JOE LOMBARDO
Governor

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

CELESTENA GLOVER
Interim Executive Officer

JACK ROBB
Board Chair

MEETING NOTICE AND AGENDA

Name of Organization:	Public Employees' Benefits Program Board
Date and Time of Meeting:	July 27, 2023 9:00 a.m.
Place of Meeting:	3427 Goni Rd Ste. 117 Carson City, NV 89706
Video Conferencing:	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=gmw9DZmfZ-Q

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/87882340465

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: 878 8234 0465 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 Jessica Crane at 775-684-7016 or email jcrane@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 by uploading your document to the *Public Comment Upload Form* located under *Contact Us* on the PEBP website, https://*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 May 25, 2023 PEBP Board Meeting
   4.2 Receipt of quarterly staff reports for the period ending March 31, 2023:
      4.2.1 Budget Report
      4.2.2 Utilization Report
   4.3 Receipt of quarterly vendor reports for the period ending March 31, 2023:
      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 May 2023

4.4 Fiscal Year 2023 Other Post-Employment Benefits (OPEB) valuation prepared by Segal in conformance with the Governmental Accounting Standards Board (GASB) requirements.

5. Discussion regarding the status of the recruitment and permanent appointment of the PEBP Executive Officer (Jack Robb, Board Chair) (Information/Discussion)

6. Election of Board Vice-Chair pursuant to Nevada Administrative Code (NAC) 287.172. Eligible candidates are April Caughron, Betsy Aiello, Michelle Kelley, Jim Barnes, Leslie Bittleston, Janell Woodward and Jennifer McClendon (Jack Robb, Board Chair) (**For Possible Action**)

7. Executive Officer Report (Celestena Glover, Interim Executive Officer) (Information/Discussion)

8. Legislative Tracking Report. Discussion regarding legislation passed during the 82nd Legislative Session, 2023 (Celestena Glover, Interim Executive Officer) (Information/Discussion**)**

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 of January 1, 2023 – March 31, 2023 (Celestena Glover, Interim Executive Officer) (**For Possible Action**)

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

    10.1 Contract Overview

    10.2 New Contracts

    10.3 Contract Amendments

    10.4 Contract Solicitations

    10.5 Status of Current Solicitations

11. Public Comment

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

12. Adjournment

The supporting material to this agenda, also known as the Board Packet, is available, at no charge, on the PEBP website at www.pebp.state.nv.us/meetings-events/board-/meetings (under the Board Meeting date referenced above). Contact Jessica Crane at PEBP, 3427 Goni Rd, Suite 109, Carson City, NV 89706 (775) 684-7016 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 Jessica Crane at (775) 684-7016 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 Jessica Crane 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 May 25, 2023 PEBP Board Meetings

   4.2 Receipt of quarterly staff reports for the period ending March 31, 2023:

   - 4.2.1 Budget Report
   - 4.2.2 Utilization Report

   4.3 Receipt of quarterly vendor reports for the period ending March 31, 2023:

   - 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 May 2023

4.1

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

4.1 Approval of Action Minutes from the May 25, 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)
May 25, 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
Dr. Jennifer McClendon, Member

FOR THE BOARD:
Mr. Mike Detmer, Chief Deputy Attorney General

FOR STAFF:
Mr. Nik Proper, Operations Officer
Ms. Michelle Weyland, Administrative Services Officer
Mr. Tim Lindley, Quality Control Officer
Ms. Wendi Lunz, Executive Assistant

OTHER PRESENTERS:
Mandee Bowsmith-DHRM
Richard Ward – Segal
Scott McEachern - Segal
Julie Weissmann-Pillar RX
Helmut Braun – UMR

1. Open Meeting; Roll Call

   - Board Chair Robb opened the meeting at 9:00 a.m.

2. Public Comment

   - Terri Laird - RPEN
   - Tess Opferman - AFSCME

3. PEBP Board disclosures for applicable Board meeting agenda items. (Mike Detmer, Chief 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 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

BOARD ACTION ON ITEM 4
MOTION: Motion to approve all items except 4.2.1.
BY: Member April Caughron
SECOND: Member Michelle Kelley
VOTE: Unanimous; the motion carried

BOARD ACTION ON ITEM 4.2.1
MOTION: No action needed.
BY: Chair Robb

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**)

BOARD ACTION ON ITEM 5
MOTION: Motion to approve.
BY: Member April Caughron
SECOND: Vice Chair Jim Barnes
VOTE: Unanimous; the motion carried

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

BOARD ACTION ON ITEM 6
MOTION: Motion to move forward with the recruitment for the PEBP Executive Officer, bringing the candidates that meet minimum qualifications to the board for interview.
BY: Member Betsy Aiello
SECOND: Member Michelle Kelley
VOTE: Unanimous; the motion carried

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

BOARD ACTION ON ITEM 7
MOTION: Motion to move forward with the repricing starting July 1.
BY: Member Michelle Kelley
SECOND: Member Betsy Aiello
VOTE: Unanimous; the motion carried

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**)

BOARD ACTION ON ITEM 9
MOTION: Motion to accept the report from CTI and correct the associated penalties as outlined in the agenda item.
BY: Member Michelle Kelley
SECOND: Member April Caughron
VOTE: Unanimous; the motion carried

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**)

BOARD ACTION ON ITEM 10
MOTION: Motion to accept the report from CTI on UMR's performance and assess the penalties as indicated.
BY: Member Michelle Kelley
SECOND: Member Betsy Aiello
VOTE: Unanimous; the motion carried

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

BOARD ACTION ON ITEM 11.2.1
MOTION: Motion to select Vivo Technologies for our video conferencing.
BY: Member Betsy Aiello
SECOND: Member April Caughron
VOTE: Unanimous; the motion carried

11.2.2 National Diabetes Prevention Pilot Program

BOARD ACTION ON ITEM 11.2.2
MOTION: Motion for staff to contract with Nevada Business Group on Health.
BY: Member April Caughron
SECOND: Member Michelle Kelley
VOTE: Unanimous; the motion carried

11.2.3 Manpower

BOARD ACTION ON ITEM 11.2.3
MOTION: Motion that PEBP contract with Manpower to employ Ms. Glover as the interim CEO.
BY: Member Michelle Kelley
SECOND: Member Betsy Aiello
VOTE: Unanimous; the motion carried

11.2.4 Financial Auditor

BOARD ACTION ON ITEM 11.2.4
MOTION: Motion for the board to authorize to contract with Eide Bailly, LLP for outside financial audits.
BY: Member April Caughron
SECOND: Member Betsy Aiello
VOTE: Unanimous; the motion carried

11.3 Contract Amendments

11.3.1 Express Scripts

BOARD ACTION ON ITEM 11.3.1
MOTION: Motion to accept the recommendation for Express Scripts contract as written.
BY: Member Betsy Aiello
SECOND: Member Michelle Kelley
VOTE: Unanimous; the motion carried

11.3.2 UHC, Inc.

BOARD ACTION ON ITEM 11.3.2
MOTION: Motion to approve an amendment with UHC to increase the life insurance.
BY: Member Michelle Kelley
SECOND: Member Betsy Aiello
VOTE: Unanimous; the motion carried

12. Public Comment

- Chris Syverson – Nevada Business Group on Health

13. Adjournment

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

4.2

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

    4.1 Approval of Action Minutes from the May 25, 2023 PEBP Board Meetings.

    4.2 Receipt of quarterly staff reports for the period ending March 31, 2023

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 March 31, 2023:

4.2.1 Budget Report

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Interim Executive Officer

JACK ROBB
Board Chair

AGENDA ITEM

[X] Action Item
[ ] Information Only

Date: July 27, 2023

Item Number: IV.II.I

Title: Chief Financial Officer Budget Report

Summary

This report addresses the Operational Budget as of March 31, 2023 to include:

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

Budget Account 1338 – Operational Budget – Shown below is a summary of the operational budget account status as of March 31, 2023, 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 $286.6 million as of March 31, 2023, compared to $258.0 million as of March 31, 2022, or an increase of 11.1%. Total expenses for the period have increased by $11.6 million or 3.9% for the same period.

The budget status report shows Realized Funding Available (cash) at $128.6 million. This compares to $121.8 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 3/31/2023	Work Program	Percent	Actual as of 3/31/2022	Fiscal Year 2022 Close	Percent
Beginning Cash	148,854,786	148,854,786	100%	159,011,280	159,011,280	100%
Premium Income	264,114,567	390,499,657	68%	237,316,511	348,069,497	68%
All Other Income	22,488,889	16,362,322	137%	20,692,739	32,877,594	63%
Total Income	286,603,456	406,861,979	70%	258,009,250	380,947,090	68%
Personnel Services	1,670,180	2,935,386	57%	1,648,654	2,382,790	69%
Operating - Other than Personnel	2,423,477	3,084,395	79%	1,509,303	2,919,211	52%
Insurance Program Expenses	302,424,925	410,458,880	74%	291,855,079	385,500,378	76%
All Other Expenses	297,896	424,234	70%	214,939	301,205	71%
Total Expenses	306,816,477	416,902,895	74%	295,227,975	391,103,584	75%
Change in Cash	(20,213,021)	(10,040,916)		(37,218,725)	(10,156,494)	
REALIZED FUNDING AVAILABLE	128,641,765	138,813,870	93%	121,792,555	148,854,786	82%
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	16,384,876	26,556,981		9,575,505	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% ($134.8 million vs $144.8 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:

- 2.10% fewer state actives,
- 0.96% more state non-Medicare retirees,
- 14.3% fewer non-state actives,
- 24.68% fewer non-state, non-Medicare retirees
- 5.27% more state Medicare retirees, and
- 2.67% 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 March 31, 2023:

        4.2.1 Budget Report

        4.2.2 Utilization Report

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Interim Executive Officer

JACK ROBB
Board Chair

AGENDA ITEM

[X] Action Item
[ ] Information Only

Date: July 27, 2023

Item Number: IV.II.II

Title: Self-Funded CDHP, LDPPO, and EPO Plan Utilization Report for the period ending March 31, 2023

This report addresses medical, dental, prescription drug and HSA/HRA utilization for the PY 2023 period ending March 31, 2023. 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 Q3 Plan Year 2023 utilization data.

Executive Summary

CONSUMER DRIVEN HEALTH PLAN (CDHP)

The Consumer Driven Health Plan (CDHP) experience for Q3 of Plan Year 2023 compared to Q3 of Plan Year 2022 is summarized below.

- Population:
  - 13.6% decrease for primary participants
  - 17.0% decrease for primary participants plus dependents (members)
- Medical Cost:
  - 2.8% increase for primary participants
  - 7.1% increase for primary participants plus dependents (members)
- High-Cost Claims:
  - There were 87 High-Cost Claimants accounting for 34.3% of the total plan paid for Q3 of Plan Year 2023
  - 10.5% decrease in High-Cost Claimants per 1,000 members
  - 16.2% increase in average cost of High-Cost Claimant paid
- Top three highest cost clinical classifications include:
  - Cancer ($5.2 million) – 23.5% of paid claims
  - Cardiac Disorders ($2.1 million) – 9.3% of paid claims
  - Infections ($1.8 million) – 8.3% of paid claims
- Emergency Room:
  - ER visits per 1,000 members increased 1.4%
  - Average paid per ER visit increased 19.0%
- Urgent Care:
  - Urgent Care visits per 1,000 members decreased at 0.4%
  - Average paid per Urgent Care visit decreased 31.8% (decrease from $66 to $45)
- Network Utilization:
  - 99.7% of claims are from In-Network providers
  - Q3 of Plan Year 2023 In-Network utilization increased 0.3% over PY 2022
  - Q3 of Plan Year 2023 In-Network discounts increased 2.8% over PY 2022

- Prescription Drug Utilization:
  - Overall:
    - Total Net Claims decreased 13.8%
    - Total Gross Claims Costs decreased 5.0% ($1.7 million)
    - Average Total Cost per Claim increased 10.2%
      - From $104.39 to $115.05
  - Member:
    - Total Member Cost decreased 12.7%
    - Average Participant Share per Claim increased 1.3%
    - Net Member PMPM increased 5.4%
      - From $29.02 to $30.58

- Plan
  - Total Plan Cost decreased 2.4%
  - Average Plan Share per Claim increased 13.3%
  - Net Plan PMPM increased 17.8%
    - From $85.32 to $100.53
  - Net Plan PMPM factoring rebates increased 11.2%
    - From $59.30 to $65.97

LOW DEDUCTIBLE PPO PLAN (LDPPO)

The Low Deductible PPO Plan (LDPPO) experience for Q3 of Plan Year 2023 compared to Q3 of Plan Year 2022 is summarized below.

- Population:
  - 73.0% increase for primary participants
  - 66.6% increase for primary participants plus dependents (members)
- Medical Cost:
  - 6.6% decrease for primary participants
  - 3.0% decrease for primary participants plus dependents (members)
- High-Cost Claims:
  - There were 43 High-Cost Claimants accounting for 30.3% of the total plan paid for Q3 of Plan Year 2023
  - 21.9% decrease in High-Cost Claimants per 1,000 members
  - 17.2% decrease in average cost of High-Cost Claimant paid
- Top three highest cost clinical classifications include:
  - Cancer ($3.5 million) – 36.9% of paid claims
  - Endocrine/Metabolic Disorders ($1.1 million) – 12.1% of paid claims
  - Trauma/Accidents ($1.1 million) – 11.4% of paid claims
- Emergency Room:
  - ER visits per 1,000 members increased 9.0%
  - Average paid per ER visit increased 27.1%
- Urgent Care:
  - Urgent Care visits per 1,000 members increased by 19.4%
  - Average paid per Urgent Care visit decreased 16.1% (decrease from $1188 to $99)
- Network Utilization:
  - 99.3% of claims are from In-Network providers
  - Q3 of Plan Year 2023 In-Network utilization increased 0.5% over PY 2022
  - Q3 of Plan Year 2023 In-Network discounts increased 0.3% over PY 2022

- Prescription Drug Utilization:
  - Overall:
    - Total Net Claims increased 75.6%
    - Total Gross Claims Costs increased 102.5% ($9.2 million)
    - Average Total Cost per Claim increased 15.3%
      - From $104.26 to $120.20

- Member:
  - Total Member Cost increased 77.3%
  - Average Participant Share per Claim decreased 1.0%
  - Net Member PMPM increased 3.5%
    - From $22.39 to $23.18
- Plan
  - Total Plan Cost increased 108.2%
  - Average Plan Share per Claim increased 18.6%
  - Net Plan PMPM increased 21.6%
    - From $98.33 to $119.56
  - Net Plan PMPM factoring rebates decreased 6.5%
    - From $84.07 to $78.59

PEBP PREMIER PLAN (EPO)

The PEBP Premier Plan (EPO) experience for Q3 of Plan Year 2023 compared to Q3 of Plan Year 2022 is summarized below.

- Population:
  - 14.3% decrease for primary participants
  - 14.1% decrease for primary participants plus dependents (members)
- Medical Cost:
  - 27.2% increase for primary participants
  - 27.2% increase for primary participants plus dependents (members)
- High-Cost Claims:
  - There were 42 High-Cost Claimants accounting for 32.5% of the total plan paid for Q3 of Plan Year 2023
  - 20% increase in High-Cost Claimants per 1,000 members
  - 7.9% increase in average cost of High-Cost Claimant paid
- Top three highest cost clinical classifications include:
  - Cancer ($2.2 million) – 21.3% of paid claims
  - Pregnancy-related Disorders ($1.7 million) – 16.2% of paid claims
  - Cardiac Disorders ($1.5 million) – 14.5% of paid claims
- Emergency Room:
  - ER visits per 1,000 members increased by 2.8%
  - Average paid per ER visit increased by 42.7%
- Urgent Care:
  - Urgent Care visits per 1,000 members increased by 1.7%
  - Average paid per Urgent Care visit decreased 15.2%
- Network Utilization:
  - 96.3% of claims are from In-Network providers
  - In-Network utilization decreased 3.7% over PY 2022
  - In-Network discounts decreased 3.3% over PY 2022

- Prescription Drug Utilization:
    - Overall:
        - Total Net Claims decreased 11.1%
        - Total Gross Claims Costs increased 2.8% ($0.4 million)
        - Average Total Cost per Claim increased 15.6%
            - From $126.12 to $145.79
    - Member:
        - Total Member Cost decreased 4.3%
        - Average Participant Share per Claim decreased 7.7%
        - Net Member PMPM increased 11.5%
            - From $36.74 to $40.97
    - Plan
        - Total Plan Cost increased 4.2%
        - Average Plan Share per Claim increased 17.2%
        - Net Plan PMPM increased 21.4%
            - From $176.34 to $214.11
        - Net Plan PMPM factoring rebates increased 3.7%
            - From $134.75 to $139.74

DENTAL PLAN

The Dental Plan experience for Q3 of Plan Year 2023 is summarized below.

- Dental Cost:
    - Total of $18,531,014 paid for Dental claims
        - Basic claims account for 32.4% ($5.6 million)
        - Preventive claims account for 27.4% ($4.7 million)
        - Diagnostic claims account for 24.1% ($4.2 million)
        - Major claims account for 16.1% ($2.8 million)

HEALTH REIMBURSEMENT ARRANGEMENT

The table below provides a list of CDHP HRA account balances as of March 31, 2023.

HRA Account Balances as of March 31, 2023			
$Range	**# Accounts**	**Total Account Balance**	**Average Per Account Balance**
0	1,069	0	0
$.01 - $500.00	2,798	633,345	226
$500.01 - $1,000	1,985	1,326,709	668
$1,000.01 - $1,500	662	804,150	1,215
$1,500.01 - $2,000	373	649,229	1,741
$2,000.01 - $2,500	319	714,019	2,238
$2,500.01 - $3,000	196	543,889	2,775
$3,000.01 - $3,500	194	633,154	3,264
$3,500.01 - $4,000	183	681,225	3,723
$4,000.01 - $4,500	122	519,141	4,255
$4,500.01 - $5,000	91	434,509	4,775
$5,000.01 +	**636**	**5,377,428**	**224,132**
Total	**8,628**	**$12,316,799**	**$1,428**

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 third quarter of Plan Year 2023. The CDHP total plan paid decreased 11.1% over the same time for Plan Year 2022, however on a PMPM basis the plan experienced an increase of 7.1%. The LDPPO total plan paid increased 61.5% over Q3 of Plan Year 2022 however on a PMPM basis the plan experienced a decrease of 3.0%. The EPO total plan paid increased 9.1% over Q3 of Plan Year 2022 and on a PMPM basis the plan experienced an increase of 27.2%. 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
January 1, 2023 – March 31, 2023

DATASCOPE™

Nevada Public Employees' Benefits Program
HDHP Plan
July 2022 – March 2023 Incurred,
Paid through May 31, 2023

UMR℠

Overview

- Total Medical Spend for 3Q23 was $64,366,069 of which 75.3% was spent in the State Active population. When compared to 3Q22, this reflected a decrease of 11.1% in plan spend, with State Actives having a decrease of 13.3%.
  - When compared to 3Q21, 3Q23 decreased 28.3%, with State Actives having a decrease of 30.0%.
- On a PEPY basis (annualized), 3Q23 reflected an increase of 3.0% when compared to 3Q22. The largest group, State Actives, had an increase of 1.4%.
  - When compared to 3Q21, 3Q23 increased 1.5%, with State Actives increasing 2.2%.
- 89.8% of the Average Membership had paid Medical claims less than $2,500, with 25.3% having no claims paid at all during the reporting period.
- There were 87 high-cost Claimants (HCC's) over $100K, that accounted for 34.3% of the total spend. HCCs accounted for 35.3% of total spend during 3Q22, with 117 members hitting the $100K threshold. The largest diagnosis grouper was Cancer accounting for 23.5% of high-cost claimant dollars.
- IP Paid per Admit was $27,014 which is a decrease of 26.6% compared to 3Q22.
- ER Paid per Visit is $2,283, which is an increase of 19.0% compared to 3Q22.
- 99.7% of all Medical spend dollars were to In Network providers. The average In Network discount was 67.9%, which is an increase of 4.3% compared to the PY22 average discount of 65.1%.

Paid Claims by Age Group

Paid Claims by Age Group																				
	3Q22									3Q23									% 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	$	2,108,956	$	926	$	20,673	$	9	$	2,129,629	$	935	$	4,636,463	$	3,161	$	33,929	$	23	$	4,670,392	$	3,184	119.3%	240.4%
1	$	383,043	$	164	$	21,786	$	9	$	404,829	$	173	$	295,269	$	158	$	17,144	$	9	$	312,413	$	168	-22.8%	-3.1%
2 - 4	$	864,495	$	105	$	178,489	$	22	$	1,042,984	$	127	$	622,175	$	109	$	124,473	$	22	$	746,648	$	131	-28.4%	3.0%
5 - 9	$	821,727	$	50	$	531,588	$	32	$	1,353,315	$	82	$	985,888	$	79	$	200,278	$	16	$	1,186,166	$	95	-12.4%	15.6%
10 - 14	$	2,047,288	$	109	$	323,156	$	17	$	2,370,444	$	126	$	1,275,224	$	86	$	238,634	$	16	$	1,513,858	$	102	-36.1%	-19.1%
15 - 19	$	2,592,756	$	127	$	633,125	$	31	$	3,225,881	$	158	$	3,588,200	$	219	$	555,472	$	34	$	4,143,672	$	253	28.5%	60.2%
20 - 24	$	2,249,291	$	97	$	702,835	$	30	$	2,952,126	$	127	$	2,479,557	$	123	$	914,832	$	45	$	3,394,389	$	168	15.0%	32.3%
25 - 29	$	3,125,327	$	172	$	648,291	$	36	$	3,773,618	$	207	$	2,726,306	$	198	$	717,660	$	52	$	3,443,966	$	251	-8.7%	20.8%
30 - 34	$	3,815,513	$	179	$	1,232,238	$	58	$	5,047,751	$	236	$	4,203,153	$	249	$	750,398	$	45	$	4,953,551	$	294	-1.9%	24.4%
35 - 39	$	4,397,149	$	192	$	1,079,150	$	47	$	5,476,299	$	239	$	2,672,843	$	146	$	1,236,947	$	67	$	3,909,790	$	213	-28.6%	-10.8%
40 - 44	$	4,775,233	$	211	$	1,493,552	$	66	$	6,268,785	$	277	$	3,331,268	$	172	$	1,607,018	$	83	$	4,938,286	$	255	-21.2%	-7.8%
45 - 49	$	5,685,606	$	262	$	1,962,152	$	90	$	7,647,758	$	352	$	3,803,016	$	206	$	1,677,703	$	91	$	5,480,719	$	297	-28.3%	-15.5%
50 - 54	$	7,557,223	$	306	$	2,879,089	$	117	$	10,436,312	$	423	$	6,754,006	$	322	$	2,982,170	$	142	$	9,736,176	$	463	-6.7%	9.6%
55 - 59	$	10,706,665	$	402	$	4,151,665	$	156	$	14,858,330	$	558	$	7,948,416	$	343	$	4,172,614	$	180	$	12,121,030	$	523	-18.4%	-6.4%
60 - 64	$	13,547,590	$	436	$	5,840,171	$	188	$	19,387,761	$	623	$	12,907,547	$	472	$	5,434,512	$	199	$	18,342,059	$	670	-5.4%	7.6%
65+	$	7,685,809	$	398	$	3,932,792	$	204	$	11,618,601	$	601	$	6,136,737	$	339	$	4,422,523	$	244	$	10,559,260	$	583	-9.1%	-3.0%
Total	**$**	**72,363,670**	**$**	**241**	**$**	**25,630,754**	**$**	**85**	**$**	**97,994,424**	**$**	**326**	**$**	**64,366,069**	**$**	**258**	**$**	**25,086,307**	**$**	**101**	**$**	**89,452,376**	**$**	**359**	**-8.7%**	**10.0%**

Financial Summary (p. 1 of 2)

	Total				State Active				Non-State Active			
Summary	**3Q21**	**3Q22**	**3Q23**	**Variance to Prior Year**	**3Q21**	**3Q22**	**3Q23**	**Variance to Prior Year**	**3Q21**	**3Q22**	**3Q23**	**Variance to Prior Year**
Enrollment												
Avg # Employees	23,300	19,061	16,465	-13.6%	19,498	15,625	13,359	-14.5%	4	3	3	0.0%
Avg # Members	42,277	33,380	27,711	-17.0%	36,719	28,347	23,187	-18.2%	8	8	8	0.0%
Ratio	1.8	1.8	1.7	-4.0%	1.9	1.8	1.7	-3.9%	2.2	2.7	2.7	0.0%
Financial Summary												
Gross Cost	$119,929,648	$99,158,042	$86,994,559	-12.3%	$93,517,553	$76,691,001	$65,464,986	-14.6%	$33,890	$49,469	$34,301	-30.7%
Client Paid	$89,725,067	$72,363,670	$64,366,069	-11.1%	$69,187,243	$55,885,730	$48,458,781	-13.3%	$21,436	$33,462	$23,704	-29.2%
Employee Paid	$30,204,581	$26,794,372	$22,628,491	-15.5%	$24,330,310	$20,805,272	$17,006,205	-18.3%	$12,454	$16,008	$10,596	-33.8%
Client Paid-PEPY	$5,134	$5,062	$5,212	3.0%	$4,731	$4,769	$4,837	1.4%	$7,566	$14,872	$10,535	-29.2%
Client Paid-PMPY	$2,830	$2,890	$3,097	7.2%	$2,512	$2,629	$2,787	6.0%	$3,430	$5,577	$3,951	-29.2%
Client Paid-PEPM	$428	$422	$434	2.8%	$394	$397	$403	1.5%	$630	$1,239	$878	-29.1%
Client Paid-PMPM	$236	$241	$258	7.1%	$209	$219	$232	5.9%	$286	$465	$329	-29.2%
High Cost Claimants (HCC's) > $100k												
# of HCC's	113	117	87	-25.6%	81	81	63	-22.2%	0	0	0	0.0%
HCC's / 1,000	2.7	3.5	3.1	-10.5%	2.2	2.9	2.7	-4.9%	0.0	0.0	0.0	0.0%
Avg HCC Paid	$247,427	$218,227	$253,617	16.2%	$241,137	$235,740	$256,535	8.8%	$0	$0	$0	0.0%
HCC's % of Plan Paid	31.2%	35.3%	34.3%	-2.8%	28.2%	34.2%	33.4%	-2.3%	0.0%	0.0%	0.0%	0.0%
Cost Distribution by Claim Type (PMPY)												
Facility Inpatient	$852	$1,041	$1,049	0.8%	$737	$923	$956	3.6%	$0	$0	$0	0.0%
Facility Outpatient	$846	$867	$1,000	15.3%	$706	$768	$869	13.2%	$2,826	$4,236	$2,164	-48.9%
Physician	$1,074	$930	$1,049	12.8%	$1,019	$890	$962	8.1%	$603	$1,306	$1,786	36.8%
Other	$58	$52	$0	-100.0%	$50	$48	$0	-100.0%	$1	$35	$0	0.0%
Total	$2,830	$2,890	$3,097	7.2%	$2,512	$2,629	$2,787	6.0%	$3,430	$5,577	$3,951	-29.2%
	Annualized	Annualized	Annualized		Annualized	Annualized	Annualized		Annualized	Annualized	Annualized	

Financial Summary (p. 2 of 2)

	State Retirees				Non-State Retirees				
Summary	**3Q21**	**3Q22**	**3Q23**	**Variance to Prior Year**	**3Q21**	**3Q22**	**3Q23**	**Variance to Prior Year**	**Peer Index**
Enrollment									
Avg # Employees	3,267	2,991	2,732	-8.7%	531	442	371	-15.9%	
Avg # Members	4,926	4,502	4,081	-9.4%	625	523	436	-16.7%	
Ratio	1.5	1.5	1.5	-0.7%	1.2	1.2	1.2	-0.8%	1.6
Financial Summary									
Gross Cost	$22,376,015	$20,279,351	$18,225,283	-10.1%	$4,002,190	$2,138,221	$3,269,990	52.9%	
Client Paid	$17,349,714	$15,085,396	$13,455,139	-10.8%	$3,166,674	$1,359,082	$2,428,444	78.7%	
Employee Paid	$5,026,301	$5,193,955	$4,770,144	-8.2%	$835,516	$779,138	$841,546	8.0%	
Client Paid-PEPY	$7,080	$6,724	$6,567	-2.3%	$7,958	$4,104	$8,722	112.5%	$6,297
Client Paid-PMPY	$4,697	$4,468	$4,397	-1.6%	$6,760	$3,464	$7,430	114.5%	$3,879
Client Paid-PEPM	$590	$560	$547	-2.3%	$663	$342	$727	112.6%	$525
Client Paid-PMPM	$391	$372	$366	-1.6%	$563	$289	$619	114.2%	$323
High Cost Claimants (HCC's) > $100k									
# of HCC's	28	34	25	-26.5%	5	3	3	0.0%	
HCC's / 1,000	5.7	7.6	6.1	-18.8%	8.0	5.7	6.9	20.1%	
Avg HCC Paid	$251,403	$175,686	$188,781	7.5%	$277,565	$154,760	$394,479	154.9%	
HCC's % of Plan Paid	40.6%	39.6%	35.1%	-11.4%	43.8%	34.2%	48.7%	42.4%	
Cost Distribution by Claim Type (PMPY)									
Facility Inpatient	$1,426	$1,787	$1,246	-30.3%	$3,112	$1,032	$4,134	300.6%	$1,149
Facility Outpatient	$1,782	$1,442	$1,670	15.8%	$1,637	$1,258	$1,695	34.7%	$1,333
Physician	$1,377	$1,160	$1,480	27.6%	$1,899	$1,097	$1,601	45.9%	$1,301
Other	$112	$79	$0	-100.0%	$113	$76	$0	-100.0%	$96
Total	$4,697	$4,468	$4,397	-1.6%	$6,760	$3,464	$7,430	114.5%	$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**	**3Q23**	**Variance to Prior Year**	**PY21**	**PY22**	**3Q23**	**Variance to Prior Year**	**PY21**	**PY22**	**3Q23**	**Variance to Prior Year**
Enrollment												
Avg # Employees	23,242	18,943	16,465	-13.1%	19,450	15,526	13,359	-14.0%	4	3	3	0.0%
Avg # Members	42,168	33,089	27,711	-16.3%	36,612	28,082	23,187	-17.4%	9	8	8	0.0%
Ratio	1.8	1.8	1.7	-4.0%	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	$86,994,559	-37.0%	$131,056,101	$106,593,460	$65,464,986	-38.6%	$45,142	$55,484	$34,301	-38.2%
Client Paid	$129,698,896	$104,706,277	$64,366,069	-38.5%	$100,360,791	$80,561,976	$48,458,781	-39.8%	$31,594	$38,304	$23,704	-38.1%
Employee Paid	$37,913,265	$33,371,175	$22,628,491	-32.2%	$30,695,310	$26,031,484	$17,006,205	-34.7%	$13,548	$17,181	$10,596	-38.3%
Client Paid-PEPY	$5,580	$5,527	$5,212	-5.7%	$5,160	$5,189	$4,837	-6.8%	$7,898	$12,768	$10,535	-17.5%
Client Paid-PMPY	$3,076	$3,164	$3,097	-2.1%	$2,741	$2,869	$2,787	-2.9%	$3,510	$4,788	$3,951	-17.5%
Client Paid-PEPM	$465	$461	$434	-5.9%	$430	$432	$403	-6.7%	$658	$1,064	$878	-17.5%
Client Paid-PMPM	$256	$264	$258	-2.3%	$228	$239	$232	-2.9%	$293	$399	$329	-17.5%
High Cost Claimants (HCC's) > $100k												
# of HCC's	173	160	87		124	115	63		0	0	0	
HCC's / 1,000	4.1	4.8	3.1		3.4	4.1	2.7		0.0	0.0	0.0	
Avg HCC Paid	$253,370	$251,190	$253,617	1.0%	$251,442	$262,921	$256,535	-2.4%	$0	$0	$0	0.0%
HCC's % of Plan Paid	33.8%	38.4%	34.3%	-10.7%	31.1%	37.5%	33.4%	-10.9%	0.0%	0.0%	0.0%	0.0%
Cost Distribution by Claim Type (PMPY)												
Facility Inpatient	$893	$1,153	$1,049	-9.0%	$778	$1,028	$956	-7.0%	$0	$0	$0	0.0%
Facility Outpatient	$942	$939	$1,000	6.5%	$794	$821	$869	5.8%	$2,124	$3,554	$2,164	-39.1%
Physician	$1,176	$1,011	$1,049	3.8%	$1,112	$964	$962	-0.2%	$1,339	$1,200	$1,786	48.8%
Other	$65	$62	$0	-100.0%	$56	$56	$0	-100.0%	$48	$34	$0	0.0%
Total	$3,076	$3,164	$3,097	-2.1%	$2,741	$2,869	$2,787	-2.9%	$3,510	$4,788	$3,951	-17.5%
			Annualized				Annualized				Annualized	

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

	State Retirees				Non-State Retirees				
Summary	**PY21**	**PY22**	**3Q23**	**Variance to Prior Year**	**PY21**	**PY22**	**3Q23**	**Variance to Prior Year**	**Peer Index**
Enrollment									
Avg # Employees	3,269	2,981	2,732	-8.3%	519	433	371	-14.4%	
Avg # Members	4,936	4,486	4,081	-9.0%	611	514	436	-15.1%	
Ratio	1.5	1.5	1.5	-0.7%	1.2	1.2	1.2	-0.8%	1.6
Financial Summary									
Gross Cost	$31,611,056	$27,879,066	$18,225,283	-34.6%	$4,899,862	$3,549,442	$3,269,990	-7.9%	
Client Paid	$25,416,793	$21,491,378	$13,455,139	-37.4%	$3,889,718	$2,614,619	$2,428,444	-7.1%	
Employee Paid	$6,194,263	$6,387,688	$4,770,144	-25.3%	$1,010,144	$934,823	$841,546	-10.0%	
Client Paid-PEPY	$7,774	$7,210	$6,567	-8.9%	$7,501	$6,033	$8,722	44.6%	$6,642
Client Paid-PMPY	$5,149	$4,791	$4,397	-8.2%	$6,362	$5,091	$7,430	45.9%	$4,116
Client Paid-PEPM	$648	$601	$547	-9.0%	$625	$503	$727	44.5%	$553
Client Paid-PMPM	$429	$399	$366	-8.3%	$530	$424	$619	46.0%	$343
High Cost Claimants (HCC's) > $100k									
# of HCC's	48	44	25		5	5	3		
HCC's / 1,000	9.7	9.8	6.1		8.2	9.7	6.9		
Avg HCC Paid	$234,370	$199,873	$188,781	-5.5%	$280,896	$231,987	$394,479	70.0%	
HCC's % of Plan Paid	44.3%	40.9%	35.1%	-14.2%	36.1%	44.4%	48.7%	9.7%	
Cost Distribution by Claim Type (PMPY)									
Facility Inpatient	$1,515	$1,808	$1,246	-31.1%	$2,727	$2,262	$4,134	82.8%	$1,190
Facility Outpatient	$1,954	$1,612	$1,670	3.6%	$1,599	$1,488	$1,695	13.9%	$1,376
Physician	$1,555	$1,280	$1,480	15.6%	$1,925	$1,227	$1,601	30.5%	$1,466
Other	$125	$91	$0	-100.0%	$110	$115	$0	-100.0%	$84
Total	$5,149	$4,791	$4,397	-8.2%	$6,362	$5,091	$7,430	45.9%	$4,116
			Annualized				Annualized		

Paid Claims by Claim Type – State Participants

Net Paid Claims - Total State Participants	3Q22				3Q23				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical									
Inpatient	$ 22,226,208	$ 5,736,832	$ 822,495	$ 28,785,535	$ 19,003,003	$ 3,794,559	$ 393,683	$ 23,191,246	-19.4%
Outpatient	$ 33,659,521	$ 7,459,530	$ 1,066,539	$ 42,185,591	$ 29,455,778	$ 8,187,369	$ 1,079,528	$ 38,722,675	-8.2%
Total - Medical	**$ 55,885,730**	**$ 13,196,362**	**$ 1,889,034**	**$ 70,971,125**	**$ 48,458,781**	**$ 11,981,929**	**$ 1,473,211**	**$ 61,913,921**	**-12.8%**

Net Paid Claims - Per Participant per Month	3Q22				3Q23				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical	$ 397	$ 619	$ 338	$ 424	$ 403	$ 612	$ 295	$ 427	0.9%

Paid Claims by Claim Type – Non-State Participants

Net Paid Claims - Total Non-State Participants	3Q22				3Q23				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical									
Inpatient	$ 435	$ 409,616	$ 58,330	$ 468,381	$ -	$ 361,518	$ 1,082,334	$ 1,443,852	208.3%
Outpatient	$ 33,026	$ 574,298	$ 316,838	$ 924,163	$ 23,704	$ 580,477	$ 404,115	$ 1,008,296	9.1%
Total - Medical	**$ 33,462**	**$ 983,914**	**$ 375,168**	**$ 1,392,544**	**$ 23,704**	**$ 941,995**	**$ 1,486,449**	**$ 2,452,148**	**76.1%**

Net Paid Claims - Per Participant per Month	3Q22				3Q23				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical	$ 1,239	$ 649	$ 153	$ 348	$ 878	$ 898	$ 649	$ 728	109.2%

Paid Claims by Claim Type – Total Participants

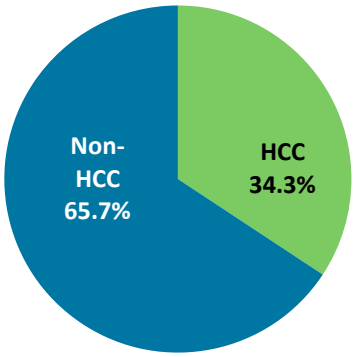
Net Paid Claims - Total Total Participants	3Q22				3Q23				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical									
Inpatient	$ 22,226,643	$ 6,146,448	$ 880,825	$ 29,253,916	$ 19,003,003	$ 4,156,077	$ 1,476,017	$ 24,635,097	-15.8%
Outpatient	$ 33,692,548	$ 8,033,829	$ 1,383,377	$ 43,109,753	$ 29,479,482	$ 8,767,846	$ 1,483,643	$ 39,730,971	-7.8%
Total - Medical	**$ 55,919,191**	**$ 14,180,276**	**$ 2,264,202**	**$ 72,363,669**	**$ 48,482,486**	**$ 12,923,923**	**$ 2,959,660**	**$ 64,366,069**	**-11.1%**

Net Paid Claims - Per Participant per Month	3Q22				3Q23				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	
Medical	$ 398	$ 621	$ 281	$ 422	$ 403	$ 626	$ 406	$ 434	3.0%

Cost Distribution – Medical Claims

3Q22							3Q23					
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
107	0.3%	$25,533,404	35.3%	$805,272	3.0%	$100,000.01 Plus	81	0.3%	$22,061,710	34.3%	$539,659	2.4%
132	0.4%	$9,560,695	13.2%	$936,099	3.5%	$50,000.01-$100,000.00	107	0.4%	$8,068,065	12.5%	$677,496	3.0%
218	0.7%	$7,897,303	10.9%	$1,279,622	4.8%	$25,000.01-$50,000.00	235	0.8%	$8,528,547	13.3%	$1,286,496	5.7%
573	1.7%	$9,198,850	12.7%	$3,085,994	11.5%	$10,000.01-$25,000.00	561	2.0%	$9,156,663	14.2%	$2,859,035	12.6%
882	2.6%	$6,423,732	8.9%	$3,108,317	11.6%	$5,000.01-$10,000.00	766	2.8%	$5,558,687	8.6%	$2,596,454	11.5%
1,334	4.0%	$4,895,855	6.8%	$3,289,271	12.3%	$2,500.01-$5,000.00	1,093	3.9%	$4,026,747	6.3%	$2,719,630	12.0%
17,183	51.5%	$8,792,734	12.2%	$11,649,056	43.5%	$0.01-$2,500.00	12,940	46.7%	$6,965,649	10.8%	$9,658,452	42.7%
5,062	15.2%	$0	0.0%	$2,628,644	9.8%	$0.00	4,925	17.8%	$0	0.0%	$2,291,268	10.1%
7,889	23.6%	$61,096	0.1%	$12,099	0.0%	No Claims	7,004	25.3%	$0	0.0%	$0	0.0%
33,380	**100.0%**	**$72,363,670**	**100.0%**	**$26,794,372**	**100.0%**		**27,711**	**100.0%**	**$64,366,069**	**100.0%**	**$22,628,491**	**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	36	$5,191,253	23.5%
Cardiac Disorders	63	$2,056,065	9.3%
Infections	43	$1,839,004	8.3%
Pregnancy-related Disorders	6	$1,709,189	7.7%
Spine-related Disorders	17	$1,608,853	7.3%
Congenital/Chromosomal Anomalies	6	$1,496,105	6.8%
Neurological Disorders	49	$1,244,326	5.6%
Gastrointestinal Disorders	52	$1,065,347	4.8%
Endocrine/Metabolic Disorders	35	$891,734	4.0%
Mental Health	29	$860,409	3.9%
All Other		$4,102,396	18.6%
Overall	**----**	**$22,064,683**	**100.0%**

Utilization Summary (p. 1 of 2)

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

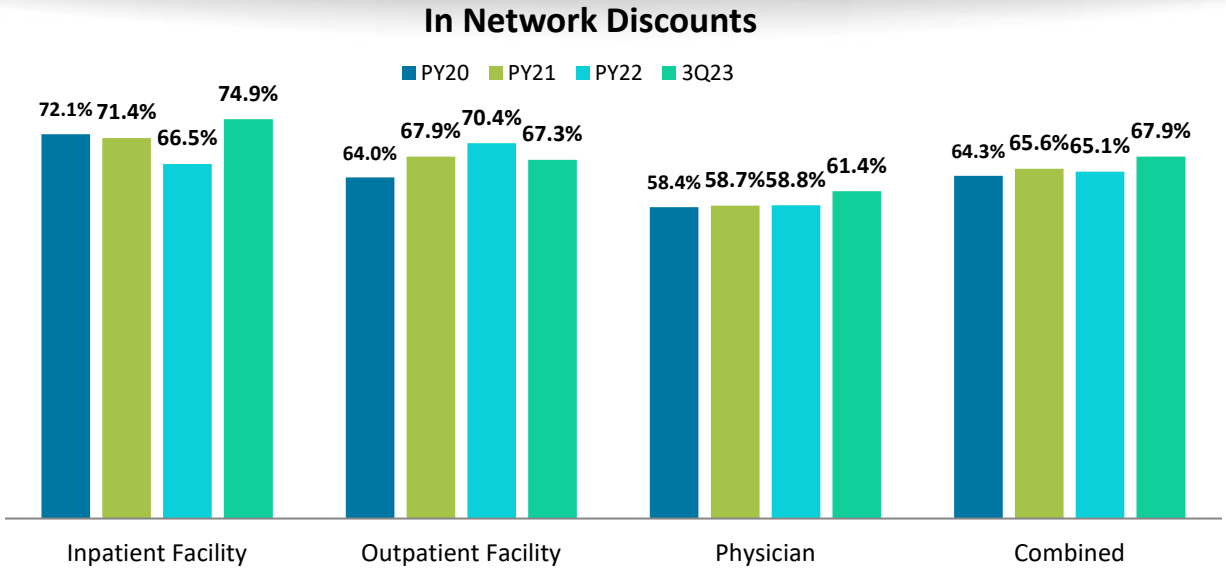
	Total				State Active				Non-State Active			
Summary	**3Q21**	**3Q22**	**3Q23**	**Variance to Prior Year**	**3Q21**	**3Q22**	**3Q23**	**Variance to Prior Year**	**3Q21**	**3Q22**	**3Q23**	**Variance to Prior Year**
Inpatient Summary												
# of Admits	1,246	1,036	820		996	758	612		0	0	0	
# of Bed Days	8,564	7,071	4,956		6,914	5,152	3,665		0	0	0	
Paid Per Admit	$34,400	$36,824	$27,014	-26.6%	$33,763	$38,349	$27,718	-27.7%	$0	$0	$0	0.0%
Paid Per Day	$5,005	$5,395	$4,470	-17.1%	$4,864	$5,642	$4,628	-18.0%	$0	$0	$0	0.0%
Admits Per 1,000	39	41	39	-4.9%	36	36	35	-2.8%	0	0	0	0.0%
Days Per 1,000	270	282	238	-15.6%	251	242	211	-12.8%	0	0	0	0.0%
Avg LOS	6.9	6.8	6.0	-11.8%	6.9	6.8	6.0	-11.8%	0	0	0	0.0%
# Admits From ER	658	572	475		500	376	328		0	0	0	
Physician Office												
OV Utilization per Member	3.9	3.7	3.7	0.0%	3.7	3.5	3.4	-2.9%	3.8	3.7	3.2	-13.5%
Avg Paid per OV	$74	$77	$80	3.9%	$75	$79	$76	-3.8%	$78	$79	$71	-10.1%
Avg OV Paid per Member	$286	$286	$293	2.4%	$276	$276	$256	-7.2%	$301	$290	$224	-22.8%
DX&L Utilization per Member	7.5	7.2	9.2	27.8%	7.1	6.8	8.4	23.5%	8	15.5	6.2	0.0%
Avg Paid per DX&L	$52	$50	$46	-8.0%	$49	$47	$43	-8.5%	$323	$204	$92	0.0%
Avg DX&L Paid per Member	$387	$366	$423	15.6%	$346	$322	$366	13.7%	$2,582	$3,161	$566	0.0%
Emergency Room												
# of Visits	3,660	3,691	3,088		3,118	3,077	2,461		1	4	3	
Visits Per Member	0.12	0.15	0.15	0.0%	0.11	0.14	0.14	0.0%	0.16	0.67	0.50	0.0%
Visits Per 1,000	115	147	149	1.4%	113	145	142	-2.1%	160	667	500	0.0%
Avg Paid per Visit	$2,208	$1,918	$2,283	19.0%	$2,225	$1,948	$2,379	22.1%	$15,692	$1,117	$4,167	0.0%
Urgent Care												
# of Visits	6,927	6,732	5,566		6,217	5,944	4,920		3	5	3	
Visits Per Member	0.22	0.27	0.27	0.0%	0.23	0.28	0.28	0.0%	0.48	0.83	0.50	0.0%
Visits Per 1,000	218	269	268	-0.4%	226	280	283	1.1%	480	833	500	0.0%
Avg Paid per Visit	$75	$66	$45	-31.8%	$74	$66	$45	-31.8%	$104	$106	$42	0.0%
	Annualized	Annualized	Annualized		Annualized	Annualized	Annualized		Annualized	Annualized	Annualized	

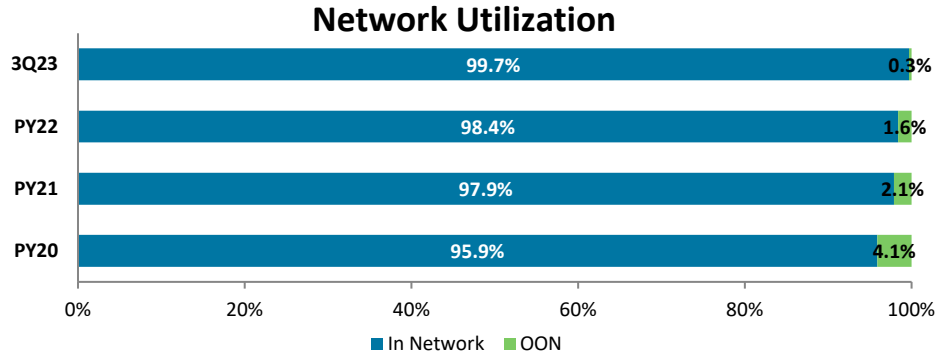
Utilization Summary (p. 2 of 2)

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

	State Retirees				Non-State Retirees				
Summary	**3Q21**	**3Q22**	**3Q23**	**Variance to Prior Year**	**3Q21**	**3Q22**	**3Q23**	**Variance to Prior Year**	**Peer Index**
Inpatient Summary									
# of Admits	209	238	165		41	40	43		
# of Bed Days	1,411	1,697	966		239	222	325		
Paid Per Admit	$35,678	$34,238	$25,474	-25.6%	$43,377	$23,317	$22,909	-1.7%	$16,632
Paid Per Day	$5,285	$4,802	$4,351	-9.4%	$7,441	$4,201	$3,031	-27.9%	$3,217
Admits Per 1,000	57	70	54	-22.9%	88	102	132	29.4%	76
Days Per 1,000	382	503	316	-37.2%	510	566	994	75.6%	391
Avg LOS	6.8	7.1	5.9	-16.9%	5.8	5.6	7.6	35.7%	5.2
# Admits From ER	134	168	118		24	28	29		
Physician Office									
OV Utilization per Member	5.0	4.9	4.9	0.0%	6.6	6.6	7.5	13.6%	5.0
Avg Paid per OV	$71	$73	$102	39.7%	$56	$34	$37	8.8%	$57
Avg OV Paid per Member	$355	$355	$503	41.7%	$372	$227	$279	22.9%	$286
DX&L Utilization per Member	10.1	9.7	12.8	32.0%	11.9	9.5	19.7	107.4%	10.5
Avg Paid per DX&L	$63	$63	$56	-11.1%	$68	$52	$35	-32.7%	$50
Avg DX&L Paid per Member	$639	$618	$719	16.3%	$801	$499	$692	38.7%	$522
Emergency Room									
# of Visits	476	530	523		65	80	101		
Visits Per Member	0.13	0.16	0.17	6.3%	0.14	0.20	0.31	55.0%	0.24
Visits Per 1,000	129	157	171	8.9%	139	204	309	51.5%	235
Avg Paid per Visit	$1,990	$1,821	$1,987	9.1%	$2,767	$1,441	$1,441	0.0%	$943
Urgent Care									
# of Visits	625	718	573		82	65	70		
Visits Per Member	0.17	0.21	0.19	-9.5%	0.18	0.17	0.21	23.5%	0.3
Visits Per 1,000	169	213	187	-12.2%	175	166	214	28.9%	300
Avg Paid per Visit	$79	$62	$48	-22.6%	$86	$38	$37	-2.6%	$84
	Annualized	Annualized	Annualized		Annualized	Annualized	Annualized		

Provider Network Summary





Diagnosis Grouper Summary

Diagnosis Grouper	Total Paid	% Paid	Insured	Spouse	Child	Male	Female
Cancer	$7,875,987	12.2%	$5,214,994	$1,994,307	$666,686	$3,705,858	$4,170,129
Gastrointestinal Disorders	$5,291,936	8.2%	$3,548,767	$884,420	$858,749	$2,484,979	$2,806,956
Health Status/Encounters	$5,086,346	7.9%	$3,095,765	$704,577	$1,286,004	$1,909,308	$3,177,038
Cardiac Disorders	$5,002,603	7.8%	$3,566,677	$1,340,067	$95,859	$2,472,615	$2,529,988
Pregnancy-related Disorders	$4,154,176	6.5%	$1,350,083	$488,504	$2,315,590	$893,370	$3,260,806
Spine-related Disorders	$3,558,966	5.5%	$1,816,661	$381,615	$1,360,691	$898,715	$2,660,251
Infections	$3,438,252	5.3%	$2,509,135	$403,701	$525,415	$2,132,900	$1,305,352
Musculoskeletal Disorders	$3,411,288	5.3%	$2,501,758	$575,800	$333,731	$1,390,566	$2,020,722
Trauma/Accidents	$3,375,635	5.2%	$2,413,678	$385,832	$576,125	$1,852,448	$1,523,187
Neurological Disorders	$3,192,739	5.0%	$1,874,660	$779,049	$539,030	$1,075,421	$2,117,318
Mental Health	$2,904,513	4.5%	$837,690	$329,541	$1,737,282	$862,860	$2,041,653
Renal/Urologic Disorders	$2,101,065	3.3%	$1,291,269	$525,743	$284,053	$1,274,210	$826,855
Pulmonary Disorders	$2,083,165	3.2%	$1,284,272	$185,473	$613,420	$1,104,187	$978,978
Eye/ENT Disorders	$1,934,709	3.0%	$1,218,529	$295,755	$420,425	$888,117	$1,046,592
Endocrine/Metabolic Disorders	$1,894,222	2.9%	$1,265,520	$528,137	$100,565	$1,087,892	$806,330
Congenital/Chromosomal Anomalies	$1,820,390	2.8%	$69,482	$29,017	$1,721,891	$1,666,223	$154,167
Medical/Surgical Complications	$1,158,797	1.8%	$972,912	$59,828	$126,056	$761,798	$396,998
Gynecological/Breast Disorders	$1,150,823	1.8%	$821,878	$217,810	$111,135	$19,007	$1,131,816
Hematological Disorders	$899,795	1.4%	$265,051	$561,993	$72,751	$640,907	$258,888
Diabetes	$810,033	1.3%	$636,373	$66,437	$107,223	$427,803	$382,230
Dermatological Disorders	$747,964	1.2%	$589,601	$80,765	$77,598	$446,774	$301,190
Non-malignant Neoplasm	$744,158	1.2%	$638,452	$73,392	$32,314	$221,480	$522,678
Vascular Disorders	$573,194	0.9%	$278,905	$283,836	$10,453	$226,645	$346,549
Miscellaneous	$458,002	0.7%	$285,010	$63,811	$109,181	$166,632	$291,369
Abnormal Lab/Radiology	$367,163	0.6%	$302,359	$51,932	$12,872	$154,907	$212,256
Medication Related Conditions	$123,386	0.2%	$50,015	$18,181	$55,191	$75,168	$48,218
Cholesterol Disorders	$91,735	0.1%	$76,853	$12,672	$2,211	$45,899	$45,836
Dental Conditions	$66,308	0.1%	$13,525	$84	$52,698	$53,586	$12,721
Allergic Reaction	$34,524	0.1%	$11,779	$10,245	$12,499	$7,946	$26,578
External Hazard Exposure	$13,946	0.0%	$12,151	$1,374	$421	$6,945	$7,001
Cause of Morbidity	$220	0.0%	$70	$26	$125	$96	$125
Social Determinants of Health	$29	0.0%	$29	$0	$0	$29	$0
Total	**$64,366,069**	**100.0%**	**$38,813,901**	**$11,333,922**	**$14,218,246**	**$28,955,292**	**$35,410,777**

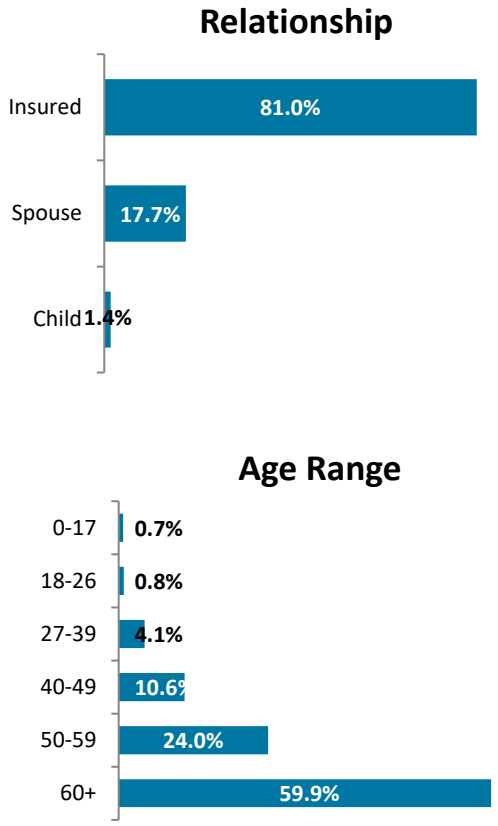
Mental Health Drilldown

	PY20		PY21		PY22		3Q23	
Grouper	Patients	Total Paid	Patients	Total Paid	Patients	Total Paid	Patients	Total Paid
Depression	1,485	$1,137,444	1,597	$1,103,414	1,156	$1,279,244	798	$735,082
Developmental Disorders	144	$790,389	179	$1,179,402	113	$719,871	93	$671,088
Alcohol Abuse/Dependence	125	$868,472	136	$1,288,204	101	$873,612	105	$335,942
Mental Health Conditions, Other	1,222	$686,307	1,220	$771,034	911	$431,490	649	$274,941
Mood and Anxiety Disorders	1,791	$437,001	1,920	$638,818	1,486	$406,189	1,043	$230,788
Bipolar Disorder	327	$340,422	315	$464,418	225	$197,224	166	$141,524
Psychoses	55	$78,740	54	$86,357	32	$70,201	27	$107,308
Eating Disorders	47	$74,872	55	$647,596	44	$596,928	27	$104,377
Complications of Substance Abuse	47	$257,582	42	$202,208	22	$89,081	24	$87,042
Substance Abuse/Dependence	121	$1,068,150	140	$213,345	86	$540,594	62	$63,743
Schizophrenia	31	$43,420	26	$141,033	25	$110,357	18	$50,206
Sexually Related Disorders	51	$24,993	68	$90,021	42	$11,305	49	$47,911
Attention Deficit Disorder	433	$58,455	482	$72,965	374	$57,319	315	$25,759
Sleep Disorders	526	$40,584	564	$76,491	371	$46,254	266	$22,728
Tobacco Use Disorder	149	$6,011	126	$8,010	106	$6,184	75	$5,071
Personality Disorders	19	$18,981	25	$16,690	19	$13,480	8	$1,005
Total		**$5,931,821**		**$7,000,007**		**$5,449,334**		**$2,904,513**

Diagnosis Grouper – Cancer

Diagnosis Sub-Grouper	Patients	Claims	Total Paid	% Paid
Cancer Therapies	72	494	$2,764,964	35.1%
Breast Cancer	160	1,652	$1,067,905	13.6%
Cancers, Other	91	919	$903,260	11.5%
Secondary Cancers	57	405	$735,723	9.3%
Lymphomas	36	422	$335,605	4.3%
Brain Cancer	10	206	$295,325	3.7%
Prostate Cancer	95	612	$224,768	2.9%
Colon Cancer	34	361	$222,232	2.8%
Thyroid Cancer	52	229	$202,785	2.6%
Cervical/Uterine Cancer	42	311	$184,968	2.3%
Leukemias	31	483	$184,630	2.3%
Carcinoma in Situ	87	345	$173,283	2.2%
Bladder Cancer	15	177	$142,229	1.8%
Ovarian Cancer	23	222	$135,460	1.7%
Lung Cancer	22	184	$130,292	1.7%
Non-Melanoma Skin Cancers	225	489	$63,968	0.8%
Myeloma	9	124	$58,545	0.7%
Kidney Cancer	16	61	$28,033	0.4%
Melanoma	40	122	$21,456	0.3%
Pancreatic Cancer	3	6	$555	0.0%
Overall	**----**	**----**	**$7,875,987**	**100.0%**

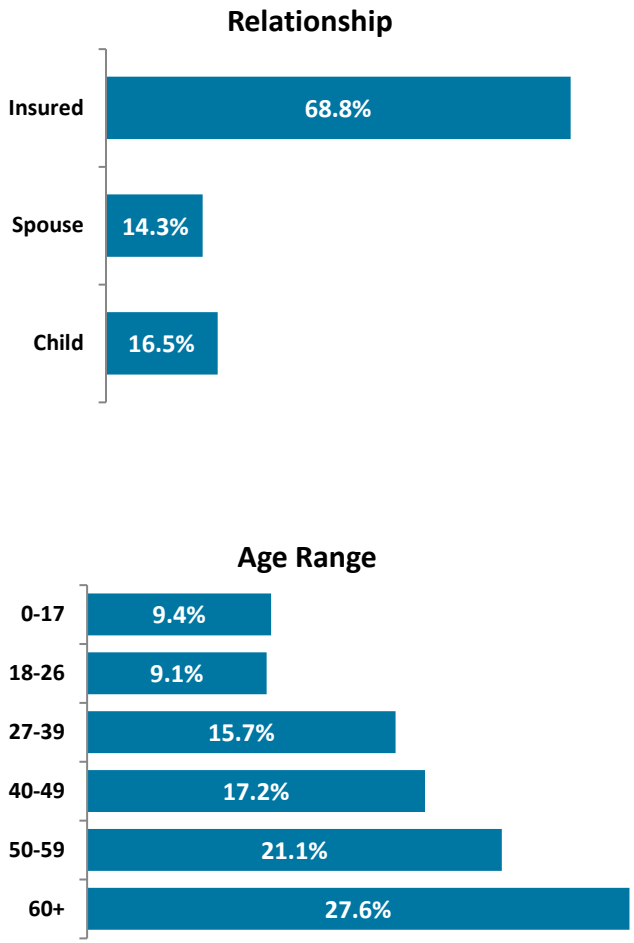
*Patient and claim counts are unique only within the category



Diagnosis Grouper – Gastrointestinal Disorders

Diagnosis Sub-Grouper	Patients	Claims	Total Paid	% Paid
GI Disorders, Other	664	1,524	$833,153	15.7%
Abdominal Disorders	1,312	3,153	$787,024	14.9%
Hernias	175	565	$724,153	13.7%
Upper GI Disorders	642	1,522	$579,662	11.0%
Inflammatory Bowel Disease	73	364	$462,599	8.7%
GI Symptoms	812	1,713	$394,122	7.4%
Liver Diseases	256	473	$356,383	6.7%
Gallbladder and Biliary Disease	141	522	$344,662	6.5%
Appendicitis	35	210	$326,533	6.2%
Diverticulitis	138	280	$143,092	2.7%
Constipation	202	335	$85,189	1.6%
Ostomies	33	225	$70,793	1.3%
Hemorrhoids	146	243	$60,602	1.1%
Hepatic Cirrhosis	23	134	$57,039	1.1%
Pancreatic Disorders	32	102	$45,054	0.9%
Peptic Ulcer/Related Disorders	35	49	$10,965	0.2%
Esophageal Varices	7	17	$10,911	0.2%
	----	----	$5,291,936	100.0%

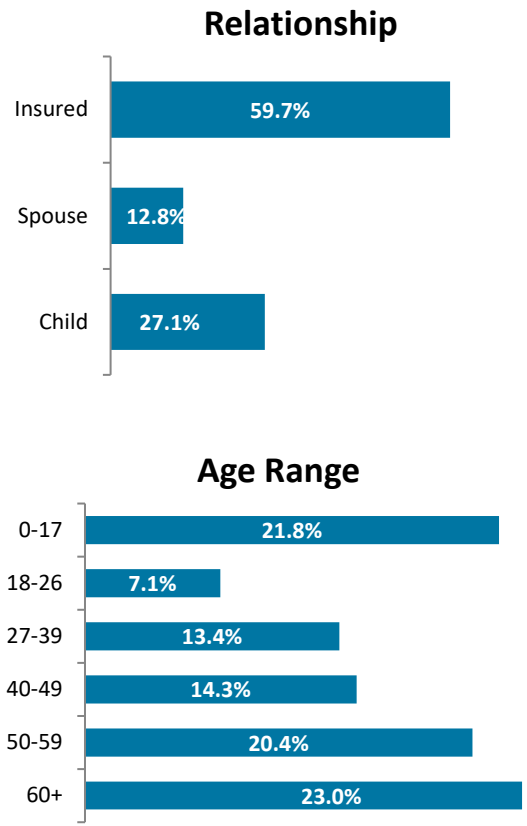
*Patient and claim counts are unique only within the category



Diagnosis Grouper – Health Status/Encounters

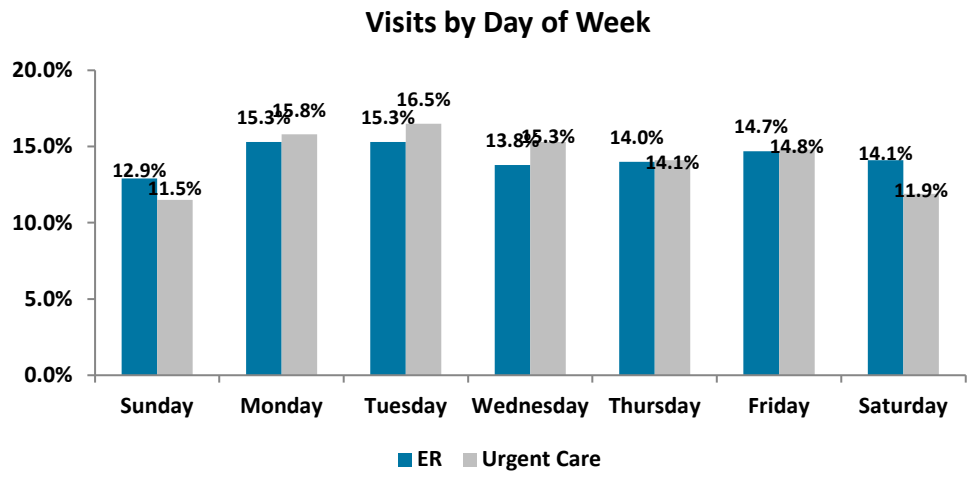
Diagnosis Sub-Grouper	Patients	Claims	Total Paid	% Paid
Screenings	5,443	10,716	$1,879,755	37.0%
Exams	7,180	13,507	$1,301,203	25.6%
Prophylactic Measures	3,752	5,040	$820,062	16.1%
Encounters - Infants/Children	2,316	3,307	$491,977	9.7%
Prosthetics/Devices/Implants	379	1,363	$210,699	4.1%
Personal History of Condition	630	1,023	$147,453	2.9%
Aftercare	365	772	$113,431	2.2%
Family History of Condition	127	188	$61,045	1.2%
Encounter - Transplant Related	36	226	$22,774	0.4%
Encounter - Procedure	45	55	$11,902	0.2%
Lifestyle/Situational Issues	83	177	$8,405	0.2%
Counseling	172	263	$6,016	0.1%
Acquired Absence	44	55	$4,469	0.1%
Health Status, Other	92	132	$4,017	0.1%
Miscellaneous Examinations	17	26	$1,755	0.0%
Follow-Up Encounters	12	22	$1,330	0.0%
Blood Type	2	2	$53	0.0%
Donors	1	1	$0	0.0%
Patient Non-compliance	1	1	$0	0.0%
Overall	**----**	**----**	**$5,086,346**	**100.0%**

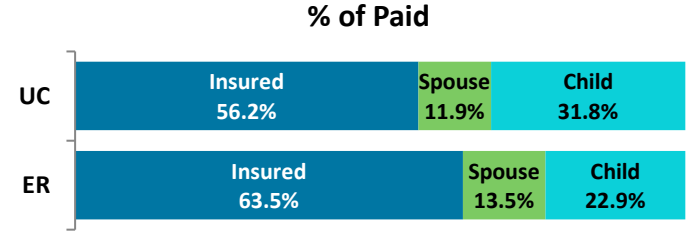
*Patient and claim counts are unique only within the category



Emergency Room / Urgent Care Summary

	3Q22		3Q23		Peer Index	
ER/Urgent Care	**ER**	**Urgent Care**	**ER**	**Urgent Care**	**ER**	**Urgent Care**
Number of Visits	3,691	6,732	3,088	5,566		
Visits Per Member	0.15	0.27	0.15	0.27	0.22	0.35
Visits/1000 Members	147	269	149	268	221	352
Avg Paid Per Visit	$1,918	$66	$2,283	$45	$968	$135
% with OV*	84.2%	79.9%	80.7%	78.5%		
% Avoidable	14.0%	32.2%	16.1%	41.4%		
Total Member Paid	**$3,937,212**	**$732,746**	**$3,940,686**	**$708,013**		
Total Plan Paid	**$7,079,338**	**$444,312**	**$7,051,027**	**$250,789**		
*looks back 12 months	Annualized	Annualized	Annualized	Annualized		





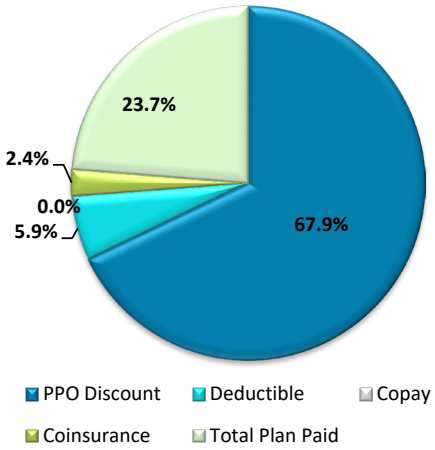
ER / UC Visits by Relationship						
Relationship	**ER**	**Per 1,000**	**Urgent Care**	**Per 1,000**	**Total**	**Per 1,000**
Insured	1,844	112	3,268	4,380	5,112	310
Spouse	377	118	570	863	947	296
Child	867	108	1,728	1,655	2,595	322
Total	**3,088**	**111**	**5,566**	**201**	**8,654**	**312**

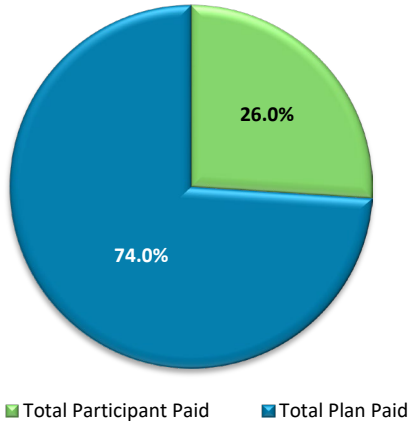
Hospital and physician urgent care centers are included in the data.
Paid amount includes facility and professional fees.

