciliation
Discounts	($481,078.05)	($495,962.06)
Dispensing Fees	$36,096.38	$39,940.07
FY2022	($481,078.05)	($495,962.06)

ESI Response – Reconciliation of Pricing Guarantees:

ESI calculated a shortfall of $495,962.06, which was paid to the client on 11/15/2022.

BENEFIT PAYMENT ACCURACY REVIEW

Benefit Payment Accuracy Review Findings

Cost share indicates the dollar amount required to be paid by the member when a prescription drug is purchased. A PillarRx cost share audit compares the plan design received from ESI to the plan design received from PEBP. Benefit plan design rules are created to ensure members' claims have been properly adjudicated at the pharmacy.

Member Cost Share

Cost share (copay, deductible, or coinsurance) represented the dollar amount required to be paid by the member when a prescription drug was purchased. Our observations and conclusions relative to cost share application are shown in the following chart.

Member Cost Share (7/1/2021 – 6/30/2022)	
Total Claims	**Cost Share Collected**
463,998	$17,291,807.78

PillarRx submitted 130 claims based on 12 different scenarios to ESI that represented potential exceptions to the copayment requirements for FY2022. ESI's response provided adequate explanation and documentation for each category of exception for each scenario. No further action is required.

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

ESI Response – Benefit Payment Accuracy:

ESI notes 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 Retail Processing Accuracy	99% of all claims paid with NO errors	100% - ESI noted no errors for Retail Claim Financial, and Retail Processing Accuracy. 100% – PillarRx noted no errors for Retail Claim Financial, and Retail Processing Accuracy.	Met Met
Mail Order Claim Financial Accuracy Mail Order Claim Processing Accuracy	99% of all claims paid with NO errors unless subject to intervention.	100% - ESI noted no errors for Mail Order Processing Accuracy. 100% - PillarRx noted no errors for Mail Order Processing Accuracy.	Met Met
Specialty Claim Financial Accuracy Specialty Claim Processing Accuracy	99% of all claims paid with NO errors unless subject to intervention.	100% – PillarRx noted no errors for Specialty Financial Accuracy. 100% – PillarRx noted no errors for Specialty Claim Processing Accuracy.	Met 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% - PillarRx noted no errors for Rebate Amounts Accuracy.	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.	100% - PillarRx noted no errors for Rebate Remittance.	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.	0.7 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.	1.0 business days	Met

Telephone Services			
Customer Service Response Time	Average time to answer all calls should be 30 seconds or less.	8.3 seconds	Met
Abandonment Rate	3% or less calls abandoned.	0.7%	Met
Member Satisfaction			
Member Satisfaction Survey	One random sample member survey completed annually on PEBP specific basis or PEBP specific responses to a book of business survey.	Target- 90% or greater ESI Score- 80% ESI did not meet the target for member satisfaction and has not provided proof of payment to PEBP or has not indicated if a penalty applies.	Not Met

ESI Response – Performance Guarantee Review:
ESI agrees that the Member Satisfaction Survey metric was missed and a penalty is applicable. The State of Nevada Public Employee Benefit Program's (PEBP's) pharmacy plan will provide ESI with a payment request upon completion of the audit which has not yet been received. ESI notes the penalty is based on the admin fees for the year.

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 FY2022		
Component Description	**Number of Claims**	**Total Minimum Contract Rebate**
Brand 1-83 DS	14,346	$2,797,470.00
Brand 84-90 DS	5,244	$3,067,740.00
Specialty Accredo	3,274	$4,501,750.00
Specialty	897	$22,425.00
Mail Brand	5,834	$3,412,890.00
TOTAL	**29,595**	**$13,802,890.00**

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. No further action is required.

ESI Rebate Payments FY 2022		
Allocation Period	**Payment Date**	**Total Amount**
FY22 Q1: 7/1/21-9/30/21	10/28/2021	$4,543,186.83
FY22 Q2: 10/1/21-12/31/21	1/28/2022	$3,266,255.84
FY22 Q3: 1/1/22-3/31/22	4/28/2022	$3,434,141.52
FY22 Q4: 4/1/22-6/30/22	8/28/2022	$8,396,429.01
	TOTAL	**$19,640,013.20**

ESI Response – Rebate Review:
ESI agrees the minimum rebates owed was exceeded and no further action is required.

Express Scripts has completed the research for the findings presented above. The Account Team will work directly with Nevada PEBP and is available to discuss plan benefit set-up directly with Nevada PEBP should any questions remain.

EXPRESS SCRIPTS®

May 16, 2023

Public Employees' Benefits Program
3427 Goni Road, Suite 109
Carson City, NV 89706

Dear Mr. Lindley,

After our last miss on the Member Satisfaction PG we took quite a few steps to try and identify meaningful trends that could be turned over to our Service Delivery Team (*Service Delivery Team offers deep operational knowledge, expertise and execution to deliver a superior member experience*) to work with the call center on an action plan. Some things that were done are as follows:

- We had a dedicated Service Delivery Manager assigned to help us identify and track any PEBP service related complaints and be our liaison into the call center experience
- Based on the results of prior Member Satisfaction Surveys that showed complaints of high wait times, we engaged our Call Center Routing Team to ensure calls were being efficiently directed to available call center teams and that there were no unnecessary long hold times; results showed call wait times between 5-48 seconds.
    - Additional comments included:
        - Coverage of Medications (members don't like going through PA process, mbrs want a better understanding of which meds are covered, access to more covered drugs)
        - How to use the benefits (members want to better understand the PA process, how mail order works, reimbursement for out of pocket expenses/submitting a direct claim)
        - Price of Medication (members want lower prices)
- Account Team did a full review of PEBP specific Client Page to identify any opportunities to make content more user friendly and easily accessible for call center staff.
- We engaged our Quality team for targeted call listening sessions to try and identify trends and areas of common concern; No specific trends were identified as opportunities.
    - Top three drivers of calls were 1) Order Status 2) Refills/Renewals 3) Verify drug coverage
- Account Manager created complaint/escalation tracking reports to identify any ongoing trends.
- Acct Team scheduled ongoing quarterly calls with PEBP staff to discuss any specific member issues and share ongoing customer service reports. These calls continue today.

Based on the most recent survey results, we have re-engaged our Service Delivery Team to re-visit some of these activities to see if any new concerns are identified. We will continue to share those findings as they are known.

Unfortunately, overall survey response rates are typically less than 10%, and are often a contributing factor to the final outcome of the PG.

Should you have any questions regarding this letter, please do not hesitate to contact me.

Respectfully,

Nancy Langeland

Senior Account Executive

10.

10. Discussion and acceptance of Claim Technologies Incorporated audit findings for State of Nevada Public Employees' Benefits Program Plans administered by UMR Benefits for the period of October 1, 2022 – December 31, 2022. (Nik Proper, Operations Officer) **(For Possible Action)**

JOE LOMBARDO
Governor

STATE OF NEVADA
PUBLIC EMPLOYEES' BENEFITS PROGRAM
3427 Goni Rd, Suite 109 | Carson City, Nevada 89706
Telephone 775-684-7000 | 702-486-3100 | 1-800-326-5496
www.pebp.state.nv.us

LAURA RICH
Executive Officer

JACK ROBB
Board Chair

Date: May 25, 2023

Item Number: X

Title: UMR Performance Guarantees Summary

SUMMARY

This report provides the PEBP Board and members of the public with supplemental information regarding CTI's audit of PEBP's Third-Party Administrator, UMR, and the performance guarantees that were not part of the Random Sample Audit results. The tables below illustrate additional penalties being assessed by PEBP for self-reported, unmet performance guarantees not captured in the second quarter audit for fiscal year 2023.

REPORT

Claims Administration

There are a total of nineteen (19) measurement categories of service and performance guarantees related to claims administration. In addition to any exceptions noted in the audited performance guarantees, there were six guarantees reported to be "Not Met" with penalties calculated against total fees of $1,292,524.65:

Performance Guarantee	Result	Fees at Risk	Calculated Penalty
1.4 Claim Adjustment Processing Time	NOT MET	1.0%	$12,925.25
1.5 (Customer Service) Telephone Service Factor	NOT MET	1.0%	$12,925.25
1.6 Call Abandonment Rate	NOT MET	1.0%	$12,925.25
1.7 First Call Resolution Rate	NOT MET	2.0%	$25,850.49
1.8 Open Inquiry Closure (98.00% within 5 Business Days)	NOT MET	1.0%	$12,925.25
1.9 CSR Audit	NOT MET	1.0%	$12,925.25
Total		**7.0%**	**$90,476.73**

Network Administration

There are a total of six (6) measurement categories of service and performance guarantees related to network administration. There was one (1) guarantee reported to be "Not Met" with penalties calculated against total fees of $664,856.00:

Performance Guarantee	Result	Fees at Risk	Calculated Penalty
2.1 EDI Claims Repricing Turnaround Time	NOT MET	2.0%	$13,297.12
Total			**$13,297.12**

Utilization Management and Case Management

There are a total of thirteen (13) measurement categories of service and performance guarantees related to Utilization Management and Case Management. There was one (1) guarantee reported to be "Not Met" with penalties calculated as the number of unreported high-cost claims (8 claims) against fees of $1,000.00 per occurrence:

Performance Guarantee	Result	Fees at Risk	Calculated Penalty
3.2 Notification of high-cost claims (per occurrence)	NOT MET	$1,000 per occurrence	$8,000.00
Total			**$8,000.00**

Summary

This is a brief summary of the performance guarantees where the measurements were determined to be "Not Met:"

Performance Guarantee	Calculated Penalty
1. Claims Administration	$90,476.73
2. Network Administration	$13,297.12
3. Utilization Management and Case Management	$8,000.00
Total	**$111,773.85**

The penalties, totaling $111,773.85, are administratively and automatically assessed by PEBP to the vendor. In conjunction with the audited penalties totaling $45,238.37, the calculated penalties for the period ending 12/31/2022 total **$157,012.22.**

DRAFT 05/15/2023

Comprehensive Claim Administration Audit

QUARTERLY FINDINGS REPORT

State of Nevada Public Employees Benefit Plan

Administered by UMR Insurance Company

Audit Period: October 1, 2022 – December 31, 2022
Audit Number 1.FY23.Q2

Presented to

State of Nevada Public Employees Benefit Plan

May 25, 2023

CLAIM TECHNOLOGIES INCORPORATED

TABLE OF CONTENTS

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 UMR Insurance Company's (UMR's) administration of the State of Nevada Public Employees Benefit Plan (PEBP) medical and dental plans.