Savings Summary – Medical Claims

Description	Dollars	PPPM	% of Eligible
Eligible Charges	$284,721,117	$1,921	100.0%
PPO Discount	$184,120,095	$1,243	64.7%
Deductible	$15,986,523	$108	5.6%
Copay	$58,825	$0	0.0%
Coinsurance	$6,583,143	$44	2.3%
Total Participant Paid	**$22,628,491**	**$153**	**7.9%**
Total Plan Paid	**$64,366,069**	**$434**	**22.6%**

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





Paid Claims by Age Range – Dental

Dental Paid Claims by Age Group												
	3Q21		3Q22		3Q23		% Change	
Age Range	Dental Plan Paid	Dental PMPM	Dental Plan Paid	Dental PMPM	Dental Plan Paid	Dental PMPM	Dental Plan Paid	Dental PMPM
<1	$ 6,732	$ 1	$ 8,125	$ 2	$ 6,193	$ 2	-23.8%	-20.2%
1	$ 39,930	$ 8	$ 38,589	$ 8	$ 37,555	$ 9	-2.7%	12.7%
2 - 4	$ 292,346	$ 18	$ 304,460	$ 20	$ 297,020	$ 21	-2.4%	5.3%
5 - 9	$ 946,052	$ 31	$ 942,227	$ 32	$ 868,316	$ 31	-7.8%	-1.9%
10 - 14	$ 996,686	$ 28	$ 951,380	$ 28	$ 953,784	$ 29	0.3%	4.4%
15 - 19	$ 1,183,780	$ 32	$ 1,076,080	$ 29	$ 1,072,350	$ 29	-0.3%	0.0%
20 - 24	$ 744,485	$ 18	$ 678,238	$ 17	$ 650,075	$ 17	-4.2%	-2.6%
25 - 29	$ 735,064	$ 24	$ 646,038	$ 23	$ 555,431	$ 21	-14.0%	-8.7%
30 - 34	$ 907,351	$ 25	$ 857,552	$ 25	$ 724,862	$ 22	-15.5%	-10.5%
35 - 39	$ 1,058,840	$ 27	$ 1,038,679	$ 27	$ 919,981	$ 25	-11.4%	-7.6%
40 - 44	$ 1,032,669	$ 27	$ 1,025,864	$ 27	$ 995,763	$ 26	-2.9%	-2.9%
45 - 49	$ 1,120,566	$ 28	$ 1,080,130	$ 29	$ 989,198	$ 26	-8.4%	-8.8%
50 - 54	$ 1,292,156	$ 30	$ 1,343,834	$ 31	$ 1,263,941	$ 29	-5.9%	-5.1%
55 - 59	$ 1,513,204	$ 33	$ 1,519,728	$ 34	$ 1,414,266	$ 32	-6.9%	-5.0%
60 - 64	$ 1,887,026	$ 37	$ 1,934,543	$ 39	$ 1,717,029	$ 36	-11.2%	-7.8%
65+	$ 4,841,824	$ 40	$ 5,085,544	$ 42	$ 4,764,184	$ 39	-6.3%	-6.7%
Total	**$ 18,598,711**	**$ 30**	**$ 18,531,011**	**$ 31**	**$ 17,229,950**	**$ 29**	**-7.0%**	**-5.1%**

Dental Paid Claims – State Participants

Dental Paid Claims - Total State Participants	3Q22				3Q23				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Dental	$ 12,252,482	$ 1,616,498	$ 381,149	$ 14,250,129	$ 11,370,567	$ 1,583,426	$ 342,505	$ 13,296,498	-6.7%
Dental Exchange	$ -	$ -	$ 2,598,995	$ 2,598,995	$ -	$ -	$ 2,453,723	$ 2,453,723	-5.6%
Total	**$ 12,252,482**	**$ 1,616,498**	**$ 2,980,145**	**$ 16,849,125**	**$ 11,370,567**	**$ 1,583,426**	**$ 2,796,228**	**$ 15,750,221**	**-12.3%**

Dental Paid Claims - Per Participant per Month	3Q22				3Q23				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Dental	$ 52	$ 52	$ 55	$ 52	$ 49	$ 51	$ 53	$ 49	-6.4%
Dental Exchange	$ -	$ -	$ 51	$ 51	$ -	$ -	$ 47	$ 47	-6.8%

Dental Paid Claims – Non-State Participants

Dental Paid Claims - Total Non-State Participants	3Q22				3Q23				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Dental	$ 4,512	$ 114,130	$ 171,607	$ 290,248	$ 3,120	$ 69,024	$ 156,068	$ 228,212	-21.4%
Dental Exchange	$ -	$ -	$ 1,391,641	$ 1,391,641	$ -	$ -	$ 1,251,517	$ 1,251,517	-10.1%
Total	**$ 4,512**	**$ 114,130**	**$ 1,563,247**	**$ 1,681,889**	**$ 3,120**	**$ 69,024**	**$ 1,407,586**	**$ 1,479,729**	**-12.0%**

Dental Paid Claims - Per Participant per Month	3Q22				3Q23				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Dental	$ 55	$ 42	$ 43	$ 42	$ 58	$ 39	$ 42	$ 41	-2.8%
Dental Exchange	$ -	$ -	$ 43	$ 43	$ -	$ -	$ 41	$ 41	-3.4%

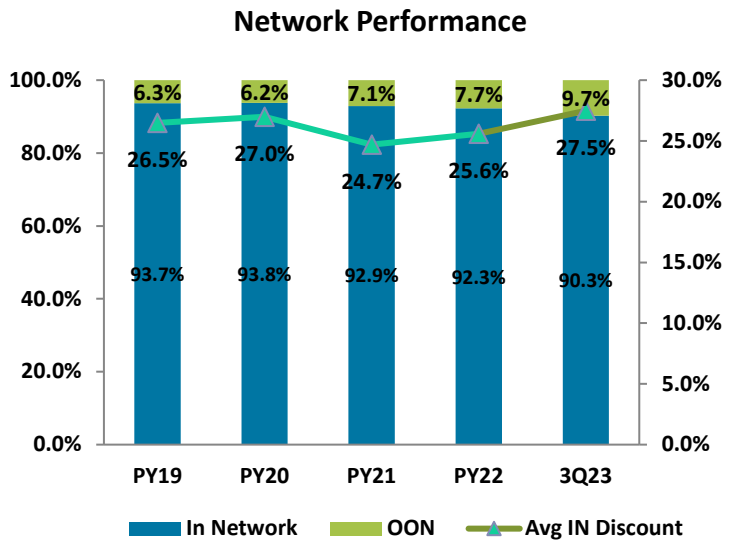
Dental Paid Claims – Total Participants

Dental Paid Claims - Total Total Participants	3Q22				3Q23				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Dental	$ 12,256,993	$ 1,730,629	$ 552,756	$ 14,540,378	$ 11,373,687	$ 1,652,449	$ 498,574	$ 13,524,710	-7.0%
Dental Exchange	$ -	$ -	$ 3,990,636	$ 3,990,636	$ -	$ -	$ 3,705,240	$ 3,705,240	-7.2%
Total	**$ 12,256,993**	**$ 1,730,629**	**$ 4,543,392**	**$ 18,531,014**	**$ 11,373,687**	**$ 1,652,449**	**$ 4,203,814**	**$ 17,229,950**	**-7.0%**

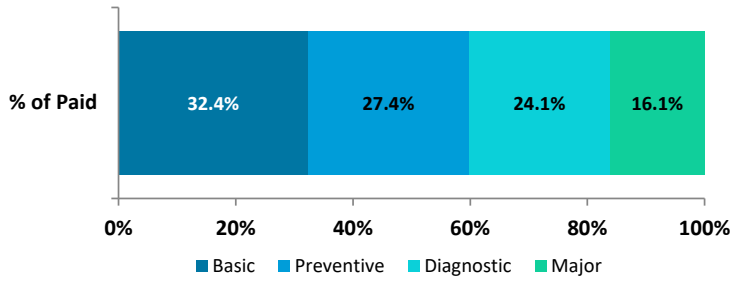
Dental Paid Claims - Per Participant per Month	3Q22				3Q23				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	
Dental	$ 52	$ 51	$ 51	$ 52	$ 49	$ 50	$ 49	$ 49	-6.3%
Dental Exchange	$ -	$ -	$ 49	$ 49	$ -	$ -	$ 45	$ 45	-7.0%

Dental Claims Analysis

Cost Distribution								
Paid Claims Category	Avg # of Members	% of Members	# Claims	# of Claims	Total Paid	% of Paid	Total EE Paid	% of EE Paid
$1,000.01 Plus	4,312	6.6%	17,410	19.3%	$6,453,537	37.5%	$3,933,161	49.2%
$750.01-$1,000.00	1,829	2.8%	6,343	7.1%	$1,619,202	9.4%	$907,552	11.3%
$500.01-$750.00	3,376	5.2%	10,532	11.7%	$2,112,144	12.3%	$1,042,218	13.0%
$250.01-$500.00	11,639	17.9%	29,155	32.4%	$4,127,595	24.0%	$1,096,202	13.7%
$0.01-$250.00	18,186	27.9%	26,126	29.0%	$2,917,472	16.9%	$975,435	12.2%
$0.00	394	0.6%	442	0.5%	$0	0.0%	$44,158	0.6%
No Claims	25,354	39.0%	0	0.0%	$0	0.0%	$0	0.0%
Total	**65,089**	**100.0%**	**90,008**	**100.0%**	**$17,229,950**	**100.0%**	**$7,998,726**	**100.0%**



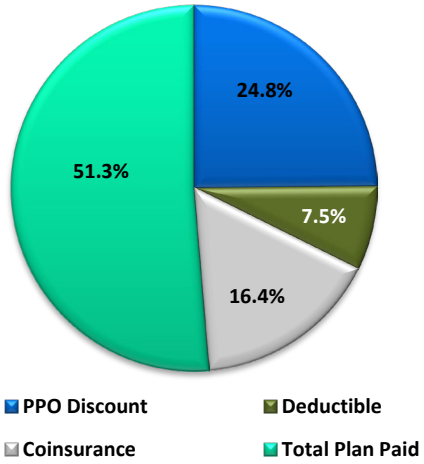
Claim Category	Total Paid	% of Paid
Basic	$5,574,552	32.4%
Preventive	$4,723,810	27.4%
Diagnostic	$4,155,975	24.1%
Major	$2,775,613	16.1%
Total	**$17,229,950**	**100.0%**

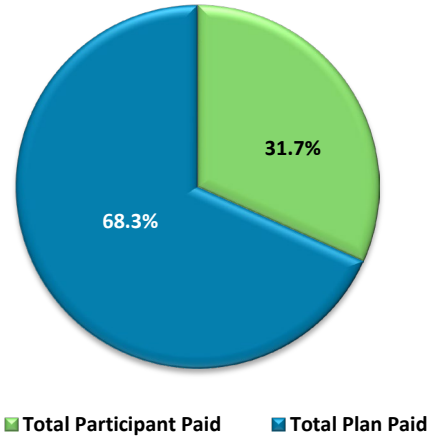


Savings Summary – Dental Claims

Description	Dollars	PPPM	% of Eligible
Eligible Charges	$33,187,097	$113	100.0%
PPO Discount	$8,338,811	$28	25.1%
Deductible	$2,506,083	$9	7.6%
Coinsurance	$5,492,643	$19	16.6%
Total Participant Paid	**$7,998,726**	**$27**	**24.1%**
Total Plan Paid	**$17,229,950**	**$59**	**51.9%**

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	1,002	973	29	96.2%
	<2 asthma related ER Visits in the last 6 months	1,002	1,001	1	99.9%
	No asthma related admit in last 12 months	1,002	1,000	2	99.8%
Chronic Obstructive Pulmonary Disease	No exacerbations in last 12 months	214	205	9	95.8%
	Members with COPD who had an annual spirometry test	214	39	175	18.2%
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	189	182	7	96.3%
	Follow-up OV within 4 weeks of discharge from HF admission	6	6	0	100.0%
Diabetes	Annual office visit	946	899	47	95.0%
	Annual dilated eye exam	946	369	577	39.0%
	Annual foot exam	946	383	563	40.5%
	Annual HbA1c test done	946	787	159	83.2%
	Diabetes Annual lipid profile	946	716	230	75.7%
	Annual microalbumin urine screen	946	669	277	70.7%
Hyperlipidemia	Hyperlipidemia Annual lipid profile	3,989	3,200	789	80.2%
Hypertension	Annual lipid profile	4,086	2,797	1,289	68.5%
	Annual serum creatinine test	3,948	3,166	782	80.2%
Wellness	Well Child Visit - 15 months	198	192	6	97.0%
	Routine office visit in last 6 months (All Ages)	27,181	15,926	11,255	58.6%
	Colorectal cancer screening ages 45-75 within the appropriate time period	11,255	5,080	6,175	45.1%
	Women age 25-65 with recommended cervical cancer/HPV screening	8,457	5,734	2,723	67.8%
	Males age greater than 49 with PSA test in last 24 months	4,440	2,166	2,274	48.8%
	Routine exam in last 24 months (All Ages)	27,181	22,448	4,733	82.6%
	Women age 40 to 75 with a screening mammogram last 24 months	7,188	4,221	2,967	58.7%

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	178	0.65%	6.42	$13,370
Asthma	1,125	4.13%	40.60	$11,999
Atrial Fibrillation	294	1.08%	10.61	$30,493
Blood Disorders	1,605	5.90%	57.92	$25,346
CAD	596	2.19%	21.51	$20,797
COPD	212	0.78%	7.65	$22,998
Cancer	1,074	3.95%	38.76	$25,752
Chronic Pain	660	2.43%	23.82	$22,011
Congestive Heart Failure	190	0.70%	6.86	$56,001
Demyelinating Diseases	64	0.24%	2.31	$39,128
Depression	1,633	6.00%	58.93	$13,010
Diabetes	1,702	6.26%	61.42	$15,996
ESRD	39	0.14%	1.41	$76,576
Eating Disorders	84	0.31%	3.03	$27,968
HIV/AIDS	36	0.13%	1.30	$74,712
Hyperlipidemia	4,961	18.23%	179.02	$9,284
Hypertension	4,125	15.16%	148.85	$12,119
Immune Disorders	104	0.38%	3.75	$67,604
Inflammatory Bowel Disease	93	0.34%	3.36	$39,715
Liver Diseases	525	1.93%	18.94	$26,529
Morbid Obesity	755	2.77%	27.24	$17,691
Osteoarthritis	1,076	3.95%	38.83	$15,533
Peripheral Vascular Disease	167	0.61%	6.03	$21,957
Rheumatoid Arthritis	155	0.57%	5.59	$24,680

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 March 31, 2023

Express Scripts

Membership Summary	1Q-3Q FY2023 CDHP	1Q-3Q FY2022 CDHP	Difference	% Change
			Membership Summary	
Member Count (Membership)	27,720	33,449	(5,729)	-17.1%
Utilizing Member Count (Patients)	19,723	25,050	(5,327)	-21.3%
Percent Utilizing (Utilization)	71.2%	74.9%	(0.04)	-5.0%

Claim Summary			Claims Summary	
Net Claims (Total Rx's)	284,290	329,736	(45,446)	-13.8%
Claims per Elig Member per Month (Claims PMPM)	1.14	1.10	0.04	3.6%
Total Claims for Generic (Generic Rx)	243,426	279,555	(36,129.00)	-12.9%
Total Claims for Brand (Brand Rx)	40,864	50,181	(9,317.00)	-18.6%
Total Claims for Brand w/Gen Equiv (Multisource Brand Claims)	1,130	2,021	(891.00)	-44.1%
Total Non-Specialty Claims	280,345	325,562	(45,217.00)	-13.9%
Total Specialty Claims	3,945	4,174	(229.00)	-5.5%
Generic % of Total Claims (GFR)	**85.6%**	**84.8%**	0.01	1.0%
Generic Effective Rate (GCR)	**99.5%**	**99.3%**	0.00	0.3%
Mail Order Claims	79,194	79,645	(451.00)	-0.6%
Mail Penetration Rate*	32.0%	28.3%	0.04	3.7%

Claims Cost Summary			Claims Cost Summary	
Total Prescription Cost (Total Gross Cost)	$32,708,629	$34,421,341	($1,712,712.00)	-5.0%
Total Generic Gross Cost	$3,738,579	$4,676,045	($937,466.00)	-20.0%
Total Brand Gross Cost	$28,970,050	$29,745,295	($775,245.00)	-2.6%
Total MSB Gross Cost	$629,317	$825,870	($196,553.00)	-23.8%
Total Ingredient Cost	$32,225,558	$33,678,814	($1,453,256.00)	-4.3%
Total Dispensing Fee	$447,194	$726,082	($278,888.00)	-38.4%
Total Other (e.g. tax)	$35,878	$16,445	$19,433.00	118.2%
Avg Total Cost per Claim (Gross Cost/Rx)	**$115.05**	**$104.39**	$10.66	10.2%
Avg Total Cost for Generic (Gross Cost/Generic Rx)	$15.36	$16.73	($1.37)	-8.2%
Avg Total Cost for Brand (Gross Cost/Brand Rx)	$708.94	$592.76	$116.18	19.6%
Avg Total Cost for MSB (MSB Gross Cost/MSB ARx)	$556.92	$408.64	$148.28	36.3%

Member Cost Summary			Member Cost Summary	
Total Member Cost	**$7,629,342**	**$8,737,701**	($1,108,359.00)	-12.7%
Total Copay	$6,005,466	$6,585,546	($580,080.00)	-8.8%
Total Deductible	$1,623,877	$2,152,158	($528,281.00)	-24.5%
Avg Copay per Claim (Copay/Rx)	$21.12	$19.97	$1.15	5.8%
Avg Participant Share per Claim (Copay+Deductible/RX)	**$26.84**	**$26.50**	**$0.34**	**1.3%**
Avg Copay for Generic (Copay/Generic Rx)	$6.85	$8.54	($1.69)	-19.8%
Avg Copay for Brand (Copay/Brand Rx)	$145.87	$126.56	$19.31	15.3%
Avg Copay for Brand w/ Generic Equiv (Copay/Multisource Rx)	$162.88	$103.55	$59.33	57.3%
Net PMPM (Participant Cost PMPM)	**$30.58**	**$29.02**	$1.56	5.4%
Copay % of Total Prescription Cost (Member Cost Share %)	23.3%	25.4%	-2.1%	-8.1%

Plan Cost Summary			Plan Cost Summary	
Total Plan Cost (Plan Cost)	**$25,079,287**	**$25,683,639**	**($604,352.00)**	**-2.4%**
Total Non-Specialty Cost (Non-Specialty Plan Cost)	$9,098,426	$9,400,461	($302,035.00)	-3.2%
Total Specialty Drug Cost (Specialty Plan Cost)	$15,980,860	$16,283,178	($302,318.00)	-1.9%
Avg Plan Cost per Claim (Plan Cost/Rx)	**$88.22**	**$77.89**	$10.33	13.3%
Avg Plan Cost for Generic (Plan Cost/Generic Rx)	$8.50	$8.19	$0.31	3.8%
Avg Plan Cost for Brand (Plan Cost/Brand Rx)	$563.06	$466.20	$96.86	20.8%
Avg Plan Cost for MSB (MSB Plan Cost/MSB ARx)	$394.03	$305.09	$88.94	29.2%
Net PMPM (Plan Cost PMPM)	**$100.53**	**$85.32**	**$15.21**	**17.8%**
PMPM without Specialty (Non-Specialty PMPM)	$36.47	$31.23	$4.02	17.3%
PMPM for Specialty Only (Specialty PMPM)	$64.06	$54.09	$9.97	18.4%
Specialty % of Plan Cost	63.7%	63.40%	$0.00	0.5%
Rebates Received (Q1-Q3 FY2023 actual)	$8,622,319	$7,831,838	$790,481.62	10.1%
Net PMPM (Plan Cost PMPM factoring Rebates)	**$65.97**	**$59.30**	**$6.66**	**11.2%**
PMPM without Specialty (Non-Specialty PMPM)	$15.36	$18.20	$0.92	5.0%
PMPM for Specialty Only (Specialty PMPM)	$50.00	$46.73	$3.27	7.0%

Appendix B

Index of Tables
UMR Inc. – LDPPO Utilization Review for PEBP
January 1, 2023 – March 31, 2023

DATASCOPE™

Nevada Public Employees' Benefits Program
Low Deductible Plan
July 2022 – March 2023 Incurred,
Paid through May 31, 2023

UMR℠

Overview

- Total Medical Spend for 3Q23 was $40,641,821 with an annualized plan cost per employee per year (PEPY) of $7,500. This is a decrease of 6.6% when compared to 3Q22.
  - IP Cost per Admit is $25,147 which is 43.1% lower than 3Q22.
  - ER Cost per Visit is $3,164 which is 27.1% higher than 3Q22.
- Employees shared in 13.8% of the medical cost.
- Inpatient facility costs were 21.5% of the plan spend.
- 83.3% of the Average Membership had paid Medical claims less than $2,500, with 19.0% of those having no claims paid at all during the reporting period.
- 43 members exceeded the $100k high-cost threshold during the reporting period, which accounted for 23.1% of the plan spend. The highest diagnosis category was Cancer, accounting for 36.9% of the high-cost claimant dollars.
- Total spending with in-network providers was 99.5%. The average In Network discount was 63.5%, which is .5% higher than the PY22 average discount of 63.2%.

Paid Claims by Age Group

Paid Claims by Age Group																
	3Q22						3Q23						% 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	$ 2,510,787	$ 3,361	$ 2,590	$ 3	$ 2,513,377	$ 3,365	$ 1,518,680	$ 1,096	$ 32,133	$ 23	$ 1,550,813	$ 1,119	-38.3%	-66.7%
1	$ 141,285	$ 155	$ 5,402	$ 6	$ 146,687	$ 161	$ 316,887	$ 241	$ 6,767	$ 5	$ 323,654	$ 246	120.6%	52.6%
2 - 4	$ 297,529	$ 100	$ 37,317	$ 13	$ 334,846	$ 113	$ 827,960	$ 171	$ 36,202	$ 7	$ 864,162	$ 178	158.1%	57.8%
5 - 9	$ 362,472	$ 70	$ 118,464	$ 23	$ 480,936	$ 93	$ 722,944	$ 83	$ 408,937	$ 47	$ 1,131,881	$ 130	135.3%	40.0%
10 - 14	$ 678,264	$ 111	$ 145,125	$ 24	$ 823,389	$ 134	$ 1,122,395	$ 119	$ 254,200	$ 27	$ 1,376,595	$ 146	67.2%	8.5%
15 - 19	$ 913,464	$ 146	$ 266,479	$ 43	$ 1,179,943	$ 189	$ 1,829,743	$ 169	$ 384,266	$ 36	$ 2,214,009	$ 205	87.6%	8.6%
20 - 24	$ 994,840	$ 159	$ 216,750	$ 35	$ 1,211,590	$ 194	$ 1,888,855	$ 184	$ 569,764	$ 56	$ 2,458,619	$ 240	102.9%	23.6%
25 - 29	$ 1,048,733	$ 225	$ 308,742	$ 66	$ 1,357,475	$ 292	$ 1,739,117	$ 214	$ 830,260	$ 102	$ 2,569,377	$ 316	89.3%	8.4%
30 - 34	$ 1,417,621	$ 250	$ 566,223	$ 100	$ 1,983,844	$ 349	$ 2,973,992	$ 304	$ 786,743	$ 80	$ 3,760,735	$ 385	89.6%	10.1%
35 - 39	$ 2,418,723	$ 369	$ 553,538	$ 84	$ 2,972,261	$ 453	$ 3,032,290	$ 272	$ 1,056,147	$ 95	$ 4,088,437	$ 367	37.6%	-19.0%
40 - 44	$ 2,266,667	$ 353	$ 758,455	$ 118	$ 3,025,122	$ 471	$ 3,483,133	$ 324	$ 1,560,761	$ 145	$ 5,043,894	$ 469	66.7%	-0.5%
45 - 49	$ 1,919,035	$ 335	$ 592,479	$ 103	$ 2,511,514	$ 438	$ 3,701,372	$ 386	$ 1,613,085	$ 168	$ 5,314,457	$ 554	111.6%	26.4%
50 - 54	$ 1,857,615	$ 294	$ 939,584	$ 149	$ 2,797,199	$ 443	$ 4,438,374	$ 427	$ 2,139,231	$ 206	$ 6,577,605	$ 632	135.1%	42.8%
55 - 59	$ 3,370,313	$ 576	$ 852,916	$ 146	$ 4,223,229	$ 722	$ 4,890,498	$ 524	$ 1,967,460	$ 211	$ 6,857,958	$ 735	62.4%	1.8%
60 - 64	$ 3,169,026	$ 644	$ 1,499,096	$ 305	$ 4,668,122	$ 948	$ 6,626,446	$ 801	$ 2,764,763	$ 334	$ 9,391,209	$ 1,135	101.2%	19.7%
65+	$ 1,792,081	$ 962	$ 417,242	$ 224	$ 2,209,323	$ 1,186	$ 1,529,135	$ 487	$ 775,753	$ 247	$ 2,304,888	$ 734	4.3%	-38.1%
Total	**$ 25,158,456**	**$ 329**	**$ 7,280,402**	**$ 95**	**$ 32,438,858**	**$ 424**	**$ 40,641,821**	**$ 319**	**$ 15,186,469**	**$ 119**	**$ 55,828,290**	**$ 439**	**72.1%**	**3.3%**

Financial Summary (p. 1 of 2)

	Total			State Active			Non-State Active		
Summary	**3Q22**	**3Q23**	**Variance to Prior Year**	**3Q22**	**3Q23**	**Variance to Prior Year**	**3Q22**	**3Q23**	**Variance to Prior Year**
Enrollment									
Avg # Employees	4,175	7,226	73.0%	3,780	6,561	73.6%	1	1	0.0%
Avg # Members	8,493	14,150	66.6%	7,830	13,028	66.4%	2	2	0.0%
Ratio	2.0	2.0	-3.4%	2.1	2.0	-3.9%	2.0	2.0	0.0%
Financial Summary									
Gross Cost	$29,751,991	$47,147,759	58.5%	$25,837,154	$40,990,958	58.7%	$31,539	$12,127	-61.5%
Client Paid	$25,158,456	$40,641,821	61.5%	$21,781,871	$35,216,533	61.7%	$26,601	$9,284	-65.1%
Employee Paid	$4,593,536	$6,505,938	41.6%	$4,055,283	$5,774,424	42.4%	$4,938	$2,842	-42.4%
Client Paid-PEPY	$8,034	$7,500	-6.6%	$7,683	$7,156	-6.9%	$35,468	$12,379	-65.1%
Client Paid-PMPY	$3,949	$3,830	-3.0%	$3,709	$3,604	-2.8%	$17,734	$6,190	-65.1%
Client Paid-PEPM	$669	$625	-6.6%	$640	$596	-6.9%	$2,956	$1,032	-65.1%
Client Paid-PMPM	$329	$319	-3.0%	$309	$300	-2.9%	$1,478	$516	-65.1%
High Cost Claimants (HCC's) > $100k									
# of HCC's	33	43	30.3%	27	34	25.9%	0	0	0.0%
HCC's / 1,000	3.9	3.0	-21.9%	3.5	2.6	-24.3%	0.0	0.0	0.0%
Avg HCC Paid	$263,630	$218,375	-17.2%	$273,797	$225,632	-17.6%	$0	$0	0.0%
HCC's % of Plan Paid	34.6%	23.1%	-33.2%	33.9%	21.8%	-35.7%	0.0%	0.0%	0.0%
Cost Distribution by Claim Type (PMPY)									
Facility Inpatient	$1,330	$822	-38.2%	$1,299	$769	-40.8%	$566	$0	0.0%
Facility Outpatient	$1,023	$1,366	33.5%	$915	$1,252	36.8%	$6,869	$584	0.0%
Physician	$1,545	$1,642	6.3%	$1,447	$1,582	9.3%	$10,299	$5,606	-45.6%
Other	$52	$0	-100.0%	$49	$0	-100.0%	$0	$0	0.0%
Total	$3,949	$3,830	-3.0%	$3,709	$3,604	-2.8%	$17,734	$6,190	-65.1%
	Annualized	Annualized		Annualized	Annualized		Annualized	Annualized	

Financial Summary (p. 2 of 2)

	State Retirees			Non-State Retirees			
Summary	**3Q22**	**3Q23**	**Variance to Prior Year**	**3Q22**	**3Q23**	**Variance to Prior Year**	**Peer Index**
Enrollment							
Avg # Employees	374	637	70.4%	21	27	26.3%	
Avg # Members	630	1,080	71.4%	32	39	21.5%	
Ratio	1.7	1.7	0.6%	1.5	1.5	-3.9%	1.6
Financial Summary							
Gross Cost	$3,641,943	$5,851,517	60.7%	$241,355	$293,157	21.5%	
Client Paid	$3,152,224	$5,156,304	63.6%	$197,759	$259,699	31.3%	
Employee Paid	$489,719	$695,213	42.0%	$43,596	$33,458	-23.3%	
Client Paid-PEPY	$11,248	$10,800	-4.0%	$12,490	$12,985	4.0%	$6,642
Client Paid-PMPY	$6,669	$6,364	-4.6%	$8,211	$8,879	8.1%	$4,116
Client Paid-PEPM	$937	$900	-3.9%	$1,041	$1,082	3.9%	$553
Client Paid-PMPM	$556	$530	-4.7%	$684	$740	8.2%	$343
High Cost Claimants (HCC's) > $100k							
# of HCC's	6	9	50.0%	1	1	0.0%	
HCC's / 1,000	9.5	8.3	-12.5%	31.1	25.6	0.0%	
Avg HCC Paid	$199,468	$179,387	-10.1%	$110,440	$104,131	0.0%	
HCC's % of Plan Paid	38.0%	31.3%	-17.6%	55.8%	40.1%	0.0%	
Cost Distribution by Claim Type (PMPY)							
Facility Inpatient	$1,743	$1,435	-17.7%	$901	$1,517	68.4%	$1,190
Facility Outpatient	$2,188	$2,600	18.8%	$4,088	$5,214	27.5%	$1,376
Physician	$2,649	$2,330	-12.0%	$3,174	$2,148	-32.3%	$1,466
Other	$89	$0	-100.0%	$48	$0	-100.0%	$84
Total	$6,669	$6,364	-4.6%	$8,211	$8,879	8.1%	$4,116
	Annualized	Annualized		Annualized	Annualized		

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

	Total			State Active			Non-State Active		
Summary	**PY22**	**3Q23**	**Variance to Prior Year**	**PY22**	**3Q23**	**Variance to Prior Year**	**PY22**	**3Q23**	**Variance to Prior Year**
Enrollment									
Avg # Employees	4,336	7,226	66.6%	3,926	6,561	67.1%	1	1	0.0%
Avg # Members	8,762	14,150	61.5%	8,071	13,028	61.4%	2	2	0.0%
Ratio	2.0	2.0	-3.0%	2.1	2.0	-3.4%	2.0	2.0	0.0%
Financial Summary									
Gross Cost	$40,570,436	$47,147,759	16.2%	$35,366,785	$40,990,958	15.9%	$38,494	$12,127	-68.5%
Client Paid	$34,446,692	$40,641,821	18.0%	$29,933,591	$35,216,533	17.6%	$33,556	$9,284	-72.3%
Employee Paid	$6,123,744	$6,505,938	6.2%	$5,433,194	$5,774,424	6.3%	$4,938	$2,842	-42.4%
Client Paid-PEPY	$7,944	$7,500	-5.6%	$7,624	$7,156	-6.1%	$33,556	$12,379	-63.1%
Client Paid-PMPY	$3,931	$3,830	-2.6%	$3,709	$3,604	-2.8%	$16,778	$6,190	-63.1%
Client Paid-PEPM	$662	$625	-5.6%	$635	$596	-6.1%	$2,796	$1,032	-63.1%
Client Paid-PMPM	$328	$319	-2.7%	$309	$300	-2.9%	$1,398	$516	-63.1%
High Cost Claimants (HCC's) > $100k									
# of HCC's	41	43	4.9%	33	34	3.0%	0	0	0.0%
HCC's / 1,000	4.7	3.0	-35.0%	4.1	2.6	-36.2%	0.0	0.0	0.0%
Avg HCC Paid	$286,071	$218,375	-23.7%	$305,172	$225,632	-26.1%	$0	$0	0.0%
HCC's % of Plan Paid	34.0%	23.1%	-32.1%	33.6%	21.8%	-35.1%	0.0%	0.0%	0.0%
Cost Distribution by Claim Type (PMPY)									
Facility Inpatient	$1,269	$822	-35.2%	$1,257	$769	-38.8%	$424	$0	-100.0%
Facility Outpatient	$1,043	$1,366	31.0%	$933	$1,252	34.2%	$5,152	$584	-88.7%
Physician	$1,567	$1,642	4.8%	$1,468	$1,582	7.8%	$9,883	$5,606	-43.3%
Other	$53	$0	-100.0%	$50	$0	-100.0%	$1,319	$0	-100.0%
Total	$3,931	$3,830	-2.6%	$3,709	$3,604	-2.8%	$16,778	$6,190	-63.1%
		Annualized			Annualized			Annualized	

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

	State Retirees			Non-State Retirees			
Summary	**PY22**	**3Q23**	**Variance to Prior Year**	**PY22**	**3Q23**	**Variance to Prior Year**	**Peer Index**
Enrollment							
Avg # Employees	388	637	64.2%	21	27	25.5%	
Avg # Members	657	1,080	64.4%	32	39	20.9%	
Ratio	1.7	1.7	0.6%	1.5	1.5	-3.9%	1.6
Financial Summary							
Gross Cost	$4,886,927	$5,851,517	19.7%	$278,229	$293,157	5.4%	
Client Paid	$4,252,910	$5,156,304	21.2%	$226,635	$259,699	14.6%	
Employee Paid	$634,017	$695,213	9.7%	$51,594	$33,458	-35.2%	
Client Paid-PEPY	$10,968	$10,800	-1.5%	$10,665	$12,985	21.8%	$6,642
Client Paid-PMPY	$6,473	$6,364	-1.7%	$7,027	$8,879	26.4%	$4,116
Client Paid-PEPM	$914	$900	-1.5%	$889	$1,082	21.7%	$553
Client Paid-PMPM	$539	$530	-1.7%	$586	$740	26.3%	$343
High Cost Claimants (HCC's) > $100k							
# of HCC's	8	9	12.5%	1	1	0.0%	
HCC's / 1,000	12.2	8.3	-31.6%	31.0	25.6	-17.3%	
Avg HCC Paid	$193,399	$179,387	-7.2%	$111,053	$104,131	-6.2%	
HCC's % of Plan Paid	36.4%	31.3%	-14.0%	49.0%	40.1%	-18.2%	
Cost Distribution by Claim Type (PMPY)							
Facility Inpatient	$1,452	$1,435	-1.2%	$675	$1,517	124.7%	$1,190
Facility Outpatient	$2,262	$2,600	14.9%	$3,333	$5,214	56.4%	$1,376
Physician	$2,676	$2,330	-12.9%	$2,969	$2,148	-27.7%	$1,466
Other	$83	$0	-100.0%	$50	$0	-100.0%	$84
Total	$6,473	$6,364	-1.7%	$7,027	$8,879	26.4%	$4,116
		Annualized			Annualized		

Paid Claims by Claim Type – State Participants

Net Paid Claims - Total State Participants	3Q22				3Q23				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical									
Inpatient	$ 8,667,213	$ 880,840	$ 1,944	$ 9,549,997	$ 8,889,971	$ 1,283,201	$ 10,531	$ 10,183,702	6.6%
Outpatient	$ 13,114,658	$ 2,234,103	$ 35,337	$ 15,384,099	$ 26,326,563	$ 3,708,372	$ 154,199	$ 30,189,135	96.2%
Total - Medical	**$ 21,781,871**	**$ 3,114,943**	**$ 37,281**	**$ 24,934,095**	**$ 35,216,533**	**$ 4,991,574**	**$ 164,730**	**$ 40,372,837**	**61.9%**

Net Paid Claims - Per Participant per Month	3Q22				3Q23				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical	$ 640	$ 997	$ 156	$ 667	$ 596	$ 932	$ 443	$ 623	-6.6%

Paid Claims by Claim Type – Non-State Participants

Net Paid Claims - Total Non-State Participants	3Q22				3Q23				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical									
Inpatient	$ 1,051	$ 19,252	$ 5,164	$ 25,467	$ -	$ 47,476	$ 564	$ 48,040	88.6%
Outpatient	$ 25,550	$ 133,244	$ 40,099	$ 198,893	$ 9,284	$ 88,780	$ 122,879	$ 220,943	11.1%
Total - Medical	**$ 26,601**	**$ 152,496**	**$ 45,263**	**$ 224,360**	**$ 9,284**	**$ 136,256**	**$ 123,444**	**$ 268,984**	**19.9%**

Net Paid Claims - Per Participant per Month	3Q22				3Q23				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical	$ 3,801	$ 1,439	$ 539	$ 1,139	$ 1,032	$ 1,117	$ 1,046	$ 1,080	-5.1%

Paid Claims by Claim Type – Total Participants

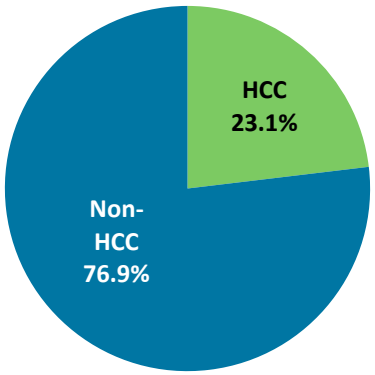
Net Paid Claims - Total Total Participants	3Q22				3Q23				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical									
Inpatient	$ 8,668,264	$ 900,092	$ 7,107	$ 9,575,463	$ 8,889,971	$ 1,330,677	$ 11,095	$ 10,231,743	6.9%
Outpatient	$ 13,140,208	$ 2,367,347	$ 75,437	$ 15,582,992	$ 26,335,847	$ 3,797,152	$ 277,079	$ 30,410,078	95.1%
Total - Medical	**$ 21,808,472**	**$ 3,267,439**	**$ 82,544**	**$ 25,158,456**	**$ 35,225,818**	**$ 5,127,829**	**$ 288,174**	**$ 40,641,821**	**61.5%**

Net Paid Claims - Per Participant per Month	3Q22				3Q23				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical	$ 641	$ 1,012	$ 256	$ 669	$ 596	$ 936	$ 588	$ 625	-6.6%

Cost Distribution – Medical Claims

3Q22							3Q23					
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
31	0.4%	$8,699,776	34.6%	$165,116	3.6%	$100,000.01 Plus	39	0.3%	$9,291,746	22.9%	$164,028	2.5%
34	0.4%	$2,484,479	9.9%	$163,320	3.6%	$50,000.01-$100,000.00	52	0.4%	$4,157,579	10.2%	$222,857	3.4%
77	0.9%	$2,782,530	11.1%	$299,336	6.5%	$25,000.01-$50,000.00	132	0.9%	$4,738,511	11.7%	$472,032	7.3%
203	2.4%	$3,289,052	13.1%	$680,467	14.8%	$10,000.01-$25,000.00	468	3.3%	$7,607,951	18.7%	$1,281,956	19.7%
320	3.8%	$2,398,248	9.5%	$654,879	14.3%	$5,000.01-$10,000.00	600	4.2%	$4,426,192	10.9%	$1,069,593	16.4%
510	6.0%	$1,909,754	7.6%	$726,862	15.8%	$2,500.01-$5,000.00	1,061	7.5%	$3,927,204	9.7%	$1,132,702	17.4%
5,283	62.2%	$3,594,300	14.3%	$1,882,433	41.0%	$0.01-$2,500.00	9,004	63.6%	$6,492,638	16.0%	$2,157,654	33.2%
100	1.2%	$0	0.0%	$21,043	0.5%	$0.00	103	0.7%	$0	0.0%	$5,115	0.1%
1,935	22.8%	$317	0.0%	$80	0.0%	No Claims	2,690	19.0%	$0	0.0%	$0	0.0%
8,493	**100.0%**	**$25,158,456**	**100.0%**	**$4,593,536**	**100.0%**		**14,150**	**100.0%**	**$40,641,821**	**100.0%**	**$6,505,938**	**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	$3,464,099	36.9%
Endocrine/Metabolic Disorders	16	$1,139,955	12.1%
Trauma/Accidents	15	$1,072,564	11.4%
Cardiac Disorders	26	$740,927	7.9%
Neurological Disorders	20	$623,665	6.6%
Medical/Surgical Complications	12	$446,002	4.7%
Gastrointestinal Disorders	23	$316,499	3.4%
Renal/Urologic Disorders	14	$244,858	2.6%
Pulmonary Disorders	23	$237,628	2.5%
Spine-related Disorders	10	$196,756	2.1%
All Other		$907,154	9.7%
Overall	**----**	**$9,390,106**	**100.0%**

Utilization Summary (p. 1 of 2)

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

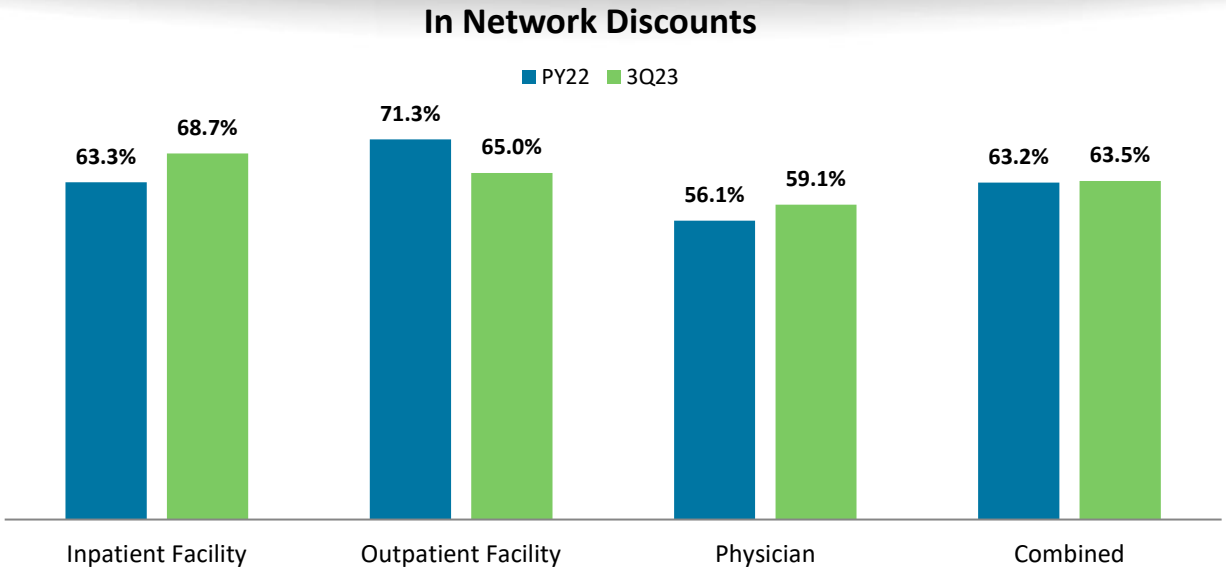
	Total			State Active			Non-State Active		
Summary	**3Q22**	**3Q23**	**Variance to Prior Year**	**3Q22**	**3Q23**	**Variance to Prior Year**	**3Q22**	**3Q23**	**Variance to Prior Year**
Inpatient Facility									
# of Admits	239	411		206	370		1	0	
# of Bed Days	1,294	1,781		1,181	1,585		1	0	
Paid Per Admit	$44,229	$25,147	-43.1%	$45,460	$24,333	-46.5%	$2,303	$0	0.0%
Paid Per Day	$8,169	$5,803	-29.0%	$7,930	$5,680	-28.4%	$2,303	$0	0.0%
Admits Per 1,000	38	39	2.6%	35	38	8.6%	667	0	0.0%
Days Per 1,000	203	168	-17.2%	201	162	-19.4%	667	0	0.0%
Avg LOS	5.4	4.3	-20.4%	5.7	4.3	-24.6%	1	0	0.0%
# Admits From ER	120	205		99	179		0	0	
Physician Office									
OV Utilization per Member	4.6	4.9	6.5%	4.5	4.8	6.7%	14.7	12.7	-13.6%
Avg Paid per OV	$126	$116	-7.9%	$120	$116	-3.3%	$299	$295	-1.3%
Avg OV Paid per Member	$586	$571	-2.6%	$539	$553	2.6%	$4,385	$3,740	-14.7%
DX&L Utilization per Member	8.1	10.1	24.7%	7.7	9.7	26.0%	29.3	25.3	-13.7%
Avg Paid per DX&L	$51	$58	13.7%	$48	$57	18.8%	$97	$57	-41.2%
Avg DX&L Paid per Member	$408	$589	44.4%	$368	$552	50.0%	$2,845	$1,452	-49.0%
Emergency Room									
# of Visits	850	1,536		788	1,406		1	0	
Visits Per Member	0.13	0.14	7.7%	0.13	0.14	7.7%	0.67	0	0.0%
Visits Per 1,000	133	145	9.0%	134	144	7.5%	667	0	0.0%
Avg Paid per Visit	$2,490	$3,164	27.1%	$2,466	$3,192	29.4%	$4,222	$0	0.0%
Urgent Care									
# of Visits	1,972	3,925		1,847	3,719		0	2	
Visits Per Member	0.31	0.37	19.4%	0.31	0.38	22.6%	0.00	1.33	0.0%
Visits Per 1,000	310	370	19.4%	315	381	21.0%	0	1,333	0.0%
Avg Paid per Visit	$118	$99	-16.1%	$117	$98	-16.2%	$0	$154	0.0%
	Annualized	Annualized		Annualized	Annualized		Annualized	Annualized	

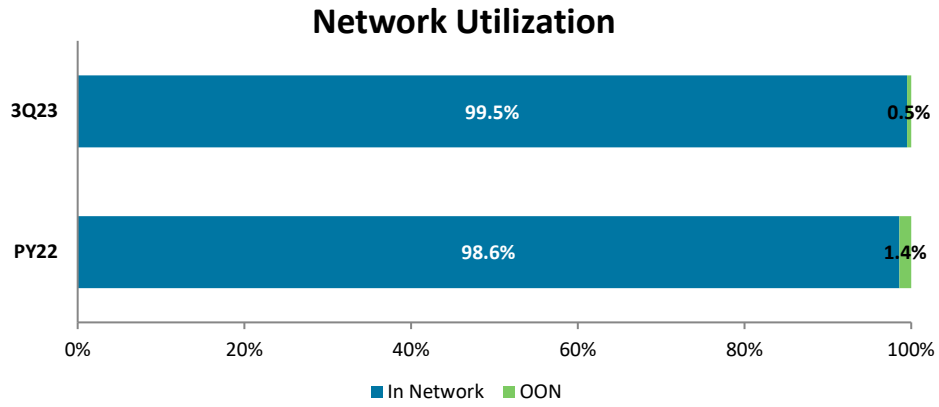
Utilization Summary (p. 2 of 2)

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

	State Retirees			Non-State Retirees			
Summary	**3Q22**	**3Q23**	**Variance to Prior Year**	**3Q22**	**3Q23**	**Variance to Prior Year**	**Peer Index**
Inpatient Facility							
# of Admits	25	40		7	1		
# of Bed Days	91	193		21	3		
Paid Per Admit	$41,443	$32,111	-22.5%	$23,928	$47,476	98.4%	$18,822
Paid Per Day	$11,385	$6,655	-41.5%	$7,976	$15,825	98.4%	$3,265
Admits Per 1,000	53	49	-7.5%	291	34	-88.3%	70
Days Per 1,000	193	238	23.3%	872	103	-88.2%	402
Avg LOS	3.6	4.8	33.3%	3.0	3.0	0.0%	5.8
# Admits From ER	17	26		4	0		
Physician Office							
OV Utilization per Member	6.2	6.5	4.8%	6.9	7.8	13.0%	5.4
Avg Paid per OV	$185	$120	-35.1%	$100	$87	-13.0%	$96
Avg OV Paid per Member	$1,153	$775	-32.8%	$694	$683	-1.6%	$515
DX&L Utilization per Member	12.5	15.1	20.8%	13	17.6	35.4%	11.0
Avg Paid per DX&L	$69	$67	-2.9%	$85	$68	-20.0%	$50
Avg DX&L Paid per Member	$857	$1,012	18.1%	$1,103	$1,197	8.5%	$543
Emergency Room							
# of Visits	60	126		1	4		
Visits Per Member	0.13	0.16	23.1%	0.04	0.14	0.0%	0.22
Visits Per 1,000	127	156	22.8%	42	137	0.0%	221
Avg Paid per Visit	$2,785	$2,921	4.9%	$1,827	$1,034	0.0%	$968
Urgent Care							
# of Visits	123	200		2	4		
Visits Per Member	0.26	0.25	-3.8%	0.08	0.14	0.0%	0.35
Visits Per 1,000	260	247	-5.0%	83	137	0.0%	352
Avg Paid per Visit	$139	$102	-26.6%	$70	$69	0.0%	$135
	Annualized	Annualized		Annualized	Annualized		

Provider Network Summary





Inc Jul22-Mar23, Pd through May23

Diagnosis Grouper Summary

Diagnosis Grouper	Total Paid	% Paid	Insured	Spouse	Child	Male	Female
Cancer	$4,535,958	11.2%	$2,488,676	$1,897,238	$150,043	$1,489,826	$3,046,131
Gastrointestinal Disorders	$3,541,650	8.7%	$2,280,620	$791,137	$469,894	$1,247,494	$2,294,156
Health Status/Encounters	$3,229,906	7.9%	$1,740,454	$430,132	$1,059,320	$1,153,027	$2,076,879
Trauma/Accidents	$2,892,534	7.1%	$1,147,893	$1,134,306	$610,335	$1,220,739	$1,671,795
Cardiac Disorders	$2,625,002	6.5%	$1,718,474	$740,874	$165,654	$1,572,479	$1,052,523
Pregnancy-related Disorders	$2,546,229	6.3%	$1,257,899	$480,128	$808,202	$381,126	$2,165,103
Neurological Disorders	$2,477,942	6.1%	$1,481,739	$340,473	$655,730	$795,477	$1,682,465
Mental Health	$2,342,514	5.8%	$985,502	$404,607	$952,405	$854,521	$1,487,993
Musculoskeletal Disorders	$2,253,249	5.5%	$1,450,313	$463,419	$339,517	$851,636	$1,401,613
Endocrine/Metabolic Disorders	$2,034,050	5.0%	$1,326,191	$583,800	$124,060	$426,416	$1,607,634
Eye/ENT Disorders	$1,876,181	4.6%	$969,961	$220,792	$685,427	$721,094	$1,155,086
Spine-related Disorders	$1,506,481	3.7%	$1,083,037	$311,536	$111,908	$823,177	$683,303
Gynecological/Breast Disorders	$1,337,008	3.3%	$952,423	$210,450	$174,135	$37,900	$1,299,109
Pulmonary Disorders	$1,261,260	3.1%	$614,739	$209,120	$437,401	$660,113	$601,147
Infections	$1,159,103	2.9%	$615,146	$175,804	$368,152	$592,501	$566,601
Renal/Urologic Disorders	$1,033,062	2.5%	$568,579	$194,766	$269,717	$406,602	$626,460
Non-malignant Neoplasm	$777,324	1.9%	$554,268	$191,797	$31,260	$176,875	$600,449
Medical/Surgical Complications	$659,298	1.6%	$513,223	$39,985	$106,090	$474,132	$185,166
Dermatological Disorders	$452,478	1.1%	$260,520	$72,972	$118,986	$188,760	$263,718
Diabetes	$375,801	0.9%	$223,971	$130,252	$21,577	$208,041	$167,760
Miscellaneous	$369,171	0.9%	$223,052	$59,795	$86,324	$133,968	$235,204
Congenital/Chromosomal Anomalies	$317,080	0.8%	$26,889	$145,645	$144,546	$255,152	$61,929
Abnormal Lab/Radiology	$313,117	0.8%	$226,110	$67,990	$19,017	$92,453	$220,663
Hematological Disorders	$245,957	0.6%	$156,732	$45,120	$44,106	$141,993	$103,964
Vascular Disorders	$157,391	0.4%	$95,100	$52,265	$10,026	$80,842	$76,549
Medication Related Conditions	$127,753	0.3%	$66,805	$6,599	$54,349	$60,506	$67,247
Cholesterol Disorders	$106,009	0.3%	$83,618	$19,210	$3,182	$55,670	$50,339
Allergic Reaction	$42,762	0.1%	$13,809	$818	$28,134	$13,446	$29,316
External Hazard Exposure	$25,889	0.1%	$11,094	$150	$14,644	$5,783	$20,105
Dental Conditions	$18,634	0.0%	$3,452	$2,057	$13,125	$9,945	$8,689
Social Determinants of Health	$941	0.0%	$831	$110	$0	$435	$506
Cause of Morbidity	$87	0.0%	$26	$61	$0	$0	$87
Total	**$40,641,821**	**100.0%**	**$23,141,145**	**$9,423,408**	**$8,077,267**	**$15,132,129**	**$25,509,692**