Scope

CTI performed an audit for the period of October 1, 2022 though December 31, 2022 (quarter 2 (Q2) for Fiscal Year (FY) 2023). The population of claims and amount paid during the audit period reported by UMR:

Medical and Dental	
Total Paid Amount	$49,649,252
Total Number of Claims Paid/Denied/Adjusted	187,175

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

- Quarterly Performance Guarantees Validation
- 100% Electronic Screening with Targeted Samples
- Random Sample Audit
- Data Analytics

Auditor's Opinion

Based on these findings, and in CTI's opinion:

1. UMR's Financial Accuracy, Overall Accuracy and Claim Turnaround Time did not meet the service objective and a penalty is owed (breakdown in summary below).
2. CTI recommends UMR should:
   - Review the financial errors identified in the random sample audit and determine if system changes or claim processor training could help reduce or eliminate errors of a similar nature in the future. Specific focus should be directed towards the identification of duplicate payments.
   - Review the 100% Electronic Screening with Targeted Sample results and focus on the most material findings.
   - Where appropriate, verify claim processor coaching, feedback, and retraining has occurred because most errors were manually processed.

Summary of UMR's Guarantee Measurements

Based on CTI's Random Sample Audit results, UMR did not meet the claims processing measurements for PEBP in Q2 FY2023 and a penalty is owed. Reported administrative fees for the quarter totaled $1,292,524.65.

Quarterly Metric	Guarantee	Met/Not Met	Penalty	Calculated Penalty
Financial Accuracy (p.16)	99.4%	Not Met – 97.95%	1.5%	$19,387.87
Overall Accuracy (p.17)	98%	Not Met – 97.0%	1%	$12,925.25
Turnaround Time	92% in 14 Days	Met – 92.9%	0%	$0
	99% in 30 Days	Not Met – 97.5%	1%	$12,925.25
		Total Penalty	3.5%	$45,238.37

AUDIT OBJECTIVES

This report contains CTI's findings from the audit of UMR Insurance Company's (UMR) administration of the State of Nevada Public Employees Benefit Plan (PEBP) plans. We provide this report to PEBP, the plan sponsor, and UMR, the claim administrator. A copy of UMR'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 the audit findings on the data and information provided by PEBP and UMR. The validity of those 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 UMR 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 UMR used to pay PEBP's claims during the audit period. While performing the audit, CTI complied with 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 UMR's claim administration were to determine whether:

- UMR followed the terms of its contract with PEBP;
- UMR 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 UMR was incurred.

QUARTERLY PERFORMANCE GUARANTEE VALIDATION

As part of CTI's quarterly audit of PEBP, we reviewed the Performance Guarantees included in its contract and reports provided by UMR. The self-reported results for Q2 FY2023 are in the table below.

	Metric	Service Objective	Actual	Met/ Not Met
CLAIMS ADMINISTRATION – SERVICES AND PERFORMANCE GUARANTEES				
1.4	**Claim Adjustment Processing Time:** measured from the time a prior claim submission requiring an adjustment is identified through the date the claim adjustment is processed by service facility personnel.	95.00% 7 Calendar/ 5 Business Days	86.4%	Not Met
1.5	**Telephone Service Factor:** Defined as the percentage of the Client telephone inquiries answered by facility Customer Service Representatives (CSRs) within 30 seconds. Measured from the time the caller completes the prompts of the automated telephone system to the time the caller reaches a CSR.	85.00% Calls answered within 30 seconds	70.2%	Not Met
1.6	**Call Abandonment Rate:** total number of participant and provider calls abandoned, divided by the total number of calls received by the facility's customer service telephone system.	3.00%	5.7%	Not Met
1.7	**First Call Resolution Rate:** the percentage of telephone inquiries completely resolved within a 'window period' of time. A call is considered 'resolved' when the same participant or a family member under the same subscriber ID has not contacted the administrator's customer service facility again regarding the same issue within 60 calendar days of the initial call.	95.00%	94.8%	Not Met
1.8	**Open Inquiry Closure:** addresses the time taken in hours and/or days by CSRs at the administrator's service facility to close open inquiries placed by participants of PEBP to the facility.	90.00% 48 Hours 98.00% 5 Business Days	94.9% 96.4%	Met Not Met
1.9	**CSR Audit, or Quality Scores:** determined by the process used to evaluate the effectiveness and accuracy of participant telephone call handling at the administrator's customer service facility.	97.00%	95.2%	Not Met
1.10	**CSR Callback Performance:** measured from the CSR commitment data in hours and/or days to the time the actual callback was placed to the participant.	90.00% Within 24 Hours	Unable to Report*	Unable to Report*
1.11	**Participant Email Response Performance:** measured from the time an email is received by the administrator's response team to the time in hours or days to the time the actual email response is sent to the participant.	90.00% Within 8 Hours 95.00% Within 24 Hours	100% 100%	Met Met
1.12	**Member Satisfaction:** At least 95%-member satisfaction with the services. Measured as the number of satisfied to highly satisfied survey ratings divided by the total number of survey responses. Survey tool and survey methodology to be mutually agreed upon by Offeror and PEBP.	95.0%	NA	Reported Annually
1.13	**Account Management – Plan will guarantee that the services provided by the TPA's team during the guarantee period will be satisfactory to PEBP. Areas of satisfaction will include:**			
	Knowledge/Capabilities – Account representative demonstrates competence in getting issues and problems resolved.	Agree	NA	Met
	Responsiveness – All calls returned within at most 24 hours; along with an alternate person identified who can assist with service issues when account representative is unavailable.			

	Metric	Service Objective	Actual	Met/ Not Met
	Ability to meet deadlines – Supplying all requested materials accurately and in a timely manner, along with all necessary documentation (i.e., enrollment kits, rate confirmations, plan performance work plans, group contracts, ZIP code file, etc.).			
	Professionalism – Demonstrates objectivity and empathy with customer problems.			
	Flexibility – Ability to meet client-specific needs.			
	Participation in periodic meetings – Attendance at all required client meetings or conference calls.			
	Guarantee measured with staff responses to internal questionnaire. A scale from 1 to 5 will be used to measure performance, where 1 means 'very dissatisfied' and 5 means 'very satisfied'; and 2 through 4 are defined, respectively.			
	Periodic program reports will be provided and presented with recommended actions. Standard program reports, within 30 days to quarter-end. Year-end activity report, within 45 days of program year end.			
	Open Enrollment Support: Accurate materials will be provided at least 60 days prior to the open enrollment period starting on April 1 each year. Representative will be available, if requested, for up to 5 employee benefit fairs.			
	Service Objective (out of a score of 5 on internal questionnaire):	350		
1.14	**Eligibility Processing:** Confirm daily and weekly eligibility and enrollment within specified business days of the receipt of the eligibility information, given that information is complete and accurate.	98.00% 2 Business Days	100.00%	Met
1.15	**Data Reporting:** Offeror will provide PEBP with 100% of the applicable reports (within 10 business days for standard reports and within 10 business days of Plan year-end for Annual Reports and Regulatory documents).	100% 10 Business Days	NA	PEBP Waived 10-day requirement
1.17	**ID Card Production and Distribution**	100% 10 Business Days	100%	Met
1.18	**Disclosure of Subcontractors:** Offeror will provide the identity of the subcontractors who have access to PEBP member PHI. Provide identity of subcontractors who have access to PHI within 30 calendar days of the subcontractors' gaining access.	100% 30 Calendar Days	100%	Met
1.19	**PHI:** Offeror will store PEBP member PHI data on designated servers. Must remove PEBP member PHI within 3 business days after offeror knows or should have known using commercially reasonable efforts that such PHI is not store on a designated server.	100% 30 Business Days	100%	Met
NETWORK ADMINISTRATION – SERVICES AND PERFORMANCE GUARANTEES				
2.1	**EDI Claims Re-Pricing Turnaround Time:** At least 97% of medical claims covered under the PEBP Medical PPO Network must be electronically re-priced within business 3 days and 99% within business 5 days.	97.00% 3 Business Days 99.00% 5 Business Days	90% 98%	Not Met Not Met
2.2	**EDI Claims Re-Pricing Accuracy:** At least 97% of claims re-priced by the PPO Network must be accurate and must not cause a claim adjustment by PEBP's TPA.	97.00%	98.9%	Met
2.3	**Data Reporting – Standard Reports (Quarterly reporting to include Service Performance Standards, Guarantee, Method of Measurement, Actual Performance Results, and Pass/Fail indicator.)** Standard reports must be delivered within business 10 days of end of reporting period or event as determined by PEBP.	100% 10 Business Days	NA	PEBP Waived 10-day requirement
2.4	**Subcontractor Disclosure:** 100% of all subcontractors used by vendor are disclosed prior to any work done on behalf of PEBP. Business Associate Agreements completed by all subcontractors.	100%	NA	Reported Annually
2.5	**Provider Directory:** Best efforts to resolve 100% of complaints within 10 business days. Provider Directory issue resolution log maintained by Vendor and periodically reviewed with PEBP.	100% 10 Business Days	100%	Met

	Metric	Service Objective	Actual	Met/ Not Met
2.6	**Website:** A website hosting a reasonably accurate and updated Provider directory must be available and accessible on all major browsers 99% of time.	99.00%	100%	Met
UTILIZATION MANAGEMENT/CASE MANAGEMENT – SERVICES AND PERFORMANCE GUARANTEES				
3.1	**Data Reporting – Standard Reports (Quarterly reporting to include Service Performance Standards, Guarantee, Method of Measurement, Actual Performance Results, and Pass/Fail indicator.)** Standard reports must be delivered within calendar 10 days of end of reporting period or event as determined by PEBP.	100% 10 Calendar Days	100%	Met
3.2	**Notification of potential high expense cases. High expense case is defined as a single claim or treatment plan expected to exceed $100,000.00.** Designated PEBP staff will be notified within 5 business days of the UM/CM vendors initial notification of the requested Service.	100% 5 Business Days	87%	Not Met
3.3	**Pre-Certification Requests:** Precertification requests from healthcare providers shall be completed in accordance with URAC/NCQA standards and turn-around timeframes; 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.	98.00% 5 Business Days	NA	Reported Annually
3.4	**Concurrent Hospital Reviews:** 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.	98.00% 2 Business Days	NA	Reported Annually
3.5	**Retrospective Hospital Reviews:** 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.	98.00% 5 Business Days	NA	Reported Annually
3.8	**Hospital Discharge Planning:** 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.	95.00% 3 Business Days	NA	Reported Annually
3.9	**Large Case Management:** CM will identify and initiate case management for chronic disease, high dollar claims, and ER usage.	95.00%	NA	Reported Annually
3.10	**Utilization Management for Medical Necessity and Center of Excellence Usage:** 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.	98.00%	NA	Reported Annually
3.11	**Return On Investment (ROI) Guarantee – Utilization Management/Case Management:** 2:1 Savings to Fees for Utilization Management/Case Management.	100%	NA	Reported Annually
3.12	**Disclosure of Subcontractors:** 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.	100% 60 Calendar Days	NA	Reported Annually

	Metric	Service Objective	Actual	Met/ Not Met
3.13	**Unauthorized Transfer of PEBP Data:** 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 calendar days prior to the changes being implemented. Implementation will not be in effect until PEBP has provided written authorization.	100% 60 Calendar Days	NA	Reported Annually

**Note for 1.10 from UMR Leadership: "The CSR Callback performance guarantee is not something UMR has tracked or reported on previously. We found through the development and verification of the callback report that how we are entering and tracking the results will not work for properly reporting on the performance guarantee. UMR is in the process of implementing a new policy in recording callback data so that it can be properly reported as a performance guarantee going forward. We will be able to supply callback performance guarantee results starting with 1/1/2023 calls going forward."*

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 UMR 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 UMR during the audit period for both medical and dental claims. The accuracy and completeness of UMR's data directly impacted the screening categories we completed and the integrity of the 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
- Patient cost share
- Fraud, waste, and abuse
- Timely filing
- Coordination of benefits
- Large claim review
- Case and disease management
- Specific reinsurance reimbursement

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 UMR, we readjudicated each line on every claim the plan paid or denied during the audit period against the plan's benefits. CTI's Technical Lead Auditor tested a targeted sample of claims to provide insight into UMR's claim administration as well as operational policies and procedures. We followed these procedures to complete CTI's ESAS process:

- ***Electronic Screening Parameters Set*** – We used PEBP's plan document provisions to set the parameters in ESAS.
- ***Data Conversion*** – We converted and validated PEBP's 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, CTI's auditors analyzed the findings to confirm results were valid. Note: 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. This quarter's targeted sample was expanded to 150 from the normal 50 samples at the request of PEBP. We selected 150 cases and sent UMR a questionnaire for each.

Targeted samples verified if the claim data supported CTI's finding and if CTI's understanding of plan provisions matched UMR'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 CTI's ESAS results. It should be noted that dollar amounts associated with the results represent potential payment errors and process improvement opportunities. To substantiate the findings, CTI would have to perform additional testing to provide the basis for remedial action planning or reimbursement.

Categories for Process Improvement

The following summary shows, by category, the number of line items or claimants with process improvement opportunities remaining after CTI's analysis and removal of verified false positives. A CTI auditor reviewed UMR's responses and supporting documentation. The administrator responses shown in the ESAS Detail Findings Report on the following page were copied directly from UMR's reply to audit findings. **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 PEPB can discuss how to reduce errors and re-work in the future with UMR.**

Categories for Potential Amount at Risk				
Client: PEBP **Screening Period:** Q2 FY2023				
Category	**Number of Line Items**	**Number of Claimants**	**Billed Charge**	**Allowed Amount***
Duplicate Payments				
Providers and/or Employees	254	75	$142,802	$55,209
Exclusions				
Marriage Counseling	2,939	747	$539,120	$294,290
Limitations				
Hearing Aids - $1,500 Per Aid Per Aid 36 Months	27	13	$55,638	$43,928
Fraud, Waste, and Abuse				
Specialty Medications – Non-Hospital	322	134	$689,944	$427,439
Large Payments to Subscribers	74,034	23,536	$12,534,507	$8,816,302
Durable Medical Equipment (DME) Over Medicare Allowance	46	32	$7,639	$3,783
Copay Application				
Diagnostic Mammography	52	13	$39,316	$11,846
Preventive Services				
Preventive Services Denied	1,909	921	$264,308	$0
PPO Provider Without Discount	16,672	6,626	$3,650,459	$3,650,459
End Stage Renal Disease	578	10	$1,727,035	$257,035

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

Electronic screening of every service line 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 UMR for written response. After review of the response and any additional information provided, CTI confirmed the potential for process improvement.

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

The detailed report is longer than normal due to the expanded sample.

ESAS Findings Detail Report				
QID	**Under/ Over Paid**	**UMR Response**	**CTI Conclusion**	**Manual or System**
Duplicate Payments				
25	$36.00	Agree.	Procedural deficiency and overpayments identified for duplicate claim payments. Note that any $0.00 Under/Over Paid amounts indicates an incorrect deductible accumulation occurred.	☒ M ☐ S
26	$58.45			☒ M ☐ S
27	$11.72			☒ M ☐ S
28	$193.70			☒ M ☐ S
30	$104.48			☒ M ☐ S
70	$37.50			☒ M ☐ S
71	$85.00			☐ M ☒ S
72	$214.20			☐ M ☒ S
73	$163.50			☐ M ☒ S
75	$0.00			☒ M ☐ S
76	$0.00			☒ M ☐ S
77	$0.00			☒ M ☐ S
78	$315.20			☐ M ☒ S
79	$111.20			☐ M ☒ S
80	$33.60			☐ M ☒ S
81	$21.00			☐ M ☒ S
83	$180.80			☐ M ☒ S
84	$39.00			☐ M ☒ S
85	$77.00			☐ M ☒ S
86	$682.00			☐ M ☒ S
89	$66.00			☒ M ☐ S
90	$72.00			☐ M ☒ S
93	$38.24			☒ M ☐ S
94	$1,237.46			☒ M ☐ S
95	$31.20			☐ M ☒ S
97	$90.00			☐ M ☒ S
98	$22.32			☒ M ☐ S
102	$908.80			☐ M ☒ S
104	$74.00			☐ M ☒ S
105	$61.00			☒ M ☐ S
106	$88.00			☒ M ☐ S

ESAS Findings Detail Report				
QID	**Under/ Over Paid**	**UMR Response**	**CTI Conclusion**	**Manual or System**
107	$19.10			☒ M ☐ S
108	$37.96			☒ M ☐ S
109	$506.40			☐ M ☒ S
110	$200.80			☐ M ☒ S
111	$24.87			☒ M ☐ S
112	$200.80			☒ M ☐ S
113	$107.20			☐ M ☒ S
114	$22.40			☐ M ☒ S
116	$0.00			☒ M ☐ S
117	$1,275.43			☐ M ☒ S
118	$77.00			☐ M ☒ S
119	$132.80			☐ M ☒ S
121	$0.00			☒ M ☐ S
122	$28.00			☒ M ☐ S
123	$0.00			☐ M ☒ S
124	$50.00			☐ M ☒ S
125	$90.00			☐ M ☒ S
126	$90.00			☐ M ☒ S
127	$16.00			☐ M ☒ S
128	$0.00			☐ M ☒ S
129	$43.00			☐ M ☒ S
130	$13.00			☐ M ☒ S
131	$74.00			☐ M ☒ S
132	$46.00			☐ M ☒ S
74	$5.99	Disagree. Claims xxxxxx4507 and xxxxxx4521 are not duplicate claims. The claims were submitted by different referring physicians and with different diagnosis codes.	Procedural deficiency and overpayment of $5.99 identified. There was one preventive visit from Dr. Gxxxx for 10/13/22. There were no visits billed by Dr. Kxxxxx in the first or second quarter data. Verification was not provided documenting these two providers ordered the same comprehensive metabolic panel for this member on the same day.	☒ M ☐ S
96	$4.40	Disagree. The claims are not duplicate, different diagnosis codes, and different referring physicians were billed.	Procedural deficiency and overpayment of $4.40 identified. There was a visit from Dr. Kxxx for 10/7/22. There were no visits billed by Mxx Bxxxx in the first or second quarter data. Verification was not provided documenting these two providers ordered the same glycated hemoglobin test for this member on the same day.	☒ M ☐ S
115	$208.60	Disagree. The member was seen in the ER for services on 11-3-2022. Sample claim xxxxxx67456 is the physicians claim and claim	Procedural deficiency and overpayment of $208.60 identified. Duplicate claims are from Dr. Sxxxx Wxxxx (claim numbers	☐ M ☒ S