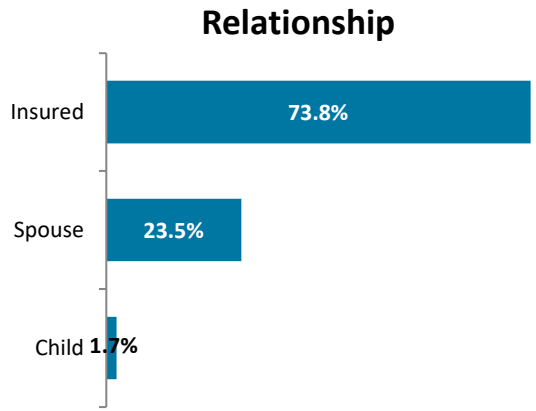
Mental Health Drilldown

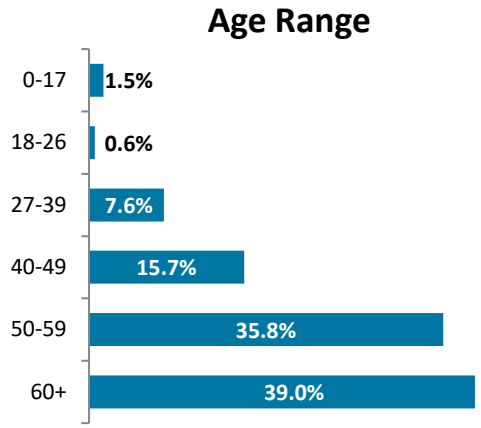
	PY22		3Q23	
Grouper	Patients	Total Paid	Patients	Total Paid
Depression	453	$568,975	711	$612,628
Mood and Anxiety Disorders	613	$271,735	924	$491,263
Mental Health Conditions, Other	431	$351,519	642	$379,079
Alcohol Abuse/Dependence	20	$75,926	57	$223,326
Developmental Disorders	59	$215,640	90	$159,032
Bipolar Disorder	107	$247,201	160	$138,419
Attention Deficit Disorder	199	$80,894	356	$92,308
Eating Disorders	24	$147,776	38	$90,077
Schizophrenia	4	$2,259	10	$42,786
Sleep Disorders	124	$26,517	187	$41,612
Substance Abuse/Dependence	29	$68,285	42	$26,112
Sexually Related Disorders	28	$8,553	46	$20,270
Psychoses	6	$10,965	10	$11,694
Personality Disorders	14	$15,495	15	$8,696
Tobacco Use Disorder	16	$4,458	40	$2,663
Complications of Substance Abuse	6	$27,466	10	$2,548
Total		**$2,123,665**		**$2,342,514**

Diagnosis Grouper – Cancer

Diagnosis Sub-Grouper	Patients	Claims	Total Paid	% Paid
Cancer Therapies	25	158	$2,302,858	50.8%
Breast Cancer	79	737	$769,818	17.0%
Secondary Cancers	21	170	$253,811	5.6%
Non-Melanoma Skin Cancers	67	227	$214,191	4.7%
Cancers, Other	50	316	$204,159	4.5%
Brain Cancer	4	140	$201,966	4.5%
Prostate Cancer	28	192	$133,635	2.9%
Thyroid Cancer	28	124	$129,143	2.8%
Colon Cancer	7	91	$95,693	2.1%
Lymphomas	16	205	$70,281	1.5%
Cervical/Uterine Cancer	14	43	$36,928	0.8%
Carcinoma in Situ	35	86	$31,156	0.7%
Leukemias	7	77	$26,534	0.6%
Lung Cancer	10	110	$24,257	0.5%
Myeloma	2	60	$18,680	0.4%
Melanoma	18	40	$13,472	0.3%
Kidney Cancer	11	36	$7,679	0.2%
Pancreatic Cancer	1	17	$1,189	0.0%
Ovarian Cancer	2	6	$479	0.0%
Bladder Cancer	1	1	$29	0.0%
Overall	**----**	**----**	**$4,535,958**	**100.0%**

*Patient and claim counts are unique only within the category

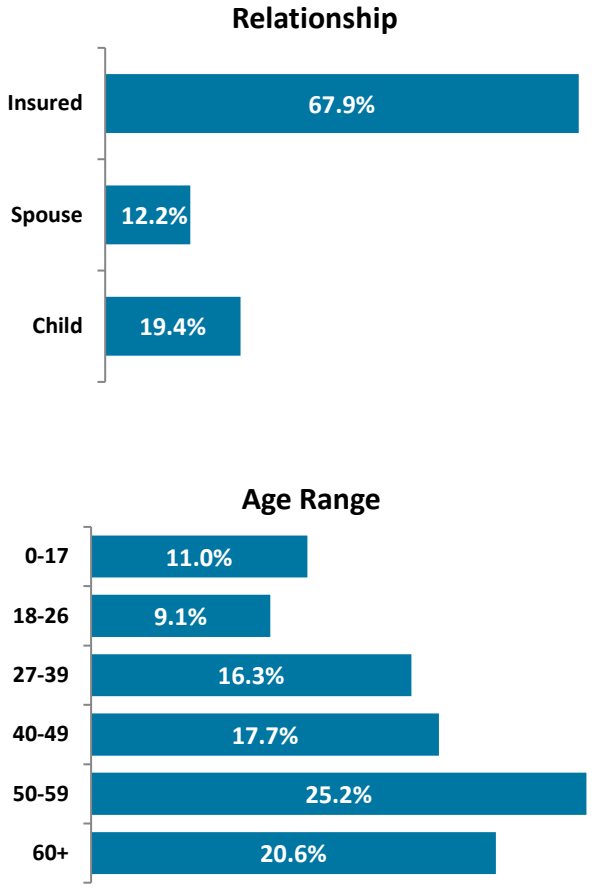




Diagnosis Grouper – Gastrointestinal Orders

Diagnosis Sub-Grouper	Patients	Claims	Total Paid	% Paid
GI Disorders, Other	419	1,033	$661,795	18.7%
Abdominal Disorders	834	1,923	$640,960	18.1%
Gallbladder and Biliary Disease	88	409	$519,266	14.7%
Upper GI Disorders	431	953	$371,953	10.5%
Hernias	87	261	$344,911	9.7%
GI Symptoms	514	1,006	$218,532	6.2%
Appendicitis	13	70	$168,272	4.8%
Diverticulitis	71	163	$165,023	4.7%
Inflammatory Bowel Disease	55	245	$131,680	3.7%
Pancreatic Disorders	20	84	$107,678	3.0%
Constipation	141	265	$74,454	2.1%
Liver Diseases	159	305	$53,300	1.5%
Hemorrhoids	97	189	$36,003	1.0%
Ostomies	12	70	$21,982	0.6%
Peptic Ulcer/Related Disorders	19	34	$19,237	0.5%
Hepatic Cirrhosis	12	23	$4,668	0.1%
Esophageal Varices	2	3	$1,935	0.1%
	----	----	$3,541,650	100.0%

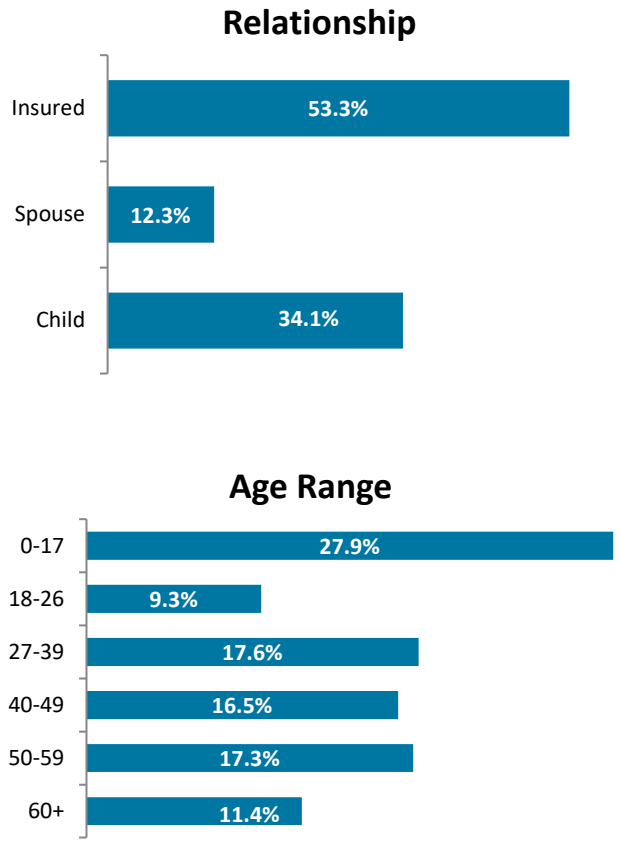
*Patient and claim counts are unique only within the category



Diagnosis Grouper – Health Status/Encounters

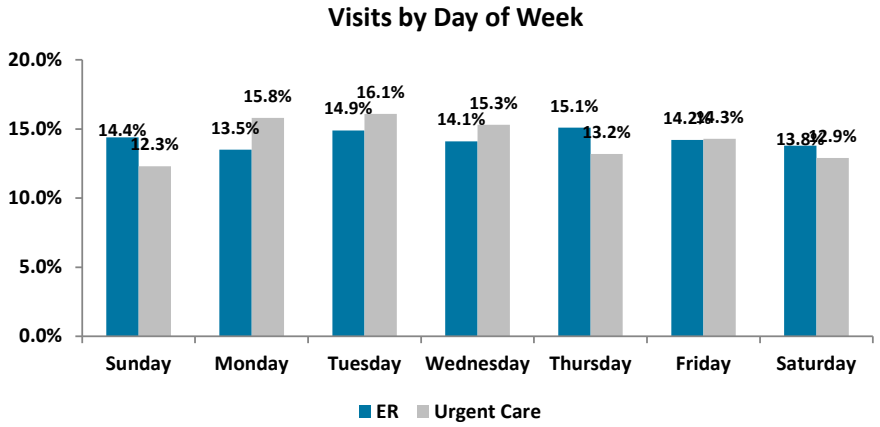
Diagnosis Category	Patients	Claims	Total Paid	% Paid
Screenings	3,102	6,139	$1,005,949	31.1%
Exams	4,074	7,542	$804,738	24.9%
Prophylactic Measures	2,535	3,513	$644,462	20.0%
Encounters - Infants/Children	1,785	2,718	$400,554	12.4%
Personal History of Condition	377	715	$152,744	4.7%
Prosthetics/Devices/Implants	154	510	$72,278	2.2%
Aftercare	170	349	$60,248	1.9%
Family History of Condition	101	145	$39,707	1.2%
Encounter - Transplant Related	13	63	$16,941	0.5%
Encounter - Procedure	51	64	$8,421	0.3%
Counseling	87	150	$6,600	0.2%
Lifestyle/Situational Issues	49	95	$4,696	0.1%
Acquired Absence	14	19	$4,583	0.1%
Follow-Up Encounters	3	9	$3,190	0.1%
Donors	2	2	$2,625	0.1%
Miscellaneous Examinations	21	44	$1,436	0.0%
Health Status, Other	36	43	$736	0.0%
Overall	**----**	**----**	**$3,229,906**	**489.5%**

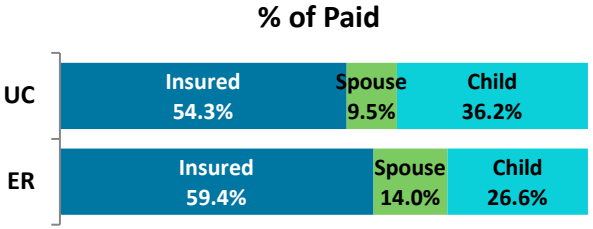
*Patient and claim counts are unique only within the category



Emergency Room / Urgent Care Summary

	3Q22		3Q23		Peer Index	
ER/Urgent Care	**ER**	**Urgent Care**	**ER**	**Urgent Care**	**ER**	**Urgent Care**
Number of Visits	850	1,972	1,536	3,925		
Visits Per Member	0.13	0.31	0.14	0.37	0.22	0.35
Visits/1000 Members	133	310	145	370	221	352
Avg Paid Per Visit	$2,490	$118	$3,164	$99	$968	$135
% with OV*	79.4%	76.6%	80.6%	75.2%		
% Avoidable	12.0%	34.7%	14.8%	43.2%		
Total Member Paid	**$506,025**	**$135,239**	**$1,045,041**	**$286,090**		
Total Plan Paid	**$2,116,500**	**$232,696**	**$4,860,123**	**$386,704**		
*looks back 12 months from ER visit	Annualized	Annualized	Annualized	Annualized		





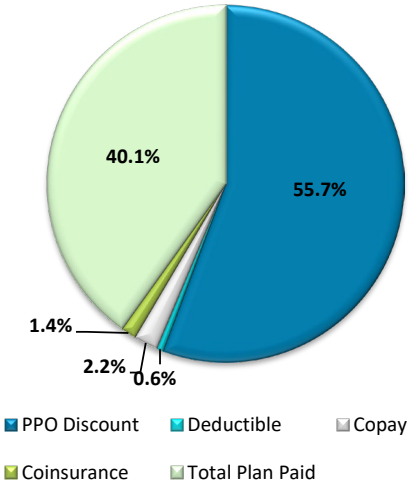
ER / UC Visits by Relationship						
Relationship	**ER**	**Per 1,000**	**Urgent Care**	**Per 1,000**	**Total**	**Per 1,000**
Insured	798	110	2,115	293	2,913	403
Spouse	212	119	413	232	625	351
Child	526	102	1,397	272	1,923	374
Total	**1,536**	**109**	**3,925**	**277**	**5,461**	**386**

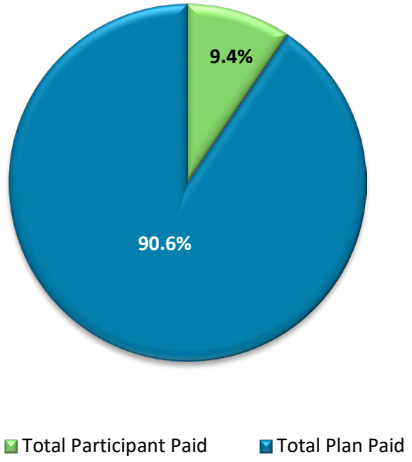
Hospital and physician urgent care centers are included in the data.
Paid amount includes facility and professional fees.

Savings Summary – Medical Claims

Description	Dollars	PPPM	% of Eligible
Eligible Charges	$132,903,113	$4,244	100.0%
PPO Discount	$83,776,441	$2,675	63.0%
Deductible	$0	$0	0.0%
Copay	$3,568,455	$114	2.7%
Coinsurance	$2,937,483	$94	2.2%
Total Participant Paid	**$6,505,938**	**$208**	**4.9%**
Total Plan Paid	**$40,641,821**	**$625**	**30.6%**

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	653	638	15	97.7%
	<2 asthma related ER Visits in the last 6 months	653	652	1	99.8%
	No asthma related admit in last 12 months	653	648	5	99.2%
Chronic Obstructive Pulmonary Disease	No exacerbations in last 12 months	59	57	2	96.6%
	Members with COPD who had an annual spirometry test	59	11	48	18.6%
Congestive Heart Failure	No re-admit to hosp with Heart Failure diag w/in 30 days of HF inpatient stay discharge	4	4	0	100.0%
	No ER Visit for Heart Failure in last 90 days	63	58	5	92.1%
	Follow-up OV within 4 weeks of discharge from HF admission	4	4	0	100.0%
Diabetes	Annual office visit	492	470	22	95.5%
	Annual dilated eye exam	492	175	317	35.6%
	Annual foot exam	492	214	278	43.5%
	Annual HbA1c test done	492	418	74	85.0%
	Diabetes Annual lipid profile	492	375	117	76.2%
	Annual microalbumin urine screen	492	340	152	69.1%
Hyperlipidemia	Hyperlipidemia Annual lipid profile	1,821	1,532	289	84.1%
Hypertension	Annual lipid profile	1,631	1,245	386	76.3%
	Annual serum creatinine test	1,411	1,220	191	86.5%
Wellness	Well Child Visit - 15 months	130	116	14	89.2%
	Routine office visit in last 6 months (All Ages)	14,704	9,701	5,003	66.0%
	Colorectal cancer screening ages 45-75 within the appropriate time period	4,646	2,009	2,637	43.2%
	Women age 25-65 with recommended cervical cancer/HPV screening	4,884	3,046	1,838	62.4%
	Males age greater than 49 with PSA test in last 24 months	1,468	711	757	48.4%
	Routine exam in last 24 months (All Ages)	14,704	12,200	2,504	83.0%
	Women age 40 to 75 with a screening mammogram last 24 months	3,469	2,025	1,444	58.4%

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	145	0.99%	10.25	$11,513
Asthma	701	4.77%	49.54	$13,037
Atrial Fibrillation	96	0.65%	6.78	$21,339
Blood Disorders	728	4.95%	51.45	$23,176
CAD	196	1.33%	13.85	$27,005
COPD	56	0.38%	3.96	$33,715
Cancer	394	2.68%	27.85	$29,156
Chronic Pain	333	2.26%	23.53	$20,084
Congestive Heart Failure	63	0.43%	4.45	$54,214
Demyelinating Diseases	41	0.28%	2.90	$55,107
Depression	1,207	8.20%	85.30	$11,212
Diabetes	758	5.15%	53.57	$17,012
ESRD	8	0.05%	0.57	$62,945
Eating Disorders	81	0.55%	5.72	$11,565
HIV/AIDS	16	0.11%	1.13	$37,407
Hyperlipidemia	2,192	14.90%	154.92	$12,455
Hypertension	1,643	11.17%	116.12	$14,808
Immune Disorders	72	0.49%	5.09	$50,579
Inflammatory Bowel Disease	71	0.48%	5.02	$24,021
Liver Diseases	277	1.88%	19.58	$24,393
Morbid Obesity	449	3.05%	31.73	$16,347
Osteoarthritis	428	2.91%	30.25	$17,540
Peripheral Vascular Disease	37	0.25%	2.61	$16,215
Rheumatoid Arthritis	87	0.59%	6.15	$28,738

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 March 31, 2023

Express Scripts

Membership Summary	1Q-3Q FY2023 LDPPO	1Q-3Q FY2022 LDPPO	Difference	% Change
			Membership Summary	
Member Count (Membership)	14,114	8,243	5,871	71.2%
Utilizing Member Count (Patients)	10,992	6,652	4,340	65.2%
Percent Utilizing (Utilization)	77.9%	80.7%	(0)	-3.5%

Claim Summary			Claims Summary	
Net Claims (Total Rx's)	150,839	85,898	64,941	75.6%
Claims per Elig Member per Month (Claims PMPM)	1.19	1.16	0.03	2.6%
Total Claims for Generic (Generic Rx)	126,915	71,440	55,475.00	77.7%
Total Claims for Brand (Brand Rx)	23,924	14,458	9,466.00	65.5%
Total Claims for Brand w/Gen Equiv (Multisource Brand Claims)	791	615	176.00	28.6%
Total Non-Specialty Claims	148,712	84,846	63,866.00	75.3%
Total Specialty Claims	2,127	1,052	1,075.00	102.2%
Generic % of Total Claims (GFR)	**84.1%**	**83.2%**	0.01	1.2%
Generic Effective Rate (GCR)	**99.4%**	**99.1%**	0.00	0.2%
Mail Order Claims	46,900	22,863	24,037.00	105.1%
Mail Penetration Rate*	36.0%	31.3%	0.05	4.7%

Claims Cost Summary			Claims Cost Summary	
Total Prescription Cost (Total Gross Cost)	$18,130,993	$8,955,427	$9,175,566.00	102.5%
Total Generic Gross Cost	$2,397,534	$1,691,335	$706,199.00	41.8%
Total Brand Gross Cost	$15,733,460	$7,264,092	$8,469,368.00	116.6%
Total MSB Gross Cost	$385,529	$211,758	$173,771.00	82.1%
Total Ingredient Cost	$17,877,625	$8,769,974	$9,107,651.00	103.9%
Total Dispensing Fee	$227,143	$179,227	$47,916.00	26.7%
Total Other (e.g. tax)	$26,225	$6,226	$19,999.00	321.2%
Avg Total Cost per Claim (Gross Cost/Rx)	**$120.20**	**$104.26**	$15.94	15.3%
Avg Total Cost for Generic (Gross Cost/Generic Rx)	$18.89	$23.67	($4.78)	-20.2%
Avg Total Cost for Brand (Gross Cost/Brand Rx)	$657.64	$502.43	$155.21	30.9%
Avg Total Cost for MSB (MSB Gross Cost/MSB ARx)	$487.39	$344.32	$143.07	41.6%

Member Cost Summary			Member Cost Summary	
Total Member Cost	**$2,944,180**	**$1,660,829**	$1,283,351.00	77.3%
Total Copay	$2,944,180	$1,660,829	$1,283,351.00	77.3%
Total Deductible	$0	$0	$0.00	0.0%
Avg Copay per Claim (Copay/Rx)	$19.52	$19.33	$0.18	1.0%
Avg Participant Share per Claim (Copay+Deductible/RX)	**$19.52**	**$19.33**	**$0.18**	**1.0%**
Avg Copay for Generic (Copay/Generic Rx)	$6.30	$7.38	($1.08)	-14.6%
Avg Copay for Brand (Copay/Brand Rx)	$89.65	$78.42	$11.23	14.3%
Avg Copay for Brand w/ Generic Equiv (Copay/Multisource Rx)	$26.74	$36.34	($9.60)	-26.4%
Net PMPM (Participant Cost PMPM)	**$23.18**	**$22.39**	$0.79	3.5%
Copay % of Total Prescription Cost (Member Cost Share %)	16.2%	18.5%	-2.3%	-12.4%

Plan Cost Summary			Plan Cost Summary	
Total Plan Cost (Plan Cost)	**$15,186,813**	**$7,294,598**	**$7,892,215.00**	**108.2%**
Total Non-Specialty Cost (Non-Specialty Plan Cost)	$7,646,094	$4,135,189	$3,510,905.00	84.9%
Total Specialty Drug Cost (Specialty Plan Cost)	$7,540,719	$3,159,409	$4,381,310.00	138.7%
Avg Plan Cost per Claim (Plan Cost/Rx)	**$100.68**	**$84.92**	$15.76	18.6%
Avg Plan Cost for Generic (Plan Cost/Generic Rx)	$12.59	$16.30	($3.71)	-22.8%
Avg Plan Cost for Brand (Plan Cost/Brand Rx)	$567.99	$424.01	$143.98	34.0%
Avg Plan Cost for MSB (MSB Plan Cost/MSB ARx)	$460.66	$307.98	$152.68	49.6%
Net PMPM (Plan Cost PMPM)	**$119.56**	**$98.33**	**$21.23**	**21.6%**
PMPM without Specialty (Non-Specialty PMPM)	$60.19	$55.74	$4.45	8.0%
PMPM for Specialty Only (Specialty PMPM)	$59.36	$42.59	$16.77	39.4%
Rebates Received (Q1-Q3FY2023 actual)	$5,203,910	$1,057,776	$4,146,134.40	392.0%
Net PMPM (Plan Cost PMPM factoring Rebates)	**$78.59**	**$84.07**	**($5.48)**	**-6.5%**
PMPM without Specialty (Non-Specialty PMPM)	$34.20	$38.12	$0.92	5.0%
PMPM for Specialty Only (Specialty PMPM)	$43.75	$36.57	$7.18	19.6%

Appendix C

Index of Tables
UMR Inc. – EPO Utilization Review for PEBP
January 1, 2023 – March 31, 2023

DATASCOPE™

Nevada Public Employees' Benefits Program
EPO Plan
July 2022 – March 2023 Incurred,
Paid through May 31, 2023

UMR℠

Overview

- Total Medical Spend for 3Q23 was $31,354,299 with an annualized plan cost per employee per year (PEPY) of $12,015. This is an increase of 27.2% when compared to 3Q22.
  - IP Cost per Admit is $36,091 which is 1.0% higher than 3Q22.
  - ER Cost per Visit is $2,969 which is 42.7% higher than 3Q22.
- Employees shared in 9.4% of the medical cost.
- Inpatient facility costs were 29.6% of the plan spend.
- 76.9% of the Average Membership had paid Medical claims less than $2,500, with 13.5% having no claims paid at all during the reporting period.
- 42 members exceeded the $100k high-cost threshold during the reporting period, which accounted for 32.5% of the plan spend. The highest diagnosis category was Cancer, accounting for 21.3% of the high-cost claimant dollars.
- Total spending with in-network providers was 96.3%. The average In Network discount was 56.6%, which is 5.5% lower than the PY22 average discount of 59.9%.

Paid Claims by Age Group

Paid Claims by Age Group																
	3Q22						3Q23						% 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	$ 2,001,147	$ 3,046	$ 2,715	$ 4	$ 2,003,862	$ 3,050	$ 2,379,872	$ 3,724	$ 13,867	$ 22	$ 2,393,739	$ 3,746	19.5%	22.8%
1	$ 191,946	$ 284	$ 2,337	$ 3	$ 194,283	$ 288	$ 227,152	$ 428	$ 622	$ 1	$ 227,774	$ 429	17.2%	49.0%
2 - 4	$ 367,663	$ 161	$ 12,468	$ 5	$ 380,131	$ 167	$ 420,955	$ 227	$ 11,697	$ 6	$ 432,652	$ 233	13.8%	39.8%
5 - 9	$ 344,358	$ 92	$ 41,655	$ 11	$ 386,013	$ 103	$ 280,221	$ 88	$ 58,186	$ 18	$ 338,407	$ 106	-12.3%	3.0%
10 - 14	$ 636,567	$ 129	$ 157,887	$ 32	$ 794,454	$ 161	$ 671,772	$ 159	$ 114,048	$ 27	$ 785,820	$ 186	-1.1%	15.5%
15 - 19	$ 1,203,297	$ 202	$ 261,248	$ 44	$ 1,464,545	$ 246	$ 1,053,568	$ 207	$ 442,665	$ 87	$ 1,496,233	$ 294	2.2%	19.7%
20 - 24	$ 831,880	$ 156	$ 240,741	$ 45	$ 1,072,621	$ 201	$ 1,002,478	$ 212	$ 168,786	$ 36	$ 1,171,264	$ 248	9.2%	23.1%
25 - 29	$ 763,543	$ 307	$ 677,677	$ 273	$ 1,441,220	$ 580	$ 870,027	$ 439	$ 207,726	$ 105	$ 1,077,753	$ 544	-25.2%	-6.2%
30 - 34	$ 1,176,433	$ 359	$ 329,699	$ 101	$ 1,506,132	$ 460	$ 1,122,946	$ 422	$ 1,177,122	$ 442	$ 2,300,068	$ 863	52.7%	87.8%
35 - 39	$ 2,204,180	$ 490	$ 518,534	$ 115	$ 2,722,714	$ 605	$ 2,625,510	$ 720	$ 649,214	$ 178	$ 3,274,724	$ 898	20.3%	48.5%
40 - 44	$ 1,692,313	$ 369	$ 1,313,542	$ 286	$ 3,005,855	$ 655	$ 2,270,331	$ 584	$ 1,163,597	$ 299	$ 3,433,928	$ 883	14.2%	34.9%
45 - 49	$ 2,468,106	$ 476	$ 838,196	$ 162	$ 3,306,302	$ 638	$ 1,846,880	$ 424	$ 958,636	$ 220	$ 2,805,516	$ 644	-15.1%	1.0%
50 - 54	$ 2,890,648	$ 452	$ 1,660,941	$ 260	$ 4,551,589	$ 711	$ 3,853,217	$ 652	$ 1,570,454	$ 266	$ 5,423,671	$ 917	19.2%	29.0%
55 - 59	$ 4,970,624	$ 743	$ 1,699,257	$ 254	$ 6,669,881	$ 997	$ 4,104,232	$ 707	$ 1,918,213	$ 330	$ 6,022,445	$ 1,037	-9.7%	4.0%
60 - 64	$ 4,885,999	$ 626	$ 2,858,483	$ 366	$ 7,744,482	$ 993	$ 6,368,155	$ 957	$ 2,769,661	$ 416	$ 9,137,816	$ 1,374	18.0%	38.4%
65+	$ 2,109,465	$ 617	$ 1,389,204	$ 406	$ 3,498,669	$ 1,023	$ 2,256,983	$ 714	$ 1,307,445	$ 414	$ 3,564,428	$ 1,128	1.9%	10.3%
Total	**$ 28,738,168**	**$ 423**	**$ 12,004,585**	**$ 177**	**$ 40,742,753**	**$ 600**	**$ 31,354,299**	**$ 538**	**$ 12,531,941**	**$ 215**	**$ 43,886,240**	**$ 753**	**7.7%**	**25.5%**

Financial Summary (p. 1 of 2)

	Total				State Active				Non-State Active			
Summary	**3Q21**	**3Q22**	**3Q23**	**Variance to Prior Year**	**3Q21**	**3Q22**	**3Q23**	**Variance to Prior Year**	**3Q21**	**3Q22**	**3Q23**	**Variance to Prior Year**
Enrollment												
Avg # Employees	4,654	4,058	3,479	-14.3%	3,953	3,403	2,903	-14.7%	4	3	2	-35.7%
Avg # Members	8,552	7,549	6,481	-14.1%	7,599	6,635	5,653	-14.8%	4	3	2	-35.7%
Ratio	1.8	1.9	1.9	0.0%	1.9	2.0	2.0	0.0%	1.1	1.0	1.0	0.0%
Financial Summary												
Gross Cost	$41,440,953	$32,474,418	$34,617,679	6.6%	$32,245,097	$27,933,037	$28,755,420	2.9%	$37,532	$4,170	$3,859	-7.5%
Client Paid	$38,712,086	$28,738,168	$31,354,299	9.1%	$29,990,996	$24,842,309	$26,085,488	5.0%	$35,154	$3,120	$3,050	-2.2%
Employee Paid	$2,728,868	$3,736,250	$3,263,380	-12.7%	$2,254,101	$3,090,728	$2,669,933	-13.6%	$2,378	$1,050	$810	-22.9%
Client Paid-PEPY	$11,090	$9,443	$12,015	27.2%	$10,115	$9,734	$11,982	23.1%	$11,718	$1,337	$2,033	52.1%
Client Paid-PMPY	$6,036	$5,076	$6,451	27.1%	$5,262	$4,992	$6,153	23.3%	$10,546	$1,337	$2,033	52.1%
Client Paid-PEPM	$924	$787	$1,001	27.2%	$843	$811	$998	23.1%	$977	$111	$169	52.3%
Client Paid-PMPM	$503	$423	$538	27.2%	$439	$416	$513	23.3%	$879	$111	$169	52.3%
High Cost Claimants (HCC's) > $100k												
# of HCC's	39	35	42	20.0%	30	30	33	10.0%	0	0	0	0.0%
HCC's / 1,000	4.6	4.6	6.5	39.7%	4.0	4.5	5.8	29.2%	0.0	0.0	0.0	0.0%
Avg HCC Paid	$284,578	$224,770	$242,425	7.9%	$236,048	$238,978	$246,809	3.3%	$0	$0	$0	0.0%
HCC's % of Plan Paid	28.7%	27.4%	32.5%	18.6%	23.6%	28.9%	31.2%	8.0%	0.0%	0.0%	0.0%	0.0%
Cost Distribution by Claim Type (PMPY)												
Facility Inpatient	$1,416	$1,409	$1,910	35.6%	$997	$1,425	$1,787	25.4%	$0	$0	$0	0.0%
Facility Outpatient	$1,905	$1,331	$2,168	62.9%	$1,720	$1,282	$2,065	61.1%	$5,899	$33	$210	0.0%
Physician	$2,536	$2,232	$2,373	6.3%	$2,399	$2,188	$2,301	5.2%	$3,977	$1,172	$1,823	55.5%
Other	$179	$103	$0	-100.0%	$146	$97	$0	-100.0%	$670	$132	$0	-100.0%
Total	$6,036	$5,076	$6,451	27.1%	$5,262	$4,992	$6,153	23.3%	$10,546	$1,337	$2,033	52.1%
	Annualized	Annualized	Annualized		Annualized	Annualized	Annualized		Annualized	Annualized	Annualized	

Financial Summary (p. 2 of 2)

	State Retirees				Non-State Retirees				
Summary	**3Q21**	**3Q22**	**3Q23**	**Variance to Prior Year**	**3Q21**	**3Q22**	**3Q23**	**Variance to Prior Year**	**Peer Index**
Enrollment									
Avg # Employees	571	564	511	-9.4%	126	88	63	-28.1%	
Avg # Members	786	794	736	-7.3%	162	117	90	-23.0%	
Ratio	1.4	1.4	1.4	2.1%	1.3	1.3	1.4	6.7%	1.6
Financial Summary									
Gross Cost	$5,883,954	$4,047,960	$5,579,441	37.8%	$3,274,369	$489,251	$278,958	-43.0%	
Client Paid	$5,487,651	$3,504,302	$5,063,279	44.5%	$3,198,284	$388,437	$202,482	-47.9%	
Employee Paid	$396,303	$543,658	$516,162	-5.1%	$76,085	$100,814	$76,476	-24.1%	
Client Paid-PEPY	$12,809	$8,281	$13,200	59.4%	$33,874	$5,900	$4,278	-27.5%	$6,297
Client Paid-PMPY	$9,304	$5,888	$9,174	55.8%	$26,341	$4,418	$2,992	-32.3%	$3,879
Client Paid-PEPM	$1,067	$690	$1,100	59.4%	$2,823	$492	$356	-27.6%	$525
Client Paid-PMPM	$775	$491	$764	55.6%	$2,195	$368	$249	-32.3%	$323
High Cost Claimants (HCC's) > $100k									
# of HCC's	9	6	10	0.0%	2	0	0	0.0%	
HCC's / 1,000	11.4	7.6	13.6	0.0%	12.4	0.0	0.0	0.0%	
Avg HCC Paid	$140,131	$116,268	$203,715	0.0%	$1,377,955	$0	$0	0.0%	
HCC's % of Plan Paid	23.0%	19.9%	40.2%	0.0%	86.2%	0.0%	0.0%	0.0%	
Cost Distribution by Claim Type (PMPY)									
Facility Inpatient	$1,444	$1,280	$3,065	139.5%	$20,963	$1,403	$213	-84.8%	$1,149
Facility Outpatient	$3,615	$1,794	$3,091	72.3%	$2,164	$1,047	$1,150	9.8%	$1,333
Physician	$3,807	$2,667	$3,018	13.2%	$2,774	$1,839	$1,629	-11.4%	$1,301
Other	$437	$147	$0	-100.0%	$440	$129	$0	-100.0%	$96
Total	$9,304	$5,888	$9,174	55.8%	$26,341	$4,418	$2,992	-32.3%	$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**	**3Q23**	**Variance to Prior Year**	**PY21**	**PY22**	**3Q23**	**Variance to Prior Year**	**PY21**	**PY22**	**3Q23**	**Variance to Prior Year**
Enrollment												
Avg # Employees	4,635	4,021	3,479	-13.5%	3,934	3,370	2,903	-13.9%	4	3	2	-29.3%
Avg # Members	8,519	7,491	6,481	-13.5%	7,566	6,579	5,653	-14.1%	4	3	2	-29.3%
Ratio	1.8	1.9	1.9	0.0%	1.9	2.0	2.0	0.0%	1.1	1.0	1.0	0.0%
Financial Summary												
Gross Cost	$57,531,667	$44,187,042	$34,617,679	-21.7%	$45,628,807	$37,820,607	$28,755,420	-24.0%	$41,511	$4,744	$3,859	-18.7%
Client Paid	$53,783,772	$39,320,787	$31,354,299	-20.3%	$42,531,149	$33,797,612	$26,085,488	-22.8%	$39,013	$3,622	$3,050	-15.8%
Employee Paid	$3,747,895	$4,866,255	$3,263,380	-32.9%	$3,097,659	$4,022,996	$2,669,933	-33.6%	$2,498	$1,122	$810	-27.8%
Client Paid-PEPY	$11,605	$9,779	$12,015	22.9%	$10,811	$10,030	$11,982	19.5%	$9,753	$1,278	$2,033	59.1%
Client Paid-PMPY	$6,314	$5,249	$6,451	22.9%	$5,621	$5,137	$6,153	19.8%	$9,003	$1,278	$2,033	59.1%
Client Paid-PEPM	$967	$815	$1,001	22.8%	$901	$836	$998	19.4%	$813	$107	$169	57.9%
Client Paid-PMPM	$526	$437	$538	23.1%	$468	$428	$513	19.9%	$750	$107	$169	57.9%
High Cost Claimants (HCC's) > $100k												
# of HCC's	58	46	42	-8.7%	43	40	33	-17.5%	0	0	0	0.0%
HCC's / 1,000	6.8	6.1	6.5	5.5%	5.7	6.1	5.8	-3.9%	0.0	0.0	0.0	0.0%
Avg HCC Paid	$290,301	$237,083	$242,425	2.3%	$270,803	$246,357	$246,809	0.2%	$0	$0	$0	0.0%
HCC's % of Plan Paid	31.3%	27.7%	32.5%	17.3%	27.4%	29.2%	31.2%	6.8%	0.0%	0.0%	0.0%	0.0%
Cost Distribution by Claim Type (PMPY)												
Facility Inpatient	$1,531	$1,432	$1,910	33.4%	$1,194	$1,437	$1,787	24.4%	$0	$0	$0	0.0%
Facility Outpatient	$1,988	$1,442	$2,168	50.3%	$1,813	$1,382	$2,065	49.4%	$4,568	$27	$210	677.8%
Physician	$2,609	$2,259	$2,373	5.0%	$2,458	$2,209	$2,301	4.2%	$3,917	$1,142	$1,823	59.6%
Other	$185	$116	$0	-100.0%	$156	$109	$0	-100.0%	$518	$109	$0	-100.0%
Total	$6,314	$5,249	$6,451	22.9%	$5,621	$5,137	$6,153	19.8%	$9,003	$1,278	$2,033	59.1%
			Annualized				Annualized				Annualized	

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

	State Retirees				Non-State Retirees				
Summary	**PY21**	**PY22**	**3Q23**	**Variance to Prior Year**	**PY21**	**PY22**	**3Q23**	**Variance to Prior Year**	**Peer Index**
Enrollment									
Avg # Employees	574	564	511	-9.3%	122	85	63	-25.7%	
Avg # Members	791	796	736	-7.5%	158	114	90	-20.6%	
Ratio	1.4	1.4	1.4	2.1%	1.3	1.3	1.4	6.7%	1.6
Financial Summary									
Gross Cost	$8,174,556	$5,794,991	$5,579,441	-3.7%	$3,686,792	$566,699	$278,958	-50.8%	
Client Paid	$7,625,090	$5,071,309	$5,063,279	-0.2%	$3,588,520	$448,244	$202,482	-54.8%	
Employee Paid	$549,466	$723,682	$516,162	-28.7%	$98,272	$118,455	$76,476	-35.4%	
Client Paid-PEPY	$13,276	$8,998	$13,200	46.7%	$29,354	$5,279	$4,278	-19.0%	$6,642
Client Paid-PMPY	$9,643	$6,373	$9,174	44.0%	$22,748	$3,946	$2,992	-24.2%	$4,116
Client Paid-PEPM	$1,106	$750	$1,100	46.7%	$2,446	$440	$356	-19.1%	$553
Client Paid-PMPM	$804	$531	$764	43.9%	$1,896	$329	$249	-24.3%	$343
High Cost Claimants (HCC's) > $100k									
# of HCC's	15	8	10	25.0%	2	0	0	0.0%	
HCC's / 1,000	19.0	10.1	13.6	35.2%	12.7	0.0	0.0	0.0%	
Avg HCC Paid	$144,889	$131,446	$203,715	55.0%	$1,509,798	$0	$0	0.0%	
HCC's % of Plan Paid	28.5%	20.7%	40.2%	94.2%	84.1%	0.0%	0.0%	0.0%	
Cost Distribution by Claim Type (PMPY)									
Facility Inpatient	$1,565	$1,443	$3,065	112.4%	$17,532	$1,101	$213	-80.7%	$1,190
Facility Outpatient	$3,680	$2,015	$3,091	53.4%	$1,836	$940	$1,150	22.3%	$1,376
Physician	$3,977	$2,742	$3,018	10.1%	$2,993	$1,800	$1,629	-9.5%	$1,466
Other	$420	$174	$0	-100.0%	$388	$106	$0	-100.0%	$84
Total	$9,643	$6,373	$9,174	44.0%	$22,748	$3,946	$2,992	-24.2%	$4,116
			Annualized				Annualized		

Paid Claims by Claim Type – State Participants

Net Paid Claims - Total State Participants	3Q22				3Q23				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical									
Inpatient	$ 8,471,031	$ 873,780	$ 4,115	$ 9,348,925	$ 9,033,701	$ 1,090,193	$ 798,039	$ 10,921,934	16.8%
Outpatient	$ 16,371,278	$ 2,440,402	$ 186,005	$ 18,997,686	$ 17,051,786	$ 2,918,420	$ 256,627	$ 20,226,833	6.5%
Total - Medical	**$ 24,842,309**	**$ 3,314,182**	**$ 190,120**	**$ 28,346,611**	**$ 26,085,488**	**$ 4,008,613**	**$ 1,054,666**	**$ 31,148,767**	**9.9%**

Net Paid Claims - Per Participant per Month	3Q22				3Q23				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical	$ 811	$ 752	$ 283	$ 794	$ 998	$ 1,005	$ 1,715	$ 1,014	27.7%

Paid Claims by Claim Type – Non-State Participants

Net Paid Claims - Total Non-State Participants	3Q22				3Q23				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical									
Inpatient	$ -	$ 36,771	$ 94,213	$ 130,985	$ -	$ 14,081	$ 3,066	$ 17,147	-86.9%
Outpatient	$ 3,120	$ 136,249	$ 121,204	$ 260,572	$ 3,050	$ 68,241	$ 117,094	$ 188,385	-27.7%
Total - Medical	**$ 3,120**	**$ 173,020**	**$ 215,417**	**$ 391,557**	**$ 3,050**	**$ 82,323**	**$ 120,159**	**$ 205,532**	**-47.5%**

Net Paid Claims - Per Participant per Month	3Q22				3Q23				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical	$ 111	$ 536	$ 461	$ 479	$ 169	$ 601	$ 279	$ 351	-26.7%

Paid Claims by Claim Type – Total

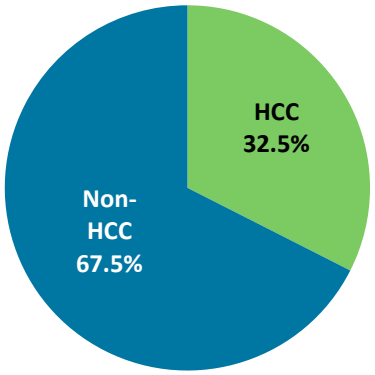
Net Paid Claims - Total Total Participants	3Q22				3Q23				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical									
Inpatient	$ 8,471,031	$ 910,551	$ 98,328	$ 9,479,910	$ 9,033,701	$ 1,104,274	$ 801,105	$ 10,939,081	15.4%
Outpatient	$ 16,374,398	$ 2,576,652	$ 307,209	$ 19,258,258	$ 17,054,836	$ 2,986,662	$ 373,720	$ 20,415,218	6.0%
Total - Medical	**$ 24,845,429**	**$ 3,487,203**	**$ 405,537**	**$ 28,738,168**	**$ 26,088,537**	**$ 4,090,936**	**$ 1,174,826**	**$ 31,354,299**	**9.1%**

Net Paid Claims - Per Participant per Month	3Q22				3Q23				% Change
	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Actives	Pre-Medicare Retirees	Medicare Retirees	Total	Total
Medical	$ 811	$ 737	$ 356	$ 787	$ 998	$ 992	$ 1,123	$ 1,001	27.2%

Cost Distribution – Medical Claims

3Q22							3Q23					
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
31	0.4%	$7,866,946	27.4%	$112,834	3.0%	$100,000.01 Plus	39	0.6%	$10,181,843	32.5%	$159,612	4.9%
32	0.4%	$2,371,079	8.3%	$118,610	3.2%	$50,000.01-$100,000.00	42	0.7%	$2,968,710	9.5%	$139,181	4.3%
111	1.5%	$3,995,292	13.9%	$303,463	8.1%	$25,000.01-$50,000.00	149	2.3%	$5,198,545	16.6%	$384,316	11.8%
286	3.8%	$4,547,462	15.8%	$561,133	15.0%	$10,000.01-$25,000.00	299	4.6%	$4,798,981	15.3%	$554,771	17.0%
420	5.6%	$3,134,834	10.9%	$665,249	17.8%	$5,000.01-$10,000.00	370	5.7%	$2,694,737	8.6%	$518,302	15.9%
763	10.1%	$2,777,473	9.7%	$688,247	18.4%	$2,500.01-$5,000.00	600	9.3%	$2,235,486	7.1%	$531,489	16.3%
4,879	64.6%	$4,043,507	14.1%	$1,283,224	34.3%	$0.01-$2,500.00	4,031	62.2%	$3,275,996	10.4%	$974,103	29.8%
32	0.4%	$0	0.0%	$3,369	0.1%	$0.00	76	1.2%	$0	0.0%	$1,605	0.0%
996	13.2%	$1,575	0.0%	$120	0.0%	No Claims	875	13.5%	$0	0.0%	$0	0.0%
7,549	**100.0%**	**$28,738,168**	**100.0%**	**$3,736,250**	**100.0%**		**6,481**	**100.0%**	**$31,354,299**	**100.0%**	**$3,263,380**	**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	15	$2,167,205	21.3%
Pregnancy-related Disorders	3	$1,654,292	16.2%
Cardiac Disorders	27	$1,479,023	14.5%
Infections	17	$854,311	8.4%
Medical/Surgical Complications	12	$740,869	7.3%
Gastrointestinal Disorders	24	$594,273	5.8%
Trauma/Accidents	12	$488,393	4.8%
Hematological Disorders	17	$465,025	4.6%
Spine-related Disorders	9	$326,595	3.2%
Neurological Disorders	19	$303,251	3.0%
All Other		$1,108,606	10.9%
Overall	**----**	**$10,181,843**	**100.0%**

Utilization Summary (p. 1 of 2)

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

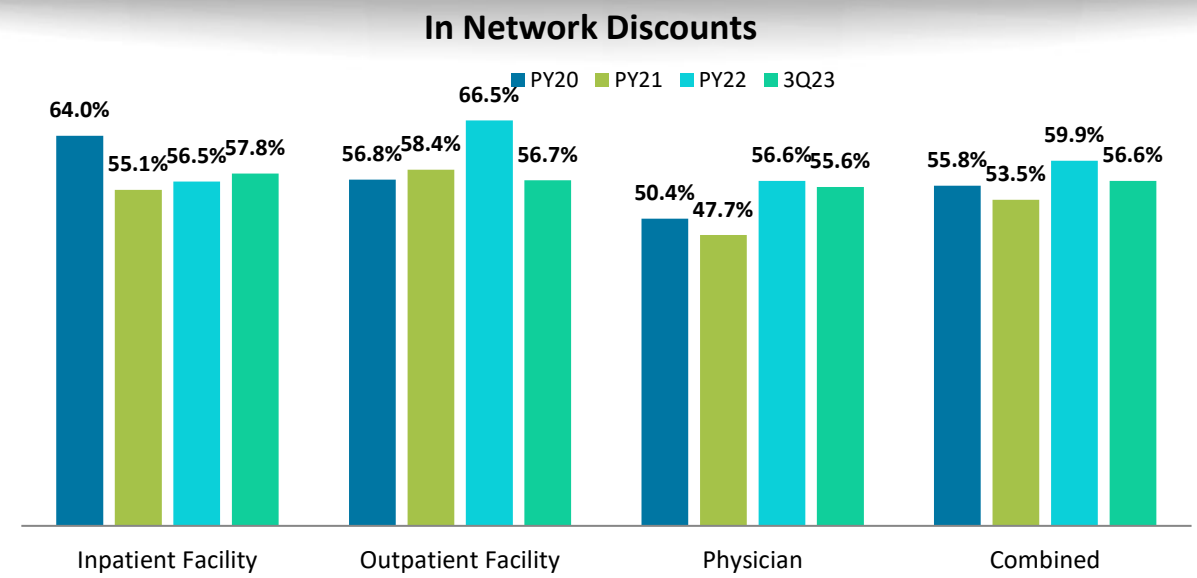
	Total				State Active				Non-State Active			
Summary	**3Q21**	**3Q22**	**3Q23**	**Variance to Prior Year**	**3Q21**	**3Q22**	**3Q23**	**Variance to Prior Year**	**3Q21**	**3Q22**	**3Q23**	**Variance to Prior Year**
Inpatient Summary												
# of Admits	352	312	293		292	269	240		0	0	0	
# of Bed Days	2,494	1,857	1,444		1,824	1,577	1,103		0	0	0	
Paid Per Admit	$40,766	$35,747	$36,091	1.0%	$33,199	$36,815	$35,866	-2.6%	$0	$0	$0	0.0%
Paid Per Day	$5,754	$6,006	$7,323	21.9%	$5,315	$6,280	$7,804	24.3%	$0	$0	$0	0.0%
Admits Per 1,000	55	55	60	9.1%	51	54	57	5.6%	0	0	0	0.0%
Days Per 1,000	389	328	297	-9.5%	320	317	260	-18.0%	0	0	0	0.0%
Avg LOS	7.1	6.0	4.9	-18.3%	6.2	5.9	4.6	-22.0%	0.0	0.0	0.0	0.0%
# Admits From ER	176	158	133		136	129	103		0	0	0	
Physician Office												
OV Utilization per Member	6.1	5.6	5.5	-1.8%	5.9	5.4	5.3	-1.9%	5.1	5.6	6.0	7.1%
Avg Paid per OV	$147	$152	$158	3.9%	$149	$153	$163	6.5%	$136	$158	$132	-16.5%
Avg OV Paid per Member	$898	$853	$863	1.2%	$878	$829	$866	4.5%	$693	$881	$793	-10.0%
DX&L Utilization per Member	10.2	9.6	11.4	18.8%	9.7	9.2	10.9	18.5%	17.4	4.7	29.3	523.4%
Avg Paid per DX&L	$68	$56	$70	25.0%	$66	$57	$73	28.1%	$61	$40	$17	-57.5%
Avg DX&L Paid per Member	$692	$540	$806	49.3%	$640	$524	$794	51.5%	$1,059	$189	$513	171.4%
Emergency Room												
# of Visits	938	1,021	897		822	877	763		2	0	0	
Visits Per Member	0.15	0.18	0.18	0.0%	0.14	0.18	0.18	0.0%	0.60	0.00	0.00	0.0%
Visits Per 1,000	146	180	185	2.8%	144	176	180	2.3%	600	0	0	0.0%
Avg Paid per Visit	$2,788	$2,080	$2,969	42.7%	$2,789	$2,057	$3,026	47.1%	$5,449	$0	$0	0.0%
Urgent Care												
# of Visits	1,859	2,343	2,046		1,695	2,121	1,838		0	0	0	
Visits Per Member	0.29	0.41	0.42	2.4%	0.30	0.43	0.43	0.0%	0.00	0.00	0.00	0.0%
Visits Per 1,000	290	414	421	1.7%	297	426	434	1.9%	0	0	0	0.0%
Avg Paid per Visit	$153	$151	$128	-15.2%	$154	$153	$130	-15.0%	$0	$0	$0	0.0%
	Annualized	Annualized	Annualized		Annualized	Annualized	Annualized		Annualized	Annualized	Annualized	

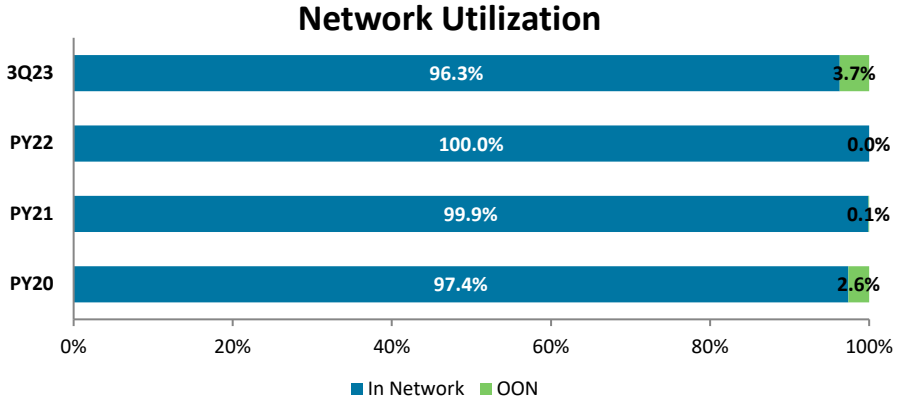
Utilization Summary (p. 2 of 2)

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

	State Retirees				Non-State Retirees				
Summary	**3Q21**	**3Q22**	**3Q23**	**Variance to Prior Year**	**3Q21**	**3Q22**	**3Q23**	**Variance to Prior Year**	**Peer Index**
Inpatient Summary									
# of Admits	53	35	51		7	8	2		
# of Bed Days	457	215	334		213	65	7		
Paid Per Admit	$32,554	$31,922	$38,220	19.7%	$418,577	$16,574	$8,773	-47.1%	$16,632
Paid Per Day	$3,775	$5,197	$5,836	12.3%	$13,756	$2,040	$2,507	22.9%	$3,217
Admits Per 1,000	90	59	92	55.9%	58	91	30	-67.0%	76
Days Per 1,000	775	361	605	67.6%	1,754	739	103	-86.1%	391
Avg LOS	8.6	6.1	6.5	6.6%	30.4	8.1	3.5	-56.8%	5.2
# Admits From ER	36	24	29		4	5	1		
Physician Office									
OV Utilization per Member	8.0	6.9	6.6	-4.3%	6.7	7.1	6.5	-8.5%	5.0
Avg Paid per OV	$136	$153	$134	-12.4%	$144	$117	$73	-37.6%	$57
Avg OV Paid per Member	$1,080	$1,059	$883	-16.6%	$972	$826	$473	-42.7%	$286
DX&L Utilization per Member	14.7	13.3	15.6	17.3%	12.8	9.9	13.1	32.3%	10.5
Avg Paid per DX&L	$79	$52	$60	15.4%	$65	$49	$37	-24.5%	$50
Avg DX&L Paid per Member	$1,159	$684	$941	37.6%	$837	$481	$480	-0.2%	$522
Emergency Room									
# of Visits	96	125	113		18	19	21		
Visits Per Member	0.16	0.21	0.20	-4.8%	0.15	0.22	0.31	40.9%	0.24
Visits Per 1,000	163	210	205	-2.4%	148	216	310	43.5%	235
Avg Paid per Visit	$2,976	$2,428	$2,933	20.8%	$1,452	$825	$1,092	32.4%	$943
Urgent Care									
# of Visits	142	193	187		22	29	21		
Visits Per Member	0.24	0.32	0.34	6.3%	0.18	0.33	0.31	-6.1%	0.3
Visits Per 1,000	241	324	339	4.6%	181	330	310	-6.1%	300
Avg Paid per Visit	$143	$148	$121	-18.2%	$133	$63	$62	-1.6%	$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	$3,344,788	10.7%	$2,719,237	$512,089	$113,463	$2,086,213	$1,258,575
Pregnancy-related Disorders	$3,073,179	9.8%	$857,496	$275,862	$1,939,822	$784,931	$2,288,248
Cancer	$3,071,101	9.8%	$2,101,849	$358,644	$610,608	$1,052,275	$2,018,826
Gastrointestinal Disorders	$2,267,422	7.2%	$1,742,647	$282,486	$242,289	$998,115	$1,269,308
Health Status/Encounters	$2,023,487	6.5%	$1,223,792	$218,365	$581,331	$818,970	$1,204,517
Musculoskeletal Disorders	$1,790,860	5.7%	$1,191,568	$477,366	$121,925	$765,368	$1,025,492
Spine-related Disorders	$1,542,214	4.9%	$1,180,625	$288,112	$73,477	$500,734	$1,041,480
Trauma/Accidents	$1,536,634	4.9%	$649,382	$586,985	$300,268	$935,375	$601,260
Infections	$1,519,247	4.8%	$1,042,508	$315,771	$160,967	$765,635	$753,612
Eye/ENT Disorders	$1,481,219	4.7%	$828,053	$146,148	$507,018	$592,114	$889,105
Neurological Disorders	$1,404,669	4.5%	$919,038	$353,961	$131,670	$456,475	$948,194
Mental Health	$1,182,281	3.8%	$463,537	$154,442	$564,302	$365,566	$816,715
Pulmonary Disorders	$961,429	3.1%	$536,479	$106,007	$318,942	$304,959	$656,470
Endocrine/Metabolic Disorders	$913,006	2.9%	$804,824	$64,304	$43,879	$324,194	$588,812
Medical/Surgical Complications	$883,058	2.8%	$575,518	$302,992	$4,548	$27,342	$855,716
Gynecological/Breast Disorders	$758,406	2.4%	$614,754	$80,288	$63,363	$7,850	$750,555
Diabetes	$553,487	1.8%	$413,563	$114,218	$25,706	$419,319	$134,168
Hematological Disorders	$549,385	1.8%	$515,167	$7,408	$26,810	$457,064	$92,321
Renal/Urologic Disorders	$526,782	1.7%	$404,504	$55,930	$66,347	$282,491	$244,290
Non-malignant Neoplasm	$344,242	1.1%	$224,176	$109,090	$10,977	$116,342	$227,900
Dermatological Disorders	$322,782	1.0%	$209,909	$58,895	$53,978	$145,782	$177,000
Congenital/Chromosomal Anomalies	$309,051	1.0%	$17,535	$22,532	$268,984	$130,251	$178,800
Miscellaneous	$299,434	1.0%	$153,743	$51,535	$94,156	$129,597	$169,837
Vascular Disorders	$243,155	0.8%	$132,626	$106,368	$4,162	$141,722	$101,433
Abnormal Lab/Radiology	$237,628	0.8%	$191,363	$31,866	$14,399	$76,857	$160,771
Cholesterol Disorders	$84,009	0.3%	$74,292	$8,369	$1,347	$28,397	$55,612
Medication Related Conditions	$69,569	0.2%	$26,919	$26,285	$16,365	$17,337	$52,232
Allergic Reaction	$38,070	0.1%	$9,022	$584	$28,464	$23,440	$14,629
Dental Conditions	$18,194	0.1%	$10,577	$930	$6,688	$9,691	$8,502
External Hazard Exposure	$5,454	0.0%	$3,799	$326	$1,329	$1,194	$4,260
Social Determinants of Health	$58	0.0%	$58	$0	$0	$40	$18
Cause of Morbidity	$0	0.0%	$0	$0	$0	$0	$0
Total	**$31,354,299**	**100.0%**	**$19,838,560**	**$5,118,155**	**$6,397,584**	**$12,765,640**	**$18,588,659**

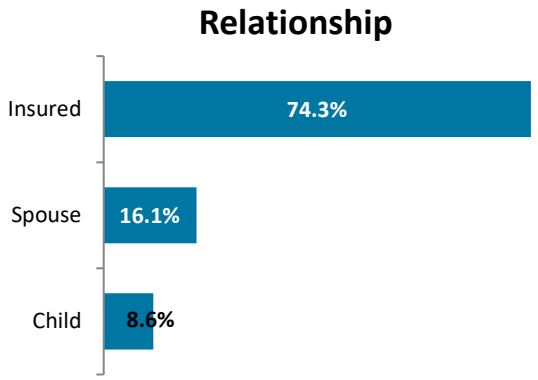
Mental Health Drilldown

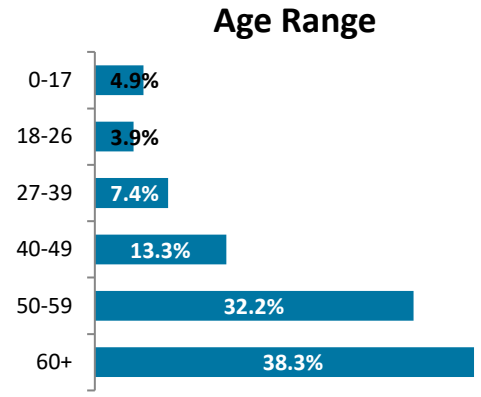
	PY20		PY21		PY22		3Q23	
Grouper	Patients	Total Paid	Patients	Total Paid	Patients	Total Paid	Patients	Total Paid
Depression	598	$910,160	625	$833,183	505	$720,907	397	$390,860
Mood and Anxiety Disorders	665	$513,247	711	$655,375	636	$361,898	499	$230,123
Mental Health Conditions, Other	572	$599,986	609	$876,606	458	$367,897	324	$199,620
Alcohol Abuse/Dependence	47	$243,386	43	$163,692	37	$110,736	23	$105,841
Bipolar Disorder	149	$206,258	127	$261,349	107	$171,696	93	$52,326
Developmental Disorders	50	$123,894	65	$155,300	58	$89,043	40	$52,187
Attention Deficit Disorder	178	$84,996	180	$98,736	179	$76,754	173	$44,881
Eating Disorders	16	$86,923	24	$370,761	23	$51,995	18	$29,690
Sleep Disorders	180	$35,203	187	$38,478	148	$43,716	111	$19,540
Substance Abuse/Dependence	45	$74,263	57	$45,039	39	$14,853	33	$18,170
Schizophrenia	10	$9,300	9	$10,631	6	$2,286	9	$13,346
Complications of Substance Abuse	21	$116,313	14	$63,661	8	$12,407	5	$9,292
Personality Disorders	10	$10,154	14	$20,064	17	$47,043	12	$5,902
Psychoses	10	$6,353	7	$55,219	6	$9,762	7	$4,215
Sexually Related Disorders	16	$5,705	27	$81,154	27	$85,457	24	$3,983
Tobacco Use Disorder	45	$3,028	38	$4,775	36	$4,114	34	$2,306
Total		**$3,029,167**		**$3,734,023**		**$2,170,566**		**$1,182,281**