ESAS Findings Detail Report				
QID	**Under/ Over Paid**	**UMR Response**	**CTI Conclusion**	**Manual or System**
		xxxxxx12977 from Renown Regional is the ER claim.	xxxxxx4265 and xxxxxx7456) the same laceration repair, procedure code 12015; place of service emerg room and outpt hosp. The member history documents an emergency room charge for this procedure only; there was no additional outpatient hospital visit for a laceration repair on this date of service.	
Plan Exclusions				
Marriage Counseling				
50	$40.00	Agree. The claim is Pended and reviewed based on Procedure and Diagnosis selections are coded in the UMR system to identify these claims. Marriage Counseling is excluded on this plan. Coding in the UMR system has been updated to deny all future claims billed with this type of diagnosis. This claim will be adjusted to deny, and an overpayment request will be sent to the provider. This results in a $40.00 overpayment. UMR will run impact report to adjust/review any claims related to Marriage Counseling.	Procedural deficiency and overpayment of $40.00 identified. Per page 94 of the plan document, marriage counseling was not covered by the plan.	☒ M ☐ S
Limitations				
Hearing Aids $1,500 Per Aid Per Ear Every 36 Months				
150	$3,000.00	Agree. Claim xxxxxx02248 is a duplicate to xxxxxx31247. xxxxxx02248 has been adjusted and an overpayment of $3,000.00 has been requested.	Procedural deficiency and overpayment of $3,000.00 identified. Duplicate payments were made, and the hearing aid limitation was exceeded.	☒ M ☐ S
Potential Fraud, Waste, and Abuse				
Specialty Medications				
35	$20,635.99	Agree. An incorrect allowance was provided on this claim from the Network team. Additional coaching has taken place and an additional quality review has been initiated. The allowable for code J0878 is $374.00. This results in a $20,635.99 overpayment. Claim xxxxxx37760 was adjusted on 3/29/2023.	Procedural deficiency and overpayment cited. The incorrect allowance for J0878 resulted in a $20,635.99 overpayment.	☒ M ☐ S
Large Payments to Subscribers				
36	$1,207.60	Agree. The CFR released payment to the member in error. Claim xxxxxx30978 was processed on 1/29/2023 and on 1/30/2023 was adjusted to issue payment to the provider. The overpayment was received on 3/30/2023.	Procedural deficiency and overpayment of $1,207.60 identified. Payment was issued to the member in error. Refund of overpayment received 3/30/23.	☒ M ☐ S
Durable Medical Equipment Over Medicare Allowance				
33	$329.20	Agree. Benefits are determined based on the billed services and the provider's contract for DME. Claims are reviewed based on services billed. Procedure and Diagnosis selections are	Procedural deficiency and overpayment of $329.20 identified. The incorrected allowed amount was paid for DME.	☒ M ☐ S

ESAS Findings Detail Report				
QID	**Under/ Over Paid**	**UMR Response**	**CTI Conclusion**	**Manual or System**
		coded in the UMR system to identify these claims. The CFR did not enter the correct allowed amount, based on provider contract. This claim was adjusted on 2/7/2023 and results in a $329.20 overpayment.		
Incorrect Copayment				
Diagnostic Mammogram				
16	($88.40)	Agree. The CFR did not apply the $40.00 outpatient diagnostic mammogram copay, then 100%. Additional coaching has taken place with the CFR. This results in a $88.40 underpayment. Claim was adjusted on 4/19/2023.	Procedural deficiency and underpayment of $88.40 identified. Per page 40 of the EPO plan document, diagnostic mammograms should have had a $40.00 copay applied then paid at 100%. The deductible was over accumulated by $100.00 and coinsurance by $28.40.	☒ M ☐ S
54	($97.19)	Agree. 77066 did not take a copay originally. The claim was adjusted on 2/9/2023 to add the copay per plan language. Claim was adjusted to apply a $40.00 copay on 2/9/2023.	Procedural deficiency and underpayment of $97.19 identified. The diagnostic mammogram should have had a $40.00 copay applied then 100%. The claim was corrected on 2/9/23.	☒ M ☐ S
Preventive Services				
Preventive Services Denied				
9	($440.00)	Disagree. This claim is for genetic testing. Only certain codes are preventive and S0265 is not. Authorization from the UM Vendor does not exist for code S0265. This claim denied correctly.	Procedural deficiency and underpayment of $440.00 identified. Services are for BRCA genetic counseling for member with family history of breast cancer and are payable under preventive benefits per page 58 of the plan document; and are under the recommended preventive benefits of USPSTF.	☒ M ☐ S
PPO Provider Without Discount				
69	$2,642.08	Agree. This provider participates with SHO. The claim was not routed to manual repricing. The claim was adjusted on 2/15/2023 to apply the repricing for this claim.	Procedural deficiency and overpayment of $2,642.08 identified. The provider discount was not applied to the claim. The claim was corrected on 2/15/23.	☒ M ☐ S
End Stage Renal Disease				
21	$113.16	Agree. Documentation from HSB. Dialysis started 05/18/18. Patient has Medicaid. UMR would be primary over Medicaid. Per employee dependent had other insurance Anthem as primary and that termed on 08/01/2022. UMR is third 07/01-31/22. Effective 08/01/2022 UMR is primary. Term date was confirmed with Anthem. This was paid in error. Overpaid $113.16- refund received 3/30/2023.	Procedural deficiency and overpayment of $113.16 identified. UMR was not primary until 8/1/22.	☒ M ☐ S

Additional Observations

During the Targeted Sample Analysis, CTI's 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	Sample Number
Charges for psychotherapy to treat attention deficit hyperactivity disorder (ADHD) were paid by UMR. UMR and PEBP should work together to ensure benefits were applied appropriately and in accordance with the plan document.	48, 138, 139, and 140

RANDOM SAMPLE AUDIT

Objectives

The objectives of CTI's 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. UMR's performance was measured using the following key performance indicators:

- Financial Accuracy
- Claims Payment Accuracy
- Claims Processing Accuracy

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

Methodology

CTI's 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. CTI's auditors reviewed each sample claim selected to ensure it conformed to plan specifications, agreements, and negotiated discounts. We recorded the audit findings in CTI's 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 UMR 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 PEBB can discuss how to reduce errors and re-work in the future with UMR.**

CTI communicated with UMR in writing about any errors or observations using system-generated response forms. We sent UMR a preliminary report for its review and written response. We considered UMR's written response, as found in the Appendix, when producing the final reports. Note that the administrator responses have been copied directly from UMR'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 total paid in the 200-claim audit sample was $485,409.00. The claims sampled and reviewed revealed $1,152.61 in underpayments and $7,204.22 in overpayments, for an absolute value variance of $8,356.83. This reflects a weighted Financial Accuracy rate of 97.95% over the stratified sample. This is a decline in performance from the prior period. Detail is provided in the following Random Sample Findings Detail Report.

UMR did not meet the Performance Guarantee for PEBP in Q2 FY2023 of 99.4% for this measure. The penalty owed is 1.5% of the administrative fees of $1,292,524.65 or $19,387.87.

Claims Payment Accuracy

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

The audit sample revealed 6 incorrectly paid claims and 194 correctly paid claims. This is an improvement from the prior period. Detail is provided in the table below, Random Sample Findings Detail Report.

Total Claims	Incorrectly Paid Claims		Accuracy
	Underpaid Claims	Overpaid Claims	
200	3	3	97.0%

Overall Accuracy

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

Although performance improved from the prior period, UMR did not meet the Performance Guarantee for PEBP in Q2 FY2023 of 98% for this measure. The penalty owed is 1.0% of the administrative fees of $1,292,524.65 or $12,925.25. Detail is provided in the table below, Random Sample Findings Detail Report.

Correctly Processed Claims	Incorrectly Processed Claims		Accuracy
	System	Manual	
194	0	6	97.0%

Random Sample Findings Detail Report				
Audit No.	**Under/ Over Paid**	**UMR Response**	**CTI Conclusion**	**Manual or System**
Denied Eligible Expense				
1060	($65.00)	Agree. There is a benefit on this claim for speech therapy. This claim will be adjusted and results in a $65.00 underpayment.	Adjudication error and underpayment of $65.00 identified for denial of eligible speech therapy charge.	☒ M ☐ S
1129	($673.61)	Agree. This claim denied based on the primary diagnosis billed which is not a valid diagnosis for the treatment. UMRs processing system flagged this claim to deny appropriately. There is other diagnosis on the claim in the 2nd, 3rd and 4th positions that would have allowed the service to be paid per the plan benefits. This claim will be adjusted to allow based on the other diagnosis on the claim. Claim xxxxxx60355 was adjusted 4/10/2023.	Adjudication error and underpayment of $673.61 identified. Eligible expenses for continued hospital care services were denied on this claim. There is an approved precertification on file for this inpatient stay and it should have been covered by the plan based on plan document page 35. Claim was corrected on 4/10/23.	☒ M ☐ S
PPO Discount				
1039	$5,783.09	Agree. The SHO allowed amount should be $1080. This results in a $5783.09 overpayment. Refund received 4/6/2023.	Adjudication error and overpayment of $5,783.09 identified. The discount amount was processed on the claim as $45,435.12 and it should have been $52,664.00.	☐ M ☐ S
1103	$1,366.99	Agree. This is a SHO contracted provider. UMR processed the claim with SHO pricing	Adjudication error and overpayment of $1,366.99 identified. The discount	☒ M ☐ S

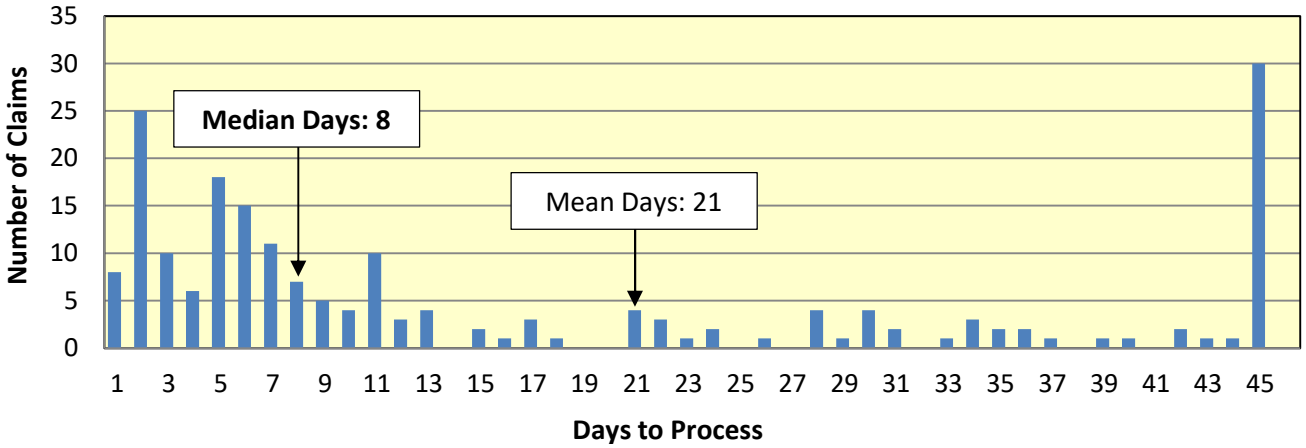
Random Sample Findings Detail Report				
Audit No.	**Under/ Over Paid**	**UMR Response**	**CTI Conclusion**	**Manual or System**
		however code 70450 rev 350 was allowed at a percentage and should be at the per visit rate of $698.00. This results in a $1366.99 overpayment. Refund received 4/6/2023.	applied for revenue code 350 should have been $5,735.00.	
Copayment Calculation				
1134	($414.00)	Agree. A $30.00 copay should apply to each service. This results in a $414.00 underpayment. UMR will adjust this claim accordingly.	An adjudication error and underpayment of $414.00 identified. The copay should have been $30.00 per visit, and it was $0.00, with coinsurance applied. The plan states on page 40, a $30.00 copay per visit for applied behavioral therapy for the treatment of autism disorders from an in-network provider.	☒ M ☐ S
Duplicate Payment				
1114	$54.14	Agree. This is duplicate payment. The provider added a modifier to procedure code 90460 and rebilled. This change would not affect the payment. This results in a $54.14 overpayment on claim xxxxx1565. Refund received 4/3/2023.	Adjudication error and overpayment of $54.14 identified. A duplicate expense was paid.	☒ 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 a few claims with extended turnaround time from distorting the true performance picture.

Median and Mean Claim Turnaround



UMR met the Performance Guarantee for PEBP in Q2 FY2023 of 92% processed within 14 days. This is an improvement from the prior period. UMR did not meet the Performance Guarantee of 99% processed

within 30 days for this measure. The penalty owed for this Performance Guarantee is 1.0% of the administrative fees of $1,292,524.65 or $12,925.25.

Additional Observations

During the Random Sample Audit, CTI's 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
Out-of-sample duplicate claim payments were identified for the sampled claims resulting in overpayments of $100.00 and $690.30, respectively.	1015 and 1059

DATA ANALYTICS

Medical Findings

This component of the audit used PEBP's 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 that calculating discounts in a consistent manner across CTI's book of business will allow for more meaningful comparisons to be made.

Scope

CTI compared submitted charges to allowable charges for 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

We were unable to calculate provider discounts for PEBP because UMR did not provide the data in their electronic claim data file.

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 other federal health care programs.

Scope

CTI received and converted an electronic data file containing every PEBP claim processed by UMR during the audit period. The claims screened included medical (not including prescription drug) and dental claims paid or denied during the audit period. Through electronic screening, we identified every 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 provider as sanctioned. CTI's screening indicated the following provider 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	SHELBY,JAMES,S,DDS	1	$157	$157	$157
				Totals	**1**	**$157**	**$157**	**$157**

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 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. CTI's review analyzed in-network preventive care services to determine if UMR paid services in compliance with PPACA guidelines.

Scope

CTI's review included each in-network service 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%. CTI's 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.

CTI's 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.

Report

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 99.67% of the procedure codes identified as preventive services were paid by UMR at 100% when provided in-network. The following report provides an outline for discussion between PEBP and UMR.

Preventive Care Services Compliance Review												
		Claim Lines Submitted	Denied	Applied Deductible		Applied Copay		Applied Coinsurance		Paid @100%		
Edit Guideline	Preventive Service Benefit	#	#	#	Amount	#	Amount	#	Amount	#	Amount	%
HHS	Breastfeeding support and counseling - women	73	20	5	$1,102	3	$150	0	$0	43	$3,707	81.13%
USPSTF-A,B	Cholesterol abnormalities screening - women >19	701	54	26	$429	0	$0	27	$85	594	$8,112	91.81%
USPSTF-A	Cholesterol abnormalities screening - men 35-75	631	75	12	$179	0	$0	10	$27	533	$6,939	95.86%
USPSTF-B	Breast cancer mammography screening - >39	3,735	35	0	$0	0	$0	0	$0	3,699	$348,924	99.97%

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).

CTI's claim system code editing analysis identified services submitted to the plan and paid by UMR that Medicare and Medicaid would have denied. **Since UMR 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 UMR 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 every payer.

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. CTI's reports are grouped by outpatient hospital services and non-facility claims using CMS' quarterly updated data. If UMR is not currently using these CMS edits, CTI's reports will help PEBP evaluate the savings it would have realized had the PTP Edits been in place.

Outpatient Hospital Services (facility claims with codes not designated inpatient)								
Primary		Secondary			Primary Description	Secondary Description	Line	Amount
Code	Mod	Code	Mod	Mod Use			Count	CMS Would
74177	TC	96374		YES	CT ABD & PELV W/CONTRAST	THER/PROPH/DIAG INJ IV PUSH	11	$6,690
					Standards of medical / surgical practice			
99213		99212		YES	Office/outpatient visit for E&M of estab patient, 2	Office/outpatient visit for E&M of estab pat	89	$5,788
					Misuse of column two code with column one code			
71275	TC	96374		YES	CT ANGIOGRAPHY CHEST	THER/PROPH/DIAG INJ IV PUSH	6	$4,568
					Standards of medical / surgical practice			
92526	GN	97530	GP	YES	ORAL FUNCTION THERAPY	THERAPEUTIC ACTIVITIES	6	$4,500
					Misuse of column two code with column one code			
70496		70450		YES	CT ANGIOGRAPHY HEAD	CT HEAD/BRAIN W/O DYE	1	$2,847
					Misuse of column two code with column one code			
92526	GN	97110	GP	YES	ORAL FUNCTION THERAPY	THERAPEUTIC EXERCISES	5	$2,256
					Misuse of column two code with column one code			
88173	TC	88333	TC	YES	CYTOPATH EVAL FNA REPORT	INTRAOP CYTO PATH CONSULT 1	2	$1,824
					CPT Manual or CMS manual coding instructions			
96374		96372		YES	THER/PROPH/DIAG INJ IV PUSH	THER/PROPH/DIAG INJ SC/IM	5	$1,738
					CPT Manual or CMS manual coding instructions			
70551	TC	70544	TC	YES	Mri brain stem w/o dye	MR ANGIOGRAPHY HEAD W/O DYE	1	$1,586
					Misuse of column two code with column one code			
90471		99283		YES	IMMUNIZATION ADMIN	EMERGENCY DEPT VISIT	1	$1,458
					CPT Manual or CMS manual coding instructions			
						Top 10 TOTAL	**127**	**$33,256**
						GRAND TOTAL	**369**	**$71,057**