Diagnosis Grouper – Cardiac Disorders

Diagnosis Sub-Grouper	Patients	Claims	Total Paid	% Paid
Atrial Fibrillation	56	241	$776,074	23.2%
Heart Valve Disorders	58	163	$451,300	13.5%
Chest Pain	220	586	$396,749	11.9%
Congestive Heart Failure	35	154	$329,555	9.9%
Myocardial Infarction	15	78	$306,523	9.2%
Coronary Artery Disease	91	240	$278,896	8.3%
Cardiac Arrhythmias	154	293	$276,064	8.3%
Hypertension	542	1,076	$179,366	5.4%
Pulmonary Embolism	14	68	$112,860	3.4%
Cardio-Respiratory Arrest	19	60	$97,337	2.9%
Cardiac Conditions, Other	127	279	$84,476	2.5%
Ventricular Fibrillation	2	3	$20,665	0.6%
Shock	5	50	$17,697	0.5%
Cardiomyopathy	17	44	$17,226	0.5%
Overall	**----**	**----**	**$3,344,788**	**100.0%**

*Patient and claim counts are unique only within the category

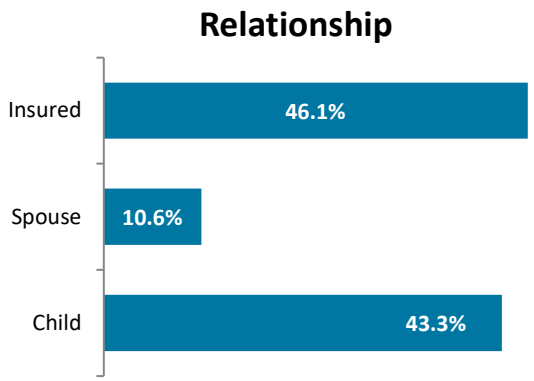


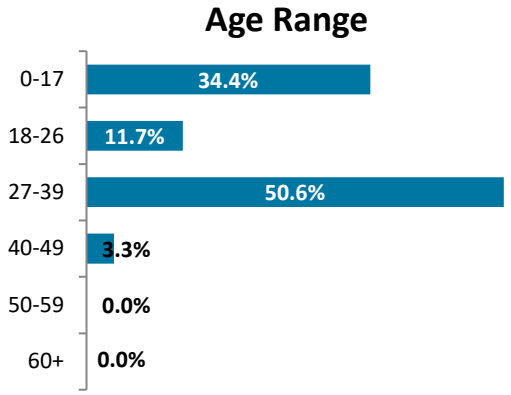


Diagnosis Grouper – Pregnancy-related Disorders

Diagnosis Sub-Grouper	Patients	Claims	Total Paid	% Paid
Perinatal Disorders	29	181	$1,176,517	38.3%
Pregnancy Complications	89	498	$575,887	18.7%
Labor and Delivery Related	59	182	$548,965	17.9%
Liveborn Infants	62	181	$453,883	14.8%
Fetal Distress	3	177	$203,285	6.6%
Supervision of Pregnancy	100	502	$96,212	3.1%
Abortion Related	9	20	$9,274	0.3%
Cesarean Delivery	7	9	$5,968	0.2%
Birth Injury	1	1	$1,973	0.1%
Prematurity and Low Birth Weight	1	3	$1,124	0.0%
Ectopic Pregnancy	1	1	$93	0.0%
Overall	**----**	**----**	**$3,073,179**	**100.0%**

*Patient and claim counts are unique only within the category

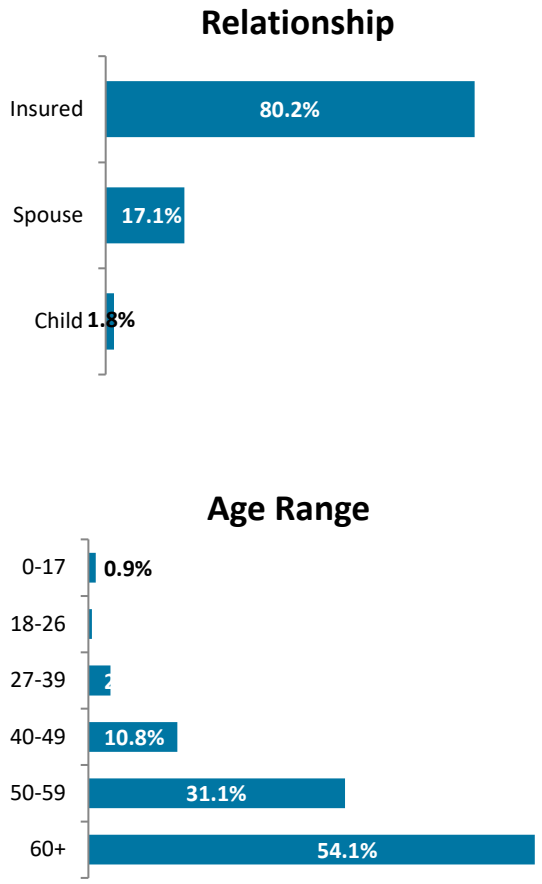




Diagnosis Grouper – Cancer

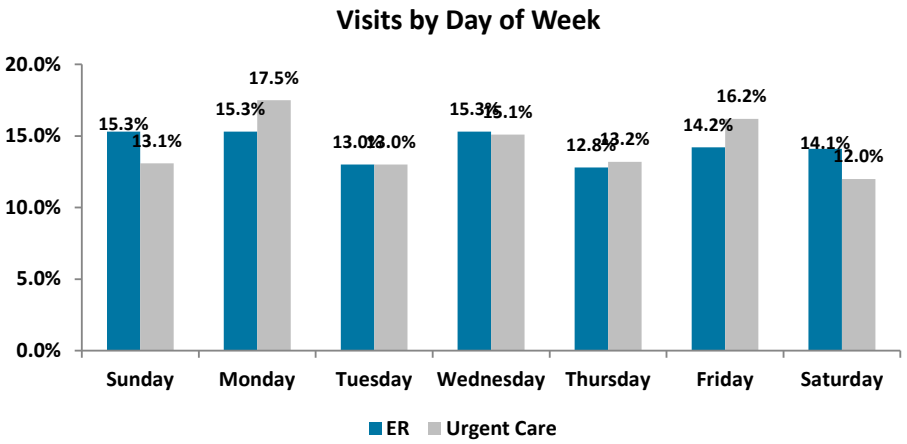
Diagnosis Sub-Grouper	Patients	Claims	Total Paid	% Paid
Cancer Therapies	18	91	$872,339	28.4%
Melanoma	8	70	$519,571	16.9%
Breast Cancer	38	372	$412,243	13.4%
Brain Cancer	2	71	$233,565	7.6%
Secondary Cancers	9	83	$220,494	7.2%
Cancers, Other	24	153	$140,415	4.6%
Carcinoma in Situ	27	84	$133,885	4.4%
Leukemias	6	86	$113,391	3.7%
Prostate Cancer	18	188	$112,645	3.7%
Colon Cancer	5	118	$68,226	2.2%
Non-Melanoma Skin Cancers	76	175	$54,435	1.8%
Lung Cancer	3	44	$48,368	1.6%
Cervical/Uterine Cancer	6	30	$36,158	1.2%
Lymphomas	9	70	$28,794	0.9%
Ovarian Cancer	4	28	$19,306	0.6%
Pancreatic Cancer	3	40	$19,001	0.6%
Kidney Cancer	8	22	$16,174	0.5%
Thyroid Cancer	12	36	$14,167	0.5%
Myeloma	1	6	$7,636	0.2%
Bladder Cancer	1	1	$285	0.0%
Overall	**----**	**----**	**$3,071,101**	**100.0%**

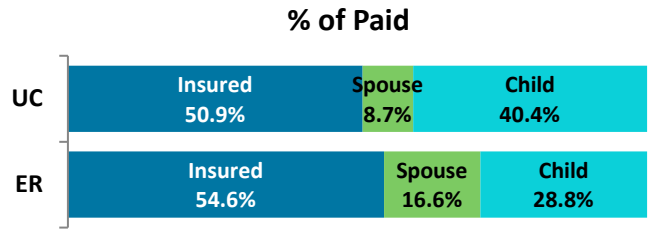
*Patient and claim counts are unique only within the category



Emergency Room / Urgent Care Summary

	3Q22		3Q23		Peer Index	
ER/Urgent Care	**ER**	**Urgent Care**	**ER**	**Urgent Care**	**ER**	**Urgent Care**
Number of Visits	1,021	2,343	897	2,046		
Visits Per Member	0.18	0.41	0.18	0.42	0.22	0.35
Visits/1000 Members	180	414	185	421	221	352
Avg Paid Per Visit	$2,080	$151	$2,969	$128	$968	$135
% with OV*	91.1%	89.4%	89.9%	88.9%		
% Avoidable	12.6%	34.6%	14.5%	43.2%		
Total Member Paid	**$571,079**	**$104,063**	**$498,378**	**$97,039**		
Total Plan Paid	**$2,140,421**	**$357,667**	**$2,662,933**	**$262,221**		
*looks back 12 months from ER visit	Annualized	Annualized	Annualized	Annualized		





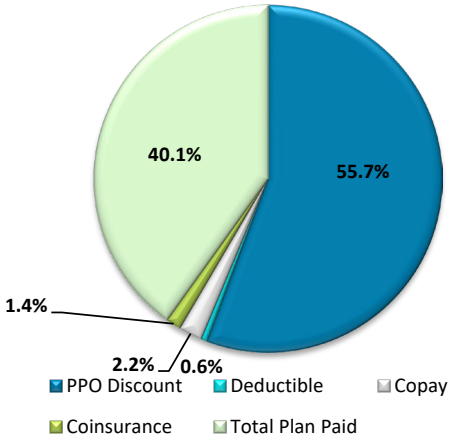
ER / UC Visits by Relationship						
Relationship	**ER**	**Per 1,000**	**Urgent Care**	**Per 1,000**	**Total**	**Per 1,000**
Insured	468	135	1,047	301	1,515	436
Spouse	120	183	187	285	307	467
Child	309	132	812	346	1,121	478
Total	**897**	**138**	**2,046**	**316**	**2,943**	**454**

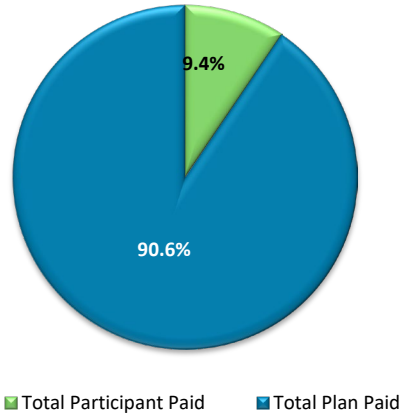
Hospital and physician urgent care centers are included in the data.
Paid amount includes facility and professional fees.

Savings Summary – Medical Claims

Description	Dollars	PPPM	% of Eligible
Eligible Charges	$79,658,140	$2,544	100.0%
PPO Discount	$43,503,732	$1,389	54.6%
Deductible	$474,786	$15	0.6%
Copay	$1,689,434	$54	2.1%
Coinsurance	$1,099,160	$35	1.4%
Total Participant Paid	**$3,263,380**	**$104**	**4.1%**
Total Plan Paid	**$31,354,299**	**$1,001**	**39.4%**

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	403	397	6	98.5%
	<2 asthma related ER Visits in the last 6 months	403	403	0	100.0%
	No asthma related admit in last 12 months	403	403	0	100.0%
Chronic Obstructive Pulmonary Disease	No exacerbations in last 12 months	72	70	2	97.2%
	Members with COPD who had an annual spirometry test	72	7	65	9.7%
Congestive Heart Failure	No re-admit to hosp with Heart Failure diag w/in 30 days of HF inpatient stay discharge	3	2	1	66.7%
	No ER Visit for Heart Failure in last 90 days	59	56	3	94.9%
	Follow-up OV within 4 weeks of discharge from HF admission	3	2	1	66.7%
Diabetes	Annual office visit	357	349	8	97.8%
	Annual dilated eye exam	357	177	180	49.6%
	Annual foot exam	357	140	217	39.2%
	Annual HbA1c test done	357	321	36	89.9%
	Diabetes Annual lipid profile	357	276	81	77.3%
	Annual microalbumin urine screen	357	276	81	77.3%
Hyperlipidemia	Hyperlipidemia Annual lipid profile	1,135	903	232	79.6%
Hypertension	Annual lipid profile	1,161	822	339	70.8%
	Annual serum creatinine test	1,118	942	176	84.3%
Wellness	Well Child Visit - 15 months	57	55	2	96.5%
	Routine office visit in last 6 months (All Ages)	6,335	4,644	1,691	73.3%
	Colorectal cancer screening ages 45-75 within the appropriate time period	2,726	1,359	1,367	49.9%
	Women age 25-65 with recommended cervical cancer/HPV screening	1,940	1,468	472	75.7%
	Males age greater than 49 with PSA test in last 24 months	1,009	548	461	54.3%
	Routine exam in last 24 months (All Ages)	6,335	5,853	482	92.4%
	Women age 40 to 75 with a screening mammogram last 24 months	1,777	1,180	597	66.4%

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	107	1.69%	16.51	$31,087
Asthma	454	7.17%	70.05	$16,891
Atrial Fibrillation	74	1.17%	11.42	$40,062
Blood Disorders	449	7.09%	69.28	$44,344
CAD	160	2.53%	24.69	$37,964
COPD	71	1.12%	10.96	$35,252
Cancer	299	4.72%	46.13	$38,225
Chronic Pain	390	6.16%	60.18	$22,817
Congestive Heart Failure	59	0.93%	9.10	$70,601
Demyelinating Diseases	23	0.36%	3.55	$49,788
Depression	759	11.98%	117.11	$14,691
Diabetes	559	8.82%	86.25	$23,705
ESRD	9	0.14%	1.39	$35,747
Eating Disorders	37	0.58%	5.71	$14,928
HIV/AIDS	11	0.17%	1.70	$38,124
Hyperlipidemia	1,415	22.33%	218.33	$17,266
Hypertension	1,171	18.48%	180.68	$19,707
Immune Disorders	45	0.71%	6.94	$59,041
Inflammatory Bowel Disease	37	0.58%	5.71	$33,956
Liver Diseases	159	2.51%	24.53	$31,088
Morbid Obesity	326	5.15%	50.30	$21,619
Osteoarthritis	362	5.71%	55.86	$21,803
Peripheral Vascular Disease	44	0.69%	6.79	$21,357
Rheumatoid Arthritis	75	1.18%	11.57	$38,903

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 March 31, 2023

Express Scripts

Membership Summary	1Q-3Q FY2023 EPO	1Q-3Q FY2022 EPO	Difference	% Change
			Membership Summary	
Member Count (Membership)	6,498	7,570	(1,072)	-14.2%
Utilizing Member Count (Patients)	5,300	6,308	(1,008)	-16.0%
Percent Utilizing (Utilization)	81.6%	83.3%	(0)	-2.1%

Claim Summary			Claims Summary	
Net Claims (Total Rx's)	102,323	115,100	(12,777)	-11.1%
Claims per Elig Member per Month (Claims PMPM)	1.75	1.69	0.06	3.6%
Total Claims for Generic (Generic Rx)	87,084	97,782	(10,698.00)	-10.9%
Total Claims for Brand (Brand Rx)	15,239	17,318	(2,079.00)	-12.0%
Total Claims for Brand w/Gen Equiv (Multisource Brand Claims)	500	774	(274.00)	-35.4%
Total Non-Specialty Claims	100,666	113,480	(12,814.00)	-11.3%
Total Specialty Claims	1,657	1,620	37.00	2.3%
Generic % of Total Claims (GFR)	**85.1%**	**85.0%**	0.00	0.2%
Generic Effective Rate (GCR)	**99.4%**	**99.2%**	0.00	0.2%
Mail Order Claims	28,562	24,482	4,080.00	16.7%
Mail Penetration Rate*	31.0%	23.8%	0.07	7.2%

Claims Cost Summary			Claims Cost Summary	
Total Prescription Cost (Total Gross Cost)	$14,917,970	$14,516,907	$401,063.00	2.8%
Total Generic Gross Cost	$1,577,469	$2,110,079	($532,610.00)	-25.2%
Total Brand Gross Cost	$13,340,501	$12,406,828	$933,673.00	7.5%
Total MSB Gross Cost	$296,707	$210,375	$86,332.00	41.0%
Total Ingredient Cost	$14,784,656	$14,355,821	$428,835.00	3.0%
Total Dispensing Fee	$118,673	$155,096	($36,423.00)	-23.5%
Total Other (e.g. tax)	$14,642	$5,990	$8,652.00	144.4%
Avg Total Cost per Claim (Gross Cost/Rx)	**$145.79**	**$126.12**	$19.67	15.6%
Avg Total Cost for Generic (Gross Cost/Generic Rx)	$18.11	$21.58	($3.47)	-16.1%
Avg Total Cost for Brand (Gross Cost/Brand Rx)	$875.42	$716.40	$159.02	22.2%
Avg Total Cost for MSB (MSB Gross Cost/MSB ARx)	$593.41	$271.80	$321.61	118.3%

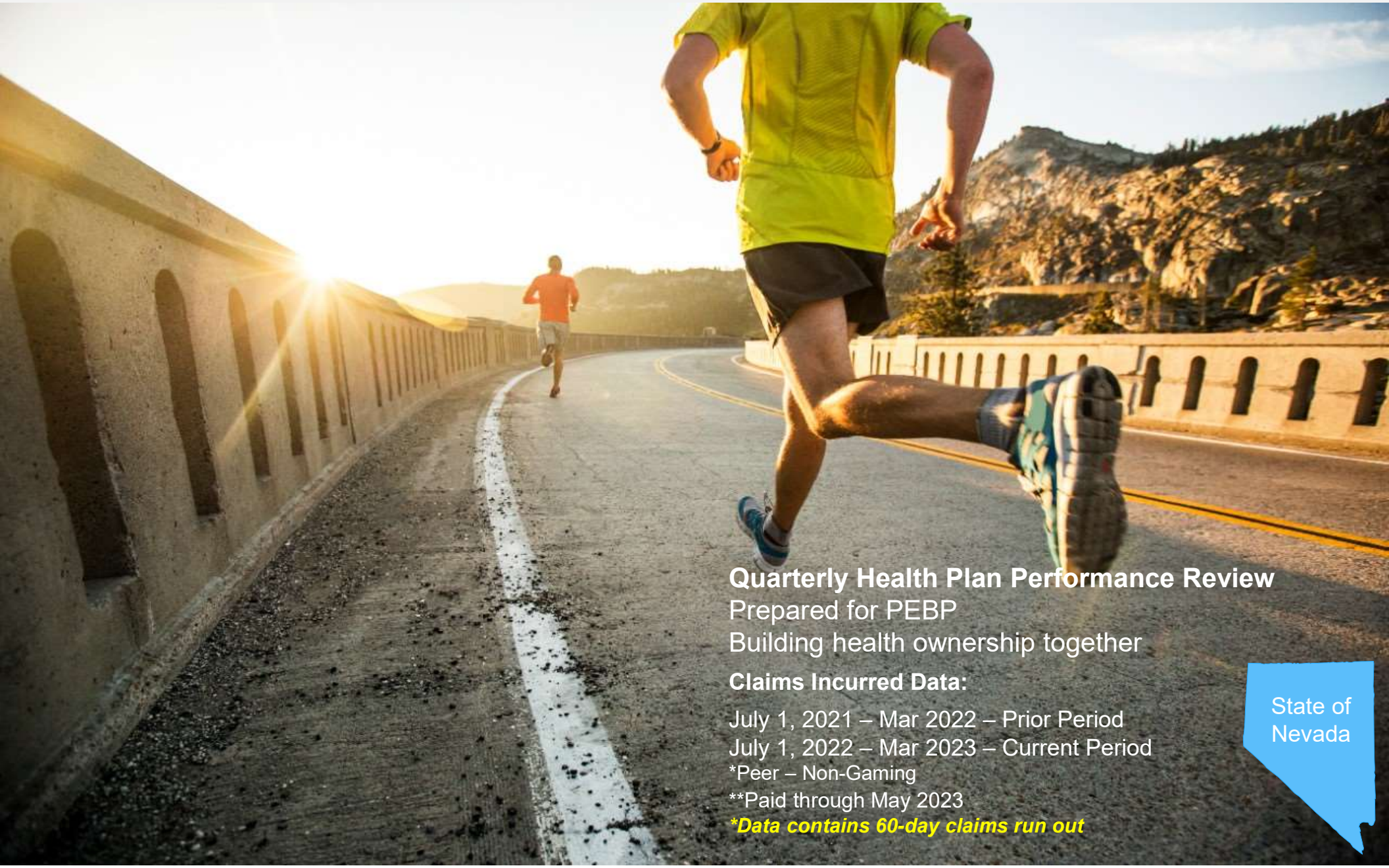
Member Cost Summary			Member Cost Summary	
Total Member Cost	**$2,396,124**	**$2,502,929**	($106,805.00)	-4.3%
Total Copay	$2,393,649	$2,492,832	($99,183.00)	-4.0%
Total Deductible	$2,474	$10,097	($7,623.00)	0.0%
Avg Copay per Claim (Copay/Rx)	$23.39	$21.66	$1.74	8.0%
Avg Participant Share per Claim (Copay+Deductible/RX)	**$23.42**	**$21.75**	**$1.67**	**7.7%**
Avg Copay for Generic (Copay/Generic Rx)	$6.67	$7.52	($0.85)	-11.3%
Avg Copay for Brand (Copay/Brand Rx)	$119.12	$102.05	$17.07	16.7%
Avg Copay for Brand w/ Generic Equiv (Copay/Multisource Rx)	$70.83	$34.86	$35.97	103.2%
Net PMPM (Participant Cost PMPM)	**$40.97**	**$36.74**	$4.23	11.5%
Copay % of Total Prescription Cost (Member Cost Share %)	16.1%	17.2%	-1.2%	-6.8%

Plan Cost Summary			Plan Cost Summary	
Total Plan Cost (Plan Cost)	**$12,521,847**	**$12,013,978**	**$507,869.00**	**4.2%**
Total Non-Specialty Cost (Non-Specialty Plan Cost)	$5,711,902	$6,136,249	($424,347.00)	-6.9%
Total Specialty Drug Cost (Specialty Plan Cost)	$6,809,944	$5,877,728	$932,216.00	15.9%
Avg Plan Cost per Claim (Plan Cost/Rx)	**$122.38**	**$104.38**	$18.00	17.2%
Avg Plan Cost for Generic (Plan Cost/Generic Rx)	$11.44	$14.06	($2.62)	-18.6%
Avg Plan Cost for Brand (Plan Cost/Brand Rx)	$756.30	$614.37	$141.93	23.1%
Avg Plan Cost for MSB (MSB Plan Cost/MSB ARx)	$522.59	$236.94	$285.65	120.6%
Net PMPM (Plan Cost PMPM)	**$214.11**	**$176.34**	**$37.78**	**21.4%**
PMPM without Specialty (Non-Specialty PMPM)	$97.67	$90.07	$7.60	8.4%
PMPM for Specialty Only (Specialty PMPM)	$116.45	$86.27	$30.18	35.0%
Rebates Received (Q1-Q3 FY2023 actual)	$4,349,325	$2,833,415	$1,515,910.21	53.5%
Net PMPM (Plan Cost PMPM factoring Rebates)	**$139.74**	**$134.75**	**$4.99**	**3.7%**
PMPM without Specialty (Non-Specialty PMPM)	$54.31	$59.39	$0.92	5.0%
PMPM for Specialty Only (Specialty PMPM)	$89.06	$72.95	$16.11	22.1%

Appendix D

Index of Tables
Health Plan of Nevada –Utilization Review for PEBP
January 1, 2023 – March 31, 2023

Power Of Partnership.



Quarterly Health Plan Performance Review

Prepared for PEBP

Building health ownership together

Claims Incurred Data:

July 1, 2021 – Mar 2022 – Prior Period

July 1, 2022 – Mar 2023 – Current Period

*Peer – Non-Gaming

**Paid through May 2023

Data contains 60-day claims run out

State of Nevada

Executive Summary

Spend and Utilization

Executive Summary Utilization & Spend

UnitedHealthcare

Population

- -4.0% decrease for employees
- -4.2% decrease for members

Medical Paid PMPM

- -31.4% decrease in overall medical paid
- -3.2% decrease in non-Catastrophic spend
- -52.2% decrease in Catastrophic spend

High-Cost Claimants

- 65 High-Cost Claimants accounted for 35.5% of medical spend
- -13.3% decrease in HCC from prior period
- Avg. Paid per case decreased -47.2%

Emergency Room

- ER Visits Per 1,000 members increased 6.5%
- Avg. paid per ER Visit increased 9.9%

Urgent Care

- Urgent Care visits per 1,000 members decreased by -15.8%
- Avg. paid per Urgent care visit increased 8.0%

Rx Drivers

- Rx Net Paid PMPM increased 18.5%
- Specialty Spend increased 40.1%
- Specialty Rx driving 44.3% of total Rx Spend

Overall Medical / Rx

- Total Medical/Rx decreased -18.0% on PMPM basis

Executive Summary Utilization & Spend

UnitedHealthcare®

Claims Paid by Age Group														
	Claims data through 3Q22						Claims data through 3Q23						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	$7,199,621	$14,489	$2,063	$4	$7,201,684	$14,493	$271,027	$542	$1,396	$3	$272,423	$545	-96.2%	-32.8%
01	$127,282	$194	$3,683	$6	$130,966	$200	$259,829	$567	$3,745	$8	$263,575	$575	192.4%	45.6%
02-04	$475,467	$264	$10,969	$6	$486,436	$270	$521,267	$304	$14,552	$8	$535,819	$313	15.5%	39.7%
05-09	$560,209	$156	$45,568	$13	$605,777	$169	$679,073	$209	$52,705	$16	$731,778	$225	34.0%	27.8%
10-14	$1,927,685	$437	$232,599	$53	$2,160,284	$490	$685,727	$166	$268,527	$65	$954,254	$232	-61.9%	23.6%
15-19	$1,359,654	$292	$185,189	$40	$1,544,844	$331	$864,221	$182	$166,599	$35	$1,030,820	$217	-37.6%	-11.7%
20-24	$857,919	$193	$265,462	$60	$1,123,381	$252	$601,522	$145	$156,344	$38	$757,866	$183	-24.6%	-36.6%
25-29	$773,829	$281	$275,814	$100	$1,049,642	$381	$1,171,902	$446	$268,596	$102	$1,440,499	$548	58.8%	2.1%
30-34	$954,174	$292	$607,096	$186	$1,561,270	$477	$1,085,870	$349	$423,275	$136	$1,509,145	$485	19.5%	-26.8%
35-39	$1,707,777	$413	$491,375	$119	$2,199,152	$531	$1,228,361	$328	$709,470	$190	$1,937,832	$518	-20.4%	59.8%
40-44	$1,438,952	$331	$512,553	$118	$1,951,505	$449	$1,322,702	$329	$590,563	$147	$1,913,265	$475	-0.9%	24.3%
45-49	$1,622,656	$330	$632,329	$129	$2,254,985	$459	$1,920,122	$381	$829,803	$165	$2,749,926	$546	15.3%	27.9%
50-54	$3,691,228	$642	$1,662,670	$289	$5,353,898	$931	$3,016,331	$532	$1,819,533	$321	$4,835,864	$853	-17.0%	11.1%
55-59	$3,082,250	$539	$1,521,893	$266	$4,604,143	$805	$2,405,469	$438	$1,762,399	$321	$4,167,868	$758	-18.7%	20.6%
60-64	$2,859,891	$517	$1,324,889	$239	$4,184,781	$756	$3,279,506	$617	$1,754,007	$330	$5,033,513	$947	19.4%	37.8%
65+	$2,603,636	$694	$1,055,598	$281	$3,659,233	$976	$2,132,898	$565	$1,201,271	$318	$3,334,169	$883	-18.7%	13.0%
Total	$31,242,230	$518	$8,829,751	$147	$40,071,981	$665	$21,445,829	$371	$10,022,786	$174	$31,468,615	$545	-21.5%	-18.0%

Financial Summary

UnitedHealthcare®

Financial and Demographic												
	Total				State Active				Retiree (State/Non-State)			
Summary	Thru 3Q21	Thru 3Q22	Thru 3Q23	▲	Thru 3Q21	Thru 3Q22	Thru 3Q23	▲	Thru 3Q21	Thru 3Q22	Thru 3Q23	▲
Avg. # Employees	3,906	3,793	3,640	-4.0%	3,414	3,322	3,214	-3.3%	493	471	427	-9.4%
Avg. # Members	6,801	6,695	6,415	-4.2%	6,168	6,075	5,837	-3.9%	632	620	578	-6.7%
Ratio	1.7	1.8	1.8	-0.2%	1.8	1.8	1.8	-0.7%	1.3	1.3	1.4	3.0%
Financial												
Medical Paid	$21,978,818	$31,242,230	$21,445,829	-31.4%	$19,279,451	$26,987,289	$19,028,441	-29.5%	$2,699,367	$4,254,942	$2,417,389	-43.2%
Member Paid	$1,450,050	$2,057,876	$1,395,822	-32.2%	$862,183	$1,470,431	$1,081,007	-26.5%	$587,867	$587,445	$314,814	-46.4%
Net Paid PEPY	$7,502	$10,981	$7,855	-28.5%	$7,530	$10,842	$7,881	-27.3%	$7,307	$11,964	$7,656	-36.0%
Net Paid PMPY	$4,309	$6,222	$4,457	-28.4%	$4,167	$5,929	$4,339	-26.8%	$5,691	$9,157	$5,578	-39.1%
Net Paid PEPM	$625	$915	$655	-28.5%	$628	$904	$657	-27.3%	$609	$997	$638	-36.0%
Net Paid PMPM	$359	$519	$371	-28.4%	$347	$494	$362	-26.8%	$474	$758	$471	-37.9%
High Cost Claimants												
# of HCC's > $50k	54	75	65	-13.3%	41	60	57	-5.0%	13	15	8	-46.7%
Avg. paid per claimant	$127,627	$222,114	$117,290	-47.2%	$142,393	$237,795	$116,041	-51.2%	$81,059	$159,389	$126,193	-20.8%
HCC % of Spend	31.1%	52.9%	35.5%	-32.8%	30.2%	52.5%	34.8%	-33.7%	37.7%	55.2%	41.2%	-25.3%
Spend by Location (PMPY)												
Inpatient	$1,431	$2,917	$1,258	-56.9%	$1,370	$2,734	$1,203	-56.0%	$2,024	$4,706	$1,172	-75.1%
Outpatient	$1,064	$1,143	$1,249	9.3%	$1,027	$1,109	$1,163	4.9%	$1,419	$1,483	$2,170	46.3%
Professional	$1,815	$2,162	$1,951	-9.8%	$1,770	$2,086	$1,973	-5.4%	$2,248	$2,968	$2,235	-24.7%
Total	$4,309	$6,222	$4,457	-28.4%	$4,167	$5,929	$4,339	-26.8%	$5,691	$9,157	$5,578	-39.1%

Paid Claims by Claim Type

UnitedHealthcare®

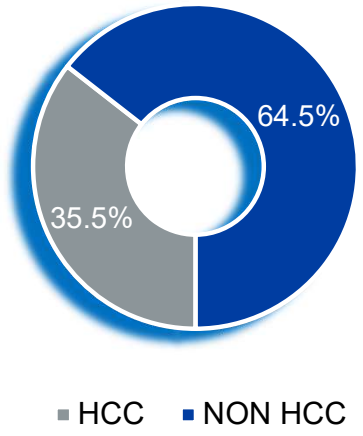
Net Paid Claims - Total Total Participants									
	Thru 3Q22				Thru 3Q23				▲
	Actives	Pre-Medicare	Medicare	Total	Actives	Pre-Medicare	Medicare	Total	
Medical									
InPatient	$12,965,406	$294,747	$1,386,205	$14,646,358	$4,937,757	$113,796	$998,745	$6,050,297	-58.7%
OutPatient	$15,070,134	$313,373	$1,212,365	$16,595,872	$13,554,409	$691,676	$1,149,447	$15,395,532	-7.2%
Total - Medical	$28,035,540	$608,120	$2,598,569	$31,242,230	$18,492,166	$805,472	$2,148,192	$21,445,829	-31.4%

Net Paid Claims - Total Total Participants									
	Thru 3Q22				Thru 3Q23				▲
	Actives	Pre-Medicare	Medicare	Total	Actives	Pre-Medicare	Medicare	Total	
Medical PMPM	$507	$490	$2,096	$518	$350	$716	$569	$371	-28.4%

Cost Distribution – Medical Claims > $50K

Thru 3Q22							Thru 3Q23					
# 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
16	0.2%	$9,844,218	31.5%	$1,038,241	10.5%	> $100k	10	0.2%	$1,616,525	7.5%	$971,593	60.1%
29	0.4%	$2,778,252	8.9%	$1,071,368	38.6%	$50k- $100k	26	0.4%	$2,649,247	12.4%	$1,062,094	40.1%
53	0.8%	$2,486,199	8.0%	$1,471,734	59.2%	$25k - $50k	55	0.9%	$2,175,965	10.1%	$1,113,084	51.2%
202	3.0%	$4,180,262	13.4%	$2,055,078	49.2%	$10k - $25k	167	2.6%	$3,527,109	16.4%	$1,837,691	52.1%
302	4.5%	$2,661,353	8.5%	$1,080,408	40.6%	$5k - $10k	316	4.9%	$2,722,222	12.7%	$1,268,169	46.6%

% Paid Attributed to Catastrophic Cases



HCC > $50k - AHRQ Chapter Conditions - Thru 3Q23			
Top 5 AHRQ Category conditions	# of Patients	Total Paid	% of Med Paid
Endocrine; nutritional; and metabolic diseases	7	$1,461,751	6.8%
Injury and poisoning	7	$1,086,685	5.1%
Neoplasms	10	$1,071,384	5.0%
Diseases of the circulatory system	11	$966,039	4.5%
Infectious and parasitic diseases	7	$816,824	3.8%

Utilization Summary

UnitedHealthcare®

Utilization Summary	Total			State Active			Retiree State/Non-State		
	Thru 3Q22	Thru 3Q23	▲	Thru 3Q22	Thru 3Q23	▲	Thru 3Q22	Thru 3Q23	▲
Inpatient									
# of Admits	341	278	-18.6%	266	254	-4.6%	75	24	-67.9%
# of Bedays	2,583	1,620	-37.3%	1,969	1,500	-23.8%	615	120	-80.5%
Avg. Paid per Admit	$42,733	$21,401	-49.9%	$46,635	$21,400	-54.1%	$28,945	$21,414	-26.0%
Avg. Paid per Day	$5,642	$3,669	-35.0%	$6,297	$3,618	-42.5%	$3,543	$4,314	21.8%
Admits Per K	67.9	57.7	-15.0%	58.3	57.9	-0.7%	161.9	55.7	-65.6%
Days Per K	514.5	336.7	-34.6%	432.1	342.6	-20.7%	1,322.6	276.2	-79.1%
ALOS	7.6	5.8	-23.0%	7.4	5.9	-20.1%	5.5	5.9	7.3%
Admits from ER	168	131	-22.0%	125	115	-8.0%	43	16	-62.8%
Physician Office Visits									
Per Member Per Year	2.7	2.3	-14.9%	2.6	2.2	-14.8%	3.2	2.7	-16.0%
Paid Per Visit	$134	$151	12.2%	$139	$156	12.1%	$97	$107	10.5%
Net Paid PMPM	$30	$29	-4.6%	$31	$29	-4.4%	$26	$24	-7.2%
Emergency Room									
# of Visits	546	557	2.0%	498	509	2.2%	48	48	0.0%
Visits Per K	108.7	115.8	6.5%	109.3	116.3	6.4%	103.3	110.7	7.2%
Avg Paid Per Visit	$2,501	$2,749	9.9%	$2,543	$2,775	9.1%	$2,063	$2,475	20.0%
Urgent Care									
# of Visits	3,604	2,909	-19.3%	3,213	2,641	-17.8%	391	268	-31.5%
Visits Per K	717.7	604.6	-15.8%	705.1	603.3	-14.4%	841.5	618.3	-26.5%
Avg Paid Per Visit	$115	$117	2.1%	$86	$90	5.1%	$84	$79	-6.3%

**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
Thyroid disorders	$1,187,242	7.0%	$821,939	$358,866	$6,437	$1,244	$1,185,999	$0
Septicemia (except in labor)	$932,976	5.5%	$687,174	$93,516	$152,286	$266,455	$666,521	$0
Complication of device; implant or graft	$547,028	3.2%	$204,885	$89,191	$252,952	$232,750	$314,279	$0
Disorders usually diagnosed in infancy childhood or adol	$390,805	2.3%	$0		$390,805	$326,349	$64,456	$0
Spondylosis; intervertebral disc disorders; other back prc	$356,693	2.1%	$311,385	$37,243	$8,065	$127,270	$229,422	$0
Diabetes mellitus with complications	$340,919	2.0%	$183,411	$79,858	$77,649	$255,708	$85,211	$0
Non-Hodgkin`s lymphoma	$320,022	1.9%	$298,643	$21,380		$31,003	$289,019	$0
Other nervous system disorders	$316,223	1.9%	$172,651	$135,467	$8,105	$31,182	$285,041	$0
Acute myocardial infarction	$307,934	1.8%	$121,979	$185,954		$242,036	$65,898	$0
Cardiac dysrhythmias	$283,721	1.7%	$221,100	$62,250	$370	$125,867	$157,854	$0
Complications of surgical procedures or medical care	$282,054	1.7%	$268,791	$13,155	$109	$204,227	$77,827	$0
Other nutritional; endocrine; and metabolic disorders	$266,775	1.6%	$155,260	$108,748	$2,767	$34,084	$232,691	$0
Viral infection	$265,888	1.6%	$61,641	$156,941	$47,306	$29,064	$236,824	$0
Mood disorders	$263,216	1.6%	$100,062	$18,686	$144,468	$108,465	$154,750	$0
Other screening for suspected conditions (not mental dis	$257,460	1.5%	$214,007	$38,952	$4,501	$76,422	$181,038	$0
Cancer of breast	$253,627	1.5%	$209,101	$44,525			$253,627	$0
Maintenance chemotherapy; radiotherapy	$252,781	1.5%	$238,144	$14,637		$74,114	$178,667	$0
Other gastrointestinal disorders	$225,936	1.3%	$157,224	$44,770	$23,942	$53,256	$172,680	$0
Osteoarthritis	$222,452	1.3%	$186,006	$36,446		$50,486	$171,966	$0
Cancer of prostate	$214,248	1.3%	$134,514	$79,733		$214,248		$0
Nonspecific chest pain	$212,570	1.3%	$124,147	$69,123	$19,300	$91,010	$121,560	$0
Medical examination/evaluation	$204,757	1.2%	$59,585	$11,307	$133,864	$82,246	$122,511	$0
Abdominal pain	$201,756	1.2%	$158,147	$15,464	$28,146	$58,718	$143,039	$0
Abdominal hernia	$185,010	1.1%	$147,247	$32,133	$5,630	$44,935	$140,075	$0
Polyhydramnios and other problems of amniotic cavity	$182,838	1.1%	$172,951	$9,887	$0		$182,838	$0

*Not Representative of all utilization

*Data based on medical spend only

Mental Health Drilldown

UnitedHealthcare®

Top 10 Mental Health				
AHRQ Category Description	Thru 3Q22		Thru 3Q23	
	Patients	Total Paid	Patients	Total Paid
Disorders usually diagnosed in infancy childhood or	46	$502,596	38	$390,805
Mood disorders	469	$277,888	412	$263,216
Anxiety disorders	445	$121,142	385	$158,454
Adjustment disorders	173	$44,910	127	$46,964
Substance-related disorders	38	$24,130	30	$46,694
Attention-deficit conduct and disruptive behavior dis	119	$18,930	133	$27,794
Suicide and intentional self-inflicted injury	14	$33,295	12	$21,469
Schizophrenia and other psychotic disorders	20	$238,524	11	$20,479
Miscellaneous mental health disorders	49	$69,136	44	$16,940
Alcohol-related disorders	25	$277,533	14	$14,890

**Not Representative of all utilization*

**Data based on medical spend only*

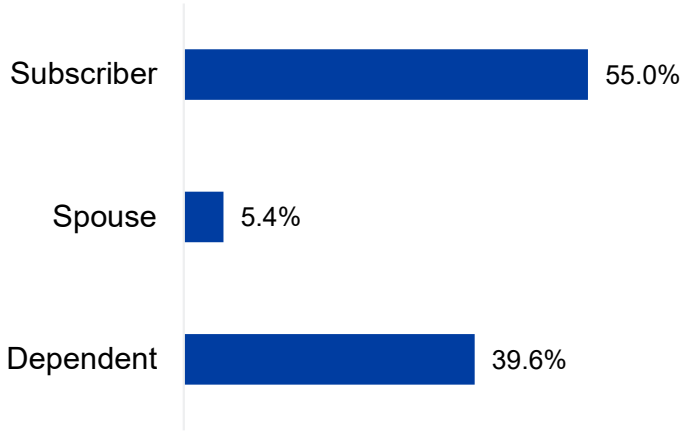
Respiratory Disorders

Respiratory Disorders				
AHRQ Category Description	Patients	Claims	Total Paid	% Paid
Other upper respiratory infections	899	1,286	$158,990	17.2%
Acute bronchitis	126	174	$133,066	14.4%
Other lower respiratory disease	462	878	$118,104	12.8%
Asthma	232	459	$107,586	11.6%
Other upper respiratory disease	384	1,199	$107,009	11.6%
Respiratory failure; insufficiency; arrest (adult)	21	112	$95,430	10.3%
Pneumonia (except that caused by tuberculosis	36	114	$93,108	10.1%
Chronic obstructive pulmonary disease	94	217	$51,640	5.6%
Acute and chronic tonsillitis	53	97	$27,761	3.0%
Influenza	61	69	$23,061	2.5%

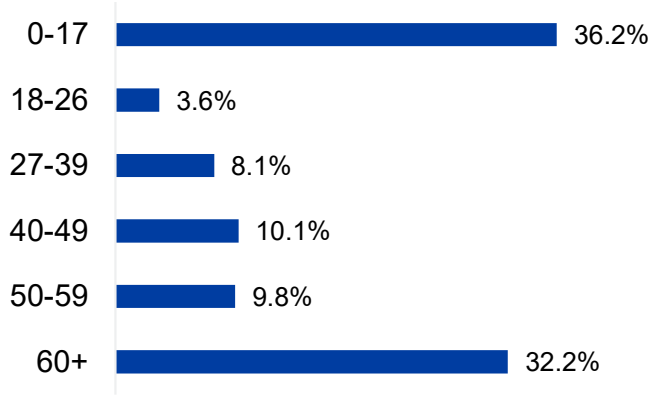
**Not Representative of all utilization*

**Data based on medical spend only*

Spend by Relationship



Spend by Age



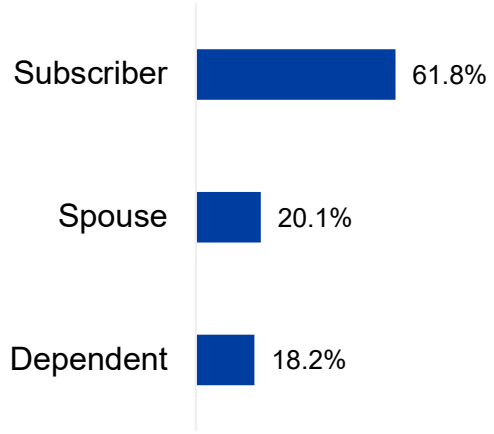
Infections

Infectious and Parasitic Diseases				
AHRQ Description	Patients	Claims	Total Paid	% Paid
Septicemia (except in labor)	16	47	$556,753	41.2%
Immunizations and screening for infectious disease	843	1,287	$101,930	7.5%
Viral infection	344	501	$96,374	7.1%
HIV infection	17	49	$5,748	0.4%
Mycoses	71	102	$2,151	0.2%
Hepatitis	13	41	$2,011	0.1%
Bacterial infection; unspecified site	7	11	$1,104	0.1%
Other infections; including parasitic	7	13	$640	0.0%
Tuberculosis	4	11	$0	0.0%
Sexually transmitted infections (not HIV or hepatitis)	8	11	$0	0.0%

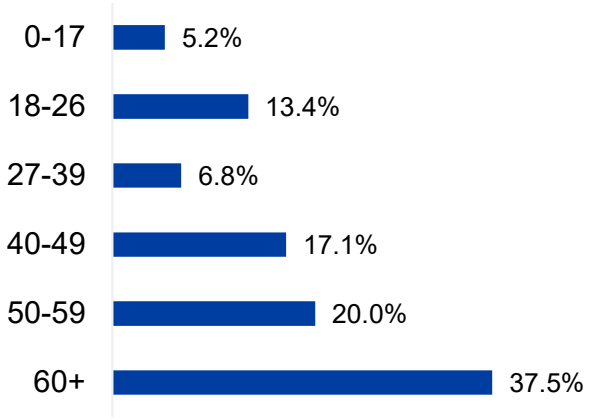
**Not Representative of all utilization*

**Data based on medical spend only*

Spend by Relationship



Spend by Age

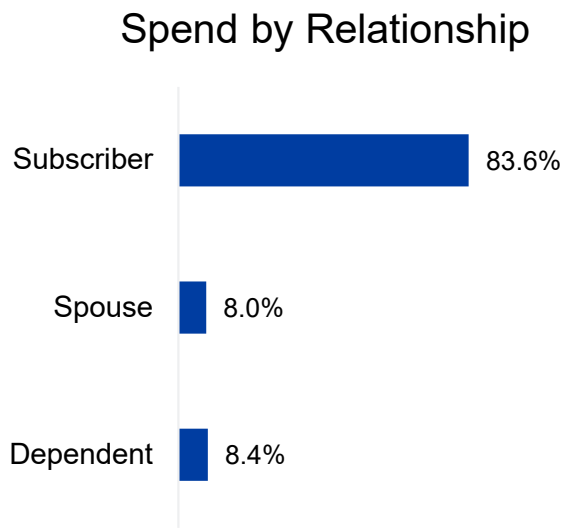


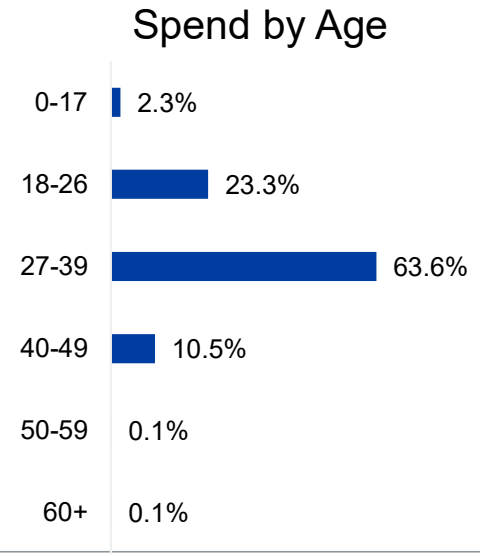
Pregnancy Related Disorders

Top 10 Complications of Pregnancy				
AHRQ Description	Patients	Claims	Total Paid	% Paid
Polyhydramnios and other problems of amniotic cavity	12	32	$182,838	19.3%
Other complications of birth;	31	55	$169,847	17.9%
Other complications of pregnancy	68	308	$105,125	11.1%
Other pregnancy and delivery including normal	79	360	$97,759	10.3%
Contraceptive and procreative management	174	368	$55,806	5.9%
Previous C-section	7	19	$52,130	5.5%
Prolonged pregnancy	6	8	$46,103	4.9%
Malposition; malpresentation	5	8	$44,733	4.7%
OB-related trauma to perineum and vulva	6	7	$41,522	4.4%
Umbilical cord complication	6	11	$38,760	4.1%

**Not Representative of all utilization*

**Data based on medical spend only*





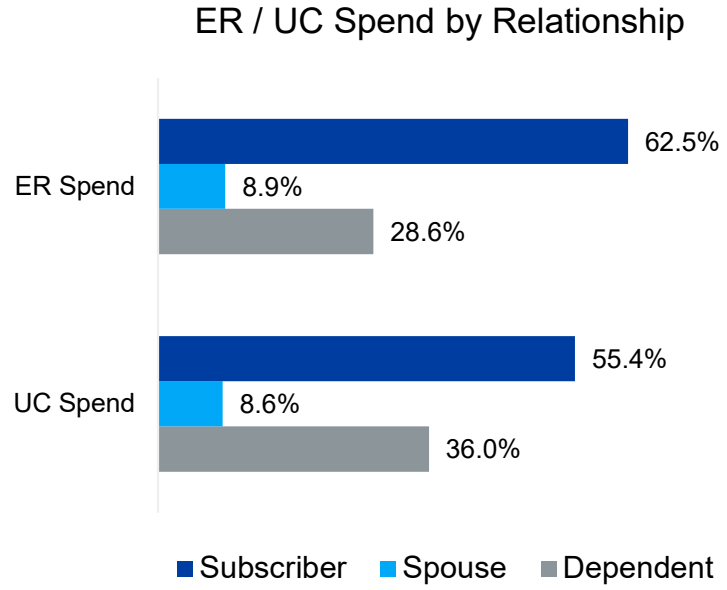
Emergency Room and Urgent Care

	Thru 3Q22		Thru 3Q23		Peer	
Metric	ER	Urgent Care	ER	Urgent Care	ER	Urgent Care
# of Visits	546	3,604	557	2,909		
Visits Per Member	0.08	0.48	0.09	0.54	0.09	0.16
Visits Per K	108.7	717.7	115.8	604.6	93.5	445.52
Avg. Paid Per Visit	$2,501	$112	$2,749	$121	$2,589	$125

**Not Representative of all utilization*

**Data based on medical spend only*

Emergency Room and Urgent Care Visits by Relationships - Thru 3Q23				
Relationship	ER Visits	ER Per K	UC Visits	UC Per K
Member	300	62.4	1,797	373.5
Spouse	53	11.0	243	50.5
Dependent	204	42.4	869	180.6
Total	557	115.8	2,909	604.6



Clinical Conditions by Medical Spend

UnitedHealthcare®

Top 15 Common Condition	# of Members	% of Members	Members Per K	PMPM
Mental Disorders	675	3.5%	35.1	$12.75
Intervertebral Disc Disorders	584	3.0%	30.3	$6.18
Diabetes with complications	390	2.0%	20.3	$5.90
Acute Myocardial Infarction	576	3.0%	29.9	$5.33
Breast Cancer	9	0.0%	0.5	$4.39
Prostate Cancer	58	0.3%	3.0	$3.71
Hypertension	71	0.4%	3.7	$2.99
Chronic Renal Failure	100	0.5%	5.2	$2.08
Asthma	227	1.2%	11.8	$1.86
Coronary Atherosclerosis	37	0.2%	1.9	$1.48
Diabetes without complications	7	0.0%	0.4	$1.36
COPD	437	2.3%	22.7	$0.89
Congestive Heart Failure (CHF)	94	0.5%	4.9	$0.41
Colon Cancer	26	0.1%	1.4	$0.03
Cervical Cancer	27	0.1%	1.4	$0.03

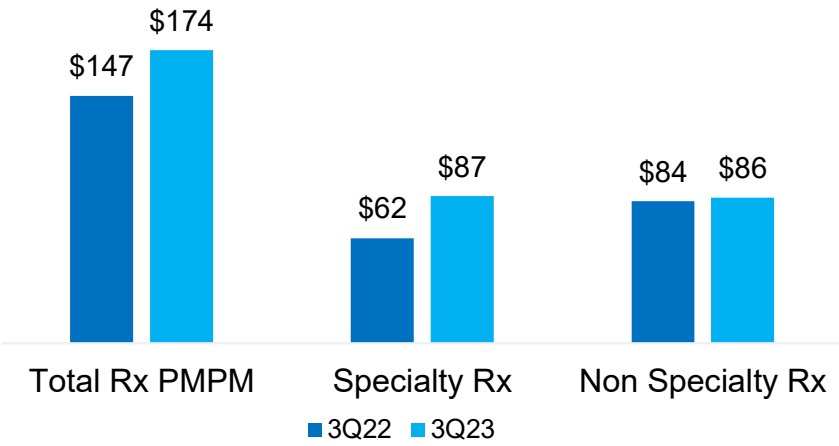
**Not Representative of all utilization*

**Data based on medical spend only*

Pharmacy Drivers

	Thru 3Q22	Thru 3Q23	Δ
Enrolled Members	6,695	6,415	-4.2%
Average Prescriptions PMPY	17.0	16.9	-0.6%
Formulary Rate	89.0%	89.8%	0.9%
Generic Use Rate	83.0%	84.6%	2.0%
Generic Substitution Rate	98.2%	98.2%	0.1%
Avg Net Paid per Prescription	$103	$123	19.2%
Net Paid PMPM	$147	$174	18.5%

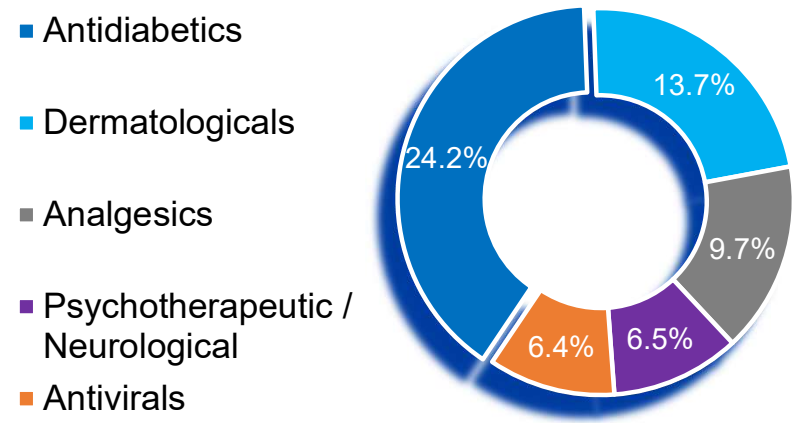
Total Rx Spend by Benefit and Type



Pharmacy Performance

- Rx spend increased of **18.5%**, (**$27 PMPM**) from prior period
- Avg. paid per Script increased **19.2%** (**$20 PMPM**) year over year
- Specialty Rx spend driving **44.3%** of Rx Spend
- Specialty Rx spend increased **40.1%** from prior period
  Specialty Rx Drivers:
  Stelara (Dermatologic) Spend up **4.1%**
  Jardiance (Antidiabetic) Spend up **1.2%**
- Tier 1 Rx drove **76.4%** of total claim volume, but only accounts for **8.5%** of overall Rx Spend

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 March 31, 2023:

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 May 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 March 31, 2023:

        4.3.1 UMR – Obesity Care Management

DATASCOPE™

Obesity Care Management Report

Nevada Public Employees' Benefits Program

July 2022 – March 2023 Incurred,

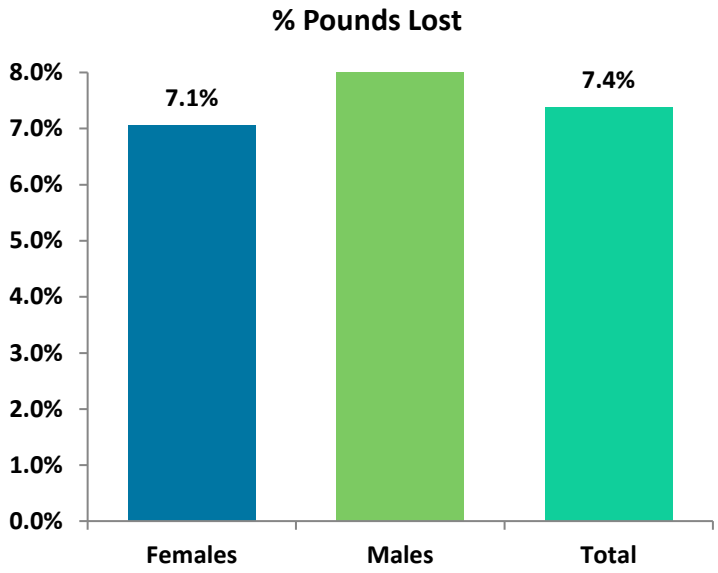
Paid through May 31, 2023

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

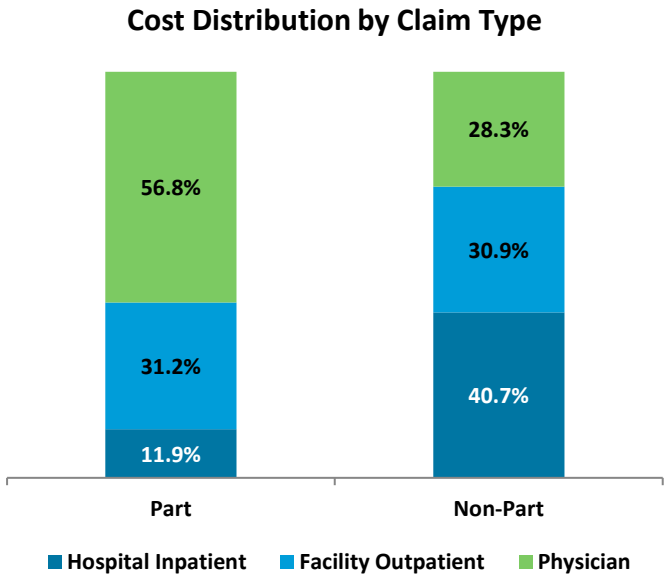
PEBP 3Q23			
Weight Management Summary	**Females**	**Males**	**Total**
# Mbrs Enrolled in Program	282	61	343
Average # Lbs. Lost	14.3	20.9	15.5
Total # Lbs. Lost	4,042.4	1,276.7	5,319.1
% Lbs. Lost	7.1%	8.6%	7.4%
Average Cost/ Member	$4,411	$4,183	$4,370



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	306	1,167	-73.8%
Avg # Members	336	1,407	-76.1%
Member/Employee Ratio	1.1	1.2	-9.1%
Financial Summary			
Gross Cost	$1,363,243	$15,710,364	
Client Paid	$1,060,043	$13,596,278	
Employee Paid	$303,200	$2,114,087	
Client Paid-PEPY	$4,621	$15,540	-70.3%
Client Paid-PMPY	$4,201	$12,881	-67.4%
Client Paid-PEPM	$385	$1,295	-70.3%
Client Paid-PMPM	$350	$1,073	-67.4%
High Cost Claimants (HCC's) > $100k			
# of HCC's	0	24	
HCC's / 1,000	0.0	17.1	0.0%
Avg HCC Paid	$0	$209,491	0.0%
HCC's % of Plan Paid	0.0%	37.0%	0.0%
Cost Distribution - PMPY			
Hospital Inpatient	$501	$5,248	-90.5%
Facility Outpatient	$1,312	$3,982	-67.1%
Physician	$2,388	$3,651	-34.6%
Total	$4,201	$12,881	-67.4%
	Annualized	Annualized	



Obesity Care Management – Utilization Summary

Summary	Participants	Non-Participants	Variance
Inpatient Facility			
# of Admits	7	190	
# of Bed Days	20	1002	
Paid Per Admit	$14,936	$31,506	-52.6%
Paid Per Day	$5,228	$5,974	-12.5%
Admits Per 1,000	28	180	-84.4%
Days Per 1,000	79	949	-91.7%
Avg LOS	2.9	5.3	-45.3%
# of Admits From ER	5	95	-94.7%
Physician Office			
OV Utilization per Member	15.1	9.5	58.9%
Avg Paid per OV	$102	$103	-1.0%
Avg OV Paid per Member	$1,533	$975	57.2%
DX&L Utilization per Member	20.4	24.5	-16.7%
Avg Paid per DX&L	$34	$56	-39.3%
Avg DX&L Paid per Member	$704	$1,380	-49.0%
Emergency Room			
# of Visits	61	356	
Visits Per Member	0.24	0.34	-29.4%
Visits Per 1,000	242	337	-28.2%
Avg Paid per Visit	$2,935	$3,439	-14.7%
Urgent Care			
# of Visits	120	563	
Visits Per Member	0.48	0.53	-9.4%
Visits Per 1,000	476	533	-10.7%
Avg Paid per Visit	$74	$103	-28.2%
	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 March 31, 2023:

        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 – March 2023 Incurred,

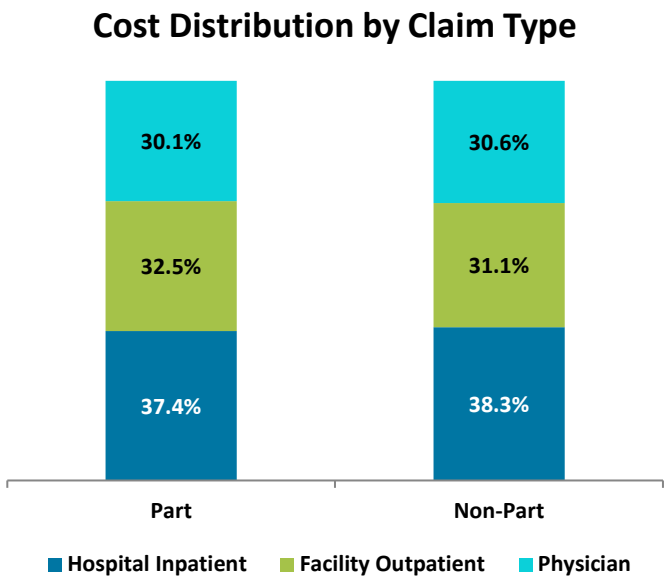
Paid through May 31, 2023

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	265	2,115	-87.5%
Avg # Members	358	2,664	-86.6%
Member/Employee Ratio	1.4	1.3	7.1%
Financial Summary			
Gross Cost	$2,183,090	$24,493,643	
Client Paid	$1,578,903	$21,062,998	
Employee Paid	$604,187	$3,430,644	
Client Paid-PEPY	$7,941	$13,277	-40.2%
Client Paid-PMPY	$5,879	$10,542	-44.2%
Client Paid-PEPM	$662	$1,106	-40.1%
Client Paid-PMPM	$490	$879	-44.3%
High Cost Claimants (HCC's) > $100k			
# of HCC's	1	43	
HCC's / 1,000	2.8	16.1	0.0%
Avg HCC Paid	$567,298	$214,802	164.1%
HCC's % of Plan Paid	35.9%	43.9%	0.0%
Cost Distribution - PMPY			
Hospital Inpatient	$2,199	$4,040	-45.6%
Facility Outpatient	$1,909	$3,278	-41.8%
Physician	$1,771	$3,225	-45.1%
Total	$5,879	$10,542	-44.2%
	Annualized	Annualized	



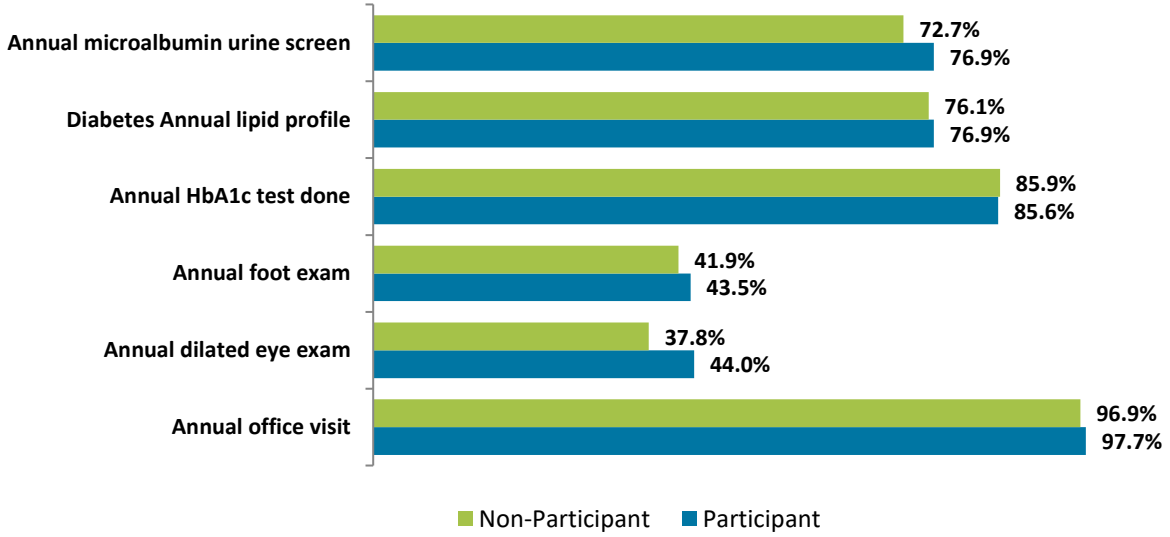
Diabetes Care Management – Utilization Summary

*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	22	258	
# of Bed Days	218	1,484	
Paid Per Admit	$29,662	$32,764	-9.5%
Paid Per Day	$2,993	$5,696	-47.5%
Admits Per 1,000	82	129	-36.4%
Days Per 1,000	812	743	9.3%
Avg LOS	9.9	5.8	70.7%
# of Admits From ER	19	163	-88.3%
Physician Office			
OV Utilization per Member	7.8	8.1	-3.7%
Avg Paid per OV	$68	$114	-40.4%
Avg OV Paid per Member	$531	$919	-42.2%
DX&L Utilization per Member	21.8	25.2	-13.5%
Avg Paid per DX&L	$30	$59	-49.2%
Avg DX&L Paid per Member	$650	$1,498	-56.6%
Emergency Room			
# of Visits	56	511	
Visits Per Member	0.21	0.26	-19.2%
Visits Per 1,000	209	256	-18.4%
Avg Paid per Visit	$2,061	$3,427	-39.9%
Urgent Care			
# of Visits	85	782	
Visits Per Member	0.32	0.39	-17.9%
Visits Per 1,000	316	391	-19.2%
Avg Paid per Visit	$84	$90	-6.7%
	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	216	211	5	97.7%	1,567	1,519	48	96.9%
	Annual dilated eye exam	216	95	121	44.0%	1,567	592	975	37.8%
	Annual foot exam	216	94	122	43.5%	1,567	656	911	41.9%
	Annual HbA1c test done	216	185	31	85.6%	1,567	1,346	221	85.9%
	Diabetes Annual lipid profile	216	166	50	76.9%	1,567	1,193	374	76.1%
	Annual microalbumin urine screen	216	166	50	76.9%	1,567	1,139	428	72.7%



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 March 31, 2023:

        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

Excutive Summary

Metrics	Jan-23	Feb-23	Mar-23	Average
Enrollment	48,231	48,480	48,406	**48,372**

Inpatient All - LTACH, AIR, SNF, and OOA

Month	Jan-23	Feb-23	Mar-23	Total	Average
Total Discharges	151	161	156	**468**	**156**
Total Discharges LOS	621	843	616	**2,080**	**693**
Average LOS	4.1	5.2	3.9	**4.4**	**4.4**

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

Inpatient Hospital Acute Only

Month	Jan-23	Feb-23	Mar-23	Total	Average
Total Discharges	101	99	94	**294**	**98**
Total Discharges LOS	442	468	330	**1,240**	**413**
Average LOS	4.4	4.7	3.5	**4.2**	**4.2**

Beddays by Facility Type

Metrics			Beddays		
Facility Type	**Jan-23**	**Feb-23**	**Mar-23**	**Total**	**Average**
Hospital	442	527	349	**1,318**	**439**
Hospital Rehabilitation	7	0	14	**21**	**11**
Skilled Nursing	0	41	54	**95**	**48**
Out of Area	172	404	238	**814**	**271**

Admits by Facility Type

Metrics			Admits		
Facility Type	**Jan-23**	**Feb-23**	**Mar-23**	**Total**	**Average**
Hospital	105	98	88	**291**	**97**
Hospital Rehabilitation	1	0	1	**2**	**1**
Skilled Nursing	0	2	4	**6**	**3**
Out of Area	50	62	52	**164**	**55**

Readmits by Facility Type

Metrics			Readmits		
Facility Type	**Jan-23**	**Feb-23**	**Mar-23**	**Total**	**Average**
Hospital	8	4	0	**12**	**4**
Hospital Rehabilitation	0	0	0	**0**	**0**
Skilled Nursing	0	0	0	**0**	**0**
Out of Area	5	4	0	**9**	**3**

Excutive Summary

Average Length of Stay by Facility

Facility Type	Metrics	Average LOS			
	Facility Name	Jan-23	Feb-23	Mar-23	Total
Hospital	CENTENNIAL HILLS HOSPITAL MEDICAL CENTER	4.5	2.7	4.2	**3.6**
	DESERT SPRINGS HOSPITAL MEDICAL CENTER	4.5	1.0	0.0	**3.8**
	HENDERSON HOSPITAL	0.0	4.5	4.0	**4.1**
	MIKE O CALLAGHAN FEDERAL HOSPITAL	0.0	1.5	1.0	**1.3**
	MOUNTAIN VIEW HOSPITAL	8.3	1.2	3.2	**4.3**
	NORTH VISTA HOSPITAL	1.0	1.0	1.0	**1.0**
	RENOWN REGIONAL MEDICAL CENTER	3.5	5.0	3.9	**4.1**
	SOUTHERN HILLS HOSPITAL	9.0	1.3	1.0	**3.4**
	SPRING VALLEY HOSPITAL	4.6	6.5	2.9	**4.0**
	ST ROSE DOMINICAN HOSPITAL SAN MARTIN CAMPUS	1.0	1.5	1.0	**1.2**
	ST ROSE DOMINICAN HOSPITAL SIENA CAMPUS	3.9	7.5	2.3	**4.8**
	SUMMERLIN HOSPITAL MEDICAL CTR	7.0	5.9	2.9	**5.0**
	SUNRISE HOSPITAL	3.1	9.5	2.4	**4.4**
	UNIVERSITY MEDICAL CENTER SO NV	28.0	4.4	7.0	**7.7**
	VALLEY HOSPITAL MEDICAL CTR	0.0	3.0	3.5	**2.5**
	Total	**4.4**	**4.7**	**3.5**	**4.2**
Hospital Rehabilitation	ENCOMPASS HEALTH REHAB OF LAS VEGAS	7.0	0.0	0.0	**7.0**
	PAM SPECIALTY HOSPITAL OF LAS VEGAS	0.0	0.0	14.0	**14.0**
	Total	**7.0**	**0.0**	**14.0**	**10.5**
Skilled Nursing	HARMON HOSPITAL	0.0	6.0	0.0	**6.0**
	SANDSTONE SPRING VALLEY LLC	0.0	0.0	12.0	**12.0**
	WELBROOK CENTENNIAL HILLS	0.0	0.0	22.0	**22.0**
	Total	**0.0**	**6.0**	**17.0**	**13.3**
Out of Area	Out of Area	3.5	6.0	4.0	**4.6**
	Total	**3.5**	**6.0**	**4.0**	**4.6**

Beddays by Facility

Facility Type	Metrics	Beddays				
	Facility Name	Jan-23	Feb-23	Mar-23	Total	Average
Hospital	CENTENNIAL HILLS HOSPITAL MEDICAL CENTER	18	19	25	**62**	**21**
	DESERT SPRINGS HOSPITAL MEDICAL CENTER	18	1	0	**19**	**10**
	HENDERSON HOSPITAL	0	9	28	**37**	**19**
	MIKE O CALLAGHAN FEDERAL HOSPITAL	0	3	1	**4**	**2**
	MOUNTAIN VIEW HOSPITAL	50	7	16	**73**	**24**

Excutive Summary

Beddays by Facility

Facility Type	Metrics	Beddays				
	Facility Name	Jan-23	Feb-23	Mar-23	Total	Average
Hospital	NORTH VISTA HOSPITAL	1	1	1	**3**	**1**
	RENOWN REGIONAL MEDICAL CENTER	178	286	135	**599**	**200**
	SOUTHERN HILLS HOSPITAL	18	5	1	**24**	**8**
	SPRING VALLEY HOSPITAL	23	13	20	**56**	**19**
	ST ROSE DOMINICAN HOSPITAL SAN MARTIN CAMPUS	2	3	1	**6**	**2**
	ST ROSE DOMINICAN HOSPITAL SIENA CAMPUS	39	45	26	**110**	**37**
	SUMMERLIN HOSPITAL MEDICAL CTR	42	53	29	**124**	**41**
	SUNRISE HOSPITAL	25	57	24	**106**	**35**
	UNIVERSITY MEDICAL CENTER SO NV	28	22	35	**85**	**28**
	VALLEY HOSPITAL MEDICAL CTR	0	3	7	**10**	**5**
	Total	**442**	**527**	**349**	**1,318**	**0**
Hospital Rehabilitation	ENCOMPASS HEALTH REHAB OF LAS VEGAS	7	0	0	**7**	**7**
	PAM SPECIALTY HOSPITAL OF LAS VEGAS	0	0	14	**14**	**14**
	Total	**7**	**0**	**14**	**21**	**0**
Skilled Nursing	HARMON HOSPITAL	0	6	0	**6**	**6**
	SANDSTONE SPRING VALLEY LLC	0	35	32	**67**	**34**
	WELBROOK CENTENNIAL HILLS	0	0	22	**22**	**22**
	Total	**0**	**41**	**54**	**95**	**0**
Out of Area	Out of Area	172	404	238	**814**	**271**
	Total	**172**	**404**	**238**	**814**	**0**

Admits by Facility

Facility Type	Metrics	Admits				
	Facility Name	Jan-23	Feb-23	Mar-23	Total	Average
Hospital	CENTENNIAL HILLS HOSPITAL MEDICAL CENTER	5	7	5	**17**	**6**
	DESERT SPRINGS HOSPITAL MEDICAL CENTER	4	1	0	**5**	**3**
	HENDERSON HOSPITAL	0	2	7	**9**	**5**
	MIKE O CALLAGHAN FEDERAL HOSPITAL	0	2	1	**3**	**2**
	MOUNTAIN VIEW HOSPITAL	6	3	5	**14**	**5**
	NORTH VISTA HOSPITAL	1	1	1	**3**	**1**
	RENOWN REGIONAL MEDICAL CENTER	52	48	33	**133**	**44**
	SOUTHERN HILLS HOSPITAL	4	2	1	**7**	**2**
	SPRING VALLEY HOSPITAL	6	2	7	**15**	**5**
	ST ROSE DOMINICAN HOSPITAL SAN MARTIN CAMPUS	1	2	1	**4**	**1**

Excutive Summary

Admits by Facility

Facility Type	Metrics	Admits				
	Facility Name	Jan-23	Feb-23	Mar-23	Total	Average
Hospital	ST ROSE DOMINICAN HOSPITAL SIENA CAMPUS	10	5	4	**19**	**6**
	SUMMERLIN HOSPITAL MEDICAL CTR	8	9	9	**26**	**9**
	SUNRISE HOSPITAL	6	9	6	**21**	**7**
	UNIVERSITY MEDICAL CENTER SO NV	2	4	6	**12**	**4**
	VALLEY HOSPITAL MEDICAL CTR	0	1	2	**3**	**1**
	Total	**105**	**98**	**88**	**291**	**0**
Hospital Rehabilitation	ENCOMPASS HEALTH REHAB OF LAS VEGAS	1	0	0	**1**	**1**
	PAM SPECIALTY HOSPITAL OF LAS VEGAS	0	0	1	**1**	**1**
	Total	**1**	**0**	**1**	**2**	**0**
Skilled Nursing	HARMON HOSPITAL	0	1	0	**1**	**1**
	SANDSTONE SPRING VALLEY LLC	0	1	3	**4**	**2**
	WELBROOK CENTENNIAL HILLS	0	0	1	**1**	**1**
	Total	**0**	**2**	**4**	**6**	**0**
Out of Area	Out of Area	50	62	52	**164**	**55**
	Total	**50**	**62**	**52**	**164**	**0**

Readmits by Facility

Facility Type	Metrics	Readmits				
	Facility Name	Jan-23	Feb-23	Mar-23	Total	Average
Hospital	CENTENNIAL HILLS HOSPITAL MEDICAL CENTER	0	0	0	**0**	**0**
	DESERT SPRINGS HOSPITAL MEDICAL CENTER	1	0	0	**1**	**1**
	HENDERSON HOSPITAL	0	0	0	**0**	**0**
	MIKE O CALLAGHAN FEDERAL HOSPITAL	0	1	0	**1**	**1**
	MOUNTAIN VIEW HOSPITAL	0	0	0	**0**	**0**
	NORTH VISTA HOSPITAL	0	0	0	**0**	**0**
	RENOWN REGIONAL MEDICAL CENTER	7	2	0	**9**	**3**
	SOUTHERN HILLS HOSPITAL	0	0	0	**0**	**0**
	SPRING VALLEY HOSPITAL	0	0	0	**0**	**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	0	0	0	**0**	**0**
	SUNRISE HOSPITAL	0	0	0	**0**	**0**
	UNIVERSITY MEDICAL CENTER SO NV	0	1	0	**1**	**0**

Excutive Summary

Facility Type	Readmits by Facility					
	Metrics	Readmits				
	Facility Name	Jan-23	Feb-23	Mar-23	Total	Average
Hospital	VALLEY HOSPITAL MEDICAL CTR	0	0	0	**0**	**0**
	Total	**8**	**4**	**0**	**12**	**0**
Out of Area	Out of Area	5	4	0	**9**	**3**
	Total	**5**	**4**	**0**	**9**	**0**

Facility Type	Readmits by Facility					
	Metrics	Readmit Rate				
	Facility Name	Jan-23	Feb-23	Mar-23	Total	Average
Hospital	CENTENNIAL HILLS HOSPITAL MEDICAL CENTER	0.0%	0.0%	0.0%	**0.0%**	**0.0%**
	DESERT SPRINGS HOSPITAL MEDICAL CENTER	25.0%	0.0%	0.0%	**20.0%**	**20.0%**
	HENDERSON HOSPITAL	0.0%	0.0%	0.0%	**0.0%**	**0.0%**
	MIKE O CALLAGHAN FEDERAL HOSPITAL	0.0%	50.0%	0.0%	**33.3%**	**33.3%**
	MOUNTAIN VIEW HOSPITAL	0.0%	0.0%	0.0%	**0.0%**	**0.0%**
	NORTH VISTA HOSPITAL	0.0%	0.0%	0.0%	**0.0%**	**0.0%**
	RENOWN REGIONAL MEDICAL CENTER	13.5%	4.2%	0.0%	**6.8%**	**6.8%**
	SOUTHERN HILLS HOSPITAL	0.0%	0.0%	0.0%	**0.0%**	**0.0%**
	SPRING VALLEY HOSPITAL	0.0%	0.0%	0.0%	**0.0%**	**0.0%**
	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	0.0%	0.0%	0.0%	**0.0%**	**0.0%**
	SUNRISE HOSPITAL	0.0%	0.0%	0.0%	**0.0%**	**0.0%**
	UNIVERSITY MEDICAL CENTER SO NV	0.0%	25.0%	0.0%	**8.3%**	**8.3%**
	VALLEY HOSPITAL MEDICAL CTR	0.0%	0.0%	0.0%	**0.0%**	**0.0%**
	Total	**7.6%**	**4.1%**	**0.0%**	**4.1%**	**0.0%**
Out of Area	Out of Area	10.0%	6.5%	0.0%	**5.5%**	**5.5%**
	Total	**10.0%**	**6.5%**	**0.0%**	**5.5%**	**0.0%**

Utilization Summary

Outpatient Case Management					
Month	**Jan-23**	**Feb-23**	**Mar-23**	**YTD**	**Average**
New Cases	180	175	175	**530**	**177**
Accepted	114	143	139	**396**	**132**
Acceptance Rate	63.3%	81.7%	79.4%	**74.7%**	**74.7%**
Average Duration (closed only)	11.1	7.8	4.3	**7.7**	**7.7**

Inpatient Case Management					
Month	**Jan-23**	**Feb-23**	**Mar-23**	**YTD**	**Average**
Open End of Month	31	28	17	**76**	**25**
Cases opened in the month	156	162	145	**463**	**154**
Cases closed in the month	151	161	156	**468**	**156**
Denied Days	11	6	12	**29**	**10**
Average LOS	4.1	5.2	3.9	**4.4**	**4.4**
NICU Open at End of Month	1	0	0	**1**	**0**
NICU Cases opened in the month	3	1	1	**5**	**2**
NICU Cases closed in the month	5	3	1	**9**	**3**
NICU Average Legth of Stay	9.0	0.7	3.0	**5.6**	**5.6**

Authorizations					
Month	**Jan-23**	**Feb-23**	**Mar-23**	**YTD**	**Average**
Total services reviewed	2,923	2,491	2,864	**8,278**	**2,759**
Services Approved	2,817	2,415	2,818	**8,050**	**2,683**
Approval Rate	96.4%	96.9%	98.4%	**97.2%**	**97.2%**
Services Denied	106	76	46	**228**	**76**
Denied Charges	$77,817	$21,373	$16,122	**$115,312**	**$38,437**
Denial Rate	4%	3%	2%	**3%**	**3%**

Denial Reason						
Metrics			**Denied**			
Denial Reason	**Dec-22**	**Jan-23**	**Feb-23**	**Mar-23**	**YTD**	**Average**
Not medically necessary	0	106	76	46	**228**	**76**

Utilization Summary

Denial Reason

Metrics	Denied					
Denial Reason	**Dec-22**	**Jan-23**	**Feb-23**	**Mar-23**	**YTD**	**Average**
None	9	11	6	12	**38**	**10**

Utilization Summary

Turn Around Time					
Month	**Jan-23**	**Feb-23**	**Mar-23**	**YTD**	**Average**
2 or fewer days	563	339	473	**1,375**	**458**
2 or fewer Pct	54.4%	41.9%	47.4%	**48.4%**	**48.4%**
5 or fewer days	662	550	721	**1,933**	**644**
5 or fewer Pct	64.0%	68.0%	72.3%	**68.0%**	**68.0%**
15 or fewer Days	977	776	992	**2,745**	**915**
15 or fewer Pct	94.4%	95.9%	99.5%	**96.6%**	**96.6%**
Over 15 days	58	33	5	**96**	**32**
Over 15 days Pct	5.6%	4.1%	0.5%	**3.4%**	**3.4%**

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

Stat					
Month	**Jan-23**	**Feb-23**	**Mar-23**	**YTD**	**Average**
Stat Request	735	715	793	**2,243**	**748**

Appeals					
Month	**Jan-23**	**Feb-23**	**Mar-23**	**YTD**	**Average**
Appeals 1st Level	4	3	4	**11.00**	**3.67**
Appeals 2nd Level	0	0	0	**0.00**	**0.00**
Appeals 3rd Level	0	0	0	**0.00**	**0.00**
Appeals Overturned	0	0	1	**1.00**	**0.33**
Appeals Upheld	2	3	4	**9.00**	**3.00**

Utilization Summary

Retro Reviews

Month	Jan-23	Feb-23	Mar-23	YTD	Average
Retros	7	2	0	**9**	**3**

Telephone Advise Nurse

Metrics

Outcome description	Jan-23	Feb-23	Mar-23	YTD	Average
Call 911	0	2	0	**2**	**2**
ER	4	7	10	**21**	**7**
Information or Advice Only	7	3	2	**12**	**4**
Other	11	13	15	**39**	**13**
PCP	10	13	10	**33**	**11**
Poison Center	0	0	1	**1**	**1**
Self-Care/Home Care	1	1	6	**8**	**3**
Urgent Care	10	15	11	**36**	**12**

Bedday Summary

Acute only

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

Month	Jan-23	Feb-23	Mar-23	YTD
Membership	48,231	48,480	48,406	**48,372**
Beddays per K	150.5	207.2	141.1	**166.3**
Admits per K	38.6	38.6	34.5	**37.2**
Average LOS	4.0	4.7	3.7	**4.2**
Readmits per K	3.2	2.0	0.0	**1.7**
Readmit Rate	8.4%	5.1%	0.0%	**4.7%**

SHO

Month	Jan-23	Feb-23	Mar-23	YTD
Beddays per K	183.3	173.0	126.5	**160.9**
Admits per K	37.7	33.6	33.6	**34.9**
Average LOS	5.0	4.8	3.4	**4.4**
Readmits per K	2.7	1.3	0.0	**1.3**
Readmit Rate	7.3%	3.9%	0.0%	**3.9%**

SHL PPO

Month	Jan-23	Feb-23	Mar-23	YTD
Beddays per K	162.9	110.2	106.2	**126.6**
Admits per K	46.2	33.0	30.9	**36.7**
Average LOS	4.8	4.7	4.2	**4.6**
Reamits per K	3.5	3.1	1.2	**2.6**
Readmit Rate	7.5%	9.3%	4.0%	**7.1%**

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 March 31, 2023:

        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	Owner	Due to internal account management team by	Results Details (Q3)	Guarantee Achieved?
Client Implementation	Enrollment materials	Enrollment materials completed/shipped within agreed upon timeframe	Implementation Tracking	.3% of premium	Emily Doehr	8/1/2022	Forms were requested on 4/18/22 meeting with PEBP. Sent customized forms and flyers on 5/9/22, prior to their May board meeting.	Yes
	Draft certificate issued	30 days from receipt of set up information	Implementation Tracking	.3% of premium	Emily Doehr	8/1/2022	Final setup information received on 4/29/22, first drafts issued to PEBP on 5/27/22.	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	Emily Doehr	8/1/2022	"Complete setup information (final UAF and questionnaire) received for employer portal access for billing and reporting on 4/29/22, system ready on 5/11/22. Second (final) draft of COCs approved by PEBP on 6/21/22, finals issued to PEBP on 6/22/22, claims ready in OnBase on 6/24/22."	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	Geoff Crain	6/16/2023	95.0%	No
	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	Geoff Crain	6/16/2023	85.0%	No
	Life Claims - Accuracy of claim payment	98% of claims processed accurately	Internal Claims Audit	.3% of premium	Geoff Crain	6/16/2023	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	Account managment			
Claim Customer Service *	Average speed of answer	80% in less than 30 seconds	Call Center Statistics	.3% of premium	Geoff Crain	6/16/2023	100.0%	Yes
	Abandonment Rate	<5% abandonment rate	Call Center Statistics	.3% of premium	Geoff Crain	6/16/2023	1.0%	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	Account managment			
			Total at Risk	**The lesser of 3% or $50,000**				

UHC Payments Q3 FY23

Jan.	$	259,384.32
Feb.	$	260,371.20
Mar.	$	260,666.88
Q1 Total	$	780,422.40
Penalty %		0.60%
Penalty $	$	4,682.53

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 March 31, 2023:

        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 –3rd Quarter Plan Year 2023

WTW's Individual Marketplace

May 1, 2023

The Public Employees Benefit Program Executive Dashboard

Quarterly Update – 3rd Quarter Plan Year 2023

Executive Summary

Plan Enrollment:

- At the end of FY Q3 2023, PEBP's total enrollment into Medicare policies through WTW's Individual Marketplace decreased to 11,333. Since inception, 119 carriers have been selected by PEBP's retirees with current enrollment in 1,892 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 6,203 and 1,874 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 Q3 2023, PEBP participant satisfaction with Enrollment Calls had an average satisfaction score result of 4.0 out of 5.0 based on 11 surveys returned.
- For Q3 2023, the average satisfaction score for Service Calls was 4.4 out of 5.0 based on 282 surveys returned.
- The combined average satisfaction score for Enrollment Calls and Service Calls was 4.4 out of 5.0 for Q3 2023.

Health Reimbursement Arrangement:

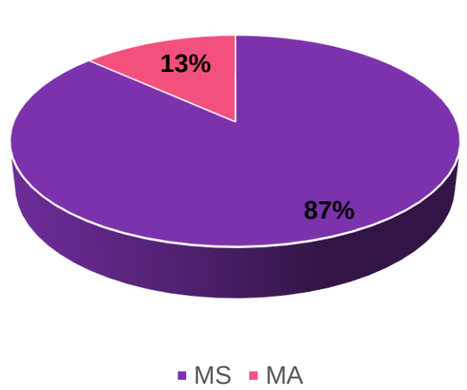
- At the end of Q3 2023 there were 13,796 Health Reimbursement Arrangement (HRA) accounts for PEBP participants.
- There were 84,168 claims processed in Q2, with 79% being submitted via Auto-Reimbursement, meaning that participants did not have to manually submit 103,787 claims for Premium Reimbursement.
- The total reimbursement amount processed for Q3 was $8,330,493.

Summary of Retiree Decisions and Costs

Retiree Plan Selection Through 03/31/2023		Previous Qtr.
Total enrolled through individual marketplace	11,333	11,339
Number of carriers**	119	118
Number of plans**	1,892	1,869

Plan Type Selection Through 03/31/2023		Previous Qtr.
Medicare Advantage (MA, MAPD)	1,505	1,451
Medicare Supplement (MS)	9,838	9,918

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 (MS)	9,918	$146
Medicare Advantage (MA,MAPD)	1,505	$0 / $10
Part D drug coverage	6,645	$23
Dental coverage	890	$37
Vision coverage	2,025	$10

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

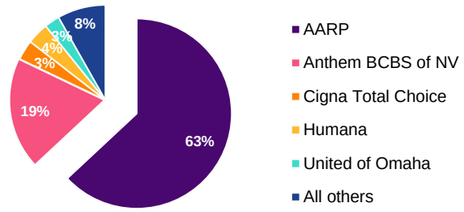
The Public Employees Benefit Program Executive Dashboard

Quarterly Update – 3rd Quarter Plan Year 2023

Summary of Retiree Carrier Choice

Top Medicare Supplement Plans	Total
AARP	6,203
Anthem BCBS of NV	1,874
Cigna Total Choice	335
Humana	363
United of Omaha	256

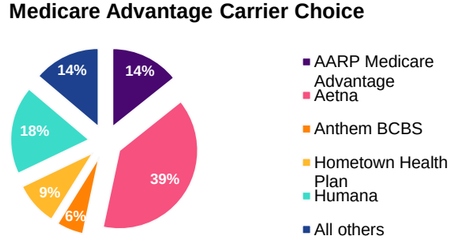
Medicare Supplement Carrier Choice



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

Top Medicare Advantage Plans	Total
AARP Medicare Advantage	215
Aetna	588
Anthem BCBS	83
Hometown Health Plan	136
Humana	275

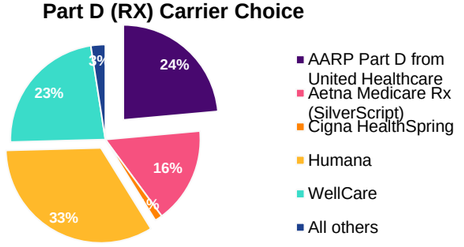
Medicare Advantage Carrier Choice



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	1,566
Aetna Medicare Rx (SilverScript)	1,085
Cigna HealthSpring	85
Humana	2,220
WellCare	1,526

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

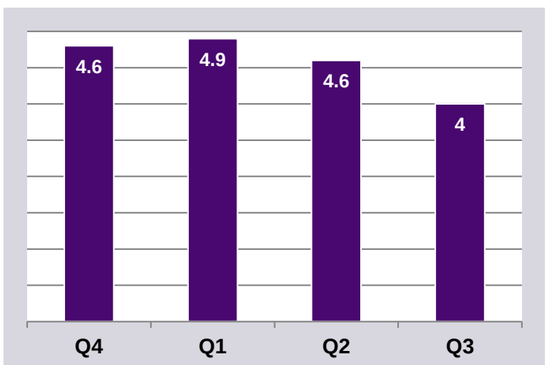
Quarterly Update – 3rd Quarter Plan Year 2023

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

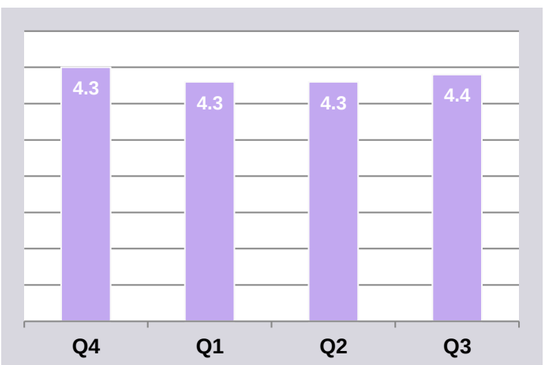
Q3 Enrollment Satisfaction

CSAT score	Count	%
5	6	55%
4	3	27%
3	-	0%
2	-	0%
1	2	18%
	11	**100%**



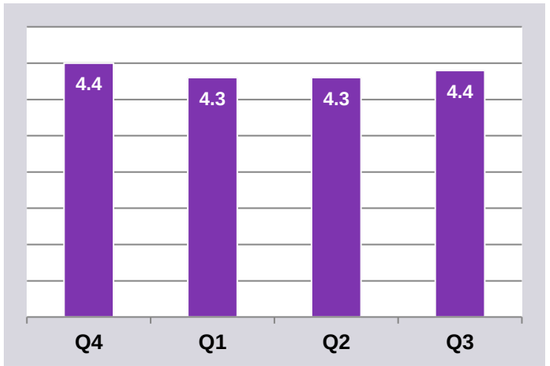
Q3 Service Satisfaction

CSAT score	Count	%
5	190	67%
4	40	14%
3	30	11%
2	12	4%
1	10	4%
	282	**100%**



Q3 Enrollment & Service Combined

CSAT score	Count	%
5	196	67%
4	43	15%
3	30	10%
2	12	4%
1	12	4%
	293	**100%**

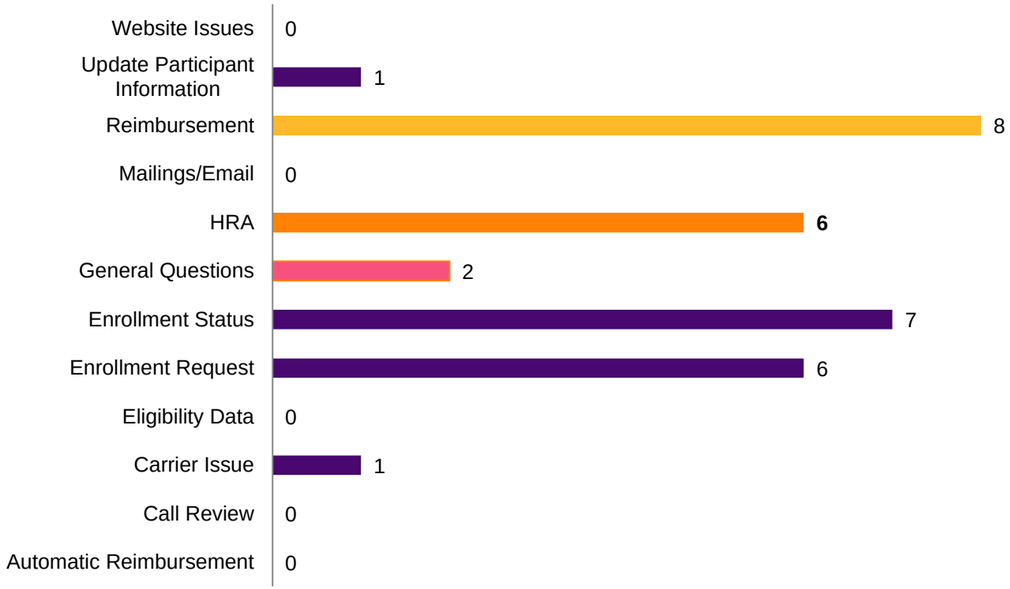


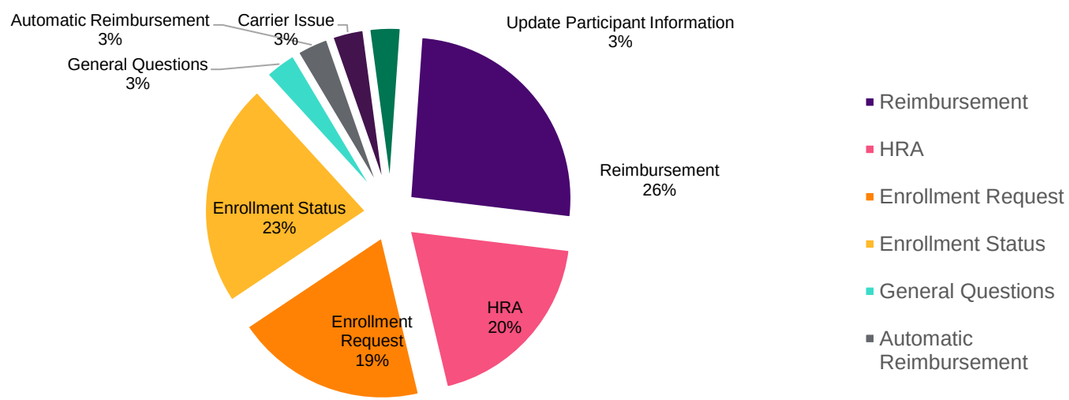
The Public Employees Benefit Program Executive Dashboard

Quarterly Update – 3rd 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 Q3-PY23 is 31 and are associated with the following categories:





Health Reimbursement Account (HRA)

Claim Activity for the Qtr.	Total
HRA accounts	13,391
Number of payments	52,233
Accounts with no balance	7,777
Claims paid amount	$8,330,493

Claims By Source	Total
A/R file	103,787
Mail	14,070
Web	9,535
Mobile App	3,418

The Public Employees Benefit Program Executive Dashboard

Quarterly Update – 3rd Quarter Plan Year 2023

Performance Guarantees*

Category	Commitment	Outcome	PG MET
Claims Turnaround Time	≤ 2 days	0.97 Days	Yes
Claim Financial Accuracy	≥ 98%	99.32%	Yes
Claim Processing Payment Precision	≥ 98%	Results not Reported on Benefits Accounts	Yes
Reports	≤ 15 business days	Met	Yes
HRA Web Services	≥ 99%	99.99%	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.	26 Seconds	Yes
Benefits Administration Customer Service Abandonment Rate Annual	≤ 5%	Annual	Yes
Customer Satisfaction	≥ 80%	92.12%	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

Spring Retiree Meetings:

WTW and Nevada PEBP held two days of virtual retiree meetings with two meetings per day on March 27 and 28. Recordings of one of each type of meeting have been posted to our Nevada PEBP specific Website at https://my.viabenefits.com/PEBP

Meeting Date/Time	Meeting Type	Attended
March 27 - 9:30 am PT	Pre-Medicare/Ageing into Medicare	113
March 27 – 12:00 pm PT	HRA/Medicare Open Enrollment	33
March 28 – 11:30 am PT	HRA/Medicare Open Enrollment	35
March 28 - 2:00 pm PT	Pre-Medicare/Ageing into Medicare	100

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 sent a communication 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.

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 was mailed in mid-February.

VIA BENEFITS

Balance Reminder

Via Benefits
PO Box 12345
City Name, PA 67890-1234
Electronic Service Requested

Identifier: 17805806, 1105910
GROUP NAME, LLC

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

10/15/2021

You have a total available balance of $1,360.00 in your reimbursement account that you can use for eligible expenses. The table below shows the available balance from each account and plan year.

Account Balance Breakdown

Account	Plan Year	Available Balance
HRA	2018	$140.00
HRA	2019	$220.00
HRA	2020	$1,200.00
Total Available Balance: $1,560.00		

We're here to assist you
If you have questions, please call Via Benefits at 1-800-888-8888 (TTY: 711), Monday through Friday 8:00 a.m. to 6:00 p.m. Time Zone.

Sincerely,
Via Benefits

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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 March 31, 2023:

        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	99.1%	
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	95%	100%
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	0	N/A
Q4 Results		

4.3.7

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

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4.3.1 UMR – Obesity Care Management

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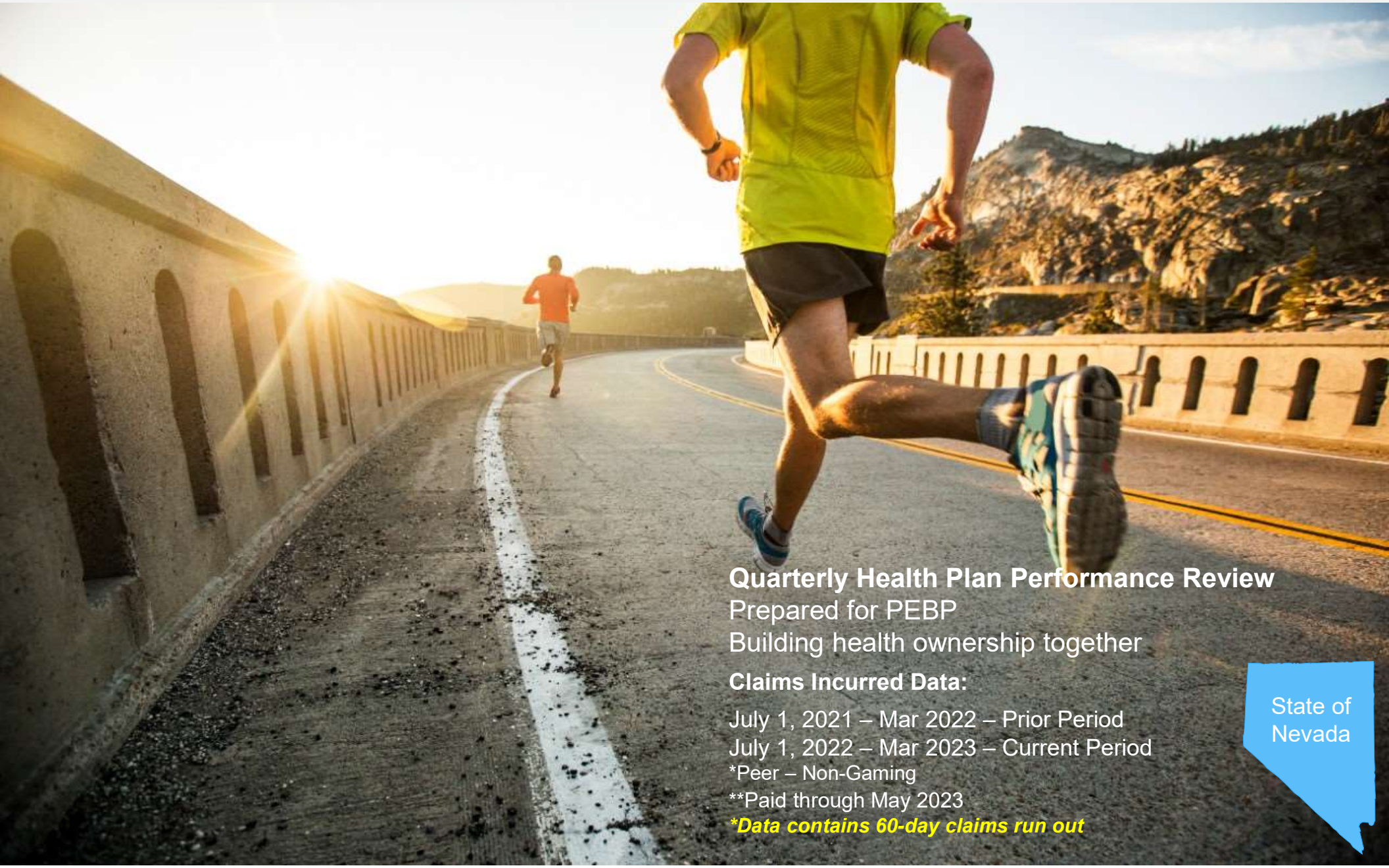
4.3.6 Sierra Healthcare Options and UnitedHealthcare Plus Network

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 – Mar 2022 – Prior Period

July 1, 2022 – Mar 2023 – Current Period

*Peer – Non-Gaming

**Paid through May 2023

Data contains 60-day claims run out

State of Nevada

Executive Summary

Spend and Utilization

Executive Summary Utilization & Spend

UnitedHealthcare

Population

- -4.0% decrease for employees
- -4.2% decrease for members

Medical Paid PMPM

- -31.4% decrease in overall medical paid
- -3.2% decrease in non-Catastrophic spend
- -52.2% decrease in Catastrophic spend

High-Cost Claimants

- 65 High-Cost Claimants accounted for 35.5% of medical spend
- -13.3% decrease in HCC from prior period
- Avg. Paid per case decreased -47.2%

Emergency Room

- ER Visits Per 1,000 members increased 6.5%
- Avg. paid per ER Visit increased 9.9%

Urgent Care

- Urgent Care visits per 1,000 members decreased by -15.8%
- Avg. paid per Urgent care visit increased 8.0%

Rx Drivers

- Rx Net Paid PMPM increased 18.5%
- Specialty Spend increased 40.1%
- Specialty Rx driving 44.3% of total Rx Spend

Overall Medical / Rx

- Total Medical/Rx decreased -18.0% on PMPM basis

Executive Summary Utilization & Spend

UnitedHealthcare®

Claims Paid by Age Group														
	Claims data through 3Q22						Claims data through 3Q23						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	$7,199,621	$14,489	$2,063	$4	$7,201,684	$14,493	$271,027	$542	$1,396	$3	$272,423	$545	-96.2%	-32.8%
01	$127,282	$194	$3,683	$6	$130,966	$200	$259,829	$567	$3,745	$8	$263,575	$575	192.4%	45.6%
02-04	$475,467	$264	$10,969	$6	$486,436	$270	$521,267	$304	$14,552	$8	$535,819	$313	15.5%	39.7%
05-09	$560,209	$156	$45,568	$13	$605,777	$169	$679,073	$209	$52,705	$16	$731,778	$225	34.0%	27.8%
10-14	$1,927,685	$437	$232,599	$53	$2,160,284	$490	$685,727	$166	$268,527	$65	$954,254	$232	-61.9%	23.6%
15-19	$1,359,654	$292	$185,189	$40	$1,544,844	$331	$864,221	$182	$166,599	$35	$1,030,820	$217	-37.6%	-11.7%
20-24	$857,919	$193	$265,462	$60	$1,123,381	$252	$601,522	$145	$156,344	$38	$757,866	$183	-24.6%	-36.6%
25-29	$773,829	$281	$275,814	$100	$1,049,642	$381	$1,171,902	$446	$268,596	$102	$1,440,499	$548	58.8%	2.1%
30-34	$954,174	$292	$607,096	$186	$1,561,270	$477	$1,085,870	$349	$423,275	$136	$1,509,145	$485	19.5%	-26.8%
35-39	$1,707,777	$413	$491,375	$119	$2,199,152	$531	$1,228,361	$328	$709,470	$190	$1,937,832	$518	-20.4%	59.8%
40-44	$1,438,952	$331	$512,553	$118	$1,951,505	$449	$1,322,702	$329	$590,563	$147	$1,913,265	$475	-0.9%	24.3%
45-49	$1,622,656	$330	$632,329	$129	$2,254,985	$459	$1,920,122	$381	$829,803	$165	$2,749,926	$546	15.3%	27.9%
50-54	$3,691,228	$642	$1,662,670	$289	$5,353,898	$931	$3,016,331	$532	$1,819,533	$321	$4,835,864	$853	-17.0%	11.1%
55-59	$3,082,250	$539	$1,521,893	$266	$4,604,143	$805	$2,405,469	$438	$1,762,399	$321	$4,167,868	$758	-18.7%	20.6%
60-64	$2,859,891	$517	$1,324,889	$239	$4,184,781	$756	$3,279,506	$617	$1,754,007	$330	$5,033,513	$947	19.4%	37.8%
65+	$2,603,636	$694	$1,055,598	$281	$3,659,233	$976	$2,132,898	$565	$1,201,271	$318	$3,334,169	$883	-18.7%	13.0%
Total	$31,242,230	$518	$8,829,751	$147	$40,071,981	$665	$21,445,829	$371	$10,022,786	$174	$31,468,615	$545	-21.5%	-18.0%

Financial Summary

UnitedHealthcare®

Financial and Demographic												
	Total				State Active				Retiree (State/Non-State)			
Summary	Thru 3Q21	Thru 3Q22	Thru 3Q23	▲	Thru 3Q21	Thru 3Q22	Thru 3Q23	▲	Thru 3Q21	Thru 3Q22	Thru 3Q23	▲
Avg. # Employees	3,906	3,793	3,640	-4.0%	3,414	3,322	3,214	-3.3%	493	471	427	-9.4%
Avg. # Members	6,801	6,695	6,415	-4.2%	6,168	6,075	5,837	-3.9%	632	620	578	-6.7%
Ratio	1.7	1.8	1.8	-0.2%	1.8	1.8	1.8	-0.7%	1.3	1.3	1.4	3.0%
Financial												
Medical Paid	$21,978,818	$31,242,230	$21,445,829	-31.4%	$19,279,451	$26,987,289	$19,028,441	-29.5%	$2,699,367	$4,254,942	$2,417,389	-43.2%
Member Paid	$1,450,050	$2,057,876	$1,395,822	-32.2%	$862,183	$1,470,431	$1,081,007	-26.5%	$587,867	$587,445	$314,814	-46.4%
Net Paid PEPY	$7,502	$10,981	$7,855	-28.5%	$7,530	$10,842	$7,881	-27.3%	$7,307	$11,964	$7,656	-36.0%
Net Paid PMPY	$4,309	$6,222	$4,457	-28.4%	$4,167	$5,929	$4,339	-26.8%	$5,691	$9,157	$5,578	-39.1%
Net Paid PEPM	$625	$915	$655	-28.5%	$628	$904	$657	-27.3%	$609	$997	$638	-36.0%
Net Paid PMPM	$359	$519	$371	-28.4%	$347	$494	$362	-26.8%	$474	$758	$471	-37.9%
High Cost Claimants												
# of HCC's > $50k	54	75	65	-13.3%	41	60	57	-5.0%	13	15	8	-46.7%
Avg. paid per claimant	$127,627	$222,114	$117,290	-47.2%	$142,393	$237,795	$116,041	-51.2%	$81,059	$159,389	$126,193	-20.8%
HCC % of Spend	31.1%	52.9%	35.5%	-32.8%	30.2%	52.5%	34.8%	-33.7%	37.7%	55.2%	41.2%	-25.3%
Spend by Location (PMPY)												
Inpatient	$1,431	$2,917	$1,258	-56.9%	$1,370	$2,734	$1,203	-56.0%	$2,024	$4,706	$1,172	-75.1%
Outpatient	$1,064	$1,143	$1,249	9.3%	$1,027	$1,109	$1,163	4.9%	$1,419	$1,483	$2,170	46.3%
Professional	$1,815	$2,162	$1,951	-9.8%	$1,770	$2,086	$1,973	-5.4%	$2,248	$2,968	$2,235	-24.7%
Total	$4,309	$6,222	$4,457	-28.4%	$4,167	$5,929	$4,339	-26.8%	$5,691	$9,157	$5,578	-39.1%

Paid Claims by Claim Type

UnitedHealthcare®

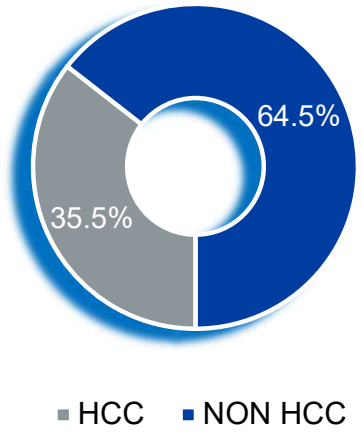
Net Paid Claims - Total Total Participants									
	Thru 3Q22				Thru 3Q23				▲
	Actives	Pre-Medicare	Medicare	Total	Actives	Pre-Medicare	Medicare	Total	
Medical									
InPatient	$12,965,406	$294,747	$1,386,205	$14,646,358	$4,937,757	$113,796	$998,745	$6,050,297	-58.7%
OutPatient	$15,070,134	$313,373	$1,212,365	$16,595,872	$13,554,409	$691,676	$1,149,447	$15,395,532	-7.2%
Total - Medical	$28,035,540	$608,120	$2,598,569	$31,242,230	$18,492,166	$805,472	$2,148,192	$21,445,829	-31.4%

Net Paid Claims - Total Total Participants									
	Thru 3Q22				Thru 3Q23				▲
	Actives	Pre-Medicare	Medicare	Total	Actives	Pre-Medicare	Medicare	Total	
Medical PMPM	$507	$490	$2,096	$518	$350	$716	$569	$371	-28.4%

Cost Distribution – Medical Claims > $50K

Thru 3Q22							Thru 3Q23					
# 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
16	0.2%	$9,844,218	31.5%	$1,038,241	10.5%	> $100k	10	0.2%	$1,616,525	7.5%	$971,593	60.1%
29	0.4%	$2,778,252	8.9%	$1,071,368	38.6%	$50k- $100k	26	0.4%	$2,649,247	12.4%	$1,062,094	40.1%
53	0.8%	$2,486,199	8.0%	$1,471,734	59.2%	$25k - $50k	55	0.9%	$2,175,965	10.1%	$1,113,084	51.2%
202	3.0%	$4,180,262	13.4%	$2,055,078	49.2%	$10k - $25k	167	2.6%	$3,527,109	16.4%	$1,837,691	52.1%
302	4.5%	$2,661,353	8.5%	$1,080,408	40.6%	$5k - $10k	316	4.9%	$2,722,222	12.7%	$1,268,169	46.6%

% Paid Attributed to Catastrophic Cases



HCC > $50k - AHRQ Chapter Conditions - Thru 3Q23			
Top 5 AHRQ Category conditions	# of Patients	Total Paid	% of Med Paid
Endocrine; nutritional; and metabolic diseases	7	$1,461,751	6.8%
Injury and poisoning	7	$1,086,685	5.1%
Neoplasms	10	$1,071,384	5.0%
Diseases of the circulatory system	11	$966,039	4.5%
Infectious and parasitic diseases	7	$816,824	3.8%

Utilization Summary

UnitedHealthcare®

Utilization Summary	Total			State Active			Retiree State/Non-State		
	Thru 3Q22	Thru 3Q23	▲	Thru 3Q22	Thru 3Q23	▲	Thru 3Q22	Thru 3Q23	▲
Inpatient									
# of Admits	341	278	-18.6%	266	254	-4.6%	75	24	-67.9%
# of Bedays	2,583	1,620	-37.3%	1,969	1,500	-23.8%	615	120	-80.5%
Avg. Paid per Admit	$42,733	$21,401	-49.9%	$46,635	$21,400	-54.1%	$28,945	$21,414	-26.0%
Avg. Paid per Day	$5,642	$3,669	-35.0%	$6,297	$3,618	-42.5%	$3,543	$4,314	21.8%
Admits Per K	67.9	57.7	-15.0%	58.3	57.9	-0.7%	161.9	55.7	-65.6%
Days Per K	514.5	336.7	-34.6%	432.1	342.6	-20.7%	1,322.6	276.2	-79.1%
ALOS	7.6	5.8	-23.0%	7.4	5.9	-20.1%	5.5	5.9	7.3%
Admits from ER	168	131	-22.0%	125	115	-8.0%	43	16	-62.8%
Physician Office Visits									
Per Member Per Year	2.7	2.3	-14.9%	2.6	2.2	-14.8%	3.2	2.7	-16.0%
Paid Per Visit	$134	$151	12.2%	$139	$156	12.1%	$97	$107	10.5%
Net Paid PMPM	$30	$29	-4.6%	$31	$29	-4.4%	$26	$24	-7.2%
Emergency Room									
# of Visits	546	557	2.0%	498	509	2.2%	48	48	0.0%
Visits Per K	108.7	115.8	6.5%	109.3	116.3	6.4%	103.3	110.7	7.2%
Avg Paid Per Visit	$2,501	$2,749	9.9%	$2,543	$2,775	9.1%	$2,063	$2,475	20.0%
Urgent Care									
# of Visits	3,604	2,909	-19.3%	3,213	2,641	-17.8%	391	268	-31.5%
Visits Per K	717.7	604.6	-15.8%	705.1	603.3	-14.4%	841.5	618.3	-26.5%
Avg Paid Per Visit	$115	$117	2.1%	$86	$90	5.1%	$84	$79	-6.3%

**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
Thyroid disorders	$1,187,242	7.0%	$821,939	$358,866	$6,437	$1,244	$1,185,999	$0
Septicemia (except in labor)	$932,976	5.5%	$687,174	$93,516	$152,286	$266,455	$666,521	$0
Complication of device; implant or graft	$547,028	3.2%	$204,885	$89,191	$252,952	$232,750	$314,279	$0
Disorders usually diagnosed in infancy childhood or adol	$390,805	2.3%	$0		$390,805	$326,349	$64,456	$0
Spondylosis; intervertebral disc disorders; other back prc	$356,693	2.1%	$311,385	$37,243	$8,065	$127,270	$229,422	$0
Diabetes mellitus with complications	$340,919	2.0%	$183,411	$79,858	$77,649	$255,708	$85,211	$0
Non-Hodgkin`s lymphoma	$320,022	1.9%	$298,643	$21,380		$31,003	$289,019	$0
Other nervous system disorders	$316,223	1.9%	$172,651	$135,467	$8,105	$31,182	$285,041	$0
Acute myocardial infarction	$307,934	1.8%	$121,979	$185,954		$242,036	$65,898	$0
Cardiac dysrhythmias	$283,721	1.7%	$221,100	$62,250	$370	$125,867	$157,854	$0
Complications of surgical procedures or medical care	$282,054	1.7%	$268,791	$13,155	$109	$204,227	$77,827	$0
Other nutritional; endocrine; and metabolic disorders	$266,775	1.6%	$155,260	$108,748	$2,767	$34,084	$232,691	$0
Viral infection	$265,888	1.6%	$61,641	$156,941	$47,306	$29,064	$236,824	$0
Mood disorders	$263,216	1.6%	$100,062	$18,686	$144,468	$108,465	$154,750	$0
Other screening for suspected conditions (not mental dis	$257,460	1.5%	$214,007	$38,952	$4,501	$76,422	$181,038	$0
Cancer of breast	$253,627	1.5%	$209,101	$44,525			$253,627	$0
Maintenance chemotherapy; radiotherapy	$252,781	1.5%	$238,144	$14,637		$74,114	$178,667	$0
Other gastrointestinal disorders	$225,936	1.3%	$157,224	$44,770	$23,942	$53,256	$172,680	$0
Osteoarthritis	$222,452	1.3%	$186,006	$36,446		$50,486	$171,966	$0
Cancer of prostate	$214,248	1.3%	$134,514	$79,733		$214,248		$0
Nonspecific chest pain	$212,570	1.3%	$124,147	$69,123	$19,300	$91,010	$121,560	$0
Medical examination/evaluation	$204,757	1.2%	$59,585	$11,307	$133,864	$82,246	$122,511	$0
Abdominal pain	$201,756	1.2%	$158,147	$15,464	$28,146	$58,718	$143,039	$0
Abdominal hernia	$185,010	1.1%	$147,247	$32,133	$5,630	$44,935	$140,075	$0
Polyhydramnios and other problems of amniotic cavity	$182,838	1.1%	$172,951	$9,887	$0		$182,838	$0

*Not Representative of all utilization

*Data based on medical spend only

Mental Health Drilldown

UnitedHealthcare®

Top 10 Mental Health				
AHRQ Category Description	Thru 3Q22		Thru 3Q23	
	Patients	Total Paid	Patients	Total Paid
Disorders usually diagnosed in infancy childhood or	46	$502,596	38	$390,805
Mood disorders	469	$277,888	412	$263,216
Anxiety disorders	445	$121,142	385	$158,454
Adjustment disorders	173	$44,910	127	$46,964
Substance-related disorders	38	$24,130	30	$46,694
Attention-deficit conduct and disruptive behavior dis	119	$18,930	133	$27,794
Suicide and intentional self-inflicted injury	14	$33,295	12	$21,469
Schizophrenia and other psychotic disorders	20	$238,524	11	$20,479
Miscellaneous mental health disorders	49	$69,136	44	$16,940
Alcohol-related disorders	25	$277,533	14	$14,890

**Not Representative of all utilization*

**Data based on medical spend only*

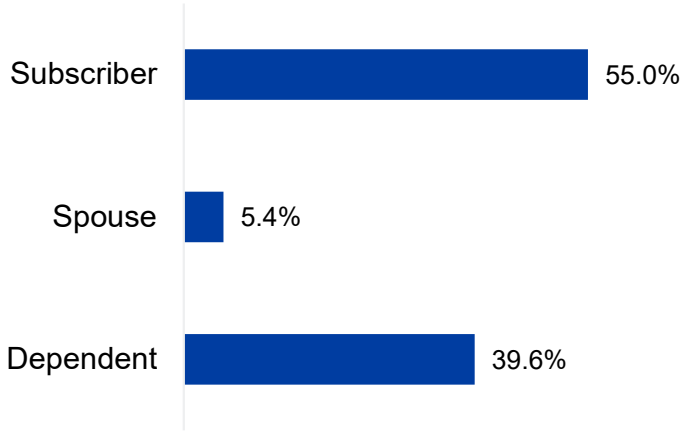
Respiratory Disorders

Respiratory Disorders				
AHRQ Category Description	Patients	Claims	Total Paid	% Paid
Other upper respiratory infections	899	1,286	$158,990	17.2%
Acute bronchitis	126	174	$133,066	14.4%
Other lower respiratory disease	462	878	$118,104	12.8%
Asthma	232	459	$107,586	11.6%
Other upper respiratory disease	384	1,199	$107,009	11.6%
Respiratory failure; insufficiency; arrest (adult)	21	112	$95,430	10.3%
Pneumonia (except that caused by tuberculosis	36	114	$93,108	10.1%
Chronic obstructive pulmonary disease	94	217	$51,640	5.6%
Acute and chronic tonsillitis	53	97	$27,761	3.0%
Influenza	61	69	$23,061	2.5%