Non-Facility (non-facility claims with CPT codes:00100 - 99999)								
Primary		Secondary			Primary Description	Secondary Description	Line	Amount
Code	Mod	Code	Mod	Mod Use			Count	CMS Would
58552	79	44180	51,79,59	NO	LAPARO-VAG HYST INCL T/O	LAP ENTEROLYSIS	1	$698
					CPT "separate procedure" definition			
60650	LT	44180	51	NO	LAPAROSCOPY ADRENALECTOMY	LAP ENTEROLYSIS	1	$698
					CPT "separate procedure" definition			
93975		76700		YES	VASCULAR STUDY	US EXAM ABDOM COMPLETE	2	$658
					Misuse of column two code with column one code			
44626	58	44005	51	NO	REPAIR BOWEL OPENING	FREEING OF BOWEL ADHESION	1	$421
					CPT "separate procedure" definition			
70546		70551		YES	MR ANGIOGRAPH HEAD W/O&W/DYE	Mri brain stem w/o dye	1	$350
					Misuse of column two code with column one code			
99214	25	99354		NO	Office/outpatient visit for E&M of estab patient, 3	Prolonged service(s) in outpt setting requiri	2	$276
					CPT Manual or CMS manual coding instructions			
84481		84480		NO	FREE ASSAY (FT-3)	ASSAY TRIIODOTHYRONINE (T3)	14	$273
					More extensive procedure			
90461		99392	5	YES	IM ADMIN EACH ADDL COMPONENT	PREV VISIT EST AGE 1-4	1	$193
					CPT Manual or CMS manual coding instructions			
84439		84436		NO	ASSAY OF FREE THYROXINE	ASSAY OF TOTAL THYROXINE	19	$179
					More extensive procedure			
90460		99391	5	YES	IM ADMIN 1ST/ONLY COMPONENT	Per pm reeval est pat infant	1	$173
					CPT Manual or CMS manual coding instructions			
						Top 10 TOTAL	**43**	**$3,918**
						GRAND TOTAL	**127**	**$7,199**

Medically Unlikely Edits (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, and ancillary.

Note: UMR's Outpatient Hospital screening had no results.

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**
95165	30	ANTIGEN THERAPY SERVICES	15	$9,831
		Rationale: Clinical: Data		
J0475	8	BACLOFEN 10 MG INJECTION	2	$5,772
		Rationale: Prescribing Information		
88185	35	FLOWCYTOMETRY/TC ADD-ON	5	$5,605
		Rationale: Clinical: Data		
31295	1	Nasal/sinus endoscopy, surgical, w dilation (balloon dila	2	$3,427
		Rationale: CMS Policy		
97151	8	BEHAVIOR ID ASSESSMENT BY PHYS/QHP EA 15 MIN	2	$1,504
		Rationale: Clinical: CMS Workgroup		
97155	24	ADAPT BHV TX PRTCL MODIFICAJ PHYS/QHP EA 15 MIN	2	$1,470
		Rationale: Clinical: Society Comment		
30140	1	RESECT INFERIOR TURBINATE	6	$1,367
		Rationale: CMS Policy		
54512	1	EXCISE LESION TESTIS	1	$1,063
		Rationale: CMS Policy		
31267	1	ENDOSCOPY MAXILLARY SINUS	2	$831
		Rationale: CMS Policy		
97153	32	ADAPTIVE BEHAVIOR TX BY PROTOCOL TECH EA 15 MIN	1	$533
		Rationale: Clinical: Society Comment		
		Top 10 TOTAL	**38**	**$31,403**
		GRAND TOTAL	**83**	**$33,362**

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**
K0553	1	THER CGM SUPPLY ALLOWANCE	3	$2,925
		Rationale: Code Descriptor / CPT Instruction		
A4253	1	BLOOD GLUCOSE/REAGENT STRIPS	8	$842
		Rationale: Nature of Equipment		
E0443	1	PORTABLE 02 CONTENTS, GAS	3	$530
		Rationale: Code Descriptor / CPT Instruction		
V2510	2	CNTCT GAS PERMEABLE SPHERICL	4	$330
		Rationale: Anatomic Consideration		
V2520	2	CONTACT LENS HYDROPHILIC	3	$330
		Rationale: Anatomic Consideration		
A7032	6	REPLACEMENT NASAL CUSHION	2	$259
		Rationale: Published Contractor Policy		
A7520	1	TRACH/LARYN TUBE NON-CUFFED	1	$232
		Rationale: Published Contractor Policy		
A7046	1	REPL WATER CHAMBER, PAP DEV	5	$203
		Rationale: Published Contractor Policy		
A7038	6	POS AIRWAY PRESSURE FILTER	2	$146
		Rationale: Published Contractor Policy		
V2521	2	CNTCT LENS HYDROPHILIC TORIC	1	$110
		Rationale: Anatomic Consideration		
		Top 10 TOTAL	**32**	**$5,907**
		GRAND TOTAL	**39**	**$5,914**

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. CTI's analysis encompasses the three types of procedures with global surgical packages: simple, minor, and major. Each type has specific global periods including simple – one day, minor – ten days, and 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 the findings, we will help PEBP identify strategies to monitor and eliminate unbundling within PEBP's plan.

Audit Period 10/1/2022 - 12/31/2022									
	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 Periods		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
363261413	0	$0	1	100.0%	$2,613	1	$115	6	$2,142
770465765	8	$21,004	2	20.0%	$2,867	2	$747	1	$427
270028866	180	$129,938	61	25.3%	$10,622	49	$6,688	3	$413
455557052	2	$480	3	60.0%	$1,415	1	$172	2	$403
860800150	14	$31,585	3	17.6%	$3,208	1	$113	2	$287
956005449	2	$24	2	50.0%	$57	1	$88	1	$192
203395567	156	$36,182	11	6.6%	$2,827	8	$1,125	1	$190
20566741	32	$20,580	10	23.8%	$1,017	9	$1,414	1	$186
463758279	0	$0	1	100.0%	$263	0	$0	3	$150
880365656	22	$11,006	6	21.4%	$1,831	5	$687	1	$141
Top 10	**416**	**$250,798**	**100**	**19.4%**	**$26,719**	**77**	**$11,148**	**21**	**$4,532**
Overall Total	**5,038**	**$1,648,198**	**1,096**	**17.9%**	**$175,466**	**998**	**$108,195**	**25**	**$4,785**

CONCLUSION

UMR showed improvement in Overall Accuracy, Payment Accuracy, and Claim Turnaround Time from the Quarter 1 FY2023 audit; however, performance in Financial Accuracy declined from the prior period.

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

APPENDIX – ADMINISTRATOR RESPONSE TO DRAFT REPORT

Additional information submitted to CTI from the administrator in response to the draft report is reviewed and observations may be removed prior to the final report being published. While a removed observation will not be included in the final report, it may be referenced in the administrator's response to the draft report.

UMR's response to the draft report follows:

UMR

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

April 19, 2023

Joni,

Thank you for the opportunity to respond to the recent review of the State of Nevada Public Employees' Benefit Program Q2Y23 audit draft report.

Medical - ESAS Targeted Sample Analysis:

Duplicate Payments

QID 98 - UMR agrees with this error. This claim received a system edit for duplicate and the CFR bypassed the edit. Additional coaching has taken place with the CFR. This results in a $22.32 overpayment for on procedure CPT A7038. Claim [redacted] was adjusted on 2-3-2023.

QID 107-108 - UMR agrees with this error. This claim received a system edit for duplicate and the CFR bypassed the edit. Additional coaching has taken place with the CFR. This results in a $57.06 overpayment. Claim [redacted] was adjusted on 3-15-2023. QID 107 is the same claim number as QID 108.

QID 111-112 – UMR agrees with this finding. This claim received a system edit for duplicate and the CFR bypassed the edit. Additional coaching has taken place with the CFR. This results in a $24.87 overpayment on procedure CPT 87491. Claim [redacted] requires an adjustment. QID 111 is the same claim number as QID 112.

QID 25 – UMR disagrees with this finding. The provider of service did not mark this claim as a corrected claim and billed with two different TIN numbers. UMRs duplicate logic would not flag this claim as a duplicate.

QID 26 – UMR agrees with this finding. This claim received a system edit for duplicate and the Customer First Representative (CFR) bypassed the edit. Additional coaching has taken place with the CFR. This results in a $58.45 overpayment. Claim [redacted] was adjusted on 2-6-2023 and the overpayment was received on 3-23-2023.

QID 27 – UMR agrees with this finding. This claim received a system edit for duplicate and the CFR bypassed the edit. Additional coaching has taken place with the CFR. This results in a $11.42 overpayment. Claim [redacted] was adjusted on 2-6-2023 and the overpayment was received on 3-13-2023.

QID 28 – UMR agrees with this finding. Both claims were received on the same day which allowed them to pass through the UMR system with no duplicate edit. The claims were manually processed by a CFR and could have been identified as a duplicate. Additional training has been provided to the CFR. This results in a $193.70 overpayment. Claim [redacted] was adjusted on 2-6-2023.

715-841-7262 Julie.Frahm@UMR.com

QID 30 - UMR agrees with this finding. This claim was manually entered by the CFR. The CFR should have followed processing procedures to verify duplicate. Additional coaching has taken place with the CFR. This results in a $104.48 overpayment. Claim [redacted] was adjusted on 2-6-2023.

QID 74 and 96 – UMR disagrees with these findings. The claims in question were submitted by Lab Corp of American and each claim has different referring physicians and different diagnosis codes.

QID 75- 77 - UMR agrees with this finding. This claim received a system edit for duplicate and the CFR bypassed the edit. Additional coaching has taken place with the CFR. This results in a $314.64 overpayment. Claim [redacted] requires an adjustment. QID75 is the same claim number as QID 76 and QID 77.

QID 86 – UMR agrees with this finding. UMR received corrected claim with Medicare payments. CFR should have checked claim history and adjusted previously processed claim [redacted] as a duplicate. This results in a $682.00 overpayment. Claim [redacted] was adjusted on 3-7-2023.

QID 89 – UMR agrees with this finding. This claim received a system edit for duplicate and the CFR bypassed the edit. Additional coaching has taken place with the CFR. This results in a $66.00 overpayment. Claim [redacted] requires an adjustment.

QID 93-94 – UMR agrees with this finding. This claim received a system edit for duplicate and the CFR bypassed the edit. Additional coaching has taken place with the CFR. This results in a $11.42 overpayment. Claim [redacted] was adjusted on 2-6-2023 and the overpayment was received on 3-13-2023. QID 93 is the same claim number as QID 94.

QID 115 – UMR disagrees with this finding. The member was seen in the ER for services on 11-3-2022. Sample claim [redacted] is the physicians claim and claim [redacted] from Renown Regional is the ER claim.

Exclusions

Marriage Counseling QID 50 – UMR agrees with this finding. Marriage Counseling is excluded on this plan. Coding in the UMR system has been updated to deny all future claims billed with this type of diagnosis. Claim [redacted] was adjusted on 3-31-23. This results in a $40.00 overpayment.

Attention Deficit Hyperactivity Disorder

QID 48,138, 139, and 140 – UMR disagrees with this finding. Per the plan intent, attention deficit disorder is a covered diagnosis when treatment is related to the management of ADD/ADHD diagnosis and medication maintenance only. In addition, 90833 is psychotherapy that includes biofeedback and is allowed per the plan benefit.

Dental, Occlusal Guard

QID 44 – UMR disagrees with this finding. This claim is for the treatment of TMJ. This device was approved through the UM Vendor with auth [redacted].

Limitations

Hearing Aids -QID 150 – UMR agrees with this finding. There is a hearing aid limitation on this plan, and it was exceeded with the processing of this claim. UMR will provide additional coaching to the processing staff and review the procedures for tracking dollar maximums on the plan. This results in a $3000.00 overpayment. Claim [redacted] was adjusted on 2-21-2023.

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Fraud, Waste, Abuse

Specialty Medications QID 35 – UMR agrees with this finding. An incorrect allowance was provided on this claim from the Network team. Additional coaching has taken place and an additional quality review has been initiated. The allowable for code J0878 is $374.00. This results in a $20,635.99 overpayment. Claim [redacted] was adjusted on 3-29-2023.

Large Payments to Subscribers – QID 36 – UMR disagrees with this finding. The CFR released payment to the member in error. Claim [redacted] was processed on 1-29-2023 and on 1-30-2023 was adjusted to issue payment to the provider. The overpayment was received on 3-30-2023.

Durable Medical Equipment Over Medicare Allowance

QID 33 - UMR agrees with this finding. An incorrect allowance was provided on this claim from the Network team. Additional coaching has taken place and an additional quality review has been initiated. This results in a $329.20 overpayment. Claim [redacted] was adjusted on 2-7-2023.

Incorrect Copayment

Diagnostic Mammogram

QID 16 – UMR agrees with this finding. The CFR did not apply the $40.00 outpatient diagnostic mammogram copay, then 100%. Additional coaching has taken place with the CFR. This results in a $88.40 underpayment. Claim [redacted] was adjusted on 4-19-2023.

QID 54 – UMR agrees with this finding. The CFR did not apply the $40.00 diagnostic mammogram copay, then 100%. Additional coaching has taken place with the CFR. This results in a $97.19 underpayment. Claim [redacted] was adjusted on 2-9-2023.

Speech Therapy

QID 17 – UMR disagrees with this finding. Per the plan benefits, a $40.00 copay for therapy applies one copay per day, not per service. This member had two therapy services on the same day. The copay applied to claim [redacted].

Preventive Services

Preventive Services Denied

QID 9 – UMR disagrees with this finding. This claim is for genetic testing. Only certain codes are preventive and S0265 is not. Authorization from the UM Vendor does not exist for code S0265. This claim denied correctly.

PPO Provider without Discount

QID 69 – UMR agrees with this finding. The CFR processed this claim without routing to the pricing team for a discount. Additional coaching has taken place. This results in a $2642.08 overpayment. Claim [redacted] was adjusted on 2-15-2023 and the overpayment was received on 3-23-2023.

End Stage Renal Disease

QID 21 – UMR agrees with this finding. The CFR processed this claim as primary and should have denied the claim for a primary carrier explanation of benefits. This results in a $113.16 overpayment. Claim [redacted] was adjusted on 2-1-2023 and the overpayment was received on 3-30-2023.

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Dental - ESAS Targeted Sample Analysis:

Duplicate Payments

QID 70- UMR disagrees with this finding. The provider of service billed two claims with different billed amounts and was not noted as a corrected claim. The claims did not flag for duplicate for this reason. There is a $37.50 overpayment on claim [redacted].

QID 71-73 – UMR disagree with this finding. This is not a duplicate payment as the provider billed two separate claims with different tax ID numbers. The claim did not flag for duplicate as the provider TINs do not match. The provider will need to submit a corrected claim. QID 71 is the same claim number as QID 73.

QID 72 – UMR agrees with this finding. Code D2150 should not have allowed twice. This results in a $163.20 overpayment. The claim was adjusted on 3-23-2023.

QID 78 UMR disagrees with this finding. The provider of service billed two claims with different billed amounts and was not flagged as a corrected claim. The claims did not flag for duplicate for this reason. There is a $315.20 overpayment on claim [redacted]. The claim was adjusted on 2-6-2023 and the overpayment was received on 3-6-2023.

QID 79 UMR disagrees with this finding. The provider of service billed two claims with different billed amounts and was not flagged as a corrected claim. The claims did not flag for duplicate for this reason. There is a $111.20 overpayment on claim [redacted]. The claim was adjusted on 2-13-2023 and the overpayment was received on 3-16-2023.

QID 80-81, 83, 102 - UMR disagrees with this finding. The provider of service billed two claims with different billed amounts and was not flagged as a corrected claim. The provider will need to submit a corrected claim to determine duplicate and payment amounts. QID 80 is the same claim number as QID 81.

QID 84-85- UMR disagrees with this finding. The provider of service billed two claims with different billed amounts and was not flagged as a corrected claim. The claims did not flag for duplicate for this reason. There is a $116.00 overpayment on claim [redacted]. The claim was adjusted on 2-16-2023 and the overpayment was received on 3-20-2023. QID 84 is the same claim number as QID 85.

QID 90 - UMR disagrees with this finding. The provider of service billed two claims with different billed amounts and was not flagged as a corrected claim. The claims did not flag for duplicate for this reason. There is a $72.00 overpayment on claim [redacted]. The claim was adjusted on 2-9-2023 and the overpayment was received on 3-14-2023.

QID 95 – UMR disagrees with this finding. The provider of service billed two claims with different billed amounts and was not flagged as a corrected claim. The claims did not flag for duplicate for this reason. There is a $31.20 overpayment on claim [redacted]. The claim was adjusted on 3-20-2023.

QID 97 – UMR disagrees with this finding. The provider of service billed two claims with different billed amounts and was not flagged as a corrected claim. The claims did not flag for duplicate for this reason. There is a $90.00 overpayment on claim [redacted]. The claim was adjusted on 2-10-2023.

QID 104-106 – UMR disagrees with this finding. The provider of service billed two claims with different billed amounts and was not flagged as a corrected claim. The claims did not flag for duplicate for this reason. There is a $223.00 overpayment on claim [redacted]. The claim was adjusted on 2-16-2023 and the overpayment was received on 3-20-2023. QID 104 is the same claim number as QID 105 and QID 106.

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QID 109-110 – UMR agrees with this finding. This was a manual processing error. Additional coaching has taken place with the CFR. This results in a $707.20 overpayment. Claim [redacted] was adjusted on 2-9-2023 and the overpayment was received on 3-14-2023. QID 109 is the same claim number as QID 110.

QID 127-129 – UMR disagrees with this finding. The provider of service billed two claims with different billed amounts and was not flagged as a corrected claim. The claims did not flag for duplicate for this reason. There is a $59.00 overpayment on claim [redacted]. The claim was adjusted on 2-13-2023 and the overpayment was received on 3-23-2023. QID 127 is the same claim number as QID 128 and QID 129.

Medical Random -Denied Eligible Expense

Sample 1060 – UMR agrees with this finding. This claim denied for speech therapy and should have allowed. This results in a $65.00 underpayment. The claim was adjusted on 2-13-2023. An impact report was reviewed and identified 264 additional claims requiring adjustment. The adjustments are in progress.

Sample 1129 – UMR disagrees with this finding. This claim denied based on the primary diagnosis billed which is not a valid diagnosis for the treatment. UMRs processing system flagged this claim to deny appropriately. There is other diagnosis on the claim in the 2nd, 3rd and 4th positions that would have allowed the service to be paid per the plan benefits. This claim will be adjusted to allow based on the other diagnosis on the claim. Claim [redacted] was adjusted 4-10-2023.