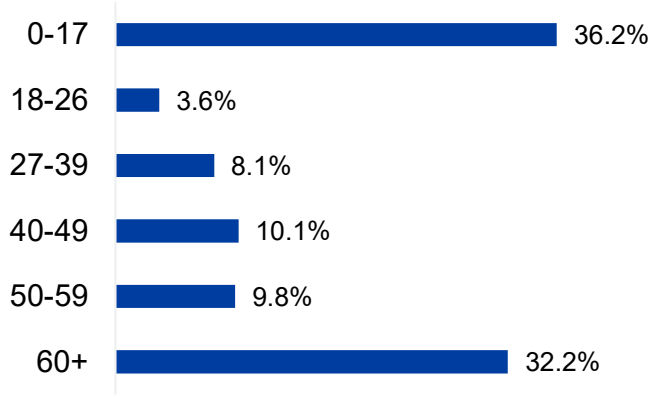
**Not Representative of all utilization*

**Data based on medical spend only*

Spend by Relationship



Spend by Age



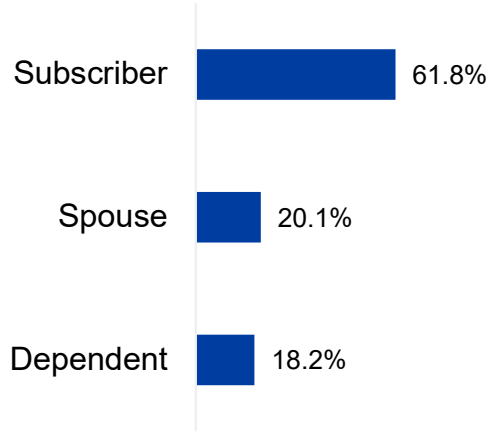
Infections

Infectious and Parasitic Diseases				
AHRQ Description	Patients	Claims	Total Paid	% Paid
Septicemia (except in labor)	16	47	$556,753	41.2%
Immunizations and screening for infectious disease	843	1,287	$101,930	7.5%
Viral infection	344	501	$96,374	7.1%
HIV infection	17	49	$5,748	0.4%
Mycoses	71	102	$2,151	0.2%
Hepatitis	13	41	$2,011	0.1%
Bacterial infection; unspecified site	7	11	$1,104	0.1%
Other infections; including parasitic	7	13	$640	0.0%
Tuberculosis	4	11	$0	0.0%
Sexually transmitted infections (not HIV or hepatitis)	8	11	$0	0.0%

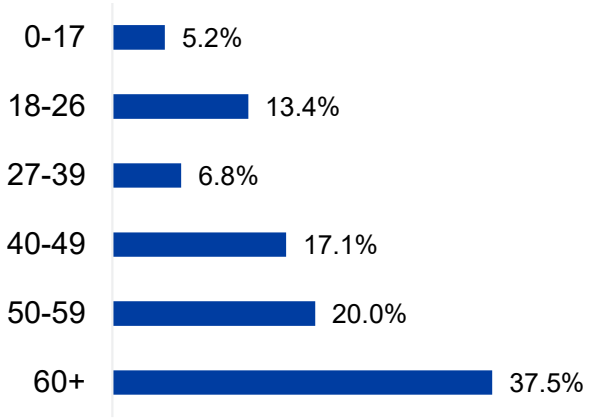
**Not Representative of all utilization*

**Data based on medical spend only*

Spend by Relationship



Spend by Age

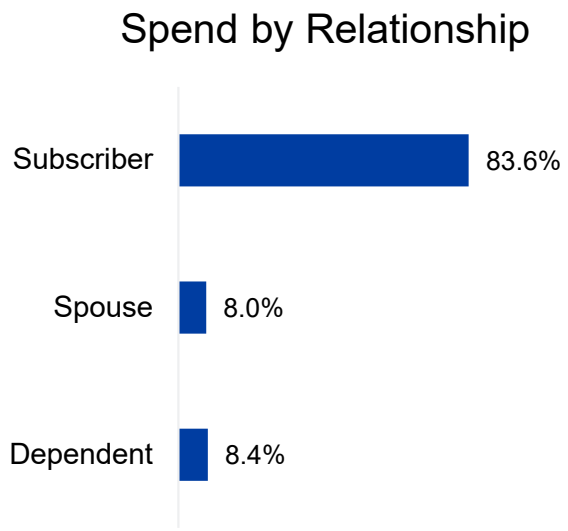


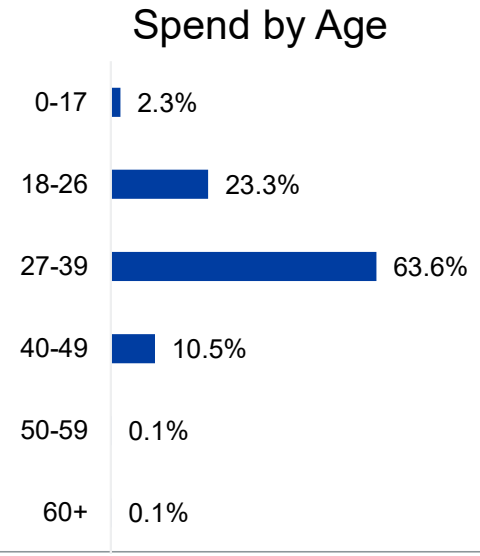
Pregnancy Related Disorders

Top 10 Complications of Pregnancy				
AHRQ Description	Patients	Claims	Total Paid	% Paid
Polyhydramnios and other problems of amniotic cavity	12	32	$182,838	19.3%
Other complications of birth;	31	55	$169,847	17.9%
Other complications of pregnancy	68	308	$105,125	11.1%
Other pregnancy and delivery including normal	79	360	$97,759	10.3%
Contraceptive and procreative management	174	368	$55,806	5.9%
Previous C-section	7	19	$52,130	5.5%
Prolonged pregnancy	6	8	$46,103	4.9%
Malposition; malpresentation	5	8	$44,733	4.7%
OB-related trauma to perineum and vulva	6	7	$41,522	4.4%
Umbilical cord complication	6	11	$38,760	4.1%

**Not Representative of all utilization*

**Data based on medical spend only*





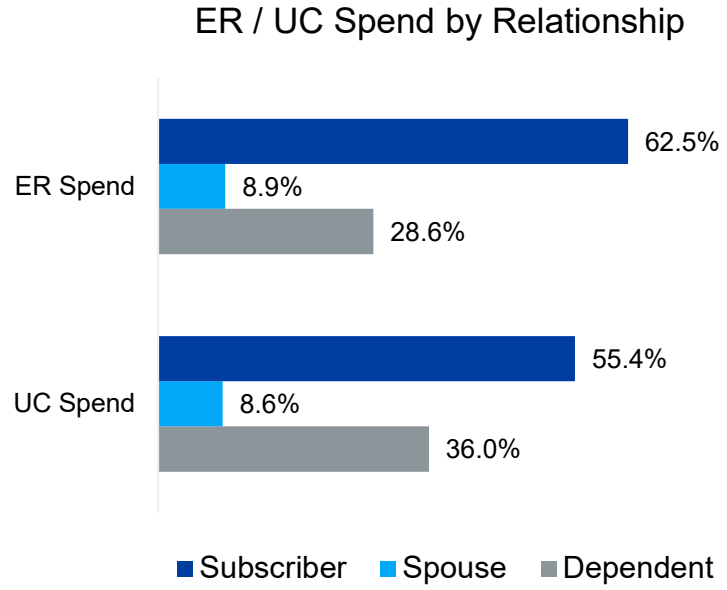
Emergency Room and Urgent Care

	Thru 3Q22		Thru 3Q23		Peer	
Metric	ER	Urgent Care	ER	Urgent Care	ER	Urgent Care
# of Visits	546	3,604	557	2,909		
Visits Per Member	0.08	0.48	0.09	0.54	0.09	0.16
Visits Per K	108.7	717.7	115.8	604.6	93.5	445.52
Avg. Paid Per Visit	$2,501	$112	$2,749	$121	$2,589	$125

**Not Representative of all utilization*

**Data based on medical spend only*

Emergency Room and Urgent Care Visits by Relationships - Thru 3Q23				
Relationship	ER Visits	ER Per K	UC Visits	UC Per K
Member	300	62.4	1,797	373.5
Spouse	53	11.0	243	50.5
Dependent	204	42.4	869	180.6
Total	557	115.8	2,909	604.6



Clinical Conditions by Medical Spend

UnitedHealthcare®

Top 15 Common Condition	# of Members	% of Members	Members Per K	PMPM
Mental Disorders	675	3.5%	35.1	$12.75
Intervertebral Disc Disorders	584	3.0%	30.3	$6.18
Diabetes with complications	390	2.0%	20.3	$5.90
Acute Myocardial Infarction	576	3.0%	29.9	$5.33
Breast Cancer	9	0.0%	0.5	$4.39
Prostate Cancer	58	0.3%	3.0	$3.71
Hypertension	71	0.4%	3.7	$2.99
Chronic Renal Failure	100	0.5%	5.2	$2.08
Asthma	227	1.2%	11.8	$1.86
Coronary Atherosclerosis	37	0.2%	1.9	$1.48
Diabetes without complications	7	0.0%	0.4	$1.36
COPD	437	2.3%	22.7	$0.89
Congestive Heart Failure (CHF)	94	0.5%	4.9	$0.41
Colon Cancer	26	0.1%	1.4	$0.03
Cervical Cancer	27	0.1%	1.4	$0.03

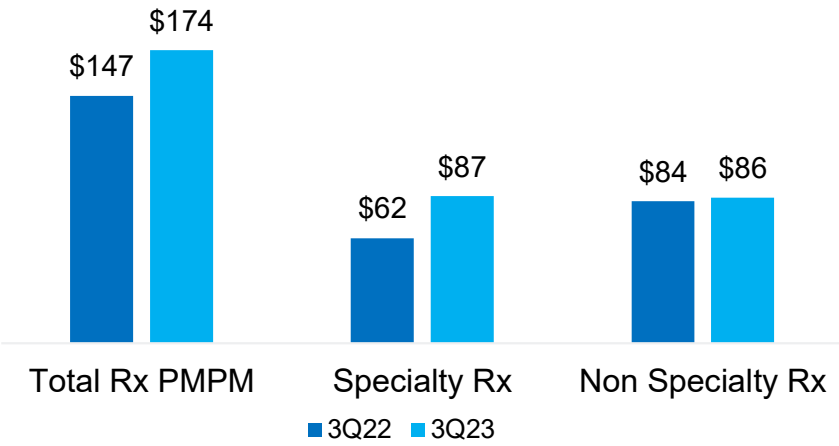
**Not Representative of all utilization*

**Data based on medical spend only*

Pharmacy Drivers

	Thru 3Q22	Thru 3Q23	Δ
Enrolled Members	6,695	6,415	-4.2%
Average Prescriptions PMPY	17.0	16.9	-0.6%
Formulary Rate	89.0%	89.8%	0.9%
Generic Use Rate	83.0%	84.6%	2.0%
Generic Substitution Rate	98.2%	98.2%	0.1%
Avg Net Paid per Prescription	$103	$123	19.2%
Net Paid PMPM	$147	$174	18.5%

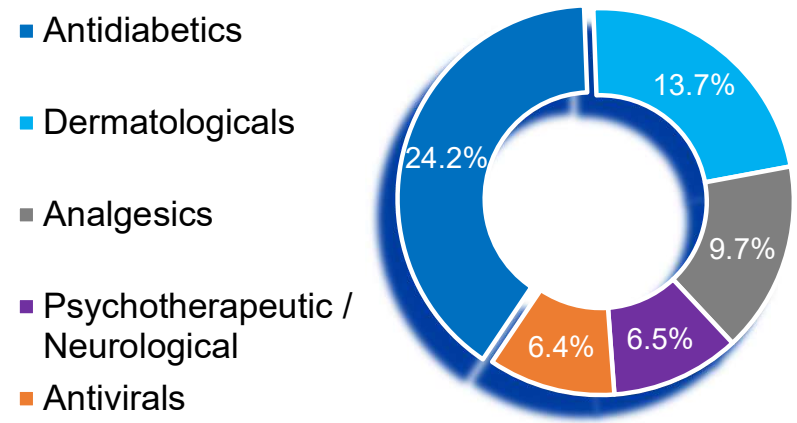
Total Rx Spend by Benefit and Type



Pharmacy Performance

- Rx spend increased of **18.5%**, (**$27 PMPM**) from prior period
- Avg. paid per Script increased **19.2%** (**$20 PMPM**) year over year
- Specialty Rx spend driving **44.3%** of Rx Spend
- Specialty Rx spend increased **40.1%** from prior period
  Specialty Rx Drivers:
  Stelara (Dermatologic) Spend up **4.1%**
  Jardiance (Antidiabetic) Spend up **1.2%**
- Tier 1 Rx drove **76.4%** of total claim volume, but only accounts for **8.5%** of overall Rx Spend

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 March 31, 2023:

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 May 2023

Virtual Care Engagement Monthly Report

UMR – STATE OF NEVADA

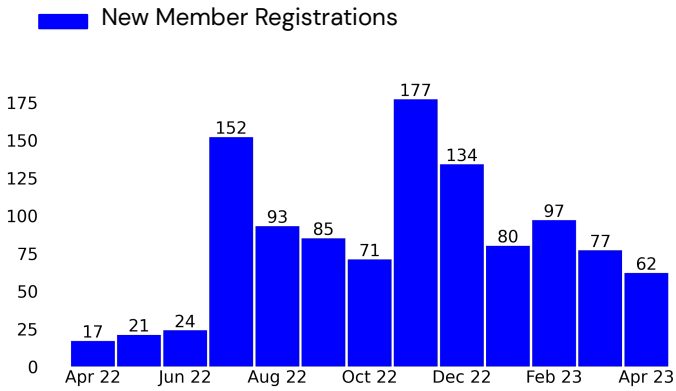
Reporting Period: 2023-04-01 to 2023-05-01

Member Engagement

62	230	279
Registrations This Month	Unique Visitors This Month	Total Visits This month

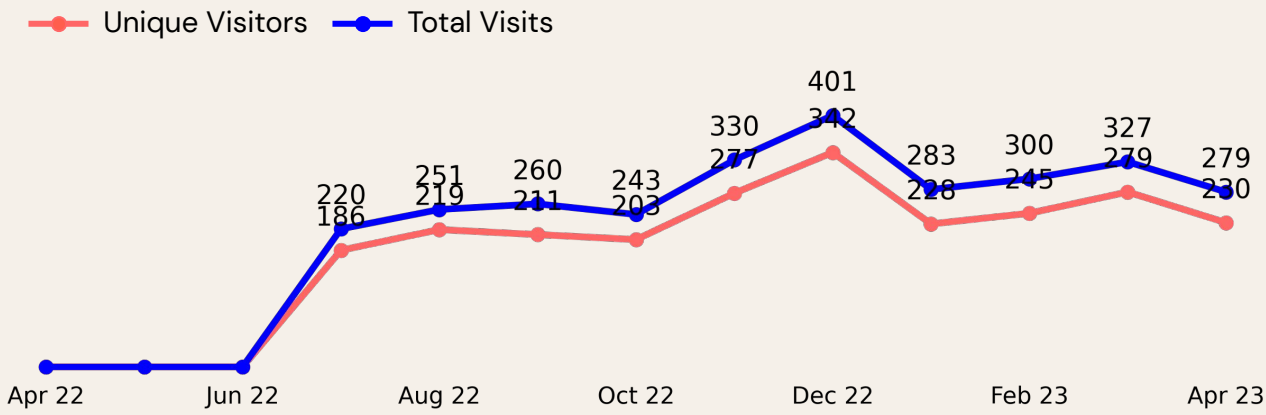
This section highlights how many members have engaged with our services, as measured by registrations and visits. Registration is a leading indicator of program health, as it opens the door to continuous engagement with members and supporting them when clinical needs arise. Monitoring monthly engagement 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	**2,226** Registrations Since Launch	Registration Rate Since Launch
Employee Covered Lives	**316** Registrations Year to Date	Registration Rate Year to Date

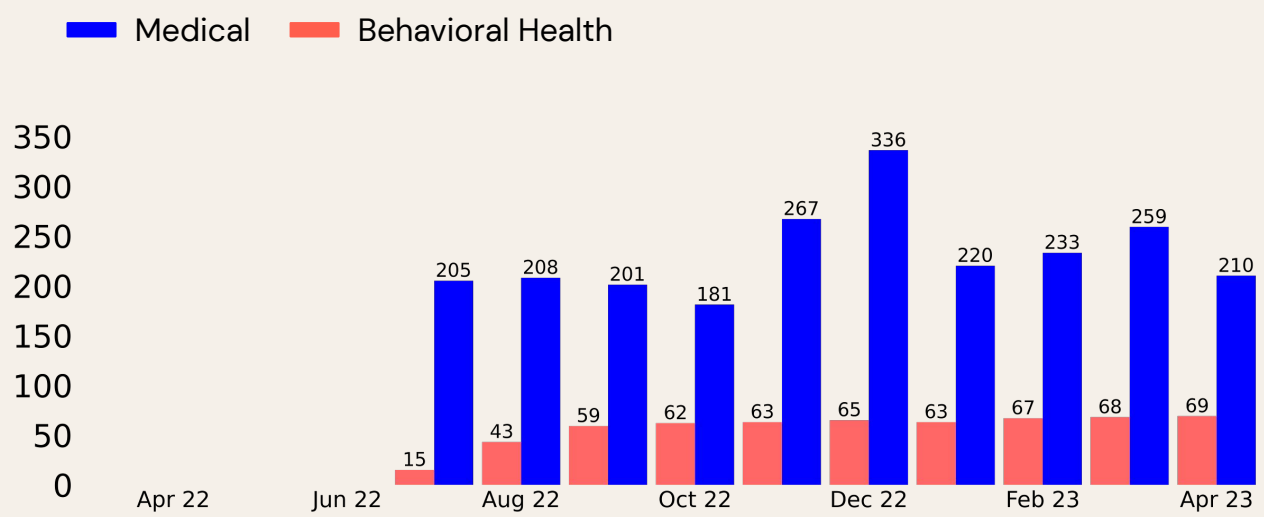
Visits Last 12 Months



2,895 Visits Since Launch	**1,578** Unique Visitors Since Launch	**1.8** Average Visits Per Visitor Since Launch	Engagement Rate Since Launch (Visitors/Lives)	
1,189 Visits Year to Date	**784** Unique Visitors Year to Date	**1.5** Average Visits Per Visitor Year to Date	Engagement Rate Year to Date (Visitors/Lives)	

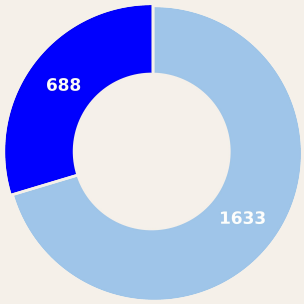
Member Engagement

Medical & Behavioral Health Visits (Rolling 12 Months)



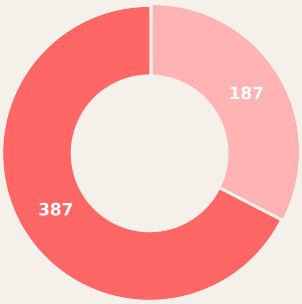
Member Demand by Visit Type Lifetime to Date

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

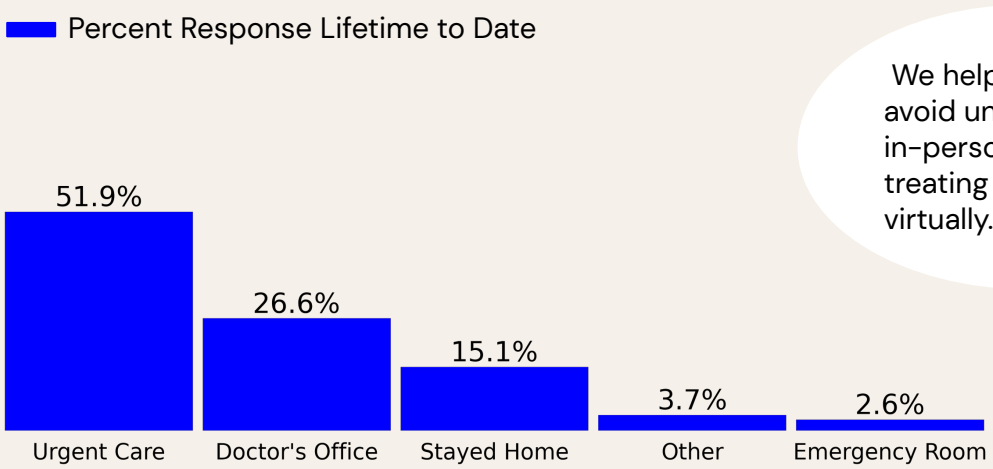
10AM – Noon

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

Member Access

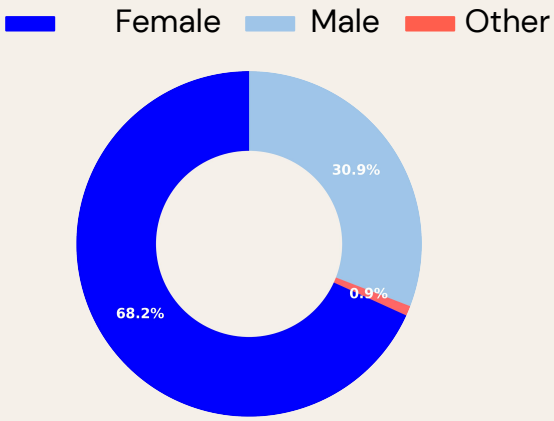
This section highlights our impact on increasing members' access to appropriate medical and behavioral health care, and their satisfaction with our services. We improve access to care by seeing members after hours (when brick & mortar providers are closed) and by making it easier to visit with a provider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

Without Included Health, where would you have gone?

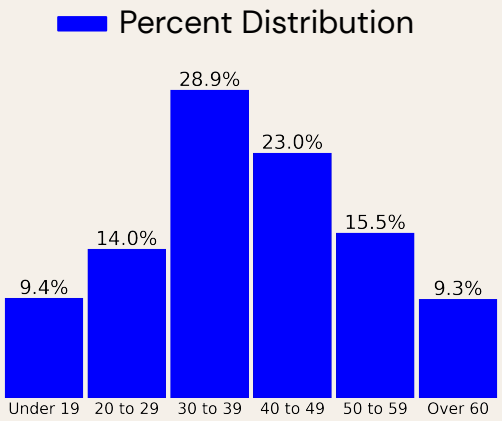


We help members avoid unnecessary in-person visits by treating their needs virtually.

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	5.17 min	17.9 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 Lifetime to Date
Congestion / sinus problem	73	935
Cough	57	808
Fatigue / weakness	53	682
Headache	62	661
Sore throat	45	622
Difficulty sleeping	48	543
Nasal discharge	34	486
Fever	14	346
Difficulty / pain swallowing	26	331
Sputum / productive cough / phlegm	25	311

Member Conditions

Top 10 Diagnoses

ICD-10 Diagnoses	Visits This Month	Visits Lifetime to Date
Other upper respiratory infections	70	654
Anxiety disorders	49	424
Mood disorders	36	301
Urinary tract infections	35	252
COVID-19	7	184
Administrative/social admission	21	162
Cough, unspecified	17	141
Inflammation; infection of eye (except that c..	16	132
Other upper respiratory disease	12	117
Adjustment disorders	9	105

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

324	71.1%	30	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	20	294
prednisone	15	221
albuterol	11	154
amoxicillin/potassiu..	14	150
nitrofurantoin monoh..	20	148
ipratropium nasal	14	137
fluticasone nasal	11	108
methylprednisolone	9	95
amoxicillin	8	92
nirmatrelvir/ritonavir	3	90

Top Labs	Count This Month	Count Lifetime to Date
Comprehensive Metabo..	2	33
CBC+diff	1	30
Urinalysis, Complete..	4	25
TSH with Reflex to F..	1	24
Lipid Panel	2	24
Urine Culture, Routine	3	20
Hemoglobin A1c	2	20
Chlamydia/GC, Urine	1	15
Vitamin D	1	14
HIV-1/2 Ag/Ab, 4th G..	1	10

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

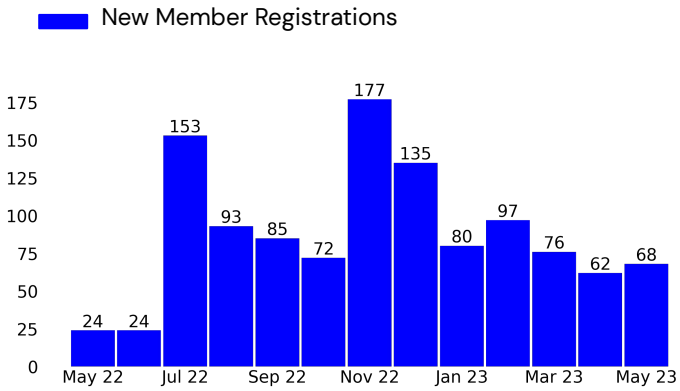
Reporting Period: 2023-05-01 to 2023-06-01

Member Engagement

68	244	303
Registrations This Month	Unique Visitors This Month	Total Visits This month

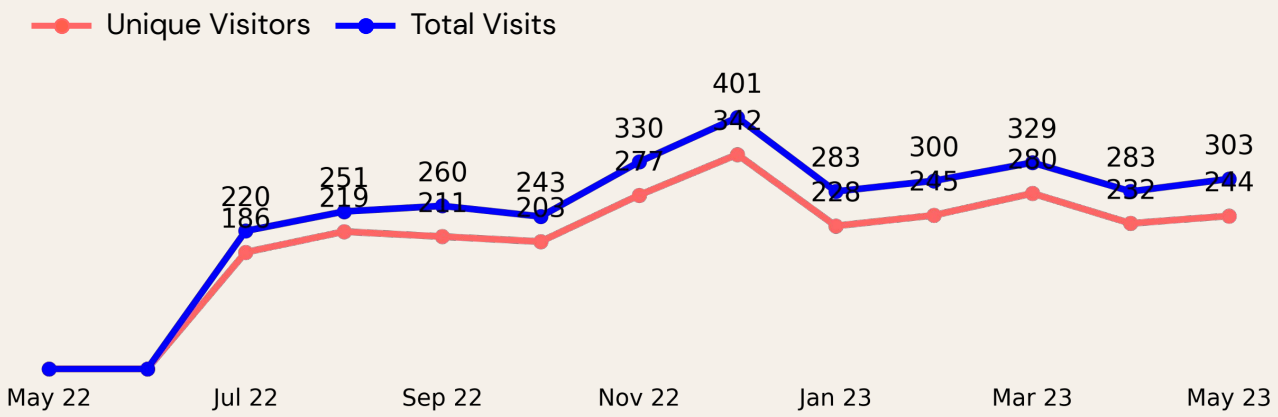
This section highlights how many members have engaged with our services, as measured by registrations and visits. Registration is a leading indicator of program health, as it opens the door to continuous engagement with members and supporting them when clinical needs arise. Monitoring monthly engagement 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	**2,329** Registrations Since Launch	Registration Rate Since Launch
Employee Covered Lives	**383** Registrations Year to Date	Registration Rate Year to Date

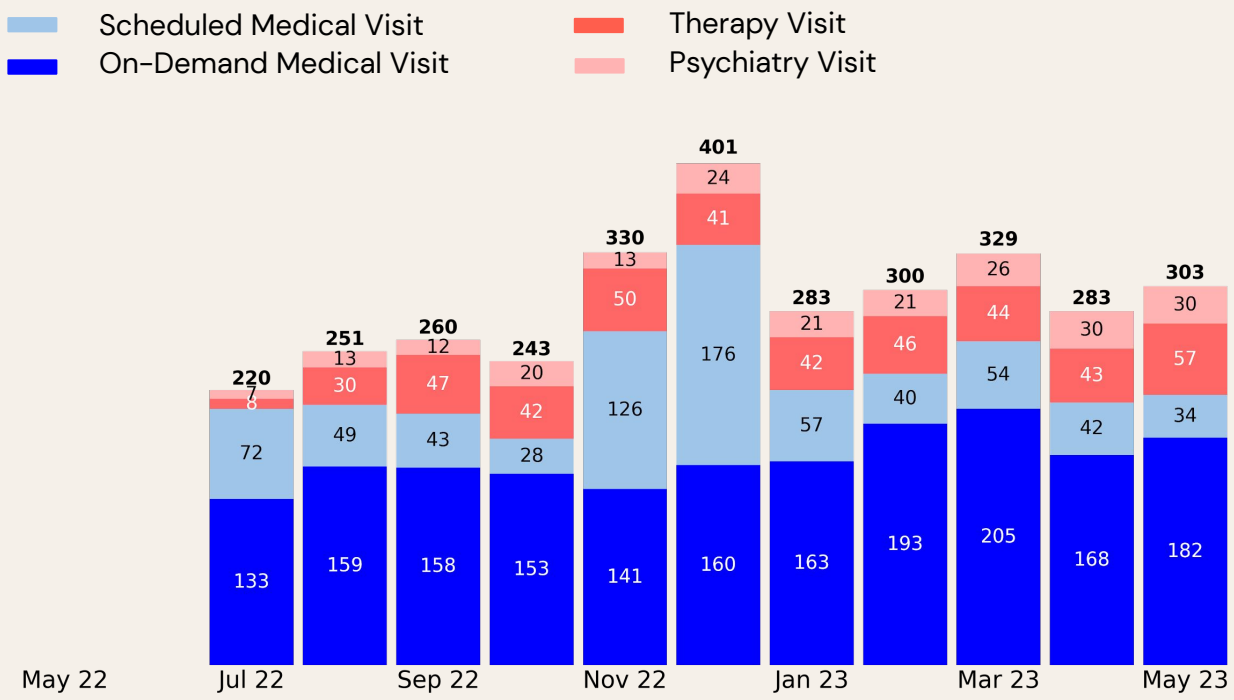
Visits Last 12 Months



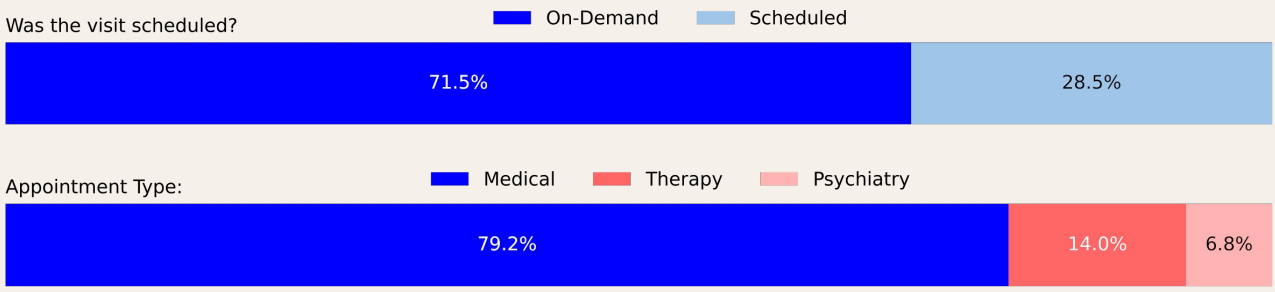
3,204 Visits Since Launch	**1,685** Unique Visitors Since Launch	**1.9** Average Visits Per Visitor Since Launch	Engagement Rate Since Launch (Visitors/Lives)	
1,498 Visits Year to Date	**919** Unique Visitors Year to Date	**1.6** Average Visits Per Visitor Year to Date	Engagement Rate Year to Date (Visitors/Lives)	

Member Engagement

Medical & Behavioral Health Visits (Rolling 12 Months)



Member Demand by Visit Type Lifetime to Date



Most Popular Day for Visits Lifetime to Date

Monday

Most Popular Time for Visits Lifetime to Date

10AM – Noon

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Member Access

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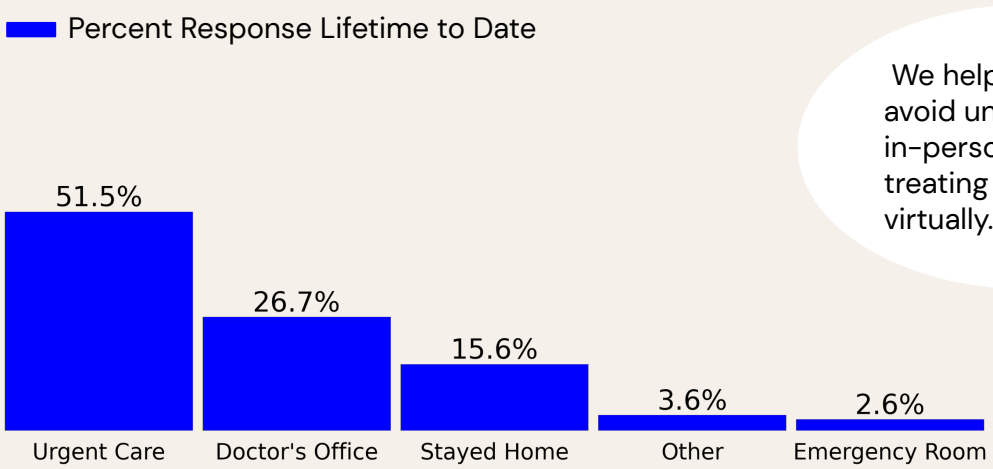

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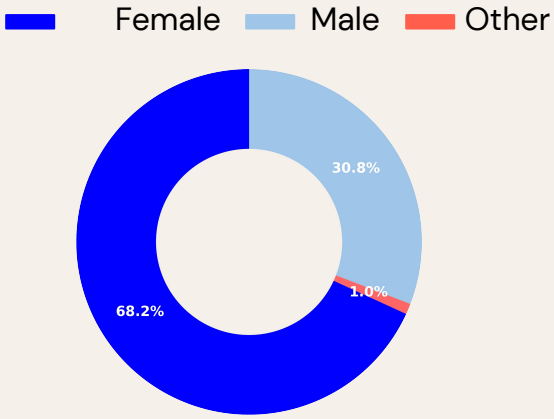
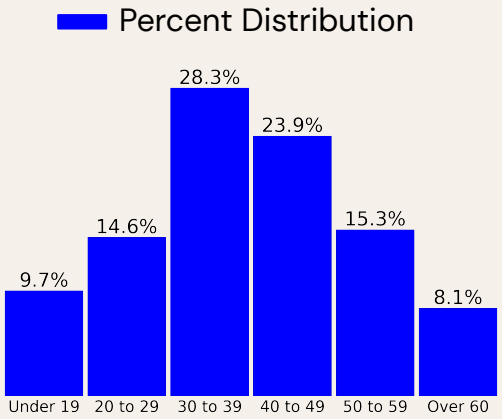
Visits by Reported Gender Year to Date



Visits by Age Year to Date



Member Experience Metrics	This Month	Lifetime to Date
Average Member Rating	4.97 / 5 (N = 237)	4.96 / 5 (N = 2,348)
Average Wait Time for On-Demand Medical Appointments	7.47 min	16.86 min

Member Clinical Needs

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Member Reported Symptoms

Top 10 Symptoms

Symptom	Visits This Month	Visits Lifetime to Date
Congestion / sinus problem	81	1,016
Cough	61	869
Fatigue / weakness	72	754
Headache	64	725
Sore throat	71	693
Difficulty sleeping	58	601
Nasal discharge	49	535
Fever	42	388
Difficulty / pain swallowing	43	374
Sputum / productive cough / phlegm	31	342

Member Conditions

Top 10 Diagnoses

ICD-10 Diagnoses	Visits This Month	Visits Lifetime to Date
Other upper respiratory infections	71	725
Anxiety disorders	65	491
Mood disorders	41	342
Urinary tract infections	23	275
COVID-19	4	188
Administrative/social admission	10	172
Cough, unspecified	10	151
Inflammation; infection of eye (except that c..	12	144
Other upper respiratory disease	23	140
Adjustment disorders	11	120

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

331	70.3%	42	3.6%
Prescriptions This Month	of visits resulted in a prescription order Lifetime to Date	Lab Orders This Month	of visits resulted in a lab order Lifetime to Date

Top Prescriptions and Testing Orders

Top Prescriptions	Count This Month	Count Lifetime to Date
benzonatate	18	312
prednisone	17	238
amoxicillin/potassiu..	20	170
albuterol	13	167
nitrofurantoin monoh..	15	163
ipratropium nasal	15	152
fluticasone nasal	10	118
methylprednisolone	10	105
amoxicillin	12	104
nirmatrelvir/ritonavir	2	92

Top Labs	Count This Month	Count Lifetime to Date
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Urinalysis, Complete..	3	28
Lipid Panel	3	27
TSH with Reflex to F..	2	26
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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.

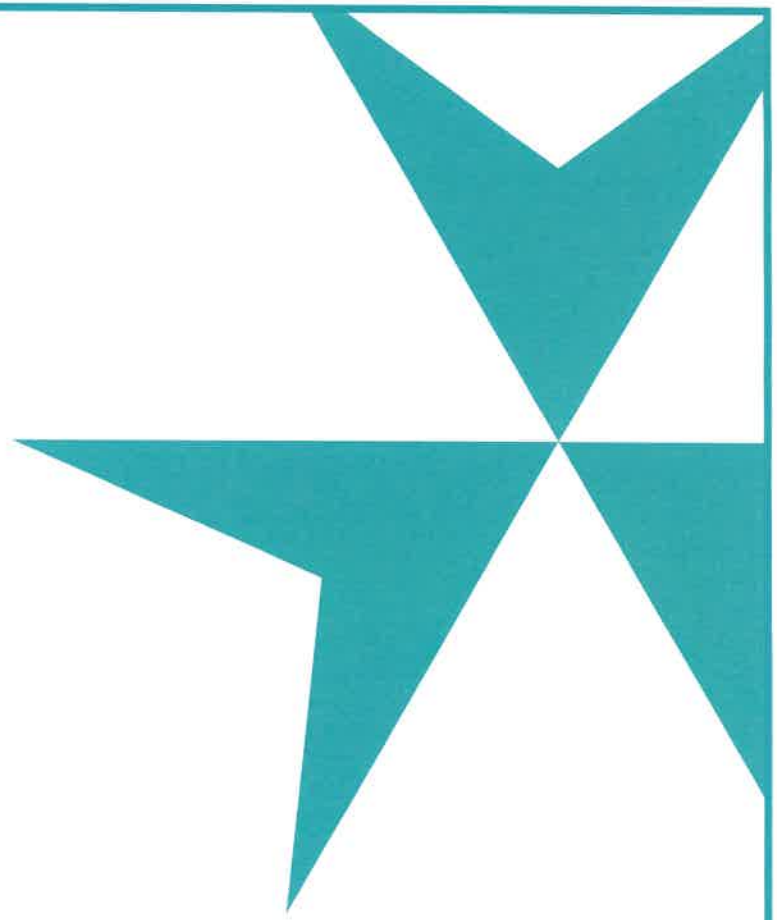
4.4

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

4.4 Fiscal Year 2023 Other Post-Employment Benefits (OPEB) valuation prepared by Segal in conformance with the Governmental Accounting Standards Board (GASB) requirements.

State of Nevada
Retiree Health and Life Insurance Plan

Governmental Accounting Standards Board (GASB) Statements 75 Actuarial Valuation and Review of Other Postemployment Benefits (OPEB) as of June 30, 2022 for Employer Reporting as of June 30, 2023



This report has been prepared at the request of the Nevada PEBP to assist in administering the Plan. This valuation report may not otherwise be copied or reproduced in any form without the consent of the Nevada PEBP and may only be provided to other parties in its entirety. The measurements shown in this actuarial valuation may not be applicable for other purposes.

Segal

Segal

500 North Brand Boulevard
Suite 1400
Glendale, CA 91203-3338
segalco.com

July 18, 2023

Board of Trustees
State of Nevada Public Employees' Benefits Program
3427 Goni Rd, Suite #109
Carson City, NV 89706

Dear Board Members:

We are pleased to submit this Actuarial Valuation and Review of Other Postemployment Benefits (OPEB) as of June 30, 2022 under Governmental Accounting Standards Board Statement No. 75. The report summarizes the actuarial data used in the valuation, discloses the Net OPEB Liability (NOL), and analyzes the preceding year's experience.

This report was based on the census data provided by the State of Nevada and the terms of the Plan as of June 30, 2022. The actuarial calculations were completed under the supervision of Daniel J. Rhodes, FSA, FCA, MAAA and Mehdi Riazi, FSA, FCA, EA, MAAA.

The measurements shown in this actuarial valuation may not be applicable for other purposes. Future actuarial measurements may differ significantly from the current measurements presented in this report due to such factors as the following: plan experience differing from that anticipated by the economic or demographic assumptions; changes in economic or demographic assumptions; and changes in plan provisions or applicable law.

The actuarial valuation has been completed in accordance with generally accepted actuarial principles and practices. To the best of our knowledge, the information supplied in this actuarial valuation is complete and accurate. Further, in our opinion, the assumptions used in this valuation and described in Section 3, Exhibit II are reasonably related to the experience of and the expectations for the Plan. The actuarial projections are based on these assumptions and the plan of benefits as summarized in Section 3, Exhibit III.

Sincerely,

Segal

Richard Ward, FSA, FCA, MAAA
Senior Vice President

Daniel J. Rhodes, FSA, FCA, MAAA
Senior Vice President & Consulting Actuary

Mehdi Riazi, FSA, FCA, EA, MAAA
Vice President & Consulting Actuary

Table of Contents

Section 1: Actuarial Valuation Summary

Purpose and basis

This report presents the results of our actuarial valuation of the State of Nevada's (the "State") Public Employees Benefits Program (PEBP) Retiree Health and Life Insurance Plan as of June 30, 2022, required by Governmental Accounting Standards Board (GASB) Statement No. 75, *Accounting and Financial Reporting for Postemployment Benefits Other than Pensions.* The actuarial computations made are for purposes of fulfilling plan accounting requirements. Determinations for purposes other than meeting financial accounting requirements may be significantly different from the results reported here. This valuation is based on:

- The benefit provisions of the State of Nevada PEBP Retiree Health and Life Insurance Plan, as administered by Nevada PEBP;
- The characteristics of covered active members, terminated vested members, and retired members and beneficiaries as of June 30, 2022, provided by Nevada PEBP and Nevada Public Employees' Retirement System (PERS);
- The assets of the Plan as of June 30, 2022, provided by Nevada PEBP;
- Health care trends and other medical related assumptions; and
- Other (non-health) actuarial assumptions, regarding employee terminations, retirement, death, disability etc. based on the State of Nevada PERS Actuarial Experience Study as of June 30, 2020, dated September 10, 2021.

Highlights of the valuation

Accounting and Financial Reporting

1. For GASB 75 reporting as of June 30, 2023, the NOL was measured as of June 30, 2022. The Plan's Fiduciary Net Position (plan assets) and the TOL were valued as of the measurement date. Consistent with the provisions of GASB 75, the assets and liabilities measured as of June 30, 2022 are not adjusted or rolled forward to the June 30, 2023 reporting date.
2. The Net OPEB Liability (NOL) as of June 30, 2022 is $1,442,207,734, a decrease of $107,942,821, from the prior Aon valuation NOL of $1,550,150,555. The main reasons for the decrease were:

   a. Valuation assumption changes decreased the Net OPEB Liability by $159,738,443. This was a result of a decrease in obligations due to raising the discount rate from 2.16% to 3.54%, lowering the valuation-year per capita health claims costs, updating the mortality, retirement, turnover, and disability rates, and decreasing the male spouse age difference from 4 years younger to 3 years younger. The decrease in liability was partially offset by utilizing PERS dates of hire, including actives hired after January 1, 2012, and updating the future trend on per-capita health claims costs.

   b. An actuarial experience gain decreased the NOL by $19,315,612. This was the net result of gains and losses due to demographic changes and actual 2022 contributions and benefit payments that were different from expected. We have taken these actuarial gains and losses into account in reviewing our assumptions for the current valuation.

   c. Plan changes to the Medicare Exchange HRA amounts increased the Net OPEB Liability by $38,605,492. The current plan of benefits is summarized in Exhibit III of Section 3.
3. The Annual OPEB Expense increased to $91,116,378 for the measurement period ending June 30, 2022. The expense was $76,323,290 last year. The increase to the OPEB expense was mainly due to the plan change. Per GASB's requirements, the liability impact of a plan change is fully recognized in the current year's expense.
4. The valuation date was changed from January 1 to June 30, mostly so that Segal could leverage June 30, 2022 PERS census data. We would not expect the change to the valuation date to have a significant impact on the valuation of results.

Funding (pay-as-you-go)

5. It is our understanding that Nevada PEBP funds OPEB Plan benefits on a pay-as-you-go basis. Under GASB Statement No. 75, if the State were to begin funding OPEB benefits, it would be able to take advantage of a higher discount rate than what is being currently used, which would result in a lower reported liability.

Summary of key valuation results

Reporting Date for Employer under GASB 75		June 30, 2023	June 30, 2022
Measurement Date		**June 30, 2022**	**June 30, 2021**
Disclosure elements for fiscal year ending June 30:	• Total OPEB Liability	$1,422,115,023	$1,540,182,727
	• Plan Fiduciary Net Position (Assets)	(20,092,711)	(9,967,828)
	• Net OPEB Liability	$1,442,207,734	$1,550,150,555
	• Plan Fiduciary Net Position as a percentage of Total OPEB Liability	(1.41)%	(0.64)%
	• OPEB Expense	91,116,378	76,323,290
	• Service Cost at Beginning of Year	52,675,056	55,710,061
	• Total Payroll	$2,277,677,722	$2,090,281,552
Key assumptions as of June 30:	• Discount rate	3.54%	2.16%
	• Inflation rate	2.50%	2.75%

Important information about actuarial valuations

An actuarial valuation is a budgeting tool with respect to defining future uncertain obligations of a postretirement health plan. As such, it will never forecast the precise future stream of benefit payments. It is an estimated forecast – the actual cost of the plan will be determined by the benefits and expenses paid, not by the actuarial valuation.

In order to prepare a valuation, Segal relies on a number of input items. These include:

Plan of benefits	Plan provisions define the rules that will be used to determine benefit payments, and those rules, or the interpretation of them, may change over time. Even where they appear precise, outside factors may change how they operate. For example, a plan may provide health benefits to post-65 retirees that coordinates with Medicare. If so, changes in the Medicare law or administration may change the plan's costs without any change in the terms of the plan itself. It is important for the State to keep Segal informed with respect to plan provisions and administrative procedures, and to review the plan summary included in our report to confirm that Segal has correctly interpreted the plan of benefits.
Participant data	An actuarial valuation for a plan is based on data provided to the actuary by the plan. Segal does not audit such data for completeness or accuracy, other than reviewing it for obvious inconsistencies compared to prior data and other information that appears unreasonable. It is not necessary to have perfect data for an actuarial valuation: the valuation is an estimated forecast, not a prediction. The uncertainties in other factors are such that even perfect data does not produce a "perfect" result. Notwithstanding the above, it is important for Segal to receive the best possible data and to be informed about any known incomplete or inaccurate data.
Assets	The valuation is based on the market value of assets as of the valuation date, as provided by the State.
Actuarial assumptions	In preparing an actuarial valuation, Segal starts by developing a forecast of the benefits to be paid to existing plan participants for the rest of their lives and the lives of their beneficiaries. To determine the future costs of benefits, Segal collects claims, premiums, and enrollment data in order to establish a baseline cost for the valuation measurement, and then develops short- and long-term health care cost trend rates to project increases in costs in future years. This forecast also requires actuarial assumptions as to the probability of death, disability, withdrawal, and retirement of each participant for each year, as well as forecasts of the plan's benefits for each of those events. The forecasted benefits are then discounted to a present value, typically based on an estimate of the rate of return that will be achieved on the plan's assets or, if there are no assets, a rate of return based on a yield or index rate for 20-year, tax-exempt general obligation municipal bonds with an average rating of AA/Aa or higher (or equivalent quality on another rating scale). All of these factors are uncertain and unknowable. Thus, there will be a range of reasonable assumptions, and the results may vary materially based on which assumptions the actuary selects within that range. That is, there is no right answer (except with hindsight). It is important for any user of an actuarial valuation to understand and accept this constraint. The actuarial model necessarily uses approximations and estimates that may lead to significant changes in our results but will have no impact on the actual cost of the plan. In addition, the actuarial assumptions may change over time, and while this can have a significant impact on the reported results, it does not mean that the previous assumptions or results were unreasonable or wrong.

Section 1: Actuarial Valuation Summary

Models	Segal accounting results are based on proprietary actuarial modeling software. The accounting valuation models generate a comprehensive set of liability and cost calculations that are presented to meet accounting standards and client requirements. Our Actuarial Technology and Systems unit, comprising both actuaries and programmers, is responsible for the initial development and maintenance of these models. The models have a modular structure that allows for a high degree of accuracy, flexibility and user control. The client team programs the assumptions and the plan provisions, validates the models, and reviews test lives and results, under the supervision of the responsible actuary. Our claims costs assumptions are based on proprietary modeling software as well as models that were developed by others. These models generate per capita claims cost calculations that are used in our valuation software. Our Health Technical Services Unit, comprised of actuaries and programmers, is responsible for the initial development and maintenance of our health models. They are also responsible for testing models that we purchase from other vendors for reasonableness. The client team inputs the paid claims, enrollments, plan provisions and assumptions into these models and reviews the results for reasonableness, under the supervision of the responsible actuary.

Section 1: Actuarial Valuation Summary

The user of Segal's actuarial valuation (or other actuarial calculations) should keep the following in mind:

The actuarial valuation is prepared for use by the Nevada PEBP. It includes information for compliance with accounting standards and for the plan's auditor. Segal is not responsible for the use or misuse of its report, particularly by any other party.
If the State is aware of any event or trend that was not considered in this valuation that may materially change the results of the valuation, Segal should be advised, so that we can evaluate it.
An actuarial valuation is a measurement at a specific date – it is not a prediction of a plan's future financial condition. Accordingly, Segal did not perform an analysis of the potential range of financial measurements, except where otherwise noted. The actual long-term cost of the plan will be determined by the actual benefits and expenses paid and the actual investment experience of the plan.
Sections of this report include actuarial results that are not rounded, but that does not imply precision.
Critical events for a plan include, but are not limited to, decisions about changes in benefits and contributions. The basis for such decisions needs to consider many factors such as the risk of changes in plan enrollment, emerging claims experience, health care trend, and investment losses, not just the current valuation results.
Segal does not provide investment, legal, accounting, or tax advice. Segal's valuation is based on our understanding of applicable guidance in these areas and of the plan's provisions, but they may be subject to alternative interpretations. The State should look to their other advisors for expertise in these areas.
While Segal maintains extensive quality assurance procedures, an actuarial valuation involves complex computer models and numerous inputs. In the event that an inaccuracy is discovered after presentation of Segal's valuation, Segal may revise that valuation or make an appropriate adjustment in the next valuation.
Segal's report shall be deemed to be final and accepted by the State upon delivery and review State should notify Segal immediately of any questions or concerns about the final content.

As Segal has no discretionary authority with respect to the management or assets of the Plan, it is not a fiduciary in its capacity as actuaries and consultants with respect to the Plan.

Section 1: Actuarial Valuation Summary

Actuarial Certification ***July 18, 2023***

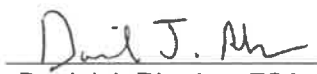
This is to certify that Segal has conducted an actuarial valuation of certain benefit obligations of State of Nevada Postretirement Health and Life Insurance Plan's other postemployment benefit programs as of June 30, 2022, in accordance with generally accepted actuarial principles and practices. The actuarial calculations presented in this report have been made on a basis consistent with our understanding of GASB Statement No. 75 for the determination of the liability for postemployment benefits other than pensions.

The actuarial valuation is based on the plan of benefits verified by the PEBP and reliance on participant, premium, claims and expense data provided by the PEBP or from vendors employed by the PEBP. Segal does not audit the data provided. The accuracy and comprehensiveness of the data is the responsibility of those supplying the data. Segal, however, does review the data for reasonableness and consistency.

The actuarial computations made are for purposes of fulfilling plan accounting requirements. Determinations for purposes other than meeting financial accounting requirements may be significantly different from the results reported here. Accordingly, additional determinations may be needed for other purposes, such as judging benefit security at termination of the plan, or determining short-term cash flow requirements.

Future actuarial measurements may differ significantly from the current measurements presented in this report due to such factors as the following: retiree group benefits program experience or rates of return on assets differing from that anticipated by the assumptions; changes in assumptions; increases or decreases expected as part of the natural operation of the methodology used for these measurements (such as the end of an amortization period); and changes in retiree group benefits program provisions or applicable law. Retiree group benefits models necessarily rely on the use of approximations and estimates, and are sensitive to changes in these approximations and estimates. Small variations in these approximations and estimates may lead to significant changes in actuarial measurements. The scope of the assignment did not include performing an analysis of the potential change of such future measurements except where noted.

To the best of our knowledge, this report is complete and accurate and, in our opinion, presents the information necessary to comply with GASB Statement No. 75 with respect to the benefit obligations addressed. The signing actuaries are members of the Society of Actuaries, the American Academy of Actuaries, and other professional actuarial organizations and collectively meet the "General Qualification Standards for Statements of Actuarial Opinions" to render the actuarial opinion contained herein.



Daniel J. Rhodes, FSA, FCA, MAAA
Senior Vice President & Consulting Actuary
Certifying Claims & Medical Trend Calculations

Mehdi Riazi, FSA, FCA, EA, MAAA
Vice President & Consulting Actuary
Certifying Liability Calculations

Section 2: GASB 75 Information

General information about the OPEB plan

Plan Description

Plan administration. The Public Employees' Benefits Program (PEBP) of the State of Nevada administers the OPEB plan - a multiple-employer, cost-sharing OPEB plan that is used to provide OPEB for permanent full-time employees of the State.

Plan membership. At June 30, 2022, the State's OPEB plan membership consisted of the following:

Retired members or beneficiaries currently receiving benefits*	12,692
Vested terminated members entitled to but not yet receiving benefits**	18,495
Active members	28,015
Total	**59,202**

* *Retiree and Beneficiary counts only include State participants.*

** *Vested Terminated counts include Non-State participants. The Nevada PERS census data, determined as the best source for vested terminated participants, does not differentiate between State and non-State participants. The participation assumption for vested terminated members has been adjusted downward to reflect only future State retirees from this group.*

Benefits provided.

Non-Medicare retirees are eligible for medical and prescription drug benefits via four separate health plan options. Premiums for non-Medicare retirees vary based on date of hire, date of retirement, and years of service.

Medicare retirees are eligible for medical and prescription drug benefits through the Exchange. Medicare retirees hired before January 1, 2012 are eligible for a monthly Exchange HRA contribution of $195 if retired prior to January 1, 1994, or $13 per year of service, up to a maximum of 20 years of service if retired on or after January 1, 1994.

Section 2: GASB 75 Information

Benefits provided (continued). Retirees and spouses who are over the age of 65 can maintain their healthcare coverage on a non-Exchange plan until the younger spouse reaches the age of 65. In addition, retirees over the age of 65 who are not eligible for free Part A coverage are allowed to stay on a non-Exchange health plan. In these situations, the retiree contribution for a retired member who is over the age of 65 is reduced by the Part B premium credit. The Part B reimbursement is not provided to spouses who are over the age of 65. Enrollment in Medicare Part B is required for retirees who are over the age of 65. Retirees over the age of 65 who are eligible for free Medicare Part A are required to enroll in Medicare Part A and a health plan offered by the Medicare Exchange.

Duration of coverage. Until both the retiree and spouse become Medicare-eligible, whereupon they will move to the Exchange. Certain retirees over age 65 are not eligible for Medicare Part A. Lifetime benefits are provided to members hired prior to January 1, 2012.

Dependent coverage. Benefits are available for dependents. However, beneficiaries and spouses do not receive any Exchange benefits. Couples can remain on a non-Medicare plan until the younger spouse reaches age 65. A member who is older than 65 and has a spouse who is younger than 65 is required to enroll in Medicare. The plan will pay secondary to Medicare and will reimburse the member $135.10 towards the Medicare Part B premium. Surviving spouses of retirees, and surviving spouses of active employees who had at least 10 years of service, are allowed to maintain their health coverage to age 65 but are required to pay the full blended premiums.

Life insurance. Any retiree with retiree health insurance coverage, either through the CDHP PPO, LD PPO, EPO, HMO, or Medicare Exchange is provided a basic life insurance benefit of $12,500 free of charge. Retirees can purchase additional coverage at their own expense.

Retiree contributions. Retiree and spouse contribution rates are periodically reset by the PEBP. The monthly contributions shown below were effective from July 1, 2022 through June 30, 2023. Employees hired on or after January 1, 2012, or hired between January 1, 2010 and January 1, 2012 with less than 15 years of service, as well as all surviving spouses, are required to pay the plan's overall blended premium rates for coverage.

	CDHP PPO	LD PPO	HMO/EPO
Retiree	$241.26	$262.44	$355.30
Retiree + Spouse	588.96	631.34	817.06
Surviving Spouse	670.83	691.98	779.47

Section 2: GASB 75 Information

Retiree contributions (continued). Service-based adjustments are applied to the CDHP PPO, LD PPO, EPO, and HMO premiums as follows. These service-based adjustments do not apply to spouses, surviving spouses, or employees hired on or after January 1, 2012.

Years of Service	Change in Premium ($)
5	+373.50
6	+336.15
7	+298.80
8	+261.45
9	+224.10
10	+186.75
11	+149.40
12	+112.05
13	+74.70
14	+37.35
15	0
16	-37.35
17	-74.70
18	-112.05
19	-149.40
20+	-186.75

Net OPEB liability

Reporting Date for Employer under GASB 75	June 30, 2023	June 30, 2022
Measurement Date	**June 30, 2022**	**June 30, 2021**
Components of the Net OPEB Liability		
Total OPEB Liability	$1,422,115,023	$1,540,182,727
Plan Fiduciary Net Position	(20,092,711)	(9,967,828)
Net OPEB Liability	$1,442,207,734	$1,550,150,555
Plan Fiduciary Net Position as a percentage of the Total OPEB Liability	(1.41)%	(0.64)%

The Net OPEB Liability was measured as of June 30, 2022 and 2021. Plan Fiduciary Net Position (plan assets) was valued as of the measurement dates and the Total OPEB Liability was determined from actuarial valuations using data as of June 30, 2022 and January 1, 2020, respectively.

Section 2: GASB 75 Information

Actuarial assumptions. The Total OPEB Liability was measured by an actuarial valuation as of June 30, 2022 using the following actuarial assumptions, applied to all periods included in the measurement, unless otherwise specified:

Inflation	2.50%
Salary increases	4.20% to 9.10%, for Regular members and 4.60% to 14.50% for Police/Fire members, varying by service, including inflation
Discount rate	3.54%
Healthcare cost trend rates	
Medical/Prescription Drug	4.80% increase effective July 1, 2023, then 7.25% graded down 0.25% to ultimate 4.50% over 11 years.
Retiree Premiums	First year trend rates were based on actual increases effective July 1, 2023. Afterwards, premium increases were expected to be in-line with the underlying medical and prescription drug claims trend assumption.
Dental	4.00%
Administrative Costs	3.00%
Part B Reimbursement	0% and 27.17%, effective July 1, 2023 and 2024, respectively, then 4.50%
Demographic assumptions	The demographic assumptions which are not unique to the OPEB valuation were based on the 2020 Actuarial Experience Study conducted for the Public Employees' Retirement System of the State of Nevada, dated September 10, 2021. For details, please see Exhibit II, Section 3.

Determination of discount rate and investment rates of return

Since the State funds this Plan on a pay-as-you-go-basis, GASB requires the discount rate be based on a yield or index rate for 20-year, tax-exempt general obligation municipal bonds with an average rating of AA/Aa or higher (or equivalent quality on another rating scale). To comply with this requirement, the discount rate is based on an index of 20-year, tax-exempt general obligation bonds. Specifically, the chosen rate is 3.54%, the Bond Buyer 20-Bond GO Index rate published closest to, but not later than, the measurement date of June 30, 2022.

Sensitivity

The following presents the NOL as well as what the NOL would be if it were calculated using a discount rate that is 1-percentage-point lower (2.54%) or 1-percentage-point higher (4.54%) than the current rate. Also, shown is the NOL as if it were calculated using healthcare cost trend rates that were 1-percentage-point lower or 1-percentage-point higher than the current healthcare trend rates.

	1% Decrease (2.54%)	Current Discount Rate (3.54%)	1% Increase (4.54%)
Net OPEB Liability (Asset)	$1,585,910,661	$1,442,207,734	$1,317,795,147
	1% Decrease in Health Care Cost Trend Rates	**Current Health Care Cost Trend Rates**	**1% Increase in Health Care Cost Trend Rates**
Net OPEB Liability (Asset)	$1,372,482,148	$1,442,207,734	$1,522,051,369

Schedule of changes in Net OPEB Liability – Last two fiscal years

Reporting Date for Employer under GASB 75	June 30, 2023	June 30, 2022
Measurement Date	June 30, 2022	June 30, 2021
Total OPEB Liability		
Service cost	$52,675,056	$55,710,061
Interest	33,718,089	33,852,685
Change of benefit terms	38,605,492	0
Differences between expected and actual experience	(19,315,612)	(2,313,154)
Changes of assumptions	(159,738,443)	(937,989)
Benefit payments, including refunds of member contributions	(64,012,286)	(44,187,551)
Net change in Total OPEB Liability	$(118,067,704)	$42,124,052
Total OPEB Liability – beginning	1,540,182,727	1,498,058,675
Total OPEB Liability – ending	$1,422,115,023	$1,540,182,727
Plan Fiduciary Net Position		
Contributions – employer[1]	$53,980,293	$39,563,787
Contributions – employee	0	0
Net investment income	(92,890)	307,551
Benefit payments, including refunds of member contributions[1]	(64,012,286)	(44,187,551)
Administrative expense	0	0
Other	0	0
Net change in Plan Fiduciary Net Position	$(10,124,883)	$(4,316,213)
Plan Fiduciary Net Position – beginning	(9,967,828)	(5,651,615)
Plan Fiduciary Net Position – ending	$(20,092,711)	$(9,967,828)
Net OPEB Liability – ending	$1,442,207,734	$1,550,150,555
Plan Fiduciary Net Position as a percentage of the Total OPEB Liability	(1.41)%	(0.65)%
Covered payroll	$2,277,677,722	$2,090,281,552
Plan Net OPEB Liability as percentage of covered payroll	63.32%	74.16%

[1] For the measurement period ending June 30, 2022,
(1) benefit payments were calculated using actual underlying claims, premiums, and HRA benefits, net of retiree contributions, and
(2) employer contributions reflect contributions to the retiree health benefits trust plus contributions related to benefits that were not reimbursed by the retiree health benefits trust.

Section 2: GASB 75 Information

Notes to Schedule:

Benefit changes[1]:	The Medicare Exchange HRA benefit for participants who retired prior to January 1, 1994 increased from $180 per month to $195 per month.
	The monthly Medicare Exchange HRA benefit for participants who retired on or after January 1, 1994 increased from $12 per year of service to $13 per year of service.
Changes of assumptions/methods:	Dates of hire from the Public Employees' Retirement System of the State of Nevada (Nevada PERS) June 30, 2022 pension valuation were used to determine each employee's total State service and their respective benefit tier. This change increased the total OPEB liability (TOL).
	The discount rate increased from 2.16% to 3.54%. This change lowered the TOL.
	Per-capita health claims costs and the future trend on such costs were updated based on more recent data. These changes lowered the TOL.
	Employees hired on or after January 1, 2012 are now included in the GASB 75 valuation and were assumed to have a 35% participation rate at retirement. This change increased the TOL.
	Retirement, turnover, disability, mortality, inflation, and salary increase assumptions were updated based on the 2020 Nevada PERS Actuarial Experience Study. These updates lowered the TOL.
	The spouse age-difference assumption for future male retirees was updated from the spouse being 4 years younger to the spouse being 3 years younger. This change lowered the TOL.
	The service adjustments applied to current State and Non-State retirees were removed. Liabilities for State retirees are based on the service amounts provided to Segal without any adjustment. Non-State retirees were excluded from the valuation. This change had a very small impact on the TOL.

[1] This benefit change was effective July 1, 2020, but had not been reflected in prior GASB 75 valuations.

Deferred outflows of resources and deferred inflows of resources

Reporting Date for Employer under GASB 75	June 30, 2023	June 30, 2022
Measurement Date	**June 30, 2022**	**June 30, 2021**
Deferred Outflows of Resources		
Changes of assumptions or other inputs	20,491,312	86,508,148
Net difference between projected and actual earnings on OPEB plan investments	0	0
Difference between expected and actual experience in the Total OPEB Liability	0	0
Total Deferred Outflows of Resources	$20,491,312	$86,508,148
Deferred Inflows of Resources		
Changes of assumptions or other inputs	119,834,117	6,715,613
Net difference between projected and actual earnings on OPEB plan investments	437,575	545,153
Difference between expected and actual experience in the Total OPEB Liability	27,069,113	55,967,226
Total Deferred Inflows of Resources	$147,340,805	$63,227,992
Deferred outflows of resources and deferred inflows of resources related to OPEB will be recognized as follows:		
Reporting Date for Employer under GASB 75 Year Ended June 30:		
2023	N/A	$5,050,743
2024	$(37,516,835)	10,787,943
2025	(45,131,289)	7,572,962
2026	(44,145,028)	(86,492)
2027	(56,341)	0
2028	0	0
Thereafter	0	0

The average of the expected service lives of all employees was 3.98 and was determined by:

- Calculating each active employee's expected remaining service life as the present value of $1 per year of future service at zero percent interest.
- Setting the remaining service life to zero for each nonactive or retired member.
- Dividing the sum of the above amounts by the total number of active employee, nonactive and retired members.

Schedule of recognition of change in total Net OPEB Liability

Increase (Decrease) in OPEB Expense Arising from the Recognition of the Effects of Differences between Expected and Actual Experience on Total OPEB Liability

Reporting Date for Employer under GASB 75 Year Ended June 30	Differences between Expected and Actual Experience	Recognition Period (Years)	2022	2023	2024	2025	2026	Thereafter
2019	0	0.00	0	0	0	0	0	0
2020	(31,485,200)	4.78	(6,586,900)	(5,137,600)	0	0	0	0
2021	(72,984,434)	4.79	(15,236,834)	(15,236,834)	(12,037,098)	0	0	0
2022	(2,313,154)	3.98	(581,194)	(581,194)	(569,572)	0	0	0
2023	(19,315,612)	3.98	N/A	(4,853,169)	(4,853,169)	(4,853,169)	(4,756,105)	0
Net increase (decrease) in OPEB expense			N/A	$(25,808,797)	$(17,459,839)	$(4,853,169)	$(4,756,105)	$0

Section 2: GASB 75 Information

Increase (Decrease) in OPEB Expense Arising from the Recognition of the Effects of Assumption Changes

Reporting Date for Employer under GASB 75 Year Ended June 30	Assumption Changes	Recognition Period (Years)	2022	2023	2024	2025	2026	Thereafter
2019	(36,851,300)	4.78	(6,013,300)	0	0	0	0	0
2020	37,971,500	4.78	7,943,800	6,196,300	0	0	0	0
2021	124,244,784	4.79	25,938,368	25,938,368	20,491,312	0	0	0
2022	(937,989)	3.98	(235,676)	(235,676)	(230,961)	0	0	0
2023	(159,738,443)	3.98	N/A	(40,135,287)	(40,135,287)	(40,135,287)	(39,332,582)	0
Net increase (decrease) in OPEB expense			N/A	$(8,236,295)	$(19,874,936)	$(40,135,287)	$(39,332,582)	$0

Section 2: GASB 75 Information

Increase (Decrease) in OPEB Expense Arising from the Recognition of the Effects of Differences between Projected and Actual Earnings on OPEB Plan Investments

Reporting Date for Employer under GASB 75 Year Ended June 30	Differences between Projected and Actual Earnings	Recognition Period (Years)	2022	2023	2024	2025	2026	2027	Thereafter
2019	(110,300)	5.00	(21,900)	0	0	0	0	0	0
2020	(149,300)	5.00	(29,900)	(29,700)	0	0	0	0	0
2021	(196,153)	5.00	(39,231)	(39,231)	(39,229)	0	0	0	0
2022	(432,452)	5.00	(86,490)	(86,490)	(86,490)	(86,492)	0	0	0
2023	(281,706)	5.00	N/A	(56,342)	(56,341)	(56,341)	(56,341)	(56,341)	0
Net increase (decrease) in OPEB expense			N/A	$(211,763)	$(182,060)	$(142,833)	$(56,341)	$(56,341)	$0

Section 2: GASB 75 Information

Total Increase (Decrease) in OPEB Expense

Reporting Date for Employer under GASB 75 Year Ended June 30	Total Increase (Decrease) in OPEB Expense	2022	2023	2024	2025	2026	2027	Thereafter
2019	(36,961,600)	(6,035,200)	0	0	0	0	0	0
2020	6,337,000	1,327,000	1,029,000	0	0	0	0	0
2021	51,064,197	10,662,303	10,662,303	8,414,985	0	0	0	0
2022	(3,683,595)	(903,360)	(903,360)	(887,023)	(86,492)	0	0	0
2023	(179,335,761)	N/A	(45,044,798)	(45,044,798)	(45,044,798)	(44,145,028)	(56,341)	0
Net increase (decrease) in OPEB expense		N/A	$(34,256,855)	$(37,516,835)	$(45,131,289)	$(44,145,028)	$(56,341)	$0

OPEB expense

Reporting Date for Employer under GASB 75	June 30, 2023	June 30, 2022
Measurement Date	**June 30, 2022**	**June 30, 2021**
Components of OPEB Expense		
Service cost	$52,675,056	$55,710,061
Interest on the Total OPEB Liability	33,718,089	33,852,685
Current-period benefit changes	38,605,492	0
Expensed portion of current-period difference between expected and actual experience in the Total OPEB Liability	(4,853,169)	(581,194)
Expensed portion of current-period changes of assumptions or other inputs	(40,135,287)	(235,676)
Member contributions	0	0
Projected earnings on plan investments	374,596	124,901
Expensed portion of current-period differences between actual and projected earnings on plan investments	(56,342)	(86,490)
Administrative expense	0	0
Other	0	0
Recognition of beginning of year deferred outflows of resources as OPEB expense	32,134,668	33,882,168
Recognition of beginning of year deferred inflows of resources as OPEB expense	(21,346,725)	(46,343,165)
OPEB Expense	**$91,116,378**	**$76,323,290**

Schedule of reconciliation of Net OPEB Liability

Reporting Date for Employer under GASB 75	June 30, 2023	June 30, 2022
Measurement Date	**June 30, 2022**	**June 30, 2021**
Beginning Net OPEB Liability	$1,550,150,555	$1,503,710,290
OPEB expense	91,116,378	76,323,290
Employer contributions	(53,980,293)	(39,563,787)
New net deferred inflows/outflows	(134,290,963)	(2,780,235)
Recognition of prior deferred inflows/outflows	(10,787,943)	12,460,997
Ending Net OPEB Liability	$1,442,207,734	$1,550,150,555

Statement of Fiduciary Net Position

	June 30, 2022
Assets	
Cash with Treasurer	$3,491,998
Receivables	
• Intergovernmental Receivable	20,584
• Due From Other Funds	107,288
• Due From Component, Units, Net	1,334,319
Total receivables	1,462,191
Total Assets	**4,954,189**
Liabilities	
Payables:	
• Due to Other Funds	25,046,900
Total liabilities	**25,046,900**
Net position restricted for OPEB	**(20,092,711)**

Section 3: Supporting Information

Exhibit I: Summary of Participant Data

	As of June 30, 2022
Number of retirees	12,319
Average age of retirees	69.86
Number of spouses	2,354
Average age of spouses	67.28
Number of surviving spouses	373
Average age of surviving spouses	76.61
Number inactive vested[1]	18,495
Average age of inactive vested	49.15
Number of actives[2]	28,015
Average age of actives	45.04
Average service of actives	8.74

[1] Based on discussions with the State, we agreed to use the June 30, 2022 Nevada PERS census data for vested terminated participants. Only vested terminated employees who were younger than age 65 as of the valuation date were included. The PERS database was the best source of data available for vested terminated participants. However, we were not able to determine which vested terminated PERS participants were State employees. As a result, the participation assumption for current vested terminated participants was adjusted downward to reflect the fact that the census data includes State and Non-State vested terminated participants.

[2] Of the 28,015 active employees, 18,198 were hired on or after January 1, 2012.

Exhibit II: Actuarial Assumptions and Actuarial Cost Method

Data:	Detailed census data, premium data and claim experience, financial data, and summary plan descriptions for OPEB were provided by the PEBP.
Actuarial Cost Method:	Entry Age Normal level % of pay
Asset Valuation Method:	Market Value
Measurement Date:	June 30, 2022
Actuarial Valuation Date:	June 30, 2022
Discount Rate:	3.54% bond index as of June 30, 2022
Inflation Rate:	2.50%
Investment Return Assumption:	2.50%; same as Inflation Rate assumption
Unknown Data for Participants:	Same as those exhibited by members with similar known characteristics. If not specified, members are assumed to be male. Active participants with unknown dates of hire were assumed to enter at age 36. Participants with unknown Regular or Police/Fire indicators were assumed to be General employees. Participants with unknown State or Non-State indicators were assumed to be State employees.
Demographic and Salary Assumptions:	The demographic and salary increase assumptions that are common to the PERS pension valuation were based on the 2020 Actuarial Experience Study for the Public Employees' Retirement System of the State of Nevada dated September 10, 2021. The demographic assumptions that are unique to the GASB 75 valuation (such as enrollment elections, dependent coverage assumptions, and relative ages of spouses) are based on the plan's experience and are reviewed every full valuation.

Section 3: Supporting Information

Salary Increases:

Inflation: 2.50% plus
Productivity pay increases: 0.50% plus
Merit and promotion salary increases:

	Rate (%)	
Years of Service	**Regular**	**Police/Fire**
0 – 1	6.10	11.50
1 – 2	5.00	8.20
2 – 3	4.40	5.80
3 – 4	4.00	5.20
4 – 5	3.70	4.90
5 – 6	3.40	4.70
6 – 7	3.30	4.40
7 – 8	3.20	4.20
8 – 9	3.00	4.00
9 – 10	2.80	3.90
10 – 11	2.60	3.50
11 – 12	2.30	2.80
12 – 13	2.10	2.20
13 – 14	1.90	2.00
14 – 15	1.80	1.90
15 – 16	1.70	1.70
16 – 17	1.60	1.70
17 – 18	1.50	1.70
18 – 19	1.40	1.70
19 – 20	1.30	1.70
20 & Over	1.20	1.60

Future salary increases are assumed to occur at the beginning of the year.

Postretirement Mortality Rates	*Healthy* • **Regular Members:** Pub-2010 General Healthy Retiree Headcount-Weighted Above-Median Mortality Table (separate tables for males and females) with rates increased by 30% for males and 15% for females, projected generationally with the two-dimensional mortality improvement scale MP-2020. • **Police/Fire Members:** Pub-2010 Safety Healthy Retiree Headcount-Weighted Above-Median Mortality Table (separate tables for males and females) with rates increased by 30% for males and 5% for females, projected generationally with the two-dimensional mortality improvement scale MP-2020. *Disabled* • **Regular Members:** Pub-2010 Non-Safety Disabled Retiree Headcount-Weighted Mortality Table (separate tables for males and females) with rates increased by 20% for males and 15% for females, projected generationally with the two-dimensional mortality improvement scale MP-2020. • **Police/Fire Members:** Pub-2010 Safety Disabled Retiree Headcount-Weighted Mortality Table (separate tables for males and females) with rates increased by 30% for males and 10% for females, projected generationally with the two-dimensional mortality improvement scale MP-2020. *Beneficiaries* **Regular and Police/Fire Current Beneficiaries in Pay Status:** Pub-2010 Contingent Survivor Headcount-Weighted Above-Median Mortality Table (separate tables for males and females) with rates increased by 15% for males and 30% for females, projected generationally with the two-dimensional mortality improvement scale MP-2020.

Preretirement Mortality Rates:

- **Regular Members:** Pub-2010 General Employee Headcount-Weighted Above-Median Mortality Table (separate tables for males and females), projected generationally with the two-dimensional mortality improvement scale MP-2020.
- **Police/Fire Members:** Pub-2010 Safety Employee Headcount-Weighted Above-Median Mortality Table (separate tables for males and females), projected generationally with the two-dimensional mortality improvement scale MP-2020.

The Pub-2010 Headcount-Weighted Mortality Tables reasonably reflect the projected mortality experience of the Plan as of the measurement date. The generational projection is a provision made for future mortality improvement.

Disability Rates:

	Disability Rates (%)	
Age	Regular	Police/Fire
22	0.01	0.00
27	0.03	0.06
32	0.04	0.16
37	0.10	0.32
42	0.20	0.50
47	0.30	0.80
52	0.55	0.70
57	0.70	0.50
62	0.30	0.30
65 & Over	0.00	0.00

Disability rates are applied only for members with:

- 5 to 30 years of service for Regular members with a date of membership before July 1, 2015,
- Less than 33 1/3 years of service for Regular members with a date of membership on or after July 1, 2015,
- Less than 25 years of service for Police/Fire members with a date of membership before January 1, 2010, or
- Less than 30 years of service for Police/Fire members with a date of membership on or after January 1, 2010.

Section 3: Supporting Information

Termination Rates:

Years of Service	Termination Rates (%)	
	Regular	Police/Fire
0 – 1	15.75	14.50
1 – 2	12.75	8.25
2 – 3	10.25	6.50
3 – 4	8.25	5.50
4 – 5	7.50	4.50
5 – 6	6.50	4.25
6 – 7	5.75	3.25
7 – 8	5.25	2.50
8 – 9	4.75	2.50
9 – 10	4.50	1.90
10 – 11	4.25	1.40
11 – 12	3.25	1.25
12 – 13	3.00	1.00
13 – 14	2.75	0.90
14 – 15	2.25	0.80
15 – 16	2.25	0.70
16 – 17	2.25	0.60
17 – 18	2.00	0.50
18 – 19	1.75	0.40
19 – 20	1.75	0.30
20 – 21	1.75	0.30
21 – 22	1.75	0.30
22 – 23	1.75	0.30
23 – 24	1.75	0.30
24 – 25	1.50	0.30
25 & Over	1.50	0.30

No termination is assumed after a member reaches the earliest retirement age.

Section 3: Supporting Information

Retirement Rates:

Regular members with an effective date of membership before January 1, 2010:

	Retirement Rates (%)					
	Years of Service					
Age	5 – 9	10 – 19	20 – 24	25 – 27	28 – 29	30 & Over
45	0.00	0.10	0.10	0.50	20.00	20.00
46	0.00	0.20	0.20	1.00	20.00	20.00
47	0.00	0.30	0.30	1.50	20.00	20.00
48	0.00	0.40	0.40	2.00	20.00	20.00
49	0.00	0.50	0.50	2.00	20.00	20.00
50	0.20	0.60	0.70	2.00	20.00	20.00
51	0.30	0.70	1.00	2.00	20.00	20.00
52	0.40	0.80	1.20	3.00	20.00	20.00
53	0.50	1.00	1.50	3.00	20.00	20.00
54	0.60	1.20	2.00	3.00	20.00	20.00
55	0.80	1.50	3.00	3.00	20.00	20.00
56	1.00	2.00	3.50	4.00	20.00	20.00
57	1.50	2.50	4.00	7.00	20.00	20.00
58	2.00	3.00	5.00	7.00	20.00	20.00
59	2.50	4.00	7.00	11.00	20.00	20.00
60	5.00	11.00	18.00	25.00	21.00	21.00
61	6.00	10.00	15.00	20.00	21.00	21.00
62	7.00	11.00	16.00	20.00	20.00	20.00
63	8.00	11.00	16.00	20.00	20.00	20.00
64	9.00	11.00	16.00	20.00	20.00	20.00
65	18.00	19.00	22.00	22.00	25.00	25.00
66	18.00	19.00	22.00	22.00	25.00	25.00
67	18.00	19.00	22.00	22.00	25.00	25.00
68	18.00	19.00	22.00	22.00	25.00	25.00
69	18.00	19.00	22.00	22.00	25.00	25.00
70	20.00	20.00	25.00	30.00	30.00	30.00
71	20.00	20.00	25.00	30.00	30.00	30.00
72	20.00	20.00	25.00	30.00	30.00	30.00
73	20.00	20.00	25.00	30.00	30.00	30.00
74	20.00	20.00	25.00	30.00	30.00	30.00
75 & Over	100.00	100.00	100.00	100.00	100.00	100.00

Retirement Rates (continued):

Regular members with an effective date of membership on or after January 1, 2010 and before July 1, 2015:

	Retirement Rates (%)					
	Years of Service					
Age	5 – 9	10 – 19	20 – 24	25 – 27	28 – 29	30 & Over
45	0.00	0.00	0.00	0.00	20.00	20.00
46	0.00	0.00	0.00	0.00	20.00	20.00
47	0.00	0.00	0.00	0.00	20.00	20.00
48	0.00	0.00	0.00	0.00	20.00	20.00
49	0.00	0.00	0.00	0.00	20.00	20.00
50	0.00	0.00	0.00	0.00	20.00	20.00
51	0.00	0.00	0.00	0.00	20.00	20.00
52	0.00	0.40	0.70	1.70	20.00	20.00
53	0.00	0.60	0.90	1.80	20.00	20.00
54	0.00	0.80	1.30	1.90	20.00	20.00
55	0.20	1.00	2.00	2.00	20.00	20.00
56	0.40	1.40	2.50	2.90	20.00	20.00
57	0.60	1.90	3.00	5.20	20.00	20.00
58	0.80	2.30	3.90	5.40	20.00	20.00
59	1.00	3.20	5.60	8.80	20.00	20.00
60	2.00	4.00	6.00	10.00	21.00	21.00
61	3.50	6.00	10.00	15.00	21.00	21.00
62	4.00	10.30	15.00	18.70	20.00	20.00
63	5.00	10.30	15.00	18.70	20.00	20.00
64	7.00	10.30	15.00	18.70	20.00	20.00
65	17.00	17.80	20.60	20.60	25.00	25.00
66	17.00	17.80	20.60	20.60	25.00	25.00
67	17.00	17.80	20.60	20.60	25.00	25.00
68	17.00	17.80	20.60	20.60	25.00	25.00
69	17.00	17.80	20.60	20.60	25.00	25.00
70	19.00	18.70	23.40	28.10	30.00	30.00
71	19.00	18.70	23.40	28.10	30.00	30.00
72	19.00	18.70	23.40	28.10	30.00	30.00
73	19.00	18.70	23.40	28.10	30.00	30.00
74	19.00	18.70	23.40	28.10	30.00	30.00
75 & Over	100.00	100.00	100.00	100.00	100.00	100.00

Section 3: Supporting Information

Retirement Rates (continued):

Regular members with an effective date of membership on or after July 1, 2015:

	Retirement Rates (%)					
	Years of Service					
Age	5 – 9	10 – 19	20 – 24	25 – 29	30 – 33.3	33.3 & Over
45	0.00	0.00	0.00	0.00	7.20	20.00
46	0.00	0.00	0.00	0.00	8.30	20.00
47	0.00	0.00	0.00	0.00	9.40	20.00
48	0.00	0.00	0.00	0.00	10.40	20.00
49	0.00	0.00	0.00	0.00	11.50	20.00
50	0.00	0.00	0.00	0.00	12.60	20.00
51	0.00	0.00	0.00	0.00	13.70	20.00
52	0.00	0.40	0.60	1.50	14.80	20.00
53	0.00	0.50	0.80	1.60	15.80	20.00
54	0.00	0.70	1.20	1.70	16.90	20.00
55	0.20	0.90	1.80	1.80	18.00	20.00
56	0.40	1.30	2.30	2.60	18.00	20.00
57	0.50	1.70	2.70	4.70	18.00	20.00
58	0.70	2.10	3.50	4.90	18.00	20.00
59	0.90	2.90	5.00	7.90	18.00	20.00
60	1.80	3.60	5.40	9.00	18.90	21.00
61	3.20	5.40	9.00	13.50	18.90	21.00
62	3.60	9.30	13.50	16.80	18.00	20.00
63	4.50	9.30	13.50	16.80	18.00	20.00
64	6.30	9.30	13.50	16.80	18.00	20.00
65	15.30	16.00	18.50	18.50	22.50	25.00
66	15.30	16.00	18.50	18.50	22.50	25.00
67	15.30	16.00	18.50	18.50	22.50	25.00
68	15.30	16.00	18.50	18.50	22.50	25.00
69	15.30	16.00	18.50	18.50	22.50	25.00
70	17.10	16.80	21.10	25.30	27.00	30.00
71	17.10	16.80	21.10	25.30	27.00	30.00
72	17.10	16.80	21.10	25.30	27.00	30.00
73	17.10	16.80	21.10	25.30	27.00	30.00
74	17.10	16.80	21.10	25.30	27.00	30.00
75 & Over	100.00	100.00	100.00	100.00	100.00	100.00

Retirement Rates (continued):

Police/Fire members with an effective date of membership before January 1, 2010:

	Retirement Rates (%)					
	Years of Service					
Age	5 – 9	10 – 19	20 – 22	23 – 24	25 – 29	30 & Over
40	0.00	0.10	0.00	0.00	0.00	0.00
41	0.00	0.20	0.00	20.00	20.00	0.00
42	0.00	0.30	1.00	20.00	20.00	0.00
43	0.00	0.40	2.00	20.00	20.00	0.00
44	0.00	0.50	3.00	20.00	20.00	0.00
45	0.00	0.70	3.50	20.00	20.00	20.00
46	0.00	0.90	4.00	20.00	20.00	20.00
47	0.00	1.10	4.50	20.00	20.00	20.00
48	0.00	1.30	5.00	20.00	20.00	20.00
49	0.00	1.50	6.50	20.00	20.00	20.00
50	1.50	4.50	16.00	23.00	23.00	23.00
51	1.50	4.50	13.00	23.00	23.00	23.00
52	1.50	5.00	13.00	23.00	23.00	23.00
53	1.50	6.00	13.00	23.00	23.00	23.00
54	1.50	7.00	13.00	23.00	23.00	23.00
55	4.50	11.00	18.00	25.00	25.00	25.00
56	4.50	11.00	18.00	25.00	25.00	25.00
57	4.50	11.00	18.00	25.00	25.00	25.00
58	4.50	11.00	18.00	25.00	25.00	25.00
59	4.50	11.00	18.00	25.00	25.00	25.00
60	5.00	18.00	26.00	35.00	35.00	35.00
61	6.00	18.00	26.00	35.00	35.00	35.00
62	7.00	18.00	26.00	35.00	35.00	35.00
63	8.00	18.00	26.00	35.00	35.00	35.00
64	9.00	18.00	26.00	35.00	35.00	35.00
65	20.00	25.00	40.00	50.00	50.00	50.00
66	20.00	25.00	40.00	50.00	50.00	50.00
67	20.00	25.00	40.00	50.00	50.00	50.00
68	20.00	25.00	40.00	50.00	50.00	50.00
69	20.00	25.00	40.00	50.00	50.00	50.00
70 & Over	100.00	100.00	100.00	100.00	100.00	100.00

Retirement Rates (continued):

Police/Fire members with an effective date of membership on or after January 1, 2010 and before July 1, 2015:

	Retirement Rates (%)					
	Years of Service					
Age	5 – 9	10 – 19	20 – 24	25 – 27	28 – 29	30 & Over
40	0.00	0.00	0.00	0.00	0.00	0.00
41	0.00	0.00	0.00	0.00	0.00	0.00
42	0.00	0.00	0.70	0.00	0.00	0.00
43	0.00	0.00	1.50	10.90	20.00	0.00
44	0.00	0.00	2.40	12.00	20.00	0.00
45	0.00	0.00	2.90	13.10	20.00	20.00
46	0.00	0.00	3.40	14.20	20.00	20.00
47	0.00	0.00	3.90	15.40	20.00	20.00
48	0.00	0.00	4.50	16.50	20.00	20.00
49	0.00	0.00	6.00	17.60	20.00	20.00
50	0.00	2.10	15.00	21.50	23.00	23.00
51	0.00	2.30	12.20	21.50	23.00	23.00
52	0.00	2.80	12.20	21.50	23.00	23.00
53	0.00	3.50	12.20	21.50	23.00	23.00
54	0.00	4.40	12.20	21.50	23.00	23.00
55	2.80	7.20	16.90	23.40	25.00	25.00
56	3.00	7.80	16.90	23.40	25.00	25.00
57	3.20	8.40	16.90	23.40	25.00	25.00
58	3.40	9.10	16.90	23.40	25.00	25.00
59	3.50	9.70	16.90	23.40	25.00	25.00
60	4.10	16.90	24.30	32.80	35.00	35.00
61	5.10	16.90	24.30	32.80	35.00	35.00
62	6.10	16.90	24.30	32.80	35.00	35.00
63	7.20	16.90	24.30	32.80	35.00	35.00
64	8.30	16.90	24.30	32.80	35.00	35.00
65	18.70	23.40	37.50	46.80	50.00	50.00
66	18.70	23.40	37.50	46.80	50.00	50.00
67	18.70	23.40	37.50	46.80	50.00	50.00
68	18.70	23.40	37.50	46.80	50.00	50.00
69	18.70	23.40	37.50	46.80	50.00	50.00
70 & Over	100.00	100.00	100.00	100.00	100.00	100.00

Retirement Rates (continued):

Police/Fire members with an effective date of membership on or after July 1, 2015:

	Retirement Rates (%)				
	Years of Service				
Age	5 – 9	10 – 19	20 – 24	25 – 29	30 & Over
40	0.00	0.00	0.00	0.00	0.00
41	0.00	0.00	0.00	0.00	0.00
42	0.00	0.00	0.70	0.00	0.00
43	0.00	0.00	1.50	10.90	0.00
44	0.00	0.00	2.40	12.00	0.00
45	0.00	0.00	2.90	13.10	20.00
46	0.00	0.00	3.40	14.20	20.00
47	0.00	0.00	3.90	15.40	20.00
48	0.00	0.00	4.50	16.50	20.00
49	0.00	0.00	6.00	17.60	20.00
50	0.00	2.10	15.00	21.50	23.00
51	0.00	2.30	12.20	21.50	23.00
52	0.00	2.80	12.20	21.50	23.00
53	0.00	3.50	12.20	21.50	23.00
54	0.00	4.40	12.20	21.50	23.00
55	2.80	7.20	16.90	23.40	25.00
56	3.00	7.80	16.90	23.40	25.00
57	3.20	8.40	16.90	23.40	25.00
58	3.40	9.10	16.90	23.40	25.00
59	3.50	9.70	16.90	23.40	25.00
60	4.10	16.90	24.30	32.80	35.00
61	5.10	16.90	24.30	32.80	35.00
62	6.10	16.90	24.30	32.80	35.00
63	7.20	16.90	24.30	32.80	35.00
64	8.30	16.90	24.30	32.80	35.00
65	18.70	23.40	37.50	46.80	50.00
66	18.70	23.40	37.50	46.80	50.00
67	18.70	23.40	37.50	46.80	50.00
68	18.70	23.40	37.50	46.80	50.00
69	18.70	23.40	37.50	46.80	50.00
70 & Over	100.00	100.00	100.00	100.00	100.00

Section 3: Supporting Information

Retirement Rates: Vested Terminated	Inactive vested participants with less than 10 years of service are assumed to retire at age 65. Those with 10 or more years of service are assumed to retire at age 60.
Retirement Rates: Higher Education	For Higher Education employees, the assumed rates of retirement are the same as those used for Regular employees, except no rates of retirement are assumed unless the member has at least 5 years of service and is at least 60 years old.
Participation and Coverage Election:	90% of active employees with active healthcare coverage 60% of actives without active coverage and future vested terminated employees 35% for future retirees who would be required to pay the full "un-subsidized" rates for coverage 35% for eligible surviving spouses of active employees. Surviving spouses of retirees are assumed to continue coverage after the retiree's death. 5% of current vested terminated employees. The census data provided for current vested terminated participants as of the valuation date was from the PERS and Judges pension valuations. This census data for current vested terminated participants includes many participants who are in the pension plans, but who were never participants in the retiree healthcare plan. In other words, they worked for employers who are not participating in the State's retiree healthcare plan. The participation assumption of 5% reflects the fact that the census data includes participants who we know will not be eligible for the State's retiree healthcare benefits at retirement. All current and future retirees are assumed to be eligible for Medicare at age 65. Dental coverage is assumed for all participants on the non-Exchange health plans. No separate dental participation assumption is needed for retirees who are on the Medicare Exchange because the maximum HRA benefit is valued for each retiree. Life insurance coverage is provided to all retirees who have healthcare coverage, either through the Exchange or non-Exchange health plans. Reinstated retirees do not receive the $12,500 basic life insurance benefit.
Dependents:	Demographic data was available for spouses of current retirees. For future retirees, male participants were assumed to be three years older than their spouses and female participants were assumed to be two years younger than their spouses. Of those actives who elect to continue their health coverage at retirement, 30% of males and 15% of females were assumed to have an eligible spouse who also opts for health coverage at that time.

Section 3: Supporting Information

Per Capita Cost Development

Per-capita claims costs for the self-insured CDHP PPO, LD PPO, and EPO were based on retiree claims experience furnished by PEBP for periods July 1, 2020 through June 30, 2022. Claims were developed on an incurred basis and were adjusted for plan changes and renegotiated pharmacy contracts. The historical claims were trended forward to the valuation year using a 5.0% assumption for medical costs and a 10.0% assumption for prescription drug costs. Per-capita costs for the fully-insured HMO were based on the premiums charged by the insurer, effective July 1, 2022, and the demographics of the active employees and retirees who elected the HMO. A weighted average set of per capita costs was developed based on the enrollment in each of the plan options. Actuarial factors were used to estimate individual costs by age in accordance with ASOP 6, and to reflect Medicare offsets for those participants who are eligible for Medicare.

Per-capita claims costs for the self-insured dental plan were based on retiree claims experience furnished by PEBP for periods July 1, 2020 through June 30, 2022. Dental claims were developed on an incurred basis and include administrative expenses. The historical claims were trended forward to the valuation year using a 4.0% assumption.

Per Capita Health Costs

The annual per capital dental claims cost for the plan year 2022/2023 was estimated to be $379.
2022/2023 medical and prescription drug claims costs, excluding assumed expenses, are shown in the table below for retirees and for spouses at selected ages. These costs are net of deductibles and other benefit plan cost sharing provisions. The blended claims estimates shown below were used for all current and future retirees, regardless of their current health plan election, and were based on the health plan distribution of current retirees. Post-65 claims costs apply to Medicare-eligible retirees that are not in an Exchange plan.

Age	Male	Female
50	$8,633	$9,116
55	9,742	9,895
60	11,216	10,727
64	13,631	11,646
65	4,800	3,987
70	5,391	4,460
75	5,955	4,689
80	6,236	5,005
85+	6,530	5,342

Administrative Expenses

An administrative expense of $283 per participant increasing at 3.0% per year was added to projected incurred medical and prescription drug claim costs in developing the benefit obligations. The expense was based on actual medical and prescription drug administrative expenses paid for the periods July 1, 2021 through June 30, 2022

CDHP PPO: HRA Contributions

An annual HRA contribution of $382 was added to projected incurred medical and prescription drug claims costs. The $382 dollar benefit equals the $600 annual HRA benefit or retirees who elect the CDHP PPO multiplied by the assumed percentage of retirees choosing the CDHP PPO (63.7%). The HRA contribution associated with the CDHP PPO was not assumed to increase.

Section 3: Supporting Information

Health Care Cost Trend Rates:

Health care trend measures the anticipated overall rate at which health plan costs are expected to increase in future years. The rates shown below are "net" and are applied to the net per capita costs shown above. The trend shown for a particular plan year is the rate that is applied to that year's cost to yield the next year's projected cost. The first-year trends reflect the 2023/2024 plan year premiums. The PEBP Part B premium reimbursement is assumed to be reset to the prevailing Part B premium in plan year 2024/2025.

	Rate (%)			
Increase Effective July 1,	Medical/ Prescription Drug	Dental	Admin	Part B Reimbursements
2023	4.80	4.00	3.00	0.00
2024	7.25	4.00	3.00	27.17
2025	7.00	4.00	3.00	4.50
2026	6.75	4.00	3.00	4.50
2027	6.50	4.00	3.00	4.50
2028	6.25	4.00	3.00	4.50
2029	6.00	4.00	3.00	4.50
2030	5.75	4.00	3.00	4.50
2031	5.50	4.00	3.00	4.50
2032	5.25	4.00	3.00	4.50
2033	5.00	4.00	3.00	4.50
2034	4.75	4.00	3.00	4.50
2035 & Later	4.50	4.00	3.00	4.50

Retiree Contribution Increase Rate:

First year trend rates for retiree contributions were based on known changes effective July 1, 2023. Retiree contributions are modeled using:
(1) the overall blended premiums
(2) the base explicit subsidy, and
(3) the service-based explicit subsidies.

The first-year trends for these components were -2.10% for the overall blended premiums, -3.50% for the base explicit subsidy, and 2.62% for the service-based explicit subsidies. After the first year, retiree contributions were assumed to follow the Medical/Prescription Drug trend.

Section 3: Supporting Information

Plan Design:	Development of plan liabilities was based on the substantive plan of benefits in effect as described in Exhibit III.
Assumption Changes since Prior Valuation:	Dates of hire from the Public Employees' Retirement System of the State of Nevada (Nevada PERS) June 30, 2022 pension valuation were used to determine each employee's total State service and their respective benefit tier. This change increased the total OPEB liability (TOL). The discount rate increased from 2.16% to 3.54%. This change lowered the TOL. Per-capita health claims costs and the future trend on such costs were updated based on more recent data. These changes lowered the TOL. Employees hired on or after January 1, 2012 are now included in the GASB 75 valuation and were assumed to have a 35% participation rate at retirement. This change increased the TOL. Retirement, turnover, disability, mortality, inflation, and salary increase assumptions were updated based on the 2020 Nevada PERS Actuarial Experience Study. These updates lowered the TOL. The spouse age-difference assumption for future male retirees was updated from the spouse being 4 years younger to the spouse being 3 years younger. This change lowered the TOL. The service adjustments applied to current State and Non-State retirees were removed. Liabilities for State retirees are based on the service amounts provided to Segal without any adjustment. Non-State retirees were excluded from the valuation. This change had a very small impact on the TOL.

Exhibit III: Summary of Plan

This exhibit summarizes the major benefit provisions as included in the valuation. To the best of our knowledge, the summary represents the substantive plans as of the measurement date. It is not intended to be, nor should it be interpreted as, a complete statement of all benefit provisions.

Eligibility:	Members are not required to be active immediately prior to retirement to be eligible for benefits. Members must be receiving a PERS, LRS, JRS, or RPA pension. **Service Retirement:** *For members with an effective date of membership before January 1, 2010:* • Regular: Age 65 with five years of service, or age 60 with ten years of service, or 30 years of service. • P&F: Age 65 with 5 years of service, or age 55 with ten years of Police/Fire service, or age 50 with 20 years of Police/Fire service, or 25 years of Police/Fire service. *For members with an effective date of membership on or after January 1, 2010:* • Regular: Age 65 with five years of service, or age 62 with ten years of service, or 30 years of service. • P&F: Age 65 with 5 years of service, or age 60 with ten years of Police/Fire service, or age 50 with 20 years of Police/Fire service, or 30 years of Police/Fire service. *For Regular members with an effective date of membership on or after July 1, 2015:* • Age 65 with five years of service, or age 62 with ten years of service, or age 55 with 30 years of service, or any age with 33 1/3 years of service. **Early Retirement:** Five years of service **Disability:** Five years of service and totally unable to perform current job or any comparable job for which the member is qualified by training and experience, because of injury or illness of a permanent nature, provided the member is in the employ of a participating employer at the time of application for disability retirement. Members hired before January 1, 2010 are eligible to receive a base non-Medicare subsidy, as well as service-based non-Medicare and Medicare Exchange subsidies. Members hired on or after January 1, 2012 are not eligible for any of the explicit subsidies mentioned above. However, they are eligible for non-Medicare coverage by paying the plan's overall blended premiums. Members hired on or after January 1, 2010 and before January 1, 2012 must have 15 years of service in order to be eligible for the plan's explicit subsidies, unless they retire through the disability retirement.

Section 3: Supporting Information

Benefit Types:	Non-Medicare retirees are eligible for medical and prescription drug benefits via four separate health plan options. Premiums for non-Medicare retirees vary based on date of hire, date of retirement, and years of service. Medicare retirees are eligible for medical and prescription drug benefits through the Exchange. Medicare retirees hired before January 1, 2012 are eligible for a monthly Exchange HRA contribution of $195 if retired prior to January 1, 1994, or $13 per year of service, up to a maximum of 20 years of service if retired on or after January 1, 1994. Retirees and spouses who are over the age of 65 can maintain their healthcare coverage on a non-Exchange plan until the younger spouse reaches the age of 65. In addition, retirees over the age of 65 who are not eligible for free Part A coverage are allowed to stay on a non-Exchange health plan. In these situations, the retiree contribution for a retired member who is over the age of 65 is reduced by the Part B premium credit. The Part B reimbursement is not provided to spouses who are over the age of 65. Enrollment in Medicare Part B is required for retirees who are over the age of 65. Retirees over the age of 65 who are eligible for free Medicare Part A are required to enroll in Medicare Part A and a health plan offered by the Medicare Exchange.
Duration of Coverage:	Until both the retiree and spouse become Medicare-eligible, whereupon they will move to the Exchange. Certain retirees over age 65 are not eligible for Medicare Part A. Lifetime benefits are provided to members hired prior to January 1, 2012.
Dependent Coverage:	Benefits are available for dependents. However, beneficiaries and spouses do not receive any Exchange benefits. Couples can remain on a non-Medicare plan until the younger spouse reaches age 65. A member who is older than 65 and has a spouse who is younger than 65 is required to enroll in Medicare. The plan will pay secondary to Medicare and will reimburse the member $135.10 for the Medicare Part B premium. Surviving spouses of retirees, and surviving spouses of active employees who had at least 10 years of service, are allowed to maintain their health coverage to age 65, but are required to pay the full blended premiums.
Life Insurance	Any retiree with retiree health insurance coverage, either through the CDHP PPO, LD PPO, EPO, HMO or Medicare Exchange is provided a basic life insurance benefit of $12,500 free of charge. Retirees can purchase additional coverage at their own expense.
Dental Contribution	Dental coverage is included with health benefits (no separate dental premium) for participants that have not moved to the Exchange. Dental coverage is available to retirees who are on the Medicare Exchange, but the dental premiums are separate from the medical premiums. The plan year 2022/23 monthly dental premium for State retirees who are enrolled in the Medicare Exchange was $47.61. Exchange retirees have the option of using their HRA funds towards dental premiums.
Part B Reimbursement	Retirees who are over the age of 65 and continue to have health care coverage on the CDHP PPO, LD PPO, EPO, or HMO are required to enroll in Medicare Part B. In addition to the base explicit subsidy and the service-based explicit subsidies, these retirees also received a monthly Part B premium credit/reimbursement of $135.50 in plan year 2022/23. Spouses and surviving spouses are not eligible for the Part B reimbursement.

Section 3: Supporting Information

Retiree Contributions:

Retiree and spouse contribution rates are periodically reset by the PEBP. The monthly contributions shown below were effective from July 1, 2022 through June 30, 2023. Employees hired on or after January 1, 2012, or hired between January 1, 2010 and January 1, 2012 with less than 15 years of service, as well as all surviving spouses, are required to pay the plan's overall blended premium rates for coverage.

	CDHP PPO	LD PPO	EPO/ HMO
Retiree	$241.26	$262.44	$355.30
Retiree + Spouse	588.96	631.34	817.06
Surviving Spouse	670.83	691.98	779.47
Base Explicit Subsidy Retiree	429.57	429.54	424.17
Base Explicit Subsidy Spouse	317.64	317.61	312.24

Service-based adjustments are applied to the CDHP PPO, LD PPO, EPO, and HMO premiums as follows. These service-based adjustments do not apply to spouses, surviving spouses, or employees hired on or after January 1, 2012.

Years of Service	Change in Premium ($)	Years of Service	Change in Premium ($)
5	+373.50	13	+74.70
6	+336.15	14	+37.35
7	+298.80	15	0
8	+261.45	16	-37.35
9	+224.10	17	-74.70
10	+186.75	18	-112.05
11	+149.40	19	-149.40
12	+112.05	20+	-186.75

Plan Changes since Prior Valuation:

The Medicare Exchange HRA benefit for participants who retired prior to January 1, 1994 increased from $180 per month to $195 per month. The monthly Medicare Exchange HRA benefit for participants who retired on or after January 1, 1994 increased from $12 to $13 per year of service.

Note: this change was effective July 1, 2020, but had not yet been reflected in prior GASB 75 valuations.

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Appendix A: Definition of Terms

Definitions of certain terms as they are used in Statement 75. The terms may have different meanings in other contexts.

Actuarially Determined Contribution:	A target or recommended contribution to an OPEB plan for the reporting period based on the most recent measurement available.
Assumptions or Actuarial Assumptions:	The estimates on which the cost of the Plan is calculated including: a) Investment return — the rate of investment yield that the Plan will earn over the long-term future; b) Mortality rates — the death rates of employees and pensioners; life expectancy is based on these rates; c) Retirement rates — the rate or probability of retirement at a given age; d) Turnover rates — the rates at which employees of various ages are expected to leave employment for reasons other than death, disability, or retirement.
Covered Payroll:	The payroll of the employees that are provided OPEB benefits
Discount Rate:	The single rate of return, that when applied to all projected benefit payments results in an actuarial present value that is the sum of the following: 1) the actuarial present value of projected benefit payments projected to be funded by plan assets using a long term rate of return, and 2) the actuarial present value of projected benefit payments that are not included in (1) using a yield or index rate for 20 year tax exempt general obligation municipal bonds with an average rating of AA/Aa or higher
Entry Age Actuarial Cost Method:	An actuarial cost method where the present value of the projected benefits for an individual is allocated on a level basis over the earnings or service of the individual between entry age and assumed exit age
Healthcare Cost Trend Rates:	The rate of change in per capita health costs over time
Net OPEB Liability:	The Total OPEB Liability less the Plan Fiduciary Net Position
Plan Fiduciary Net Position:	Market Value of Assets
Real Rate of Return:	The rate of return on an investment after removing inflation
Service Cost:	The amount of contributions required to fund the benefit allocated to the current year of service.
Total OPEB Liability:	Present value of all future benefit payments for current retirees and active employees taking into account assumptions about demographics, turnover, mortality, disability, retirement, health care trends, and other actuarial assumptions.
Valuation Date:	The date at which the actuarial valuation is performed

Appendix B: Accounting Requirements

The Governmental Accounting Standards Board (GASB) issued Statement Number 74 – Financial Reporting for Postemployment Benefit Plans Other Than Pension Plans, and Statement Number 75 – Accounting and Financial Reporting by Employers for Postemployment Benefits Other Than Pensions. Under these statements, all state and local government entities that provide other post-employment benefits are required to report the cost of these benefits on their financial statements. The accounting standards supplement cash accounting, under which the expense for postemployment benefits is equal to benefit and administrative costs paid on behalf of retirees and their dependents (i.e., a pay-as-you-go basis).

The statements cover postemployment benefits of medical, prescription drugs, dental, vision and life insurance coverage for retirees; long-term care coverage, life insurance and death benefits that are *not* offered as part of a pension plan; and long-term disability insurance for employees. The benefits valued in this report are limited to those described in Exhibit III of Section 3, which are based on those provided under the terms of the substantive plan in effect at the time of the valuation and on the pattern of sharing costs between the employer and plan members. The projection of benefits is not limited by legal or contractual limits on funding the plan unless those limits clearly translate into benefit limits on the substantive plan being valued.

The new standards prescribe an accrual-basis accounting requirement, thereby recognizing the employer cost of postemployment benefits over an employee's career. The standards also prescribe a consistent accounting requirement for both pension and non-pension benefits.

The total cost of providing postemployment benefits is projected, taking into account assumptions about demographics, turnover, mortality, disability, retirement, health care trends, and other actuarial assumptions. These assumptions are summarized in Exhibit II of Section 3. This amount is then discounted to determine the Total OPEB Liability. The Net OPEB Liability (NOL) is the difference between the Total OPEB Liability and market value of assets in the Plan, called the Plan Fiduciary Net Position.

Once the NOL is determined, the Annual OPEB Expense is determined as the change in NOL from the prior year with deferred recognition of certain elements. In addition, Required Supplementary Information (RSI) must be reported, including historical information about the Net OPEB Liability and the contributions made to the Plan. Appendix A of Section 3 contains a definition of terms.

The calculation of an accounting obligation does not, in and of itself, imply that there is any legal liability to provide the benefits valued, nor is there any implication that the Employer is required to implement a funding policy to satisfy the projected expense.

Actuarial calculations reflect a long-term perspective, and the methods and assumptions use techniques designed to reduce short-term volatility in accrued liabilities and the actuarial value of assets, if any.

Actuarial valuations involve estimates of the value of reported amounts and assumptions about the probability of events far into the future, and the actuarially determined amounts are subject to continual revision as actual results are compared to past expectations and new estimates are made about the future.

Appendix C: Employer Level Reporting

State of Nevada
Schedule of Employer Allocations
For the Fiscal Year Ending June 30, 2023

Employer ID	Employer	Retiree Trust Contribution Amount (a)	Allocation Percentage (b)	Benefits Not Paid by Retiree Trust (c)	Total Employer Contribution (a) + (c)
101	Board of Medical Examiners	$ 61,113	0.1542%	$ 22,143	$ 83,256
102	Nevada State Board of Nursing	43,293	0.1093%	15,694	58,987
103	Board of Pharmacy	49,482	0.1249%	17,934	67,416
104	Board of Chiropractors	2,652	0.0067%	962	3,614
105	Board of Dental Examiners	13,562	0.0342%	4,911	18,473
106	Legislative Counsel Bureau	510,427	1.2883%	184,988	695,415
108	Board of Osteopathic Medicine	5,498	0.0139%	1,996	7,494
109	Boad of Massage Therapist	6,212	0.0157%	2,254	8,466
111	Funeral and Cemetery Board	4,171	0.0105%	1,508	5,679
113	Public Employee Retirement System	108,322	0.2734%	39,258	147,580
116	Central Payroll	20,534,508	51.8271%	7,441,897	27,976,405
118	NDOT	2,132,862	5.3831%	772,964	2,905,826
128	Board of Accountancy	6,124	0.0155%	2,226	8,350
129	Board of Cosmetology	24,689	0.0623%	8,946	33,635
134	Board of Professional Engineers	8,534	0.0215%	3,087	11,621
139/140	UNLV/UNR	16,069,214	40.5571%	5,823,628	21,892,842
141	Board of Architecture	6,937	0.0175%	2,513	9,450
146	Board of Examiners for Social Workers	5,049	0.0127%	1,824	6,873
147	Liquefied Petroleum Gas Board	5,105	0.0129%	1,852	6,957
148	Board of Optometry	3,061	0.0077%	1,106	4,167
149	Board of Veterinary Examiners	3,802	0.0096%	1,378	5,180
150	Board of Examiners - Alcohol, Drugs, & Gambling	1,924	0.0049%	704	2,628
171	Nevada Physical Therapy Board	4,358	0.0110%	1,579	5,937
172	Private Investigators Licensing Board	7,543	0.0190%	2,728	10,271
173	Board of Examiners for Marriage Family Therapists & Clinical Prof Councelors	2,562	0.0065%	933	3,495
174	Nevada of Applied Behavior Analysis Board	204	0.0005%	72	276
Total		$ 39,621,208	100.0000%	$ 14,359,085	$ 53,980,293

Notes:

Per GASB 75, employer contributions include trust contributions and benefits paid by the employer with its own assets.
The $14,359,085 in benefits not paid by the retiree trust equals the difference between $64,012,286 in benefit payments and $49,653,201 in deductions from the retiree trust.
The participating employers financed the $14,359,085 differennce via premiums they pay for active employees.
The amounts in column (c) represent cash payments made on behalf of active employees, that should be reclassified as payments towards retiree healthcare benefits.
Column (c) is conceptually similar to the Implicit Subsidy estimates provided in the past.
The allocation percentages in column (b) are used to allocate the amounts in column (c) and are based on the retiree trust contribution amounts in column (a).

Section 3: Supporting Information

State of Nevada
Schedule of Deferred Inflows / Outflows by Employer
For the Fiscal Year Ending June 30, 2023

		Deferred Outflow of Resources					Deferred Inflow of Resources				
Employer ID	Net OPEB Liability	Changes in proportion and difference between employer's contributions and proportionate share of contributions	Liability Experience	Assumption Changes	Asset Experience	Total	Changes in proportion and difference between employer's contributions and proportionate share of contributions	Liability Experience	Assumption Changes	Asset Experience	Total
101	$ 2,223,884	$ -	$ -	$ 31,598	$ -	$ 31,598	$ -	$ 41,741	$ 184,784	$ 675	$ 227,200
102	1,576,333	-	-	22,397	-	22,397	-	29,587	130,979	478	161,044
103	1,801,317	-	-	25,594	-	25,594	-	33,809	149,673	547	184,029
104	96,628	-	-	1,373	-	1,373	-	1,814	8,029	29	9,872
105	493,235	-	-	7,008	-	7,008	-	9,258	40,983	150	50,391
106	18,579,962	-	-	263,990	-	263,990	-	348,731	1,543,823	5,637	1,898,191
108	200,467	-	-	2,848	-	2,848	-	3,763	16,657	61	20,481
109	226,427	-	-	3,217	-	3,217	-	4,250	18,814	69	23,133
111	151,432	-	-	2,152	-	2,152	-	2,842	12,583	46	15,471
113	3,942,996	-	-	56,023	-	56,023	-	74,007	327,626	1,196	402,829
116	747,454,445	-	-	10,620,053	-	10,620,053	-	14,029,136	62,106,548	226,782	76,362,466
118	77,635,485	-	-	1,103,068	-	1,103,068	-	1,457,157	6,450,790	23,555	7,931,502
128	223,542	-	-	3,176	-	3,176	-	4,196	18,574	68	22,838
129	898,495	-	-	12,766	-	12,766	-	16,864	74,657	273	91,794
134	310,075	-	-	4,406	-	4,406	-	5,820	25,764	94	31,678
139/140	584,917,633	-	-	8,310,682	-	8,310,682	-	10,978,447	48,601,243	177,468	59,757,158
141	252,386	-	-	3,586	-	3,586	-	4,737	20,971	77	25,785
146	183,160	-	-	2,602	-	2,602	-	3,438	15,219	56	18,713
147	186,045	-	-	2,643	-	2,643	-	3,492	15,459	56	19,007
148	111,050	-	-	1,578	-	1,578	-	2,084	9,227	34	11,345
149	138,452	-	-	1,967	-	1,967	-	2,599	11,504	42	14,145
150	70,668	-	-	1,004	-	1,004	-	1,326	5,872	21	7,219
171	158,643	-	-	2,254	-	2,254	-	2,978	13,182	48	16,208
172	274,019	-	-	3,893	-	3,893	-	5,143	22,768	83	27,994
173	93,744	-	-	1,332	-	1,332	-	1,759	7,789	28	9,576
174	7,211	-	-	102	-	102	-	135	599	2	736
Total	$ 1,442,207,734	$ -	$ -	$ 20,491,312	$ -	$ 20,491,312	$ -	$ 27,069,113	$ 119,834,117	$ 437,575	$ 147,340,805

Section 3: Supporting Information

State of Nevada
Schedule of GASB 75 Expense by Employer
For the Fiscal Year Ending June 30, 2023

	GASB 75 Expense								
						Amortization of Unrecognized (Gain)/Loss			
Employer ID	Service Cost	Interest Cost	Expected Inv. Return	Administrative Expenses	Plan Changes	Liability Experience	Asset Experience	Assumption Changes	Total
101	$ 81,224	$ 51,994	$ 579	$ -	$ 59,529	$ (39,796)	$ (12,701)	$ (330)	$ 140,499
102	57,574	36,854	409	-	42,196	(28,209)	(9,002)	(231)	99,591
103	65,791	42,114	468	-	48,218	(32,235)	(10,287)	(264)	113,805
104	3,529	2,259	25	-	2,587	(1,729)	(552)	(14)	6,105
105	18,015	11,532	128	-	13,203	(8,827)	(2,817)	(72)	31,162
106	678,613	434,390	4,826	-	497,355	(332,495)	(106,108)	(2,728)	1,173,853
108	7,322	4,687	52	-	5,366	(3,587)	(1,145)	(29)	12,666
109	8,270	5,294	59	-	6,061	(4,052)	(1,293)	(33)	14,306
111	5,531	3,540	39	-	4,054	(2,710)	(865)	(22)	9,567
113	144,014	92,185	1,024	-	105,547	(70,561)	(22,518)	(579)	249,112
116	27,299,954	17,475,108	194,142	-	20,008,107	(13,375,951)	(4,268,633)	(109,751)	47,222,976
118	2,835,551	1,815,078	20,165	-	2,078,172	(1,389,313)	(443,368)	(11,399)	4,904,886
128	8,165	5,226	58	-	5,984	(4,000)	(1,277)	(33)	14,123
129	32,817	21,006	233	-	24,051	(16,079)	(5,131)	(132)	56,765
134	11,325	7,249	81	-	8,300	(5,549)	(1,771)	(46)	19,589
139/140	21,363,475	13,675,079	151,925	-	15,657,268	(10,467,300)	(3,340,402)	(85,885)	36,954,160
141	9,218	5,901	66	-	6,756	(4,517)	(1,441)	(37)	15,946
146	6,690	4,282	48	-	4,903	(3,278)	(1,046)	(27)	11,572
147	6,795	4,350	48	-	4,980	(3,329)	(1,062)	(27)	11,755
148	4,056	2,596	29	-	2,973	(1,987)	(634)	(16)	7,017
149	5,057	3,237	36	-	3,706	(2,478)	(791)	(20)	8,747
150	2,581	1,652	18	-	1,892	(1,265)	(404)	(10)	4,464
171	5,794	3,709	41	-	4,247	(2,839)	(906)	(23)	10,023
172	10,008	6,406	71	-	7,335	(4,904)	(1,565)	(40)	17,311
173	3,424	2,192	24	-	2,509	(1,678)	(535)	(14)	5,922
174	263	169	2	-	193	(129)	(41)	(1)	456
Total	$ 52,675,056	$ 33,718,089	$ 374,596	$ -	$ 38,605,492	$ (25,808,797)	$ (8,236,295)	$ (211,763)	$ 91,116,378

Section 3: Supporting Information

State of Nevada
Schedule of Total OPEB Liability by Employer
For the Fiscal Year Ending June 30, 2023

	Total OPEB Liability (TOL)									
Employer ID	Service Cost	Interest Cost	Benefit Changes	Liability Experience	Assumption Changes	Benefit Payments	Changes in Proportion*	Net Changes	TOL (Beginning)	TOL (Ending)
101	$ 81,224	$ 51,994	$ 59,529	$ (29,783)	$ (246,317)	$ (98,707)	$ 186,243	$ 4,183	$ 2,188,716	$ 2,192,899
102	57,574	36,854	42,196	(21,112)	(174,594)	(69,965)	52,193	(76,854)	1,631,226	1,554,372
103	65,791	42,114	48,218	(24,125)	(199,513)	(79,951)	120,815	(26,651)	1,802,873	1,776,222
104	3,529	2,259	2,587	(1,294)	(10,702)	(4,289)	1,537	(6,373)	101,655	95,282
105	18,015	11,532	13,203	(6,606)	(54,631)	(21,892)	149,846	109,467	376,896	486,363
106	678,613	434,390	497,355	(248,843)	(2,057,910)	(824,670)	1,882,481	361,416	17,959,692	18,321,108
108	7,322	4,687	5,366	(2,685)	(22,204)	(8,898)	(19,848)	(36,260)	233,934	197,674
109	8,270	5,294	6,061	(3,033)	(25,079)	(10,050)	(14,248)	(32,785)	256,057	223,272
111	5,531	3,540	4,054	(2,028)	(16,773)	(6,721)	8,814	(3,583)	152,905	149,322
113	144,014	92,185	105,547	(52,809)	(436,725)	(175,010)	171,400	(151,398)	4,039,460	3,888,062
116	27,299,954	17,475,108	20,008,107	(10,010,722)	(82,787,803)	(33,175,711)	(9,429,098)	(70,620,165)	807,661,140	737,040,975
118	2,835,551	1,815,078	2,078,172	(1,039,779)	(8,598,880)	(3,445,845)	(634,218)	(6,989,921)	83,543,795	76,553,874
128	8,165	5,226	5,984	(2,994)	(24,759)	(9,922)	(647)	(18,947)	239,375	220,428
129	32,817	21,006	24,051	(12,034)	(99,517)	(39,880)	(137,753)	(211,310)	1,097,288	885,978
134	11,325	7,249	8,300	(4,153)	(34,344)	(13,763)	(734)	(26,120)	331,875	305,755
139/140	21,363,475	13,675,079	15,657,268	(7,833,852)	(64,785,280)	(25,961,527)	7,104,469	(40,780,368)	617,548,980	576,768,612
141	9,218	5,901	6,756	(3,380)	(27,954)	(11,202)	20,939	278	248,592	248,870
146	6,690	4,282	4,903	(2,453)	(20,287)	(8,130)	3,428	(11,567)	192,176	180,609
147	6,795	4,350	4,980	(2,492)	(20,606)	(8,258)	13,746	(1,485)	184,938	183,453
148	4,056	2,596	2,973	(1,487)	(12,300)	(4,929)	805	(8,286)	117,789	109,503
149	5,057	3,237	3,706	(1,854)	(15,335)	(6,145)	6,959	(4,375)	140,898	136,523
150	2,581	1,652	1,892	(946)	(7,827)	(3,137)	(2,757)	(8,542)	78,226	69,684
171	5,794	3,709	4,247	(2,125)	(17,571)	(7,041)	115,180	102,193	54,240	156,433
172	10,008	6,406	7,335	(3,670)	(30,350)	(12,162)	292,635	270,202	-	270,202
173	3,424	2,192	2,509	(1,256)	(10,383)	(4,161)	100,112	92,437	-	92,437
174	263	169	193	(97)	(799)	(320)	7,702	7,111	-	7,111
Total	$ 52,675,056	$ 33,718,089	$ 38,605,492	$ (19,315,612)	$ (159,738,443)	$ (64,012,286)	$ 1	$ (118,067,703)	$ 1,540,182,726	$ 1,422,115,023

* Total changes in proportionate shares sums to 1 because the total beginning of year TOL was $1 lower than actual TOL.