Medical Random - PPO discount

Sample 1039 - UMR agrees with this finding. This is the result of the CFR keying an incorrect discount amount of $45,435.12 at the time of processing. The correct pricing discount is $52,664.00. Additional coaching has taken place with the CFR. This results in a $5,783.09 overpayment. Claim [redacted] was adjusted on 3-6-2023 and the overpayment was received on 4-6-2023.

Sample 1103 – UMR agrees with this finding. This was the result of incorrect manual pricing by the MRU manual repricing analyst. Code 70450 should have been allowed at a per visit rate and not the percentage rate. The allowable should have been $698 versus the $2064.99. Additional coaching has taken place with the analyst. This results in a $1366.99 overpayment. Claim [redacted] was adjusted on 3-3-2023 and the overpayment was received on 4-6-2023.

Medical Random - Copayment Calculation

Sample 1134 – UMR agrees with this finding. A $30.00 copay and coinsurance should have applied per visit and UMR applied $0.00. Additional training and coding updates have been made for medical PC office visits. This results in $414.00 underpayment. Claim [redacted] was adjusted on 3-23-2023.

Medical Random - Duplicate Payment

Sample 1114 – UMR agrees with this finding. This is the result of the CFR overriding the duplicate logic in the system and not following system edits. Services 90460 and 90461 should have been denied a duplicate to a previously processed claim. Additional training has taken place with the CFR. This results in a $54.14 overpayment. Claim [redacted] was adjusted on 3-1-2023 and the overpayment was received on 4-3-2023.

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Dental Random - Dollar Limit Maximum Exceeded
Sample 2007 – UMR disagrees with this finding. Dental code D0270 is a preventative and diagnostic service that can be done on the same day as other non-preventative services and does not apply to the $1500.00 annual maximum.

UMR is dedicated to improving the overall experience for the State of Nevada PEBP members and will work diligently on addressing any items during this review. If you have any questions or concerns regarding our responses, please feel free to contact me at 715-841-7262.

Sincerely,

Julie Frahm
SR. External/Regulatory Audit Coordinator
UMR External Audit Department

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11.

11. Presentation and possible action on the status and approval of new PEBP contracts, contract amendments and solicitations (Michelle Weyland, Administrative Services Officer) (**For Possible Action**)

    11.1 Contract Overview

    11.2 New Contracts

        11.2.1 Vivo Technologies

        11.2.2 National Diabetes Prevention Pilot Program

        11.2.3 Manpower

        11.2.4 Financial Auditor

    11.3 Contract Amendments

        11.3.1 Express Scripts

        11.3.2 UHC, Inc.

    11.4 Contract Solicitations

        11.4.1 Financial Auditor

    11.5 Status of Current Solicitations

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LAURA RICH
Executive Officer

JACK ROBB
Board Chair

AGENDA ITEM

[X] Action Item
[ ] Information Only

Date: May 25, 2023

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 April 30, 2023.

PEBP Active Contracts Summary

Vendor	Service	Contract #	Effective Date	Termination Date	Contract Max	Current Expenditures	Amount Remaining
CliftonLarsonAllen	Financial Auditor	24088	7/1/2023	3/27/2023	$ 212,485.00	$ 101,420.00	$ 111,065.00
Health Plan of Nevada Inc	Southern Nevada HMO	23802	7/1/2021	6/30/2025	$ 192,093,848.00	$ 75,089,502.09	$ 117,004,345.91
Diversified Dental Services Inc.	Dental PPO	23810	7/1/2021	6/30/2026	$ 1,601,613.00	$ 586,462.08	$ 1,015,150.92
Lifeworks	Benefits Management System	25935	5/10/2022	12/31/2026	$ 6,145,600.00	$ 1,901,424.00	$ 4,244,176.00
Express Scripts, Inc.	Pharmacy Benefit Manager	25582	5/10/2022	6/30/2026	$ 332,109,496.00	$ 63,472,422.32	$ 268,637,073.68
United Healthcare Insurance	Group Basic Life Insurance	25607	7/1/2022	6/30/2026	$ 12,824,248.00	$ 2,819,922.17	$ 10,004,325.83
Brown & Brown of Massachusetts	Health Plan Auditor	24030	4/13/2021	6/30/2027	$ 1,581,662.00	$ 302,470.00	$ 1,279,192.00
Segal Company, Inc.	Consulting Services	25557	7/1/2022	6/30/2027	$ 4,285,410.00	$ 718,830.00	$ 3,566,580.00
HAT LTD, DBA Manpower	Temporary Employment	23928	1/1/2023	12/31/2023	$ 107,900.00	$ 35,733.75	$ 72,166.25
Capitol Reporters	Court Reporting	27029	2/1/2023	6/30/2025	$ 31,932.00	$ 2,812.00	$ 29,120.00
UMR, Inc.	TPA and Other Services	25155	7/1/2022	6/30/2028	$ 65,413,106.00	$ 8,671,746.35	$ 56,741,359.65

Recommendation

No action necessary

11.2 New Contracts

11.2.1 VIVO TECHNOLOGIES

The Public Employees' Benefits Program relocated from 901 Stewart Street to 3427 Goni Street on April 3, 2023. As part of the move PEBP needed to either purchase new video conferencing equipment or move existing equipment. It was determined that it was more cost effective to move the existing equipment.

The Public Employees' Benefits program requested and was granted a solicitation waiver to contract with Vivo Technologies as they were the vendor that originally installed the video conferencing equipment in the PEBP Board meeting room. The contract is effective from March 24, 2023, through June 30, 2023, with a total maximum contract amount of $13,800.

Recommendation

PEBP recommends the Board authorize staff to contract with Vivo Technologies to complete the equipment installation.

11.2.2 NATIONAL DIABETES PREVENTION PILOT PROGRAM

The Public Employees' Benefits Program, pursuant to the Board approval of the national Diabetes Prevention Pilot Program at the March 23, 2023, meeting, requests to contract with Nevada Business Group on Health. This would be a zero-dollar contract with a public-private partnership of community organizations, private insurers, health care organizations, employers, and government agencies. Partners will work to establish local evidence-based lifestyle change programs for people at high risk for Type 2 diabetes.

PowerPoint Presentation (state.nv.us)

Recommendation

PEBP recommends the Board authorize staff to contract with Nevada Business Group on Health.

11.2.3 FORMER STATE EMPLOYEE

The Public Employees' Benefits Program is requesting to contract with a former employee, Celestena Glover, through the use of Manpower Temporary Services. The request is made in accordance with the State Administrative Manual Chapter 0323. In her previous position, Ms. Glover was the Chief Financial Officer with responsibility for managing the PEBP Accounting Department. Ms. Glover will either act as PEBP CFO until a permanent replacement is selected and trained or pursuant to Board action in Agenda Item 5 Ms. Glover will perform the duties of PEBP's Interim Executive Officer until a permanent Executive Officer is appointed.

Recommendation

PEBP recommends the Board authorize the staff to contract with a former state employee, Celestena Glover, as the temporary Chief Financial Officer until such time as a new Chief Financial Officer is appointed.

Or pursuant to the Board action in Agenda Item 5 contract with a former state employee Celestena Glover as the Interim Executive Officer until the appointment of a permanent Executive Officer.

11.2.4 FINANCIAL AUDITOR

The Public Employees' Benefits Program is requesting to contract with Eide Bailly, LLP for PEBP's outside financial audit needs. CliftonLarsonAllen LLP, PEBP's previous financial auditor, terminated their contract with PEBP March 27, 2023, sighting that our audits took much longer and required greater resources than expected.

Eide Bailly, LLP is used by multiple state agencies and has the benefit of understanding State of Nevada processes. State Purchasing granted approval for PEBP to use the Legislative Counsel Bureau financial auditor RFP for contracting purposes. Additionally, Eide Bailly has the staffing resources necessary to complete PEBP audits in a timely manner. The effective date of the contract is anticipated to be July 13, 2023 (upon BOE approval) through June 30, 2025. Services and fees are expected to begin on or before August 1, 2023. The total cost for this contract is not to exceed $386,500.

Recommendation

PEBP recommends the Board authorize staff to contract with Eide Bailly, LLP for outside financial audits.

11.3 Contract Amendment Ratifications

11.3.1 EXPRESS SCRIPTS

The Public Employees' Benefits Program contracted with Express Scripts for pharmacy benefits management services which became effective 07/01/2022 with a termination date of 06/30/2026. This amendment makes changes to the fee schedule based on the market check completed by Segal. In addition, this amendment updates the fee schedule from Per Member Per Month (PMPM) to Per Employee Per Month (PEPM) This amendment makes no change to contract authority.

Recommendation

PEBP recommends the Board authorize staff to amend the contract between PEBP and Express Scripts for pharmacy benefits management in contract #25582 to update the fee schedule based on the market check performed by Segal and to revise the payment method from PMPM to PEPM.

11.3.2 UHC, INC.

The Public Employees' Benefits Program contracted with UHC, Inc to provide life insurance coverage for PEBP members effective 04/12/2022 with a termination date of 06/30/2026. This amendment increases the contract maximum from $12,824,248 to $21,771,427. This amendment increases contract authority to pay for the legislatively approved increases to the life insurance benefits that are part of the core benefits package for employees and retirees.

Recommendation

PEBP recommends the Board approve an amendment with UHC, Inc. for that increased life insurance benefits.

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
Centers of Excellence – Travel Concierge	04/28/23	07/13/23		Sept. 2023
Oncology Management Program	06/09/23	08/25/23		Sept. 2023

12.

12. Public Comment

13.

13. Adjournment