Section 3: Supporting Information

State of Nevada
Schedule of Plan Fiduciary Net Position by Employer
For the Fiscal Year Ending June 30, 2023

	Total Plan Fiduciary Net Position (PFNP)							
Employer ID	Employer Contributions	Investment Experience	Benefit Payments	Administrative Expenses	Changes in Proportion*	Net Changes	PFNP (Beginning)	PFNP (Ending)
101	$ 83,256	$ (143)	$ (98,707)	$ -	$ (1,226)	$ (16,820)	$ (14,165)	$ (30,985)
102	58,987	(102)	(69,965)	-	(324)	(11,404)	(10,557)	(21,961)
103	67,416	(116)	(79,951)	-	(776)	(13,427)	(11,668)	(25,095)
104	3,614	(6)	(4,289)	-	(7)	(688)	(658)	(1,346)
105	18,473	(32)	(21,892)	-	(982)	(4,433)	(2,439)	(6,872)
106	695,415	(1,197)	(824,670)	-	(12,170)	(142,622)	(116,232)	(258,854)
108	7,494	(13)	(8,898)	-	138	(1,279)	(1,514)	(2,793)
109	8,466	(15)	(10,050)	-	101	(1,498)	(1,657)	(3,155)
111	5,679	(10)	(6,721)	-	(68)	(1,120)	(990)	(2,110)
113	147,580	(254)	(175,010)	-	(1,107)	(28,791)	(26,143)	(54,934)
116	27,976,405	(48,142)	(33,175,711)	-	61,038	(5,186,410)	(5,227,060)	(10,413,470)
118	2,905,826	(5,000)	(3,445,845)	-	4,091	(540,928)	(540,683)	(1,081,611)
128	8,350	(14)	(9,922)	-	21	(1,565)	(1,549)	(3,114)
129	33,635	(58)	(39,880)	-	888	(5,415)	(7,102)	(12,517)
134	11,621	(20)	(13,763)	-	(10)	(2,172)	(2,148)	(4,320)
139/140	21,892,842	(37,673)	(25,961,527)	-	(45,980)	(4,152,338)	(3,996,683)	(8,149,021)
141	9,450	(16)	(11,202)	-	(139)	(1,907)	(1,609)	(3,516)
146	6,873	(12)	(8,130)	-	(38)	(1,307)	(1,244)	(2,551)
147	6,957	(12)	(8,258)	-	(82)	(1,395)	(1,197)	(2,592)
148	4,167	(7)	(4,929)	-	(16)	(785)	(762)	(1,547)
149	5,180	(9)	(6,145)	-	(43)	(1,017)	(912)	(1,929)
150	2,628	(5)	(3,137)	-	36	(478)	(506)	(984)
171	5,937	(10)	(7,041)	-	(745)	(1,859)	(351)	(2,210)
172	10,271	(18)	(12,162)	-	(1,908)	(3,817)	-	(3,817)
173	3,495	(6)	(4,161)	-	(635)	(1,307)	-	(1,307)
174	276	-	(320)	-	(56)	(100)	-	(100)
Total	$ 53,980,293	$ (92,890)	$ (64,012,286)	$ -	$ 1	$ (10,124,882)	$ (9,967,829)	$ (20,092,711)

* Total changes in proportionate shares sums to 1 because the total beginning of year PFNP was $1 lower than actual PFNP.

Section 3: Supporting Information

State of Nevada
Schedule of Discount Rate and Health Care Cost Trend Sensitivity by Employer
For the Fiscal Year Ending June 30, 2023

	Net OPEB Liability			Net OPEB Liability		
Employer ID	1% Decrease (2.54%)	Current Discount Rate (3.54%)	1% Increase (4.54%)	1% Decrease in Health Care Cost Trend Rates	Current Health Care Cost Trend Rates	1% Increase in Health Care Cost Trend Rates
101	$ 2,445,475	$ 2,223,884	$ 2,032,040	$ 2,116,368	$ 2,223,884	$ 2,347,003
102	1,733,400	1,576,333	1,440,350	1,500,123	1,576,333	1,663,602
103	1,980,802	1,801,317	1,645,926	1,714,230	1,801,317	1,901,042
104	106,256	96,628	88,292	91,956	96,628	101,977
105	542,381	493,235	450,686	469,389	493,235	520,542
106	20,431,287	18,579,962	16,977,155	17,681,688	18,579,962	19,608,588
108	220,442	200,467	183,174	190,775	200,467	211,565
109	248,988	226,427	206,894	215,480	226,427	238,962
111	166,521	151,432	138,368	144,111	151,432	159,815
113	4,335,880	3,942,996	3,602,852	3,752,366	3,942,996	4,161,288
116	821,931,504	747,454,445	682,975,009	711,317,695	747,454,445	788,835,085
118	85,371,157	77,635,485	70,938,231	73,882,087	77,635,485	81,933,547
128	245,816	223,542	204,258	212,735	223,542	235,918
129	988,022	898,495	820,986	855,056	898,495	948,238
134	340,971	310,075	283,326	295,084	310,075	327,241
139/140	643,199,373	584,917,633	534,459,496	556,638,957	584,917,633	617,299,896
141	277,534	252,386	230,614	240,184	252,386	266,359
146	201,411	183,160	167,360	174,305	183,160	193,301
147	204,582	186,045	169,996	177,050	186,045	196,345
148	122,115	111,050	101,470	105,681	111,050	117,198
149	152,247	138,452	126,508	131,758	138,452	146,117
150	77,710	70,668	64,572	67,252	70,668	74,581
171	174,450	158,643	144,957	150,973	158,643	167,426
172	301,323	274,019	250,381	260,772	274,019	289,190
173	103,084	93,744	85,657	89,211	93,744	98,933
174	7,930	7,211	6,589	6,862	7,211	7,610
Total	$ 1,585,910,661	$ 1,442,207,734	$ 1,317,795,147	$ 1,372,482,148	$ 1,442,207,734	$ 1,522,051,369

State of Nevada
Schedule of Deferred Inflows / Outflows Recognition by Employer
For the Fiscal Year Ending June 30, 2023

	Amounts to be Recognized in Deferred Inflows/Outflows				
Employer ID	Year-End 06/30/2024	Year-End 06/30/2025	Year-End 06/30/2026	Year-End 06/30/2027	Year-End 06/30/2028
101	$ (57,849)	$ (69,593)	$ (68,072)	$ (87)	$ -
102	(41,006)	(49,328)	(48,251)	(62)	-
103	(46,859)	(56,369)	(55,137)	(70)	-
104	(2,514)	(3,024)	(2,958)	(4)	-
105	(12,831)	(15,435)	(15,098)	(19)	-
106	(483,329)	(581,426)	(568,720)	(726)	-
108	(5,215)	(6,273)	(6,136)	(8)	-
109	(5,890)	(7,086)	(6,931)	(9)	-
111	(3,939)	(4,739)	(4,635)	(6)	-
113	(102,571)	(123,389)	(120,693)	(154)	-
116	(19,443,888)	(23,390,238)	(22,879,088)	(29,200)	-
118	(2,019,569)	(2,429,462)	(2,376,371)	(3,033)	-
128	(5,815)	(6,995)	(6,842)	(9)	-
129	(23,373)	(28,117)	(27,502)	(35)	-
134	(8,066)	(9,703)	(9,491)	(12)	-
139/140	(15,215,740)	(18,303,942)	(17,903,943)	(22,850)	-
141	(6,565)	(7,898)	(7,725)	(10)	-
146	(4,765)	(5,732)	(5,606)	(7)	-
147	(4,840)	(5,822)	(5,695)	(7)	-
148	(2,889)	(3,475)	(3,399)	(4)	-
149	(3,602)	(4,333)	(4,238)	(5)	-
150	(1,838)	(2,211)	(2,163)	(3)	-
171	(4,127)	(4,964)	(4,856)	(6)	-
172	(7,128)	(8,575)	(8,388)	(11)	-
173	(2,439)	(2,934)	(2,869)	(4)	-
174	(188)	(226)	(221)	-	-
Total	$ (37,516,835)	$ (45,131,289)	$ (44,145,028)	$ (56,341)	$ -

5.

5. Discussion regarding the status of the recruitment and permanent appointment of the PEBP Executive Officer. (Jack Robb, Board Chair) (Information/Discussion)

6.

6. Election of Board Vice-Chair pursuant to Nevada Administrative Code (NAC) 287.172. Eligible candidates are April Caughron, Betsy Aiello, Michelle Kelley, Jim Barnes, Leslie Bittleston, Janell Woodward and Jennifer McClendon. (Jack Robb, Board Chair) (**For Possible Action**)

7.

7. Executive Officer Report (Celestena Glover, Interim Executive Officer) (Information/Discussion)

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

CELESTENA GLOVER
Interim Executive Officer

JACK ROBB
Board Chair

AGENDA ITEM

☐ Action Item

☒ Information Only

Date: July 27, 2023

Item Number: VII

Title: Executive Officer Report

Summary

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

Report

Legislative Update:

The 82nd Legislative Session ended on Monday, June 5, 2023, and two subsequent special sessions were called. During the regular session several bills were passed that will have some impact on PEBP. The details of which will be included in agenda item 8.

Open Enrollment Update:

A little over 6800 members made open enrollment selections which is consistent with the number of previous years activity. PEBP took a total of 4,582 calls to assist members with questions and/or issues with open enrollment and password resets. As illustrated in the migration chart below, members migrated largely from the CDHP to the LD plan.

PLAN	PY 2023	PY 2024
CDHP	16,120	14,782
LD	7,741	9,135
EPO	3,353	3,150
HMO	3,553	3,532
Dental	9,173	9,100
Declined	2,496	2,525

Note: Count reflects primary members only.

Voluntary Benefits Update:

PEBP received word from Corestream, the voluntary benefits administrator, on June 14, 2023, stating that they incorrectly calculated rates for those enrolled in Long Term Disability for Plan Year 2023. The error was caused by utilizing the benefit amount rather than the employee salary amount and affected approximately 874 participants. To correct the error, Corestream worked with the Standard to develop a plan to recoup the underpaid premiums. The following steps were agreed upon to mitigate the impact to those affected by this error.

- Corestream will spread the required collection of back premiums over the final 6-months of calendar year 2023 (July through December) to lessen the financial impact.
- Exceptions will be employees who were insured for a shorter period and therefore have smaller balances to recoup - those premiums will be collected more quickly.
- Corestream will send notices via email to those employees explaining the steps to be taken and their options.
    - PEBP staff reviewed the suggested communications and provided final approval for Corestream to begin sending emails to PEBP members affected by this error. Participants will receive the initial notification, and a reminder around mid to end of July.
- Participants will be given the option of canceling their coverage effective June 30, 2023, and will not be subject to the collection of past due premiums. The deadline for canceling their coverage is July 31, 2023. Cancelation notices will automatically be sent to those employees that choose this option.
- Employees will be directed to call Corestream directly with any questions related to this issue.

Staffing

Staffing at PEBP, as with other state agencies, continues to be a challenge. Further challenges are result of the recent transition from the previous HR software (Success Factors) to the legacy system (NEATS) which delayed the posting of recruitments for vacant positions around the state during the month of June and early July. However, we are now seeing those recruitments being posted in NEATS. In addition, during the month of June PEBP was able to fill the following vacant positions:

- Executive Assistant - Jessica Crane
- Chief Financial Officer – Michelle Weyland (internal promotion)
- Eligibility Supervisor – Wendi Lunz (internal promotion)

Recruitments for other vacant positions is ongoing and PEBP will be reviewing applications as those recruitments close. PEBP's current vacancy rates is around 30%.

8.

8. Legislative Tracking Report. Discussion regarding legislation passed during the 82nd Legislative Session, 2023. (Celestena Glover, Interim Executive Officer)
(Information/Discussion)

JOE LOMBARDO
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CELESTENA GLOVER
Interim Executive Officer

JACK ROBB
Board Chair

AGENDA ITEM

☐ Action Item

☒ Information Only

Date: July 27, 2023

Item Number: VIII

Title: Legislative Tracking Report

This report provides an update to legislation passed during the 82nd Legislative Session, 2023.

1,229 Bill Draft Requests (BDRs) were submitted during the 2023 session of which PEBP tracked a total of 194. Ultimately, 17 bills were passed and are believed to have an impact on PEBP.

Bills That May Impact the Master Plan Documents

This is a brief summary of bills that may or have impacted the PEBP Master Plan Documents (MPD) which have been updated accordingly.

AB 155
Establishes provisions relating to biomarker testing.

- Section 27 of this bill amends by requiring a managed care organization that issues a health care plan shall include in the plan coverage for medically necessary biomarker testing for the diagnosis, treatment, appropriate management and ongoing monitoring of cancer when such biomarker testing is supported by medical and scientific evidences.

Note: Biomarker testing already allowed in PEBP plans for medical necessity; therefore, no changes to the MPD were needed.

Section 27 of this bill becomes effective upon passage and approval for the purpose of adopting any regulations and performing any other preparatory administrative tasks that are necessary to carry out the provisions of this act; and on October 1, 2023, for all other purposes.

AB 156

Revises provisions relating to substance use disorders.

- Section 4.5 amends NRS 287.04335 to require the board to comply with the provisions of the applicable NRS as well as section 16.9 of AB 156.

- Section 16.9 of this bill amends NRS 695G coverage for all drugs approved by the United States Food and Drug Administration to provide medication-assisted treatment for opioid use disorder, and exempts drugs from medical management techniques other than step therapy.

  Note: "Medical management technique" is defined as a practice used to control the cost or use of health care services or prescription drugs. The term includes without limitation, the use of step therapy, prior authorization and categorizing drugs and devices based on cost, type or method of administration.

Sections 4.5 and 16.9 of AB 156 becomes effective upon passage and approval for the purpose of adopting any regulations and performing any other preparatory administrative tasks that are necessary to carry out the provisions of this action; and on January 1, 2024, for all other purposes.

SB 163

Requires certain health insurance to cover treatment of certain conditions relating to gender dysphoria and gender incongruence.

- Section 10.8 of this bill amends NRS 695G by adding provisions as set forth in sections 11 and 11.6

- Section 11 requires managed care organization that issues a health care plan shall include in the health care plan coverage for the medically necessary treatment of conditions relating to gender dysphoria and gender incongruence. Such coverage must include coverage of medically necessary psychosocial and surgical intervention and any other medically necessary treatment for such disorders.

  Note: This section provides a listing of healthcare providers to be covered as well as definitions of terms. This section also requires that a managed care organization must consider the most recent Standards of Care prescribed by the World Professional Association for Transgender Health, or its successor organizations.

- Section 11.6 of this bill prohibits discrimination with respect to participation or coverage under the plan on the basis of actual or perceived gender identity or expression.

SB 163 becomes effective on July 1, 2023.

SB 167

Prohibits the imposition of step therapy under certain circumstances.

- Section 12 of this bill amends NRS 695G by adding that a health care plan which provides coverage for prescription drugs must not require an insured to submit to a step therapy protocol before covering a drug approved by the Food and Drug Administration that is prescribed to treat a psychiatric condition'

  Note: Currently, 6,805 members are taking at least one of the 29 impacted drugs. Step therapy exists to keep drug costs down by having patients try less expensive alternatives prior to moving to the more expensive drug. In 37% of cases, patients found the less expensive alternative was effective.

SB 167 becomes effective on July 1, 2023.

SB 280

Revises provisions governing contraception. Requiring a hospital to provide the insertion or injection of certain long-acting reversible contraception if requested by a patient giving birth at a hospital.

- Section 16 of this bill amends NRS 695G.1715 to prohibit medical management techniques for contraception and prohibit refusing contraceptive injections or inserted devices.

SB 280 is effective upon passage and approval for the purpose of adopting any regulations or performing any other preparatory administrative tasks that are necessary to carry out the provisions of this act; and on January 1, 2024, for all other purposes.

SB439

Revises provisions relating to communicable diseases.

- Section 16 of the bill amends NRS 287.04335 to comply with Sections 71 and 72 of the bill.
- Section 71 of the bill requires health plans to cover drugs approved by the United States Food and Drug Administration for medication-assisted treatment for opioid use disorder, support safe withdrawal from substance use disorder and treatment for substance use disorder. Further this section does not allow a managed care organization to utilize medical management techniques, limit the covered amount of a drug or refuse to cover a drug dispensed by a pharmacy through mail order service.
- Section 72 of the bill requires health care plans to cover testing for, treatment of and prevention of sexually transmitted diseases of all insureds regardless of age and condoms for insureds who are 13 years of age or older.

Sections 16, 71 and 72 become effective upon passage and approval for the purpose of adopting any regulations and performing any other preparatory administrative tasks that are necessary to carry out the provisions of this act and on January 1, 2024 for all other purposes.

Bills Continuing Benefits Provided under the Declaration of Emergency for COVID-19

The following bills amends certain provisions provided under the Declaration of Emergency for COVID-19 that were to be no longer required as of July 1, 2023. PEBP plans continues to provide coverage under those provisions, therefore, no additional changes are required to the Master Plan Document.

AB 147

Revises provisions relating to dentistry.

- Section 39 of this bill amends NRS 695G.162 to require health care plans issued by a manage care organization for group coverage to include coverage for services provided to an insured through telehealth to the same extent as though provided in person.

AB 147 is effective upon passage and approval for the purpose of adopting any regulations and performing any other preparatory administrative tasks that are necessary to carry out the provisions of this act; and on January 1, 2024, for all other purposes.

SB 119

Provides for the continuation of certain requirements governing insurance coverage of telehealth services.

Section 1.8 of this bill amends NRS 695G.162 to require health care plans issued by a manage care organization for group coverage to include coverage for services provided to an insured through telehealth to the same extent as though provided in person

Section 1.8 of SB 119 becomes effective on July 1, 2023.

General Administration Bills

AB 7

Revises provisions relating to electronic health records. The bill requires the adoption of a framework for the electronic transmittal, maintenance and exchange of certain health information; requiring governmental entities, health care facilities and providers, insurers and insurance administrators to maintain, transmit and exchange health information electronically.

- Section 1.96 amends NRS 287.04335 to add compliance with the provisions of NRS 439.581 to 439.595 inclusive and Section 1 of the Act.
- Section 2.7 identifies the Executive Officer of PEBP as an ex officio member of the advisory committee to be established by the Director of the Department of Health and Human Services

AB 7 is effective upon passage and approval for the purpose of adopting any regulations and performing any other preparatory administrative tasks that are necessary to carry out the provisions of this act; and on July 1, 2024, for all other purposes.

AB 52

Makes various changes related to the Open Meeting Law.

- Section 2 of the bill amends NRS 241 by adding that if a vacancy occurs in the voting membership of a public body, the necessary quorum and number of votes necessary to take action on a matter is reduced as though the vacancy does not exist.
- Section 3 of the bill requires that a public body shall not consider at a meeting whether to take administrative action against a person unless the public body has given written notice to that person of the time and place of the meeting.
- Section 4 of the bill amends definitions in NRS 241.015 to make clear that a meeting must deliberate to take an action. Defines "Administrative action against a person" and further defines that a gathering of members of a public body at which a quorum is present does not include any gathering or series of gatherings of members of a public body if the members do not deliberate toward a decision or take action on any matter over which the public body has supervision, control, jurisdiction or advisory power.

AB 52 is effective on July 1, 2023.

AB 219

Makes various changes to the Open Meeting Law.

- Section 1 of this bill amends NRS 241 by adding a new section to require public comment to be taken at the beginning of a meeting before any items on which action may be taken are heard by the public body and again before the adjournment of the meeting or after each item on the agenda on which action may be taken is discussed by the public body but before the public body takes action on the item.
- Section 2 of the bill amends NRS 241 by removing the language now reflected in Section 1.

AB 219 is effective on July 1, 2023.

SB 272

Revises provisions relating to governmental administration.

- This bill amends NRS 333 (also Chapters 332, 333A and 338 of NRS) by adding a new section requiring each using agency on or before September 1 of each year, to post the number of contracts awarded during the immediately preceding fiscal year; the total dollar amount of those contracts; and the total number of contracts awarded to minority-owned businesses; women-owned businesses; LGBTQ-owned business or veteran-owned businesses; and the total dollar amount of the contracts awarded to each of those demographic groups.

SB 272 becomes effective on July 1, 2024.

SB 419

Makes revisions relating to public health.

- Section 1 of this bill adds to NRS 439 requiring notice to regulatory bodies if there is an insurance provider not in compliance with this bill. PEBP will have to have certification to contribute to the information exchange.

- Section 29 of this bill amends NRS 287.04335 to add NRS 439.581 to NRS 439.595, inclusive which is regarding Health Information Exchanges and section 1 of the act.

Note: This bill largely applies to DHHS, however should there be electronic data requirements that are imposed on PEBP, PEBP has already built these considerations into current contracts.

SB 419 has numerous sections with varying effective dates. Only those sections affecting PEBP are listed below.

- Section 1 of the bill becomes effective upon passage and approval for the purpose of adopting any regulations and performing any other preparatory administrative tasks that are necessary to carry out the provisions of this act and on July 1, 2024, for all other purposes.
- Section 29 of the bill becomes effective upon passage and approval for the purposes of adopting any regulations and performing any other preparatory administrative tasks that are necessary to carry out the provisions of this act and on July 1, 2025, for all other purposes.

Appropriations and Authorization Bills

SB 501

Establishes for the 2023-2025 biennium the subsidies to be paid to the Public Employees' Benefits Program for insurance for certain active and retired public officers and employees. Sets employer subsidies and Health Reimbursement Arrangement funding for retirees.

SB 501 becomes effective on July 1, 2023.

SB 504

Authorizes expenditures by agencies of the State Government for the 2023-2025 biennium.

SB 504 becomes effective on July 1, 2023.

SB 511

Makes various changes regarding state financial administration and makes appropriations for the support of the civil government of the State. This bill sets supplemental Basic Life Insurance for State active and state retirees as well as provides supplemental funding for active employees on a PEBP plan.

SB 511 becomes effective on July 1, 2023.

9.

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 of January 1, 2023 – March 31, 2023. (Celestena Glover, Interim Executive 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

CELESTENA GLOVER
Interim Executive Officer

JACK ROBB
Board Chair

Date: July 27, 2023

Item Number: IX

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 third 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 $1,237,363.10:

Performance Guarantee	Result	Fees at Risk	Calculated Penalty
1.4 Claim Adjustment Processing Time	NOT MET	1.0%	$12,373.63
1.5 Telephone Service Factor	NOT MET	1.0%	$12,373.63
1.8 Open Inquiry Closure	NOT MET	1.0%	$12,373.63
1.9 CSR Audit	NOT MET	1.0%	$12,373.63
Total		**4.0%**	**$49,494.52**

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 $660,756.00:

Performance Guarantee	Result	Fees at Risk	Calculated Penalty
2.1 EDI Claims Repricing Turnaround Time	NOT MET	2.0%	$13,215.12
Total			**$13,215.12**

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 were no missed performance guarantees for this period.

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	$49,494.52
2. Network Administration	$13,215.12
3. Utilization Management and Case Management	$0.00
Total	**$62,709.64**

The penalties, totaling $62,709.64, are administratively and automatically assessed by PEBP to the vendor. In conjunction with the audited penalties totaling $55,681.34, the calculated penalties for the period ending 03/31/2023 total **$118,390.98.**

Comprehensive Claim Administration Audit

QUARTERLY FINDINGS REPORT

State of Nevada Public Employees' Benefits Program

Administered by UMR Insurance Company

Audit Period: January 1, 2023 – March 31, 2023
Audit Number 1.FY23.Q3

Presented to

State of Nevada Public Employees' Benefits Program

July 27, 2023

CLAIM TECHNOLOGIES INCORPORATED

Proprietary and Confidential

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EXECUTIVE SUMMARY

This ***Quarterly Findings Report*** is a compilation of the detailed information, findings, and conclusions drawn from Claim Technologies Incorporated's (CTI's) audit of UMR Insurance Company's (UMR's) administration of the State of Nevada Public Employees' Benefits Program (PEBP) medical and dental plans.

Scope

CTI performed an audit for the period of January 1, 2023 through March 31, 2023 (quarter 3 (Q3) 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	$60,944,250
Total Number of Claims Paid/Denied/Adjusted	203,718

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 penalties are owed (breakdown in summary below).
2. CTI recommends UMR should:
    - Review the financial errors identified in the random sample audit and determine if system enhancements or claim processor training could help reduce or eliminate errors of a similar nature in the future. Specific focus should be on 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 Q3 FY2023 and penalties are owed. Reported administrative fees for the quarter totaled $1,237,363.10.

Quarterly Metric	Guarantee	Met/Not Met	Penalty	Calculated Penalty
Financial Accuracy (p.14)	99.4%	Not Met – 98.12%	1.5%	$18,560.45
Overall Accuracy (p.15)	98%	Not Met – 97.5%	1%	$12,373.63
Claim Turnaround Time	92% in 14 Days 99% in 30 Days	Not Met – 90.8% Not Met – 93.7%	1% 1%	$12,373.63 $12,373.63
		Total Penalty	4.5%	$55,681.34

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' Benefits Program (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 Q3 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	92.7%	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	83.8%	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%	2.5%	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%	95.4%	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	91.9% 92.6%	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%	96.4%	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	90.32%	Met
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.	95.00%	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	Agree	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.			
	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.).			

	Metric	Service Objective	Actual	Met/ Not Met
	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%	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	95% 100%	Not Met 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%	99.1%	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
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

	Metric	Service Objective	Actual	Met/ Not 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 10 calendar 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	100%	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
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

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

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 ESAS Findings Detail Report shows by category the line items where exceptions were noted. PEBP should work with its TPA, UMR, to examine areas of concern. 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 PEBP can discuss how to reduce errors and re-work in the future with UMR.**

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				
42	$32.00	Agree.	Procedural deficiencies and overpayments identified for duplicate claim payments. Note: Any $0.00 Under/Over Paid amounts indicates an incorrect deductible accumulation occurred.	☐ M ☒ S
43	$0.00			☐ M ☒ S
44	$0.00			☐ M ☒ S
45	$40.00			☐ M ☒ S
46	$71.00			☐ M ☒ S
47	$47.00			☐ M ☒ S
48	$39.00			☐ M ☒ S
49	$62.00			☐ M ☒ S
50	$37.00			☐ M ☒ S
51	$47.00			☐ M ☒ S
52	$62.00			☐ M ☒ S
53	$61.60			☒ M ☐ S
56	$45.00			☐ M ☒ S
57	$26.70			☐ M ☒ S
58	$71.20			☐ M ☒ S
59	$28.00			☐ M ☒ S

ESAS Findings Detail Report				
QID	Under/ Over Paid	UMR Response	CTI Conclusion	Manual or System
60	$70.00			☐ M ☒ S
61	$215.00			☐ M ☒ S
62	$0.00			☐ M ☒ S
63	$0.00			☐ M ☒ S
64	$48.00			☐ M ☒ S
65	$77.00			☐ M ☒ S
66	$46.00			☐ M ☒ S
67	$16.80			☐ M ☒ S
68	$14.40			☐ M ☒ S
69	$50.00			☐ M ☒ S
70	$79.20			☐ M ☒ S
71	$50.00			☐ M ☒ S
72	$61.00			☐ M ☒ S
73	$65.00			☒ M ☐ S
74	$50.00			☐ M ☒ S
75	$50.00			☐ M ☒ S
76	$136.00			☒ M ☐ S
77	$136.30			☒ M ☐ S
80	$270.00			☒ M ☐ S
81	$47.00			☐ M ☒ S
82	$39.00			☐ M ☒ S
83	$62.00			☐ M ☒ S
84	$47.00			☐ M ☒ S
85	$4.80			☐ M ☒ S
86	$0.00			☐ M ☒ S
87	$39.00			☐ M ☒ S
88	$62.00			☐ M ☒ S
89	$47.00			☐ M ☒ S
90	$39.00			☐ M ☒ S
91	$62.00			☐ M ☒ S
92	$56.20			☒ M ☐ S
93	$109.60			☐ M ☒ S
94	$162.52			☒ M ☐ S
95	$36.80			☐ M ☒ S
96	$12.80			☐ M ☒ S
97	$540.80			☐ M ☒ S
98	$47.00			☐ M ☒ S
99	$62.00			☐ M ☒ S
100	$377.60			☐ M ☒ S
Plan Exclusions				
Massage Therapy				

ESAS Findings Detail Report				
QID	**Under/ Over Paid**	**UMR Response**	**CTI Conclusion**	**Manual or System**
133	$50.00	Agree. The claim is pended and reviewed based on Procedure and Diagnosis selections are coded in the UMR system to identify these claims. Massage Therapy is excluded on this plan. This should have been denied.	Procedural deficiency and overpayment remain. Massage therapy was excluded by the plan.	☒ M ☐ S
Limitations				
Pre-Certification for DME in Excess of $1,000				
143	$3,854.40	Agree. No authorization is on file for this DME. The claim was processed in error by analyst. Claim has been sent for adjustment.	Procedural deficiency and overpayment remain. Precertification for DME over $1,000.00 was not performed as required by the plan document.	☒ M ☐ S
Potential Fraud, Waste, and Abuse				
Specialty Medications				
106	$147.50	Agree. Pricing was not properly obtained resulting in a $147.50 overpayment. The claim was reprocessed on 5/5/23 to reflect corrected pricing.	Procedural deficiency and overpayment remain. UMR corrected pricing for incorrect specialty medication allowance on 5/5/23.	☒ M ☐ S
109	$1,045.90	Agree. Claim would be repriced. All therapies and supplies that are not itemized shall be reimbursed at 50% of provider's billed charges for per diems, and at AWP - 10% for pharmaceuticals. Allowable would be 0.76 * 6 units on bill = 4.56 * 90% = 4.10 allowable. Sent for reprocessing.	Procedural deficiency and overpayment remain for incorrect specialty medication allowance.	☒ M ☐ S
UCR Provider Specialty-Pain Specialist				
118	$1,906.48	Agree. Claim was paid without pricing at billed charges. This claim has been reprocessed with pricing obtained on 5/8/23. Overpayment amount is $1,906.48.	Procedural deficiency and overpayment remain; payment was issued with incorrect allowable.	☒ M ☐ S
Durable Medical Equipment Over Medicare Allowance				
103	$131.26	Agree. The Choice Plus fee schedule rate for the rental of E0601 is $43.96. The claim was adjusted on 7/11/23.	Procedural deficiency and overpayment remain. UMR allowed $208.04 for the rental instead of $43.96.	☒ M ☐ S
104	$618.61	Agree. This specific CPT is 90% of the Medicare allowable according to the contract. No manual repricing was done initially so the total amount billed was allowed ($918). Based on my review today the repricing should be as follows: E2622 ALLOWABLE= $299. Sent for reprocessing.	Procedural deficiency and overpayment remain. UMR allowed $918.00 for the rental instead of $299.39.	☒ M ☐ S
Incorrect Copayment				
Office Visit - PCP				
28	$30.00	Agree. Claim should have applied $30 copay for PCP Visit.	Procedural deficiency and overpayment remain. The provider was a family practitioner, and the	☐ M ☒ S

ESAS Findings Detail Report				
QID	**Under/ Over Paid**	**UMR Response**	**CTI Conclusion**	**Manual or System**
			PCP $30.00 copay should have been applied ($0.00 was applied).	
Diagnostic Mammogram				
19	($1.14)	Agree. Claim should have applied $40 copay for diagnostic mammogram.	Procedural deficiency and underpayment remain. Coinsurance instead of a copay was applied to the diagnostic mammogram.	☒ M ☐ S
Speech Therapy				
24	$50.00	Agree. Claim should have applied $50 copay for Speech Therapy. The claim was adjusted on 7/11/23.	Procedural deficiency and overpayment remain. A $50.00 copay should have been applied for speech therapy, code 92507-GN.	☒ M ☐ S
Occupational Therapy				
27	$50.00	Agree. Claim should have applied $50 copay for Occupational Therapy.	Procedural deficiency and overpayment remain. A $50.00 copay should have been applied for occupational therapy.	☐ M ☒ S

Preventive Services				
Preventive Services Denied				
16	Unable to calculate.	Disagree. The claim denied correctly. The member had an annual wellness exam on file at the time of processing. The original preventive visit was denied for a billing error. The provider resubmitted the claim as a medical diagnosis.	Procedural deficiency and underpayment remain. This preventive visit, procedure code 99396, was denied in error. The claim data does not include another annual wellness exam claim paid during the FY2023 period. The original claim was denied on 12/5/22, both claims had the same wellness diagnosis.	☒ M ☐ S
PPO Provider Without Discount				
37	$2,890.80	Agree. Retiree Medicare entitled due to age, not entitled to free Part A. Part B effective 12/01/19, but retiree termed Part B effective 10/31/21. We should estimate Part B and coordinate. COB is updated now correctly. Per call to COBA 855-798-2627. Part A – Not entitled; Part B – Termed 10/31/21 Allowed greater than billed, confirmed that claims are auto-pricing with SHO. This claim was adjusted on 7/11/2023.	Procedural deficiency and overpayment remain. The member was eligible for Medicare Part B but terminated their coverage. Medicare payment of 80% should have been estimated instead of allowing billed charges per page 132 of the plan document.	☒ M ☐ S

Additional Observations

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

Observation	QID Number
A $40.00 copay should have been applied for the diagnostic mammogram, code 77066. UMR states the copay is only applied to the technical component claim, however, neither the technical nor professional component claim had the $40.00 diagnostic mammogram copayment applied.	23

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
- Overall 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 $388,157.28. The claims sampled and reviewed revealed $10,758.90 in underpayments and $0.00 in overpayments, for an absolute value variance of $10,758.90. This reflects a weighted Financial Accuracy rate of 98.12% over the stratified sample. This is an improvement 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 Q3 FY2023 of 99.4% for this measure. The penalty owed is 1.5% of the administrative fees of $1,237,363.10 or $18,560.45.

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 5 incorrectly paid claims and 195 correctly paid claims. This is also an improvement in performance 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	5	0	97.50%

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.

Performance improved from the prior period. UMR did not meet the Performance Guarantee for PEBP in Q3 FY2023 of 98% for this measure. The penalty owed is 1.0% of the administrative fees of $1,237,363.10 or $12,373.63. Detail is provided in the Random Sample Findings Detail Report below.

Correctly Processed Claims	Incorrectly Processed Claims		Accuracy
	System	Manual	
195	0	5	97.50%

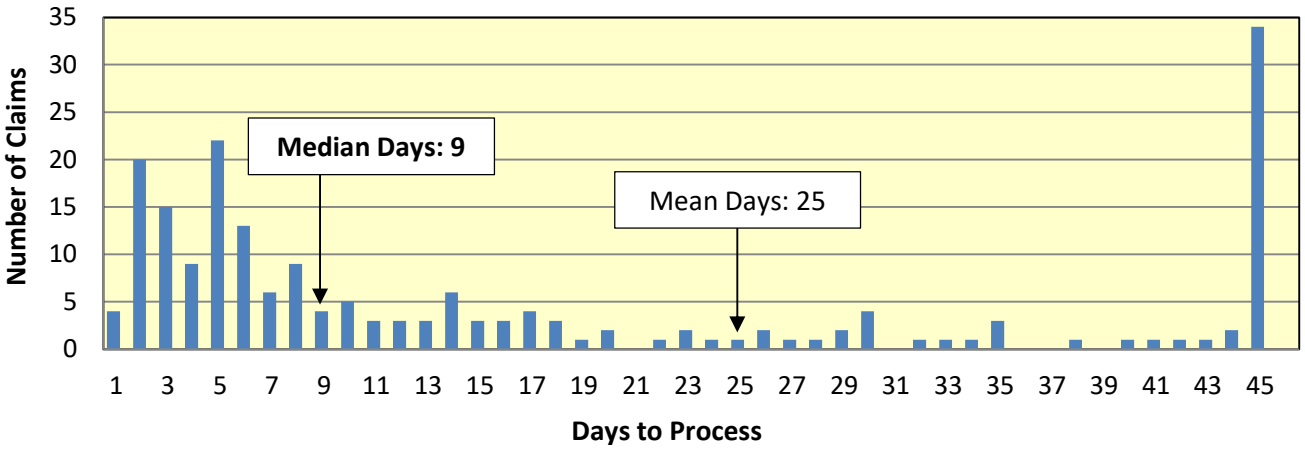
Random Sample Findings Detail Report				
Audit No.	**Under/ Over Paid**	**UMR Response**	**CTI Conclusion**	**Manual or System**
Denied Eligible Expense				
1037	($7,058.90)	Agree. CCN-xxxxxx01529 is a corrected claim to CCN-xxxxxx77099. The corrected claim was denied as a duplicate in error. Underpayment of $7058.90.	Adjudication error and underpayment remain for denial of eligible corrected claim submission.	☒ M ☐ S
2022	($102.00)	Agree with underpayment of $102.00.	Adjudication error and underpayment remain. Eligible expenses under Basic Services for 2-D oral images, procedure code D0350, were denied.	☒ M ☐ S
PPO Discount				
1072	($2,744.00)	Agree. This claim was processed without using the SHO pricing: REV 450 CPT 99284 ALLOW $2744. Family maximum OOP was met.	Adjudication error and underpayment remain due to application of incorrect provider discount.	☒ M ☐ S
1099	($804.00)	Agree. This claim was processed with the incorrect provider contract amount. The claim will be adjusted.	Adjudication error and underpayment remain for application of incorrect provider discount.	☒ M ☐ S
1150	($50.00)	Agree. Contract pricing was not utilized. Discount of $198.99 should have been applied to the claim. UMR agrees to an underpayment of $50.00.	An adjudication error and underpayment remain. The correct provider discount was not applied to the claim.	☒ 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 did not meet the Performance Guarantees for PEBP in Q3 FY2023 of 92% processed within 14 days and 99% processed within 30 days. This performance is worse than the prior period. The penalty owed for these two Performance Guarantees is 1.0% of the administrative fees of $1,292,524.65 for each metric or $25,850.50.

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 claims in the data 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	2	$1,504	$1,504	$741
				Totals	**2**	**$1,504**	**$1,504**	**$741**

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 99.25% 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.

		Claim Lines Submitted	Denied*	Applied Deductible		Applied Copay		Applied Coinsurance		Paid @100%		
Edit Guideline	Preventive Service Benefit	#	#	#	Amount	#	Amount	#	Amount	#	Amount	%
USPSTF-A	Hepatitis B screening - women	173	12	0	$0	1	$85	0	$0	113	$1,385	70.19%
USPSTF-A,B	Cholesterol abnormalities screening - women >19	790	33	0	$0	0	$0	0	$0	709	$10,800	93.66%
USPSTF-A	Cholesterol abnormalities screening - men 35-75	612	31	0	$0	0	$0	0	$0	548	$9,186	94.32%
HHS	Breastfeeding support and counseling - women	138	20	1	$110	1	$50	2	$162	114	$10,094	96.61%
HHS	Wellness Examinations - women	2,811	133	6	$4,507	0	$0	0	$0	2,634	$438,364	98.36%
USPSTF-B	Vision screening - 3- 5	143	10	0	$0	0	$0	1	$6	132	$4,469	99.25%
USPSTF-B	Healthy diet counseling	305	158	0	$0	1	$30	0	$0	146	$18,255	99.32%
USPSTF-A	Colorectal cancer screening - 45-75	770	31	0	$0	0	$0	0	$0	738	$341,185	99.86%
HHS	Contraceptive methods - women	683	45	0	$0	0	$0	0	$0	637	$123,064	99.84%
USPSTF-B	BRCA screening counseling - women	25	4	0	$0	0	$0	0	$0	19	$7,740	90.48%

*Claim lines denied may include claim lines denied as a duplicate on a previously processed claim.

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		Mod Use	Primary Description	Secondary Description	Line Count	Amount CMS Would Deny
Code	Mod	Code	Mod					
74177	TC	96374		YES	CT ABD & PELV W/CONTRAST	THER/PROPH/DIAG INJ IV PUSH	13	$9,104
					Standards of medical / surgical practice			
70496	TC	96374		YES	CT ANGIOGRAPHY HEAD	THER/PROPH/DIAG INJ IV PUSH	5	$3,757
					Standards of medical / surgical practice			
77280	TC	77336		YES	SET RADIATION THERAPY FIELD	RADIATION PHYSICS CONSULT	4	$3,500
					Misuse of column two code with column one code			
71275	TC	96374		YES	CT ANGIOGRAPHY CHEST	THER/PROPH/DIAG INJ IV PUSH	4	$2,870
					Standards of medical / surgical practice			
76819	TC	59025		YES	FETAL BIOPHYS PROFIL W/O NST	FETAL NON-STRESS TEST	3	$2,451
					Misuse of column two code with column one code			
49560		96361		YES	RPR VENTRAL HERN INIT REDUC	HYDRATE IV INFUSION ADD-ON	1	$1,922
					Misuse of column two code with column one code			
88331	TC	88333	TC	YES	PATH CONSULT INTRAOP 1 BLOC	INTRAOP CYTO PATH CONSULT 1	1	$1,623
					CPT Manual or CMS manual coding instructions			
90471		99282		YES	IMMUNIZATION ADMIN	Emergency department visit for evaluation &	2	$1,601
					CPT Manual or CMS manual coding instructions			
70553		70545		YES	Mri brain stem w/o & w/dye	MR ANGIOGRAPHY HEAD W/DYE	1	$1,601
					Misuse of column two code with column one code			
90471		99283		YES	IMMUNIZATION ADMIN	Emergency department visit for E&M of pati	1	$1,576
					CPT Manual or CMS manual coding instructions			
						Top 10 TOTAL	**35**	**$30,005**
						GRAND TOTAL	**307**	**$83,721**

Non-Facility (non-facility claims with CPT codes:00100 - 99999)								
Primary		Secondary		Mod Use	Primary Description	Secondary Description	Line Count	Amount CMS Would Deny
Code	Mod	Code	Mod					
45385	22	45380	51	YES	LESION REMOVAL COLONOSCOPY	COLONOSCOPY AND BIOPSY	1	$1,301
					More extensive procedure			
95925		95926		NO	SOMATOSENSORY TESTING	SOMATOSENSORY TESTING	1	$780
					CPT Manual or CMS manual coding instructions			
84481		84480		NO	FREE ASSAY (FT-3)	ASSAY TRIIODOTHYRONINE (T3)	14	$272
					More extensive procedure			
99203		99213	5	YES	Office/outpatient visit for E&M of new patient. 30	Office/outpatient visit for E&M of estab pat	1	$264
					Misuse of column two code with column one code			
90853		90834		YES	GROUP PSYCHOTHERAPY	Psytx pt&/family 45 minutes	2	$250
					CPT Manual or CMS manual coding instructions			
92541		92545		YES	SPONTANEOUS NYSTAGMUS TEST	OSCILLATING TRACKING TEST	1	$152
					CPT Manual or CMS manual coding instructions			
84439		84436		NO	ASSAY OF FREE THYROXINE	ASSAY OF TOTAL THYROXINE	16	$151
					More extensive procedure			
22633	AS	63056	AS	YES	Arthrodesis, combined posterior or posterolatera	Decompress spinal cord lmbr	1	$141
					Standards of medical / surgical practice			
90460		99393	5	YES	IM ADMIN 1ST/ONLY COMPONENT	PREV VISIT EST AGE 5-11	1	$126
					CPT Manual or CMS manual coding instructions			
92609	GN	92507	GN	YES	USE OF SPEECH DEVICE SERVICE	SPEECH/HEARING THERAPY	1	$108
					Misuse of column two code with column one code			
						Top 10 TOTAL	**39**	**$3,545**
						GRAND TOTAL	**67**	**$4,229**

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 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
97151	8	BEHAVIOR ID ASSESSMENT BY PHYS/QHP EA 15 MIN	4	$3,870
		Rationale: Clinical: CMS Workgroup		
A9581	20	GADOXETATE DISODIUM INJ	1	$1,500
		Rationale: Clinical: Data		
97152	16	BEHAVIOR ID SUPPORT ASSMT BY 1 TECH EA 15 MIN	1	$960
		Rationale: Clinical: CMS Workgroup		
J9395	20	INJECTION, FULVESTRANT	1	$582
		Rationale: Prescribing Information		
V2520	2	CONTACT LENS HYDROPHILIC	4	$440
		Rationale: Anatomic Consideration		
Q4038	2	CAST SUP SHRT LEG FIBERGLASS	2	$337
		Rationale: Anatomic Consideration		
83521	2	Immunoglobulin light chains free each	2	$323
		Rationale: Nature of Analyte		
Q4008	2	CAST SUP LONG ARM PED FBRGLS	2	$191
		Rationale: Anatomic Consideration		
87428	1	severe acute respiratory syndrome coronavirus and influ	1	$163
		Rationale: Nature of Analyte		
95999	1	NEUROLOGICAL PROCEDURE	1	$153
		Rationale: Clinical: CMS Workgroup		
		Top 10 TOTAL	**19**	**$8,519**
		GRAND TOTAL	**26**	**$7,544**

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	2	$1,935
		Rationale: Code Descriptor / CPT Instruction		
V2520	2	CONTACT LENS HYDROPHILIC	7	$759
		Rationale: Anatomic Consideration		
J2930	25	METHYLPREDNISOLONE INJECTION	1	$719
		Rationale: Clinical: Data		
A4595	6	TENS SUPPL 2 LEAD PER MONTH	2	$652
		Rationale: Code Descriptor / CPT Instruction		
B4034	1	ENTER FEED SUPKIT SYR BY DAY	3	$410
		Rationale: Code Descriptor / CPT Instruction		
V2521	2	CNTCT LENS HYDROPHILIC TORIC	4	$407
		Rationale: Anatomic Consideration		
A4253	1	BLOOD GLUCOSE/REAGENT STRIPS	8	$290
		Rationale: Nature of Equipment		
V2020	1	VISION SVCS FRAMES PURCHASES	2	$220
		Rationale: Clinical: Data		
E0443	1	PORTABLE 02 CONTENTS, GAS	1	$171
		Rationale: Code Descriptor / CPT Instruction		
B4035	1	ENTERAL FEED SUPP PUMP PER D	1	$169
		Rationale: Code Descriptor / CPT Instruction		
		Top 10 TOTAL	**31**	**$5,730**
		GRAND TOTAL	**38**	**$6,086**

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.

Provider Id	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	
	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
853859410	0	$0	1	100.0%	$30	1	$55	1	$32
880198997	0	$0	1	100.0%	$210	1	$104	0	$0
880175775	1	$171	1	50.0%	$171	1	$66	0	$0
880133501	7	$2,385	1	12.5%	$296	1	$144	0	$0
880107997	0	$0	1	100.0%	$707	1	$90	0	$0
870302621	0	$0	1	100.0%	$268	1	$150	0	$0
860857176	1	$166	1	50.0%	$146	1	$116	0	$0
582505541	0	$0	1	100.0%	$233	1	$129	0	$0
263147146	6	$936	2	25.0%	$311	2	$276	0	$0
260076062	3	$999	1	25.0%	$444	1	$101	0	$0
Top 10	**18**	**$4,656**	**11**	**37.9%**	**$2,815**	**11**	**$1,231**	**1**	**$32**
Overall Total	**33**	**$9,343**	**26**	**44.1%**	**$5,398**	**26**	**$2,892**	**1**	**$32**

CONCLUSION

UMR demonstrated improvement in Financial Accuracy, Overall Accuracy and Payment Accuracy from the quarter 2 FY2023 audit; and Claim Turnaround Time performance decreased.

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 INITIAL REPORT

Additional information submitted to CTI from the administrator in response to the initial 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 initial report.

UMR's response to the initial report follows:

Joni Amato
CTI
State of Nevada - PEBP
Updated Draft Responses
July 12, 2023

Hi Joni,

After our further review and per the discussion with the group on 7/11/2023, UMR has agreed to some of the previously disagreed with errors. We understand that these are selections from the Focused ESAS findings and are not used to report negatively on performance guarantees.

94 – UMR Agrees to a $162.52 overpayment.

103 – UMR Agrees to $131.26 overpayment. This claim was adjusted on 7/11/2023.

24 – UMR Agrees to a $50.00 overpayment. This claim was adjusted on 7/11/2023.

16 – UMR Agrees to this finding. The original preventive visit was denied for a billing error. The provider resubmitted the claim as a medical diagnosis.

23 – UMR Disagrees to this finding. A copay would never apply to the professional component of a mammogram; therefore, this claim is processed correctly.

61 – UMR Agrees with this finding. UMR is contacting provider for correct billing.

37 - UMR Agrees with this finding. This claim was adjusted on 7/11/2023.

Thank you for the opportunity to address these claims. Please let me know if you have any questions.

Sincerely,

Lori Fish
UMR External Audit Coordinator

115 West Wausau Ave
Wausau, WI 54401

CLAIM TECHNOLOGIES INCORPORATED
100 COURT AVENUE SUITE 306
DES MOINES, IA 50309

June 19, 2023
Revised June 22, 2023

Joni,

Thank you for the opportunity to respond to the recent review of the State of Nevada Public Employees' Benefit Program Q3Y23 audit draft report. The following is our response to the draft report completed by CTI.

Findings

UMR has reviewed samples for each of the **Categories for Potential Amount at Risk.**

- **Duplicate Payments** Providers and/or Employees
  - UMR is implementing process upgrades to reduce the number of claims paid as duplicates
- **Exclusions** Massage Therapy
  - Claims are considered based on provider contract. Review and feedback were conducted with the responsible processor(s).
- **Limitations** Pre-certification for DME in Excess of $1000.00
  - UMR has a robust editing system to identify claims requiring pre-certification. From the sample claims provided by CTI, 94% did not require pre-cert, 6% have auth on file.
- **Fraud, Waste, and Abuse**
  - **Specialty Medications**
    - The claims are pended and reviewed based on the State of Nevada guidelines.
  - **Pain Specialist**
    - Claims are considered based on provider's contract and State of Nevada Plan benefits.
  - **DME Over Medicare Allowance**
    - Claims are considered based on provider's contract and State of Nevada Plan benefits.
  - **Copay Application**
    - Claims are considered based on provider specialty.
  - **Preventive Services**
  - UMR's standard approach includes preventive care services which are mandated by HCR to be allowable at no cost sharing when delivered by a network provider.
  - **PPO Provider Without Discount**
    - Claims are considered based on provider's contract.

715-841-3284 www.UMR.com lori.fish@umr.com

UMR respectfully requests that the 'Categories for Potential Amount at Risk' be removed from this report. Our extensive review shows that most claims are processed correctly. The financial accuracy from the random samples in the audit, of 200 claims 194 paid correctly. The audit firm noted 97% accuracy.

ESAS Targeted Sample Analysis

Duplicate Payments

QID- 41, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 56, 57, 58, 59, 60, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 7576, 77, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 95, 96, 97, 98, 99, 100 UMR Agrees to duplicate payments for Dental. These claims were submitted by the provider as two claims for the same date of service with different billed amounts. UMR is committed to system upgrades to expand our duplicate claim logic. All claims have been adjusted.

QID 61- UMR Disagrees with this finding. Each claim identified has a different Tax IDs and billing address. Our efforts to upgrade UMR's system for duplicate logic is underway.

QID 79- UMR Disagrees with this finding. CPT 90833 CCN 23066246110 – provider billed claim to UMR EDI for UMR to pay as secondary. CCN 23027175912 – crossover claim from Medicare.

QID 94- UMR Disagrees with this finding. CPT 90792 CCN 22320373527 - Different TINS billing issue but same provider - education to the billing vendor has been provided.

Plan Exclusions

QID 133- UMR Agrees to $50.00 overpayment. The claim is pended and reviewed based on Procedure and Diagnosis selections are coded in the UMR system to identify these claims. Massage Therapy is excluded on this plan. This claim should have been denied. Review and feedback were completed with the responsible processor. The claim has been adjusted.

Limitations

QID 143- UMR Agrees to a $3854.40 overpayment. No authorization is on file for this DME. The claim was processed in error. Review and feedback were completed with the responsible processing team. The claim has been adjusted.

Specialty Medications

QID 106- UMR Agrees to a $147.50 overpayment. Pricing was not properly obtained resulting in a $147.50 overpayment. The claim was reprocessed on 5/5/23 to reflect corrected pricing.

QID 109- UMR Agrees to a $1045.90 overpayment. Claim should be repriced. All therapies and supplies that are not itemized shall be reimbursed at 50% of provider's billed charges for per diems, and at AWP - 10% for pharmaceuticals. Allowable would be 0.76 * 6 units on bill = 4.56 * 90% = 4.10 allowable. Review and feedback were completed with the responsible processor. The claim has been adjusted.

UCR Provider Specialty-Pain Specialist

QID 118- UMR Agrees to a $1906.48 overpayment. Claim was paid at billed charges. Pricing has been obtained and the claim is processed correctly. Review and feedback were completed with the responsible processor.

Durable Medical Equipment

QID 103- UMR Disagrees with this finding. The Choice Plus fee schedule rate for the rental of E0601 is $43.96.

QID 104- UMR Agrees to a $618.61 overpayment. This specific CPT paid at 90% of Medicare allowable according to the network contract. Review and feedback were completed with the responsible processor. The claim has been adjusted.

Office Visit – Specialist

QID 25- UMR Disagrees with this finding. The claim paid correctly per plan benefits.
QID 26- UMR Disagrees with this finding. The diagnosis on the claim is routine exam, (Z0000). Preventive services are covered at 100%, no cost share.
QID 29- UMR Disagrees with this finding. This is a prenatal visit with no cost share.

Office Visit - PCP

QID 20- UMR Disagrees with this finding. Claim are reviewed based on services billed. Procedure and diagnosis selections are coded in the UMR system.
QID 21- UMR Disagrees with this finding. Claims are reviewed based on services billed. Procedure and diagnosis selections are coded in the UMR system to identify these claims.
QID 28- UMR Agrees that a $30.00 copay for PCP visit should have been assessed. The claim has been adjusted.

Diagnostic Mammogram

QID 19- UMR Agrees with an underpayment of $1.14. The claim should have applied a $40.00 copay for diagnostic mammogram. The claim has been adjusted.
QID 23- UMR Disagrees with this finding. Claims are reviewed based on services billed. Procedure and Diagnosis selections are coded in the UMR system to identify these claims.

Speech Therapy

QID 24- UMR Disagrees with this finding. The claim priced and processed correctly.
QID 27- UMR Agrees with this $50.00 overpayment. Claim should have applied a copay. The claim has been corrected.

Preventive Services

QID 16- UMR Disagrees with this finding. The claim denied correctly. The member had an annual wellness exam on file at the time of processing.

PPO Provider Without Discount

QID 37- UMR Disagrees with this finding. Retiree Medicare entitled due to age, not entitled to free Part A. Part B effective 12/01/19, but retiree termed Part B effective 10/31/21. We should estimate Part B and coordinate. COB is now correctly updated. Per call to COBA 855-798-2627. Part A – Not entitled Part B – Termed 10/31/21 Allowed greater than billed, confirmed that claims are auto-pricing with SHO.

Random Sample Findings

Denied Eligible Expenses

Sample 1037- UMR Agrees to an underpayment of $7058.09. The corrected claim was denied as a duplicate in error.
Sample 2022- Dental – UMR Agrees with an underpayment of $102.00.

PPO Discount

Sample 1072- UMR Agrees to an underpayment of 2744.00. This claim was processed without using the SHO pricing: REV 450 CPT 99284 allow $2744. Family maximum OOP was met.
Sample 1099- UMR Agrees to an underpayment of $804.00. This claim was processed with the incorrect provider contract amount. The claim has been adjusted. Review and feedback were

completed with the responsible processor.
Sample 1150- UMR Agrees to an underpayment of $50.00. Contract pricing was not utilized. Discount of $198.99 should have been applied to the claim. The claim has been adjusted. Review and feedback were completed with the responsible processor.

Deductible Error

Sample 2026- Dental - UMR Disagrees with this finding. This claim paid correctly. Deductible was applied on this claim

UMR Editing system

UMR has a robust claim editing system. This is explained here.
Provider Claims:
■ Internal system edits: We include both CPS edits and benefit coding configuration/edits in this group. All claims received at UMR are subject to all internal system edits as defined:
■ CPS edits: These include edits for elements such as: duplicate claims, fraud control, potential third-party liability, medical necessity, and eligibility. Our claim payment system also edits for experimental and/or investigational care, and cosmetic coding.
■ Benefit coding configuration/edits: Our internal coding includes items such as: coordination of benefits (COB) option, deductibles, out-of-pocket maximums, participation, and plan maximums.
■ Reimbursement policy edits: Depending on the individual provider's relationship with UMR, each provider claim is routed through additional software, sometimes referred to as clinical editing software.
■ UnitedHealthcare providers: All UnitedHealthcare network provider claims are routed through the Ingenix Claims Edit System (iCES), an internal system, to review for bundling, unbundling, inappropriate diagnosis codes, age edits and other reimbursement policy edits specific to the provider contract.
■ Non-UnitedHealthcare and non-network providers: We purchase Claims Edit System (CES) software from Optum, and route provider claims through this system to review for bundling, unbundling, upcoding and other provider billing practices.
Hospital/Facility Claims: Hospital claims are subject to internal system edits, however, because these claims are billed with revenue codes that can include a range of services, rather than CPT/HCPCS codes, we do not review hospital claims for unbundling. Revenue coding limits the opportunity for unbundling. We also perform hospital bill reviews/large bill reviews on these claims

Summary

UMR is dedicated to improving the overall experience for the State of Nevada PEBP members and will continue to work diligently on addressing any issues highlighted by this review. Our efforts to upgrade UMR's system for duplicate logic is underway. Coaching and ongoing training is held with our dedicated processors. We continue to meet with the staff daily to go over quality reports, identifying trending errors, initiating refresher training for skill gaps, and using this data to improve the overall quality of the staff.
If you have any questions or concerns regarding our responses, please feel free to contact me at 715-841-3284

Sincerely,

Lori Fish
UMR External Audit Coordinator

CLAIM TECHNOLOGIES INCORPORATED

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

(515) 244-7322 • claimtechnologies.com

10.

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

    10.1 Contract Overview
    10.2 New Contracts
    10.3 Contract Amendments
    10.4 Contract Solicitations
    10.5 Status of Current Solicitations

JOE LOMBARDO
Governor

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

CELESTENA GLOVER
Interim Executive Officer

JACK ROBB
Board Chair

AGENDA ITEM

[X] Action Item
[ ] Information Only

Date: July 27, 2023

Item Number: X

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

10.1 Contracts Overview

Below is a listing of the active PEBP contracts as of June 30, 2023.

PEBP Active Contracts Summary							
Vendor	Service	Contract #	Effective Date	Termination Date	Contract Max	Current Expenditures	Amount Remaining
Eide Bailly	Financial Auditor	27703	7/11/2023	12/31/2026	$ 386,500.00	$ -	$ -
Health Plan of Nevada Inc	Southern Nevada HMO	23802	7/1/2021	6/30/2025	$ 192,093,848.00	$ 3,699,209.47	$ 188,394,638.53
Diversified Dental Services Inc.	Dental PPO	23810	7/1/2021	6/30/2026	$ 1,601,613.00	$ 637,666.77	$ 963,946.23
Lifeworks	Benefits Management System	25935	5/10/2022	12/31/2026	$ 6,145,600.00	$ 2,069,878.48	$ 4,075,721.52
Express Scripts, Inc.	Pharmacy Benefit Manager	25582	5/10/2022	6/30/2026	$ 332,109,496.00	$ 77,597,259.29	$ 254,512,236.71
United Healthcare Insurance	Group Basic Life Insurance	25607	7/1/2022	6/30/2026	$ 12,824,248.00	$ 3,493,506.59	$ 9,330,741.41
Brown & Brown of Massachusetts	Health Plan Auditor	24030	4/13/2021	6/30/2027	$ 1,581,662.00	$ 403,859.00	$ 1,177,803.00
Segal Company, Inc.	Consulting Services	25557	7/1/2022	6/30/2027	$ 4,285,410.00	$ 734,280.00	$ 3,551,130.00
HAT LTD, DBA Manpower	Temporary Employment	23928	1/1/2023	12/31/2023	$ 107,900.00	$ 74,566.72	$ 33,333.28
Capitol Reporters	Court Reporting	27029	2/1/2023	6/30/2025	$ 31,932.00	$ 4,110.00	$ 27,822.00
Vivo Technologies	Board Room Equipment Install	27417	4/1/2023	7/31/2023	$ 13,830.00	$ 3,457.50	$ 10,372.50
UMR, Inc.	TPA and Other Services	25155	7/1/2022	6/30/2028	$ 65,413,106.00	$ 9,344,882.04	$ 56,068,223.96

Recommendation

No action necessary

10.2 New Contracts

NO NEW CONTRACTS

Recommendation

No action necessary

10.3 Contract Amendment Ratifications

NO NEW CONTRACT AMENDMENTS

Recommendation

No action necessary.

10.4 Contract Solicitation Ratifications

PEBP does not currently have any contract solicitations for ratification.

10.5 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	05/26/23	07/13/23		Sept. 2023
Oncology Management Program	08/01/23	09/05/23		Sept. 2023

11.

11. Public Comment

12.

12. Adjournment